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Practice Loss Postulate Perpetuated by Third Circuit

A recent decision by the Third Circuit Court of Appeals reversed a lower court's decision; denied the motion to dismiss filed by the defendants, University of Pittsburgh Medical Center (UPMC) and its subsidiaries; and, ordered the *qui tam* action to proceed to the discovery phase of the lawsuit. This *Health Capital Topics* article will discuss the court's review and analysis of the compensation arrangements between UPMC and its neurosurgeons, and the potential implications of this case on healthcare providers.

Factual Background

UPMC is a large nonprofit healthcare system that owns a number of hospitals, medical practices, and other subsidiaries.[1] Three of the UPMC subsidiaries are also implicated in this case because they each employed one or more of the neurosurgeons who provided services to UPMC's hospitals beginning in 2006.[2] The compensation arrangements at issue were substantially similar in their methodology – each neurosurgeon had a base salary and a threshold number of work relative value units (wRVUs) that they were expected to achieve each year.[3] Should a neurosurgeon's annual productivity exceed that threshold, then UPMC paid the surgeon $45 per extra wRVU performed. On the other hand, if the surgeon did not achieve their threshold, their base salary for the subsequent year would be reduced.[4]

Judicial Analysis

In general, the court found that the relators' complaint sufficiently alleged the three elements of a Stark Law violation: (1) a referral of *designated health services* (DHS) by the neurosurgeons to the hospitals; (2) the existence of an indirect compensation arrangement (i.e., an unbroken chain of financial relationships connecting the surgeons with UPMC); and, (3) a Medicare claim for the referred service.[5] Further, the court ruled that the relators' complaint satisfied the three elements of a False Claims Act (FCA) violation: (1) "*the defendant presented or caused to be presented to an agent of the United States a claim for payment*"; (2) "*the claim was false or fraudulent*"; and, (3) "*the defendant knew the claim was false or fraudulent*."[6]

The appellate decision specifically addressed two questions:

(1) "*[W]ho bears the burden of pleading Stark Act exceptions under the False Claims Act?*" and,

(2) "*[D]o the relators offer enough facts to plausibly allege that the surgeons' pay varies with, or takes into account, their referrals?*"[7]

The court held that the answer to the first question is the defendants, asserting that the exceptions to the Stark Law function as affirmative decisions, which pleading burden resides with the defendant, i.e., UPMC.[8]

The majority of the court's opinion focused on answering the second question. In determining the answer, the court first examined whether the relators had sufficiently alleged that the surgeons' compensation varied with, or took into account, the volume and value of their referrals.[9] The court recognized the requirement that relators must show either *correlation* or *causation* between compensation and referrals, and dedicated a number of pages teasing out the difference between those two terms.[10] While this article will not focus on that (somewhat esoteric) discussion, suffice it to state that the court found that the relators sufficiently showed *both* correlation and causation (even though they were only required to show one).[11]

Second, the court examined whether the structure of the surgeons' contracts plausibly alleged correlation between their pay and referrals.[12] Of note, the court relied heavily on the reasoning in the 2013 4th Circuit case, *United States ex rel. Drakeford v. Tuomey*,[13] in finding that the relators sufficiently alleged that both the base salaries and the bonuses paid to the neurosurgeons varied with referrals.[14] The "*referrals*" made by the neurosurgeons, according to the court, constituted the surgeries or other procedures that the surgeons performed at a UPMC hospital, as the surgeons inherently referred the associated hospital claims (i.e., the *ancillary service and technical component* [ASTC]) that were provided and billed by the UPMC hospitals.[15]

Third, the court found that the neurosurgeons' suspiciously high compensation suggested causation, as "*[c]ompensation for personal services above the fair market value of those services can suggest that the compensation is really for referrals*."[16] In its reasoning on this point, the court relied upon five alleged facts that,

(Continued on next page)

"*viewed together, make plausible claims that the surgeons' pay exceeded their fair market value*":[17]

(1) "*[S]ome surgeons' pay exceeded their collections*" – The court found that "*at least three surgeons...were paid more than [UPMC] collected for their service*."[18] This is possibly due in part to the fact that UPMC allegedly "*credits surgeons with 100 percent of the [wRVUs] that they generate, even if [UPMC] cannot collect on all of them. So at least three surgeons (maybe more) were paid more than they [brought] in*."[19]

(2) "*[M]any surgeons' pay exceeded the 90th percentile of neurosurgeons nationwide*" – Some surgeons "*were sometimes paid two or three times more than the 90th percentile*"; in fact, one surgeon's 2011 bonus, by itself, "*exceeded the 90th percentile of total compensation in some surveys*."[20] It is worth noting, however, that the court did not identify the industry surveys to which they compared the UPMC surgeons' pay or productivity.

(3) "*[M]any generated [wRVUs] far above industry norms*" – "*[A]ll but one of the surgeons reported [wRVUs] above the 90th percentile in 2006 and 2007...A few even seemed 'super human,' racking up two to three times the 90th percentile*."[21] [Emphasis in original.]

(4) "*[T]he surgeons' bonus per [wRVU] exceeded what the defendants collected on most of those [wRVUs]*" – The neurosurgeons were paid a bonus of $45 per wRVU in excess of their wRVU threshold,[22] which is more than the Medicare reimbursement rate of approximately $35,[23] i.e., their bonuses exceeded the Medicare reimbursement rate. The majority reasoned that because "'*the majority of all claims submitted by [UPMC]...were submitted to federal health insurance programs such as Medicare and Medicaid'...we cannot assume that private payments [i.e., money from commercial insurers] suffice to make up the difference*," i.e., mitigate the difference between the bonus payment for and the Medicare reimbursement for each wRVU.[24] In other words, they claim, while paying bonuses that are more than the Medicare rate per wRVU is not enough by itself, more than 50% of UPMC's payor mix was comprised of Medicare and Medicaid, so it was improbable, if not impossible, for private insurance to have made up that difference such that UPMC was not incurring a loss in these bonus payments to the surgeons.

(5) "*[T]he government alleged in its settlement agreement that [UPMC] had fraudulently inflated the surgeons' [wRVUs]*" – The court focused on the fact that "*the Neurosurgery Department as a whole realized astounding 'annual growth rates of [wRVUs] of 20.3%, 57.1% and 20.0%' in 2007, 2008, and 2009*"[25] – in fact, "'*[t]wo of the surgeons more than doubled their output in just a few years" allegedly by "'artificially inflat[ing] the number of [wRVUs]...*'"[26] The majority also seemed to place great weight on the government's comments related to the part of this case that was settled. The government alleged a "*fudging [of] the numbers*" in its settlement agreement, asserting that surgeons claimed to have served as surgery assistants when they did not, and to have billed more expensive surgeries than they actually performed.[27] The court found the government's choice to intervene in part of the lawsuit, and its allegations in the settlement agreement, to be "*cause for suspicion*," rendering plausible claims sufficient to pass this stage of judicial scrutiny.[28]

Concurring Opinion

The concurring judge, although in agreement with the majority as to most of their legal conclusions, raised the practical concern that this ruling could open the floodgates of litigation. Specifically, he worried that the court is "*sending signals to hospitals throughout the Third Circuit, and the nation, that their routine business practices are somehow shady or suspicious and could leave them vulnerable to significant litigation*"[29]; that "*any hospital that pays its affiliated physicians according to some metric of the work they personally perform at the hospital falls under suspicion of violating the Stark Act...*"[30]; and, that "*top hospitals that offer doctors performance bonuses...could be sued and [be] forced to suffer through discovery or to settle.*"[31] In fact, "*many of the factors the majority points to as suspicious and indicating causation would likely be present in many cases where nothing untoward has occurred*."[32] The judge then concluded that "*the only way to evade suspicion [of violating the Stark Act] altogether...would be to pay those doctors a flat annual salary – and a modest one at that*."[33] The majority's reply to this concern was that, pursuant to the *Granston Memorandum*, the federal government has the power to dismiss frivolous *qui tam* (a/k/a whistleblower) suits (over relators' objections) when warranted[34] – however, as noted by a national health law firm, this assurance "*affords the [healthcare] industry cold comfort in light of the fact that the government has exercised this authority in relatively few cases*."[35]

The concurring judge specifically took issue with the majority's focus on the wRVU bonus payments exceeding the Medicare reimbursement rate. The concurrence points out that the "*$45/wRVU rate is actually **below the national average** compensation per wRVU*."[36] [Emphasis added.] It follows, the judge reasons, that "*it is clear enough that $45 per wRVU is not aberrantly high*."[37]

Implications for Healthcare Providers

Despite the potentially significant implications of this case on hospitals, health systems, and physicians, it is important to note at the outset that the standard of review

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in this case was at the motion to dismiss stage (i.e., an early stage) of the lawsuit. At this stage, the standard of review is simply whether "*the complaint states a plausible claim to relief...[and p]lausible does not mean possible*."[38] As specifically relates to this case, does "*the complaint sufficiently allege[] referrals and a compensation arrangement*"?[39]

Notwithstanding the standard of review at this early stage of litigation, some of the court's reasoning within its opinion serves as an eye-opening, key development in the progression of the *Practice Loss Postulate* (PLP),[40] the concept that a financial arrangement that operates at a "*book financial loss*," is, in and of itself, dispositive evidence of a hospital's payment of consideration based on the volume and/or value of referrals.[41] The court's opinion specifically relied upon the 4th Circuit's reasoning in the *Tuomey* case, one of the first cases to rely on the PLP in its reasoning, and a milestone in a series of costly judgments and settlements against vertically integrated health systems for allegedly violating the Stark Law.[42] In *Tuomey*, a private, non-profit community hospital in South Carolina was found to have violated the Stark Law when it entered into more than fifteen employment agreements, all of which allegedly were designed to induce and maintain referral relationships.[43] Specifically, the relator alleged that Tuomey Healthcare System entered into compensation contracts with area physicians, conferring salary and benefits to those physicians in excess of the net collections received from their professional practices.[44] Tuomey would then bill Medicare for the ASTC associated with these physicians' professional services (i.e., a "*facility fee*"), because Tuomey provided the space, nurses, equipment, and other items required for the delivery of those services.[45] The court relied upon considered the testimony of the relator and the Department of Justice's expert witness, who, after the 4th Circuit issued its opinion, noted:

> "*Case documents I examined and the testimony I reviewed shows that Tuomey took into account the value and volume of anticipated physician referrals by…Acknowledging that the hospital's technical and facility fees earned each time the physicians performed an outpatient surgery are reasonable 'off-sets' for its $1.5 [million] annual operating losses. Notably because Tuomey's technical and facilities earned [sic] are deemed to be the physicians' patient referrals.*"[46] [Emphasis Added]

Similarly, in this case, a majority of three federal judges directly articulated judicial support for the validity of the inference that a "*financial hit*" or "*loss*" generated by a vertically integrated physician or physician practice may signal the payment of compensation, remuneration, and consideration to physicians as an inducement of legally impermissible referrals from physicians.[47]

Further, as noted by the concurring judge, such a threshold, i.e., wherein any amount paid to a physician must be less than he or she collected from Medicare in order to ensure legal permissibility, does not reflect the realities of the healthcare delivery system. As the concurrence stated, the bonus amount paid per wRVU was below the national average compensation per wRVU; thus, the court's reasoning on this topic indicates that hospitals with more challenging payor mixes (i.e., treating larger Medicare and/or Medicaid populations) cannot pay their physicians as much in compensation for fear of exceeding the Medicare reimbursement rate per wRVU, a significant potential detriment to hospitals seeking to recruit physicians to provide services to more indigent, older, and/or higher acuity patients (e.g., at safety-net hospitals and Disproportionate Share Hospitals (DSH)).[48] Further, the court fails to take into account for other realities within the healthcare delivery, such as the requirements of nonprofit hospitals that must fulfill their charitable mission, as well as hospitals that serve as trauma centers (which require staffing of certain specialties).

Conclusion

Despite the low pleading standard required to proceed past this stage of the lawsuit, the 3rd Circuit's opinion in this case is nevertheless a concerning continuation of the idea that an employment arrangement wherein an employed physician is compensated more than the employer hospital collects for the physician's component of a given procedure may be legally impermissible. As addressed by the concurring judge, such a low standard (although it may not survive the latter stages of litigation) may open the floodgates of litigation, and expose hospitals to additional costly lawsuits on which they must expend substantial resources in order to defend.

However, this ruling may be short lived, in light of the recently proposed changes to the Stark Law, wherein the *Centers for Medicare and Medicaid Services* (CMS) challenged some of these judicial reasoning, e.g., stating that "*a productivity bonus will not take into account the volume or value of the physician's referrals solely because corresponding hospital services...are billed each time the employed physician personally performs a service*."[49] In fact, subsequent to the publication of this proposed rule, UPMC filed a *Petition for Panel Rehearing or Rehearing En Banc*, requesting that the case be reheard by the original four judges, or the entirety of the 3rd Circuit Court of Appeals, the reasoning for which request was based heavily on the proposed rule language.[50] Depending on the outcome of this ruling, the 3rd Circuit's original ruling will be overturned, or the case will be affirmed, and ordered to proceed to discovery. Hospitals, health systems, and physicians would be well-served to monitor the developments in this case, especially at the motion for summary judgment stage, wherein the court will likely reconsider these facts, but at a much higher standard of review.

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1 "United States of America ex rel. J. William Bookwalter, III, MD, et al. v. UPMC, et al." No. 18-1693 (3rd Cir. Sept. 17, 2019), p. 7.
2 *Ibid*, p. 7, 36.
3 *Ibid*, p. 7.
4 *Ibid*, p. 8.
5 *Ibid*, p. 14.
6 *Ibid*, p. 34 (citing "False Claims" 31 U.S.C. § 3729(a)(1)).
7 It is important to note that part of this original lawsuit was settled by UPMC and the Department of Justice in 2016, as relates to the claims for physician services; the government declined to intervene on the claims regarding the hospital services, which is the focus of this current action on appeal. *Ibid*, p. 6.
8 *Ibid.*
9 *Ibid*, p. 18.
10 *Ibid*, p. 18-22.
11 *Ibid*, p. 22.
12 *Ibid*, p. 3.
13 "United States ex rel. Drakeford v. Tuomey" 976 F. Supp. 2d 776 (D.S.C. 2013). For more information regarding this case, see "Increasing Scrutiny of Healthcare Fraud and Abuse Laws" Health Capital Topics, Vol. 7, Issue 2 (February 2014), https://www.healthcapital.com/hcc/newsletter/02_14/HTML/EMBOLDENING/7.2_emboldening_part_3_2.27.php (Accessed 10/21/19).
14 "United States of America ex rel. J. William Bookwalter, III, MD, et al. v. UPMC, et al." No. 18-1693 (3rd Cir. Sept. 17, 2019), p. 24-25.
15 *Ibid*, p. 15.
16 *Ibid*, p. 25.
17 *Ibid*, p. 27.
18 *Ibid.*
19 *Ibid.*
20 *Ibid*, p. 28.
21 *Ibid*.
22 *Ibid*, p. 29.
23 *Ibid*.
24 *Ibid.* (citing App. 193 ¶ 233).
25 *Ibid*, p. 30 (citing App. 171 ¶¶ 127-28).
26 *Ibid*, p. 30 (citing App. 171 ¶¶ 127-28).
27 *Ibid*, p. 30-31.
28 *Ibid*.
29 *Ibid*, concurring op., p. 2.
30 *Ibid*, concurring op., p. 11.
31 *Ibid*, p. 39.
32 *Ibid*, concurring op., p. 3.
33 *Ibid*, concurring op., p. 12.
34 "Memorandum: Factors for Evaluating Dismissal Pursuant to 31 U.S.C. 3730(c)(2)(A)" Michael D. Granston, U.S. Department of Justice, January 10, 2018, p. 1.
35 "Third Circuit Perpetuates Tuomey's Controversial Stark Law "Volume or Value" Standard" By Tony Maida, et al., McDermott Will & Emery, October 2, 2019, https://www.mwe.com/insights/third-circuit-perpetuates-tuomeys-controversial-stark-law-volume-or-value-standard/ (Accessed 10/18/19).
36 "United States of America ex rel. J. William Bookwalter, III, MD, et al. v. UPMC, et al," concurring op., p. 3 (citing Appellee's Brief, p. 49).
37 *Ibid*, concurring op., p. 3.
38 *Ibid*, p. 10.
39 *Ibid*, p. 14-15.
40 For more information on the PLP, see "Practice Loss Postulate (PLP) Regulatory Trend Misapplies Economic Theory to Healthcare Integration" Health Capital Topics, Vol. 9, Issue 6 (June 2016), https://www.healthcapital.com/hcc/newsletter/06_16/HTML/PHP/9.6_hc_topics_june_16_plp_abstract_6.22.php (Accessed 10/21/19).
41 *See, e.g.*, "United States ex rel. Drakeford v. Tuomey Healthcare System, Inc." 675 F.3d 394, 407 (4th Cir. 2012); "United States ex rel. Parikh v. Citizens Medical Center" Case No. 6:10-cv-00064, (S.D. TX. September 20, 2013), Memorandum and Order, p. 27-28; "United States ex rel. Reilly v. North Broward Hospital District, et al.," Case No. 10-60590-CV (S.D.Fla. September 11, 2012), Relator's Third Amended Complaint Under Federal False Claims Act, p. 31; "United States ex rel. Payne et al. v. Adventist Health System et al.," Case No. 3:12cv856-W (W.D.N.C. February 13, 2013), Relator's Amended Complaint, p. 56.
42 *See, e.g.*, "United States ex rel. Parikh v. Citizens Medical Center" Case No. 6:10-cv-00064, (S.D. TX. September 20, 2013), Memorandum and Order, p. 27-28; "United States ex rel. Reilly v. North Broward Hospital District, et al.," Case No. 10-60590-CV (S.D.Fla. September 11, 2012), Relator's Third Amended Complaint Under Federal False Claims Act, p. 31; "United States ex rel. Payne et al. v. Adventist Health System et al.," Case No. 3:12cv856-W (W.D.N.C. February 13, 2013), Relator's Amended Complaint, p. 56.
43 "United States ex rel. Drakeford v. Tuomey Healthcare Systems, Inc." 675 F.3d 394, 399 (4th Cir. 2012).
44 *Ibid*.
45 *Ibid*.
46 *Ibid*, Supplement to Expert and Rebuttal Reports, By Kathleen McNamara, p. 15.
47 "United States of America ex rel. J. William Bookwalter, III, MD, et al. v. UPMC, et al." No. 18-1693 (3rd Cir. Sept. 17, 2019), p. 29, 39.
48 *Ibid*, concurring op., p. 3 (citing Appellee's Brief, p. 49).
49 "Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations" Federal Register Vol. 84, No. 201 (October 17, 2019), p. 55795. For more information on this topic, see the article entitled "Proposed Stark Law Changes: Healthcare Valuation Implications" in this month's issue of *Health Capital Topics*.
50 "Petition for Panel Rehearing or Rehearing En Banc" United States of America ex rel. J. William Bookwalter, III, MD, et al. v. UPMC, et al., No. 18-1693 (3rd Cir. October 15, 2019).

(Continued on next page)

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