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**Hospital Employment of Physicians:**
Complying With Stark Law and Anti-Kickback Statute

Evaluating Employment Models, Structuring Agreements, and Planning for Physician-Hospital Alignment

Thursday, November 12, 2015

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

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Déjà Vu All Over Again!

Haven’t We Done This Before?

Why the Emphasis on Physician Employment Now

When the Concept Failed in the 1980s and 1990s?
Current Round of Employment Based Upon Different Principles from Prior Attempts and is Being Undertaken For Different Reasons

- Prior attempts were expensive failures because
  - Large amounts paid for goodwill and other intangibles
  - Employment compensation was often guaranteed
    - Result was dramatic drop off in production
- Current models focus upon achieving integration through performance based compensation structures and lean asset purchases limited to hard assets
Why the Trend Towards Employment Now?

- For Hospitals:
  - Reform! Reform! Reform! Healthcare reform mandates integration through accountable care organizations and bundled payments
  - Staking out/increasing market share
  - Capturing higher HOPD reimbursement rates and ancillary service revenues
  - Satisfying coverage needs
  - Addressing marketing considerations using high profile and profitable specialty services
  - Increased willingness of administrations to work with physicians
Why the Trend Towards Employment Now?

- For Physicians
  - Reform! Reform! Reform!
  - Concerns regarding reimbursement amid climate of political gridlock
  - Increasingly aggressive managed care environment
  - Heavy and expensive regulatory and IT burdens
  - Security/lifestyle concerns
  - Increased trust of hospital administrations
Why the Current Trends Towards Employment?

- Employment arrangements are not the only means for achieving integration
- Gainsharing
- Management and Co-Management Relationships
  e.g. Physician groups are paid to manage service lines for a management fee consisting of two components: (i) monthly flat fee and (ii) variable bonuses conditioned on the achievement of certain benchmarks
Regulatory Framework

- Corporate Practice of Medicine Doctrine: State law doctrine aimed at preventing non-physicians from impairing the medical judgment of physicians through employment
  - Health law version of “Blue Sky” laws in that they vary from state to state and the law is sometimes contained in case law and not only statute
  - There is often a state law exception which allows hospitals to employ physicians
  - Even under the most stringent of corporate practice state law regimes the benefits of physician employment can usually be realized
    e.g. “Captive PC Model.”
“Captive PC Model”

- Health System
- Stock restriction agreement with President or governing body of PC granting “say” over fundamental matters
- “Friendly” PC
- Physician employment or personal services agreements
- Physicians

*ReedSmith*
Anti-Referral Statutes

- **Federal Stark Statute**: 42 U.S.C. 1395.nn. Civil federal statute which prohibits referrals of certain “designated health services” by physicians to providers with which they have a “financial relationship” unless an exception is satisfied
  - compensation relationship
  - ownership relationship

- **Strict Liability Statute**: Intent is irrelevant. Penalties for violation include heavy fines and possible exclusion from participation in federal programs
Regulatory Framework continued.

- Stark Law Exceptions Applicable to Compensation Relationships:
  - Bona Fide Employment Relationships – 42 CFR 411.357(c)
    - Employment for identifiable services
    - Remuneration is (i) fair market value, (ii) commercially reasonable even if no referrals were to be made to the employer and (iii) is not determined in a manner which tracks the volume or value of referrals but productivity bonuses may be paid for services personally performed by the physician
  - Emphasis on Bona Fide! The Government will confirm

    § e.g. U.S. v. Campbell, M.D. 2011 WL 43013 (D.N.J.); (Action against physician under the False Claims Act on grounds that physician did not actually perform the full “menu” of services under his part time employment agreement and that agreement was merely a vehicle to obtain referrals)
Regulatory Framework continued.

- Personal Services Arrangements – 42 CFR § 411.357(d)
  - Arrangement is set out in writing, signed by the parties and describes the services being offered
  - The arrangement covers all services being performed by the physician
  - The contracted for services do not exceed those which are necessary
  - The term is for at least one year
  - Compensation is set in advance, does not exceed FMV and is not calculated in a manner that takes into account volume or value of referrals
  - The arrangement does not violate the federal anti-kickback statute

*14
Regulatory Framework continued.

- Stark Law Exceptions Applicable to Ownership Relationships:
  - In states where the corporate practice of medicine imposes barriers to employment, “captive practices” may remain intact, and an exception for ownership relationships as well as compensation relationships must be identified.

- Recent Stark Law Cases Raise the Red Caution Flag!
  - **U.S. ex rel. Drakeford v. Tuomey Healthcare System**
    - $237 million judgment awarded against South Carolina hospital as a result of Stark non-compliant part-time employment contracts
    - Recently settled for $72.4 million
  - Other cases, e.g. **Adventist Health Systems** ($118 million qui tam settlement)
  - **Tuomey** facts:
    - The hospital’s outpatient surgery center (“OSC”) and a competing physician-owned ASC received CONs at approximately the same time.
Regulatory Framework continued.

- **Tuomey** facts (cont’d):
  - Hospital engaged a consultant to assist it in evaluating the potential loss from competition and to design a plan to make up the difference. The result was a part time employment arrangement involving 19 local specialists who were all:
    - only employees of the hospital when they performed outpatient procedures
    - contractually bound to bring all of their outpatient procedures to the hospital’s OSC and to not otherwise compete within a wide radius of the OSC
    - compensated through base salaries and productivity bonuses of 80% of net collections. The package resulted in the physicians receiving approximately 131% of the professional revenue generated by them on the cases performed at the OSC
    - given full time benefits
Regulatory Framework continued.

- The **Tuomey** situation was “heavy” with experts
  - Numerous lawyers gave conflicting advice. The hospital seemed to be “opinion shopping”
  - The consultant issued a cursory fair market value analysis which did not square with the pertinent facts
- Liability stemmed from a qui tam action filed by a physician with whom the hospital was unable to contract.
Regulatory Framework continued.

- **Toumey “lessons learned”**
  - Potential liability for Stark missteps can be astronomical; consider being proactive in identifying problems with even existing contracts and self reporting
  - Physician compensation must not be based upon the volume or value of anticipated referrals
  - Physician compensation must meet both the fair market value and commercial reasonableness tests
  - Not all fair market analyses are created equal. In *Tuomey* the fmv report was deficient in its face
  - STOP! and RETHINK! your arrangement when confronted with conflicting legal opinions
  - Use “new and improved” structures cautiously. The “elastic” and over generous *Tuomey* structure appeared to the jury to be merely a “case buying scheme”
Regulatory Framework continued

- Federal Anti-Kickback Statute: 42 U.S.C. 1320a-7b. Criminal statute which provides for the imposition of severe fines and possible imprisonment if “illegal remuneration” is paid or received in exchange for the referral of services covered by Medicare or Medicaid
  - Intent based statute but threshold for intent is very low. Statute may be violated if only one purpose of the payment is to steer referrals
- Safe harbors exist which will insure participants in a transaction that they will not be prosecuted if all elements of the safe harbor are satisfied
  - Failure to satisfy all of the elements of a safe harbor will expose an arrangement to a “facts and circumstances” test
Regulatory Framework continued

- **Safe Harbor for Payments to Employees**: 42 CFR 1001.952(i). Payments by employers in a bona fide employment relationship are exempt
  - “Employees” is defined using the common law definition of the term: (i) ability to direct, (ii) exclusivity during the periods of employment, etc.
  - A0-08-22: OIG has acknowledged that the safe harbor is applicable for part time physician employees
Regulatory Framework continued

- **Safe Harbor for Personal Services**: 42 CFR 1001.952(d).
  - Agreement set out in writing covers all the services to be offered
  - Periods of time in which the services to be offered are spelled out with precision
  - The term of the agreement is not for less than one year
  - The aggregate compensation to be payable over the term is set in advance and is consistent with fair market value
  - The services which are performed do not violate state or federal law
  - The services performed do not exceed those which are reasonably necessary
Government on Alert For Sham Contractual Joint Ventures and/or Quasi Employment Relationships

- A0-08-10: OIG declined to “bless” an arrangement under which urology groups would enter into part time leases of space, equipment and personnel services from another physician group to provide intensity-modulated radiation therapy.

- OIG concluded that the arrangement bore the hallmarks of a suspect contractual joint venture referenced in Special Advisory Bulletin – 68 Fed.R. 23146, April 20, 2003
  - One party expands into a related business by contracting with an existing provider to provide services to the first party’s existing patients.
  - The second party essentially provides all services on a turnkey basis to the first party’s patient base.
  - The profits which the first party receives from referring its existing patients to the second party under the turnkey arrangement would comprise kickbacks.
Regulatory Framework continued

- Under both Stark and the AKS “Fair Market Value” is absolutely key
  - Stark Definition: “…. the compensation that would be included in a service agreement, as the result of bona fide bargaining between well informed parties … who are not … in a position to generate business for the other party.”
  - comparables are very useful
  - third party valuations highly recommended
- Must also consult state anti-referral and AKS statutes!
Important Provisions in the Bipartisan Budget Act

Effective November 2, 2015 “off campus” (i.e. more than 250 yards from the hospital) hospital outpatient departments (“HOPDs”) will not be billed at hospital rates but rather will be reimbursed at the lower ambulatory surgery center (“ASC”) or Medicare Physician Fee Schedule (“MPFS”) rates.

The legislation:

- Will not apply to HOPDs opened before November 2, 2015
- Will not apply to dedicated emergency departments
- Will permit HOPDs (including hospital-owned clinics) opened after November 2, 2015 to be reimbursed at the higher HOPD rates with the lower ASC or MPFS rates taking effect January 1, 2017
Direct Employment

- Hospital or hospital controlled professional corporations (e.g., “friendly” or “captive” PCs) directly employs physicians
  - IRS Section 501(c)(3) status
  - One-time structuring considerations
  - Infrastructure intensive – credentialing (possible payor lag), billing and collection, HR, etc. . .

- Consider hospitals experience in running a practice
  - Primary Care
  - Multi-disciplinary
Direct Employment continued

- Less Implication – less hassle than other models
  - Stark Bona Fide Employee Exception
  - AKS Safe Harbor
  - Compensation – use of a valuation consultant for insulation
  - Corporate Practice of Medicine
  - State anti-referral laws (NJ key example)

- Physicians talk to each other – contract consistency is key
  - Compensation/benefits
  - Call
  - Noncompetition provisions
Direct Employment and Asset Purchase

- Asset purchase vs. stock purchase
  - Exposure associated with the practice’s prior acts
  - Considerations for agreement’s representations and warranties
  - Corporate practice of medicine considerations

- Hospital’s strategy and market may drive decision to choose purchase/employment rather than only employment

- Immediate integration of a service line/patient base

- Conducting thorough due diligence is key

- Valuation Methodology
Physician Leasing Arrangements

- Services can be leased by Hospital from a physician group, or by a physician group from a Hospital

- Provides for low-level integration in the context of higher level of relationship development
  - May lead to future high-level integration

- Legal Considerations
  - Stark Personal Services Exception
  - AKS Personal Services Safe Harbor
  - AO 08-10 (Aug. 26, 2008)

- As with most of the various relationships between Hospitals and physicians, FMV is critical
  - In its purest form, a leasing arrangement is mostly dependent on the parties agreeing on what the leased services are worth from a FMV perspective
FMV Issues to Keep in Mind

- Asset/service line being purchased
  - What is being valued?
  - Does having a “value” necessarily translate into FMV?
  - Will referrals from the Seller be necessary post-purchase?

- Practice lease/PSA
  - Is payment based on $/wRVU?
  - How is amount determined?
  - Upside/downside risk?
  - Methodology the same for both?
Practice becomes an MSO and enters into a management agreement with the Hospital. Staff (and possibly mid-levels) remain employees of the Practice.
Physician Enterprise Model

- Often considered a step toward more fulsome integration (e.g., direct employment)
- Provides for low-level integration in the context of higher level of relationship development
  - May lead to future high-level integration
  - Potential challenges with lower level of integration?
- Can be unwound more easily than employment/purchase model – Practice entity (the new MSO) remains intact and ready to be re-converted to a medical practice
Physician Enterprise Model continued

- May be financially lucrative for participation physicians
  - Incentive based compensation
  - Hospital negotiated rates
  - Guaranteed revenue stream for physicians
- Less administratively burdensome to Hospital
- Less costly to Hospital than purchasing assets (thought the ultimate savings may be lower than expected depending on valuation methodology utilized to value a practice)
Physician Enterprise Model

- Fair market value
  - Management services
  - Physician compensation
  - Office space and equipment

- Employment of physicians
  - Employment Safe Harbor/Exception

- Management Services
  - Personal Services Safe Harbor/Exception
  - Office Rental Safe Harbor/Exception
  - Equipment Lease Safe Harbor/Exception
Physician Recruitment Arrangements

- Recruitment Arrangements facilitate a strong high level relationship, but with low level integration
- AKS/Stark safe harbor and exception
- Key compliance considerations
  - Community Needs Assessment
  - Distance requirements/fresh out of schooling
  - Arrangement can cover only net new costs directly attributable to the recruited physician
  - Medicaid patients
  - Employment agreement noncompetition provisions – not necessarily impermissible – but should be very carefully drafted to allow the recruited physician to continue practicing in the community if employment with the Practice ends.
Physician Recruitment Arrangements continued

- Practical considerations
  - Review budgets at early stage of discussions
  - Be frank about expectations from day 1
  - Point person at both Hospital and Practice
- Repayment of the forgivable loan if the arrangement is terminated
Practical Stumbling Blocks

- Regardless of model – know as much as you can about your potential “partners”
  - Diligence is key
- Do the Hospital’s goals match up with the actual day-to-day activities of the physician/practice?
  - Research
  - Labs
  - Other ancillary services
Practical Stumbling Blocks continued

- Leases
  - Who owns the space? FMV rent?
  - If it’s not the physician/group, does the lease term enable the Hospital to move forward with larger strategic considerations?
  - Are there subleases? To whom?

- Who really owns the assets?
  - UCC search
  - Serving as collateral to a loan or line of credit?

- HR considerations
  - Mid-levels
  - Administrative staff
Hospital Employment of Physicians: Legal Strategies

Physician Employment Agreements and Ancillary Agreements

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Topics to be Addressed

- Duties and Responsibilities
- Autonomy
- Term and Termination
- Compensation and Benefits
- Incentive Pitfalls to Avoid
- Restrictive Covenants
Duties and Responsibilities

- Why do the parties care?
  - Employer: Maintain Flexibility
  - Employee: Achieve Certainty

- Duties and Responsibilities may differ significantly from the historical medical practice employment agreement
Duties and Responsibilities

- Hours (patient / clinical hours); FTE, PTE?
- Services
- Administrative Responsibilities
- Billing and Compliance
- Compliance with professional standards, employer’s policies, rules and regulations
- Non-Employer Based Activities
- Patient Selection
- Fee Establishment
- Facilities; Location; Referrals
- Equipment
Autonomy

- What does “Autonomy” encompass?
  - At the Hospital
  - During “off hours”?
- Who controls decision making
  - Clinical?
  - Administrative?
- Where, how and how strong is the physician(s) voice?
  - Governance?
  - Deadlock?
Term and Termination

- **Term**
  - 1, 3 or 5 year terms
  - Conditions to Effective Date?
  - Patient care obligations contemporaneous with Effective Date?

- **Renewals**
  - Automatic?
  - Notice requirements
  - Ties to other obligations
Term and Termination

- **Termination**
  - For Cause – by the Employer
    - If the Employer is unable to obtain malpractice insurance covering Employee;
    - If the Employee’s license to practice medicine is revoked, terminated, limited, conditioned, suspended, restricted in any way;
    - If the Employee’s license to prescribe or dispense controlled substances is revoked, terminated, limited, conditioned, suspended, restricted in any way;
    - If the Employee is found guilty of professional misconduct by any professional organization having jurisdiction;
    - If the Employee is excluded, terminated, suspended or declared ineligible to participate in Medicare, Medicaid, or any other governmental program providing compensation for services rendered to patients;
    - If the Employee is charged with the commission [conviction] of a felony crime, or a crime involving moral turpitude.
    - If the Employee’s medical staff membership or clinical privileges at the Hospital are revoked, terminated, limited, conditioned, suspended, restricted in any way;
    - The Employee’s failure or refusal to faithfully and diligently perform the duties of, or adhere to the provisions of this Agreement.
    - If the Employee’s board certification is restricted, limited, suspended or revoked;
    - If the Employee commits or engages in any act or practice, including without limitation the abuse of alcohol or drugs, which is detrimental to the care and treatment of the Employer’s patients or otherwise detrimental to the Employer.
    - If the Employee fails to commence services hereunder on the Commencement Date.
  - Change in Control – By the Employer or Employee
Term and Termination

- **Termination**
  - For Cause – By Employee
    - Employer’s licensure, certification or accreditation expires or is revoked, terminated, limited, conditioned, suspended, restricted in any way or not renewed;
    - Employer is excluded, terminated, suspended, or declared ineligible to participate in Medicare, Medicaid, or any other governmental program providing compensation for services rendered to patients;
    - Employer fails or refuses to perform or fulfill any of Employer’s duties, obligations or covenants under the Agreement;
    - Employer files for bankruptcy, is adjudicated bankrupt, takes advantage of applicable insolvency laws, make an assignment for the benefit of a creditor, or a receiver or its equivalent has been appointed for Hospital’s property.
Term and Termination

- Termination
  - Without Cause
    - Implications of the “no-cut”
    - Mutual?
      - Might this change at a renewal period?
    - What notice?
    - Accelerated Removal Options by the Employer?
  - Death or Disability
Term and Termination

- Impact on other obligations
  - Tail coverage
  - Bonus payments
  - Restrictive Covenants
  - Severance Pay
  - Any unwind of a related purchase transaction
- Access to Medical Records
- Return of Property
- Due Process
Compensation

- **Typical Arrangements**
  - Base for the entire term
  - Base + Productivity
  - Productivity, less expenses (periodic reconciliation)
  - Compensation for administrative duties, research?

- **Typical Adjustments**
  - Base adjustments if fail to meet a minimum productivity threshold
  - Conversion Factors
  - “Soft” factors – patient satisfaction, quality measures
  - Outside income?
Compensation and Benefits

- Issues:
  - Fair market value measurement
  - Base salary or pure production
  - Some measure other than wRVUs (what about quality?)
  - Credit for “other services” at the Hospital? Cash or Credit?
  - Ancillaries
  - How / when does the formula adjust?
  - Audit rights
Compensation and Benefits

- **Typical Benefits:**
  - All standard benefits provided to similarly situated employees
  - Retirement
  - Paid Time Off
  - Medical Insurance

- **Unique Benefits**
  - Signing Bonus
  - Moving Expenses; Housing Allowance
  - Professional Society Fees and Dues
  - Professional Liability Insurance
  - CME (time and money)
  - Business Expenses
  - Payment of Student Loans
  - Severance Payments
  - Athletic Facilities
  - Educational Expenses (non-CME)
  - Child Care
  - Life Insurance
Incentive Pitfalls to Avoid

- Commercially reasonable? Watch for “overnight successes” (moving from 65\textsuperscript{th} percentile to 95\textsuperscript{th} percentile)
- \(1+1=1.5\)
- No ties to productivity + a long “no cut” term
- Failure to obtain a fair market value analysis of the compensation
- Overextending the employee = overpayment of compensation
- Failure to reconcile and collect shortfalls or offset against future payments
Restrictive Covenants

- Not to Compete
  - Generally valid during the term of the employment agreement (e.g., moonlighting, teaching, research)
  - Vary State by State
    - Consider reasonableness of term, scope and duration
    - Whether the Court will blue-pencil?
    - In conjunction with the purchase of the Practice?
  - To which of the specific duties might the restrictive covenant apply? (e.g., patient care, ownership in competing ancillary?)
  - Variances based upon termination
  - Sunset provisions
Restrictive Covenants

- Non-Solicitation
  - Patients
  - Employees
- Confidentiality
  - Generally enforceable
- Intellectual Property
  - Who owns what?
  - Does the participation terminate with the Agreement?
- Sunsets, carve-outs and limited exceptions are less prevalent
- Ability to address competition indirectly through these provisions
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