Physician Arrangements Panel

HCCA Dallas Regional 2020

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Common Types of Arrangements

- Employment
- Professional Services Agreement (PSA)
- Call Coverage
- Medical Directorship
- Management Services Agreement (MSA)
- Leases (Equipment, Staff, Space, etc.)
- Clinical Co-Management
- Gainsharing
- Quality and Efficiency Programs (QEP)
- Clinically Integrated Network / ACO
- Business Acquisition / Sale
- Others

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Major Risks

- Healthcare Regulations
  - False Claims Act
  - Anti Kickback Statute
  - Stark Law
- Fair Market Value
  - Aggregate compensation
- Services performed
  - US v. Campbell (UMDNJ)
- Cherry picking

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False Claims Act (FCA)

- Subject to civil liability any person who:
  - (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;
  - (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; or
  - (C) conspires to commit a violation of the FCA.*
- To properly plead a violation of the FCA, the United States or a relator must plead:
  - (1) a false statement or fraudulent course of conduct;
  - (2) made or carried out with the requisite scienter;
  - (3) that was material; and
  - (4) that is presented to the Government.**
- An FCA suit may be brought either by the United States or, under the statute's *qui tam* mechanism, by a private relator with original knowledge of wrongdoing.+

* 31 U.S.C. § 3729(a)(1)(A–C).
** *U.S. ex rel. Steury v. Cardinal Health, Inc.*, 625 F.3d 262, 268 (5th Cir. 2010).
+ 31 U.S.C. § 3730(a, b).

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Anti-Kickback Statute (AKS) and Stark Laws

Anti-Kickback Statute

- AKS provides criminal penalties for knowingly and willfully offering or paying any remuneration (including any kickback) **directly** or **indirectly**, overtly or covertly, **in cash** or **in kind** to **any person** (physician) to induce such person to refer an individual (patient) to a person for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program.*

Stark Laws

- Stark Laws bar entities from submitting claims to federal health care programs if the services forming the basis of the claims were furnished pursuant to referrals from physicians with which the entities had a financial relationship.**

* 42 U.S.C. § 1320a–7b(b)(2).
** 42 U.S.C. § 1395nn(a)(1).

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Why is this important?

- In FY19, OIG recovered over $5 billion from criminal and civil actions
  - 809 total criminal actions
  - 695 civil actions
- DOJ recovered over $3 billion from False Claims Act cases in FY19.
  - Over $2.1 billion from qui tam cases alone

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What does case law tell us?

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977 F.Supp.2d 654

United States District Court,

S.D. Texas,

Victoria Division.

2013

UNITED STATES OF AMERICA, EX. REL. DAKSHESH PARIKH, ET AL, PLAINTIFFS,

V.

CITIZENS MEDICAL CENTER, ET AL, DEFENDANTS.

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Settlement

- Citizens Medical Center (Citizens), a county-owned hospital in Victoria, Texas, agreed to pay the United States $21,750,000 to settle allegations that it violated the False Claims Act by engaging in improper financial relationships with referring physicians.
- The settlement resolved allegations that the hospital provided compensation to several cardiologists that exceeded the fair market value of their services. The settlement also resolved allegations that the hospital paid bonuses to emergency room physicians that improperly took into account the value of their cardiology referrals.

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Original Claims

- Relators practiced at Citizens and exercised privileges there. Relators alleged that Citizens, acting through Defendant Brown, violated the FCA predicated on Defendants' submission of Medicare and Medicaid claims rendered in violation of the AKS for federal health care programs, and the Stark, by implementing:
  - Bonus and fee-sharing programs for different groups of emergency room physicians working at the hospital who referred patients for cardiology treatment at Citizens.
  - Employing cardiologists and other physicians at above-market salaries and providing them discounted office space.
  - Demanding that Relators refer all their surgical patients to the hospital's exclusive cardiac surgeon.

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ER Physicians

- Relators alleged that the ER physicians, including twelve doctors identified by name, received illegal bonuses for referring ER patients to the hospital's Chest Pain Center.
- To increase revenues, Citizens allegedly knowingly and willfully paid the ER Physicians illegal bonuses based on the volume, value, and revenue generated from the ER Physicians' patient referrals to the hospital's Chest Pain Center.
- Relators alleged that Citizens created two shell companies used to funnel bonus payments to the ER physicians and argued that this act of obfuscation demonstrates intent to violate the law.
- To plead FCA liability predicated on AKS violations, Relators need only allege the particular details of a scheme to offer kickbacks in order to induce referrals, coupled with reliable indicia leading to a strong inference that claims based on such referrals were actually submitted to Medicare or Medicaid.
- FCA predicated on the Stark laws require the amount of the remuneration paid be consistent with the services' fair market value and not be determined in a manner that takes into account the volume or value of the referrals, and the remuneration be commercially reasonable.
- All of the alleged FCA violations predicated on Citizens violating AKS and Stark through its financial arrangements with the ER physicians have been pleaded properly and are supported with sufficient evidence.

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Defense Argument –Personally Performed Services and Court Response

- …[T]the hospital's argument that the 28 individual referrals alleged are exempt under Stark's personal services exception, *see* 42 U.S.C. § 1395nn(h)(5); 42 C.F.R. § 411.351 (exception from liability for referrals for which the services rendered were personally performed by the same physician who made the referrals), ignores two critical facts. On one hand, it does not cover all the allegations, because three of the 28 individual patients that the ER physicians referred to the Chest Pain Center were then treated by other physicians. *See* Docket Entry No. 49 ¶ 54 (for patients K.H., R.C., and R.G.). **More fundamentally**, even if the referring physicians personally performed the services, it fails to account for the fact that the **facility fee portion of each bill is considered a Stark referral**. *See United States ex rel. Drakeford v. Tuomey Healthcare Sys., Inc.,* 675 F.3d 394, 406-07 (4th Cir.2012) (adopting the Health Care Financing Administration's interpretation that "the personal services exception does not extend to a facility fee a hospital bills for a facility component resulting from a personally performed service").

1 31 U.S.C. § 3729(a)(1)(A–C)

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Defense Argument-Employed Physician Defense

- Defense: The hospital's final argument concerning the ER physician allegations is that, because the ER physicians were employed by Citizens beginning in 2010, all Medicare and Medicaid claims submitted after that point fall within the AKS's and Stark's employment exceptions. *See* Docket Entry No. 53 at 12-15. The AKS's employment exception states that no violation of the statute will occur for "any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services." 42 U.S.C. § 1320a-7b(b)(3)(B). Stark's employment exemption applies to "[a]ny amount paid by an employer to a physician... who has a bona fide employment relationship with the employer for the provision of services" with several qualifications. 42 U.S.C. § 1395nn(e)(2). Those qualifications include that the employment be for identifiable services, **the amount of the remuneration paid be consistent with the services' fair market value** and **not be determined in a manner that takes into account the volume or value of the referrals**, and the remuneration **be commercially reasonable.**

1 31 U.S.C. § 3729(a)(1)(A–C)

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Defense Argument-Employed Physician Defense

- **Defense Burden**: The AKS's employment exemption only excepts compensation paid to "bona fide" employees, who are defined under 26 U.S.C. § 3121(d)(2) as "individual[s] who, under the usual common law rules applicable in determining the employer-employee relationship, ha[ve] the status of an employee." 26 U.S.C. § 3121(d)(2); *see Robinson,* 505 Fed.Appx. at 387. Thus, whether the ER physicians count as bona fide employees under the AKS depends on Citizens meeting its burden of showing that the common law factors — which include whether Citizens had the right to control the manner and means of the physicians' work, the method of payment, and Citizens' control over the physicians' work hours — support such a conclusion. *See Robinson,* 505 Fed. Appx. at 387-88 (analyzing these factors and finding that two individuals were not bona fide employees for purposes of the AKS). **And with respect to Stark's employment exception, the ER physicians' compensation must not vary with the volume or value of their referrals. 42 U.S.C. § 1395nn(e)(2).**

1 31 U.S.C. § 3729(a)(1)(A–C)

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Cardiologists

- Relators alleged that Citizens operated a separate kickback scheme with a group of cardiologists, identifying five cardiologists by name, that Citizens **employed at above-market salaries** and provided with **various other financial incentives** in order to induce them to refer their patients for cardiac surgery and other services at the hospital.
- Relators also alleged that the five cardiologists were provided with benefits including malpractice coverage, health and dental insurance, dictation services, paid advertising, and that Citizens rented office space to them at below-market rates.
- Relators alleged that Citizens **gave** the cardiologists **all these benefits in order to induce them to refer** their patients for services at Citizens, particularly for cardiac surgery with the hospital's exclusive cardiac surgeon.

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Cardiologists-Improper Remuneration

- The Court held that Relators made several allegations that provide a strong inference of the existence of a kickback scheme. "Relators have made several allegations that, if true, provide a strong inference of the existence of a kickback scheme. **Particularly, the Court notes Relators' allegations that the cardiologists' income more than doubled after they joined Citizens, even while their own practices were costing Citizens between $400,000 and $1,000,000 per year in net losses**. Even if the cardiologists were making less than the national median salary for their profession, **the allegations that they began making substantially more money once they were employed by Citizens is sufficient to allow an inference that they were receiving improper remuneration. This inference is particularly strong given that it would make little apparent economic sense for Citizens to employ the cardiologists at a loss unless it were doing so for some ulterior motive — a motive Relators identify as a desire to [977 F.Supp.2d 671] induce referrals.** Relators' allegations are more than sufficient to satisfy Rule 9(b) as interpreted by *Grubbs.* The AKS- and Stark-predicated FCA allegations concerning the cardiologist group survive the motion to dismiss.

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Gastroenterologists

- Relators alleged that Citizens was allegedly running a **bonus** scheme with these physicians similar to that which it was engaged in with the ER physicians.
- Citizens had several gastroenterologists on staff who operated a colonoscopy screening program at the hospital, for which they and the hospital properly billed Medicare and Medicaid, however, Citizens also paid each of the gastroenterologists an Additional Bonus Payment of approximately $1,000 per day for each day per month that the physician participates in the hospital's screening program.
- Defendant Brown allegedly had complete discretion to award screening days to physicians, and assigned disproportionate time to various participating physicians based on their patient referrals to Citizens.
- Alleging schemes under which physicians receive work time and financial benefits (even in the absence of direct compensation) may be sufficient to plead AKS and Stark predicated FCA violations.

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Urologists and the Lithotripsy Group

- Relators plead that Citizens entered into an exclusive contract for lithotripsy services with an entity named Matagorda Lithotripsy, LLP. According to Relators, in addition to the normal bills the urologists properly submit to Medicare and Medicaid, Citizens would pay Matagorda Lithotripsy $2,500 for each procedure performed, of which the entity would then pay $1,000 to the owners of Matagorda.
- Citizens allegedly also provided **office space** to urologist at below-market rates and in exchange, the urologists referred virtually all of their patients, including their Medicare and Medicaid patients, to Citizens and refused to perform procedures at the only other hospital in Victoria, DeTar Hospital.
- Relators also alleged that the urologists transferred patients from DeTar to Citizens by performing consultations with numerous Medicare and Medicaid patients at DeTar and then discharging those patients in order to refer them to Citizens for the actual urology procedures.
- Relators' allegations were sufficient because they specifically pleaded the existence of a scheme to violate the FCA, including details that allow an inference that the urologists were, in essence, poaching patients from DeTar to increase their referrals at Citizens.

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Quotes About the Settlement

- Principal Deputy Assistant Attorney General Benjamin C. Mizer of the Justice Department's Civil Division: "In addition to yielding a recovery for taxpayers, this settlement should deter similar conduct in the future and help make health care more affordable."
- U.S. Attorney Kenneth Magidson of the Southern District of Texas: "Any type of false claim or improper behavior under our health care fraud laws are serious allegations that will not be taken lightly…The settlement announced today represents the effectiveness of our continuing efforts and an example of our priorities in this arena."

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Requirement for Pleading Inducement Under the AKS

- Relators and the United States argue in response that the inducement element of the AKS is an intent requirement, requiring only the allegation that Citizens intended to induce referrals by making kickbacks…
- Court-This issue turns on the interplay between the FCA and the AKS. On its own, **the AKS does not require actual inducement**. **[977 F.Supp.2d 665]**
- The statute makes it unlawful to pay kickbacks "to any person to induce such person ... to refer an individual" for reimbursable services. 42 U.S.C. § 1320a-7b(b)(2)(A). The AKS's plain language thus makes it unlawful for a defendant to pay a kickback **with the intent to induce a referral, whether or not a particular referral results…** As long as Relators plead with particularity that Citizens made kickbacks with the intent of inducing referrals, and they plead "particular details of a scheme ... paired with reliable indicia that lead to a strong inference that claims were actually submitted," the separate elements of the AKS and FCA are satisfied.

1 31 U.S.C. § 3729(a)(1)(A–C)

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Applicability of Stark to Medicaid Claims

- Defense-Another argument Citizens makes concerns the allegations that it violated the FCA by submitting claims to Medicaid in violation of Stark. According to Citizens, it cannot be liable under the FCA for these acts because it, as a private Medicaid provider, submits claims to Texas rather than to the United States. It also argues that liability cannot be found because there are no regulations or guidance explaining how Stark is supposed to affect private Medicaid providers.

- **Court--[977 F.Supp.2d 666] Although Stark originally applied only to Medicare claims, it was later expanded to apply to Medicaid claims. *See* 42 U.S.C. § 1396b(s)** (barring states from receiving federal reimbursements for Medicaid expenditures if the reimbursements would be blocked under Stark as Medicare expenditures). Thus, the only difference between holding a defendant liable for Stark-predicated FCA violations based on Medicare claims and those based on Medicaid claims is that the former are submitted to the federal government directly, while the latter are submitted to the states, which in turn receive federal funding to help pay the claims. The hospital's arguments on this point fail because it does not matter, for purposes of the FCA, whether a claim is submitted to an intermediary or directly to the United States. *See* 31 U.S.C. § 3729(b)(2)

1 31 U.S.C. § 3729(a)(1)(A–C)

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Medicaid Liability Cont.

- Moreover, even if its own Medicaid claims to Texas did not create FCA liability, Citizens could still be liable for causing Texas to submit a claim in violation of Stark. Causing a third party to present a false claim or use a false record creates FCA liability just as if the defendant had presented or used the claim or record itself. *See* 31 U.S.C. § 3729(a)(1)(A, B); *United States v. Caremark, Inc.,* 634 F.3d 808, 814-17 (5th Cir. 2011) (holding that the similarly worded language of the pre-2010 FCA allowed a defendant to be liable because "its false statements caused the state Medicaid agencies to make false statements to the Government"). **A number of courts have used this rationale in allowing Stark-predicated FCA liability for claims submitted by private Medicaid providers**. *See, e.g., Rogan,* 459 F.Supp.2d at 722 (holding that Medicaid claims for services rendered in violation of the Stark Act were false claims); *United States v. Halifax Hosp. Med. Ctr.,* 2012 WL 921147, at *4 (M.D.Fla. Mar. 19, 2012)

1 31 U.S.C. § 3729(a)(1)(A–C)

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MOTION TO DISMISS: QUALIFIED IMMUNITY

- **…**which argues that as public officials they are entitled to a qualified immunity defense. If that defense applies to FCA claims, they would have an immunity "insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known." *Harlow v. Fitzgerald,* 457 U.S. 800, 818, 102 S.Ct. 2727, 73 L.Ed.2d 396 (1982). **For the reasons discussed below, the Court holds that the FCA does not provide a qualified immunity defense…**

1 31 U.S.C. § 3729(a)(1)(A–C)

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MOTION TO DISMISS: QUALIFIED IMMUNITY

- **…** "it just makes little sense that Congress would have intended to include an immunity defense, albeit a qualified one, for a government official accused of stealing from the government, especially when the defrauded government could be his employer.[6]"…An examination of the policy rationales that have justified immunity defenses in other areas thus leads to the same conclusion as precedent and history: **the FCA does not include a qualified immunity defense."**

- ***U.S. ex rel. Parikh v. Brown****, No. 13-41088 (5th Cir. Oct. 1, 2014)*
  The United States Court of Appeals for the Fifth Circuit granted a petition for a panel rehearing in this case. It withdrew its prior opinion in the case and filed a **new opinion, which also affirmed the district court's ruling denying qualified immunity to an employed cardiologist and to an administrator of a county-owned hospital**

1 31 U.S.C. § 3729(a)(1)(A–C)

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UNITED STATES OF AMERICA, EX. REL. J. WILLIAM BOOKWALTER, III, M.D., ET AL, PLAINTIFFS,

V.

UPMC, ET AL, DEFENDANTS.

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Facts and Allegations

- Neurosurgeons are employed by affiliates of UPMC and provide services at hospitals owned by UPMC
  - Compensation structure: base salary + WRVU incentive
  - If WRVU threshold was not satisfied, base salary could be adjusted downward in future years
- Physicians paid at or above the 90th percentile
- Allegations of fraud:
  - Surgeons reported acting as assistants on surgeries or teaching physicians when they did not.
  - Surgeons billed for parts of surgeries that never happened.
  - Surgeons performed surgeries that were medically unnecessary or needlessly complex.
- Government intervened as to physician services but not as to the hospital services.

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Third Circuit Opinion

- Analyzes the arrangement as an indirect compensation relationship
  - "Unbroken chain" of financial relationships connecting the referring doctor with provider of referred services
  - Compensation must vary with, or take into account, volume or value of referrals
  - Service provider must know, recklessly disregard, or deliberately ignore that the doctor's compensation varies with, or takes into account, volume or value of referrals

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"Varies With" vs. "Takes into Account"

- "Varies with" = causal relationship
- "Takes into account" = correlation
- Holding: structure of the relationship satisfied correlation, and the "suspiciously high" compensation suggested causation.
  - Reaffirmation (and extension?) of *Tuomey*

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Did pay exceed fair market value?

Court says these five factors are enough "smoke" to make fire "plausible."

1. Pay exceeding collections (for some surgeons)
2. Pay exceeding the 90th percentile of neurosurgeons nationwide
3. High WRVU generation
4. Bonus per WRVU exceeded UPMC's collections
5. Allegation that UPMC fraudulently inflated the surgeons' WRVUs

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Bookwalter Next Steps and Implications

- Following petition for rehearing, Third Circuit vacated their original opinion and issued a revised opinion in December.
  - Eliminates interpretation of "varies with" and relies on "takes into account"
- Remanded to district court, where defendants can argue application of Stark safe harbors

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How do we translate these lessons to advise clients?

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Difficulties in physician arrangements

- What is “value or volume of referrals?”
  - The audit trail
  - Do valuations take this into account?
- How do we move compensation from one form (e.g. wRVU) to another for (e.g., risk based)?
  - Immobilize physician practice
  - Cultural and success considerations
- Toumey, Advent Health, Broward Health

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Difficulties in physician FMV

- How does compensation correlate to work performed and revenue collected?
  - Community Health Network complaint
- Is FMV of aggregate compensation more important than FMV of the different parts?
- What if FMV results are significantly more than what physicians earn in private practice?
- What is a reasonable rate of return?

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Commercial Reasonableness

- What is a sound business purpose?
- Does a physician practice have to be profitable?
- How do we document consideration of commercial reasonableness?

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Legal/Compliance Risk

- How do we ensure that all arrangements are routed through appropriate review and approval channels?
  - Intake process, fair market value review, appropriate governance approvals, drafting and implementation
- Once in place, how do we know that arrangements are being administered the way they are set up?

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Buyer/Seller Risk

- Meridian Health
  - Should non-controlling shares be worth less than controlling shares
- DaVita
  - Projections must match actual results
  - Use of commonly accepted valuation theory

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New Help on the Horizon or More Risk?

- Regulatory Sprint
  - Proposed changes to Stark and Anti Kickback Law
  - May be able to account for volume of referral so long as payment is made to reduce the cost and improve quality of healthcare
  - Do you still need a valuation?

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