PHYSICIAN PRACTICE LOSSES –
THE ELEPHANT IN THE ROOM

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Herd Midkiff, CVA
Partner – Director of Consulting Services

Haley Adams, CVA
Senior Manager, Consulting Services
Disclaimer

This presentation and associated remarks are intended to facilitate a general discussion regarding legal and valuation issues that may arise in the context of healthcare valuations. Although information contained in this presentation has been carefully compiled from sources believed to be reliable, the accuracy of the information is not guaranteed. It is not intended to be comprehensive or as accounting, business, financial, investment, legal, tax or other professional advice, and should not be relied upon as such.
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Rules and Regulations
Why Does It Matter?

**STARK LAW (STARK)**
- Prohibits physicians from making referrals for DHS payable by Medicare or Medicaid to an entity in which the physician (or an immediate family member) has a direct or indirect financial relationship
- Strict liability (intent doesn’t matter)
- Administrative Penalties
- Failure to meet exception is violation

**ANTI-KICKBACK STATUTE (AKS)**
- Makes it illegal to knowingly and willfully offer, pay, solicit or receive remuneration in return for referring, purchasing, leasing, ordering, or arranging any item or service that is reimbursed under a federal health care program
- Intent based statute
- Criminal Penalties

**FALSE CLAIMS ACT**
- Makes it illegal to knowingly make a false record or file a false claim regarding any federal health care program
- Mandatory minimum penalty provision and treble damages
- Qui Tam provisions and protections
- Treble damages
- Violation of Stark or AKS is a violation of False Claims Act

1 - 42 U.S. Code § 1395nn
2 - 42 U.S.C. §1320a-7b
3 - 31 U.S.C. § § 3729-33
Rules and Regulations

Why Does It Matter?

- Bona Fide Employment Exception [STARK]\(^4\)
  - Employment is for identifiable services.
  - Amount of remuneration is consistent with the *fair market value* of the services and is not determined in a manner that takes into account the volume or value of any referrals by the referring physician.
  - Remuneration is provided under an agreement that would be *commercially reasonable* even if no referrals were made to the employer.

4 - 42 CFR § 411.357(c)
• Personal Services and Management Contracts Safe Harbor [AKS]
  o Agreement is set out in writing.
  o Agreement covers all services to be provided for the term of the agreement and specifies the services to be provided.
  o If agreement is intended to provide for services on a periodic or part-time basis, the agreement specifies exactly the schedule of such intervals, their precise length and the exact charge for such intervals.
  o Term of agreement is no less than 1 year.
  o Aggregate compensation paid over the term of the agreement is set in advance, is consistent with fair market value in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made under Medicare, Medicaid or other Federal Health Care programs.
  o Aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the commercially reasonable business purposes of the services.
## Fair Market Value & Commercial Reasonableness
### What Does It Mean?

<table>
<thead>
<tr>
<th>FAIR MARKET VALUE (FMV)</th>
<th>IRS Revenue Ruling 59-60</th>
<th>Stark Law</th>
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<tbody>
<tr>
<td></td>
<td>The amount at which property would change hands between a <em>willing buyer and a willing seller</em>, when the former is not under any compulsion to buy, and the latter is not under any compulsion to sell, both parties having reasonable knowledge of the relevant facts.</td>
<td>The value in arm’s-length transactions, consistent with the general market value. ‘General market value’ means the price that an asset would bring or the compensation that would be included in a service agreement as the results of <em>bona fide</em> bargaining between well-informed parties to the agreement <em>who are not otherwise in a position to generate business for the other party</em>, on the date of acquisition of the asset or at the time of the service agreement.</td>
</tr>
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# Fair Market Value & Commercial Reasonableness
## What Does It Mean?

<table>
<thead>
<tr>
<th>COMMERCIAL REASONABLENESS (CR)</th>
<th>Details</th>
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| **Centers for Medicare & Medicaid Services (1998)** | An 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*.  
7 - 63 Fed. Reg. 1659, 1700 |
| **Centers for Medicare & Medicaid Services (2004)** | An arrangement will be considered ‘commercially reasonable’ *in the absence of referrals* if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were *not potential DHS [designated health services] referrals*.  
8 - 69 Fed. Reg. 16054, 16093 |

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7 - 63 Fed. Reg. 1659, 1700  
8 - 69 Fed. Reg. 16054, 16093
Fair Market Value & Commercial Reasonableness

How Is It Evaluated?

- **Income Approach**: A general way of determining a value indication of the compensation in a service arrangement using one or more methods that calculate and appraise the anticipated economic benefits of the arrangement over a set period.

- **Market Approach**: A general way of determining a value indication of the compensation paid for services by using one or more methods that compare the subject arrangement to arrangements for similar services that have been sold.

- **Cost Approach**: A general way of determining a value indication of the compensation in an arrangement for services by quantifying the amount of money required to replace the future services capability or utility of the arrangement.

9 - Volume One of the BVR/AHLA Guide to Valuing Physician Compensation and Healthcare Service Arrangements (2nd Edition)
Fair Market Value & Commercial Reasonableness

How Is It Evaluated?

CR QUESTIONS TO CONSIDER

• Is the transaction consistent with FMV?
• Does the transaction involve a resource needed by the purchaser and is the resource reasonable available from the provider?
• Is there a lower cost or better alternative to the referral source?
• Is the transaction negotiated on an arm’s length basis?
• Does the transaction allow the parties to better serve patients?
• Do the underlying economics of the transaction make sense?
• DOES THE TRANSACTION MAKE SENSE WITHOUT REFERRALS?
“Now the government is apparently upping the ante by arguing in some situations that lack of profit is tantamount to lack of commercial reasonableness, which would yank an arrangement out of the arms of a Stark exception,” Baumann says. “This is a new approach they want to take, and it is a somewhat novel approach. It's not how the phrase was interpreted in the past.”

- Linda Baumann, attorney at Arent Fox

10 – Article entitled In New Angle on Stark Cases, Government Hits Hospitals for Lack of Physician Profit, accessed at https://aishealth.com/archive/rmc070912-02
Recent Cases
What Have We Learned?

Halifax
(2014 - Florida)
Settlement: $85M

- 3 neurosurgeons paid 100% of collections after covering cost of base salary only
- Government argued compensation was in excess of FMV and the incentive compensation guaranteed the practice would operate at a loss.

Tuomey
(2015 - South Carolina)
Settlement: $72.4M
(1/3 of original award)

- Compensation formula for part-time physicians resulted in physicians being paid amounts in excess of net collections, thus guaranteeing practice losses.
- Practice losses of approximately $1.5M - $2M per year on physicians' compensation compared to collections
- Government argued that Tuomey knew in advance it would lose money but was willing to do so in order to secure outpatient surgery referrals and that compensation varied based on referrals (physicians only earned money for services that also generated a facility fee).
“And, ladies and gentlemen, Tuomey thought it was going to be about $968,000 a year they were going to lose on these. But, remember, it turned out to be a lot more than that. It turned out to be one-and-a-half million dollars a year, every year…

Now, why would Tuomey voluntarily lose $968,000 a year? Why would it continue to lose $1.5 million a year? Ladies and gentlemen, you know the answer to that. You have been hearing it for four weeks. Because they got something for that. And what did they get? They got referrals.”¹¹

¹¹ – Transcript from the first Tuomey trial, pp. 1927-28
## Recent Cases

### What Have We Learned?

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Settlements</th>
<th>Details</th>
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| **Citizens Medical Center**| **Settlement: $21.75M**   | - Combined physician salaries increased from $630K to $1.4M in the first year of employment by Citizens.  
- Practice losses of $400K in 2008 and $1M in 2009.  
- Government argued compensation to cardiologists exceeded FMV, despite compensation being less than median.  
- Judge noted that if allegations were true, it would make little economic sense for Citizens to employ the cardiologists at a loss, except when the motive is to induce referrals. |
| **Columbus Regional**      | **Settlement: $35M (Hospital)** and **Settlement: $425K (Dr. Pippas)** | - Qui Tam Relator was former hospital administrator.  
- Government argued Dr. Pippas received improper salary and medical director payments from Columbus Regional.  
- Government argued compensation in excess of collections for personally performed services.  
- Government argued physician is responsible for his / her conduct, consistent with the Yates Memo. |
Recent Cases
What Have We Learned?

North Broward
(2015 - Florida)
Settlement: $69.5M

- Compensation in excess of benchmark 90th %iles, which was not aligned with productivity levels.
- Hospital had “Contribution Margin Reports” referencing hospital and ancillary revenue generated by each employed physician.
- Government asserted that the hospitals used the Contribution Margin Reports to evaluate physician compensation proposals, and that physician referrals were used to justify compensation levels and substantiate practice losses.

Adventist Health
(2015 – Florida, North Carolina, Tennessee, Texas)
Settlement: $115M

- Government argued hospital willing to pay in excess of FMV and absorb consistent losses due to referrals.
- Government argued compensation was above FMV for part-time work.
- Government argued bonuses were based on revenue from referrals, not only on personally performed services. This included non-physician provider productivity.
- Government argued employed physicians received perks.
- Government argued Adventist had coding anomalies that were not corrected.
Recent Cases
What Have We Learned?

“...the conduct of Broward Health's financial strategists responsible for physician recruitment and compensation evidence the following four primary facts: (1) Broward Health has deliberately recruited, employed, and agreed to pay physicians based in part on anticipated profits from referrals from such physicians to Broward Health's hospitals and clinics, (2) Broward Health has not simply compensated employed physicians based on the value of physicians' personally performed services and revenue from such services, (3) Broward Health has *deliberately planned and budgeted for massive net operating losses from the overcompensation of employed physicians while secretly tracking profits from referrals by such physicians to Broward Health's hospitals and clinics*, and (4) Broward Health has deliberately compensated its employed physicians at *commercially unreasonable* levels if profits from referrals by such physicians were not considered.”

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12 - Relator's (USA ex rel. Michael Reilley, M.D.) Third Amended Complaint (emphasis added)
Current Government Philosophy
What Are They Saying?

• Strong enforcement activity expected to continue

• June 9, 2015 DHS/OIG Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability

• September 9, 2015 - Yates Memo
  o Hold the individuals who perpetrated the wrong doing accountable
  o Intended as a deterrence, to change corporate behavior and promote confidence in the system
    ❖ Focus on individuals
    ❖ Coordination of civil and criminal
    ❖ No release of individual culpability when resolving matters
    ❖ Disregard for individual’s ability to pay
Physician Practice Losses
Why Do They Exist?

QUALITATIVE REASONS
- Community need / shortage area
- Charitable mission
- Patient care
- Required services for trauma designation
- Business plans
- Recruitment history (e.g., offers rejected on the basis of the compensation & benefits package offered)

QUANTITATIVE REASONS
- Ramp up periods for new physicians
- Poor payer mix
- Removal of ancillary services
- Allocation of hospital / health system overhead expenses
- Excess square footage
- Medical Directorship or ER call services embedded in employment agreement that would otherwise be paid to independent physician

RED FLAGS
- Physician compensation in excess of FMV
- Reliance on surveys ONLY to set physician compensation
- Services not necessary and/or duplicative of services provided by others
- Documentation related to referrals to hospital / health system to offset practice losses
Commercial Reasonableness Analysis
What Does It Contemplate?

START

FMV

Nature & Scope of Services

Necessity of Services

Enterprise / Organization and Service Provider Elements

Other Specific Elements / Facts

Otherwise Legally Permissible

Business Purpose

No Referrals

FINISH

Post-Transaction Financial Feasibility Analysis

13 – Adapted from Volume One of the BVR/AHLA Guide to Valuing Physician Compensation and Healthcare Service Arrangements (2nd Edition)
## Risk Management
### What Can You Do?

<table>
<thead>
<tr>
<th>BEST PRACTICES</th>
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<tbody>
<tr>
<td>• Develop risk management program</td>
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<tr>
<td>• Develop and utilize due diligence checklists</td>
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<td>• Develop standard contracting processes</td>
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<tr>
<td>• Involve Legal Counsel early</td>
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<tr>
<td>• Obtain third party FMV &amp; CR opinion</td>
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<tr>
<td>• Create Physician Compensation / Transaction Review Committee</td>
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<tr>
<td>• Determine risk thresholds</td>
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<tr>
<td>• Consider “approved models” that have been tested by internal or external FMV &amp; CR analyses</td>
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<tr>
<td>• Document unique facts and circumstances related to each transaction</td>
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<tr>
<td>• Document legitimate reasons why losses are anticipated to exist and any plans to reduce such losses going forward</td>
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Questions?

Herd Midkiff
Partner - Director of Consulting Services
hmidxiff@jtaylor.com
(817) 546 - 7036

Haley Adams
Senior Manager, Consulting Services
hadams@jtaylor.com
(817) 546 - 7039