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Expert Analysis

Turning an Exacting Eye to Physician-Hospital Compensation

By **Richard Strassberg**

And **William Harrington**

Salary negotiations are always fraught with emotion. But imagine a world where you have to worry that your boss might pay you too much. Sounds crazy. But this is exactly the kind of concern that most hospitals and doctors have to confront.

In June 2015, the Department of Health and Human Services (HHS) issued an "alert" about its concern that hospitals are overcompensating doctors in order to pay illegal kickbacks. HHS is suspicious of arrangements where hospitals appear to overpay doctors in exchange for patient referrals. Typically, such alerts are written at a time when an agency is developing cases that fit a consistent pattern. Indeed, in the six months since the alert, the HHS has brought a number of cases involving hospitals allegedly overcompensating physicians. The cases provide a guide to the key areas of concern for hospitals and physicians.

The HHS-OIG Fraud Alert

On June 9, 2015, the Office of Inspector General for the Department of Health and Human Services (the HHS-OIG) issued a fraud alert[1] cautioning physicians in particular that while "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 HHS-OIG placed the onus on physicians to ensure that compensation arrangements reflect fair market value for bona fide services the physicians actually provide to their patients and admonished physicians to take the initiative in ensuring compliance by diligently analyzing the terms and conditions of such arrangements.

The alert followed recent settlements between the HHS-OIG and 12 individual physicians who entered into "questionable" medical directorship and other compensation arrangements. According to the HHS-OIG, these physicians received compensation which considered the volume and value of referrals, did not reflect fair market value for the services performed and compensated physicians for services not actually rendered. Several of the physicians also entered into compensation arrangements where the health care entity paid the salaries of the physicians' staff.

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The alert and corresponding settlements signal a new focus on physician accountability in unlawful compensation and kickback schemes. It appears that HHS-OIG is now focused on subjecting both the health care entities and individual physicians to criminal and civil penalties. For hospitals and physicians, it's worth knowing that payment of a "kickback" renders an arrangement illegal even if a patient is otherwise getting medically necessary, excellent quality health care.

The Applicable Law

Physician-hospital compensation arrangements implicate three related federal statutes. The Anti-Kickback Statute[2] provides criminal penalties for physicians and health care entities "who knowingly and willfully solicit[] or receive[] any remuneration" in exchange for patient referrals from federal health care programs. Remuneration includes anything of value, such as rent, staffing compensation, and excessive compensation for medical directorships or consultancies.

Physicians and health care entities who pay or accept kickbacks face jail terms up to five years per violation, fines up to $25,000 per violation and expulsion from participation in federal health care programs. Penalties up to $50,000 per kickback plus three times the amount of the remuneration may also be assessed.

The Physician Self-Referral Law,[3] more commonly referred to as the Stark Law, prohibits physicians who have a financial relationship, including compensation arrangements, with a health care entity from referring patients to that entity to receive "designated health services" billed to federal health care programs. While the Stark Law includes exceptions for many legitimate hospital-physician arrangements, it generally mandates all payments made to referring physicians be at fair market value for the services rendered. Compensation taking into consideration the volume or value of the physician's referrals to the hospital is strictly prohibited. Civil penalties for Stark Law violations include denial of payments, refund of payments, a $15,000 per service civil monetary penalty and civil assessments of up to three times the amount claimed.

The False Claims Act[4] prohibits the submission of fraudulent claims for payment to federal health care programs. Claims that violate the Anti-Kickback Statute and/or the Stark Law may also render the claim fraudulent under the False Claims Act. Civil penalties for false claims violations include fines up to three times the program's loss plus $11,000 per claim filed.

Prosecutions and Settlements

Since the June alert, HHS-OIG has issued a flurry of announcements related to ongoing investigations. The cases highlight critical areas of focus for hospitals and physicians.

Sacred Heart Hospital.[5] In July 2015, the former executives and two physicians of the now-shuttered Sacred Heart Hospital on Chicago's West Side were sentenced to prison terms for their roles in orchestrating and participating in unlawful compensation schemes for physicians providing Medicare and Medicaid patient referrals. From 2001 to April 2013, the executives conspired to pay kickbacks and bribes to physicians to induce them to refer patients to the hospital for services that would be reimbursed by Medicare and Medicaid. The kickbacks were disguised in

RICHARD STRASSBERG *and* WILLIAM HARRINGTON *are partners at Goodwin Procter, based in the New York office.* ELIZABETH DAVID, *an associate at the firm, contributed to this article.*

a variety of ways, including a sublease for space the hospital never used and teaching contracts to instruct non-existent students.

The court imposed prison sentences on the individuals running the hospital and the doctors involved in the scheme that ranged from six months to 54 months, and included the imposition of an order of forfeiture for $8.48 million.

Mercy Medical Communities.[6] In August, Mercy Health Springfield Communities, formerly known as St. John's Health System, and Mercy Clinic Springfield Communities, formerly known as St. John's Clinic, agreed to pay the United States $5.5 million to settle allegations that they violated the False Claims Act by submitting false claims to Medicare for services rendered to patients referred by physicians who received bonuses based on a formula that took into consideration the value of the physicians' referrals of patients to the clinic. According to the settlement, physicians were placed in different "stark groups" based on the volume and value of services ordered. Physicians who ordered high-volume and value services were placed in a stark group with similar high-volume and value orders. The proceeds from these services then went into a single pot for each stark group and were divided among like-value orders.

North Broward Hospital District.[7] In September 2015, North Broward Hospital District agreed to pay the United States $69.5 million to settle allegations that it violated the False Claims Act by providing commercially unreasonable compensation to nine employed physicians that exceeded the fair market value of their services. The compensation formulas, which considered the volume and value of physician referrals, would have resulted in major net operating losses if the profits from Medicare and Medicaid referrals were not considered. Physicians were awarded contracts with excessive compensation levels, guaranteeing base salaries in excess of their gross revenues from previous years and offering bonuses based on inflated rates of compensation per relative value units, or referral revenues, based on the allegations in the settlement. The Justice Department noted "this settlement should deter similar conduct in the future and help make health care more affordable."

Adventist Health Systems.[8] In September 2015, Adventist Health Systems agreed to pay $115 million to settle allegations that it violated the False Claims Act by submitting false claims to the Medicare and Medicaid programs for services rendered to patients referred by employed physicians who received bonuses based on a "bottom line" and "pay for play" formulas that unlawfully took into consideration the number of tests and procedures ordered by the referring physician. Adventist Health also allegedly compensated physicians in amounts that exceeded fair market value and were commercially unreasonable.

Tuomey Healthcare System.[9] In October 2015, Tuomey Healthcare System agreed to pay the United States $72.4 million to settle a $237 million judgment against it for entering into contracts with 19 specialist physicians that required the physicians to refer their outpatient procedures to Tuomey and, in exchange, paid them compensation that far exceeded fair market value, was not commercially reasonable, and took into consideration the volume and value of the referrals. On average, physicians were paid over 130 percent of the amount their own services generated for the hospital. The Justice Department warned that it is "determined to prevent the kind of abuses uncovered in this case, and [is] willing to take such cases to trial to protect the integrity of the Medicare program."

Change in Incentives

The issues with physician-hospital compensation arrangements arise in part from the financial incentives baked into federal health care repayments. For example, Medicare assumes that hospital care, by its very nature, is more expensive than its office-based counterpart and so pays higher reimbursement rates for the same procedures when performed by hospital-employed physicians rather than independent physicians. Historically, higher hospital rates have been justified by a mixture of reasons, including hospital hours, emergency room overhead, and hospital's stricter regulatory and reporting requirements.

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The differences in compensation schematics means that the same physician doing the same work will be paid more by the government if they sell their private practices to hospitals. In recent years, there have been dramatic increases in the number of physicians working for hospitals and other health care entities across the spectrum of specialties. While other motivations for hospital-owned practices play a role in this trend away from independent practice—including the benefits of having health systems manage a patient's entire health care experience—the reimbursement discrepancies are a critical focus of the drive for physician-hospital mergers.

This reimbursement disparity has, to a limited extent, changed. In February 2015, the Obama administration asked Congress in its budget reform to "[e]ncourage efficient care by improving incentives to provide care in the most appropriate ambulatory setting."[10] The proposed budget would effectively equalize reimbursement payments between independent physicians and physicians who work in "off-campus," hospital-owned practices.[11] Only those physicians who work "on-campus" would continue to receive the higher hospital reimbursement rate. On Nov. 2, the budget bill was passed, eliminating the Medicare reimbursement distinctions between hospitals and independently owned outpatient clinics and offices.[12] However, the equalization of Medicare reimbursement rates for off-campus facilities is only applicable to off-campus entities acquired going forward. Existing hospital-owned off-campus outpatient clinics and offices are permitted to continue to capitalize on the Medicare reimbursement disparities.

The rapidly changing landscape of doctor compensation makes assessing the appropriate level of play all the more challenging for doctors and hospitals. But it is clear that HHS is focused on ensuring that hospitals do not pay doctors more than fair market rates.

1. Office of Inspector General, Department of Health and Human Services, "Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability," (June 9, 2015), available at http://oig.hhs.gov/compliance/alerts/guidance/Fraud_Alert_Physician_Compensation_06092015.pdf.
2. Criminal Penalties for Acts Involving Federal Health Care Program 42 U.S.C. §1320a-7b(b) (2006).
3. Limitation on Certain Physician Referrals 42 U.S.C. §1395nn (2010).
4. False Claims, 31 U.S.C. §§3729-3733 (2006).
5. See Press Release, "U.S. Attorney's Office, Northern District of Illinois, Former Chief Operating Officer of Sacred Heart Hospital Sentenced to 21 Months in Prison for Conspiring in Kickback Scheme," (July 31, 2015), available at http://www.justice.gov/usao-ndil/pr/former-chief-operating-officer-sacred-heart-hospital-sentenced-21-months-prison; see also Complaint, *U.S. v. Novak*, No. 13 CR 312 (N.D. Ill. April 15, 2013); Amended Complaint, *U.S. v. Novak*, No. 13 CR 312 (N.D. Ill. March 18, 2014).
6. See Press Release, Department of Justice, Office of Public Affairs, "Missouri Hospital Agrees to Pay United States $5.5 Million to Settle Alleged False Claims Act Violations," (Aug. 13, 2015), available at http://www.justice.gov/opa/pr/missouri-hospital-agrees-pay-united-states-55-million-settle-alleged-false-claims-act; see also *First Amended Complaint, U.S. ex rel. Moore v. Mercy Health Springfield Communities f/k/a St. John's Health System, Inc.*, No. 13-3019-CV (W.D. Mo. Aug. 29, 2013).
7. See Press Release, U.S. Attorney's Office, Southern District of Florida, "Florida Hospital District Agrees to Pay United States $69.5 Million to Settle False Claims Act Allegations," (Sept. 15, 2015), available at http://www.justice.gov/opa/pr/florida-hospital-district-agrees-pay-united-states-695-million-settle-false-claims-act; see also "Realtor's Second Amended Complaint Under Federal False Claims Act," *U.S. ex rel. Reilly v. North Broward Hospital District*, No. 10-60590 (S.D. Fla. Sept. 29, 2011).
8. See Press Release, Department of Justice, Office of Public Affairs, "Adventist Health System Agrees to Pay $115 Million to Settle False Claims Act Allegations," (Sept. 21, 2015), available at http://www.justice.gov/opa/pr/adventist-health-system-agrees-pay-115-million-settle-false-claims-act-allegations; see also *First Amended Complaint, U.S. ex rel. Dorsey v. Adventist Health Systems/Sunbelt*, No. 3:13-CV-217 (W.D.N.C. Jul. 17, 2013).
9. Press Release, Department of Justice, Office of Public Affairs, "United States Resolves $237 Million False Claims Act Judgment Against South Carolina Hospital that Made Illegal Payments to Referring Physicians," (Oct. 16, 2015), available at http://www.justice.gov/opa/pr/united-states-resolves-237-million-false-claims-act-judgment-against-south-carolina-hospital.
10. Office of Management and Budget, Fiscal Year 2016 Budget of the U.S. Government, 106 (Feb. 2, 2015) available at https://www.whitehouse.gov/sites/default/files/omb/budget/fy2016/assets/budget.pdf.
11. Discussion Draft, H.R. _, 114th Cong., 35-39 (Oct. 26, 2015) available at http://docs.house.gov/billsthisweek/20151026/BILLS-114hr-PIH-BUDGET.pdf#page=35.
12. H.R. 1314, 114th Cong. (2015) (enacted).

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