

Fair Market Value and Commercial Reasonableness Primer: Why Is It Important and How to Mitigate Risk

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I. Applicable Laws

The phrase “Fair Market Value” (“FMV”) is often touted amongst healthcare attorneys, but depending on the context it has a specific, defined meaning. Importantly, however, FMV is often the driving factor in identifying whether a particular transaction is compliant with federal (and sometimes state) regulations. It is thus important to understand how the FMV concept relates to these below-listed laws. The following regulations utilize the FMV standard, albeit using slightly different approaches:

a. Stark Law

The Stark Law prohibits a physician (or immediate family member) from referring a Medicare or Medicaid patient to an entity with which s/he has a financial relationship unless the transaction meets one of the enumerated exceptions. (42 CFR § 411.351) The Stark Law is only implicated if the referral is for a particular “designated health service” detailed in the CPT code, as maintained by the Centers for Medicare and Medicaid Services (CMS).

Violations of the Stark Law entail civil penalties and potential exclusion from Medicare and Medicaid. Inappropriate services provided contrary to the Stark Law are considered overpayments. The Stark Law is a strict liability statute – meaning you either meet all elements of an exception, or you do not. Intent is of no matter. Ten Stark Law exceptions contain an FMV requirement. For some exceptions, the standard is that any compensation be “consistent with FMV”, while in others, the requirement is that compensation does not “exceed FMV”.

b. Anti-Kickback Statute

The Anti-Kickback Statute (“AKS”) applies to anyone and prohibits the exchange of anything of value in an effort to induce the referral of business payable by a federal healthcare

program. (42 USC § 1320a-7b). Violations may result in criminal implications in addition to monetary fines, however, intent is a required element to prove a violation. If *one purpose* of a transaction is to compensate for or receive referrals, the single purpose is sufficient to establish a violation. The Anti-Kickback Statute provides several (statutory and regulatory-based) safe harbors; three of them require compensation to be FMV. Although not meeting each element of a safe harbor is not *per se* illegal, the protections provided by that safe harbor can no longer be relied on if the compensation involved is not FMV. Therefore, setting compensation at FMV is crucial to avoid scrutiny under the Anti-Kickback Statute regardless if all elements of a safe harbor can be met.

c. Private Inurement Statute

The Private Inurement Statute outlines that tax-exempt entities cannot provide excess benefits to non-tax-exempt individuals or entities. IRC §501(c)(3). A 501(c)(3) tax-exempt entity that violates the Private Inurement Statute may lose its status under the IRS. An “inurement” is generally defined as unjust enrichment from the entity’s earnings to another party. *See People of God Community v. Commissioner*, 75 T.C. 127 (1980). As such, a violation of this statute can occur when payments are made contrary to fair market value.

d. Foreign Corrupt Practices Act (“FCPA”)

The Foreign Corrupt Practices Act makes it unlawful for certain people or entities to make payments to government officials to obtain or retain business. 15 U.S.C. §§ 78dd-1, et seq. The FCPA has a broad reach as it can apply to illegal conduct anywhere around the globe and applies to public companies and their officers, directors, owners, agents, and employees. During the summer of 2017, the U.S. Department of Justice’s (“DOJ”) Health Care Fraud Unit and FCPA announced a joint effort to more stringently enforce violations of the False Claims Act and FCPA.¹

Although not a novel partnership, these agencies understand that the majority of other nations have government-run health systems, so healthcare companies will undoubtedly deal with public officials when doing business. As such, they must ensure that their employees, directors, and so forth act accordingly – and, for example, avoid any dealings, payments, or transfers of value outside fair market value.

e. Sunshine Laws

The Physician Payment Sunshine Act is a more recent law, as it was established under the Patient Protection and Affordable Care Act (“ACA”).² It requires medical manufacturers and group purchasing organizations to report certain payments, ownership relationships, or transfers of value to physicians in specific scenarios to (primarily) increase transparency of those relationships. Since these relationships and respective payments are disclosed, any not meeting

¹ See, e.g. “Dep’t of Justice: Fraud Section Year in Review 2017”, U.S. DEP’T OF JUSTICE, CRIMINAL DIV., FRAUD SECTION, pg. 5; available at <https://www.justice.gov/criminal-fraud/file/1026996/download>.

² 42 U.S.C. § 1320a-7h.

fair market value may subject the parties to governmental scrutiny and subsequent violations under the Stark Law or Anti-Kickback Statute.

f. State Laws

For example, many states, Texas included, have their own regulations to combat fraud in the healthcare market. Texas has an anti-kickback statute that is referred to as the Texas Patient Solicitation Act (“Texas Act”). *See generally* Tex. Occ. Code § 102.001 et seq. It generally tracks the federal statute although importantly it is “payor indifferent” and therefore applies to all arrangements whether reimbursement is solely cash pay, from a private payor, or governmental payor. Avoiding a violation under this Texas Act can be accomplished by complying with one of the federal safe harbors – many of which include fair market value as an element.

II. Defining Fair Market Value

There are multiple definitions of fair market value.

a. IRS Definition

The IRS defines fair market value as follows:

The price, expressed in terms of cash equivalents, at which a property would change hands between a hypothetical willing and able buyer and a hypothetical willing and able seller, acting at arm’s length in an open and unrestricted market, when neither is under compulsion to buy nor to sell, and when both have reasonable knowledge of the relevant facts. (IRS Rev Ruling 59-60)

Notably, this definition not does refer to any caveats should referrals or business generated exist amongst the parties. Any healthcare entity should strive to meet the FMV definition under the more pertinent healthcare regulations to avoid governmental scrutiny.

a. Anti-Kickback Statute

Unlike the Stark Law, as outlined below, the Anti-Kickback Statute does not explicitly define “FMV” although establishing it is one of the conditions to meet several safe harbors. The OIG has provided some insight on FMV in meeting these safe harbors which tracks the Stark Law definition, and focuses on eliminating any value related to generating referrals.

b. Stark Law

The Stark Law rules define FMV as:

The price that an asset would bring as the result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in a position to generate business for the other party, on the date of the acquisition of the asset or at the time of the service agreement. Usually, the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market at the time of acquisition....where

the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.”(42 C.F.R.§ 411.351).

This has three important concepts – (1) FMV is defined as a price established between *well-informed parties* without a referral relationship; (2) FMV is established on the date of the purchase or service agreement; and, (3) the price is *usually* based on comparable transactions or sales.

The Stark Law statute – which refers to leased-based arrangements- defines FMV as:

the value in arm’s length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee. 42 USC § 1395nn(h)(3).

What is noteworthy here is the focus on the attempt to preclude attributing value to the lease based on referrals between the parties.

Overall, the Stark Law explains that FMV needs to be established based on the facts and conditions of each arrangement.³ FMV can be calculated a variety of ways so long as it is “commercially reasonable” and gives “evidence that the compensation is comparable to what is ordinarily paid for an item or service in the location at issue, by parties in arm’s-length transactions who are not in a position to refer to one another”.⁴

CMS acknowledges that FMV can be established via a range of methodologies, but the underlying factors always include (or should include, if your valuator understands these parameters) (1) geographic location and (2) the nature of the transaction.⁵

III. Commercial Reasonableness

Most Stark Law exceptions requiring FMV also require that the arrangement be commercially reasonable (either implicitly or explicitly).⁶ The same is true for the three Anti-Kickback Statute safe harbors with a FMV requirement.

However, neither the Stark Law nor the Anti-Kickback Statute define “commercial reasonableness”(“CR”). CMS’ initial commentary did relay its perspective on the role and importance of CR, at least as to how it relates to the Stark Law – an arrangement is CR if it is a

³ 72 Fed. Reg. 51015-16 (Sept. 5, 2007).

⁴ 66 Fed. Reg. 944 (Jan. 4, 2001), and 72 Fed. Reg. 51015.

⁵ 69 Fed. Reg. 16107 (March 26, 2004), and 69 F.R. 16107 and 72 Fed. Reg. 51015-16.

⁶ The Stark Law exception for personal services and management agreements does not use the phrase “commercial reasonableness” but does require that “the aggregate services contracted for do not exceed those that are necessary for the legitimate business purposes of the arrangement.” 42 CFR § 411.357(d).

“sensible, prudent arrangement from the perspective of the particular parties involved, even in the absence of any potential referrals.”⁷

In 2004 CMS further clarified its views on the CR requirement, noting that it is intended to be objective, and that an arrangement would make commercial sense if entered into by a reasonable entity of similar type and size and a reasonable physician (or family member or group practice) of similar scope and specialty, even if there were no potential DHS referrals.”⁸

More recently, the DOJ’s proposed jury instruction defined commercial reasonable in the *Halifax* case as:

“An arrangement is ‘commercially reasonable’ if the arrangement would make commercial sense if entered into by a reasonable hospital of similar type and size and a reasonable physician of similar scope and specialty, even if there were not potential referrals.”⁹

Putting these definitions together, the key elements to establishing CR include: (1) a sensible and prudent business arrangement; (2) commercial sense; (3) parties contracting from the perspective of no referrals; and (4) reasonable and necessary services.

Some physician-based examples of arrangements that, although set at FMV, may not be CR include:

- A nursing home contracts several medical directors for the same service line, but there was previously only one medical director;
- A hospital recruits three additional specialized surgeons but has not seen a significant change in the patient population and needed services;
- A hospital establishes a call coverage program and corresponding payment but includes physician specialists that have minimal frequency of being called into the emergency department.

To meet the higher threshold of CR there must be some justification for why the parties are entering into an arrangement. FMV and CR cannot be used interchangeably. An arrangement must meet both the FMV and CR requirements.

In sum:

- For an arrangement to be commercially reasonable, fair market value standards must be met.
- However, an arrangement that is fair market value might not be commercially reasonable.

⁷ 63 Fed. Reg. 1700, Jan. 9, 1998.

⁸ 69 Fed. Reg. 16093, Mar. 26, 2004.

⁹ *United States ex rel. Baklid-Kunz v. Halifax Hospital Medical Center*, No. 6:09-cv- 01002 (M.D. Fla. Feb. 14, 2014) [Dkt. 565-2] at 10.

IV. Enforcement Efforts

The federal government has expressly indicated it wants to increase enforcement of healthcare-related fraud. Attorney General Jeff Sessions has held several press conferences on the efforts including recent crackdowns include false claims filings and violations of the False Claims Act.¹⁰

Governmental agencies have been notifying the public of the importance of FMV for many years now, including in a 2015 Fraud Alert posted by the OIG. The OIG reiterated that hiring physicians for certain services paid for in excess of FMV put not just the hiring entity at risk, but the physician also.¹¹ In that alert, the OIG stated:

Physicians who enter into compensation arrangements such as medical directorships must ensure that those arrangements reflect fair market value for bona fide services the physicians actually provide. Although many compensation arrangements are legitimate, a compensation arrangement may violate the anti-kickback statute if even one purpose of the arrangement is to compensate a physician for his or her past or future referrals of Federal health care program business.

The government also continually disperses listings of enforcement actions against companies and individuals in which the government alleges violations of the Anti-Kickback Statute.¹²

These enforcement efforts not only include increased vigilance, but the potential to increase penalties and pass new legislation.¹³ Hospitals, hospital executives, and physicians are all targets. Therefore, attentiveness and scrutiny of any healthcare-based arrangement to ensure FMV is prudent and necessary to avoid governmental investigations leading to allegations of illegal activity.

V. Recent Case Law

An examination of the federal government's recent enforcement efforts related to FMV over the past decade reveals a pattern of enforcement that can be distilled into a handful of key takeaways which healthcare attorneys in particular should take note of when considering FMV.

Takeaway #1 – Services Must Be Provided

¹⁰ See, e.g., Nicholson, Charles, "Dallas Physician Operator Arrested For Largest Health Care Fraud Scheme in DOJ History", NBC-DFW, Jun. 29, 2018, <https://www.nbcdfw.com/news/local/Dallas-Physician-Operator-Arrested-For-Largest-Health-Care-Fraud-Scheme-in-DOJ-History-486996811.html>.

¹¹ DEP'T OF HEALTH & HUMAN SERVS, OFF. OF INSPECTOR GEN, Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability (Jun. 9, 2015) [https://oig.hhs.gov/compliance/alerts/guidance/Fraud Alert Physician Compensation 06092015.pdf](https://oig.hhs.gov/compliance/alerts/guidance/Fraud%20Alert%20Physician%20Compensation%2006092015.pdf).

¹² See, generally, HHS, OIG, "Latest Enforcement Actions" <https://oig.hhs.gov/>.

¹³ Hedges, Mike, "Attorney General Jeff Sessions Discusses Taking On Medicare Fraud", AARP, Apr. 2018, available at <https://www.aarp.org/money/scams-fraud/info-2018/jeff-sessions-interview.html>.

*United States ex rel. Williams v. Health Management Associates, Inc. (2014)*¹⁴

In *US v. Health Management Associates*, (“HMA”) the federal government alleged that five hospitals in Georgia and South Carolina directly violated federal Anti-Kickback Statute 42 U.S.C. § 1320a-7b¹⁵ when they paid clinics providing prenatal care (the “Clinics”) to refer mothers to their hospitals for delivery and submitted Medicaid claims for deliveries resulting from such referrals, among other allegations.

Ostensibly, the Clinics provided translation and eligibility services to HMA as the patient base in question largely comprised undocumented Hispanic mothers. For such services the Clinics were paid between \$15,000 and \$20,000 per month under a services agreement.¹⁶ The federal government alleged that the services agreement was “designed to conceal the underlying financial motive, which was the purchasing of Clinic referrals by [HMA]”.¹⁷

The federal government’s primary support was that the Clinics did not actually provide all of the services for which it billed HMA. Upon investigation, HMA’s director of nursing services told the government prosecutor that HMA used AT&T Interpreter services, not interpreters from the Clinics, which was also confirmed by e-mails from human resources personnel at HMA.¹⁸

As a result, the federal government asserted claims under the False Claims Act, False Claims civil conspiracy, unjust enrichment, and payment under mistake of fact theories, all supported by the government’s allegation that HMA had an illegal pay-for-referrals deal with the Clinics and submitted claims to Medicaid for services rendered to Clinic patients who were referred to HMA because of the services agreement. As a result, the government also alleged that HMA falsely certified compliance with the Anti-Kickback Statute when it submitted cost reports to Medicare.

The court was unequivocal in its assessment that **these payments included sums for which no actual service was performed, and thus violates the Anti-Kickback statute.**

Takeaway #2 – Do Not Base Pay On Referrals

*United States ex rel. Drakeford, M.D. v. Tuomey (2013)*¹⁹

United States v. Tuomey is among the most notable cases of the last decade involving the Stark Law and has been the subject of much analysis and discussion. While much of the discussion since this decision concerns its application to the False Claims Act and the legal construction of Stark Law, it also provided guidance on the payment of referrals by way of inflated physician compensation.

¹⁴ *United States ex rel. Williams v. Health Mgmt. Assocs. Inc. et al.*, 3:12-cv-151 (M.D. Ga.)

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *United States ex rel. Drakeford v. Tuomey*, 976 F. Supp. 2d 776 (D.S.C. 2013).

Tuomey Healthcare System (“THS”) entered into compensation contracts with nineteen specialist physicians as part-time independent contractors.²⁰ THS agreed to pay each physician an annual base salary that fluctuated based on THS’s net collections for the procedures performed by the physicians, plus a productivity bonus equal to 80 percent of the physicians’ net collections and an incentive bonus that could reach as high as 7 percent of the productivity bonus; these base salary amounts combined with the bonuses resulted in aggregate salaries for the physicians which were 31 percent greater than their net collections for the period in question.²¹ The federal government alleged that these arrangements were designed to vary with the volume or value of referrals as an inducement to the physicians to perform professional services at THS’s ambulatory surgery center as opposed to a competing center; such an arrangement would result in the preservation of technical revenues at THS’s ambulatory surgery center. Per the government, this represented a prohibited financial arrangement between THS and the physicians under the Stark Law.

THS contended in defense that there was no proof that the physician salaries varied with the volume or value of referrals. Instead, THS asserted that the physicians’ compensation was based solely on collections for the physicians’ own professional services and that each physician’s base salary was derived from data regarding historical collections. As such, THS’s position was that the arrangements were permissible indirect compensation arrangements under 42 C.F.R. § 411.357(p).²²

Ultimately, through a variety of evidence including testimony in which THS representatives acknowledged the physicians’ compensation increased with each Medicare procedure performed by the physician and that THS received technical revenues each time in connection with such referral, **the court agreed that base salaries and bonus payments which are based on the volume or value of referrals are direct financial relationships which are impermissible under the Stark Act.**

Takeaway #3 – Arrangement Must Be Reasonable

*United States v. Campbell (2011)*²³

In *US v. Campbell*, the defendant was a cardiologist engaged in his own private practice. The defendant was approached by a local medical school and associated university hospital to join the hospital on a part-time basis as a Clinical Assistant Professor (“CAP”). While the duties and services expected from a CAP were teaching, lecturing, and research-based initiatives, the hospital’s alleged motivation in recruiting CAPs was to increase the number of cardiothoracic patients referred to the hospital as the hospital was required by the state of New Jersey to perform a minimum number of cardiac procedures to maintain its status as a Level 1 Trauma Center.

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

²³ *U.S. v. Campbell*, 2011 WL 43013, No. 08-1951 (D. N.J., Jan. 4, 2011).

In exchange for the services required to be performed as a CAP on a part-time basis, the defendant received an annual salary of \$75,000. Defendant testified that he "duly performed all of the services enumerated in the contract which he was given the opportunity to perform, and that he was compensated until the contract was canceled."²⁴

The government alleged that the CAP contract between the defendant and the hospital was a sham contract designed only to induce referrals of cardiothoracic patients to the hospital in violation of the Stark Law. The dispute in the matter was to what extent the defendant actually performed the services outlined his contract and whether or not the compensation paid under the contract for such services was reasonable.

The defendant ultimately admitted that he did not perform all of the duties enumerated in his contract and did not believe he was expected to do so. **The court found that, because there was no requirement to perform the duties of a CAP, the \$75,000 received by the defendant in the 10 months he was under contract with the hospital could not be considered commercially reasonable or representative of fair market value.**²⁵

*United States ex rel. Singh v. Bradford Regional Medical Center (2010)*²⁶

US v. Bradford Regional Medical Center ("BRMC") centered on a pair of internal medicine providers in Pennsylvania who purchased their practice from BRMC in April of 2000 and formed an LLC through which they practiced moving forward. Prior to the purchase of their practice from BRMC, the physicians were significant referral sources to BRMC, particularly for nuclear imaging services. During 2001, the physicians developed plans to acquire their own nuclear camera, information which filtered through to BRMC. According to BRMC, the physicians in question ordered 42.5% of BRMC's nuclear studies at the time and the physicians' practice could support the purchase of its own nuclear camera given the volumes at stake.²⁷

BRMC attempted to negotiate a joint venture with the physicians to prevent the siphoning of patients, but were unable to successfully do so and in June 2001 the physicians entered into a long-term lease for their own nuclear camera and, after installation, stopped referring patients to BRMC for nuclear imaging tests.

The parties continued to negotiate after the installation of the machine and, between April and September of 2003, came to a temporary solution wherein BRMC would sublease the nuclear camera from the physicians' practice, the practice would provide nuclear testing for BRMC patients, and the practice and its physicians would agree to a non-compete agreement with respect to provision of nuclear imaging tests. Before executing the lease, BRMC had an FMV analysis performed, which concluded that the payments per the sublease were "reasonable".²⁸

²⁴ *U.S. v. Campbell*, 2011 WL 43013, No. 08-1951 (D. N.J., Jan. 4, 2011)

²⁵ *Id.*

²⁶ *U.S. ex Rel. Singh v. Bradford Regional Medical Center*, Civil No. 04-186 Erie. (W.D. Pa. May. 31, 2007)

²⁷ *Id.*

²⁸ *Id.*

Effective October 1, 2003, BRMC and the practice executed the equipment sublease for a five year period. The payments under the sublease included a payment equal to the lease payments due to the equipment lessor, plus \$23,655 per month for all other rights under the sublease including the non-compete²⁹.

The relators and government alleged that the payments for referrals came in several forms, including:³⁰

- The camera, the subject of the equipment sublease, remained at the practice's office despite the sublease specifying it would be moved to BRMC's campus;
- Because the camera remained at the practice's office, BRMC paid additional amounts to the practice for rent and other expenses;
- BRMC paid the practice a 10% fee for handling billing collections on behalf of BRMC for all tests performed on the subject camera;
- The parties ceased using the camera when the practice leased a new nuclear camera even though the newly leased camera was located at BRMC's campus;
- The seller of the new camera bought out the remainder of the lease on the practice's old nuclear camera, but BRMC continued to make payments to the practice for the old nuclear camera;
- After the buyout of the former camera lease, the practice remained in possession of the camera until it was given away as a charitable donation; and,
- There was no signed written agreement between the parties for the payment of rent and other expenses, the collection fee, payment by BRMC for the new nuclear camera and service agreement, or the buyout of the old camera lease.

In view of the above allegations, the court found that a prohibited direct financial relationship existed between BRMC and the practice's physicians individually for the period of time the sublease agreement was in effect. The defendants argued that because the payments by BRMC to the practice were fixed and did not fluctuate based on the number of patients referred to BRMC by the practice's physicians then there could be no unlawful indirect compensation agreement.

The court did not accept this "bright line" exception defense and concluded, referencing the multiple precedent decisions, the Stark Law itself, the Stark Law regulations, and CMS' interpretations, a fixed compensation arrangement in excess of fair market value can nonetheless constitute an inducement for referrals.³¹

The question then became whether or not the payments were representative of fair market value. Although the court notes that the payments represented a fair value between each of the parties in question, such a determination of fairness relied on the ability of the parties to refer business to each other. The court noted that section 411.351 defines fair market value as a "result of bona fide bargaining between well-informed parties to the agreement who are not otherwise in

²⁹ *Id.*

³⁰ *Id.*

³¹ U.S. ex Rel. Singh v. Bradford Regional Medical Center Civil No. 04-186 Erie. (W.D. Pa. May. 31, 2007)

a position to generate business for the other party . . . where the price or compensation has not been determined in any manner that takes into account the volume or value of anticipated or actual referrals.”³² **The court concluded that the compensation arrangement between the parties was greater than what would be paid in the absence of the physicians’ ability to refer volume to BRMC, and therefore the payment stream was not fair market value under the Stark Law.**

Takeaway #4 – Must Reflect Actual Deal

*United States ex rel. Kosenske, M.D. v. Carlisle HMA, Inc. (2009)*³³

US vs. Carlisle HMA concerned a group of four anesthesiologists (“BMAA”) who entered into an agreement to provide anesthesiology services to Carlisle Hospital and Health Systems (“Carlisle”). Under the agreement, BMAA would provide all anesthesia services at Carlisle’s hospital in Carlisle, Pennsylvania (the “Hospital”). BMAA was to be the exclusive provider of 24/7 anesthesia coverage at the Hospital and practice only at the Hospital; in return, the Hospital would provide personnel, space, equipment, and supplies to support the provision of anesthesiology services by BMAA at the Hospital. BMAA would also be provided the opportunity to provide exclusive services at any new Carlisle facility opened in the future, but was not obligated to do so. Finally, no pain management services were being provided at the time the contract was signed, and BMAA was not obligated to provide exclusive pain management services at the Hospital in the future, only a limited scope of pain management services.³⁴

Fifteen months after the execution of the services agreement in 1992, a single BMAA physician and a Hospital nurse began providing pain management services in addition to the anesthesia services. In 1998, the Hospital built a dedicated pain clinic (the “Clinic”). BMAA provided a physician to provide pain management services at the Clinic who did not have anesthesiology duties at the Hospital when working at the Clinic; the Hospital did not charge BMAA for the use of the Clinic space and remitted payment to BMAA under the agreement signed in 1992 to cover anesthesiology services at the Hospital.³⁵

The Court determined that the arrangement between BMAA and the Hospital in which BMAA provided physician coverage and was not charged for use of the space (where BMAA collected professional fees from Medicare and the Hospital collected technical fees from Medicare) implicated the Stark Law and did not qualify for the personal service exception.

Given that the Stark Law was implicated, the question became whether or not the payment stream between BMAA and the Hospital constituted fair market value. The court concluded that the payment stream for services rendered at the Clinic did not represent fair market value because there was no agreement in place covering the subject services. The Hospital’s use of an agreement signed six years prior and intended for the provision of different

³² *Id.*

³³ *US Ex Rel. Kosenske v. Carlisle HMA, Inc.*, 554 F.3d 88 (3rd Cir. 2009).

³⁴ *Id.*

³⁵ *Id.*

services under a materially different set of circumstances was not sufficient to cover the definition of fair market value. **The court ruled that the Hospital's use of an agreement which did not reflect the actual deal in question was insufficient to vouch for the fair match of service and compensation.**

Takeaway #5 – Listen to Good Advice

*United States ex rel. Pogue v. Diabetes Treatment Centers for America (2008)*³⁶

This 14 year piece of litigation involved the relationship between Diabetes Treatment Centers for America (“DTCA”) and the physicians it contracted with to serve as medical directors at its treatment centers in hospitals throughout the United States. The government alleged that DTCA’s compensation of the medical directors was intended to induce referrals to its treatment centers, in violation of the Stark Law and AKS.

The Court was unequivocal in its assessment that the payments to medical directors were in excess of fair market value for their services and were designed specifically to induce referrals from the medical director physicians, and that referred admissions into DTCA’s facilities were a primary performance evaluation metric for the medical directors.³⁷

With the pattern of payment for referrals firmly established, the defendant asserted a good-faith defense in that defendant relied on its counsel’s advice and therefore defendant’s conduct did not satisfy the knowledge standard found in the AKS. Evidence submitted by the government, however, showed numerous and repeated warning from defendant’s counsel to defendant about potential AKS violations related to the payment relationship. In a letter addressed to DTCA in 1989, defendant’s counsel outlined its concerns as follows:³⁸

“...we are receiving an increasing number of requests—several each week—involving different methods of compensating doctors who happen to be the source, or the potential source, of substantial referrals. While some of these proposals are doubtless clean, some are not and the mere volume of the transactions casts a shadow even upon those that might otherwise pass [*sic*] muster. Thus we have an increasing concern about your ability to successfully defend all of the arrangements which are now in place and many of the arrangements for which our opinion has been sought...We get the feeling that some of your people who are negotiating contracts may not fully appreciate all of the considerations that go into dealing with this problem.”

After this initial warning, defendant’s counsel continued to monitor relevant case law and keep defendant updated with developments in such case law and continued to make recommendations to mitigate potential violations of the Stark Law and AKS. Defendant’s

³⁶ *US Ex Rel. Pogue v. Diabetes Treatment Centers*, 565 F. Supp. 2d 153 (D.C. 2008).

³⁷ *Id.*

³⁸ *Id.*

counsel even went as far as to keep a “Fraud & Abuse” file in which he recorded his warnings to the defendant along with a summary of such warnings.³⁹

Furthermore, the hospitals with which DTCA contracted to provide services also expressed concern about the medical director contracts taking into account the volume of referrals and any prosecution which might have extended to the contracting hospitals as a result.⁴⁰ Such hospitals also proposed amendments to their contracts to expressly provide that payment would not be tied to the volume or value of referrals.

Ultimately, the court found that the defendant repeatedly and deliberately ignored advice from counsel and those it did business with over a six year period leading up to the action taken against it by the government.

Recent Development: Forest Park Medical Center

In November of 2016, a grand jury indicted 20 physician-owners of Forest Park Medical Center Dallas (“FPMC”), a physician-owned surgical hospital located in Dallas, Texas.⁴¹ FPMC’s business model was focused on high-reimbursement out-of-network procedures for individuals with private insurance. Prior to its opening in 2009 and continuing in 2013, FPMC and its physicians allegedly paid \$40 million in bribes and kickbacks to physicians, chiropractors, lawyers, and other business associates in exchange for referring patients to FPMC. Furthermore, FPMC allegedly attempted to, and did, sell patients with Medicare and Medicaid benefits to other facilities in exchange for cash. The government estimates that from 2009 to 2013 FPMC billed patient insurance plans (and some federally funded programs, specifically TRICARE) over \$1.5 billion and collected more than \$200 million.⁴²

Although the litigation is ongoing and the outcome is yet unclear, the indictment suggests that simply avoiding performance of volumes for Medicare, Medicaid, or other government program patients does not provide a clear path to exemption from the jurisdiction of the Department of Justice (“DOJ”). The indictment suggests that the defendants may have believed that the DOJ did not have jurisdiction to bring charges related to the kickback scheme as the scheme was intended to apply only to patients with private insurance in the state of Texas. Despite this plan, the government alleges that FPMC billed at least \$95 million on behalf of patients in government programs including TRICARE, the Federal Employee Compensation Act, and the Federal Employee Health Benefits Plan.⁴³

Additionally, per the indictment, an act as simple as the data from a check containing kickback funds being uploaded to a server in Atlanta represents a facility of

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ United States of America v. Alan Andrew Beauchamp et al, In the United States District Court for the Northern District of Texas Dallas Division, November 16, 2016 available at <https://www.darkintelligencegroup.com/wp-content/uploads/FOREST-PARK-Med-Ctr-INDICTMENT-1.pdf>

⁴² *Id.*

⁴³ United States of America v. Alan Andrew Beauchamp et al, In the United States District Court for the Northern District of Texas Dallas Division, November 16, 2016.

interstate commerce, may have caused a violation of the Travel Act and therefore presented the DOJ with jurisdiction in this case.

VI. Conclusion

As stated earlier, the phrase “Fair Market Value” is used often by those in the healthcare industry and, despite the importance of the concept of FMV in healthcare transactions, the meaning and use of the term can often be ambiguous at best. Hopefully the above discussion of applicable laws, examination of the construction of those laws, and analysis of recent applicable case law has helped provide clarity and structure to the use and definition of FMV in healthcare transactions.