



Be Careful What You Say: Physician Affiliation Tricks of the Trade to Reduce Your Risk



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1

THE BELLS THAT CANNOT BE UNRUNG...

- *We need to pay these physicians in a manner that reflects the revenue we will get from their downstream referrals...*
- *Let's make sure we have a surrogate that will pay a physician for the ancillaries they refer to the hospital...*
- *The compensation paid under the PSA needs to ensure there isn't a leakage of referrals from these physicians...*

2

Agenda

1. Healthcare Regulatory Laws

2. Recent Litigation Around Physician Affiliations

3. Impossible Day and Cost Sharing Arrangements

4. Documenting Physician Relationships in a Regulatory Compliant Manner

5. Practical Tips

6. Q&A

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3

From: [REDACTED]
Sent: Monday, December 23, 2024 5:41 PM
To: [REDACTED]
Cc: [REDACTED]
Subject: Re: [EXTERNAL] [REDACTED] RE: URGENT-FMV Opinion

Hi [REDACTED],

Thank you for reaching out. [REDACTED] Faculty Plan is part of [REDACTED] University Health system. They are a multi-billion health system with thousands of providers. He rounds at our hospital but also goes to other [REDACTED] hospitals. The daily commitment is actually a 2-4 days a week visiting in person but he is managing patients and fielding calls daily. As discussed on the phone, we will be provided a rate by [REDACTED] and we will negotiate but ultimately will accept what they feel is fair. [REDACTED] is our largest referral source for this market and very important to my leadership. I cannot confirm that I will be able to obtain a statement especially prior to the contract renewal.

Best Regards,

[REDACTED]
Market Chief Executive Officer

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4

Healthcare Regulatory Laws



5

Stark Law - The Prohibition (42 U.S.C. §1395nn)

(1) The Referral Prohibition

- If a [physician](#) (or immediate family member of a physician)
- Has a [financial relationship](#) with an entity (such as a hospital)
- The physician may not make a [referral](#) to that entity
- For Medicare [designated health services](#) (“DHS”)
- Unless an [exception](#) applies

(2) The Billing Prohibition

- The entity cannot bill Medicare for services furnished pursuant to a prohibited referral

Intent does not matter

6

Stark Law – Key Exceptions



Employment arrangements



Personal services agreements



Office/Equipment Leases



Physician recruitment agreements



Fair market value exception

7

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7

Stark Law – Consequences of Violation



Absolute requirement to repay all claims for Medicare services furnished pursuant to a prohibited referral



Substantial civil monetary penalties



Exclusion from federal programs for circumvention schemes



Claims submitted in violation of the Stark Law may be false claims under the False Claims Act

8

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8

Anti-Kickback Statute (42 USC §1320a-7b(b))

Makes it a crime for any person to knowingly and willfully offer, pay, solicit or receive anything of value to induce or reward referrals or to generate Federal health care program business

Government
need only
prove one
purpose

Penalties

Each violation is
a felony,
punishable by up
to 10 years
imprisonment and
\$100,000

Civil penalties up
to \$100K+

False Claims Act
liability (\$11-
22K+/claim,
treble damages,
qui tam, self-
report)

Exclusion

Voluntary
Safe Harbors

OIG Self-
Disclosure
Protocol

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9

False Claims Act ("FCA") (31 U.S.C. § 3729(a)(1))



- Imposes liability if a person,
 - Knowingly
 - Presents or causes to be presented
 - A false or fraudulent
- Non-compliance with the Stark Law and Anti-Kickback Statute are a frequent basis for FCA liability
- Other bases for FCA liability:
 - Upcoding/unbundling
 - Billing for services not provided
 - Billing for medically unnecessary services
 - Not repaying overpayment within 60 days

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False Claims Act Penalties and Qui Tam



FCA Violations punishable by:

Treble (3x) damages

Per-claim penalties of ~\$11,000 to ~\$22,000



Billions of dollars recovered every year



FCA action can be brought directly by government, or by a private person (“relator” or “whistleblower”) in a *qui tam* action



Relator files complaint under seal and serves upon government



Government has 60 days to investigate and make intervention decision

11

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11

Fair Market Value



According to the Stark Law (and similar definitions in the Federal Anti-Kickback Statute), the general meaning of fair market value is *the value in an arm’s-length transaction, consistent with the general market value of the subject transaction.*¹ Further, *with respect to compensation for services,*² “general market value” means *the compensation that would be paid at the time the parties enter into the service arrangement as the result of bona fide bargaining between well-informed parties that are not otherwise in a position to generate business for each other.*

As opposed to the meanings specifically associated with rental of equipment or rental of office space.³

f.n.1 42 CFR § 411.351.

f.n.2 As opposed to assets or rental of equipment or office space.

f.n.3 Also refer to 42 U.S.C. § 1320a-7b.

12

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12

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Recent Litigation Around Physician Affiliations



Community Health Network ("CHN")*



Settled for \$345 Million Dollars

Allegations:

- Paid physicians as much as double what they were paid in private practice
- Hired valuation firm to determine fair market value but provide them with false compensation figures
- Shopped different valuation firms
- Ignored warnings from the valuation firm that compensation was too high
- Paid bonuses based on meeting referral targets
- Qui Tam relator was former CFO/COO

**United States and the State of Indiana ex rel. Thomas Fischer v. Community Health Network, Inc., et al.*

Erlanger Health System*



Settled for an unknown amount (potential allegations exceeded \$60 Million)

Allegations:

- Paid physicians above FMV for referrals
- Compensation decisions were based on financial metrics that tracked physicians' expected referral patterns and their overall impact on the health system's financial performance.
- Qui Tam relators was former CFO and CCO

**United States, the State of North Carolina and the State of Tennessee, ex rel Alana Sullivant and J. Britton Tabor, v. Murphy Medical Center, Inc. doing business as Erlanger Western Carolina Hospital and Chattanooga-Hamilton County Hospital Authority doing business as Erlanger Health System and Erlanger Medical Center*

Steward Health*



Settled for \$4.753 Million Dollars

Allegations:

- Hospital paid nearly \$5 million in incentive compensation to the chief of cardiac surgery for increasing the number of surgical cardiovascular cases performed at the hospital.
- Arrangement resulted in more than 1,000 claims to Medicare in violation of the Stark Law, resulting in tens of millions of dollars in improper Medicare payments.
- Steward had annual Stark Law training and numerous internal policies that require compensation arrangement do not vary based on the volume or value of referrals

**United States of America, et al, ex rel. Joseph Nocie v Steward Health Care System, LLC, Steward Medical Group and Steward St. Elizabeth's Medical Center of Boston, Inc.*

ChristianaCare Health Services*



Settled for \$47.1 Million Dollars

Allegations:

- Had an exclusive contract with a private outside neonatology group of physicians
- Provided free services to private neonatology group of physicians in the form of free or below FMV professional care provided to infants in the NICU by Christiana-employed hospitalists, residents and nurse practitioners

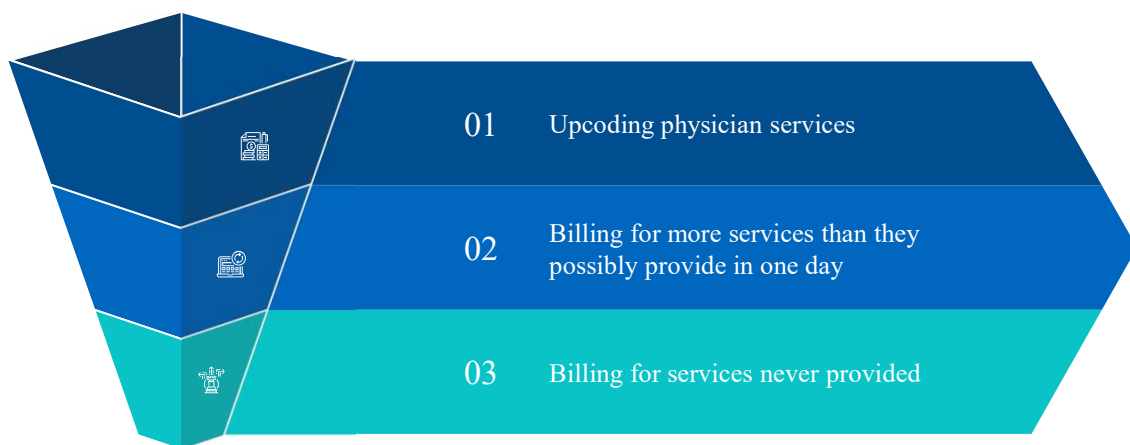
**United States of America et al. v. Chirstiana Care Health Care Services, Inc. et al.*

Impossible Day and Cost Sharing Arrangements

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19

Impossible Day Fraudulent Schemes



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20

David Judd, N.P.



Pled guilty - submitted \$1.248 Million in false claims

- Scheme ran 2015 to 2020
- Submitted claims for 164 days which were determined to be “implausible”
 - On May 12, 2018, claimed he saw 58 patients during the day and billed more than 45 hours of face time with the patients.
 - Submitted claims for patients he allegedly saw when he was traveling out of state
 - Billed for seeing multiple patients during the same blocks of time

IPC Healthcare and Team Health Holdings, Inc.*



Settled for \$4.384 Million

- Among other allegations, the defendants allowed the hospitalists to regularly bill for “impossible days” within the State of Michigan, i.e., provide such a high volume of inpatient service or procedures in one day that there is no way the hospitalist could have performed all of the procedures

Preventative and Diagnostic Medical Center, P.A. and Dr. Sehgal

Settled for \$700,000

- False Claims Act allegation that Dr. Sehgal provided evaluation and management services that were upcoded using CPT codes that indicated more complex services, or services longer in duration, than the evaluation and management services actually provided to patients, e.g.,
 - On March 2, 2018, the time associated with CPT codes billed by Dr. Sehgal exceeded 43 hours
 - Billed for services purportedly provided by Dr. Sehgal on days when Dr. Sehgal was not in the United States.

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23

Documenting Physician Relationships in a Regulatory Compliant Manner

24

Medicare and other Federal health care programs rely on physicians' medical judgment to treat patients with appropriate, medically necessary services, and to submit accurate claims for Medicare-covered health care items and services
-- MLN Booklet

25

Physician Contracting Process



26

Determination of Need



- First step in determining commercial reasonableness
- Ability to avoid any conflicts of interest, especially as it relates to covered persons under Stark
- Use internal documentation (e.g., needs assessment) when available

Determination of Need

MEDICAL DIRECTOR PLANNING WORKSHEET			
Department:			
Supervising Director:			
Proposed Hours per Month:			
Number of Physicians on Medical Staff Participating in Program:			
	Yes	No	Reasoning
Is the directorship required by law?			State law:
Is there another medical director that can perform the services?			If yes, why are the services not combined?

Process Execution



- Use SBAR – Situation, Background, Assessment, and Recommendation
 - What are the duties required under the agreementf
 - What will the total cost be
 - Who manages the parties
- Allows for proper approvals prior to full documentation
 - CFO
 - CEO
 - Legal – Need for Attorney Client Privilege protection
- Compliance with compensation and other internal policies

Supporting Documentation / Approval Process



- Determination of parties involved in negotiation
- Fair market value analysis
 - Internal / External
- Commercial reasonable analysis
- Legal opinions
- Legal contract(s)

Execution / Monitoring



- Monitor the use of leased space, medical supplies, medical devices, equipment, or other patient care items
- Review of tracking services and activity logs
- Maintain centralized tracking system for new, existing, and renewed arrangements
- Track all remuneration to ensure compliance with financial terms of the arrangement

Practical Tips



Practical Tips



- Valuator Engagement
 - Work Product/Privileged engagements by legal counsel
 - Common Interest/Joint Defense Agreement
 - Joint Engagement
 - Commercial reasonableness opinions
 - Telephone call with valuers to discuss initial drafts
- Documentation on why affiliation furthers health care system's community needs
- Physician Arrangement Request Form
- Follow Policies

SMG Employment Agreement: FT/PT Request



- The following are required before requesting an EA:
 - ND ELT- approved SMG and Hospital BPs
 - **Physician Arrangement Request Form** (including FMV Attestation)
 - Reference checks
- SMG Director must complete and distribute **Physician Arrangement Request Form** to support compensation being offered
 - Information on form must include Fair Market Value (FMV) for the proposed compensation,
 - When compensation exceeds the 75th percentile of MGMA Benchmark, a written explanation is required
 - SMG uses MGMA for FMV determinations
 - Generally, BPs with concordant productivity/compensation can be used
- Upon completion, SMG Director should send the **Physician Arrangement Request Form** to Christine via email to draft the Employment Agreement (EA)
 - Employment start dates should allow sufficient time for licensing, medical staff credentialing, and payor enrollment
 - Offers outside the range of the approved BP require updates by the SMG M&A associates, approval by SMG COO and Hospital President, and ND ELT before the offer can be made
 - Final offer must be approved by SMG President
- **Please allow sufficient time for processing**

Q&A



35



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36



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