Hospital Executives and Physicians Convicted in Kansas City Case

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Practice Area: Health Law

In a case which has dominated the health industry press, a federal jury in Kansas recently convicted two hospital executives and two physicians of criminal violations of the federal anti-kickback law. The Hospital CEO, COO and two physicians face lengthy prison sentences. Two hospital lawyers were also indicted, but charges against them were dismissed during the trial. Sentencing is set for August and the convictions will likely be appealed, but the story of the case accentuates the changing risks in modern healthcare.

Consulting arrangements, "gain-sharing," medical director contracts, and other payment mechanisms to physicians, in the context of intensifying competition for shrinking health care dollars, are becoming more and more commonplace and complex. While the specific arrangements in Kansas City may only be instructive in the extreme, numerous pieces of the story may be reflective of arrangements that are not that uncommon, as well as documentation failures that inevitably occur. In addition, the case highlights lessons that may too often be overlooked.

Lessons to be Learned

The latter part of this article provides more detailed facts and circumstances of the *U.S. v. Anderson, et al*. case as they have been reported in the public media. Below are some lessons the case teaches, which apply to even the most limited of arrangements with a physician:

- **If physicians who admit or refer patients receive value for performing any services, the institution needs to assure that the services are performed, and that the institution pays only fair market value for them.** Documentation must support that physician effort was in fact expended, and that such services were in proportion to the payments. Services involve both time expenditure as well as work product in the form of reports, records, etc. Any connection between payment for services and the reality of admissions or referrals is presumptively problematic.
- **Document, document, document.** A written understanding of service requirements is essential, as well as periodic valuation of whether the services are being performed. Payments based on actual hours worked and documented can be one option.
- **Hospital management and governance should have independent confirmation of the appropriateness of the payment relationship.** A review committee consisting of individuals other than insider directors should conduct an evaluation of arrangements involving payments to physicians. Counsel can review arrangements that raise questions.
- **Do it now.** Longstanding arrangements may garner a sense of legitimacy as time passes, irrespective of the underlying reality. Because a government audit has not yet focused on an arrangement does not make it legal. The longer an arrangement remains in place, the easier it is to rationalize and the harder it is to change.
- **Listen.** Corporate compliance plans should contain provisions to encourage employees at all levels to disclose and discuss suspect or problematic arrangements with the compliance officer. Those who participate in the rumor mills and grapevines of today may be the government witnesses of tomorrow.
- **When in doubt as to whether any arrangement providing something of value paid to a physician might be considered as a payment for referrals, err in favor of terminating it.** Government investigators are strong proponents of the "smell test" in early stages of review. Compliance officers should follow suit.
- **Individuals, not just institutions, can be targets.** In this case, individuals may go to jail.
- **Evidence that an arrangement is legitimate must be available.** After the government completed its case in Anderson, the defendants, in reality, had to prove conclusively the propriety of the arrangement, and apparently did not do so.

The *Anderson* Case

The verdict was the product of a seven-year government investigation. Two physicians, Dr. Robert LaHue and his brother, Dr. Ronald LaHue, ran a practice that provided medical care to thousands of nursing home patients. The charges alleged improper arrangements with Baptist Medical Center, a 315-bed hospital in Kansas City, Missouri, and improper actions by Baptist's former CEO, COO, and a VP. A federal criminal court jury found the two physicians, the CEO and the COO guilty of Medicare fraud. *U.S. v. Anderson, et al.,* No. 98-20030-01/07-JWL, 1999 WL 79656 (D. Kan. Jan. 22, 1999) U.S. District Court, Kansas. Prior to the criminal prosecution of the individuals, Baptist had settled charges against it for $17.5 million, denying allegations of its involvement in the referral scheme.

While the heart of the case were payments under "consulting agreements" between the physicians and the Hospital, other payments were also present. The defense claimed that under these arrangements, Baptist paid both the physicians $75,000 per year for the physicians' consulting and assistance in setting up and running an innovative geriatric care program. The clinic program included a system of transportation that coordinated care prior to admission, which, all in all, was argued to have brought needed care to Medicare patients.

The physicians did also refer Medicare patients to the Hospital. Baptist received nearly $42 million in Medicare reimbursement over the course of the arrangement based on referrals from the two physicians.

The government claimed that the consulting agreements were shams, that the physicians did not perform the services called for by the agreements, and that in fact the payments to the physicians violated anti-kickback laws.

Key Evidence

It is impossible to know the facts on which the jury focused in reaching its decision. Nonetheless, press reports of the evidence include circumstances that merit discussion.

For example, the testimony of a former Baptist executive was likely important to the outcome. He testified that the agreements between the Hospital and the physicians were outright shams, were intended to disguise the kickbacks as consulting fees, that Hospital executives knew that the physicians were not performing the consulting duties, and that Hospital executives were interested only in ensuring the flow of the physicians' referrals. Other testimony reported about the case includes the following:

- The parties determined the amount of consulting fees to be paid before they agreed upon the scope of the services to be provided.
- Most witnesses could not identify any consulting services provided by the physicians.
- A time study in 1992 revealed that the physicians each worked on consulting duties for no more than two hours per week, resulting in compensation of $750 per hour, almost four times the estimated fair market value for physician services.
- Hospital officials who suspected that the physicians were not performing the services called for in the consulting agreements, directed Hospital staff to look into it, but did nothing further.
- A former Hospital CFO testified that he feared the Hospital was violating the anti-kickback laws, but stopped expressing his concerns for fear that it would cost him his job.
- A Hospital VP testified that Hospital executives were deeply concerned about maintaining the physicians' referrals, which they confirmed in dozens of documents shown to the jury.
- The original consulting agreements expired in 1987, but for the next six years the Hospital continued to pay the physicians.

The defendants are likely to appeal. They are reported to be focusing their appeal at least in part on a crucial jury instruction given by the Court to the effect that if the Hospital paid the physicians to induce patient referrals, the anti-kickback laws were violated **even if there were other legitimate purposes for the referrals**. This instruction is called the "onepurpose test" which formed the basis for the conviction of another physician in *U.S. v. Greber*. The *Greber* position has been questioned by experts in the field, but continues to be supported by the government. Given that the case resulted from seven years of investigation and more than eight weeks of trial, other issues on appeal will likely be asserted.

U.S. v. Anderson sends a loud and disquieting message to health care providers. Even though the trial judge noted in his decision dismissing charges against the attorneys for the Hospital that the laws and regulations prohibiting payment for referrals are extremely complex, defendants in this case were convicted. There are many appropriate steps, however, that providers can take to eliminate, if not significantly reduce, the risk of violations. Compliance programs and procedures cannot be merely a current buzz-word or cyclical organizational task. Government review and enforcement is only going to increase in scope as more federal dollars are poured into enforcement agencies. The *Anderson* case most likely will not remain unique.
