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Regulatory Scrutiny for Physician Compensation Continues

Since the beginning of September 2015, the *Department of Justice* (DOJ) and the *Office of Inspector General* (OIG) have announced three major settlements with health systems relating to physician compensation issues. In *United States ex rel. Barker v. Columbus Regional Healthcare System et al.*, the Columbus, Georgia-based organization Columbus Regional Healthcare System agreed to pay a minimum of $25 million to settle allegations of healthcare fraud & abuse through excessive physician compensation and upcoding of physician services.[1] In *U.S. ex rel. Reilly v. North Broward Hospital District*, the Broward County, Florida-based government hospital, North Broward Hospital District, agreed to pay $69.5 million to settle allegations of tracking physician referral dollars to offset the losses of employing physicians in violation of the Stark Law.[2] Finally, in *U.S. ex rel. Payne et al. v. Adventist Health System et al.*, Adventist Health System agreed to pay $115 million to settle allegations of employing physicians at a loss, which would be covered by referrals for inpatient and ancillary services by the employed physicians, in violation of the Stark Law.[3] The short timeframe between the settlement announcements, coupled with the high dollar value of the settlements, reflect the OIG's continued push to scrutinize physician compensation arrangements after the OIG issued its "*Special Fraud Alert*" on physician compensation issues in June 2015[4] and should put organizations and boards of directors on high alert for potential regulatory violations. This Health Capital Topics article will review the allegations contained in each lawsuit and discuss how these cases highlight how healthcare organizations may be prudent to seek additional protection in their efforts to maintain compliance with federal fraud and abuse laws.

Of the three recent cases settled with the DOJ and OIG, two broke the inglorious record for largest settlement amount without litigation in relation to the *Stark Law*. The first of the three cases was settled between the government and Columbus Regional Healthcare System for $25 million, with the potential for Columbus Regional to pay an additional $10 million.[5] In *U.S. ex rel. Barker v. Columbus Regional Healthcare System*, a relator, or whistleblower, filed two lawsuits alleging, in part, that Columbus Regional physicians, particularly oncologists, associated with an affiliated cancer center, were compensated in excess of *fair market value* (FMV) for their physician salaries as well as through medical directorship arrangements that were not *commercially reasonable*.[6] The complaints also alleged that Columbus Regional submitted claims to federal healthcare programs for upcoded physician services that were inappropriate based on patients' medical records.[7] At the time of filing, the relator had served as an administrative director at a cancer center within Columbus Regional; however, the relator had experience with healthcare compliance issues through previous employment as a compliance officer for another healthcare company.[8]

In addition to payment by Columbus Regional, the settlement agreement also provided that one of the physicians who allegedly received excessive salary and directorship payments from Columbus Regional agreed to be held liable to pay $425,000 to resolve the allegations.[9] The individual lawsuit is yet another reminder that the government is also holding individuals liable for their role in healthcare fraud and abuse violations. As mentioned in previous *Health Capital Topics* articles, this heightened focus on individual liability emphasizes the importance of physicians and boards of directors to ensure that physician compensation arrangements can withstand regulatory scrutiny.[10]

Less than two weeks after the Columbus Regional settlement, the DOJ and OIG announced a then-record breaking settlement with Florida-based North Broward Hospital District to resolve allegations of fraudulent financial arrangements with referring physicians.[11] The lawsuit, which settled for $69.5 million, alleged that the hospital district compensated nine physicians in excess of FMV for their services, at levels which were not commercially reasonable, and at levels that took into account the volume or value of referrals by the physicians.[12] In this case, the relator alleged that North Broward's financial strategists purposely tracked the physicians' referrals in "*Contributive Margin Reports*," which were then used to cover the "*massive direct losses*" from excessively compensating the physicians.[13] This lawsuit highlights a particular approach utilized by the OIG and DOJ to determine whether to intervene in a healthcare fraud and abuse case filed by a relator: that employing physicians at a loss can be a sign of excessive physician compensation under the Stark Law.

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The complaint alleges that, for North Broward, employing physicians at a loss is not a "*commercially sustainable business model*," alleging that employing physicians at a loss "*is only sustainable by anticipating and allocating hospital referral profits to cover the massive direct losses from excessive physician compensation*."[14] Furthermore, it emphasizes the government's use of the one-purpose test, which states that if even one purpose of a compensation arrangement is to induce referrals, then the entire arrangement violates the *Anti-Kickback Statute*.[15]

The most recent of the three settlements arose from a group of relators' claim against Adventist Health System for over-compensating and rewarding physicians in an effort to induce referrals.[16] The settlement, which broke the record set only one week prior by North Broward for largest award to the government for Stark Law violations without a trial, amounted to a staggering $115 million dollars.[17] The complaint, filed a group of relators associated with compliance activities within the Adventist system,[18] alleged that Adventist repeatedly authorized non-commercially reasonable compensation arrangements that exceeded FMV with physicians such that the hospitals would have been forced to operate at a loss, but for the referrals generated by the physicians.[19] The physicians allegedly received bonuses that were tied to the number of tests and procedures ordered, and also allegedly coded their services improperly in order to obtain a higher reimbursement amount for the services rendered.[20] Examples alleged in the relators' complaint included: (1) payment by Adventist of a physician's luxury car leases; (2) payment by Adventist for a physician's private practice supplies, staff, equipment, and malpractice insurance; and, (3) payment of a $710,000 bonus by Adventist to a dermatologist who worked part-time.[21]

These three settlements highlight both the government's heightened pursuit of physician compensation arrangements in light of its June 2015 fraud alert as well as its development of its attitude toward employment of a *trained and assembled physician workforce* (TAWF) by hospitals and health systems. Each of the complaints were similar in that each alleged that the physicians were compensated at rates that could only be commercially reasonable if they took into account the value or volume of referrals. Additionally, the complaints alleged that the physicians at issue received remuneration for their services that did not fit within the range of FMV. However, arguably the most troubling thread connecting these three cases is that the government, through the relators, argued that the hospitals employed physicians at a loss, which was offset by the physicians' alleged referrals. This assumption seems to imply that a hospital cannot employ physicians at a loss without committing healthcare fraud, or in other terms, that hospitals have to employ physicians at a gain. This attitude towards physician employment could discourage hospitals from hiring physicians, and it seems to defeat the purpose for physicians to join a hospital, since a physician who must increase hospital profits would be incentivized to work in private practice instead, wherein he/she could keep the profits for him/herself. Additionally, this approach ignores two critical facts that help guide determinations of value for TAWF:

(1) "*[I]ndividual discrete intangible assets may hold value even in the absence of positive net cash flow being generated by the enterprise in its entirety*;" and,

(2) "*[T]he possibility that there may be economic benefit of avoided costs that potential purchasers obtain by purchasing an assembled, trained workforce that fits into the strategic mission of the purchasing organization*."[22]

It may be beneficial for healthcare organizations to consider these three cases when examining their own compliance programs. Early preventive measures to pinpoint any potential areas of concern could significantly reduce the likelihood of a future healthcare fraud investigation or lawsuit. Additionally, providers may feel more comfortable with obtaining a certified opinion, prepared in compliance with professional standards by an independent credential valuation professional (under the advice of legal counsel) and supported by adequate documentation, as to whether each of the elements of a proposed transaction are both at FMV and commercially reasonable, so as to establish a risk adverse, defensible position that the transactional arrangement, including physician compensation arrangements, can withstand regulatory scrutiny.

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1 "United States ex rel. Barker v. Columbus Regional Healthcare System et al.," Case No. 4-14-cv-304 (M.D.Ga. December 29, 2014), Relator's Complaint, p. 13, 14, 27; "Georgia Hospital System and Physician to Pay More than $25 Million to Settle Alleged False Claims Act and Stark Law Violations" U.S. Department of Justice, September 4, 2015, http://www.justice.gov/opa/pr/georgia-hospital-system-and-physician-pay-more-25-million-settle-alleged-false-claims-act-and (Accessed 9/16/15).

2 "United States ex rel. Reilly v. North Broward Hospital District, et al.," Case No. 10-60590-CV (S.D.Fla. September 11, 2012), Relator's Third Amended Complaint Under Federal False Claims Act, p. 29-31; "Florida Hospital District Agrees to Pay United States $69.5 Million to Settle False Claims Act Allegations" U.S. Department of Justice, September 15, 2015, http://www.justice.gov/usaosdfl/pr/floridahospitaldistrictagreespayunitedstates695millionsettlefalseclaimsact (Accessed 9/16/15).

3 "United States ex rel. Payne et al. v. Adventist Health System et al.," Case No. 3:12cv856-W (W.D.N.C. February 13, 2013), Relator's Amended Complaint, p. 56-57; "Adventist Health System Agrees to Pay $115 Million to Settle False Claims Act Allegations" U.S. Department of Justice, September 21, 2015, http://www.justice.gov/opa/pr/adventist-health-system-agrees-pay-115-million-settle-false-claims-act-allegations (Accessed 9/22/15).

4 "Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability" Office of Inspector General, U.S. Department of Health and Human Services, June 9, 2015, http://oig.hhs.gov/compliance/alerts/guidance/Fraud_Alert_Physician_Compensation_06092015.pdf (Accessed 10/12/15).

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7 "U.S. ex rel. Barker v. Columbus Regional Health System" Case No. 4:12-cv-304 (M.D. Ga May 10, 2013), Amended Complaint, p. 21.

8 "U.S. ex rel. Barker v. Columbus Regional Health System" Case No. 4:12-cv-304 (M.D. Ga May 10, 2013), Amended Complaint, p. 3.

9 "Georgia Hospital System and Physician to Pay More than $25 Million to Settle Alleged False Claims Act and Stark Law Violations" By DOJ, September 4, 2015, http://www.justice.gov/opa/pr/georgia-hospital-system-and-physician-pay-more-25-million-settle-alleged-false-claims-act-and (Accessed 10/9/15).

10 See July 2015's "Fraud Alert Puts Added Pressure on Physicians" and the 3-part series on Commercial Reasonableness and ACOs in August, September, and October 2015.

11 "Adventist Health System to pay $118.7 million settlement over Stark, False Claims allegations" By Lisa Schencker, Modern Healthcare, September 21, 2015, http://www.modernhealthcare.com/article/20150921/NEWS/150929974 (Accessed 10/9/15).

12 "Florida Hospital District Agrees to Pay United States $69.5 Million to Settle False Claims Act Allegations" By DOJ, September 15, 2015, http://www.justice.gov/usao-sdfl/pr/florida-hospital-district-agrees-pay-united-states-695-million-settle-false-claims-act (Accessed 10/9/15); "U.S. ex rel. Reilly v. North Broward Hospital District" Case No. 10-60590-CV (S.D.Fla. September 11, 2012), Relator's Third Complaint under Federal False Claims Act, p. 8.

13 "U.S. ex rel. Reilly v. North Broward Hospital District" Case No. 10-60590-CV (S.D.Fla. September 11, 2012), Relator's Third Complaint under Federal False Claims Act, p. 28-31.

14 "United States ex rel. Reilly v. North Broward Hospital District, et al.," Case No. 10-60590-CV (S.D.Fla. September 11, 2012), Relator's Third Amended Complaint Under Federal False Claims Act, p. 31.

15 "United States ex rel. Reilly v. North Broward Hospital District, et al.," Case No. 10-60590-CV (S.D.Fla. September 11, 2012), Relator's Third Amended Complaint Under Federal False Claims Act, p. 26.

16 "Adventist Health System Agrees to Pay $115 Million to Settle False Claims Act Allegations" By DOJ, September 21, 2015, http://www.justice.gov/opa/pr/adventist-health-system-agrees-pay-115-million-settle-false-claims-act-allegations (Accessed 10/9/15).

17 *Ibid*.

18 "U.S. ex rel. Payne v. Adventist Health System et al." Case no. 3:12cv856-W (W.D.N.C. February 13, 2013), Relator's Amended Complaint p. 9-10.

19 "U.S. ex rel. Payne v. Adventist Health System et al." Case no. 3:12cv856-W (W.D.N.C. February 13, 2013), Relator's Amended Complaint p. 4-6.

20 DOJ, September 21, 2015.

21 U.S. ex rel. Payne v. Adventist Health System et al." Case no. 3:12cv856-W (W.D.N.C. February 13, 2013), Relator's Amended Complaint, p. 72, 77.

22 "Valuation of Healthcare Intangible Assets in the Absence of Positive Net Cash Flows" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, CVA, CM&AA, Todd A. Zigrang, MBA, MHA, ASA, FACHE, John R. Chwarzinski, MSF, MAE, and Jonathan T. Wixom, MBA, Business Valuation Review, Vol. 34, No. 3 (Fall 2015) p. 144.

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