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

WEDNESDAY, MARCH 7, 2018

1pm Eastern | 12pm Central | 11am Mountain | 10am Pacific

Today’s faculty features:

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Hunter A. Wolfel, Manager, HealthCare Appraisers, Denver

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Presentation Overview

• Introductions
• Discussion of Legal Landscape
• Overview of Valuation and Current Landscape in Physician Compensation
• FMV Pitfalls and Commercial Reasonableness Issues
• Case Studies
• Q&A
Introductions
Overview of Legal Landscape
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 3 “How’s”

- When analyzing physician compensation, at least three tests are involved:
  - How Come?
    - Is the compensation commercially reasonable?
  - How Calculated?
    - Is the compensation based on the volume or value of the physician’s referrals?
  - How Much?
    - Is the compensation within the range of fair market value?
How Come?
Commercial Reasonableness

• Two questions:
  • Why did the parties enter into the arrangement?
  • Would the terms of the arrangement be different in the absence of any referrals between the parties?

• Many Stark exceptions include a commercial reasonableness requirement
  • the arrangement must be “commercially reasonable even if no referrals were made between the parties”

• Neither the statute nor the regulations define “commercial reasonableness”
How Come?
Commercial Reasonableness

- CMS Commentary
  - The “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
  - The 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
How is Compensation Determined?
- Is the Compensation calculated based on the volume or value of the physician’s referrals?
- Are referrals taken into account in determining compensation?

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.”

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 ....”
- To fit within the Indirect Compensation Arrangement Exception, compensation may not be based on the volume or value of referrals.
How Much?
Fair Market Value

• **Statutory Definition of Fair Market Value:**
  • “The term ‘fair market value’ means the value in arms length transactions, consistent with the general market value, . . .” 42 USC § 1395nn(h)(3)

• **Regulatory Definition of Fair Market Value**
  • “Fair market value means 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
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).
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))
If a physician (or an immediate family member) of such physician) has a financial relationship with an entity ..., then the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under Medicare.

The entity may not present or cause to be presented a claim to Medicare or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a prohibited referral.

If a person collects amounts billed in violation of this prohibition, that person must refund those amounts on a timely basis.

UNLESS an exception applies...
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. 
  \( (42 \text{ U.S.C. } \S 1395nn(g)(1)) \)

- Stark Law Self-Disclosure Protocol required by ACA provides alternative for resolution purposes.

- Often boot-strapped under FCA.

- Civil monetary penalties and exclusion. 
  \( (42 \text{ U.S.C. } \S 1395nn(g)(3)-(4)) \)
Stark Law Amendments?

- Roundtable in December 2015 hosted by Senate Committee on Finance and House Committee on Ways and Means to the Stark Law and its potential affect on innovative payment models
- Recommendations from repealing compensation arrangement provisions to creating new exceptions
- **Draft legislation being presented to Congress** – an exception for “coordinated network arrangements”; revisions to definition of FMV (creates safe harbor for hourly compensation below the 75\(^{th}\) percentile) and new definition of “commercial reasonableness” (means that the services or items purchased or contracted for are of use in the business of the purchasing or contracting party and are of the kind and type of items or services purchased or contracted for by similarly situated entities)
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 v. IOAS Exception

#### Comparison of IOAS and Employment Exceptions

<table>
<thead>
<tr>
<th></th>
<th>In-Office Ancillary Services (IOAS)</th>
<th>Employment</th>
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<tbody>
<tr>
<td><strong>Profit Sharing</strong></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><strong>Productivity Bonus</strong></td>
<td>Bonus may include services performed “incident to” physician services</td>
<td>Bonus only based on personally performed services</td>
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<tr>
<td><strong>Vary with DHS Volume or Value?</strong></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>
</tr>
<tr>
<td><strong>Restrictions</strong></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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## Above or Below FMV?

<table>
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<tr>
<th><strong>Physicians refer Patients to Hospital</strong></th>
<th><strong>Below</strong></th>
<th><strong>Above</strong></th>
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<tbody>
<tr>
<td>(<em>Stark &amp; AKS apply</em>)</td>
<td>Upper Limit of FMV</td>
<td>Lower Limit of FMV</td>
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<tr>
<th><strong>Hospital Refers Patients to Physicians</strong></th>
<th><strong>Above</strong></th>
<th><strong>Below</strong></th>
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<tr>
<td>(<em>only AKS applies</em>)</td>
<td>Lower Limit of FMV</td>
<td>Upper Limit of FMV</td>
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<tr>
<th><strong>Both Parties Refer Patients to Each Other</strong></th>
<th><strong>Within</strong></th>
<th><strong>Within</strong></th>
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<tbody>
<tr>
<td>(<em>Stark and AKS apply</em>)</td>
<td>FMV Range</td>
<td>FMV Range</td>
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Overview of Valuation and Current Landscape of Physician Compensation under Employment Agreements
FMV Process

• Parties involved
  • Client (e.g., hospital)
  • Valuator
  • Legal counsel

• Process of obtaining an opinion
  • Engagement
  • Due diligence
  • Issuance of opinion and subsequent review of the opinion
Basic Valuation Approaches

- **Income Approach**
  - Definition
  - Problems

- **Asset (Cost) Approach**
  - Definition
  - Problems

- **Market Approach**
  - Definition
  - Problems
Common Valuation Issues in the Healthcare Landscape

- Problems in Healthcare Valuation
  - Data between parties in a position to refer cannot be utilized (does that leave anything?)
  - Complex Healthcare Payment System - Fee-For-Service vs. Value-Based, etc.
    - How to Value Quality Payments?
    - Lack of historical data/metrics/comparables
  - Technology development
  - Changes to system

- Practical Problems for Parties
  - Parties’ expectations oftentimes do not represent FMV
  - Rigorous, arm’s-length negotiation may not result in a FMV outcome
  - Certain market data is simply not reliable
Employment Agreements

Overview

• More physicians are employed or aligned (i.e., foundation model/PSA) with hospitals and health systems.

• Causes:
  • Reimbursement pressure, particularly on imaging and other ancillaries
  • Push toward integrated networks for quality and efficiency goals (ACO’s, CIN’s, etc.)
  • Costs, risk tolerance and lifestyle considerations for physicians are pushing more physicians to seek a closer relationship with a hospital or health system, either through employment or a PSA type of arrangement
  • Recession of 2008
Market Trends in Employment Agreements

- Productivity-based models are in vogue; median compensation per wRVU is a widely viewed metric.

- Other compensation models:
  - Fixed Compensation Only
  - Greater-of Models
  - Shift-Based or Hourly Compensation
  - Compensation to Professional Collections
  - Net Income Model

- Benefit plans are becoming more robust.

- Employment agreements have many moving parts... the “terms and features” are critically important.
If you label compensation layers by different names, you can stack them higher and higher!

- Additional Fixed Compensation
- Productivity bonus
- Quality bonus
- Admin/Medical director pay
- ED Call pay
- APP Supervision
- Teaching/Preceptorship Compensation
- Relocation costs
- Excess vacation
- Excess benefits
Market Trends in Physician Compensation

- Upward trend in physician compensation overall.

MGMA Median Compensation

- Volatility in the year over year compensation changes

![Median Compensation Chart]

Year to Year Change in Median Compensation by Specialty

Source: MGMA Physician Compensation and Production Survey; 2014 through 2017 versions of the survey
Employment Agreements: Using Survey Data

- Problems with Survey Data:
  - Surveys are voluntary – not random samples
  - Limited regional and local data
  - Surveys are just data – not compensation systems
  - Survey data can be misleading (e.g., physician productivity data)

- As one example (from 2017 MGMA data), for general surgery:
  - 90th percentile cash compensation = $652,000
  - 90th percentile wRVUs = 11,361
  - 90th percentile compensation per wRVU = $104.13
  - Therefore, 11,361 x $104.13 = approx. $1,183,000!! (i.e., 181.4% of the 90th percentile)

Source: MGMA Physician Compensation and Production Survey 2017 Report based on 2016 Data
Observed Relationship between Compensation and Production

Quartiles Grouped by Work RVUs for Surgery: General

Source: MGMA Physician Compensation and Production Survey 2017 Report based on 2016 Data
Observed Relationship between Compensation and Production

Source: MGMA Physician Compensation and Production Survey 2017 Report based on 2016 Data
Observed Relationship between Compensation and Production

Source: MGMA Physician Compensation and Production Survey 2017 Report based on 2016 Data
Common FMV Pitfalls
Issues in Employment Agreements: Misapplications

- Survey Data
- “Stacking” Services (are additional services provided in addition to clinical services requirements?)
- Production compensation to personally performed services
- Appropriate modifiers in billing
- FMV opinion
  - Misapplied “units”
  - FMV opinion included critical governing assumptions that were not considered in its application.
Issues in Employment Arrangements: Practice Losses

- Can Compensation Plans Result in Practice Losses?
  - What magnitude of losses is acceptable?
  - Can you use a compensation formula that guarantees losses?
Issues in Employment Arrangements: 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?
Arbitrage Opportunities

- 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.
Case Studies
Cases Covered

- Bradford Regional Medical Center
- Halifax Hospital Medical Center
- All Children’s Medical Center
- Solinger
- Citizens Medical Center
- Memorial Health System
- Lexington County Health Services
- Infirmary Medical Center
- Mercy Springfield Hospital
- Berkeley HeartLab
### Bradford


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<tr>
<th>Pressures:</th>
<th>Addition of competing nuclear imaging camera by community physicians on the medical staff.</th>
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<tbody>
<tr>
<td><strong>Compensation Arrangement:</strong></td>
<td>Sublease arrangement for use of physician group’s camera exclusively by Bradford, consisting of total pass-through cost of lease plus four times as much for a covenant-not-to-compete. Bradford also paid physician group rent for camera space, secretarial and administrative expenses associated with operation, and a billing fee equal to 10% of all Bradford collections.</td>
</tr>
<tr>
<td><strong>Exception(s) Relied Upon:</strong></td>
<td>Indirect Compensation, Equipment Rental, Space Rental, Fair Market Value</td>
</tr>
<tr>
<td><strong>Government’s Position:</strong></td>
<td>Bradford’s compensation to physician group was an indirect compensation arrangement that was not fair market value because it <em>reflected</em> the anticipated referrals of the physicians.</td>
</tr>
<tr>
<td><strong>Court Holding:</strong></td>
<td>No exceptions applied to the compensation arrangements at issue because they took into account the volume or value of anticipated referrals generated by the physicians to refer and, therefore, could not meet the FMV requirement.</td>
</tr>
<tr>
<td><strong>Bad Facts:</strong></td>
<td>An FMV opinion obtained by Bradford determined that the non-compete agreement was fair market value because it protected several revenue streams and expected that the physicians would refer to Bradford since they would not have a financial interest to refer to their own facility. Damaging CEO deposition testimony.</td>
</tr>
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Bradford Medical Center

• Hospital threatens loss of privileges for owners of competing nuclear camera - settlement involved various payments to physicians

• 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
  • Valuator created a table of expected revenues the hospital would receive with the non-compete in place

• Components of the analysis included consideration of CT/MRI revenues/expenses, inpatient net revenues and outpatient net revenues, even though the physicians were only thinking about adding CT/MRI to the ancillary services furnished in their practice.

• Valuation based on assumption that that the physicians would refer the business to the hospital in the absence of a financial interest in their own facilities and services.
Bradford and the Volume or Value Standard

The Court held:

“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] 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.”
Bradford’s Bad Facts

- According to deposition testimony of the CEO, the purpose of the arrangement was not simply to acquire a piece of equipment. The CEO expected the hospital would receive a substantial number of referrals from the two physician as a result of the sublease.

- In response to a “hypothetical question” of whether he would have entered into the sublease arrangement if he knew that the hospital would not receive any referrals from the physicians, the CEO responded that he would not have.
Halifax
(United States ex rel. Baklid-Kunz v. Halifax Hospital Medical Center et al., M.D. Fla. No. 6:09-cv-Orl-31TBS, Nov. 13, 2013)

<table>
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<tr>
<th>Pressures:</th>
<th>Substantial revenue for oncology technical services (alleged to be 10x as much as oncology professional services).</th>
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</thead>
</table>
| Compensation Methodology: | • Annual base salary  
• Productivity bonus – incentive compensation pool which equaled 15% of operating margin for Medical Oncology Program **based on** personally performed services |
| Exception(s) Relied Upon: | Bona Fide Employment (Indirect Compensation Arrangement in the alternative) |
| Government’s Position: | Halifax failed to meet Bona Fide Employment exception because the basis of the productivity bonus included DHS revenues generated by the physicians. |
| Court Holding: | The productivity bonus pool included DHS revenues in violation of the Stark law. Just because the proportional share of the pool was determined through a physician’s personally performed services, the ultimate bonus still varied based on referrals made. |
| Bad Facts: | Advice of Counsel Defense did not apply because counsel had not opined that arrangement was lawful, just that there were colorable arguments about its legality. |
• Hospital created a pool of dollars to distribute based on a percentage of revenues generated by the oncology department, which included DHS revenues.

• The pool was allocated to each physician in group based on personally performed services.

• The employment exception to the Stark Law allows the payment of productivity bonuses “based on services personally performed by the physician”

• Legal analysis: “In this case, the payment by [the Hospital] is a productivity bonus, and it is based on services performed personally by the Oncologists. Thus, the literal language of the Production Bonus Exception appears to be satisfied.”

• But lots of qualifying language, including “a regulator may argue that the exception is not satisfied . . .”
Halifax Hospital Decision
(United States ex rel. Baklid-Kunz v. Halifax Hospital Medical Center et al., M.D. Fla. No. 6:09-cv-Orl-31TBS, Nov. 13, 2013)

- 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).

- Side Issue: Be consistent with your advice; don’t write one thing, but say something else.
### All Children’s Health System

(United States ex rel. Schubert v. All Children’s Health System, Inc. et al., M.D. Fla. No. 8:11-cv-01687-T-27EAJ, Nov. 15, 2013)

<table>
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<tr>
<th>Pressures:</th>
<th>Competitive market for recruitment of pediatric subspecialists.</th>
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<tr>
<td><strong>Compensation Methodology:</strong></td>
<td>Despite relator’s development of a compensation package that would be between 25 and 75 percent of a nationwide median salary range, nearly 1/3rd of recruited physicians were paid above the 75th percentile.</td>
</tr>
<tr>
<td><strong>Exception(s) Relied Upon:</strong></td>
<td>None (instead arguing that Stark does not apply to Medicaid and even if it does, relator failed to sufficiently allege that financial relationship existed).</td>
</tr>
<tr>
<td><strong>Relator’s Position:</strong></td>
<td>Physician group operated at a loss with excessive compensation, but this was a financial boon for All Children’s due to physician referrals. Stark law applies to Medicaid in the same manner it applies to Medicare.</td>
</tr>
<tr>
<td><strong>Court Holding:</strong></td>
<td>As a threshold matter, Stark applies to Medicaid claims through the payment of the FFP to the State (All Children’s allegedly caused the state to request FFP). The relator sufficiently alleged financial relationship that took into account anticipated referrals and ability of physicians to generate business.</td>
</tr>
<tr>
<td><strong>Bad Facts:</strong></td>
<td>CEO ignored Board-approved compensation valuation plan developed by relator after substantive research on fair market value. Physician groups operated at a loss because of physician salaries, questioning whether the arrangement was commercially reasonable.</td>
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</table>
• Court rules in favor of Relator
  • “Reading the [Complaint] in the light most favorable to Relator, it adequately alleges that physicians’ salaries were inflated above fair market value to compensate them for their ability to generate additional revenue for the [Hospital] through referrals and test.”
  • Court cites with approval the CMS commentary that fixed compensation takes into account the volume or value of referrals if the payment exceeds fair market value.
<table>
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<tr>
<th>Pressures:</th>
<th>No apparent pressures.</th>
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<tbody>
<tr>
<td>Compensation Methodology:</td>
<td>As part of an Academic Medical Center, University of Louisville Medical School Fund received grants and paid faculty salaries to physicians. Norton d/b/a Kosair Children’s Hospital contributed to the Fund, which ultimately flowed to physicians who referred to Kosair for items and services payable by Medicaid.</td>
</tr>
<tr>
<td>Exception(s) Relied Upon:</td>
<td>AMC Exception</td>
</tr>
<tr>
<td>Relator’s Position:</td>
<td>Academic service agreements with physicians were “shams” since no adequate time-keeping documentation and hospital and university failed to have adequate written agreement in place. Relator’s valuation expert alleged that physician salaries exceeded fair market value.</td>
</tr>
<tr>
<td>Court Holding:</td>
<td>Court ruled that the hospital met elements of AMC exception, which were broad and intended to allow flexibility. Court noted that “[a]ny definition of fair market value that would automatically deem anything over the median or indeed, anything at the 80th percentile, as necessarily not being fair market value would seem illogical.” It also held that when a third party is setting physician salaries, amounts contributed that may support those salaries do not result in the salaries themselves being determined in a manner that takes into account volume or value of referrals.</td>
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How to Reconcile All Children’s and Villafane?

- **Villafane**
  - “[a]ny distribution of salaries in a marketplace will show some higher or lower than others. Provided a salary is well within a statistical distribution defining the market as a whole, it seems difficult to argue that it is not fair market value.”
  - “[a]ny definition of fair market value that would automatically deem anything over the median or indeed, anything at the 80th percentile, as necessarily not being fair market value would seem illogical.”

- **All Children’s**
  - Relator adequately alleged that the salaries were inflated above FMV to compensate them for the ability to generate additional revenues through referrals and tests. Thus, the compensation takes into account the volume or value of referrals generated by the physicians.
Citizens Medical Center
(United States ex rel. Parikh v. Citizens Medical Center, No. 6:10-CV-64, S.D. Tex. 2014).

• Relators alleged numerous improper arrangements between the hospital and specialty physicians
• Relator alleged that ER Physicians were paid bonuses for referring patients to the chest pain center; bonuses were paid by sharing the revenue generated in the chest pain center with the referring ER physicians.
• Also alleged a bonus system wherein gastroenterologists who participated in hospital’s colonoscopy screening program received bonus compensation for referring patients to the hospital.
  • GI physicians would receive $1,000/day for overseeing screening services.
  • No additional work required by the physician.
• Court ruled that relators’ allegations against ER and GI physicians were sufficient to survive a motion to dismiss
Citizens Medical Center
(United States ex rel. Parikh v. Citizens Medical Center, No. 6:10-CV-64, S.D. Tex. 2014).

- Cardiologists were paid above-market guaranteed salary and provided discounted office space as incentives in exchange for Medicare and Medicaid referrals; hospital purchased physician practices to lock up imaging referrals
  - Doctors were guaranteed “many times more in salary than [they] earned in private practice” and were able to rent office space “at a significantly reduced rate below the fair market value”
  - Cardiologists’ salaries more than doubled after they became employed by the hospital (but still below national median). The hospital lost money on the cardiologists’ practices, but continued to employ them for the referrals.
- Court: It would make little economic sense for the hospital to employ cardiologists at a loss unless it were doing so for some ulterior motive – a motive Relators identify as a desire to induce referrals.
- Didn’t matter to the court that the physicians were paid below the national median.
Memorial Health System – Savannah, Georgia

- Relator (former CEO) allegation that Memorial paid excessive bonuses to the 100 physicians it employed ($4.2 million in bonuses paid to 45 hospital employed physicians and $3 million in bonuses to 55 community-based physicians).
- Government alleged that the compensation paid to physicians by Memorial Health was inconsistent with FMV, took into account the volume or value of referrals, and was not commercially reasonable in the absence of referrals.
- Memorial reported an $18.6 million loss, of which $8.5 million was attributable to community-based physician practices during the compensation period. Every member of one group was paid at or above 90th percentile of the MGMA.
- Comment of the Chairman of Memorial's Strategic Planning Committee: "that addressing [fair market value] issues was a difficult decision and the Board recognized that Memorial could not continue to pay the salaries at the same [then current] level," but that Memorial also "could not afford to lose paying patient referrals to the hospital."
- Memorial paid $9.9 million to settle allegations it violated the False Claims Act.
Lexington
(United States ex rel. Hammett v. Lexington County Health Services, No. 3:14-cv-03653 (D. S.C.) (Settlement announced July 18, 2016))

- Allegations that hospital purchased physician practices to lock up imaging referrals
- Allegation that hospital offered purchase price greater than FMV for practice and offered employment agreements to physicians significantly in excess of prior salary to make up for loss of imaging/ancillary revenue
- 7-year employment contracts to lock in favorable compensation
- Hospital would track referrals of imaging physicians made to hospital and thereafter discuss referral patterns with physicians
  - Relator was “punished” by hospital for allegedly exercising independent medical judgment regarding imaging referrals

“[The hospital used] excessive compensation formulas that can only be explained as consideration for the past and future referrals the physician will generate.”
Hospital would track referrals of imaging physicians made to hospital and thereafter discuss referral patterns with physicians

Tiered compensation formula paying higher amounts for higher wRVU threshold

DOJ declined to intervene but the Relator continued to pursue the case

Case settled for $17mm

Hospital entered into CIA
<table>
<thead>
<tr>
<th><strong>Pressures:</strong></th>
<th>No apparent pressures – simple captive P.C. gone wrong.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Compensation Methodology:</strong></td>
<td>Infirmary paid physicians on a compensation percentage basis (57 – 61%) that included collections of DHS referrals rendered by Infirmary without involvement of the referring physician. Physician group was also compensated by Infirmary and provided “Preset Stark Bonuses” based on a physician’s referred DHS collections in the prior year or years, as well as an equal distribution to all physicians of any amounts left over.</td>
</tr>
<tr>
<td><strong>Exception(s) Relied Upon:</strong></td>
<td>In-Office Ancillary Services Exception</td>
</tr>
<tr>
<td><strong>Government’s Position:</strong></td>
<td>IOAS exception requires a single legal entity – payments by Infirmary and its associated clinics to physicians and group did not satisfy definition of “group practice” and improperly included DHS referrals in compensation method.</td>
</tr>
<tr>
<td><strong>Court Holding:</strong></td>
<td>Case awaiting trial, but magistrate judge has recommended that case in chief go forward, but that Infirmary (the hospital) and its clinic holding subsidiary should be dismissed, leaving just the individual clinics as defendants.</td>
</tr>
<tr>
<td><strong>Bad Facts:</strong></td>
<td>Infirmary updated employment agreements in response to Stark law changes to include only personally performed services in compensation methodology but did not, in practice, change how it compensated physicians.</td>
</tr>
</tbody>
</table>
Details Matter

• **Infirmary Decision**
  • Health System and subordinate entities focused on compliance for Stark law purposes and updated agreements after Stark regulatory changes.
  • However, there was a disconnect between legal and business operations, and compensation methodology was not actually updated to accord with the revised agreements.
  • Importance of periodic internal audits.
  • Group practice definition typically viewed in a hyper-technical way, whereas courts are more willing to find a *bona fide* employment relationship even if staffing company or similar entity involved. Need to attend to group practice details.
• Health system operating multiple related entities took ownership of infusion center from employed physicians

• As a result of collection compensation model, physicians lost margin after restructuring, but hospital agreed to make it up through management fees and “work RVU for drug administration”

• Health system backed into these fees; not based on physician work, expenses, malpractice, etc.
  • Raised questions of FMV and commercial reasonableness
  • Physicians required to be immediately available for supervision but were actively involved in patient care in connected department
• Focus on adequacy of gov’t valuation expert’s determination
• Plaintiff attempted to exclude government’s fair market value expert witness
• Court held:
  • Expert correctly excluded volume and value of referrals from assessment
  • Multiple methods of FMV assessment are not necessary for a fair assessment to be carried out – Expert used Cost-Based approach (instead of a Market approach or an Income approach) and upheld
  • Expert assessed commercial reasonableness, including space, equipment and supplies needed to perform services at issue
Questions?

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