Reinhart

Medical Directorship and Physician Compensation by Post-Acute and Long-Term Care Providers – Best Practices in a Time of Increased Government Scrutiny

The U.S. Department of Health and Human Services Office of Inspector General ("OIG") issued a fraud alert on June 9, 2015 warning health care providers that physician compensation arrangements, including medical directorships, may result in significant liability. Enforcement agencies continue to focus on physicians as a result of their unique ability to direct business to the health care provider entities that pay them.

Physicians play a critical role in the post-acute and long term care services industry. Physicians serving as medical directors determine whether individuals are eligible for hospice care or home health services. They are tasked with implementing resident care policies and coordinating medical care in skilled nursing facilities. Physicians frequently serve in a dual role as medical director and attending physician for many skilled nursing residents.

Enforcement Activity

Many post-acute and long-term care providers that entered into questionable medical directorship arrangements have also entered into large settlements over the past year. In many cases, the OIG and the U.S. Department of Justice ("DOJ") alleged that compensation paid to physicians constituted improper remuneration under the Anti-Kickback Statute because payments took into account the volume or value of referrals, did not reflect fair market value for the services to be performed and the physicians did not actually perform the agreed-upon services.

For example, Hebrew Homes Health Network ("Hebrew Homes") of Florida agreed to pay $17 million to settle allegations that it violated the False Claims Act by improperly paying physicians for referrals of Medicare patients requiring skilled nursing care.[1] Over a period of approximately seven years, Hebrew Homes hired numerous physicians to serve as medical directors under contracts that specified job duties and hourly requirements. Hebrew Homes contracted with multiple medical directors at a time. The physicians did not perform the activities

POSTED:

Jan 14, 2016

RELATED PRACTICES:

Health Care
https://www.reinhartlaw.com/practices/health-care

RELATED SERVICES:

Long Term Care, Assisted Living and Senior Independent Housing Services
https://www.reinhartlaw.com/services/long-term-care-assisted-living-senior-independent-housing-services

RELATED PEOPLE:

Robert J. Heath
https://www.reinhartlaw.com/people/robert-heath

All materials copyright © 2025 Reinhart Boerner Van Deuren S.C. All rights reserved.

required of them under their contracts. The DOJ alleged that the physicians were paid for referrals to Hebrew Homes because referrals increased exponentially after the physicians were on the Hebrew Homes payroll.

Medical Director Agreement

Irrespective of the setting in which a medical director provides service, it is critical that the physician and the provider entity that pays the physician enter into an agreement that outlines the services to be provided by the physician ("Medical Director Agreement"). Failing to enter into a Medical Director Agreement, or entering into a deficient Medical Director Agreement, can result in significant liability for both parties under fraud and abuse laws, including the federal Anti-Kickback Statute,[2] the Stark Law[3] and the False Claims Act.[4] Significant problems can arise for both the individual physicians and the provider entities as a result of questionable payments or compensation that is above fair market value.

Personal Services and Management Agreement Safe Harbor

Health care provider entities and physicians can protect themselves from liability under the Anti-Kickback Statute by ensuring that relationships between provider entities and physicians fall squarely within the personal services and management contracts safe harbor. To fall within the personal services and management agreement safe harbor, medical directorship arrangements must meet all of the following requirements:

1. The agreement must be set out in writing and signed by the parties.
2. The agreement must cover all of the services to be provided by the physician over the term of the agreement.
3. If the agreement is intended to provide for the services on a periodic, sporadic or part-time basis, rather than on a full-time basis, the agreement must specify exactly the schedule of intervals, their precise length and the exact charge for the intervals.
4. The term of the agreement must be for at least one year.
5. The aggregate compensation must be set in advance, be consistent with fair market value in arms-length transactions, and not be determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties for which payment may

All materials copyright © 2025 Reinhart Boerner Van Deuren S.C. All rights reserved.

be made in whole or in part under Medicare, Medicaid or other federal health care programs.
6. The services performed under the agreement must not involve counseling or promotion of a business arrangement.
7. The aggregate services must not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose of the services.

Conclusion

Provider entities and physicians, particularly in the post-acute and long term care industry, must ensure that medical directorships are closely monitored and appropriately documented. Please contact Rob Heath or your Reinhart attorney if you have any questions about liability exposure related to your medical directorship arrangement or if you would like assistance either drafting a new Medical Director Agreement or revising your existing Medical Director Agreement so that it meets all current requirements and qualifies for the personal services and management agreement safe harbor.

_____

[1] Article

[2] The federal Anti Kickback Statute is a criminal statute that prohibits the exchange, or offer to exchange, of anything of value in an effort to induce or reward the referral of federal health care program business. 42 U.S.C. § 1320a 7b(b).

[3] The Stark Law prohibits physicians from referring patients who receive health care services payable by Medicare or Medicaid to entities that furnish designated health services with which the physician has a financial relationship, unless an exception applies. 42 U.S.C. § 1395nn.

[4] Under the False Claims Act, health care providers may be held liable if they (a) knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval; (b) knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim; or (c) conspire to violate the False Claims Act. 31 U.S.C. § 3729(a)(1)(A) (C).

[5] 42 C.F.R. § 1001.952.

All materials copyright © 2025 Reinhart Boerner Van Deuren S.C. All rights reserved.

These materials provide general information which does not constitute legal or tax advice and should not be relied upon as such. Particular facts or future developments in the law may affect the topic(s) addressed within these materials. Always consult with a lawyer about your particular circumstances before acting on any information presented in these materials because it may not be applicable to you or your situation. Providing these materials to you does not create an attorney/client relationship. You should not provide confidential information to us until Reinhart agrees to represent you.

All materials copyright © 2025 Reinhart Boerner Van Deuren S.C. All rights reserved.