Physician Organizations Bootcamp Webinar and Roundtable Discussion Series: The Anatomy of Physician Integration, Part III—Fraud and Abuse

This bootcamp webinar and roundtable discussion series is sponsored by the Physician Organizations (Physicians) Practice Group, and is co-sponsored by the Antitrust; Business Law and Governance (BLG); Fraud and Abuse (Fraud); Health Information and Technology (HIT); Hospitals and Health Systems (HHS); In-House Counsel (In-House); Labor and Employment (Labor); Payors, Plans, and Managed Care (PPMC); and Tax and Finance (Tax) Practice Groups; and the Accountable Care Organization (ACO) Task Force.

Tuesday, June 11, 2013 • 1:00-2:30 pm Eastern

Presenters

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Presentation Roadmap

• Review of Gatsby Hypothetical

- Key concepts:
  - Integration and the fraud and abuse laws
  - Potential pathways under traditional safe harbors and stark exceptions
  - ACO waivers
  - Valuation of medical practice and physician services
  - What does case law mean for the future (Tuomey, Halifax)
The Great Gatsby – The Anatomy of Physician Integration

Meet our Subject:

- Dr. Jay Gatsby is a 57-year-old orthopedic surgeon and president and founder of the four-office, 14-physician West Egg Orthopedic Specialists, P.A. West Egg also has two MRIs and four physical therapists

- Concerned with income in his twilight years amid witnessing declining reimbursement in his practice, Dr. Gatsby is hoping to pay off some debts by selling the practice, with a high value in the purchase price placed on goodwill
The Great Gatsby – The Anatomy of Physician Integration, cont’d

- The Scenario
  - Dr. Gatsby is being courted by two organizations
    - Klipspringer Multi-Specialty Group, Nick Carraway, CEO
      - Physician practice representing nine different medical specialties
      - Vying to become an ACO
      - Believes the addition of a robust orthopedic group would aid in becoming an ACO
    - West Egg Medical Center, Daisy Buchanan, CEO
      - Already presented West Egg Orthopedic Specialists with a letter of intent to purchase the assets of the practice
      - Hospital Chief Medical Officer, Jordan Baker, agreed to implement incentives for West Egg Orthopedics regarding patient discharges over the weekend and improved on-time starts in the operating room
Fraud and Abuse Laws

- Physician Self-Referral Law ("Stark")
- Federal Anti-Kickback Statute
- Civil Monetary Penalties Law ("gainsharing" and "beneficiary inducement" CMPs)
What are the Risks?

- Overutilization?
- Stinting?
- “Cherry Picking”? 
- “Lemon Dropping”?
- Swapping?
- Gaming?
Integration Models

- Employment
- Gainsharing
- Pay-for-Performance
- Joint Ventures
- Contracting/Co-Management
- Electronic Health Records
- Risk Sharing Arrangements
Existing Potential Pathways

Gainsharing/Co-Management

- Transparency/Accountability
- Quality
- No Referral Payments

Pay-For-Performance

- OIG Ad. Op. 12-22
- OIG Ad. Op. 8-16
Existing Potential Pathways

**Employment**
- AKS safe harbor (1001.952(i))
- Stark exception (411.355(c))

**Contracting/Co-Management**
- AKS safe harbors/ Stark exceptions
Existing Potential Pathways

Joint Ventures

- OIG Special Fraud Alert
- AKS safe harbors

Risk Sharing Arrangements

- AKS safe harbors/ Stark exceptions
Existing Potential Pathways

Electronic Health Records (EHRs)

• AKS safe harbor/Stark exceptions
• 2013 Sunset
AKS/Stark Guideposts (but see safe harbors and exceptions for details)

Fair Market Value

Commercially Reasonable

≠ Reflect Volume/Value

In Writing
Medicare Shared Savings Program
Shared Savings Program (§ 3022 of ACA)

- Groups of providers accountable for care of assigned beneficiaries
  - Parts A and B
  - Meet quality and performance benchmarks
- Beneficiary freedom of choice
- Payment
  - Fee-for-service payments
  - Shared savings
ACO Shared Savings Distribution

- **Background**
  - Substantial investment in ACO infrastructure
  - Substantial ongoing costs for technology, facilities, and personnel

- **Shared savings payments made to ACO** – options for distribution
  - Payment for infrastructure
  - Payment for operating costs
  - Payment to ACO participant and/or ACO provider/supplier classes
    - Hospitals
    - Physicians
    - CAHs, RHCs, and FQHCs
ACO Shared Savings Distribution, cont’d

- Pooling models among ACO participating physicians
  - Group-focused models
  - Individual-focused models
  - Hybrid models

- Scoring participating physician performance
  - Importance of data
  - Objectivity in setting metrics and benchmarks
  - Linking physician performance to ACO objectives
Distribution Methodology, cont’d

- Hypothetical example, cont’d

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<td>Infrastructure</td>
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<td>PCP pool</td>
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<td>Specialist pool</td>
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<td><strong>Total</strong></td>
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Distribution Methodology, cont’d

- Hypothetical example, cont’d

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<tr>
<td>Spec 1</td>
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<td>100.00%</td>
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## Distribution Methodology, cont’d

$1,200,000 Allocable Shared Savings After ROI and Operating Overhead

20 Percent Attributed to Specialist Performance

<table>
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<tr>
<th></th>
<th>Total</th>
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**Total**: $240,000 $81,133 $79,012 $79,854
Medicare Shared Savings
Waiver Authority

“The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this section.”

-Section 1899(f) of the Social Security Act

Stark  AKS  CMP
General Terms Applying to All Waivers

- Parties only required to meet criteria for 1 waiver
- Standard: “reasonably related to the purposes of the Shared Savings Program”
  - Less prescriptive than “directly related” standard
  - Incentives to attract primary care physicians permissible
    - Cannot pay per value or volume of referrals
    - Cannot be required to refer within the ACO (MSSP integrity provisions)
- No requirement for written and signed agreement
- No requirement that arrangements are fair market value or assessed to be commercially reasonable
Pre-participation waiver

- Waiver may only be used 1 time by an ACO
  - Clarification? ACO can only claim this waiver during a single one year period
  - Multiple arrangements during the year permitted
- Does not cover arrangements with drug and device manufacturers, distributors, HHA or DME companies
- ACOs must publicly disclose a description of the arrangement
- Addresses issues with joint venture formation
  - For example, joint ownership of ACO by hospital and physician group, hospital provides 100% ACO capital
Participation waiver

- **Blanket waiver**
  - Covers all aspects of an arrangement between an ACO, one or more ACO participants or ACO providers/suppliers or any combination

- ACOs must publicly disclose a description of the arrangement
- Likely to encompass most arrangements undertaken by ACOs
- No specific waiver for private payer arrangements
  - But, participation waiver promotes flexibility for ACOs participating in commercial plans - does not turn on source of funds for the arrangement
Shared savings distribution waiver

- Affords ACOs latitude to use shared savings in arrangements with outside parties
  - “Reasonably related” standard
- Not required to publicly disclose a description of the arrangement
- Shared savings distributions may also fall under ACO participation waiver
Compliance with physician self-referral law waiver

- Rule creates consistency between self-referral law and anti-kickback law
- Waiver applies to any arrangement, not just those dealing with distributions of shared savings
- May be subsumed by participation waiver
- Only applies to ACO arrangements
  - ACO providers and suppliers may have independent arrangements involving beneficiaries not assigned to ACO
Beneficiary inducement waiver

- Waiver does NOT extend to items or services provided to beneficiaries to encourage them to seek care from ACO participants, providers or suppliers
  - Also part of MSSP program integrity provisions
- Scope of waiver
  - Reasonably related to medical care: blood pressure cuffs for hypertensive patients, but not theater tickets, no waiver of copayments
  - Compare to other Beneficiary Inducement CMP exception for preventive care
- Waiver applies to all beneficiaries, not just those assigned to the ACO
Program Integrity Safeguards

- Compliance Plans
- Compliance with Program Requirements
- Conflicts of Interest
  - Members of governing body must disclose relevant financial interests
- Screening of ACO Applicants
- Prohibition on Certain Required Referrals and Cost Shifting
- Record Retention
- Beneficiary Inducements
- Termination if MSSP integrity requirements not met
Fair Market Value

Valuation of Physician Practices

Valuation of Physician Compensation Arrangements
Factors Contributing to Integration Movement

- Physician shortages (now and projected) and lifestyle balance demands
- Declining physician incomes (i.e., erosion of reimbursement, increasing overhead, fewer ancillary opportunities) and threats
  - Sustainable Growth Rate
- Working capital needs in physician practices (i.e., investment in electronic health record systems)
- Changes in U.S. population demographics (i.e., age, health)
- Inexorable growth in health care costs
  - National Health Expenditures are projected to increase from $8,953 per capita or 17.9 percent of GDP in 2012 to $14,103 per capita and 19.6 percent of GDP in 2021 (1)
- Unsustainable trend of cost-shifting to privately insured
- Affordable Care Act provisions related to care delivery, payment reforms, program integrity, access, and cost control
- Government and private payer demands for quality
- Additional regulatory and payer-induced practice management burdens
- Wide acceptance of hospital-physician models and significant publicity surrounding large practice transactions

Fair Market Value Definitions

- Traditional definitions of FMV
  - Internal Revenue Service
    - Business valuation: Revenue Ruling 59-60
    - Reasonable compensation (exempt organizations): Treasury regulations on intermediate sanctions
  - Appraisal industry and sanctioning bodies
    - The International Glossary of Business Valuation Terms
Fair Market Value Definitions, cont’d

- Health care regulatory definitions of FMV
  - Stark law definition of FMV
    - Assets
    - Service agreements
    - Equipment leases
    - Space rental
  - CMS commentary on FMV compensation
  - Federal anti-kickback safe harbors
    - Space rental
    - Equipment rental
Fair Market Value Definitions, cont’d

- Key distinction in the FMV definitions
  - The regulatory definitions of FMV prohibit consideration of the parties’ positions to refer federal health care program beneficiaries or otherwise generate business for one another.
  - Taking into account the ability to generate referrals can result in FMV outside the health care industry, but is a fatal valuation error under Stark and AKS (e.g., Bradford, Tuomey).
Valuation of Physician Practice

Asset- or Cost-Based Approach

• Adjusted net asset method used to estimate the fair market value of a health care business enterprise
• Most appropriate when value of business is dependent upon tangible asset values
• Seldom appropriate in valuing operating companies, but is used in professional practices with little or no goodwill
• NOT a substitute for valuation under income-based approach
• When used in conjunction with other approaches, generally results in floor value of tangible assets
• May be useful in allocating purchase price in a transaction

Valuation of Physician Practice, cont’d

### Income-Based Approach

- Income approach is comprised of several methods, including the discounted cash flow method, the capitalized earnings method, and the capitalized excess earnings method.
- Given the reimbursement and regulatory volatility in the industry, the discounted cash flow method is often used in health care business enterprise valuations.
- Conceptually based in theory that investor will make an investment with expectation of receipt of some greater amount in the future.
- Applies the principle of future benefits – establishing an anticipated future income stream and converting that stream to value at a specified point in time – generally in the present.
- Concept of present value, or the amount in today’s dollars that an investor would pay for the anticipated future income stream.
- Based in theory on a fraction:
  - The numerator of which is future stream of economic benefits
  - The denominator of which is risk, quantified as the required rate of return
  - A higher denominator (read, “higher risk”) equates to lower value.
- Future economic benefit drives the model, measured in:
  - Cash flows or earnings
  - Controlling or minority
  - Pre-tax or after-tax
Valuation of Physician Practice, cont’d

Market-Based Approach

- Simple in theory, but difficult in application with truly comparable data
- Methods include guideline private and public company transactions
  - Guideline publicly traded company method
  - Guideline company transaction method
- Finding common ground:
  - Revenues
  - Pre-tax income
  - EBIT, EBITDA
- Rules of thumb and misconceptions:
  - “Quick and dirty” valuation
  - “Back of the napkin” valuation
  - Considered reasonableness tests, rather than primary valuation methods
Valuation of Physician Practice, cont’d

- Valuation method examples
  - Asset-based approach: adjusted net asset method
    - Essentially restates the subject company’s balance sheet to the standard of value (e.g., fair market value)
    - Generally results in a control-level value (see minority interest discount)
  - Income-based approach: discounted cash flow method
    - Equates the subject interest to an investment, the purpose of which is to generate a return to the investor
    - Normalization of financial statements
    - Projected cash flows
    - Determination and application of discount and capitalization rates
      - Measurement of risk, beginning with an assessment of risk-free returns
      - Higher inherent risk equates to greater return
      - Company-specific strengths and weaknesses
  - Market-based approach: guideline public company and guideline transactions methods
    - Search for “comparables”
    - Analysis of analytical ratios and common financial indicators
Valuation of Physician Practice, cont’d

- Valuation method examples
  - Reconciliation and synthesis
    - Valuation methods seldom produce similar results, and usually one or more outliers exist
    - Reconciliation provides for an understanding of why results are different
    - Synthesis considers the relative importance and impact of divergent methods

- Valuation discounts and premiums
  - Discount for lack of marketability
    - Investors place great value on the ability to convert an investment into cash
    - Unlike publicly traded companies, a ready market does not necessarily exist for closely held health care providers
    - The degree to which a discount exists depends on facts and empirical evidence
    - Restricted stock and initial public offering studies analyze the value of liquidity
  - Discount for lack of control (minority interest discount)
    - Minority interests lack the degree of control in a controlling interest
    - The degree to which a discount (or premium) exists is largely dependent upon the effective control that can be exercised by the minority owner
Valuation of Physician Practice, cont’d

- The controversy continues with respect to use of the asset-based approach to include the value of intangible assets (including workforce assets) in valuing medical practices absent post-transaction cash flows
  - Proponents of the use of the asset-based approach to value medical practices with intangible value in workforce assets ascribe value to the workforce assets vis-à-vis the adjusted net asset method
  - Proponents of the use of the income-based approach support determination of the existence of intangible value through income-based methodology such as the discounted cash flow method before allocating any intangible value to workforce assets
Valuation of Physician Practice, cont’d

- Problematic consideration of post-transaction factors
  - Failure to apply post-transaction compensation in income-based approach
  - Reimbursement of post-transaction entity
    - Valuation failure in missed standard of value
    - Misapplication of post-transaction reimbursement
  - Volume or value of referrals
    - Inputs into the valuation model that are based on the volume or value of referrals of federal health care program beneficiaries (including Stark DHS)
  - Synergies of buyer and seller
Compensation Valuation Approaches

Cost-Based Approach

- Methods under the cost approach arrive at indications of value using alternatives to the subject arrangement or the bundling of items and/or services that comprise the subject arrangement.
- In compensation arrangements, cost approach applies similar valuation techniques to determine an indication of value by considering the cost to replace or reproduce the service with a similar service.
- Methods include:
  - Cost Build-Up Method
Compensation Valuation Approaches,

**Income-Based Approach**

- Methods under the income approach arrive at indications of value by measuring the expected economic benefits of the parties to the subject arrangement over the period of the arrangement.
- Compensation valuation engagements use the income approach to consider professional and/or technical component fees and appropriate matching of costs. Often, this can result in a comparative assessment of two parties’ rates of returns, given relative risk, capital investment, utilization of resources.
- Methods include:
  - Net Available Earnings Method
Compensation Valuation Approaches,

**Market-Based Approach**

- Methods under the market approach arrive at indications of value by comparing amounts paid/received by similar parties for similar services under similar circumstances.
- In valuing service arrangements, understanding the characteristics of the data is key to ensuring true comparability of benchmarks such as productivity, compensation and compensation-to-production metrics.
- Methods include:
  - Published Survey Data Method
  - Production-Based Compensation Method
Compensation Valuation Approaches, cont’d

- Valuation of quality incentives
  - Cost-based approach
    - Limited application to valuing quality incentives
  - Income-based approach
    - Limited application to valuing quality incentives
  - Market-based approach
    - Market comparables
      - Medicare and Medicaid payments for quality and reporting
      - Third-party payer incentives
    - Market-based incentive rate applied to aggregate compensation or WRVU conversion factor
Compensation Valuation Approaches, cont’d

- Blind use of published survey data is filled with weaknesses in determining FMV without a clear understanding of the application of the data
  - Understanding implications of payer mix and local reimbursement patterns on physician compensation
    - Considerations of distinctions in local market factors on the use of published survey data
  - Example of reported compensation survey data (cash compensation and compensation ratio data) for cardiology that can include the following, resulting in an overpayment of a hospital-employed cardiologist:
    - Profit paid in the form of distribution from procedures performed in-office that will be performed in the hospital post-employment
    - Profit from employment of mid-level providers and employed physicians that will be employed by the hospital
    - Profit from technical component of ancillary services that will be converted to hospital outpatient services post-employment

- The “High Producer / High Conversion Factor Fallacy” argued by many physicians and hospitals
Compensation Valuation Approaches, cont’d

- Precautions against “stacking” of individual components of fixed and incentive compensation
  - Base compensation
  - Productivity incentives
  - On-call pay
  - Administrative compensation
  - Quality incentives
  - Supervision of mid-level providers
Commercial Reasonableness

- CMS (then HCFA) defined “commercially reasonable” as:
  - An arrangement which appears to be “a sensible, prudent business agreement, from the perspective of the particular parties involved, even in the absence of any potential referrals.” [63 Fed. Reg. (Jan. 9, 1998), 1700.]
- CMS later addressed the definition of commercially reasonable in the Stark law, which states:
  - 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 not potential designated health service referrals. [69 Fed. Reg. (Mar. 26, 2004), 16093.]
- The OIG defines commercial reasonableness as:
Commercial Reasonableness, cont’d

- Client, outside counsel, and valuation expert all play important roles in the assessment of commercial reasonableness
  - Valuation expert has the unique position of knowledge as to the fair market value and certain business aspects of the transaction
  - Client understands the strategic and business reasons for the transaction or arrangement
  - Outside counsel understands the legal aspects of the arrangement or transaction and has the ability to represent that the structure complies with exceptions and safe harbors found in the fraud and abuse laws
What Does Case Law Mean for the Future?

- Case involved exclusive, indirect part-time compensation arrangements with 19 physicians over a 10-year term.
- Compensation provisions included:
  - Annual guaranteed base salary based on outpatient procedure net cash collections
  - Production bonus based on 80 percent of net collections
  - Incentive bonus of up to 7 percent of the production bonus
- Benefit package similar to full-time benefits

**Government Position**
- Alleged violations of Stark law
  - Not FMV
  - Took into account the volume/value of referrals
U.S. ex. rel., Drakeford v. Tuomey Healthcare System, Inc., cont’d

- First Trial
  - Split Verdict: Stark violation but no FCA violation
  - $41 million in damages, but new FCA trial ordered

- Fourth Circuit Appeal
  - Partial striking of jury verdict violated right to jury trial
  - Remanded for new trial

- Second Trial
  - Jury Verdict
    - Stark violation and $39 million in damages
    - FCA violation and government seeking $237 million FCA award
    - No damages or penalties ruling yet

- U.S. ex. rel. Elin Baklid-Kunz v. Halifax Medical Center, et. al.
  - In June 2009 when Complaint was filed, Relator was Director of Physician Services
  - Complaint alleges:
    - Admission criteria not met
    - Failure to establish medical necessity
    - Repetitive up-coding and under-coding
    - Improper billing of services performed by RNs
    - Violations of the Stark law through financial incentives to staff physicians, including oncologists and urologists
    - Payment of excessive compensation to neurosurgeons greatly in excess of FMV in violation of Stark law
    - Payment of excessive compensation for medical directorships without legitimate services
    - Other allegations
Questions