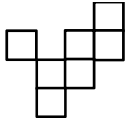


# **Back to the Future: Hospitals Hiring Physicians Once Again**

Co-Sponsored by HealthCare Appraisers, Inc., and the  
Fraud and Abuse (Fraud), Hospitals and Health Systems (HHS)  
and Physician Organizations (Physicians) Practice Groups

March 11, 2009 · 1:00-2:30 pm (EST)

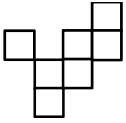


## Speakers

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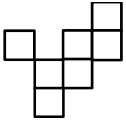
## Moderator

- Marc D. Goldstone, Esq., General Counsel  
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[mgoldstone@browardhealth.org](mailto:mgoldstone@browardhealth.org)



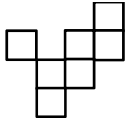
## **Disclaimer – (Marc)**

- Nothing herein is the official position of Broward Health, Community Health Systems, the Hall Render law firm, HealthCare Appraisers, Inc., or any affiliates or parent organizations thereof.
- The opinions expressed are personal to the presenters, and the hypothetical case studies presented are for illustration purposes only.
- Your mileage may vary; priced higher in Hawaii and Alaska. Our drivers carry less than \$20 in cash.



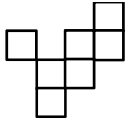
## Road Map to the Presentation (Marc)

- Brief Discussion of the Black Letter Law
- Issues of Importance to Hospitals, Physicians, and Valuers
- Special Discussion of Employment Exception
- Observations Regarding the FMV Process
- Case Studies – Setting the stage for dealing with “gray area” arrangements
- Q & A



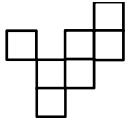
## Employment Exception Under Stark (Art)

- Exception for bona fide employment relationships  
[42 U.S.C. § 139nn(e)(2); 42 C.F.R. 411.357(c)]
  - Employment is for identifiable services.
  - Amount of payment consistent with FMV and, except for personally provided services, does not take into account volume or value of any referrals by referring physician.
  - Payment for employment agreement is commercially reasonable.



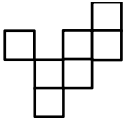
## Stark – Non-Employment Exceptions (Art)

- **Personal Services** 42 C.F.R. 411.357(d)
  - Aggregate services do not exceed those that are reasonable and necessary for legitimate business purposes of arrangement.
  - Compensation is set in advance, does not exceed FMV, and does not take into account volume or value of referrals.
- **Fair Market Value** 42 C.F.R. 411.357(l)
  - Compensation is set in advance, consistent with FMV, and not determined in a manner that takes into account volume or value of referrals.
  - Arrangement is commercially reasonable and furthers the legitimate business purposes of the parties.
- See 69 FR 16067/16068 for comparison of exceptions.



# Stark Requirements for Mandated Referrals (Art)

- Stark's Employment Exception does allow mandated referrals 42 C.F.R. 411.354(d)(4)
  - Compensation is set in advance.
  - Compensation is FMV – payment does not take into account the volume or value of anticipated or required referrals.
  - Arrangement also meets a Stark exception.
  - Referral requirement relates to the scope of arrangement and referral requirement is reasonably necessary to effectuate the legitimate business purpose of the arrangement.



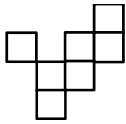
## AKS Employment Safe Harbor (Art)

- Extends to “any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

[42 U.S.C. § 1320a-7b(b)(3)(B)] [42 C.F.R. § 1001.952(i)]

- Anti-kickback Safe Harbor does not have an FMV standard - Is there an implicit FMV standard?
- See OIG AO 08-22.
- There is also an AKS Personal Services Safe Harbor:
  - 42 CFR 1001.952 (d)

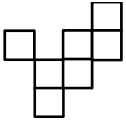




## **Why is the Employment Exception different than other permissible referral source financial arrangements? Are there differences with a distinction? (Rachel)**

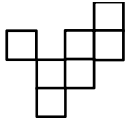


- For anti-kickback purposes, the government clearly favors employment, given its ease to fit into a safe harbor.
- For Stark, CMS has given employment an advantage related to the need (or lack thereof) for a written agreement and ability to set compensation in advance and/or changing compensation terms in less than one year.
- However, under Stark, CMS has made it clear that the only favored status for compensation is the group practice (which allows for payment of profits from DHS).
- Provides for the ability of Hospital to require referrals of DHS and applies to both employment and contractor arrangements.
- Allows for incentive payments (based on personally performed services – not referrals for DHS).



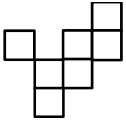
## The Case Law-Is It Helpful? (Rachel)

- "[A] hospital or individual may lawfully enter into a business relationship with a doctor and even hope for or expect referrals from that doctor, so long as the hospital is motivated to enter into the relationship for legal reasons entirely distinct from its collateral hope for referrals." *U.S. v. McClatchey*, 217 F.3d 823, 834 (10th Cir. 2000).
- "[A] hope, expectation or belief that referrals may ensue from remuneration for legitimate services is not a violation of the Anti-Kickback Statute." *U.S. v. Rogan*, 459 F. Supp. 2d 692, 714 (N.D. Ill. 2006).



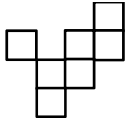
# Issues of Importance to Hospitals (Rachel)

- Definition of Fair Market Value (“FMV”)
  - **FMV is NOT investment value/”enterprise value”.**
  - FMV, for purposes of Stark, is not identical to the IRS definition of FMV; the IRS standard does not prohibit consideration of OTHER arrangements between parties in a position to refer business to one another.
- Establishing FMV for compensation for CLINICAL services and ADMINISTRATIVE services (what’s the difference?)
- The business reality: How to incentivize physicians to be productive and efficient with office expenses
- Impact of physician's historical “private practice” compensation vs. FMV
  - Does physician seek employment to increase compensation/to maintain current “high end” compensation?



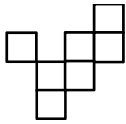
## **Issues of Importance to Physicians (Art)**

- Comparisons to historical income
- Understanding of employment duties / expectations
- Addressing issue of "giving" practice to hospital for no consideration
- Loss of autonomy / control over practice
- Concern of impact of hospital's mismanaging / over-managing on earning potential
- Loss of patients / referral sources due to alignment with single hospital



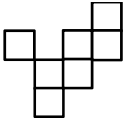
## Issues of Importance to Valuers (Scott)

- Background facts and contract terms
- Understanding the method of proposed compensation and the issues of each (*e.g.*, annual salary vs. productivity-based)
- Issues of compensation “stacking”
- Additional compensation unrelated to performance (*e.g.*, sign-on bonuses, tail insurance coverage)
- Misuse of available benchmark survey data (*e.g.*, cherry-picking state vs. national data, multiplying data from various categories)
- Miscalculation of wRVU data (providing total wRVUs, CMS 2007 adjustment; issues of over-counting)



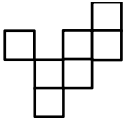
## FMV Process: When does it make sense to bring in outside valuers? (Rachel)

- Not required absent a CIA or other settlement agreement.
- The Government PREFERS it [Stark I – 66 FR 945 (1/4/01)].
- Recommended for high-value transactions, based on recent DPAs requiring outside appraisals for hourly rates above a certain dollar threshold.
- Very important for obtaining the "rebuttable presumption" for arrangements with disqualified persons under the IRS intermediate sanctions regulations.
- Consider for:
  - Transactions on the “riskier” end of the spectrum (physician compensation > 90<sup>th</sup> %, etc.)
  - When physician has existing referral stream



## **A Little Prognostication (Marc)**

- A recent survey by the Health Management Academy of 46 systems reported that 88% of the responding CEO's and CMO's predicted that physician employment will be the "new dominant standard" for medical staff relationships, representing a "permanent shift" in the landscape.

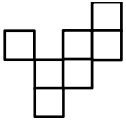


## Case Study 1 (Marc)



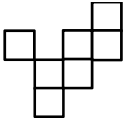
- Rural not-for-profit Hospital; Sole provider in community with demonstrated need for Primary Care MDs.
- Hospital wants to hire a local Board Certified Internist.
- Physician asks for salary = Average of past 3 years' practice income, as documented by his Form 1040s. His income = 70% of MGMA / Office visits = 72% of MGMA
- Pro forma shows that the Hospital will lose \$95k in first year of employment and will level off at a \$75k/year loss in Year 3.
- Hospital's compliance officer balks at the arrangement, indicating that it will not meet Stark's "commercial reasonableness" test due to the ongoing loss.





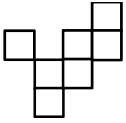
## Discussion of Case Study 1 (Rachel / Scott)

- What is “commercial reasonableness”? Can a physician practice operating at a loss ever be “commercially reasonable”?
- Is the magnitude of the loss dispositive? A loss in and of itself does not present an issue from an FMV standpoint.
- How relevant is past income (“strip out” of practice ancillaries)? Is it just a “guidepost”? What about payor mix?
- Base Salary vs. Incentivized approach; does that help?
- What if income was 80% of MGMA but productivity was 70%? What if the ratio was 90% and 70%?
- Is there “goodwill”/intangible purchase price consideration (If so, how does that affect post-sale compensation?)
- If you can’t hire this physician, is there ever a situation where you can hire one?



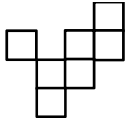
## Case Study 2 (Marc)

- Investor-owned hospital in Honolulu, HI - one of three hospitals in the service area.
- Hospital recruits a board-eligible orthopedic surgeon from the mainland.
- There are several orthopedic surgeons in the service area, but none currently on the Hospital's medical staff.
- Hospital provides physician a one-year income guarantee with a three-year service obligation to follow. Physician also takes orthopedic call in Hospital's ED 365 days/year.
- At the end of the income guarantee period, physician demands to be employed or he threatens to leave the Hospital's geographical service area.



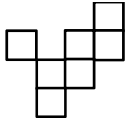
## Case Study 2 (cont'd) ((Marc))

- Physician produces at 50% of MGMA (combined office and surgical volume).
- Doctor asks for compensation at MGMA 75<sup>th</sup> Percentile plus a medical directorship of \$10,000/month.
- Hospital wants to offer MGMA 50<sup>th</sup> Percentile as base salary, plus an "upside only" bonus of \$71/RVU (*i.e.*, 75<sup>th</sup> P MGMA) for every RVU generated by the doctor in excess of the 50% MGMA RVU benchmark.
- The doctor's financials show that he collects ~\$61/RVU.



## Discussion of Case Study 2 (Art and Scott)

- Threat of anticipatory breach of the recruitment agreement's community service obligation.  
(Can that just be made to "go away"?)
- Does "stacking" of administrative services result in greater-than-FMV total compensation? How many hours can the doctor work per day? Per week? Per month?
- Programmatic considerations: Clinical service line needs 1.4 doctors to operate; how do you find a 0.4 doc?
- 365-days / year of call – What is that worth?
- Can you pay more per RVU than you expect to collect?
- Productivity and compensation are skewed.  
See following table for dangers



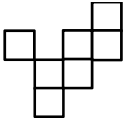
## Use of Benchmark Data (Scott)

### 75<sup>th</sup> Percentile Comparison Data

Specialty	Compensation Per wRVU	wRVUs	Calculation based on combination	Linear Interpolation of Result
Cardiology Invasive	\$61.64	11,332	\$698,504	106% 90P
Cardiovascular Surgery	\$66.74	13,537	\$903,459	134% 90P
Orthopedic Surgery	\$71.42	10,504	\$750,196	86P

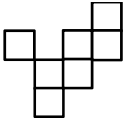
### 90<sup>th</sup> Percentile Comparison Data

Specialty	Compensation Per wRVU	wRVUs	Calculation based on combination	Linear Interpolation of Result
Cardiology Invasive	\$80.92	13,562	\$1,097,437	166% 90P
Cardiovascular Surgery	\$98.14	15,491	\$1,520,287	226% 90P
Orthopedic Surgery	\$97.97	13,147	\$1,288,012	161% 90P



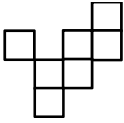
## Case Study 3 (Marc)

- Urban public safety net hospital in Philadelphia, with a poor payor mix.
- Solo neurosurgeon on staff who also covers the ED at two nearby suburban non-profit hospitals and another investor-owned hospital 20 miles away.
- He wants to stay in practice at the public hospital, as it is a Level 1 trauma center, and the doctor is a fellowship-trained spine trauma surgeon. However, the poor payor mix and voracious plaintiff's bar are forcing him to think about a change.



## **Case Study 3 (cont'd) (Marc)**

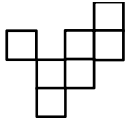
- Doctor would like to become an employee of the public hospital (and thus subject to the employer's statutory "sovereign immunity").
- Doctor proposes to continue providing call coverage at the three community hospitals and will turn over the call coverage fees (in excess of \$1k/day) and reassign all professional fees to the public hospital for services provided at all 4 hospitals.
- Doctor asks for compensation calculated at 75% of professional charges for all services provided to patients at all 4 hospitals.



## Discussion of Case Study 3 (Rachel and Scott)

- Poor Payor Mix very challenging to deal with - Can the hospital ever “break even” on this practice?
- Nationwide shortage of neurosurgeons - How does that affect the deal?
- Trauma center required to have a neurosurgeon to maintain state licensure - How does that affect the deal?
- Safety Net Hospital - Does the obligation to provide indigent care create an “exception to the exception”?
  - At what point does the government feel that the hospital should eliminate a program versus employing a physician at a loss where the overall program makes money (*i.e.*, Is the hospital buying the referrals)?
- Easier determination for sole community provider for significant area but less so if service is available across town or next town over.

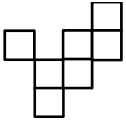




## Discussion of Case Study 3 (cont'd) (Rachel and Scott)

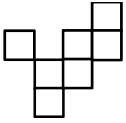


- Compensation based on % of charges is problematic and risky
- More preferred alternative is a compensation model based on a percentage of pre-comp earnings, with a “tie-back” to productivity.
- Given shortage of neurosurgeons, and hospital’s trauma mandate, likely allow for a greater “disparity” between productivity and compensation.
- Ensure that agreements are very clear regarding physician obligations for call coverage.
  - Not highly unusual that a physician would agree to take coverage for 3 facilities on the same night. However, hospitals should be careful that the physician is not “overselling” availability.



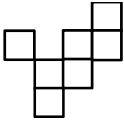
## Case Study 4 (Marc)

- Suburban physician-owned hospital, with three independent ophthalmologists on staff (practice in a single group)
- All of their surgical volume performed in the Hospital's operating suites.
- Doctors notify the Hospital that they plan to resign from the medical staff and will open a one-room ASC in their medical office (which does not have to be separately licensed, in accordance with State regulations).
- Doctors each cover every third night of call in the Hospital's ED but will no longer do so once they resign.



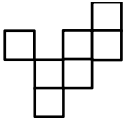
## Case Study 4 (cont'd) (Marc)

- Hospital offers doctors half-time employment to all of them for all of their surgeries, with a fixed salary consistent with 50% of MGMA, regardless of production.
- Doctors reply that they each have varying levels of productivity and wish to be compensated accordingly.
- Hospital counteroffers to accept the half-time employment, continue ED call every third day, and reassign all professional fees for surgical procedures performed during employment to Hospital.
- Doctors request compensation of 125% of reassigned professional collections (net of bad debt), and each physician wants a sign-on bonus of \$50,000.



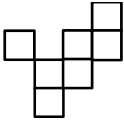
## Discussion of Case Study 4 – (Art and Scott)

- ASC pull-out just a feature of the marketplace allowing physician ownership of ASCs.
  - Attempting to offset this market factor through employment compensation is not advisable (*i.e.*, likely more investment value than FMV).
- Part-time employment arrangements are inherently more complex.
  - What is the doctor doing the other 50% of the time?
  - Issues regarding normalizing overhead and collections
  - Issues related to establishing and assessing productivity
- Issues with interpretation of Survey data. Paying someone at the median is not de facto half-time compensation - whereas paying half of the median value, depending on productivity, may be reasonable.
- Call coverage becomes a key issue. Assuming no compensation provided for the 365 days, could assign a value to the “excess call”.



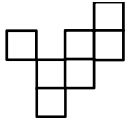
## Discussion of Case Study 4 (cont'd) (Art and Scott)

- At 125% of collections, by design, the proposed compensation approach would result in losses.
  - This is not the main issue, as many compensation models have “baked in” losses but are designed to assure physician makes “reasonable” salary (*e.g.*, a gross-up of collections to adjust for payor mix issues, net revenue model with a carved out amount to address payor mix or volume issues in a rural setting).
- Likely more reasonable to put doctors on a more traditional model like a “pre-compensation earnings model,” whereby they receive a designated percentage (*i.e.*, 75%, 90%,) of practice earnings after accounting for physician salary, benefits and and Opex.



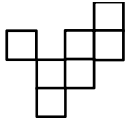
## Discussion of Case Study 4 (cont'd) (Art and Scott)

- Sign-on bonuses in and of themselves are usually commercially reasonable.
  - Issue becomes the “magnitude” of the bonus. (e.g., Is there market support for it?)
  - Typically would be included in physician’s compensation, but can be amortized over a multi-year period.
  - Ensure that there is a “payback” provision in the agreement in the event the arrangement terminates early.



## Questions? - MARC

- Thank you for your kind attention!



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