by Erika Mekies

Hospital Employment of Physicians

Physician employment at hospitals remains on a healthy growth path. Hospitals employed some 211,500 physicians in 2010, a 34 percent increase since 2000, according to the latest annual survey conducted by Merritt Hawkins.[1]

A number of factors account for the surge: a decrease in reimbursement paid to physicians by Medicare and managed care organizations; an increase in overhead costs for physician practices; an increasingly complex regulatory environment; a growth in malpractice insurance costs; a regulatory mandate to convert to electronic medical records requiring a large upfront expenditure; and an increasing physician's desire for a better work-life balance.[2] Additionally, the law offers an incentive for hospitals and physicians to team up in the form of accountable care organizations and earn bonuses for more efficient, higher quality care.[3]

While costs and other expenditures are driving hospitals and physicians to come together, federal fraud and abuse laws create a dilemma in other areas, namely the hospital-physician financial relationship.[4] There are various ways to structure the hospital-physician relationship, each of which can be structured in a different manner to comply with regulatory guidelines. So long as there are no state statutory prohibitions, direct employment of physicians within the hospital is the most effective way of meeting Stark Law exceptions and the Anti-Kickback Statute's safe harbors for bona fide employment relationships.[5]

Complying With the Stark Law

The Stark Law generally prohibits a physician from referring Medicare or Medicaid patients for designated health services, including hospital inpatient and outpatient services, to an entity with which the physician or a member of the physician's immediate family has a financial relationship, unless the referral meets an exception under the statute or regulations.[6]

When a hospital employs a physician, the parties' financial agreement with respect to such employment must comply with a Stark Law exception. The Stark Law's employment exception permits a physician's bona fide employment by a hospital if: (1) the employment is for identifiable services; (2) the compensation is consistent with the fair market value for the services rendered and is not determined in a manner that takes into account, directly or indirectly, the volume or value of the physician's referrals; and (3) the employment contract is commercially reasonable even if no referrals were made to the designated health services entity.[7]

Avoiding Anti-Kickback Statute Violations

The Anti-Kickback Statute provides for criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration to induce a referral, or recommend the referral of an individual to another person or entity for the furnishing or arranging for the furnishing of any item or service that may be paid in whole or in part by any federally funded healthcare program.[8] For purposes of the statute, "remuneration" includes the transfer of anything of value, including cash, free goods, services, discounts, or items priced below fair market value.[9]

The U.S. Congress directed the U.S. Department of Health and Human Services' Office of the Inspector General to promulgate regulations that create "safe harbors" for various business transactions and payment practices that would not be subject to criminal prosecution under the statute, and that would not form a basis for civil monetary penalties or Medicare/Medicaid exclusion proceedings.[10]

The Anti-Kickback Statute, however, does not prohibit, and specifically excludes from the definition of "remuneration," payments made by employers to their bona fide employees for the furnishing of items or services that may be reimbursable by a federal healthcare program.[11] For purposes of this safe harbor, the term "employee" is defined in the Internal Revenue Code (IRC).[12] Thus, in addition to complying with the employment exception under the Stark Law, which as previously noted, requires (among other things) an agreement that sets forth the compensation that is consistent with fair market value and does not take into account the value or volume of referrals, hospital employers must ensure that their physician employees constitute bona fide employees as defined by the Internal Revenue Service (IRS).[13]

IRC Considerations

Nonprofit hospitals must also take into account their tax-exempt

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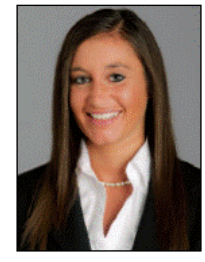

status when employing physicians. Pursuant to § 501(c)(3) of the IRC, a tax-exempt entity must be "organized and operated exclusively for religious, charitable, scientific … or educational purposes."[14] In addition, the tax-exempt entity must ensure that no part of their net earnings inure to the private benefit of any individual.[15] This "private benefit" prohibition precludes the income or assets of a tax-exempt organization from being transferred away from the organization to one or more outside individuals.[16] The act of receiving an excess economic benefit by an "insider" is referred to as an "inurement." Under a five-factor, all-the-facts-and-circumstances analysis set forth in the U.S. Treasury Regulations, that inurement may lead to revocation of the entity's tax-exempt status.[17] A private benefit case may be established if the hospital pays more than fair market value as compensation for the physicians' services.[18]

State Corporate Practice of Medicine Prohibitions

Hospitals and physicians entering into employment relationships must understand that state corporate practice of medicine laws govern such arrangements. The corporate practice of medicine doctrine generally prohibits corporate entities from directly employing physicians. The doctrine's underlying theory is that it protects patients from the potential abuses of commercialized medicine, which causes physicians to divide their loyalties between profits and the delivery of quality patient care.[19]

Most corporate practice of medicine specifically excludes hospital employment of physicians from their corporate practice of medicine. California and Texas, for example, consider most hospitals to be corporate entities that cannot directly employ physicians.[20]

Case in Point—*United States v. Sulzbach*

In September 2007, the federal government filed a federal False Claims complaint against the former corporate integrity program director of Tenet Healthcare, Christi Sulzbach. Sulzbach, an attorney, allegedly had knowledge of and failed to stop Tenet Healthcare from paying employed physicians compensation based on referrals for hospital-based ancillary lab services.[21]

The government alleged that Sulzbach knew that the employed physicians in question received substantial pay raises compared to the physicians' reported wages prior to their hospital employment. The hospital also allegedly took into consideration the value of the physicians' expected ancillary laboratory referrals when setting the physicians' compensation.[22] At the U.S. Senate hearing on the Sulzbach matter, Sen. Charles Grassley (R-IA), chairman of the Senate Finance Committee, put it succinctly: "[I]t doesn't take a pig farmer to smell the stench of conflict in that arrangement."[23]

The government requires annual compliance reports to be submitted, and in her reports, Sulzbach verified that Tenet was in compliance with all federal program requirements, including the Stark Law. The complaint, however, sought to have Sulzbach personally pay three times the damages incurred by the government, as well as fines of up to $10,000 for each of approximately 70,000 claims for payment that Tenet submitted to Medicare.[24]

While the physicians may not have been receiving more than fair market value for their services, this act may satisfy only the first part of the compensation test. The physician's compensation must also be commercially reasonable, absent the referrals that

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[32]*Id.* at 180.

[33]*See, e.g.*, Thomas M. Burton, *FDA Won't Appeal Free-Speech Marketing Decision*, Wall St. J. L. Blog (Jan. 23, 2013, 8:20 PM), online.wsj.com/article/SB10001424127887324539304578260323575925896.html; Greg Ryan, *FDA Wise to Duck High Court Off-Label Ruling, Atty Says*, Law360 Blog (Jan. 24, 2013, 9:51 PM), www.law360.com/newyork/articles/408974/fda-wise-to-duck-high-court-off-label-ruling-attys-say.

[34]Ryan, *supra* note 32.

[35]*Id.* (citations omitted).

[36]Erica Teichert, *FDA Official Says Off-Label Ruling Won't Limit Enforcement*, Law 360 Blog (Jan. 30, 2013, 2:58 PM), www.law360.com/lifesciences/articles/411478?utm_source=shared articles&utm_medium=email&utm_campaign=shared-articles.

[37]*See, e.g.*, *GlaxoSmithKline to Plead Guilty and Pay $3 Billion to Resolve Fraud Allegations and Failure to Report Safety Data*, U.S. DOJ (July 2, 2012), www.justice.gov/opa/pr/2012/July/12-civ-842.html (last visited Jan. 30, 2013) (documenting settlement with GlaxoSmithKline for false and misleading claims with respect to the drug Paxil and its marketing to patients under 18); *id.* (documenting settlement with GlaxoSmithKline for false and misleading statements with respect to the safety of Avandia).

[38]*Bextra and Celebrex Settlement Information Website*, Third-Party Payor Home Page, www.bextracelebrexsettlement.com/TPPHomepage.htm (last visited Jan. 30, 2013).

[39]*Pediatric Paxil Third-Party Payor Settlement*, Pediatric Paxil Third-Party Payor Settlement Information, www.pediatricpaxiltppsettlement.com/docs.htm (last visited Feb. 1, 2013).

[40]*Deadline for Serostim Settlement Extended to Sept. 27!*, Prescription Access Litig. Blog, blog.prescriptionaccess.org/?cat=142 (last visited Feb. 1, 2013).

[41]*Id.*; *Civil Settlement Agreement between the United States and Serono, Inc.*, www.corporatecrimereporter.com/documents/Serono-CivilSettlementAgreement.pdf; *Serono to Pay $704 Million for the Illegal Marketing of AIDS Drug*, U.S. DOJ, www.justice.gov/opa/pr/2005/October/05_civ_545.html (last visited Feb. 1, 2013).

[42]517 F.3d 935 (7th Cir. 2008).

[43]425 U.S. 748 (1976).

[44]517 F.3d at 940.

[45]*Id.*

[46]202 F.3d 331 (D.C. Cir. 2000).

[47]*Id.* at 333.

[48]*Id.*

[49]*Id.* at 336.

[50]*Id.*

[51]Memorandum and Order Re: Defendant's Post-Trial Motion to Dismiss the Indictment, for Acquittal or for a New Trial, No. C 08-00164 MHP, 2010 U.S. Dist. LEXIS 75528, at *1 (N.D. Cal. July 27, 2010).

[52]*Id*. at **2-3.

[53]*Id.* at *47 (citations omitted).

[54]Memorandum and Order Re: Defendant's Motions in Limine re: "Labeling" and to Exclude Protected First Amendment Speech or, in the Alternative, to Dismiss the Indictment, No. C 08-00164 MHP, 2009 U.S. Dist. LEXIS 47255, at *17 (N.D. Cal. June 3, 2009) (citations omitted).

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will arise between the physician and the hospital. A hospital might be paying a doctor fair market value according to some national standard, but a lack of commercial reasonableness could still be alleged because the collections from the doctor's direct services do not cover the doctor's compensation and his or her fair share of overhead. Moreover, a hospital-employed physician's compensation may not be "determined" in a manner that takes referrals of designated health services including ancillary services and other hospital services, into account.[25]

Defendant Sulzbach's Motion for Summary Judgment was granted on the grounds that this case was barred by the statute of limitations. Although no final decision was entered, the government does not tread lightly and the penalties are severe.

Case in Point—Covenant Medical Center in Waterloo, Iowa

Covenant Medical Center in Waterloo, Iowa, agreed to pay the United States $4.5 million to resolve allegations that it violated the False Claims Act. The United States accused Covenant of violating the Stark Law by paying commercially unreasonable compensation, far above fair market value, to five employed physicians who referred their patients to Covenant for treatment. These physicians were among the highest paid hospital-employed physicians not just in Iowa, but in the entire United States. Two of the physicians were reportedly each paid more than $2 million per year.[26]

Underscoring the government's intent to ardently pursue cases of fraud, U.S. Attorney Matt M. Dummermuth of the Northern District of Iowa stated: "This payment is the largest ever related to claims of healthcare fraud in the Northern District of Iowa … we are actively working with our investigative partners to ensure Medicare funds are properly spent, and we will continue to aggressively pursue all types of fraud in order to protect federal healthcare dollars."[27]

Hospitals may be willing to pay what it takes to hold on to their most profitable physicians. Yet, both physicians and hospitals need to recognize the significant risks in establishing such relationships, and find a balance. This may necessitate engaging an independent valuation agent for objective appraisal of the agreed-upon compensation.

Accountable Care Organizations as an Alternative

Accountable Care Organizations (ACOs) are a creation of the Medicare statute and were created by Congress in the Accountable Care Act (ACA) as part of the Medicare shared savings program. They are a type of clinical integration in which groups of hospitals, physicians, and other providers come together in one integrated model to coordinate services to a designated group of patients, providing quality care, and sharing in costs savings realized as a result of their joint efforts.[28]

The ACO program is designed to improve beneficiary outcomes and increase the value of care by promoting accountability and requiring coordinated care, as well as encouraging investment in infrastructure and redesigned care processes.[29] Hospitals employing

physicians, or in partnership with physicians or other practitioners, are eligible to form an ACO.[30] For hospitals and physicians clinically integrating as an ACO, the Anti-Kickback Statute and Stark Law are waived as long as an ACO meets certain specified conditions.[31] The waivers are robust, comprehensive, and cover the full range of activities necessary for ACOs to achieve the goals set by Congress.[32] Waivers cover ACO activities from startup through operations, as well as incentives to beneficiaries. Each of the waivers is self-implementing, meaning, there is no "permission" process.[33]

Will It Last?

Physician employment by hospitals (and its continued upward trend) has some historical roots. In the 1990s, managed care and health maintenance organizations started a trend of hospital purchases of primary care practices to secure referral bases. Hospitals lost money however, when physicians' productivity dropped. Unlike in the 1990s, hospitals now typically use productivity-based compensation instead of salaried arrangements.[34] This time around, hospitals are refining or fine-tuning their contractual and administrative management and consolidation of practices to better negotiate with insurers, and monitor productivity and quality.[35] Hospitals are also giving physicians a greater role in governance and management. Hospital executives believe giving physicians a larger leadership role makes employment more palatable to physicians, enhances physician loyalty, and helps improve the clinical effectiveness of care.[36]

Conclusion

Due to the recent changes in healthcare law and the many factors driving physicians and hospitals to collaborate, it appears that physician employment in hospitals is here to stay, albeit under the government's watchful eye. Tony West, assistant attorney general for the U.S. Department of Justice's civil division, stated: "Healthcare providers must act in the best interest of their patients. The Justice Department will protect patients by pursuing hospitals that have improper financial relationships with physicians."

The government will continue to aggressively pursue all types of fraud. For the hospital-physician relationship to work, hospitals and physicians must work together to come up with employment agreements that meet the regulatory requirements, and pass muster under the law including compliance with the appropriate legal statutes (e.g., Stark Law, the Anti-Kickback Statute, etc.).

Hopefully, the result will be that optimal patient care is maintained and physicians are appropriately compensated. ⊙

Endnotes

[1]Robert Lowes, *Number of Physicians Employed by Hospitals Snowballing*, Medscape.com, Jan. 24, 2012, *available at* www.Medscape.com.

[2]*Id.*

[3]*Id.*

[4]Michael Levinson et al., *Seeking Safe Harbor*, Trustee Mag., May 2012, *available at* www.trusteemag.com [hereinafter Levinson et al.].

[5]Michael A. Cassidy et al., *Hospital/Physician Integration: Three Key Models*, Am. Health Law. Ass'n, Oct. 2011 [hereinafter Cassidy et al.].

[6]*See* 42 U.S.C. § 1395nn.

[7]*See id.* § 411.352(c).

[8]*See id.* § 1320a-7b(b).

[9]*See*, *e.g.*, Off. Insp. Gen. Op. No. 10-08 (June 10, 2010).

[10]Cassidy et al., *supra* note 5.

[11]*See* 42 C.F.R. § 1001.952(i).

[12]*Id.*

[13]*See* 26 U.S.C. § 3121(d)(2).

[14]*See id.* § 501(c)(3).

[15]*Id. See also* Treas. Reg. § 1.501(c)(3)-1(c)(2).

[16]Cassidy et al., *supra* note 5.

[17]*See* Treas. Reg. § 1.501(c)(3)-1(f). The five-factor test considers the following: (1) the size and scope of the organization's regular and ongoing activities that further exempt purposes before and after the private inurement transaction occurred; (2) the size and scope of the private inurement transaction in relation to the size and scope of the organization's regular and ongoing activities that further exempt purposes; (3) whether the organization has been involved in multiple private inurement transactions with one or more persons; (4) whether the organization has implemented safeguards that are reasonably calculated to prevent private inurement transactions; and (5) whether the amount of the excess economic benefit has been repaid to the organization, plus interest at the applicable federal rate, or whether the organization has made good-faith efforts to seek return of the excess amount, plus interest, from the insider who benefitted from the private inurement transaction. Depending on the particular situation, the IRS may assign greater or lesser weight to some factors than to others.

[18]Cassidy et al., *supra* note 5.

[19]*Id.*

[20]*Id.*

[21]*United States v. Sulzbach*, No. 07-61329 CIV, 2010 WL 1531492 (S.D. Fla. Apr. 16, 2010); Barry F. Rosen, *Hospital-Employed Physicians: The Lessons of* Sulzbach, Mid-Atl. Health L. Topics, Fall 2008.

[22]*Id.*

[23]Michael Z. Gurland, *From the Sideline to the Front Line:* United States v. Sulzbach: *In-House Counsel and Compliance Officers at Risk for Corporate Fraud Prosecutions*, Nov. 28, 2007, www.ngelaw.com/publications/from-the-sideline-to-the-front-line/#_ednref2.

[24]*Id.*

[25]*Id.*

[26]U.S. Department of Justice, Covenant Medical Center to Pay U.S. $4.5 Million to Resolve False Claims Act Allegations (Aug. 25, 2009).

[27]*Id.*

[28]Levinson et al., *supra* note 4.

[29]*Id*.

[30]*Id.*

[31]*Id.*

[32]*Id.*

[33]*Id.*

[34]*Id.*

[35]*Id.*

[36]*Id.*