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Report on Medicare Compliance Volume 31, Number 11. March 28, 2022

A Brief Summary of Top Risks in Hospital-Physician Transactions

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Here's a rundown of the top risks in health care relationships, according to Shannon Sumner and Carol Carden, principals in PYA.[1] Contact Sumner at ssumner@pyapc.com and Carden at ccarden@pyapc.com.

10 Common Healthcare Compliance Concerns Related to Hospital/Physician Transactions

1 Healthcare Real Estate	*Office space, ambulatory surgery centers (ASCs), timeshares, etc.* Common concerns and challenges include: • Hospital leases space to physicians at below fair market value (FMV) rates, or not under commercially reasonable (CR) terms (e.g., month-to-month lease term when there is sufficient demand for space under a long-term lease). • Hospital leases space from physicians at above FMV rates or not under CR terms (e.g., 40-year lease term, but not a master lease). • Terms are long-term in nature, so transactions are not easily discoverable. • Different company names representing real estate LLCs are often utilized, as it is rare for physician practices to own real estate within the practice corporation.

2 Collections-Based Compensation Formula	*Any compensation formula that pays physicians under a methodology based all, or in part, on collections (e.g., physicians under employment or professional services arrangements [PSAs]) can be prone to error.* *Formulas based upon work relative value units (wRVUs) are commonplace but should be based on "personally performed wRVUs." In other words, formulas generally should not include wRVUs from nurse practitioners, physician assistants, or other non-MDs, particularly if the physicians are not financially responsible for the mid-level providers' costs. Applicable regulatory guidance includes Stark Law, Anti-Kickback Statute, IRS requirements.* Common concerns and challenges include: • Compensation per wRVU exceeds industry benchmarks by an excessive amount and is not supported by high-commercial population percentage or other external factors. • Absent valid environmental reasons, high compensation to physicians may result in steep penalties for physician practices. • Lack of reasonable correlation of physician productivity to related compensation (e.g., absent other environmental factors such as excessive call coverage, physician is paid at 90th percentile for their specialty but produces wRVUs at the 25th percentile). • Lack of governance approval/oversight for highly compensated physicians.
3 Administrative Compensation for Physicians/Physician Practices	*Medical directorships, consulting agreements, advisory committees, etc.* Common concerns and challenges include: • Work is either not performed or requires far less time than physician compensation payment suggests (e.g., medical director is paid a stipend for 20 hours per month, but is only working 5 hours per month routinely). • Payments are made without supporting timecards or other documentation, such as work product or deliverables, to substantiate administrative duties. • Services are not CR (e.g., two medical directors in the same system are compensated for the same development of clinical protocol).
4 Purchase Price of Entities Acquired From Physicians	*Physician practices, ASCs, imaging centers, buildings.* Common concerns and challenges include: • Purchase price exceeds FMV (e.g., the Department of Justice prosecuted a case where buy-in was higher than buy-out because the purchaser deliberately utilized different variables). • Payment for intangible value (e.g., the value above fixed assets and other tangible assets)—often referred to as "goodwill." Goodwill accounting definition: Goodwill is the difference between the FMV of the entity acquired in total, minus the FMV of the identifiable tangible and intangible assets acquired.

5 Call Coverage	*Restricted versus unrestricted call coverage, medical staff by-law requirements, call pay for employed physicians, etc.* Common concerns and challenges include: • Significant call coverage payments are made to specialists who are infrequently called into the emergency room (ER) (e.g., ear, nose, throat specialist [non-trauma]; oncologist). • Payments exceeding industry benchmarks are made for calls on a per-day basis.
6 Compensation "Stacking"	*Individual compensation elements, as well as the totality of the compensation package, should be consistent with FMV.* Common concerns and challenges include: • Physician receives payment for employment, call coverage, and medical directorships, all of which are FMV independently but, when stacked together, exceed FMV or are not CR (e.g., in order for all services to be rendered, the physician is required to routinely work 3,500 hours per year).
7 Disproportionate Share (DSH) Strategies	*Extra hospital reimbursement from federal and some state programs if providing a disproportionate share of medical services to indigent patients.* *Hospitals, including Medicaid hospitals with nearly the required ratio, may pursue acquisition strategies for obtaining clinics or other healthcare access points with a high Medicaid indigent population in order to ensure continued qualification for DSH payments.* Common concerns and challenges include: • At times, these acquisitions are above FMV, because they are valuable to a hospital but not to "any willing buyer," which is the FMV standard.
8 Physician Recruitment Agreements/ Income Guarantees	*Hospital recruitment of a physician to a private practice in a community, with the hospital "subsidizing" their practice until the physician is self-sustaining.* *This arrangement often occurs because the community needs the specific type of physician. Regulations stipulate that if the physician is recruited to an existing private practice, only the "incremental expenses" can be covered in the subsidy.* Common concerns and challenges include: • Allocations of historical practice expenses that are fixed in nature (e.g., one receptionist) are shared equally among all physicians, including the newest hire, resulting in a derived benefit by physicians already in the market. The concern is that the private practice can add new physicians and financially benefit themselves at no risk.

9 Hospital-Based Physician Subsidies	*Hospital-based physicians (e.g., anesthesiologist, emergency room physician, radiologist, pathologist) often subsidized by hospitals under the notion that they are required to see all patients regardless of ability to pay.* *Hospitals are required to staff for availability regardless of the number of patients (e.g., each open operating room needs a certified registered nurse anesthetist or anesthesiologist, even if there are no cases).* Common concerns and challenges include: • In these subsidy cases, payment of physician salaries needs to be reasonable (around median), particularly if subsidy is large, so there is no appearance that the subsidy is disguising physician compensation that is in excess of FMV.
10 Ambulatory Surgery Center (ASC) Distribution Methodology	*Distributions to owners in a joint venture that are preferential to physician-owners versus hospital.* Common concerns and challenges include: • Physicians receive distributions disproportionate to their ownership as disguised kickbacks for patient referrals into the ASC or as inpatients for their hospital partners.

Other Issues	• Clinical trials/research.
	  ◦ Physician investigators compensated above FMV for leadership role.
	  ◦ Liberally qualifying patients for trials.
	• Shared savings distribution methodologies.
	• Billing for mid-level providers.
	• Transactions involving cardiology, oncology, or orthopedics due to large volume of inpatient and outpatient activity and "heavy" Medicare payer mix.
	• Lithotripsy transactions with urologists greater than FMV.
	• Outsourced providers of clinical (e.g., wound care, hospitalists) not compliant—either lack of oversight or not FMV—and could compromise patient safety and quality of care.