Fair market value and physician compensation

DEFINING THE REGULATORY LANDSCAPE

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Dr. Jones is an orthopedist who has been a physician partner in a private group practice for the past 15 years. She cares for both Medicare and Medicaid beneficiaries. Her office provides a variety of ancillary services to patients. As an experienced physician in the community, she also holds a medical directorship over the orthopedic service line at a local hospital. She also takes and is paid for orthopedic surgery ER call coverage at two local hospitals.

Dr. Jones' practice is similar to thousands of physician practices across the country. While seemingly harmless, there are operational and financial aspects of her practice that increase her compliance risk. Other industries may enter similar financial arrangements to improve operational efficiencies, increase profitability and render services vertically along the supply chain. Physicians are no different. However, a physician's financial transactions and compensation are subject to a significant level of regulatory scrutiny and need to be set at fair market value (FMV) to navigate safely.

WHY IS FMV IMPORTANT TO YOU?

Physician transactions are highly regulated by federal law, a variety of state-specific fraud and abuse statutes and governmental agencies. The activities and transactions of most physicians in private practice and those employed by health systems are impacted by these regulations. For the purposes of this discussion, Stark Law and Anti-Kickback statute (AKS) are highlighted.

Stark Law prohibits physicians from referring Medicare and Medicaid patients for specific designated health services (DHS)[1] to entities with which the physician and/or immediate family member have a financial relationship unless certain exceptions are met. Similarly, AKS prevents those who knowingly and willfully offer, pay, solicit or receive remuneration to induce business payable by Medicare and Medicaid unless certain safe harbors are satisfied. Table 1 provides an illustration of how Dr. Jones, from the earlier example, must consider the implications of Stark on her practice and the potential need to meet the requirements of an exception.

To satisfy many of these exceptions, the compensation for the arrangement is required to be at FMV. As such, Dr. Jones' compensation from her practice, ER call coverage and medical directorship service needs to be within FMV. If not, she runs the risk of being outside of compliance and subject to criminal and civil penalties. As such it is critical that the definition of FMV be understood.

EDITOR'S NOTE

This is the first article in a three-part series on FMV in the healthcare space as it relates to physician compensation and other transactions. Check forthcoming issues of *MGMA Connection* magazine for Part 2 ("Real-world examples of FMV for physicians and medical practices") and Part 3 ("Physician FMV and compensation design in the context of value-based care").

AUTHOR'S NOTE

The information in this article comes from a valuation analyst's perspective and is not meant to substitute for legal advice.

TABLE 1. EXAMPLES OF REFERRAL AND FINANCIAL AGREEMENTS IMPACTED BY STARK LAW AND ANTI-KICKBACK STATUTE

REFERRAL SERVICE	ENTITY RECEIVING REFERRAL	FINANCIAL ARRANGEMENT
DHS service: Imaging services and/or physical therapy (PT) services	Patients referred to her group practice for in-house imaging or PT	Dr. Jones has an ownership interest in the practice within which she refers
	Patients referred to an imaging center or PT clinic	Dr. Jones and/or an immediate family member may have a direct or indirect financial interest in the entity
	Patients referred to a hospital	Dr. Jones is compensated for ER call coverage thereby establishing a financial arrangement
DHS service: Outpatient hospital services	Patients referred to hospital for outpatient radiation therapy	Dr. Jones is compensated as a medical director at the hospital thereby establishing a financial arrangement

DEFINING FMV WITHIN THE CONTEXT OF COORDINATED CARE AND VALUE-BASED COMPENSATION

Given the significance of FMV to regulatory compliance, it is important to understand its relationship to physicians and healthcare entities.[2] While the definition of FMV has its roots in business valuation,[3] FMV in the healthcare industry is a regulatory definition. Stark Law currently provides some regulatory guidance on the definition of FMV, with the following key distinctions:

a. Parties to the agreement "are not otherwise in a position to generate business for the other party."[4]

b. FMV "has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals."[5]

These distinctions have resulted in some regulatory ambiguity when determining FMV and has presented challenges for physicians, hospitals and health systems to engage in

value-based models in which care is coordinated between parties through referrals.

On Oct. 9, 2019, the Department of Health & Human Services (HHS) announced proposed changes to Stark Law and AKS to facilitate physicians and hospitals to coordinate care and encourage value-based compensation.[6] While the rule has not been finalized, the proposed change provides an exception for value-based arrangements, which do not include a requirement for FMV. If finalized, this will be key for physician practices entering into economic affiliations with other healthcare entities to improve the quality of patient care through integrated networks. While this will allow for more innovative transactions and arrangements if finalized, the importance of maintaining compensation at FMV will remain.

PENALTIES, FINES ASSOCIATED WITH REGULATORY VIOLATIONS

It is imperative that physicians and practices understand that they enter financial arrangements at their own risk. For instance, Stark Law is a strict liability statute that does not require intent to result in a violation. This creates liability even for those who make a good-faith effort to comply with the law. In addition, the criminal and civil penalties under Stark and AKS, respectively, cannot be understated. Violations under Stark and AKS may result in civil monetary penalties, exclusion from programs, False Claims Act liability, non-payment for services and refunds to beneficiaries.[7] Under AKS, the violation may also result in a felony subject to imprisonment.[8]

Here are some examples of violations and penalties from the Department of Justice (DOJ) and Office of Inspector General (OIG):

November 2019: Improper compensation arrangements

Sutter Health and Sacramento Cardiovascular Surgeons Medical Group Inc. agreed to pay $46 million to resolve allegations they violated Stark Law. Specifically, Sutter hospitals submitted Medicare claims that resulted from referrals by physicians to whom its hospitals:

1. Paid compensation under professional services arrangements (PSAs) that exceeded FMV of the services provided
2. Leased office space at below-market rates
3. Reimbursed physician-recruitment expenses that exceeded the actual recruitment expenses at issue.[9]

This case identifies three common transactions between physician practices and hospitals that have the potential of violating Stark Law. Specifically, the PSAs involved compensation from ER call coverage as well as medical directorship agreements. It is important to note that the physician group contributed. While the bulk of the agreed-upon payment was paid by Sutter Health, the physician group paid $500,000 toward the settlement.

September 2019: False Claims liability for alleged kickback scheme

TridentUSA Health Services LLC settled to pay $8.5 million to resolve two False Claims Act cases. The government alleged that, from approximately June 2006 through September 2019, Trident engaged in illegal "swapping" arrangements under which Trident provided mobile X-rays to skilled nursing facilities (SNFs) at prices below Trident's costs to provide the services, or below FMV, for the

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purpose of inducing the facilities to refer lucrative federal health program business to Trident.[10]

This case illustrates the importance of not only avoiding payment above FMV but also considering the pitfalls of payment below FMV. When a physician accepts payment below FMV for a particular service, it could be assumed they are receiving other undue benefits in return. Setting compensation within FMV would eliminate this possible interpretation.

March 2019: Allegations of kickbacks in exchange for referrals

MedStar Health settled with the government and agreed to pay $35 million to resolve allegations that it paid a cardiology group for referrals. The cardiology group had 16 PSAs with MedStar; many of these agreements were for administrative services. The government considered the compensation under these agreements to be in excess of FMV for the services provided. Given the fact that the compensation terms were above FMV, the excess value was considered to be for the practice's effort to increase referrals for cardiology procedures.[11]

In this case, it was also alleged that some of the paid services were not even performed by the physicians in the group. Considering the Dr. Jones example, it is important that physicians be compensated within FMV for administrative services documented and performed. If not, the government will consider this a Stark violation and the excess compensation a kickback for referrals to the hospital.

These case examples each resulted in settlements. The DOJ recovered $2.6 billion in settlements and judgments from healthcare entities and physicians in 2019, marking 10 consecutive years of recovering in excess of $2 billion annually.[12]

WHERE DO WE GO FROM HERE?

While attempts are being made to reduce the complexity surrounding these regulations, it is important for physicians and physician practices to understand the regulatory environment to better understand and ensure compliance.

Part 2 of this series will delve into specific illustrative transactions and explore how the economic terms of these arrangements, as well as the numerous key value drivers, are used to derive the FMV compensation range. ■

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NOTES

1. i.) Clinical laboratory services; ii.) PT, occupational therapy and outpatient speech language pathology services; iii.) Radiology and certain other imaging services; iv.) Radiation therapy services and supplies; v.) Durable medical equipment and supplies; vi.) Parenteral and enteral nutrients, equipment and supplies; vii.) Prosthetics, orthotics and prosthetic devices and supplies; viii.) Home health services; ix.) Outpatient prescription drugs; x.) Inpatient and outpatient hospital services.
2. Aguilar J, Bell N. "COVID-19: Physician compensation and fair market value (FMV) under the blanket Stark waiver." MGMA. April 27, 2020. Available from: mgma.com/covid-stark-waiver.
3. "International Glossary of Business Valuation Terms." June 8, 2001. Adopted by American Institute of Certified Public Accountants, American Society of Appraisers, Canadian Institute of Chartered Business Valuators, National Association of Certified Valuation Analysts, The Institute of Business Appraisers.
4. Phase II, Interim Final Rule, *42 CFR Section 411.351* [published at 69 Federal Register 16128 (effective July 26, 2004)].
5. Ibid.
6. HHS. "HHS Proposes Stark Law and Anti-Kickback Statue Reforms to Support Value-Based and Coordinated Care." Oct. 9, 2019. Available from: bit.ly/3ghd40g.
7. OIG. "Fraud and Abuse Statutes, Administrative Authorities, and Self-Disclosures." HHS. Available from: bit.ly/3bYsyms.
8. OIG. "Comparison of the Anti-Kickback Statute and Stark Law." HHS. Available from: bit.ly/3geQaH3.
9. Office of Public Affairs (OPA). "California Health System and Surgical Group Agree to Settle Claims Arising from Improper Compensation Arrangements." Department of Justice. Nov. 15, 2019. Available from: bit.ly/2XrbkJm.
10. OPA. "Trident USA Health Services LLC to Pay $8.5 Million to Resolve False Claims Act Liability for Alleged Kickback Scheme." DOJ. Sept. 25, 2019. Available from: bit.ly/36rSzte.
11. OPA. "MedStar Health to Pay U.S. $35 Million to Resolve Allegations that it Paid Kickbacks to a Cardiology Group in Exchange for Referrals." DOJ. March 21, 2019. Available from: bit.ly/3e8OooO.
12. OPA. "Justice Department Recovers over $3 Billion from False Claims Act Cases in Fiscal Year 2019." DOJ. Jan. 9, 2020. Available from: bit.ly/36t8dEP.