Physician Arrangement Bootcamp

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Today's Agenda

- Regulatory Environment
- Fair Market Value and Commercial Reasonableness
- Use of Surveys in Setting / Valuing Physician Compensation
- The Valuation Process and Value Drivers
- Valuation Examples
- Managing the Contracting Process
- When to Utilize Outside Valuations
- Minimizing Risks

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Regulatory Environment

Why is it important to document arrangements with MDs properly?

- Stark law, Anti-kickback Statute and False Claims Act
- Prohibits payment for service rendered in violation of Stark
- No payment for physician referrals of DHS if an exception is not met

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High-Level Regulatory References

	Stark	Anti-Kickback	IRS Private Inurement
Parties at Risk	Physicians & DHS entities	All parties	Non profit entities & individual or for-profit entity
Types of Referrals	DHS Referrals	Anything that generates business for the provider	Existence of referrals acceptable, strategic value
Intent Required	Strict liability (intent not required)	Intent required	Varies by situation, rebuttable presumption key
Criminal vs. Civil	Civil penalties only	Criminal and civil penalties	Civil penalties only (vary by circumstance)
Exceptions / Safe Harbors	Arrangements are prohibited unless exceptions are met	Voluntary safe harbors	Rebuttable presumption (Intermediate Sanctions)
FMV	Most exceptions require FMV	Not required, OIG has taken stance that lack of FMV is evidence of possible kickback	Payments for reasonably necessary items / services must be at FMV
Commercial Reasonableness	Many exceptions require commercial reasonableness	Not required but preferred by OIG	Goods and services must be necessary to achieve Mission or objectives

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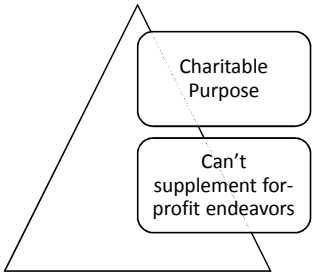
Other IRS Non-Profit Issues



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Physician Arrangements Where Physician Receives Compensation

- Employment
- Professional Services
- Medical Director
- Supervision of Mid-levels
- Call Agreements
- Recruitment Incentives

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Arrangements Where Physician Pays Compensation

Lease	Timeshare License	Equipment Rental

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Infamous Enforcement Actions

- **Tuomey**
  - Qui tam lawsuit brought by whistleblower
    - Alleged that part-time physician employment agreements entered into by Tuomey were above fair market value and not commercially reasonable
    - Notable that Tuomey had obtained legal and fair market value opinions approving the arrangements
    - Jury initially held that Tuomey violated the Stark Law, but not the False Claims Act
  - Court subsequently awarded $44.9 million (plus interest) in damages to the Government related to Stark Law violations
  - In 2013, Tuomey was again found guilty of Stark and False Claims Act liability
    - Over $39 million in actual penalties
    - FCA - Over $237 million in civil penalties
  - Fair market value and commercial reasonableness were central to the court findings
    - U.S. Circuit Court of Appeals upheld judgment on July 2, 2015
    - $72.4 million settlement in October 2015

Infamous Enforcement Actions (cont'd)

- **Halifax**
  - Qui tam lawsuit brought by compliance official within the organization
    - Alleged that compensation arrangement with employed oncologists violated Stark prohibitions against compensation for DHS referrals
    - Compensation incentive equal to 15% of the "operating margin"
      - Did not comply with Stark's Employment Exception
  - Halifax settled claim for $85 million in March 2014
    - Full damages may have exceeded $1.1 billion
    - Later settled a False Claims case for $1 million
  - Compensation deemed to be based on the volume or value of referrals
  - Legal fees estimated to be near $40 million
- **Banks-Jackson Commerce Hospital**
  - Payments to cardiology medical director exceeded FMV
  - Violated Stark and AKS
  - $500,000 settlement – physician paid $200,000

Infamous Enforcement Actions

» **Adventist**

- Qui tam lawsuit brought by three whistleblowers
  - Alleged that employed physicians received compensation for referrals
  - Whistleblowers claimed that system paid for leases of Mustang and BMW for a surgeon and that a part-time dermatologist received $710,000 in annual salary and bonuses
  - System was also accused of using improper modifiers in Medicare billings
- Settled claim for $118.7 million in September of 2015
  - Largest ever settlement reached without litigation under Stark Law
  - Previous record was set one week earlier by North Broward Hospital District ($69.5 million)

Infamous Enforcement Actions (cont'd)

- **Mercy Clinic Springfield Communities**
  - Qui tam lawsuit brought by employed pediatrician
    - Alleged that physician specialties were divided into "Stark Groups" according to the amount of referrals generated and paid bonuses ("Specialty Funding") accordingly.
    - Whistleblower received bonus of $39,000 in 2014 which was deemed to exceed FMV
  - Settled claim for $5.5 million in August of 2015

New Litigation Involving Stark

- **Pacific Alliance Medical Center settlement**
  - Qui Tam suit by employee
    - Allegations were the Hospital paid above-market rates to rent space in physicians' offices
    - Marketing on behalf of physicians' practices
    - Violated AKS and Stark
      - Chan v. PAMC, CV13-4273 (C.D. Cal.)
      - Settled June 28, 2017 for $42 million. Relator got $9.2 million

New Litigation Involving Stark (cont'd)

- **Meadows Regional Medical Center settlement**
  - False Claims Act allegations
    - Allegations included improper compensation arrangements
    - Violated AKS and Stark
    - Establish compliance program and designate compliance officer
      - Settled with DOJ November 17, 2017 for $12.875 million and Corporate Integrity Agreement

New Litigation Involving Stark (cont'd)

- **Pine Creek Medical Center**
  - False Claims Act allegations by marketing employees
    - Physician owned hospital
    - Hospital paid for marketing and advertising-radio, tv, website upgrades, etc.
    - Violated AKS and Stark
      - Settled with DOJ December 1, 2017 for $7.5 million and Corporate Integrity Agreement
      - Us ex. Rel. Suzanne Scott v. Pine Creek Medical Center, LLC

New Litigation Involving Stark (cont'd)

- **Emcare**
  - False Claims Act allegations by competing physicians
    - Physicians alleged to admit patients for tests when not necessary
    - Use of exclusive provider contracts to induce referrals
    - DOJ believes violated AKS and Stark
      - Settled with DOJ December 1, 2017 for $7.5 million and Corporate Integrity Agreement
      - US ex. Rel. Mason, etc. v. Health Management Associates 3:10CV472 (WDNC)

New Litigation Involving Stark (cont'd)

- **UPMC Hamot and Medicor settlement**
  - False Claims Act allegations
    - Exclusive contract for cardiologists at hospital expanded into paired leadership with several medical director contracts
    - Contracts expired in 2016 but kept paying
    - Violated AKS and Stark
      - Settled with DOJ March 7, 2018 for $20.75 million
      - US ex. Rel. Emanuele v. Medicor 10-cv-00245-JFC (W.D.Pa.)

Be Mindful of Enforcement Actions and Their Significance

Practical Significance
• Critical Focus on Fair Market Value • Suspect Types of Arrangements • Importance of Commercial Reasonableness • Pitfalls of Opinion Shopping • Settlement rather than Litigation • Role of Whistle Blowers • Physician Compensation Methods Matter • FMV is not a Free Pass • Physicians are Accountable Too • Governance and Process Controls are Essential • Violation Costs Far Exceed Benefits of Improper Arrangements

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Fair Market Value and Commercial Reasonableness

FMV is part of Commercial Reasonableness

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Fair Market Value ("FMV") and commercial reasonableness are separate standards

Fair Market Value	Commercial Reasonableness
Stark Law Definition: *"Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition, or the compensation that has been included in bona fide service agreements with comparable terms at the time of the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals."*	No formal definition in law, defined in commentary as: • *"Sensible, prudent business agreement from the perspective of the parties"* • *"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"*

Can an arrangement be FMV, but not commercially reasonable?

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Government Guidance on FMV and Commercial Reasonableness

» **Government guidance limited on both standards**

» **Fair Market Value**
- Stark II, Phase II no longer valid, but provided foundation for valuation profession; reiterated in Phase III regs.
  - Blending of multiple, objective, independently published sources and consistency in approach encouraged
- Documentation necessary to support FMV will vary
- External valuations do not ensure FMV, but can be relevant to intent
- FMV for administrative services may differ from FMV for clinical services
- "Double counting" identified as a potential cause for violation of FMV (e.g., call pay for employed physicians)

» **Commercial Reasonableness**
- Examples of commercially unreasonable behavior provided
  - Lease of space from physician practice with no intention to use it
  - Pay FMV Total Compensation, but include incentives tied to DHS referrals
- An arrangement may be FMV, but it may not be commercially reasonable

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Common Physician Arrangements

Require Fair Market Value and Commercial Reasonableness Compliance

Employment Agreements
Professional Service Agreements
Medical or Program Directorship Agreements
Call or Clinical Coverage Agreements
Co-Management Agreements
Independent Contractor Agreements
Shared Use or Cost Agreements
Lease Agreements
Management Service Agreements
Others (Clinically Integrated Networks, ACOs, etc.)

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Methods of determining FMV

FMV Methodology Overview

- **Three Common Valuation Approaches**
  - Income Approach
    - Value based on expected future cash flows
      - "Going concern" or "DCF"
  - Cost Approach ("Asset Approach")
    - Value based on replacement cost
  - Market Approach
    - Value based on market information and known transactions
- **Market approach is most widely used in compensation valuation given regulatory limitations**
  - Income Approach Challenge: might consider income from referrals
  - Cost Approach Challenge: substitution of equivalent service transactions may not be practical

Common Market Approach Methods

- Published Data Method
  - Deriving value from descriptive statistics in surveys
- Hybrid Cost / Market Method
  - Valuing units of services at market rates (e.g. $/WRVU)
- Market Comparable Method
  - Adapting compensation from similar known arrangements

Methods may be weighted differently depending on facts and circumstances. Why?

Commercial Reasonableness Discussion – Clinic Subsidies

» **Losses in employed physician practices are facing increased scrutiny from regulators**

» **Individual situations will dictate whether or not a subsidy is warranted**
- Community need
- Local market dynamics (e.g., rural vs. urban, payer mix, patient demand)
- Coverage vs. throughput considerations (hospital-based specialties)
- Physician recruitment and retention (more national than regional)
- Program development and sustainability
- Quality of care / care coordination considerations
- Hospital financial inefficiencies (e.g., lower than average collections rate)
- Matching contribution / adjustment of valued services that do not track to WRVUs or third-party payor reimbursement (i.e., leadership roles, teaching services, midlevel supervision, etc.)

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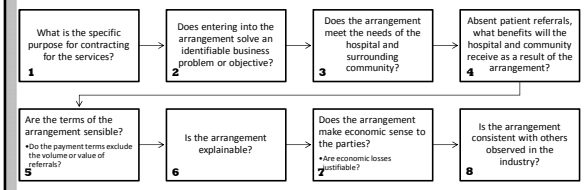
Commercial Reasonableness Checklist



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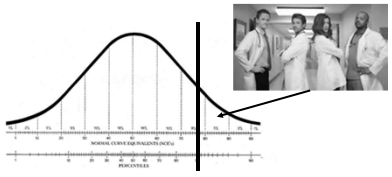
Use of Surveys in Valuation and Physician Compensation

Bonus Discussion: "90th Percentile"



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Prevalence of Published Data in Valuation Analysis

» **Though not perfect, survey-based methodologies often relied upon heavily in valuation analysis**

Strengths	Weaknesses
Multiple surveys available with reasonable sample sizes reported across broad array of specialties	Survey participation voluntary; vary from year to year
Industry-accepted methodology understood by administration and physicians	Error (survey design, respondent error, analytical and reporting errors – insufficient rigor)
Data reported on multiple arrangement types allows for flexibility (annual compensation, $/WRVU, etc.)	Sample bias and lack of statistical representativeness
Best resources for valuing and setting compensation	Subject to "cherry-picking" and inappropriate application of data
	Limited detail on sources of compensation within total compensation

Do survey sources have any liability?

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Common Survey Sources

- Association of American Medical Colleges
- American College of Physician Executives / Cejka
- AMGA
- Gallagher / IHS
- Medical Group Management Association
- Sullivan Cotter Associates
- Others…

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Factors to Consider when Utilizing Survey Data

» **Physician / Arrangement Specific Factors**
- FTE status
- Historical compensation and productivity
- Unique training or sub-specialization

» **Market Specific Factors**
- Community Need / Demand for Services
- Supply / Demand of Key Specialties
- Payer Mix and Reimbursement
- Practice Efficiency / Expense
- Community Expectations
- Remoteness / Access to Other Services
- Competition

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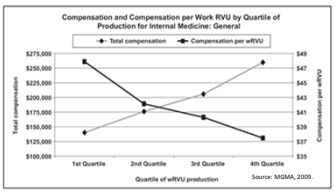
Common Pitfalls in Use of Survey Data

- **Inconsistent application of data ("Cherry Picking")**
- **Data may unexplainably vary from year to year**
- **Failure to normalize data to match survey definitions**
  - E.g., including malpractice premium in calculation of compensation
- **Matching annual compensation / productivity percentiles to ratios**



* Must use judgment when applying survey data!

Survey Data in Market Methods

Three sub-methodologies under the Market Approach all rely upon different types of survey data

Survey Data

- Published Compensation Method
  - Published surveys report total annual compensation by physician specialty
  - Often normalized to hourly rates
- Productivity Method (Hybrid Cost Approach)
  - Published surveys report annual productivity (typically WRVUs) per FTE physician
  - Production matched with compensation ratios ($/WRVU) to match compensation to work effort
  - Collections and Compensation to Collections ratios
- Market Comparable Method
  - Compensation arrangements identified through an internal database and primary research

***** Valuations involving management services may utilize survey data for cost items in addition to compensation.**

Application of the 90th Percentile

- **Discussion within valuation industry around when / if it is appropriate to apply the 90th percentile of survey data**
- **Although it can be viewed as an aggressive approach by some, there are a number of situations where the 90th percentile is a valid comparison**
- **Specific instances where 90th percentile may be applicable**
  - WRVUs that exceed the 90th percentile
  - Sub-specialty data not available, broader specialty data applied as a proxy (e.g., hematology / oncology vs. bone marrow transplant)
  - Significant training, sub-specialization and / or leadership responsibilities ("KOL" status)
  - Calculation of premium for PRN coverage
  - Additional circumstances, analyzed case-by-case
- **Additional documentation and analytical rigor is advised when the 90th percentile is selected**

$/WRVU and Highly Productive Physician

- Employed physicians consistently exceeding 90th percentile WRVUs
- Philosophically, physicians should be rewarded for more work…to a point
- Safeguards should be in place to validate production and quality at these levels (coding audits, financial analysis of professional collections, etc.)
- The organization takes on risk with respect to quality, patient satisfaction and physician burnout as productivity moves farther above 90th percentile (what resources can be deployed to support?)

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Valuing Compensation

Compensation Valuation Examples

- At a high level, the goal of compensation is to match the expectations of the hospital to the physician's duties and performance while considering market factors and regulatory requirements

Can Be Assigned Value	Can't Be Assigned Value
Personally performed clinical services	MLP incident-to WRVUs
Administrative / medical director svcs.	Profits from ancillary services
On-call coverage (varies by situation)	Other non-personally performed services *
Mid-level provider supervision	
Clinical oversight (e.g., infusion therapy)	

* Can physicians be compensated for the professional services performed by APCs?

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Compensation Valuation – Drivers of Value

1. Service Expectations

- Anticipated Burden
  - FTE level, call schedules, etc.
- Scope of Duties / Services
  - Specialty, clinical vs. administrative commitments, program leadership, etc.
- Special Qualification Requirements
  - Certifications, special training, experience, etc.
- Level of Income Risk
  - Guaranteed compensation vs. incentive compensation
- Organizational Strategy Objectives
  - Business Purpose
  - Achievement of explicit organizational goals, performance outcomes, etc.

Compensation Valuation – Drivers of Value

2. Market Conditions

- Prevailing Compensation Trends and Available Data
  - Statistics from recognized surveys, insights from comparable arrangements, etc.
- Recruitment and Retention Challenges
  - Supply and demand, turnover rates, locums utilization, etc.
- Competitive Environment – supply and demand
- Health Plan Reimbursement Levels / Methods
- Unique Environmental Factors, such as
  - Demonstrated community needs, cost of living, desirability of location or position, physician-population ratios, patient insurance mix, etc.

Compensation Valuation – Drivers of Value

3. Financial and Regulatory Constraints

- Fiscal Conditions
  - Hospital / Service Line Financial State
  - Independent Viability of Physician Practices
- Payer / Reimbursement Climate
  - Payer Mix
- Compliance – Medicare and IRS rules, State Laws
  - FMV
  - Commercial Reasonableness

Compensation Valuation – Drivers of Value

4. Performance

- Volume of Work
  - Collections, hours, shifts, WRVUs, etc.
- Value of Work
  - Reimbursement per unit of work, etc.
- Quality of Work
  - Clinical outcomes, observance of standards of care, value-based payment – accountable care, etc.
- Formal Administrative Duties, Leadership / Citizenship
  - Program oversight, management duties, patient satisfaction, etc.
- Other Contributions

Common FMV Consideration

Fair Market Value

Factor	Call	Med. Director	PSA / Employment
Duties / Expectations / Burden	Trauma vs. Non-Trauma Restricted vs. Unrestricted / Time Backup Subspecialty Coverage / Qualification Acuity and Intensity of Cases Limitations on Elective Work Related Duties Relationship to Other Service Lines Legal / EMTALA	Hospital Strategy / Mission Qualifications – KOL? Time Commitments Intensity of Involvement Related Duties Leadership Expectations	FTEs Qualifications Scope of Services - Subspecialty Requirements - Administrative - Call - Academics - Outreach Coverage Requirements Infrastructure
Community Need / Demand / Market Dynamics	ER Volumes Patient Demographics Supply of Qualified Providers Physician Turnover Community Hardship Remoteness / Isolation Locums Utilization Frequency of Call / MD	Service Line Requirements Department Size Availability of Qualified Physicians	Economic Viability of Independent Practice Supply of Qualified Physicians Recruitment / Retention Challenges Cost of Living Competition
Payer Mix and Reimbursement	Reimbursement Un / Favorability Collectability of Pro. Fees Recipient of Pro. Fees	Quality / Value-based Reimbursement	Prevailing Reimbursement Levels Charitable Mission Compensation Method Ancillaries
Efficiency / Practice Expense	Practice Disruption Hospital Efficiency OR / Staff Availability	Impact on Private Practice Time Commitments	Infrastructure Requirements Ancillaries
Unique / Situational Factors	Geographic Draw Size of System Mission	Mission Strategy	History

Overhead Considerations in Physician Arrangements

Fair Market Value

Note: overhead can only be paid for once.

Arrangement Type	Yes / No / Depends	Details
Employment	No	Hospital naturally covers overhead for employed physicians.
Call	Depends	- Valuation of call typically considers only the employment costs that physicians will incur on their own. These costs are typically incorporated into the underlying hourly rates utilized in the valuation. - Since the hospital is not buying 100% of the physicians' services, it should not cover 100% of their overhead. ** If employment costs are already covered through a separate agreement with the physicians, then they should be excluded from the valuation of call.
Medical Directorship	Depends	Valuation of directorships typically considers only the employment costs that physicians will incur on their own. These costs are typically incorporated into the underlying hourly rates utilized in the valuation. - Since the hospital is not buying 100% of the physicians' services, it should not cover 100% of their overhead. ** If employment costs are already covered through a separate agreement with the physicians, then they should be excluded from the valuation of the directorship.
PSA	Yes / Depends	If hospital is acquiring 100% of physician services, then it will cover 100% of reasonable, FMV overhead. ** If PSA is structured as a subsidy, the valuation will net compensation and overhead against expected revenue. *** If PSA is encounter-based (less than 100% of the physician services), then valuation will adjust to account for employment costs or portion of total overhead.

Valuation Examples

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Case Study #1 – Medical Directorship

- Community physician designated as infusion therapy medical director
- Physician dedicates between 10 and 12 hours per month to medical director duties and responsibilities
- No other financial relationship with the organization outside of medical directorship

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Medical Director FMV Analysis

Physician duties and responsibilities matched to FMV hourly rates for specialty	1. Hourly Medical Director Compensation Calculated	Average of multiple published surveys applied (including southern region MGMA data) and normalized to hourly rates	To the extent available, market comparable examples blended with published survey data
	2. Allocation for Physician Benefits and Select Operating Expenses	Based on cost data reported by MGMA regarding operating expenses for physician-owned hematology / oncology practices	Included to recognize the independent contractor relationship between the parties
	3. Average Monthly Physician Time Requirement Estimated	Often times a range of hours (minimum and maximum) can be laid out in the contractual documents	Interview with management or the medical director is performed to validate the estimated hours and create documentation for file

How many hours per year per FTE physician?

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Case Study #2 – Employed Physician (Stacking)

- Employed orthopedic surgeons exceeding 90th percentile WRVUs
- Physicians all participate in call coverage rotation
- Select physicians provide administrative / medical director services
- Each physician supervises one physician assistant

Case Study #2 – Employed Physician (Stacking)

Services built up individually but reconciled to ensure no double-counting occurs (OIG Opinion Letter 12-15)	1. Compensation for clinical services	Published compensation, productivity and market comparable methods reconciled	
	2. On-call coverage	Because physicians are employed, only disproportionate coverage should be compensated	Potential "double-dip" if physicians are paid for call coverage and receive WRVU credit.
	3. Medical director services	FMV compensation for medical director services calculated consistent with methodology discussed previously	

Case Study #2 – Employed Physician (Stacking)

- Stacking of payments for additional duties and responsibilities can be appropriate
- Surveys report annual figures and ratios in terms of TOTAL compensation, so it is important to evaluate arrangements in these terms
- MGMA definition of total compensation as an example:

> Total compensation - The amount reported as direct compensation on a W2, 1099, or K1 (for partnerships) plus all voluntary salary reductions such as 401(k), 403(b), Section 125 Tax Savings Plan, and Medical Savings Plan. The amount should include salary, bonus and/or incentive payments, research stipends, honoraria, and distribution of profits. However, it does not include the dollar value of expense reimbursements; fringe benefits paid by the medical practice such as retirement plan contributions; life and health insurance; automobile allowances; or any employer contributions to a 401(k), 403(b), or Keogh Plan.

Case Study #2 – Employed Physician (Stacking)

Is Included in Compensation	May Be Included in Compensation	Not Included in Compensation
Reimbursement for clinical services (base and incentive compensation)	Payments for on-call coverage	Health, life insurance, LTD, other benefits
	Payments for medical directorship	Malpractice insurance premiums
	Distributions from ownership interests (if run through practice)	Employer contribution to qualified retirement plans
	Payments for research / academic activity	

How much compensation for call and administrative services is included in survey data of annual compensation?

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Managing the Contracting Process

Have a Process in Place

- Why do we want or need the Arrangement?
- Who needs to sign off on the Arrangement?
- Does the idea fit within the community needs assessment?
- When will you use outside valuation?
- When will you use outside legal?

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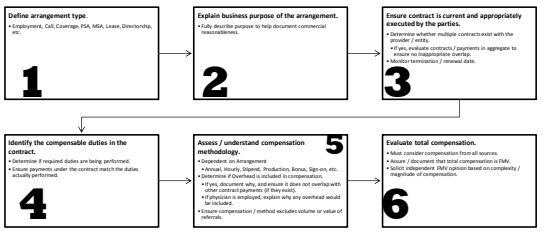
Compliance Officers – Physician Arrangements Checklist



Role of Legal Counsel

- Manage process
- Maintain privilege
- Review process
- Draft the agreements

Determining When Outside Valuation is Necessary

- Not all arrangements require outside valuations
- Organizations set their own requirements and thresholds for determining when an outside valuation is needed
  - Level of sophistication and capacity
  - Risk tolerance
  - Legal guidance
  - Enforcement / compliance history
  - Presence of conflict
- Establish internal process and accountability for authorizing, negotiating, valuing, approving and monitoring arrangements

Determining When Outside Valuation is Necessary

Outside valuations may be triggered by conditions within an arrangement:

- Market data comparison – total compensation will exceed 75th percentile
- Market data comparison – physician productivity will exceed the 90th percentile (may also merit coding and quality audits)
- Multiple arrangements exist with a single provider / entity ("Stacking")
- Complex arrangements involving multiple physicians / specialties / services; joint ventures
- Provider holds significant administrative / leadership position within hospital (in addition to being very clinically productive)
- Parties may have a conflict of interest – physician is a member of the hospital board of directors
- In combination with practice acquisition – hospital purchases a physician practice, then employs the physician(s) – practice valuation and compensation valuation must be reconciled
- Others…case by case determination

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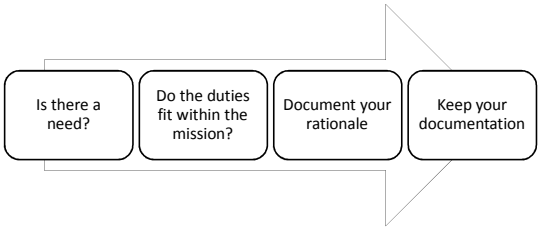
Minimizing Risk

Should the relationship be created?



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Risks Vary with Type of Arrangement

Call Agreements
Burden to provider – present or phone
Frequency that called in
Are providers required to take call - bylaw provisions
Patient Volume
Who is billing for services

Timeshare Arrangements
Costs for utilities, equipment
Personnel, etc.

Recruitment Incentives Risks
Geographical limitations
Patient Draw

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What if the Arrangement is illegal?

- Investigation by DOJ or OIG or State
  - Under Yates Memo there can be individual responsibility for actions
- Whistleblower action under False Claims Act
  - Technical Stark Violation or AKS issue
  - Usually filed by disgruntled competitor, physician, employee or consultant
- Stark Self-Referral Disclosure Protocol
  - Disclosure to CMS
  - Different from SDP to OIG

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QUESTIONS?

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