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Advanced Fair Market Value: Complex Hospital-Physician Compensation Arrangements

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Overview

- Ensuring your hospital has a defensible fair market value analysis process;
- Must organizations start to focus on commercial reasonableness when analyzing fair market value?
- How will organizations address fair market value in the move from volume to value?
- Specific case study discussions of documenting fair market value for physician supervision/collaboration, administrative services, team based models of care, and more.

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Defensible Fair Market Value Analysis Process

- Organizations should establish a vibrant fair market value documentation process. Departments involved include:
  - Compliance
  - Legal
  - Finance
  - Operations
  - Audit

MEDICARE AND MEDICAID FRAUD AND ABUSE LAW
("ANTI-KICKBACK STATUTE")
42 U.S.C. 1320a-7b

- Under the Anti-kickback Statute, it is illegal to knowingly or willfully:
  - offer, pay, solicit, or receive remuneration;
  - directly or indirectly;
  - in cash or in kind;
  - in exchange for;
    - referring an individual; or
    - furnishing or arranging for a good or service; and
- for which payment may be made under Medicare or Medicaid.

PENALTY

Fined
not more than $25,000 or imprisoned for not more than
five (5) years
or both

Stark Act
42 U.S.C. 1395nn

- The Stark II Act prohibits a physician from making a ***Referral***
  - to an ***Entity***
  - for the furnishing of a ***Designated Health Service***
  - for which payment may be made under Medicare
  - if the physician (or an immediate family member)
  - has a ***Financial Relationship*** with the entity

Stark II Act

Proof of Intent is *Not* Required

Penalty

Denial of payment or refund; civil money penalties (up to $100,000) and exclusions from federal and state programs for improper claims or schemes

Exceptions

- Permitted ***Ownership*** and ***Compensation*** Arrangements:
  - Physician Services
  - In-office Ancillary Services
  - Services to Members of Prepaid Health Plans
  - Academic Medical Centers
  - Implants Furnished by ASC
  - Dialysis-related Drugs Furnished by End Stage Renal Disease Facility
  - Preventative Screening Tests, Immunizations and Vaccines
  - Eyeglasses and Contact Lenses Following Cataract Surgery
  - Intra-family Rural Referrals*

***New Phase II (7/26/04 effective date)**

Exceptions

- Permitted ***Ownership*** Interests:
  - Publicly-traded securities
  - Mutual Fund Investment
  - Rural Provider (75% of DHS to Rural Residents)
  - Hospitals in Puerto Rico
  - Hospital Ownership (whole, not department or floor)
    - Applies only to Physician-owned hospitals up to December 31, 2010 – such hospitals cannot i) Expand physician ownership percentage, or ii) Expand capacity such as patient rooms, procedure rooms, etc.

Exceptions

- Permitted ***Compensation*** Arrangements:
  - Rental of Office Space
  - Rental of Equipment
  - Employment Relationships
  - Personal Service Arrangement
  - Physician Recruitment
  - Isolated Transactions
  - Services Unrelated to Provision of Designated Health Services
  - Hospital-affiliated Group Practice Arrangements
  - Fair Market Value Payments Made by Physicians for Items and Services (i.e., clinical laboratory services)

Exceptions

- Permitted ***Compensation*** Arrangements:
  - Charitable Donations by Physician
  - Non-monetary Compensation (Benefits) up to $407 Per Year
  - Fair Market Value Compensation
  - Medical Staff Incidental Benefits (not to exceed $34 per benefit)
  - Risk-sharing Arrangements (i.e., withholds, bonuses, risk pools)
  - Compliance Training
  - Indirect Compensation Arrangements
  - Referral Services

Exceptions

- Permitted ***Compensation*** Arrangements:
  - Obstetrical Malpractice Insurance Subsidies
  - Professional Courtesy
  - Retention Payments in Underserved Areas
  - Community-wide Health Information Systems
  - Electronic Prescribing Items and Services
  - Electronic Health Records Items and Services

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Bona Fide Employment Exception

(Applies to *Compensation* Relationships)

- Employment is for identifiable services;
- Amount of remuneration under employment is:
  - Consistent with ***fair market value***, ***reasonable*** and determined through ***arm's length negotiations***
  - Not determined in manner which takes into account volume or value of referrals by referring physician; and
  - Remuneration is provided pursuant to agreement that would be commercially reasonable ***even if no referrals*** were made to employer

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Bona Fide Employment Exception

(Applies to *Compensation* Relationships)

- Productivity bonuses can be paid if based on services *performed personally* by the physician (i.e., worked RVUs)

Bona Fide Employment Exception

(Applies to *Compensation* Relationships)

- Requiring referrals
- An employer ***can require*** an employee to refer to a particular provider, practitioner or supplier so long as:
  - the compensation is set in advance
  - the compensation is fair market value
  - the referral requirement
    - is in writing signed by the parties
    - is not required if the ***patient expresses a preference*** for a different provider
    - does not require physician to refer if patients' ***insurance does not cover services*** at required providers
    - does not require physician to refer if the physician believes that the required referral is ***not in the patient's best medical interest***

Bona Fide Employment Exception

(Applies to *Compensation* Relationships)

- Requiring referrals (Continued)
  - The required referrals relate ***solely*** to the physician's services covered by the scope of the employment and the referral requirement is reasonably necessary for the legitimate business purposes of the compensation arrangement between the employer and the employee

Bad
Medical Director - Inpatient

Good
Employed Primary Care – Inpatient

Defensible Fair Market Value Analysis Process

- Typical pathway for physician compensation arrangements include:
  1. ***Operations*** identifying needed physician financial arrangement.
  2. Consultation with the ***Finance*** Department regarding a) proposed financial terms, b) fair market value documentation issues, and c) analyzing the commercial reasonableness of i) proposed financial arrangement from an operations perspective, and ii) compensation terms.

Defensible Fair Market Value Analysis Process

3. Consultation with ***Legal*** Department regarding a) legal structure of compensation arrangement to comply with the Anti-Kickback Statute and Stark Law, and b) fair market value/commercial reasonableness analysis.
4. ***Compliance*** oversight of the operational and legal requirements in 1. and 2. above.
5. ***Audit*** structure for oversight of the compensation arrangement.
6. Approval by Physician Arrangements Review ***Committee*** of FMV and Commercial Reasonableness.

Defensible Fair Market Value Analysis Process

Typical third party surveys include:

- **Sullivan, Cotter & Associates, Inc. - Physician Compensation and Productivity Survey**
- **HayGroup - Physicians Compensation Survey**
- **Hospital and Healthcare Compensation Service - Physician Salary Survey Report**
- **Medical Group Management Association - Physician Compensation and Productivity Survey**
- **ECS Watson Wyatt - Hospital and Health Care Management Compensation Report**
- **William M. Mercer - Integrated Health Networks Compensation Survey**

Defensible Fair Market Value Analysis Process

Total Compensation

	All Practice Types								
Specialty	Group Count	Count	Mean	Std Dev	10th %tile	25th %tile	Median	75th %tile	90th %tile
Allergy/Immunology	115	261	$361,302	$165,385	$187,249	$240,869	$316,661	$469,862	$613,725
Anesthesiology	143	2,763	$449,558	$157,899	$263,682	$370,573	$446,062	$529,061	$638,611
Anesthesiology: Pain Management	68	216	$498,102	$194,516	$274,816	$377,892	$453,128	$639,331	$723,579
Bariatrics (Nonsurgical)	11	14	$322,019	$174,026	$166,021	$228,698	$246,262	$397,030	$662,951

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Defensible Fair Market Value Analysis Process

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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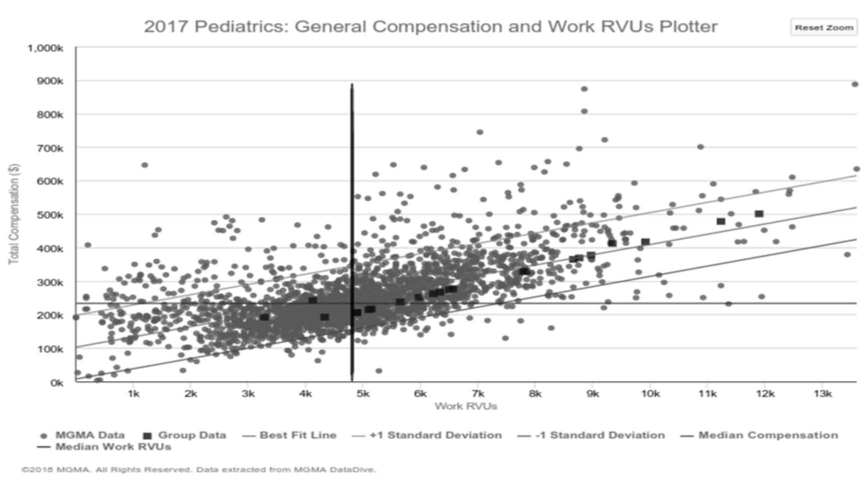
Defensible Fair Market Value Analysis Process

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

Defensible Fair Market Value Analysis



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Defensible Fair Market Value Analysis Process

- Be careful with the compensation per wRVU benchmark data.
  - 90th percentile physicians, based upon productivity, do not earn compensation per wRVU at the 90th percentile.
  - For most specialties, compensation per wRVU should remain approximately at the 50th percentile.

Defensible Fair Market Value Analysis Process

Specialty: Orthopedic Surgery

	50th	**75th**	**90th**
wRVUs*	8,184	10,946	14,109
x $74.71(50th)*	$611,427	$817,776	$1,054,083
x $118.30 (90th) *	$968,167	$1,294,912	$1,669,095
Benchmark Range*	$597,914	$776,389	$994,900

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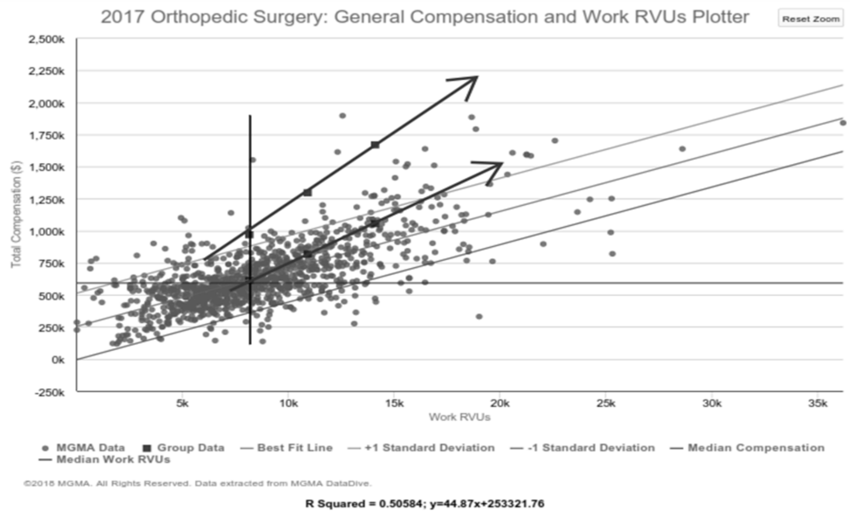

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Defensible Fair Market Value Analysis Process

➢ 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:

- Extremely high productivity
- High demand/low supply for specialty
- Thought leader in specialty
- Historic compensation above 90th percentile for *personally performed services* (do not include revenue from ancillary services or midlevel providers)
- Super sub-specialization or multi-specialty
- Nationally renown program

Defensible Fair Market Value Analysis Process

- 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.

Employment

Research

On-Call

Medical Staff Officer

Medical Directorship

Allocation of Office Space for Independent Contractor

FMV Process

- Contract Request and Document Management System
- Customized workflows for all contract types:
  - Physician Employment
  - Professional Service Agreements
  - Supply Chain
  - Real Estate
  - Design & Construction
  - Research
- No contract and no signature unless contract request submitted through database

FMV Process

- Capturing all components of compensation:
  - Clinical
  - Call Pay
  - Administrative
  - Medical Director
  - Academic
  - Sign-on Bonus
  - Office Space (Independent Contractor)

FMV Process

- Once survey is complete, the request routes for FMV review.
- FMV department performs an initial fair market value assessment to determine if we already have an FMV opinion that covers the proposed compensation arrangement.
- If no existing FMV, the FMV department reviews the proposal to determine if the proposed compensation is at or below the 60^{th} percentile annual salary for the appropriate specialty according to national benchmark data.
- If the proposed compensation exceeds the 60^{th} percentile compensation benchmark, then the proposed compensation is sent for an outside FMV/commercial reasonableness opinion.

Commercial Reasonableness

Commercial Reasonableness Questionnaire
(from Halifax Health)

1. What is the business purpose of this arrangement?
2. Does this arrangement further Halifax Health's mission and/or pursuit of strategic goals?
3. Justify the amount of services
4. Can the function be performed by a non-physician? If yes, discuss why you are seeking a physician.
5. If services are rendered on an hourly or part time basis, are there mechanisms in place to ensure the services are actually performed by the physician? If yes, please describe them. Otherwise, respond with "full time".
6. Is there a continued need for the services? If yes, please describe.
7. Are these services duplicated elsewhere? If so, does this new agreement create an excessive supply of services given our facility's need?

Commercial Reasonableness

- 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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Commercial Reasonableness

- The following services may not be commercially reasonable:
  - Two medical directors over a department when only one is needed.
  - Paying the physician for questionable consulting services.
  - Renting a piece of equipment full-time when only used once a month (assuming rental for one day is less than full-time rental).
  - Purchase of physician's medical office building with no intention to use building.
  - Large net losses to the hospital.
  - Rate may be FMV, but fail CR test.

FMV With Transition from Volume to Value

Volume: The most commonly used productivity measures, in order, are the following: wRVUs, collections, net income, and patient visits.[1]

[1] 2011 Physician Compensation and Productivity Survey by Sullivan, Cotter & Associates, Inc. Of those that use productivity based incentive measures, 74% use work RUVs.

FMV With Transition from Volume to Value

Health care organizations are placing a greater concentration, and thus a greater percentage of compensation, based upon ***value*** of medical services as opposed to traditional productivity compensation arrangements.

FMV With Transition from Volume to Value

➢ Areas of focus for value include:
- Quality
- Access
- Patient Panel Development/Maintenance

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FMV With Transition from Volume to Value

Quality:

- Education
- Meeting attendance
- Value Based Care
  - NGACO RAF, Medicaid peds RAF, Medicaid quality, Saturday Access
- Quality measures
  - Adult: BMI(G), HTN, CCS, BCS(G), Depr Screen(G), DM composite, Pneumovax(G)
  - Peds: Immun by 2(G); develop screen, asthma med control; depr screen(G); BMI(G); HTN screen(G)
- Innovation measures
  - Video visits, RIE, pediatric collaboratives

FMV With Transition from Volume to Value

- Access compensation can include:
  - Maintaining office hours outside of the traditional 8 am – 5 pm
  - Managing practice to permit scheduling of appointment within two business days (i.e. maintaining a schedule so that 20% of the schedule is available two business days before requested appointment).
  - Maintaining Saturday office hours.

FMV With Transition from Volume to Value

An example of a Panel Incentive is as follows:

Age Adjusted Panel Size per clinical FTE	Incentive per clinical FTE
2,500	$ 25,000
2,750	$ 30,000
3,000	$ 35,000
3,250	$ 40,000
3,500	$ 45,000
3,750	$ 50,000
4,000	$ 55,000
4,250	$ 60,000

Age adjusted, by way of example, could include a 20% reduction for patients below the age of 18 and a 20% increase for patients above the age of 65.

FMV With Transition from Volume to Value

- Examples of non-productivity quality indicators, based upon the percentage of patients receiving wellness services, based upon a percentage of the patient panel receiving such non-productivity services, is as follows:
  - Breast cancer screening
  - Rectal cancer screening
  - Depression screen
  - Pneumonia vaccination
  - High blood pressure consultation
  - Cholesterol screening
  - Aspirin utilization for patients with coronary heart disease
  - Childhood immunizations
  - Tobacco use screening and cessation counseling

FMV With Transition from Volume to Value

Fair market value in the ***aggregate***, is still a requirement in non-productivity compensation models due to the requirements under the exceptions under the Stark Law and the safe harbors under the Anti-Kickback Statue.

Case Studies

Beaumont Hospital

Background

Beaumont employs approximately 450 full-time employed physicians and 2,500 private practitioners credentialed to have admitting privileges. Currently, Beaumont ranks second in the nation for the number of Medicare patients who are provided services.

Allegedly, in mid-2007, Beaumont saw a drop in revenues relating to the loss of medical insurance programs associated with the auto industry. The change in payer mix and internal financial inefficiencies were internally quantified initially as a patient revenue loss of $1,600 per every Medicare patient which represented almost 50% of all patients.

Beaumont had been under investigation by the DOJ since 2011.

Case Studies
Beaumont Hospital

Four lawsuits were filed by under the *qui tam* or whistleblower, provisions under the False Claims Act, which permit private parties to sue on behalf of the government for false claims. *More than 21* physicians affiliated or employed by Willian Beaumont Hospital were referenced in four whistleblower lawsuits.

***Unites States ex rel. David Felten, M.D., Ph.D. v. William Beaumont Hospitals, et al.*, No. 2:10-cv-13440 (E.D. Mich)**

***United States ex rel. Karen Carbone v. William Beaumont Hospitals, et al.*, No. 11-cv-12117 (E.D. Mich)**

***United States ex rel. Cathryn Pawlusiak v. William Beaumont Hospitals, et al.*, No. 2:11-cv-12515 (E.D. Mich)**

***United States ex rel. Karen Houghton v. William Beaumont Hospitals, et al.*, No. 2:11-cv-14312 (E.D. Mich)**

Case Studies
Beaumont Hospital

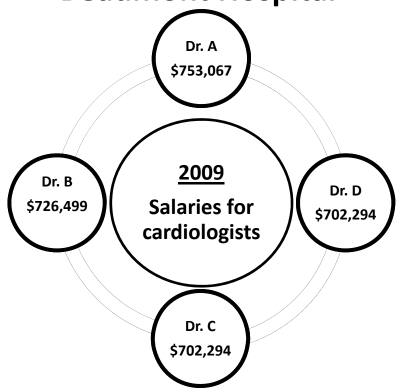
Between 2004 and 2012 *allegations* were made regarding Beaumont Hospital

- ***Allegedly***, Beaumont provided compensation substantially in excess of fair market value and free or below fair market value office space and employees to certain physicians (eight physicians) in exchange for patient referrals;

  - ***Allegedly***, nine cardiologists who were salaried by Beaumont as full-time employees (1.0 FTE) were allowed to maintain a private practice ***and*** keep remuneration from that private practice; whereas salaries for other physicians were covered by the billables collected for their clinical work.

  - ***Allegedly***, out of the nine cardiologists who received full-time salaries from Beaumont, the top four were being paid ***well above any other Beaumont physician***.

Case Studies
Beaumont Hospital



MGMA2018 Provider Compensation; 2017 Data

	25th Percentile	50th Percentile	75th Percentile	90th Percentile
Cardiologist: Noninvasive	$377,500	$479,882	$593,251	$731,027

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Case Studies
Beaumont Hospital

- ***Allegedly***, as full-time employees of Beaumont Hospital, clinical nurses were being used for research clinical trials who ***did not report*** their involvement to the Research Institute, thereby the nurses salaries were "*rolled up*" to the **Medicare Cost Report**, not the research grant.
  - *Prior to 2005 Beaumont made no effort to segregate research and T&E (travel and expense); consequently all research-based time was reported as a clinical activity and "rolled up" to the Medicare Cost Report.*
- ***Allegedly***, the Academic Heart & Vascular PLLC had its private offices of the grounds at Beaumont which the office rental agreement requires them ***to pay less*** than fair market value for the office space.

- ***Allegedly***, Medicaid claims were submitted to the Federal Medicaid and Medicare Program for these services of the *referred* patients;
- ***Allegedly***, Beaumont misrepresented that a CT radiology center qualified as an outpatient department of Beaumont in claims to Federal health care programs;
- ***Allegedly***, Beaumont allowed cost reporting irregularities.
  - Failure to properly account for research nurses where their time is being billed as "clinical" rather than under the "research" category on the Medicare time and effort reports.

Case Studies
Beaumont Hospital

- ***Allegedly***, Beaumont allowed Research Fraud.
  - ***Allegedly,*** a "surplus" budget was to be created for physician-researcher's discretionary spending. Upon accepting research from a vendor, the researcher is supposed to bill the research study budget for all non standard-of-care and for research salaries; however, instead, research services were rolled up onto Beaumont's Cost Reports.
  - ***Allegedly,*** physicians carried out private research on private patients in their private offices using funds, research nurses and resources which were provided by Beaumont. Beaumont provided the resources to these private physicians.
  - ***Allegedly,*** private physicians used space paid for by Beaumont Research Institute or Beaumont Foundation (philanthropic funds) for "private" research and/or clinical research office visits for private patients and presumably being billed through Medicare or private insurance.

Case Studies
Beaumont Hospital

SETTLEMENT
$84.5 Million Settlement as of August 2, 2018

1. **Avoid the "triple damage multiplier" in which the fine can be tripled when a defendant loses a case at trial. In addition, calculation of "per claim penalties" also could increase financial damages beyond what was agreed in the settlement.**
2. **Avoid additional exposure if Beaumont litigated against the government and had lost**
3. **Settlement consists of $82.74 million to the United States; and $1.76 million to the state of Michigan for Medicaid**
4. **Up to a 25% split between the four (4) physicians who filed cases against Beaumont Hospital**
5. **A five-year Corporate Integrity Agreement Implemented by the Department of Health and Human Services Office of the Inspector General with oversight of physician financial arrangements to be conducted by a Legal Independent Review Organization.**

Case Studies

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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Case Studies

North Broward Hospital District

- For instance: One orthopedic surgeon was alleged paid at least $1,391,184.23 in 2008 and $1,557,984.40 in 2009

- MGMA 90th 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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Case Studies

North Broward Hospital District

- 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

Case Studies

North Broward Hospital District

- 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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Case Studies

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 90th 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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Case Studies

Adventist Health System

- Employment agreements included caps on compensation **<u>that were not enforced.</u>** 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 99th percentile. Other agreements required the physician not to be paid more than certain dollar figures or no more than the 90th 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 90th percentile on MGMA
- Many physicians ***paid in excess of 90th percentile*** fell below the ***50th percentile in work RVUs***

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Case Studies

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

Case Studies

Volume or Value Analysis with Case Studies

- Cannot ***take into account*** volume or value.
- Four levels of volume and value:

i. Paying a doctor for each referral of designated health services. ***Clearly prohibited***.

ii. 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***.

iii. 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***.

iv. Fixed bonus pool or bonus based upon overall success of AMC, both financially and based upon quality metrics. ***Unlitigated***.

Case Studies

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.

Case Studies

Halifax Hospital Medical Center

- 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.

Case Studies

Halifax Hospital Medical Center

- 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 90th percentile of FMV.

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Case Studies

Halifax Hospital Medical Center

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

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

Source: MGMA DataDive Provider Compensation 20XX. Used with permission from MGMA, 104 Inverness Terrace East, Englewood, Colorado 80112. 877.275.6462. www.mgma.com. Copyright 2008. Used with permission from MGMA, 104 Inverness Terrace East, Englewood, Colorado 80112. 877.275.6462. www.mgma.com. Copyright 2008."

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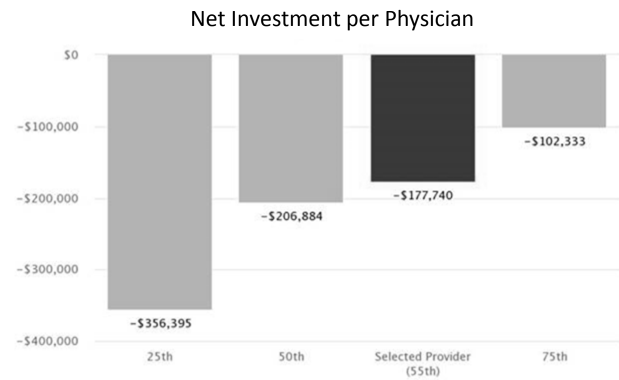
Average Loss per Hospital Employed Physician



Medical Group Strategy Council's 2017 Investment Benchmarking, Advisory Board Company

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Average Loss per Hospital Employed Physician

In 2012, losses in excess of $200,000 per hospital-employed physician were not unusual, according to the Medical Group Management Association.

According to Health Law & Policy , January 11, 2015, the cost for a hospital to employ a physician is increasing, with a new report out of Kentucky revealing that 58% of hospitals reported annual per-physician losses of more than $100,000—an increase of 17% over the prior year.

As of October 2016, and according to the Medical Group Management Association, median losses on hospital-owned multispecialty practices narrowed to $128,000 per physician from $183,000 in 2012.

"MGMA Cost Survey: 2013 Report Based on 2012 Data" and "MGMA Cost Survey: 2016 Report Based on 2015 Data"

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Average Loss per Hospital Employed Physician

- AMGA found the operating loss per physician increased from 10 percent of net revenue in 2016 to 17.5 percent of net revenue last year.
- During the two-year period of 2016 and 2017, the median loss per physician increased from $95,138 to $140,856.
- Median gross professional revenue rose from $1.2 million to $1.3 million during that same time period. However, median net professional revenue fell from $682,735 to $681,322, according to the survey.

Average Loss per Hospital Employed Physician

- Financial performance varied by group size and type. Private physician practices saw their operating margin increase $16,378 per physician between 2016 and last year. The 2016 survey showed a loss of $13,982, but last year's survey showed a profit of $2,396.
- Integrated health systems saw their median operating loss per physician increase approximately 15 percent between 2016 and 2017, from a median loss of $211,961 up to a median loss of $243,918, according to the survey.
- But large integrated groups, with more than 300 physicians, saw their median operating loss per physician decrease, from a median loss of $172,746 in 2016 to a median loss of $35,477 in 2017.

Case Studies

Halifax Hospital Medical Center

- 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 received 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

Questions

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