MDRANGER

Commercial Reasonableness Toolkit

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Background

Stark and Anti-kickback laws require physician contracts to meet the standards of commercial reasonableness and fair market value. Until recently regulatory agencies provided no formal definition for commercial reasonableness; however in early 2021 CMS and the OIG issued extensive revisions to safe harbors to the Federal anti-kickback statutes to clarify valuation requirements that appear in many of the Stark law exceptions.[1] A new definition of commercial reasonableness was provided with the stated intent to reduce compliance burdens on providers and law enforcement, *including limiting the need for external consultants to verify compliance*. We advise initiating any contract review with an assessment of commercial reasonableness, before considering fair market value.

The new definition states:

> ***Commercially reasonable*** *means that the particular arrangement furthers 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.*[2]

Commentary on the final rule further states:

> *The determination that an arrangement is commercially reasonable does not turn on whether the arrangement is profitable; compensation arrangements that do not result in profit for one or more of the parties may nonetheless be commercially reasonable… We acknowledge that, even knowing in advance that an arrangement may result in losses to one or more parties, it may be reasonable, if not necessary, to nevertheless enter into the arrangement.* ***Examples of reasons why parties would enter into such transactions include community need, timely access to health care services, fulfillment of licensure or regulatory obligations, including those under the Emergency Medical Treatment and Labor Act (EMTALA), the provision of charity care, and the improvement of quality and health outcomes.***

In the preamble to the new regulations, CMS stated that the final regulations are 'consistent' with its prior positions on Phase I of the Stark law issuance, hence the new rules are considered by CMS to be 'clarifications' not revisions.

In addition to being commercially reasonable hospital-physician agreements must be consistent with fair market value to comply with federal and state regulations. These are separate legal standards, thus a contract may be consistent with fair market value but not meet the standards of commercial reasonableness in some arrangements.

The following checklists should help answer and document this key question:

Does this arrangement make clinical, operational and business sense without factoring in potential referrals from the contracting physician?

1. https://www.federalregister.gov/documents/2020/12/02/2020-26072/medicare-and-state-health-care-programs-fraud-and-abuse-revisions-to-safe-harbors-under-the

2. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-411/subpart-J/section-411.351

Commercial Reasonableness Checklist

CATEGORY	CRITERIA	IMPACT
1. Alignment with Mission and Goals	Does the arrangement align with and facilitate achievement of the organizational mission and goals?	If not, it may not be commercially reasonable.
2. Industry Practice	Is the arrangement reasonably prevalent in similar organizations (size, type) or are there legitimate reasons for an atypical arrangement?	The more uncommon, the less likely it is to be commercially reasonable.
3. Frequency and Intensity of Need	How often is the service needed? How intense is the workload?	If frequency or intensity of service is low, commercial reasonableness may be questionable.
4. Alternatives	Are there *less costly* alternatives that are equivalent or better with respect to quality of care?	If yes, the arrangement may not be commercially reasonable.
5. Duplication	Is there a duplication of service arrangements?	If yes, the arrangement may not be commercially reasonable.
6. Financial Performance	Does the cost of the arrangement justify identifiable benefits?	If the associated service results or contributes to economic losses, it may not be commercially reasonable unless there is a demonstration of need or other justification.
7. Qualifications	Is the physician qualified to provide the services?	If not, the arrangement may not be commercially reasonable.
8. Evaluation Metrics	Are there well defined and objective measures of performance? Is the evaluation process defined?	If not, the arrangement may not be commercially reasonable.
9. Payment Terms	Is there a defined payment amount, with a defined maximum payout?	If not, the arrangement may not be commercially reasonable.

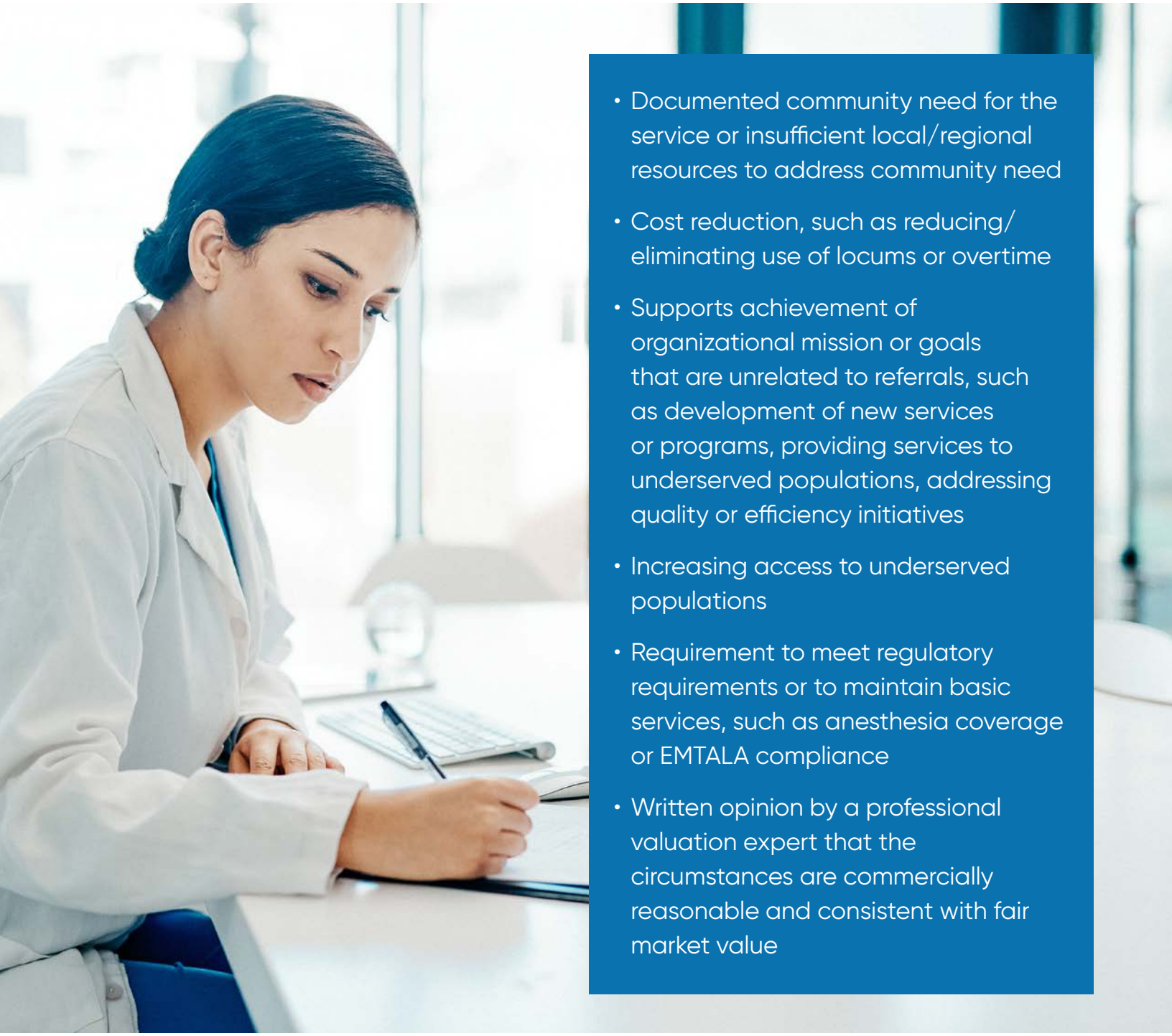
High Risk Circumstances Checklist

In addition to the checklist provided above, the following situations should be reviewed and documented carefully with respect to necessity and commercial reasonableness since they represent areas of prior Stark violations:

- Call coverage services with very low frequency demand for emergency department services (e.g. dermatology)
- Call coverage by two specialties with overlapping scope of practice
- Coverage arrangements for multiple campuses that are in close proximity, particularly for low volume emergency departments
- Directorships for programs with only one physician or a single small single specialty group of physicians providing the service
- Multiple directorships for the same specialty
- Multiple directorships with the same physician
- Multiple agreements (coverage or medical administrative) with the same medical group
- Communications or agreements that indicate the value of referrals resulting from the arrangement
- Agreements with employed physicians that, when combined with paid salary, exceed fair market value benchmarks (since Total Compensation benchmarks include compensation from *all sources*, including administrative and call services)
- Unique arrangements with a subset of physicians providing the same service

Examples of Non-Standard Justifications

CMS and the OIG have indicated that there are circumstances that could be commercially reasonable even when an arrangement does not meet *standard* criteria. In these situations, the agreements and circumstances should be reviewed and justification of commercial reasonableness carefully documented. Circumstances cited as possible valid reasons to pay for services not typically considered reasonable include:



- Documented community need for the service or insufficient local/regional resources to address community need
- Cost reduction, such as reducing/eliminating use of locums or overtime
- Supports achievement of organizational mission or goals that are unrelated to referrals, such as development of new services or programs, providing services to underserved populations, addressing quality or efficiency initiatives
- Increasing access to underserved populations
- Requirement to meet regulatory requirements or to maintain basic services, such as anesthesia coverage or EMTALA compliance
- Written opinion by a professional valuation expert that the circumstances are commercially reasonable and consistent with fair market value

Assessing Commercial Reasonableness

The determination of commercial reasonableness can be more subjective than determining fair market value. It is not enough to simply assert that an agreement (a) is necessary for the operation of the hospital (b) makes business sense and (c) the compensation level was established without regard for potential referrals. Documentation of the benefits and need for the specific contract for the specific situation, in addition to market data supporting the prevalence of the type of contract will bolster compliance reviews. Evaluating commercial reasonableness should be the first step in any compliant contract review process. Using a checklist like the one in this document provides a framework for documentation of your organization's consideration of commercial reasonableness.

Be cautious if your institution has never had a contract that failed the 'test' of commercial reasonableness. A prudent question to ask yourself, the valuation consultant, contracting director or facility administrator is:

Has our process and criteria for documenting commercial reasonableness ever resulted in a negative finding for a proposed agreement?

If the answer to this question is "no," the process and criteria for the judgment being applied may be ineffective in the absence of a thoughtful and consistent commercial reasonableness review and documentation process.

With the right tools, policy, and education, documenting commercial reasonableness should become a routine and straightforward process for most transactions. This resource can help to identify contracts that need additional documentation or external validation to meet the standard of commercial reasonableness.

MD Ranger Percent Paying and Number of Positions Benchmarks

Some types of market data can help to document commercial reasonableness. Because MD Ranger collects subscriber data that includes a comprehensive inventory of all contracted physician services, it can report the percentage of hospitals in its database that pay for the service.

If the percentage of MD Ranger hospitals that pay for a service is high, it is a strong indication that paying for the service is commercially reasonable. The percent benchmarks apply to all hospitals and do not take into account hospital characteristics such as hospital size, trauma status, physician supply, or factors that could influence a commercial reasonableness assessment, although special reports can be ordered to test particular characteristics.

TOP FIVE MOST FREQUENTLY PAID ED COVERAGE SERVICES

SERVICE	% PAYING FOR CALL COVERAGE
Urology	79%
General Surgery	73%
Orthopedic Surgery	70%
Gastroenterology	62%
Neurosurgery	52%

Conversely, if the percentage of MD Ranger hospitals that pay for a service is low, it is less likely that payment for the service is commercially reasonable. For low frequency services, additional information on hospital size, program requirements and community need should be reviewed and documented in the commercial reasonableness analysis.

MD Ranger also reports benchmarks for the total number of paid positions for hospitals, which can help document the reasonableness of multiple medical directors for programs such as cardiology and behavioral health.

Case Studies

SPINE SURGERY CALL COVERAGE

A busy Level 2 trauma center maintained neurosurgery coverage through a contract with a panel of neurosurgeons, all of whom had full privileges that included spine surgery. The contract requires the on-call physician to be restricted for the full 24-hour day, precluding them from performing non-emergency surgery. Furthermore, the neurosurgery contract provided first and second call, as required for trauma certification. A panel of orthopedic surgeons that specializes in spine surgery proposed that the hospital create an on-call panel for spine cases. Because the hospital had already secured continuous and restricted coverage for emergency spine injuries from qualified surgeons, and because spine surgery is rarely needed on an emergent basis, the proposed additional coverage arrangement was found to be duplicative and, therefore, did not meet the standard of commercial reasonableness.

Case Studies

ELECTROPHYSIOLOGY CARDIOLOGY Medical Director and Co-Management Agreement

There is a single electrophysiology (EPS) specialist on the staff of a community hospital. The hospital proposed to contract with this physician to be the medical director of electrophysiology with responsibilities for outreach to other hospitals, clinical quality improvement and a co-management agreement that focused on quality and cost control.

By applying the review criteria in the Commercial Reasonableness Checklist, it was found that one segment of the position, the co-management agreement, was commercially reasonable. The work was directly supportive of the hospital's goals for quality improvement and cost management and the agreement included defined time commitments, measurable performance outcomes and a defined level of compensation that was found consistent with fair market value.

However, the segments of the work for outreach to other hospitals and clinical quality improvement was found not to be commercially reasonable. As the sole EPS physician on the medical staff, the physician's private practice was indistinguishable from the medical staff in the EPS subspecialty, hence the hospital should not be paying this physician for marketing and internal quality reviews of his own private practice. Further, there is no practical way to evaluate how any work done exclusively for the hospital might be different from the physician's private practice work.

Case Studies

ICU COVERAGE OF TWO CAMPUSES

A two-hospital system has campuses 15 minutes apart. The hospital has two separate agreements with a single group of pulmonary medicine/critical care physicians. Each agreement provides for a combination of on-site coverage (consistent with Leapfrog standards) at each campus during daytime hours and on-call coverage for other hours of the day. The agreements call for separate physicians for each hospital.

The volume of off-hours calls is relatively low, with very low probability of simultaneous calls from each campus. This low volume raises a significant concern about whether it is commercially reasonable to pay separate physicians in the same medical group to be on-call at each hospital. The hospital should consider if there is a reasonable alternative to distinct agreements: specifically, could there be a single agreement for the group to cover each campus during the daytime hours and to provide a *combined* call panel for after-hours coverage. Relevant factors to review would be ICU census, frequency of call, patient profiles for each ICU, etc.

Case Studies

RURAL HOSPITAL SPECIALTY SERVICES

A thirty bed hospital in a town two hours from the closest large hospital maintains a basic emergency department, medical, and surgical services. Although it does not provide pediatric services, a regional children's hospital has held monthly specialty clinics in cardiology and neurology. The children's hospital determined that it was no longer viable to provide monthly onsite services at no cost and requested payment for providing telephone consultations with transfer assistance as well as stipend support for quarterly onsite visits.

Coverage payments and clinic stipends for many pediatric specialties are uncommon, particularly at small and rural hospitals; however, large children's hospitals often have outreach clinics to enhance access to underserved populations. The hospitals reviewed outreach clinic visits, hospital emergency visits and patients' residence and determined that the monthly visits were under-used but quarterly visits would be fully subscribed. Furthermore, the families requiring the service could not easily travel to the regional hospital for care management. The children's hospital provided evidence that there was a shortage of physicians in the specialty and that in order to recruit additional physicians to provide the outreach services, a subsidy was needed given the time and cost of travel and poor payer mix. The rural hospital was able to negotiate a monthly telephone coverage payment for emergency and transfer support and a daily stipend for the quarterly onsite clinic days. Payment was based on an analysis of collections data, onsite and travel time and compensation, benefit and practice support costs for the specialists.

The arrangement was determined to be commercially reasonable based on documented community need and the estimated cost of providing the services.

About MD Ranger

Standardize & streamline the FMV process with MD Ranger

- Do you have difficulties establishing and documenting commercial reasonableness?
- Do you lack access to information that could help you benchmark physician transactions?
- Do you struggle with your FMV process and strategy?
- Do you think your organization could become more efficient and use fewer resources?

Discover if MD Ranger is the right fit for your organization.
Reach out today: **info@mdranger.com** or **650-692-8873**

MDRanger

At last, a single source for all physician transaction benchmarks with powerful tools for market rate documentation, analytics, monitoring, and audits.

- **Identify the precise benchmark you need instantly** to determine the most appropriate, compliant rates
- **Access an unmatched scope of benchmarks** with 1,500+ benchmarks ranging from ED call to medical direction and hospital-based stipends
- **Automate FMV documentation** and save money on outside valuations
- **Compare physician costs, contracts, salaries and productivity** to similar organizations and analyze spending across your health system or medical group
- **Rely on MD Ranger's large database and sample sizes** to provide stable benchmarks
- **Evaluate commercial reasonableness** using statistics that capture the percent of hospitals paying for a service

Available Benchmarks

- Call coverage per diems, per activation, per episode
- Medical director hourly rates, annual hours, annual rates
- Physician administrative and leadership roles like quality, care/case management, Chief of Staff, and more
- Hospital-based physician stipends, and other payments including incentive components
- Clinical hourly rates
- Diagnostic testing
- Telemedicine arrangements
- Locum Tenens rates
- Total cash compensation*
- wRVUs*
- Professional collections*
- Total cash compensation per wRVU*
- Total cash compensation percent of professional collections*
- Base/productivity cash compensation*
- Base/productivity cash compensation per wRVU*
- Base/productivity cash compensation percent of professional collections*
- Advanced practice provider supervision*
- Base vs. productivity compensation break out*
- Quality payments*
- Administrative component*
- Call coverage component*
- Compensation by component*

(*From Gallagher's *2021 Physician Compensation and Production Survey*)

Match your organization to available benchmark slices:

- Trauma status
- Bed size
- Average Daily Census
- Teaching status
- Urban vs. rural location
- Payor mix