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DOJ Announces Record-Breaking FCA Settlement

On December 19, 2023, the U.S. Department of Justice (DOJ) announced that it had entered into a $345 million settlement with Community Health Network Inc. (CHN), a healthcare network headquartered in Indianapolis, to resolve claims that the hospital violated the False Claims Act (FCA) by knowingly submitting Medicare claims for services which were referred in violation of the Stark Law.[1] This settlement is notable in part because it is the largest Stark-related FCA settlement ever reached by the DOJ.[2] This Health Capital Topics article reviews the allegations underlying the case and settlement.

The Stark Law prohibits physicians from referring Medicare patients to entities with which the physicians or their family members have a financial relationship for the provision of designated health services (DHS).[3] Further, when a prohibited referral occurs, entities may not bill for services resulting from the prohibited referral.[4] Under the Stark Law, DHS include, but are not limited to, the following:

(1) Inpatient and outpatient hospital services;
(2) Radiology and certain other imaging services;
(3) Radiation therapy services and supplies;
(4) Certain therapy services, such as physical therapy;
(5) Durable medical equipment; and,
(6) Outpatient prescription drugs.[5]

Civil penalties under the Stark Law include overpayment or refund obligations, a potential civil monetary penalty of $15,000 for each service, or up to $100,000 per arrangement or scheme, and exclusion from Medicare and Medicaid programs.[6] Further, violation of the Stark Law can trigger a violation of the False Claims Act (FCA).[7] The FCA prohibits any person from knowingly submitting, or causing to submit, false claims to the government.[8] FCA violators are liable for treble damages (i.e., "three times the government damages"), as well as for a penalty linked to inflation.[9] Not only does the FCA give the U.S. government the ability to pursue fraud, it also enables private citizens to file suit on behalf of the federal government through what is known as a "*qui tam*," "*whistleblower*," or "*relator*" suit.[10]

CHN is a nonprofit healthcare system comprised of ten acute care and rehabilitation hospitals, as well as over 200 sites of care and affiliates throughout Central Indiana.[11] In fiscal year 2022, CHN reported total gains and revenues of $3.1 billion, but $182 million in net asset decreases.[12]

The government's complaint alleged that, starting in 2008 and 2009, senior management at CHN recruited and employed physicians for the illegal purpose of capturing their lucrative downstream referrals.[13] The organization recruited hundreds of specialists, including neurosurgeons, cardiovascular specialists, and breast surgeons, by offering (and ultimately paying) salaries that were "magnitudes higher" – often double – what the specialists earned in private practice.[14] CHN's physician compensation plans included three components: base, retention, and incentive compensation.[15] For each specialty, CHN calculated a "hospital reimbursement differential" (based on each physician's historical utilization and referrals), which calculated the difference between the (lower) Medicare reimbursement the physicians received in private practice and the (higher) amount that CHN would be reimbursed if the physicians furnished those same services in the hospital.[16] This "reimbursement differential" was then allegedly used by CHN to fund the excessive specialist salaries.[17]

The government cited documentation that CHN was aware of the Stark Law's requirements that employed physician compensation must be fair market value and cannot take into account the volume or value of referrals.[18] CHN engaged a valuation firm to analyze the salaries CHN intended to pay their physicians, and the firm repeatedly made it clear that the compensation needed to be within fair market value.[19] The firm stated that "compensation needed to be less than the 75th percentile of national benchmark salary data or the compensation per productivity (measured by physician work units or collections) needed to be less than the 60th percentile of national benchmark salary data," in order to be within the range of fair market value.[20] CHN also allegedly provided the valuation firm with false compensation figures in order to induce the firm to render a favorable valuation opinion.[21] The government also alleged that CHN "valuation shopped," i.e., sought multiple different valuation opinions in an effort to support the proposed salaries.[22]

In addition to excessive base compensation, CHN also allegedly paid physicians incentive compensation in the form of financial performance bonuses, based on the physicians reaching target referrals to CHN's network.[23] The incentive compensation had three components: service line financial performance, physician-driven metrics, and network financial performance.[24] The

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physician-driven component represented 50% of the incentive compensation, and the network financial performance and service line performance each accounted for 25%.[25] CHN allegedly awarded the service line financial performance portion of the incentive payment based on meeting targeted revenues, which were generated by the physician's referrals to the hospital.[26] As a result, during the term of their employment agreements, physicians made DHS referrals to CHN, e.g., referrals for outpatient and inpatient hospital services.[27] By conditioning incentive compensation on meeting certain revenue targets based on referrals to CHN and their affiliates and subsidiaries, CHN took into account the value or volume of referrals in determining physician compensation, in direct violation of the Stark Law.[28]

Pursuant to the settlement agreement, CHN must pay the federal government a settlement amount of $345 million, $167 million of which is restitution, plus interest at a rate of 4.75% per annum.[29] Additionally, CHN entered into a five-year corporate integrity agreement (CIA) with the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG), which requires, among other items: (1) an independent review organization (IRO) to perform reviews of both arrangements and fee-for-service claims; and (2) a compliance expert to review the effectiveness of CHN's compliance program each year and report to the Board of Directors of CHN.[30] The compliance expert's reports must be reviewed by the Board and submitted to the OIG.[31] Notably, it is unusual for the OIG to require IROs for both arrangement reviews and claims reviews; it is also uncommon for the OIG to require a compliance expert be retained.[32]

Although the case was recently settled, the investigation into CHN began in 2014, after a whistleblower complaint was filed by the nonprofit's former chief operating officer and chief financial officer.[33] The complaint was investigated by the Federal Bureau of Investigation (FBI) and the OIG.[34]

Principal Deputy Assistant Attorney General Brian Boynton stated in the settlement announcement that "the Stark Law was enacted to ensure that the clinical judgment of physicians is not corrupted by improper financial incentives."[35] Boynton also said that the "recovery demonstrates the department's resolve to protect the integrity of federal healthcare programs and to safeguard the taxpayer dollars used to support these important programs."[36]

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1 "Indiana Health Network Agrees to Pay $345 Million to Settle Alleged False Claims Act Violations" Department of Justice, December 19, 2023, https://www.justice.gov/opa/pr/indiana-health-network-agrees-pay-345-million-settle-alleged-false-claims-act-violations (Accessed 1/3/24).
2 "In Biggest Stark-Based FCA Settlement Ever, Indiana Hospital Pays $345M, Has Unusual CIA" Cosmos, January 8, 2024, https://compliancecosmos.org/biggest-stark-based-fca-settlement-ever-indiana-hospital-pays-345m-has-unusual-cia?authkey=397b654b5ad1def15af0c61ff1eddbf256e768772d89d5ec9b0e8bdc4d298a82&_zs=esOUL1&_zl=ovXK7 (Accessed 1/19/24).
3 "CRS Report for Congress: Medicare: Physician Self-Referral ("Stark I and II")" By Jennifer O'Sullivan, Congressional Research Service, The Library of Congress, July 27, 2004, available at: http://www.policyarchive.org/handle/10207/bitstreams/2137.pdf (Accessed 1/3/24); "Limitation on certain physician referrals" 42 U.S.C. § 1395nn.
4 42 U.S.C. § 1395nn(a)(1)(A).
5 42 U.S.C. § 1395nn(a)(1)(B); "Definitions" 42 C.F.R. § 411.351 (2015). Note the distinction in 42 C.F.R. § 411.351 regarding what services are included as DHS: "Except as otherwise noted in this subpart, the term 'designated health services' or DHS means only DHS payable, in whole or in part, by Medicare. DHS do not include services that are reimbursed by Medicare as part of a composite rate (for example, SNF Part A payments or ASC services identified at §416.164(a)), except to the extent that services listed in paragraphs (1)(i) through (1)(x) of this definition are themselves payable through a composite rate (for example, all services provided as home health services or inpatient and outpatient hospital services are DHS)."
6 42 U.S.C. § 1395nn(g).
7 "Comparison of the Anti-Kickback Statute and Stark Law" Health Care Fraud Prevention and Enforcement Action Team (HEAT) Office of Inspector General (OIG), https://oig.hhs.gov/documents/provider-compliance-training/939/StarkandAKSChartHandout508.pdf (Accessed 1/3/24).
8 "The False Claims Act" U.S. Department of Justice, February 2, 2022, https://www.justice.gov/civil/false-claims-act (Accessed 1/3/24).
9 *Ibid.*
10 *Ibid.*
11 "Community Health Network pays $345M to settle illegal referral scheme allegations" By Dave Muoio, Fierce Healthcare, December 19, 2023, https://www.fiercehealthcare.com/regulatory/community-health-network-pays-345m-settle-illegal-referral-scheme-allegations (Accessed 1/3/24).
12 *Ibid.*
13 "United States' Complaint In Intervention" Department of Justice, January 6, 2020, https://www.justice.gov/opa/media/1329616/dl?inline (Accessed 1/3/24), ¶ 51.
14 *Ibid*.
15 *Ibid*, ¶ 293-296.
16 *Ibid*, ¶ 52.
17 *Ibid*.
18 *Ibid*, ¶ 53.
19 *Ibid*.
20 *Ibid.*
21 *Ibid.*
22 *See* "United States' Complaint In Intervention" Department of Justice, January 6, 2020, https://www.justice.gov/opa/media/1329616/dl?inline (Accessed 1/3/24), ¶¶ 54, 159-162.
23 Department of Justice, January 6, 2020, https://www.justice.gov/opa/media/1329616/dl?inline (Accessed 1/3/24), ¶ 55.
24 *Ibid*, ¶ 293-296.
25 *Ibid*, ¶ 293-296.
26 *Ibid*, ¶ 302-304.
27 *Ibid*.
28 *Ibid*.
29 "Settlement Agreement" Department of Justice, December 18, 2023, https://www.justice.gov/opa/media/1329621/dl?inline (Accessed 1/15/24), ¶ 5, 12.
30 "Corporate Integrity Agreement between the Office of Inspector General of the Department of Health and Human Services and Community Health Network, Inc." available at: https://oig.hhs.gov/fraud/cia/agreements/Community_Health_Network_12182023.pdf (Accessed 1/19/24).
31 *Ibid*.
32 Cosmos, January 8, 2024.
33 Muoio, Fierce Healthcare, December 19, 2023.
34 *Ibid*.
35 *Ibid.*
36 *Ibid*.

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Mr. Zigrang is the co-author of "*The Adviser's Guide to Healthcare - 2nd Edition*" [AICPA - 2015], numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Guide to Valuing Physician Compensation and Healthcare Service Arrangements* (BVR/AHLA); *The Accountant's Business Manual* (AICPA); V*aluing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies; Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Society of Appraisers (ASA); the National Association of Certified Valuators and Analysts (NACVA); the American Health Lawyers Association (AHLA); the American Bar Association (ABA); the Association of International Certified Professional Accountants (AICPA); the Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

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