No. 18-1693

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

UNITED STATES OF AMERICA EX REL. J. WILLIAM BOOKWALTER, III, M.D., ROBERT J. SCLABASSI, M.D., AND ANNA MITINA,

Plaintiffs-Appellants,

v.

UPMC AND UNIVERSITY OF PITTSBURGH PHYSICIANS D/B/A UPP DEPARTMENT OF NEUROSURGERY,

Defendants-Appellees.

On appeal from the United States District Court for the Western District of Pennsylvania No. 2:12-cv-145, Judge Cathy Bissoon

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MOTION OF AMICI CURIAE AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FEDERATION OF AMERICAN HOSPITALS, HOSPITAL AND HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA AND NEW JERSEY HOSPITAL ASSOCIATION TO FILE AN AMICUS BRIEF IN SUPPORT OF PETITIONERS

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The American Hospital Association, the Association of American Medical Colleges, the Federation of American Hospitals, the Hospital and Healthsystem Association of Pennsylvania and the New Jersey Hospital Association herby move this court for leave to file an *amicus curiae* brief in the above-captioned case in support of Defendants-Appellees' Petition for Rehearing or Rehearing En Banc. Defendants/Appellees, UPMC and University of Pittsburg Physicians d/b/a UPP Department of Neurosurgery, consent to the filing of this motion. Plaintiffs/Appellants take no position on the motion. The proposed *amicus* brief is attached as Exhibit A and a proposed Order is being filed herewith.

The filing of an amicus brief during reconsideration of whether to grant rehearing is authorized with the leave of the court by Fed. R. App. P 29(b). The rule requires that the amici have a sufficient "interest" in the case and that their brief is "desirable" and discusses matters that are "relevant to the disposition of the case." Fed. R. App. P. 29; *Neonatology Assocs., P.A. v. Comm'r*, 293 F.3d 128 (3rd Cir. 2002). This Circuit has rejected attempts to read the requirements of the rule narrowly and indeed has expressed a desire to "err on the side of granting" such motions. *Neonatology Assocs.,* 293 F.3d at 132-33.

The American Hospital Association represents nearly 5,000 hospitals, health systems, and other health care organizations, plus 43,000 health care leaders who belong to professional membership groups. AHA members are committed to

improving the health of communities they serve and to helping ensure that care is available and affordable to all. AHA educates its members on health care issues and advocates to ensure that their perspectives are considered in formulating health policy.

The Association of American Medical Colleges is a not-for-profit association representing all 154 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems; and more than 80 academic and scientific societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 173,000 faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The Federation of American Hospitals is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. The Federation's members include teaching and non-teaching long-term and short-stay acute care, inpatient rehabilitation, psychiatric and cancer hospitals in urban and rural communities across America. These hospitals provide a critical range of services, including acute, post-acute, and ambulatory services. Dedicated to a market-based philosophy, the Federation provides representation and advocacy on behalf of its members to Congress, the

Executive Branch, the judiciary, media, academia, accrediting organizations and the public.

The Hospital and Healthsystem Association of Pennsylvania is the statewide membership services organization that advocates for nearly 240 Pennsylvania acute and specialty care, primary care, subacute care, long-term care, home health, and hospice providers, as well as the patients and communities they serve.

The New Jersey Hospital Association (NJHA) has served as New Jersey's premier healthcare association since its inception in 1918. NJHA currently has over 400 members across the healthcare continuum including hospitals, health systems, nursing homes, home health, hospice, and assisted living, all of which unite through NJHA to promote their common interests in providing quality, accessible and affordable healthcare in New Jersey. In furtherance of this mission, NJHA undertakes research and healthcare policy development initiatives, fosters public understanding of healthcare issues, and implements pilot programs designed to improve clinical outcomes and enhance patient safety. NJHA regularly appears before all three branches of government to provide the judiciary and elected and appointed decision makers with its expertise and viewpoint on issues and controversies involving hospitals and health systems.

The amici have a deep understanding of the compensation models of hospitals within the Third Circuit and across the country. Significantly, amici have

a deep understanding and can assist the Court in understanding the impact of the Third Circuit's decision not only on Defendants in this case but on hospitals and physicians nationwide.

For all the foregoing reasons, the American Hospital Association, the Association of American Medical Colleges, the Federation of American Hospitals, the Hospital and Healthsystem Association of Pennsylvania, and the New Jersey Hospital Association respectfully request that the Court grant their motion for leave to file a brief as *amici curiae.* A proposed order is being submitted with this motion.

Dated: October 22, 2019

Respectfully submitted,

/s/ William B. Schultz

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CERTIFICATE OF SERVICE

This is to certify, this twenty-second day of October 2019, that a true and correct copy of the foregoing document was filed electronically via the CM/ECF system. All counsel of record are registered CM/ECF users and service will be accomplished by the CM/ECF system.

/s/William B. Schultz
William B. Schultz

EXHIBIT A

No. 18-1693

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

UNITED STATES OF AMERICA EX REL. J. WILLIAM BOOKWALTER, III, M.D., ROBERT J. SCLABASSI, M.D., AND ANNA MITINA,

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On appeal from the United States District Court for the Western District of Pennsylvania No. 2:12-cv-145, Judge Cathy Bissoon

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BRIEF OF AMICI CURIAE AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, FEDERATION OF AMERICAN HOSPITALS, HOSPITAL AND HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA AND NEW JERSEY HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and Third Circuit Local Appellate Rule 26.1, *amici curiae* American Hospital Association, Association of American Medical Colleges, Federation of American Hospitals, Hospital and Healthsystem Association of Pennsylvania and New Jersey Hospital Association, each state that they have no parent corporations and that no publicly held corporation owns 10% or more of any of their stock.

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IDENTITY AND INTERESTS OF *AMICI CURIAE*[1]

The identity and interests of the *amici curiae* are described in the Motion seeking leave to file this brief.

INTRODUCTION

In his concurrence, Judge Ambro sounded an alarm as to the impact of the panel's opinion, declaring that the majority "send[s] signals to hospitals throughout the Third Circuit, and the nation, that their routine business practices are somehow shady or suspicious and could leave them vulnerable to significant litigation, with all the trouble and expense that brings." Concurring Op. at 2. Productivity-based compensation is not just "routine" hospital practice – it is a nearly *ubiquitous* feature of how hospitals pay doctors. Relying on the panel's decision, a *qui tam* relator can proceed to costly and protracted discovery by alleging nothing more than that a hospital uses this standard compensation model. Unless overturned, the panel's decision may force hospitals to adopt fundamental changes to their compensation practices at significant cost and loss of productivity. In any event, the decision will require hospitals to incur tremendous costs defending against an onslaught of Stark Law litigation.

[1] Defendants/Appellees consented to the filing of this brief. Plaintiffs/Appellants take no position. Pursuant to Fed. R. App. P. 29(a)(4)(E), amici certify that: no party's counsel authored this brief in whole or in part; no party or party's counsel contributed money to fund preparing or submitting the brief; and no person–other than the amici, their members, and their counsel–contributed money to fund preparing or submitting the brief.

The panel decision has already begun to reverberate through the hospital community.[2] Hospitals are being forced to reexamine methods of compensating doctors that the Centers for Medicare & Medicaid Services ("CMS") has *repeatedly endorsed*, including just three weeks ago. This appeal "involves a question of exceptional importance" that warrants rehearing *en banc*. Fed. R. App. P. 35(a)(2).

BACKGROUND

The Ethics in Patient Referrals Act, 42 U.S.C. § 1395nn, commonly known as "the Stark Law" or "Stark," is intended to prohibit physician referrals motivated by a financial interest. *United States ex rel. Kosenske v. Carlisle HMA, Inc.*, 554 F.3d 88, 95 (3d Cir. 2009). Stark prohibits a doctor's referral to an entity "if [the] physician (or an immediate family member of such physician) has a financial relationship with [the] entity." 42 U.S.C. § 1395nn(a)(1). One such financial relationship – an "indirect compensation arrangement" – exists if "[t]he referring physician (or immediate family member) receives aggregate compensation . . . that

[2] *See, e.g.*, Shannon K. DeBra & Elizabeth A Kastner, *Recent Stark Act Decision Could Have Significant Impact for Employed Physicians Compensated Based on Personal Productivity*, (Oct. 7, 2019), https://www.bricker.com/insights-resources/publications/recent-stark-act-decision-could-have-significant-impact-for-employed-physicians-compensated-based-on-personal-productivity; Stephen A. Jonas, *et al.*, *Common Physician Compensation Arrangement May Face Increased Scrutiny Under Stark Law*, (Sept. 24, 2019), https://www.wilmerhale.com/en/insights/client-alerts/20190920-common-physician-compensation-arrangement-may-face-increased-scrutiny-under-stark-law.

varies with, or takes into account, the volume or value of referrals or other business generated by the referring physician." 42 C.F.R. § 411.354(c)(2)(ii). Importantly, Stark also contains numerous statutory and regulatory exceptions that describe circumstances – such as "bona fide employment relationships" and "personal service arrangements" – that "shall not be considered to be a compensation arrangement" within the meaning of the Stark's referral prohibition. 42 U.S.C. § 1395nn(e).

Nothing in Stark prevents a hospital from paying bonuses to doctors that it employs, directly or indirectly, based on the volume of the doctors' personally performed services. That is clear from the law, regulations, and guidance. The statutory exception for "bona fide employment" expressly endorses "the payment of remuneration in the form of a productivity bonus based on services performed personally by the physician." 42 U.S.C. § 1395nn(e)(2). CMS regulations provide that the statutorily prohibited referrals do "not includ[e] any designated health service personally performed or provided by the referring physician." 42 C.F.R. § 411.351. As CMS has emphasized in guidance, "all physicians, whether employees, independent contractors, or academic medical center physicians, can be paid productivity bonuses based on work they personally perform." *Medicare Program; Physicians' Referrals to Health Care Entities with Which They Have Financial Relationships (Phase II)*, 69 Fed. Reg. 16,054, 16,067 (Mar. 26, 2004).

Just three weeks ago, in a proposed rule, CMS resoundingly echoed its longstanding endorsement of productivity bonuses:

> [F]or clarity, we reaffirm the position we took in the [2004] regulation. With respect to employed physicians, *a productivity bonus will not take into account the volume or value of the physician's referrals solely because corresponding hospital services . . . are billed each time the employed physician personally performs a service*. . . . [U]nder a personal service arrangement, an entity may compensate a physician for his or her personally performed services using a unit-based compensation formula—*even when the entity bills designated health services that correspond to such personally performed services*—and the compensation will not take into account the volume or value of the physician's referrals if the compensation meets the conditions of the special rule at § 411.354(d)(2).

Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 84 Fed. Reg. 55,766, 55,795 (Oct. 17, 2019) (emphasis added). The proposed rule would also delete the "varies with" language from the definition of an indirect compensation arrangement. *See id.* at 55,841-42; *see also supra* at 2-3 (describing current 42 C.F.R. § 411.354(c)(2)). The message from CMS could not be clearer: Stark permits a hospital to pay a unit-based productivity bonus for a doctor's personally performed services, and no issues arise "solely because corresponding health services . . . are billed each time the employed physician personally performs a service." 84 Fed. Reg. at 55,795.

Notwithstanding this clear guidance from CMS and in Stark itself, the panel concluded that a *qui tam* relator can plead a Stark violation merely by alleging that doctors were paid a productivity bonus for their personally performed services, and

that services by the doctors generally resulted in corresponding services that the hospital billed to Medicare.

The panel arrived at that jarring result by adopting an over-simplified view of what must be alleged at the pleadings stage in order to make out a claim. According to the panel, "the relators have pleaded that the doctors' pay correlated with the value of their Medicare referrals," and "a correlation suggests that hospitals are rewarding doctors for referrals." Majority Op. at 21, 25. Under the panel's approach, a relator can adequately plead such a correlation simply by alleging that a hospital compensated its doctors based on their own personal work (for example, number of surgeries) and that the doctors' personal work resulted in hospital charges (for example, an inpatient charge for room and board), for which the hospital billed Medicare. *See id.* at 23-25. As Judge Ambro's concurrence points out, this will *necessarily* be the case whenever a hospital compensates a doctor for his or her own labor. Concurring Op. at 11. The upshot of this decision is that any hospital is presumptively in violation of Stark, and is susceptible to incurring the overwhelming expenses that come with defending Stark lawsuits, if it compensates doctors based on the volume of their own work.

It is entirely commonplace, and indeed encouraged by federal regulators, for hospitals to compensate doctors based on their productivity. The panel has cast a

shadow of suspicion on these standard compensation arrangements, sending shockwaves through the hospital community.

ARGUMENT

I. It Is Overwhelmingly Common for Hospitals to Compensate Doctors That They Employ Based on the Doctors' Personal Productivity.

In his concurring opinion, Judge Ambro wrote that, under the logic of the majority opinion, "I cannot see why most of the top hospitals in the country, many of whom likely employ similar compensation schemes to UPMC's, would not be vulnerable to a Stark lawsuit that could survive a motion to dismiss and proceed to discovery." Concurring Op. at 11-12. Judge Ambro was right to be concerned: many hospitals *do* employ compensation models similar to UPMC's.

Surveys have documented that an overwhelming majority of doctors are compensated, at least in part, based on their productivity, and that the most common productivity metric is work relative value units ("wRVUs"), the metric used by UPMC. One example is the annual survey by the American Medical Group Association ("AMGA"), which is a "widely-used source of market data" in this area. Second Am. Compl. ¶ 120. For AMGA's 2017 annual survey, 83% of respondents reported the use of wRVUs as a determinant of compensation.[3] For

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[3] Wayne M. Hartley *et al.*, *Value-Based Care's Impact on Physician Compensation: Pay Increases in Primary Care Amid Stalling Productivity Levels Across Specialties,* Group Practice Journal at 13–14 (Sept. 2017), http://www.amga.org/wcm/SM/660812.pdf.

AMGA's 2019 annual survey, the number was 79%.[4] Similarly, a 2019 study by a nationally recognized physician search and recruiting firm found that 70% of physician recruitment searches offered some form of productivity bonus as an incentive.[5]

Entities that employ physicians are overwhelmingly likely to compensate them based on the quantity of work that they perform. Hospitals have increasingly used wRVUs as a metric for compensation to *comply* with Stark. Tying compensation to wRVUs – a fixed performance metric that does not reflect collections – is viewed in the industry as a safe alternative to the collections-based bonuses at issue in *United States ex rel. Drakeford v. Tuomey*, 792 F.3d 364 (4th Cir. 2015).

One reason that these compensation structures have proliferated is that hospitals have relied on CMS's guidance that they are permissible. *See supra* at 3-4. Given this track record of CMS approval, it is especially problematic that the panel held that a relator can plead a *knowing* Stark violation, as is necessary to

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[4] Christopher Cheney, *AMGA: Physician Compensation Rose Significantly in 2018*, HealthLeaders Media at 2 (Aug. 30, 2019), https://www.healthleadersmedia.com/clinical-care/amga-physician-compensation-rose-significantly-2018.

[5] Merritt Hawkins, *2019 Review of Physician and Advanced Practitioner Recruiting Incentives* at 11 (2019), https://www.merritthawkins.com/uploadedFiles/merritthawkins_2019_incentivereview.pdf.

support liability under the False Claims Act, *see* 31 U.S.C. § 3729(a)(1), based on nothing more than the payment of productivity bonuses.

If the panel decision is permitted to stand, then any hospital that pays doctors based on their own productivity risks a Stark lawsuit. This is because, as Judge Ambro's opinion points out, "the majority makes clear that *any* compensation based on a physician's own labor, in its view, 'necessarily' varies with referrals." Concurring Op. at 11. In other words, the panel's decision casts a cloud of suspicion on a standard feature of doctor compensation that has met with CMS approval. This alone raises a question of exceptional importance that merits *en banc* review.

II. The Panel's Decision Is Likely to Result in Hospitals Having to Divert Substantial Resources from Serving Their Patients.

The panel opinion dramatically lowers the barrier to bringing Stark claims that can survive a motion to dismiss. All a relator needs to do is point to productivity bonuses, allege that a physician's own work generally entails ancillary services billed to Medicare, and *voila*: the hospital is under suspicion of violating Stark .[6]

[6] As the panel opinion points out (Op. at 39), the Justice Department is empowered to dismiss *qui tam* suits. But as the memorandum that the panel cites acknowledges, "[dismissal] of cases may be rare . . . because . . . the government typically will investigate a *qui tam* action only to the point where it concludes that a declination [regarding intervention] is warranted." Michael D. Granston, United

Defending a Stark lawsuit can be an overwhelmingly long and costly endeavor.[7] And the risks associated with pursuing such litigation to the finish line can be extreme: "The combination of the Stark Law and the [False Claims Act] often yields astronomical exposure for the defendants (recoupment, plus treble damages, attorneys' fees and civil penalties of [$10,781 to $21,563] per claim)."[8] For both of these reasons, the pressure on hospitals to settle Stark claims that survive a motion to dismiss – even meritless ones – is overwhelming. Prospective relators and the *qui tam* bar know this.

To avoid the substantial and costly litigation that the majority opinion has facilitated, hospitals may need to fundamentally restructure how they hire and pay doctors. As Judge Ambro suggested in his concurring opinion, "the only way to evade suspicion altogether, short of abandoning the widespread practice of hospitals employing their own doctors . . . , would be to pay those doctors a flat annual salary." Concurring Op. at 12. The panel opinion will result in a massive

States Dep't of Justice, Memorandum: Factors for Evaluating Dismissal Pursuant to 31 U.S.C. 3730(c)(2)(A) at 4 (Jan. 10, 2018).

[7] For example, the parties in *Tuomey* anticipated needing 50 depositions per side, not including experts, with the United States (which had intervened) reserving the right to seek up to 75. Discovery Plan, *United States ex rel. Drakeford v. Tuomey*, Case No. 3:05-cv-02858-MBS, ECF No. 110 at 2 (July 3, 2008).

[8] American Health Lawyers' Association, *A Public Policy Discussion: Taking the Measure of the Stark Law*, at 16 (2009), https://www.healthlawyers.org/hlresources/PI/ConvenerSessions/Documents/Stark%20White%20Paper.pdf. The penalties range was adjusted for inflation in 2016. *Civil Monetary Penalties Inflation Adjustment*, 81 Fed. Reg. 42,491, 42, 494 (June 30, 2016).

and costly disruption in hospital employment of doctors at a time when CMS is affirmatively trying to "remove potential regulatory barriers to care coordination and value-based care" rooted in the fact that "the consequences of noncompliance with [Stark] are so dire." 84 Fed. Reg. at 55,768.

III. Rule 9(b) Requires That the Relators Specifically Identify How UPMC's Compensation Violates the Stark Law.

The panel did not adequately adhere to its obligation to prevent the sort of indiscriminate and crippling Stark litigation that the majority opinion licenses. Under Federal Rule of Civil Procedure 9(b), a *qui tam* relator must do more than merely allege facts that make it plausible that the defendant is liable. The relator must also allege "with particularity the circumstances constituting fraud." Fed. R. Civ. P. 9(b).

Understanding that Stark's referral prohibition implicates huge swaths of financial relationships that were not problematic, Congress authorized CMS to issues regulations identifying exceptions that would set boundaries to potential exposure. 42 U.S.C. § 1395nn(b)(4) (providing that the referral prohibition "shall not apply . . . [i]n the case of any . . . financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse"). For any hospital that directly or indirectly employs doctors, compliance efforts are overwhelmingly focused on the exceptions, not the referral prohibition itself. It is essentially meaningless to accuse a hospital of knowingly violating the

Stark Act simply by virtue of employing doctors through a direct or indirect compensation arrangement without also considering whether the hospital qualified for one of the Stark exceptions.

To plead a Stark violation with particularity, as Rule 9(b) requires, a relator must plead that a hospital *knew* it violated Stark, including its exceptions. Thus, a relator must allege how a compensation arrangement violates the Stark Act, for example by alleging that specific aspects of a hospital's compensation package incentivized doctors to make referrals. If courts do not allow consideration of the exceptions at the pleading stage, hospitals that use standard and innocuous compensation agreements will be drawn into needless and costly litigation.

CONCLUSION

It cannot be correct that a relator can obtain discovery on a Stark claim by alleging nothing more than that a hospital compensates doctors based on their own work productivity. Whether the solution lies in a more careful reading of the "varies with or takes into account" standard, in a more searching application of the pleading requirements of Rule 9(b), or in a re-examination of the rule that the burden of pleading and proving Stark exceptions lies with the defendant, the *en*

banc Court should review the panel's decision in order to consider a ruling that would avoid the havoc that the majority opinion will otherwise wreak.

Dated: October 22, 2019

Respectfully submitted,

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CERTIFICATE OF BAR MEMBERSHIP

Pursuant to Local R. 28.3(d) and Local R. 46.1(e), I certify that I, William B. Schultz, am admitted as an attorney and counselor of the United States Court of Appeals for the Third Circuit.

Dated: October 22, 2019

/s/William B. Schultz

William B. Schultz

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(g), I certify the following:

1. This brief complies with the type-volume limitations of Fed. R. App. P. 29(b)(4) because it contains 2600 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f) and Local R. 29.1(b), according to the count of Microsoft Word.

2. This brief complies with the typeface and style requirements of Fed. R. App. P. 32(a)(5) and 32(a)(6) because it has been prepared in Microsoft Word using 14-point Times New Roman font.

3. This brief complies with the electronic filing requirements of Local R. 31.1(c) because the text of the electronic brief is identical to the text of the paper copies and because Cylance was run on the file containing the electronic version of this brief and no viruses were detected.

Dated: October 22, 2019

/s/William B. Schultz

William B. Schultz

CERTIFICATE OF SERVICE

This is to certify, this twenty-second day of October 2019, that a true and correct copy of the foregoing document was filed electronically via the CM/ECF system. All counsel of record are registered CM/ECF users and service will be accomplished by the CM/ECF system.

/s/William B. Schultz
William B. Schultz

No. 18-1693

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

UNITED STATES OF AMERICA EX REL. J. WILLIAM BOOKWALTER, III, M.D., ROBERT J. SCLABASSI, M.D., AND ANNA MITINA,

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Defendants-Appellees.

On appeal from the United States District Court for the Western District of Pennsylvania
No. 2:12-cv-145, Judge Cathy Bissoon

[PROPOSED] ORDER

Upon consideration of the Motion of the American Hospital Association, the Association of American Medical Colleges, the Federation of American Hospitals, the Hospital and Healthsystem Association of Pennsylvania and the New Jersey Hospital Association for leave to file an *amicus curiae* brief in the above-captioned case in support of Defendants-Appellees' Petition for Rehearing or Rehearing En Banc, it is hereby

ORDERED that said motion is granted.

Dated: October ___, 2019 ____________________________