Fair Market Value in Hospital and Physician Transactions: Complying with Anti-Kickback and Self-Referral Laws

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Fair Market Value in Hospital & Physician Transactions: Meeting FMV Requirements in Federal Anti-Kickback and Self-Referral

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May 21, 2014
Presentation Overview

- Discussion of Legal Landscape
- Common Hospital/Physician Arrangements and FMV Approaches
- FMV Pitfalls/Commercial Reasonable Issues
Legal Issues to Consider

- Anti-Kickback Statute - 42 U.S.C. §1320a-7b(b)
- The federal Physician Self-Referral Prohibition
  42 U.S.C. §1395nn
- Internal Revenue Code prohibition on Private Benefit/Private Inurement
- Civil Monetary Penalty Laws - 42 U.S.C. §1320a-7q(b)
The Antikickback Statute (AKS)

- **42 U.S.C. §1320a-7b(b)**
- Prohibits the offer or payment of any remuneration to any person to induce that person to
  - refer an individual to a person for the provision of any item or service; or
  - purchase, order, or arrange for, or recommend purchasing, ordering, or arranging for, any service, facility or item for which payment may be made, in whole or in part, under any Federal health care program.
- Statutory prohibitions apply to both sides of the arrangement
- AKS applies to all health care providers and anyone else who can influence referrals
AKS (cont.)

- Intent-based statute
  - Cannot violate the statute without acting “knowingly and willfully” with intent to induce or reward referrals.
  - Actual knowledge or specific intent — “With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.” ACA §6402(h)

- Felony statute
  - Fines
  - Imprisonment

- A claim resulting for items/services resulting from violation of the AKS constitutes a false or fraudulent claim under the FCA. ACA §6402(f) (But even pre-2010, AKS allegations often bootstrapped onto FCA).
AKS Exceptions and Safe Harbors

• AKS statute includes exceptions and OIG created regulatory “safe harbors”
  • Very narrowly defined
  • Must satisfy ALL criteria to have protection
  • If arrangement falls within safe harbor, OIG claims the arrangement is immune from prosecution, regardless of intent

• Fitting a financial relationship into a safe harbor is not required; arrangements that do not meet the requirements of a safe harbor are not presumptively illegal.

• Advisory Opinion Process available
Physician Self-Referral (“Stark”) Law

- **42 U.S.C. §1395nn**
- Originally enacted in 1989 to address concerns regarding overutilization of clinical lab services. Effective 1995, applied to a broader range of services.
- Statute prohibits physicians from engaging in “financial relationships” (i.e., compensation arrangements and ownership interests) with entities to whom they refer patients for Designated Health Services.
- If physician engages in a prohibited financial relationship with entity to which he refers patients for DHS, then the entity is prohibited from billing Medicare for DHS provided to those patients and Medicare is prohibited from paying for such services. *(42 U.S.C. §1395nn(a)(1)(B))*
- **HHS will not pay Medicaid programs for services violating Stark.** *(42 U.S.C. §1396b(s))*
Stark Law (cont.)

- Statute and regulations create exceptions permitting certain narrowly-defined financial relationships.
- Proscriptive statute – if an arrangement between a physician and DHS entity implicates the statute, then the arrangement must fit within an exception.
- Strict liability statute – intent of the parties is irrelevant for purposes of determining whether the statute is violated.
- Both statute and regulations set forth various exceptions and must satisfy ALL the requirements of an exception to have protection.
Stark Law (cont.)

- Government has taken the position that full value of claims submitted must be repaid (42 U.S.C. §1395nn(g)(1))
- Stark Law Self-Disclosure Protocol required by ACA provides alternative for resolution purposes
- Often boot-strapped under FCA
- Civil monetary penalties and exclusion (42 U.S.C. §1395nn(g)(3)-(4))
AKS vs. Stark Law

• AKS applies to all health care providers and anyone else who can influence referrals; Stark applies only to physicians and DHS entities to whom they refer.

• AKS applies to all items or services reimbursable under FHCP; Stark applies only to Designated Health Services.

• AKS requires willful intent to induce referrals; Stark imposes strict liability.

• Failure to fit relationship within AKS safe harbor does not mean automatic violation; failure to fit relationship within Stark exception does mean automatic violation.
As amended by the Fraud Enforcement and Recovery Act of 2009 (FERA), liability under the False Claims Act occurs when a person or entity:

1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

2) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; or

3) conspires to commit a violation of any of certain provisions of the False Claims Act (including the two listed above).

Violations are punished by penalties of not less than $5,500 and not more than $11,000 per claim, plus treble damages for the amount of damages the Government sustains.

FCA is the primary enforcement tool for combatting fraud and abuse in federal health care programs.
False Claims Act (cont.)

- **Qui Tam** provisions of the FCA permit any person to file an FCA lawsuit, under seal, in the name of the United States
  - “Relators” receive a percentage of any settlement – 15 - 25% if the government intervenes and 25 - 30% if the government does not intervene and the relator moves forward with the suit.

- Conduct must be “knowing,” defined (§ 3729(a)(1(b)) as:
  - Actual knowledge of the information
  - Deliberate ignorance of truth or falsity of the information
  - Reckless disregard of truth or falsity of information

- Statute of Limitations is no more than:
  - 6 years from the date the violation is committed; or more than 3 years after the date the facts materials to the right of action are known or reasonably should have been known by the official of the United States charged with responsibility to act in the circumstances (but no more than 10 years after the violation is committed)
2009 Expansion of the FCA

- FERA expands federal FCA liability to include, among other things, retention of overpayments.

- **Section 3729(a)(1)(G):**
  “Any person who ...knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government or **knowingly conceals** or **knowingly and improperly avoids or decreases an obligation** to pay or transmit money or property to the Government ...” (emphasis added)

- **Obligation** defined as:
  “an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or **from the retention of any overpayment**...” (emphasis added) *(31 U.S.C. § 3729(b)(3))*

- Creates FCA liability for knowingly retaining any overpayment.
ACA 60-Day Report/Return Rule

• ACA Section 6402(a): If a person has received an overpayment, the person shall:
  • Report and return the overpayment to the Secretary, the state, an intermediary, a carrier, or contractor, as appropriate; and
  • Notify the Secretary, the State, an intermediary, a carrier, or contractor in writing of the reason for the overpayment
• Deadline for reporting and returning is the later of:
  • The date which is 60 days after the date on which the overpayment was identified; or
  • The date any corresponding cost report is due, if applicable
• Enforcement: Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3), for purposes of the FCA.)
Common Hospital/Physician Arrangements and FMV Approaches
Employment Agreements

Overview

- Physician employment is very active.
- Productivity-based models are in vogue; median compensation per wRVU is a widely viewed metric.
- Employment agreements have many moving parts... the “terms and features” are critically important.
- Can in-market physicians be paid at higher rates?
- Benefit plans are becoming more robust.
Employment Agreements Using Survey Data

• Confucius Statistician say... “If you torture the data long enough, it will confess to the crime it did not commit.”

• Market data can be misused in a variety of ways, including:
  • Cherry picking from among different surveys and/or tables (e.g., national vs. regional data)
  • Failure to consider ownership/ancillary profits that may be inherent in 90\textsuperscript{th} percentile compensation
Employment Agreements
Compensation per wRVU

Example of misuse of MGMA data:
- For Orthopedic Surgery: General
  - 90\textsuperscript{th} percentile cash compensation - $934,000
  - 90\textsuperscript{th} percentile wRVUs – 13,795
  - 90\textsuperscript{th} percentile compensation per wRVU - $105.18

Where is this going?
- 90\textsuperscript{th} percentile wRVUs x 90\textsuperscript{th} percentile compensation per wRVU = $1,451,000... 155% of 90th %ile compensation!!
- MGMA states that there is an inverse relationship between physician compensation and compensation per wRVU
- Median compensation per wRVU is dramatically different than median compensation.
- “Total” vs. “work”
- Multiple Procedures
- Site of service
Employment Agreements
Net Income Compensation Models

• Calculation of applicable revenues
• Calculation of appropriate O/H expense
  • Available benchmark data
  • Normalizing historical experience

• Accounting for physician extenders
  • Who pays?
  • What credit can accrue to the physician?

• Distribution of net income
  • Is it acceptable to distribute it all?
Employment Agreements
“Stacking”

If you label compensation layers by different names, you can stack them higher and higher!

- Sign-on bonus
- Productivity bonus
- Medical directorship (valuing admin versus clinical time)
- Co-management agreement
- Quality bonus
- Retention bonus
- Call pay
- Tail insurance
- Excess vacation
- Relocation costs
- Excess benefits
Compensation Plans that Result in Practice Losses
  • What magnitude of losses is acceptable?
  • Are practice operating expenses fully allocated to the practice?
  • Can you use a compensation formula that guarantees losses?
  • Incremental/bonus compensation that increases losses?

Income Guarantees
  • Time frame of the guarantee
  • Factors for establishing compensation
  • Overly large sign-on bonuses
FMV Pitfalls
Issues in Employment Arrangements

- Net Income Compensation Models
  - Is physician receiving any revenue credit for ancillary services?
  - Does the methodology meet the requirements of the arrangement?
- Any safeguards directed to high volume producers?
  - 90\(^{th}\) percentile? 125\% of the 90\(^{th}\) percentile?
  - Are services coded correctly?
  - Ceiling on compensation?
AKS Employment Exception

• AKS Statutory Exception and Regulatory Safe Harbor
  • The statutory employee exception protects “any amount paid by an employer to a [bona fide] employee . . . for employment in the provision of covered items or services.”
  • No FMV requirement
  • But see United States v. Borrasi, in which the government successfully argued that paying employees for referrals was illegal in any amount. (No. 09-4088 (7th Cir. 2011)). Cased involved sham employment arrangements to shield bribes to physicians and therefore not a bona fide employment arrangement.
Stark Law Employment Exception

- Stark Law Employment Exception:
  - Identifiable Services
  - Remuneration is consistent with FMV of services and not determined in a manner that takes into account the volume or value of any referrals
  - Commercial Reasonableness
  - Productivity bonuses based on personally performed services
Stark Law Employment Exception

• What Are Personally Performed Services?
  • Just that – services provided directly by the “referring” physician

  • CMS has indicated that any request of another individual, including employees, contractors, coworkers or under “incident to” billing guidelines, constitutes a referral. 66 Fed. Reg. 871 (2001).

  • Furthermore, technical components of hospital services represent a referral even though the physician’s professional services for the same procedures does not
Stark Law Employment Exception

Comparison of IOAS and Employment Exceptions

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<thead>
<tr>
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<th>IOAS</th>
<th>Employment</th>
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<tbody>
<tr>
<td>Profit Sharing</td>
<td>Profits of DHS revenue may be shared between owners (subject to restrictions)</td>
<td>May not share profits with employed physicians</td>
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<tr>
<td>Productivity Bonus</td>
<td>Bonus may include services performed “incident to” physician services</td>
<td>Bonus only based on personally performed services</td>
</tr>
<tr>
<td>Vary with DHS Volume or Value?</td>
<td>Neither may be based directly on v/v of DHS referrals</td>
<td>Neither may be based directly or indirectly on v/v of DHS referrals</td>
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<tr>
<td>Restrictions</td>
<td>Must be in a “group practice” and meet significant other requirements (location, percentage of practice)</td>
<td>Need only have “bona fide employment relationship” (consistent with IRS definition)</td>
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Stark Law Employment Exception

- **Halifax Hospital Decision**
  - Recent case in Florida found Stark Law violation where payments to employed oncology group not protected by exception.
  - Group was given a percentage of all revenues of oncology department, which included DHS revenues, and then pool was allocated to each physician in group based on personally performed services.
  - Court held that “The Incentive Bonus was not a ‘bonus based on services personally performed’ . . . [but] was divided up based on services personally performed . . . The bonus itself was based on factors in addition to personally performed services -- including revenue from referrals made by the Medical Oncologists for DHS. The fact that each oncologist could increase his or her share of the bonus pool by personally performing more services cannot alter the fact that the size of the pool (and thus the size of each oncologist’s bonus) could be increased by making more referrals.” (emphasis in original).
Stark Law Employment Exception

- All Children’s Health System Decision
  - Unlike AKS, employment exception requires FMV
  - Relator alleged that, despite the compensation plan she developed such that pediatric neurosurgeons would be paid between 25th and 75th salary percentile, hospital executives overcompensated these physicians.
  - Physician group operated at a loss while hospital saw “financial boon” due to referrals.
  - Nearly 1/3 paid above the 75th percentile.
  - Treatment of Medicaid claims?
Fair Market Value - What is it?

- Stark Law Definition: “the value in arm's-length transactions, consistent with the general market value. ‘General market value’ means the price that an asset would bring as the result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. 42 CFR § 411.351 (Definitions)
Fair Market Value - What is it?

- CMS Commentary of FMV:
  - “Ultimately, fair market value is determined based on facts and circumstances. The appropriate method will depend on the nature of the transaction, its location, and other factors. Because the statute covers a broad range of transactions, we cannot comment definitively on particular valuation methodologies.” 72 Fed. Reg. 51012, 51015.
  - “[T]he statute covers such a wide range of potential transactions that it is not possible to verify and list appropriate benchmarks or objective measures for each.” 69 Fed. Reg. 16054, 16107 (CMS discussions of the FMV standard)
  - “[W]e will consider a range of methods of determining fair market value and that the appropriate method will depend on the nature of the transaction, its location, and other factors. While good faith reliance on a proper valuation may be relevant to a party’s intent, it does not establish the ultimate issue of the accuracy of the valuation figure itself.” 69 Fed. Reg. 16054, 16107
**Volume or Value Standard - What is it?**

- Definition of an Indirect Compensation Arrangement (second prong):
  - “The referring physician ... receives aggregate compensation ... that varies with, or takes into account, the volume or value of referrals or other business generated by the referring physician ....”

- Requirement of many compensation exceptions:
  - “The compensation to be paid ... is set in advance, does not exceed [FMV], ... and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.”

- Tuomey Court: “We conclude from the regulatory definition of [FMV] and the applicable agency commentary that compensation based on the volume or value of anticipated referrals implicates the volume or value standard.”
Volume or Value Standard - What is it?

- Bradford Regional Hospital:
  - “There really is no dispute that the amount of the non-compete payments was arrived at by considering the amount of business BRMC would receive from the doctors. Although Defendants do not explicitly state that they ‘took into account’ the anticipated referrals from [the doctors] Vaccaro in arriving at the non-compete amount, a review of their briefs shows that Defendants implicitly concede that the value of the doctors’ anticipated referrals was a part of the negotiations.”

- “We conclude that the compensation arrangement between BRMC and the doctors is ‘inflated to compensate for the [doctors] ability to generate other revenues.’ 66 Fed.Reg at 877. Specifically, we find that the amount of the compensation arrangement was arrived at by taking into account the anticipated referrals from the doctors. We therefore conclude that the compensation arrangement between BRMC and the doctors is not ‘fair market value’ under the Stark Act.”
FMV and the Volume or Value Standard – Cases

Consider the Tuomey Case

**Two Long Trials**
- 2nd Trial (April 2013) large verdict against Tuomey – likely will be appealed

1st Appellate opinion (March 2012) – two key rulings:
- Facility component of personally performed services are referrals.
- Fixed compensation that considers *anticipated referrals* “by necessity takes into account the volume or value of such referrals” under Stark.

Possible lessons to be learned (from trials and appeal)?
- The existence of an “independent” FMV report may not be persuasive.
  - Valuator lack of independence and/or lack of experience
  - Counsel and their clients should consider whether a valuation analysis/conclusion is compelling (whether prepared internally or by
Compare Tuomey with Bradford Case (2010)

- Nuclear Camera case – Hospital threatens loss of privileges for owners of competing nuclear camera - settlement involved various payments to physicians
- Intent questions – CEO makes bad statements in deposition
- Questions and issues with valuation report:
  - No mention of Stark FMV definition – used IRS standard instead
  - Half page of analysis devoted to supporting a payment for a non-compete in the amount of $284,000 per year
- Components of the analysis included consideration of CT/MRI revenues/expenses. However, the physicians were only thinking about adding CT/MRI.
- Does consideration of referrals run afoul of Federal regulations, even if the resulting compensation is consistent with FMV?
- Case ultimately settled before trial on intent issue.
Commercial Reasonableness – What is it and Who Decides?

- OIG: “commercially reasonable business purpose” - reasonably calculated to further the business purpose of the purchaser; demonstrated by intrinsic commercial value to the purchaser. 64 Fed. Reg. 63518, 63525

- The Stark Law: “arrangement appears to be a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals.” 63 Fed. Reg. 1659, 1700

- CMS Commentary: “any reasonable valuation is acceptable, and the determination should be based upon the specific business in which the parties are involved, not business in general. In addition, we strongly suggest that the parties maintain good documentation supporting valuation.” 66 Fed. Reg. 856, 919

- More CMS Commentary: arrangement makes “commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician ... of similar scope and specialty, even if there were no potential referrals.” 69 Fed. Reg. 16054, 16093
Common FMV Pitfalls
FMV Pitfalls
Use of Tainted Market Data

• Generally, any market data used to establish FMV must be “arm’s-length.” Healthcare transactions are frequently suspect.

• A market approach is the preferred valuation approach for many types of compensation arrangements.

• For certain types of arrangements, virtually no “non-tainted” data is available.

• The valuator must consider alternate approaches.
  • Consider whether the arrangement can be “cross-walked” to a non-healthcare setting. If the arrangement would make sense in a non-healthcare setting, it may make sense in healthcare (provided that referrals are never considered/value).
FMV Pitfalls
Misapplication of a FMV Opinion

Examples:

- Opinion was valid only over a specified range of outcomes.
- Misapplied “units”
  - Surgical cases vs. procedures; patients vs. “fractions”
  - Unrestricted vs. restricted call
  - 24-hour on-call rate applied to a 14-hour call period
- FMV opinion is ambiguous or conditional.
- FMV opinion included critical governing assumptions that were not considered in its application.
FMV Pitfalls
An Unreliable FMV Opinion

- Even with a fair market value assessment, many things can still go wrong:
  - The terms and provisions assumed by the appraiser may not match the agreement.
  - The valuator may have lacked sufficient knowledge of the subject matters.
  - Consider the “shelf life” of the appraisal, and whether there are any post-closing obligations (such as a true-up).
  - Is the appraisal compelling? Does it appear to meet the standard that regulators may require?
• A physician organization is paid to provide turnkey management services on behalf of a hospital service line. The physicians then engage a professional non-physician owned organization to provide material components of the services.

• A hospital pays a physician group $1,500 per day for call coverage; that group in turn contracts with unrelated physicians to provide the coverage for $1,000 per day.
Questions?

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