Structuring Physician Compensation to Comply with Stark: How to Navigate in Turbulent Waters

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Webinar Agenda

- Physician Compensation Trends
- Regulatory Background
- Recent Cases and Enforcement Trends
- Common Pitfalls and Problem Physicians
- Strategies to Ensure Compliance

Physician Compensation Trends

Increasing use of quality incentives in physician compensation plans

• Organization has not yet developed measures to take advantage of value based payments • No dollars at risk for quality	• Some physicians are placed on models that reward for quality • Represents 5-10% of cash opportunity	• The majority of compensation models use quality incentives • Represents 10%-15% of cash opportunity	• Quality measures have been developed over a long period of time and are present in all compensation arrangements • Up to 20% of compensation at risk

Maturity of Organization

Physician Compensation Trends

- Increasing demand for advanced practice clinicians (APCs)

With the shift to a value-based payment model, health care organizations will need to focus on efficiency, evidence-based treatment protocols, and coordination of care

Using more APCs to treat patients will allow for more physician time for patients with chronic illnesses (even with the physician's supervision responsibilities) and encourage patient-centered coordination of care

Most hospitals have increased the size of their APC workforce in the past year, are planning to increase the number in the future and recruiting APC's has become one of the biggest areas for recruitment firms

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Physician Compensation Trends

Pay for Performance is critical

According to the *2013 Physician Compensation and Production Survey* put out by the Medical Group Management Association (MGMA), approximately half of all medical practices reported in the survey compensate their physicians based on 100 percent productivity models

- Work relative value units (wRVUs) still dominant – although many organizations shifting to net professional collections or a "market" wRVU rate that is benched to professional collections
- "Quality" becoming a much bigger component of compensation
- Other incentives (e.g., expense management, network / system based incentives, etc.)

Definition of "performance" is changing

Not just about "pure productivity" anymore

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Physician Compensation Trends

"Quality" compensation, bundled payments, etc., becoming more important and require performance in new areas including:

- Improved health status for the defined population being served
- Percentage of patient care delivered within accepted clinical care protocols
- Patient satisfaction scores
- Physician satisfaction scores
- Reduction in readmissions
- Volume measures – panel size / patients under management

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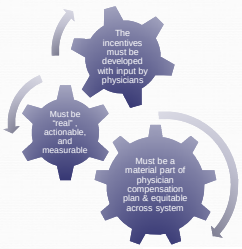
Physician Compensation Trends

- Focus on a few key performance areas with multiple metrics
- Typically range from 5 percent to 10 percent of a physician's compensation
- Most organizations "phase in" and start with smaller amounts (e.g., $15,000 to $40,000 per physician for surgeons) and gradually increase amount over time
- These incentives are generally not additive, and must be "covered" (at least in part) with physician productivity, and / or are only paid if group financial triggers are obtained
- These incentives can be "goal" oriented (e.g., only paid if goal is achieved, or process oriented)
- Data and measurement systems will be critical to plan success

Quality Incentive Key Criteria:



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Physician Compensation Trends

Reimbursement issues impacting physician income

- Reduced reimbursement for physician services pushing more physicians to employment
  - According to the MGMA 2012 & 2013 Physician Compensation and Production Surveys, the percentage of medical practices reported in the survey as being owned by physicians decreased from approximately 25 percent to approximately 17 percent over the most recent two-year period of survey data
- Payments shifting to "qualitative" areas and requires physicians to pursue new sources of revenue (e.g., Meaningful Use funds, payer quality incentives, etc.)
- More health care organizations are reviewing their "investment" per physician and are basing compensation on their ability to pay competitively and what is best for the long term viability of the network

Compensation models becoming more complex and having more components

- Clinical, administrative / medical directorship, call, teaching, research, APC supervision, recruitment, etc.
- While this may be appropriate, "multiple" contracts / payments for services has increased compliance / fair market value issues
  - This is a major area for outside regulators

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Physician Compensation Trends

Call Pay

- Call pay is and will continue to be a significant issue for physicians on a national basis
- Below is a listing of statistics on call coverage / pay, as reported in the *2012 Physician On-Call Pay Survey Report* put out by Sullivan, Cotter & Associates (SCA):
  - Overall, two-thirds (66 percent) of physicians providing on-call coverage receive on-call pay
  - More than one-half (56 percent) of survey participants report that their on-call pay expenditures have increased in the past 12 months
  - More than one-half (58 percent) of survey participants have expressed difficulty finding physicians to provide call coverage
  - More than one-quarter (28 percent) of organizations indicated that at least some physicians must provide a specified number of days of uncompensated coverage before receiving call pay (*i.e.*, excess call pay)
- Employed physicians do, at times, receive some additional payment for providing excess call coverage to hospital emergency departments that is above and beyond what would reasonably be expected in the market

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Physician Compensation Trends

- APC Supervision Pay
  - In general, supervision of APCs has increased dramatically over recent years in both employed and independent settings
  - Physicians utilize APCs as a means to make their practice more productive, improve patient access, improve volumes, etc.
  - Compensating physicians for the supervision of APCs is prevalent (60 to 70 percent) in many of the organizations we work with
  - Payments are typically structured in one of the following formats:
    - Fixed annual payment
    - Revenue less expense model
    - Payment per wRVU
  - From a valuation standpoint, we review both the physician's and APC's productivity in order to ascertain the impact of the supervised APC on the physician's practice
- Benchmarking Total Physician Income Critical
  - Analyzing all forms of physician payments critical
    - With current environment still primarily productivity driven, an analysis of physician compensation to productivity should be conducted for each specialty/physician – see sample on next page

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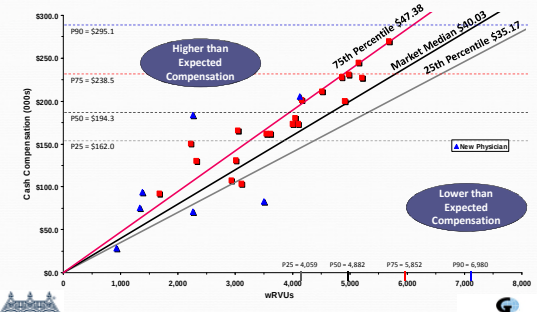
Physician Benchmarking Example



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Regulatory Background

- Applicable Laws
  - Stark Law – prohibits physician from referrals to an entity for designated health services (DHS)
  - Anti-kickback Statute (AKS) - prohibits remuneration for referrals
  - False Claims Act (FCA) – prohibits submission of false claims
  - IRS Section 501(c)(3) prohibits private benefit and private inurement
  - Civil Monetary Penalty Law (CMP) - prohibits hospital payments to physicians to reduce medically necessary services to Medicare/Medicaid patients

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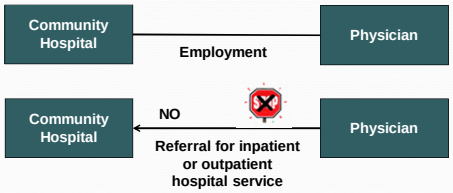
Stark Law Prohibition

- Stark Law prohibits a physician from referring to an entity for "designated health services" (DHS) payable by Medicare or Medicaid if the physician has a "financial relationship" with the entity, **AND**
- Entity may not bill Medicare, an individual or another payor for DHS from the prohibited referral, **UNLESS**
- The arrangement satisfies **ALL** requirements of a Stark exception

Stark Law Example



UNLESS, satisfies Stark Employment Exception

Stark Law Employment

- Stark Employment Exception:
  - Excepts payment by employer to a **bona fide** employee physician for services if:
    - For **identifiable** services
    - Consistent with **FMV** of the services
    - Does not **take into account** (directly or indirectly) the **volume or value of any referrals** by the referring physician
    - Agreement would be **commercially reasonable** even if no referrals were made to the employer
    - Payment may include a productivity bonus based on the physician's **personally performed** services

3 Key Stark Compliance Concepts

- Exceptions for common compensation arrangements require that compensation is
  - **FMV**,
  - **commercially reasonable**, and
  - does not "**take into account" the volume or value of referrals** between the parties

Stark and FMV

Stark defines FMV as:

- The value in arms-length transactions, consistent with the general market value. General market value is the compensation that would be included in a service agreement 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, at the time of the service agreement.
- Usually the fair market price is the compensation that has been included in *bona fide* service agreements with comparable terms at the time of the agreement, 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 U.S.C. §1395nn(h)(3); 42 CFR §411.351.

Stark and Commercial Reasonableness

- Commercial reasonableness = Would a prudent person enter into the arrangement even if no referrals
- CMS commentary on Stark exceptions indicate commercial reasonableness = reasonable and necessary for the legitimate business purposes of the arrangement

"An arrangement is commercially reasonable if the arrangement would make commercial sense if entered into by a reasonable hospital of similar type and size and a reasonable physician of similar scope and specialty, even if there were no potential referrals." Tuomey 2nd Trial Jury Instructions

Stark and Commercial Reasonableness

Consider business purposes:

- Strategic objectives
- Demonstrated community need for specialty or service
- Objective to add or expand services to community or segment of patients (e.g., indigent, submarket)
- Quality improvement goals
- Unique skills of the physician

Consider contract/business terms:

- Net cost of arrangement to hospital
- Scope of duties
- Length of term/termination rights
- Reason for/any non-standard terms
- Ability to review/change/update compensation

Ask: Would parties enter into agreement if there were no referrals?

Stark and Not "Taking Into Account"

- "Taking into account" volume or value of anticipated referrals

Government View	vs.	Traditional View
Did the parties consider referrals when deciding to enter into the contract with fixed compensation? Jury question?		Does the physician's compensation formula directly take into account (i.e. change based on) the volume or value of referrals? Is fixed compensation inflated to reflect volume or value of referrals?

- Government is treating the "taking into account" standard as outside the four corners of the contract
- Expectation or planning for referrals may create risk in current environment
- Exercise caution with business projections, budget and other operational information that projects or assumes referrals to hospital
- Creates an intent-based test in an otherwise strict liability law

Taking into account volume or value of anticipated referrals

- Stark Law Phase I: Compensation arrangements should be at fair market value for the work or service performed and not ***"inflated to compensate for the physician's ability to generate other revenue."*** 66 FR at 877.
- *"So long as the payment is fixed in advance of the term of the agreement, is consistent with fair market value for the services performed (that is, payment does not take into account the volume or value of the anticipated or required referrals), and otherwise complies with the requirements of the applicable exception, the fact that [the contract] requires the referrals to certain providers will not vitiate the exception."* 66 FR at 877 (emphasis added).
- *"Fixed compensation to a physician that is not based solely on the value of the services the physician is expected to perform, but also takes into account additional revenue the hospital anticipates will result from the physician's referrals, that such compensation by necessity takes into account such referrals."* Tuomey 4th Circuit Opinion, 2012

Stark and Directing Referrals

- Stark Law permits an employer to condition an employed physician's compensation on the physician referring patients to specified providers (i.e., within the system) if the compensation arrangement:
  - Is set in advance for the term of the agreement
  - Is consistent with FMV for the services (and payment does not take into account the volume or value of anticipated or required referrals)
  - Otherwise complies with a Stark exception
  - Complies with **both** of the following:
    - Referral requirement is in a written agreement signed by the parties
    - Referral requirement does not apply if the patient expresses a preference for a different provider, or the patient's insurer requires a different provider, or the referral is not in the patient's best medical interest in the physician's judgment
  - The required referrals relate solely to the physician's services covered by the employment

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The False Claims Connection

- A Stark Violation renders all claims based on tainted referrals false claims in violation of the False Claims Act
- Reimbursement received in payment of a false claim is an overpayment
- Retaining an "identified" overpayment for more than 60 days is a false claim unless it is resolved by repayment or self-disclosure

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Legal Concept Overview

Comparison of Anti-Kickback Statute, Stark Law, and False Claims Act

Anti-Kickback Statute	Stark Law	False Claims Act

• Intent:
  • Required
  • Knowing and willful to violate this statute
  • One purpose test
• Involved Parties:
  • Healthcare entities and professionals
  • Liability is on both sides of the transaction
• Penalties:
  • Felony charges: fine of up to $25,000
  • Criminal charges: imprisonment of up to 5 years
  • Potential exclusion from Medicare, Medicaid, and other federal healthcare programs
  • Potential for FCA liability
	• Intent:
	  • Not required
	  • Strict liability
	• Involved Parties:
	  • Physicians (Stark gives a broad definition of "physician") and entities that bill Medicare for DHS
	  • Liability on DHS entity
	• Penalties:
	  • Nonpayment or refund of reimbursement for services from tainted referrals
	  • Civil penalties up to $15,000 per claim plus 2x the reimbursement
	  • Potential exclusion from Medicare, Medicaid, and other federal healthcare programs
	  • Potential for FCA liability
	  • No criminal charges
		• Intent:
		  • Required
		  • Knew or should have known
		• Involved Parties:
		  • Healthcare entities and professionals
		• Penalties:
		  • $5,500 to $11,000 per claim plus treble damages
		  • Criminal charges: imprisonment of up to 5 years and/or fines up to $250,000 (individual) and $500,000 (organization)[2]
		  • Potential exclusion from Medicare, Medicaid, and other federal healthcare programs

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Future Outlook

OIG Fraud Alert and Yates Memo

- Fraud Alert: Physician Compensation Arrangements May Result in Significant Liability
  - **Physicians** who enter into compensation arrangements (e.g., medical directorships) must ensure those arrangements reflect fair market value for bona fide services the physicians actually provide
  - Basically, physicians are an integral part of these schemes and should be subject to liability under the Civil Monetary Penalties Law

- Yates Memo: Individual Accountability for Corporate Wrongdoing
  - One of the most effective ways to combat misconduct/fraud is by seeking accountability from the individuals who perpetrated the wrongdoing
  - Identified 6 key steps to strengthen the government's pursuit of individual corporate wrongdoing including:
    - Corporations must provide the DOJ with complete facts about individual wrongdoers or the organization will not have their cooperation considered as a mitigating factor
    - Absent extraordinary circumstances, the DOJ will avoid resolving matters in a way that prevent or dismiss charges or claims against culpable individual officers or employees
    - Pursuit of civil actions should not be governed solely by the individual's ability to pay a judgment
  - Government will hold culpable **individuals** accountable (e.g., board of directors, officers, and employees)

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RECENT STARK AND PHYSICIAN COMPENSATION CASES

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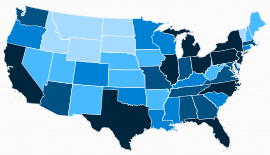
Recent Cases

Who's at Risk?

Medicare Spending

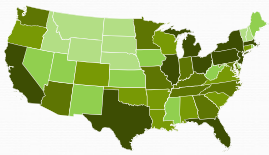


2009

spending in millions of dollars

- 1–10: $14,105 and Above
- 11–20: $7,971 - $11,743
- 21–30: $4,967 - $7,943
- 31–40: $1,905 - $4,657
- 41–50: Below $1,824

Medicaid Spending



FY2014

spending in millions of dollars

- 1–10: $12,574 and Above
- 11–20: $7,907 - $12,098
- 21–30: $4,896 - $7,612
- 31–40: $1,995 - $4,884
- 41–50: Below $1,817

Centers for Medicare & Medicaid Services (Health Expenditures by State of Provider, 1980-2009)

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Recent Cases

Cases to Be Reviewed

Adventist HEALTH SYSTEM
children's hospital
JOHNS HOPKINS MEDICINE
BROWARD HEALTH North Broward Medical Center
Citizens MEDICAL CENTER The Heart Hospital
Columbus Regional Health
HALIFAX HEALTH
A CENTURY STRONG
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Recent Cases

Citizens Medical Center – Victoria County, Texas, April 2015

- Background
  - Whistleblowers
    - Three interventional cardiologists who were essentially barred from practicing at Citizens once a resolution was passed granting employed cardiologists the exclusive right to practice at the county hospital
  - Compensating cardiologists in excess of fair market value in violation of the Stark law and AKS
    - Compensated at 2x higher rates than in private practice
  - Illegal cash bonuses to various emergency room physicians in exchange for patient referrals to the hospital's chest pain center
    - Also detailed similar kickback arrangements for hospitalists, gastroenterologists, and urologists
  - Once referred to the pain center, the hospital allegedly performed medically unnecessary nuclear stress tests on patients
    - Including on patients of the whistleblowing physicians without their knowledge, order, or consent

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
VICTORIA DIVISION

UNITED STATES OF AMERICA, ex. Rel.
HASHEM PARIKH, et al.
Plaintiffs,
VS
CITIZENS MEDICAL CENTER, et al.
Defendants.

CIVIL ACTION NO. 6:15cv71(Vol)

MEMORANDUM AND ORDER

This is a qui tam suit brought against Citizens Medical Center, a county owned hospital in Victoria, alleging multiple violations of the False Claims Act (the FCA). Relators are three cardiologists who formerly practiced at Citizens. Defendants are Citizens and two individuals. David Brown, the hospital's administrator, and Dr. William Campbell, Jr., a cardiologist employed by the hospital. Relators allege that Citizens has been violating the FCA since at least 2007 by, among other things, running a kickback scheme in which it paid bonuses and financial incentives to physicians who referred patients for treatment at the hospital, employing physicians in violation of Texas's ban on the corporate practice of medicine, and providing worthless and unnecessary medical services.

Defendants move to dismiss Relators' claims under Rule 12(b)(6), arguing that Relators have failed to plead legally sufficient claims and that the individual Defendants are entitled to qualified immunity. The Court has considered the

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Recent Cases

Citizens Medical Center

- Alleged Violations?
  - Bonus for referrals to Chest Pain Center for employed emergency medicine physicians
    - In exchange for bonus payments, the ER physicians referred Medicare and Medicaid patients to the Chest Pain Center for which the government has paid reimbursement
    - Revenue from the Chest Pain Center was split in half with the referring ER physicians
    - Compensation was directly linked to the volume or value of referrals to the Chest Pain Center
  - Compensation above Fair Market Value, despite substantial practice losses, to induce referrals for employed cardiologists
    - Hospital moved to dismiss the claims because the cardiologists were compensated less than the national market median
      - 2008 United States ex re Villafane v Solinger found that:

> "…any definition of fair market value that would automatically deem anything over the median or indeed anything at the 80th percentile, as necessarily not being fair market value would seem illogical"

    - Cardiology practices were costing Citizens between $400,000 and $1,000,000 in net losses
    - Cardiologist income more than doubled following employment
    - Alleged makes little economic sense for the hospital to employ the cardiologists at a loss unless it were to induce referrals

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Recent Cases

Citizens Medical Center

- Results
  - The Department of Justice alleged violated Stark because:
    - Employed cardiologists' salaries exceeded fair market value
    - Bonuses to the employed emergency medicine physicians were for referrals
  - Significant court findings
    - *"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 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 induce referrals."* S.D. Tex, Sept. 20, 2013
    - Citizens did not admit any wrongdoing but settled for:

$21.8 MILLION

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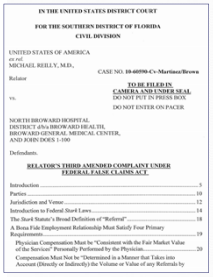
Recent Cases

North Broward Hospital District, Broward County, Florida September, 2015

- Background
  - Whistleblower – Dr. Michael Reilly (orthopedic surgeon)
    - Offered employment in 2010
    - Alerted Broward leadership in 2003, 2004, 2009 of possible violations but was ignored
    - Referred to Broward Health officials as being:

      "…just like Lance Armstrong. Deny, deny, deny. Stonewall, stonewall, stonewall… They just thought I was going to go away."
  - Compensating 9 physicians across specialties in excess of fair market value
    - Hospital used secret "Contribution Margin Reports"
      - Included hospital and ancillary revenue generated by each physician
      - Tracked referral profits
  - Employed physician practices resulted in significant losses
  - Suspicious medical director tracking practices



IN THE UNITED STATES DISTRICT COURT

FOR THE SOUTHERN DISTRICT OF FLORIDA

CIVIL DIVISION

UNITED STATES OF AMERICA ex rel. MICHAEL REILLY, M.D., Relator

vs.

NORTH BROWARD HOSPITAL DISTRICT d/b/a BROWARD HEALTH, BROWARD GENERAL MEDICAL CENTER, AND JOHN DOES 1-100

Defendants.

CASE NO. 10-60590-Cv-Martinez/Brown

TO BE FILED IN CAMERA AND UNDER SEAL DO NOT PUT IN PRESS BOX

DO NOT ENTER ON PACER

RELATOR'S THIRD AMENDED COMPLAINT UNDER FEDERAL FALSE CLAIMS ACT

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The Stark Statute's Broad Definition of "Referral" 18
A Bona Fide Employment Relationship Must Satisfy Four Primary Requirements 19
Physician Compensation Must be "Consistent with the Fair Market Value of the Services" Personally Performed by the Physician 20
Compensation Must Not be "Determined in a Manner that Takes into Account (Directly or Indirectly) the Volume or Value of any Referrals by

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Recent Cases

North Broward Hospital District

- Alleged Violations?
  - Compensation to numerous physicians in excess of FMV (over 90th percentile) and not commercially reasonable due to practice losses
  - Numerous doctors were paid excess of $1 million even though collections for their personal work were much less
    - Compensation took into account referrals evidenced by "Contribution Margin Reports"
  - Physicians penalized for referring uninsured patients
    - Charity care was very low even though Broward is a public entity
      - In 2009, 25 employed physicians practicing that produced total revenue from compensated care of just over $13 million, but their total charity care was "a minuscule $8"
  - Medical Director
    - Complaint labeled medical director practices as a "boondoggle"

      Boondoggle (bo͞on dôgal,- dôgal) *noun.*
      1. work or activity that is wasteful or pointless but gives the appearance of having value

      - "One medical director does his personal exercise workout and counts such hours as his 'medical director' hours. One 'medical director does not know how to read studies in the laboratory for which he is the director. Yet another 'medical director' counts hours doing procedures as 'director' hours."
  - Broward claims that medical director issues were a result of a technical issue and that doctors could have been doing a better job of keeping their time

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Recent Cases

North Broward Hospital District

- Results
  - No doctor now makes more than $860,000
  - Broward agreed to enter into a 5 year Corporate Integrity Agreement

    "As a result of the investigation, Broward Health announced a major new policy for physician compensation that will not pay physicians based on the volume or value of referrals," - Dr. Reilly
  - To settle physician compensation fair market value allegations, Broward settled for:

    $69.5 MILLION
  - Broward admitted no liability
    - Chair of North Broward's Board of Commissioners "It is important to note that those allegations were focused solely on highly complicated contracts with physicians. This investigation was never about patient care."
  - Dr. Reilly, now retired, speaks out against hospitals hiring physicians

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Recent Cases

Adventist Health System – 10 States, September 2015

- Background
  - Whistleblowers
    - Risk manager, executive director of physician services, and compliance office for physician officers employed by Adventist's Park Ridge Health hospital in Hendersonville, North Carolina
  - Adventist told its hospitals to purchase physician practices/groups or employ nearby physicians so it could control all patient referrals in the area
  - Engaged in a scheme to pay excessive compensation, perks and benefits to physicians and mid-level providers to induce them to refer patients to Adventist hospitals for inpatient and ancillary services
  - Overall physician compensation was above fair market value, as evidenced by "substantial and consistent losses" on their physician practices, which were tolerated only because Adventist recovered those losses and profited by capturing referrals
  - Adventist tracked referrals from employed physicians and encouraged low referrers to increase referrals
  - Tracked "contribution margin" by physician and limited access to high-level officers on a "need to know" basis and compared practice losses to contribution margins to determine profitability
  - Bonuses were based on revenue from referrals (including facility fee), not just on personally performed services
  - Employed physicians received perks, such as car lease payments and payments to cover the cost of office staff
  - Did not correct physician miscoding

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Recent Cases

Adventist Health System

- Alleged Violations?
  - Excessive perks and bonuses
    - System paid for leases of a BMW and Mustang for a surgeon
    - A $366,000 base salary for a family practice physician (more than doubled the salary that similar practitioners in that area) due to the extraordinarily high level of facility fee referrals to Adventist for x-ray and CBC test
    - Bonus of nearly $368,000 plus salary (total $710,000) for a dermatologist who worked at Adventist just three days a week (also covered costs for staff, equipment, and malpractice) and was in private practice the rest of the time
  - Coding allegations
    - Up coded Medicare claims for patients in nursing and assisted-living facilities
    - Submitted claims for service by doctors without proper credentials to work at the hospitals where they were filling in for regular docs
    - Unbundled services and submitted them as separate claims to get larger reimbursements
    - Submitted claims for services that weren't documented in patients medical records
  - Adventist voluntarily self disclosed some physician compensation and billing and coding issues after the initial allegations

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Recent Cases

Adventist Health System

- Results
  - Set a centralized process to set physician compensation, among other things
  - Was not required to enter into a corporate integrity agreement
    - Indicates that the current compliance program is effective enough to prevent future issues arising
    - Adventist may have also benefited from self disclosing at least some portion of the covered conduct
  - Largest Stark settlement related to an investigation without litigation:

$118.7 MILLION

  - Admitted no liability

"The number of Stark cases being brought under the False Claims Act may be increasing as whistle-blowers become more aware of such settlements, as they are entitled to a % of whatever money the government is able to recover." – Defense attorney

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Recent Cases

Columbus Regional Medical Center, Georgia, September 2015

- Background
  - Whistleblower, Richard Barker
    - Former Administrative Director of the Cancer Center
    - Joined Regional Healthcare in September 2011
    - October 2011 alerts CEO of issues
    - Barker files false claims act complaint
    - June 2013 place on administrative leave with pay
    - September 2013 Barker ends employment
  - Excessive salary to Dr. Andrew Pippas (2003-2013), Medical Director of John B. Amos Cancer Center
    - 2013 compensation = $1.5 million
  - Organization in general was "top heavy" with medical directors
  - Billed federal healthcare programs for higher levels of service than supported by documentation
    - Billed for oncology procedures at higher than actual rates
    - Oncology over-coding rates of 63% (Dr. Pippas = 68%, no under-coding)
      - CMS acceptable rate is 10.5%

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
COLUMBUS DIVISION

RICHARD BARKER, on behalf of the United States of America and the State of Georgia,

Plaintiff,

vs.

CASE NO. 4:12-CV-108 (CDL)

COLUMBUS REGIONAL HEALTHCARE SYSTEM, INC., THE MEDICAL CENTER, JOHN B. AMOS CANCER CENTER, REGIONAL ONCOLOGY LLC, ANDREW PIPPAS, and COLUMBUS REGIONAL ONCOLOGY TREATMENT CENTER,

Defendants.

ORDER

Defendant Thomas J. Tidwell ("Tidwell") filed a motion to dismiss Plaintiff's Complaint against him (ECF No. 15). Tidwell argues that Plaintiff has not alleged his claims with sufficient specificity and that the present allegations fail to state a claim upon which relief may be granted. At this stage of the litigation, the Court must accept Plaintiff's factual allegations as true. The Court finds that these allegations are stated with sufficient particularity to put Tidwell on notice of the claims asserted against him. Moreover, when these allegations are accepted as true, they state a claim for relief

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Recent Cases

Columbus Regional Medical Center

- Alleged Stark and False Claims Act Violations?
  - Compensation failed the Stark Employment exception
    - Above fair market value
      - Productivity was artificially inflated by the productivity of other practitioners and physicians
    - Compensated for "volume or value" of referrals
      - Chemotherapy and other referrals
    - Outside of commercial reasonableness
      - Compensated more than what Columbus collected from personally performed professional services (allegedly 2X)
      - Dr. Pippas also received $300,000 stipend for two Medical Directorship
  - False Claims Act
    - Extremely high upcoding rates
      - Whistleblower attacked the WRVU compensation model arguing that it encouraged Dr. Pippas to document higher level of visits than were necessary to increase his compensation
    - Lack of documentation for office visits
    - Filed bills for services that were not included within the reimbursement for the administration of chemotherapy
  - Incriminating internal emails

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Recent Cases

Columbus Regional Medical Center

- Results
  - Columbus Regional resolved allegations and settled for:

$35 MILLION

  - Paid $25 million up front, with no more than $10 million in contingent payments
  - Columbus Regional will enter into a Corporate Integrity Agreement with the Department of Health and Human Services-Office of the Inspector General
  - Was Dr. Pippas settled personally for:

$425 MILLION

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Recent Cases

Tuomey Healthcare System – South Carolina, 2013

- Stark and False Claims Act Violation
  - Tuomey hires 19 part-time surgeons to perform surgery in hospital outpatient department
    - 10-year term
    - Full-time benefits, including malpractice, family health insurance
    - Increase in earnings, income with generous incentive and productivity bonus
    - Hospital losing money on practices
  - Disgruntled surgeon files Qui Tam Action alleging Stark and False Claims Act Violations
  - 2 Jury Trial and multiple appeals:
    - 2010 - Jury finds Tuomey violate Stark Law but not False Claims Act
    - 2010-2012: Fourth Circuit Decision finds
      - Outpatient technical fee associated with personally performed surgery is a referral
      - Fixed compensation based on hospital revenue from anticipated referrals "takes into account" referrals

> *"It stands to reason that if a hospital provides fixed compensation to a physician that is not based solely on the value of the services the physician is expected to perform, but also takes into account additional revenue the hospital anticipates will result from the physician's referrals, that such compensation by necessity takes into account the volume or value of such referrals."*

  - 2014-2015: Retrial
    - Tuomey argued they were relying on the advice of their lawyers
    - Finds Tuomey violated both Stark and False Claims Act
    - Tuomey loses 3rd case in 10 years

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Recent Cases

Tuomey Healthcare System

- Result
  - Court upheld Stark and False Claims Act violation
    - 21,730 false claims to Medicare worth $39.3 million × 3 = $117,900,000
    - $5,500 minimum civil penalty per false claim allowed by law × 21,730 false claims = $119,515,000

$237 MILLION

    - Settled for $72.4 million contingent upon the completion of the sale of Tuomey to Palmetto Health
  - Judge stated that the Stark laws complexity, paired with the False Claims Act is *"a booby trap rigged with strict liability and potentially ruinous exposure"*

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Recent Cases

Halifax Hospital Medical Center- Florida, 2013

- Background:
  - Halifax entered into employment agreements with 6 medical oncologists
  - Oncologists treated patients on both an IP and OP basis, and ordered OP prescription drugs for patients
  - In 2005, oncologists became eligible to earn incentive

Beginning with the fiscal year ending September 30, 2005, an equitable portion of an Incentive Compensation pool which is equal to 15% of the operating margin for the Medical Oncology program as defined by the financial statements produced by the Finance Department on a quarterly basis. The amount of the incentive compensation distributed to the Employee shall be determined by the Medical Oncology Practice Management Group. This compensation shall be paid annually according to the operating margin for the fiscal year.

  - Operating margin was made up of "revenue and direct expenses from outpatient medical oncology services" and revenue consisted of outpatient medical oncology services, physician services, and related outpatient oncology pharmacy charges
  - Incentive compensation was divided based on an individual's personally performed services

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

ELIN BAKLID-KUNZ,

Relator,

v. Case No: 6:09-cv-1802-Orl-31TBS

HALIFAX HOSPITAL MEDICAL CENTER,

Defendant.

ORDER

This matter comes before the Court without a hearing on the Motion for Summary Judgment (Doc. 663) filed by the Defendant, Halifax Hospital Medical Center ("Halifax"), and the response in opposition (Doc. 665) filed by the Plaintiff, Elin Baklid-Kunz ("Baklid-Kunz" or the "Relator").

Halifax raises three issues in its motion: (1) whether the Relator has provided sufficient evidence as to damages, (2) whether a failure to abide by certain Medicare "conditions of participation" can render Medicare claims "false" for purposes of the False Claims Act, 31 U.S.C. §§ 3729 *et seq.*, and whether some of the Relator's claims are barred by the statute of limitations.[1]

I. Background

The Relator filed the instant suit under seal on June 16, 2009, contending *inter alia* that Halifax regularly admitted Medicare patients whose admissions were not medically necessary.

[1] Although the motion is filed as one for summary judgment, the latter two issues raised by Halifax are more properly the subject of motions in limine, and the Court construes them as such.

Recent Cases

Halifax Hospital Medical Center

- Stark Law Violation?
  - Halifax submitted Medicare claims resulting from referrals made by the oncologists for DHS (i.e., OP prescription drugs)
    - Halifax argued arrangement fit within bona fide employment exception (so referrals were not prohibited)

Bona Fide Employment Exception:[1]

A. The employment is for identifiable services

B. The amount of remuneration under the employment –
i. is consistent with the fair market value of the services, and
ii. is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician

C. The remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the employer, and

D. The employment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

"The Government contends [these] requirements were not satisfied because the Incentive Bonus, and therefore the Medical Oncologists' remuneration, varied based on referrals for designated health services. More particularly, the Government points out that the pool from which the Incentive Bonus was drawn was equal to 15% of the operating margin of the Medical Oncology program, and the program's revenue included fees for designated health services such as outpatient prescription drugs and outpatient services not personally performed by the Medical Oncologists. Thus, revenue from referrals made by the Medical Oncologists would flow into the Incentive Bonus pool, and additional referrals would be expected to increase the size of the pool. All other things being equal, this would in turn increase the size of the Incentive Bonus received by the referring Medical Oncologist."

  - Halifax also argued the government failed to produce evidence that oncologists actually made referrals of DHS during the time frame[2]

[1] Note that the exception "shall not prohibit the payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or an immediate family member of such physician)"

[2] During the five year period under review, the hospital had submitted over 75,000 Medicare claims totaling over $34 million with one or more of the oncologists identified in the claim form as the "attending," "operating," or "other" physician

Recent Cases

Halifax Hospital Medical Center

- Result
  - Court concluded evidence of referrals for DHS made by the oncologists during the time period the Incentive Bonus was in effect, thereby violating the Stark Law
    - Halifax argued the bonus pool was divided up based on each oncologist's personally performed services
    - While true, the bonus itself was based on factors in addition to personally performed services
      - *"The fact that each oncologist could increase his or her share of the bonus pool by personally performing more services cannot alter the fact that the size of the pool (and thus the size of each oncologist's bonus) could be increased by making more referrals."*
  - So what are the damages (treble damages and a fine of $11,000 per claim) on…
    - More than 75,000 tainted claims
    - More than $34 million in Medicare referrals
    - Whistleblower and attorney fees
  - After spending more than **$15 MILLION** in legal fees and facing as much as **$1.1 BILLION** in damages and civil penalties if it had gone before a jury, Halifax settled with the DOJ for:

$85 MILLION

Common Pitfalls: We Got an FMV Opinion but …

- Draft opinion received based on proposed terms; terms changed, but never sent to valuation consultant
- Final opinion never delivered
- Final opinion not read to ensure it matches the terms of the final agreement
- Agreement is revised after commencement, or upon renewal, and no updated FMV opinion is obtained
- Opinion not rendered by qualified valuation consultant

Common Pitfalls: Stacking/Overlapping Arrangements

- Physician enters into Employment Agreement for professional services with quality bonus but already has Medical Director Agreement and is in CoManagement program and CIN
  - Can't pay twice for same service or item
  - Can't be two places at once
  - Can't work more than 24 hours per day
- Must consider all services and all payments together to determine if aggregate is commercially reasonable and FMV

Common Pitfalls: Use and Misuse of Survey Data

- Pay at 75th percentile MGMA, but what does that really mean?
  - 75th percentile total cash compensation?
  - 75th percentile rate per wRVU?
  - Can you pay a 75th percentile producer a 75th percentile rate per wRVU?

EXAMPLE: Physician hears hospital pays at 75th percentile so demands 75th percentile base pay and incentive compensation at 75th percentile rate per wRVU

PROBLEM: 75th percentile TCC + incentive at 75th percentile/wRVU may exceed fair market value

- **BOTTOM LINE:** If misuse data, compensation will fail the Stark FMV requirement

So You Want to Hire a Rock Star?

- Top of their professional field based on:
  - Education and training
  - Publications, speaking, research/funding
  - Cutting edge or rare skills
  - Media darling or frequent "expert"
  - Leadership experience/academic roles
- Position often involves both clinical services, leadership, research and other responsibilities
- Hospital may be pressured to offer generous packages to attract and retain "Rock Star" talent
- What are the risks?

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Rock Star Physician

Consider Overall Package

Identify Multiple Roles

- Clinical services
- Chief Clinical Officer, Physician Network Leader, Department Chair, Medical Director
- Research, Publishing, Speaking
- Other

Ask

- Is each role commercially reasonable?
- Is the total package of services commercially reasonable?
- Are there overlapping duties?
- Is it possible for one person (even "Rock Star") to perform all roles as intended?
- Where does the total compensation package fall as compared to other physicians?
- Do the physician's Rock Star qualities justify higher compensation?
- Should the total compensation be capped?

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So You've Hired a Highly Productive Physician . . .

Who are They?

- Off the charts wRVUs
- Workaholic
- Leverages mid-level providers or other staff
- May demand compensation at rates above FMV on surveys
- Compensation may be all wRVU based or include incentive bonus based on wRVUs, resulting in total clinical compensation above the 75th percentile on surveys
- Compensation model may also include performance-based payments for achieving quality measures, growth measures, citizenship, patient experience, other

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Highly Productive Physician

Risk	Option/Solution
• Compensation model results in compensation above 75th percentile	• Verify wRVUs through audits to ensure properly coded, correct use of modifiers, services personally performed and not including services of APCs or others
	• Ensure using current CMS Physician Fee Schedule wRVUs
• Physician performs high levels procedures/services	• Audit services to confirm medical necessity, documentation or workflow concerns such as use of MA or overlapping surgeries
• Compensation model results in compensation above 90th or 100th percentile	• Restructure compensation model to reduce rate paid per wRVU as production reaches higher levels
	• Include cap on total compensation, triggering independent investigation as to defensibility

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Oops, this physician just isn't panning out as planned …

- New physician enters into three-year Employment Agreement with guaranteed base at median TCC and productivity bonus at 50% rate/wRVU for wRVUs worked over threshold
- At end of year one, performance review reflects Physician failed to perform median wRVUs

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Low Producing Physician

Risk	Option/Solution
• Compensation paid exceeds FMV for actual services performed in year one of three year agreement	• Include language in agreement to reset base compensation annually based on prior year's actual performance prior to start of subsequent year
• Continued payment in excess of FMV in years two and three	• Use a "draw" model to offset/refund any amounts paid in prior year in excess of actual production (e.g., median rate/wRVU x actual worked wRVUs)
	• Include language in agreement allowing employer to amend or terminate the agreement if compensation is determined to exceed FMV or counsel advises agreement fails to comply with law
	• Audit practice to identify workflow operational concerns affecting productivity

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5 Strategies to Ensure Compliance

Strategy #1 – Document intent / business case / community benefit

- Too often when we review an agreement there is little in the file regarding why the agreement is necessary, supports the hospital's mission and improves patient access and care
  - This can result in "selective amnesia"
- Documenting the intent of the agreement and how it benefits the community is a key component to ensuring fair market value
  - The government spends a lot of time looking at these issues, and in absence of documentation can assume the worst

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5 Strategies to Ensure Compliance

Strategy #2 – Use qualified counsel / consultants and limit number of negotiators

- Too often hospitals create physician agreements without the help of qualified health care legal counsel and consultants
- In some instances the hospitals that are investigated relied on outside advice – turns out it was bad advice
- Limit number of individuals that can negotiate physician contracts – keeps consistency and helps prevent deals from getting done in back room and on golf course

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5 Strategies to Ensure Compliance

Strategy #3 – Limit use of email / watch communications

- In every investigation we have been involved in, email communications were used by the government as a key component of their fact finding and building of their case
  - Many physicians / executives will put certain statements in email that they would not otherwise say in conversation
- If you have a "bad" chain of emails, actively and aggressively address issue and document how the issue was addressed
- Train / educate your employees / physicians on proper use of email
- Some clients have actually called off certain deals because of "bad" emails

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5 Strategies to Ensure Compliance

Strategy #4 – Keep it simple

- Many of the agreements that get reviewed are overly complex
- Complexity can appear as if you are trying to "back into a number" and / or raise commercial reasonableness concerns
- If physicians don't understand how they are paid they are more likely to complain
- If auditors don't understand compensation model they will assume the worst (e.g., only for referrals)

5 Strategies to Ensure Compliance

Strategy #5 – Have a contract management database / system and a process for reviewing / approving physician compensation arrangements

- Most hospitals have no idea how many agreements they have and no consistent process for reviewing and approving physician arrangements
- Hospitals can get in trouble when they realize that they have more than one contract with a physician group (e.g. ,"stacking") or find out that they have multiple contracts for the same service
  - More than 1.0 FTE services provided by a physician – not enough time in the day
  - Contracts for similar / same services (e.g., two sleep medicine directors)

5 Strategies to Ensure Compliance

Strategy #5 – *Continued*

- Some hospitals have forgotten when contract expires, when compensation needs to be updated / adjusted, or when other contract terms change such that when the agreement is reviewed it is out of compliance
  - This type of system allows you to monitor payments
    - One client paid a physician for services for one year after they were dead
  - Continually update file as changes are made to compensation, strategy, business model etc.
  - Have a process and follow it

Q & A

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APPENDIX

Steps in Assessing Physician Compensation

Step One

Gather all pertinent facts, including, but not limited to:

- Physician background / CV
- Record of prior year(s) earning levels
- Record of prior year(s) productivity (e.g., wRVUs, professional collections, time and effort)
- Demonstrated clinical outcomes
- Qualitative performance
- Other activities (e.g., medical directorships, outreach, teaching, research, etc.)

Confirm the facts through due diligence

- Internal and external review

Steps in Assessing Physician Compensation

Step Two

Apply the Common Sense Test – *"Does this deal make sense?"*

- Meet with the physician
- Engage all stakeholders early on in the valuation process
  - Identify the accountable executives, *"Who has the historical perspective?"* and *"Where does the buck stop?"*
- Address whether the proposed plan is consistent with the organization's typical approach to like transactions
- Identify and / or define the strategic rationale

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Steps in Assessing Physician Compensation

Step Three

Conduct Market Analysis

- Benchmark physician data to market
  - Total compensation (cash + benefits)
  - Physician productivity
- Ensure full understanding of any and all other forms of compensation
- Utilize available tools
  - Use all relevant and available sources and tools to include:
    - Published survey sources
    - 990 reports
    - Specialty specific separate survey cuts
    - External proprietary data sources
    - Custom surveys

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Steps in Assessing Physician Compensation

Step Four

Step back and revisit entirety of the analysis, to include all relevant facts and circumstances related to the transaction

- Ask the following from an objective, outside perspective:
  - "Does the transaction and the corresponding analysis make sense?"
  - "Is there rational reasoning behind our decision?"
    - What are the key reasons in support of paying the physician at the proposed level?
    - Is the payment rational and sustainable? (e.g., If it all goes bad in a year, then what?)
    - Does the structure of the arrangement make sense?
    - Have we identified and considered alternatives that may be more economically sustainable?

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Steps in Assessing Physician Compensation

Step Five

The key to a strong defense of any physician compensation arrangement is thorough documentation

Documentation to include:

- Business case for doing the transaction
- Internal and external valuation reports
- Legal review
- Historical perspective to set the context related to the execution of the transaction

The documentation should be comprehensive, persuasive, and support the course of action

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