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The Pitfalls of Facility-Commissioned Coverage Stipend Fair Market Valuation

We hear the word "fair" a lot these days. We're asked to pay our "fair" share of taxes. We're asked to bear our "fair" share of the sacrifice. It's painfully obvious that those demanding your "fair" share are also demanding the right to determine what's fair.

Then you won't be surprised over the epidemic of "fair" infecting the permitted parameters of agreements between hospital-based groups and hospitals. Of course, I'm talking about "fair" in the context of fair market value, one of the key elements of healthcare compliance, from federal and state antikickback laws, to Stark and state law prohibitions on so-called “self-referral”, to the limits of deals entered into by not-for-profit hospitals and health systems.

And you won't be surprised to learn that, in reality, the fair market valuation process often is hardly fair, blind to value, and generally ignores the true market. In a sense, it's simply Orwellian doublespeak. Well, that's not exactly true, because it has a tremendously real impact on the level of coverage stipend support paid to medical groups and, therefore, on the amount of physician compensation, and that impact is negative.

The hospital-valuation consultant complex

On January 17, 1961, in his Presidential farewell address to the nation, Dwight D. Eisenhower warned against the establishment of a "military-industrial complex”, a term with which you’re likely familiar in the sense that it’s used to portray the cozy relationship among politicians, defense contractors, and the armed forces. It describes the fact that the defense industry and its players give political contributions to politicians who then endorse defense spending, which results in purchases by the armed forces from the defense industry.

Due to the expanded scope of compliance laws turning on the issue of fair market value, and the increasing trend of hospital-physician transactions such as exclusive contracts with stipend support, hospital acquisition of physician practices, hospital employment of physicians, and so-called “physician alignment”, the relationship between hospitals and health systems, the large purchasers of valuation services, and the large valuation consulting firms selling those services, has tightened.

Hospitals and their executives rely on valuation opinions to avoid prosecution for violating the law and are willing to pay for those defensive opinions.

Consultants desire the substantial fees they charge hospitals for the rote number crunching they perform -- in a very real sense the consultants actually do understand value, at least in respect of the value of their services, in that they take a relatively small amount of labor and sell it for the value it truly represents: the value of relative safety for their clients.

But at the same time, they are overly cautious to cover their own behinds in terms of an improper valuation opinion -- this leads to nonsensical ceilings on opined value to build so much safety into the opinion that it becomes something other than a true valuation of your services.

And here's the kicker: Hospitals and their administrators are happy to receive the by-product, a valuation that fits well below the full amount of the compensation or support that they would otherwise have to pay if the actual market were truly analyzed.

It's uncertain whether hospitals actively encourage this level of "safety" or whether they are merely happy to receive its benefits, but either way it creates a false ceiling that ignores fairness, value, and the actual market.

The 75th percentile

This over cautiousness causes valuation consultants to often state that they never opine as to the bona fides of a deal at more than the 75th percentile of value as reported on national, or large-area regional (for example, "Western region") studies. Of course, some valuation consulting firms conduct their own studies and sell that information to those same hospital clients.

Think about this for a minute. In order for the 75th percentile to exist, there must be a top value and the other values that are found in the fourth quartile, the highest quartile. Those fourth quartile values cannot simply be assumed to be outside the realm of actual fair market value. Yet valuation consultants ignore the existence of that top quartile, which must exist to determine the 75th percentile maximum to which they will opine!

So, to recap:

- The hospital gives the consultant money for the valuation opinion.
- The consultant gives the hospital protection in the form of a valuation opinion as to fair market value.
- And the consultant gives the hospital the benefit of a valuation that ignores everything above the 75th percentile -- in other words, it relieves the hospital of the burden of paying anything above an arbitrary cap.

The compensation death spiral

As if the present impact of artificially capping the market is not bad enough, let's look at its effect as that process continues to play out over time.

We'll start with a prototypical hospital-based group, Oak Tree Group, that's negotiating with Community Hospital over the amount of a coverage stipend in connection with the renewal of its exclusive contract.

Setting aside all of the strategic issues in respect of maximizing stipend support, the valuation consultants engaged by Community Hospital opine that the 75th percentile of compensation gleaned from averaging national compensation surveys is $X. The consultants are adamant that they won't opine as to a value greater than the 75th percentile. Community Hospital agrees to pay Oak Tree a coverage stipend based on $X as the fair market value in connection with the renewal term.

At the time of the valuation, these valuation consultants and their competitors are all referencing a small number of national compensation surveys and they're all pointing to somewhere near $X dollars as the 75th percentile and, therefore, as the maximum per-physician compensation they will bless in their valuation opinions.

With exclusive contracts generally having a two- to three-year term, within several years, at the time that Oak Tree and Community Hospital are negotiating the stipend support for their subsequent exclusive contract, due to the prevalence of deals in effect over the ensuing time period at the $X maximum, the national compensation surveys relied on by Community Hospital's valuation consultants now indicate that $X-Y dollars is the new 75th percentile. In other words, due to the prevalence of valuation opinions at $X dollars three years prior, $X is now at the top of the range in the fourth quartile and can no longer be justified in terms of the protection that valuation consultants seek in issuing their opinions. In its place comes the new 75th percentile, $X-Y.

Of course, flash forward another two or three years and the 75th percentile is now well below $X-Y. And the cycle starts all over again, and again and again.

I once thought that if this continues unabated, physicians will eventually be working for a bag of peanuts. But then I realized that if valuation opinions are still essential at that point in time, it's more likely to be for three-quarters of a bag.

What you must do

If you'd like to create a better future for your group in respect of "fair" stipend support, there are steps that you must begin to take.

To begin, you need to understand and appreciate that a strategy in connection with stipend support can't be separated from your group's strategy in respect of the entire contractual relationship with a hospital.

And that contracting strategy must be consistent with your group's overall business strategy.

As is the case in respect of any strategic issue of this complexity, it takes considerable time and effort to deploy the required tactics. This includes significant research as to the definition of the relevant market, the development of supporting data, the complete understanding of the valuation process, and the complete understanding of the ways and ways not to present data.

Data consists of a set of “facts”, but those facts are useful to strategy in the same sense that the shirt that I am wearing as I type this is made of millions of strands of cotton fiber. They were woven into an elegant dress shirt along with thread and buttons, but they could have become a T-shirt or even a Q-Tip.

How you select, interpret, amplify, and reject “data” is only a part of the overall story of valuation, and, therefore, only a part of overall coverage stipend negotiation strategy.

Wisdom. Applied. 172: From Crossfit to Crossing Over from Pure Medical Practice to Lifestyle Business

Many people tend to think within professional silos. Barbers cut hair. Farmers farm. And, doctors practice medicine. Why?

All Things Personal

On the way home, I stopped at the market to buy some red leaf lettuce, radishes, and a bunch of broccoli.

When I got to the front of the store, the few lines with checkers were jammed. But the six stations for "self checkout" were wide open.

If I had had a few items with barcodes, I might've opted for self checkout, but there I was with a bunch of vegetables. I imagined the hassle of finding them on a chart in order to put in the correct SKU code and then weigh them. So, instead, I stood in line and thought about this column.

Of course, self checkout isn’t for the customers' benefit – it's all about shifting labor costs from the market to the customers.

In an economic sense, it's like the story of the whitewashed fence in the novel *The Adventures of Tom Sawyer*, by Mark Twain. Tom, ordered by his Aunt Polly to whitewash the fence, convinces other kids to pay him in trinkets and treasures for the privilege of doing the whitewashing.

At the market, the customers pay, via their labor, for the "privilege" of skipping the long lines created by the store when it purposefully reduced the number of staffed checkout lines.

Ah, there's a negotiation lesson here.

If this were a negotiation, you'd never be wise to trade something of value such as a demand for a certain provision or a concession on price, in return for, well, nothing.

Remember the lesson of the self checkout line. No, I'm not telling you to skip self checkout when you're really in a rush and the line from check stand number 2 stretches from the front of the store to the dairy counter.

Instead, use it as a tool to remember not to give up a concession in a negotiation without obtaining something of value in return.

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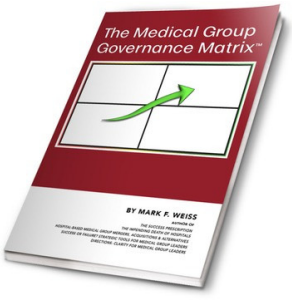

Books and Publications

We all hear, and most of us say, that the pace of change in healthcare is quickening. That means that the pace of required decision-making is increasing, too. Unless, that is, you want to take the “default” route. That’s the one is which you let someone else make the decisions that impact you; you’re just along for the ride. Of course, playing a bit part in scripting your own future isn’t the smart route to stardom. But despite your own best intentions, perhaps it’s your medical group’s governance structure that’s holding you back. In fact, it’s very likely that the problem is systemic. The Medical Group Governance Matrix introduces a simple four-quadrant diagnostic tool to help you find out. It then shows you how to use that tool to build your better, more profitable future. Get your free copy here.

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