PAYING EMPLOYEES FOR REFERRING HEALTHCARE BUSINESS

By Kim C. Stanger

09/20/2020

Many healthcare employers may want to incentivize or compensate their employees for referring patients to or generating business for the employer, but they (appropriately) fear application of the federal Stark law or Anti-Kickback Statute. As explained more fully below, however:

- Stark only applies to payments to physicians (or the physician's immediate family members) if the physician refers certain designated health services payable by Medicare or Medicaid; it does not apply to referrals by non-physicians, nor does it apply to referral-based compensation arrangements involving non-DHS referrals.
- The Anti-Kickback Statute contains an exception that permits referral-based compensation to bona fide employees for legitimate services payable by federal healthcare programs.

Of course, the foregoing only applies to compensation paid to bona fide employees, not to independent contractors or other entities. In addition, employers need to beware other state or federal laws that may apply in certain circumstances.

I. Stark Law.

The federal Ethics in Patient Referrals Act ("Stark") prohibits physicians from referring patients for certain designated health services ("DHS") payable by Medicare or Medicaid to entities with which the physician (or a member of the physician's immediate family[i]) has a financial relationship unless the transaction fits within a regulatory safe harbor. (42 U.S.C. § 1395nn; 42 C.F.R. § 411.353). Violations may result in significant penalties and repayments.[ii] But the scope of Stark is relatively limited:

First, Stark only applies to referrals by physicians[iii]; it does not apply to referrals or other business generated by non-physician employees unless the physician is effectively controlling the employees' referrals. (42 C.F.R. § 411.353(a)). Consequently, Stark generally does not prohibit referral-based compensation to employees who are not physicians or immediate family members of physicians.

Second, Stark only applies to referrals by physicians for certain designated health services ("DHS")[iv] payable by Medicare or Medicaid. (42 C.F.R. § 411.353(a)). It does not prohibit a physician from referring non-DHS to her/his employer, including items or services outside the definition of DHS or DHS that are not payable by Medicare or Medicaid.

Third, Stark only applies to referrals[v] by the physician to other entities; it does not apply to services personally performed by the physician. (42 C.F.R. §§ 411.351, definition of *referral*, 411.353(a), and 411.357(c)(4)). An employer may always pay an employed physician based on services the physician personally performs.[vi]

Fourth, Stark's "bona fide employee" safe harbor generally excepts:

> Any amount paid by an employer to a physician (or immediate family member) who has a bona fide employment relationship with the employer for the provision of services if the following conditions are met:
>
> (1) The employment is for identifiable services.
>
> (2) The amount of the remuneration under the employment is—
>
> (i) Consistent with the fair market value of the services; and
>
> (ii) Except as provided in paragraph …(4) of this section, is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician.
>
> (3) The remuneration is provided under an arrangement that would be commercially reasonable even if no referrals were made to the employer.
>
> (4) Paragraph … (2)(ii) of this section does not prohibit payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or immediate family member of the physician).

(42 C.F.R. § 411.357(c), emphasis added). Significantly, the safe harbor only requires that the compensation not vary with the volume or value of "referrals", which is defined as referrals for DHS. (42 C.F.R. § 411.351, definition of *referrals*). In contrast, the safe harbor applicable to independent contractors requires that the compensation not vary with the "volume or value of any referrals or other business generated between the parties", *i.e.*, non-DHS business. (42 C.F.R. § 411.357(d)(1)(v), emphasis added). The net effect is that referral-based compensation may be paid to employed physicians or their immediate family members so long as the compensation formula does not take into account referrals for DHS.[vii]

Fifth, although an employed or contracted physician's compensation formula generally may not vary with the volume or value of referrals for DHS, Stark's special rules on compensation allow an employer to require an employed physician to refer business to the employer subject to certain limitations:

> A physician's compensation from a bona fide employer … may be conditioned on the physician's referrals to a particular provider, practitioner, or supplier, provided that the compensation arrangement meets all of the following conditions. The compensation arrangement:
>
> (i) Is set in advance for the term of the arrangement.
>
> (ii) Is consistent with fair market value for services performed (that is, the payment does not take into account the volume or value of anticipated or required referrals).
>
> (iii) Otherwise complies with an applicable exception under §411.355 or §411.357.
>
> (iv) Complies with both of the following conditions:

(A) The requirement to make referrals to a particular provider, practitioner, or supplier is set out in writing and signed by the parties.

(B) The requirement to make referrals to a particular provider, practitioner, or supplier does not apply if the patient expresses a preference for a different provider, practitioner, or supplier; the patient's insurer determines the provider, practitioner, or supplier; or the referral is not in the patient's best medical interests in the physician's judgment.

(v) The required referrals relate solely to the physician's services covered by the scope of the employment, the arrangement for personal services, or the contract, and the referral requirement is reasonably necessary to effectuate the legitimate business purposes of the compensation arrangement. In no event may the physician be required to make referrals that relate to services that are not provided by the physician under the scope of his or her employment, arrangement for personal services, or contract.

(42 C.F.R. § 411.354(d)(4)).[viii]

In short, Stark generally prohibits paying employed physicians (or their immediate family members) in a manner that varies directly with the volume or value of their referrals for DHS but it may be possible to compensate them based on their referrals for non-DHS. The danger is that employers and those implementing such a compensation arrangement may not understand the distinction and/or become careless; before you know it, the compensation may factor in referrals for DHS as well as non-DHS resulting in potential Stark violations. Employers should carefully consider the practical compliance challenges before establishing a referral-based compensation formula for employed physicians.

II. The Anti-Kickback Statute.

Given the relatively narrow scope of Stark, the federal Anti-Kickback Statute ("AKS") is often the more relevant hurdle for most employee compensation arrangements, especially compensation for non-physicians. The AKS generally prohibits knowingly and willfully offering, paying, soliciting or receiving any remuneration to induce referrals for items or services payable by federal healthcare programs. (42 U.S.C. § 1320a-7b(b)). Violations may result in significant criminal, civil and administrative penalties.[ix] The AKS is subject to two significant limitations, however:

First, the AKS only applies to referrals for items or services payable by federal healthcare programs; it does not apply to remuneration offered for referrals for private pay business. Employer compensation programs that reward referrals for private pay business—not government program business—should not implicate the AKS. Nevertheless, there are risks in such programs. As with Stark, it may be difficult to implement the program in a way to ensure referrals for federal program business are not factored into the compensation. In addition, the OIG has cautioned that such "carve out" programs in which remuneration is paid solely for private pay business may have the effect of also inducing federal program business and, therefore, violate the AKS. (*See, e.g.*, OIG Adv. Op. 12-06 at p.6-7).[x]

Second, more importantly, the AKS expressly excepts "any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered

items or services." (42 U.S.C. § 1320a-7b(b)(3)(B)). Consistent with the statutory exception, the regulations implementing the AKS contain the following "bona fide employee" safe harbor:

> *Employees.* [For purposes of the AKS], "remuneration" does not include any amount paid by an employer to an employee, who has a bona fide employment relationship with the employer, for employment in the furnishing of any item or service for which payment may be made in whole or in part under Medicare, Medicaid or other Federal health care programs. For purposes of … this section, the term employee has the same meaning as it does for purposes of 26 U.S.C. § 3121(d)(2).

(42 C.F.R. § 1001.952(i)). Under 26 U.S.C. § 1321(d)(2), "any individual who, under the usual common law rules applicable in determining the employer-employee relationship, has the status of an employee." For purposes of this article, I will refer to both the statutory employment exception and the regulatory employment safe harbor as the "employee safe harbor."

The HHS Office of Inspector General ("OIG"), courts, and commenters discussing the employee safe harbor have generally identified two potential issues that must be considered when evaluating application of the safe harbor: (1) whether the person receiving the remuneration is a "bona fide employee"; and (2) whether the remuneration is intended to generate referrals instead of the "furnishing of any item or service" payable by federal health care programs. (*See, e.g.,* D. Romano, *How Safe Are the Safe Harbors? An In-Depth Look at Statutory and Regulatory Exceptions to the Anti-Kickback Statute*, 30 Health Lawyer 1 at 6-8 (12/17)).

A. Bona Fide Employment.

Whether a person is a bona fide employee for purposes of the employee safe harbor depends on the common law test for employee-employer relationships. As one court explained,

> Whether a worker is an "employee" is based on "the hiring party's right to control the manner and means [of the work]," which is determined by considering the following factors:
>
>> the skill required; the source of the instrumentalities and tools; the location of the work; the duration of the relationship between the parties; whether the hiring party has the right to assign additional projects to the hired party; the extent of the hired party's discretion over when and how long to work; the method of payment; the hired party's role in hiring and paying assistants; whether the work is part of the regular business of the hiring party; whether the hiring party is in business; the provision of employee benefits; and the tax treatment of the hired party.

(*United States v. Vernon*, 723 F.3d 1234, 1271 (11th Cir. 2013), *quoting Nationwide Mut. Ins. Co. v. Darden*, 503 U.S. 318, 323–24, 112 S.Ct. 1344, 1348, 117 L.Ed.2d 581 (1992); *see also United States v. Sanjar*, 876 F.3d 725, 747 (5th Cir. 2017) ("Factors relevant to determining if an employment relationship is bona fide include the manner of payment, whether the work is part of the employer's regular business, and the employer's control

over work hours."); *United States v. Crinel*, 2015 U.S. Dist. LEXIS 77773, *13 (listing 13 factors to determine whether an employee relationship exists); *United States v. Halifax Hosp. Med. Ctr.,* 213 WL 6196562 at *6 (M.D. Fla. 2013) (listing 25 factors for determining whether a person is an employee)).

Several courts have held that, no matter how the parties characterize the relationship, the employee safe harbor does not apply if the person receiving the remuneration is really not a bona fide employee under the common law rules for determining employee status. (*See, e.g., United States v. Vernon*, 723 F.3d 1234, 1249-51 (11th Cir. 2013) (no bona fide employment relationship where the purported employee rarely visited the company headquarters, received no oversight or direction from company employees, earned significantly more than other sales representatives in similar jobs, did not have to comply with company policies and procedures, and spent a majority of his time performing non-work related tasks); *United States v. Robinson*, 505 Fed. Appx. 385, 387-88 (5th Cir. 2013) (no bona fide employment where the purported employees did not receive regular paychecks, received no training or direction about marketing, did not have office hours or on-site offices, work was not sufficiently controlled by the company, and received payments solely as a fee or commission for each referral they provided to the company); *United States v. Job*, 387 Fed. Appx. 445, 454 (5th Cir. 2010) (no bona fide employment relationship where the purported employee was not trained, had no set hours, was not required to work fulltime, did not perform work on the employer's premises, split expenses with the employer, and was paid purely by commission)).

B. Remuneration for Providing Covered Services.

There is some authority suggesting that the employee safe harbor does not apply if the remuneration is paid for referrals instead of the furnishing of items or services payable by government healthcare programs. In a 1992 letter discussing compensation in the sale of a physician practice, the OIG official included the following footnote:

> We would also note that while the anti-kickback statute contains a statutory exemption for payments made to employees by an employer, the exemption does not cover any and all such payments. Specifically, the statute exempts only payments to employees which are for "the provision of covered items or services". Accordingly, since referrals do not represent covered items or services, payments to employees which are for the purpose of compensating such employees for the referral of patients would likely not be covered by the employee exemption.

(Letter from D. McCarty Thornton to T.J. Sullivan dated 12/22/92 ("Thornton footnote"), available at https://oig.hhs.gov/fraud/docs/safeharborregulations/acquisition122292.htm). Consistent with the Thornton footnote, several courts have held or suggested that the employee exception does not apply if the remuneration is paid for referrals, not for "providing" or "furnishing" covered services. (*See, e.g., United States v. Luis*, 966 F.Supp.2d 1321,1330-31 (S.D. Fla. 2013), aff'd, 564 Fed.Appx. 493 (11th Cir. 2014), *rev'd*, 578 U.S. ——, 136 S.Ct. 1083, 194 L.Ed.2d 256 (2016), *and vacated and remanded*, 653 Fed.Appx. 904 (11th Cir. 2016) (defendant allegedly paid nurses to recruit patients); *United States v. Borrasi*, 639 F.3d 774, 782 (7th Cir. 2011); *United States v. Starks*, 157 F.3d 833, 839 (11th Cir. 1998); *see also United States v. George*, 900 F.3d 405, 413-14 (7th Cir. 2018); *United States ex rel. Obert–Hong v. Advocate Health Care*, 211 F.Supp.2d 1045, 1050 (N.D.Ill. 2002)).

Nevertheless, most courts and commentators that have considered the issue have expressly rejected the foregoing analysis and authorities and/or upheld referral-based payments to bona fide employees under the employee safe harbor exception. (*See, e.g., Carrel v. AIDS Healthcare Found., Inc.*, 898 F.3d 1267 (11th Cir. 2018); *United States v. AIDS Healthcare Found., Inc*., 262 F.Supp.3d 1353, 1362 (S.D. Fla. 2017); *United States ex rel. Wall v. Vista Hospice Care, Inc*., 2016 U.S. Dist. LEXIS 80160 (N.D. Tex. 2016); *Crinel*, 2015 U.S. Dist. LEXIS 77773; *Hericks v. Lincare, Inc*., 2014 U.S. Dist. LEXIS 39706, *53-54 at n.17 (E.D. Pa. 2014); *Halifax Hosp.*, 2013 WL 6196562 at *8; *State v. Harden,* 983 So.2d 480 (Fla. 2006); *New Boston Gen. Hosp., Inc. v. Texas Workforce Comm'n*, 47 S.W.3d 34 (Tx.App. 2001)). The analysis in these cases is persuasive for the following reasons:

1. OIG Commentary Approves Commission-Based Compensation.

The 1992 Thornton footnote is hardly authoritative. As one court noted,

> The letter from the Associate General Counsel concerns the acquisition of physician practices by hospitals and the possible payments to those physicians; not only is this letter inapposite to this case, which involves bona fide employees receiving payment from their employer while working for that employer, it is over twenty years old and the author also only suggested in a footnote that payment for referrals of patients would "likely" not be covered by the employee exemption.

(*Hericks*, 2014 U.S. Dist. LEXIS 39706, *53-54 at n.17; *see also Vista Hospice,* 2016 U.S. Dist. LEXIS 80160, *75-76 ("This Court finds [the Thornton footnote's] prediction of likelihood to be the equivalent of dictum, and that, in this Courts' view, in inaccurate.")).

More importantly, the footnote expressly contradicts the OIG's official commentary to its employee safe harbor. When the safe harbor was originally proposed in 1989, the OIG stated:

> This statutory exemption permits an employer to pay an employee in whatever manner he or she chooses for having that employee assist in the solicitation of Medicare or State health care program business. The proposed exemption follows the statute in that it applies only to bona fide employee-employer relationships.
>
> In response to the October 21, 1987 request for comments, many commenters suggested that we broaden the exemption to apply to independent contractors paid on a commission basis. We have declined to adopt this approach because we are aware of many examples of abusive practices by sales personnel who are paid as independent contractors and who are not under appropriate supervision. We believe that if individuals and entities desire to pay a salesperson on the basis of the amount of business they generate, then to be exempt from civil or criminal prosecution, they should make these salespersons employees where they can and should exert appropriate supervision for the individual's acts.

(54 FR 3088, 3093 (1/23/89), emphasis added). In its 1991comments to the final rule, the OIG reaffirmed that the employee safe harbor "permit[s] an employer to pay an employee in whatever manner he or she cho[oses]

for having that employee assist in the solicitation of program business ….” (56 FR 35952, 35953 (7/29/91)). Again, the OIG distinguished bona fide employment relationships from independent contractor relationships:

> *Comment:* Many commenters urged the OIG to extend this exception to apply to independent contractors paid on a commission basis. …
>
> *Response:* We continue to reject this approach because of the existence of widespread abusive practices by salespersons who are independent contractors and, therefore, who are not under appropriate supervision and control. Although two commenters asserted that they could achieve appropriate supervision and control of independent contractors by including restrictive terms in the contract, we cannot expand this provision to cover such relationships unless we can predict with reasonable certainty that they will not be abusive. We are confident that the employer-employee relationship is unlikely to be abusive, in part because the employer is generally fully liable for the actions of its employees and is therefore more motivated to supervise and control them.
>
> …
>
> *Comment*: One commenter inquired whether a part-time employee paid on a commission-only basis falls within the employee exception.
>
> *Response:* As long as a bona fide employer-employee relationship exists between the part-time employee and the employer, such a relationship falls within the scope of this provision.

(*Id.* at 35981, emphasis added).

It is difficult to reconcile the Thornton footnote with the OIG's official commentary. If the OIG truly intended to backtrack on its published commentary, one would expect that it would have done so in a more official manner rather than sticking the new rule in an indefinite footnote of a letter addressing a different issue. There does not appear to have been any other official OIG pronouncement affirming or expanding the proposition raised in the 1992 Thornton footnote. To the contrary, in Advisory Opinion 07-03, the OIG reaffirmed its 1991 commentary that "the risk of fraud and abuse is typically reduced with bona fide employer-employee relationships, in part because the employer is generally fully liable for the actions of its employees and is thus more motivated to supervise and control them. (*See* 56 Fed. Reg. 35952, 35961 (July 29, 1991))."[xi]

Courts have frequently cited the official OIG commentary approving commission-based employee compensation programs when concluding that the employee safe harbor permits such programs. (*See, e.g., AIDS Healthcare Found*., 262 F.Supp.3d at 1362; *Vista Hospic*e, 2016 U.S. Dist. LEXIS 80160, *77-78; *Harden*, 938 So.2d at 488-89).

2. The Cases that Prohibit Payment for Referrals are Distinguishable.

The cases most often cited for the proposition that the employee safe harbor does not apply to payments for referrals have markedly distinguishable facts from the typical referral-based employee compensation program.

In *Starks*, the defendant paid two non-employees $250 for each patient they referred to the defendant. The 11th Circuit concluded that the employee safe harbor did not apply because:

> even if Starks and Siegel believed that they were bona fide employees, they were not providing "covered items or services." As the government has shown, Starks received payment from Siegel and Future Steps only for referrals and not for any legitimate service for which the Hospital received any Medicare reimbursement. At the same time, persons in either Siegel's or Starks's position could hardly have thought that either Starks or Henry was a bona fide employee; unlike all of Future Steps's other workers, Starks and Henry did not receive regular salary checks at the Hospital. Instead, they clandestinely received their checks (often bearing false category codes) or cash in parking lots and other places outside the Project Support clinic so as to avoid detection by other Project Support workers.

(147 F.3d at 839). Significantly, *Starks* did not address situations in which employees are paid a commission for referrals within the context of a bona fide employment relationship that involved the provision of legitimate patient care services. Later courts have distinguished *Starks* on this basis. For example, the court in *Hericks v. Lincare* noted, "in *Starks*, the individuals received payment from the treatment center only for referrals and not for any legitimate service eligible for Medicare reimbursement. In this case, the employees are employed by Lincare for more than simply referrals." (2014 U.S. Dist. LEXIS 39706, *54 at n.17; *accord AIDS Healthcare Found.,* 262 F.Supp.3d at 1368-69; *Vista Hospice,* 2016 U.S. Dist. LEXIS 80160 *79; *Harden*, 938 So.2d at 495). In *Carrel*—a subsequent case from the same court that decided *Starks*—the 11th Circuit distinguished *Starks* because the payments "were made to non-employees in exchange for referrals not contemplated by a healthcare program", and confirmed that an employer may pay employees for referrals for covered services, at least where the federal program pays for such referral services. (898 F.3d at 1275).

Similarly, in *Borrasi*, the defendant was convicted of AKS violations based on compensation for referrals paid through both a sham employment arrangement as well as additional remuneration conferred outside the scope of the alleged employment relationship. (639 F.3d at 777). On appeal, the 7th Circuit upheld the jury instructions relevant to the AKS:

> To convict Borrasi, the instruction required the jury to find … that some amount was paid not pursuant to a bona fide employment relationship.… Because at least part of the payments to Borrasi was "intended to induce" him to refer patients to Rock Creek, "the statute was violated, even if the payments were also intended to compensate for professional services."

(639 F.3d at 781, *quoting United States v. Greber*, 760 F.2d 68, 71 (3d Cir.1985)). But as in *Starks*, the facts in *Borrasi* were fairly egregious and confirmed there was no bona fide employment relationship and/or payments were made outside any bona fide relationship, thereby negating application of the employee safe harbor:

> In order to conceal these bribes, Borrasi and other Integrated employees were placed on the Rock Creek payroll, given false titles and faux job descriptions, and asked to submit false time sheets. Borrasi, for example, was named "Service Medical Director" and was allegedly required to be available at all times; Baig later testified that Borrasi was not expected to perform any of the

> duties listed in his job description. According to minutes of Rock Creek's various committee meetings, Borrasi and some Integrated physicians occasionally attended meetings and submitted reports of their work. But they attended only a very small percentage of the actual meetings, and multiple witnesses testified to rarely seeing them in the Rock Creek facility for meetings or other duties. Jonas, Jawich, and Roper each testified that the Integrated physicians did not perform their assigned administrative duties, their reports and time sheets notwithstanding. Baig testified that he, Borrasi, and Mamoon did not expect the Integrated physicians to perform any actual administrative duties.
>
> In addition, Rock Creek paid the salary for Integrated's secretary, as well as lease payments for one of Integrated's offices. This arrangement purportedly gave Rock Creek an outpatient clinic at Borrasi's building and certainly supplemented Borrasi's rent. Further, Baig was paid both to oversee the admission and stays of Integrated's referrals to Rock Creek and also to ensure the referred patients were returned to nursing homes and facilities that Borrasi could access and control. These methods enabled Rock Creek and Borrasi to maximize their Medicare reimbursement claims.

(639 F.3d at 777). Again, *Borrasi* did not address a situation in which referral-based compensation is paid solely within the parameters of a bona fide employment relationship that included the provision of legitimate services. As the *AIDS Healthcare Found.* court explained,

> Importantly though, like Starks, Borrasi was never a bona fide employee of the organization that paid him kickbacks. In fact, Borrasi actively faked his employment at that organization to conceal the bribes he received. (*Id*. at 777). The Court finds Borrasi inapplicable because there is no evidence that AHF fraudulently employed Rodriguez to hide the bonus payments at issue.

(262 F.Supp.3d at 1366).

In *Luis*, the defendant paid employed nurses to recruit patients for services. In considering the applicability of the employee safe harbor, the district court stated:

> The text of the safe-harbor provision upon which Luis relies states that "remuneration" does not include "any amount paid by an employer to an employee ... *in the furnishing* of any item or service for which payment may be made in whole or in part under Medicare." 42 C.F.R. § 1001.952 (emphasis added). Similarly, the safe harbor contained in § 1320a–7b states that it will apply to "any amount paid by an employer to an employee ... *for employment in the provision of* covered items or services." § 1320a–7b(b)(3)(B) (emphasis added). The emphasized language in both of these provisions makes clear that the safe-harbor provisions will only apply when payments made to an employee compensate the employee for furnishing or providing covered items or services or items or services payable by Medicare, not simply for referring patients.

(966 F. Supp.2d at 1330-31, emphasis in original). Citing *Starks* and *Borrasi,* the district court concluded that because the nurses were paid in part for referrals, the compensation structure violated the AKS even if the patients received covered items or services. (*Id.* at 1331). The court went on to note, however, that even if the employee safe harbor permitted payment for referrals for covered services, the defendants in *Luis* fraudulently billed Medicare for services that were not medically necessary or never provided and, therefore, the safe harbor would not apply on that basis. (*Id*.). Thus, *Luis* is distinguishable from a situation in which compensation is paid for referrals for legitimate services that are properly billed to Medicare. (*AIDS Healthcare Found*., 262 F.Supp.3d at 1370 n.13).

3. A Number of Courts Have Rejected the Analysis in *Stark*, *Borresi*, and/or *Luis*.

Aside from the factual differences, several courts have expressly rejected the analysis (or lack thereof) in *Starks*, *Borresi*, and/or *Luis.* For example, courts have repeatedly pointed out that *Starks* contains no substantive analysis of the relevant statutes to support is conclusions.[xii] In *Vista Hospice,* for example, the court stated:

> *Starks* engaged in no substantive analysis of the exception, and commented on the "covered items or services" clause without relying on it—the defendants in that case clearly were not bona fide employees, clandestinely receiving checks or cash for their referrals in parking lots to avoid detection. *See United States v. Crinel*, 2015 U.S. Dist. LEXIS 77773, 2015 WL 3755896, at *5 (E.D. La. 2015) (disagreeing with *Starks* and stating that the *Starks* court engaged in no substantive analysis of the statute). Here, it is uncontested that the payments at issue were to bona fide employees.

(2016 U.S. Dist. LEXIS 80160 *79; *see also AIDS Healthcare Found.,* 262 F.Supp.3d at 1364-65; *Harden,* 938 So.2d at 495; *Hericks,* 2014 U.S. Dist. LEXIS 39706, *54 at n.17).

In *Crinel,* the court also provided a cogent critique of the *Borrasi* decision:

> In *United States v. Borrasi*, the Seventh Circuit undertook the in-depth analysis missing in *Stark*s but, in this Court's opinion, focused on the wrong statutory provision. Specifically, the court focused on one of the substantive provisions of the anti-kickback statute—42 U.S.C. § 1320a-7b(b)(1)—as opposed to the safe-harbor provision in 42 U.S.C. § 1320a-7b(b)(3)(B). The Seventh Circuit held the substantive provision is violated "if part of [a] payment compensated past referrals or induced future referrals." The Court then applied this interpretation to the safe-harbor defense, finding the defense did not apply, because "at least part" of the payments to the defendant were intended to induce future referrals. In other words, the Seventh Circuit essentially held that if a particular payment violates a substantive provision of the anti-kickback statute, the safe harbor provision does not apply. This reading allows the rule to swallow the exception.

(2015 U.S. Dist. LEXIS 77773, *19; *accord Vista Hospice,* 2016 U.S. Dist. LEXIS 80160, *79; *see also AIDS Healthcare Found.,* 262 F.Supp.3d at 1365-66).

The analysis in *Luis*—which generally parallels the Thornton footnote—has been repeatedly rejected. In *AIDS Healthcare Found.*, for example, the court stated:

> [T]he *Luis* court's discussion seemingly narrow[s] what the text of the safe harbor actually protects. The [employment] exception's statutory text exempts "any amount paid by an employer to an employee ... *for employment in the provision* of covered items or services." 42 U.S.C. § 1320a–7(b)(3)(B) (emphasis added). Although … *Luis* read this provision to exempt only the specific amounts paid by an employer to an employee for "providing" or "furnishing" covered services, other courts have rejected such a constrained reading. *See Hericks v. Lincare, Inc.*, No. 07-387, 2014 WL 1225660, at *14 n.17 (E.D. Penn. Mar. 25, 2014) (applying employee safe harbor because "the employees are employed by [the defendant] for more than simply referrals" and perform other covered services).

(262 F.Supp.3d at 1368). The court noted that *Luis's* interpretation "would read the exception out of the statute." (*Id.* at 1366).

The *Vista Hospice* court reached the same conclusion. In that case:

> Relator claims the bona fide employee exception does not apply, because Defendants have not shown that bonuses to employees were "for employment in the provision of covered items or services." Defendants, on the other hand, claim all of their employees were employed in the provision of covered services: hospice services eligible for reimbursement under [Medicare].
>
> The text of the statute supports Defendants' position. The statutory exception applies to payments *for employment in the provision of* covered services, not for providing covered services. 42 U.S.C. 1320a-7b(b)(3)(B)…. On its face, therefore, the exception protects payments to employees of entities in the business of providing covered services of hospice care, not only for specific direct patient care for which bills can be submitted to Medicare.
>
> Further, the structure of the statute supports this reading of it. If the exception did not apply to payments intended to induce referrals or business for the program, it would be superfluous. The court in *U.S. ex rel. Baklid-Kunz v. Halifax Hospital Medical Center* rejected the argument that a bonus paid to employees to induce referrals was not protected by the safe harbor:
>
>> [T]he Bona Fide Employment Exception provides that the normal prohibition on payments to induce referrals does not apply where the payments are made to a (for lack of a better word) legitimate employee. The Relator would change that to read that the prohibition on payments to induce referrals does not apply where the payments are made to a legitimate employee *unless they are payments to induce referrals*. The exceptions set forth in the Anti-Kickback Statute and accompanying regulations "provide immunity from prosecution for

> behavior that might have violated the Anti-Kickback Statute." . . . The Relator's interpretation of the Bona Fide Employment Exception would eviscerate it.

(2016 U.S. Dist. LEXIS 80160, *75-76 (quoting *Halifax Hosp.*, 2013 WL 6196562 at *8, emphasis in original).

Along the same lines, the *Crinel* court rejected the prosecutor's argument that "payment of Medicare referral fees never falls under the safe harbor, even if made to a bona fide employee":

> The Government's interpretation contravenes "the elementary canon of construction that a statute should be interpreted so as not to render one part inoperative." The antikickback statute criminalizes the payment or receipt of Medicare referral fees. The safe-harbor provision expressly exempts certain payments of referral fees. If this exemption does not apply to Medicare referral fees under some circumstances, what purpose does it serve? In other words, if all Medicare referral fees were illegal, there would be no safe-harbor provision. Under the Government's strained interpretation, it is impossible to imagine any scenario in which a defendant could successfully invoke the safe harbor defense.

(2015 U.S. Dist. LEXIS 77773, *17; *see also Hericks*, 2014 U.S. LEXIS 39706, *54 at n.17, ("Because the safe harbor language applies to payment to individuals for employment in the provision of covered items and services, and because the Lincare employees are employed in the provision of covered items and services, the cash bonuses for referrals are not necessarily illegal remuneration in violation of the Anti-Kickback Statute.")).

4. Cases Involving Bona Fide Employees Have Generally Applied the Employee Safe Harbor.

As discussed above, the facts in *Starks*, *Borresi*, and *Luis* differ significantly from the situation in most referral-based compensation programs for employees. Courts that have considered the employee safe harbor in the context of bona fide employment relationships have consistently upheld referral-based compensation for employees, including the following:

- Bonuses paid to employed "Linkage Coordinators" to refer patients to employer for AIDS-related services. (*Carrel*, 898 F.3d 1267 and *AIDS Healthcare Found*., 262 F.Supp.3d at 1368).
- Cash incentives (including a $15 per referral bonus) given to employed drivers and service representatives who generated business for the employer. (*Hericks,* 2014 U.S. LEXIS 39706 *43 and n.17).
- Incentive compensation pool offered to employed oncologists based on operating margin of oncology program. (*Halifax Hosp*., 2013 WL 6196562).
- "Per head" payments to employees for soliciting and driving Medicaid-eligible children to employer for dental treatment. (*Harden*, 983 So.2d 480).

- Employed physicians allegedly required to make referrals to hospital and paid a percentage fee for referred patients. (*Obert–Hong*, 211 F.Supp.2d 1045).

- $1,000 commission paid to employed marketer for each long term care facility she recruited to enter contracts for medical services from hospital. (*New Boston Gen. Hosp.,* 47 S.W.3d 34).

The *Vista Hospice* case provides a good example. In that case, Vista Hospice

> offered financial incentives to all classes of its employees to generate admissions and retain patients, by paying bonuses to employees for meeting admission and census goals. These programs most frequently rewarded salespeople, but sometimes rewarded all staff. For example, the 2004 "Growth Incentive Plan" provided cash incentives to all site employees if the site reached a "target goal" for new admissions. Site executive directors received $1000 for hitting the admissions quota, and $75 for each additional admission, and admission coordinators would receive $500 for reaching the quota, and $50 for each additional admission. A "March Madness" plan awarded $500 weekend getaways to the top executive directors, area vice presidents, and regional vice presidents in each region who exceeded admissions goals for the month, while a "Spring Madness" promotion awarded the same to patient care managers and admissions coordinators at sites in each area achieving the highest average compared to the plan for achieving admissions goals over three months.

(2016 U.S. Dist. LEXIS 80160 *27-28). The *qui tam* relator argued that Vista Hospice "had a comprehensive, pervasive program to bonus employees, all of them, at times, but certainly and regularly the sales employees, for the purpose of obtaining patients and retaining them on census." (*Id.* at *75). After a thorough review of the cases and arguments discussed above (including the argument that the employee safe harbor did not apply to payments for referrals), the court concluded that the employee safe harbor protected the census-based incentive payments:

> Relator's interpretation reads the bona fide employee exception out of the statute and is inconsistent with the text, structure, and purpose of the exception. No binding case law supports such an interpretation, and the Court rejects it. Therefore, because Relator relies on bonuses paid to Defendants' bona fide employees for employment in the provision of hospice services, Relator cannot prevail on her AKS theory.

(2016 U.S. Dist. LEXIS 80160, *80-81).

5. Payments to Induce Fraudulent Conduct.

The foregoing analysis assumes that the compensation is paid to incentivize the provision of legitimate services. Some cases have distinguished payments to refer covered services from those in which payments are made to incentivize illegal conduct, *e.g.*, fraudulent billing practices, provision of medically unnecessary care, *etc*. (*See, e.g., Luis*, 966 F. Supp.2d at 1330-31 (employee safe harbor does not apply to compensation arrangements that promote fraudulent billing for services that were not medically necessary or never

provided)). The *Crinel* court offered an interpretation of the employee safe harbor that factors in the difference between paying for referrals for legitimate service versus paying for fraudulent practices:

> The starting point is the text of the statute, which exempts payments made to employees "for employment in the provision of covered items or services." <u>If an employee refers a patient who is actually eligible for Medicare and receives medically necessary services, the employer may provide appropriate compensation in the form of a referral fee</u>. <u>If, on the other hand … an employee receives a referral fee from its employer/co-conspirator as part of a scheme to provide benefits to individuals ineligible to receive them, the safe-harbor provision is not applicable</u>. The Court believes this interpretation best harmonizes all provisions of the anti- kickback statute and accords with Congressional intent.

(2015 U.S. Dist. LEXIS 77773, *23 (emphasis added)).

OIG commentary supports this distinction. For example, the OIG's Compliance Program Guidance for home health agencies warns against "[c]ompensation programs that offer incentives for number of visits performed and revenue generated", and explains:

> The current nature of the home health benefit (*i.e.*, no limits on reimbursable home health visits in a cost-reimbursed system) and customary business pressures create risks associated with incentives (*e.g.*, payments benefits, *etc.*) for productivity and volume of services. Such risks include over-utilization and billing for services not provided in order to meet internal goals and budget benchmarks imposed by home health agency management.

(63 FR at 42414 n.35).

> Clarifying and emphasizing these areas of concern through training and educational programs are particularly relevant to a home health agency's marketing and financial personnel, in that the pressure to meet business goals may render these employees vulnerable to engaging in prohibited practices.

(*Id.* at 42421). Among other things, the Guidance suggests that home health agency compliance programs should:

> Provide that the compensation for billing department personnel and billing consultants should not offer any financial incentive to submit claims regardless of whether they meet applicable coverage criteria for reimbursement or accurately represent the services rendered;

(*Id.* at 42415).

As with home health agencies, the OIG Compliance Program Guidance for Hospices warns that

> the compensation for hospice admission personnel, billing department personnel and billing consultants should not offer any financial incentive to bill

> for hospice care regardless of whether applicable eligibility criteria for reimbursement is met.

(64 FR at 54037).

Admittedly, it may be difficult to draw a line between programs that promote legitimate activities and those that promote abusive conduct, but as *Vista Hospice* demonstrates, employee incentive programs that promote legitimate services should receive employee safe harbor protection. Any employer implementing a referral-based compensation program should ensure that it is carefully structured and requires strict compliance with Medicare, Medicaid and other similar payer rules.

In summary, although there is some authority to suggest that paying employees for referrals violates the federal AKS, the majority of—and better reasoned—cases that have addressed the issue have concluded that the employee safe harbor applies to incentive-based compensation programs so long as: (1) the compensation is paid to a bona fide employee, and (2) the compensation relates to referrals or the generation of legitimate items or services, not to induce fraudulent misconduct. These cases are consistent with the OIG's official commentary that the employee safe harbor "permit[s] an employer to pay an employee in whatever manner he or she cho[oses] for having that employee assist in the solicitation of program business …." (56 FR 35953 (7/29/91)). (*See* OIG Adv. Op. 08-22).

III. Beware Other Laws

Although the federal AKS and Stark laws are most often cited, employers wishing to pay employees for healthcare referrals must beware other potentially applicable laws. For example, the Eliminating Kickbacks in Recovery Act ("EKRA") generally prohibits offering remuneration in exchange for referrals to a recovery home, clinical treatment facility, or laboratory. (18 U.S.C. § 220). Unlike the AKS, EKRA applies to referrals for private pay business as well as items or services payable by federal government programa. Like the AKS, EKRA does contain a limited exception for payments to employees, *i.e.*,

> a payment made by an employer to an employee or independent contractor (who has a bona fide employment or contractual relationship with such employer) for employment, if the employee's payment is not determined by or does not vary by-
>
> (A) the number of individuals referred to a particular recovery home, clinical treatment facility, or laboratory;
>
> (B) the number of tests or procedures performed; or
>
> (C) the amount billed to or received from, in part or in whole, the health care benefit program from the individuals referred to a particular recovery home, clinical treatment facility, or laboratory;

(18 U.S.C. § 220(b)). Unfortunately, we do not have additional guidance or regulatory safe harbors defining the scope of the EKRA exception.

More importantly, many states have their own anti-kickback statute[xiii], self-referral prohibition, or fee-splitting statutes.[xiv] The scope of such laws vary widely: some apply to only government healthcare programs; others

apply to private payers, as well; still others apply to specific types of healthcare providers; *etc.* Healthcare employers need to be familiar with the laws applicable in their state and their specific situation. Interestingly, at least one state supreme court has held that the federal AKS employment exception preempts contrary state laws. (*Harden*, 938 So.2d 480).

IV. Conclusion.

Contrary to common belief, referral-based compensation formulas do not necessarily violate the federal Stark and AKS. Often such incentive-based programs for bona fide employees may be structured to comply with applicable laws, especially when not involving physicians. On a federal level, the key is to ensure that the program is limited to bona fide employees, not independent contractors or other persons, and that the program does not incentivize referrals for services that are inappropriate or not properly billable to federal programs. To that end, employers should work with their compliance officers and, if necessary, knowledgeable attorneys to structure the compensation programs to comply with the laws and minimize the risk of fraud and abuse.

---

[1] Note that Stark applies to an employer's compensation arrangement with a referring physician's immediate family member in addition to a compensation arrangement with the physician; accordingly, compensation arrangements with family members of a DHS-referring physician must be analyzed for Stark compliance. For purposes of Stark,

> *Immediate family member or member of a physician's immediate family* means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

(42 C.F.R. § 411.351).

[2] Stark law violations may result in civil fines of up to $25,000+ per violation and up to $170,000+ per scheme in addition to self-reporting and repayment of amounts received for services rendered per improper referrals. (42 U.S.C. § 1395nn(g); 42 C.F.R. §§ 1003.300 and 1003.310; 45 C.F.R. § 102.3). In addition, Stark law violations likely result in False Claims Act violations, thereby triggering additional penalties and the potential for *qui tam* lawsuits. (31 U.S.C. §§ 3729 and 3730; 42 U.S.C. §§ 1320a-7a and 1320a-7k(d); 28 C.F.R. §§ 85.5 and 1003.200(a) and (b)(k)).

[3] "*Physician* means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor …" (42 C.F.R. § 411.351).

[4] As defined by Stark,

> *Designated health services (DHS)* means any of the following services (other than those provided as emergency physician services furnished outside of the U.S.)…
> (1)(i) Clinical laboratory services.
> (ii) Physical therapy, occupational therapy, and outpatient speech-language pathology services.
> (iii) Radiology and certain other imaging services.
> (iv) Radiation therapy services and supplies.
> (v) Durable medical equipment and supplies.
> (vi) Parenteral and enteral nutrients, equipment, and supplies.
> (vii) Prosthetics, orthotics, and prosthetic devices and supplies.
> (viii) Home health services.
> (ix) Outpatient prescription drugs.
> (x) Inpatient and outpatient hospital services.

(42 C.F.R. § 411.351).

[5] Under Stark, *referral* generally means

> the request by a physician for, or ordering of, or the certifying or recertifying of the need for, any designated health service for which payment may be made under Medicare [or Medicaid], including a request for a consultation with another physician and any test or procedure ordered by or to be performed by (or under the supervision of) that other physician, but not including any designated health service personally performed or provided by the referring physician. A designated health service is not personally performed or provided by the referring physician if it is performed or provided by any other person, including, but not limited to, the referring physician's employees, independent contractors, or group practice members.

(42 C.F.R. § 411.351).

[6] For more information concerning paying physicians based on services they personally perform, see our article at https://www.hollandhart.com/paying-hospital-employed-physicians-for-services-performed-by-others?rel=0&wmode=transparent&autoplay=1.

[7] If certain conditions are satisfied, Stark also allows physician groups to compensate employed physicians based on the overall profits of the group (*see* 42 C.F.R. §§ 411.352(i) and 411.355(a)-(b)), which, of course, will be impacted by the employed physician's referrals. For more information about group practice compensation arrangements, see our article at https://www.hollandhart.com/group-compensation-arrangements-stark-requirements.

[8] For more information concerning an employer's ability to require referrals, see our article at https://www.hollandhart.com/requiring-referrals-from-employees-and-contractors.

[9] An AKS violation is a felony punishable by up to 10 years in prison, a $100,000 criminal penalty, a $100,000+ civil penalty that is subject to annual inflation adjustments, treble damages, and exclusion from participating in the Medicare or Medicaid programs. (42 U.S.C. §§ 1320a-7 and 1320a-7b(b)(2)(B); 42 C.F.R. §§ 1003.300 and 1003.310; 45 C.F.R. § 102.3). An AKS violation is also a *per se* violation of the federal False Claims Act (42 U.S.C. § 1320a-7b(g); 31 U.S.C. § 3729), which exposes defendants to mandatory self-reports and repayments, additional civil penalties of $11,000+ to $22,000+ per claim, treble damages, private *qui tam* lawsuits, and costs of suit. (31 U.S.C. §§ 3729 and 3730; 42 U.S.C. §§ 1320a-7a and 1320a-7k(d); 28 C.F.R. §§ 85.5 and 1003.200(a) and (b)(k)).

[10] For more information about such "carve out" programs, see our article at https://www.hollandhart.com/carving-out-federal-programs-does-not-preclude-anti-kickback-liability.

[11] Although the OIG has had the opportunity to clarify or modify its position on referral-based employee compensation arrangements in several advisory opinions, it has so far declined to do so. For example:

In Advisory Opinion 09-02, the OIG relied on the employee safe harbor to approve an employment agreement involving a mental health professional in which the professional was paid for administrative and clinical services. The opinion is a bit ambiguous in that the factual section states that the employer "would pay the Practitioner compensation based on revenues received for services delivered personally by her as well as total revenues of the Clinic," which may, of course, be impacted by the employee's referrals; however, the OIG's analysis states, "The compensation she received was based on professional services (including administrative services) she personally performed," and does not reference the overall revenues of the clinic. (OIG Adv. Op. 09-02 at 2, 4). The opinion does not contain any express discussion of referrals.

In Advisory Opinion 08-22, the OIG approved a part-time employment agreement with two physicians in which they were paid based on the services they personally performed; there was no discussion of pay for referrals.
In Advisory Opinion 07-03, the OIG relied on the employee safe harbor to approve a hospital's plan to pass credit card rewards to employees based on the employee's performance. In that opinion, the requestor represented that it would not base the incentive on referrals; consequently, the OIG did not address referral-based compensation programs.

In Advisory Opinion 00-02, the OIG approved a program that would reward non-physician employees for submitting cost-saving suggestions that are subsequently implemented. In so doing, the OIG noted that "even if the anti-kickback statute were implicated, payments made to Hospital employees under the Proposed Arrangement may fit within the employee exception, depending on the specific suggestion." (OIG Adv. Op. 00-02 at n.4).

In Advisory Opinion 98-9, the OIG relied on the employee safe harbor to approve a collective bargaining agreement between a hospital and union that would give union nurses, health care aides, and certain other non-physician hospital service workers up to a 4% pay increase based on the number of admissions of union members. The requestors represented that those who were in a position to

make referrals would not be allowed to participate in the program; accordingly, the OIG did not address referral-based employee compensation structures.

[12] In two other cases, the courts suggested that the employee safe harbor does not apply if the payment was intended to induce referrals, but those statements appear in dicta, the context makes the statements ambiguous, and, like *Starks*, the statements were not accompanied by any analysis. (*See George*, 900 F.3d at 413-14 (no safe harbor protection where the defendant "was paid for referrals and not for the provision of items or services covered by Medicare, as required for that safe harbor provision to apply."); *Obert–Hong*, 211 F.Supp.2d at 1050 (employee compensation is exempt from the AKS "unless directly related to referrals.")). Accordingly, those cases are inapposite. (*See AIDS Healthcare Found.,* 262 F.Supp. at 1370 n.11).

[13] For example, Idaho Code § 41-348 prohibits paying or receiving a payment in exchange for referrals for healthcare services or providing services with the knowledge that the patient was referred in exchange for a payment. The Idaho AKS is broader than the federal statute: it extends to payments to induce referrals for any healthcare services, not just those payable by federal programs.

[14] Fee splitting statutes are common in state licensing statutes. For example, the Idaho Medical Practices Act prohibits "[d]ividing fees or gifts or agreeing to split or divide fees or gifts received for professional services with any person, institution or corporation in exchange for referral." (Idaho Code § 54-1814(8). Depending on how broadly the relevant licensing board interprets the statute, it may prohibit certain remunerative relationships as well as investment interests in provider practices.

About the Author:
Kim Stanger is an attorney in Holland & Hart's Boise office specializing in healthcare law. He guides facilities and professionals through the many regulatory, transactional, and practical challenges facing the rapidly evolving healthcare industry. He is a frequent publisher of health law alerts on the Holland & Hart Health Law Blog.

This publication is designed to provide general information on pertinent legal topics. The statements made are provided for educational purposes only. They do not constitute legal or financial advice nor do they necessarily reflect the views of Holland & Hart LLP or any of its attorneys other than the author. This publication is not intended to create an attorney-client relationship between you and Holland & Hart LLP. Substantive changes in the law subsequent to the date of this publication might affect the analysis or commentary. Similarly, the analysis may differ depending on the jurisdiction or circumstances. If you have specific questions as to the application of the law to your activities, you should seek the advice of your legal counsel.

© Holland & Hart LLP 2020. All rights reserved.