VMG HEALTH

Healthcare Fair Market Valuation Hot Topics

2025 Healthcare Law & Management Symposium – June 5, 2025

Meet The Presenters

Meet the Team

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Experience

William Teague is a managing director based in the Nashville office and has been with VMG Health since 2010. William specializes in providing valuation, transaction advisory, and management consulting services to the firm's healthcare clients. He has been involved in over 500 engagements having particular experience with acute care hospitals, radiation/proton therapy centers, behavioral health hospitals, ambulatory surgery centers, medical transport companies, physician groups and home health/hospice agencies.

William serves as a trusted financial advisor to his clients in support of transactions, affiliations, joint ventures, recapitalizations, the development of de novo facilities and for other strategic planning purposes. In this capacity, his experience includes performing valuations of businesses/assets, preliminary due diligence support, risk assessments and feasibility or market studies. In addition, he has helped clients develop detailed proformas, improve financial performance of existing facilities and plan for new investment projects. Finally, William has extensive experience with intellectual property valuation, such as trade name / branding arrangements and certificates of need (CON).

More About Me

Mr. Teague graduated summa cum laude and holds a Bachelor of Science in Finance and Economics from the University of Tennessee at Knoxville. He holds the Chartered Financial Analyst (CFA) and Certified Valuation Analyst (CVA) designation.

Areas of Expertise

- Business Enterprise Valuation
- Complex Equities Valuation
- Fairness Opinions
- Financial Reporting Valuation
- Growth & Strategy Development
- Mergers & Acquisitions Advisory
- Provider Benchmarking & Risk Assessment
- Reimbursement Consulting & Analytics
- Value-Based Care Strategy & Valuation
- Due Diligence

Meet the Team

Experience

Todd J. Sorensen is a Managing Director at VMG Health. He specializes in providing valuation and transaction advisory services to the firm's healthcare clients. He has acted as financial advisor in transactions with physician groups, acute care hospitals, urgent care and free-standing emergency rooms/departments, home health and hospice, inpatient rehab, inpatient behavioral health, Medicare Advantage plans, imaging centers, radiation therapy (including proton therapy), ambulatory surgery centers, home health agencies, and physical and occupational therapy centers. Sorensen has also assisted buyers and sellers with purchase price allocations including intangible asset and personal goodwill valuations for tax planning.

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More About Me

Prior to joining VMG Health, Sorensen was with the Financial Advisory Group of Ernst & Young. Sorensen helped play an integral role in the development of healthcare valuation services. He has assisted in the development of financial tools that allow clients to make better decisions concerning efficient deployment of capital. Sorensen holds an MBA degree and is designated as a Certified Valuation Analyst (CVA).

Areas of Expertise

- Business Enterprise Valuation
- Complex Equities Valuation
- Fairness Opinions
- Financial Reporting Valuation
- Intangible Assets Valuation
- Succession Planning

FMV Overview

Definition of Fair Market Value

Premise of Value That Meets the Stark and Private Inurement Regulations

FAIR MARKET VALUE – IRS DEFINITION

"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)

GENERAL MARKET VALUE – STARK LAW DEFINITION

"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. 411.651)

Why Is A Valuation Needed?

- Regulatory Considerations
- Due Diligence
- Expertise / Transaction Advisory
- Seller Education
- Analytical Support
- Financial reporting

Regulatory Considerations

Stark Law / Physician Self-Referral Law

Prohibits referrals from a physician for designated health services; Civil penalties; Covers Medicare and Medicaid programs

If a **physician** (or an **immediate family member**) has a **financial relationship** with an entity:

- The physician may not make a **referral** to the **entity** for the furnishing of designated health services for which payment otherwise may be made by the Medicare program; and
- The entity may not bill any individual, third-party payor, or other entity for **designated health services** furnished pursuant to a prohibited referral.

Exceptions and more information is found in 42 C.F.R. §§ 411.351, et seq.

Underlined/bolded words have specific definitions in the context of Stark Law

Stark penalties: $15,000 per prohibited claim plus refund; potential exclusion, and $100,000 per circumvention scheme

Regulatory Considerations

Anti-Kickback Statute

Prohibits referrals from anyone for any services paid for by healthcare programs; Criminal and civil penalties; Covers all programs

AKS prohibits offer, payment, solicitation or receipt of remunerations to induce or reward referrals of services reimbursable by a federal healthcare program.

Violations of AKS are criminal and civil offenses and are punishable by:

- Five years imprisonment and a fine of up to $25,000
- Civil monetary penalty of up to $50,000
- Exclusion from participation in the Medicare and Medicaid programs

More information is found in 42 C.F.R. §§ 411.351, et seq(42 U.S.C. § 1320a-7b

Private Inurement Statute

Tax-exempt entities cannot provide excess benefits to non tax-exempt individuals or entities.

FMV vs Strategic / Synergistic Value

Fair Market Value	Strategic / Synergistic	Investment
✓ Adjusting reimbursement rates to market participant rates	✗ Adjusting reimbursement rates to acquirer's contracted rates	
✓ Market participant cost savings and volume projections	✗ Acquirer specific cost efficiencies and volume projections	
✓ Fair market value rent rate	✗ Related-party rent arrangements	
✓ Post-transaction compensation	✗ Payments for referrals or downstream business	
✓ Terms consistent with observable market data	✗ Inconsistent application of market benchmarks	

Commercial Reasonableness

Economic / Financial Reasonableness

- Consider if the subject arrangement is essential to the operations of the Organization and identify and define the specific purpose of the subject agreement.
- Consider if the subject arrangement represents a sensible and prudent business arrangement, excluding the consideration of referrals.
- Understand how current economic conditions have been considered in relation to the subject arrangement.
- Ensure that the subject arrangement furthers the strategic and financial goals of the Organization.
- Determine why alternative models have not been chosen, if applicable, that may result in similar services being offered to the organization by a provider with similar qualifications at lower costs.

Operational Reasonableness

- Consider the Organization's size, patient population, and patient demand when assessing the need for the services (patient acuity and need warrants services).
- Consider how the subject arrangement furthers patient care, patient satisfaction, and overall public benefit.
- Ensure there are safeguards to reduce and eliminate the possibility of fraud, prohibited referrals, waste, or abuse in relation to the subject arrangement.
- Establish a written agreement containing the material terms of the arrangement.

Physician / Clinical Reasonableness

- Ensure a physician is required to perform the services.
- Ensure a physician of a particular specialty is required to perform the services if relying upon an indication of value which represents a specialty specific opinion.
- Ensure the physician possesses the specialized training, qualifications, and experience required to provide the services.
- Determine that the duties of the physician under the subject arrangement will not be duplicative of any other duties performed by the Organization's personnel once the arrangement commences.

FMV DOES NOT ALWAYS = COMMERCIALLY REASONABLE

&

COMMERCIALLY REASONABLE DOES NOT ALWAYS = FMV

Other Valuation Considerations

Valuation Accuracy

An FMV opinion is distinct from a Quality of Earnings ("Q of E") engagement. In performing the FMV valuation, the data provided by the Client is assumed to be materially true and correct. VMG does not independently audit or test the data, rather it accepts the data as presented. The Client should ensure that VMG is equipped with all knowable facts and considerations during the engagement.

Validity Periods

There are no public guidelines regarding the validity periods for a FMV opinion. The FMV opinion is valid as long as the general economy and specific facts and circumstances surrounding the subject remain stable.

Valuation Approaches Overview

The following are the three primary approaches to valuation.

Cost Approach

- Used to identify value associated with “recreating” the service capability of the identified asset or service.

Income Approach

- Development of a forecast / economic benefits related to identified asset or service

Market Approach

- Value derived from observed multiples of comparable companies *(EV/Rev. or EV/EBITDA)*
- Or, observed economics from similar transactions/arrangements

Trends and Hot Topics – Business Transactions

General Market Observations

"Medicare Payment Policy – Report to Congress"
"In considering updates to FFS payment rates, ***we may make recommendations that redistribute payments within a payment system to correct biases that may make treating patients with certain conditions or in certain areas financially undesirable****, make certain procedures relatively more profitable, or otherwise result in differences that could undermine access to care for some beneficiaries. We may also recommend changes to improve program integrity."*

Report to the Congress: Medicare Payment Policy, March 2025

"Five Things to Know About Medicare Site-Neutral Payment Reforms"
"Amid rising concerns about health care spending and voters' worries about health care affordability, there is growing, ***bipartisan interest in proposals to align Medicare payments for outpatient services across care settings****, otherwise known as "site neutral" payments. The goal of this approach would be for Medicare to pay the same rate for the same service,* ***whether it is provided in a hospital outpatient department (HOPD), ambulatory surgical center (ASC), or freestanding physician office, subject to patient safety and quality safeguards."***

"Site-neutral Medicare pay eyed to fund Trump tax cuts"
"Republicans eager to ***offset the cost of cutting taxes*** *may see lower Medicare spending on outpatient care as a source of budgetary savings"*

Modern Healthcare, March 18, 2025

February 25, 2025 07:27 PM

House sets up potential Medicaid cuts with budget bill passage

MICHAEL MCAULIFF

House Republicans released a budget blueprint on Wednesday that orders the primary healthcare committee to slash spending by $880 billion.

ASC vs. HOPD Reimbursement

Medicare Reimbursement Build-Up: Site of Service

Key Facts

- The table represents the Medicare technical reimbursement build-up for the top 25 CPT codes performed in ASCs in 2024 (based on payments to CMS).
- VMG has calculated a HOPD and ASC conversion factor based on wage indices published by CBSA. The following geography was utilized: Chicago-Naperville-Evanston, IL.
- **Risk of site neutral reimbursement?**

		Medicare Technical Reimbursement		*HOPD vs. ASC*	
CPT Code	**CPT Code Description**	**HOPD**	**ASC**	**$ Variance**	**% Variance**
66984	Xcapsl ctrc rmvl w/o ecp	$2,248	$1,213	($1,035)	-46%
27447	Total knee arthroplasty	$12,699	$9,276	($3,423)	-27%
45380	Colonoscopy and biopsy	$1,139	$627	($511)	-45%
63685	Ins/rplc spi npg/rcvr pocket	$29,961	$25,909	($4,051)	-14%
63650	Implant neuroelectrodes	$6,599	$5,073	($1,526)	-23%
43239	Egd biopsy single/multiple	$875	$482	($393)	-45%
27130	Total hip arthroplasty	$12,699	$9,470	($3,229)	-25%
66991	Xcapsl ctrc rmvl insj 1+	$5,043	$3,826	($1,216)	-24%
64483	Njx aa&/strd tfrm epi l/s 1	$879	$485	($395)	-45%
64590	Ins/rpl prph sac/gstr npg/r	$21,107	$19,467	($1,640)	-8%
66982	Xcapsl ctrc rmvl cplx wo ecp	$2,248	$1,213	($1,035)	-46%
64635	Destroy lumb/sac facet jnt	$1,863	$920	($943)	-51%
29827	Sho arthrs srg rt8tr cuf rpr	$6,903	$3,478	($3,425)	-50%
36902	Intro cath dialysis circuit	$5,515	$2,589	($2,925)	-53%
64493	Inj paravert f jnt l/s 1 lev	$879	$485	($395)	-45%
64561	Implant neuroelectrodes	$6,599	$5,164	($1,435)	-22%
66821	After cataract laser surgery	$561	$309	($252)	-45%
G0105	Colorectal scrn; hi risk ind	$882	n/a	n/a	n/a
0784T	Ins/rplmt eltrd ra spi nstim	$13,143	$9,456	($3,687)	-28%
0275T	Perq lamot/lam lumbar	$6,903	$5,187	($1,715)	-25%
65820	Relieve inner eye pressure	$3,923	$2,096	($1,827)	-47%
G0121	Colon ca scrn not hi rsk ind	$882	n/a	n/a	n/a
C9740	Cysto impl 4 or more	$8,889	$7,530	($1,358)	-15%
62323	Njx interlaminar lmbr/sac	$667	$368	($300)	-45%
15823	Revision of upper eyelid	$1,760	$970	($790)	-45%

Health System Investing in ASC Strategies

ASC Market is Highly Fragmented but Beginning to Consolidate

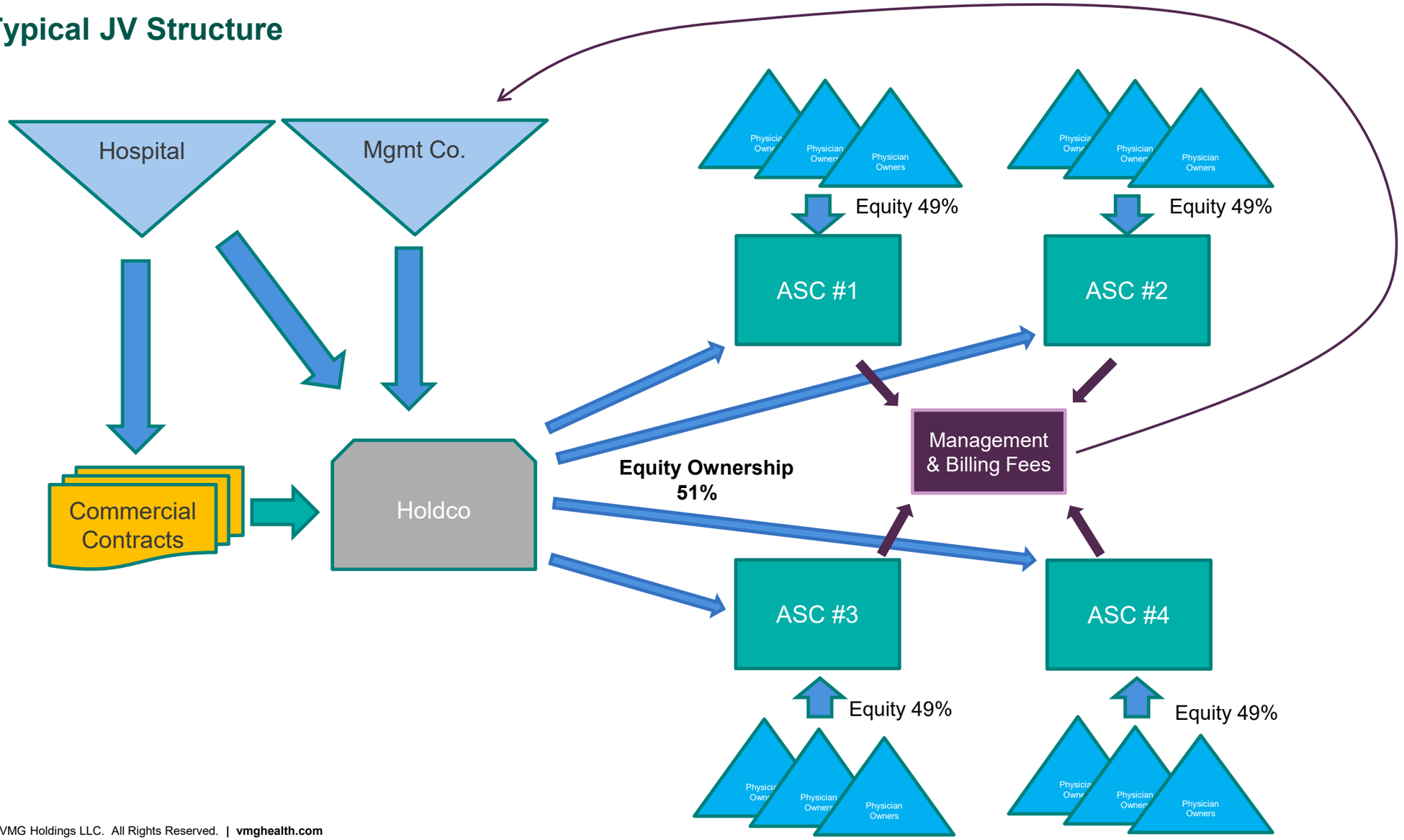
	Center Count						
Company Name	2011	2019	2020	2021	2022	2023	2024
United Surgical Partners International (Tenet Healthcare)	204	264	310	430	440	476	520
Surgical Care Affiliates (Optum)	145	186	230	250	320	320	320
AmSurg	223	258	250	250	260	250	250
SurgCenter Development*	56	200	155	-	-	-	-
HCA	116	125	120	145	150	150	150
Surgery Partners Holdings	11	119	110	133	145	137	132
Other Management/Multi-Site Operators (est.)	584	546	550	567	549	608	768
Total Centers	**1,339**	**1,698**	**1,725**	**1,775**	**1,864**	**1,941**	**2,140**
Total Medicare Certified Centers	*5,217*	*5,788*	*5,837*	*5,906*	*6,028*	*6,223*	*6,394*
Major Operators as a % of Total Medicare Cert. Centers	***25.7%***	***29.3%***	***29.6%***	***30.1%***	***30.9%***	***31.2%***	***33.5%***

Key Trends / Topics

- Many health systems are behind in building out ASC strategy – patients and payors continuing to pressure eligible cases to move out of hospital. Hospitals playing catch up after pausing due to financial distress.
- Health system management company joint ventures proliferating. Some health systems going it alone.
- Physician syndication is key to success – are they buying in / selling at FMV?
- Private equity backed physician practice management companies investing in ASCs to support physician investments (orthopedics, cardiology, etc.) that are impacting health systems significantly.
- Buy or build strategies – Denovo is increasingly expensive with construction costs/inflation. Time to market? Valuations in ASC space at a premium.
- Employed physicians allowed to buy into ASCs?

Typical JV Structure

Typical JV Structure



Other Ancillary Joint Ventures

Health Systems continuing to enter into JV models with noncore Ancillary Services

- Hospital motivations include need for capital, operational expertise, divest operating losses, etc. Operators want market access, regulatory support (CON), use of health system brand and leverage with payors.
- Common JVs include behavioral health, home health, hospice, inpatient rehab and diagnostic imaging.
- Health system contribute assets as part of transaction. Is contribution at FMV? Health systems valuation carve outs are complicated – Historical P/Ls rarely accurate depiction of underlying operation.
- Related service agreements – billing, management, managed care contracting, branding, IT, other purchased services, etc. at FMV?
- How does the physician component work? PSA? Integration with broader service lines of hospital?
- Is a subsidy required to the JV from hospital for certain patients/services? Reimbursement rate guarantee? How is that treated in the valuation?

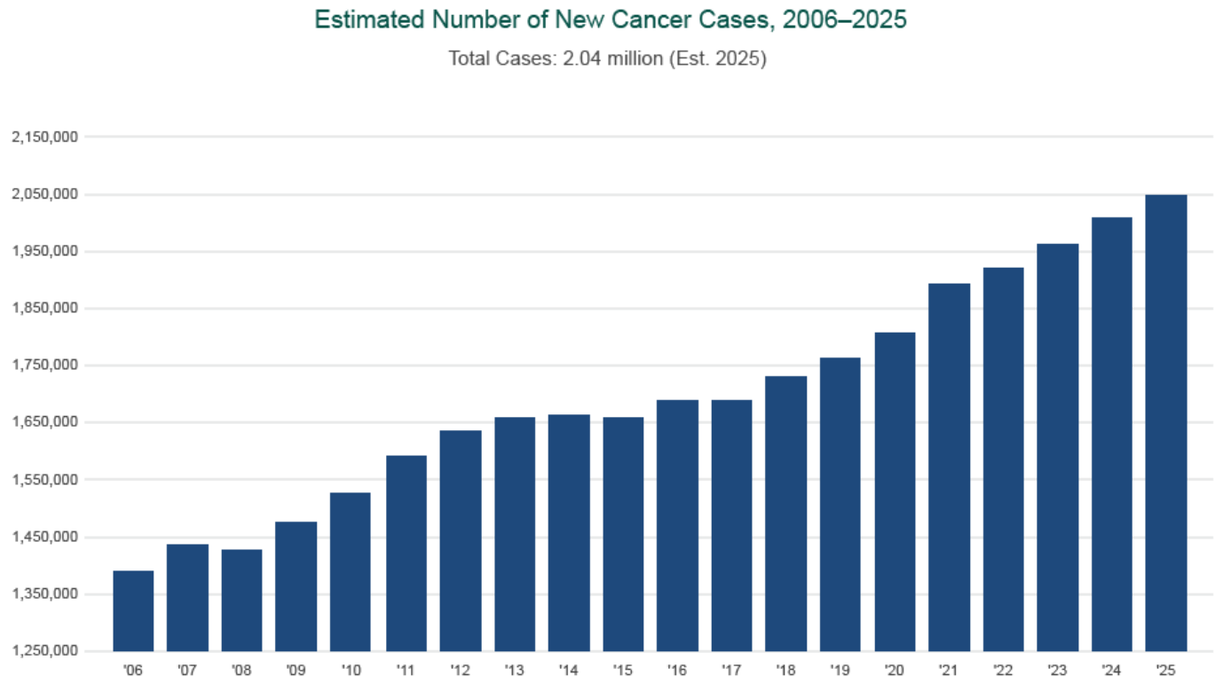
Oncology

One of the more significant trends within the oncology sector has been the strategic acquisition of oncology platforms by major pharmaceutical distributors targeting vertical integration.

Industry Trends

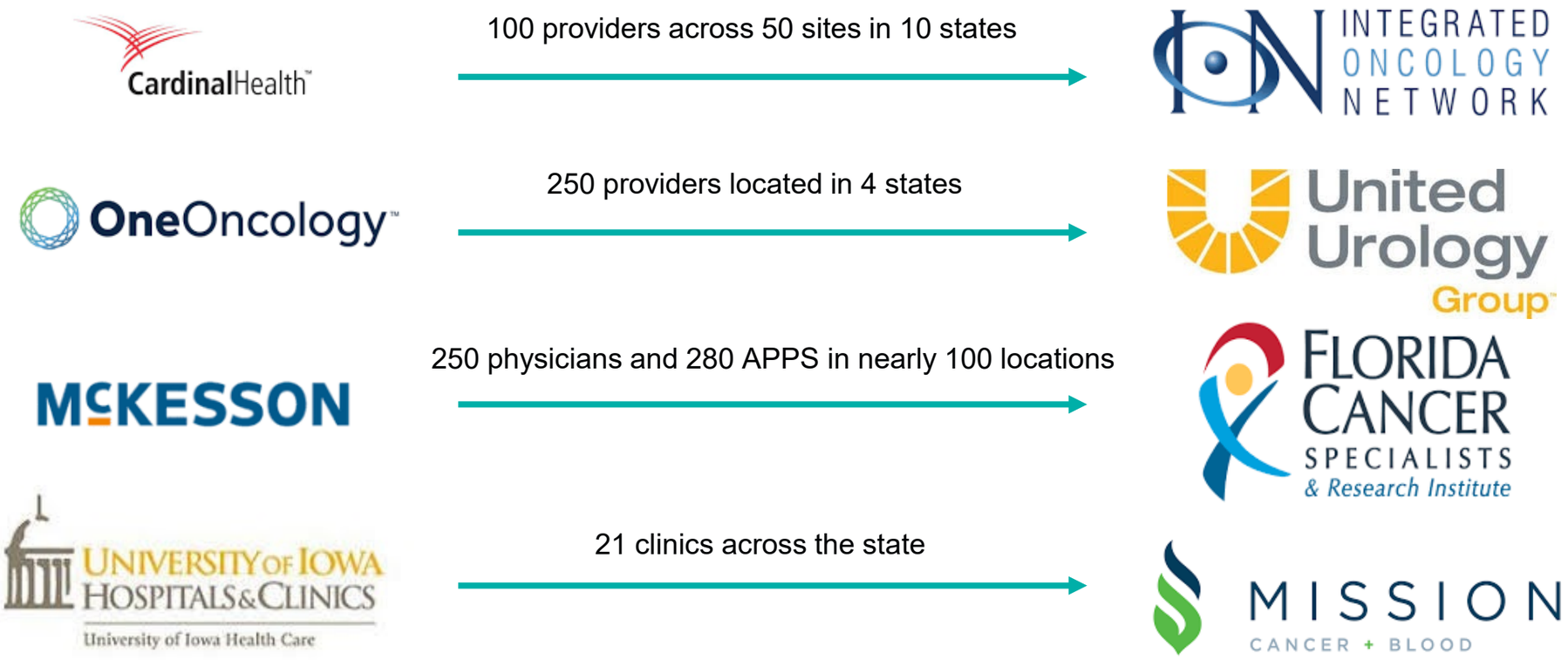
- After many large players acquired, 2025 expected to have a focus on integration and tuck in acquisitions.
- Companies pursuing new income streams – oral pharmacy, research, data monetization, VBC, etc.
- Regulatory changes to 340b?
- Value based enterprise / value-based care models?

"We will continue to evaluate high-quality assets in strategic areas of importance, but we'll focus on integration and tuck-in acquisitions to the multi-specialty and oncology platforms that we have just acquired." – Aaron E. Alt, CFO Cardinal Health



M&A Trends / Notable Transactions

Mega deals by strategic acquirers in recent years have also driven numerous tuck in transactions across the country. Hospitals pursuing 340b strategies also driving transaction activity.



Key Valuation Considerations by Subindustry

Physician Services

- Provider compensation
- Provider productivity relative to compensation
- Age of physician
- Employed vs. non-employed providers
- In-office ancillary services
- Capacity constraints

Urgent Care Centers

- Staffing model
- Location
- Demographics
- Seasonality
- Competition
- Oversaturation
- Capacity, payor mix and reimbursement

Ambulatory Surgery Centers

- Physician utilizer attributes: Ownership percentage, age, specialty
- Medical supplies / staffing expense
- Case mix
- Reimbursement
- Single-specialty vs. multi-specialty
- Control vs. minority

Diagnostic Imaging Centers

- Age of equipment
- Demand in the marketplace. Neutral site reimb at play?
- Competition and referral source dynamics. Impact of private equity investment in PPM?
- Radiologist read fees & other professional fees. Future subsidy required?

Key Valuation Considerations by Subindustry

Acute Care Hospitals

- Occupancy & average length of stay (ALOS)
- Sustainability of supplemental government payments? Changes to Medicaid?
- Depth in key service lines
- Brand / reputation
- Physician subsidy / losses?
- Quality of market and relative market share. Have or Have not?

Post Acute Care

- Payor mix, 60% rule
- Acuity of patients (case mix index)
- ALOS, occupancy
- Staffing model (Ex. Use of PTA's vs. physical therapists)
- Freestanding vs. Department of Hospital
- CON states

Behavioral Health

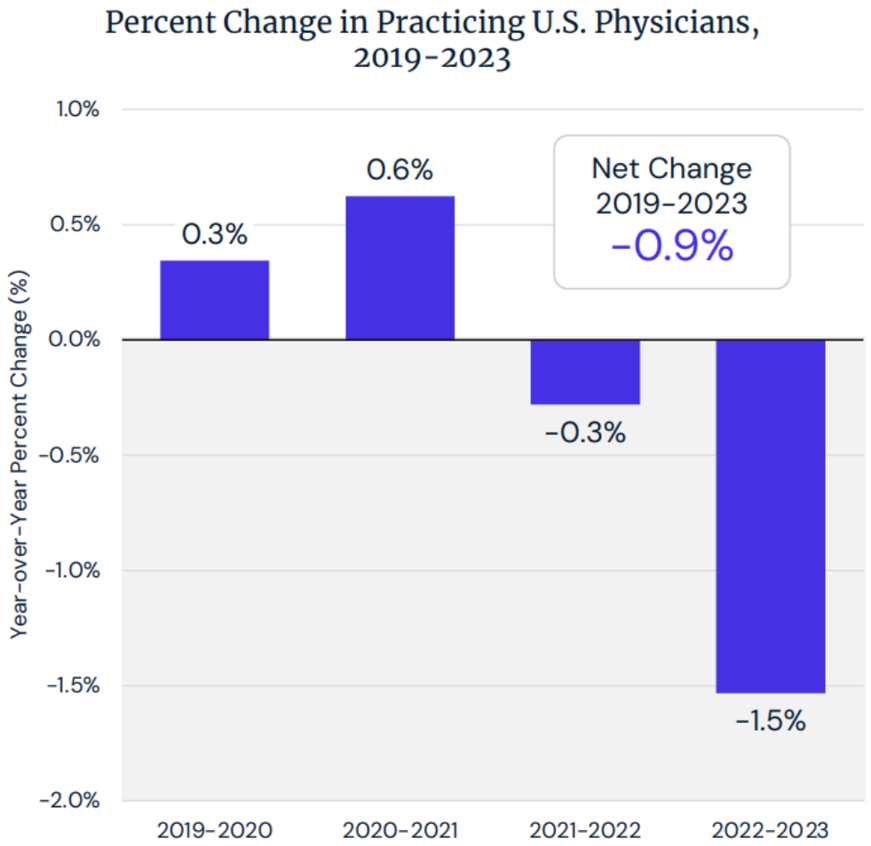
- Occupancy & ALOS
- Payor mix
- In network? Out of network strategies under pressure.
- Supplemental payments?
- Staffing model
- CON states

Oncology

- Treatment mix, number of ancillaries offered (oral pharmacy, radiation, etc.)
- Drug gross margin? Ability for typical buyer to realize savings
- Physician base dynamics.
- Size and scale.
- Ability to recruit new physicians at assumed compensation levels?

Trends and Hot Topics – Physician Compensation

Physician Services – Supply & Demand



Share of physicians in 2023 that are new since 2019: **3.0%**
Share of 2019 physicians no longer practicing in 2023: **2.4%**
Physicians that changed practice locations from 2019 to 2023: **31.3%**

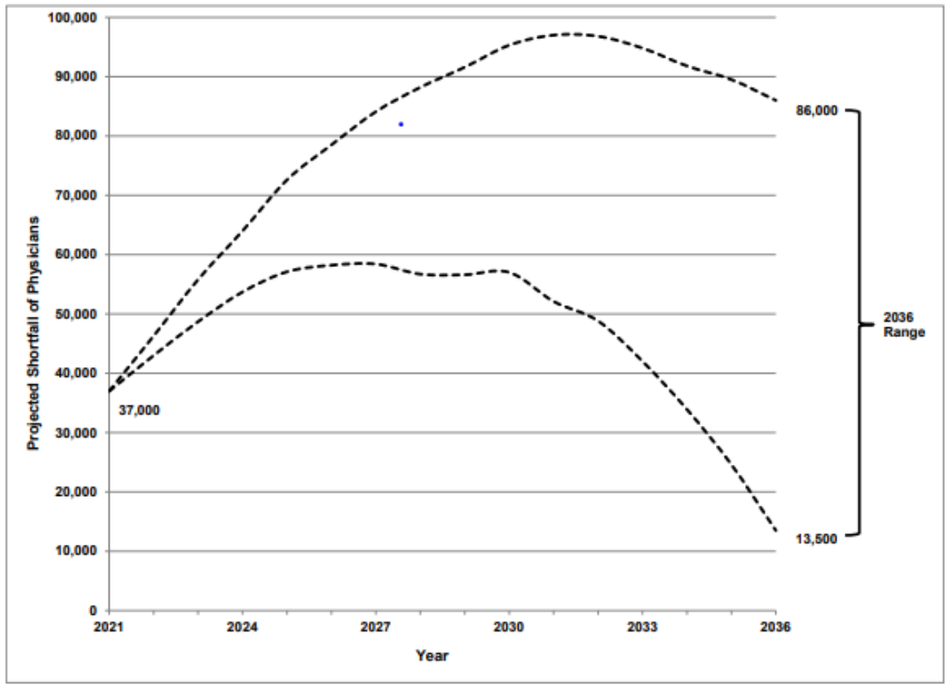
Heightened Competition from Health Systems, & Private Equity, and Other Buyers

Sources: Trilliant Health's 2024 Trends Report and VMG Research

Projected Physician Shortage

Total Physician Supply and Demand

Exhibit 1: Total Projected Physician Shortfall Range, 2021-2036



Comparing each supply to each demand scenario and looking at the 25th-to-75th percentile of supply adequacy for total physicians shows a projected shortage of between 13,500 and 86,000 physicians by 2036 (Exhibit 1).

Projected physician shortage of between 13,500 and 86,000 by 2036

Aging population

+

Aging workforce

+

Strain on healthcare workers

+

Growth of healthcare sector

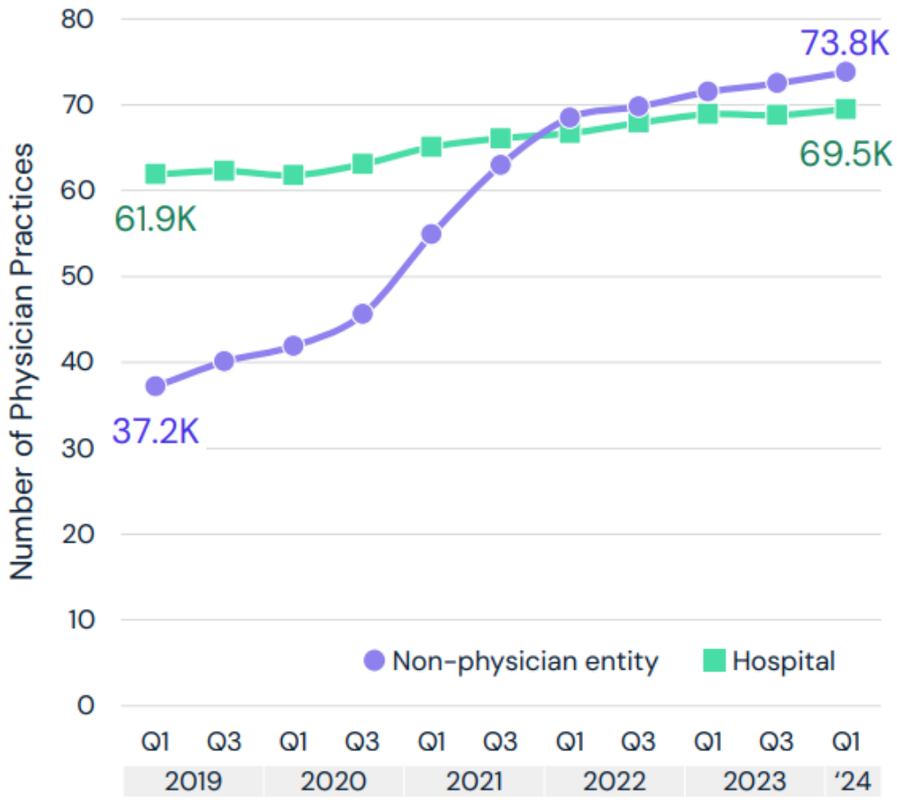
→

Physician Shortage

Will AI, greater leverage of APPs, digital/virtual care undermine the importance of the physician and lessen the impact?

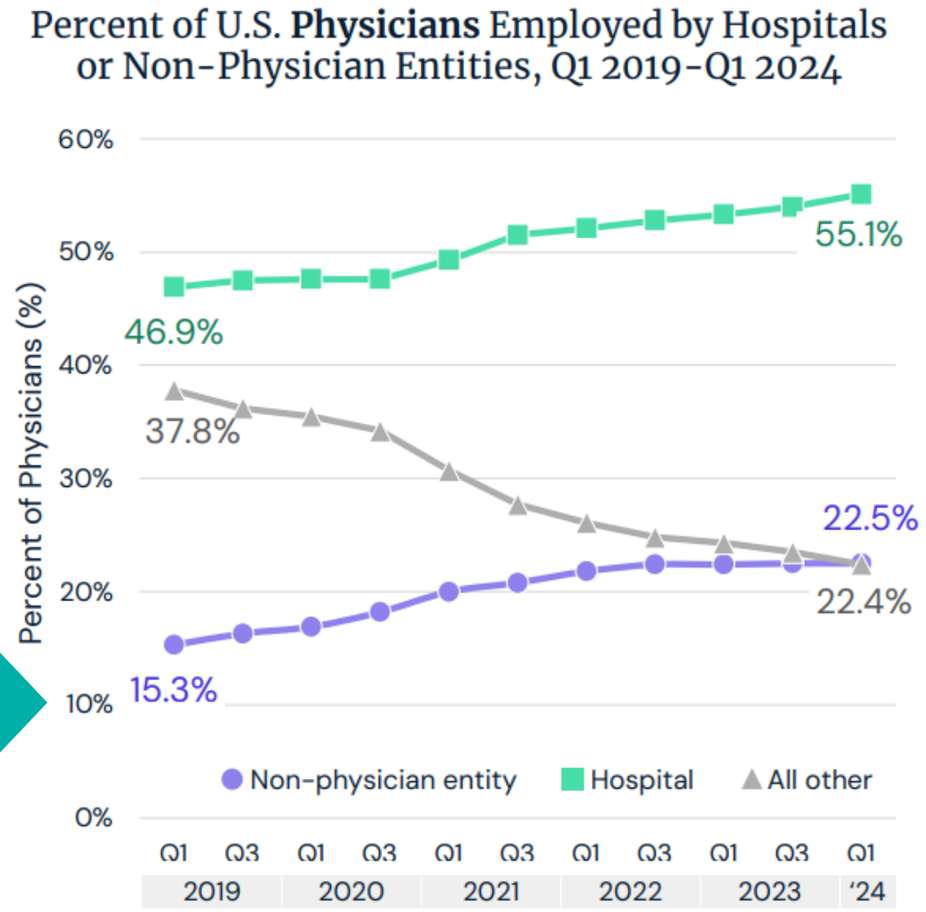
[1] *AAMC, The Complexities of Physician Supply and Demand, Summary Report, March 2024*

Physician Services – Employment Shifts



Health insurers (Optum), private equity and other corporate entities now own more physician practices than hospitals.

A growing share of physicians are employed by a non-physician entity rather than a hospital.



Note: Non-physician entities include health insurers, private equity firms and other corporate entities that own a controlling share of the practice. All other includes independent practices.

Sources: Trilliant Health's 2024 Trends Report and VMG Research

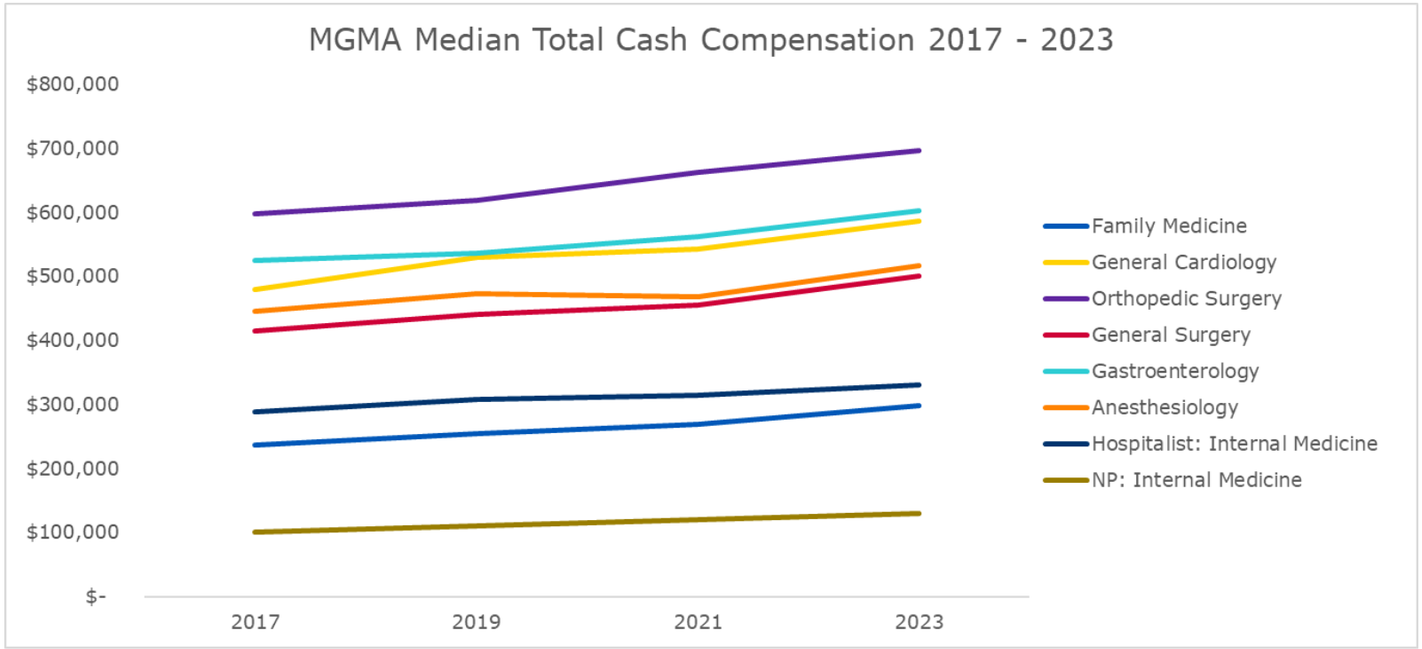
Physicians Have Choices

Traditional Private Practice	"Roll-up" Model Practice	Private Equity Backed Practice
Pay-vider	Vertically Integrated Corporate Retailers	Hospital and Health System-Owned
Traditional Office Setting	Hospital Based	Virtual / Telemedicine

And for Physicians thinking about selling their practices, often the choice is between:

- Risk
- Equity payment now
- Higher compensation into the future

Compensation Continues to Increase



Source: Medical Group Management Association, Physician Compensation and Production Surveys, 2018 - 2024

Compensation of a primary care physician continues to grow at a faster rate than that of other specialists

Specialty	CAGR 2017 - 2021	CAGR 2021 - 2023
Family Medicine	3.22%	5.22%
General Cardiology	3.13%	3.86%
Orthopedic Surgery	2.56%	2.55%
General Surgery	2.30%	4.96%
Gastroenterology	1.69%	3.51%
Anesthesiology	1.17%	5.05%
Hospitalist: Internal Medicine	2.16%	2.45%
NP: Internal Medicine	4.47%	3.77%

Common Types of Compensation Arrangements

Clinical Services

- Patient or WRVU-based services.
- Most common services provided by employed physicians.
- In a typical employment arrangement, usually comprises largest part of total compensation.

On-call Coverage Services

- Primarily for emergency department coverage.
- Unrestricted (off-site), but available when called.
- Typically respond by phone within 15 minutes and in-person within 30 minutes.

Physician Administrative Services

- Any non-clinical administrative services that require a physician.
- Examples include medical director, physician executive, research, and consulting, among others.

Coverage Services

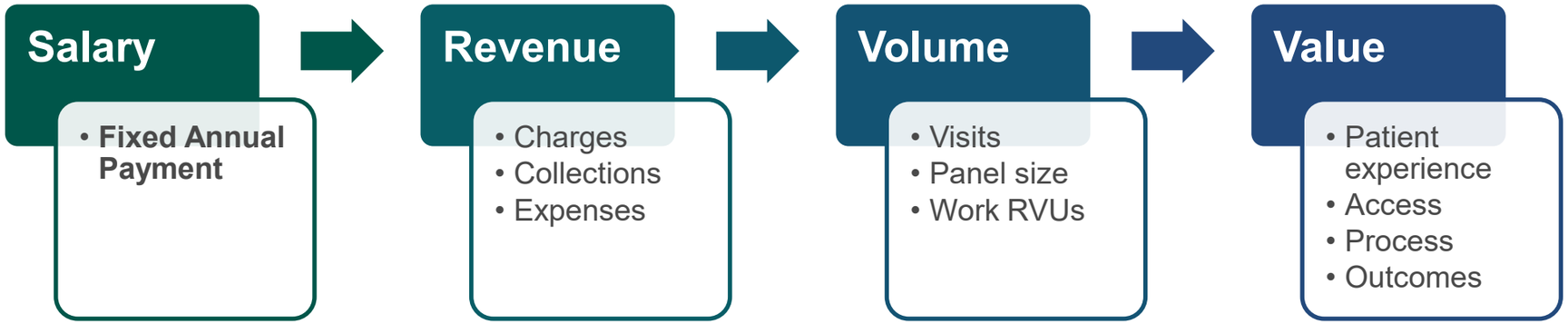
- Hospital based coverage that requires providers to be on-site.
- May include both on-site and off-site coverage
- Examples include Anesthesia, Laborist, NICU, PICU, Trauma, etc…

Value Based Care / Pay For Performance

- Payments that are in addition to fee-for-service compensation for improving clinical quality patient outcomes and clinical cost of care
- Examples include PSAs with quality bonuses, service line co-management, value-based distributions from payors or ACOs/CINs, and hospital efficiency improvement programs among others.

Value-Based Compensation

As payment evolves, so does physician compensation.....



Compensation Design to Support:

- Standardization
- Transition to value-based care
- Alignment with payment models
- Service line integration

Two major questions:

1. How can we fairly “split up the pie”?
2. How do we incentivize physicians to help “make the pie bigger”?

Clinical Comp: Common Misconceptions

- Compensation below 75th percentile is always FMV. Median is always FMV.
- Reported comp per wRVU should increase with production
- Matching WRVU percentiles and compensation percentiles means FMV
- The hospital down the street's offer must be FMV
- Compensation levels are similar market to market
- Organizations can "pick and choose" which market data to use
- If each component of comp is FMV, total comp is FMV.

Survey Data Considerations

- Limited number of respondents. Declining number of independent physician respondents. Circular reference?
- Not all respondents report data for each metric.
- Survey data collection process is not a perfect science. Reliant on self-reporting (MPFS issues, etc.). Limited local market data.
- Total cash compensation may include multiple sources of pay (clinical pay, on-call, quality incentives, administrative pay, practice earnings, etc.)
- Total Cash Compensation definitions differ between the surveys
- Lack of additional context metrics (quality, hours, etc.)

Example – Misapplication of Survey Metrics

Reported compensation per Work RVU at upper quartiles tends to misalign total cash compensation and productivity levels.

Example

Category	75th	90th
Annual Work RVUs Generated	10,730	13,652
Multiplied by: Compensation per Work RVU	$91.92	$119.02
Equals: Total Cash Compensation	$986,302	$1,624,861
Total Cash Compensation %-ile	***90th***	***165% of 90th***
Productivity Percentile	***75th***	***90th***

Example – Compensation is Market Dependent

Important Factors

1. Total Collections
2. Commercial Reimbursement
3. Payor Mix
4. Service/Procedure Mix

Example (Impact of Only Collections & Commercial Reimb.)

		Dallas		Houston	
Payor Mix		**Reimb.**	**Total**	**Reimb.**	**Total**
Total Medicare RVUs	5,000	$36.50	$182,500	$36.50	$182,500
Total Commercial RVUs	5,000	$48.55	$242,725	$29.20	$146,000
Total	**10,000**		**$425,225**		**$328,500**
Less: Practice Overhead			$175,000		$175,000
Less: Physician Salary & Benefits			$250,000		$250,000
Equals: Net Income (Loss)			**$225**		**($96,500)**

Value Based Care Compensation Considerations

Has an agreement been drafted that details the services and responsibilities of each party, fee structure/flow of funds (if applicable), and quality metrics/gates (if applicable)?

Have all eligible physicians been asked to participate?

Is the term of the agreement longer than 1 year?

Have appropriate safeguards been put into place to ensure patient safety and to prevent reduction in patient care?

Has there been a review of various VBC programs to ensure there is no overlap of services or payments?

Have the subject outcomes metrics been determined in advance?

Do the selected outcomes metrics align directly with the payor's patient population, service line, and/or the hospital's mission and values?

Are the selected outcomes metrics based on credible medical evidence?

Has performance been benchmarked against historical and national data in order to identify areas of opportunity and superior outcomes?

Has physician participant risk and/or responsibility for outcomes under the VBC model been considered?

Has an infrastructure been put into place to track and monitor performance and/or expenses incurred?

Have the parties ensured that the payments to the physician participants in the VBC program are CR and consistent with FMV?

Recent Enforcement Actions - Takeaways

Recent Settlement – Community Health Network

Summary

- Agreed to pay $345 million to resolve allegations the it violated the Stark Law. Whistle blowers were ex CFO and COO.
- Complaint alleged senior management recruited physicians for employment for the purpose of capturing their lucrative “downstream referrals.”
- Recruited hundreds of local physicians by paying them salaries that were significantly higher — sometimes as much as double — what they were receiving in their own private practices.
- Community hired a valuation firm to analyze the compensation it proposed paying to its recruited specialists. The complaint alleged that Community knowingly provided the firm with false compensation figures so that the firm would render a favorable opinion. The complaint further alleged that Community ignored repeated warnings from the valuation firm regarding the legal perils of overcompensating its physicians.
- In addition to paying specialists excessive compensation, the complaint alleged that Community awarded incentive compensation to physicians, in the form of certain financial performance bonuses that were based on the physicians reaching a target of referrals to Community’s network, again in violation of the Stark Law.

Community Health Network

Takeaways

- Don’t give your valuation firm bad data. They are not performing an audit or due diligence in most cases. Garbage in – garbage out.
- Using “rules of thumb” is dangerous. 75th percentile or below is not automatically FMV.
- Don’t “shop” around for firms that will support your desired outcome.
- Structure compensation models in a way that do not reflect impact of downstream referrals.

Recent Settlement – Christiana Care

Summary

- Agreed to pay $42.5 million to resolve allegations the it violated the Stark Law. Whistle blowers was chief compliance officer.
- Alleged that ChristianaCare had provided illegal remuneration to non-employee neonatologists and surgeons in the form of services from ancillary support providers (including nurse practitioners, hospitalists, and physician assistants).
- The lawsuit alleged that the services of the ancillary support providers impermissibly sought to induce those neonatologists and surgeons to refer their patients to ChristianaCare hospitals and created financial relationships between the non-employee providers and ChristianaCare.

ChristianaCare®

Takeaways

- It doesn't have to be cash comp to violate Stark Law – consideration can take many forms.
- Providing staff, equipment, space without charge or below market rates is seen as inducement by the government.

VMG Health: Background and Services

The Leading Healthcare Consulting Firm for **Business Performance**

30 Years

Since 1995, we've taken the business of healthcare to new levels of quality, innovation, and performance, keeping up with market, regulatory, and technology changes along the way.

320+ Professionals

Backed by 320+ experienced professionals with diverse credentials, VMG Health is known for exceptional client service, built on expertise and strong personal connections.

70,000 Engagements

VMG Health serves a diverse national client base—from large health systems to private equity firms—serving as the single source for valuation, strategic, and compliance needs.

VMG Health Services

From supporting traditional transactions to navigating the complexities of compliance and cybersecurity, VMG Health has the expertise and technology solutions that empower organizations to grow and develop while delivering quality care. We're taking the business of healthcare to new levels of quality, innovation, and performance.

- **M&A & Transaction Advisory**
- **Valuation Advisory**
- **Strategic Consulting**
- **Coding, Audit & Compliance**
- **Physician Enterprise & Medical Group Solutions**
- **Recruitment & Human Resources Support**
- **Operational Performance Consulting**
- **Litigation & Dispute Resolution**

Experts in Every Healthcare Sector

Our team is equipped to provide expert guidance along the entire continuum of care, including areas of innovation and high growth.

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- Health Systems & Hospitals
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- Kidney Care
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- Medical Transport
- Medical Device & Life Sciences
- Oncology
- Ophthalmology & Eyecare
- Pharmacy
- Physician Practices
- Post-Acute Care
- Risk-Bearing Organizations & Health Plans
- Telehealth
- Urgent Care & Free-Standing Emergency Departments

What Our Clients Say

92%

Client Satisfaction Rating

Deep relationships. Our secret to your success.

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Who We Serve

We are proud to serve a diverse group of healthcare organizations across the nation. Below are a few representative clients.

VMG HEALTH

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QUESTIONS?

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