



PRESIDENT'S MESSAGE

March 2015

Trusted Advocacy for
Fairness and Due
Process™ - "What's in
your wallet?"



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Late one evening in 1974 before beginning an ED night shift moonlighting at William A. Foote Memorial Hospital, 45 miles west of my residency training ground in Ann Arbor at University of Michigan, I decided to check my mailbox in the ED break room. I was looking for the latest version of the ED schedule (remember, this was long before the Internet), but what I found was an envelope containing a membership card to the American College of Emergency Physicians. ACEP was a fledgling organization that arose in East Lansing, 30 miles straight north of Foote, in support of the nascent specialty of Emergency Medicine. The ED group at Foote, in close contact with ACEP's nearby headquarters and eager to support the new organization, had paid my membership dues.

As I placed the ACEP card in my wallet, could I possibly have imagined that decades later in California, I would have lengthy and detailed conversations about the beginning of ACEP with the niece of one of ACEP's East Lansing founders? Even more improbable, could I have guessed I'd be writing this editorial, four decades later, on the critical issues of *Practice Fairness and Due Process*—largely ignored, practically and historically speaking, by ACEP, but a part of the

heart of AAEM? Answer to both questions: never in a million years.

Fast-forward 41 years to January 22, 2015, and a conversation I had with one of the regional directors of *CEP-America*, now reportedly providing care for over 25% of all the ED visits in California.¹ This RD I spoke with is familiar with Good Samaritan Hospital in San Jose. "Good Sam," owned by Hospital Corporation of America (NYSE symbol: HCA), is one of HCA's flagship facilities in California, enjoying an excellent payor mix and serving the area around Los Gatos, a tony bedroom community at the southwestern end of Silicon Valley. CEP-A has held the ED contract at Good Sam for over 20 years. The following background information on Good Sam and HCA is critical to understanding the gist of the dialogue I had with the RD.

EmCare, now a large division of Envision Healthcare as a part of the Envision IPO in August, 2013, is engaged in what AAEM believes is a fee-splitting arrangement, which raises concerns over violation of federal fee-splitting laws.² During a lecture at AAEM's 2014 Scientific Assembly in New York, CEP-A's CEO, Wesley Curry, presented several case studies of ED con-



tracts CEP-A had lost to EmCare and TeamHealth, *before* the birth of Envision. I have carefully read the voluminous analyses by the multiple investment banks that advised clients on the Envision IPO. Those complex documents mention the *joint venture* between EmCare and HCA—a *new* arrangement that could place CEP-A's contract at Good Sam at even greater risk of turnover to EmCare. Perhaps even more concerning when linked to the joint venture, those same investment banking notes refer to "*cross selling of multiple service lines*" as part EmCare's strategy. Put simply, it appears that EmCare is not only poised to offer HCA "anesthesiology, hospitalist, *surgery* and radiology" specialty services, but is willing to form a joint venture with HCA in which physician-generated fees are split with HCA. *Surgeons*, take note here: EmCare could now have *you* in its crosshairs.

AAEM is strongly opposed to the joint venture practice, and believes it may violate state and federal laws that prohibit fee-splitting arrangements over which working physicians have no control. ACEP, whose list of former presidents includes the founders of both EmCare and TeamHealth, has thus far failed to join AAEM in formal support of the thousands of physicians potentially harmed by the spread of hospital staffing company joint ventures and the possible fee-splitting they may hide. It is important to note that AAEM is advocating at a federal level for billing transparency. AAEM has long held that every emergency physician should know exactly what is billed in his/her name. Such transparency could aid physicians in ultimately understanding the line-item details of the management fees they incur.

Good Sam's anesthesiologists have recently merged their practice with *California Emergency Physicians-America*,³ apparently hoping to avoid facing the prospect of either working for EmCare or leaving Silicon Valley in search of better employment opportunities. A newly minted CEP-A anesthesiologist recently wrote on CEP-A's website: "So why did we choose to join an integrated acute care practice in which specialties such as emergency and hospital medicine could easily overshadow our own? One simple reason: external market forces threatened our practice model."³ I believe the Good Sam anesthesiologists understand the significant temptation for HCA to award *all* the hospital-based physician contracts at Good Sam to EmCare, in exchange for the new revenue stream from a joint venture. Have those CEP-A anesthesiologists done an opportunity cost analysis of the value of future cash flows to EmCare-HCA in a joint venture?⁶ Do the anesthesiologists know what a monopsony is, especially in relation to the prisoner's dilemma in game theory?¹² And most importantly, do they understand how to break the prisoner's dilemma and restore physician autonomy and medical

professionalism in the interest of better patient care?¹² No easy questions here, but the answers are critical to ensuring fairness and due process.

A cascade of contract turnovers could create an enormous cash cow that could line the pockets of HCA and EmCare senior managers and Envision Health investors alike. Are the anesthesiologists in CEP-A prepared to split fees directly with HCA, eliminating EmCare as the "middleman," in order to retain their exclusive service contract at Good Sam? These complex questions go to the heart of fair market value, and again, AAEM has a long record of decrying fee-splitting arrangements such as those between HCA and EmCare, euphemistically spun as a "joint venture."⁴

Now, back to that conversation with the CEP-A regional director. I asked him whether CEP-A had worked out a revenue division arrangement between the emergency physicians and their new anesthesiologist partners at Good Sam. The RD turned my question around and asked me, "Are you worried about revenue sharing?" "I'm worried about *fairness* in the development of any revenue-sharing process," I replied, noting that I had spent over 15 years studying the fair market value of management services in EM and had completed a 600-page draft toolkit for AAEM to inform members on the complex subject of practice fairness in our specialty. Developing a revenue-sharing model equitably would require starting with a *definition* of fairness, I pointed out. The RD's response was at once revealing and alarming: "Different people think different things are fair."

Three years earlier I had asked a high level CEP-A officer for his definition of *fairness*, in the context of the complexity of healthcare reform as it might affect emergency medicine. "I don't like that word, I don't know what that word means—it means different things to different people," he replied. Is there a pattern here at the top of CEP-A, with respect to lack of understanding of fair market value and fair process? Are CEP-A's rank-and-file physicians, who generate the income stream that pays the senior management, fully aware of the fair market value of management services and potential interest conflicts inherent in the CEP-A voting structure? More tough questions here for the EM group that touts itself for seeing over 25% of all the ED patients in the state of California and is bent on further expansion.

As a part of an important learning process, I hope the CEP-A RD and the CEP-A officer who appointed the RD as a part of an upper management circle in CEP-A—and *every hospital-based physician will consider the following:*

Fair Market Value Standards: Clear evidence that fairness, and its corollary, fair market value, matters in Emergency Medicine and other hospital based specialties—just

as it matters everywhere else.

Multiple public policies underscore the importance of fair market value (FMV) concepts and standards, and a broad consensus of Business Valuation Standards has at its nucleus a formal definition of the FMV of property, including *intangible assets*—which are clearly the central issue in any financial appraisal of hospital-based physician group operations, including revenue sharing and management services.^{5,6} The following standards are used nationally as fundamental methods for FMV determinations; AAEM believes that application of these standards in assessing hospital-based physician business entities is long overdue.⁷

IRS Revenue Rulings are issued to provide interpretive regulations that add operational substance to the tax laws passed by Congress. *Revenue Ruling 59-60*, widely cited by the courts and in the appraisal community since its publication in 1959, defines FMV as

“the price at which property [including intangibles] would change hands between a willing buyer and a willing seller when the former is *not under any compulsion to buy*, and the latter is *not under any compulsion to sell*, both parties having *reasonable knowledge of the common facts*.” [italics added].⁸

Thus, no transaction or process is fair without *common knowledge*, which game theorists define as “I know that you know that I know that you know...” every relevant fact about the transaction. Any tampering with this pure “hall of mirrors” common knowledge process shared by the two negotiating parties is the point at which the process becomes corrupt, and the “fair” disappears from fair market value. AAEM believes the history of EM is rife with wholesale manipulation of the information relevant to the details of the cash flows at the financial heart of EM business arrangements.⁹ As information is withheld, often in ways both subtle and intimidating, AAEM believes that arrangements, including pyramid growth buy-sell agreements based on lop-sided organizational voting structures, discriminate against the young physicians at the bottom of the pyramid. With limited choice in a marketplace often dominated by those in the inner circle of large management groups, AAEM believes that EPs exploited by financial arrangements lose the fair practice environment that is vital to the delivery of the highest quality emergency care—and ultimately patient care may suffer.

So critical is the concept of fair market value to the public policy surrounding pension and welfare payments, both clearly *vital societal safety net provisions*—*not unlike*

our nation's emergency departments—that the Department of Labor, acting through the Pension and Welfare Benefits Administration (PWBA), issued Proposed Regulations Relating to the Definition of Adequate Consideration (53 Federal Register 17632). Here “adequate consideration... means the fair market value of the asset as determined in good faith by the *trustee or named fiduciary* [italics added] involved in the management of pension and welfare benefits serving the public good.” This complex proposal process stipulates that value determinations “require a fiduciary to apply sound business principles of evaluation and conduct a prudent investigation of the circumstances at the time of the valuation.” Furthermore, the PWBA proposed that “the fiduciary making the valuation must itself be independent of all the parties of the transaction... or rely on the report of an appraiser who is independent of all the parties to the transaction...” These proposed requirements in summary defined action in “good faith” by the fiduciary. Though the PWBA subsequently withdrew its complex proposal after seven years of public commentary, to this day the proposal still widely informs the community of business valuation analysts and highlights the public merit of a transparent valuation process.⁷

In *Setting Limits Fairly: Learning to Share Resources for Health*, authors Norman Daniels and James Sabin bring forth the concept of “*accountability for reasonableness*” as an adaptable means “to answer a central question about justice and health care: how can a society or a health plan meet population health needs fairly under resource limitations?”¹⁰ The authors cite that “the following four conditions make more precise the notion for accountability for reasonableness:

1. **Publicity Condition:** Decisions... must be publicly accessible [Editor's note: this is the FMV transparency requirement.]
2. **Relevance Condition:** The rationales... should aim to provide a *reasonable* explanation [regarding] how the organization seeks to provide “value for money” in meeting the varied needs of a defined population... [Editor's Note: this is one side of the valuation argument.]
3. **Revision and Appeals Condition:** There must be mechanisms for challenge and dispute resolution regarding... decisions, and more broadly, opportunities for revision and improvement of policies in light of new evidence or arguments. [Editor's Note: this is in effect the other side of the valuation argument]
4. **Regulative Condition:** There is voluntary or public regulation of the process to ensure that conditions 1-3 are met. [Editor's Note: this in essence ensures that a “win-win” outcome occurs and is analogous to either party being able to walk away until a mutually

acceptable arrangement is reached—thus avoiding “win-lose,” “lose-win” and “lose-lose” outcomes.]”

Just as these authors note, “There is no escaping the need to construct a fair process for setting limits to health care,” so can one argue that fairness matters in *all* aspects of health care resource allocation—including *management costs in the practice of emergency medicine and other hospital-based specialties, and the development of complex revenue sharing arrangements.*

In summary, the universal themes in fair market valuation standards and fairness-based processes are 1) *common knowledge*, which is synonymous with the more popular term *transparency*, and 2) *lack of compulsion*, the option of either party to walk away until mutually favorable terms are reached. Until AAEM adopted the role of *The Trusted Advocate of Fairness in Emergency Medicine™*, the EM community had never had an entity committed to acting in good faith to promote transparency and lack of compulsory acceptance of win-lose terms in the countless negotiations that define the business of EM. Any medical specialty organization committed to advocating for fairness and acting as an agent on behalf of its members,¹¹ can adopt the standards cited above.

So, to physicians concerned about their loss of autonomy and medical professionalism to what AAEM believes may be a potentially illegal fee-splitting arrangement thinly disguised as a “joint venture,” consider actor Samuel L. Jackson’s pressing question on the advantages of the Capital One credit card: “What’s in *your* wallet?” What medical professional organization has been on the record for over 20 years consistently opposing any and all arrangements and processes that are not *rigorously fair*? Moreover, what professional organization is currently championing due process at a federal level, advocating that due process—a basic 5th Amendment right—be made a provision for Conditions of Participation in the federally sponsored Medicare program? The answer is unequivocal: The American Academy of Emergency Medicine.

CEP-A’s Jay Kaplan is in line for the president’s gavel at ACEP. In regard to the fundamental issues of Practice Fairness and Due Process,¹² I wait with great interest to see how years in CEP-A’s inner circle may affect Dr. Kaplan’s upcoming presidency, and whether he can influence ACEP to reach across the aisle and join AAEM in supporting the thousands of hospital-based physicians potentially hurt by fee-splitting and other joint venture arrangements. Now that a Florida emergency physician has filed a suit against HCA, EmCare and EM-1 Medical Services alleging wrongful termination after she questioned a corporate decision to limit ED staffing during a period of serious ED crowding, *resulting in a risk to patient safety*, support for fair and equitable practice environments is no longer an abstract issue.¹³ This case also raises concern about potential violation of statutes that ban the corporate practice of medicine.¹⁴ AAEM and ACEP united in formal support of practice fairness and due process rights

would represent a landmark step in protecting emergency physicians and their patients. I believe such united support is long overdue and would be welcomed everywhere.

By the way, I still have both membership cards in my wallet. How about you?

Respectfully submitted,

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AAEM: *The Trusted Advocate of Fairness in Emergency Medicine™*

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