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NOVEMBER 2015
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HEALTH CARE LAW ALERT

Three More Major Stark Law Whistleblower Cases End with Multi-Million Dollar Payouts

The 2015 trend for health care fraud and abuse enforcement is shaping up to be multi-million dollar settlements of Stark law whistleblower cases. The technical legal background of this issue can be summarized as follows. The federal physician self-referral prohibition or "Stark" law prohibits a physician from, among other things, referring Medicare patients to hospitals with which the physician has a financial relationship (including an employment arrangement) unless the terms of that relationship satisfy one of the highly technical exceptions to the prohibition. The Stark law also prohibits hospitals from submitting claims to Medicare for any services they render to patients who are referred in violation of the Stark prohibition. Finally, the federal False Claims Act, which encourages and financially rewards whistleblower lawsuits, is violated when an entity or person "knowingly" submits a claim to Medicare for services that are ineligible for reimbursement. When the Stark law and the federal False Claims Act are brought together, it creates whistleblower nirvana.

Recently, three pending whistleblower lawsuits alleging Stark law and federal False Claims Act violations settled, for a combined total of almost $260 million. When coupled with the settlement in the Columbus Regional Healthcare System case which we reported on in September (view previous Alert here), the total paid by hospital defendants in these four cases alone may exceed $290 million.

September 15, 2015 - North Broward Hospital District (Florida)

North Broward Hospital District settled a whistleblower lawsuit for $69.5 million. Dr. Michael Reilly, a medical staff member at several North Broward facilities, brought this lawsuit alleging that the hospital system paid its employed physicians, including cardiologists and orthopedic surgeons, excessive compensation which was not fair market value, was not commercially reasonable and, in fact, was designed to reward the physicians for the volume or value of their patient referrals for other services within the system. Dr. Reilly indicated that he had been offered employment under these terms, but had declined on the advice of his attorney. Dr.

Reilly's allegations centered in part on secretive "Contribution Margin" reports that North Broward executives had prepared on each physician-employee. These reports were allegedly used to determine the system's return on its investment in physician-employees by calculating whether each physician-employee's excessive compensation was offset by the value of his/her referrals of patients for other services within the system. Dr. Reilly also alleged that physician-employees whose contribution margins did not reach desired levels were pressured to refer more paying patients within the system. North Broward agreed to the settlement, but denied any wrongdoing and highlighted in its prepared statement that there were no allegations of poor quality patient care.

Dr. Reilly will personally receive $12 million of the total settlement. In addition, it has been reported that North Broward paid in excess of $10 million in legal fees to defend itself against the allegations.

September 21, 2015 - Adventist Health System (Florida, North Carolina, Tennessee and Texas)

Adventist Health System settled two related whistleblower lawsuits for $118.7 million. Four Adventist employees, including a Corporate Vice President who served as Chief Operating Officer of the Physician Enterprise Division of Adventist, brought two lawsuits, each raising similar allegations. In part, the lawsuits alleged that an inordinate number of physician-employees in the Adventist system had unreasonably high compensation. Specifically, the whistleblowers alleged that the compensation of many physician-employees exceeded the 90th percentile of the applicable Medical Group Management Association (MGMA) physician compensation surveys, with some totaling between 200% and 300% of that benchmark. In addition, one of the lawsuits alleged that the wRVUs (work Relative Value Units - a measurement of patient-specific physician work and complexity) attributed to each physician for purposes of calculating compensation was highly suspect. In one case, the suit alleged that a physician was attributed with personally performing wRVUs that would normally require the full time services of between five and seven individual physicians.

Similar to the North Broward case, the suits also alleged that the Adventist executive management team prepared and reviewed secretive contribution margin reports that calculated how much the system was reimbursed for hospital-based services (sometimes referred to as "Medicare Part A" revenue) arising from patients referred by each physician-employee. Further, the suits alleged that Adventist executives openly acknowledged that the compensation structure was intended to pay physician-employees a portion of the Medicare Part A revenue arising from their personal referrals. The lawsuits also alleged that executives at Adventist brushed off compliance concerns raised by employees, including the whistleblowers, regarding the structure of these compensation plans while at the same time treating the reports as highly confidential - allegedly indicating that the executives knew that the compensation structure violated federal law.

While there has been no announcement of how the settlement amount will be split as among the four whistleblowers, a rough calculation places the total at between $17 million and $29

million. Notably, Adventist settled another whistleblower case earlier this year for $5.4 million. In that case it was alleged that Adventist failed to provide for appropriate supervision of radiation oncology services for which it billed Medicare, in violation of the Medicare reimbursement rules.

October 16, 2015 - Tuomey Healthcare System (South Carolina)

Tuomey Healthcare System settled its long-running battle defending against a whistleblower lawsuit for $72.4 million and an agreement to be sold to Palmetto Health. As we reported in July (view previous Alert here), the federal Court of Appeals for the Fourth Circuit upheld the lower court's determination that Tuomey had violated the Stark and federal False Claims Act, with regard to compensation paid to 20 part-time physician-employees, paving the way for the government to pursue Tuomey's payment of $237 million in damages which the lower court had previously awarded. Tuomey had long argued that paying that amount would bankrupt the small, rural, not-for-profit hospital and cause it to close its doors. The settlement ended the tortured legal battle and appears to ensure that a hospital will still be operated in Sumter, South Carolina. Michael Drakeford, M.D., the whistleblower in this case, will receive $18.1 million from the settlement.

The Tuomey case highlighted such controversial issues as legal opinion shopping, the sophistication (or lack thereof) of external valuations (Tuomey had an external valuation but the expertise of the valuation agent was successfully attacked by the prosecution) and whether or not compensation of physicians employed in hospital-affiliated physician practices is ever fair market value and/or commercially reasonable if such physician practices are not financially self-sufficient, absent consideration of the revenue the hospital receives for services rendered to patients referred by the physician-employees. Many health lawyers have questioned certain aspects of the legal analysis, rationale and conclusions contained in the Court of Appeals' and trial court's decisions, but the settlement will preclude further judicial analysis of these points.

Take Aways from the Recent Settlement

It is difficult to say definitively what lessons or advice hospitals, health systems and physicians should take from this recent spate of settlements, but the following are worthy of consideration in crafting future financial relationships:

- Securing external, expert valuations of compensation arrangements in advance of "sealing the deal" between physicians and hospitals is highly advisable, particularly when overall compensation is expected to exceed 75% of MGMA. This would provide contemporaneous and objective evidence that the hospital and the physicians felt, based on reliable external advice, that the arrangement was fair market value and commercially reasonable even without considering revenue from ancillary referrals.

- If hospitals and/or physicians choose to seek external valuations or legal opinions, both parties must be prepared to live with the results. Shopping for second opinions,

ignoring the results of external valuations or opinions and/or attempting to mitigate the impact of proceeding contrary to such advice or opinions simply by having external advisors refrain from finalizing their advice in writing are all paths fraught with legal and compliance risks and unintended consequences.

- Using contribution margin reports which reflect the financial result for the hospital of physician-employees' patient referrals is a very sensitive area. While there may be legitimate operational reasons for reviewing this data, doing so in the context of compensation calculations, decision-making and/or negotiations is not advisable.

- Compensation arrangements must be implemented as written. From a legal and compliance standpoint, failing to comply with the terms of a written agreement is worse than not having a written agreement at all.

- Hospital administration and physicians ignore internally-raised compliance concerns at their own peril. Once a compliance failure is identified, quick action is required **INCLUDING REPAYMENT OF RELATED OVERPAYMENTS IF CONCERNS ARE VALIDATED.**

- Hospital administration and physicians should not rely on the hope that a sophisticated legal argument aimed at defending an arrangement, could, theoretically, be made, if a cutting-edge financial relationship is ever questioned by regulators or a whistleblower. With the final chapter of Tuomey having been written, it is less and less likely that enforcement actions where Stark, False Claims Act and/or anti-kickback violations are alleged will ever reach a courtroom. The goal, therefore, should be to prepare contemporaneous records in the planning stages and to implement transactions carefully, in order to provide objective evidence that would lead regulators - and possibly whistleblowers' attorneys - to the conclusion that challenging a particular transaction would not be a fruitful endeavor.

Please do not hesitate to contact one of our Firm's health law attorneys identified below if you would like more information on this issue.

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