

Elaborating on Sham Transactions as Evidence of Violations of the Anti-Kickback Statute

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I. INTRODUCTION

An old proverb states: truth stands the test of time, but lies are soon exposed. The fraudulent actions of health care professionals are largely responsible for recent increases in health care costs.¹ In 2000, the nation's health care programs lost approximately \$39 billion dollars because of fraud.² Similarly, the government issued \$12.1 billion dollars in erroneous Medicare payments in 2001, many the result of fraud.³ Because the potential gain is so great, individuals both inside and outside the industry are willing to risk criminal liability by committing health care fraud.⁴

Throughout the 1990s, the federal government dedicated

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1. Anne W. Morrison, *An Analysis of Anti-Kickback and Self-Referral Law in Modern Health Care*, 21 J. LEGAL MED. 351, 351-53 (2000); Andrea Tuwiner Vavonese, Comment, *The Medicare Anti-Kickback Provision of the Social Security Act—Is Ignorance of the Law an Excuse for Fraudulent and Abusive Use of the System?*, 45 CATH. U. L. REV. 943, 944 (1996).

2. Health Care Fraud: A Serious & Costly Reality for All Americans, at http://www.nhcaa.org/pdf/all_about_hcf.pdf (last visited Dec. 18, 2002). "Other estimates by government and law enforcement agencies place the loss as high as 10 percent of . . . [the nation's] . . . annual expenditure-or \$130 billion-each year." *Id.*

3. *Id.* Previous estimates reported that over \$11.9 billion has been obtained through fraudulent Medicare claims. Joan H. Krause, *Health Care Providers and the Public Fisc: Paradigms of Government Harm Under the Civil False Claims Act*, 36 GA. L. REV. 121, 124 (2001). Some have estimated that by 2008, health care spending will reach \$2.2 trillion "and will account for 16.2% of the Gross Domestic Product." Amy Schofield & Linda D. Weaver, *Health Care Fraud*, 37 AM. CRIM. L. REV. 617, 618 (2000).

4. Nichole A. Berryman et al., *Health Care Fraud*, 38 AM. CRIM. L. REV. 913, 915-16 (2001) (stating that Medicare continues to be a target for fraud). See also Theodore N. McDowell, *The Medicare-Medicaid Anti-Fraud and Abuse Amendments: Their Impact on the Present Health Care System*, 36 EMORY L.J. 691, 713-14 (1987) ("Retrospective reimbursement creates incentives to increase the quantity and scope of services and . . . [o]verutilization becomes attractive.").

significant resources toward combating and controlling fraud and abuse in federal health care programs.⁵ Although governmental efforts prevent some abuses, many lawbreakers have circumvented existing controls by creating transactions capable of disguising Medicare fraud.⁶

Congress enacted the Anti-Kickback Statute to combat particular types of fraud in the health care industry.⁷ This Note discusses the origin and current state of the Anti-Kickback Statute, explores the concept of “sham transactions” and their role in preventing health care fraud, and enumerates proposals on how changes can be made to assist in the war against health care fraud. Part II of this Note examines the history of the Anti-Kickback Statute, the “intent” requirement, the federal regulations, and the exceptions and safe harbor provisions. Part III explores the theory of sham transactions and subsequent case law. Part IV of this Note analyzes how sham transactions apply to the Anti-Kickback Statute. Part V proposes the incorporation of sham transactions as circumstantial evidence demonstrating violations of the Anti-Kickback Statute. Part VI will summarize and conclude the Note.

II. STATUTORY BACKGROUND

A. The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b

1. The Original Statute

For decades, there were concerns about “the access of medical care and the distribution of health care costs in [the United States].”⁸

5. D. McCarty Thornton, “*Sentinel Effect*” Shows Fraud Control Effort Works, 1245 PLI/Corp 69, 71 (April 2001) (claiming that “The investigation and prosecution of health care fraud has been a top priority of the federal government in recent years”). See also John T. Boese & Beth C. McClain, *Why Thompson is Wrong: Misuse of the False Claims Act to Enforce the Anti-Kickback Act*, 51 ALA. L. REV. 1, 19 (1999) (claiming that as health care costs have steadily risen, Congress has demanded tougher prosecution of health care fraud).

6. Vavonese, *supra* note 1, at 951 (“Despite attempts at statutory solutions, fraud and abuse continue to be a costly problem”).

7. Robert N. Rabees, *Kickbacks as False Claims: The Use of the Civil False Claim Act to Prosecute Violations of the Federal Health Care Program’s Anti-Kickback Statute*, 2001 L. REV. MICH. ST. U. DET. C.L. 1, 2 (2001).

8. Tamsen Douglass Love, Note, *Toward a Fair and Practical Definition of “Willfully” in the Medicare/Medicaid Anti-Kickback Statute*, 50 VAND. L. REV. 1029, 1034 (1997).

Attempting to alleviate these concerns, in 1965 Congress created the Medicare/Medicaid system.⁹ The Social Security Amendments Act¹⁰ incorporated the original Anti-Kickback Statute under the general antifraud section.¹¹ This was, however, only a temporary solution because the Social Security Act did not address kickbacks and other inducements under Medicare and Medicaid.¹² As a result, in 1972 Congress made it illegal to solicit or offer kickbacks, bribes, or rebates in exchange for patient referrals under the Medicare or Medicaid system.¹³ This act made it a misdemeanor to receive bribes or other financial incentives in connection with the referral of patients under the Medicare or Medicaid system, or in the furnishing Medicare or Medicaid services.¹⁴ The legislative history indicates that the original statute intended to prevent unethical transactions draining federal health care programs.¹⁵

9. *Id.*

10. Social Security Amendments of 1983, Pub. L. No. 98-21, § 201, 97 Stat. 65, 107-08 (1983). For a description of the Act's application, see Douglas A. Blair, *The "Knowingly and Willfully" Continuum of the Anti-Kickback Statute's Scientist Requirement: Its Origins, Complexities, and Most Recent Judicial Developments*, 8 ANNALS HEALTH L. 1, 2 (1999).

11. See Love, *supra* note 8, at 1035.

12. *Id.* at 1035-37.

13. *Id.* at 1035.

14. *Id.* It is worth noting that there was no intent requirement under the 1972 statute. *Id.*

15. ROBERT FABRIKANT ET AL., HEALTH CARE FRAUD: CRIMINAL, CIVIL, AND ADMINISTRATIVE LAW § 2.13 (2001) (citing H.R. REP. NO. 92-231, 92d Cong., 1st Sess. 108 (1971), reprinted in 1972 U.S.C.C.A.N. 4989, 5093). Specifically, Congress stated:

Your committee believes that a specific provision defining acts subject to penalty under the Medicare and Medicaid programs should be included to provide penalties for certain practices which have long been regarded by professional organizations as unethical, as well as unlawful in some jurisdictions, and which contribute appreciably to the cost of the Medicare and Medicaid programs. Thus, under the committee bill, the criminal penalty provision would include such practices as the soliciting, offering, or accepting of kickbacks or bribes, including the rebating of a portion of a fee or charge for a patient referral, involving providers of health care services. In addition, the provision would include penalties for concealing or failing to disclose knowledge of any event affecting a person's right to any benefit payment with the intent to defraud, or for knowingly and willfully converting benefits or payments to improper use.

2. The Congressional Amendments

Although the original statute appeared to address Congress's concerns, numerous problems soon arose.¹⁶ Early cases addressing violations of the statute focused exclusively on whether or not someone had specifically violated the act.¹⁷ The central area of disillusion was whether a certain act was illegal based on a court's interpretation of the terms "kickbacks or bribes."¹⁸ Some courts narrowly construed these terms.¹⁹ To illustrate, in *United States v. Zacher*, the court addressed a nursing home operator over-charging the families of patients under Medicaid.²⁰ On appeal, the Second Circuit had to determine whether the extra charges constituted a bribe under the Anti-Kickback Statute.²¹ The Second Circuit interpreted the definition of a bribe narrowly, as involving "corruption, breach of trust, or violation of duty,"²² and held that the nursing home operator did not violate the statute.²³

Other courts have offered a broader interpretation of "kickbacks or bribes."²⁴ In *United States v. Hancock*, the district court convicted

H.R. REP. NO. 92-231, 92d Cong., 1st Sess. 108 (1971), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5093.

16. Timothy J. Aspinwall, *The Anti-Kickback Statute Standard(s) of Intent: The Case for a Rule of Reason Analysis*, 9 ANNALS HEALTH L. 155, 161 (2000).

17. *See* FABRIKANT ET AL., *supra* note 15, at 3. In most of the cases, "the . . . facts of the . . . cases were rarely in dispute." *Id.*

18. *Id.*

19. *See, e.g.*, *United States v. Porter*, 591 F.2d 1048 (5th Cir. 1979); *United States v. Zacher*, 586 F.2d 912 (2d Cir. 1978). In *Porter*, physicians providing Medicare services were receiving payments for referring blood tests to certain laboratories receiving Medicare reimbursement. 591 F.2d at 1051. These blood tests were done manually and cost Medicare \$214 as opposed to \$35 at another facility through an automated system. *Id.* The Fifth Circuit had to determine whether the physicians violated the Anti-Kickback Statute based on the payments they received and the substantial difference in the reimbursement rates. *Id.* The Fifth Circuit reasoned that there was authorization for Medicare reimbursement to the laboratories because the Anti-Kickback Statute did not include such actions under the kickback terminology. *Id.* at 1052-54.

20. 586 F.2d at 912.

21. *Id.* at 914.

22. *Id.* at 915.

23. *Id.* at 916-17.

24. *See, e.g.*, *United States v. Ruttenberg*, 625 F.2d 173, 176 (7th Cir. 1980); *United States v. Tapert*, 625 F.2d 111, 121 (6th Cir. 1980); *United States v. Hancock*, 604 F.2d 999, 1002 (7th Cir. 1979).

the defendant for soliciting and receiving kickbacks.²⁵ The court first determined the objective of the Anti-Kickback Statute,²⁶ then considered whether the statute was unconstitutionally vague because an intent requirement was not incorporated into the statute's language.²⁷ The Seventh Circuit held that the term "kickback" requires one to receive payments for a corrupt purpose because the intent of the statute was to prevent an abuse of the federal government health care programs.²⁸

Other issues arose out of the original statute in addition to the problem of whether one should apply a narrow construction of the term kickback. One of these issues was that the original statute did not deter individuals from violating the statute because the offense was classified as a misdemeanor, not a felony.²⁹

25. 604 F.2d at 1001. The defendants, licensed in chiropractic medicine, obtained blood and tissue samples from their patients and billed Medicare. *Id.* However, the defendants were receiving and soliciting money from the laboratory for the patient referrals. *Id.*

26. *Id.*

27. *Id.* at 1002.

28. *Id.* at 1001. The Seventh Circuit stated:

[P]otential for increased costs to the Medicare-Medicaid system and misapplication of federal funds is plain, where payments for the exercise of such judgments are added to the legitimate costs of the transaction . . . [T]hese are among the evils Congress sought to prevent by enacting the kickback statutes . . . [T]his requirement of corruption is a sufficient requirement of mental culpability to withstand constitutional attack, especially in the context of Congress' regulation of the expenditure of enormous sums of federal funds under the Medicare and Medicaid programs.

Id. at 1001-02.

29. *See* Aspinwall, *supra* note 16, at 161. Specifically, Congress announced:

Recent hearings and reports, however, indicate that such penalties have not proved adequate deterrents against illegal practices by some individuals who provide services under medicare and medicaid. In addition, these misdemeanor penalties appear inconsistent with existing Federal criminal code sanctions which make similar actions punishable as felonies. Also, it has been brought to the attention of the committee by U.S. Attorneys' offices which have utilized these Social Security Act sanctions in the prosecution of medicare and medicaid fraud cases that the existing language of these penalty statutes is unclear and needs clarification.

The bill would strengthen the penalty provisions in existing law which relate to persons providing services under medicare and medicaid. Most fraudulent acts now classified as misdemeanors would become felonies. Penalties for these acts would be increased to a maximum \$25,000 fine, up to five years imprisonment or both.

In addition, the bill would clarify and restructure those provisions in existing law which define the types of financial arrangements and conduct to be classified as illegal under medicare and medicaid.

3. The 1977 and 1980 Amendments

Congress identified problems with the original 1972 statute, and made amendments in 1977.³⁰ Specifically, Congress clarified what types of illegal acts constituted violations of the Anti-Kickback Statute.³¹ The 1977 amendments made a violation of the statute a felony punishable by a fine up to \$25,000 and/or five years in prison.³² Congress declared that evidence of illegal kickbacks could manifest in various forms, hence an expansive application of the statute was necessary.³³ The 1977 Amendments noted that to violate the statute, the transaction did not have to result in a kickback.³⁴ Rather, Congress wanted to apply the Anti-Kickback Statute in a manner that demonstrated the severe consequences of illegal acts on federal health care programs.³⁵

H.R. REP. NO. 95-393, pt.2, at 53 (1977), 95th Cong., 1st Sess., *reprinted in* 1977 U.S.C.C.A.N. 3039, 3055.

30. *See* Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, sec. 1877, § 4(a), 97 Stat. 1175, 1179-81 (1997) (current version codified at 42 U.S.C. § 1320a-7b(b) (1994)).

31. Aspinwall, *supra* note 16, at 161. *See also* H.R. REP. NO. 95-393, pt.2, at 53, *reprinted in* 1977 U.S.C.C.A.N. 3039, 3056. “Despite the 1972 amendments, congressional investigations revealed that provider fraud and abuse continued to proliferate.” William R. Kucera, Jr., Note, *Hanlester Network v. Shalala: A Model Approach to the Medicare and Medicaid Kickback Problem*, 91 Nw. U. L. REV. 413, 418 (1996).

32. *See* Pub. L. No. 95-142, § 4(b)(1), 91 Stat. 1175, 1180 (1977) (codified as amended at 42 U.S.C. § 1396(h) (1994)); *see also* H.R. REP. NO. 95-393, pt.2, at 53, *reprinted in* 1977 U.S.C.C.A.N. 3039, 3055.

33. Love, *supra* note 8, at 1037.

34. H.R. REP. NO. 95-393, pt.2, at 46, *reprinted in* 1977 U.S.C.C.A.N. 3039, 3056. “The expanded definition, which included the language ‘made or offered’ in exchange for a referral, also made the anti-kickback statute a stronger weapon against fraud and abuse practices.” Morrison, *supra* note 1, at 354-55.

35. *Id.* Specifically, Congress wanted to “give a clear, loud signal to the thieves and the crooks and the abusers that we [Congress] mean to call a halt to their exploitation of the public and the public purse.” 123 CONG. REC. S31767 (daily ed. Sept. 30, 1977) (statement of Sen. Talmadge). Congress further stated:

[F]raud in these health care financing programs adversely impacts on all Americans. It cheats taxpayers who must ultimately bear the financial burden of misuse of funds in any government sponsored program. It diverts from those most in need, the nation’s elderly and poor, scarce program dollars that were intended to provide vitally needed quality health services. The wasting of program funds through fraud also further erodes the financial stability of those state and local governments whose budgets are already overextended and who must commit an ever-increasing portion of their financial resources to fulfill the obligations of their medical assistance programs. In

After the 1977 Amendments, Congress was concerned that the government would prosecute individuals for inadvertent acts violating the Anti-Kickback Statute.³⁶ Reacting to this concern, Congress amended the act in 1980 to require a violator act knowingly and willfully.³⁷

4. The Current Anti-Kickback Statute

In 1987, Congress consolidated the anti-kickback laws into section 112B(b) of the Social Security Act.³⁸ The current Anti-Kickback Statute³⁹ provides that one cannot receive or offer illegal remuneration to induce business reimbursed under the Medicare/Medicaid system.⁴⁰ Congress wanted to continue the original intent of the statute to cease practices that were draining federally funded health care programs' resources through fraudulent transactions,⁴¹ even though the amendments exempted certain transactions from government prosecution.⁴²

addition to these adverse financial consequences, the activities of those who seek to defraud these programs unfairly call into question and honesty and integrity of the vast majority of practitioners and health care institutions.

H.R. REP. NO. 95-393(II), pt.2, at 44, *reprinted in* 1977 U.S.C.C.A.N. 3039, 3047.

36. *See* Love, *supra* note 8, at 1038. "The Committee is concerned that criminal penalties may be imposed under current law to an individual whose conduct, while improper, was inadvertent." H.R. REP. NO. 96-1167, at 59 (1980), *reprinted in* 1980 U.S.C.C.A.N. 5526, 5572.

37. Love, *supra* note 8, at 1038 (citing Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 917, 94 Stat. 2625 (1980)). "Accordingly, the section clarifies current law to assure that only persons who knowingly and willfully engage in the proscribed conduct could be subject to criminal sanctions." H.R. REP. NO. 96-1167, *supra* note 36, at 59.

38. Pub. L. No. 100-93, sec. 1128, § 2, 101 Stat. 680 (1987) (codified at 42 U.S.C. § 1320a-7b(b)).

39. 42 U.S.C. § 1320a-7b(b)(3).

40. 42 U.S.C. § 1320a-7b.

41. H.R. REP. NO. 231 (1971), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5093. *See also* Aspinwall, *supra* note 16, at 155 ("The primary purpose of this statute is to eliminate unnecessary health care costs and compromises in quality that can result when providers are given financial inducements to make referrals.").

42. *See* FABRIKANT ET AL., *supra* note 15, at 3-4. Even though the statute "has been amended several times to broaden its general application and provide for specific, limited exceptions (e.g. discounts, risk-sharing arrangements), these principles have remained at the core of the statute's prohibitions." *Id.* at 3.

B. The “Intent Requirement” Under the Anti-Kickback Statute

An individual violates the Anti-Kickback Statute when he or she “knowingly and willfully solicits or receives any remuneration” for referrals paid under a “Federal health care program.”⁴³ Courts have not provided consistent interpretations of the intent requirement of the Anti-Kickback Statute.⁴⁴ Rather, courts have determined on a case-by-case basis whether the act was committed knowingly and willfully.⁴⁵

1. The Specific Intent Requirement

The Ninth Circuit, in *Hanlester Network v. Shalala*,⁴⁶ ruled that an individual must “know of” and “intend to” violate the law in order to be held criminally liable under the Anti-Kickback Statute.⁴⁷ In *Hanlester*, the plaintiff (a corporation that owned medical laboratories)⁴⁸ entered into a contract with SmithKline BioScience Laboratories (SKBL) which provided that SKBL would supply laboratory management services to the plaintiff.⁴⁹ These contracts resulted in the plaintiff sending the majority of its laboratory testing to SKBL for a substantial profit.⁵⁰ The Department of Health and Human Services eventually notified the plaintiff that its conduct violated the Anti-Kickback Statute.⁵¹ The plaintiff responded by arguing that the Anti-Kickback Statute was vague regarding whether or not someone must knowingly or willfully violate the statute to be held criminally liable.⁵² Addressing this argument, the Ninth Circuit

43. 42 U.S.C. § 1320a-7b(b)(1).

44. See Aspinwall, *supra* note 16, at 165-66.

45. *Id.*

46. 51 F.3d 1390 (9th Cir. 1995).

47. *Id.* at 1400. This approach has also been employed by numerous other courts. See, e.g., Ratzlaf v. United States, 510 U.S. 135, 146 (1994); United States v. Davis, 132 F.3d 1092, 1094 (5th Cir. 1998); Feldstein v. Nash County Community Health Services, Inc., 51 F. Supp. 2d 673, 681 (E.D.N.C. 1999); United States v. Vaghela, 970 F. Supp. 1018, 1022-23 (M.D. Fla. 1997).

48. 51 F.3d at 1394.

49. *Id.*

50. *Id.*

51. *Id.*

52. *Id.* at 1397.

held that a wrongdoer must engage in conduct with the “specific intent to disobey the law” for there to be a willful violation.⁵³

2. The One Purpose Test

Other cases have interpreted the intent requirement like a strict liability standard, holding that any attempt to induce remuneration violates the statute.⁵⁴ The Third Circuit in *United States v. Greber* employed this approach. In *Greber*, a company providing physicians with treatment assessment services paid referring physicians for professional services.⁵⁵ The Third Circuit held that if “payments were intended to induce the physician to use [the company’s] services, the statute was violated, even if the payments were also intended to compensate for professional services.”⁵⁶ The Third Circuit adopted the one-purpose test, stating that if any purpose of a business arrangement is to induce referrals, one violates the Anti-Kickback Statute.⁵⁷

53. *Id.* at 1400. The Ninth Circuit’s reasoning in *Hanlester* relied largely on the United States Supreme Court case *Ratzlaf v. United States*, 510 U.S. 135 (1994). In *Ratzlaf*, the Supreme Court determined that a “willful” violation of a statute requires the wrongdoer to “[know that] the structuring he undertook was unlawful.” *Id.* at 138.

54. *See, e.g.*, *United States v. LaHue*, 261 F.3d 993, 1003-04 (10th Cir. 2001); *United States v. McClatchey*, 217 F.3d 823, 835 (10th Cir. 2000); *United States v. Bay State Ambulance and Hospital Rental Service, Inc.* 874 F.2d 20, 29-30 (1st Cir. 1989); *United States v. Kats*, 871 F.2d 105, 108 (9th Cir. 1989); *United States v. Greber*, 760 F.2d 68, 72 (3d Cir. 1985).

55. 760 F.2d at 72. Basically, the company “billed Medicare for the monitor service and, when payment was received, forwarded a portion to the referring physician . . . The government charged that the referral fee was 40 percent of the Medicare payment, not to exceed \$65 per patient.” *Id.*

56. *Id.* The court’s reasoning for this interpretation relied on the fact that “[e]ven if the physician performs some service for the money received, the potential for unnecessary drain on the Medicare system remains . . . [because] . . . [t]he statute is aimed at the inducement factor.” *Id.* at 71.

57. *Id.* at 72. The Third Circuit in *Greber* adopted the Seventh Circuit’s reasoning in *United States v. Hancock*, 604 F.2d 999 (7th Cir. 1979), as the justification for the one-purpose test. 760 F.2d at 71-72. In *Hancock*, the court determined what the Anti-Kickback Statute was trying to achieve, and whether the statute was unconstitutional and vague because it did not have the word “intent” as an element of the crime. 604 F.2d at 1001-02.

3. The Middle Ground Approach

Some courts have taken a middle ground approach, finding that the intent requirement of the Anti-Kickback Statute is satisfied when the wrongdoer knows their actions are wrongful.⁵⁸ The Eighth Circuit in *United States v. Jain* embraced this approach. In *Jain*, the Court held that a violation of the Anti-Kickback Statute occurs when evidence demonstrates that the accused knew that their actions were illegal.⁵⁹ The Eighth Circuit reasoned that the intent requirement established by the Supreme Court in *Ratzlaf v. United States*,⁶⁰ relying upon *Hanlester*, was not applicable to the Anti-kickback Statute.⁶¹ Specifically, the Eighth Circuit noted that “[t]he statute at issue in *Ratzlaf* made criminal a willful violation of another anti-structuring statute . . . [while under] the Medicare anti-kickback statute . . . the word ‘willfully’ modifies a series of prohibited acts.”⁶²

58. See, e.g., *United States v. Jain*, 93 F.3d 436, 440 (8th Cir. 1996); *United States v. Neufeld*, 908 F. Supp. 491, 497 (S.D. Ohio 1995), *aff’d*, 149 F.3d 1185 (6th Cir. 1998).

59. 93 F.3d at 440. The court defined the word “willfully” as “unjustifiably and wrongfully, known to be such by the defendant.” *Id.* The Eighth Circuit indicated that:

Both the plain language of the statute, and respect for the traditional principle that ignorance of the law is no defense, suggest that a heightened *mens rea* standard should only require proof that [the defendant] knew his conduct was wrongful, rather than proof that he knew it violated ‘a known legal duty’.

Id. at 441.

60. 510 U.S. 135 (1994).

61. 93 F.3d at 440-41.

62. *Id.* at 441. See also *Love*, *supra* note 8, at 1052-53 (discussing the relevancy of the *Jain* outcome); See generally *United States v. Neufeld*, 908 F. Supp. 491 (S.D. Ohio 1995). In *Neufeld*, the Southern District Court of Ohio used the 1980 amendments to the Anti-Kickback Statute to determine the proper interpretation of “willful.” *Id.* at 496. Specifically, the court stated that Congress included the “knowingly and willfully” standard to protect individuals who inadvertently violated the Anti-Kickback Statute from prosecution. *Id.* The court determined that if someone’s purpose was to commit a wrongful act then there was a willful intent and a violation of the statute. *Id.* at 497. Moreover, the court rejected the Ninth Circuit’s reasoning in *Hanlester* and chose to follow the Eighth Circuit’s reasoning in *Jain*. *Id.* This logic appears to be consistent with the OIG’s interpretation of certain changes to the regulations, because there was concern about the “intent in changing certain language in the definition of discount from ‘in exchange for any agreement to buy a different good or service’ to ‘to include (induce) the purchase of a different good or service.’” Medicare and State Health Care Programs: Fraud and Abuse; Clarification of the Initial OIG Safe Harbor Provisions and Establishment of Additional Safe Harbor Provisions Under the Anti-Kickback Statute, 64 Fed. Reg. 63,518, 63,530 (Nov 19, 1999) (codified at 42 C.F.R. § 1001.952 (2000)). The OIG responded to these concerns by indicating that the changed language was “consistent with the anti-kickback statute, which

C. The Federal Regulations of the Anti-Kickback Statute

The House Report of 1972 indicates Congress's concern with inappropriate transactions that drain resources and contribute to the rising cost of Medicare and Medicaid programs.⁶³ At first glance, it appears that the Anti-Kickback Statute prevents all types of transactions. However, there are five statutory exceptions.⁶⁴ When confusion emerged as to which arrangements qualified as exceptions,⁶⁵ the Medicare and Medicaid Patient and Program Protection Act (MMPPA) of 1987, specifically required the development and promulgation of regulations.⁶⁶

In 1991, the Office of Inspector General (OIG) promulgated a series of "safe harbor" regulations.⁶⁷ The OIG's safe harbor provisions exempted certain business practices from criminal liability under the Anti-Kickback Statute which, on the surface, are capable of inducing referrals under federal and state health care programs.⁶⁸ For example, the Anti-Kickback Statute does not always apply to general discount arrangements.⁶⁹ Congress intended to permit discounts

prohibits inducements to refer Federal health care program business, even if there is no actual referral made or agreement to refer." *Id.*

63. See H.R. REP. NO. 231, at 108 (1971), *reprinted in* 1972 U.S.C.C.A.N. 4989, 5093 (discussing ethical concerns and unlawful acts of professionals in the health care industry).

64. 42 U.S.C. § 1320a-7b(b)(3). These exceptions include: discounts, payments to employees, vendor payments to certain group purchasing organizations, certain waivers of patient co-payments or deductible amounts, and payments under certain risk-sharing arrangements. *Id.*

65. Congress noted that "the existing language of . . . [the] statute is unclear and need[s] clarification." H.R. REP. NO. 95-393, *reprinted in* 1977 U.S.C.C.A.N. 3039, 3055.

66. See Pub. L. No. 100-93, 101 Stat. 680 (1987).

67. 42 C.F.R. § 1001.952 (2000).

68. *Id.* The OIG's creation of safe harbor regulations clarified those "business and payment practices that would not be treated as violations of the anti-kickback statute, even though they technically might not comply with its terms." Linda A. Baumann, *Navigating the Now Safe Harbor to the Anti-Kickback Statute*, 12 No. 3 HEALTH LAW 1, 1 (2000). The safe harbor regulations had a goal to permit "certain non-abusive arrangements, while encouraging beneficial and innocuous arrangements." 64 Fed. Reg. at 63,518. In creating different amendments to the regulatory safe harbor provisions, the OIG examines provisions to ensure that additional exceptions correlate with the goals of the statute. *Id.* at 63,520.

69. 42 U.S.C. § 1320a-7b(b)(3)(A). Specifically,

The bill would specifically exclude the practice of discounting or other reductions in price from the range of financial transactions to be considered illegal under Medicare and Medicaid, but only if such discounts are properly disclosed and reflected in the cost for which reimbursement could be claimed. The committee included this

between businesses and programs when the discount “could fairly [and equally] benefit the Federal health care programs.”⁷⁰ The OIG noted that illegitimate discounts would create problems for federal health care programs possessing the authority to establish appropriate reimbursement levels without draining the programs’ ability to provide appropriate reimbursement.⁷¹ Nevertheless, the OIG created certain measures to ensure that the utilization of legitimate discount arrangements would continue in the industry.⁷²

provision to ensure that the practice of discounting the normal course of business transactions would not be deemed illegal.

H.R. REP. NO. 95-393, *reprinted in* 1977 U.S.C.C.A.N. 3039, 3056. Congress allowed discounting so as to “encourage providers to seek discounts as a good practice which results in savings to medicare and medicaid program costs.” *Id.* The OIG wanted to ensure that discount agreements based on arm’s length transactions were not subject to the restrictions of the statute. 64 Fed. Reg. at 63,530. “The independent status of the safe-harbor provisions from the ‘discount exception,’ however, does not mandate their isolation from each other when one is looking for guidance as to the proper interpretation and application of one of the statutory exceptions to criminal liability.” *United States v. Shaw*, 106 F. Supp. 2d 103, 113 (D. Mass. 2000). Rather, “a court is wise to consider those discounting arrangements the regulatory agency, charged with aiding the implementation of and the corporate compliance with the statute, considers non-fraudulent and non-abusive under the safe-harbor provisions promulgated under the authority granted it by congress.” *Id.*

70. 64 Fed. Reg. at 63,529. The OIG stated that “Congress did not intend to include within this provision the practice of a seller giving away, or reducing the price of, one good in connection with the purchase of a different good.” Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. 35,952, 35,978 (July 19, 1991) (codified at 42 C.F.R. § 1001.952 (2000)).

71. *Id.* Specifically:

[W]here the particular item that is being given away may result in a more effective means of delivering the supplies to the health care provider, these types of discounts cause problems because they often shift costs among reimbursement systems or distort the true costs of all the items . . . [making it] difficult for the Medicare and Medicaid programs to determine the proper reimbursement levels.

Id.

72. *Id.* The OIG is very explicit in the regulations, and provides reporting methods for those transactions that incorporate discounts. 42 U.S.C. § 1320a-7b(b)(3)(A); 42 C.F.R. § 1001.952(h). The discount safe harbor reporting methods focus on whether the entity is a buyer, seller, or offeror. The regulations note that a buyer is: “(i) a health maintenance organization (HMO) or a competitive medical plan (CMP) acting in accordance with a risk contract; (ii) an entity which reports its costs on a cost report [(e.g. hospitals or nursing homes)]; [or] (iii) an individual or entity [that seeks reimbursement through the submission of claims (e.g. physicians or pharmacies)].” 42 C.F.R. § 1001.952(h)(1)(i)-(iii). Although originally not permitted, rebate arrangements are permissible in certain situations. The OIG stated:

Accordingly, we are defining a ‘rebate’ for purposes of the safe harbor as a discount,

Additionally, the 1999 the OIG report addressed other concerns related to discounts that were common and legitimate,⁷³ especially those concerns relating to “bundled goods.”⁷⁴ In response to these concerns, the OIG indicated that the purpose of limitations on discounts for bundled items and services was to ensure that federal health care programs benefited from such arrangements.⁷⁵ The OIG emphasized that when federal health care programs benefit from the arrangements the exceptions would be applicable.⁷⁶

III. SHAM TRANSACTIONS

A. Theory and Background

Sham transactions are transactions that attempt to circumvent the requirements of the Anti-Kickback Statute by manipulating the provisions of the OIG regulations.⁷⁷ Such transactions are those that would satisfy the requirements of the OIG regulations’ safe harbor provision in form, but are “actually a facade for improper relationships hidden beneath.”⁷⁸ The OIG assists prosecutors and

the terms of which are fixed at the time of the sale and disclosed to the buyer at the time of sale, but which is not given at the time of sale. ‘Terms’ refers to the methodology that will be used to calculate the rebate (e.g. percentage of sales or a fixed amount per item purchased during a given period of time).

64 Fed. Reg. at 63,529. For those buyers that fall under 42 C.F.R. § 1001.952(h)(1)(iii), there is no requirement for charge-based buyers to report discounts on costs or claims submitted to federal health care programs. They are required to “provide information documenting the discount upon request of the Secretary [of HHS].” 64 Fed. Reg. at 63,529.

The regulations note that a seller’s requirements for reporting depend on the type of buyer that is involved. 42 C.F.R. § 1001.952(h)(2). A seller does not need to report the amount of the discount to the buyer if the buyer is an HMO 42 C.F.R. § 1001.952(h)(2)(i). For a cost report buyer, the seller must inform the buyer of the discount on the invoice and notify the buyer of its reporting obligations. 42 C.F.R. § 1001.952(h)(2)(ii)(A) & (B).

73. 64 Fed. Reg. at 63,530.

74. *Id.* The OIG upheld their previous ruling declining the incorporation of bundled goods into the discount exception under the regulations. *Id.*

75. *Id.* at 63,529. In situations where an arrangement has the potential for fraud and abuse, the federal government might not be willing to take such risk and exempt an arrangement from the restriction of the Anti-Kickback Statute. Boese & McClain, *supra* note 5, at 28-29.

76. *See supra* notes 71-72 (discussing the OIG’s reporting requirements for services reimbursed by federal health care programs).

77. *See infra* notes 79-80 (discussing the OIG’s sham transaction proposals).

78. *See FABRIKANT ET AL., supra* note 15, at 11.

those within the health care field in determining what types of actions provide evidence of sham transactions.

The OIG regulations first addressed sham transactions that induced patient referrals from physicians through office leases, where the physicians did not use the office itself.⁷⁹ The OIG indicated that this type of arrangement was one of the most frequent forms of Anti-Kickback Statute violations.⁸⁰ In 1994, the OIG proposed a rule that would address sham transactions.⁸¹ The OIG in 1999 declined to incorporate such a rule per se, as commentators indicated that the regulations were already too broad.⁸² Nevertheless, the OIG indicated that if the form of an arrangement did not correlate with the substance of the arrangement, the OIG would be entitled to investigate the transaction.⁸³ The OIG indicated that a contract would not be protected by the safe harbor provisions if it was a sham transaction, and that the same criteria determined whether office and equipment leases were sham contracts for the other safe harbor provisions.⁸⁴

79. See 56 Fed. Reg. at 35,972. The OIG has noted that “sham contracts in which remuneration is exchanged for property that does not exist or space which is not used are among the most egregious kickback arrangements.” *Id.*

80. *Id.* Specifically, in 1991 the OIG stated, “sham office leases in which the space is not actually used are among the most common and abusive kickback schemes.” *Id.* Furthermore, the OIG noted that examples of such situations are when “physicians who entered into office rental contracts with other referring physicians, solely in order to obtain the referrals, and diagnostic services companies and clinical laboratories that lease space from physicians which the laboratories in reality do not use, as kickbacks for the physicians’ patient referrals.” *Id.*

81. Medicare and State Health Care Programs: Fraud and Abuse; Clarification of the OIG Anti-Kickback Provisions, 59 Fed. Reg. 37,202, 37,203 (July 21, 1994) (codified at 42 C.F.R. § 1001). The OIG noted that “[b]ecause of the broad variety of transactions subject to the Medicare and Medicaid anti-kickback statute and the ability of individuals to manipulate the safe harbors in ways not contemplated, we believe that a general rule preventing sham arrangements from receiving safe harbor protection would be appropriate.” *Id.*

82. 64 Fed. Reg. at 63,530.

83. *Id.* The OIG explained:

We emphasize, however, that for purposes of determining compliance with the safe harbors, we will evaluate both the form and substance of arrangements. To be protected, the form must accurately reflect the substance. As we have explained in the context of space and equipment rentals: If a sham contract is entered into, which on paper looks like it complies with these provisions, but where there is no intent to have the space or equipment used or the services provided, then clearly we will look behind the contract and find that in reality payments are based on referrals.

Id.

84. *Id.*

However, when it failed to enumerate the specific circumstantial evidence that demonstrated a violation of the Anti-Kickback Statute, the OIG left the final determination of whether a transaction was a sham to the courts.⁸⁵

B. Anti-Kickback Statute Case Law and Sham Transactions

Cases involving the Anti-Kickback Statute identified some of the different transactions that constituted sham transactions.⁸⁶ In *United States v. LaHue*,⁸⁷ the defendants, attending physicians at a university hospital, desired an increase in their salaries.⁸⁸ The defendants did not receive their request, but received an attractive offer from Baptist Hospital, a competing hospital in the area.⁸⁹ The contract Baptist Hospital offered was primarily for consulting services.⁹⁰ The defendants accepted the contract and substantial referrals began to occur to Baptist from the defendants, while referrals to the university hospital decreased.⁹¹ At the same time, the defendants were receiving compensation while not performing most of their contractual obligations.⁹²

On appeal, the Tenth Circuit concluded that there was sufficient evidence to support conviction.⁹³ The court focused on the fact that the Director of Geriatric Services at Baptist Hospital was not aware

85. *Id.* This is supported by the fact that the OIG did not expand on the “form versus substance” determination. *Id.*

86. *United States v. Liss*, 265 F.3d 1220, 1230-1231 (11th Cir. 2001); *United States v. LaHue*, 261 F.3d 993 (10th Cir. 2001); *United States v. McClatchey*, 217 F.3d 823 (10th Cir. 2000).

87. 261 F.3d at 993.

88. *Id.* at 997.

89. *Id.* At this time, the defendants had significant amounts of patients that required referrals for inpatient hospitalization. *Id.*

90. *Id.* at 997-98. In addition, the parties conducted negotiations in a different manner by establishing a fee for services first and then determining what services the defendants were to perform. *Id.* at 997. There was testimony indicating the fees were higher than the normal amount for similar services. *Id.*

91. *Id.* at 998.

92. *Id.* at 998-1000.

93. *Id.* at 1005. The court determined that “the evidence produced at trial clearly demonstrated defendants negotiated and entered ‘consulting’ contracts in an attempt to camouflage an underlying agreement to exchange remuneration for patient referrals . . . [t]herefore, defendants’ conduct is the very conduct contemplated by the Act.” *Id.*

of the contract between the defendants and the hospital, yet the standard practice warranted the director's knowledge of such agreements.⁹⁴ Despite concerns about the defendants' compensation and lack of services performed, no action was taken by the hospital to stop the defendants from receiving compensation.⁹⁵ Moreover, hospital management knew that the defendants were being paid much more than the standard compensation for their services.⁹⁶

Courts have also found evidence of a sham transaction when one is compensated for services that did not cost anything to provide, or when such compensation significantly deviates from fair market value.⁹⁷ In certain circumstances, such arrangements "lack[] economic reality."⁹⁸ In *United States v. Hemmingson*, Ferrouillet, an attorney, assisted a failed mayoral campaign in New Orleans.⁹⁹ The campaign incurred substantial expenses generating heavy debt.¹⁰⁰ When Ferrouillet failed to raise sufficient funds to pay off the debts, he entered into a contract with the defendant.¹⁰¹ Under the contract's terms, Ferrouillet initially received \$20,000 in the form of a retainer, and would then draw \$1,000 per month for his consulting services.¹⁰² When Ferrouillet received the money, he deposited half of the proceeds into an account to pay off the campaign debts.¹⁰³

The defendant and Ferrouillet were indicted for their fraudulent acts.¹⁰⁴ The Fifth Circuit rejected the defendant's argument that they complied with the contract in good faith.¹⁰⁵ Based on the fact that no work was performed on the contract, yet proceeds were drawn by

94. *Id.* at 999-1000.

95. *Id.* at 1000.

96. *Id.*

97. *See, e.g., LaHue*, 261 F.3d at 999; *McClatchey*, 217 F.3d at 830; *United States v. Schluneger*, 184 F.3d 1154, 1157-58 (10th Cir. 1999); *United States v. Moeller*, 80 F.3d 1053, 1057 (5th Cir. 1996); *United States v. Hemmingson*, 157 F.3d 347, 351-53 (5th Cir. 1988).

98. *Buckmaster v. Commissioner of Internal Revenue*, 1997 WL 266963, *3 (U.S. Tax Ct. 1997).

99. 157 F.3d at 351-52.

100. *Id.* at 352.

101. *Id.*

102. *Id.* The contract was boilerplate and did not contain unique drafting terms. *Id.*

103. *Id.*

104. *Id.* at 352-53.

105. *Id.* at 354. The court determined that the defendant intended the check to go to the "campaign funds" account. *Id.*

Ferrouillet, the court determined that the contract was a sham.¹⁰⁶

Case law has also indicated that deviation from normal standards of practice or protocol may constitute circumstantial evidence demonstrating a sham transaction.¹⁰⁷ In *Hemmingson*, the Fifth Circuit held that deviation from normal industry practice (in this case, the practice of law) demonstrated that the parties never intended to comply with the terms of the contract.¹⁰⁸ Similarly, in *LaHue*, the Tenth Circuit focused on the fact that the Director of Geriatric Services at Baptist Hospital was not aware of the contract between the hospital and the defendants.¹⁰⁹ The court reasoned that under normal practices, the director of such a department would know about agreements that were occurring within the department.¹¹⁰ The court also placed emphasis on evidence indicating that the defendants' fees were higher than the standard amount for similar services.¹¹¹

Contracts created before or during a transaction to conceal the illegal acts of a party have also been held to constitute sham transactions.¹¹² In *United States v. Harris*, the defendant was president and CEO of two corporations.¹¹³ The corporations entered into a loan contract with a bank that enabled them to borrow funds for business operations secured by the corporations' assets.¹¹⁴ In return, the bank required the corporations to maintain minimum levels of capital.¹¹⁵ When the corporations began to suffer financial

106. *Id.* at 354-55.

107. *See, e.g., id.* at 354; *LaHue*, 261 F.3d at 997-99; *Buckmaster*, 1997 WL 266963, *4 (U.S. Tax Ct. 1997). *But cf.* Boese & McClain, *supra* note 5, at 2 (arguing that the government "ignore[s] certain technical violations of the AKA").

108. 157 F.3d at 354.

109. 261 F.3d at 993.

110. *Id.*

111. *Id.* at 1006.

112. *See, e.g., McClatchey*, 217 F.3d at 830; *Jinro America Inc. v. Secure Investment, Inc.*, 266 F.3d 993, 999 (9th Cir. 2001); *United States v. Harris*, 79 F.3d 223 (2d Cir. 1996); *United States v. Scott*, 37 F.3d 1564, 1576 (10th Cir. 1994); *Gerlach v. John Deere Co.*, 897 F.2d 1048, 1050 (10th Cir. 1990); *United States v. Curry*, 681 F.2d 406, 415-16 (5th Cir. 1982); *Cook's Bryan, Inc. v. State of Texas*, 459 S.W.2d 682, 687 (Tex. Civ. App. 1970) ("Making a contract to accomplish an illegal purpose can be expected to try to conceal that purpose.").

113. 79 F.3d at 225-26. *International Inc.* was one company, located in Puerto Rico, and *Arochem* was the other company providing management services to *International*. *Id.* at 226.

114. *Id.*

115. *Id.*

hardships the defendant overstated their financial worth to pass an audit.¹¹⁶ The defendant directed the corporations' management to conceal deficits by creating false contracts showing a generation of income.¹¹⁷ The corporations successfully passed the audit and used the report from the auditors to secure funds from the bank.¹¹⁸ The corporations continued incurring losses, but their financial statements continued to show earnings.¹¹⁹ When it appeared that they were not going to pass the next audit, the defendant created more false documents to conceal deficits.¹²⁰

The defendant received numerous indictments upon the bank's discovery of the corporations' true financial status.¹²¹ The court found that defendant committed bank fraud.¹²² In finding fraud, the court focused on the fact that when it was apparent to the corporations that they were not going to pass the audits, the defendant concealed the financial status of the corporations to obtain more funds from the bank.¹²³ These acts of concealment constituted sham transactions punishable under the Anti-Kickback Statute.¹²⁴

Prior case law also indicates that when someone is eligible to receive funds based on fraudulent statements, such transactions are shams.¹²⁵ In *United States v. Schluneger*, the federal government granted a contract to Minelli for various projects along the Arkansas

116. *Id.*

117. *Id.* The managers from the companies also "created false documents, such as false warehouse receipts and warranty titles, in an effort to make it appear that the . . . contract has been performed." *Id.* Even after these efforts, however, the companies still needed to conceal additional deficits, and thus the managers "responded by altering documents to indicate that the \$25 million in oil purchases had been paid before the end of the prior fiscal year." *Id.* at 227.

118. *Id.*

119. *Id.*

120. *Id.* at 227. "The sham contracts added approximately \$47 million to the assets of the Companies." *Id.*

121. *Id.* at 231-32.

122. *Id.* at 231. Specifically, the "indictment stated that, in order to conceal and disguise the nature, location, source and ownership of funds [Harris] transferred approximately \$7.5 million . . . knowing that these funds were the proceeds of frauds on financial institutions." *Id.*

123. *Id.* at 232. The necessary evidence was the bank extending credit by relying on "on the fraudulent monthly financial statements and borrowing base reports provided by the [defendants]." *Id.*

124. *Id.*

125. *See, e.g.,* In Re Gerlach, 897 F.2d 1048, 1050 (10th Cir. 1990); *United States v. Schluneger*, 184 F.3d 1154, 1159-60 (10th Cir. 1999); *United States v. Thompson*, 125 F. Supp. 2d 1297, 1299 (D. Kansas 2000).

River.¹²⁶ In the event that Minelli defaulted on the contract, the defendants acted as guarantors, covering any loss to the federal government.¹²⁷ Minelli subsequently defaulted on the contract, and the defendants elected to perform the remaining contract obligations themselves using subcontractors.¹²⁸

At the time of the default, the unpaid balance on the contract was \$1,690,000 and the defendants accepted a bid from Skyline to complete the contract for \$1,200,000.¹²⁹ The defendants informed the federal government of their intent to complete the contract and proceeded accordingly.¹³⁰ Unknown to the federal government, however, the defendants had arranged for transactions with the goal of stealing money from the federal government.¹³¹

The defendants arranged for Skyline to complete the \$1,690,000 project for only \$1,200,000, with the remaining \$490,000 going to the defendants.¹³² The defendants justified their receiving this additional money pursuant to another contract providing consulting services to Skyline.¹³³ These fees, however, were false, as the defendants had no intention of performing any consulting work.¹³⁴ When Skyline decided to breach the contract with the federal government, the defendants' plan was discovered.¹³⁵ The defendants were convicted of conspiracy to defraud the government.¹³⁶ The court focused on the fact that the defendants' inflated bids made them eligible for reimbursement levels to which they were not entitled.¹³⁷

126. 184 F.3d at 1156.

127. *Id.*

128. *Id.*

129. *Id.* at 1157.

130. *Id.* This agreement prevented the defendants from receiving any compensation from the work performed, except those costs incurred in the completion of the work. *Id.*

131. *Id.* Specifically, the defendants "entered into a series of agreements . . . which had the intent and effect of billing the government for more than their actual costs and expenses." *Id.*

132. *Id.*

133. *Id.*

134. *Id.* Under the terms of the contract between the defendants and Skyline, Skyline would pay defendants, under a different name, almost 30% of each payment Skyline received from the federal government. *Id.*

135. *Id.*

136. *Id.* at 1157-58.

137. *Id.* at 1158. Moreover, "[a]lthough Skyline believed these fees to be legitimate, in fact they were bogus, and, as the evidence at trial showed, [the defendants never] performed any consulting work." *Id.* at 1157.

IV. ANALYSIS

The OIG becomes concerned when the form and substance of a transaction do not correlate, suggesting a sham transaction in violation of the Anti-Kickback Statute. The fact patterns in the case law discussed in Part III focus on circumstantial evidence sufficient to demonstrate a violation of the Anti-Kickback Statute. Specifically, the conduct this circumstantial evidence demonstrates must run afoul of Congress's intent to prevent inducements and to protect legitimate business transactions, and the courts' concern with whether or not one intends to violate the Anti-Kickback Statute.

One interpretation of the statute's prohibition of remuneration through federal health care programs advocates a policy of preventing individuals from receiving payments for work that they have not done. As previously discussed, prior adjudication has explored scenarios exploiting federal reimbursement, and has deemed such scenarios illegal shams.¹³⁸ Federal health care programs are designed to provide assistance for individuals in need, and reimbursement to companies that provide such assistance. Deceptive tactics to receive reimbursement from the federal government is not only illegal, but also runs afoul of many of Congress's concerns upon enacting the Anti-Kickback Statute.¹³⁹

The Anti-Kickback Statute's legislative history stresses Congress's concern about the misapplication of funds reimbursed under federal health care programs.¹⁴⁰ Congress indicated that one of the main contributors to excessive increases in health care costs¹⁴¹ and the depletion of funds from state and federal health care programs¹⁴² is improper reimbursement. Moreover, such

138. *See supra* Part III.B-C.

139. *See supra* notes 8, 15, 28, 29, 63.

140. *Id.*

141. *See supra* note 35. It is evident that money is a very important factor for both Congress and the OIG. This is apparent in Congress's concern related to legitimate discounts not subject to the Anti-Kickback Statute benefiting the federal health care programs. *See supra* notes 69-70.

142. *See supra* notes 8, 35, 63. Congress was concerned about the stability of state and federal health care programs; this stability is clearly contingent upon the amount of funds available for reimbursement of services provided.

inappropriate reimbursement¹⁴³ creates a burden on taxpayers,¹⁴⁴ making it difficult for the federal government to determine appropriate reimbursement levels under federal health care programs.¹⁴⁵

As previously discussed, prior adjudication has held that significant deviations from standard practices provide circumstantial evidence of sham transactions.¹⁴⁶ It is evident from the Statute's legislative history that both Congress and the OIG want to protect legitimate business deals from the restrictions of the Anti-Kickback Statute.¹⁴⁷ Congress's explicit language exemplifies this policy against infringing upon legitimate arms-length transactions,¹⁴⁸ especially those that financially benefit federal health care programs.¹⁴⁹ This intention is supported by the creation of exceptions and safe harbors, such as discounts.¹⁵⁰ Nevertheless, critical to such a "shield" from the ramifications of a violation of the Anti-Kickback Statute is the legitimacy of such transactions.

Although the courts apply different standards in determining whether one intends to violate the Anti-Kickback Statute,¹⁵¹ the cases discussed reveal how circumstantial evidence can demonstrate intent to violate a particular statute. The notion that a lack of economic reality may provide circumstantial evidence of a sham transaction correlates with the legislative history and the regulations of the Anti-Kickback Statute.¹⁵² However, it is difficult to determine the

143. The author suggests that this behavior is inappropriate based on the language of Congress in describing such behavior as unethical by those individuals in the industry. *See supra* notes 15, 63.

144. *See supra* note 35.

145. *See supra* note 69.

146. *See supra* Part III.B-C. Courts have indicated that certain deviations clearly support that a particular contract was not legitimate and a sham, such as (1) no performance of a contract yet financial compensation, (2) inappropriate billing for services, and (3) breakdowns in communication between appropriate parties.

147. *See supra* notes 67-76 and accompanying text.

148. *See supra* note 69.

149. *See supra* notes 69-70 and accompanying text.

150. *See supra* notes 71-72. It is evident that the OIG approved legitimate discount arrangements as not susceptible to the provisions of the statute when they benefited all parties, including the government. *See supra* note 69.

151. *See generally supra* Part II.B (discussing the different approaches used by the courts in determining intent to violate the Anti-Kickback Statute).

152. *See supra* discussion in Part III.B (discussing fake arrangements as violations of the

economic reality of a transaction when the reimbursement is for services that are never performed.¹⁵³ In addition, the creation of false documentation to conceal an illegal act, or the concealment of an illegal act after becoming aware of an inquiry by the federal government, provides the necessary circumstantial evidence of a sham transaction and a violation of the statute. As mentioned, there are explicit instructions on how providers should report certain transactions, such as discounts.¹⁵⁴ These compliance requirements provide a motive to create false documents to appease the government. Nevertheless, a deliberate deviation from the normal standards of operation provides circumstantial evidence of a willful violation if the normal operations were subject to the limitations of the statute.

In each of these scenarios, the circumstantial evidence indicates an intentional violation of the Anti-Kickback Statute. Unless someone is involved in illegal activities, there appears to be no other reason for the creation of false documentation.¹⁵⁵

V. PROPOSAL

The Anti-Kickback Statute vests the OIG with the authority to administer and interpret regulations. The OIG attempted to clarify which transactions constitute violations of the statute.¹⁵⁶ As implemented, however, it is the courts, not the OIG, who determine whether the evidence is sufficient to show a violation of the statute.

Anti-Kickback Statute).

153. *See supra* discussion in Part III.B. *See also supra* notes 97, 120 and accompanying text (citing cases which hold that a lack of performance, supplemented with financial compensation, demonstrates a lack of intent to comply with contractual terms, making such transactions shams). Congress was clearly concerned about abuses of federal health care programs when enacting the statute, and these actions only drain from the federal health care programs, taking money away from needy individuals. *See supra* notes 8, 63. There is clearly no intent to perform a contract when one receives reimbursement for services not performed, thus negating any good faith and fair dealing effort required by Congress.

154. *See supra* note 72.

155. *See supra* notes 112-24. The prior cases have noted a common theme that someone is knowledgeable about their legal requirements when they decide to create false documentation to make it appear as though their actions are legitimate.

156. *See supra* notes 83-85 (discussing the OIG's approach to addressing sham transactions).

This approach has produced inconsistent interpretations of the intent standard which courts use under the Anti-Kickback Statute.¹⁵⁷ To remedy this situation, the OIG should provide clarity on circumstantial evidence, exemplifying when the form and substance of a particular transaction constitute a sham under the Anti-Kickback Statute.

Such additional guidance would be beneficial in three ways. First, as discussed, the OIG has the vested authority to enumerate regulations relating to the Anti-Kickback Statute.¹⁵⁸ Even though prior adjudication and professional scholarship have attempted to ascertain Congress's intent behind the Anti-Kickback Statute, the legislative history indicates that in the ever changing field of health care, the OIG should facilitate clarity on Anti-Kickback Statute issues.

The OIG's clarification of the type of circumstantial evidence that would demonstrate when the form and substance of a transaction constitute a sham transaction would assist in the debate as to the intent requirement. Clearly, cases in which there are likely to be violations of the Anti-Kickback Statute should not be determined based on what intent requirement is used, or what definition of "willful" is adopted by the court. Rather, such cases should focus on whether or not the accused party attempted to do something that Congress was trying to prevent.

The different scenarios proposed still appear to violate the statute, even though the intent debate is not apparent. In the various scenarios discussed, the willful intent of the alleged violator is so palpable that the issue of what "intent" test to use or what definition of "willful" to adopt is immaterial. There is not an "intent" requirement if sufficient evidence demonstrates that someone created false documentation to conceal transactions that would ordinarily constitute a violation of the Statute. Whether an individual is concealing their actions from those monitoring the transactions, or is receiving prohibited funds, there is intent to deceive the federal government.

157. *See supra* note 153 (discussing the different interpretations of a willful intent to violate the Anti-Kickback Statute).

158. *See supra* notes 77-85.

The OIG's clarification of what actions constitute a sham transaction would provide guidance to those in the health care industry. It is clear that Congress and the OIG want to ensure that legitimate business practices in the health care industry are not subject to the provisions of the Anti-Kickback Statute.¹⁵⁹ Moreover, the legislative history indicates that many transactions can appear to fall within the restrictions of the Anti-Kickback Statute, yet should not be subject to such restrictions.¹⁶⁰ The potential state of bewilderment a health care provider might be subjected to from this language could be clarified though additional guidance from the OIG. Such information would assist health care professionals in the manners in which they operate and how their contract formation can comply with the statute and regulations.

Another approach to this problem is to put the "sham contract" terminology in the Anti-Kickback Statute itself. Having the regulations as the only source to address the issue may not be the best approach, as more individuals may attempt to take advantage of a growing industry. More importantly, even though prior adjudication may be used as authority for an agency's interpretation of a particular statute, inconsistency is less likely to be demonstrated when Congress's intentions are directly addressed in the statute.

Each of these suggestions are realistic. The OIG has the authority to interpret the statute, and can provide ample time for notice and comments from those within the industry. The OIG interpretations might take time, but they could potentially prevent countless dollars in litigation and provide clarity for those within the health care industry. Although incorporating the sham transaction terminology directly into the statute may require a great deal of slow-moving legislative reform, the amendments are feasible and appropriate in light of Congress's purpose in enacting the statute.

159. See *supra* notes 67-76 and accompanying text (discussing the concerns that Congress and the OIG had in ensuring that legitimate business deals were not subject to the provisions of the Anti-Kickback Statute).

160. See *supra* note 68 (discussing when legitimate business transactions do not have to comply with the statute even though such transactions might appear to fall under the statute's restrictions).

VI. CONCLUSION

Congress passed the Anti-Kickback Statute to prevent abuse of federally funded health care programs. Although the statute itself contains areas where its vagueness opens doors to potential abuse, Congress has provided the OIG with the authority to protect against such abuses through the promulgation of regulations. The OIG has begun to address the creative means by which certain individuals have attempted to take advantage of such vagueness by indicating that it would initiate investigations when certain transactions appearing legitimate are actually not.

With the continued amount of money potentially available to be subject to fraudulent actions of others, individuals willing to take such risks will become even more creative in their schemes to drain federally funded health care programs. The OIG will need to express, through regulations, the various types of transactions that constitute sham transactions. Such actions will provide prosecutors and other legal officials with the authority to enforce the Anti-Kickback Statute, with guidance on what evidence to look for, and with the means to provide consistency throughout the federal court system.