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INSIDE

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$50 Million Stark Settlement Shows Risk of Violation, Whistleblowers

The recent $50 million settlement by a West Virginia hospital shows the danger of violating or skating on the edge of federal laws regarding kickbacks. It also shows the vulnerability of healthcare organizations to current and former employees who are willing to allege wrongdoing to get a piece of the recovered funds.

The Department of Justice (DOJ) alleged that from 2007 to 2020, under the direction of its prior management, the hospital systematically violated the Stark Law and Anti-Kickback Statute (AKS) by "knowingly and willfully paying improper compensation to referring physicians that was based on the volume or value of the physicians' referrals or was above fair market value."

> THE CASE IS YET ANOTHER REMINDER TO HOSPITALS OF THE IMPORTANCE OF STRUCTURING PHYSICIAN COMPENSATION ARRANGEMENTS IN A MANNER THAT IS CONSISTENT WITH FAIR MARKET VALUE.

A former executive vice president filed a whistleblower complaint in 2017 under the qui tam provisions of the False Claims Act (FCA), which allow individuals to bring a lawsuit on behalf of the government and share in the proceeds. The employee had expressed concerns about the arrangement and then was fired for not cooperating with it, according to the DOJ. The whistleblower will receive $10 million of the $50 million settlement.

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This settlement is among the pantheon of recent significant settlements with hospitals concerning alleged FCA violations predicated on violations of the Stark law and the AKS, says **Travis Lloyd**, JD, partner with Bradley in Nashville, TN. It reflects the government's continued emphasis on combatting healthcare fraud. It is yet another reminder to hospitals of the importance of structuring physician compensation arrangements in a manner that is consistent with fair market value and does not take into account, directly or indirectly, the volume or value of physician referrals, he says.

The alleged misconduct in this case is fairly straightforward, Lloyd explains. Among other things, the hospital allegedly paid physicians far in excess of fair market value and tied incentive compensation to the net revenue attributable to physicians, including technical fees billed by the hospital in connection with the physicians' services.

Two features of the settlement stand out to Lloyd. First, the hospital was not required to enter into a corporate integrity agreement in connection with the settlement — a difference from prior settlements concerning similar allegations. This likely reflects the fact that a new operator took over the management of the hospital shortly after the government intervened in the case, he says.

"The case also is remarkable for the fact that the defendant hospital filed a countersuit against the relator, a former executive vice president of the hospital, in which it alleged that the relator breached his fiduciary duty to the hospital by not reporting and attempting to prevent the misconduct in the qui tam action," he says.

The hospital dropped that suit shortly after filing it in 2019.

Hospital Should Have Known

The most surprising thing about the case is that it happened at all, says **Ericka L. Adler**, JD, shareholder with Roetzel & Andress in Chicago. There is a wealth of past cases and instructions from regulators regarding this type of fraud allegation, she says.

The case might not have been a surprise if it occurred 10 years ago when the rules were not quite as clearly defined, she explains, but now there is no excuse for now for the kind of arrangement alleged by the DOJ.

Adler often is involved with contracts in which entities are negotiating similar arrangements. She says they always rely on compliance language to ensure they meet the legal requirements for fair market value. When Adler negotiates physician contracts, she finds the hospital

EXECUTIVE SUMMARY

A hospital's $50 million settlement over kickback allegations holds lessons for hospitals. The hospital allegedly paid physicians for more than fair market value.

- A healthcare appraisal firm should determine fair market value.
- A physician compensation committee is an essential part of oversight.
- Billing errors and omissions insurance are available.

usually is quite rigid about following valuations. Even if she thinks the valuation is too long, the hospitals often are so risk-averse they usually will not yield.

"If one party doesn't like it, too bad, because the hospital is not going to take the risk of noncompliance. The fact that this happens tells me it involved people who didn't think they were going to get caught and that everyone was on the same page about it being a good deal for both sides," she says. "The doctors were happy and getting a lot of money, fairly greedy. I found it kind of shocking because I thought everyone knew that this was not acceptable, not likely something they would get away with, and there have been so many other identical situations where people got in trouble."

The case also illustrates the danger of whistleblowers, Adler says. The days of hiding shenanigans by threatening or firing employees who have the dirt on the company are long gone.

"No matter how small or big you are, where you are located geographically, how loyal you think your people are, you're likely going to get caught," Adler says. "They assumed their team was on the same page and ignored any complaints or concerns, thinking they won't be the ones to get caught."

Adler notes the physicians in this case were operating at a loss, yet still commanded extraordinarily high compensation from the hospital. That suggests an arrangement that would go beyond any fair market value compensation, she says.

"There are gray areas because fair market value is not an exact number, but this seemed egregious, that there was no reasonable way people would think this was going to pass the smell test," Adler says. "This wasn't offering them just a little bit above fair market value and you can say that's not a big deal."

Physicians may not be intimately familiar with Stark and AKS, and will readily accept a very high compensation, Adler notes.

"I talk about that with my clients. Almost every time, it's like they're hearing about it for the very first time, especially with the younger doctors," Adler says. "If an offer that is obviously unreasonable comes through, I put the blame on the compliance people in the hospital because they are the ones who should be aware of this. In this case, I'm shocked the doctors' lawyers didn't say something and tell them it was too good to be true."

"NO MATTER HOW SMALL OR BIG YOU ARE, WHERE YOU ARE LOCATED GEOGRAPHICALLY, HOW LOYAL YOU THINK YOUR PEOPLE ARE, YOU'RE LIKELY GOING TO GET CAUGHT."

The allegation about the hospital firing the executive vice president for questioning the compensation program was especially concerning. "If the whistleblower's allegations are to be believed, they did just about everything wrong here," Adler says.

In many cases, the hospital gambles on the fact that many employees who could file a qui tam lawsuit will not do so because of the potential risk to reputation and loss of employment.

"I think that's common, and some employers count on it. Employees who have knowledge of wrongdoing look at the potential payoff, and that can be huge, but they also look at what might happen if it goes nowhere and they've ruined their careers," Adler says. "In this case, you had someone who followed through."

The determination of fair market value compensation is key to this case. It appears the hospital did not follow accepted procedures, says **Rob Fuller**, JD, partner with Nelson Hardiman in Los Angeles.

Fair market value is a safe harbor against kickback allegations, Fuller explains. There is some wiggle room when determining that value.

The hospital can test the wind as to what fair market value is, but cannot be so far out as to pay double or triple the market rate. "If you paid them 120%, no one would be upset; that would just be super-high market value. You can't go way beyond that and plead ignorance, because there are plenty of resources for both nationwide and regional standards," Fuller says. "They were pretty callous and just figured they would never get caught. A hospital administrator in this day and age is not unaware of the Anti-Kickback Statute and the personal services safe harbor."

Informed Employees Can Blow Whistle

Part of what makes the FCA so dangerous is lawsuits can be brought by anyone with information about the arrangement, notes **Scott Bennett**, JD, an attorney with Coppersmith Brockelman in Phoenix.

"Many False Claims lawsuits have been brought by insiders, including hospital executives, compliance officers, and even in-house attorneys.

This case highlights the need for hospitals to not just have compliance programs on paper, but to put them into practice," he says. "There should be mechanisms in place to make sure that people are comfortable reporting potential legal violations, and that the hospital thoroughly investigates and responds to all concerns — even if those concerns relate to physicians who generate a lot of business for the hospital."

There were allegations that an internal hospital memo stated the hospital's physician practices were operating at a loss because of the high salaries paid to physicians. The DOJ has taken the position that a hospital losing money on a physician practice indicates the compensation is more than fair market value, Bennett says. Although that is debatable as a legal matter, he says, hospitals should take a hard look at any arrangement where they are losing money on physicians to ensure the arrangement complies with the Stark Law and AKS.

"The best way for hospitals to ensure that the compensation they are paying physicians is legally compliant is to get a fair market value opinion regarding the compensation from a healthcare appraisal firm," Bennett says. "Hospitals should also do their own ballpark comparison of physicians' compensation to benchmarks such as MGMA surveys of physician compensation."

Assign Responsibility for Oversight

Hospital systems avoid overpaying physicians by assigning responsibility for oversight of physician compensation and by following well-defined processes for setting and approving each compensation arrangement, says **Keith A. Smith**, JD, an attorney with Moore & Van Allen in Charlotte, NC. Specifically, Smith says a hospital system should use a physician compensation governance structure, a written compensation policy succinctly documenting the system's compensation philosophy, objectives, and robust internal controls.

"Optimal governance structure includes a physician compensation committee, with physician and nonphysician members who do not have management responsibility for running the physician practices, operating under a charter and with authority delegated by the hospital system board," Smith says. "The compensation committee should be charged with approving the standard physician compensation arrangements and any variations from those established standards."

The hospital system's corporate compliance team should regularly review and audit the physician compensation program's internal controls, which include rules, policies, and procedures for determining fair market value, commercial reasonableness, and when to engage external compensation experts, Smith says.

Health systems mitigate the risk of physician compensation arrangements running afoul of fraud and abuse laws by establishing a physician compensation governance structure, a compensation philosophy, and internal controls. "Using these formal structures, a health system sets clear lines of responsibility and accountability for maintaining a compliant physician compensation program," Smith advises.

Risky Game to Play

The payment of excessive compensation to patient referral sources is risky, says **Geoffrey R. Kaiser**, JD, partner with Rivkin Radler in Uniondale, NY. Stark prohibits a physician from referring patients for certain categories of "designated health services" (such as laboratory testing or imaging services) to any entity with which the referring physician has a prohibited financial relationship. The AKS prohibits the payment of anything of value for the purpose of inducing the referral of patients for the provision of any item or service reimbursable under a federal healthcare program.

Stark is a civil law and a strict liability statute under which knowledge and intent are not relevant to liability, Kaiser explains. The AKS is a criminal statute under which the prohibited activity must be knowing and willful to trigger liability. Both statutes include certain exceptions for qualifying arrangements with employees and independent contractors.

"However, under Stark, all of these exceptions require that the financial relationships be commercially reasonable and fair market value without taking into account the volume or value of referrals. Under the AKS, the same requirements apply to personal services arrangements with independent contractors," he says.

To be protected under the AKS employee safe harbor, the compensation paid must be for employment in the furnishing of items or services reimbursable under a federal healthcare program. While the safe harbor does not reference fair market value or commercial reasonableness, paying employees for their referrals would be viewed with suspicion by many courts, Kaiser says.

"In short, a hospital may not pay excessive compensation to its physicians as an incentive for patient

referrals without risking liability under these laws," he says.

Complicated Web of Laws

This case emphasizes the healthcare business is much more complicated that what happens at the bedside, says **Rochelle Sweetman**, JD, risk management consultant with Marsh & McLennan Agency in Sioux Falls, SD. Healthcare providers, physician groups, facilities, and systems, as well as drug and device manufacturers, laboratories, and insurers are governed by a complicated web of federal, state, and local regulations, she notes.

From the federal perspective, Stark, the AKS, and the FCA provide frameworks for the DOJ to bring enforcement actions against healthcare entities, Sweetman says. In 2019 alone, the DOJ recovered more than $2.6 billion in healthcare fraud claims. For the last 10 years, recoveries from the healthcare industry have exceeded $2 billion each year, she notes.

Sweetman notes defending cases brought by the government can be extremely expensive. In addition to the potential for refunding any overpayments, healthcare entities incur expenses from defense attorneys, as well as forensic accounting and audit expenses. Most significantly, they may be subject to civil fines and penalties imposed by the government, which often seeks exemplary damages in multiples of the alleged amount of fraudulent payments, she says.

Billing Insurance Available

An important lesson from this case is the commercial availability of billing errors and omissions (E&O) insurance, Sweetman says. Healthcare entities may find some billing E&O coverage in their directors' and officers' policies, but often the amount of available coverage is limited. In light of the demand for such coverage, insurers have developed standalone billing E&O policies.

"These policies can help cover the legal expenses to defend an allegation of billing impropriety, as well as associated fines and penalties, although not disgorgement — the return of payments improperly received," she says. "In addition, coverage may be available for the expenses of voluntarily disclosing billing issues to the government prior to any government action. Some billing E&O policies also cover claims brought by commercial payers, further helping healthcare entities protect their balance sheet from fraudulent billing claims." ■

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