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# Physician compensation governance

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Over the past several years, hospitals and health systems have been parties to numerous significant settlements associated with alleged improper compensation arrangements with physicians, including Tuomey ($72 million),[1] Adventist Health System ($118.7 million), North Broward Hospital District ($69.5 million),[2] and recently, Kalispell Regional Healthcare System ($24 million).[3]

And as though that was not enough of a financial blow, the Department of Justice has, and continues to implement, the Yates Memo,[4] which holds individual executives accountable for their role in permitting noncompliant physician arrangements. This includes, among others, Ralph J. Cox III, the chief executive officer of Tuomey Health System, who entered into a personal settlement of $1 million.[5] Although the Centers for Medicare & Medicaid Services (CMS) has indicated it intends to make the Stark Law[6] less burdensome for providers,[7] if and until that time comes, healthcare organizations must continue to be vigilant and precise in their compliance programs, particularly regarding physician compensation arrangements.

## Pertinent laws and regulations

The following brief review of the pertinent laws and regulations that affect healthcare organizations will help put the subject matter in context.

### The Stark Law

The Physician Self-Referral Law (aka, the Stark Law) was enacted in 1989 to address concerns that financial motives could be used to inappropriately influence a physician's healthcare decision-making. Specifically, the Stark Law prohibits a physician from referring designated health services (DHS)[8] that are payable by Medicare or Medicaid to a healthcare entity with whom the physician (or the physician's immediate family member) has a financial relationship unless the relationship falls squarely within one of the identified exceptions. If the referral does not meet one of the enumerated exceptions, the law prohibits the healthcare entity from billing for those improperly referred services.

Intent does not matter; if the arrangement doesn't fit precisely within an exception, strict liability ensues. Defensibility against a Stark Law claim requires that the arrangement be fair market value, commercially reasonable, and does not otherwise take into account the volume or value of the referrals or other business generated by the physician. Violations of the Stark Law carry civil penalties, such as an overpayment/repayment obligation, False Claims Act (FCA) liability, civil monetary penalties, federal healthcare program exclusion for "knowing" violations, potential civil monetary penalty in the amount of $15,000 per prohibited referral/service, and a civil assessment of up to three times the amount claimed.

## Anti-Kickback Statute

In addition to the Stark Law, the Anti-Kickback Statute (AKS)[9] applies to referrals from anyone and prohibits the offering, paying, soliciting, or receiving anything of value, in cash or kind, to induce or reward referrals or otherwise generate federal healthcare program business. Additionally, the AKS applies to any items and services and not just DHS. Because the AKS is a criminal law, intent (knowing and willing) must be proven to have an actionable claim.

In contrast to the Stark Law's mandatory exceptions, the AKS provides voluntary safe harbors. This means that an arrangement does not have to fall precisely within the safe harbor to be legal, but the more closely an arrangement fits within a safe harbor, the less risk is involved. Violation of the AKS may result in civil/administrative penalties, such as FCA liability, federal healthcare program exclusion, the potential of a civil monetary penalty of $50,000 per violation, and a civil assessment of up to three times the amount of the kickback. And because it is a criminal statute, a violation carries criminal fines up to $25,000 per violation and up to a five-year prison term.

## False Claims Act

The False Claims Act[10] remains the federal government's primary tool for enforcing the numerous fraud and abuse laws. The FCA's intent is to punish providers for knowingly submitting claims for payment to Medicare or Medicaid that it "knows" or "should have known" were false or fraudulent. The "knowing" standard includes not only actual knowledge but also instances where the individual acted in "deliberate ignorance" or "reckless disregard." Penalties for the FCA include fines of three times the program's loss plus up to $22,927 per claim filed. And for purposes of this penalty, a claim means every instance of an item or service that was fraudulently or falsely billed. The FCA includes within it the whistleblower provision that permits a private individual to file a claim on behalf of the government (qui tam) and receive a percentage of recoveries. In addition to the civil FCA, a criminal FCA[11] exists that could result in imprisonment and criminal fines if a provider is found in violation.

## 501(c)(3) and the Intermediate Sanctions Rules

Congress enacted the Taxpayer Bill of Rights[12] in 1996, which gives the Internal Revenue Service (IRS) the authority to impose "intermediate sanctions" on persons within a 501(c)(3) organization that uses tax-exempt organizational assets for inappropriate personal gain. The final regulations were released by the IRS in 2002. The regulations set forth the penalty excise tax that the IRS can impose on any organizational leader who approved the transaction and the applicable "disqualified person" who is determined to have participated in an "excess benefit transaction" (i.e., one that exceeds fair market value). A disqualified person is defined as one who is determined to have substantial influence over the organization's affairs, which applies to board members who are entitled to vote, chief executive officers, and other members of the executive team. Still others may be deemed disqualified based on the particular facts and circumstances.

In many organizations, certain physicians have substantial influence over decision-making in particular segments of a healthcare organization, such as an entity's heart institute or cancer center where revenues from the program are substantial. These physicians may be viewed as potential disqualified persons. If an organization demonstrates that the compensation paid to a disqualified person is reasonable as of the time the parties enter into the compensation arrangement, organizations are afforded a rebuttable presumption of reasonableness by the IRS, so long as the governing body approves the transaction (having relied on fair market value comparability data) and adequate documentation is retained. For this reason, many organizations seek board approval of some, if not all, physician compensation arrangements.