CIVIL MONEY PENALTIES: REASONABLE PENALITIES TO COMBAT FRAUD OR A STRAIN ON THE HEALTH CARE COMMUNITY

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INTRODUCTION

Your typical healthcare fraud claim involves gross billing or filing a reimbursement claim for services not rendered.[1] Implemented in response to capacious litigation, federal fraud and abuse laws have raised "a number of analytical and practical challenges for both" health care providers and the legal community at large.[2] Due to this rising frequency of healthcare fraud, millions of dollars are lost annually and the quality of healthcare services has diminished.[3] Recently, the enactment of the Affordable Care Act has been met with great resistance and criticism. However, prior to the enactment of this comprehensive healthcare reform legislation, Congress enacted numerous federal fraud and abuse laws.[4] This laundry list of federal fraud and abuse laws instituted by Congress, include Stark Law, Anti-Kickback Statute, the False Claims Act, Exclusion Statute and Civil Money Penalties Law. In addition to criminal prosecution, various statutes and regulations impose severe fines and penalties. Perhaps the most significant and preferred measure in the battle against healthcare fraud undertaken by Congress is the imposition of Civil Money Penalties, as this deterrent measure is continually evolving.[5]

In order to understand how federal fraud and abuse laws have taken their current form, a brief illustration of the evolution of federal healthcare reimbursement practice and criteria is

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[1] KATHLEEN S. SWENDIMAN & JENNIFER O'SULLIVAN, CONG. RESEARCH SERV., 97-895A, HEALTH CARE FRAUD: A

[2] Robert G. Homchick, *The Federal Fraud and Abuse Laws*, American Health Lawyers Ass'n, Sept. 21, 2000.

[3] Karen Chopra, *Qui Tam – A Whistle Blowers Weapon in the War on Healthcare Fraud*, 4 MICH. ST. U. J. MED. & L. 205, 210 (2000) (discussing qui tam claims).

[4] JENNIFER STAMAN, CONG. RESEARCH SERV., RS22743, HEALTH CARE FRAUD AND ABUSE LAWS AFFECTING MEDICARE AND MEDICAID: AN OVERVIEW 1 (2010).

[5] Sanford V. Teplitzky, *Medicare and Medicaid Fraud and Abuse Issues*, American Health Lawyers Ass'n, Oct. 9, 1997.

essential. Formerly, the criteria for obtaining reimbursements for federal healthcare programs was very seamless and was not armored with the modern-day safeguards that Congress has imposed.[6] Prior to 1983, the reimbursement process functioned under the direct cost reimbursement system.[7] Under the direct cost reimbursement system, a physician or entity was reimbursed the actual dollar amount for the cost of the patient.[8] There was only one prerequisite, which required that the cost for the treatment be reasonable.[9] However, in 1983, Congress made dramatic modifications to curtail the soaring cost of the various federal healthcare programs.[10] The new reimbursement process that made obtaining reimbursements quite cumbersome is referred to as the prospective payment system ("PPS").[11] Under the PPS, a physician or entity is only entitled to reimbursement of a fixed predetermined amount.[12] "This sum is determined by the average cost of treating a patient in a particular Diagnostic-Related Group (DRG), regardless of the Medicare patient's actual cost to the hospital."[13]

To lay the proper foundation for my article and position, I referenced various regulations and statutes above that may be imposed upon any individual or entity found in violation of federal fraud and abuse laws. As such, I will concentrate the remainder of my article on the adverse and crippling impact that civil money penalties have had on Tuomey Healthcare System, Inc.

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[6] Francis J. Hearn, Jr., *Curing the Health Care Industry: Government Response to Medicare Fraud and Abuse*, 5 J. CONTEMP. HEALTH L. & POL'Y 175, 175 (1989) (discussing the governmental legislative measures).

[7] *Id.*

[8] *Id.*

[9] *Id.*

[10] *Id.*

[11] *Id.*

[12] Hearn, *supra* note 6, at 175.

[13] *Id.*

The recent Fourth Circuit case, *United States ex rel., Drakeford v. Tuomey Healthcare System, Inc.*, caught the attention of both the healthcare and legal community. In addition to various facilities, Tuomey Health Care System, Inc. operates a community hospital that serves the small city of Sumter, South Carolina. On May 8, 2013, Tuomey was levied approximately $238 million in fines and penalties for violation of Stark Law and the False Claims Act. The court concluded that an entity violates Stark Law if that entity enters into an exclusive contract arrangement with an outside physician to provide outpatient procedures at its facilities' whereby the physician is compensated with a productivity bonus above market value.[14] The violation stemmed from 21,730 submitted claims "tainted by illegal compensation arrangements."[15]

Although federal fraud and abuse laws target individuals or entities that engage in self-referrals, Tuomey was prosecuted pursuant to Stark Law and the court equated Tuomey's compensation arrangements to self-referrals. Before I express my distaste for the Tuomey decision, I want to emphasize that I am in no way a proponent of an entity or individual found in violation of federal fraud and abuse laws. I must also note that, Tuomey should be penalized for any false claim submission, but this penalty must be reasonable. However, I do not concur with the court on levying excessive civil money penalties upon Tuomey. As a result of slamming Tuomey with such hefty fines, the Sumter community might be out of their only community hospital. This article will discuss the adverse impact and strain that civil money penalties impose on the health care community, as well as outline the various fraud and abuse laws within the Tuomey decision.

[14] Richard Kusserow, *Tuomey Healthcare Systems Found Guilty of Stark Violations*, COMPLIANCE.COM, (May 2013), http://www.compliance.com/tuomey-healthcare-systems-guilty-of-stark-violations.

[15] *Id.*

POLICY JUSTIFICATION FOR FEDERAL FRAUD AND ABUSE LAWS

Emerging regulations enacted by Congress are deterrent in nature and serve as a vehicle to safeguard against Medicare and Medicaid fraud.[16] Consequently, various regulatory measures such as Stark Law have been implemented due to rising litigation.[17] Although met with resistance, Stark Law has had a positive and immediate impact in both the public and private sector.[18] In particular, Stark Law has led to the implementation of corporate compliance programs and has placed restrictions upon physicians in investing in freestanding imaging centers.[19] Conversely, the addition of exceptions and loopholes "have driven the restructuring of the healthcare delivery system and in some cases created either an un-level playing field or unclear boundaries."[20]

The federal government has not enacted numerous federal fraud and abuse laws to simply flex its muscles. Rather, the effective efforts of the federal government impact the health of our economy. The expenses that are incurred in healthcare fraud litigation are funded by taxpayer dollars. The efforts of the federal government to combat healthcare fraud "can help ease budgetary pressures on federal healthcare spending, relieving the cost containment burden that has been imposed in recent years on physician and facility payments."[21]

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[16] Robert Hudock & Patricia Wagner, *Analysis of the HITECH Act's Incentives to Facilitate Adoption of Health Information Technology,* EBGLAW.COM (Apr. 2009), http://www.ebglaw.com/files/28043_ClientAlertHITECH.pdf.

[17] David E. Matyas, *A Public Policy Discussion: Taking the Measure of the Stark Law*, EBGLAW.COM, http://www.ebglaw.com/files/30455_DMatyas.pdf (last visited Jul. 15, 2014).

[18] *Id.*

[19] *Id.*

[20] *Id.*

[21] Cynthia A. Brown, *Complex Rules in Place to Combat Fraud and Abuse*, (Jan. 3, 2014 9:12 PM), http://www.facs.org/ahp/pubs/1fraud0800.pdf.

The most severe of the penalties and sanctions that may be imposed upon an individual or entity is the civil money penalty. Enacted in 1981, Civil Money Penalties ("CMP") Law was instituted to serve as an "administrative adjunct to criminal proceedings as an additional means of sanctioning persons who submit false claims for payment under the Medicare and Medicaid programs."[22] Furthermore, the primary purpose behind CMP Law was to make the federal government whole for out of pocket litigation expenses incurred to investigate and litigate fraudulent submissions.[23]

FRAUD AND ABUSE LAWS

A. "STARK LAW" – PHYSICIAN SELF-REFERRAL LAW

Stark Law prevents a physician or entity from engaging in self-referrals for federal healthcare patients for services to entities with which the physician has a financial relationship or interest.[24] Congressman Pete Stark initiated Stark Law in 1989 in order to establish a bright-line test "to determine whether impermissible conflicts of interest were present in physician arrangements, regardless of the parties' intent."[25] Congressman Stark felt that such a bright-line test would provide "unequivocal guidance" for healthcare providers and serve as a guide to aide healthcare providers in deciphering between what actions were legal and what actions were not.[26]

Accordingly, Congress passed Stark I, the first enactment of the Stark Law, prohibiting physicians from maintaining a financial relationship or interest with any clinical laboratory to

[22] Bernstein v. Sullivan, 914 F.2d 1395, 1397 (10th Cir. 1990).

[23] *Id.*

[24] Jennifer A. Hanson, *The Academic Medical Center Exception to the Stark Law: Compliance by Teaching Hospitals*, 61 ALA. L. REV. 373, 374 (2010) (discussing the AMC exception).

[25] *Id.*

[26] *Id.* at 375.

which their Medicare or Medicaid patients were referred.[27] In an effort to expand Stark I, Congress passed Stark II, which prohibited referrals to any entity with which a physician or immediate family member of the physician had a financial relationship or interest.[28] The "expansive" intent of Congress was evident as any entity included a broad range of "designated health services."[29]

In an effort to deter physicians from maintaining a financial relationship, Congress has enacted various civil penalties and sanctions. Each and every single violation of Stark law carries harsh civil penalties and sanctions.[30] Such civil penalties and sanctions may include: "denial of payment for a designated health service, requiring refunds on a timely basis for certain claims, civil money penalty up to fifteen thousand dollars and exclusion for improper claims, and a civil penalty of up to one hundred thousand dollars and exclusion for circumvention schemes."[31] The fundamental purpose for the implementation of the Stark Law was for it to serve as a payment statute.[32] "The primary sanction is the denial of payment or, if amounts have already been billed and collected, the timely refund of the amounts collected."[33]

B. ANTI-KICKBACK STATUTE

In addition to Stark Law, Congress enacted the Anti-Kickback Statute ("AKS") as an additional safeguard to deter self-referrals among physicians. The Anti-Kickback Statute was enacted by Congress to curtail "certain practices which have long been regarded by professional organizations as unethical ... and which contribute appreciably to the cost of the Medicare and

[27] *Id.*

[28] *Id.*

[29] *Id.*

[30] Hanson, *supra* note 24, at 376.

[31] *Id.*

[32] *Id.*

[33] *Id.*

Medicaid programs."[34] Unlike Stark Law, the Anti-Kickback Statute has a scienter or intent requirement. Under this statute, it is unlawful to "knowingly and willfully offer, pay, solicit, or receive any remuneration to induce referrals of items or services reimbursable by any federal healthcare program."[35] The statute does not limit remuneration to cash.[36] Rather, remuneration may be "direct or indirect, overt or covert, in cash or in kind."[37]

There has been a lack of uniformity among the courts in their interpretation of the Anti-Kickback Statute's intent requirement.[38] The Ninth Circuit instituted a rigid intent standard whereas the Third Circuit instituted a broader interpretation of the intent standard.[39] In *Hanlester Network v. Shalala*, the Ninth Circuit placed the burden on the government to show "that the individual or entity engaged in the prohibited conduct with knowledge that the conduct was illegal and with a specific intent to disobey the law."[40] Conversely, in *United States v. Greber*, the Third Circuit implemented the "one-purpose test."[41] The court concluded that, "If the payments were intended to induce the physician to use [the services], the statute was violated, even if the payments were also intended to compensate for professional services."[42]

Similar to Stark Law, a violation of the Anti-Kickback Statute carries harsh civil penalties and sanctions. In its continued effort to deter self-referrals among physicians, Congress has classified a violation of the Anti-Kickback Statute as a felony punishable up to five years

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[34] David M. Deaton, *What is Safe About the Government's Recent Interpretation of the Anti-Kickback Statute Safe Harbors?. . . and Since When Was Stark an Intent-Based Statute?*, 36 J. HEALTH L. 549, 552 (2004) (discussing safe harbor exceptions).

[35] *Id.*

[36] *Id.*

[37] *Id.*

[38] *Id.*

[39] *Id.*

[40] Hanlester Network v. Shalala, 51 F.3d 1390, 1400 (9th Cir. 1995)

[41] United States v. Greber, 760 F.2d 68, 69 (3d Cir. 1985).

[42] *Id.*

imprisonment and the assessment of a fine up to $25,000.[43] Moreover, an individual or entity in violation of the statute may be assessed civil money penalties or exclusion from participation in the Medicare and Medicaid programs.[44]

C. THE CIVIL FALSE CLAIMS ACT

To date, the most effective means in combating health care fraud is the Civil False Claims Act ("FCA").[45] Enacted in 1863, the FCA was established to combat fraud targeted towards the Union Army.[46] In its present day version, after numerous amendments, the FCA has expanded "beyond its modest military origins to encompass virtually any individual or entity that transacts business with the federal government."[47] A violation under the present day version of the FCA may result in "a civil penalty of $5,500 to $11,000 per claim," plus treble damages.[48] In recent years, health care providers have proven to be the most vulnerable under the act. Due to the high volume of Medicare and Medicaid claims submitted, the statutory penalties can quickly "reach astronomical proportions."[49]

31 U.S.C. §3729(a)(1) of the FCA is the most frequently cited provision against health care providers.[50] This provision imposes liability "when: (1) a defendant presents, or causes to be presented, a claim for payment or approval; (2) the claim is false or fraudulent; and (3) the defendant's acts are undertaken knowingly."[51] The "knowledge" requirement that is explicitly

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[43] *Id.*

[44] *Id.*

[45] Joan H. Krause, *"Promises to Keep": Health Care Providers and the Civil False Claims Act*, 23 Cardozo L. Rev. 1363, 1369 (2002) (discussing the history and purpose of the FCA).

[46] *Id.*

[47] *Id.* at 1369-70.

[48] *Id.* at 1370.

[49] *Id.*

[50] *Id.*

[51] Krause, *supra* note 45, at 1370.

referenced in the provision is not limited to purposeful or intentional ignorance; rather, knowledge also entails recklessness.[52] Unlike the Anti-Kickback Statute which has a scienter requirement, it appears that Congress intended the violation of the FCA as a strict liability offense. This broadens the net of potential violations.

Furthermore, there are additional provisions within the False Claims Act that impose liability upon health care providers.[53] 31 U.S.C. §3729(a)(2), the false records provision, prevents health care providers from knowingly making a false statement or record to obtain payment for a claim.[54] 31 U.S.C. §3729(a)(3) prohibits a healthcare provider from defrauding the government by obtaining a false claim.[55] Moreover, in 1986, the FCA underwent amendments, namely, one amendment, which prohibited reverse false claims.[56] "Reverse false claims, involve the use of false records "to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government."[57]

A unique feature of the FCA is the qui tam provision.[58] The qui tam provision allows a private citizen, or "whistleblower" to file suit on behalf of the government.[59] And this "whistleblower" is incentivized by potentially retaining fifteen to thirty percent of the suit's proceeds.[60] The whistleblower only retains the right to file suit on behalf of the government if

[52] *Id.*

[53] *Id.*

[54] *Id.*

[55] *Id.*

[56] *Id.*

[57] Krause, *supra* note 45, at 1370.

[58] *Id.* at 1371.

[59] *Id.*

[60] *Id.*

the information obtained is from the "original source" and not information that has already been disclosed to the public.[61]

D. EXCLUSION STATUTE

In the event that Medicare or Medicaid fraud occurs, the Office of Inspector General ("OIG") may exclude a physician or entity from participation in any Federal Health Care program.[62] The OIG is an independent body created via statute that serves a regulatory function in overseeing programs instituted by the Department of Justice ("DOJ").[63] The following criminal offenses may prompt exclusion: "(1) Medicare or Medicaid fraud; (2) patient abuse or neglect; (3) felony convictions for other health-care-related fraud, theft, or other financial misconduct; and (4) felony convictions for unlawful manufacture, distribution, prescription, or dispensing of controlled substances."[64] In 1977, Congress narrowly limited exclusion from participation for program-related crimes.[65] However, on May 8, 2013, Congress expanded the offenses that may prompt exclusion.[66] Accordingly, the OIG has been granted wide latitude of discretion on which exclusion may be imposed. For example, other criminal offenses that may lead to exclusion are: misdemeanor convictions that are unrelated to health care fraud, suspension of a health care license, unlawful prescription of a controlled substance, or financial integrity to name a few.[67] Essentially, a physician or entity may provide health care services

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[61] *Id.*

[62] U.S. DEP'T OF HEALTH AND HUMAN SERV., A ROADMAP FOR NEW PHYSICIANS: AVOIDING MEDICARE AND MEDICAID FRAUD AND ABUSE 1, 7 (2012), *available at* http://oig.hhs.gov/compliance/physician-education/roadmap_web_version.pdf.

[63] U.S. Dep't of Justice, http://www.justice.gov/oig/ (last visited Dec. 27, 2013).

[64] U.S. DEP'T OF HEALTH AND HUMAN SERV., *supra* note 62, at 7.

[65] H. Carol Saul, *OIG updates guidance on effect of exclusion from federal health care programs.* LEXOLOGY (Jan. 6, 2014, 9:40 PM), http://www.lexology.com/library/detail.aspx?g=bacfb9cf-8022-426a-a2bd-58132fd6dac5.

[66] *Id.*

[67] U.S. DEP'T OF HEALTH AND HUMAN SERV., *supra* note 62, at 7.

with patients that receive Medicare or Medicaid benefits, but may not file reimbursement claims from the federal government.[68]

E. CIVIL MONEY PENALTIES LAW

The primary purpose for the implementation of Civil Money Penalties Law was to make the government whole for "monies paid on fraudulent submissions and the cost of investigating such fraudulent submissions."[69] By the authority granted under the Social Security Act, the OIG may impose civil money penalties upon physicians or entities that commit health care fraud through the Civil Money Penalties Law ("CMP").[70] Implemented to serve a complementary and deterrent function with other various health care fraud violations, CMPs may be imposed in addition to criminal proceedings against an individual or entity.[71] When initiating CMP Law, Congress' expansive intent is evident, as CMP liability is not limited to physicians or entities.[72] Rather, CMP liability may be imposed on individuals contracting with "excluded individuals or violation of Anti-kickback statutes."[73] Depending upon the degree or nature of the offense, CMPs can reach astronomical numbers.[74] A physician or entity may incur CMPs for knowingly filing a fraudulent or false reimbursement claim, violation of AKS, or violation of Stark Law.[75] Each violation may result in a fine ranging from $10,000 to $50,000. Furthermore, CMP Law confers upon the OIG to a "damage assessment that is three times the claim and a damage

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[68] *Id.*

[69] 42 U.S.C.A. § 1320a–7a (1981).

[70] Madeleine Lovette, *An introduction to the False Claims, Anti-Kickback, Stark, Exclusion, and Civil Monetary Penalty laws*, AM. ACAD. OF ORTHOPAEDIC SURGEONS (Jan. 7, 2014, 6:12 PM), http://www.aaos.org/news/aaosnow/aug11/advocacy3.asp.

[71] HARVEY L. MCCORMICK, MEDICARE AND MEDICAID CLAIMS AND PROCEDURE § 12:38 (4th ed. 2011).

[72] *Id.*

[73] *Id.*

[74] *Id.*

[75] *Id.*

assessment not more than three times the total amount of remuneration offered, paid, solicited, or received under the anti-kickback statutes."[76] Finally, an individual or entity that remains in their prohibited relations, may be assessed a daily fine of $10,000.[77]

UNITED STATES EX REL. DRAKEFORD V. TUOMEY HEALTHCARE SYSTEMS, INC

A. BACKGROUND

Tuomey Hospital ("Tuomey") provides both inpatient and outpatient services in Sumter County, South Carolina.[78] Tuomey does not employ the bulk of physicians that provide services to Tuomey, but rather, specialty physician groups employ these physicians.[79] The event that gave rise to this litigation can be traced back to early 2003.[80] Members of Sumter County's gastroenterology group notified Tuomey that the specialist group would consider performing outpatient surgical procedures in-house, rather than at Tuomey Hospital.[81] After determining that it would potentially lose 9.6 million dollars over a thirteen-year span, Tuomey commenced recruitment of various gastroenterologists and contracted with nineteen specialists in a part-time capacity.[82] The 9.6 million dollar figure was ascertained by an empirical analysis that Tuomey conducted, which revealed that Tuomey would lose 80% of its physicians if those physicians had access to alternate ambulatory surgical centers ("ASC") or outpatient surgery centers ("OCS").[83]

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[76] MCCORMICK, *supra* note 71.
[77] *Id.*
[78] United States ex rel. Drakeford v. Tuomey, 675 F.3d 394, 399 (4th Circuit 2012).
[79] *Id.*
[80] *Id.*
[81] *Id.*
[82] United States ex rel. Drakeford v. Tuomey, 976 F. Supp. 2d 776, 781 (D.S.C. 2013).
[83] *Id.*

Tuomey entered into individual part-time employment contracts with nineteen physicians between January 1, 2005 and November 15, 2006.[84] Each of the nineteen contracts were set for a fixed term of ten years and contained a non-compete clause during the ten year term and two years after the natural termination of the contract.[85] All nineteen contracts consisted of essentially identical terms whereby each of the nineteen physicians were required to perform outpatient procedures exclusively at Tuomey's facilities.[86] Additionally, each contract enabled Tuomey to collect payment from third-party payors performed by the contracting physicians and each physician "expressly reassigned to Tuomey all benefits payable to the physician by third-party payors, including Medicare and Medicaid."[87] In turn, Tuomey would compensate the physicians at an annual base salary "that fluctuated based on Tuomey's net cash collections for the outpatient procedures."[88] To further incentivize the specialists, Tuomey agreed to compensate each physician with a "productivity bonus" which equaled 80 percent of the total collections and an additional incentive bonus up to 7 percent of the "productivity bonus."[89]

Because Tuomey expressly reassigned all benefits payable to the physicians by third-party payors, Tuomey generated two billings for the outpatient procedures performed.[90] There was a "professional component" and a "facility component."[91] The "professional component" consisted of the professional fee for the physicians' services and the "facility component"

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[84] *Id.*

[85] *Id.*

[86] *Id.*

[87] *Id.*

[88] *Drakeford*, 976 F. Supp. 2d at 781.

[89] *Id.*

[90] *Id.*

[91] *Id.*

consisted of the facility fee for the use of Tuomey's OSC, staff, and equipment.[92] Each time one of Tuomey's contracting physicians performed an outpatient procedure pursuant to the terms of the contract, Tuomey submitted reimbursement claims to third-party payors, including Medicare and Medicaid, which included both the "professional component" and the "facility component."[93]

In 2005, whistleblower, Michael K. Drakeford, M.D., initiated a qui tam complaint on behalf of the government against Tuomey Health Care System ("Tuomey") under the False Claims Act.[94] Dr. Drakeford alleged that Tuomey submitted false claims as a result of contracts entered into with their physicians.[95] After the government intervened and amended the complaints, the government alleged that payments made to Tuomey under the Medicare and Medicaid programs were unlawful.[96] The government alleged that these payments violated Stark Law, 42 U.S.C. §1395m, and thus in violation of the False Claims Act, 31 U.S.C. §3729.[97]

B. PROCEDURAL HISTORY

The United States originally filed their complaint on March 5, 2010.[98] After a few weeks of trial and jury deliberation, on March 29, 2010, the jury returned a verdict in favor of the government.[99] The jury found Tuomey in violation of Stark Law but not in violation of the

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[92] *Id.*

[93] *Id.*

[94] On the Bootstraps of Tuomey's Recent $238 Million Hospital Judgment: Court Finds Similar Stark Law Violation in Halifax, , UNGARETTI & HARRIS ATTORNEYS AT LAW (Nov. 20, 2013) (on file with author), *available at* http://www.uhlaw.com/publications-709.html [hereinafter Bootstraps].

[95] *Id.*

[96] *Drakeford*, 976 F. Supp. 2d at 781.

[97] *Id.*

[98] *Id.* at 782.

[99] *Id.*

FCA.[100] Subsequently, both parties filed several post-trial motions and a hearing was set for June 3, 2010.[101] The honorable Matthew J. Perry, Jr. granted a new trial on the issue of the FCA, but found that Tuomey submitted claims in violation of the Stark Law and that the United States was entitled to claims paid to Tuomey in the amount of $44,888.651, plus prejudgment interest.[102]

Consequently, Tuomey appealed the judgment amount of $44,888.651 and with respect to Counts IV and V, argued that its Seventh Amendment right was violated because Judge Perry's judgment was based on the jury's interrogatory answer pertaining to the Stark Law.[103] However, due to Judge Perry's untimely passing, the case was reassigned to the Fourth Circuit.[104] The Fourth Circuit found that Tuomey's was deprived of its right to a trial by jury and remanded the case to the district court.[105]

Following the second jury trial that commenced on April 16, 2013, the jury returned a verdict in favor of the government.[106] The Fourth Circuit found that Tuomey violated Stark Law and violated the FCA by submitting 21,730 false claims totaling $39,313,065.00.[107] In response to this verdict, Tuomey filed five post-trial motions.[108] However, all five counts were denied, as the court cited that each argument was without merit.[109] Ultimately, U.S. District Judge

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[100] *Id.*

[101] *Id.*

[102] Drakeford, 976 F. Supp. 2d at 782.

[103] *Id.*

[104] *Id.*

[105] *Id.*

[106] *Id.* at 783.

[107] *Id.*

[108] Drakeford, 976 F. Supp. 2d at 783.

[109] *Id.* at 790.

Margaret Seymour ruled in favor of the government and imposed $237.5 million in Stark Law penalties and FCA fines on October 1, 2013.[110]

C. KEY ISSUE(S)

i. Whether the facility component of Tuomey's billed facility fee to Medicare for the outpatient procedures performed by Tuomey's contracted physicians, constitutes a "referral" within the meaning of the Stark Law?

In order to address the first issue, the court relied on The Centers for Medicare & Medicaid Services ("CMS") preamble.[111] Per the preamble, "…in the context of inpatient and outpatient hospital services, there would still be a referral of any hospital service, technical component, or facility fee billed by the hospital in connection with the personally performed service."[112] To serve as a guide for its analysis, the court referred to and referenced the agency's interpretation of the Stark Law.[113] Accordingly, the court concluded that the facility component constituted a referral within the meaning of the Stark Law.[114]

ii. Whether Tuomey's contracts fall under the Stark Law's "volume or value" standard, if assuming Tuomey factored the "volume or value of anticipated facility component referrals" when computing their physicians' compensation?[115]

The court once again relied on the CMS preamble when it addressed the second issue.[116] Accordingly, the court determined that compensation arrangements that factor anticipated referrals are in direct violation of the Stark Law's fair market value requirement.[117] Fair market value as defined by Stark Law is, "compensation that 'has not been determined in any manner

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[110] Bootstraps, s*upra* note 94,.

[111] *Id.*

[112] *Id.*

[113] *Id.*

[114] *Id.*

[115] *Id.*

[116] Watterson, *supra* note 111.

[117] *Id.*

that takes into account the volume or value of *anticipated* or actual referrals."'[118] There will always exist a violation, when the physicians' compensation is inflated by the physicians' ability to generate additional revenue for the hospital rather than for the actual services provided.[119]

D. TUOMEY CONCLUSION

The Tuomey decision illustrates the importance of exercising competence and diligence in day-to-day operations. The board that managed Tuomey Healthcare System, Inc. heavily relied on an external expert's document appraisal for review of the physicians' compensation arrangements. Unfortunately, there were several aspects of the compensation arrangements that raised suspicion and subsequently resulted in litigation. Ordinarily, the Department of Justice ("DOJ") is hesitant to challenge and investigate compensation arrangements that are "well documented and supported by expert opinion." Instead, the DOJ will look to the totality of the circumstances.

DISCUSSION

The recent decision of *United States ex rel. Drakeford v. Tuomey Healthcare System, Inc.* has sparked much debate regarding the long-standing custom within the healthcare community, the performance bonus. On October 1, 2013, the Fourth Circuit assessed Tuomey Healthcare System with fines and penalties approximating $238 million. The court found *Tuomey* in violation of Stark Law and the False Claims Act. It is my contention that the fines and penalties assessed to Tuomey are overly punitive.

Traditionally, performance bonuses have been customary between hospitals and physicians within the healthcare community. When viewed on a macroscopic level, performance bonuses just make perfect sense. The sheer volume of patients that physicians' are inundated

[118] *Id.*

[119] *Id.*

with make the performance bonus system highly appealing and beneficial for both the hospital and the physician. However, there have been numerous pieces of legislation passed by Congress that potentially threaten this customary practice with crippling consequences.

The *Tuomey* decision was decided under the guise of the "self-referral" system. As previously stated, I am not a proponent of the actions of Tuomey Healthcare System, Inc.; yet, the magnitude of the punishment is overly punitive. There is no contesting that civil money penalties are levied to send a message to the rest of the world, but are they necessary when legitimate healthcare services are rendered? Despite incentivizing their contracted part-time physicians with productivity bonuses, Tuomey did provide legitimate healthcare services. It would be one thing to file a reimbursement claim for services not rendered, but in the case at hand, Tuomey's physicians actually rendered legitimate services.

The *Tuomey* court relied on The Centers for Medicare & Medicaid Services preamble in their determination that Tuomey's compensation arrangement was in direct violation of Stark Law. Yet, Stark Law does not explicitly speak to such compensation arrangements. Stark Law simply prohibits an individual or entity from engaging in self-referrals for Medicare or Medicaid patients for services when there exists a financial relationship. In other words, a conflict of interest is inevitable for an individual or entity when there is a financial incentive to perform services or to refrain from performing services. The net effect of this can have adverse consequences. The health and well-being of patients may be in jeopardy. However, here the financial incentive for Tuomey's physicians is to treat more members of the Sumter community. How can the contracted physicians have a conflict of interest when their only source of income is Tuomey Healthcare System, Inc.? In a sense, the physicians are not wearing two hats; rather, their loyalty lies solely with Tuomey.

The standard remedy for a Stark Law violation is exclusion from any mandated federal healthcare program, timely return of reimbursed claims, any reimbursements received plus the imposition of civil money penalties of $15,000 per claim. Whereas, the standard course of action for a False Claims Act violation is the imposition of civil money penalties ranging from $5,500 to $11,000 per claim plus treble damages. In sum, the fines levied in violation of a federal fraud and abuse law are exorbitant and add up at a rapid pace. Clearly, the Tuomey opinion suggests that such a compensation arrangement should not be mimicked elsewhere. However, the imposition of such a hefty fine might leave Sumter without a community hospital.

When creating law in the form of an opinion, a court has a duty to consider any collateral impact that such a ruling might have on society at large. I'm not sure if the Tuomey court considered the collateral effect that the Sumter community might potentially endure if such hefty fines were imposed. Pursuant to the court's interpretation of the Stark statute, Tuomey must refund any reimbursements received and must be assessed the requisite fines and penalties per violation. However, it is my contention that the civil money penalty plus treble damages are overly punitive. The legislative intent for instituting civil money penalty law clearly states that such penalties are levied to make the government whole. In 2012, the federal government recovered $4.2 billion in taxpayer dollars from their healthcare fraud enforcement efforts.[120] For each dollar expended toward recovery, the government recovered $7.90, which is over a "50% return on investment."[121] This hardly appears to be in line with Congress' legislative intent to make the federal government whole. To the contrary, the government appears to be made in a better position than whole. If the roles were reversed and a private citizen asked the court to

[120] Christopher J. Shaughnessy, *Annual Report Details Record Breaking Success in Health Care Fraud Prevention*, HEALTH CARE LAW (Dec. 24, 2013 (11:20 AM), http://mcbrayerhealthcare.com/category/health-care-fraud-and-abuse-control-program/.

[121] *Id.*

award damages that placed the private citizen in a better position than "whole," the courts would never allow such remedial action. The court would likely argue that the private citizen would be unjustly enriched. Then, why should the federal government hypocritically circumvent the system and be placed in a better position than whole? This is contrary to the inception and purpose of CMP Law and Tuomey should not be subjected to this injustice.

CONCLUSION

Although the landmark decision of *Tuomey* has some substantive value, the impact of the decision on the Sumter community is crippling. The fines and penalties imposed upon Tuomey are overly punitive. Admittedly, there are a few bad apples that abuse and defraud the government, however, the punitive nature and degree of the penalties are without justification. As iterated above, the Federal fraud and abuse laws were instituted to combat healthcare fraud. However, Civil Money Penalty Law was enacted to make the government whole. Here, the government's judgment against Tuomey is textbook unjust enrichment, as the government is placed disproportionally in a better position had the violations never occurred.

The Tuomey decision has one significant collateral impact; the town of Sumter is in jeopardy of losing a community hospital. For every city or town, regardless of population size, access to healthcare is essential. In essence, if Tuomey is unsuccessful in their settlement effort with the federal government, Sumter's access to their community hospital will be in jeopardy. The members of the Sumter community should not be denied access to quality healthcare simply because a court interpreted Tuomey's compensation arrangements to be self-referrals within the language of a preamble.