

Fair Market Value and Commercial Reasonableness: *Physician Compensation Agreements*

Webinar By:
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About the Presenter

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the President of **HEALTH CAPITAL CONSULTANTS (HCC)**, where he focuses on the areas valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the evaluation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.



Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia. He is a Fellow of the American College of Healthcare Executives, and serves as President of the St. Louis Chapter of the American Society of Appraisers (ASA). He has co-authored “*Research and Financial Benchmarking in the Healthcare Industry*” (STP Financial Management) and “*Healthcare Industry Research and its Application in Financial Consulting*” (Aspen Publishers). He has additionally taught before the Institute of Business Appraisers and CPA Leadership Institute, and has presented healthcare industry valuation related research papers before the Healthcare Financial Management Association; the National CPA Health Care Adviser’s Association; Association for Corporate Growth; Infocast Executive Education Series; the St. Louis Business Valuation Roundtable; and, Physician Hospitals of America.

INTRODUCTION

Growth of Physician Employment by Hospitals

- Hospitals focused on recruiting primary care physicians during the 1990s
- However, recent attention has turned to specialty practitioners, resulting in a growing number of specialists being employed by hospitals
- Hospitals are also employing physicians for medical directorship, management, administrative, on-call and executive positions
- Physician providers continue to face reimbursement decreases for professional services, as well as, growing legislative efforts to restrict physician ownership in ancillary services and technical component (ASTC) revenue streams

Compensation for Hospital-Employed Physicians

- Arrangements must:
 - i. Be for *Bona Fide* employment
 - ii. Have compensation that is *Fair Market Value (FMV)* and is not related to referrals
 - iii. Be *Commercially Reasonable* to avoid legal impermissibility under the **Stark** and **Anti-Kickback** statutes
- Arrangements where any threshold is not met can also be found legally impermissible under the **Federal False Claims Act (FCA)**
 - Provider cannot *knowingly* submit a claim for reimbursement to a government entity for services under compensation arrangements which are deemed to be Stark and Anti-Kickback violations
 - A suit filed under the FCA is known as a “*whistleblower suit*” or a “*qui tam action*”

Increasing Scrutiny of Physician and Executive Compensation

- **Rebuttable Presumption:** If all three parts are met, executive compensation is presumed to be at *FMV*
 - Compensation approved by an authorized body whose members have no conflicts of interest
 - Compensation has been based on a reliable set of data
 - Authorizing Body documented the basis for pay-setting
- February 2009: IRS Report on not-for-profit executive compensation
 - Results: Compensation high, but 85% of hospitals followed **Rebuttable Presumption** process (pay-setting practices are defensible under Internal Revenue Code)

Increasing Scrutiny of Physician and Executive Compensation

- February 2009: IRS Report on not-for-profit executive compensation
 - Report questions the validity of comparable data used
 - Variations in reporting and high executive pay rates have prompted questions regarding the use of comparables, as well as, the efficacy of the **Rebuttable Presumption** process at setting compensation at **FMV**
 - Significant variations in how hospitals accounted for: bad debt; community benefit; and, uncompensated care
 - Report makes no policy recommendations, but it may be used as a basis for executive compensation reform (e.g., executive pay caps, similar to the ones recently created for the financial sector)

Increasing Scrutiny of Physician and Executive Compensation

- May 2009: **Fraud Enforcement and Recovery Act (FERA)**
 - Broadens definition of “*knowingly*” used in the False Claims Act (FCA)
 1. *“Has actual knowledge of the information;*
 2. *Acts in deliberate ignorance of the truth or falsity of the information; or,*
 3. *Acts in reckless disregard of the truth or falsity of the information.”*
 - Reduces government’s burden of proof – no longer required to provide “*proof of specific intent to defraud*”
 - **FERA** will facilitate easier prosecution for violations of the FCA

Increasing Scrutiny of Physician and Executive Compensation

- **2009** – DOJ and HHS create the **Health Care Fraud Prevention and Enforcement Action Team (HEAT)**
 - Launching over 1,000 investigations
 - Leading to 800 indictments
 - Resulting in 600 convictions
- **2009** – \$2.5 billion was recovered and returned to the Medicare Trust Fund
- **2010** – Federal government estimated to have spent \$1.7 billion fighting fraud and abuse
- **2011** – Healthcare reform began allocating \$100 million, annually, to finance the cost of fraud and abuse investigations

“Heat Task Force Official Website,” stopmedicarefraud.gov, (accessed 9/23/10).

“Sebelius, Holder: New Healthy Reform Law Will Help Prevent Medical Fraud,” By Andrew Villegas, Kaiser Health News, May 13, 2010, <http://www.kaiserhealthnews.org/Stories/2010/May/13/health-fraud-shorttake.aspx>, (accessed 9/23/2010).

FAIR MARKET VALUE (FMV)

Definition of Fair Market Value (FMV)

Stark Law

- *“The value in arm’s-length transactions, consistent with the **General Market Value**”*
 - **General Market Value:** *“The price that an asset would bring, as the 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 the agreement, where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.”*

Definition of Fair Market Value (FMV) *Centers for Medicare & Medicaid Services (CMS)*

- CMS (f/k/a Health Care Financing Administration) made the following statements regarding when a payment for services provided is at *FMV*:
 - “[W]e believe the relevant comparison is aggregate compensation paid to physicians practicing in similar academic settings located in similar environments. **Relevant factors include geographic location, size of the academic institutions, scope of clinical and academic programs offered, and the nature of the local health care marketplace.**”
 - “. . . [We] intend to accept any method [for establishing FMV] that is **commercially reasonable and provides us with evidence that the compensation is comparable to what is ordinarily paid for an item or service in the location at issue, by parties in arm's-length transactions who are not in a position to refer to one another . . .** The amount of documentation that will be sufficient to confirm [FMV] . . . will vary depending on the circumstances in any given case; that is, there is no rule of thumb that will suffice for all situations.” [emphasis added]

Definition of Fair Market Value (FMV) *Centers for Medicare & Medicaid Services (CMS)*

- In Stark II, Phase III, CMS provided the following guidance for valuing administrative positions:
 - *“A fair market value [FMV] hourly rate may be used to compensate physicians for both administrative and clinical work, provided that the rate paid for clinical work is [FMV] for the clinical work performed and the rate paid for administrative work is fair market value for the administrative work performed. We note that the fair market value of administrative services may differ from the fair market value of clinical services.”*

Definition of Fair Market Value (FMV)

Case Law

- **FMV** is defined as *“the price a willing buyer would pay a willing seller... when neither is under compulsion to buy or sell.”*
- Providing a discount is not evidence that an agreement is below **FMV** if there is no comparison between the original or discounted rates and **FMV**
 - In addition, the Medicare rate is not necessarily equivalent to **FMV**
- An Illinois district court noted that **FMV** may differ from traditional economic valuation formulas, which take into account referrals
 - As the **Anti-Kickback Statute** prohibits any inducement for those referrals, they must be excluded from any **FMV** calculation
- Proving that an arrangement is at **FMV** is imperative in complying with requirements of the **Stark Law**
 - *“Payment exceeding fair market value is in effect deemed payment for referrals.”*

Klaczak v. Consolidated Medical Transport, 458 F.Supp.2d 622 (N.D. Ill. 2006); *U.S. ex rel. Obert-Hong v. Advocate Health Care*, 211 F.Supp.2d 1045 (N.D. Ill. 2002).
American Lithotripsy Society v. Thompson, 215 F.Supp.2d 23 (D. D.C. 2002).

Definition of Fair Market Value (FMV) *Internal Revenue Service (IRS)*

- 501 (c)(3) enterprises must avoid “*excess benefit*” transactions
- **Equates reasonable compensation to the value of services provided**
 - “[A]mount that would ordinarily be paid for like services by the enterprises (whether taxable or tax-exempt) under like circumstances”
- **Valuation standard (as cited by IRS Regulation) is *Fair Market Value***
 - “[P]rice at which property or the right to use property would change hands between a willing buyer and a willing seller, neither being under any compulsion to buy, sell, or transfer property or the right to use property, and both having reasonable knowledge of relevant facts”

Stark Law Implications

- **FMV** is a critical requirement for compliance under the **Stark Law**
 - Stark Law prohibits a physician from making referrals for “**designated health services**” that may be paid for by Medicare or Medicaid to an entity with which the physician has a *financial relationship*, and prohibits the entity from billing
 - **Designated health services** are clinical laboratory services; physical therapy services; occupational therapy services; radiology services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.
 - **Financial relationships** can be direct or indirect ownership or direct or indirect compensation
 - Suspect arrangements may be at FMV if there is an applicable Stark Law Exception

Stark Law Implications

Stark Law Exceptions

- Referrals are exempted from Stark Law under the exceptions for “*bona fide employment relationships*” and “*personal services agreements*”
- Used in: medical director; executive; on-call; and, other physician services arrangements

Requirements for Exception	“Bona fide employment relationship”	“Personal service agreements”
The employment is for identifiable services (provided by physician to entity)	×	×
Amount of remuneration under the employment is consistent with FMV of the services	×	× ¹
Amount of remuneration under the employment is not determined in a manner that accounts for (directly or indirectly) the volume or value of any referrals by the referring physician	×	×
Remuneration is provided under an agreement that would be commercially reasonable even if no referrals were made to the employer	×	
Arrangement (which must be at least 12 months) specifies, in writing, services covered and is signed by both parties		×
Aggregate services “must not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement”		×
Services provided must not involve promotion of business arrangement that is a violation of state or federal law		×

Note:

1. Compensation must also be set in advance

“Health Care Fraud and Abuse: Practical Perspectives,” Edited By Linda A. Baumann, The American Bar Association & The Bureau of National Affairs, Inc., Washington, D.C., (2002), pp. 280; “Exception to the referral prohibition related to compensation arrangements,” 42 CFR 411.357 (Oct. 1 2004).

Stark Law Implications

Stark Law Exceptions

- Other exceptions that use *FMV*:
 - Medical Office Lease
 - Equipment Lease
 - Indirect Compensation
 - Isolated Transaction
 - Fair Market Value Compensation
 - Academic Medical Centers

Stark Law Implications

Independent Contractors vs. Group Practice Physicians

- Preceding discussion about *FMV* is related to compensation paid to physicians who are either employed or performing services on an independent contractor basis, *not* compensation paid or distributed to physician members of a “*group practice*” as defined within **Stark Law**
- Compensation paid within the “*group practice*” setting has fewer regulatory restrictions

Stark Law Implications

Compensation Paid Under Exceptions to the Stark Law

	A	B	C	D	E	F
1	Terms of Exception	Group Practice Physicians [1877(h)(4);411.352]	Bona Fide Employment [1877(e)(2);411.357(c)]	Personal Service Arrangements [1877(e)(3); 411.357(d)]	Fair Market Value [411.347(1)]	Academic Medical Centers [411.355(e)]
2	Must compensation be Fair Market Value?	No	Yes - 1877(e)(2)(B)(i)	Yes - 1877(e)(3)(A)(v)	Yes - 411.357 (1)(3)	Yes - 411.355 (e)(1)(ii)
3	Must compensation be "set in advance"?	No	No	Yes - 1877 (e)(3)(A)(v)	Yes - 411.357 (1)(3)	Yes - 411.355 (e)(1)(ii)
4	Scope of "Volume of value" restriction	DHS referrals - 1877(h)(4)(A)(iv)	DHS referrals 1877(e)(2)(B)(ii)	DHS referrals or other business - 1877 (e)(3)(A)(v)	DHS Referrals or other business - 411.357(1)(3)	DHS referrals or other business - 411.355(e)(1)(ii)
5	Scope of productivity bonuses allowed	Personally performed services and "incident to," plus indirect - 1877(h)(4)(B)(i)	Personally Performed services - 1877 (e)(2)	Personally performed services - 411.351 ("referral") and 411.354(d)(3)	Personally performed services - 411.351 ("referral") and 411.354(d)(3)	Personally performed services - 411.351 ("referral") and 411.351 (d)(3)
6	Overall profit shares allowed	Yes - 1877(h)(4)(B)(i)	No	No	No	No
7	Written agreement required	No	No	Yes, minimum 1 year term	Yes (Except for employment), no minimum term	Yes, written agreement(s) or other document(s)
8	Physician Incentive Plan (PIP) exception for services to plan enrollees?	No, but risk-sharing arrangement exception at 411.357(n) may apply	No, but risk-sharing arrangement exception at 411.357(n) may apply	Yes, and risk-sharing arrangement exception at 411.357 may also apply	No, but risk-sharing arrangement exception at 411.357(n) may apply	No, but risk-sharing arrangement exception at 411.357(n) may apply

¹Stark II, Phase II," 69 Fed. Reg. 16067-68 (Mar. 26, 2004).

Anti-Kickback Statute Implications

- **FMV** is a critical requirement for compliance under **Anti-Kickback Statute**
- **Anti-Kickback** prohibits “*knowingly and willfully*” receiving payments (direct or indirect, cash or in kind) in return for
 - a) “*referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal healthcare program,*” or
 - b) “*purchasing, leasing, ordering or arranging for or recommending purchasing, leasing, ordering any good, facility, or service, or item for which payment may be made in whole or in part under a Federal health care program*”

Anti-Kickback Statute Implications

Exceptions to Anti-Kickback Statute

- **Safe Harbors** protect a given arrangement from **Anti-Kickback** scrutiny, but there is no *per se* **Anti-Kickback** violation for arrangements falling outside a safe harbor
- OIG Advisory Opinions assume ***FMV***

Anti-Kickback Statute Implications

Anti-Kickback Exceptions

Employment Exceptions

- In addition to the Anti-Kickback *safe harbor*, there is an *exception* for any amount paid by an employer (who has a **bona fide employment** relationship with such employee) for employment in the provision of covered items or services
- The IRS definition of “*employee*” is utilized by both the **Anti-Kickback Statute** and **Stark Law** for purpose of determining “*employee*” status
- The IRS uses an 11-factor test for “*employee*” status broken into three general categories: (1) behavioral control; (2) financial control; and, (3) type of relationship between the parties
- These factors are taken together as evidence of a bona fide employment relationship; not all factors are necessary to satisfy the test and no single factor is dispositive

Anti-Kickback Statute Implications

IRS Determinates of “Employee” Status

Behavioral Control	
1	Instructions that the business gives to the worker
2	Training that the business gives to the worker
Financial Control	
1	The extent to which the worker has unreimbursed business expenses
2	The extent of the worker's investment
3	The extent to which the worker makes his or her services available to the relevant market
4	How the business pays the worker
5	The extent to which the worker can realize a profit or loss
Type of Relationship	
1	Written contracts describing the relationship the parties intended to create
2	Whether or not the business provides the worker with employee-type benefits, such as insurance, a pension plan, vacation pay, or sick pay
3	The permanency of the relationship
4	The extent to which services performed by the worker are a key aspect of the regular business of the company

Anti-Kickback Statute Implications

Anti-Kickback Safe Harbors

- Two safe harbors apply to compensation for physician clinical, on-call, and executive services:

(1) Employment Safe Harbor

- Payments can be made from employer to employee under a bona fide employment relationship for the furnishing of any item or service for which payment may be made under Medicare or Medicaid
- No *FMV* requirement

Anti-Kickback Statute Implications

Anti-Kickback Safe Harbors

- Two safe harbors apply to compensation for physician clinical, on-call, and executive services:

(2) Personal Service and Management Contacts Safe Harbor

- Allows for compensation to be paid to physicians and executives that are acting as independent contractors, provided that these conditions are met:
 - Written agreement signed by both parties;
 - Term of at least one year;
 - Agreement must specify aggregate payment amounts and such payment amounts must be set in advance; and,
 - Compensation must be reasonable, at *FMV*, and determined through arm's length negotiations

Anti-Kickback Statute Implications

Anti-Kickback Safe Harbors

- Other Safe Harbors using *FMV*:
 - Space Lease
 - Equipment Lease
 - Personal Services and Management Contracts
 - Ambulance Replenishing
- Can the opportunity to earn a *FMV* return or payment violate the **Anti-Kickback Statute**?
 - Contract Joint Ventures
 - Reading Panels

COMMERCIAL REASONABLENESS (CR)

Definition of *Commercial Reasonableness*

- **Department of Health and Human Services (HHS)**

- Arrangement appears to be *“a sensible prudent business agreement from the perspective of the particular parties involved, even in the absence of any potential referrals.”*

- **Stark II, Phase II**

- *“An arrangement will be considered ‘**commercially reasonable**’ in the absence of referrals if the arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician . . . of similar scope and specialty, even if there were no potential DHS referrals.”*

Determining Commercial Reasonableness

Questions to Consider

- Is it necessary to have a physician perform a certain service?
- Is it necessary to have a physician of that specialty perform a certain service?

Both *services* and *payments* must be considered *commercially reasonable* for the arrangement to survive scrutiny

Determining Commercial Reasonableness

IRS's Determination of *Commercial Reasonableness*

- Factors the IRS considers when determining the ***commercial reasonableness*** of a physician compensation arrangement:
 - Specialized training and experience of the physician
 - The nature of duties performed and the amount of responsibility
 - Time spent performing duties
 - Size of the organization
 - The physician's contribution to profits
 - National and local economic conditions

"Integrated Delivery Systems and Joint Venture Dissolutions Update," By Charles F. Kaiser, et al, 1995 EO CPE Text, Internal Revenue Service, (1995).

"Physician Compensation Arrangements: Management & Legal Trends," By Daniel K. Zismer, 1999, p. 204.

Determining Commercial Reasonableness

IRS's Determination of *Commercial Reasonableness*

- Factors the IRS considers when determining the ***commercial reasonableness*** of a physician compensation arrangement:
 - Time of year when compensation is determined
 - Whether the compensation is in part or in whole payment for a business or assets
 - Salary ranges for equivalent physicians in comparable organizations
 - Independence of the board or committee that determines physician compensation arrangement

"Integrated Delivery Systems and Joint Venture Dissolutions Update," By Charles F. Kaiser, et al, 1995 EO CPE Text, Internal Revenue Service, (1995).

"Physician Compensation Arrangements: Management & Legal Trends," By Daniel K. Zismer, 1999, p. 204.

Determining Commercial Reasonableness

IRS's Determination of *Excess Benefit Transaction Rule*

- Factors the IRS considers when determining if an incentive arrangement has violated the ***excess benefit transaction rule***:
 - Whether the compensation arrangement was established by an independent board of directors
 - Whether the incentive arrangement results in total physician compensation which is reasonable
 - Whether there was an arm's-length relationship between the physician and the hospital
 - Whether there is a ceiling on the compensation arrangement which indicates the maximum the physician may earn to protect against projection errors or windfall benefits

Determining Commercial Reasonableness

IRS's Determination of *Excess Benefit Transaction Rule*:

- Factors the IRS considers when determining if an incentive arrangement has violated the *excess benefit transaction rule*:
 - Whether the compensation arrangement may potentially reduce the charitable services that the organization may otherwise provide
 - Whether the compensation arrangement takes into account the quality of care and patient satisfaction data
 - Whether the arrangement accomplishes the organization's charitable purposes if the amount the physician earns under the arrangement depends on net revenues, which also dictate how much the organization charges for its services
 - Whether the arrangement transforms the relationship between the organization and the physician into a joint venture

"IRS FY 2000 Exempt Organization Continuing Professional Education," Internal Revenue Service, July 1999, p. 30 Note: The IRS website indicates that this material was designed specifically for training purposes only and should not be relied upon as authority for setting or sustaining a technical position.

Determining Commercial Reasonableness

IRS's Determination of *Excess Benefit Transaction Rule*

- Factors the IRS considers when determining if an incentive arrangement has violated the ***excess benefit transaction rule***:
 - Whether the arrangement distributes profits to persons who are in control of the organization
 - Whether the arrangement serves a real discernible business purpose which is independent of any purpose to operate the exempt organization for the impermissible benefit of the physicians
 - Whether the arrangement includes controls to avoid abuse, unwarranted benefits and unnecessary utilization
 - Whether the arrangement rewards the physician for services he/she actually performs, or based on performance in an area where he/she performs no significant function

"IRS FY 2000 Exempt Organization Continuing Professional Education," Internal Revenue Service, July 1999, p. 30 Note: The IRS website designates that this material was designed specifically for training purposes only and should not be relied upon as authority for setting or sustaining a technical position.

Determining Commercial Reasonableness

Violations of *FMV* & *CR* Under Stark and Anti-Kickback

- Increasing scrutiny of compensation arrangements indicates that the courts will focus on determining whether physicians are ***actually performing*** the services specified in the arrangement
- If a physician is ***not*** performing services which are required within the scope of the compensation agreement, the arrangement will not meet the threshold of ***commercial reasonableness***

ESTABLISHING FMV & CR

Stark Law

Stark II, Phase II:

- CMS will “*consider a range of methods of determining FMV and that the appropriate method will depend on the **nature of the transaction, its location, and other factors***”

Stark II, Phase III

- Temporary creation of **voluntary safe harbor** for hourly payments to physicians for their personal services, but due to infeasibility and impracticality, the **Stark II, Phase II voluntary** physician hourly compensation **safe harbor** was **eliminated** in **Stark II, Phase III**

“Stark Law: Definitions,” 42 C.F.R. 411.351 (2009).

“Stark II, Phase II,” 69 Fed. Reg. 16092, 16107 (Mar. 26, 2004).

“Stark II, Phase III,” 72 Fed. Reg. 51015 (Sept. 5, 2007).

U.S. vs. SCCI Hospital Houston (2004)

- **July 14, 2004** - Qui tam action (eventually settled)
- U.S. challenged the *commercial reasonableness* of the compensation paid by the hospital to the three physician medical directors
- **Government's financial expert proposed:**
 - *Commercial reasonableness* depends on the agreement being *essential to the functioning of the hospital*
 - In order to be *commercially reasonable*, there had to be **sound business reasons** for paying medical director fees to referring physicians

U.S. vs. SCCI Hospital Houston (2004)

- **Government's financial expert assessed *commercial reasonableness* through evaluating the:**
 - Size of the hospital, number of patients, patient acuity levels and patient needs
 - Quality, activities, and involvement of medical staff and the need for medical direction
 - Number of regular committees and meetings that require physician involvement
 - Quality of the hospital management and interdisciplinary coordination of patient services

U.S. vs. SCCI Hospital Houston (2004)

- **Government's financial expert concluded that *commercial reasonableness depends on the hospital***
 - Performing a regular assessment of the actual duties performed by the medical director
 - Assessing how effectively the medical director is performing his duties and whether there is a bona fide need for continuing the services

Covenant Medical Center (2009)

August 25, 2009 – Covenant Medical Center (Covenant) in Waterloo, IA, has agreed to pay \$4.5 million to the U.S. Government to settle fraud allegations

Allegations Against Covenant:

- Covenant submitted false claims to Medicare for reimbursement of five physicians who referred patients to the hospital
- Pay for physicians was *far above FMV* and was not *commercially reasonable*
- The Department of Justice utilized the False Claims Act (FCA) as a tool to prosecute this *violation of the Stark Law*, which states that *payment must be at FMV and commercially reasonable without considering referrals*

"Iowa Hospital to Pay \$4.5 Million", BNA's Health Law Reporter, August 27, 2009; "Iowa Hospital Pays \$4.5 Million in Fraud Case", by Nigel Duara, Chicago Tribune, August 25, 2009, <http://www.chicagotribune.com/news/chi-ap-ia-iowahospital-frau,0,7910766,print.story> (Accessed 8/29/2009); "Waterloo Hospital Pays Feds \$4.5 Million", by Tony Leys, DesMoinesRegister.com, August 26, 2009, <http://www.desmoinesregister.com> (Accessed 8/29/2009); "Covenant to Pay Feds \$4.5M to Settle Fraud Allegations", by Courier Staff, August 25, 2009, WCFCourier.com (Accessed 8/29/2009); "Settlement Agreement between the United States Department of Justice and Covenant Medical Center", August 25, 2009.

Covenant Medical Center (2009)

Settlement and Notes

- IRS 990 forms from 2002 showed that Covenant's five highest paid physicians made anywhere from \$633,000 to \$2.1 million per year
- How the government determined **FMV** (or CR) is unknown, but payment rates were far above those for physicians at other hospitals in Iowa, and more than triple the compensation paid to similarly situated physicians at the Mayo Clinic in Minnesota
- U.S. Attorney Matt Dummermuth: *"It's the combination of referrals without being fair-market value and commercially reasonable...[that] has the potential to compromise ... medical judgment, when there's improper financial incentives potentially at play...."*
- Covenant revealed that the physicians were specialists who had been working in understaffed areas, but denied any wrongdoing and cited the settlement as a business decision
- The physicians face no government sanctions or charges

"Iowa Hospital to Pay \$4.5 Million", BNA's Health Law Reporter, August 27, 2009; "Iowa Hospital Pays \$4.5 Million in Fraud Case", by Nigel Duara, Chicago Tribune, August 25, 2009, <http://www.chicagotribune.com/news/chi-ap-ia-iowahospital-frau,0,7910766,print.story> (Accessed 8/29/2009); "Waterloo Hospital Pays Feds \$4.5 Million", by Tony Leys, DesMoinesRegister.com, August 26, 2009, <http://www.desmoinesregister.com> (Accessed 8/29/2009); "Covenant to Pay Feds \$4.5M to Settle Fraud Allegations", by Courier Staff, August 25, 2009, WFCCourier.com (Accessed 8/29/2009); "Settlement Agreement between the United States Department of Justice and Covenant Medical Center", August 25, 2009.

U.S. ex rel. Kosenske v. Carlisle HMA, Inc. (2009)

- Hospital entered into exclusive service arrangement with anesthesiology group for the provision of 24/7 anesthesiology services at the hospital
- In exchange, hospital provided physicians with free space, as well as free equipment and supplies reasonably necessary to the physicians' provision of anesthesiology services at the hospital
- 6 years later, hospital opened a freestanding Pain Clinic and granted anesthesiology group exclusive right to provide pain management services to patients in the clinic, as well as provided physicians free space, equipment, and support personnel
- No new written agreement reached regarding Pain Clinic, and original agreement only contemplated provision of anesthesiology services at the hospital

U.S. ex rel. Kosenske v. Carlisle HMA, Inc. (2009)

- Third Circuit Court of Appeals found arrangement between hospital and physicians was a violation of **Stark Law**
- Arrangement did not qualify for the *personal services exception* because no mention of pain management services or the Pain Clinic in the written agreement between the parties
 - i.e., no evidence of arm's length negotiations reflecting **FMV** regarding the arrangement at Pain Clinic
- *“As a legal matter, a negotiated agreement between interested parties does not ‘by definition’ reflect fair market value.”*
- **FMV** must be consistent with the *“general market value,”* which is the price an asset would bring as the result of bona fide bargaining between well-informed parties *who are not otherwise in a position to generate business for the other party.*

Tuomey Healthcare System, Inc. (2010)

March 29, 2010 - District Court of South Carolina

- In a *qui tam* suit, Tuomey Healthcare System, Inc. was found to have violated Stark Law based on employment agreements that provided compensation in excess of *FMV* to 19 part-time physicians
- Each physician was: (1) paid an annual base salary that fluctuated based on the hospital's net cash collections for the outpatient services; (2) paid a "productivity bonus" equivalent of 80% of the net collections; and, (3) eligible for up to 7% of the productivity bonus as an additional incentive on top of the bonus
- The agreements were secured to prevent specialist physicians from redirecting their patients away from Tuomey's outpatient surgery center to a new surgery center

Tuomey Healthcare System, Inc. (2010)

March 29, 2010 – District Court of South Carolina

- The government's expert testified that the compensation paid by Tuomey to the part-time physicians exceeded *FMV* and was not *commercially reasonable* based on factors such as:
 - The 10-year term of the arrangements
 - The part-time contracts were exclusive and they covered only outpatient procedures
 - Giving full-time benefits to part-time employees was inconsistent with Tuomey's normal policies
 - The physicians were paid more than physicians in other high-cost areas
 - Productivity bonus/incentive payments kicked in with the first dollar earned, thereby tying the compensation to the *volume or value* of referrals
 - Other amenities provided: healthcare insurance, reimbursement for CME, periodicals, and cell phones

Tuomey Healthcare System, Inc. (2010)

July 13, 2010- District Court of South Carolina

- In a post-trial hearing, the District Court ordered Tuomey to pay \$44.8 million plus interest for the Stark Law violation
- Ordered a new trial on the Government's FCA action due to relevant testimony being erroneously excluded

Tuomey Healthcare System, Inc. (2012)

March 30, 2012- Fourth Circuit Court of Appeals

After hearing the appeal of the case's 2010 ruling, the Fourth Circuit Court of Appeals:

- Dismissed the case and ordered a new trial for procedural reasons
- Provided commentary on several issues related to what constitutes a “*referral*” under the Stark Law

Tuomey Healthcare System, Inc. (2012)

March 30, 2012- Fourth Circuit Court of Appeals

Stark Law Definition of *Referrals*

- As interpreted by the court, physicians are making *referrals* to a hospital, as defined by Stark Law, when they admit patients to the hospital to undergo outpatient services that the physicians themselves will perform
- Unless the physician-hospital arrangement qualifies for a Stark exception, any claims for facility fees based on those *referrals* are prohibited when a financial relationship exists between the hospital and the physician

U.S. ex rel. Drakeford v. Tuomey Healthcare Sys. Inc., 675 F.3d 394 (4th Cir. 2012) at 407; "Fourth Circuit Vacates Stark Damages Award; Provides Interpretation of Key Stark Law Provisions" McDermott Will & Emery, April 19, 2012, <http://www.mwe.com/Fourth-Circuit-Vacates-Stark-Damages-Award-Provides-Interpretation-of-Key-Stark-Law-Provisions-04-19-2012/> (Accessed 4/20/12).

Tuomey Healthcare System, Inc. (2012)

March 30, 2012- Fourth Circuit Court of Appeals

Stark Law Volume or Value Standard

- **Government:** Tuomey violated volume or value standard because *“it included a portion of the value of the anticipated facility component referrals in the physicians’ fixed compensation”*
- **Tuomey:** The volume or value standard merely concerned whether the physicians’ compensation *“takes into account the volume or value of referrals”* but not whether the parties to the agreements considered referrals when deciding whether or not to enter into the employment contracts

Tuomey Healthcare System, Inc. (2012)

March 30, 2012- Fourth Circuit Court of Appeals

Stark Law Volume or Value Standard – The Court's Conclusions

- Compensation based on the volume or value of **anticipated** referrals implicates the **volume or value standard** under Stark Law.
- Contracts which require a physician to refer patients to a particular provider as a condition of compensation do not violate the Stark Law as long as certain conditions are satisfied:
 - Must be fixed in advance for the term of the agreement
 - Must be consistent with **FMV** for the services performed
 - i.e., does not take into account the **volume or value** of the **anticipated** or required referrals
 - Must otherwise comply with the requirements of one of the applicable Stark Law exceptions

Tuomey Healthcare System, Inc. (2012)

March 30, 2012- Fourth Circuit Court of Appeals

Stark Law Volume or Value Standard (continued)

- Hospitals that provide fixed compensation to a physician must base it solely on the value of the services the physician is expected to perform
 - Compensation that *takes into account* additional revenue the hospital anticipates to result from the physician's referrals *takes into account* the ***volume or value*** of such referrals
- Even when fixed compensation does not fluctuate with referrals, it may still "*take into account*" referrals if it:
 - Exceeds ***FMV***, and
 - Was inflated to compensate the physician for generating other revenue

U.S. ex rel. Drakeford v. Tuomey Healthcare Sys. Inc., 675 F.3d 394 (4th Cir. 2012), at 408-409; "Fourth Circuit Issues Decision in Tuomey Discussing Stark Law Issues" By Jesse Witten, American Health Lawyers Association, April 10, 2012, <http://www.healthlawyers.org/Members/PracticeGroups/FA/EmailAlerts/Pages/FourthCircuitIssuesDecisioninTuomeyDiscussingStarkLawIssues.aspx> (Accessed 4/20/12); "Fourth Circuit Vacates Stark Damages Award; Provides Interpretation of Key Stark Law Provisions" McDermott Will & Emery, April 19, 2012, <http://www.mwe.com/Fourth-Circuit-Vacates-Stark-Damages-Award-Provides-Interpretation-of-Key-Stark-Law-Provisions-04-19-2012/> (Accessed 4/20/12).

Tuomey Healthcare System, Inc. (2012)

March 30, 2012- Fourth Circuit Court of Appeals

- On retrial, jury will have to determine if the language of the employment contracts indicates the ***volume or value*** of ***anticipated*** referrals were taken into account

May 8, 2013- District Court of South Carolina

- A Federal Jury found that Tuomey violated the Stark Law and False Claims Act by filing claims under 19 part-time physician employment agreements
- Damages were assessed against Tuomey in amount of \$39,313,065

"Fourth Circuit Issues Decision in Tuomey Discussing Stark Law Issues" By Jesse Witten, American Health Lawyers Association, April 10, 2012, <http://www.healthlawyers.org/Members/PracticeGroups/FA/EmailAlerts/Pages/FourthCircuitIssuesDecisioninTuomeyDiscussingStarkLawIssues.aspx> (Accessed 4/20/12); "Fourth Circuit Vacates Stark Damages Award; Provides Interpretation of Key Stark Law Provisions" McDermott Will & Emery, April 19, 2012, <http://www.mwe.com/Fourth-Circuit-Vacates-Stark-Damages-Award-Provides-Interpretation-of-Key-Stark-Law-Provisions-04-19-2012/> (Accessed 4/20/12); *U.S. ex rel. Drakeford v. Tuomey Healthcare Sys. Inc.*, 675 F.3d 394 (4th Cir. 2012), at 408- 409; "Tuomey Violates Stark Law and FCA through Physician Employment Agreements" By Walter Cartin, Esq., American Health Lawyers Association, May 9, 2013, <http://www.healthlawyers.org/Members/PracticeGroups/HHS/emailalerts/Pages/TuomeyViolatesStarkLawandFCAthroughPhysicianEmploymentAgreements.aspx> (Accessed 7/12/13).

OVERVIEW OF COMPENSATION ARRANGEMENTS

Guiding Economic Concepts Related to Valuing Services

Principle of Utility

- Basis of all ***economic*** values derive from the usefulness, or ***utility***, derived from the use of properties or services
- Accordingly, “***An object can have no value unless it has utility***”
 - Economic value analysis should be based on benefits expected to be derived from the ***utility*** of the physician executive services

Principle of Substitution

- What normally sets the limit of what would be paid for a good is the cost of ***an equally desirable substitute*** or one of ***equal utility***
- Compensation arrangement should be based on the cost of an equally desirable substitute, or one of ***equal utility***

Guiding Economic Concepts Related to Valuing Services

- Opportunity Cost
- Compensation for physician management, administrative, and executive positions has been based on the physician's historical clinical practice earnings
- Increasing concern that payment based on lost "*opportunity cost*," may not meet regulatory scrutiny under Stark Law
- Given that lost "*opportunity cost*" should not be the sole basis of determining the FMV of an agreement, the valuator must apply the Economic Principles of Utility and Substitution

"Beyond Anti-Mark-up: 'Stand in the Shoes' and Other Practical Implications," By Michael W. Paddock, Crowell & Moring LLP, (February 2008).

"Health Law: 2007 Highlights and Reminders for 2008." By Hanesboone, "Health Care Alert," (2008), p.3.

Guiding Economic Concepts Related to Valuing Services

Economic Value Analysis

- ***Economic Value Analysis*** should focus on the economic benefits expected to be derived from the *use* of the physician executive services in the future
- A detailed examination of the attributes of the physician executive performing the administrative services must be undertaken; each element of the attributes must be:
 - *Identified* as to their existence
 - Classified as to the specific factors and traits (i.e., **task, duty, responsibility, accountability**) which would exhibit the means by which they would reasonably be expected to provide *utility* to the hospital

Guiding Economic Concepts Related to Valuing Services

Economic Value Analysis

- Intrinsic to identifying and classifying each attribute is selecting the appropriate metric to be utilized in measuring the utility provided
 - **Tasks and Duties:** discretely identifiable metrics (e.g., physician hour requirements)
 - **Responsibility and Accountability:** more complex metrics
 - Not easily quantified, despite often being the attribute of *utility that produces an equal or greater economic benefit* to the organization
 - Value related to *responsibility* and *accountability* will provide greater economic benefit to the contracting organization *vis a vis* the **risk/reward continuum** and the physician's relative risk in undertaking the given *responsibility* and *accountability* attached to the terms of the contract

Guiding Economic Concepts Related to Valuing Services

Work RVU as a Fungible Commodity

- “A National Study of Resource-Based Relative Value Scales for Physician Services” By William C. Hsiao, PhD, et. al., (1988)
 - Broke down physician services into fungible units known as Relative Value Units (RVUs)
 - Total RVU comprised of three weighted inputs:
 - **Work (52%) / Practice Expense (44%) / Malpractice Cost (4%)**
 - Theory: by breaking down physician services into fungible commodities, equivalence per unit of care across physician services and specialties might ensure equitable, reasonable reimbursement rates while additionally providing a tool for cost containment
 - “*Work*” defined as time, mental effort and judgment, technical skill and physician effort, and psychological stress variables

Guiding Economic Concepts Related to Valuing Services

Healthcare as a Fungible Commodity

“Money is the classic example of the fungible product. It represents recognized value, but one dollar bill is just as good as the next...the doctor-patient visit as a fungible commodity? Why not?”

Guiding Economic Concepts Related to Valuing Services

Healthcare as a Fungible Commodity

“ [I]f health care is ‘fungible,’ then by implication the parts of health care are also interchangeable. Practically speaking, this also includes providers and patients as they are simply reduced to their identity and purpose within the confines of a business relationship. Just as the seller is interested only in providing that which the buyer needs (or desires) in so far as there is sufficient financial reward, the buyer is only concerned with obtaining the desired object (or service). Who they are makes no real difference. Commodification dictates that a physician is like any other, as long as they are matched with respect to specialty. He or she ceases to be the indispensable community caregiver, and instead becomes the link between company and profit, or shareholder and dividend. Patients, by the same token, are no longer seen as individuals with unique personalities and health care needs but as a source of revenue; they become “covered lives” and a “business asset whose value is inversely proportional to the cost of health care resources their care is predicted (statistically or otherwise) to consume.”

Enterprises? Assets? Services?

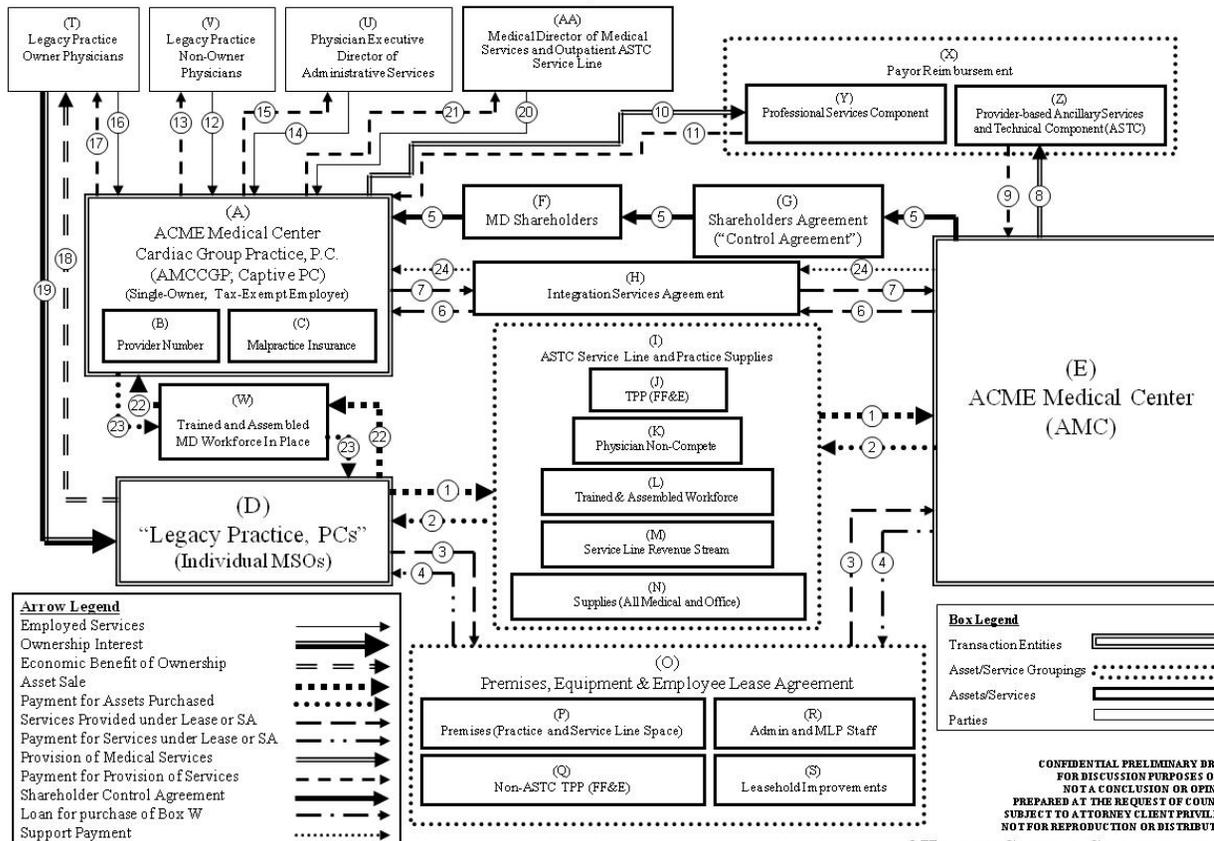
- **FMV** compensation for clinical services should be payment for only those specified services (i.e., wRVUs)
- Payment for profit from enterprise related activities (e.g. ASTC) should not be disguised as an increased \$ per wRVU compensation

A wRVU is a wRVU!

Enterprises? Assets? Services?

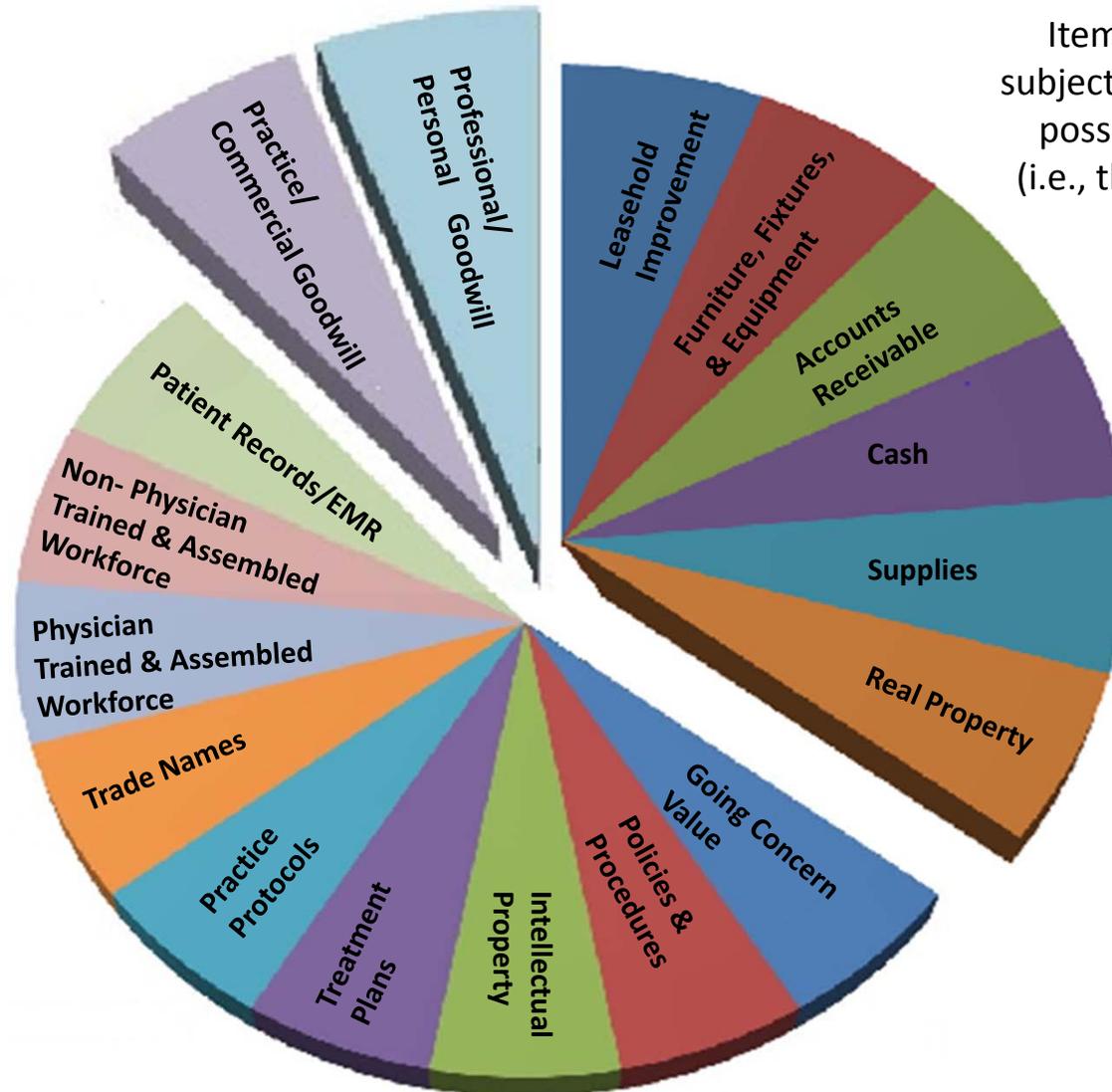
Summary of Transactions

ACME Medical Center
Summary of Transaction



Enterprises? Assets? Services?

Classification of Tangible and Intangible Assets



Tangible Assets

Items owned by the subject enterprise that possess a physicality (i.e., they can be seen or touched)

Intangible Assets

Non-physical items that grant certain specified property rights and privileges of ownership and that have or promise economic benefits to the owner(s) of the subject enterprise

Employment Compensation Arrangements May Include

- Base salary
- Productivity-based compensation
- A combination of equal pay and productivity-based compensation
- Compensation based on a per/RVU method
- Incentive bonus based on productivity
- An annual stipend for performance of administrative services
- Incentive payments based on achieving quality of patient and beneficial outcomes based on agreed upon measures
- Fixed base salary plus an incentive bonus paid based on the enterprise value
- Incentive payments based on specified permissible gainsharing arrangements, e.g., achieving certain cost savings and efficiencies
- Incentive payments paid based on the contributions and economic inputs of the employed physician(s) to achieve specified enhancement of the performance of the enterprise, e.g., development of a “*Center of Excellence*”

Physician Compensation Expense Allocation

- Compensation paid for physician clinical, on-call, and administrative services is distinct from **reimbursement** by a third-party payor for physician clinical services performed
- Compensation is an **economic expense burden** allocated against the revenue stream generated from the professional physician services performed by the employed physicians
- **Economic expenses burden** related to the physician's **malpractice insurance expense burden** must be properly allocated and accounted for in determining **FMV** and **commercial reasonableness** of proposed physician compensation transactional arrangements

Compensation Benchmarking Sources

Generally accepted benchmarking data related to valuation of physician and executive compensation for clinical, administrative, and on-call services

	A	B	C	D	E
	Name	Publisher	Clinical	Medical Director	On-Call
1	Medical Group Compensation and Financial Survey	American Medical Group Association	×	×	
2	Cost Survey for Single-Specialty Practices	Medical Group Management Association	×		
3	Physician Compensation and Productivity Survey Report	Sullivan Cotter and Associates, Inc.	×	×	×
4	Physician Compensation Survey	National Foundation for Trauma Care	×		
5	Physician Executive Compensation Survey	American College of Physician Executives		×	
6	Physician Compensation and Production Survey	Medical Group Management Association	×		
7	Physician Salary Survey Report: Hospital-Based Group HMO Practice	John R. Zabka Associates	×	×	
8	Survey Report on Hospital and Healthcare Management Compensation	Watson Wyatt Data Services		×	
9	Cost Survey for Multispecialty Practices	Medical Group Management Association	×		
10	Healthcare Executive Compensation Survey	Integrated Healthcare Strategies		×	
11	Physician On-Call Pay Survey Report	Sullivan Cotter and Associates, Inc.			×
12	Management Compensation Survey	Medical Group Management Association		×	
13	Survey of Manager and Executive Compensation in Hospitals and Health Systems	Sullivan Cotter and Associates, Inc.		×	
14	Executive Compensation Assessor	Economic Research Institute		×	
15	Top Management and Executive	Abbott Langer Association, Economic Research Institute, and Salaries Review		×	
16	Executive Pay in the Biopharmaceutical Industry	Top 5 Data Services, Inc.		×	
17	Executive Pay in the Medical Device Industry	Top 5 Data Services, Inc.		×	
18	Hospital Salary & Benefits Report, 2007-2008	John R. Zabka Associates, Inc.		×	
19	US IHN Health Networks Compensation Survey Suite	Mercer, LLC		×	
20	Intellimarker	American Association of Ambulatory Surgery Centers	×	×	
21	Medical Directorship and On-Call Compensation Survey	Medical Group Management Association		×	×

Physician Clinical Services

Gainsharing

- Arrangement “*under which a hospital gives physicians a share of the reduction in the hospital’s costs (that is, the hospital’s cost savings) attributable in part to the physicians’ efforts*”
- Historically, gainsharing has been found to violate the **Civil Monetary Penalty Statute** (prohibits hospital for providing a payment to a physician as an inducement to reduce services) and **Anti-Kickback Statute**
- **2005**: OIG began to approve gainsharing arrangements due to benefits of decreased costs and increased quality
- **2009 Physician Fee Schedule** solicited comments regarding a possible new exception to **Stark Law** for shared savings programs (despite CMS’s own concern for potential abuse)

Physician On-Call Services

Growing Need for Compensation for Provision of On-call Services Due to:

- Physician shortage and increased demand due to aging Baby Boomers
- Aging physician workforce
- Physicians demanding more “*regular*” work hours
- Physicians increasingly building practice through participation in ambulatory surgery centers and physician-owned specialty hospitals
- Physicians often receive inadequate payment for services provided while on-call as patients in the ED are often uninsured or under-insured

“OIG Advisory Opinion No. 07-10,” Office of the Inspector General, Department of Health and Human Services, September 2007, www.oig.gov.

“OIG Advisory Opinion No. 09-05,” Office of the Inspector General, Department of Health and Human Services, May 2009, www.oig.gov.

Physician On-Call Services

OIG Approval of On-Call Compensation Arrangements

- **September 2007 (Opinion 07-10)**
 - First advisory opinion addressing on-call compensation arrangements
 - Physician's paid per-diem rate for on-call duties
 - On-call arrangement had sufficient safeguards to prevent Fraud – almost met the **Personnel Services and Management Safe Harbor**
 - Per Diem rates tailored to physician's burden and likelihood of response
 - Independent third party determined per diem rates were at **FMV**
 - Payment not affected by volume or value of referrals
 - All physicians had equal on-call coverage, payment not higher for certain specialties

Physician On-Call Services

OIG Approval of On-Call Compensation Arrangements

- **May 2009 (Opinion 09-05)**
 - Physicians paid on-call compensation for services to patients ineligible for Medicaid/other state health insurance programs - payment covered physician fees, emergency & inpatient services
 - Valuation methodology for compensation considered patient acuity, average length of stay, and physician time
 - On-call arrangement had sufficient safeguards to prevent Fraud – almost met the Personnel Services and Management Safe Harbor
 - Payments to physicians for services rendered, rather than availability (e.g., “lost opportunity”)

Physician On-Call Services

OIG Guidelines for Setting On-Call Compensation Arrangements at *FMV*

- Conduct independent, third party analysis, to determine if arrangement is at *FMV*
- Ensure all physicians are eligible and payment is not based on the volume or value of referrals provided to the hospital
- Ensure equal division of on-call duties among all physicians
- Demonstrate that the hospital has a “*legitimate, unmet need*” for on-call coverage and that compensation will ameliorate the situation
- Avoid payments for “*lost opportunity*” when services are not actually provided

“OIG Advisory Opinion No. 07-10,” Office of the Inspector General, Department of Health and Human Services, September 2007, www.oig.gov.

“OIG Advisory Opinion No. 09-05,” Office of the Inspector General, Department of Health and Human Services, May 2009, www.oig.gov.

Physician Administrative Services

Assessing *FMV* of Medical Directorships

- Employer should **document** the methodology used to set compensation
- Beneficial for employer to **track *and* document** the actual number of hours the medical director spends performing the services, as well as to make sure the documentation is consistent with the hours outlined in the medical director agreement
- ***“Justifying the need for medical director services goes hand-in-hand with showing that the services are actually furnished.”***

“Fair Market Value Support Required: Physicians in Administrative Roles,” By Jen Johnson, American Health Lawyers Association, Articles and Analyses, June 2008.
“Health Care Fraud and Abuse: Practical Perspectives,” Edited By: Linda A. Baumann, The American Bar Association & The Bureau of National Affairs, Inc., Washington, D.C., (2002), pp. 281.

Documentation per Type of Physician Service

	A Valuation Analysis Information Request	B C D Type of Physician Service		
		Clinical	On-Call	Administrative, Executive, Management
1	Proposed agreement for services	x	x	x
2	Number of shifts/week and hours/week anticipated under proposed agreement	x	x	
3	Number of times current on-call physician was (a) paged; and (b) required to be present at employer for past two years		x	
4	All other agreements for similar positions at the employer entity	x	x	x ¹
5	Curriculum vitae (CV) for the physician performing the clinical services	x	x	
6	Documentation of board certification, qualifications, tenure of physician performing services under all similar agreements	x	x	x
7	Employer's medical staff bylaws and roster	x	x	x
8	Documentation of historical productivity for past two years	x ²	x ²	x ³
9	Documentation of offers made to previous physician executives			x
10	Documentation as to the medical staffs need for administrative direction			x
11	Time sheet records of time and work spent on each administrative function			x
12	Size or employer, number of patients, acuity levels of patients, specific needs related to a particular service line			x
13	Number of committees/meetings that require physician's involvement or attendance and average frequency and duration of each meeting			x
14	Description of quality programs, including centers of excellence and "never event" committees			x

Notes:

1. E.g., employer's medical directorship agreement(s) with annual hour requirements and annual compensation paid to each director.
2. In the form of clinical productivity (measured in wRVUs, gross charges, net revenue, or count by CPT code).
3. More specifically, that employer assesses the effectiveness (as opposed to productivity) of the physician executive at performing his/her tasks, at least annually (as opposed to every two years).

Valuation Methodology for Physician Services

	A	B	C	D
	Valuation Methodology: Elements for Consideration	Clinical	On-Call	Administrative
1	Range (percentile) of compensation measured	×	×	×
2	Specialty or subspecialty need to be matched	×		
3	Metric of comparability must be selected	× ¹	× ²	×
4	How the hourly rate (if applicable) and full-time equivalency (FTE) are calculated must be determined	×		
5	Whether on-call services are restricted or unrestricted ³		×	
6	Determination of FMV for specific tasks, duties, responsibilities, and accountabilities required for services ⁴	×	×	×
7	Determine whether productivity-based compensation is based on: (1) percentage of collections; (2) percentage of gross charges; or, (3) per RVU basis ⁵	×		

Notes:

- e.g., charges, collections, RVU, etc.
- e.g., hourly, weekly, daily, annual metrics
- Restricted*: physician is required to stay on premises during call
Unrestricted: physician is not required to stay on premises during call
- May be beneficial to use the Principle of Substitution and Principle of Utility (e.g., Stark II, Phase III: Hourly rate may be used if it is set at FMV)
- Percentage of Collections*: may be high incentive to treat patients with higher paying payors
Percentage of Gross Charges: beneficial as it is not based on patient payor mix, but may cause physician compensation to fluctuate
Per RVU Basis: beneficial as compensation is based on productivity, but careful consideration should be paid to account for whether compensation is based on a total RVU basis or solely on a work RVU basis

"Stark II, Phase III," 72 Fed. Reg. 51015-16, September 5, 2007.

ROLE OF THE VALUATION TEAM

Role of the Valuation Advisor

- Legal counsel typically does not provide a legal opinion as to the **FMV** or **commercial reasonableness** of a compensation arrangement
- Legal counsel will most likely obtain an independent valuation consultant to provide a certified valuation opinion as to the **FMV** and/or **commercial reasonableness** of a compensation arrangement
- Courts have found thorough valuations of both lease and compensation arrangements as persuasive evidence of **FMV** as against a less thorough valuation of a government expert witness

Role of Legal Counsel

- Advise as to the legal permissibility of the underlying transaction
- Draft physician employment/independent contractor agreements
 - Include all physician duties in the agreement
- Serve as liaison between valuation consultant and hospital health system
- Ensure valuation is consistent with the transaction documents
- Attempt to maintain attorney-client privilege

U.S. ex rel. Goodstein v. McLaren Regional Medical Center, 202 F.Supp.2d 671 (E.D. Mich. 2002).
U.S. ex rel. Villafane v. Solinger, 543 F.Supp.2d 678 (W.D. Ky. 2008).

CONCLUDING REMARKS

Adherence to Commercial Reasonableness Thresholds

- Physician compensation agreements can be at *FMV* while simultaneously **not** be *commercially reasonable*
- Failure to comply with *commercial reasonableness* thresholds in executing physician compensation arrangements may result in a finding of legal impermissibility under the **Stark Law** and **Anti-Kickback Statute**
- Submitting such claims for reimbursement may also be found to be legally impermissible under the **False Claims Act**

OIG Compliance Program Guidelines

- Effective compliance program may help avoid potential violation of Stark Law, Anti-Kickback Statute, and Federal False Claims Act
- Build on-going compliance into the agreements, e.g., periodically assess *FMV* and periodically audit compliance with duties required by the agreement.
- These seven components provide a solid basis for a voluntary compliance program:
 1. Conducting internal monitoring and auditing;
 2. Implementing compliance and practice standards;
 3. Designating a compliance officer;
 4. Conducting appropriate training and education;
 5. Responding appropriately to detected offenses and developing corrective action;
 6. Developing open lines of communication; and
 7. Enforcing disciplinary standards through well-publicized guidelines

Summary of CR Compensation Arrangements

- Compensation arrangements are likely to be deemed ***commercially reasonable*** if they are:
 - At ***FMV***;
 - The arrangements list the actual duties being performed by the physician;
 - Those services are *reasonably necessary* to the provider based on the details of the situation; and
 - The services could not be adequately performed for less compensation

Importance of Documentation and Obtaining a Certified Opinion of Value

- Critical to obtain and maintain documentation that the compensation arrangement is **both** of at ***FMV*** and ***commercially reasonable*** in order to withstand scrutiny from OIG and the IRS
- A certified opinion by independent valuation consultant as to whether the proposed transaction is at ***FMV*** and ***commercially reasonable*** will enhance the efforts of healthcare entities and providers in establishing that their proposed compensation arrangement is in compliance