Remaining Stark-Compliant with "Practice Losses" and Ancillary Services

White Paper

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Abstract: With the passage of the Affordable Care Act and MACRA, the transition to value-based reimbursement is underway. As such, hospitals and health systems will need to consider various alignment options, such as whether or not to enter into employment agreements with physicians or physician practices. Unfortunately, such employment arrangements typically result in the hospital or health system incurring substantial and continuing losses. This White Paper will examine the reasons for and dangers these losses present, as well as discuss strategies for mitigating losses.

Key Words: billing, employment, physicians, Stark, practice losses, ancillary services, outpatient, off-campus provider-based billing, Balanced Budget Act of 2015, referral, group practice

INTRODUCTION

The Patient Protection and Affordable Care Act of 2009 ("ACA") was enacted with the hope of achieving three goals: "[improve] the individual experience of care, [improve] the health of populations, and [reduce] the per capita costs of care for populations."[1] While many provisions of the law sought to increase access to health insurance, the law also ushered in the era of value-based reimbursement.[2] Instead of compensating providers based on the number of procedures performed (e.g. "volume-based" incentives), value-based reimbursement examines the cost and effectiveness of treatment provided to a patient by his or her physician.

Providing value in health care often means aligning various providers to ensure that a patient's care is integrated. These alignment arrangements, particularly employment arrangements between a health system and a physician or physician practice, often result in the health system contracting with the employed provider at a loss ("practice subsidies"). Practice losses are due to the significant costs incurred by the health system when entering into employment arrangements, such as increased overhead, human resources, billing, legal expenses, as well the employed entity providing care for a more adverse payer mix of patients than was experienced in private practice. However, one of the biggest reasons for significant and continuing practice losses is due to hospitals acquiring medical practices and charging facility fees for ancillary services (also known as split-billing) of the practices, effectively removing that revenue stream from the purchased practice.

While these losses can alarm the hospital or health system executives and administrators, it is important for health system leaders to understand that these losses are not uncommon. Further, hospitals and health systems may reduce these losses by evaluating a hospital's strategic physician-acquisition strategy and tying physician compensation to physician productivity.

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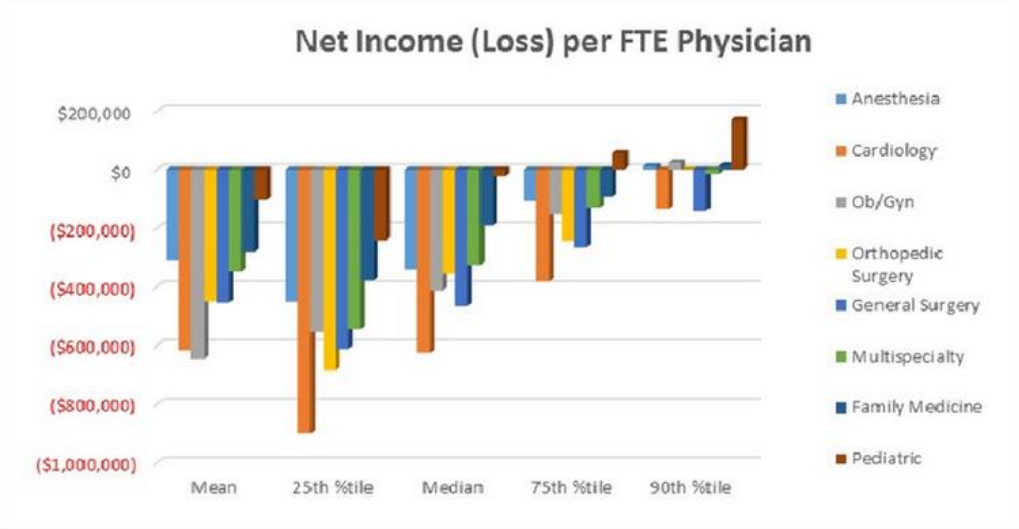
[1] Donald Berwick, Thomas Nola & John Whittington, *The Triple Aim: Care, Health, and Costs,* 27 HEALTH AFF. 760, 760 (2008).
[2] The details of the value-based payment reforms are beyond the scope of this White Paper.

PHYSICIAN ALIGNMENT CAUSES PRACTICE LOSSES

ADVERSE ECONOMIC CONDITIONS EXPERIENCED IN HOSPITAL EMPLOYMENT

Since the passage of the ACA, hospitals have been purchasing, acquiring, and employing physician practices as part of their integration strategy.[3] Some hospitals also hope that "by acquiring practices, especially in specialties that drive hospital admissions, hospital beds will remain full during the transition [from fee-for-service reimbursement to value-based reimbursement]."[4] However, this strategy has resulted in substantial and continuing financial losses to the hospital or health system. The economic realities of hospital-based employment almost always lead to the hospital operating the practice at a loss when comparing the expenses paid by the hospital or health system versus the professional net revenue received from the practice. An illustration of the changing economics of a private practice model to a hospital-employed practice model is helpful.



[5]

In a private practice setting, the provider performs medical services to the patient and either bill the patient or submits a claim for reimbursement to the payer. The bill or claim is for the overall charges for the procedure (gross charges). If the provider submits a claim to a payer, the payer will reduce the amount of gross charges by an agreed-upon amount. Because it is exceedingly

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[3] Beth Kutscher, *Making Physicians Pay Off: Hospitals Struggle to Balance Current Costs with Future Benefits of Employing Docs*, MODERN HEALTHCARE, (February 22, 2014), http://www.modernhealthcare.com/article/20140222/MAGAZINE/302229986

[4] *Id.*

[5] Tim Smith, *Mitigating Compliance Risks Posed by Physician Practice Losses,* Ankura Consulting Group, (June 9, 2015), https://ankuraconsultinggroup.com/Blog/html/ts-6-9-15.html

rare for physicians and payers not to have contracts detailing the agreed-upon fee schedules, the approved amounts are stated in the contract between the physician and the payer. The payer will pay a specific amount of the contracted-for charges, and then the provider is left to collect the remainder from the patient, excluding the contractual losses.[6] After the private practice pays operating expenses, such as occupancy, employment taxes, and malpractice insurance expenses, any remaining revenue is considered to be income for the practice.

However, when a provider joins a hospital or health system, the physician or the acquired practice's bottom line is subject to more adverse economic conditions common to hospital reimbursement. While the hospital or health system may have better contractual rates with the commercial payers, the payer mix in a hospital or health system is typically worse than that experienced in private practice. [7] "The percentage of Medicare charges is approximately the same, but integrated delivery system-owned multispecialty groups have twice the percentage of Medicaid charges, five times the charity care, and 10% less commercial insurance."[8] The adverse payer mix yields less reimbursement than private practice physicians who perform the same amount of work.[9] The new adverse payer mix is due to a private practice being able to control their payer mix, while non-profit hospitals are required to treat every type of patient, regardless of the patient's health insurance plan. Along with an adverse payer mix, hospital billing offices are typically not as efficient as private practice billing offices (due in part to the hospital's payer mix) in collecting outstanding amounts owed by patients. [10, 11] This factor results in less revenue for the employed practice.

Practice losses can also stem from the hospital being required to upgrade its IT infrastructure, "pay comprehensive benefits packages, and assume the costs of maintaining office space, equipment, and staff. The health system may also pay particular practice group overhead

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[6] The amount received from the payer and the patient is known as a provider's net collections.

[7] A provider's payer mix is a percentage breakdown of the amount of patients that are covered by Medicare, Medicaid, commercial insurance, and those patients that are self-pay. Providers typically receive more reimbursement from commercial payers than Medicare, who typically pay more than Medicaid, who typically pay more than self-pay patients.

[8] David Gans, *Why Hospital-Owned Medical Groups Lose Money*, MED. GROUP MGMT. ASS'N 2, (April 2012), available at http://www.mgma.com/Libraries/Assets/Practice%20Resources/Publications/MGMA%20Connexion/2012/Data-Mine-Why-hospital-owned-medical-groups-lose-money---MGMA-Connexion-magazine-April-2012.pdf

[9] *Id.*

[10] "A recent study found that hospitals collect from only 35 percent of patients at the point of service which represents just 19.8 percent of patient-owed fees." *Maximize patient collections at the point of service*, AVAILITY, (last accessed August 12, 2016), https://www.availity.com/business-challenges/hospitals-and-health-systems/improving-patient-collections.

[11] The average collections recovery rate for hospitals is 15.3% while the average rate for non-hospitals is 21.8%. *Healthcare Collection Statistics*, ACA INT'L, (last accessed August 12, 2016), http://www.acainternational.org/products-healthcare-collection-statistics-5434.aspx.

expenses such as HR, legal services, and accounting."[12] Additionally, the market may dictate that certain physicians receive a higher amount of compensation than other physicians. "A study by the American Hospital Association projects a shortage of 56,000 Primary Care physicians and 7,000 Orthopedic Surgeons by 2015. Shortages in these specialties have resulted in higher salaries paid by hospitals than these doctors can make in private practice."[13]

As stated above, hospitals and health systems are forced to offer lucrative benefit and compensation packages to recruit high-quality physicians. First, many benefit packages allow for six weeks of vacation and ten days of continuing medical education seminars. Such benefit packages typically do not exist in private practice. Second, the median salary is usually higher in an employment setting than in a private practice setting. For example, the average amount of compensation for a primary care physician (excluding obstetricians) in a physician-owned practice is approximate $215,000 per year according to the 2015 MGMA physician compensation report.[14] Conversely, the average salary for a hospital-owned practice is approximate $226,000.[15] The salaries only increase for rural hospitals since those hospitals usually must offer higher salaries to recruit physicians to practice in rural areas.[16] Failure to provide these salaries and benefit packages could result in the hospital failing to provide a particular service line to the community, due to that hospital failing to recruit physicians that offer that line of care. This failure then negatively impacts the ability of the hospital to provide value to its patients.

Ancillary Services

Similarly, changes in hospital financial reporting make it appear that the practice is losing money when compared with how the practice performed before the acquisition. For example, when employed by a hospital, a provider's "ancillary revenues for services (e.g., lab tests) that previously were billed by the practice are billed through the hospital. This is primarily because the hospital may bill the services at the higher HOPD rates. All that remains for the practice is to charge and collect on the E/M codes, therefore making it appear as if the practice incurred losses on those procedures. The result is lower income for the practice, making the practice to seem to perform worse than it had historically performed."[17]

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[12] David Miller, *Can you Explain Practice Losses to Your Board?*, Healthcare Strategy Group, (last accessed August 12, 2016), http://www.healthcarestrategygroup.com/thought-leadership/articles/can-explain-practice-losses-board/

[13] *Id.*

[14] Medical Group Management Association, *2015 Provider Compensation Survey*, Med. Group Mgmt. Ass'n, (last accessed August 16, 2016), https://www.mgma.com/my-account/my-dashboard.

[15] *Id.*

[16] Susan Morse, *How Much Money do Doctors Make? Way More in Rural Areas, Report Says*, Healthcare Fin., (Jan. 30, 2015), http://www.healthcarefinancenews.com/news/how-much-money-do-doctors-make-way-more-rural-areas-report-says.

[17] Luke Sullivan and Conor McCaw, *Evaluating Reasons for Physician Practice Losses*, Healthcare Fin. Mgmt. Ass'n, (Monday, December 8, 2014), http://www.hfma.org/Content.aspx?id=26345

However, this begs the question: Why can't the practice refer all ancillary services to a hospital-owned organization, or why can't the ancillary service revenues be shared with the employed physicians? Because a financial relationship exists between the hospital and the employed physician, Stark controls what type of referrals are made to the hospital as well as any other entity with which the physician has a financial relationship.

Stark's[18] in-office ancillary services states that in-office ancillary services may be performed by (1) a member of the physician's group practice or a member of the physician's staff in (a) "a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians' services, or (b) in another building which is used by the group practice for the provision of some or all of the group's clinical laboratory services or for the centralized delivery of the group's designated health services[19] (other than clinical laboratory services."[20] The takeaway from the in-office ancillary services exception is that the employed practice must be considered a group practice[21] under Stark. If the above requirements are not met, then the employed entity cannot perform the in-office ancillary services.

It is important to note that for referrals[22] for CT scans, PET scans, and MRIs, the referring physician must (1) give the patient a written disclosure of other providers that provide similar services at the time the referral is made; (2) include within the disclosure five alternative providers of the service being referred that are located within a 25-mile radius of the referring provider's office; and (3) document the disclosure process that was given at the time of the

[18] *See "Stark Requirements," infra*.

[19] Stark defines designated health services as "clinical laboratory services, physical therapy services, occupational therapy services; radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devises and supplies; home health services; outpatient prescription drugs; inpatient and outpatient hospital services; outpatient speech-language pathology services." 42 U.S.C.S. § 1395nn(h)(6) (LEXIS current through P.L. 114-219).

[20] § 1395nn(b)(1-2) (LEXIS).

[21] "The term 'group practice' means a group of two or more physicians legally organized as a partnership, professional corporation, foundation, not for profit corporation, faculty practice plan or similar association [subject to various requirements]. § 1395nn(h)(4) (LEXIS).

[22] Stark exempts certain services from being designated as a referral. "A request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, a request by a radiologist for diagnostic radiology services, and a request by a radiation oncologist for radiation therapy, if such services are furnished by (or under the supervision of) such pathologist, radiologist, or radiation oncologist pursuant to a consultation requested by another physician does not constitute a "referral" by a "referring physician." § 1395nn(h)(5) (LEXIS).

referral.[23] It is critical to determine whether a referral has been made for this requirement to apply. "For example, the disclosure requirement does not apply where a radiation oncologist is requesting radiation therapy or ancillary services necessary for, and integral to, the provision of radiation therapy."[24]

Provider-Based Off-Campus Hospital Billing

Further compounding practice losses was the passage of the Bipartisan Budget Act of 2015, which lowered the amount of reimbursement that a hospital could bill for certain outpatient procedures. On November 2, 2015, President Obama signed into law the Bipartisan Budget Act of 2015 (BBA), which significantly changes how Medicare pays for outpatient services furnished at particular hospital locations. This legislation institutes a "site-neutral" payment policy for new off-campus provider-based hospital outpatient locations established on or after November 2, 2015. [25]

Before the BBA, Medicare paid more for outpatient services furnished by hospital provider-based outpatient departments, regardless of location, than in a freestanding physician practice or ambulatory surgical center. The increased reimbursement was due to the hospital's ability to bill for a facility fee under the Outpatient Prospective Payment System (OPPS).[26] Effective January 1, 2017, the BBA will change this paradigm for off-campus hospital provider-based outpatient facilities established on or after November 2, 2015. Rather than be reimbursed under OPPS, the appropriate facility will be reimbursed either under the Physician Fee Schedule (PPS) or the Ambulatory Surgical Center Payment System (APC), whichever is appropriate.[27]

The BBA defines an off-campus outpatient department of a provider as "a department of a provider as (1) defined in section 413.65(a)(2) of such provider; or (2) within the distance (described in such definition of campus) from a remote location of a hospital facility (as defined in such section 413.65(a)(2))."

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[23] *CMS Issues Final Rule on Changes to Stark In-Office Ancillary Services Exception*, McGuireWoods, (December 1, 2010), https://www.mcguirewoods.com/Client-Resources/Alerts/2010/12/CMS-Issues-Final-Rule-on-Changes-to-Stark-In-Office-Ancillary-Services-Exception.aspx

[24] *Id.*

[25] Richard Church, Darlene Davis and Ryan Severson, *New Law Excludes Provider-Based Off-Campus Outpatient Hospital Locations from OPPS*, K&L Gates, (July 27, 2016), http://www.klgates.com/new-law-excludes-new-provider-based-off-campus-outpatient-hospital-locations-from-opps-12-08-2015/.

[26] The Physician Fee Schedule and Ambulatory Surgical Center Payment System facility component was generally less than OPPS facility fee. *Id.*

[27] *Id.*

CMS regulations define campus as the "physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings, but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus."[28] Further, CMS defines a remote location of a hospital as "a facility or organization that is either created by, or acquired by, a hospital that is the main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider."[29] Remote locations include the specific physical facility and the personnel and equipment needed to deliver the services at that facility.[30]

This definition means that "hospital outpatient departments within 250 yards of the hospital's main buildings or a remote location of a hospital (i.e. on campus) would continue to be paid under the OPPS." [31] Relevant off-campus hospital-based departments beyond 250 yards would fall under the requirements of BBA. This payment reduction will apply to "most provider-based clinics, physician offices, and ambulatory surgical centers located within a 35-mile radius of the main hospital."[32]

The BBA does not apply to dedicated emergency departments, outpatient departments created before November 2, 2015, or other provider-based entities such as rural health clinics.[33] Because the change takes effect January 1, 2017, provider-based off-campus outpatient facilities will continue to be paid under the OPPS until December 31, 2016.[34] The analysis above demonstrates that "practice losses" are not out of the ordinary; however, if the losses become excessive, one could be investigated by the Department of Justice for violating the Physician Self-Referral Law ("Stark").

[28] 42 C.F.R. § 413.65(a)(2) (2016).
[29] *Id.*
[30] *Id.*
[31] Bipartisan Budget Act of 2015, 114 P.L. 74, § 603 (codified as amended at 42 U.S.C. § 1395l(t) (2012)); 42 C.F.R. § 489.24(b) (2016); Church, *supra* note 25.
[32] Laura Nelso and Sara Noel, *Reimbursement Change for Off-Campus Provider-Based Clinics, Physician Offices, and Ambulatory Surgical Centers*, Stinson Leonard Street, (July 27, 2016), https://www.stinson.com/Resources/Alerts/2015_Alerts/Reimbursement_Change_for_Off-Campus_Provider-Based_Clinics,_Physician_Offices,_and_Ambulatory_Surgical_Centers.aspx.
[33] Church, *supra* note 25.
[34] Nelso, *supra* note 32.

ALARMING STARK SETTLEMENTS RESULTING FROM "PRACTICE LOSSES"

STARK REQUIREMENTS

The Stark Law states if "a physician [who] has a financial relationship with an entity specified in paragraph (2), then the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made…and the entity may not present or cause to be presented a claim…or bill to any individual, third-party payor, or other entity for designated health services furnished under a referral prohibited under subparagraph (A)."[35] A financial relationship is "a compensation arrangement…between the physician (or an immediate family member of such physician and the entity)."[36]

Because nearly every healthcare-related financial arrangement potentially violates the Stark Law (*e.g.,* employment arrangements between hospitals and physicians), Congress enacted many exceptions to the Stark Law including one for bona fide employment relationships. This exception provides:

> (2) Bona fide employment relationships. Any amount paid by an employer to a physician (or an immediate family member of such physician) who has a bona fide employment relationship with the employer for the provision of services if--
>
> (A) the employment is for identifiable services,
> (B) the amount of the remuneration under the employment--
> (i) *is consistent with the fair market value of the services*, and
> (ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician,
> (C) the remuneration is provided pursuant to an agreement which would be *commercially reasonable* even if no referrals were made to the employer, and
> (D) the employment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.
> Subparagraph (B)(ii) shall not prohibit the payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or an immediate family member of such physician).[37]

Regarding the commercial reasonableness requirement of a compensation arrangement, CMS believes an agreement to be commercially reasonable if "in the absence of referrals [the arrangement was] entered into by a reasonable entity of similar type and size and a reasonable

[35] 42 U.S.C.S. § 1395nn(a)(1)(a-b) (LEXIS current through P.L. 114-195).
[36] §1395nn(a)(2)(B) (LEXIS).
[37] § 1395nn(e)(1)(2) (LEXIS) (emphasis added).

physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS (Designated Health Services) referrals."[38] This guidance makes it clear that the hospital or health system must analyze the entire arrangement and not simply any one part of the agreement in isolation.[39] Because guidance on how to determine commercial reasonableness is relatively sparse, the U.S. government typically relies on expert witnesses to determine whether to prosecute a hospital based upon the commercial reasonableness of the agreement.[40]

In determining the commercial reasonableness of a particular transaction, it is helpful to consider a number of factors: (1) whether the services provided by the physician or practice group is essential to the many goals and strategies of the hospital or health system; (2) whether the "arrangement makes rational sense from a general business perspective;" (3) whether the proposed arrangement will develop a service line of the hospital or health system; and (4) whether there will be a duplication in another service line provided by the hospital or health system.[41]

Practice Losses as the Basis for Stark Violations

Many private citizens, as well as government officials, are pursuing alleged Stark violations based upon the "practice losses" theory. The reasoning behind this approach is relatively straightforward: it makes little economic sense to employ a provider whose expenses and compensation exceed his or her net professional services collections.[42] Therefore, since there must be another reason for employing the provider, the hospital or health system must be employing the provider for its anticipated volume or value of referrals – an alleged arrangement

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[38] Medicare Program; Physicians' Referrals to Health Entities With Which They Have Financial Relationships (Phase II); Interim Final Rule, Fed. Reg. 16093 (March 26, 2004) (to be codified at 42 C.F.R. 411 and 424).

[39] *Analysis of the Interconnectivity between Fair Market Value and Commercial Reasonableness*, Elliot Davis Decosimo 3, (last accessed August 12, 2016), available at http://www.elliottdavis.com/assets/Analysis-of-the-Interconnectivity-between-Fair-Market-Value-and-Commercial-Reasonableness.pdf

[40] "As a result, under the Stark Law, the factors to take into account to determine commercial reasonableness and FMV (fair market value) are likely to be ultimately established by the government's expert witnesses' reports in FCA (False Claims Act) litigation (where the government is seeking treble damages and substantial civil penalties) rather than by notice and comment rulemaking by the specialized agency charged with developing the regulations." Robert Salcido, *Minimizing Exposure to Stark Law Liability in False Claims Act Cases by Isolating Those Who Determine Fair Market Value from Those Who Measure Contribution Margin or Other Similar Operational Data*, Akin Group 3, (October 28, 2015), available at https://www.akingump.com/images/content/3/8/v2/38744/The-Salcido-Report-Minimizing-Exposure-to-Stark-Law-Liability.pdf

[41] *Analysis of the Interconnectivity between Fair Market Value and Commercial Reasonableness*, *supra* note 39, at 2-3.

[42] *Why Providers Must Address the Practice Losses Argument During Fraud and Abuse Legal Proceedings*, Advisory Board, (10:22 AM – December 11, 2015), https://www.advisory.com/daily-briefing/2015/12/11/why-providers-must-address-the-practice-losses-argument

that is prohibited by Stark.[43] This theory was alleged in *United States ex rel. Drakeford v. Tuomey*, 792 F.3d 364 (4th. Cir. 2015).

Tuomey was a non-profit hospital in a rural and underserved area in South Carolina.[44] In 2000, after experiencing losses from physicians performing outpatient surgical procedures at offsite locations instead of at the hospital, Tuomey negotiated part-time employment agreements with various doctors.[45] During the negotiations, Tuomey sought numerous opinions from valuation experts regarding whether the arrangements violated Stark.[46] The terms of the arrangements consisted of a guaranteed portion of the salary as well as the physicians receiving a large productivity bonus based upon the physicians' previous year's collections.[47] Tuomey also paid the physicians' billing and collection costs, malpractice insurance, and the physicians' share of employment taxes.[48] Dr. Drakeford, who brought the initial *qui tam* suit against Tuomey, rejected Tuomey's employment offer, claiming that the agreements violated Stark due to the group's compensation exceeding their net collections.[49] The jury found that Tuomey's employment contracts only violated Stark and not the False Claims Act, and the trial court ordered Tuomey to pay approximately $39 million in damages to the U.S. government.[50] Believing Tuomey had also violated the False Claims Act as well as the Stark Law, the government appealed the jury's verdict.

The 4th Circuit panel found that "Stark's volume or value standard can be implicated when aggregate compensation varies with the volume or value of referrals or otherwise takes into account the volume or value of referrals."[51] Because the physician's base salary is adjusted each year depending upon the previous year's collections, and because the employed physicians received a vast majority of their salary by way of a productivity bonus, the court found that the employment arrangement unlawfully factored in the volume and value of the employed physicians' referrals.[52] Because of this, the court found that Tuomey's compensation arrangements violated Stark and the False Claims Act, and ordered Tuomey to pay $237,454,195 to the government for its unlawful employment agreement.[53]

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[43] *Id.*
[44] *U.S. ex rel. Drakeford v. Tuomey*, 792 F.3d 364, 370 (4th. Cir. 2015).
[45] *Id.* at 370-371.
[46] *Id.*
[47] *Id.*
[48] *Id.*
[49] *Id.*
[50] *Id.* at 373.
[51] *Id.* at 379, *citing* 42 C.F.R. § 411.354(c)(2)(ii).
[52] "In sum, the more procedures the physicians performed at the hospital, the more facility fees Tuomey collected, and the more compensation the physicians received in the form of increased base salaries and productivity bonuses." *Drakeford, supra* note 44.
[53] *Id.* at 389.

As stated earlier, in his *qui tam* suit, Dr. Drakeford alleged the physician compensation arrangements were commercially unreasonable due to the physicians' compensation exceeding the group's net collections. While Drakeford asserted this claim, the Department of Justice used an expert witness at trial to advocate that "practice losses" can be a basis for determining that a compensation arrangement is commercially unreasonable.[54] Specifically, during the second trial, the Department of Justice's ("DOJ") expert witness, Ms. McNamara, testified to the following:

> A. [Referring to Plaintiff's Exhibit 576] This is the amount of money Tuomey is losing on these practices from the beginning of the contract starting in 2005. So through 2005 and 2008 they lost $4.4 million on these financial arrangements. And if you project that out to the term of the contract for those ten years, they would lose approximately $14 million. And the way the financial – the way that this is modeled, the compensation model is set up, they can never, ever make any money on these contracts. They will always lose money every single year for all ten years.
>
> Q. How did that information impact your opinions on commercial reasonableness?
>
> A. It was just one of the issues that I took into account when evaluating my commercial reasonableness. Are they protecting the financial interests of the hospital by entering into these arrangements? That – these material losses along with some other issues I had made me determine that the arrangements were not commercially reasonable.[55]

Further, Ms. McNamara stated:

> A. [Regarding Plaintiff's Exhibit 577 which demonstrated the financial impact of the employment arrangements] So mathematically, no matter how efficient Tuomey was at managing the physician practices they would never, ever be able to make money. And on the average, it averaged anywhere from 171 percent to 231 percent of collections. So, again, absent those referrals one would have to question why a hospital would enter into this type of arrangement.[56]

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[54] Michael Peregrine, *The 'Practice Losses' Theory as an Enterprise Risk*, BNA INSIGHTS, 19 HFRA 924, (July 10, 2016). Transcript of Record at 975-81, *U.S. ex rel. Drakeford v. Tuomey Healthcare Sys., Inc*., No. 3:05-CV-02858-MJP (D.S.C.); David Pursell, *Commercial Reasonableness: The New Target*, J. OF HEALTH CARE COMPLIANCE 74, (March – April 2011); T. Reed Stephens and Tony Maida, *A Post-Tuomey Future: Huge Stark Law Hospital Settlements*, LAW360, (October 7, 2015).

[55] Transcript for April 23, 2013 at 1155-1156, *U.S. ex rel. Drakeford v. Tuomey,* 976 F. Supp. 2d 776 (D. S.C. 2013), *aff'd,* 792 F.3d 364 (4th. Cir. 2015).

[56] *Id*. at 1159.

When cross-examined regarding what Ms. McNamara considers to be a commercially unreasonable compensation arrangement, she stated:

> Q. Well, so then I understand that the compensation agreements do not have to be structured such that the hospital is guaranteed to make a profit to be considered commercially reasonable?
>
> A. I believe that if a compensation arrangement is structured that the hospital is guaranteed to lose money then given the particular – in this case given these particular facts and circumstances I would say is not commercially reasonable. Now there are situations whereby the hospital owns and operates a free clinic, obviously, they need to enter an arrangement with the physician, and that's pretty much guaranteed to lose money. So there are different circumstances, where, yes, it's okay for a hospital to lose money on their physician practice, that's why each one is evaluated separately.[57]

While the *Tuomey* court did not affirm the jury's verdict by the "practice losses" theory, one federal court has given credence to the theory. In *United States v. ex rel. Parikh v. Citizens Medical Center,* 977 F. Supp. 2d 654 (S.D. Tex. 2013), Drs. Dakshesh Parikh, Harish Chandna, and Ajay Gaalla alleged that Citizens Medical Center violated the Stark and Anti-Kickback Statute (and consequently, the False Claims Act) by "implementing bonus and fee-sharing programs for emergency room physicians working at the hospital who referred patients for cardiology treatment at Citizens, employing cardiologists at above-market salaries and providing them discounted office space, and demanding that Relators refer all their surgical patients to the hospital's exclusive cardiac surgeon, Dr. Yusuke Yahagi."[58]

In denying Citizens' request to dismiss a particular Anti-Kickback Statute allegation, the court stated, "Even if the cardiologists were making less than the national median salary for their profession, the claims that they began making substantially more money once Citizens employed them is sufficient to allow an inference that they were receiving improper remuneration. *This inference is particularly strong given that it would make little apparent economic sense for Citizens to employ the cardiologists at a loss unless it were doing so for some ulterior motive—a motive Relators identify as a desire to induce referrals* [emphasis added]."[59]

After *Tuomey*, there was an increase in the *qui tam* suits alleging Stark violations based primarily on the "practice losses" theory. On September 4, 2015, Columbus Regional Medical Center entered into a settlement agreement where they agreed to pay $35 million regarding various

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[57] Transcript for April 24, 2013 at 1220-1221, *U.S. ex rel. Drakeford v. Tuomey*, 976 F. Supp. 2d 776 (D. S.C. 2013), *aff'd*, 792 F.3d 364 (4th Cir. 2015).
[58] *U.S. ex rel. Parikh v. Citizens Medical Center,* 977 F.Supp.2d 654, 660 (S.D. Tex. 2013).
[59] *Id.* at 671.

Stark and False Claim Act allegations.[60] The *qui tam* relator in this matter filed two complaints. In his first *qui tam* complaint, the Relator's primary assertion was that Columbus up-coded its claims.[61] The government did not intervene in the Relator's first complaint.[62] The Relator then filed a second *qui tam* complaint in which he alleged that Columbus's physician compensation agreements were neither commercially reasonable nor were they of fair market value due to the employed physicians' compensation exceeding its net collections.[63] The government intervened in this matter, and instead of suffering a fate similar to Tuomey, Columbus opted to settle the case for $35 million.[64]

Another settlement that involved the "practice losses" theory was that of North Broward Hospital District. In this matter, "the relator alleged that the compensation was [in] excess of fair market value and was commercially unreasonable because it was over the 90th percentile of total cash compensation as published in physician compensation surveys and generated substantial practice losses for Broward."[65] It is unclear from the settlement agreement on exactly which allegations the DOJ's violations were based; however, as stated above, the DOJ has in the past argued that the presence of practice losses indicates that a compensation arrangement is commercially unreasonable.[66] Similar to Columbus Regional Medical Center, the risk presented by Stark and the False Claims Act was too high to proceed to trial, and on September 11, 2015, Broward opted to settle the allegations for $69.5 million.[67]

Finally, in the largest settlement in healthcare fraud litigation history, on September 21, 2015, Adventist Health System "agreed to pay $118.7 million to resolve allegations that it violated the False Claims Act by submitting claims in violation of the Stark Law and by miscoding claims."[68] Two complaints were filed by *qui tam* relators alleging numerous Stark violations, including that "compensation paid to physicians and non-physician practitioners was above fair market value,

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[60] Tony Maida, *Huge Stark Law Hospital Settlements and Physician Culpability – The New Normal Post-Tuomey*, McDermott Will & Emery, (September 25, 2015), https://www.mwe.com/en/thought-leadership/publications/2015/09/huge-stark

[61] *Id.*

[62] *Id.*

[63] *Id.*

[64] *Id.*

[65] The *qui tam* relator made other allegations such as stating that the arrangement would only be self-sustaining if one took into account the hospital facility fees, and that "Broward pressured physicians to limit charity care, even though Broward is a public entity." *Id.*

[66] *Id.*

[67] *Id.*

[68] Linda Baumann and Samula Cohen, *Stark Law is Coming: Adventist Health System Pays $118.7 Million in Third Large September Settlement,* Health Care Counsel, (October 2, 2015), http://healthcarecounselblog.com/articles/stark-law-coming-adventist-health-system-pays-1187-million-third-large-september-settlement

as evidenced by consistent physician practice losses."[69, 70] The Department of Justice indicated its intention to continue prosecuting providers based upon the "practice losses" theory by stating:

> Would-be violators should take notice that my office will use the False Claims Act to prevent and pursue health care providers that threaten the integrity of our healthcare system and waste taxpayer dollars. Companies that financially reward physicians in exchange for patient referrals – as the government contended in this case [Adventist Health System] – undermine the physicians' impartial medical judgment at the expense of patients and taxpayers, said Special Agent in Charge Derrick L. Jackson of the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) in Atlanta. We will continue to investigate such wasteful business arrangements.[71]

RECOMMENDATIONS TO REDUCE "PRACTICE LOSSES"

As is demonstrated above, it is not out of the ordinary for an employed practice to have substantial and continuing practice losses as a result of the changing economics from that experienced in private practice to that encountered in a hospital setting. However, hospitals and health systems should consider not charging the increased hospital technical fees, and allow the practice to charge their lower technical fee, in regards to performed in-office ancillary services. While this will result in less revenue for the hospital, this might be a good idea for two reasons.

First, while the Affordable Care Act expanded the number of insured individuals, the plans that resulted from the ACA are mostly high-deductible plans. Therefore, patients will be paying more and more healthcare costs out of their own pockets instead of relying on health insurers to pay said expenses. Therefore, charging the higher technical fee could result in negative publicity from patients as they realize a lower fee could have been charged had the hospital desired. Further, and perhaps more importantly, as is demonstrated above, relators and government officials are taking a closer look at practices that sustain significant practice losses. Hospitals

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[69] *Id.*

[70] "The Adventist hospitals kept careful track of the value of the referrals the physician employees made to the hospitals, according to the complaint. Losses suffered by the hospitals were due in large part to overcompensation of physicians, the complaint said. For instance, one doctor at Park Ridge was marked in Adventist financial records as a "recurring issue" because he needed to bring in approximately $70,000 per month in billings for the hospital to break even on the compensation Adventist paid him, but he was bringing in only about $57,000 per month." *Adventist Health System's 118.7 million settlement stated with Phillips & Cohen's whistleblower lawsuit,* PHILLIPS & COHEN, LLP, (September 21, 2015), http://www.phillipsandcohen.com/2015/Adventist-Health-System-s-118-7-million-settlement-started-with-Phillips-Cohen-s-whistleblower-lawsuit.shtml.

[71] *Adventist Health System Agrees to Pay $115 Million to Settle False Claims Act Allegations,* U.S. DEPT. JUST., (September 21, 2015), https://www.justice.gov/opa/pr/adventist-health-system-agrees-pay-115-million-settle-false-claims-act-allegations

have settled for tens, if not hundreds of millions of dollars primarily due to the presence of substantial and continuing practice losses, and hospitals and health systems would be advised to take what measures they can to reduce and contain these losses with the intent of remaining compliant with Stark.

SUMMARY/CONCLUSION

The ACA and MACRA furthered the transition to value-based reimbursement. As a result, many organizations will need to consider various alignment strategies to take advantage of the value-based payment reforms. As a result of aligning, particularly when aligning through employment arrangements with hospitals and health systems, many hospitals or health systems sustain practice losses. This is due to a number of reasons, including encountering a more adverse payer in a hospital setting, needing to pay more competitive salaries to employed providers, and the treatment of ancillary services by the hospital or health system.

However, hospitals and health systems should be aware that the presence of significant and continuing "practice losses" have resulted in large settlements to resolve allegations that compensation arrangements violate Stark due to the arrangements allegedly being commercially unreasonable. To the extent allowable, hospitals and health systems should allow employed physicians and practices to perform in-office ancillary services, as it will reduce practice losses as well as generate positive publicity with patients due to most patients having high deductible health plans.