Health System Practice ‘Losses’ Make Headlines, Plaintiffs Make New Stark ‘Law’

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Health systems routinely employ physicians, either directly or through corporate affiliates. Media reports and anecdotal evidence suggest such practices routinely, perhaps uniformly, result in net practices losses for the system when measured solely based on physician practice revenues.¹

Does this fact have any legal import under the Stark Law?

This article will explain the “practices losses” theory and explore its implications from a legal and policy perspective.

**An Explanation and Exploration of the “Practice Losses” Theory**

The Stark Law does not state in statute or regulation that practice “losses” violate or necessarily result in a violation of the Stark Law.

Further, the United States Department of Health and Human Services, the agency to which Congress delegated authority to interpret, implement and enforce the Stark Law, has never publicly taken the position that practice “losses” violate or cause a health system or hospital to violate the Stark Law.

Indeed, the academic medical center (AMC) exception promulgated by the Centers for Medicare & Medicaid Services (CMS) recognizes the “symbiotic relationship among faculty, medical centers and teaching institutions . . .” and expressly contemplates that teaching hospitals will transfer funds to “subsidize” or cover the “losses” of the physician practices operated by the faculty’s respective medical schools.

While CMS did not believe that faculty physicians “are necessarily less economically-motivated than their private practice counterparts,” it concluded that a comprehensive exception that includes fair market value (FMV) and volume/value standards created adequate safeguards notwithstanding an AMC’s projected “losses” on the physicians’ practices. Nevertheless, relators and some within the Department of Justice (DOJ) suggest that “losses” on physician practices by health system employers are patently suspect, if not outright indicative, of a Stark Law violation.

While the “practice losses” theory is seemingly most relevant in the context of assessing a health system’s compliance with the commercial reasonableness standard, it is also advanced by plaintiffs to challenge the fair market value and volume/value standards.

**Volume/Value Standard and the “Practice Losses” Theory**

A casual observer of an integrated delivery/health system’s projected or tolerated “losses” on physician services might ask the question, “why would the system accept such ‘losses’ but for referrals?” Plaintiffs claim that projected or tolerated practice “losses” means that the compensation is intended to account for the value of the physician’s utilization of its facilities.

The claim that projected or tolerated “losses” must reflect intent to reward the physician for the value of

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3 The authors put “losses” in quotation marks because the loss calculation requires that one indulge the fiction that the physician practice is operated as a standalone practice.


5 Where the physician is directly employed by the hospital, the employment exception includes all three standards. In the case of employment by a hospital affiliate, the definition of an indirect compensation arrangement includes only the volume/value standard, but relators or the DOJ may argue that an arrangement that is not at fair market value or not commercially reasonable “takes into account” the volume/value of the physician’s referrals to the system.

6 Based on the MGMA’s 2014 data, the following specialties report the following compensation-to-collection ratios: cardiology (non-invasive) - 0.947, internal medicine - 0.998, oncology - 1.096, gynecology-oncology - 0.912, orthopaedic surgery-trauma - 1.129, psychiatry-general - 1.206, pulmonary medicine-critical care - 1.217, cardiovascular surgery - 1.303, and neurosurgery - 0.965. Note that these figures do not account for practice expenses other than total cash compensation, such as benefits and fixed overhead expenses.

7 In denying a motion to dismiss claims predicated on alleged violations of the federal anti-kickback statute and the Stark Law, the court in United States of America ex rel. Parikh v. Citizens Medical Center, noted “Relators’ allegations that the cardiologists’ income more than doubled after they joined Citizens, even while their own practices were costing Citizens between $400,000 and $1,000,000 per year in net losses. Even if the cardiologists were making less than the national median salary for their profession, the allegations that they began making substantially more money once they were employed by Citizens is sufficient to allow an inference that they were receiving improper remuneration. This inference is particularly strong given that it would make little apparent 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
the physician’s referrals for hospital services is, we would argue, predicated on the fiction that the integrated delivery/health system is in the physician services business and, thus, the only reason for employing the physicians is to earn income from physician services.

Of course, other health care companies routinely hire physicians with no expectation of anything but costs and expenses, not income. For a managed care risk plan, physician services are a pure cost and expense of being in the health insurance business.

Academic medical centers and research organizations pay physicians for clinical, teaching and research activities that are largely a cost and expense for these organizations.

Physician services are a cost and expense of being in the integrated delivery/health system business, especially as the fee-for-service system is replaced by value-based purchasing, bundled payments, and other innovations.8

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In 2016, for example, Medicare will require that hospitals deliver joint replacements to Medicare beneficiaries on a bundled basis.

In sum, the notion that integrated delivery/health systems that employ physicians are in the physician services business and, thus, must earn income from physician services, presumes a quaint and outmoded paradigm of health care payment and delivery that Medicare, at Congress’ behest, is in the process of upending.

The theory that projected or tolerated practice “losses” can constitute evidence of intent to pay for the volume or value of hospital services is also arguably inconsistent with a statute that was intended to create “bright line” rules and to avoid the federal anti-kickback statute’s search for the actor’s intent and state of mind.

It is true that courts that have considered the question have all held that compensation fails the volume/value standard if the compensation takes into account either the actual volume or value of the physician’s referrals or the anticipated volume or value of the physician’s referrals,8 and there is support for this position in CMS commentary.10

As CMS expressed it, aggregate fixed or flat compensation that does not vary or fluctuate with the volume or value of referrals does nevertheless still fail the volume/value standard if it is above fair market value or otherwise “inflated to reflect” the volume or value of a physician’s referrals.11

Perhaps recognizing the extent to which a determination of whether compensation takes into account anticipated referrals would turn on intent, CMS stated that it would take a case-by-case determination based on the facts and circumstances, as even above-FMV compensation does not necessarily mean that the compensation takes into account the volume/value of anticipated referrals.12

In Singh v. Bradford Regional Medical Center, the court admitted evidence that a valuation consultant used the volume and value of the physicians’ expected referrals as a key factor in the valuator’s determination of the fair market value of the compensation.13 The defendant hospital established fixed payments based on this valuation, evidencing, the court held, that the hospital’s lease payments, while not varying or fluctuating with referrals, were intended to account for the value of the physicians’ anticipated referrals.

Two other courts, however, have concluded that evidence of intent alone is insufficient to show that the compensation took into account the volume/value of anticipated referrals. In Villafane, the plaintiffs alleged that a hospital “subsidized” medical school faculty salaries because of the physicians’ referrals to the hospital,

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8 For other reasons why a health system might treat an employed physician as a cost, apart from referrals, see footnote 16. The authors contend that there are too many reasons why a health system would incur the cost of physician employment, apart from referrals, for the mere fact of “losses,” alone, to support a reasonable inference that the intent of the compensation is to account for the value of referrals.9

9 Singh v. Bradford Regional Medical Center, 752 F. Supp. 2d 602, 621 (W.D. Pa. 2010) (“Relators argue that ‘anticipated referrals’ is a proper basis for a finding that compensation takes into account the value or volume of referrals by citation to the Stark regulations and to the Centers for Medicare and Medicaid Services’ . . . interpretation of the regulations. We agree.”) (14 HFRA 981, 12/11/10); United States ex rel. Dukerford v. Tuomey Healthcare Sys., Inc., 675 F.3d 394, 408 (4th Cir. 2012). (“Our analysis . . . yields the conclusion that compensation arrangements that take into account anticipated referrals do implicate the volume or value standard. . . . It stands to reason that if a hospital provides fixed compensation to a physician that is not based solely on the value of the services that the physician is expected to perform, but also takes into account additional revenue that the hospital anticipates will result from the physician’s referrals, that such compensation by necessity takes into account the value or volume of such referrals.”) (16 HFRA 283, 4/18/12).


11 Id.

12 At least one court has rejected the notion that CMS’s position is that above-FMV compensation necessarily takes into account the volume or value of referrals. Cardiovascular and Thoracic Surgeons, Inc. v. St. Elizabeth Med. Ctr., Inc., No. 1:10-cv-846 (S.D. Ohio, Sept. 11, 2012).

13 Singh, 752 F. Supp. 2d at 621.
and, thus, the faculty school salaries failed the volume/value standard of the Stark academic medical center exception.

The court found no evidence that CMS intended for the volume/value standard to go beyond the face of the compensation arrangement and to require an examination of the parties’ intent, concluding that “where no violation appears on the face of the arrangement, either in the form of above-fair market value compensation or of a provision allowing for increases or decreases in payment based on the number of referrals made, the text and history of the Stark Law’s desire to create a ‘bright-line’ rule would seem to argue against establishing a violation on the basis of intent alone.”

Accordingly, the court held that, since the defendants’ salaries were set at fair market value, and did not vary over the term of the arrangement, the volume/value standard of the academic medical center exception was “easily met.”

The Tuomey court concurred with Villafane on this point, but held that, apart from Tuomey’s intent, a reasonable jury could have found that the compensation Tuomey paid to part-time surgeons and proceduralists “varied with” the volume or value of the physicians’ referrals to Tuomey given the correlation between the physicians’ collections-based compensation and the volume of the physicians’ referrals to Tuomey for outpatient surgeries or procedures.

Accordingly, the court indicated, while the trial court correctly permitted the jury to look outside the four corners of the employment agreement at how the compensation operated in the context of the physicians’ referrals to Tuomey, the jury’s decision was not dependent on evidence of Tuomey’s intent alone.

We would argue that, at least outside of the Bradford court’s jurisdiction, a hospital can reasonably take the position that evidence of practice “losses” projected or tolerated because of hospital margin generated by the physicians is alone insufficient to establish a volume/value defect in its compensation. Query, however, whether a health system can afford to take the risk that plaintiffs prevail in light of the Draconian financial consequences of Stark/FCA liability.

Commercial Reasonableness and the Practice Losses Theory

The “practice losses” theory appears most intuitively compelling when used to challenge a defendant’s satisfaction of the commercial reasonableness standard.

The Stark employment and indirect compensation arrangement exceptions both require that the compensation arrangement be one that would be commercially reasonable even if no “referrals” were made to the employer.


15 Although the Tuomey court was focused on whether the compensation “varied with” the volume or value of the physicians’ referrals and, thus, created an indirect compensation arrangement between Tuomey and physicians employed by affiliated practice entities, it appears that the court would have had little difficulty reaching the conclusion that the compensation “took into account” the volume of referrals as well and thus failed the volume/value standard of the indirect compensation arrangement exception (the ‘ICA exception’).

“Referrals,” however, by legal definition, are limited to referrals for the Stark Law’s Medicare-covered designated health services.

The extent to which hospital employers derive a financial benefit from Medicare (not to mention Medicaid) reimbursement is debatable, but what is not controversial is that FMV compensation to a physician that, coupled with normalized practice overhead expenses, exceeds practice receipts will typically be profitable—and therefore arguably commercially reasonable—considering only hospital margin related to the physician’s utilization of the health system for commercial patients.

Further, the commercial reasonableness standard requires commercial reasonableness in the absence of referrals to the employer.

If a physician-employee with a significant practice “loss” is employed by a hospital affiliate and not the hospital itself, the physician’s FMV compensation arrangement would be commercially reasonable even if the physician made no referrals to the employer considering the physician’s referrals to the health system’s hospital and other facilities (which, in this case, are not the employer).

This strict reading of the regulatory text may seem counter-intuitive or even sophistry to someone who believes practice “losses” should violate the Stark Law, but the Stark Law is a strict-liability payment rule and thus arguably warrants a strict reading of its text in the light of CMS commentary.

Even absent such textual arguments, where the purpose of physician employment is to create an integrated delivery system designed with an eye toward the triple aim and evolving payment structures that contemplate close collaboration between health systems and physicians, employment that generates “losses” may nevertheless be commercially reasonable apart from referrals.

And there are numerous other circumstances when “losses” can be commercially reasonable apart from referrals, for the simple reason that the health system must pay competitive compensation (not fully funded by the physician’s professional clinical receipts) to recruit a physician to meet a mission- or business-related purpose.16 In the current legal environment, however,

16 Examples of such commercially reasonable “losses” include the desire to meet a community need involving a poor payor-mix, the need for certain medical specialties to provide restricted call coverage unsupported by clinical productivity to meet accreditation, certification or other requirements, the de-
close attention to how documentation, financial reporting and internal communications regarding “losses” can be perceived is clearly warranted.

**“Practice Losses” Theory and Health Policy Considerations**

The “practice losses” theory raises two health policy issues. First, as noted above, the theory is predicated on a paradigm of fee-for-service health care payment and delivery that is near-universally judged to be dysfunctional and requiring fundamental restructuring.

The “practice losses” theory depends on viewing physician and hospital services as separate dis-integrated fee-for-service businesses.

If the Medicare program is committed to clinical integration and continuity of care, going so far as to require certain bundled payments in 2016, the tension in simultaneously advancing the “practice losses” theory appears unresolvable.

Second, there is probably no integrated delivery/health system in the country that does not maintain significant practice “losses”; such “losses” appear to be an inescapable consequence of health system-physician employment. FCA settlements on the basis of the “practice losses” theory have the potential to make both health policy and Stark “law” without a serious discussion of whether health system-physician employment advances our nation’s health policy objectives. Whether on a Congressional or agency level or both, a broad-based conversation on these issues outside the context of high-stakes litigation is urgently needed.

\[17\] See footnote 1.