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Suspect Financial Arrangements Between Hospitals and Hospital-Based Physicians

Daniel Melvin

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INTRODUCTION

Hospital-based physicians such as anesthesiologists, radiologists and pathologists naturally covet exclusive independent contracts with hospitals. Such contracts ensure access to a stream of patients referred by other physicians on the hospital's medical staff and consequently, competition is fierce.

Some hospitals have been accused of exploiting this situation by extracting economic benefits from hospital-based physicians or their group practices -- a *quid pro quo* for the exclusive contract with the hospital. The Office of the Inspector General, Department of Health and Human Services (OIG) has cited the following examples:

- A hospital furnishes no, or token, reimbursement to pathologists for professional services to the hospital (Part A services) in return for the pathologists' opportunity to provide professional services to patients and bill Medicare for those services under Part B.

- Radiologists are required to pay 50 percent of their gross receipts to a facility's endowment fund.

- A radiology group is required to allocate 33 percent of its profits exceeding a set amount to the hospital for capital improvements, equipment and other hospital expenditures.

*Associate, Kamensky & Rubinstein, Chicago, IL. B.A., Azusa Pacific University; 1978; M.A., Fuller Theological Seminary, 1981; J.D., DePaul University College of Law, 1995.*
A radiology group is required to purchase radiology equipment and donate the equipment to the hospital upon termination of the contract for any reason.¹

These reported arrangements raise the issue of whether hospital-based physicians are in fact solicited by hospitals in return for referring Medicare and Medicaid business in violation of the anti-kickback provisions of Title 11 of the Social Security Act (the Anti-Kickback Statute).² Further, the form of these payments raises the issue of whether the payments violate state laws prohibiting physicians from dividing fees.³

This article first reviews pertinent provisions of the Anti-Kickback Statute and discusses enforcement agency statements and judicial decisions relating to the question of financial relationships between hospitals and hospital-based physicians. Next, this article considers the impact of state physician fee-splitting prohibitions on such financial arrangements. Finally, the enforceability of illegal arrangements between hospitals and hospital-based physicians is considered.

THE ANTI-KICKBACK STATUTE

The Anti-Kickback Statute contains a two-part prohibition. First, the statute prohibits anyone from knowingly and willfully soliciting or receiving any remuneration in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service reimbursable under Medicare or Medicaid. Similarly, the statute prohibits receiving any remuneration in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering any good, facility, service or item reimbursable under Medicare or Medicaid.⁴

¹ OIG, Management Advisory Report No. OEI-09-89-00330, reprinted in Medicare and Medicaid Guide (CCH) at 39,669 [hereinafter MAR]. The author is aware of one hospital-based group that was asked to set aside a percentage of its receipts to fund research and subsidize the compensation of hospital staff in the department.


³ See, e.g., 225 ILCS 60/22(14), as amended by Pub. Act. 89-201 § 5 (prohibiting fee-splitting by Illinois physicians).

Second, the statute prohibits anyone from knowingly and willfully offering or paying any remuneration to induce another person to make a referral for the furnishing or arranging for the furnishing of any item or service reimbursable under Medicare or Medicaid. Similarly, the statute prohibits any remuneration to induce the purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service or item reimbursable under Medicare or Medicaid. For the Purposes of the Anti-Kickback Statute, "remuneration" means remuneration paid or received directly or indirectly, overtly or covertly, in cash or in kind.\(^5\)

Violation of the Anti-Kickback Statute is a felony, and a criminal conviction may result in a fine of not more than $25,000, imprisonment for up to five years, or both.\(^6\) Further, the Secretary of the Department of Health and Human Services (HHS) has the authority to exclude from participation in all federal health programs any individual or entity that the Secretary determines has violated the Anti-Kickback Statute.\(^7\)

There are five statutory exceptions to the ban on paying remuneration in return for or to induce Medicare and Medicaid referrals:

1. payments to bona fide employees;
2. discounts or other price reductions that are properly disclosed in cost reports;
3. rebates paid to group purchasing agents from vendors, provided all discounts are reported to the provider and reflected in cost reports;
4. waiver of coinsurance payments under Medicare Part B under certain conditions; and
5. remuneration between certain managed care organizations and individuals or entities pursuant to qualifying risk-sharing arrangements.\(^8\)

In addition, the OIG has promulgated "safe harbor" regulations delineating financial arrangements that will not be subject to criminal

\(^{5}\) Id. § 1320a-7b(b)(2).
\(^{6}\) Id. § 1320a-7b(b)(1), (2).
\(^{7}\) Id. § 1320a-7(b)(7).
\(^{8}\) Id. § 1320a-7(b)(3).
prosecution or serve as a basis for exclusion from the Medicare and Medicaid programs. However, the statutory exceptions and "safe harbors" do not apply to the types of financial arrangements between hospital-based physicians and hospitals discussed here.

**OIG MANAGEMENT ADVISORY REPORT**

On January 31, 1991, the OIG issued a Management Advisory Report (MAR) to the Health Care Financing Administration (HCFA), the agency responsible for administering the Medicare program, on the subject of financial arrangements between hospitals and hospital-based physicians. The MAR alerted HCFA to potential violations of the Anti-Kickback Statute arising from certain financial arrangements between hospitals and hospital-based physicians. Specifically, the OIG found that hospitals materially influence the flow of Medicare and Medicaid patients to hospital-based physicians. Therefore, arrangements that require hospital-based physicians to split their revenues with hospitals, or make payments to the hospitals in excess of the fair market value of the services or items provided by the hospital, are suspect, although not per se violations of the Anti-Kickback Statute.

The OIG based its conclusion in part on dictum in *United States v. Lipkis*, a decision of the Ninth Circuit Court of Appeals. In *Lipkis*, the court described an arrangement between a medical management company and a clinical laboratory. The management company received 20 percent of the clinical laboratory's revenues derived from business generated by the management company, which it alleged was "fair compensation for specimen collection and handling services." However, upon review, the court observed that the fair market value of these services was substantially less than the compensation paid to the

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10 MAR, supra note 1, at ____.
11 Id. at 28, 416.
12 United States v. Lipkis, 770 F.2d 1447 (9th Cir. 1985).
13 Id. at 1449.
management company "and there was no question that [the laboratory] was paying for the referrals as well as the described services."14

Applying the court's reasoning to financial arrangements between hospitals and hospital-based physicians, the OIG concluded that an inference can be drawn that illegal remuneration occurs when hospital-based physicians are required to pay the hospital for personnel services, space or equipment on terms other than fair market value.15 To illustrate, the OIG cited reported instances of contracts requiring hospital-based physicians to make payments to a hospital in excess of the fair market value of the services furnished by the hospital. The OIG also considered specific instances where hospital-based physicians were reportedly required to pay a percentage of their gross receipts to a hospital's endowment fund or capital improvements fund.16 The OIG found that all such arrangements appear to violate the Anti-Kickback Statute.17

The OIG also concluded, without citing any evidence, that such financial arrangements between a hospital and hospital-based physicians can cause the very problems the Anti-Kickback Statute was intended to address. For example, hospitals may award exclusive contracts to physicians based on improper financial considerations rather than the professional qualifications of the physicians. The prospect of remuneration from physicians may also give the hospital an incentive to adopt policies and practices that increase utilization of services reimbursable under Medicare Part B. Furthermore, hospital-based physicians may even be encouraged to increase utilization to offset revenues diverted to the hospital.18

The American Hospital Association (AHA), upon review of the initial draft of the MAR, flatly rejected the OIG's conclusion that contracts with hospital-based physicians involve the "referral" of patients. The AHA contended there is no evidence that payments from hospital-based physicians to hospitals affect utilization or the volume of

14 Id.
15 MAR, supra note 1, at 28, 416.
16 Id.
17 Id.
18 Id. at 28, 416-17.
business ultimately billed to Medicare. Moreover, the AHA argued that HCFA has on a number of previous occasions recognized that hospitals derive revenue from hospital-based physician services but has never challenged such arrangements as violative of the Anti-Kickback Statute.20

In response to the AHA's comments, the OIG first contended that case law interpreting the Anti-Kickback Statute “makes it clear” that the statute applies to those who can materially influence the flow (not just the volume) of Medicare and Medicaid business.21 Since hospitals control which physicians will receive an exclusive contract with the hospital, the OIG maintains that the hospital can materially affect the flow of Medicare and Medicaid business to the hospital.22

Second, the OIG contended that proof of over-utilization is not an element of an Anti-Kickback Statute offense.23 In creating the statute, Congress intended to address financial arrangements that have the potential for causing over-utilization, assuming the potential exists whenever a party pays remuneration for the referral of Medicare and Medicaid business.24 Certain financial arrangements between hospitals and hospital-based physicians, the OIG argued, can create incentives for over-utilization, resulting in increased utilization by hospital-based physicians and hospital policies that encourage utilization.25

Furthermore, the OIG was not persuaded by the AHA's argument that HCFA's long-time recognition that physician revenues sometimes accrue to hospitals is dispositive.26 HCFA's pronouncements, the OIG pointed out, do not purport to address fraud and abuse concerns since

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20 AHA Letter, supra note 19, at 3-7.
22 Id.
23 Id. at 3.
24 Id.
25 Id.
26 Id.
enforcement of the Anti-Kickback Statute is primarily the OIG's responsibility. Thus, the OIG found it was obligated to address financial arrangements that have the potential to harm the Medicare and Medicaid programs and beneficiaries.\textsuperscript{27} Having rejected the AHA's arguments, the OIG's final draft of the MAR reflected only minor revisions to the original draft.

The final draft of the MAR also attaches as an appendix a letter from the College of American Pathologists (CAP).\textsuperscript{28} CAP strongly supports the MAR, and states that the report underscores the problem of hospitals extracting remuneration from pathologists in the form of free, or deeply discounted, clinical pathology services reimbursable to the hospital under Medicare Part A in exchange for the pathologist's "franchise" to provide and bill for anatomic pathology services.\textsuperscript{29} The American College of Radiology has endorsed the MAR as well.\textsuperscript{30}

The OIG's report reflects the agency's enforcement policy and therefore must be taken seriously. However, it is not law and thus in order to properly address the issues raised by the MAR, it is necessary to revisit the language of the Anti-Kickback Statute and the relevant judicial decisions interpreting the statute.

\textbf{JUDICIAL OPINIONS AND THE ANTI-KICKBACK STATUTE}

No federal court has directly addressed the anti-kickback issue raised by financial arrangements between hospital-based physicians and hospitals. However, federal courts have addressed two threshold questions of statutory interpretation: the meaning of "knowingly and willfully" (the "scienter issue"); and the meaning of "any remuneration" in the context of remuneration to induce referrals (the "remuneration issue").

\textsuperscript{27} Id. at 4.


\textsuperscript{29} Id.

The Scienter Issue

The Anti-Kickback Statute sanctions anyone who "knowingly and willfully" solicits, receives, offers or pays any remuneration barred by the statute. The scienter issue was addressed in Hanlester Network v. Shalala, which involved the appeal of a Health and Human Services (HHS) ruling excluding from Medicare the participants of three laboratory joint ventures.\textsuperscript{31} Hanlester Network was the general partner in three laboratory joint ventures engaged in an investment marketing plan that allowed physician-investors to profit indirectly from referrals to one of the joint venture laboratories.\textsuperscript{32} Each laboratory joint venture entered into a management agreement with a reference laboratory, and although approximately 85 to 90 percent of the physician-ordered tests from the joint venture labs were performed by the reference laboratory, the joint venture laboratories retained an appreciable percentage of the net revenues.\textsuperscript{33}

Relying on the United States Supreme Court decision in Ratzlaf v. United States,\textsuperscript{34} the Ninth Circuit Court of Appeals construed "knowingly and willfully" as it appears in section 1128B(b)(2) of the Anti-Kickback Statute to require knowledge that the Anti-Kickback Statute prohibits offering or paying remuneration to induce referrals; and conduct prohibited by the statute with the "specific intent to disobey the law."\textsuperscript{35} This construction requires that the government prove the defendant acted with knowledge that his or her conduct was unlawful. Based on its construction of the scienter standard, the court did not find the individual appellants had developed and operated the laboratory venture with the specific intent of disobeying the law but rather, that they had believed the venture was lawful.\textsuperscript{36} In addition, the court held that HHS failed to prove the profitable arrangement with the reference

\textsuperscript{31} Hanlester Network v. Shalala, 51 F.3d 1390, 1395-96 (9th Cir. 1995).
\textsuperscript{32} Id. at 1394-95.
\textsuperscript{33} Id. at 1395, 1401.
\textsuperscript{34} Ratzlaf v. United States, 510 U.S. 135 (1994).
\textsuperscript{35} Hanlester, 51 F.3d at 1400.
\textsuperscript{36} Id. at 1401.
laboratory was solicited by the appellants in return for referrals for laboratory tests.\textsuperscript{37}

The OIG has been highly critical of the \textit{Hanlester} court's interpretation of the Anti-Kickback Statute's scienter standard, and one official has publicly stated that the OIG has no intention of following the decision in other federal appellate circuits.\textsuperscript{38} However, in the absence of a conflict in the federal appellate courts, the Solicitor General has turned down the OIG's request that the government appeal the \textit{Hanlester} decision to the United States Supreme Court.\textsuperscript{39}

No court outside of the Ninth Circuit appears to have followed the \textit{Hanlester} court's interpretation of the scienter standard. In an opinion and order responding to a physician's motion to dismiss a criminal indictment filed by the federal government in \textit{United States v. Neufeld}, the United States District for the Southern District of Ohio rejected the \textit{Hanlester} court's construction of "knowingly and willfully."\textsuperscript{40} Analyzing the physician's claim that the Anti-Kickback Statute is unconstitutionally vague, the court considered the statute's heightened scienter standard and concluded that the \textit{Ratzlaf} analysis relied upon by the Ninth Circuit in \textit{Hanlester} could not be applied to the Anti-Kickback Statute. The court gave two reasons for its conclusion: the language and legislative history of the Anti-Kickback Statute does not support a definition of "willful" requiring knowledge of illegality; and the inherent unlawfulness of the conduct prohibited by the statute militated against a standard of "willfulness" requiring knowledge of illegality.\textsuperscript{41}

In \textit{Neufeld}, the court noted that Congress evinced an intent not to subject inadvertent violations of the statute to criminal prosecution. However, the court concluded that a concern for prosecuting inadvertent violations of the statute does not "mandate the availability of a defense of ignorance of the law."\textsuperscript{42} Nevertheless, the court declined to enunciate

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\begin{itemize}
\item \textsuperscript{37} \textit{Id.}
\item \textsuperscript{38} \textit{Lead Report - Fraud and Abuse}, Health L. Rep. (BNA) No. 4 at 500 (June 15, 1995) (quoting remarks by D. McCarty Thornton, Chief Counsel, OIG, HHS before the Annual Meeting of the National Health Lawyers Association).
\item \textsuperscript{39} \textit{NHLA, No Supreme Court Appeal in Hanlester Case}, 24 NEWS REPORT 6 (1995).
\item \textsuperscript{40} \textit{United States v. Neufeld}, 908 F. Supp. 491 (S.D. Ohio 1995).
\item \textsuperscript{41} \textit{Id.} at 496.
\item \textsuperscript{42} \textit{Id.}
\end{itemize}
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an exact definition of the scienter requirement, holding only that the statute's heightened scienter requirement was sufficient to withstand the physician's claim that the Anti-Kickback Statute is unconstitutionally vague.\textsuperscript{43}

In \textit{United States v. Jain}, the Eighth Circuit Court of Appeals distinguished \textit{Hanlester}.\textsuperscript{44} The court observed that the \textit{Hanlester} case involved review of an administrative proceeding and that the \textit{Hanlester} court had adopted the heightened scienter standard in \textit{Ratzlaf} "without considering any alternatives to the general rule."\textsuperscript{45} The "general rule," advanced by the federal government at trial and on appeal is that "willfully" in a criminal statute "refers to consciousness of the act but not to consciousness that the act is unlawful."\textsuperscript{46}

Appealing his conviction under the Anti-Kickback Statute for "knowingly and willfully" receiving remuneration in return for referring Medicare patients to an acute care psychiatric hospital, the defendant in \textit{Jain} argued that \textit{Ratzlaf} and \textit{Hanlester} should control the federal trial court's instruction on the \textit{mens rea} element.\textsuperscript{47} At trial, the federal trial court adopted a middle ground, instructing the jury that "the word 'willfully' means unjustifiably and wrongfully, known to be such by the defendant."\textsuperscript{48}

The Eighth Circuit court agreed that the Anti-Kickback Statute resembles the anti-structuring provisions of the Money Laundering Control Act of 1986 at issue in \textit{Ratzlaf}, in that it potentially includes conduct that is not "inevitably nefarious."\textsuperscript{49} The court cited the elaborate "safe harbor" regulations mandated by Congress as evidence that the acts prohibited by the Anti-Kickback Statute are not obviously evil or inherently bad.\textsuperscript{50} Only conduct that is "inevitably nefarious" warrants the presumption that "anyone consciously engaging in it has

\textsuperscript{43} \textit{Id.} at 497.
\textsuperscript{44} \textit{United States v. Jain}, 93 F.3d 436, 441 (8th Cir. 1996).
\textsuperscript{45} \textit{Id.} (citing \textit{United States v. Neufeld}, 908 F. Supp. 491, 497 (S.D. Ohio 1995)).
\textsuperscript{46} \textit{Jain}, 93 F.3d at 441 (quoting \textit{Cheek v. United States}, 498 U.S. 192, 209 (1991) (Scalia, J. concurring)).
\textsuperscript{47} \textit{Jain}, 93 F.3d at 440.
\textsuperscript{48} \textit{Id.} (quoting the trial court's jury instructions).
\textsuperscript{49} \textit{Jain}, 93 F.3d at 440 (quoting \textit{Ratzlaf v. United States}, 510 U.S. 135, 146-48 (1994)).
\textsuperscript{50} \textit{Jain}, 93 F.3d at 440.
fair warning of a criminal violation." Thus, the Jain court agreed that a heightened scienter standard for the Anti-Kickback Statute is appropriate.

The Jain court, however, rejected the Ratzlaf standard, observing that the statute in Ratzlaf criminalized a willful violation of another anti-structuring statute. Since a person cannot "willfully" violate a statute without knowing what the statute prohibits, the Supreme Court required proof the defendant intentionally violated a "known legal duty." In contrast, the court observed that the Anti-Kickback Statute prohibits a series of acts. Consequently, the plain language of the statute and respect for the traditional principle that ignorance of the law is no defense, suggests that the scienter standard for the Anti-Kickback Statute is not require proof the defendant knew that his conduct violated a known legal duty, but rather, that the government is required only to prove the defendant "knew that his conduct was wrongful."

If Neufeld and Jain are any indication, the judicial trend is to interpret the scienter element of the Anti-Kickback Statute as requiring the defendant to act with knowledge of the wrongfulness of the act. While this is a higher standard than the general rule that consciousness of the prohibited act is sufficient mens rea for criminal liability, this standard does not require a showing that the defendant intentionally violated a known legal duty.

The Remuneration Issue

The argument has been made that reasonable remuneration paid for services rendered or items furnished cannot, as a matter of law,

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51 Id.
52 Id.
53 Id. at 441 (citing Ratzlaf, 510 U.S. at 140-41).
54 Jain, 93 F.3d at 441.
55 Id.
56 Distinguishing the language of the statute at issue in Ratzlaf from the "knowing and willful" language of the Anti-Kickback Statute, the District Court of Appeal of Florida also rejected the Hanlester court's application of the Ratzlaf analysis to the Anti-Kickback Statute. Medical Dev. Network v. Professional Respiratory Care/Home Medical Equip. Servs., 673 So. 2d 565 (Fla. App. Ct. 1996).
constitute remuneration to induce referrals in violation of the Anti-Kickback Statute. However, two leading federal appellate court decisions have rejected this argument.

In United States v. Greber, the Third Circuit Court of Appeals held that the Anti-Kickback Statute is violated if even one purpose of a payment is to induce referrals for services or items covered by Medicare or Medicaid.\(^57\) The "one purpose" rule means that it is not enough that payments are intended, in part, or primarily, as remuneration for services or items actually furnished. If even one purpose of a payment is to induce referrals for Medicare or Medicaid business, the payment is illegal.

In United States v. Bay State Ambulance and Hospital Rental Service,\(^58\) the First Circuit Court of Appeals reviewed the criminal convictions of a municipal hospital executive, an ambulance service and its president and sole shareholder. The hospital executive, who had a consulting relationship with the ambulance company for which he was compensated, was instrumental in awarding an exclusive contract to the ambulance service. He was convicted of one count of conspiracy to violate the Anti-Kickback Statute and two counts of accepting remuneration in return for referring Medicare business to the ambulance company. The ambulance company and its president and sole shareholder were both convicted of conspiring to violate the Anti-Kickback Statute and for paying remuneration to induce the referral of Medicare business.\(^59\)

The defendants in Bay State Ambulance argued, inter alia, that payments by the ambulance company to the hospital executive were reasonable compensation for consulting services rendered and therefore, as a matter of law, could not constitute illegal remuneration.\(^60\) The defendants contended that the trial judge had erred in not requiring the government to prove either that the payments were not compensation for services rendered or that the payments were of substantially greater value.

\(^{59}\) Id. at 22.
\(^{60}\) Id. at 29.
value than the services rendered.\textsuperscript{61} The trial court's instruction, upheld on appeal, provided that if the jury found the payments were made for two or more purposes, the government must prove that the "primary purpose" of the payments was to induce referrals of Medicare business.\textsuperscript{62} Thus, consistent with \textit{Greber}, the court adopted the view that payment of reasonable remuneration for services rendered does not preclude a finding that the remuneration was paid to induce referrals in violation of the Anti-Kickback Statute.\textsuperscript{63}

\textbf{REMUNERATION TO HOSPITALS IN RETURN FOR REFERRALS TO HOSPITAL-BASED PHYSICIANS}

The only judicial decision applying the Anti-Kickback Statute to financial arrangements between hospitals and hospital-based physicians is \textit{Virginia Radiology Associates, P.C. v. Culpeper Memorial Hospital}.\textsuperscript{64} In this case, one of the plaintiffs, Virginia Radiology Associates, P.C. (VRA), alleged that its contract to operate the radiology department of the defendant-hospital was terminated wrongfully in violation of state public policy. Specifically, VRA alleged the hospital terminated VRA's exclusive contract in retaliation for VRA's refusal to renegotiate the contract to include illegal terms. The hospital's new contract terms required VRA to:

(i) make cash contributions towards the purchase of equipment for the hospital's radiology department;

\begin{footnotesize}
\textsuperscript{61} Id.
\textsuperscript{62} Id. at 29-30.
\textsuperscript{63} United States \textit{v.} Bay State Ambulance \& Hosp. Rental Serv., 874 F.2d 20, 30 (1st Cir. 1989) (\textit{citing} United States \textit{v.} Greber, 760 F.2d 68, 71 (3d Cir. 1985), \textit{cert. denied}, 474 U.S. 988 (1985) and United States \textit{v.} Hancock, 604 F.2d 999, \textit{cert. denied}, 444 U.S. 991 (1979) (rejecting argument, under prior statute which did not include "remuneration," that fees for legitimate services could not be illegal kickbacks). The court declined to reach the question whether the government need only prove that inducement to refer Medicare business was \textit{one} purpose of the payment, holding only that the lower court's \textit{primary purpose} instruction was not inconsistent with Congressional intent. \textit{Id}.
\end{footnotesize}
(ii) contract with a wholly-owned subsidiary of the hospital for billing services involving fees in excess of 12 percent of gross receipts; and
(iii) contract with another wholly-owned subsidiary of the hospital for "practice management" services involving management fees in excess of the fair market value of the services to be provided.  

VRA declined to accede to the hospital's new contract terms because it believed that such payments, especially the equipment fund contribution and the practice management contract, would each constitute a violation of the Anti-Kickback Statute.  

At trial, after hearing the plaintiff's case-in-chief, the hospital rested without putting forth a defense. The court granted VRA's motion for summary judgment and sent the case to the jury on the question of damages only, where the jury awarded VRA zero dollars, despite the fact that VRA's evidence of damages in the amount of $2,996,973 was unrebutted by the hospital. On VRA's post-trial motion for additur the court awarded the radiology group $2,996,973 in damages and agreed with VRA's view of the law, concluding that:

when the hospital refers patients to the Radiology Department for their services only upon condition that [sic the] hospital receives money for "practice-management" services for which there is no evidence of fair market value, or where cash contributions are demanded for the purchase of equipment for the Radiology Department which the hospital owns as a condition for referral there is a violation of Title 42 of the U.S. Code, § 1320a-7b.  

Thus, the court held the hospital's demands and retaliatory termination of the radiology contract was a violation of public policy. The hospital did not contradict or offer rebuttal of VRA's testimony on the scope of the Anti-Kickback Statute and an expert's conclusion that the practice management fees demanded by the hospital were not

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65 Id. at 4.
66 Id.
67 Id. at 23.
68 Id. at 12.
commensurate with the fair market value of the services provided.\textsuperscript{69} This failure of the hospital partially explains why the court's opinion lacks a detailed consideration of the legal and factual issues raised by the hospital's actions under the Anti-Kickback Statute.

While not engaging in an overt analysis of the statutory language that failure of the hospital found to be precise and unambiguous, the court nevertheless resolved an interpretative issue — whether the award of an exclusive contract to hospital-based physicians constitutes a referral, purchase, lease, or order, or an arrangement for or recommendation of a purchase, lease or order of services covered by Medicare and Medicaid. If an exclusive contract with a hospital constitutes none of these things, the Anti-Kickback Statute is not implicated by any financial arrangement between the hospital and hospital-based physician group awarded the exclusive contract. For convenience, in the discussion in this article, the term "referral issue" will be used and will be added to the discussion of the scienter and remuneration issues as they apply to financial relationships between hospitals and hospital-based physicians.

The Referral Issue

In its report on financial arrangements between hospitals and hospital-based physicians, the OIG cites \textit{Bay State Ambulance} for the proposition that case law makes it clear that the Anti-Kickback Statute's proscriptions apply to those who can materially influence the flow of Medicare and Medicaid business.\textsuperscript{70} Indeed, the defendants in \textit{Bay State Ambulance} did not contest the government's theory that the city hospital could direct Medicare business to the defendant ambulance company merely by awarding them an exclusive contract for the city's front-line (911) ambulance service. The parties appear to have accepted without argument that awarding the exclusive contract with the hospital constituted a referral or an arrangement for the purchase of services reimbursable under Medicare and Medicaid. Therefore, under \textit{Bay State


\textsuperscript{70} MAR, \textit{supra} note 1, at 28, 415.
Ambulance, payments to anyone for the purpose of affecting the outcome of the contract bidding process violate the Anti-Kickback Statute.71

In Virginia Radiology, the court summarily concluded that “when the hospital refers its patients to the Radiology Department for their services only upon condition that [sic the] hospital receives” remuneration from VRA, the Anti-Kickback Statute is violated.72 It should be noted, however, that the court understood the hospital did not actually refer patients to the Radiology Department, but rather, arranged for radiology services covered by Medicare and Medicaid to be furnished.73

Although the Virginia Radiology court did not expressly state the proposition, the case illustrates that the Anti-Kickback Statute prohibits not only “referrals” as that term is commonly understood, but also arrangements and recommendations to purchase, lease or order any good or service covered by Medicare and Medicaid.74 A hospital presumably arranges for the purchase or order of Medicare and Medicaid-covered physician services when it installs a group of physicians in a department of the hospital. Furthermore, a hospital’s award of an exclusive contract to a physician group may also be characterized fairly as a recommendation since the hospital presumably awards the contract, in significant part, out of concern for the quality of care in the department. Thus, when a hospital grants a physician group an exclusive contract to furnish physicians’ services in the hospital, the Anti-Kickback Statute appears to be implicated.

71 United States v. Bay State Ambulance & Hosp. Rental Serv., 874 F.2d 20, 27 (1st Cir. 1989) (stating that the parties stipulated that the ambulance company received approximately $171,883 in Medicare funds for two years of the ambulance service contract with the hospital).


73 See id. (quoting a phrase from the Anti-Kickback Statute that seemingly emphasizes that payment in return for arranging for the furnishing of any item or service covered by Medicare and Medicaid is prohibited by the statute). A review of the entire clause from which the court quotes suggests that the court misinterpreted the phrase or intended to quote the next clause in the Anti-Kickback Statute which unambiguously prohibits payments “in return for... arranging for... ordering any good, facility, service, or item” reimbursable under Medicare or Medicaid. Compare 42 U.S.C. §1320a-7b(b)(1)(A) with § 1320a-7b(b)(1)(B) (emphasis supplied).

The Scienter Issue

The Anti-Kickback Statute's heightened scienter standard requiring proof the defendant "knowingly and willfully" engaged in the prohibited conduct was not an issue in Virginia Radiology. However, it is instructive to note that the hospital was "guided and counseled" by a lawyer "who practiced specifically in health care law." Although VRA declined to enter into the proposed arrangement on the advice of counsel, the hospital's counsel appears not to have been persuaded of the arrangement's illegality. Had there been a reasonable difference of legal opinion as to whether the arrangement violated the Anti-Kickback Statute, the hospital could have argued in their defense that, acting on the advice of counsel, they did not act with intent to violate a known legal duty. Therefore, under Hanlester, the hospital did not act with the requisite intent.

However, even in jurisdictions where the Hanlester court's scienter standard is controlling, or followed, payments to hospitals by hospital-based physicians are not likely to enjoy the same appearance of good faith based on industry custom found to exist in Hanlester. The OIG's report on payments to hospitals by hospital-based physicians, published in January 1991, and the decision in Virginia Radiology should deprive most hospitals of an "ignorance of the law" defense when charged with soliciting payments from hospital-based physicians.

The Remuneration Issue

The remuneration at issue in Virginia Radiology involved the purchase of equipment for the hospital's radiology department and payment of fees for practice management services. The court heard, and accepted as credible, expert testimony that the management fee demanded by the hospital was inconsistent with fair market value of the services to be

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75 Virginia Radiology, slip op. at 4.
76 See Hanlester Network v. Shalala, 51 F.3d 1390, 1401 (9th Cir. 1995) (observing that the management services agreement at issue was a "relatively common practice in clinical laboratory field.")
77 Virginia Radiology, slip op. at 4.
rendered.\textsuperscript{78} Thus, the court concluded the hospital solicited remuneration in return for referrals in violation of the Anti-Kickback Statute.\textsuperscript{79}

It should be noted, however, that \textit{Greber} and \textit{Bay State Ambulance} both stand for the proposition that remuneration may have two purposes, and if one purpose (\textit{Greber}) or the primary purpose (\textit{Bay State Ambulance}) of the remuneration is to induce referrals of Medicare business, the payment is illegal remuneration under the Anti-Kickback Statute.\textsuperscript{80} Thus, even if the fee paid by VRA was consistent with the fair market value of the practice management services furnished by the hospital, the payment could still be illegal remuneration if even one purpose of the payment was to remunerate the hospital for the exclusive contract to staff the radiology department.

Consider for example the hospital's threat to cancel VRA's contract if VRA did not contract with the hospital for billing services. The mere fact that VRA may have eventually paid the hospital a negotiated amount consistent with the fair market value of the billing services rendered would not have changed the fact that the billing arrangement and the fees generated thereby were solicited \textit{in return for} (i.e., made a condition of maintaining) the exclusive contract. Thus, remuneration paid by a hospital-based physician group consistent with the fair market value of services rendered by the hospital may still be illegal under both \textit{Greber} and \textit{Bay State Ambulance} if one purpose of the remuneration is to obtain or maintain the exclusive contract with the hospital. Accordingly, hospitals that foist billing, staff, or practice management services on hospital-based physicians that do not request the services, risk violating the Anti-Kickback Statute even if the fees involved are consistent with fair market value of the services rendered.

\textsuperscript{78} \textit{Id.} at 9, 12-13.
\textsuperscript{79} \textit{Id.} at 12.
THE BAN ON PHYSICIAN FEE-SPLITTING ARRANGEMENTS

Many states have enacted laws prohibiting physicians from splitting their fees except in specified circumstances. The scope of these statutes varies from state to state, however, case law developments in Illinois illustrate how such laws can bear directly on financial arrangements between hospitals and hospital-based physicians. Section 22 of the Illinois Medical Practice Act of 1987 provides that the Department of Professional Regulation may revoke, suspend, place on probationary status, or take any other appropriate disciplinary action with respect to the license of a physician for:

Dividing with anyone other than physicians with whom the licensee practices in a partnership, Professional Association, limited liability company, or Medical Professional Corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered.

At least three contracts have been declared illegal and void under Illinois law because they were found to violate the fee-splitting ban. Significantly, two of these cases involved an obligation by a physician to split a percentage of collections from patient billings with a non-physician. Although one case involved "fee-splitting" in the classical sense of splitting a fee in exchange for patient referrals, the fee-splitting in the other cases involved payment toward the purchase of a medical practice, and the payment (in part) for legitimate practice management services. In the later cases, the Illinois appellate court

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81 See e.g., FLA. STAT. ANN. § 458.331(1)(j); IDAHO CODE § 54-1814(8); 225 ILCS 60/22(14), as amended by Pub. Act. 89-201 § 5; N.Y. Educ. Law § 6509-a; OHIO REV. CODE § 4731.22(B)(17); TENN. CODE ANN. § 63-6-225(a); WIS. STAT. § 448.08(1).
82 225 ILCS 60/22(14), as amended by Pub. Act. 89-201 § 5.
84 E & B Marketing Enterprises, 568 N.E.2d at 339.
85 Desnick, 614 N.E.2d at 379.
86 Schwartz, 628 N.E.2d at 656.
held that the fee-splitting ban is not limited to fee-splitting in the classical sense, but rather, prohibits all fee-splitting arrangements not specifically authorized by Section 22 of the Illinois Medical Practice Act. Thus, even if legitimate services are furnished to the physician and the fee-splitting arrangement constitutes payment commensurate with the fair market value of such services, fee-splitting is an improper method of payment in Illinois.

State physician fee-splitting bans may implicate financial arrangements between hospitals and hospital-based physicians. Arrangements whereby a hospital-based physician group splits a percentage of gross or net revenues with a hospital in return for an exclusive contract, may violate the state's physician fee-splitting ban, because the arrangement amounts to payments in return for referrals -- the classical fee-splitting arrangement. However, the fee-splitting arrangement may, as in Illinois, violate the state's fee-splitting ban even if the arrangement constitutes payment commensurate with the fair market value of services rendered by the hospital, e.g., practice management services. Thus, a financial arrangement that complies with the Anti-Kickback Statute may still be barred by a state's prohibition on physician fee-splitting.

THE ENFORCEABILITY OF ILLEGAL ARRANGEMENTS BETWEEN HOSPITALS AND HOSPITAL-BASED PHYSICIANS

As Virginia Radiology illustrates, a financial arrangement between a hospital and hospital-based physicians that is illegal may render the contract between the parties unenforceable. In Virginia Radiology, the illegality of the contract modifications demanded by the hospital barred the hospital from enforcing the termination provisions of the contract with the radiology group, which otherwise permitted the hospital to

87 Desnick, 614 N.E.2d at 381; Schwartz, 628 N.E.2d at 659.
terminate the contract without cause upon sixty days written notice. Federal courts have declined to enforce lease arrangements and “income guarantee” repayment terms between hospitals and physicians where the agreements were found to violate the Anti-Kickback Statute. Similarly, courts have declined to enforce contracts that involved illegal fee-splitting arrangements under state law.

The illegality of the financial arrangement proposed by a hospital may, as in Virginia Radiology, afford a hospital-based physician group a legal basis for rejecting demands that it subsidize the hospital’s operating and capital costs. However, an illegal arrangement may also give the hospital an opportunity to avoid contractual obligations to a hospital-based physician group, such as instances where a hospital has been recently purchased by another hospital wishing to avoid a contractual obligation to the physician group currently operating a department of the hospital. Thus, physicians and hospitals must not only guard against potential criminal and administrative sanctions under the Anti-Kickback Statute and, in the case of physicians, threats to their medical license under state fee-splitting bans, they must also consider the effect of financial arrangements on the enforceability of their contracts with each other.

CONCLUSION

The Anti-Kickback Statute prohibits hospitals from soliciting, and hospital-based physician groups from paying remuneration in return for exclusive contracts to staff and operate hospital departments. Hospital-based physician groups may pay for the fair market value of services or items that they receive voluntarily from the hospital, and invest

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59 Virginia Radiology, slip op. at 3.
61 E & B Marketing Enterprises, 568 N.E.2d at 339.
62 Cf. Vana, 1993 WL 597402 at *1 (refusing to enforce lease agreement against hospital that was successor in interest to hospital-lessee that originally entered into lease agreement with physicians).
voluntarily in the hospital and programs that benefit the hospital. However, if such economic arrangements are in fact involuntary subsidies of the hospital's operating and capital costs solicited by the hospital in return for the exclusive contract with the hospital, the arrangement violates the Anti-Kickback Statute.

Furthermore, paying the hospital a percentage of the physician's gross or net revenues may violate state prohibitions on physician fee-splitting because it involves the impermissible sharing of professional fees with a lay entity. A state's fee-splitting ban may apply even if the arrangement involves payments consistent with the fair market value of the services rendered by the hospital.

Both hospitals and hospital-based physicians must also keep in mind that agreements that include illegal remuneration or fee-splitting terms are probably unenforceable. Thus, parties must consider the consequences of entering into an agreement that may someday prove unenforceable.