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Valuation Firms at Center of False Claims Act Lawsuit

On January 6, 2020, the *U.S. Department of Justice* (DOJ) intervened in a whistleblower *False Claims Act* (FCA) lawsuit premised on violations of the *Stark Law*.[1] Indianapolis-based *Community Health Network* (CHN), an integrated healthcare system,[2] is alleged to have violated the Stark Law by participating in above *fair market value* (FMV) compensation structures that were partly established on the referrals that the physicians made to the hospital system.[3] The complaint places at the focal point of the alleged violations of the Stark Law (and subsequent FCA violations) the involved valuation firms' statements to CHN, valuation techniques, and professional opinions to CHN.[4] This *Health Capital Topics* article will review CHN's allegedly illegal compensation arrangements with its specialists and its incentive compensation structure, as well as the role of the valuation firms in the fact pattern set forth by the government.

The Stark Law governs those physicians (or their immediate family members) who have a financial relationship (i.e., an ownership investment interest or a compensation arrangement) with an entity, and prohibits those individuals from making Medicare referrals to those entities for the provision of *designated health services* (DHS).[5] Notably, the law contains a large number of exceptions, which describe ownership interests, compensation arrangements, and forms of remuneration to which the Stark Law does not apply.[6] Most of these exceptions require in part that compensation not exceed FMV.[7] In litigation, these exceptions often function as an affirmative defense(s) for the defendant.

Significantly, a violation of the Stark Law can trigger a violation of the FCA.[8] FCA imposes liability on any person who *knowingly* submits a false or fraudulent claim or uses false records to induce payment from the U.S. government.[9] The FCA also allows for private individual whistleblowers, called *qui tam relators*, to enforce FCA violations.[10] The government may seek to intervene in FCA *qui tam* cases.[11]

CHN is accused of recruiting and then paying breast surgeons, cardiovascular specialists, and neurosurgeons sizeable compensation amounts that often exceeded FMV.[12] The compensation amounts were intended to facilitate the integration of these providers into CHN's health network.[13] The complaint claims that the salaries provided to physicians were significantly higher than what the physicians were previously receiving when they operated as private practices;[14] for example, the complaint asserts that CHN employment compensation arrangements "*essentially doubled the salaries of all cardiovascular specialists*."[15]

The complaint places valuation firms at the forefront of the fact pattern. Upper-level management at CHN allegedly knew of the high compensation levels and was instructed to utilize professional valuation firms to obtain justification for the payment amounts.[16] CHN is accused of having "*shopped around*" for favorable valuation opinions and then allegedly provided false information to the selected valuation firms in order to induce a favorable FMV opinion.[17] However, according to the complaint, the valuation firms routinely communicated to CHN that the majority of the compensation structures were far above FMV (describing the compensation structures as "*staggering*" and "*astounding*").[18]

The complaint purports that compensation and integration strategies were intended to prevent the "*leakage*" of referrals from physicians to competing hospitals.[19] One such example is CHN's 2009 breast cancer surgeon integration.[20] The complaint states that the integration was premised and financed from breast surgeon referrals for ancillary services.[21] The complaint quotes an internal document from CHN explaining that the compensation structure of the breast cancer surgeons would be partially based on the "*reimbursement differential*," i.e., the difference between what Medicare would pay the physicians for an ancillary service (such as imaging and radiation oncology) and what Medicare would pay the hospital.[22] In other words, the "*reimbursement differential*" is alleged to have been used to "*fund the integration and pay the physicians their salaries*."[23]

In describing the breast cancer surgeon integration, the complaint details the FMV analysis process.[24] The complaint quotes the valuation report in forming the basis of its allegations relating to the integration.[25] The valuation firm found the proposed physician compensation to be at the 97th percentile of industry market data, in the 84th percentile based on *work relative value units* (wRVUs), and in the 56th percentile based on a per collections ratio.[26] Ultimately, the valuation firm could only find CHN's proposed compensation to be reasonable for a one-year period.[27] Importantly, the FMV opinion was predicated on data provided to the valuation

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firm by CHN,[28] which data the complaint alleges was intentionally erroneous and contained ancillary and technical services, in addition to the personally performed professional services.[29]

The complaint asserts other violations of Stark Law, such as CHN's 2009 integration of cardiovascular specialists.[30] CHN allegedly paid 34 specialists at the 90th percentile of national industry market data.[31] The complaint directly quotes an internal communication between CHN's CFO and CEO purporting the central role that the cardiovascular testing referrals would play in "*funding the venture.*"[32] The internal communications paint the picture that CHN strongly considered (and based the compensation amounts on) the volume and value of the cardiovascular physicians' referrals when designing and implementing their compensation structures.[33] In fact, the 10% higher compensation rate for the cardiologists (over the vascular surgeons) is alleged to be based on the higher "*outpatient technical net revenues*," according to quoted internal documents. [34]

Similar to the breast surgeon integration transaction, the complaint looked to the role of the valuation firms in this cardiovascular integration. Quoting internal emails, the complaint asserts that the CHN upper-level management specifically avoided certain valuation firms due to their perceived "*conservative*" valuation methodology, which might have resulted in an unfavorable opinion for CHN.[35] Valuation firm selection, according to internal emails quoted, appears to have been made on the basis of the firm's perceived leniency with a willingness to state that higher compensation amounts were FMV and whether they "*appear[ed] to have physician eligibility requirements for purposes of a physician qualifying for the 90th percentile*."[36] CHN allegedly engaged a valuation firm for a preliminary opinion on the basis of the valuation firm's perceived leniency, but apparently did not receive the opinion they sought.[37]

CHN then allegedly engaged a second valuation firm in hopes of receiving a favorable opinion; however, the second valuation firm stated in their draft analysis that "*This [compensation program] is well beyond any professional standard that [the valuation firm] would use for this assessment.*"[38] According to the second firm's valuation report, the compensation for at least 27 of the 34 cardiovascular specialists exceeded FMV under the firm's "*traditional analysis*."[39] However, the valuation report noted that the compensation may still be warranted on the basis of "*more lenient*" criteria, i.e., (1) satisfaction of certain "*business judgment factors*"[40] and (2) meeting certain (slightly higher) industry normative benchmark thresholds.[41] The valuation firm admitted that such criteria were "*outside the generally accepted standards*" and were to be applied only "*on an exception basis.*"[42] However, 23 of the 34 cardiovascular specialists still did not satisfy these additional, exceptional benchmark thresholds; therefore, the valuation firm did not analyze the "*business judgment factors*" of those proposed compensation arrangements.[43] The valuation opinion stated that "*the majority of the cardiologists and for all of the cardiovascular surgeons do not meet the criteria...as [a] measure of...FMV*."[44] Nevertheless, CHN's compensation committee allegedly approved the compensation plan despite (1) not receiving a favorable FMV opinion and (2) the stated concerns of the CHN Board of Directors that the salaries were excessive.[45]

Four years later, supposedly due to the concern from CHN's upper-level management regarding the high compensation levels, a third valuation firm was engaged to conduct a physician benchmarking analysis, which analysis found that the cardiovascular specialists' compensation was high and CHN was "*paying the physicians more per wRVU than what is being collected*."[46]

In addition to each of the compensation arrangements with specific specialists, the complaint asserts (on a more general level) that the incentive compensation structure of CHN was in violation of the Stark Law.[47] Part of the incentive compensation was allegedly conditioned on "*hospital downstream revenue specific to the physician*."[48] The complaint alleges that by "*conditioning incentive compensation on the physicians meeting a target of revenues from their referrals to CHN*," the incentive compensation structure took "*into account the volume or value of their referrals*."[49] Based on this presumption, the complaint asserts that the incentive compensation structure violated the Stark Law.[50]

The allegations, if true, represent a clear pattern of compensation agreements being structured in accordance with "*downstream referrals*." The prominent role of valuation firms throughout the complaint exemplifies the important part that valuation firms play in ensuring compliance with federal and state fraud and abuse laws. Since the 2015 *Tuomey* case,[51] there has been increased pressure on healthcare organizations to justify their compensation arrangements according to FMV, a fact acknowledged by CHN according to the complaint.[52] The DOJ's complaint illustrates the importance of the documentation surrounding proposed compensation arrangements – not just the board minutes discussing the arrangements, and the valuation opinions submitted for the organization's consideration, but also the communications related to this documentation, which can be utilized to prove knowledge and scienter[53] by whistleblowers. Additionally, valuation firms must acknowledge the possibility that their reports and client communications may be used in litigation, while still maintaining the candidness and professionalism necessary for effective engagements and safeguarding the valuation professional's compliance with industry standards to reduce regulatory risk.

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1 "U.S. ex rel. Fischer v. Community Health Network, Inc., et al." Case No. 1:14-cv-1215 (S.D. Ind. January 6, 2020), United States' Complaint in Intervention, p. 1. Note that the government only intervened in part, and not in all of the allegations made by the whistleblower. "United States files False Claims Act complaint against Community Health Network" U.S. Department of Justice, January 7, 2020, https://www.justice.gov/usao-sdin/pr/united-states-files-false-claims-act-complaint-against-community-health-network (Accessed 1/13/20).
2 "About Community Health Network" Community Health Network, 2020, https://www.ecommunity.com/about (Accessed 1/14/20).
3 United States' Complaint in Intervention, p. 1.
4 *Ibid*, p. 15-30, 36-44, 46-54, 67.
5 "Limitation on Certain Physician Referrals" 42 U.S.C. § 1395nn(a).
6 "Limitation on Certain Physician Referrals" 42 U.S.C. § 1395nn.
7 *See* "Exceptions to the referral prohibition related to compensation arrangements" 42 C.F.R. § 411.357.
8 "False Claims" 31 U.S.C. § 3729.
9 *Ibid.*
10 "Civil actions for false claims" 31 U.S.C. § 3730.
11 *Ibid.*
12 Because the allegations regarding the neurosurgeons' compensation is so similar to those of the other specialists, this article will not discuss those arrangements. United States' Complaint in Intervention, p. 25-26.
13 United States' Complaint in Intervention, p. 17-20, 31-35, 51-53.
14 *Ibid*, p. 14.
15 *Ibid.*
16 *Ibid*, p. 15.
17 *Ibid*, p. 16.
18 *Ibid*, p. 15-16.
19 *Ibid*, p. 18.
20 "*Ibid*, p. 17-31.
21 *Ibid*, p. 18.
22 There is a reimbursement differential for certain ancillary services because hospitals receive a higher reimbursement compared to physician practices for those services. "*Ibid*, p. 19.
23 This is significant because the Stark Law prohibits compensating hospital-based physicians for the referral of patients to ancillary services (e.g., diagnostic imaging), save for the personally performed professional component (if applicable). *Ibid*, p. 20.
24 *Ibid*, p. 25.
25 *Ibid.*
26 *Ibid*, p. 25-26.
27 *Ibid*, p. 25-27.
28 *Ibid*, p. 28.
29 *Ibid.*
30 *Ibid*, p. 33.
31 *Ibid.*
32 *Ibid*, p. 34.
33 *Ibid*, p. 35.
34 *Ibid.*
35 *Ibid*, p. 37.
36 *Ibid.*
37 *Ibid*, p. 39.
38 *Ibid*, p. 40.
39 This "traditional analysis," which is described more fully in the complaint, consisted of the following considerations: (1) total cash compensation (TCC) not in excess of the 75th percentile; and, (2) TCC per wRVU not in excess of the 60th percentile. *Ibid*, p. 41-42.
40 Such factors included: strategic importance of service line, community need, clinical outcomes achieved, financial performance of service line, recruitment or retention difficulties, individual accomplishments, leadership/business skills, grant dollars received, name recognition, individual training, historical compensation, offer letters from competitors, temporary compensation during physician shortages, and exceptional work effort. *Ibid*, p. 42-43.
41 These benchmark conditions (both of which had to be met) were: (1) TCC exceeding "the 75th percentile of the market, and clinical cash compensation to productivity ratios...between the 60th...and the 75th percentile of the market, particularly if based on wRVUS [sic], **and** non-clinical hourly pay rates...do not exceed the 75th percentile"; and, (2) "Total compensation exceeds the 7th percentile of the market due to benefit levels that are between the 50th...and the 75th percentile of the market." *Ibid*, p. 41-42.
42 *Ibid*, p. 42.
43 *Ibid*, p. 43.
44 *Ibid*, p. 44.
45 *Ibid*, p. 44-45.
46 *Ibid*, p. 48. This threshold is sometimes termed the "*Tuomey cap*." United States ex rel. Drakeford v. Tuomey Healthcare System, Inc, 92 F.3d 364 (4th Cir. 2015).
47 *Ibid*, p. 61-62.
48 *Ibid*, p. 62.
49 *Ibid*, p. 63.
50 *Ibid.*
51 United States ex rel. Drakeford v. Tuomey Healthcare System, Inc, 92 F.3d 364 (4th Cir. 2015). The government successfully alleged that the healthcare system had physician compensation agreements in excess of FMV, which resulted in a large payout by the hospital.
52 United States' Complaint in Intervention, p. 49.
53 Scienter is a legal term of art defined as "a mental state in fraud (as securities fraud) that is characterized by an intent to deceive, manipulate, or defraud." "Scienter" Merriam-Webster, https://www.merriam-webster.com/legal/scienter (Accessed 1/23/20).

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