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A Cautionary Tale On Hospital-Physician Alignment Structures

By Robert Threlkeld and Elliott Coward | February 23, 2024

A recent False Claims Act settlement secured by the U.S. Department of Justice should cause parties to think carefully before structuring hospital and physician alignment relationships.

Such relationships, which can vary in form from the direct employment of physician groups to joint ventures between hospitals and physicians, can serve vital goals like improving patient care. They can also quickly violate the many legal restrictions on physician-hospital dealings and lead to onerous financial penalties.

Just ask Community Health Network, which in December agreed to a staggering $345 million fine to resolve allegations that its employment and compensation of breast surgeons, cardiovascular surgeons and other specialist physician groups violated the False Claims Act and the Stark Law.

The conduct at issue is now nearly 15 years old, but the lessons to draw from it are as relevant today as they would have been when these arrangements were executed.

The government’s case centered on the compensation for the specialist physicians, beginning with a group of five breast care surgeons. Community Health Network, the government claimed, sought to employ the breast care surgeons as a “defensive measure aimed principally at securing referrals from the surgeons, who were already practicing in the area.”[1]





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The government alleged that the breast care surgeons generated significant revenue from ancillary services, like high-end imaging. In addition, the breast care surgeons could refer patients within CHN for additional ancillary services, including radiation therapy and medical oncology, that are lucrative for CHN.[2]

As CHN knew, it would receive a higher reimbursement rate for these ancillary services than the breast care surgeons did as a physician group. Putting some or all of this reimbursement differential toward compensation would allow CHN to pay the group members at a materially higher level than they could earn in private practice — although, as we’ll see, such an approach runs afoul of the Stark Law.

The government alleged similar facts regarding the healthcare system’s employment of numerous cardiologists and cardiovascular surgeons from two separate cardiology practices.

In setting their compensation in late 2008, CHN sought to pay the cardiologists at the 90th percentile for their specialty, based on national data.[3] To justify such high salary payments, CHN again relied upon the

1

reimbursement differential it would receive — in the case of cardiologists, for services such as cardiac imaging. While it succeeded in recruiting physicians, CHN stirred up a legal hornets’ nest by paying them in a manner that could result in improper referrals and services and compensation above fair market value.

One of the biggest obstacles that healthcare systems face in trying to hire or otherwise align with physicians is offering compensation competitive with the amounts they can earn through group practices, where revenue from ancillary services can be distributed to members as long as certain requirements are met.[4]

Often that is not feasible for hospitals, due to handcuffs placed on them by the Stark Law. In addition to requiring that physician compensation reflect fair market value, the Stark Law prohibits hospitals from considering referrals in their pay packages.

Under the statute, physician compensation must be commercially reasonable without regard to the volume or value of referrals for designated health services,[5] including, for instance, radiation therapy ordered by CHN’s breast care surgeons or imaging ordered by its cardiologists.

That was the regulatory challenge that CHN faced in attempting to integrate with specialist groups. In a variety of legal and factual ways, the strategy CHN allegedly executed to overcome that challenge failed to comply with both aspects of the Stark Law mentioned above.

First, CHN’s compensation exceeded the physicians’ fair market value. While CHN engaged an independent and nationally renowned valuation firm to set its compensation for the physicians, that engagement failed to insulate CHN from legal liability.

Valuation firms cannot typically assess the structural compliance of an arrangement, and even where they are on safer ground — recommending compensation based on comparisons to other physicians’ pay — their findings are not a guarantee of commercial reasonableness.

In its 2020 Stark rulemaking, CMS reiterated that hospitals should not rely too heavily on percentile compensation benchmarks.

Regardless, CHN failed to adhere to the guardrails that the valuation firm suggested to keep physician compensation at fair market value in this case. Specifically, the firm advised that only in atypical circumstances could it justify compensation over the 75th percentile as constituting fair market value.

Even for highly productive physicians, it would be unusual for compensation at the 90th percentile to be considered fair market value. CHN routinely paid these physicians at or above that level.

CHN only compounded its problems by giving the valuation firm inaccurate productivity information. CHN’s integration model seemed to use an inflated work relative value unit, or wRVU, value as a way to backfill the revenue from ancillary services that the physicians would capture at their group practices, but couldn’t at CHN. Such a workaround is, of course, prohibited.

Second, and more fundamentally, CHN violated the Stark Law’s ban on considering the volume or value of referrals. CHN’s entire integration model was built on the reimbursement differential that the hospital would receive for ancillary services over and above what the physicians could generate on their own.

Doing so rendered the compensation dependent on the volume and value of referrals for designated health services, which may not be used to support the fair market value or commercial reasonableness of physician pay.[6]

To add to CHN’s troubles, the government alleged that CHN used a bonus structure for physicians that provided

2

**incentives for network financial performance and service line financial performance. These incentives, which rewarded physicians for meeting target revenues for referrals,[7] also violated the requirement to disregard the volume or value of referrals for designated health services.**

**CHN disputed that any of these allegations were true or violated the law. Its protestations of innocence notwithstanding, it still paid $345 million to the government.**

**CHN’s experience stands as an expensive reminder that while it is legitimate to attempt to align highly compensated physicians as employees in an integrated healthcare system, at all times compensation must be within fair market value.**

**An opinion of fair market value is just that — an opinion. It is no guaranty of compliance, and when it sits on a shelf without accurate and repeated validation it has no protective value.**

**Instead of pointing to an opinion, or to percentile benchmarks in a vacuum, healthcare systems must be able to demonstrate the commercial reasonableness of whatever compensation agreements they make.**

**To that end, a health system’s employment of physicians must be motivated by a legitimate commercial purpose other than garnering referrals. Such employment must always be for a reasonable commercial purpose even if there were no resulting technical and ancillary services referrals.**

**As CMS has said many times in the past, commercially reasonable reasons may include, without limitation, addressing community need, timely access to health care services, fulfillment of licensure or regulatory obligations, the provision of charity care, and the improvement of quality and health outcomes.**

**Failure to adhere to these first order principles can be costly indeed, as healthcare systems like CHN have**

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1. **CII at ⁋ 59.**
2. **Id. at ⁋ 63.**
3. **Id. at ⁋ 143.**
4. **See 42 C.F.R. §§ 411.352(c) & 411.355(b).**
5. **42 C.F.R. §411.357(c). See 42 C.F.R. §§ 411.354(5) & (6).**
6. **42 C.F.R. §411.357(c). See 42 C.F.R. §§ 411.354(5) & (6).**
7. **CII at ⁋ 30.**

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**3**