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Recent $345 Million Settlement Underscores Critical Importance of Appropriate Physician Compensation

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In a settlement larger than *Halifax and Tuomey* combined, an Indianapolis-based health system recently settled with the Department of Justice for $345 million to resolve Stark Law and False Claims Act allegations relating to its employed physician compensation arrangements. This massive settlement reflects the complexities and importance of appropriately structuring physician compensation, and the government's continued focus on fraud and abuse enforcement.

The matter arose as a *qui tam* action brought in 2014 by the health system's former chief financial officer and chief operating officer. For certain of the allegations in the government's intervening 2020 complaint, it is unsurprising that the government found the alleged conduct problematic. For example, the health system allegedly intentionally provided its appraisers false information on multiple occasions (including by inflating collections figures of the physicians), often doubled the salaries of physicians compared to what they had been earning in private practice, and persistently ignored multiple appraisers' warnings about large disconnects between very high compensation of numerous physicians and moderate productivity. Most devastatingly, for at least some specialties, an incentive component of compensation was allegedly explicitly dependent on the individual physician's technical referrals made in such compensation period, in flagrant violation of restrictions on determining compensation in a manner that takes into account the volume or value of referrals (the Volume/Value Element).

Perhaps because of the extent of alleged problematic conduct, in some cases, this may be a case of bad facts making bad quasi-law, in that other allegations in the government's complaint may have had their implications unduly stretched by the government. Nonetheless, the circumstances surrounding the conduct appear to have been significant enough to cause the health system to settle the claims for a sizeable settlement. Because the case was ultimately settled at an earlier procedural stage than *Halifax* or *Tuomey*, such overwrought implications do not carry the force of law, but they still suggest additional dimensions for which providers should exercise caution.

For example, the government recites the unseemly allegation that the health system calculated incremental ancillary profits it would likely receive from integrating physicians, discussed, and essentially negotiated the conceptual split of such profits with the physicians, with the health system in one case offering 40 percent and the physicians demanding 50 percent. While indeed a very unseemly negotiating approach, the government portrayed it as causing the health system to fail the Volume/Value Element. However, despite ancillary projections being reviewed by the parties and the parties essentially backing-in to prospective compensation amounts through such projections, the actual compensation approach for many specialties was either fixed guaranteed compensation or wRVU-based compensation for personally-performed services. Under the fairest reading of special rules regarding the application of the Volume/Value Element under the December 2020 rulemaking (this dimension of which was arguably retroactive), the unseemly approach of the parties should ultimately not be deemed to violate *the Volume/Value element* in instances in which the compensation was either fixed guaranteed compensation or wRVU-based compensation for personally-performed services (which seemed to be a majority of the specialties, as only a limited number of specialties had an incentive compensation component dependent on technical referrals). The most significant issue with backing into

guarantee amounts and/or wRVU rates by estimating anticipated technical profits is that the resulting guarantee amounts and wRVU rates offered by the health system seemed exorbitantly high from a *fair market value* perspective. However, even in cases where the resulting compensation is supportable from a fair market value perspective, notwithstanding the flexibility that should be available to providers under the special rules, health systems should focus on factors other than ancillary profits in their discussions and negotiations with physicians regarding salaries and/or wRVU rates.

Notably, the government seems to at least stretch the relevance of fair market value to an indirect compensation arrangements analysis. Specifically, Paragraph 28 of the government's complaint is at best imprecise, as it obscures the fact that simply exceeding fair market value does not squarely implicate the language of the "indirect compensation arrangement" definition in place at the time. That is, if a physician is employed by a physician employment vehicle and the physician's compensation is unrelated to the volume or value of referrals to a related "designated health services" entity such as a hospital, it's not fully clear that compensation purportedly above the range of fair market value would implicate the legacy "indirect compensation arrangement" definition, in which case the parties would not need to satisfy an exception for referrals to such affiliated hospital. Based on recent revisions to the definition of "indirect compensation arrangement," it is now clear that fair market value is only relevant where the parties have implicated a threshold volume/value standard. Perhaps the government was implicitly taking the position that if a health system was causing the physicians to be paid in excess of fair market value, the reasoning for that must have been to incentivize referrals even in instances in which the compensation was a set guaranteed amount or wRVU-based, thus implicating the "indirect compensation arrangement" definition in place at the time. The strength of such a position for periods prior to recent changes to the "indirect compensation arrangement" definition is debatable, but in any event, the government at best appears to oversimplify this analysis in its complaint.

Further, the availability of the in-office ancillary services exception appears underdeveloped in the parties' pleadings. As previously noted, in many instances, the physicians appear to have been employed by a health system affiliate that was separate from the hospital entities. While not displacing the indirect compensation arrangements analysis, to the extent that such physician employment entities themselves had designated health services such as some laboratory and some imaging services, presumably for many specialties the in-office ancillary services exception should have been available, as neither such exception nor the related "group practice" definition reflect a fair market value element. Health systems should reflect on whether the in-office ancillary services exception is available to its physician enterprises; while such enterprises could still implicate the indirect compensation arrangements definition if they pay their physicians for referrals to an affiliated hospital (or other affiliated "designated health services" entity), physician enterprises that satisfy the in-office ancillary services exception can potentially avoid the extreme Stark Law and False Claims Act consequences of paying physician compensation that purportedly exceeds fair market value.

One modest source of potential comfort to providers from the government's approach in its complaint is that the government's complaint did not endorse the *qui tam* relator's assertion that the employed physician's compensation additionally violated the Anti-Kickback statute. Such an omission may indicate an implicit acknowledgment by the Department of Justice of the breadth of the bona fide employment safe harbor under the Anti-Kickback Statute. We caution, however, that unknown strategic reasons might have informed the government's approach in this particular case, and it is not fully clear that the Department of Justice will consistently take such a flexible approach to the Anti-Kickback Statute's employment safe harbor, notwithstanding the recent favorable advisory opinion from the OIG.

The settlement underscores the enormous stakes of structuring physician compensation appropriately, notwithstanding competitive pressures. In addition to the $345 million settlement itself, the health system will be under a five-year corporate integrity agreement with a legal Independent Review Organization, a claims

Independent Review Organization, and a compliance expert to the Board. Additionally, separate non-intervened claims from the relator have still not been settled, and it has also not yet been determined whether the relator will be awarded attorney's fees relating to the settled claims, which would be incremental to the $345 million if awarded.

For assistance in reviewing your organization's approaches to physician compensation and opportunities to strengthen your compliance posture while maintaining competitiveness, please contact Joseph Keillor, Alissa D. Fleming, or your usual Baker Donelson attorney contact.