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HEALTH LAW NEWS

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DEPARTMENT OF JUSTICE ANNOUNCES $42 MILLION SETTLEMENT FOR ALLEGED FALSE CLAIMS ACT VIOLATIONS

Recently, the Department of Justice ("DOJ") announced it had entered into a $42 million settlement ("Settlement")[1] with the owners of a California acute care hospital ("Parent Company") to resolve allegations that the Parent Company had violated the False Claims Act by submitting false claims to Medicare and MediCal (California Medicaid) programs. The Parent Company is a fully integrated health care company comprising the Hospital at issue, a managed care organization, two physician practice associations and 50 percent ownership in a health plan specifically for MediCal. Nearly $32 million will be paid to the United States to settle allegations of false claims against Medicare and $10 million will be paid to the state of California to settle the allegations that carried potential damages of over $400 million.

BACKGROUND

A former manager of the Hospital filed the *qui tam* (i.e., whistleblower) action under seal in June 2013. The Complaint alleged improper relationships between the Parent Company and physicians and that the Parent Company compensated the physicians in excess of fair market value and took into account the volume or value of referrals to the Hospital by the physicians. In addition, the Complaint alleged that the Hospital violated the Civil Monetary Penalties Law ("CMP") by inducing federal health care program beneficiaries to choose certain providers. Although both governments declined intervention in the case, the relator moved forward. In its Settlement announcement, the DOJ stated, "This settlement is a warning to health care companies that think they can boost their profits by entering into improper financial arrangements with referring physicians."

DETAILS ALLEGED IN THE COMPLAINT

The relator alleged violations of both the Stark Law and the Anti-Kickback Statute for actions beginning in 2006. The relator alleged the Parent Company violated both statutes by entering into arrangements with physicians that accounted for the volume of the physicians' patient referrals to the Hospital and intentionally induced referrals. Allegedly problematic arrangements between the hospital and various members of its medical staff included:

- Sublease Agreements: The Hospital entered into sublease arrangements with various physicians in order to host one-hour monthly meetings with federal health care program beneficiaries in the physicians' offices. The rental value for these arrangements exceeded fair market value and accounted for the volume or value of referrals from the physicians. Additionally, the rent was paid on a monthly basis regardless of whether or not the Hospital conducted any meetings in the physicians' offices.
- Shared Marketing Agreements: The Hospital entered into Shared Marketing Agreements with physicians in order to increase the physicians' patient base and revenues. These initiatives were paid for by the Hospital matching the costs paid for by the physicians. The marketing services provided under these agreements included the advertisement of free transportation available to potential patients.
- Vendor Marketing Agreements: The Vendor Marketing Agreements were similar to the Shared Marketing Agreements but without any cost-sharing by the physicians.
- Medical Directorship Agreements: The Medical Director Agreements were entered into based upon a target number of referrals/admissions to be made to the Hospital by the physicians. The relator purported to hear the Hospital's Vice President of Business Development tell a physician that he would receive a Medical Director appointment only if the physician referred or admitted 15-20 patients each month.

The relator claimed that the Parent Company paid remuneration directly to MediCal-enrolled expectant mothers as an inducement to receive maternity services from the Hospital but only if she chose to deliver her baby at the Hospital.

ALLEGED EVIDENCE OF IMPROPER INTENT

The relator alleged that the Hospital tracked referrals from physicians and threatened to cancel (or does cancel) arrangements if referral targets went unmet. The Hospital's marketing team also allegedly conducted weekly discussions of physician referrals including physicians failing to meet referral targets.

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The relator claimed personal knowledge of key conversations. These included conversations on providing physicians with compensation in exchange for a guaranteed number of referrals and/or inpatient admissions per month. While many of these discussions were verbal, the Complaint provided evidence of written logs from physician integration representatives documenting similar communications with referring physicians. These written communications summarized conversations with physicians regarding compensation in exchange for patient referrals. In some instances, physicians were told they would receive sublease and/or marketing arrangements if they increased the number of patients they referred to the Hospital.

The Hospital allegedly tracked referrals from physicians and calculated an estimated return on investment for the compensation that was paid to the physicians in exchange for the promise of patient referrals. The Hospital's staff would then categorize referring physicians into separate tiers based upon the actual and goal volumes of patient referrals and the corresponding return on investment.

PRACTICAL TAKEAWAYS

- As a part of the Settlement, the Hospital denied most of the allegations and all liability. However, providers can learn from the behavior that led to the *qui tam* action in order to limit potential liability for similar types of arrangements and programs.
- While some of the alleged conduct of the Hospital may show evidence of an improper intent on behalf of the parties, not all of the agreements described in the Complaint are *per se* improper. As such, it is imperative for health care organizations to ensure that they are entering into arrangements for proper purposes (such as community need/benefit, satisfaction of regulatory requirements, population health management, compliance with bundled payment programs, etc.) and that **no purpose** of any proposed arrangement is to induce or reward referrals from the referring entity.
- Health care providers should consult with legal counsel regarding the safeguards that should be in place prior to implementing any protocols to monitor referrals. In addition, providers should be careful regarding calculating things like the return on investment or "contribution margin" associated with referrals by physicians.
- When engaging in new physician arrangements, particularly those that are intended to market hospital and physician services and/or provide community outreach to federal health care program beneficiaries, health care organizations should consult with legal counsel in order to ensure that the proposed arrangement is appropriate and legally compliant.
- Health care organizations that believe they may have identified arrangements that may be potentially problematic should consult legal counsel as soon as possible in order to review the arrangements and begin any necessary remedial steps.

If you have any questions or would like more information about this topic, please contact:

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[1] For a copy of the DOJ press release, click here.

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