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Brief Review of Healthcare Fraud and Abuse Prosecutions

In the first installment of this three part Health Capital Topics Series, the framework of current healthcare fraud and abuse laws, namely: (1) the Anti-Kickback Statute ("AKS"); (2) the Stark Law ("Stark"); and, (3) the False Claims Act ("FCA"), as well as, the regulatory thresholds of *Fair Market Value ("FMV")* and *Commercial Reasonableness ("CR"),* were discussed within the current era of healthcare reform in the U.S. The second installment of this three-part series will examine three of the more notable Stark violations prosecuted by the federal government.

Initially, the Department of Justice ("DOJ") and the Office of the Inspector General ("OIG") seemed to only prosecuted clear violations of Stark and AKS, and the laws' accompanying exceptions, through bringing suit against entities that reimbursed physicians in rampant excess of *FMV*. In the first lawsuit in this series, *United States ex rel. Richard Rauh v. McLeod Regional Medical Center of the Pee Dee* ("McLeod"), Richard Rauh, a *qui tam whistleblower* and former head of McLeod's physician services program, filed a lawsuit alleging that McLeod, a non-profit hospital in South Carolina, violated Stark and AKS when McLeod overpaid for physician practices and for subsequent employment agreements with the physicians throughout 1996 and 1997, evidencing an intent to induce and maintain a referral relationship.[1] McLeod had a financial relationship with the physicians of the practices that it purchased; subsequent to physician employment, the physicians made referrals to McLeod, and McLeod allegedly billed Medicare for the referred services provided. Therefore, McLeod needed to prove that its arrangement with the physicians satisfied a Stark exception, which required that McLeod pay *FMV* during its transactions. This overpayment, *i.e.*, payment in excess of *FMV*, violated any applicable Stark exception, as well as AKS's prohibition against paying in excess of *FMV* for physician practices.[2] Accordingly, McLeod settled the lawsuit with the government and Rauh for $15.9 million, which, at the time, represented the largest false claims action ever awarded in South Carolina.[3] The lawsuit, represented a relatively straight-forward analysis of the AKS, Stark, and the FCA, *i.e.*, McLeod simply overpaid for the physician practices it acquired.

In 1999, six months after the relators filed their complaint in the McLeod case, a second, similar lawsuit was filed. In this second lawsuit, *United States ex rel. Kaczmarczyk et al. v. SCCI Health Services Corp. et al.*, six former employees of SCCI Hospital Ventures, Inc. brought a *qui tam* action against: (1) SCCI Health Services Corp. ("SCCI Corporate"), a Texas-based parent corporation that owns and operates 13 long term acute care hospitals throughout the United States; (2) SCCI Hospital Ventures, Inc. ("SCCI Houston"), a 40-bed long term acute care hospital located in Houston, Texas, and subsidiary of SCCI Corporate; and, (3) physicians practicing at SCCI Houston.[4] The relators' complaint alleged that the defendants engaged in: (1) false billings for non-allowable costs, falsely-inflated costs, and costs not incurred in violation of the FCA; (2) false billings incident to Stark violations; and, (3) retaliation and wrongful discharge.[5] The government decided to only intervene in the relators' Stark violations claim,[6] and contended that SCCI Houston participated in prohibited compensation arrangements with three physicians that were disguised as legitimate medical directorships, which induced those physicians to refer patients to SCCI Houston.[7] Specifically, the government alleged that SCCI Houston entered into medical directorships contracts with those three doctors in order to secure referrals, and that the doctors were paid stipends ranging from $1,500 to $5,000 for their relatively negligible work as medical directors, in violation of Stark and the FCA, as well as other common law claims.[8]

In response, SCCI Houston filed a motion to dismiss the government's complaint, and alleged that its directorship agreements with the three physicians satisfied Stark's *personal services* exception.[9] Among other things, this *personal service arrangement* exception requires that "*the compensation to be paid over the term of the arrangement…does not exceed fair market value…*" and the contracted services do not exceed "*those that are reasonable and necessary for the legitimate business purposes of the arrangement.*"[10] The Court denied SCCI Houston's motion to dismiss the government's complaint on procedural grounds, and the lawsuit proceeded to the discovery stage.[11]

In response to SCCI Houston's allegation that their medical directorships satisfied Stark's *personal service arrangements* exception, the government retained an expert to perform a *FMV* and *CR* analysis of SCCI

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Houston's medical directorship relationships with the three doctors.[12] The expert concluded that the arrangements with the physicians were not *commercially reasonable* because: (1) SCCI Houston was a small hospital that did not require numerous medical directors; (2) the physicians' duties were similar to those performed by active staff members; and, (3) the physicians failed to work their requisite amount of hours per month.[13] Moreover, the expert concluded that the physicians' hourly rate of pay, based upon their monthly stipend and hours actually worked, significantly exceeded *FMV* for doctors of the same specialty.[14] Specifically, the expert found that the physicians' hourly rate of pay exceeded the median rate of pay for physicians of the same specialty by 54%-572%.[15]

Nearly a year and a half after the expert's report, the defendants, relators, and the United States settled the lawsuit, and the action was dismissed.[16] Similar to the McLeod case, this lawsuit represented a fairly straight-forward analysis of the FCA and Stark, *i.e.*, SCCI Houston paid physicians in significant excess of the 90th percentile hourly rates of pay for physicians of the same specialty, and therefore could not qualify for Stark exceptions that require payment consistent with *FMV*.

The third lawsuit, more accurately described as a settlement with the DOJ, occurred in August of 2009. The government alleged that Covenant Medical Center ("Covenant"), a nonprofit hospital in rural Waterloo, Iowa, contracted with physicians and allegedly paid them far in excess of *FMV*, thereby violating Stark.[17] Notably, the five highest paid physicians at Covenant earned at least $600,000, and payments to an orthopedic surgeon and a gastroenterologist allegedly equaled approximately $2 million.[18] In comparison, according to the *2010 Medical Group Management Association's Compensation and Productivity Survey* based on 2009 data, the 90th percentile compensation rates for Midwestern orthopedic surgeons and gastroenterologists were $939,263 and $841,385, respectively.[19] The DOJ noted that the physicians were "*among the highest paid hospital-employed physicians, not just in Iowa, but in the entire U.S.*"[20] Covenant agreed to pay the United States $4.5 million to resolve allegations that it violated Stark and the FCA.[21] Again, the Covenant settlement represents a fairly uncomplicated analysis of Stark and the FCA. Covenant paid its physicians more than double what the highest paid physicians in their specialty and geographic area were paid, and thereby violated Stark's prohibition against compensating physicians in excess of *FMV*.

These foregoing three cases are illustrative of the government's willingness to utilize tools which Congress has provided to combat healthcare fraud and abuse. Notably, the available data from these cases reflects hospital systems paying physicians in excess of the 90th percentile of physicians "*practicing in similar academic settings located in similar environments,*" and, thereby, violating Stark's mandate to compensate physicians consistently with *FMV*. The last article in this series will explore how the DOJ and OIG are subjecting Stark, AKS, and FCA claims to increasing scrutiny, and dramatically lowering the level of payment utilized in establishing *FMV*.

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1 "McLeod Regional Medical Center to Pay U.S. Over $15 Million to Resolve False Claims Act Allegations" Department of Justice, November 1, 2002, http://www.justice.gov/opa/pr/2002/November/02_civ_634.htm (Accessed December 16, 2013); "South Carolina Hospital Pays $15.9 Million to Settle Charges of Submitting False Claims" BNA Health Law Reporter, Vol. 11, No. 44, November 7, 2002.

2 See generally, "Limitations on certain physician referrals" 42 U.S.C. § 1395nn(b)-(e); "General exceptions to the referral prohibition related to both ownership/investment and compensation" 42 C.F.R. § 411.355(a)-(i); "Exceptions to the referral prohibition related to ownership or investment interests" 42 C.F.R. § 411.356(a)-(c); "Exceptions to the referral prohibition related to compensation arrangements" 42 C.F.R. § 411.357(a)-(p); "Hospital/Physician Integration: Three Key Models" by Michael A. Cassidy et al., American Health Lawyers Association, October 2011, p. 24; "OIG Letter to IRS" By D. McCarty Thornton, Office of the Inspector General, December 22, 1992, http://oig.hhs.gov/fraud/docs/safeharborregulations/acquisition122292.htm (Accessed 12/10/13).

3 DOJ, November 1, 2002.

4 "United States ex rel. Darryl Kaczmarczyk et al. v. SCCI Health Services Corp. et al., Second Amended Complaint and Jury Demand," No. 4:99-cv-01031, (S.D.T.X. April 12, 2004), ECF No. 101, pp. 1-3.

5 *Ibid*, pp. 29-31.

6 "United States ex rel. Darryl Kaczmarczyk et al. v. SCCI Health Services Corp. et al., United States' Notice of Election to Intervene in Part and to Decline in Part," No. 4:99-cv-01031, (S.D.T.X. October 2, 2002), ECF No. 38, p. 2.

7 "United States ex rel. Darryl Kaczmarczyk et al. v. SCCI Health Services Corp. et al., United States' Complaint," No. 4:99-cv-01031, (S.D.T.X. March 10, 2003), ECF No. 53, p. 14.

8 *Ibid*, pp. 14-15.

9 "United States ex rel. Darryl Kaczmarczyk et al. v. SCCI Health Services Corp. et al., SCCI Hospital Ventures, Inc.'s Motion to Dismiss The United States' Complaint," No. 4:99-cv-01031, (S.D.T.X. May 9, 2003), ECF No. 60, p. 2.

10 "Limitations on certain physician referrals" 42 U.S.C. § 1395nn(e)(3)(A).

11 "United States ex rel. Darryl Kaczmarczyk et al. v. SCCI Health Services Corp. et al., Memorandum Opinion," No. 4:99-cv-01031, (S.D.T.X. May 9, 2003), ECF No. 99, p. 1.

12 "United States ex rel. Darryl Kaczmarczyk et al. v. SCCI Health Services Corp. et al., Plaintiff United States' Designation of Expert Witness," No. 4:99-cv-01031, (S.D.T.X. July 12, 2005), ECF No. 217, p. 1.

13 *Ibid*, pp. 9-10.

14 *Ibid*, pp. 11-12.

15 *Ibid*.

16 "United States ex rel. Darryl Kaczmarczyk et al. v. SCCI Health Services Corp. et al., Joint Stipulation of Dismissal," No. 4:99-cv-01031, (S.D.T.X. December 19, 2006), ECF No. 276, p. 1

17 "Covenant Pays $4.5 Million to Resolve False Claims Allegations" Department of Justice, August 26, 2009, http://www.justice.gov/opa/pr/2009/August/09-civ-849.html (Accessed 12/16/13).

18 "Covenant Medical Center to Pay U.S. $4.5 Million to Resolve False Claims Act and Stark Law Allegations" by Michael Cassidy, Med Law Blog, September 1, 2009, http://www.medlawblog.com/2009/09/articles/fraud-stark/covenant-medical-center-to-pay-u-s-4-5-million-to-resolve-false-claims-act-and-stark-law-allegations/ (Accessed 12/13/13).

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19 "MGMA Physician Compensation and Productivity Survey: 2010 Report Based on 2009 Data" By Medical Group Management Association, Englewood, CO, MGMA-ACMPE, 2010, pp. 207, 221.

20 "Covenant to Pay Feds $4.5M to settle fraud allegations" WCF Courier, August 25, 2009, http://wcfcourier.com/news/breaking_news/covenant-to-pay-feds-m-to-settle-fraud-allegations/article_f067c049-eec9-5074-97b1-2e3334c13196.html (Accessed 12/16/13).

21 DOJ, August 26, 2009.

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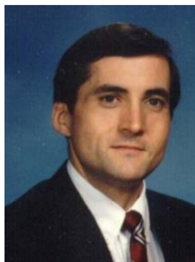

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