Some Important Questions

During a conversation about health care fraud and abuse, a physician that I have known casually for several years related an incredible story. Now in the twilight of his medical career, he reflected back—telling me that he had always tried to run an honest practice and that he had always tried to do the right thing by his patients. But he still seemed miffed—even several years later—about a minor surgical procedure he had performed at a local hospital. This doctor charged his patient $300 for his services. Shortly after the surgery, his patient called him, puzzled about the size of the bill. The doctor was shocked to learn that the hospital had charged his patient an additional $12,000.¹ Although no one could argue that the hospital was entitled to a fee for making its facilities, equipment, supplies, and staff available for the surgical procedure, many of us might wonder whether the hospital deserved to collect forty times the amount paid to the surgeon.

This incident raises three major questions. On what basis did the hospital calculate these charges? Was it taking advantage of a patient or an insurer with deep pockets? If the insurance company paid the claim with no questions asked—and raised the premiums charged to other insured patients—would anyone have even bothered to complain? These questions are at the heart of the large institutional frauds that have arisen over the past two decades.

This chapter and the next focus on frauds instigated by health care institutions, pharmaceutical firms, and equipment manufacturers. Most of these cases have received extensive media coverage and resulted in settlements in the hundreds of millions of dollars.
Profits at Any Cost

Executives at the Tenet Healthcare Corporation, the Hospital Corporation of America, and HealthSouth put profits on a pedestal. A fixation on financial performance—especially the corporation's bottom-line profits and stock market prices—may not only lead to overcharges, false billings, upcoding, and kickbacks, but also to accounting and financial fraud.

Accounting fraud involves the manipulation of accounting documents and journal entries to hide the embezzlement or the misappropriation of funds. The U.S. Securities and Exchange Commission (SEC), for example, accused California-based Medical Capital Holdings of diverting $77 million to administrative fees after telling investors the money would not be used for that purpose. In another case, the CEO of the bankrupt Granada Hills Community Hospital was held personally liable for unpaid federal payroll taxes—monies he allegedly diverted to other uses.

Accounting fraud also forms the foundation for financial fraud. These were the front-page frauds committed by WorldCom, Enron, Tyco, Adelphia, Global Crossing, and Waste Management. Financial fraud occurs when management exaggerates the financial condition of a health care institution, usually for the sake of misleading investors and regulators or for the sake of enabling executives to inflate their stock options. Financial fraud distorts either the corporation's balance sheet (overstating assets and understating liabilities to inflate corporate net worth—as was the case at Enron) or its income statements (overstating revenues and understating expenses to inflate the corporate profits—as was the case at both Enron and WorldCom). Three Cardinal Health executives agreed to pay $245,000 in civil penalties after their accounting legerdemain inflated revenue reports by 30 percent for the 2002 and 2003 fiscal years. The West Penn Allegheny Health System was the subject of a SEC probe after it made a $73 million write-down of revenues. In a few instances, accounting fraud is also used to falsify cash flow—a difficult feat to achieve unless cash is moved secretly from one place to another and counted more than once.

Tenet Healthcare Corporation

The fraud and abuse at Tenet Healthcare Corporation, one of the nation's largest hospital chains, ranks among the most devastating in U.S. health care history. The scandal implicated top-level executives, physicians, and hospital administrators at facilities throughout the United States, caused massive shareholder losses, and brought needless pain and suffering to thousands of patients.

Founded in 1968 as National Medical Enterprises (NME), the company opened hospitals in California and, soon thereafter, began offering stock to the
public. NME employed a simple set of strategies: dominate local markets, raise prices, and slash costs. When implemented with prudence, aggressive revenue-building and cost-controlling strategies can enable a company to sustain a competitive advantage in its industry and earn superior profits. When implemented with carelessness and avarice, as they often were at NME and Tenet, these strategies can precipitate massive frauds.

NME's objective was to build, own, and operate a large collection of profitable hospitals and other health care institutions. In its first decade, the company expanded operations by acquiring acute care hospitals, substance-abuse recovery facilities, nursing homes, and medical-product companies. NME also created an international consulting branch. During the late 1970s, revenues from Medicare and other public programs fueled the growth of investor-owned hospitals nationwide. NME, too, depended heavily on reimbursements from Medicare and Medicaid.

By keeping a sharp eye on changing industry conditions, NME executives were quick to acquire profitable facilities (e.g., substance-abuse centers) and they were equally quick to divest unprofitable ones (e.g., acute-care hospitals and outpatient clinics). The company acquired a number of psychiatric facilities in the early 1980s, providing it with a strong earnings base. The tremendous money-making potential of the psychiatric facilities, however, unmasked NME management's obsession with profits.

In 1991 a lawsuit was brought against NME in Texas, accusing the company of using bounty hunters and psychiatric hotlines to find patients for its facilities. Children admitted to psychiatric hospitals, NME discovered, were especially good sources of income because their insurance coverage often permitted lengthy hospital stays. Doctors who referred patients to NME facilities obtained kickbacks disguised as professional fees. To receive a kickback, a doctor making referrals would appear briefly at a hospital and provide perfunctory care to patients. These services were known factitiously as "howdy rounds" and "wave therapy." 6

As the number of patient and insurance company lawsuits against NME began to mount, the company's CEO and several top executives resigned. NME also found itself a subject of the Clinton administration's crackdown on health care fraud. In August 1993, six hundred FBI and other federal agents raided NME headquarters in Santa Monica, California, as well as eleven of its psychiatric facilities, seizing documents as evidence of criminal activity by the company executives. NME agreed subsequently to a $379 million settlement with the U.S. Department of Justice for paying kickbacks and bribes and for hiring bounty hunters to fill psychiatric hospital beds. Not surprisingly, NME's profits plummeted and its reputation was damaged irreparably. Furthermore, the company faced hundreds of millions of dollars in additional lawsuits and legal expenses, forcing it to divest itself of all
but ten of its eighty-one psychiatric facilities and seventy-three rehabilitation hospitals and clinics. All told, these divestitures generated some $460 million.

After acquiring American Medical Holdings for $3 billion, NME changed its name to Tenet Healthcare Corporation in 1995, hoping the new name would divert attention from its tarnished image. Tenet eventually became the second-largest hospital chain in the United States. Unfortunately, the company’s reincarnation as a law-abiding corporate citizen did not last. In 2002 Tenet again faced seemingly insurmountable legal difficulties after the hospital chain was charged with overbilling Medicare.

Not only did Tenet enrich itself by gouging public insurance programs, it also overcharged patients and their private insurers. A 2003 study revealed that Tenet operated sixty-four of the one hundred most expensive hospitals in the United States—including the fourteen most expensive hospitals. In California, where their prices were especially exorbitant, a patient receiving coronary bypass surgery at a Tenet hospital would pay $93,829 compared to $32,473 for the same surgery at a non-Tenet hospital. Tenet doctors were also accused of putting profits ahead of quality health care as they performed needless heart surgeries on hundreds of patients.

Senator Grassley, the aforementioned leading fighter against health care fraud and chairman of the Senate Committee on Finance, sent a scathing letter to Tenet’s acting CEO, Trevor Fetter, demanding that the company produce an array of documents pertaining to their operations. Senator Grassley’s letter of September 5, 2003, contained the following highlights:

In the annals of corporate fraud, Tenet (formerly National Medical Enterprises (NME)) more than holds its own among the worst corporate wrongdoers. When Mr. Jeffrey Barbakow became president and chief executive of NME in 1993, NME was a scandal-plagued corporation accused of, among other allegations: maintaining a corporate policy at its psychiatric facilities of paying doctors for patient referrals; imprisoning patients for insurance payments; charging insurance companies for treatment and medication that were not provided, provided at grossly inflated prices or provided when unnecessary; and milking insurance until coverage was exhausted. . . . Unfortunately, a change of names did not change the culture of fraud at the corporation. If anything, Tenet’s history of defrauding government healthcare programs reached new heights under Mr. Barbakow. . . . According to the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Tenet did not stay on the straight and narrow and has been the subject of at least 53 federal investigations dating back to the 1994 CIA [corporate integrity agreement], including among others, allegations of cost report fraud, upcoding, overbilling, duplicate billing,
Fraud at Major Hospitals

Kickbacks, providing medically unnecessary services, misrepresenting services, falsifying medical records, billing for services not rendered, providing poor quality of care, and for patient abuse... According to DOJ, many of the allegations took place during the 5-year period Tenet was under a CIA [corporate integrity agreement] with HHS-OIG. DOJ alleged that Tenet falsely certified that it was in compliance with Medicare regulations and the terms of its CIA, when in fact, Tenet knew of a significant number of fraudulent claims that had been submitted and for which Tenet had never, and still has not, made restitution to the Medicare program....Today Tenet is mired in lawsuits that detail horror stories about patient deaths and complications due to unnecessary angioplasties, coronary bypasses, and heart catheterizations at Redding Medical Center (RMC)....No recounting of Tenet's sordid corporate history should fail to note those who have profited most handsomely at Tenet. In 2002, Mr. Barbakow realized over $115 million from stock option exercises, Thomas Mackey (former-chief operating officer) realized over $14 million, and in 2001, Ms. Sulzbach realized $7.25 million from her stock options. Both Mr. Barbakow and Mr. Mackey exercised their options at prices very close to Tenet's all-time high stock value. Unfortunately for Tenet stockholders, in November 2002, Tenet's stock price plummeted on news of the outlier payment scandal and Tenet lost more than $17 billion in market value. Mr. Mackey, who allegedly orchestrated the outlier pricing strategy, is all the richer for Tenet's machinations, while Tenet stockholders are all the poorer....Tenet appears to be a corporation that is ethically and morally bankrupt.8

Tenet received undeserved bad publicity in October 2005 when the Louisiana attorney general announced an investigation into the deaths of twenty-four hospice patients at Tenet's Memorial Medical Center in New Orleans. The hospice was located on the seventh floor of Memorial, and it was operated by LifeCare through a rental agreement with Tenet. In the aftermath of Hurricane Katrina, LifeCare employees abandoned the hospital, leaving Tenet employees to care for the hospice patients. With no means of escape and beset by debilitating heat, a lack of running water, and no sewage service, twenty-four patients—many of whom were already critically ill—perished. Because the morgue was filled to capacity, Tenet employees placed the bodies of hospice patients along with their medical records in the hospital chapel. Unsubstantiated reports later surfaced accusing hospital personnel of ending the lives of some patients to spare them the ordeal of dying slowly in the horrible conditions.9 Tenet had earlier denied culpability for the patients' deaths. A doctor and two nurses were charged with second-degree murder, but a New Orleans grand jury declined to indict the trio.
Other accusations of fraud and abuse continued to plague Tenet between 2002 and 2006. On June 29, 2006, the company—by then headquartered in Dallas—agreed to a settlement of $900 million ($725 million in penalties plus $175 million in forfeited claims) for overbilling Medicare. The agreement at the time was the largest False Claims Act settlement in history, amounting to about one-fourth of Tenet's stock market value. The months of bad publicity and uncertainty preceding the settlement were major reasons for the company's stock price dropping from more than $50 a share in late 2002 to only $7.10 a share on the day of the settlement. (Tenet's stock price subsequently fell even further.) Tenet still faced potentially devastating legal problems for other billing discrepancies and for paying impermissible relocation expenses to physicians.

Of the federal government's $900 million settlement with Tenet, more than $788 million arose from claims regarding the company's receipt of excessive "outlier" payments. These payments are normally made to institutions incurring extraordinary costs for treating severely ill patients. Tenet inflated charges for these patients through a practice known as "turbo-charging." An additional $47 million of the settlement was based on claims that Tenet paid kickbacks to physicians to refer Medicare patients to its facilities. The Department of Justice said Tenet billed Medicare for services ordered by physicians with whom Tenet had an improper financial relationship. Another $46 million of the settlement applied to allegations that Tenet upcoded Medicare claims.

Tenet agreed to pay—in installments—the $725 million plus interest over a period of four years. As noted, the company also agreed to waive its right to receive $175 million in Medicare payments for services already rendered. Tenet also reached an agreement with HHS to enter into a multiyear corporate integrity agreement. The company's board of directors was expected to play a major oversight role to ensure compliance. Tenet was also required to retain an independent review organization to monitor the company's Medicare coding, physician financial relationships, hospital charges, and quality of patient care.

Tenet persevered despite its legal troubles. The company announced plans to divest eleven hospitals and to expand capital investments in its remaining hospitals. By the end of 2009, Tenet had fifty general hospitals and a critical access hospital located in twelve states, mostly in the southeastern United States, Texas, and California, with a total of 13,601 licensed beds and 57,613 employees. During FY 2009, the company had over $9 billion in operating revenues, 128,028 inpatient admissions, and 955,868 million outpatient visits.

Tenet and other private hospitals throughout the United States face many of the same problems. These problems include intense competition among local hospitals, shortages of key personnel, disputes with labor unions, and
pressure to comply with a myriad of federal and state laws. During the 1990s, approximately nine hundred hospital mergers and acquisitions took place. Mergers and acquisitions—at least in theory—promote economies of scale and enable hospitals to reduce wasteful duplicate services in locales served by more than one hospital. Private hospitals and hospital chains, however, continued to battle headwinds that cut into their profits. Hospital occupancy rates declined as fewer invasive surgeries were needed and improved pharmaceuticals enabled patients to receive treatments without an overnight hospital stay. Upgraded public and not-for-profit hospitals diverted patients from the more expensive private hospitals. Some doctors, frustrated by the mountain of insurance and other paperwork, defected and opened their own facilities.14

Tenet’s Security and Exchange Commission Form 10-K for FY 2009 revealed several additional problems plaguing the company, such as uncertainties surrounding health care reform measures and changes in the Medicare and Medicaid programs, vulnerabilities to changes in managed-care arrangements, a high volume of uninsured and underinsured patients, critical shortages of physicians and nurses in certain areas, high amounts of debt, poor financial performance, and unresolved legal issues. The latter included lawsuits by shareholders, litigation over violation of laws on wages and hours, disputes with the IRS, several whistle-blower lawsuits, real property disputes, and malpractice claims. With hospitals located in California and coastal areas, Tenet facilities are vulnerable to natural disasters such as earthquakes, brush fires, and hurricanes. All of these influences squeezed profits and may have encouraged some health care providers to cross the line into fraud and abuse.

By the middle of 2009, Tenet continued to survive by controlling costs and boosting its outpatient businesses, and dealing with bad debts from uninsured patients. “Success” in the minds of Tenet officials seemed to be based on the fact that the corporation’s losses—yes, the ones recorded in red ink—were not as bad as financial analysts had predicted.15

Tenet Healthcare ranks with the likes of Enron and WorldCom in the rogue’s gallery of white-collar crime. The collapse of Enron and WorldCom left investors with stock worth pennies a share. Health care frauds of the scope found at Tenet, however, inflict damage that is even more devastating. Tenet Healthcare endangered the health and life expectancy of trusting patients who placed their well-being in the hands of the company’s executives and health care professionals. According to the Tenet Shareholder Committee, “When the health and legal rights of ill patients are compromised to increase the corporate bottom line, it’s more than just a story about dollars and cents. No amount of money can compensate the victims who unnecessarily lost their lives, or their loved ones who they left behind, grieving and angry.”16
The Hospital Corporation of America

The Hospital Corporation of America was created in 1968 by Dr. Thomas Frist Sr., Dr. Thomas Frist Jr., and Jack Massey in conjunction with the purchase of the Park View Hospital in Nashville. The senior Frist assumed the position of HCA president with Massey—one of the Kentucky Fried Chicken founders—as board chairman. Thomas Frist Jr. took responsibility for the acquisition and development of HCA hospitals. In 1969 HCA made its first public stock offering, and, a year later, former Aetna Life Insurance chairman and CEO, John Hill, succeeded Frist Sr. as president of the hospital chain.

The growth path of HCA during the 1970s was similar to that of NME/Tenet. By 1973 HCA had fifty-one hospitals, including one in Saudi Arabia. In 1978 Donald MacNaughton, former CEO and chairman of Prudential, took the reigns as CEO of HCA. Under MacNaughton's leadership, HCA acquired General Care Corporation, General Health Services, Hospital Affiliates International, and the Health Care Corporation. These acquisitions added 133 new facilities, consisting of 55 HCA-owned hospitals and 78 hospitals managed by HCA. In 1984 HCA was named the best-managed company in health care by Investment Decisions magazine. It described HCA as a “super company that does everything right.” By the late 1980s and early 1990s, HCA had gone through several major changes, spinning off 104 acute-care hospitals (1987), becoming private by buying out investors for $5.1 billion (1989), and then once again going public in 1992. These activities were followed by a merger with the 320-hospital Columbia Hospital System in 1994 followed by another merger with Health Trust a year later. The company became known as Columbia/HCA.

During the mid-1990s, Columbia/HCA grew rapidly, acquiring hospitals at the rate of one every week. By 1997 the company was the largest hospital chain and tenth-largest employer in the United States, with 380 hospitals, 200 home health agencies, and 130 surgery centers. At this time, Columbia/HCA began to shift its business strategies from a national acquisition focus to a local operational focus, suggesting that it wanted to get better rather than bigger. Dr. Thomas Frist Jr. returned to the company as CEO in 1997. In 1998 Modern Healthcare magazine ranked 28 Columbia/HCA hospitals among its best 100 hospitals. After selling off two hospital companies, Columbia/HCA operated 190 hospitals at the end of 1999. So what went wrong?

The answer is simple: To improve their financial picture even further, Columbia/HCA had begun to play fast and loose with Medicare, Medicaid, and TRICARE reimbursement rules and to engage in widespread fraud. Storm clouds appeared as early as 1997 when federal investigators turned their attention to Columbia/HCA facilities in El Paso, Texas. The investigation, focusing on Columbia/HCA’s Medicare billings and home health operations, quickly widened
as five hundred federal agents raided company facilities in seven states.\textsuperscript{19} Health care industry analysts also publicly accused the company of placing acquisitions and profits ahead of quality patient care.\textsuperscript{20}

A year later, the federal government announced False Claims Act suits against Columbia/HCA and a former subsidiary, the Quorum Health Group, for filing inflated expense claims. The government contended that Columbia/HCA had, over a fourteen-year period, misrepresented costs to increase Medicare reimbursements. Both Columbia/HCA and Quorum were purported to have used separate sets of books, one set for actual costs and another set for Medicare claims that reflected higher-than-actual costs. The companies, for example, represented operating expenses (reimbursable at a lower rate) as capital costs (reimbursable at a higher rate). The lawsuit also claimed the companies manipulated time and square-footage calculations to inflate reimbursements.\textsuperscript{21}

In December 2000, HCA—The Healthcare Company (it changed its official name) entered into a plea agreement with the federal government to pay $840 million in criminal fines and civil penalties. The $840 million consisted of $745 million to resolve five charges of improperly billing the U.S. government and the states for health care services. An additional $95 million was levied against the company to resolve civil claims for fraudulent laboratory billing, including billings for unnecessary tests, to Medicare, Medicaid, TRICARE, and the Federal Employees Health Benefits Program.

More than $403 million of the $745 million portion of the settlement (above) was earmarked to remedy civil claims for upcoding pneumonia and other diagnoses. Another $50 million in civil assessments was levied against HCA for misclassifying nonreimbursable marketing and advertising costs as reimbursable public health education costs. HCA agreed to pay an additional $90 million to settle charges accusing the company of billing Medicare for nonreimbursable costs associated with the purchase of home health agencies. The company apparently devised a scheme to convert these costs into reimbursable “management fees” paid to third parties. Finally, HCA agreed to pay $106 million to resolve charges it had billed Medicare, Medicaid, and TRICARE for home health visits that either were not provided to patients or were provided to those who did not qualify for the care.

Two subsidiaries of HCA, Columbia Homecare Group and Columbia Management Companies, entered into a plea agreement to pay $95.3 million in criminal fines for a variety of charges, including conspiracy, false statements, fraudulent cost reporting, fraudulent billings, paying kickbacks, upcoding, and home health fraud.

HCA signed an eight-year corporate integrity agreement requiring compliance policies, procedures, and training for HCA employees. It also mandated immediate restitution of overpayments and a system enabling employees to report misconduct. HCA was forced to divest any subsidiary and to exclude any person
that had been banned from participating in a federal health care program or that had been found guilty of Medicare fraud.22

HCA’s woes continued when, in June 2003, the federal government announced a $631 civil settlement with the hospital company, bringing the total settlement amounts against HCA to $1.7 billion. The settlement was precipitated by nine whistle-blower suits against the company and its affiliated hospitals under the False Claims Act. This settlement required HCA to pay $620 million to resolve eight whistle-blower suits plus an additional $11 million to resolve irregularities in billing practices.

The charges against HCA in the 2003 settlement were similar to those made in 2001. The company was forced to pay $356 million for using hospital cost-reporting schemes to defraud Medicare, Medicaid, and TRICARE. An additional $225.5 million was levied against the company on charges that HCA hospitals and home health agencies had made illegal billings to these programs, including kickbacks for patient referrals. HCA was required to pay $17 million to the government to resolve charges over hospital billings to Medicare for nonreimbursable costs. These costs were incurred by a contractor operating wound-care centers for the company. Part of this $17 million settlement also applied to non-covered drugs manufactured by the contractor and sold to patients. Over $11 million was levied against HCA for overcharges made for transferring patients from one hospital or clinic to another, inflated charges pertaining to indigent patients, and salary and other costs that were shifted improperly. In a separate agreement, HCA paid $1.5 million to settle allegations of paying kickbacks for the referral of diabetes patients to its Atlanta West Paces Medical Center.

A U.S. Justice Department Civil Division Assistant Attorney General said, “We are grateful for the assistance given by the whistleblowers over the course of the past nine years of investigation and litigation... and we are proud of the work of government personnel as well as counsel for the whistleblowers, who together pursued these matters through investigation and strenuous litigation. This result demonstrates the commitment of the Department to the qui tam [whistleblower] statute and that the statute works as Congress intended.”23

In 2005 then U.S. Senate majority leader Bill Frist, the son of HCA founder Dr. Thomas Frist Sr. and younger brother of Dr. Thomas Frist Jr., was investigated regarding the sale of his HCA stock days before the share price dropped by 9 percent. The senator claimed he sold the shares to avoid any appearance of a conflict of interest in the event he decided to run for the U.S. presidency in 2008. Following an intensive investigation, federal authorities dropped insider trading charges against Frist after documentation revealed he had initiated plans to sell the shares months before the stock price dropped precipitously in July 2005.24 As a surgeon, former Senate majority leader, and professor of business and medicine at Vanderbilt University Bill Frist began working actively on health care reform.25
HCA was acquired for $31.6 billion in July 2006 by three private-equity firms—Bain Capital, Kohlberg Kravis Roberts, and Merrill Lynch—and the family of Bill Frist. The acquisition, at that time, represented the largest leveraged buyout in U.S. business history. It was part of a buying spree by private-equity firms to take advantage of the low cost of capital during that period. The buyout paid $51 a share to HCA shareholders, and it required a $5.5 billion cash outlay with the remainder of the transaction being financed by debt.26

By 2010 HCA was still the largest for-profit hospital chain with 170 acute-care psychiatric and rehabilitative hospitals, 100 ambulatory surgery centers, as well as diagnostic imaging, cancer treatment, and outpatient rehabilitative centers in twenty states—mostly in Florida and Texas—as well as in England.27 At that time, HCA was attempting once again to become a publicly traded company through an initial public offering of approximately $4.6 billion, giving it a market value of around $40 billion.

HealthSouth

When business strategists speak of diversified corporations, they are usually talking about firms that produce or sell a variety of products and services. HealthSouth, the largest provider of inpatient rehabilitative services in the United States, had an unusual form of diversification. Under its jaded cofounder and former CEO, Richard Scrushy (fired in 2003), HealthSouth’s business strategy consisted of both legitimate health care services alongside an array of white-collar crimes that included financial fraud, false billings, and Medicare fraud. The financial frauds made liberal use of cost-accounting machinations.

Scrushy became infamous for his flamboyant lifestyle and his questionable and highly publicized religious conversion as his legal troubles mounted. In November 2003, an eighty-five-count criminal indictment was brought against him for the overstatement of HealthSouth’s profits by $2.7 billion between 1996 and 2002.28 Although Scrushy was acquitted of federal financial fraud charges by a seemingly sympathetic and perhaps naive jury in a Birmingham, Alabama, federal court, he was convicted later of bribery and mail fraud in a separate trial. His punishment on those convictions included an eighty-two-month federal prison sentence and payment of over four hundred thousand dollars in restitution and fines. At this writing, Scrushy is incarcerated at a federal prison in Beaumont, Texas, with a scheduled release date in 2013.29

Turning away from financial fraud to the more traditional forms of health care fraud, the U.S. Department of Justice announced a settlement in which HealthSouth agreed to pay $325 million “to resolve a range of allegations involving outpatient physical therapy services and inpatient rehabilitation admissions.” The settlement, announced in late December 2004, included $169 million for
submitting claims to Medicare and other federal programs for services lacking a properly certified plan of care, for procedures rendered by persons other than licensed physical therapists, and for the billing of services not provided.

An additional $154.7 million was levied against HealthSouth for submitting hospital and office charges that were not reimbursable under Medicare. The unallowable costs included lavish entertainment and travel costs for HealthSouth's annual administrative meetings at Disney World as well as fees paid to the board of directors, public-information expenses, tax-penalty expenses, and lease claims related to rehabilitation facilities acquired from National Medical Enterprises and NovaCare. This part of the settlement also applied to reimbursements for outlier patient charges, similar to those discussed in the Tenet Healthcare case, and the medically unnecessary admission of patients to HealthSouth inpatient facilities. Finally, HealthSouth paid $1 million to settle charges of unlawfully billing Medicare for the skilled labor used in infusion-therapy services. By misclassifying these services as "ancillary," HealthSouth avoided Medicare limits imposed on services delivered at skilled-nursing facilities.

In 2007 HealthSouth and two company physicians agreed to pay the federal government a total of $14.9 million to settle allegations that the company submitted false claims to the government and paid illegal kickbacks to physicians who referred patients to its hospitals, outpatient-rehabilitation clinics, and ambulatory-surgery centers. HealthSouth agreed to pay $14.2 million, and the two physicians jointly paid $700,000.

By June 2009, despite years of legal wrangling, Richard Scrushy's financial problems were only just beginning. As in the case of the infamous O. J. Simpson, Scrushy escaped the worst of the criminal charges in the HealthSouth financial fraud suit only to be waylaid by what appears to be the biggest judgment ever levied against a single executive. Scrushy was slapped with a $2.88 billion—yes, that is billion with a "b"—civil penalty in a lawsuit brought by angry HealthSouth shareholders.

Scrushy had received as much as $40 million a year in pay and perquisites during his tenure at HealthSouth, money that fueled an ostentatious lifestyle. His conspicuous consumption included six homes and three other pieces of real estate, thirty-seven cars, seven boats, and two airplanes (not counting the twelve HealthSouth business jets he had at his disposal). And one week after his cost-cutting threw a number of HealthSouth employees out of work, Scrushy took delivery of a $6 million Sikorsky helicopter.

By the time he was hit with the huge civil judgment, much of Scrushy's net worth has been consumed by the tens of millions of dollars in legal and settlement expenses. Nevertheless, HealthSouth CEO Jay Grinney believes that Scrushy still has assets, and the company has hired investigators to look within the United States and offshore for hidden trusts, real estate, yachts, and other items of value.
As noted, Scrushy was thought to have hoodwinked a gullible hometown jury into an acquittal during his 2005 criminal-fraud trial. In the civil suit, however, the same evidence brought a very different result. Sans jury, Scrushy faced a lone justice, Jefferson County (Alabama) Circuit Court Judge Allwin E. Horn III, who was anything but gullible. Judge Horn did not believe that Scrushy, a CEO long known for his attention to detail, was unaware of the massive six-year financial fraud at HealthSouth—including a $350 million “budgeting error.” To the contrary, Judge Horn referred facetiously to Scrushy and the five CFOs who served during his tenure as “the six testifying felons.”

But HealthSouth weathered the damage inflicted by Scrushy and his henchmen. The company continues to operate as the nation’s largest provider of inpatient-rehabilitation services, with over 250,000 patients in twenty-six states and Puerto Rico. And, for the first six months of 2009, the company showed a net profit of $39.4 million. The company continued to show strong operating results through June 2010.

Antitrust Problems That Drive Up Costs and Reduce the Quality of Health Care

Noncompetitive or antitrust practices have entered the health care arena. These practices include monopolies—usually as the result of health care institution mergers or joint ventures—as well as practices such as price fixing, collusive bidding among competitors, exclusive buying or dealing arrangements, and predatory pricing.

One antitrust case involved several large hospitals in the Chicago area. The Evanston Northwestern Healthcare Corporation (ENH), consisting of two acute-care hospitals, acquired Highland Park Hospital in 2000. The merger also combined two distinct physician groups. Shortly after the merger, ENH and its associated physician group instituted significant price increases at all three hospitals. ENH also threatened payers (insurers), telling them that their contracts would be terminated if they did not agree to a package contract containing both physician and hospital services. As a result of the merger, competition was reduced and prices were increased for health care plans. ENH was subsequently forced by a Federal Trade Commission administrative law judge to divest itself of its Highland Park Hospital. On appeal, ENH was given a substitute remedy to restore fair competition by establishing separate independent contract-negotiating teams for the Evanston and Glenbrook hospitals and another for Highland Park Hospital, allowing managed-care organizations to negotiate separately with the competing hospitals. The order also contained an arbitration provision for resolving pricing disputes between the payers and ENH.
The ENH case—and others similar to it—does not seem as sinister as the mainstream cases of health care fraud and abuse. But monopolies and other noncompetitive practices dampen competition, remove incentives for providing quality products or services, and result in artificially high prices, all to the detriment of the health care consumer.

Congress first recognized problems associated with noncompetitive practices over a century ago when it passed the Sherman (Antitrust) Act (1890). Section 1 of the act prohibits certain practices such as price fixing, regardless of whether such practices cause economic harm—in legalese, these practices are known as “per se violations.” Section 2 of the act prohibits practices such as monopolies that actually cause economic damage—the “rule of reason.” Congress widened the scope of the Sherman Act and clarified issues associated with noncompetitive practices through the passage of the Clayton Act (1914) and the Robinson-Patman Act (1936). All of these laws assume that the anticompetitive practice in question affects interstate commerce, and the laws are enforced primarily by the Federal Trade Commission. The FTC also employs thirty-five attorneys to deal solely with health care antitrust issues. Ironically, the Obama administration's attempt at health care reform—which focuses heavily on controlling health care prices—may run afoul of antitrust legislation because of concerns about price-fixing arrangements.39

Antitrust litigation is extremely complex, and no bright line separates legal from illegal practices. Furthermore, certain practices may help freely competitive markets at one moment and hinder those same markets at another time. Does the merger of two community hospitals create a monopoly that drives up health care prices, or does that merger create economies of scale and cost savings that benefit consumers? The FTC claims that it will not question hospital mergers in which at least one of the hospitals has fewer than one hundred beds, forty patients per day, and is more than five years old. But are joint ventures among hospitals involving technical, specialized, or expensive clinical services contrary to the antitrust laws? The legality of such ventures, according to the FTC, depends on the number of hospitals involved as well as the weighing of “any anticompetitive effects against any procompetitive efficiencies generated by the venture, and examine whether collateral restraints, if any, are necessary to achieve the efficiencies sought by the venture.”40 How can that vague—actually horrendous—sentence provide clear guidance for hospital boards contemplating such ventures? What about competing hospitals that want to achieve efficiencies and cost savings by pooling resources for information collection and sharing? And what about hospitals participating in wage-and-salary or pricing surveys? Might these practices be regarded as price fixing or illegal collusion? According to the FTC, the devil is once again in the details of the specific sharing arrangement. The FTC says that joint purchasing arrangements among health care institutions are legal as long as they account for fewer than 35 percent of the total market for purchased items.
That rule sounds straightforward, but how does one define the relevant market and how does one know when the 35 percent limit has been exceeded? Furthermore, what potential antitrust law violations do physician and multiprovider networks create? Again, no straightforward answers are available.41

Big Partners and Little Partners

We usually think that antitrust issues arise in large organizations. The following case comes from the Boston area—home to some of the world’s most venerated educational and health care institutions—and it does, in fact, involve a very large health care institution and a very large insurer.

Partners Healthcare Company and Blue Cross Blue Shield of Massachusetts were accused of making an unwritten agreement in 2000 under which Blue Cross would give Partners a significant increase in payments as long as Partners obtained comparable increases from Blue Cross competitors. During the life of this agreement, Blue Cross boosted—by 78 percent—the rate at which it paid for medical care by Partners doctors and hospitals. This increase far exceeded those made by other Massachusetts hospitals.42 Here is an example of the differential pricing dilemma caused—at least in part—by this arrangement.

As his patient lies waiting in an adjacent exam room, Dr. James D. Alderman watches while an assistant reaches into a white envelope and pulls out a piece of paper that will determine where the man will be treated. Big money is on the line....Alderman, an interventional cardiologist plans to open the patient’s clogged artery by inserting a flexible tube with a tiny balloon at the tip. Usually he does the procedure, called angioplasty, at MetroWest Medical Center in Framingham. But he sometimes operates in Boston as part of a research program. One time in every four, by the luck of the draw, Alderman and his patient go to a big teaching hospital in the city....If the white slip of paper directs him to do the procedure in Framingham, the insurance company will pay the hospital about $17,000, not counting the physician’s fee. If Alderman is sent to Brigham and Women’s Hospital in Boston, that hospital will get about $24,550—44 percent more—even though the patient’s care will be the same in both places.... “It’s the exact same doctor doing the procedure,” said Andrei Soran, MetroWest’s chief executive. “But the cost? It’s unjustifiably higher.”43

Partners HealthCare Company was created by a 1993 merger between Brigham and Massachusetts General hospitals. The merger and subsequent growth of this nonprofit organization created what some call the proverbial “eight
hundred-pound gorilla.” Under the cover of deregulation and lax government oversight, Partners Healthcare used its size and bargaining clout—a clout based on its powerful brand name and an elite reputation—to demand higher payments from health insurance companies. The companies, in turn, passed these cost increases to their policyholders in the form of higher premiums. According to Charles Baker, president of Harvard Pilgrim Health Care, the second largest health insurer in Massachusetts after Blue Cross Blue Shield, “The same service delivered the same way with the same outcome can vary in cost from one provider to the next by as much as 300 percent.” Over its fifteen-year lifespan Partners became the biggest health care provider and largest private employer in Massachusetts, and it developed the power to drive competitors down with its ambitious expansion programs and to intimidate insurers with its threat to withdraw business.

The seed of Partner HealthCare’s tremendous growth was, reportedly, an unwritten and undisclosed—at least to the public—gentleman’s pricing agreement between Dr. Samuel O. Thier, then CEO of Partners, and William C. Van Faasen, then CEO of Blue Cross Blue Shield of Massachusetts. Thier has been described as an individual who is “formidable by almost any measure—in intellect, charm, and competitive fire.” But Partners justified its pricing based on its reputation, its ambitious expansion plans, and its quality of patient care. Some antitrust experts, however, speculated that the gentleman’s agreement between Thier and Van Faasen may have gone too far. Whether the agreement violates the Sherman Act or Massachusetts consumer protection law is uncertain. But the gentlemanly accord between the two CEOs in May 2000 has raised the ire of many Massachusetts health care consumers who believe they are being fleeced.

On April 19, 2010, the U.S. Department of Justice sent letters to Partners and the state’s three largest health insurers—Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan—requesting information about contract negotiations, rates, and reimbursement practices. Although the DOJ has requested information as part of its investigation, no antitrust charges had yet been filed. This brewing controversy also illustrates that nonprofit health care organizations can be just as ambitious and aggressive in acquiring market share and making money as their counterparts in the for-profit sector.

Now, I turn to look at a much smaller antitrust case that, by coincidence, has a name similar to that of the big case in Boston. Partners Health Network is a physician-hospital organization (PHO) representing 225 doctors and two hospitals near my home in Pickens County, South Carolina. Far from the urban Northeast, Pickens County is nestled in the foothills of the Blue Ridge Mountains in the northwest corner of the state—not far from where the early 1970s movie Deliverance was filmed. Its residents range from the very rich to the very poor.

Partners Health Network PHO claimed to operate as a “messenger model,” which allows self-employed physicians to market their services jointly as a
network. The messenger model does not, however, give self-employed physicians the right to negotiate fees collectively with health plans or to agree collectively on the fee schedule they will accept. Nevertheless, the members of Partners Health Network agreed to fix prices and other terms on which they would deal with health plans, and they refused to deal with health plans that did not adhere to the fixed-price schedule. The PHO’s executive director polled the prices of the network’s physicians and then established a fee schedule based on the highest submitted price per procedure from the physician survey. Predictably, many of the health plans were forced to raise the fees paid to Partners’ physicians, thereby raising the cost of medical care in the Pickens County area.

To resolve the problem, the FTC and Partners entered into a consent order to stop it from negotiating with health plans on behalf of physicians and to stop threatening health plans if they failed to cooperate or agree to terms with Partners. The Partners Health Network was also obliged, if a payer so requested, to terminate an existing contract without penalty.

Organized Crime’s Involvement in Health Care Fraud

Recent media accounts have described how organized crime has begun to infiltrate the U.S. health care system—stealing mainly from the Medicare program. These accounts, however, miss the distinction between the “organized” conspiracies I discuss in this book and the traditional organized crime syndicates that emerged during Prohibition and that continue to exist today.

How is organized crime defined, and how does it differ from organized rent-a-patient schemes, Internet drug trafficking, and bogus laboratories? Organized crime in the United States—at least the way sociologists and criminologists have described it—usually operates within a formal structure. Although not diagramed on paper, the structure has top-down links of communication and formal job duties for the criminal participants, such as the bosses, consiglieri (advisers), caporegimes (crew leaders), and soldiers. Organized criminals also have a strict law of silence with respect to outsiders—especially the police. As with many other participants in health care fraud, organized criminals often use legitimate business “fronts” to hide their illegal activities.

Many of the fraudulent arrangements highlighted in this book have limited life spans. Organized crime groups in the United States, however, have survived for years or even decades. Members of a criminal enterprise may come and go, but the organization itself endures. Also, organized crime is often built on the idea of a territorial monopoly. If members of a crime syndicate encroach on the business territory of a competitor, retaliation is often swift. And, as the television and movies always seem
to emphasize, organized criminals are willing to commit acts of violence against those with conflicting business interests as well as against disloyal insiders.

All of the fraud perpetrators discussed here—whether individuals or conspiracies—operated with little or no help from outsiders. Organized crime, on the other hand, depends heavily on groups outside the formal criminal structure. One such group is the “protectors”—corrupt judges, police officers, lawyers, and politicians—who, for a price, have the power to keep crime syndicate members out of trouble with the criminal justice system. Organized criminals also depend on the support of crooked accountants and attorneys. And, most important, organized crime requires a user support group (a criminologist’s word for “customers”)—drug users, prostitution patrons, and buyers of stolen goods—who are willing to pay for the services offered by a criminal group.

For decades, members of organized crime have made their living through gambling rings, loan sharking, prostitution, pornography, fencing stolen goods, racketeering, extortion, consumer scams, and drug trafficking. Their “lines of business” focus on illegal goods and services that people want to buy repeatedly—say, once a week. But federal investigators now claim that organized crime figures have made the startling discovery that health care fraud is even more lucrative than these traditional crimes. According to Timothy Menke, the head of investigations for HHS–OIG, “They’re hitting us and hitting us hard. Organized crime involvement in health care is widespread.” In May 2009, eleven men supposedly associated with the New York Bonanno crime family were indicted in South Florida for Medicare fraud along with a number of other crimes.51

Although the Bonannos are a well-established, archetypical organized crime family, other organized health care scammers are actually a hybrid between traditional organized crime syndicates and common street thugs. A Russian Armenian crime ring was indicted for stealing $20 million from Medicare through a group of clinics that they operated in the Los Angeles area. Similarly, criminal groups from the former Soviet Union and Nigeria have also been indicted for health care fraud.52 These crime rings do not always have the same structure as U.S. organized crime. Instead, they work for whoever can make money for them, and they are not shy about engaging in threats of violence, even against the elderly.

Large institutions, whether they are hospital chains or organized crime syndicates, have the wherewithal to commit health care fraud and abuse on a massive scale. A primary concern of these organizations, of course, is not the quality of the patient care they are supposed to deliver. Instead, these rogue corporations care only about making money—trimming costs to the bone, short-changing consumers, maximizing profits, and bolstering stock prices—through any means possible.
The literature on white-collar crime distinguishes between corporate and occupational crimes. Corporate crime—of primary interest in this chapter—benefits the organization, whereas occupational crime benefits the individual perpetrator. This distinction is theoretically appealing, but it is not completely accurate because corporate crimes may also benefit the individual perpetrator, who usually avoids criminal charges.

But the distinction between corporate and occupational crimes does raise the question of who should be held responsible for frauds amounting to hundreds of millions of dollars. Should government officials stick with the tried-and-true strategy of filing civil suits and extracting large settlements from multibillion dollar hospital corporations, or should they bring felony charges against the executives who precipitated these frauds? In the next chapter, I discuss another set of large organizations—pharmaceutical and medical equipment and supply companies. They too have been major players in the arena of health care fraud.