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## PHYSICIAN PRACTICE LOSSES – THE ELEPHANT IN THE ROOM

HFMA Lone Star Chapter Spring Institute  
May 12, 2016

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# Disclaimer

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*This presentation and associated remarks are intended to facilitate a general discussion regarding legal and valuation issues that may arise in the context of healthcare valuations. It is not intended to be comprehensive or as accounting, business, financial, investment, legal, tax or other professional advice, and should not be relied upon as such.*

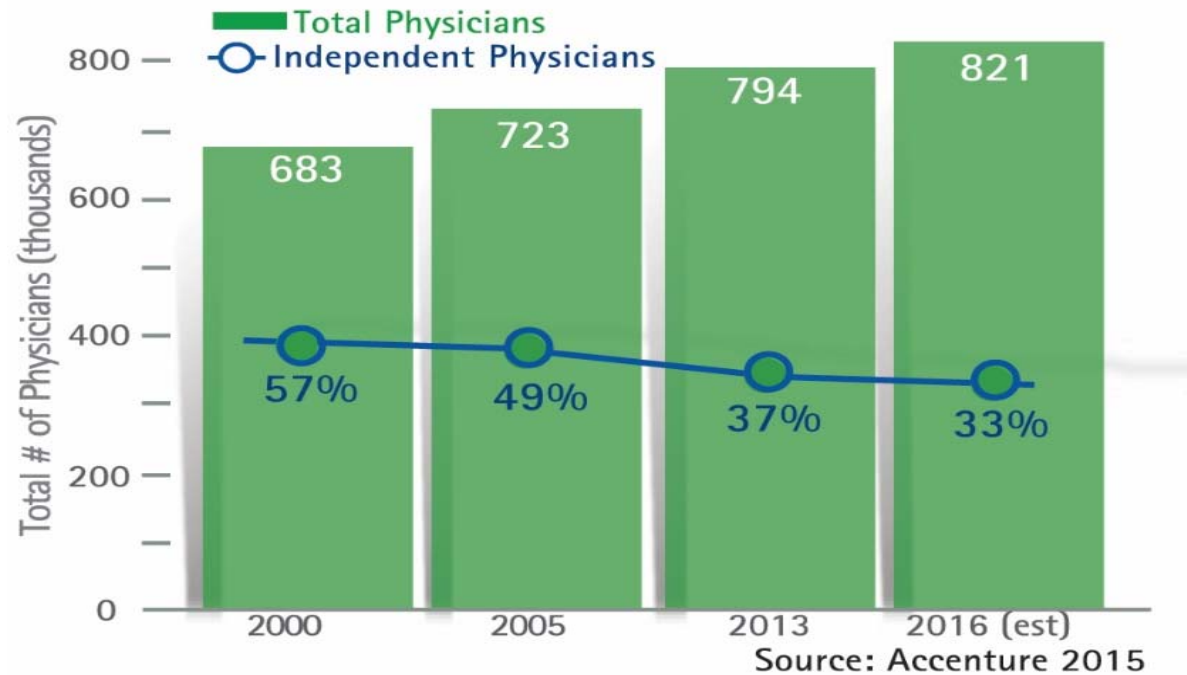
# Overview

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- Physician Employment Trends
- Rules & Regulations
- Fair Market Value & Commercial Reasonability
- Recent Court Cases
- Current Government Philosophy Regarding Practice Losses
- Reasons for Practice Losses
- Analyses to Support Practice Losses

# Physician Employment Trends

## Independent U.S. Physicians: A Swiftly Shrinking Segment Only 1 in 3 doctors will be independent by end of 2016, Accenture finds



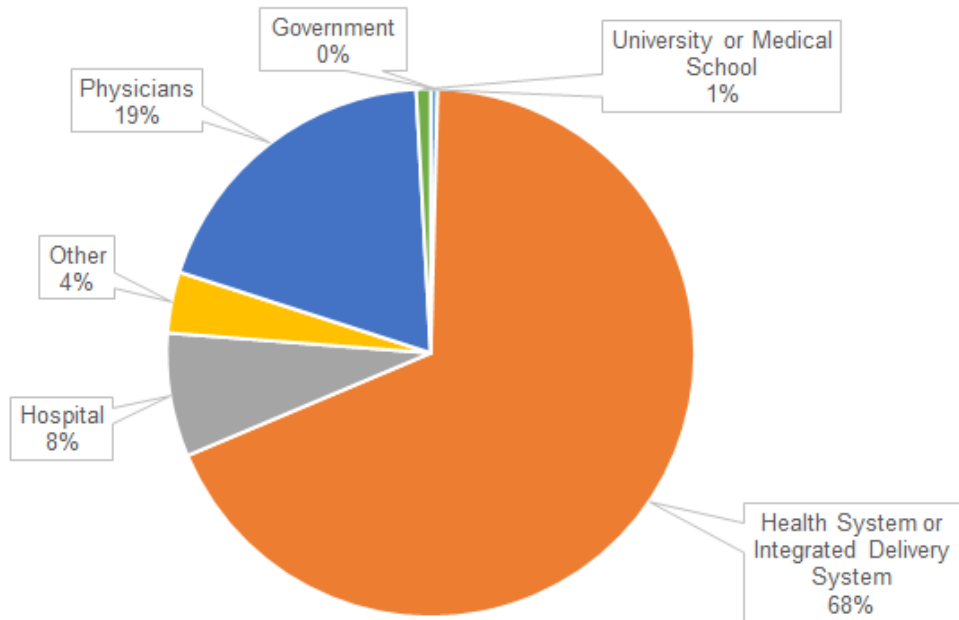
## Independent Practices Adapt to Market Conditions



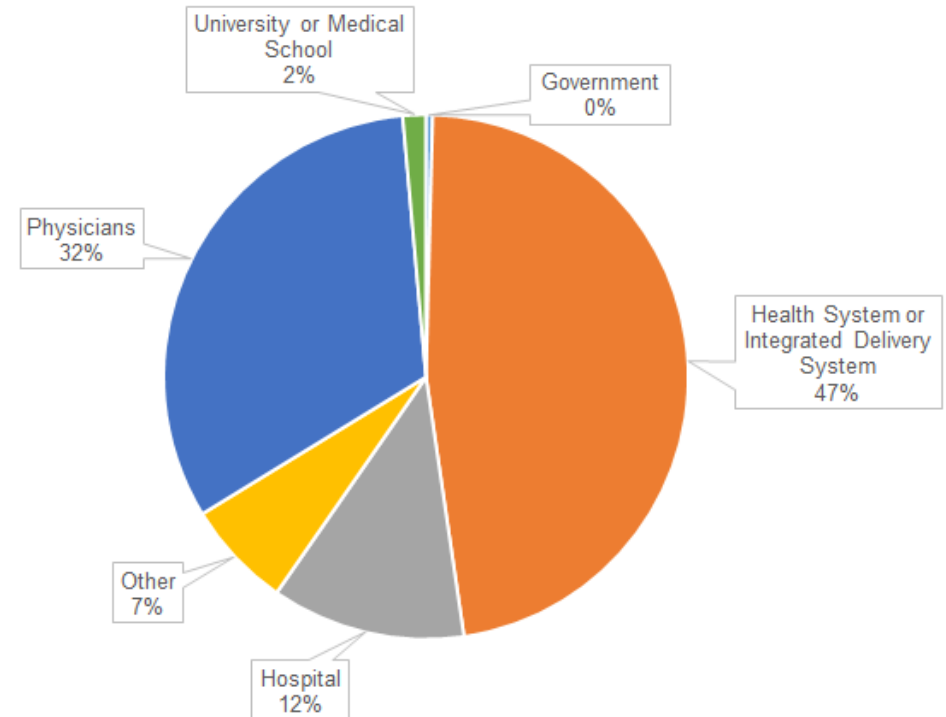
Solo doctors opt out of public programs and try low-cost staffing models to adapt to market conditions, says Accenture survey.

# Physician Employment Trends

Organization Type Breakout by Group - MGMA



Organization Type Breakout by Provider - MGMA

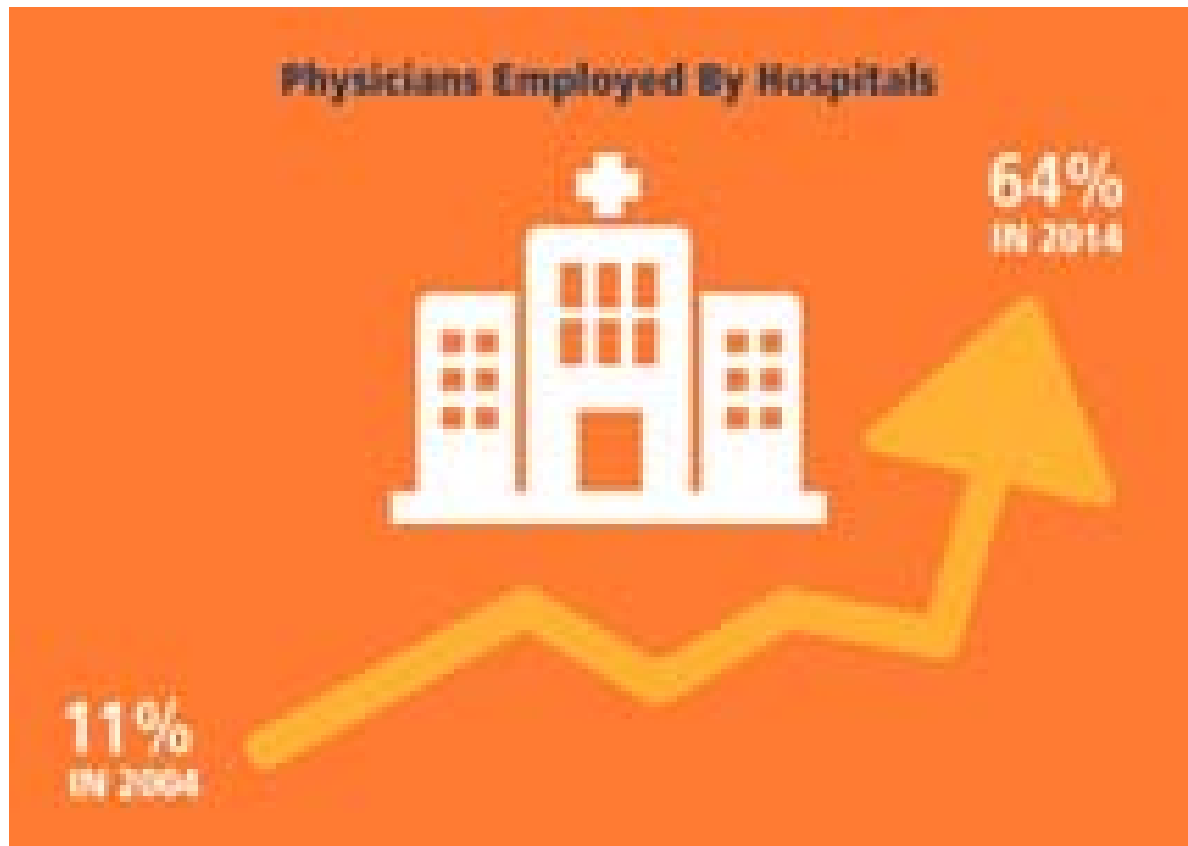


Source: Charts above were developed based on information obtained from Appendix D of Medical Group Management Association's (MGMA) *2015 Physician Compensation and Production Report: Based on 2014 Data*.

# Physician Employment Trends

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- % of newly hired physicians employed by hospitals increased from **11%** in 2004 to **64%** in 2014.

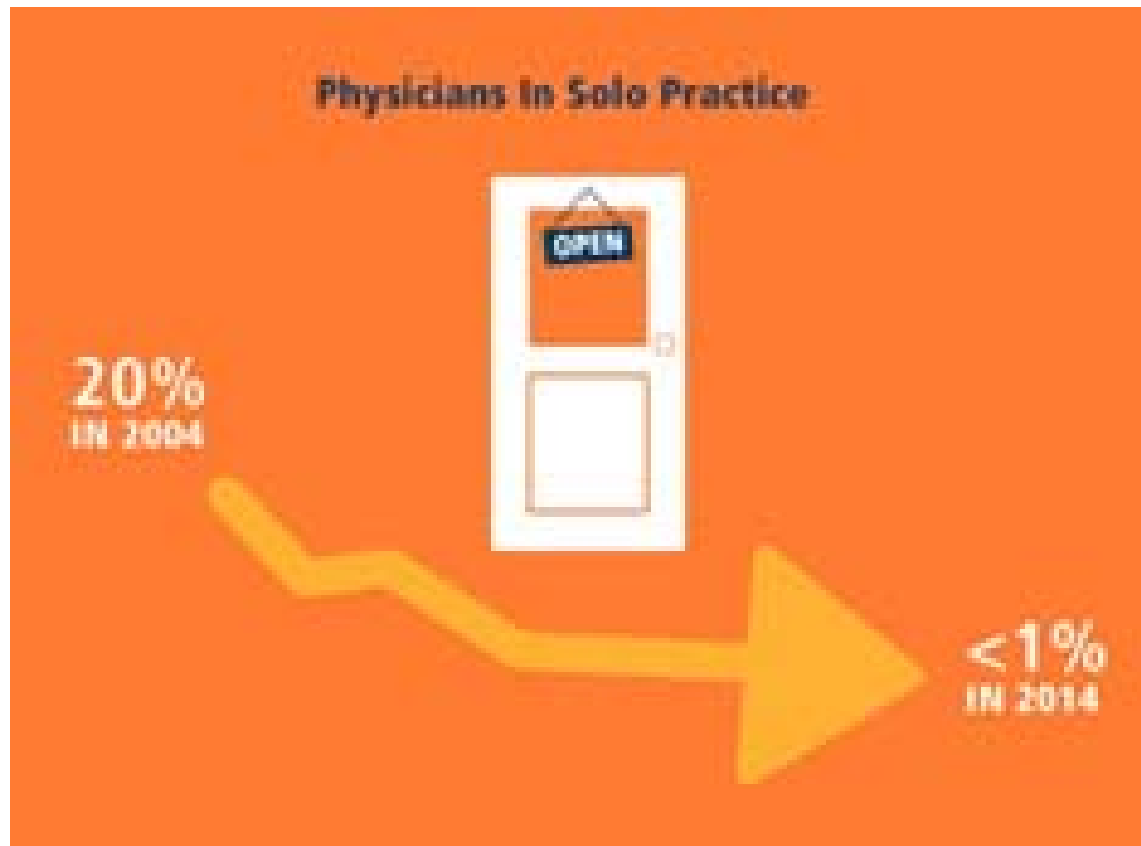


Source: Merritt Hawkins 2014 Review of Physician and Advanced Practitioner Recruiting Initiatives.

# Physician Employment Trends

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- % of newly hired physicians in solo practice decreased from **20%** in 2004 to **<1%** in 2014



Source: Merritt Hawkins 2014 Review of Physician and Advanced Practitioner Recruiting Initiatives.



# Rules & Regulations - STARK LAW

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- Prohibits physicians from making referrals for Designated Health Services (DHS) payable by Medicare or Medicaid to an entity in which the physician (or an immediate family member) has a direct or indirect financial relationship
  - Referral = Request by a physician for an item or service payable under Medicare or Medicaid, or a request by a physician for a plan of care that includes the provision of DHS; Does not include services personally performed by referring / ordering physician
  - Financial Relationship = Any direct or indirect ownership or investment in an entity furnishing DHS, or compensation arrangement with an entity furnishing DHS
- Strict liability (intent doesn't matter)
- Administrative Penalties
- Failure to meet one of the Stark exceptions is a Stark violation

Source: 42 U.S. Code § 1395nn

# Rules & Regulations - STARK LAW

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- Bona Fide Employment Exception
  - Employment is for identifiable services.
  - Amount of remuneration is consistent with the **fair market value** of the services and is not determined in a manner that takes into account the volume or value of any referrals by the referring physician.
  - Remuneration provided is provided under an agreement that would be **commercially reasonable** even if not referrals were made to the employer.

Source: 42 CFR § 411.357(c)

# Rules & Regulations - ANTI-KICKBACK STATUTE

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- Makes it illegal for any person to knowingly and willfully offer, pay, solicit or receive remuneration in return for referring, purchasing, leasing, ordering, or arranging any item or service that is reimbursed under a federal health care program
  - Applies to all federal health care programs, not just Medicare and Medicaid
  - Applies to any good or service provider under such programs
- Parties on both sides of the transaction may be in violation
- Intent based statute
- Criminal penalties
- Safe harbors offer protection from anti-kickback scrutiny

Source: 42 U.S.C. §1320a-7b

# Rules & Regulations - ANTI-KICKBACK STATUTE

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- Personal Services and Management Contracts Safe Harbor
  - Agreement is set out in writing.
  - Agreement covers all services to be provided for the term of the agreement and specifies the services to be provided.
  - If agreement is intended to provide for services on a periodic or part-time basis, the agreement specifies exactly the schedule of such intervals, their precise length and the exact charge for such intervals.
  - Term of agreement is no less than 1 year.

Source: 42 CFR § 1001.952

# Rules & Regulations - ANTI-KICKBACK STATUTE

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- Personal Services and Management Contracts Safe Harbor (cont.)
  - Aggregate compensation paid over the term of the agreement is set in advance, is consistent with **fair market value** in arms-length transactions and is not determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may be made under Medicare, Medicaid or other Federal Health Care programs.
  - Aggregate services contracted for do not exceed those which are reasonably necessary to accomplish the **commercially reasonable** business purposes of the services.

Source: 42 CFR § 1001.952

# Fair Market Value & Commercial Reasonability

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- Fair Market Value (FMV)
  - The amount at which property would change hands between a willing buyer and a willing seller, when the former is not under any compulsion to buy, and the latter is not under any compulsion to sell, both parties having reasonable knowledge of the relevant facts.
  - The value in arm's-length transactions, consistent with the general market value. 'General market value' means the price that an asset would bring or the compensation that would be included in a service agreement as the results 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.

Source: IRS Revenue Ruling 59-60

**Does this deal make sense  
without referrals?**

# Fair Market Value & Commercial Reasonability

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“We are interpreting ‘commercially reasonable’ to mean that an 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.”

CMS (1998)



# Fair Market Value & Commercial Reasonability

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“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 (or family member or group practice) of similar scope and specialty, even if there were not potential DHS [designated health services] referrals.”

CMS (2004)

# Fair Market Value & Commercial Reasonability

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- Is the transaction consistent with fair market value?
- Does the transaction involve a resource needed by the purchaser and is the resource reasonably available from the provider?
- Is there a lower cost or better alternative to the referral source?
- Is the transaction negotiated on an arm's length basis?
- Does the transaction allow the parties to better serve patients?
- Do the underlying economics of the transaction make sense?

## Recent Court Cases

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“Now the government is apparently upping the ante by arguing in some situations that lack of profit is tantamount to lack of commercial reasonableness, which would yank an arrangement out of the arms of a Stark exception,” Baumann says. “This is a new approach they want to take, and it is a somewhat novel approach. It’s not how the phrase was interpreted in the past.”

Linda Baumann, attorney at Arent Fox

Source: Quote obtained from *In New Angle on Stark Cases, Government Hits Hospitals for Lack of Physician Profit*, accessed at <https://aishealth.com/archive/rmc070912-02>.

## Recent Court Cases

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- Halifax (2014)
- Tuomey (2015)
- Citizens Medical Center (2015)
- Adventist Health System (2015)
- North Broward Hospital District (2015)
- Columbus Regional (2015)

## Recent Court Cases – HALIFAX (2014)

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- Florida
- Settlement: \$85 Million
- 6 medical oncologists
  - Incentive bonus = 15% of Operating Margin of the Medical Oncology Program, which included DHS fees
  - ❖ Government argued oncologists' bonus structure took into account referrals.
- 3 neurosurgeons
  - After base pay, received 100% of additional collections for professional services
  - ❖ Government argued compensation was in excess of FMV and that the incentive compensation guaranteed the practice would operate at a loss.

## Recent Court Cases – TUOMEY (2015)

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- South Carolina
- Settlement: \$72.4 Million (1/3 of the original award)
- 19 part-time employment agreements with specialists for outpatient surgeries only for 10 year terms
  - Base salary + productivity bonuses equal to ~80% of aggregate compensation
  - Losses of ~\$1.5 - \$2 Million per year on the physicians' compensation compared to collections
  - ❖ Government argued compensation varied based on referrals because (1) physicians only earned money for work that also generated a facility fee for the hospital and (2) compensation exceeded personal collections and included amount for referrals.

## Recent Court Cases – TUOMEY (2015)

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“One of the takeaways of this case is that physician compensation may present risk under the Stark law, even if it arguably is consistent with fair market value in the eyes of an independent valuation consultant, if some or all of the following factors are present: (1) the party paying the physician compensation is motivated by a desire to retain or secure referrals, (2) the terms and conditions contained in the compensation arrangement are highly unusual, (3) the compensation correlates with or is affected by the physician’s referrals, and (4) the compensation paid to the physician exceeds the professional fees generated by the physician.”

Source: July 2015 Hooper, Lundy & Bookman, PC article titled *Hospital Hit With \$237 Million Stark Law Judgment*, accessed at <http://www.health-law.com/newsroom-advisories-109.html>

# Recent Court Cases – CITIZENS MEDICAL CENTER (2015)

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- Texas
- Settlement: \$21.75 Million
- Employed Cardiologists
  - Combined salaries increased from \$630,000 to \$1,400,000 in the first year of employment by Citizens
  - Experienced losses of \$400,000 in 2008 and \$1,000,000 in 2009
  - ❖ Government argued that compensation to cardiologists exceeded FMV, despite compensation being less than median.
  - ❖ The judge noted that if the allegations were true, it would make little economic sense for Citizens to employ the cardiologists at a loss, except when the motive is to induce referrals.
- ED Physicians
  - ❖ Government argued that bonuses were for referrals to the Chest Pain Center.



# Recent Court Cases – COLUMBUS REGIONAL (2015)

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- Georgia
- Settlement
  - Columbus Regional: Up to \$35 Million (ability to pay process)
  - **Physician (Dr. Pippas): \$425,000**
- 2 complaints filed by whistleblower (former hospital administrator)
  - 1<sup>st</sup> – alleged improper coding & documentation
  - 2<sup>nd</sup> – alleged failure to meet Stark exception (Dr. Pippas)
  - ❖ Government argued Dr. Pippas received improper salary and medical director payments from Columbus Regional.
  - ❖ Government argued compensation in excess of collections for personally performed services.
  - ❖ Government argued physician is responsible for his / her conduct, consistent with the Yates Memo.

## Recent Court Cases – NORTH BROWARD (2015)

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- Florida
- Settlement: \$69.5 Million
- 9 physicians
  - Compensation in excess of 90<sup>th</sup> percentile in surveys, which was misaligned with productivity levels
  - Compensation generated substantial practice losses
  - Hospital had "Contribution Margin Reports" referencing hospital and ancillary revenue generated by each employed physician
  - ❖ Government asserted that the hospitals used the Contribution Margin Reports to evaluate physician compensation proposals, and that physician referrals were used to justify compensation levels and substantiate practice losses.
  - ❖ Government argued that the compensation arrangements were not commercially reasonable without referrals.

## Recent Court Cases – NORTH BROWARD (2015)

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“...the conduct of Broward Health’s financial strategists responsible for physician recruitment and compensation evidence the following four primary facts: (1) Broward Health has deliberately recruited, employed, and agreed to pay physicians based in part on anticipated profits from referrals from such physicians to Broward Health’s hospitals and clinics, (2) Broward Health has not simply compensated employed physicians based on the value of physicians’ personally performed services and revenue from such services, (3) Broward Health has ***deliberately planned and budgeted for massive net operating losses from the overcompensation of employed physicians while secretly tracking profits from referrals by such physicians to Broward Health’s hospitals and clinics***, and (4) Broward Health has deliberately compensated its employed physicians at ***commercially unreasonable*** levels if profits from referrals by such physicians were not considered.”

Source: Relator’s (USA ex rel. Michael Reilley, M.D.) Third Amended Complaint (emphasis added)

## Recent Court Cases – ADVENTIST HEALTH (2015)

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- Florida, North Carolina, Tennessee, Texas
- Settlement: \$115 Million
- 167 physicians
  - ❖ Government argued hospital willing to pay physicians in excess of FMV and absorb consistent losses due to referrals.
  - ❖ Government argued compensation was above FMV for part-time work (e.g., part-time dermatologist paid \$710,000).
  - ❖ Government argued bonuses were based on revenue from referrals, not only on personally performed services. This included non-physician provider productivity.
  - ❖ Government argued employed physicians received perks (e.g. car lease payments)
  - ❖ Government argued Adventist had coding anomalies that were not corrected.

# Current Government Philosophy Regarding Practice Losses

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- Strong enforcement activity expected to continue
- June 9, 2015 DHS/OIG Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability
- September 9, 2015 - Yates Memo
  - Hold the individuals who perpetrated the wrong doing accountable
  - Intended as a deterrence, to change corporate behavior and promote confidence in the system
    - ❖ Focus on individuals
    - ❖ Coordination of civil and criminal
    - ❖ No release of individual culpability when resolving matters
    - ❖ Disregard for individual's ability to pay

# Reasons for Practice Losses

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- Poor post-transaction transition
- Poor payer mix
- Low volumes
- Start-up of new physicians
- Removal of ancillary revenue streams
- Poor revenue cycle
- Allocations of hospital / health system overhead expenses
- Hospital pay scales & benefit packages
- Required service for trauma designation
- Unmet need in community, but not enough demand for a full-time provider
- Reliance on surveys only to set physician compensation

# Quantitative Analyses to Support Practice Losses

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- Quantify reasons for practice losses by making adjustments for the following, if applicable and reasonable:
  - Poor payer mix, if payer mix is a result of hospital / health system mission
  - Low volumes, if low for specific reasons that are out of physician and hospital / health system's control
  - Poor revenue cycle or out-of-network on key payers
  - Ancillary revenues, if such revenues will be stripped out of the practice post-transaction
  - Excess square footage
  - Excess hospital / health system overhead
  - Medical Directorship or ER call services embedded in employment agreement that would otherwise be paid to independent physician

# Qualitative Analyses to Support Practice Losses

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- Community Needs Assessment
- Recruitment History
  - Have you had offers rejected on the basis of the compensation & benefits package offered? If so, do you have the documentation to prove this pattern?
- Business Plan
  - Do you have a documented business plan or service line plan to meet needs in the community or achieve your mission?
  - Do you need specialized services (e.g., Maternal Fetal Medicine) to achieve your business plan (e.g., Women's Services Hospital)?
- Required roles (e.g., Trauma or Inpatient Rehab) for Medicare or Other Licensing Bodies



# Qualitative Analyses to Support Practice Losses – Community Needs Assessment Example

Specialty	2014			2019		
	Physician Demand	Physician Supply	Surplus / (Shortage)	Physician Demand	Physician Supply	Surplus / (Shortage)
<b>Primary Care Specialties</b>						
Family Practice	43.8	48.0	4.2	51.9	40.3	(11.6)
Internal Medicine	49.6	35.8	(13.8)	58.8	32.5	(26.3)
Pediatrics	28.7	14.0	(14.7)	34.0	11.3	(22.7)
<b>Medical Specialties</b>						
Allergy & Immunology	2.0	2.0	0.0	2.4	1.0	(1.4)
Cardiology	7.0	8.5	1.5	8.2	8.5	0.3
Dermatology	4.8	2.8	(2.0)	5.7	3.0	(2.7)
Endocrinology	1.4	2.5	1.1	1.7	2.5	0.8
Gastroenterology	4.3	5.0	0.7	5.1	5.0	(0.1)
Hematology / Oncology	4.9	3.0	(1.9)	5.9	1.0	(4.9)
Infectious Disease	1.4	1.0	(0.4)	1.6	1.0	(0.6)
Nephrology	1.7	2.0	0.3	2.0	2.0	0.0
Neurology	4.5	2.0	(2.5)	5.4	2.0	(3.4)
Pulmonology	3.1	2.0	(1.1)	3.7	2.0	(1.7)
Rheumatology	1.3	1.3	0.0	1.5	1.5	0.0
<b>Surgical Specialties</b>						
Cardiothoracic Vascular Surgery	2.2	3.0	0.8	2.7	3.0	0.3
General Surgery	18.0	15.8	(2.2)	21.3	14.8	(6.5)
Neurosurgery	2.1	1.0	(1.1)	2.5	1.0	(1.5)
Obstetrics & Gynecology	20.4	22.8	2.4	24.2	17.3	(6.9)
Ophthalmology	8.3	3.5	(4.8)	9.8	2.8	(7.0)
Orthopedic Surgery	10.7	9.5	(1.2)	12.7	7.0	(5.7)
Otolaryngology	5.3	1.0	(4.3)	6.3	1.0	(5.3)
Plastic Surgery	2.4	1.3	(1.1)	2.8	1.5	(1.3)
Urology	5.4	1.3	(4.1)	6.4	0.5	(5.9)

# Questions?

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