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Health Law

Recent Settlement Demonstrates Pitfalls of Rewarding Physicians with Access to Hospital Facilities

On May 10, 2010, The Health Alliance of Greater Cincinnati and certain affiliated hospitals (collectively the "Health Alliance") entered into a Settlement Agreement with the Office of the Inspector General of the Department of Health and Human Services ("OIG") to settle allegations of Anti-Kickback and False Claims Act violations stemming from the Hospital's method of allotting time in its cardiac diagnostic unit. The OIG's allegations and the resulting settlement illustrate potential pitfalls for hospitals that seek to reward physicians through non-monetary means, including access to and use of hospital facilities or access to potential new patients.

The Case and Settlement.

The Health Alliance operated a cardiac diagnostic unit and set the schedule for the cardiologists who were to staff the unit. Staffing the unit was a potentially lucrative assignment for cardiologists because it provided them with reimbursement for the services they performed at the unit. Assignment to the unit was also a source of new patients because a cardiologist seeing a patient who was not currently a patient of a cardiologist could retain that patient or refer the patient to another member of the cardiologist's practice group. The OIG alleged that scheduling of time to the cardiac diagnostic unit was a valuable commodity.

According to OIG, The Health Alliance assigned cardiologists to the unit based upon the volume of referrals from these cardiologists to The Health Alliance for coronary arterial bypass graph (CABG) procedures and gross revenue generated by the cardiologists for the Health Alliance for certain cardiac procedures. Thus, OIG alleged, the more patients a cardiologist referred to The Health Alliance, and the more gross revenue the cardiologist produced for The Health Alliance, the more scheduled time the cardiologist received at the cardiac diagnostic unit.

OIG alleged that the scheduling scheme violated the Anti-Kickback statute because The Health Alliance provided something of value (time in the cardiac diagnostic unit) to the cardiologists in return for referrals. The OIG further alleged that The Health Alliance violated several provisions of the False Claims Act by "knowingly" submitting claims for payment to Federal health care programs that violated the Anti-Kickback statute. In the context of the False Claims Act, "knowingly" means that The Health Alliance had actual knowledge of the violations, acted in "deliberate ignorance" of the violations or acted in "reckless disregard" of the violations and no specific intent to defraud is required.

The Health Alliance denied OIG's allegation that it scheduled cardiologists at the

Questions or Assistance?

If you have further questions regarding this case or Anti-Kickback or False Claims Act compliance, please feel free to contact one of the following members of our Health Law Practice Group.

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cardiac diagnostic unit based upon referrals and gross revenue. The Health Alliance countered that the schedule was created based upon the cardiologists who were most likely to be available at the hospital to perform the work required at the unit.

Despite such defense, The Health Alliance entered into a Corporate Integrity Agreement and a Settlement Agreement and made a $108 million payment to OIG. The 5-year Corporate Integrity Agreement, among other things, requires The Health Alliance to adopt new compliance measures and hire an independent monitor to review financial relationships with physicians.

Lessons for Hospitals.

As this case illustrates, hospitals must be careful that they do not enter into agreements with physicians that provide anything of actual or perceived value to physicians in exchange for referrals. When reviewing financial arrangements with physicians, the concept of "remuneration" in the Anti-Kickback statute should be broadly construed to include anything of value, anything that may later create or result in value to the physician or that may be otherwise financially desirable or beneficial. In particular, Hospitals should review arrangements with physicians that reward access to hospital facilities or publicize or promote providers based upon a metric that directly or indirectly considers the provider's referrals to the hospital.

This case also demonstrates the potential reach of the False Claims Act. Hospitals and other providers should recognize that violation of the Anti-Kickback statute might result in False Claims Act liability if claims relating to such violation were submitted to a Federal health care program. False Claims Act liability may be found through the submission of such claims, certifying the validity of such claims and/or the production of false records or statements related to submission of the claims. Entities violating the False Claims Act may be liable for up to three times the government's damages plus civil penalties of $5,500 to $11,000 per false claim.

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