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**WHAT WE HAVE LEARNED:**  
**FROM HALIFAX, TUOMEY, NORTH BROWARD, ADVENTIST, AND COLUMBUS REGIONAL AND CURRENT LEGAL ISSUES**

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**Department of Justice – Fraud Statistics**

- The Department of Justice (DOJ) obtained more than \$3.5 billion in settlements and judgments from civil cases involving fraud and false claims against the government in the fiscal year 2015
- Fourth year in a row that DOJ has exceeded \$3.5 billion in cases under the False Claims Act, and brings total recoveries from January 2009 to 2015 at \$26.4 billion.

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**Department of Justice – Fraud Statistics**

Of the \$3.5 billion recovered in 2015, \$1.9 billion (54.3%) came from companies and individuals in the health care industry for allegedly providing unnecessary or inadequate care, paying kickbacks to health care providers to induce the use of certain goods and services, or overcharging for goods and services paid for by Medicare, Medicaid, and other federal health care programs

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**DOJ Statistics – Health Care Fraud**

Including 2015's \$1.9 billion for health care, DOJ has recovered nearly \$16.5 billion in health care fraud since January 2009.

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**DOJ Statistics – Health Care Fraud**

The Department of Justice reports that in 2015, Hospitals were involved in nearly \$330 million in settlements and judgments!

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**DOJ Statistics – Qui Tam Actions**

- Refresher: *Qui tam* lawsuits are brought by whistleblowers under the False Claims Act and they provide a reward if recovery is received by the government
- From January 2009 to the end of fiscal year 2015, the government recovered \$19.4 billion in settlements and judgments related to **qui tam** suits and paid whistleblower awards of \$3 billion during the same period



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### DOJ Statistics – Settlements and Judgment



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### DOJ Statistics – Qui Tam Actions

- Of the **\$3.5 billion** the government recovered in fiscal year 2015, more than **\$2.8 billion** related to lawsuits filed under the **qui tam** provisions of the False Claims Act
- Whistleblowers filed 638 **qui tam** suits in fiscal year 2015 and the DOJ recovered \$2.8 billion
- Whistleblower awards during the same period totaled **\$597 million**



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### DOJ Statistics – Qui Tam Actions



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**Who Are Qui – Tam Litigants?**

- Disgruntled/Former Employees
- “Concerned” Employees
- Physicians
- Hospital/Health System Executives
- Consultants
- Compliance Staff Members

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**A Note on Settlements...**



- See Handout
- All of the cases on the Handout were either settled or are currently in an early stage of litigation.
- The only **LAW** on the books currently comes from Tuomey.
- The uncertainty of litigation combined with the treble damages and penalties from the FCA have created a huge incentive for these health systems to settle these claims.
- “Bet the Farm” litigation for these health systems

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**Medical Directorship Arrangements**

- United States v. Recovery Home Care, et al.
- Allegations:
  - From 2009 through 2012, Recovery Home Care, headquartered in West Palm Beach, Florida, allegedly paid dozens of physicians thousands of dollars per month to perform patient chart “quality” reviews
  - According to the government’s lawsuit, the physicians were over-compensated for any actual work they performed and, in reality, payments to the physicians were used to induce them to refer their patients to Recovery Home Care
  - Though the company disguised payments ranging from \$1,300 to \$2,500 a month as compensation for this work, the government alleged that the doctors did little or nothing
  - The majority of the medical director agreements allegedly required the doctor to perform five hours of work a month
  - But no documentation of services was received by Recovery

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**Medical Directorship/Real Estate Arrangements**

- United States ex rel. Parikh v. Citizens Medical Center, et al.
- Allegations:
  - Relators alleged that the Hospital knowingly and willfully paid bonuses to emergency room physicians who referred to the chest pain center and the bonuses were paid by splitting the compensation between the hospital and the referring emergency room physicians
  - Relators also alleged above-market guaranteed salary and discounted office space rentals were used as incentives in exchange for Medicare and Medicaid patient referrals.
    - Doctors were guaranteed "many times more in salary than [they] earned in private practice" and were able to rent office space "at a significantly reduced rate below the fair market value"

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**Medical Directorship/Compensation Stacking Arrangements**

- Allegations (Cont.):
  - Relators alleged a bonus system wherein gastroenterologists who participated in hospital's colonoscopy screening program received bonus compensation for referring patients to the hospital
    - A gastroenterologist would be assigned to a screening day and would perform the screenings for that day
    - The gastroenterologist would then be compensated by billing any charges to the patients' insurer, and the hospital would be compensated by billing separately for its charges
    - The hospital also compensated the gastroenterologist an additional \$1,000 "directorship" fee for each day the gastroenterologist participated in the screening program
    - But Relators alleged that the gastroenterologist did not assume any "additional work or oversight" to receive the directorship fee—"[t]here are absolutely no director responsibilities or duties for participating physicians"

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**Fair Market Value/Sale of Practice Issues**

- United States ex rel. Barker v. Tidwell
- Allegations:
  - Radiation oncologist was using old equipment
  - Legal question of whether the provider had sufficient knowledge of the equipment's effectiveness
    - False Claims for Services Provided
  - Sale of clinic was allegedly higher than fair market value -- no appraisal done -- but Columbus paid \$10 million Dollars for a clinic with outdated imaging equipment

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### Fair Market Value Issues

- United States ex rel. Barker v. Tidwell Follow-Up Notes:
- Order on Motion for Summary Judgment
  - June 2015
  - Following a summary judgment that was partly granted and partly denied
    - Dr. Tidwell's Summary judgment motion was granted as to Barker's claim based on violations of the Stark Law but denied as to Barker's claims based diagnostic billing and the Anti-Kickback Statute
- Settlement was entered into by all parties in September 2015
  - Columbus Regional has agreed to pay \$25 million, plus additional contingent payments not to exceed \$10 million, for a maximum settlement amount of \$35 million
  - **Dr. Pippas has agreed to pay \$425,000**
    - Indicative of the "Yates" memo and the DOJ's focus to go after wrongdoers individually

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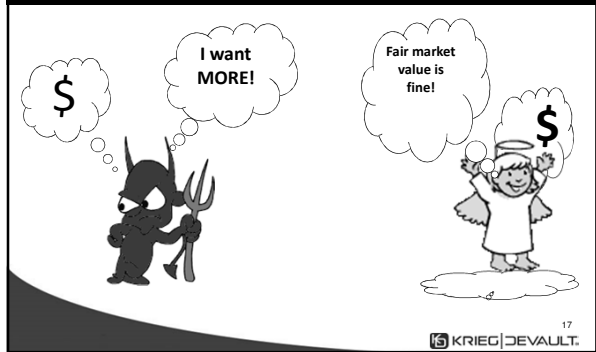
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### WHAT IS FAIR MARKET VALUE?



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### “What do you mean by FMV?”

- In the healthcare context, there are essentially 3 basic views on the meaning of FMV:
  - "Person on the street" perspective
  - Professional appraisal perspective
  - Legal/regulatory perspective
- Unfortunately, these 3 basic views frequently conflict.
- Parties can get "dazed and confused" when these 3 competing views meet to complete a transaction.



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**“The Street” View of FMV**

- Referral parties “negotiate” a price
- Rule of thumb
- Another hospital's offer
- What someone down the street gets
- A number in a survey book
- Investment value or strategic value
- Value of referrals




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**Professional Appraisal View of FMV**

“The price, expressed in terms of cash equivalents, at which property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arm’s length in an open and unrestricted market, when neither is under a compulsion to buy or sell and when both have reasonable knowledge of the relevant facts.”

*(International Glossary of Business Valuation Terms)*

“The value of services is the amount that would ordinarily be paid for like services by like enterprises, whether taxable or tax-exempt, under like circumstances.”

*(Internal Revenue Service definition of reasonable compensation - Treasury Reg. 53.4958-4(5)(b)(1)(ii).)*




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**Professional Appraisal View of FMV**

Fair Market Value means the value in arm’s length transactions, consistent with the general market value. “General market value” means the price an asset would bring as a result of bona fide bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the compensation that would be included in a service agreement as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement. 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 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.

*(Federal Physician Self-Referral Law definition of fair market value - 42 CFR §411.331)*

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**Professional Appraisal View of FMV**

- Application of traditional BV theory to CV
  - - Market
  - - Income
  - - Cost
- Not tied to referrals or referral relationship
- Application of FMV vs. synergistic value
- “knowledge of the relevant facts”
- Facts and circumstances specific
- Compensation tied to actual physician services
- Evaluation and application of relevant qualitative factors

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**Legal/Regulatory View of Fair Market Value**

According to the Stark Act, **fair market value** is “the value in arm’s-length transactions, consistent with the general market value.”




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**Legal/Regulatory View of Fair Market Value**

“General Market Value” means the price that an **asset** would bring as a result of *bona fide* bargaining between well-informed buyers and sellers who are not otherwise in a position to generate business for the other party, or the **compensation** that would be included in a service agreement as a result of *bona fide* bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of acquisition of the asset or at the time of the service agreement.

**42 C.F.R. § 411.351**

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**Legal/Regulatory View of Fair Market Value**

The Stark Act also defines *Fair Market Value* as the market price at which bona fide sales have been consummated for like type assets in a particular market.



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**Legal/Regulatory View of Fair Market Value**

For real estate, the Stark Act states that **fair market value** is “the value of rental property for general commercial purposes (not taking into account its intended use). In the case of a lease of space, this value may not be adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor when the lessor is a potential source of patient referrals to the lessee.”

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**Legal/Regulatory View of Fair Market Value**

A Fair Market Value Safe Harbor for *hourly rates* was developed under Stark in the Phase II regulations.

- > Average of 4 benchmark sources at 50<sup>th</sup> percentile or less
- > Average hourly rate for ER physicians in service area

Safe harbor deleted in Phase III regulation. However, OIG stated that safe harbor methodology is still a prudent documentation process.



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**Legal/Regulatory View of FMV**

- Stark regulations state that the definition of FMV “is qualified in ways that do not necessarily comport with the usage of the term in standard valuation techniques and methodologies.”
- *Stark example:*  
Exclusion of market comparables between parties in position to refer
- *Stark example:*  
FMV can be established by “any method that is commercially reasonable.”
- *OIG Anti-kickback statute example:*  
Footnote 5 to Advisory Opinion 09-09 cautioning the use of the Discounted Cash Flow (DCF) method for an ASC valuation

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**Avoid the FMV Definition Pitfall**

- The “Street” perspective of FMV is generally not reliable for healthcare regulatory purposes but may provide useful information.
- Regulatory definition of FMV may limit or qualify FMV methods used in professional appraisal practice.
- FMV as determined under professional appraisal standards may be more rigorous than the regulatory requirements.




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**Avoid the FMV Definition Pitfall**

- Appraisers don't give legal advice
- Appraiser should be versed in HC regulatory environment and impact on FMV
- Use of multiple appraisal methods is advisable
- Avoid inclusion of “synergy” value
- Compensation that results in significant losses should be pause for concern (Citizens)
- FMV does not ensure Commercial Reasonableness
- Step back and take a “30,000” foot view

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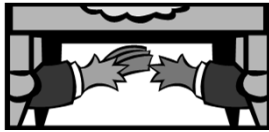
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**What Is Commercially Reasonable?**

Many of the exceptions under the Stark Act require the payment to “be commercially reasonable even no referrals were made” between the parties.



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**What Is Commercially Reasonable?**

To be commercially reasonable, both the **SERVICES** and **PAYMENT** must be commercially reasonable.



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**What Is Commercially Reasonable?**

- Separate analysis from FMV
- Commercial reasonableness is more of a “qualitative” analysis than quantitative
- Many FMV reports specifically exclude comment or opinion regarding CR
- Who determines if the transaction is CR? – often nobody knows or is asking
- CR opinion provides a “pre-transaction” document demonstrating thought regarding CR
- Seeing more government activity in this area

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### Captain Integrity<sup>SM</sup>

I want more money or I won't be your employed physician!

But that would be above fair market value.

I don't care! If you don't pay me what I want, I will never refer to you again!

If you don't pay me what I want, I will never refer to you again!

All payments to physicians must be at fair market value. Fair market value should be well documented and be contained in a written contract.

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### Benchmark Data

Data Example 1:

- Single Tier Model with a Guaranteed Cash Compensation of \$175,000 with additional incentive compensation of \$40 per RVU above 4,500 RVUs work.
- Base Compensation, RVU production and compensation per RVU all benchmarked at 50th percentile.

Percentile	Cash Compensation	RVUs	Compensation per RVUs
25	125,000	3,500	\$35
50	175,000	4,500	\$40
75	225,000	5,500	\$41
90	300,000	6,500	\$46

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### Benchmark Data

Data Example 2:

- Multiple Tiered Model
- 100% RVU Production

RVUs worked	Compensation per RVU
4,500 and below	\$30
4,501 – 5,500	\$35
5,501 – 6,500	\$40
6,501 and above	\$42

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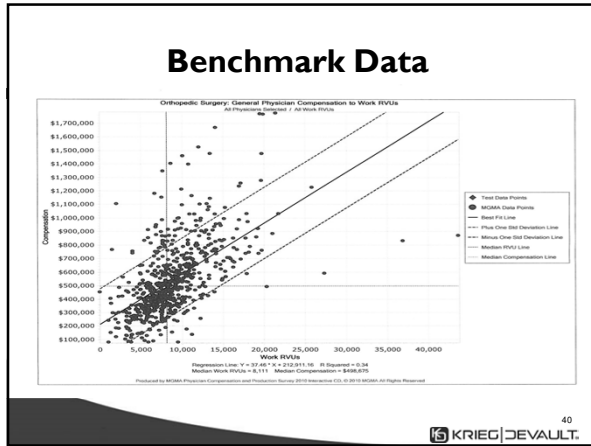
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### Benchmark Data

Specialty: Orthopedic Surgery			
	50 <sup>th</sup>	75 <sup>th</sup>	90 <sup>th</sup>
WRVUs	8,138	10,460	13,744
x 2 72.55 (50 <sup>th</sup> )*	\$590,412	\$758,873	\$997,127
x 3 87.80 (75 <sup>th</sup> )*	\$714,516	\$918,388	\$1,206,723
x 5 106.63 (90 <sup>th</sup> )*	\$867,775	\$1,115,350	\$1,465,523
Benchmark Range*	\$568,319	\$744,347	\$1,002,510

\*Based upon 2015 Physician Compensation and Production Survey from the Medical Group Management Association

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- ### Benchmark Data
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- Big variances in some specialties between surveys
  - Caution against “cherry picking” numbers (“use of multiple surveys”)
  - Which percentile do you use and why?
  - The 75<sup>th</sup> percentile “urban legend”
  - Ratio data can be easily misapplied (90<sup>th</sup>)
  - Regional vs. National data points
  - Does the survey # result in a net loss?
  - Does the survey # represent replacement cost?
  - What is included in the survey #?
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## Benchmark Data

Specialty: Orthopedic Surgery			
	50 <sup>th</sup>	75 <sup>th</sup>	90 <sup>th</sup>
wRVUs*	7,981	10,723	13,795
x \$63.54(50 <sup>th</sup> )*	\$507,113	\$681,339	\$876,534
x \$105.18 (90 <sup>th</sup> ) *	\$839,442	\$1,127,845	\$1,450,958
Benchmark Range*	\$520,119	\$682,541	\$943,059

\* Based upon 2012 Physician Compensation and Production Survey from the Medical Group Management Association

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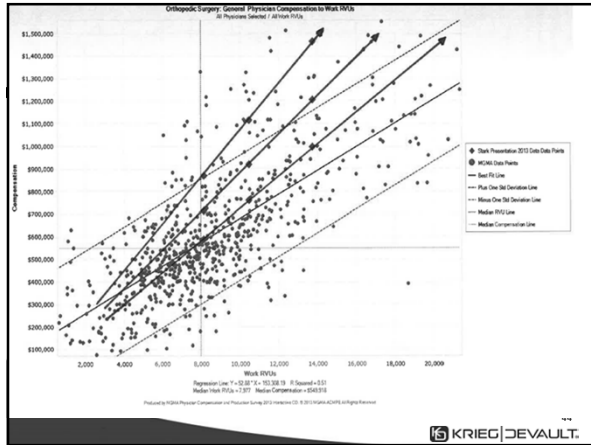
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## Productivity-Based Incentive Measures

The most commonly used productivity measures, in order, are the following: wRVUs, collections, net income, and patient visits.

2011 Physician Compensation and Productivity Survey by Sullivan, Cotter & Associates, Inc. Of those that use productivity based incentive measures, 74% use work RVUs.

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### Exceed Benchmark Data Range

Fair market value is based upon the specific financial arrangement being entered into by the parties. Factors that can cause compensation to **exceed 90th percentile** include:

- History of extremely high productivity (but...watch for red flags: mid-level production, high cost structure, short production history, etc.)
- Income approach can support compensation at that level
- Replacement cost supports - High demand/low supply for specialty or highly undesirable location
- Historic compensation above 90th percentile for personally performed services (watch for unusual ancillary usage, non-compliant compensation model, ROI vs. comp)
- Multiple services (stacking) – call, research, medical direction, CCMA, etc.
- Nationally renown program or skills (robotics, transplant, etc.)
- Super sub-specialization or multi-specialty training
- Thought leader in specialty

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### Compensation Stacking

- Aggregate compensation versus each component of compensation.
- Benchmark data includes all sources of compensation from respondents
- When analyzing fair market value compensation, understand all sources of compensation.
- Can one physician really be more than a 1.0 FTE?
- Focus on number of hours worked by physician.




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### Fair Market Value Issues

- United States ex rel. Reilly v. North Broward Hospital District, et al.
- Allegations:
  - The relator alleged that the compensation was excess of fair market value and commercially un-reasonable, because it was over the 90th percentile of total cash compensation as published in MGMA physician compensation surveys, and generated substantial practice "losses" for Broward
  - Broward tracked **and evaluated** "inpatient contribution margins" and "outpatient contribution margins"

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**Fair Market Value Issues**

- United States ex rel. Reilly v. North Broward Hospital District, et al. - Allegations Cont.:
  - For instance: One orthopedic surgeon was alleged paid at least \$1,391,184.23 in 2008 and \$1,557,984.40 in 2009
  - MGMA 90<sup>th</sup> percentile compensation for orthopedic surgeons in the Southern U.S. was \$1,209,569 in 2008
  - After evaluating the net revenue and expenses of the practice, Broward faced a net loss of \$791,630
  - However after tracking "inpatient contribution margins" and "outpatient contribution margins" this surgeon contribution margin was a profit of \$867,326

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**Fair Market Value Issues**

- United States ex rel. Reilly v. North Broward Hospital District, et al. - Allegations Cont.:
  - The physicians' compensation was not financially self-sustaining from professional income alone, but would be self-sustaining if one added the value of facility fees, which Broward tracked
  - The whistleblower argued that Broward's "Contribution Margin Reports," continually tracked referral profits and was used to **"take into account the volume and value of referrals"** when establishing compensation
  - The complaint also alleged that Broward pressured physicians to limit charity care, even though Broward is a public entity, and to keep referrals in-house, even when physicians believed the patient's care needs were better served by another facility

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**Fair Market Value Issues**

- United States ex rel. Reilly v. North Broward Hospital District, et al. Follow-Up Notes:
  - The settlement marked the largest ever reached without litigation under the Stark Law at the time
  - Because of the settlement we don't know DOJ's thoughts on:
    - The propriety of compensation that, in combination with practice overhead expenses, is in excess of collections from the physician's personally performed services
    - But we do know that a DOJ fair market value expert has asserted in litigation that physician arrangements, even for employed physicians, for departments that "lose" money are commercially un-reasonable while conceding that there is no statutory or regulatory basis for such an assertion
    - And the DOJ has asserted that hospitals that tolerate practice "losses" *because of* the value of the employed physician's referrals to the hospital are suspect

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**Fair Market Value Issues**

- Adventist Health System
- Compensation Exceeded Fair Market Value:
  - Compensation formulas based on "bottom line" by incorporating Part A and Part B revenues (DHS revenues) such that compensation varied based on volume or value of referrals. For example, oncologists were paid in part with chemotherapy revenues so that the more chemotherapy drugs a physician ordered, the more the physician was paid. This resulted in a high number of physicians exceeding the 90<sup>th</sup> percentile with some making over \$1 million/year.
  - **Bonus payments consisting of professional charges plus a significant portion, if not all, of the facility fee.** The facility fee was paid outside of the contract language.
  - Bonuses based on numbers of patients seen by the physician.

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**Fair Market Value Issues**

- Adventist Health System -- Compensation Exceeded Fair Market Value: (Cont.)
  - Employment agreements included caps on compensation **that were not enforced.** One interesting example involved an oncologist whose total compensation was nearly \$2 million and by contract was not to be paid in excess of the 99<sup>th</sup> percentile. Other agreements required the physician not to be paid more than certain dollar figures or no more than the 90<sup>th</sup> percentile and none were enforced.
  - The Dorsey *Qui Tam* complaint included an exhibit listing 167 physicians whose compensation arrangements involved alleged Stark violations, 85 of those exceeded the 90<sup>th</sup> percentile on MGMA
  - Many physicians **paid in excess of 90<sup>th</sup> percentile** fell below the **50<sup>th</sup> percentile in work RVUs**

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**Fair Market Value Issues**

- United States *ex rel. Drakeford v. Tuomey Healthcare System, Inc.*
- In 2003, several local specialty groups told Tuomey they planned to perform surgical procedures in-office instead of at Tuomey's 266-bed hospital
- To allegedly avoid a reduction in surgical case volume, Tuomey employed the 19 specialists as part-time employees
- Each of the 10-year employment contracts included essentially the same terms.
  - Physicians were required to perform outpatient procedures at a Tuomey hospital or facilities owned by Tuomey
  - Tuomey was responsible for billing and collections from patients and third-party payers, including Medicare and Medicaid
  - Tuomey compensated the physicians with annual base salaries that hinged on Tuomey's net cash collections for outpatient procedures
  - The physicians were also eligible for productivity bonuses equal to 80 percent of the net collections, along with an incentive bonus that could total up to 7 percent of the productivity bonus
  - Finally, the contracts also included a non-compete clause, prohibiting the specialists from competing with Tuomey during the 10-year term and two years after the contract expired

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**Fair Market Value Issues**

- Tuomey claimed that it had acted in good faith and sought/relied on advice from various outside law firms and consultants in connection with the employment agreements – Legal Opinion “Shopping”
- Tuomey indicated that it believed the employment agreements were commercially reasonable and not in excess of fair market value given a shortage of physicians in the community
- However, the Government discovered additional consultant reports suggesting potentially conflicting opinions as to the regulatory risk of the employment agreements

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**Fair Market Value Issues**

- The valuation Tuomey relied upon indicated productivity levels of the physicians were between the 50<sup>th</sup> and 75<sup>th</sup> percentiles
- Compensation levels exceeded the 90<sup>th</sup> percentile
- But, the valuation did not take into account any full time benefits provided
- In addition to this valuation, Tuomey sought out the expertise of a former Department of Health and Human Services attorney who had experience with the Stark Law and who advised them the physician contracts were problematic and the terms could potentially expose liability under the Stark Law

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**Fair Market Value Issues**

- Shortly after, Tuomey terminated the representation and sought advice from a new attorney
- The new attorney was placed in the position of providing guidance to Tuomey regarding compliance with the Stark Law
- This new attorney allegedly advised Tuomey that given the facts above, the Stark Law did not apply to the physician contracts

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**Fair Market Value Issues**

United States *ex rel.* Drakeford v. Tuomey Healthcare System, Inc. Follow-Up Notes:

- Major Question regarding the volume or value of referrals:
  - Here is how the Fourth Circuit interpreted the compensation structure when remanding the case back to district court:
  - "It stands to reason that if a hospital provides fixed compensation to a physician that is **not based solely on the value of the services the physician is expected to perform**, but also takes into account additional revenue the hospital anticipates will result from the physician's referrals, that such compensation by necessity takes into account the volume or value of such referrals."
- Important Takeaways from Tuomey:
  - Virtually all FCA cases are resolved through settlement agreements due to potential ramifications of losing – unusual that this case went to trial
  - Physician employment does not necessarily insulate agreements from Stark liability
  - If a proposed arrangement appears to have been developed in response to the fear of losing a referral stream, the government may look closely at issues of commercial reasonableness
  - Long-term arrangements should be reviewed periodically for compliance
  - Providers cannot blindly follow a fair market value or commercial reasonableness determination, its important to look at the analysis from a legal perspective

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**Varying Based Upon Volume or Value:  
What does this mean?**

- Two standards: i) cannot **vary** with the volume or value, and ii) cannot be **take into account** volume or value.
- Four levels of volume and value:
  - Paying a doctor for each referral of designated health services. **Clearly prohibited.**
  - Creation of a bonus pool that varies with either the gross revenue or net margin of a service line. Division of bonus pool based upon each physician's referrals of DHS. **Clearly prohibited.**
  - Creation of a bonus pool that varies with either the gross revenue or net margin of a service line. Division of bonus pool based upon percentage of work RVUs in comparison with aggregate WRVUs of all applicable physicians. **Halifax case, but unlitigated.**
  - Fixed bonus pool or bonus based upon overall success of AMC, both financially and based upon quality metrics. **Unlitigated.**

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**Fair Market Value/Bonus Issues**

➤ United States *ex rel.* Baklid-Kunz v. Halifax Hospital Medical Center, et al. Allegations:

- Lawsuit brought by the former Director of Physician Services at Halifax Health alleges that contracts with six (6) oncologists violated the Stark law and other relevant Medicare laws.
- The government alleged that the prohibited referrals resulted in the submission of 74,838 claims and overpayment of \$105,366,000.

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**Fair Market Value/Bonus Issues**

➤ United States ex rel. Baklid-Kunz v. Halifax Hospital Medical Center, et al. Allegations Cont.:

➤ Executed contracts with six medical oncologists that included an incentive bonus that improperly included the value of prescription drugs and tests that the oncologists ordered and Halifax billed to Medicare.

- Bonus Pool = 15% of Halifax Hospital's "operating margin" from outpatient medical oncology services (i.e., pool includes revenue from "designated health services" referred by oncologists)
- Does not comply with Employment Exception (1) FMV and (2) Volume/Value referral prohibition
- Share of pool paid to individual oncologists is based on each individual physician's personal productivity, not referrals
- However, pool includes "profits" from services referred, but not personally performed by oncologists.

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**Fair Market Value/Bonus Issues**

- United States ex rel. Baklid-Kunz v. Halifax Hospital Medical Center, et al.
  - Complaint alleged that Halifax paid three neurosurgeons more than fair market value for their work.
    - Bonus = 100% of collections after covering base salary, no expense sharing
    - Total Compensation = As much as double neurosurgeons at 90<sup>th</sup> percentile of FMV.

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**Fair Market Value/Bonus Issues**

Halifax Cont.:

- Bonus = 100% of collections after covering base salary, no expense sharing
  - Total Compensation = As much as double neurosurgeons at 90<sup>th</sup> percentile

AMGA 90 <sup>th</sup>	MGMA 90 <sup>th</sup>	Dr. R. K.	Dr. WK.	Dr. FMV.
\$844,703	\$1,200,051	\$1,725,302	1,160,163	1,897,524

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Median Net Income (Loss) per FTE Physician w/o Financial Support 2012 MGMA Cost Survey Data	
Practice Specialty	Net Income (Loss) per MD
Multi-Specialty Group (Hospital-Owned 10 FTE or less)	-\$12,177.00
Multi-Specialty Group (Hospital-Owned 11 to 50 FTE)	-\$16,093.00
Multi-Specialty Group (Hospital-Owned 26 to 50 FTE)	-\$18,874.00
Multi-Specialty Group (Hospital-Owned 51 to 75 FTE)	-\$22,792.00
Multi-Specialty Group (Hospital-Owned 76 to 100 FTE)	-\$26,711.00
Multi-Specialty Group (Hospital-Owned 101 to 150 FTE)	-\$30,630.00
Multi-Specialty Group (Hospital-Owned 151 FTE or more)	-\$34,549.00
Academic (All Practices)	\$37.00
Cardiology (All Practices)	-\$362,279.00
Endocrinology/Endocrinology (All Practices)	-\$141,377.00
Family Medicine (Hospital-Owned 10 FTE or less)	-\$12,233.00
Family Medicine (All Practices)	-\$12,687.00
Gastroenterology (All Practices)	\$244.00
Geriatrics/Geriatrics (All Practices)	-\$145,020.00
Hospital Medicine (All Practices)	-\$233,044.00
Infectious Disease (All Practices)	-\$67,107.00
Internal Medicine (Hospital-Owned 10 FTE or less)	-\$182,999.00
Internal Medicine (All Practices)	-\$174,855.00
Nephrology (All Practices)	-\$178,155.00
OB/GYN (All Practices)	-\$151,278.00
OB/GYN-Maternal/Fetal Medicine (All Practices)	-\$191,061.00
Obstetrics (All Practices)	-\$154,060.00
Ophthalmology (All Practices)	\$10,937.00
Ophthalmology (All Practices)	\$0.00
Ophthalmology (All Practices)	-\$223.00
Ophthalmology (All Practices)	-\$1,200.00
Ophthalmology (Hospital-Owned 10 FTE or less)	\$6,036.00
Ophthalmology (All Practices)	\$0.00
Ophthalmology (All Practices)	-\$11,829.00
Ophthalmology (All Practices)	-\$18,871.00
Ophthalmology (All Practices)	-\$6,269.00
Ophthalmology (All Practices)	\$128.00
Ophthalmology (All Practices)	-\$492,377.00
Ophthalmology (All Practices)	-\$146,385.00
Ophthalmology (All Practices)	-\$454,224.00
Ophthalmology (All Practices)	-\$210,614.00
Ophthalmology (All Practices)	-\$21,373.00
Ophthalmology (All Practices)	\$0.00
Ophthalmology (All Practices)	-\$143,111.73
Average Practice Loss per FTE Physician	

### Commercial Reasonableness/Loss Arrangements

Halifax Cont.:

➤ DOJ asserts that paying physicians more than the professional collections they generate exceeds FMV, is not commercially reasonable, and takes referrals into account:

"Given that each neurosurgeon was paid total compensation that **exceeded the collections generated for neurosurgical physician services**. Defendants could not reasonably have concluded that the compensation arrangements in those contracts were fair market value for the neurosurgical services or were commercially reasonable."


- But, there is no requirement that providing physician services must be profitable:
  - If compensation is FMV and is not adjusted for referrals, it should satisfy the Stark Law
  - Some service lines have unprofitable payor mixes or low demand
  - CMS recognizes the legitimacy of subsidizing physician compensation, e.g. in the E.D.
  - Likewise, call coverage and hospitalist services often require subsidies

### Commercial Reasonableness

- Adventist Health System
- Employed Physician Practices Consistently Lost Money But for Referrals:
  - Contribution margin from inpatient and ancillary services referrals was tracked for each physician
  - One example describes a pediatric urologist who wanted to work 3 days/month and was paid \$300,000/year based on the physician doing 80-85% of his surgeries at the hospital
  - Physician debts were routinely forgiven
  - Employment agreements included provisions requiring salary reductions if practice losses exceeded certain amounts that were not enforced

**[Potential Hard Stop]**  
**Time-Share Arrangements**

- United States ex rel. Schreane v. Memorial Health Care System and Catholic Health Initiatives
- Allegations: (Cont.)
  - In 2008, Memorial began an internal compliance review of its leases with physicians as a routine compliance-program function and found potential problems in deals with physicians who leased space and services next to the two hospitals' sleep centers
  - According to the settlement, Memorial had leases with nine physicians and/or medical groups that used hospital-owned space near the hospitals so they could see patients in between rounds or during other down time
  - The exam rooms were located in sleep centers at Memorial's two hospitals
  - In addition to the hospital space, physicians got the benefit of clerical and technical support and supplies

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**[Potential Hard Stop]**  
**Time-Share Arrangements**

- Allegations (Cont.):
  - These were time-share arrangements, in which hospitals rented the same space to different physicians or groups, each for a relatively short period of time
  - While the prices for the leases were appropriate, the Settlement states the hospitals ran into trouble when they chopped things up among the doctors for purposes of the time share
  - When the finance department did the calculations, it divided the charges for the use of hospital staff and support by the number of physicians using them, not based on time of usage.
  - "It was a mistake because the doctors are using full services during the time period they are there, and it was already allocated"

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**[Potential Hard Stop]**  
**Real Estate Valuation**

- United States ex rel. Schreane v. Memorial Health Care System and Catholic Health Initiatives
- Allegations:
  - Physicians at the Memorial North Park Professional Office Building had leases below market value for close to 20 years
  - The Chattanooga Heart Institute, with more than 20 physicians and performing about 400 surgeries per year year at Memorial, was given leases below market value for about 10 years
  - Several physicians were given \$100,000 to \$200,000 as renovation and construction allowances for the office practices in exchange for referrals to the hospital

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**[Potential Hard Stop]**  
**Real Estate Valuation**

- United States ex rel. Schreane v. Memorial Health Care System and CHI - Follow-up Notes:
  - When it submitted a self-disclosure to the HHS Office of Inspector General for problematic physician leases, Memorial Health Care System in Tennessee was unaware that an employee had already filed a False Claims Act lawsuit with similar allegations
  - Because of the false claims investigation, Memorial was **not** accepted to OIG's Self-Disclosure Protocol, and instead hammered out a settlement with the U.S. Attorney's Office for the Eastern District of Tennessee that was unrelated to the whistleblower's case

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**[Potential Hard Stop]**  
**Real Estate Valuation**

- United States ex rel. Bingham v. BayCare Health System
- Allegations:
  - BayCare created proxy organizations which entered into leases with referring physicians occupying medical office buildings
  - BayCare leased land at St. Anthony's Hospital to St. Pete MOB, LLC and agreed that the St. Pete MOB, LLC would build a medical office building to be used as the Heart Center
  - BayCare granted a non-exclusive parking easement to St. Pete MOB
  - St. Pete MOB did not incur the expense of leasing additional land for a garage nor the cost of \$3.6 million to construct 240 parking spots in addition to the cost of upkeep and taxes
  - These savings were passed on to physician tenants allegedly in order to encourage or increase referrals

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**[Potential Hard Stop]**  
**Real Estate Valuation**

- Allegations: (Cont.)
  - Leases were also amended to allow physicians, staff and patients to use BayCare's parking facilities at no charge
  - The estimated annual benefit for a referring physician was more than \$10,000
  - Additionally BayCare would bestow its tax-exempt status on the LLCs in question
  - This would eliminate the Physician tenants' proportionate share of the ad valorem real property tax liability and their personal property tax liability
  - Other remuneration: such as free valet services on St. Anthony's Hospital campus for referring physicians at the these medical office buildings

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**[Potential Hard Stop]  
Eliminating Hospital Competition**

- U.S. ex rel. Singh v. Bradford Regional Medical Center, et al.
- Allegations:
  - Relators brought a *qui tam* action alleging that hospital and physician defendants violated Stark and AKS as a result of (among other things) a nuclear camera subleasing arrangement
    - Two physicians referred patients to Bradford Regional Medical Center (BRMC) for nuclear imaging
    - BRMC learned that these Physicians planned to purchase a nuclear camera
    - BRMC determined that the nuclear imaging business was worth \$2.8 million; These Physicians referred 42.5% of that amount
    - BRMC adopted a policy that practitioners would be ineligible for staff privileges if they competed with hospital services

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**[Potential Hard Stop]  
Eliminating Hospital Competition**

- In May 2001, BRMC adopted a Policy on Physicians with Competing Financial Interests.
- The policy provided that, if a physician had a financial relationship with a competing health care entity that might have a significant impact upon the hospital, that physician would be ineligible for hospital privileges
- Specifically, the Policy states that —a practitioner who has a financial relationship with, or an ownership or investment interest in, any competing health care entity or services that has or may have a significant impact (as determined by the Board) upon the Medical Center: (i) shall be ineligible to be granted appointment (initial or reappointment) or clinical privileges to practice at the Medical Center and its facilities, and (ii) shall be ineligible for continued appointment and clinical privileges to practice at the Medical Center.

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**[Potential Hard Stop]  
Eliminating Hospital Competition**

- > Eventually, the parties entered into a sublease of the camera, the Hospital made a fixed monthly payment and an additional flat monthly fee for a noncompetition agreement from the Physicians
- > Monthly sublease payments included \$6,545 to cover Physicians' existing lease payments to GE, plus \$23,655 for all other lease rights, including a covenant not to compete
- > The non-compete fee was calculated by an independent accountant, who determined Hospital's expected revenue with and without the sublease in place
- > This analysis was wholly based on an Income Approach — "But for" referrals, hospital would lose \$X dollars

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**[Potential Hard Stop]  
Eliminating Hospital Competition**

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- U.S. ex rel. Singh v. Bradford Regional Medical Center, et al. Follow-up Notes:
- Relators argued:
  - The lease payments "took into account the volume or value of referrals"
  - The non-compete valuation was not consistent with the Stark fair market value definition
- Defendants argued:
  - A fixed monthly lease payment could not "take into account" the volume or value of referrals
  - Fair market value was supported by the appraisal and negotiation of the parties at arms' length
- Finding that the lease payments took into account the volume or value of referrals, the Court concluded that there was indirect compensation arrangement between the parties and that the "fair market value" provisions of the exceptions argued by the defendants were not met on the same basis
- The Court concluded the defendants violated the Stark Act, but was unable to conclude whether that was done knowingly for purposes of the False Claims Act

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**[Potential Hard Stop]  
Group Practice Definition**

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- Adventist Health System
- Practice Groups Fail Group Practice Conditions Under Stark:
  - Violated "Rule of 5's" by paying profits from DHS to physicians of components of the group practice consisting of less than 5 physicians. For example, 60% of the physicians in one group were independent contractors and not employees.
  - Violated "Unified Business Test" because not all practices used the centralized billing system
  - Violated "Full Range of Services Test" because physicians were employed or contracted to provide only certain services. For example, anesthesiologists employed for pain management only.

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**[Potential Hard Stop]  
Non-Physician Provider Billing**

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- Adventist Health System
- Incentive Compensation Included Services of NPPs:
  - Reimbursement per RVU set very high
  - Chargeable RVUs included those of NPPs
  - Bonuses included revenue generated by NPPs

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**[Potential Hard Stop]**  
**Free Services**

- United States v. Westchester Medical Center, et al.
  - Allegations:
    - From approximately 2000 through 2007, Westchester Medical Center maintained a financial relationship with Cardiology Consultants of Westchester, P.C., (CCW) a cardiology practice formerly operating on WMC's Valhalla campus. Allegedly WMC advanced monies to CCW to open a practice for the express purpose of generating referrals to the hospital
    - WMC provided WMC personnel to private practice physicians, without charge, for use in their private practices
    - WMC improperly discounted the cost charged to referring physicians for medical malpractice insurance coverage
    - WMC provided remuneration to physicians disguised as recruitment payments
    - WMC compensated referring physicians under service agreements that were either unsigned or in excess of fair market value
    - WMC knowingly submitted false cost reports to Medicare

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**[Potential Hard Stop]**  
**Medical Necessity/Standing Orders**

- United States ex rel. Brogdon v. Hospital Authority of Irwin County, et al.
  - Allegations of the suit concern the amount of compensation paid by the Hospital Authority of Irwin County ("ICH") to Dr. Mahendra Amin, ICH's leases with the co-defendants, and the supervision of certain diagnostic imaging services at ICH
  - Relators suggested that standing orders for the rural hospital called for unsupervised services to be performed in the absence of a Provider which were later billed and submitted to Medicare and Medicaid
  - Relators suggested that a doctor/co-owner of Irwin County Hospital would pay patients gas money to travel for care to Irwin
  - Relators suggested that Irwin County Hospital "unbundled" CT scan payments between services and supplies for more individual payments of supplies
  - Relators suggested that Irwin County Hospital would admit certain patients receiving CT-guided biopsies to the Operating Room for additional charges to Medicare and Medicaid

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**[Potential Hard Stop]**  
**Recruiting Expenses**

- United States v CDS, P.A.
- Allegations:
  - Physician whistle-blower is alleging that a clinic located in a hospital center illegally shifted physician recruiting expenses to the hospital in order to induce referrals to the hospital, in violation of the Stark law
  - The whistle-blower filed a second amended complaint on Nov. 20, 2015, after the court partially dismissed an earlier complaint on Sept. 28, 2015

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