VALUATION OF PROFESSIONAL SERVICES ARRANGEMENTS: AN ALTERNATIVE TO THE TRADITIONAL PHYSICIAN EMPLOYMENT MODEL

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As the hospital/physician landscape continues to evolve, both parties are continually looking for ways to improve their alignment opportunities. The goals of such improved alignment are often focused on better clinical outcomes and improved financial integration.

One area that is gaining increased traction is the professional services arrangement ("PSA"), with a particular emphasis on implementing the PSA model in lieu of a traditional employment arrangement. Sometimes referred to as a "foundation model" or a "synthetic employment arrangement," the PSA allows the target physicians to maintain their autonomy as a free standing group practice, receiving compensation from the hospital in exchange for providing clinical services, but without the day-to-day obligations of running a business.

From the hospital's perspective, the model allows for a significant degree of flexibility in aligning with a group while avoiding physician concerns over loss of autonomy or inability to easily "unwind" the arrangement should the relationship not work out as planned. In a typical PSA model, the hospital will employ all non-physician staff of the group, and will contract with the group practice to provide professional, clinical services to its patients. In exchange, the group receives a set rate of compensation, typically paid on a "per unit" basis, often calculated to include employment taxes, benefits and certain other retained practice expenses.

This article discusses this emerging compensation arrangement, with a particular emphasis on the rationale of the structure, determination of the appropriate "per unit" compensation rate, and varying issues that can affect the fair market value[1] ("FMV") compensation in such arrangements.

Rationale for The PSA Model

With the possible exception of television stars, it seems that no one in business re-invents themselves more than physicians and hospitals. In response to ever changing regulations,[2] whether actually implemented or simply proposed, these two parties are continually exploring new ways to relate with one another, offset changes in reimbursement structures and address the payors' (and patients') demands for ever improving clinical outcomes.

Existing against the backdrop of these environmental dynamics is an issue of lifestyle. Physicians are simply placing less and less emphasis on the days of old (*e.g.*, maintaining weekend office hours, taking many days of call coverage each month, etc.), and focusing on spending more time with family, while educating themselves on technological practice advancements. Enter the PSA: a contractual vehicle that is gaining in popularity in response to this market imperative to integrate for quality and efficiency improvement, while addressing some physicians' aversion to making the leap to full-employment.

Structured properly, the PSA is a potential financial and operational win/win. The hospital gets to leverage its infrastructure, payor contracts and provider-based status (for billing of ancillaries), while the physicians receive FMV compensation for clinical services (and can distribute such compensation within their practice group as they see fit, subject to certain constraints), a market based allowance for benefits and malpractice insurance, plus the opportunity to contract with the hospital for staffing and/or management services integral to the effective operation of the service line.

There are three main reasons why the PSA model is on the rise: (i) the decline of the independent physician model due to decreasing or uncertain reimbursement trends, increasing risk for physicians, and lifestyle considerations; (ii) the emergence of integrated health strategies, accountable care organizations ("ACOs"), and shared savings programs, including the Medicare Shared Savings Program ("MSSP") with the intent of collaborative efforts improving outcomes and reducing costs; and (iii) the offer of a viable alternative to the employment model, which cannot be used in many states and has drawbacks such as the relative lack of physician autonomy.

While the PSA model may not be desirable or even possible in all states, the corporate practice of medicine restrictions in some states may "completely bar" the employment model, making the PSA model the only viable alternative to independent practice. Many states do have exceptions for hospital-physician arrangements or some other legal vehicle (such as the foundation model in California) that allows for a similar type of PSA model relationship to be utilized.

Productivity Metrics and The Various Valuation Approaches

The typical underpinning of the PSA model is that in lieu of a traditional employment arrangement, the physician (or group, as applicable) maintains its group practice entity. The

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physician enters into an arrangement under which a hospital purchases the tangible assets and/or leases certain non-clinical staff from the physician, and then provides compensation to the physician in exchange for the provision of clinical services. Whereas a traditional employment arrangement has the ability to include a variety of compensation approaches, the PSA is typically based upon personally performed productivity, largely to avoid any possible concern over the physicians having an ownership interest in the entity performing the designated health services ("DHS") under the Stark law.[3] The most commonly used (and likely most supportable) metric is the use of work relative value units ("wRVUs"), as not only do they directly relate to the work effort of the physician, but as appropriate, also allow the hospital to "gross-up" the rate to include taxes and benefits as well as retained practice expenses (*i.e.*, malpractice insurance, CME costs, etc).[4]

The development of the applicable wRVU rate necessitates careful evaluation of FMV, and is the main area where hospitals have tended (to their potential detriment) to *overestimate* the use of a single methodology (*e.g.*, simply relying on median rates from the benchmark compensation surveys, or only relying on an internally calculated market approach, and ignoring the results of a cost or income approach).[5]

By way of background, nearly all transactions between hospitals and referring physicians implicate the Stark Law.[6] Therefore, they are required to fit into an applicable Stark law exception, otherwise they are prohibited.[7] The potential penalties for failing to meet the Stark law requirements include repayment of all tainted claims and punitive payments, as well as possible loss of Medicare eligibility. The exceptions to the Stark Law which are applicable to PSA model arrangements all require the compensation under compliant transactions to be *consistent with* FMV (as do exceptions related to employment arrangements), and importantly, the Stark law defines FMV differently from traditional notions of the term in other settings (most importantly, the IRS definition), thereby affecting the valuation approaches that can be utilized to value a particular arrangement.[8] Nevertheless, valuators generally consider the same three approaches that are applied to assets when valuing service arrangements under the Stark FMV standard. The major approaches to value include the Cost, Income and Market Approaches, and their application to PSA model arrangements will be described in greater detail below.[9]

In many respects, the valuation of PSAs is analogous to valuation of employment arrangements, since both models share many common characteristics. Many of the same approaches and techniques are utilized, with the major difference being that the physicians maintain their own practice entity and direct responsibility for certain costs (*e.g.*, taxes, benefits, etc.) requiring appropriate adjustment in the analysis.

The determination of FMV with regard to the wRVU rate will often require the valuator to undertake multiple approaches, as there could be anomalies in the underlying data that negates (or mitigates) reliance on one approach over another. For example, sole reliance on a Market Approach may not take into consideration the high percentage of poor payors in the area and/or the atypical cost structure of the target physician's practice. On the other hand, an Income Approach may yield over-inflated indications of value if the valuation firm overlooks the need to incorporate an "owner's return" in the calculations. Furthermore, the Income Approach may not be able to be performed at all if the target physician practice is unable to provide usable financial information.

With regard to a Market Approach, while in many ways it is the most straightforward (and relied upon) methodology in the context of making an FMV determination of a PSA, it is not without its drawbacks, the biggest of which is its singular dependence on making a comparison to available survey data.

Essentially, a Market Approach involves a process under which a target physician's performance is compared against available benchmark data. Unfortunately, data from otherwise reliable sources can be "misused" in a variety of ways, and in the context of a PSA or employment agreement analysis, there is potential for (i) over-emphasis on regional compensation differences; (ii) "cherry picking" from among different surveys or survey tables; (iii) failure to consider ownership/ancillary profits that may be inherent in 90th percentile compensation reported by market survey data;[10] and (iv) assuming that there is always correlation between the reported data for compensation and productivity. As such, it is prudent to review and analyze multiple metrics of productivity, including wRVUs, professional collections, median compensation per wRVU, etc. Through the use of a "percentile matching technique," the valuator will match up each productivity variable with the corresponding expected level of compensation. Since each variable has certain characteristics that may yield unintended results, the valuator will make a "weighting" determination, primarily based on the unique facts of the arrangement as well as the validity of the data.

The general correlation of reported compensation and productivity is well documented in Medical Group Management Association ("MGMA") and other physician compensation surveys,

though the degree and strength of correlation varies depending on physician specialty and circumstances. This is an inherently logical and fair result. However, while compensation and productivity are often correlated, parties are often surprised to learn that ***compensation is inversely correlated with reported productivity ratios***. This result suggests that the correlation between compensation and productivity data is simply not linear (*i.e.*, when compensation is plotted against productivity on a graph, the result is a curve shaped relationship – meaning that as productivity increases, compensation still increases, but not as rapidly at higher levels as it increases at lower productivity levels). This counter-intuitive result is where substantial confusion lies, and risks the possibility of a significant valuation error.

In contrast to the Market Approach, the consideration and use of the Cost and Income Approaches can serve to offset and mitigate the limitations of the Market Approach. While sufficient data is not always available to allow the use of all three approaches, particularly with the valuation of PSAs and employment arrangements, the use of multiple approaches allows the valuator to consider the totality of marketplace considerations in appraising a service arrangement. Furthermore, the Cost and Income Approaches allow a view into the local marketplace, as the valuator can incorporate into the analysis a full array of economic factors that may be affecting compensation of the target physician.

Under the Cost Approach, a valuator endeavors to understand the historical compensation levels of the target physician in order to make a determination about the FMV of a proposed compensation arrangement. However, the relevance of a physician's historical compensation depends on the degree of "comparability" between the physician's practice and the proposed employment arrangement. Historical compensation can be considered as an indication of the FMV for the services provided by a physician as long as the service arrangement and corresponding compensation meet certain criteria. These criteria include the following:

- The physician and the entity contracting with the physician for services did not have a referral relationship that resulted in a non-arm's-length compensation for purposes of establishing FMV under applicable healthcare regulations.[11]
- The services provided historically are substantially similar to those services that will be provided under the proposed service arrangement.
- The services are provided in an operational and/or clinical setting that is comparable to the setting under the proposed arrangement.

To undertake the analysis, the valuator will obtain "historical" practice financials for the target physician, and then make a series of normalizing adjustments to allow for an effective comparison. The adjustments to historical compensation include those that make the historical service arrangement comparable to the proposed arrangement in terms of the scope of services provided, the benefits paid in addition to cash compensation, and certain normalized operating costs associated with the provision of the services. The adjustments for normalized benefits and operating costs are made so as to place the key economics of the arrangement on a comparable basis with those expected in the marketplace.[12]

Similar to the Cost Approach, the Income Approach also requires certain financial data, but instead of normalizing historical information, the valuator will request a practice pro-forma statement of operations to be developed by the hospital.[13] The Income Approach can be used to forecast the "distributable earnings" available for physician compensation in a practice. From this amount, the valuator would make a deduction from the distributable earnings for an estimate of market-level benefits for the physicians. In addition, recognizing that there is a carrying cost to the deployment of required assets required to operate a practice, the valuator would also make a deduction from distributable earnings to account for an appropriate "owner's return on invested capital" in order to arrive at the guideline level of compensation for physician services. The valuation concept behind this approach is that a forecast of the distributable earnings reflects the future value of the physician services provided to the practice. The forecast, however, should be prepared consistent with the conceptual framework of FMV, which entails the assumption that the practice will be operated by a hypothetical, typical employer entity.

Once all applicable approaches are completed, the valuator must synthesize the results to arrive at the applicable indication of FMV compensation. In performing this synthesis, the valuator should consider whether one or more approaches yielded values that do not appropriately reflect the intent of the agreement, and each approach is assessed in terms of its relative strengths and limitations. For example, the valuator may believe that the Cost Approach, reflective solely of past expense structure and physician earnings, may not be reflective of future expenses and reimbursement levels (and thus future compensation) under a proposed arrangement. Alternatively, the valuator may ascertain that the pro-forma developed by the hospital may appear to include unreasonable assumptions. Regardless, the valuator will typically identify one or more of the approaches as yielding relevant values, and will determine the appropriate "weighting" to apply to each in order to calculate the applicable level of FMV compensation. This resulting compensation range is then converted into the proposed compensation structure to allow for a meaningful comparison.

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Potential Problems with the Valuation Process

Potential Misuse of Survey Data

In reviewing salary survey data (*e.g.*, MGMA[14]), it is important to note that while such surveys are heavily relied upon, they are not always the definitive snapshot of physician compensation in the marketplace. The widely used reference compensation surveys from MGMA, AMGA,[15] and other associations and organizations are based on voluntary participation by the respondents, without the use of any statistical sampling methods or means of validating the responses. As such, without a careful review and application of the data, the user may not realize that selecting reference values from different tables could lead to problems (*e.g.*, selecting national wRVU levels but regional compensation), or may fail to recognize that ownership and/or ancillary profits *may* be inherent in the higher percentiles of reported compensation. Following are four of the more commonly observed misconceptions and/or misuses of the compensation surveys:[16]

1. Misconception: Surveys Present Compensation Only for Physician Clinical Services

As instructed by the survey questionnaires, it is intended that *total cash compensation* from all sources, including clinical services, ancillaries (and technical revenues), medical directorships, on-call coverage, other service arrangements and owner compensation, be reported. Therefore, it can be rather easy to create a compensation "stacking" issue if one assumes that the survey data relates only to clinical services. A "stacking" issue refers to a situation where several different elements of compensation are separately evaluated and compared to total compensation survey data and deemed to be consistent with FMV on an individual basis. However, when such elements are "stacked" together in a comprehensive employment arrangement, the results far exceed survey data for total compensation. As such, the appropriate method is to also compare aggregate compensation to total compensation survey information to ensure that aggregate compensation is consistent with FMV. Stacking is discussed in greater detail below.

2. Misconception: Productivity Ratios Should Correlate with Actual Productivity (i.e. Compensation per wRVU Should be Higher if a Physician Generates More wRVUs)

In fact, the MGMA survey has clearly stated since 2009 that, in its reported survey data, there is an "inverse" relationship between productivity and the compensation per wRVU rate.[17] As such, the highest wRVU producers have the lowest comp/wRVU rate. This result is somewhat counterintuitive, and leads to substantial confusion and valuation risk.

3. Misconception: The Median Compensation per wRVU Always Represents FMV

This assumption defies statistical validity, as by the very definition of the term "median," 50 percent of the respondents make *less* (and perhaps far less) than this amount. As such, while it may sound conservative, simply defaulting to the median compensation/wRVU value as an indication of FMV may lead to an overcompensation bias in the arrangement. Thus, while 50 percent of respondents do make more than the median compensation per wRVU rate, 50 percent make less, and thus, determination of the appropriate rate requires analysis of specific circumstances and substantial care to ensure the rate properly accounts for the inverse relationship between productivity ratios and productivity itself (see misconception #2 above).

4. Misconception: Surveys Reflect the Current State of the Physician Marketplace

The major compensation surveys are published annually, and reflect the marketplace of the prior year. Thus, they are likely not reflective of any known reimbursement or marketplace changes that are impending or which have occurred since the data was gathered. Compensation from year to year is variable and volatility is due to several factors, including geographic location, cost of living, economic conditions, and most importantly, changes in reimbursement patterns and medical advancements. Furthermore, the surveys only reflect the outcomes for those that responded, an inherent bias in and of itself.

The wRVU Model: Common Mistakes

As with most aspects of a transaction, the "devil is in the details," and the proper calculation and treatment of wRVU's is no exception, especially in the PSA, as the compensation is almost always exclusively based on physician productivity. By way of additional background, the wRVU is one of three components that make up the "total" RVUs used by Medicare (and many other payors) in the adjudication of physician claims. Unfortunately, if not careful when compiling the historical productivity information for a physician or group practice, a possible mistake is to inadvertently report *total* RVU's (*i.e.*, to also include relative values for practice expense and malpractice risk) and not simply work relative values (*i.e.*, those solely related to the work effort of the physician). As such, a physician's expected productivity may be significantly overstated, and thus, in any applications of the market approach which attempt to appropriately match compensation with productivity, the resulting indications of FMV compensation will be commensurately overstated.

A second area that can result in an overstatement of wRVUs results from the failure to consider CPT coding modifiers.[18] As an example, a physician reporting a CPT code for a surgical procedure could have been an *assistant at surgery* which carries a reduced wRVU rate than for the primary surgeon. Similarly, when a surgeon performs multiple procedures on the same patient, the appropriate modifier must be used, as all follow-on procedures to the primary surgical event are subject to a reduction in value.

Other less common issues that lend themselves to possible errors in calculation are as follows:

Use of Midlevel Providers

Midlevel providers refer to non-physicians who provide medical care, such as nurse practitioners, physician assistants, imaging technologists, and other similar providers. This is always a tricky aspect of a PSA analysis, as the valuator needs to be careful to address where the midlevel provider resides in the equation (*e.g.*, if the physician is leasing the midlevel to the hospital, which is the most common practice, the benefit of any work performed, whether "incident to" (which refers to office-based services provided by the midlevel under the physician's supervision which are typically reimbursed at full physician rates) or at the "midlevel provider rate" (typically services performed by midlevels in a hospital setting, where "incident to" billing is not allowed under Medicare rules, and which are reimbursed at about 80 percent of the physician rate) would accrue to the hospital). However, if the midlevel remains the financial responsibility of the physician (for example, as reflected on the practice financials in a PSA arrangement), then it would be appropriate to have the legitimate "incident to" wRVUs count toward the physician's productivity.

Use of Blended Rate for Multiple Specialties

It is becoming increasingly common for hospitals to contemplate entering into PSA's with multi-specialty physician practices (*e.g.*, a cardiology practice that includes general cardiology, interventional cardiology and electrophysiology). Furthermore, for ease of administration, the hospital may want to pay the same compensation rate per wRVU regardless of the subspecialty. In this scenario, it is important not only to (i) calculate an applicable rate per wRVU for each subspecialty, but (ii) also obtain historical information relative to the percentage mix of wRVUs for each subspecialty, such that the applicable "weighted average" rate can be calculated. Lastly, it is also paramount to run a series of sensitivity analyses at varying levels of potential total wRVUs to ensure that the blended number still yields FMV results, regardless of the level of productivity.

One final area that deserves comment relates to the inclusion of applicable taxes and benefits in the wRVU rate (*i.e.*, the aforementioned "gross-up"). Up until several years ago, it was fairly common practice for valuation firms to simply acknowledge a hospital's statement to the effect that "benefits provided will be consistent with similarly situated employees." More recently, many in the valuation community have opened their eyes to the fact that physician benefit plans are becoming more and more robust. In certain situations, a very robust benefits plan, significantly higher than what comparable physicians receive, may be a source of a material increase in economic benefit to the physicians, and such excess benefits would generally need to be regarded as additional compensation in the FMV analysis.

On a related note, since the *reasonable* benefits and taxes are typically included in the "grossed-up" wRVU value, it is important to consider whether an increase in the physicians' wRVU productivity will result in an overpayment for benefits and taxes since these expenses are mostly fixed (*i.e.*, once the FICA limit has been reached). This is commonly handled by placing a dollar cap on overall benefits.

Evaluating Possible Compensation Stacking Issues

While the underlying compensation methodology for the employment or PSA Model may be commercially reasonable and produce results that are consistent with FMV, a hospital's desire to involve the same physician in a variety of additional compensated arrangements may result in an overall compensation arrangement that quickly becomes problematic. Since most PSAs are established on a pure productivity basis, most of the typical "stacking" culprits may be mitigated.

For example, a common accompanying arrangement is a medical directorship. Since these are most often compensated on the basis of worked and documented hours, there is *usually* not a large concern about overcompensation in the overall arrangement, since time devoted to these administrative duties may result in the generation of fewer wRVUs. However, what may appear to be a subtle change to the fact pattern (*e.g.*, the physician is paid a flat annual amount for medical director services in exchange for providing a "minimum" number of hours) can result in a situation where the total compensation may exceed FMV. In this scenario, without an effective time tracking mechanism in place, there is a possibility that the physician does not provide the required minimum number of medical director hours.

So, beware the notion that, by calling elements of compensation by different names, one can continue to "stack" the compensation higher. Essentially, all sources of compensation (including benefits, as discussed earlier) should be considered in the aggregate to establish compliance with FMV. Following are some other types of compensation arrangements that can lead to a problematic stacking issue:

- Sign-on bonus
- Quality bonus
- Call pay
- Service line management arrangement[19]

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- Productivity bonus
- Tail insurance.[20]

Conclusion

With careful planning and execution, a PSA may be an ideal vehicle to allow a hospital and physicians to better align their clinical goals and objectives. When properly structured, the PSA can mitigate physicians' aversion to traditional employment and the accompanying loss of autonomy. However, as with employment arrangements, PSAs must also comply with the FMV standard. The PSA must be commercially reasonable and consistent with FMV, both with respect to its individual components and when considered in the aggregate.

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Endnotes

1 As used herein, the term "fair market value" is as defined in 42 CFR §411.351.

2 Examples of regulations that impact hospital-physician relationships include without limitation: (1) the Physician Self-Referral Prohibition, more commonly known as the "Stark" Law (42 USC §1395nn); (2) the Federal Anti-Kickback Statute (42 USC §1320a-7b(b)); (3) the False Claims Act (31 USC §§ 3729-3733); (4) the Civil Monetary Penalties Law (42 USC §1320a-7a); (5) the Emergency Medical Treatment and Active Labor Act or "EMTALA" (42 USC §1395dd); (6) the Medicare Shared Savings Programs or "MSSP" provisions of the 2010 Patient Protection and Affordable Care Act ("PPACA") (Section 3022 of PPACA and associated regulations); (7) IRS Private Benefit and Private Inurement guidance (See for example, Treas. Reg. 53.4958 et seq.); (8) the Sustainable Growth Rate (42 USC §1848(f)); (9) Joint Commission accreditation standards and requirements; (10) Medicare Conditions of Participation (42 CFR §482 et seq.); and (11) various state regulations, including what are sometimes referred to as baby kickback laws (see for example, Fla. Stat. § 409.920(2)(e)) and laws prohibiting the "corporate practice of medicine," (or "CPOM" laws), which refer to bans on non-physician ownership of medical practices (see for example, CA Business and Professions Code 2400 and 2052 which, when considered together, represent the CPOM ban in California).

3 "DHS" or "designated health services," as defined in the Stark law at 42 USC §1395nn(h)(6). The Stark Law prohibits all financial relationships (unless an exception exists) between a physician and healthcare entities to which the physician refers patients for DHS. DHS is a list of specific services set forth in the law, including imaging, therapy and other treatments, drug administration, and most importantly, all inpatient and outpatient hospital services. Thus, all physician-hospital arrangements implicate the Stark Law if the physician refers any patients to the hospital. The list of DHS is found at 42 § CFR 411.351.

4 Relative value units ("RVUs") are based on the Resource Based Relative Value Scale ("RBRVS") system established by the Centers for Medicare & Medicaid Services ("CMS") in the Medicare Physician Fee Schedule. The RBRVS system allocates units to specific medical procedures, which are identified by The American Medical Association's current procedure terminology codes ("CPT" codes) or the "Healthcare Common Procedure Coding System" (known as "HCPCS" procedure codes), based on the general premise that certain physician services are worth more than others, whereby a standard hourly rate of compensation would fail to allow for such relative differences. CMS expends significant effort developing the RVU levels for each type of patient encounter, and they are applied consistently across all physicians. Work RVUs or "wRVUs" refer to the portion of an encounter which represents the physician's professional effort (vs. practice expense RVUs and malpractice RVUs, which relate to the other costs incurred to provide the service).

5 The MGMA *Physician Compensation and Production Survey* is widely regarded as the one of the best sources of information regarding physician compensation and productivity. Since 2009, the MGMA survey has warned users that the "compensation per wRVU" data reported by the surveys can be misleading. This is discussed in detail later in this article, and can be summarized as follows: there is a tendency for readers to assume that physicians with the highest productivity (*i.e.*, the highest reported wRVUs) must have the highest reported compensation per wRVU rate, but it turns out that the opposite is true. While compensation and productivity are loosely correlated (*i.e.*, as productivity increases, compensation also increases), the effective compensation per wRVU rate actually *decreases* as productivity increases. The reasons for this are not entirely clear, but are likely due to guaranteed compensation floors for certain physicians and the incremental costs incurred by physicians to enable them to produce the highest levels of wRVUs.

6 See note 3 above for further explanation of why physician-hospital relationships implicate the Stark law (*i.e.*, because all hospital inpatient and outpatient services are considered DHS).

7 Many transactions that implicate the Stark Law may also implicate the Anti-Kickback Statute (where violations depend on the intent of the parties) or the IRS Private Inurement guidance (for non-profit entities). However, arrangements which are consistent with the narrow Stark definition of FMV are likely also consistent with similar notions of FMV under the Anti-Kickback guidance, as well as the broader FMV standard under the IRS guidance. Analysis tends to focus on the Stark FMV standard for several reasons, namely: (i) the Stark FMV standard is narrower than the IRS FMV standard; (ii) the Stark Law is a strict liability statute (*i.e.*, parties can violate it without realizing they have done so); and (iii) it is absolutely mandatory that arrangements implicating the Stark Law fit into an applicable exception to comply with the statute (many of which have an FMV requirement).

8 CMS commentary explains that "…the definition of 'fair market value' in the statute and regulation is qualified in ways that do not necessarily comport with the usage of the term in standard valuation techniques and methodologies. For example, the methodology must exclude valuations where the parties to the transactions are at arm's length but in a position to refer to one another." (Stark II Phase II - 69 FR 16107, March 26, 2004).

[9] The three traditional approaches to valuation were set forth by the IRS in Revenue Ruling 59-60 and are further defined in the International Glossary of Business Valuation Terms; they will be described further below.

[10] Compensation data in the MGMA and other available surveys represents "total cash compensation" from all sources, which for those reporting physicians who have an ownership interest in their practice, would include ownership distributions (based on profits of the practice, including ancillary profits). It is likely that many, if not all, of the highest reported compensation values in the surveys (*i.e.*, values at the 90th percentile or above) represent some ownership compensation, which makes inherent sense, since non-owner physicians take less business risk. However, under the Stark In-Office Ancillary Services exception, certain non-owner physicians who are "members of the group" under the Stark Law may also be able to share in ancillary profits, which would be included in their reported compensation as well. However, if ancillary services are hospital provided (billed as a hospital service), physicians who are employed directly by a hospital or part of a PSA with that hospital would not be able to share in that revenue under the Stark law. Thus, survey data contains both types of physicians, requiring careful analysis when making comparisons between owner physicians and hospital affiliated physicians.

[11] See, for example, the Stark Law (42 CFR §411.350 – 411.389) and federal Anti-Kickback Law (42 USC §1320a-7b(b)).

[12] The Cost Approach is defined as "a general way of determining a value indication of an individual asset by quantifying the amount of money required to replace the future service capability of that asset," from the International Glossary of Business Valuation Terms, which is based on the definition adopted by the IRS in Revenue Ruling 59-60. The Cost Approach is based on the Principle of Substitution; *i.e.*, the premise that a prudent individual will pay no more for a property than he/she would pay to acquire a substitute property with the same utility.

[13] The Income Approach is defined as "a general way of determining a value indication of a business, business ownership interest, security, or intangible asset using one or more methods that convert anticipated economic benefits into a present single amount," from the International Glossary of Business Valuation Terms, which is based on the definition adopted by the IRS in Revenue Ruling 59-60.

[14] Medical Group Management Association's *Physician Compensation and Production Survey*.

[15] American Medical Group Association's *Medical Group Compensation and Financial Survey*.

[16] Surveys are frequently utilized by valuation professionals as one technique. However the Stark regulations do not require independent valuations for all transactions, and therefore, hospital executives, physicians and other individuals involved in completing transactions often make their own determinations of value, and may also use survey data (which is widely available) with significantly less understanding of the surveys.

[17] See Medical Group Management Association's *Physician Compensation and Production Survey¸ 2011 Report Based on 2010 Data*, page 12.

[18] A CPT coding modifier is a two digit code used to supplement information or adjust the description to provide extra details concerning a procedure or service provided by a physician. Many modifiers are intended to appropriately reduce the wRVUs associated with a particular situation, as described further in the text that follows. Modifiers are required in certain circumstances by the Medicare Program Conditions of Participation. Failing to account for modifiers that appropriately reduce wRVUs would result in overstatement of wRVUs.

[19] Service line management arrangements are utilized by hospitals to engage one group of physicians, usually in a single specialty, to provide coordinated and comprehensive management of a particular service line (*e.g.*, cardiology, neurology), in lieu of engaging multiple separate medical directors to provide the same services in a less coordinated fashion.

[20] Tail Insurance refers to the malpractice insurance to cover claims made after a physician leaves a particular position or practice. Malpractice insurance is typically sold on a "claims made" basis (meaning the coverage period covers claims made in the period, versus an "occurrence-based" policy which would cover incidents occurring during the period). Because claims may be made by former patients long after a physician leaves a practice, tail insurance is purchased to cover any claims until the applicable statute of limitations on making claims is exhausted.

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