The Legal Intelligencer

Health Care Law

Federal Government Expands Health Care Anti-Fraud Efforts

October 29, 2015

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The federal government is expanding its health care fraud efforts on both the criminal and civil sides, signaling a much more aggressive effort to pursue actions under the False Claims Act and the federal Anti-Kickback Statute. The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services announced it is creating a new litigation team dedicated to pursuing civil penalty and exclusion cases. At least 10 attorneys will be dedicated to enforcing the OIG's guidance on fraud matters and pursuing cases that the U.S. Department of Justice (DOJ) does not pursue.

As part of its stepped-up efforts, in June the OIG issued a fraud alert aimed at warning physicians about financial arrangements that can create risk of litigation under the federal Anti-Kickback Statute. The alert highlighted 12 civil, monetary penalty settlements with physicians who had a variety of financial arrangements with hospitals, home health agencies and other entities.

Separately, in June, the DOJ announced its largest-ever health care fraud takedown in terms of loss amount and number of arrests. That nationwide sweep resulted in the arrest of 243 physicians, nurses and other licensed professionals for an alleged $712 million in false Medicare billings.

While the OIG will pursue smaller and simpler cases through the civil channel, the DOJ apparently is targeting high-dollar fraud situations. The DOJ started down this path in 2013 with the landmark U.S. Court of Appeals for the Fourth Circuit case *United States ex rel. Drakeford v. Tuomey*, No. 13–2219, against the Tuomey Healthcare System. Tuomey's fraudulent scheme involved part-time employment arrangements with 19 physicians who were required to refer all of their cases to Tuomey facilities in exchange for compensation that exceeded fair market value or the test of commercial reasonableness. Thus, the compensation amounted to payment to the doctors for their referral of patients.

In *Tuomey*, the jury found them in violation of the False Claims Act. Intriguingly, the jury in one of the trials of the case found that the hospital had submitted 21,730 false claims to Medicare with a total value of over $79 million. The district court, in accordance with the FCA, trebled the damages, resulting in a judgment of more than $237 million. In July, a federal appeals court upheld the judgment amount against Tuomey.

This year the DOJ has reached settlements in two other high-dollar cases involving physician compensation arrangements. First, Georgia's Columbus Regional Healthcare System and Dr. Andrew Pippas have agreed to pay more than $25 million to resolve allegations that they violated the FCA by submitting claims in violation of the Stark Law. Columbus Regional compensated Pippas as medical director in excess of fair market value, determined in a manner that took into account the volume or value of his referrals, and was paid pursuant to an employment agreement that did not meet the test of being commercially reasonable. Reportedly, Pippas' compensation exceeded the amount he collected for his personal services. Pippas also submitted claims for payment to federal health care programs that misrepresented the level of services he provided.

Under the settlement agreement, Columbus Regional agreed to pay $25 million, plus additional contingent payments not to exceed $10 million, for a maximum settlement amount of $35 million, and Pippas agreed to pay $425,000. The settlement payment is an example of the DOJ's more aggressive efforts to maximize the taxpayer's recovery. Columbus is obligated to pay $10 million up front and $3 million per year over the next five years. In addition, Columbus may owe up to $10 million more if it meets certain revenue targets or sells certain assets.

Another Stark Law qui tam settlement was unsealed in September for $69.5 million with North Broward Hospital District in Florida. This case alleged compensation to numerous employed physicians that did not meet the Stark employment exception. The complaint alleged the compensation was in excess of fair market value and commercially unreasonable, because it was over the 90th percentile of total cash compensation as published in physician compensation surveys, and the practices incurred significant operating expense losses for Broward.

One important argument in the case is that the compensation took into account the volume or value of referrals to Broward for hospital services because the doctors' compensation was not financially self-sustaining from professional income alone, but would be self-sustaining if one added the value of facility fees, which Broward tracked.

The underlying issue is whether physician compensation is commercially reasonable if that compensation, in combination with practice overhead expenses, is in excess of collections from the physician's personally performed services. It has been reported that expert testimony and other DOJ litigation involving physician compensation that practices that lose money are commercially unreasonable. DOJ has, moreover, asserted hospitals that tolerate practice "losses" because of the value of the employed physician's referrals to the hospital are highly suspect.

This view greatly complicates a clear understanding of permissible arrangements between hospitals and physicians given the health reform initiatives that require clinical integration between hospitals and physicians. There are commercially legitimate reasons for a hospital to

employ a physician who may not "cover" their costs from professional fees alone, such as the payor mix of the hospital, other clinical and nonclinical services provided by the physician, or the need for the specialty in the community.

Centers for Medicare and Medicaid Services is also encouraging greater clinical integration between physicians and hospitals as a step toward payment based on quality rather than quantity. The OIG has provided the following guidance on paying for physician efforts to improve quality:

"However, as we discussed in Phase II, compensation related to patient satisfaction goals or other quality measures unrelated to the volume or value of business generated by the referring physician and unrelated to reducing or limiting services would be permitted under the personal service arrangements exception, provided that all requirements of the exception are satisfied (for example, compensation to reward physicians for providing appropriate preventive care services where the arrangement is structured to satisfy the requirements of the exception) (69 FR 16091)."

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