

HEALTH CARE LAW UPDATE

September 2006

Hospital Law Issues

\$14 Million Dollar Hospital Settlement: Improper Arrangements With Physicians (Practice Guarantees, Loans, Medical Directorships)

On August 18, 2006, the U.S. Department of Justice (“DOJ”) settled a whistleblower lawsuit brought under the False Claims Act against a large Ohio-based health system and one of its hospital. The nearly \$14 million settlement was the result of a lawsuit brought by a former physician employee who alleged that the hospital paid kickbacks and engaged in other illegal financial arrangements with medical staff physicians in exchange for patient referrals, in violation of the federal Anti-Kickback and Stark laws.

This settlement is noteworthy because it demonstrates:

- (i) the serious implications for hospitals that induce referrals in violation of the Anti-Kickback and Stark laws,
- (ii) the increasingly vigorous level of federal government enforcement activities with respect to such activities, and
- (iii) the proliferation of whistleblower cases being brought under the False Claims Act.

Set forth below is a brief summary of this matter and recommendations of how hospitals can avoid this type of liability.

1. The Lawsuit. Similar to the case noted in our August 2006 Health Care Law Update, this matter commenced with a “whistleblower” lawsuit filed in 2003 by a former co-chair of the Cardiothoracic Department at University

Hospital in Ohio, a few months after his employment was terminated by the hospital for alleged “disruptive and abusive behavior.” Shortly thereafter, the DOJ intervened in the case.

The lawsuit charged the hospital with illegally encouraging its physicians to exclusively refer Medicare patients to other physicians within its health system, leading to millions of dollars in false claims.

Based on public reports, the lawsuit included allegations that the hospital:

- (i) Subsidized expenses of private physician groups, such as employee salaries and equipment, through “practice guarantee agreements” (“PGAs”) with the tacit understanding that these amounts were not to be repaid. The PGAs effectively guaranteed the income of the physicians who owned separate medical practices;
- (ii) Solicited physicians (usually department chairs), to become shareholders in corporations organized for the practice of medicine; these corporations then became a mechanism through which the hospital provided compensation packages to “loyal” physicians in exchange for referrals;
- (iii) Extended interest-free loans to physicians with the tacit understanding that no repayment would be required; and

- (iv) Entered into “phony” medical directorship agreements pursuant to which physicians were paid large sums without providing any services.

The government further alleged that top hospital management, including the Chief Executive Officer, failed to discontinue the illegal practices, even after being warned by internal auditors.

As in other recent whistleblower cases, the complaint alleged that the claims submitted by the hospital to Medicare constituted “false claims” under the False Claims Act because the underlying services were provided by physicians in violation of the federal Anti-Kickback and Stark laws.

As part of the settlement, the hospital agreed to pay nearly \$14 million (of which \$1.5 million was paid to the whistleblower). Further, the hospital was required to enter into a corporate integrity agreement.

2. Significance/Recommendations. This settlement demonstrates an increasingly aggressive climate of federal government enforcement activities directed at hospitals, which has been spearheaded by whistleblower lawsuits brought under the False Claims Act. Hospitals should carefully monitor their existing arrangements with physicians to ensure that payments to physicians do not exceed fair market value for legitimate services provided by the physicians.

In addition, hospitals should take the following practical steps to avoid violations of the Anti-Kickback Law, the Stark Law and the False Claims Act:

- (i) reduce all arrangements to a written agreement;
- (ii) make sure that payments to physicians are for legitimate services which are necessary for the proper functioning of the institution and are actually provided and documented in written logs;

- (iii) where possible, obtain written and independent verification that payments to physicians do not exceed fair market value, and maintain such documentation in your files to support the fair market value of the consideration;

- (iv) monitor all payments to physicians to ensure that underlying financial assumptions remain current, and that payments are being made as provided for in the written agreement; and

- (v) implement and maintain a compliance program which not only keeps track of all physician compensation arrangements, but also ensures that billing and compliance issues which are identified in audits or otherwise (e.g. reports by employees) are both investigated and corrected (if corroborated) in a timely manner.

As a final note, once again, bear in mind that all persons affiliated with your institution — medical professionals, management, vendors and current and ex-employees — are potential “whistleblowers” who have an incentive to initiate these types of lawsuits. Thus, it is essential that all of the hospital’s arrangements be compliant with applicable laws.

We send these Updates to our clients and friends to provide information on recent developments in the law. The Updates, however, should not be relied on for legal advice in any particular matter. If you would like additional information, please contact Gary W. Herschman at gherchman@sillscummis.com or at 973-643-5783 or Anjana D. Patel at apatel@sillscummis.com or at 973-643-5097

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