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Developing your contracts and fair market value Spidey sense for compliance officers, Part 2

by Drew Williamsen, MHA, CHC, CHPC

In part one of this article, I focused on the various contracting arrangements and potential issues to be on the lookout for, for each respective type of contract.[1] I also went over red flags that may appear in a contracting arrangement—regardless of type—and how, depending on what information is or is not present, these red flags may lead to a "shell company." Shell companies aren't always bad, but be honest, don't you think of someone doing something shady when you hear or read the term "shell company?"

In this second part of the article, I will focus on fair market value (FMV) and conclude by looking at the "medically impossible day."

FMV

FMV can be confusing. It can be hard to figure out. First, FMV is not "average" compensation. It is not just a "salary" for a provider. Second, there are many fair market valuation organizations where data can come from. I recommend looking into several to see which one works best for your organization's needs if you haven't contracted with one (or two) already.

There are numerous free publications and articles that discuss trends in provider compensation; if you are interested, I suggest reading those to see what is happening in the compensation arena. This way, you can know something is wrong when you see a contract that says a neurosurgeon is to be paid $3.8 million. Depending on which FMV company your organization utilizes, you might find that the 90th percentile for neurosurgery is around $1.2 million (as it was in 2018). If you read numerous industry articles, you'll also find that the average pay for a neurosurgeon is not $1.2 million; it is actually far less. To build up one's *Spidey sense*, one needs to study or at least encounter several examples of what is and is not FMV as it relates to contracts.

Calculation

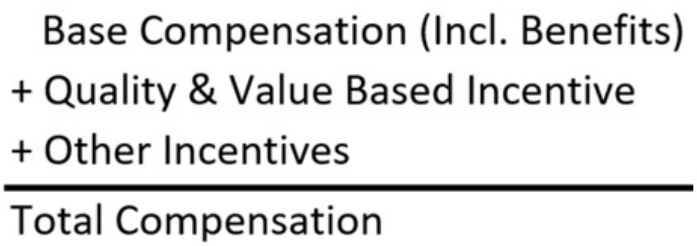
FMV is calculated by taking the entire sample of responding providers and laying out their actual compensation from lowest to highest. FMV ends up being a statistical bell curve. For example, If I were to conduct a study with 782 respondents, I would likely have a listing of 782 different numbers, all ordered from lowest to highest. The median, or 50th percentile, would be whatever the compensation is for the 391st reported compensation figure, which is right in the middle, or "median," of the pack of numbers. The 50th percentile, or median, is *not* the average. From there, math is done to determine the 75th, 90th, and all other compensation percentiles. This same process occurs when determining the work relative value unit, or wRVU. The wRVU is a methodology to help determine productivity without directly looking at the referral's volume or value. Organizations that provide

FMV will include wRVU numbers alongside the corresponding percentiles. If you ever took a statistics class, think back to what you learned; this will help you better understand how the numbers are calculated.

Suppose a proposed contract states that a provider should receive the 75th percentile of FMV; that means the provider would be earning more than or equal to three-fourths of the respondents of the associated survey, which is the top quartile of pay, again, at least according to the survey used.

To make matters even more confusing, the best practice for determining compensation isn't just providing a dollar amount based on statistical sampling. If it is proposed in a contract that a provider has a base pay of $300,000, plus the opportunity to earn more for quality- and value-based incentive pay, plus any other compensation or bonuses, the total should come right close to whatever the FMV is for the specialty at the chosen percentile. For instance, let's say the quality and value-based pay incentives maxed out at $50,000, and no other compensation or bonus money is listed in the contract; in theory, the provider would be at $350,000, which would be 75th percentile of FMV of our made-up scenario. In all likelihood, there is a good chance the provider would not earn the full quality incentive bonus as some metrics are meant to really push the limits of quality and value-based incentives; in-turn, the provider would not reach $350,000, putting the provider somewhere below the 75th percentile for actual total compensation. Here is a simple formula for determining actual compensation based on FMV:

Figure 1: Sample formula for determining actual compensation



Again, in our simple scenario including the previous mathematical formula, total compensation equals the selected FMV percentile. Scenarios can get much more complex and typically aren't this cut and dry. In December 2020, it was stated in the Stark Law Final Rule that the Centers for Medicare & Medicaid Services (CMS) expressly disavowed having any policy that compensation set at or below the 75th percentile of the physician compensation survey data is always appropriate, and that compensation above the 75th percentile is "suspect, if not presumed inappropriate."[2]

In plain terms

Well, in plain terms, just because it is at or above the 75th percentile does not mean it is bad, and just because something is below the 75th percentile doesn't always mean it is good or appropriate.

How many times has there been a provider who works harder than anyone, has very high-quality scores, meets all the incentive benchmarks, and is the type of provider that every CEO wishes they could have more of but doesn't get the pay they deserve because the organization has an archaic policy about only paying every provider at the 50th percentile no matter what? This scenario is exactly what CMS is trying to get at. Organizations need to be fluid in their approach to compensation. Should a new physician straight out of residency or fellowship receive the same compensation as an established and experienced physician of 25 years?