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Is it time to review your physician compensation arrangements?

By Lynn M. Barrett, Esq., CHC, CCP; and Stephen Shaver

As part of its *General Compliance Program Guidance* issued in November 2023, the U.S. Department of Health and Human Services Office of Inspector General advised that an entity should consider including identifying and periodically updating risks to the organization in its compliance program and then auditing and/or monitoring them.[1] For many, one such significant risk involves the entity's compensation arrangements with physicians that implicate the federal Physician Self-Referral Law (PSL)—also known as the Stark Law[2]—and/or the federal Anti-Kickback Statute (AKS).[3] In light of recent government enforcement actions and settlement, it is apparent that the time to review physician compensation arrangements may be now.

From the beginning of 2023 to the present, enforcement actions and settlements with the government involving allegations that the PSL and/or the AKS were violated appear to have been announced with increasing frequency. Many of these had one common allegation that the compensation paid to referring physicians greatly exceeded the fair market value (FMV) for the services provided and thus violated the PSL and the AKS. Many of the defendants received or sought independent FMV valuations; however, due to various alleged actions by the defendants, these valuations were not reliable and did not shield the defendants from the allegations. This includes the largest PSL settlement ever entered into; Community Health Network agreed to pay $345 million to resolve allegations it violated the PSL.[4] (The dollar value of this settlement has been compared to the *U.S. ex rel. Drakeford v. Tuomey Healthcare Sys., Inc.* case, which was ultimately settled for $72.4 million but only after a $237 million jury verdict was entered against it.)[5] Covenant Healthcare System and two physicians agreed to pay $69 million to resolve allegations they violated both the PSL and AKS.[6] Cardiac Imaging Inc. and its CEO agreed to pay $85.5 million to resolve allegations they violated the PSL;[7] and the government recently filed a complaint in intervention alleging PSL violations against Steward Health Care System.[8]

Each of these cases—and others to be subsequently discussed—provide important considerations for compliance professionals and suggests that periodic reviews of physician compensation arrangements for both contractual and operational compliance are essential to an effective compliance program.

Note: Each settlement discussed herein contained allegations only, and any person or entity did not determine liability concerning any of the allegations.

The cases

On January 1, 2020, the government filed a complaint in Intervention against Community Health Network Inc. (CHN) in connection with a 2014 qui tam complaint filed by CHN's former chief financial officer (CFO) and chief operating officer. In its complaint, the government alleged that beginning in 2008 and 2009, CHN engaged in an "aggressive campaign" to recruit physicians—many already practicing in the area—to become employees as a "defensive" measure to keep the physicians' referrals in the system.[9] One way CHN did this, according to the complaint, was by compensating these physicians "magnitudes higher" than they could have made in private practice (in some cases more than double) and well above FMV. The government further alleged that CHN paid these amounts despite the guidance received from a valuation firm, which had been retained for the purpose of determining whether compensation was "in compliance . . . including the Stark Law." The firm had advised CHN leaders that compensation should be below the 75th percentile of national benchmark salary data or below the 60th percentile of such data if physicians were to be paid on a work unit or hourly basis. The firm also advised that, while there may be exceptions to these guidelines based on factors such as community need or individual physician accomplishments, such exceptions were to be reserved for "exceptional circumstances." CHN also allegedly provided incentive compensation to physicians based on "hospital downstream revenue specific to the physician"—that is, the physicians would receive bonuses for reaching a target number of revenue based on referrals to CHN and its affiliates and subsidiaries. Based on the volume or value of referrals, these incentive payments also allegedly violated the PSL.

Notably, while the valuation firm ultimately approved CHN's compensation, this did not shield CHN from the allegations because the complaint alleged that CHN provided inaccurate information to the valuators by, for example, inflating physician collections, lowering physician compensation numbers and/or not disclosing certain information such as the existence of compensation guarantees. In one instance, CHN allegedly advised the valuator that one physician's collections were $4,801,000 when in reality they were $1,300,000 less than what was reported to the firm. CHN also allegedly "shopped" for valuators who would provide it with support for paying physicians at or above the 90th percentile and declined to retain those who were "too conservative." Further, the complaint alleges that in 2012–2013, CHN engaged a different valuation company to analyze physician compensation. This firm described the compensation as "staggering," with some physicians being paid above the 90th percentile. Despite what appears to be a consistent message from different valuators that CHN's compensation to these physicians was well above FMV, the complaint alleges that CHN continued to pay inflated amounts.

As a result of the foregoing, CHN agreed to pay $345 million to resolve allegations that it violated the False Claims Act by knowingly submitting claims to Medicare for services that were referred in violation of the PSL. It also entered into a five-year corporate integrity agreement, which requires CHN to retain both an arrangement independent review organization (IRO) to review certain arrangements for compliance with the PSL and AKS and a claims IRO to review fee-for-service claims paid by Medicare, as well as a compliance expert for the board.[10]

Paying physicians above FMV, including providing inaccurate information to a valuation consultant, were also allegations in the case against Cardiac Imaging, Inc. (CII). According to the settlement agreement, the government alleged that CII—which operated a mobile cardiac PET scanning business—contracted with cardiologists and other physicians to supervise the scans. The contracts allegedly not only required the physicians to refer exclusively to CII for mobile PET scan services but also paid every referring physician a fee of $500 or more per hour for their supervision of the tests. The government alleged that these fees substantially exceeded the FMV of the services, partly because the physicians were paid for such services when they were actually in their offices seeing other patients or for services that were never or rarely provided. Also, as in the CHN case, CII allegedly relied on a consultant's FMV analysis based on "fundamental inaccuracies" provided to the consultant about what was required from supervising physicians, as subsequently discussed in greater detail. In September 2023, CII agreed to pay $75 million plus additional amounts based on revenues CII received over a

certain dollar threshold, which additional amounts are to be paid over five years. CII's CEO—who oversaw and allegedly approved the arrangements—agreed to pay another $10.48 million in connection with the settlement. Notably, both amounts were to resolve allegations that the physician arrangements violated both the PSL and AKS and were based on CII's and the CEO's respective ability to pay. CII and the CEO have also entered into a five-year corporate integrity agreement requiring them to retain an arrangement IRO, among other requirements.

However, the CII issues involving the physician arrangements previously noted are not over. On February 1, 2024, the government filed a complaint in partial intervention against CII's former president, CFO, and one-third owner (Nassenstein).[11] According to the complaint, Nassenstein was not only responsible for negotiating and signing the contracts with the physicians but also allegedly provided the valuation consultant with flawed information, including advising it that the physicians had to remain on CII's mobile truck and oversee each scan when they did not. This alleged complaint caused the consultant to calculate the FMV based on a full-time salary plus operational costs rather than on an on-call basis. Paying an on-call rate for the physicians' availability would correlate to approximately 10%–15% of the physicians' clinical compensation. Thus, instead of the FMV being between $240 to $600 per day (an on-call-type rate), Nassenstein allegedly caused the consultant to calculate the FMV as $8,000 per day for their "full-time" supervisory services. The complaint alleged that Nassenstein then used the "fundamentally flawed, deceptive, and self-serving fair market value analysis" to recruit physicians who would refer to CII and "quashed or ignored" concerns raised by at least one CII executive.

The settlement Covenant Healthcare System entered into with the government announced in March 2023 resulted in a payment by Covenant of $69 million to resolve allegations that it entered into improper financial relationships with eight referring physicians and a physician-owned investment group in violation of the PSL and the AKS. Interestingly, the Covenant settlement was finalized in 2021 but remained under seal while the government continued its investigation into the two physicians, who also entered into settlements, as noted. In addition, the two physicians involved in the arrangements collectively paid a little over $750,000 to resolve allegations related to their relationships with Covenant. The arrangements, like those in CHN and CII, allegedly involved the payment to top referring physicians for medical directorships that were well above FMV and that were used to secure the physicians' surgical referrals. The relator's complaint also alleges that certain physicians did not fulfill their hours requirements and/or failed to keep time logs or other evidence that medical director duties were actually performed.[12] Other allegations included that Covenant provided free services to these physicians generally in the form of the free use of Covenant employees or the provision by Covenant of free management services, forgiving rental payments, and leasing equipment from a physician-owned entity through arrangements that were not negotiated in an arms-length manner. According to the relator—a physician and former employee who worked in various administrative roles for Covenant—Covenant had a "referrals-at-any-cost philosophy," which allegedly led to (among other things) Covenant using a higher relative value unit multiplier that exceeded the physicians' historical performances, paying higher amounts than those outlined in contracts (e.g., one contract was capped at 110% of the 90th percentile, yet Covenant paid more than this amount), and allowing physicians to work far fewer hours than the contracts required.

Similar FMV issues were at play in the case of Steward Healthcare System in connection with its excessive payments to a chief of cardiac surgery allegedly in an effort to increase referrals to one of Steward's hospitals in violation of the PSL. The allegations were first raised in the relator's (the former CFO) 2018 complaint and then again in the government's complaint-in-intervention filed in December 2023. The government's complaint alleges that this physician was paid aggregate compensation allegedly far in excess of FMV for each year from 2013 to 2022. Such compensation allegedly included incentive compensation based on the volume or value of referrals; it increased as the volume of the physician's referrals and the hospital and other business generated for Steward increased. According to the complaint, these payments not only violated the PSL but also Steward's own internal policies regarding physician compensation. The complaint alleged that Steward did not perform an FMV

analysis of the compensation arrangement, nor did it follow its own policy, which stated that Medical Group Management Association (MGMA) benchmarking was to be used to establish FMV for physician compensation arrangements. The policy stated that a written explanation is required if compensation exceeds the 75th percentile of the MGMA benchmark. The complaint alleged that the physician's aggregate compensation exceeded the 90th percentile and that no explanation was provided.

The list of cases involving physician compensation arrangements goes on and includes, but is not limited to:

- New York Presbyterian/Brooklyn Methodist Hospital (March 20424), which agreed to pay $17.3 million to resolve allegations, including that it entered into contracts with physicians in its infusion center that linked the physicians' compensation to the number of referrals they made to the center in violation of the PSL.[13]
- St. Francis Health System (June 2023) agreed to pay $36.5 million to resolve allegations that it violated the PLS and AKS by making payments to orthopedic surgeons tied to the volume or value of referrals.[14]