Valuation Challenges in Physician Compensation Arrangements: Meeting Compliance and Regulatory Requirements

Navigating the Complexities in PSAs, ED Call Coverage, Service Line Co-Management and Shared Savings Arrangements

THURSDAY, JULY 16, 2015

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

Today’s faculty features:

Scott M. Safriet, Partner, HealthCare Appraisers, Delray Beach, Fla.

William H. (Bill) Thompson, Chairman of the Firm, Hall Render Killian Heath & Lyman, Indianapolis

The audio portion of the conference may be accessed via the telephone or by using your computer’s speakers. Please refer to the instructions emailed to registrants for additional information. If you have any questions, please contact Customer Service at 1-800-926-7926 ext. 10.
Tips for Optimal Quality

Sound Quality
If you are listening via your computer speakers, please note that the quality of your sound will vary depending on the speed and quality of your internet connection.

If the sound quality is not satisfactory, you may listen via the phone: dial 1-866-819-0113 and enter your PIN when prompted. Otherwise, please send us a chat or e-mail sound@straffordpub.com immediately so we can address the problem.

If you dialed in and have any difficulties during the call, press *0 for assistance.

Viewing Quality
To maximize your screen, press the F11 key on your keyboard. To exit full screen, press the F11 key again.
Continuing Education Credits

In order for us to process your continuing education credit, you must confirm your participation in this webinar by completing and submitting the Attendance Affirmation/Evaluation after the webinar.

A link to the Attendance Affirmation/Evaluation will be in the thank you email that you will receive immediately following the program.

For additional information about CLE credit processing call us at 1-800-926-7926 ext. 35.
Valuation Challenges - Meeting Compliance and Regulatory Requirements in a Changing Healthcare Landscape

July 16, 2015

William H. Thompson, Esq. | Chairman, Hall Render Killian Heath & Lyman, PC

Scott M. Safriet, MBA, CVA | Partner, HealthCare Appraisers
1. Regulatory Concerns
2. Critical Issues in Valuation
3. FMV Pitfalls
4. Questions
Complex Regulatory Environment

- Complex, highly technical and overlapping requirements
- Increasing number of compensation relationships with referring physicians
- Aggressive government enforcement
- Potential whistleblowers
- Obligation to self-disclose violations and refund $
- Disproportionate Penalties = Enterprise Risk
- Physician arrangements must be **defensible** under the Stark Law
- Process and documentation should support defensibility
Legal/Regulatory Framework

- False Claims Act
- Anti-Kickback Statute
- Federal Stark Law
- Other Relevant Laws
  - Tax-Exemption Laws
  - Private Benefit and Private Inurement
  - Intermediate Sanctions
  - Civil Monetary Penalties Law
  - State Equivalents
Anti-Kickback Statute
42 U.S.C. § 1320a-7(b)(b)

Criminal Statute -

- Prohibits paying “compensation” to induce items or services payable under federal health care programs
- Intent is required (case law allows for inference of intent)
- Broad and subjective statute: “One Purpose” standard

Safe Harbors -

- Protection requires strict compliance with all conditions of the applicable safe harbor
- Failure to comply with a safe harbor does not mean an arrangement is illegal
- Arrangements that do not fit in a safe harbor must be evaluated on a case-by-case basis (i.e., is the requisite intent present?)
Anti-Kickback Safe Harbors
42 C.F.R. § 1001.952 et seq.

- Investment Interests (large entity, small entity, underserved area)
- Space Rental
- Equipment Rental
- Personal Services and Management Contracts
- Sale of Practice
- Practitioner Recruitment
- Waiver of Coinsurance/ Deductibles
- Price Reductions for Health Plans/Managed Care Organizations
- Referral Services
- Warranties

- Discounts
  - Employees
    - Group Purchasing Organizations
    - Ambulatory Surgical Centers
    - Group Practices
    - Obstetrical Malpractice and Insurance Subsidies
    - Referral Agreements for Specialty Services
    - Ambulance Replenishing
    - Health Centers
    - Electronic Prescribing/Health Records
If a Physician has a Financial Relationship with an Entity:

Then the Physician may not make a referral to that Entity for the furnishing of designated health services (“DHS”) for which payment may be made under Medicare; and

The Entity may not bill Medicare, an individual, or another payor for the DHS performed pursuant to the prohibited Referral...

... unless the arrangement fits squarely within a Stark exception.

Stark’s Three (3) Part Analysis:

Is there a Referral from a Physician (or family member) for a DHS?

Does the Physician have a Financial Relationship with the Entity furnishing the DHS (e.g., the hospital)?

Does the Financial Relationship satisfy an exception?
Designated Health Services ("DHS")

- Clinical laboratory services
- Physical therapy, occupational therapy, and speech-language pathology services
- Radiology and certain other imaging services
- Radiation therapy services and supplies
- Inpatient and outpatient hospital services
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetic devices and supplies
- Home health services
- Outpatient prescription drugs
The Stark Exceptions
42 C.F.R. § 411.350 et seq.

**Commonly Used Stark Exceptions:**
- Rental of Office Space or Equipment
- Physician Recruitment
- Personal Service and FMV Exceptions
- Isolated Transactions
- Bona Fide Employment
- In-Office Ancillary Services
- Risk-Sharing Arrangements

**Common Elements of the Stark Exceptions:**
- Signed, written agreement that specifies the services or property
- Arrangement must be commercially reasonable, and compensation must be consistent with FMV
- Compensation must be set in advance and not take into account the volume or value of referrals generated between the parties
Burden of establishing FMV rests with the parties

Appropriate valuation methods:
- CMS will not provide “bright-line” standards
- Based on facts and circumstances
- Look to nature of the transaction, location and other factors

Limited guidance from CMS:
- External valuations may be relevant to intent but will not ensure FMV
- Use of multiple, objective, independently published surveys is prudent
- Documentation sufficient to support FMV will vary – no rule of thumb
- FMV for administrative services may differ from FMV of clinical services
- Definition is qualified and may not align with standard valuation techniques and methodologies
No statutory or regulatory definition of **Commercial Reasonableness**

**Language in the Stark exceptions is illustrative:**
- CR, even if no referrals were made between the parties
- CR, taking into account the nature and scope of the transaction
- Reasonable and necessary for the legitimate business purposes of the arrangement

**CMS commentary on the CR standard:**
- **Subjective:** Sensible, prudent business agreement from the perspective of the parties
- **Objective:** Would make 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 for DHS referrals

**Would the parties do this deal if there were no referrals? Does the deal stand on its own?**
“Taking into Account” DHS Referrals

Most Stark Law exceptions prohibit “taking into account” DHS referrals:

- TIA language previously viewed as prohibiting a formula that directly considers anticipated DHS referrals
- Recent case law seems to indicate that the decision of whether or not DHS referrals were TIA should be left up to a jury’s discretion

Note: There is risk of the TIA prohibition being triggered by normal business behavior:

- Simply stating a desire (or hope) for future referrals
- Projecting referrals from physicians in order to properly operate the hospital
- Transaction planning that examines downstream revenues

Caveat: Consider 411.354(d)(4) - Narrow rule allowing directed referrals.
Stark Penalties = Enterprise Risk

**Stark Sanctions**
- Denial of payment/repayment of reimbursement
- CMPs of up to $15,000 per item or service
- CMPs of up to $100,000 for each arrangement considered to be a circumvention scheme
- Exclusion from Medicare and Medicaid

**Potential for False Claims Liability**
- A Stark violation renders all related claims false or fraudulent overpayments, thus giving rise to an FCA violation
- Retention of “identified” overpayments for over 60 days is a false claim unless repaid or self-disclosed
- Triple (3x) the amount of damages suffered by the government
- Mandatory CMPs of $5,500 to $11,000 for each claim
The Regulatory Climate

- Increases in enforcement (through *qui tam* suits)
- Allegations that compensation is not FMV, not CR, and that compensation takes into account referrals
  - June 9, 2015 OIG Fraud Alert; Physician Compensation Arrangements
- Technical issues with team-based and bonus methodologies
- Testing of the internal compensation methodologies and underlying “group practice” requirements

Recent Enforcement Actions:

- Tuomey (2015 – $237 million)
- Infirmary Health System (2014 – $25 million)
- Halifax Hospital (2014 – $85 million)
- King’s Daughters Medical Center (2014 – $40.9 million)
- Citizens Medical Center (2015 – $21.75 million)
- Westchester Medical Center (2015 – $18.8 million)
Key Takeaways

*Payment prohibition + FCA liability = Astronomical Damages*

Key Takeaways:

- Compensation models must be **defensible** under the Stark Law
- **Documentation** and **governance** process should support defensibility
- Focus on **3 Tenets of Defensibility**: Fair market value (“FMV”), commercial reasonableness (“CR”) and not taking into account (“TIA”) the volume or value of referrals
What is FMV?

- A term of art in the valuation community
- A hypothetical transaction between a hypothetical willing buyer and a willing seller
- FMV is established without regard to whether a transaction actually occurs
Physicians’ expectations are oftentimes difficult to counter.

Competing offers from other hospitals may not have been subject to an independent 3rd party valuation, and even if they have, they likely cannot be considered under the FMV definition, as they would be data “between parties in a position to refer to one another.”

Consultants can establish expectations that may or may not be realistic (i.e., not commercially reasonable and/or not FMV).

An independent appraiser should not be inherently conservative. Discussion can take place regarding the perceived riskiness of any arrangement.
Which of the Following Establishes a Defensible FMV Arrangement?

A. This was the very best we could negotiate.
B. We matched what the competing hospital is paying.
C. We would have had to close down this service line if we lost this physician.
D. We relied on MGMA data for the Midwest region.
E. All of the above.
F. None of the above.
Critical Issues in Valuation

- Employment Agreements / PSAs
- ED Call Coverage
- Service Line Co-Management Arrangements
- Gainsharing Arrangements
Roles and Responsibilities

**Role of the Client**
- The burden of establishing FMV and CR ultimately rests with the client
- The client develops and implements the internal governance and documentation processes

**Role of the Appraiser**
- Recommends compensation parameters and provides expertise
- Issues an objective third-party opinion on FMV and CR

**Role of Legal Counsel**
- Manages the valuation process consistent with the a/c privilege
- Works with the client to develop compensation plans and governance processes that support the appraiser’s FMV/CR parameters
- Carefully examines the valuation opinion to enhance defensibility
- Does not opine on FMV and CR
Employment continues at a feverish pace

Hospital employment is on the rise. In 2014, 53% of physicians reported being employed by a hospital or medical practice, up from 44% in 2013, according to a 2014 Physicians Foundation study.

New physicians overwhelmed by job opportunities, Merritt Hawkins' 2015 Final-Year Medical Residents Survey finds. Simply not enough physicians coming out of training to fill all the available openings.

63% of residents have been approached with job opportunities by hospitals, medical groups and recruiting firms 51 times or more during the course of their training.

46% have been approached by recruiters 100 times or more.
Employment agreements becoming more and more complex.

Example:

...full-time Physicians will be compensated at a base compensation of 75% of median compensation...minus $55,650 for producing 75% of median Work RVUs. If Physician works below the 75% of median Work RVUs required for his/her equivalent FTE, Physician’s base compensation will be reduced by the same percent by which WRVU threshold was not achieved.

In addition, if Physician produces above 75% of median WRVU’s...required for Physician’s full-time equivalent status, Physician will earn additional compensation in accordance with the Compensation Matrix....
Example (cont.)

Physician will be eligible to earn up to 15% of time weighted average median compensation... for achievement of performance-based measures described below.

Physician will be eligible to receive gross compensation per annum if Physician remains current on outpatient documentation of clinical encounters....

Physician will be eligible to receive gross compensation per annum if Physician remains current on inpatient documentation of clinical encounters....

Physician will be eligible to receive gross compensation per annum for utilizing ambulatory electronic medical record software and qualifying for Stage 1 Meaningful Use established by CMS/Federal Government....

Physician will be eligible to receive gross compensation per annum for attainment of 30% of all inpatient orders...and/or attainment of 60% of all inpatient orders....

Physician will be eligible to receive compensation for satisfactory performance on quarterly patient satisfaction surveys conducted by Press Ganey.

<table>
<thead>
<tr>
<th>WRVU Ranges</th>
<th>Low</th>
<th>High</th>
<th>WRVU Value</th>
<th>$/WRVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% to 75%</td>
<td>–</td>
<td>5,525</td>
<td>80%</td>
<td>$0.00</td>
</tr>
<tr>
<td>75% to 90%</td>
<td>5,526</td>
<td>6,630</td>
<td>100%</td>
<td>$41.13</td>
</tr>
<tr>
<td>90% to 110%</td>
<td>6,631</td>
<td>8,103</td>
<td>120%</td>
<td>$51.41</td>
</tr>
<tr>
<td>110% to 165%</td>
<td>8,104</td>
<td>12,155</td>
<td>80%</td>
<td>$61.70</td>
</tr>
<tr>
<td>&gt;155% above</td>
<td>12,156</td>
<td>above</td>
<td>80%</td>
<td>$41.13</td>
</tr>
</tbody>
</table>
Employment agreements becoming more and more complex.

Compensation Plan Description:

Under the Agreements, Physicians shall receive a base salary with the opportunity for additional compensation based on individual and Section work relative value unit ("wRVU(s)") production and the achievement of certain Employer-defined quality metrics. Each Physician will receive a base salary, which is determined based on wRVU production and will be adjusted up or down semi-annually based on the Physician’s actual wRVUs in the trailing twelve-month ("TTM") period relative to certain wRVU thresholds (the "wRVU Thresholds") for each applicable cardiology sub-specialty. A Physician’s wRVU production must meet or exceed the next highest wRVU Threshold in order to increase his/her base compensation. Each wRVU Threshold has a corresponding compensation indication that is determined using a percentile-matched technique. This matching technique calculates a compensation level that corresponds to benchmarked wRVU productivity based on the percentiles of productivity and compensation reported by the compensation surveys for each specialty/subspecialty. This percentile-matched compensation indication is then multiplied by 95% in order to calculate a “Base Compensation” that is appropriate for each level of productivity. Once the Base Compensation is determined for each Physician, the Base Compensation is then adjusted in the following manner in determining each Physician’s actual “Base Salary” they will receive during each semi-annual period:
In addition to Base Salary, Physicians have the ability to earn up to an additional 20% of Base Salary based on wRVU production (up to 10%) (the “Production Bonus”) and quality metrics (10% maximum) (the “Quality Bonus,” and together with Production Bonus, the “Bonuses”). The Bonuses are calculated in the following manner:
Compensation Plan Description (cont.):

The Production Bonus

- 3.3% individual Production Bonus if Physician’s wRVUs are greater than or equal to the weighted-average 40th percentile wRVUs for his/her sub-specialty (the “Individual Production Requirement”) and the Section’s wRVUs in total meets or exceeds the sum of the 50th percentile values (noting that the 50th percentile values will vary by specialty) for the number of Physicians in that particular Section. The Individual Production Requirement for the 3.3% Production Bonus increases in each year of the Agreement, as detailed below:
  - Year 1 – 40th percentile
  - Year 2 – 45th percentile
  - Year 3 - 50th percentile

- 6.6% individual Production Bonus if Physician’s wRVUs are greater than or equal to the weighted-average 55th percentile wRVUs for his/her sub-specialty and the Section’s wRVUs in total meets or exceeds the sum of the 55th percentile values for the number of Physicians in that particular Section.

- 10.0% individual Production Bonus is calculated in the same manner as the 6.6% individual Production Bonus; however, Physician and Section wRVUs are benchmarked against the 60th percentile values.
Employment Agreements: Using Survey Data

Confucius Statisticians 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 90th percentile compensation
Example of misuse of MGMA data:

For Orthopedic Surgery: General

90th percentile cash compensation - $955,000
90th percentile wRVUs – 13,831
90th percentile compensation per wRVU - $108.95

Where is this going?

90th percentile wRVUs x 90th percentile compensation per wRVU = $1,507,000... 157% of 90th percentile 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.
Employment Agreements: Perils of wRVU Models

Hospitals implementing wRVU models have been observed to make errors related to:

- “Total” vs. “work”
- GPCI adjustments
- Assistant at surgery
- Multiple procedures
- Mid-level providers
- Site-of-service differences
- CMS changes in wRVUs
- New or discontinued CPT codes
- Multiple procedure discounts (Recent)
Stacking – When is it appropriate?

Example

A cardiologist is employed on a full-time basis, and is compensated through the greater of base compensation or a predetermined rate of compensation per wRVU.

The cardiologist receives *per diem* compensation for call coverage for cardiology ED coverage...and the coverage is *restricted*.

The cardiologist has multiple medical director arrangements and/or participates in a co-management arrangement.

The cardiologist receives a rate per EKG read.
“Stacking” is the new industry watchword. If you label compensation layers by different names, you can stack them higher and higher!

- Sign-on bonus
- Productivity bonus
- Medical directorship
- Co-management agreement
- Quality bonus
- Retention bonus
- Call pay
- Tail insurance
- Excess vacation
- Relocation costs
- Excess benefits

Takeaway: Must consider *aggregate* compensation.
Quasi-Employment Agreements

- Gaining in prevalence
- Entails a PSA, with the physicians compensated as independent contractors on a wRVU basis; additional payments are made for taxes/benefits and retained practice expenses
- Payment may also be made for “leasing” of non-clinical employees and fixed assets
- FMV considerations – generally the same as employment arrangements
- Risks vs. employment: Deal must be in writing, compensation must be “set in advance,” non-competes are questionable, and gov’t may be more scrutinizing of “grossed-up” for benefits arrangements
Employment Exception

Stark Law (42 C.F.R. § 411.357(c))

- Employment is for identifiable services (need not be in writing unless a directed referral requirement)
- Compensation must be consistent with FMV (does not have to be “set in advance”), reasonable and determined at arm’s length
- Compensation cannot take into account the volume or value of referrals (productivity bonuses are allowed for personally performed services)
- Arrangement would be commercially reasonable even if no referrals are made to the employer

Anti-Kickback Statute (42 C.F.R. § 1001.952(i))

- “Remuneration” does not include any amount paid by an employer to an employee under a *bona fide* employment relationship for the furnishing of any item or service which may be payable under a federal health care program
Directed Referrals
42 C.F.R. § 411.354(d)(4)

An employer can require an employee to refer to a particular provider, practitioner or supplier as long as:

- the compensation is set in advance;
- the compensation is consistent with FMV;
- the referral requirement:
  - is in writing signed by the parties;
  - is not required if the patient expresses a preference for a different provider;
  - does not require the referral if the patient’s insurance does not cover services at the required provider;
  - relates solely to the physician’s services covered by the scope of employment and the referral requirement is reasonably necessary for the legitimate business purpose of the compensation arrangement; and
  - does not require the referral if the physician believes that the required referral is not in the patient’s best medical interest.
Stark Law

**FMV Exception** (42 C.F.R. § 411.357(1)):
- in writing, signed by the parties, and for specified services
- covers all arrangements between the parties
- does not have to be 1-year term as long as only one agreement within a year for same services
- comp is set in advance, FMV not related to volume or value of referrals
- commercially reasonable
- complies with AKS
Stark Law (cont.)

**Personal Services Exception** *(42 C.F.R. § 411.357(d))*:  
- set out in writing, signed by the parties and specifies services to be provided  
- covers all services to be provided by the physician to the entity  
  - This condition is met if contract:  
    - References all other arrangements; or  
    - References a master list of contracts maintained by entity  
- Term is for at least 1 year  
- Services are reasonable and necessary  
- Compensation is set in advance, does not exceed FMV, is reasonable and determined at arm’s length, and does not take into account the volume or value of referrals
Stark Law (cont.)

**Indirect Compensation Exception** (42 C.F.R. § 411.357(p)):
- The compensation arrangement closest to the referring physician varies based on volume or value of referrals
- In writing
- Consistent with FMV
- Commercially reasonable and furthers a legitimate business purpose
- Complies with AKS

**AKS Safe Harbor** (42 C.F.R. § 1001.952(d))
- Personal Services / Management (requirements similar to Stark exception)
Virtually all compensated on-call arrangements exist between physicians and hospitals to which they refer.

Lots of money being paid to referring physicians!

Exposure to allegations of overpayment.

Notwithstanding that market rates paid by other area hospitals may not be comparable to your hospital, “market data” as reported by physicians are frequently inaccurate.

So...market data is largely useless in establishing and defending call coverage compensation.

OK, now what?
On-Call Arrangements
Relevant Factors

- Frequency and nature of call events
  - Telephone consults
  - Required presence at the ED
  - Required response time
  - Integrity/availability of data
  - Call frequency surveys

- Nature of the specialty
  - OB (typically unfunded patients with no prenatal care)
  - Surgeons (a surgical procedure is likely required, including follow-up care)

- Compensation earned by such specialists for clinical work
- Number of physicians available to participate in call rotation
On-Call Arrangements

Relevant Factors

- Exposure to unfunded care
  - Unfunded patients
  - Low-pay patients (e.g., Medicaid)

- Additional considerations
  - “Restricted” vs. “unrestricted” call
  - Required rapid response (e.g., TPA administration)
  - Concurrent call coverage arrangements
  - Call compensation to employed physicians
Leading Issues in On-call Pay

- Comparison to *locum tenens* arrangements and rates
  - When is a *locums* not a *locums*?
- Implications of *non-exclusive* coverage
  - Is it appropriate for one physician to be paid by multiple (related or unrelated) facilities during the same coverage period?
- How much are physicians really getting paid?
- Restricted coverage
  - When is it appropriate?
  - Must be set in advance
  - Concurrent activities
Virtually any type of P4P arrangement may now be termed a co-management agreement.

Advisory Opinion 12-22 (more later)

- Provided insight into structuring a regulatory-compliant clinical co-management (or management) arrangement
- Significant emphasis on provision of “substantial” services and ensuring that quality metrics are robust and reward for improvement.

Some hospitals and health lawyers are skeptical of the arrangements.

- Some are only comfortable with hourly physician compensation arrangements.
Clinical Co-Management Arrangements

- Compensation for call coverage is oftentimes included and valued among the duties.

- Defining the service line revenues
  - Avoid double-counting revenues.

- Establish the scope of services; the arrangement may cover inpatient, outpatient, ancillary and/or multi-site services, and may encompass many specific duties.
Clinical Co-Management Arrangements

**FMV Issues:**

- Subjective aspects of establishing the management fee, and applicable valuation approaches
- Identifying base tasks and tracking the achievement of these day-to-day management tasks
- Applicable valuation methods
- Ensuring no third-party managers or management by hospital
- Must be integrated with medical director payments
- Consider the possible *effective* hourly rate.
Who monitors the metrics?

Are the metrics subject to re-basing?

Can a retrospective fact pattern cast an arrangement in a bad light? What if there is no evidence of the physicians incurring time, attending meetings, etc.?
Gainsharing – Business Case

Hospital interest in gainsharing has increased

- Changing payor models
- Increased cost-containment pressures
- New emphasis on reducing waste and improving value in all types of care delivery
- Bundled Payment for Care Improvement (“BPCI”) participation
- Recognition that physicians can be drivers of change in hospital care and that financial incentives may positively motivate physician behavior
Gainsharing - Valuation

**FMV Issues**

- Selecting appropriate valuation approach
  - Accurately defining services
  - Understanding specific facts and circumstances
  - Assessing merits and detriments of any single valuation approach (market, cost, income)
  - Assessing benefits and feasibility of performing multiple valuation approaches
- Accounting for stacked arrangements/overlapping services
- Incorporating commercial reasonableness analysis into valuation opinion (is FMV affected by commercial reasonableness?)
Gainsharing - Pitfalls

FMV Pitfalls

- Nuances of savings calculation and payment calculation methods
- No illegal payments (consider state law, Stark, Anti-Kickback, CMPL etc.)
- Accounting for “should be” safeguards
  - Payments do not take into consideration volume or value of referrals
  - No payments for reduced quality of care
  - No payments for activities already compensated through other channels
  - Patient safety/medical ethics restraints
The government’s position on gainsharing has softened

- Multiple OIG Advisory Opinions that green light hospital gainsharing arrangements
- Government demonstration projects on gainsharing
- Proposed Stark exception
- Proposed changes to CMPL (2014)
- “No Action” statement
- MACRA
Stark Phase I (915) – Stark does not preclude basing compensation on quality measures unrelated to the volume or value of referrals or other business generated by the physician.

Stark Phase II (16088)

- Stark does not bar payments based on quality measures as long as the overall compensation is FMV, does not TIA referrals, and the other conditions of the exception are satisfied.
- Stark does not prohibit payments based on achieving certain benchmarks related to the provision of appropriate preventative health care services or patient satisfaction.
- Payments to reduce or limit services could violate the CMP.

2009 PFS (38551) – Incentive payments and shared savings programs can be structured to fit within existing Stark exceptions.

Stark Incentive Payment/Shared Savings Program Exception –

Proposed, but never adopted.
Gainsharing CMP Law Prohibits:

- A hospital or critical access hospitals from:
  - knowingly making payments, directly or indirectly,
  - to a physician
  - as an inducement to reduce or limit items or services
  - provided to Medicare (Parts A or B) or Medicaid beneficiaries
  - under the direct care of the physician

Penalties

- CMP of $2,000 per patient covered by the arrangement
- Both the hospital and the physician receiving payment are subject to liability

OIG Special Advisory Bulletin (1999)

- Clarified applicability of the CMP to gainsharing arrangements
OIG Advisory Opinion 12-22 – The OIG approved a hospital/physician cardiology co-management arrangement

Applicable Safeguards

- Cost-savings measures were based on evidence and clinical outcomes
- An external valuation regarding the fair market value of the fixed and performance-based compensation was obtained
- An independent third-party review of performance fee factors and clinical outcomes was obtained
- The performance fee was conditioned on a physician not: (i) stinting on care; (ii) increasing referrals to the hospital; (iii) cherry picking patients or those with desirable insurance; and (iv) accelerating patient discharges
OIG refuses to read “medically necessary” into the CMP and instead proposes to narrow its interpretation of “reduce or limit services.”

“OIG would be unlikely to bring a case against a hospital or physician for a gainsharing arrangement that included patient and program safeguards such as those identified in our advisory opinions.”

Pending further notice from OIG, gainsharing arrangements are not an enforcement priority for OIG unless the arrangement lacks sufficient patient and program safeguards.”
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?
FMV Pitfalls
The “No Risk” Risk Premium

FMV should not be influenced by the inclusion of gratuitous contract provisions that add “false” risk.

Examples:

- Early termination provisions that are not likely to be exercised
- The perpetual renewal of a one-year lease
- Leaseback arrangements for space or personnel
FMV Pitfalls
Commercially Unreasonable

- Advertising on physician practice Web sites by recipients of referrals (e.g., pathology labs)
- Payment to physicians to coordinate their own on-call schedules
- Restricted call arrangements involving low patient encounter frequency
- Lease arrangements for equipment that should be purchased
- Hospital transaction costs that exceed the value of the underlying transaction
A physician practice (the “Manager”) that engages a third-party management company to fulfill the Manager’s obligations to a hospital may undermine the arrangement.

Both the Manager and the third-party management company may seek a “full profit” for their efforts.

The Manager may appear to be profiting from arbitrage, or the overall arrangement may appear to be a sham.
Questions?

William H. Thompson, Esq.
Hall Render Killian Heath & Lyman, PC
bthompson@hallrender.com

Scott M. Safriet, MBA, CVA
HealthCare Appraisers
ssaafriet@hcfmv.com