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Health Care Referrals out of the Shadows: Recognizing the Looming Threat of the Texas Patient Solicitation Act and Other Illegal Remuneration Statutes

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ARTICLE

HEALTH CARE REFERRALS OUT OF THE SHADOWS: RECOGNIZING THE LOOMING THREAT OF THE TEXAS PATIENT SOLICITATION ACT AND OTHER ILLEGAL REMUNERATION STATUTES

TRENTON BROWN*

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“[I]t always does very great harm to the community to encourage ignorance, error, or deception, in a profession that deals with the life and health of our fellow-creatures.”¹

I. INTRODUCTION

The rising cost of practicing medicine, the increase in health care regulations and enforcement in wake of the Affordable Care Act, and the prevalence of managed care have left physicians with a profession that is less profitable than it once was for many specialties.² In response to these

1. OLIVER WENDELL HOLMES, SR., HOMEOPATHY AND ITS KINDRED DELUSIONS: TWO LECTURES iii-iv (Boston, William D. Ticknor 1842).

2. See LEWIS A. LEFKO, IMPROPER AND ILLEGAL BUSINESS ARRANGEMENTS FOR IMAGING, INFUSION, CLINICAL LABORATORIES AND OTHER ANCILLARY SERVICES, AHILA-PAPERS P02080607, Westlaw (2006) (“With the increase in health care regulations and prevalence of managed

market changes, among other reasons, many physicians have expanded the reach of their medical practices by investing in the provision of ancillary health care services.³ Physicians supplement income from their normal practice with the profits realized from ownership interests in toxicology laboratories, imaging centers, and even pharmacies.⁴ But physicians are not simply passive investors in these organizations that provide ancillary services. They also serve as referral sources, directing their own patients to these laboratories and imaging centers when the patient is in need of additional health screening.⁵

care, physicians have found their profession to be less profitable than in the past.”); Parija Kavilanz, *Medicare Doctors’ Pay to be Cut*, CNN MONEY (Mar. 3, 2013, 5:34 PM), <http://money.cnn.com/2013/03/02/smallbusiness/medicare-doctors-spending-cuts/> [https://perma.cc/2EX6-EZ58] (announcing the tough reality that most physicians treating Medicare beneficiaries will be reimbursed cents on the dollar for their services); Parija Kavilanz, *Doctors Going Broke*, CNN MONEY (Jan. 6, 2012, 9:39 AM), http://money.cnn.com/2012/01/05/smallbusiness/doctors_broke/index.htm?iid=EL [https://perma.cc/DCK2-CFXB] (“Doctors list shrinking insurance reimbursements, changing regulations, rising business and drug costs among the factors preventing them from keeping their practices afloat.”).

3. LEFKO, *supra* note 2; accord OFFICE OF ANALYSIS AND INSPECTION, OFFICE OF INSPECTOR GEN., OAI-12-88-01410, FINANCIAL ARRANGEMENTS BETWEEN PHYSICIANS AND HEALTH CARE BUSINESSES 11 (1989) [hereinafter FINANCIAL ARRANGEMENTS] (“Referring physicians invest in a wide range of businesses. They hold interests not only in independent clinical and physiological laboratories and durable medical equipment suppliers . . . but also in home health agencies, hospitals, nursing homes, ambulatory surgical centers, and health maintenance organizations.”); Patrick A. Sutton, *The Stark Law in Retrospect*, 20 ANNALS HEALTH L. 15, 30, 46 (2011) (noting the exceptions to the Stark Law for certain ancillary services and how to prevent overutilization by physicians); Nancy L. Zisk, *Investing in Health Care: What Happens When Physicians Invest and Why the Recent Changes in the Patient Protection and Affordable Care Act Fail to Protect Patients from their Physicians’ Self-Interest*, 36 SEATTLE U. L. REV. 189, 189 (2012) (commenting that most physicians make money today “by investing in the diagnostic tools and services they recommend” to their patients).

4. See FINANCIAL ARRANGEMENTS, *supra* note 3, at 11 (examining the prevalence of physician compensation with related businesses in the medical industry, focusing on clinical laboratories); Martin F. Idzik, Note, *Physician Ownership in Pharmacies*, 41 NOTRE DAME LAW. 49, 51 (1965) (“As the drug market expanded, and profits became greater, it was only natural for some physicians to look to pharmacy as a profitable investment.” (footnote omitted)).

5. Zisk, *supra* note 3, at 190–91, 195; Marc. A. Rodwin, *Physicians’ Conflicts of Interest: The Limitations of Disclosure*, 321 NEW ENG. J. MED. 1405, 1405 (1989); Rune J. Sørensen & Jostein Grytten, *Competition and Supplier-Induced Demand in a Health Care System with Fixed Fees*, 8 HEALTH ECON. 497, 497 (1999); Sutton, *supra* note 3, at 20. In the 1989 report to Congress, the Office of Analysis and Inspection found:

Patients of referring physicians who own or invest in [independent clinical laboratories] received 45 percent more clinical laboratory services than all Medicare patients in general, regardless of place of service. They also received 34 percent more services from independent clinical laboratories than all Medicare patients in general. This increased utilization of clinical

Meanwhile, physicians have come to realize the benefits of such business endeavors. They may enjoy the provision of improved, comprehensive medical services to patients.⁶ It is more convenient to have a readily available, trusted ancillary services provider to which they can refer patients with confidence. If they have an ownership interest in the facility, they may be endowed with governing authority to help ensure the quality of the services their patients receive.⁷

A diversified medical practice generating such an apparent set of benefits would hardly seem to be grounds for the FBI knocking at a physician's door or the state attorney general's office serving her with lawsuit documents.⁸ In spite of such assumptions, the financial and referral relationships physicians have with ancillary services facilities may not be as innocuous as they seem.⁹

Investment opportunities are susceptible of being assorted into a class of suspect, and possibly unethical, business practices. This sort of practice may consist of a psychiatric mental hospital that covertly pays school guidance counselors to advise the guardians of students to admit their children into the hospital for long-term stays at the guardian's expense.¹⁰

laboratory services by patients of physician-owners cost the Medicare program \$28 million in 1987. This figure does not include any cost associated with increased utilization resulting from physician ownership interests in entities other than independent clinical laboratories.

FINANCIAL ARRANGEMENTS, *supra* note 3, at 18.

6. See Julie Foreman, *Physician Ownership of Health Care Facilities*, 108 ARCH. OPHTHALMOL. 1077, 1077 (1990) (detailing the "two-sided coin" that is physician investment, noting it "possess[es] the potential to improve quality of care" but also warning that it leads to an overutilization of services and conflicts of interest that may negatively impact the provision of services).

7. Cf. Zisk, *supra* note 3, at 195 ("Critics of limiting physician ownership argue that a physician's financial interest in the facility or diagnostic or treatment service to which he or she refers patients 'creates a strong incentive to ensure that it provides high-quality care.'" (quoting Dennis F. Thompson, *Understanding Financial Conflicts of Interest*, 329 NEW. ENG. J. MED. 573, 573 (1993))).

8. See Kathleen Quiroz & Clifford E. Robertson, *More and More Physicians Finding FBI Knocking on Door*, SAN ANTONIO M.D. NEWS (June 22, 2015), <http://sanantonio.mdnews.com/more-and-more-physicians-finding-fbi-knocking-door> [<https://perma.cc/G3KN-VZD5>] (warning physicians to evaluate existing and potential arrangements with healthcare providers and suppliers to ensure they are complying with federal and state fraud and abuse laws).

9. See, e.g., Foreman, *supra* note 6, at 1077 ("[O]verutiliz[ation of] services and the conflict[s] of interest may have the negative effect of increasing Medicare costs, jeopardizing the quality of patient care and improperly influencing the physician's exercise of his independent professional judgment." (quoting Theodore N. McDowell, Jr., *Physician Self Referral Arrangements: Legitimate Businesses or Unethical "Entrepreneurialism"*, 15 AM. J.L. & MED. 61, 65 (1989))).

10. See Gregg Timmons, Comment, *Crisis in the Mental Health Care Industry: An Analysis of the Practices of Private, For-Profit Psychiatric Hospitals and the Governmental Response*, 31 HOUS. L. REV. 323, 331-32 (1994) (recounting a similar story in the early 1990s out of Lubbock, Texas).

Or that of a drug treatment center that compensates a local pharmacy employee \$250 for each underage pregnant girl he refers to the center requesting emergency contraception pills under a threat of contacting the girl's parents or local authorities.¹¹ What physicians who invest in ancillary services facilities may have in common with the scenarios above is that they may be engaging in the practice of exchanging illegal remuneration for healthcare patient referrals.

Through the eyes of the law, the revenues a physician realizes from the profits of the ancillary services facility to which she refers her patients may be viewed in the same manner as the kickback to the school counselor and the \$250-per-head bounty the pharmacy employee earns. All of these payments are made in exchange for the person's referral; and such remuneration's potential to compromise a physician's better medical judgment, at the expense of a patient's wellbeing, is too great a risk. Consequently, Congress and state legislatures have enacted laws that prohibit self-referrals and the exchange of remuneration for referrals, if the provision of ancillary services is not properly structured.¹² The most prominent of these statutes are the Federal Anti-Kickback Statute (the Anti-Kickback Statute)¹³ and the Physician Self-Referral Law—more commonly referred to as the Stark Law.¹⁴ In the State of Texas, the Patient Solicitation Act (the TPSA)¹⁵ follows the Anti-Kickback Statute, prohibiting financial payments and rewards for patient referrals.¹⁶

11. See Kathryn Leaman, *State Anti-Kickback Statutes: Where the Action Is*, HEALTH L. & POL'Y, Fall 2008, at 22, 22 (describing the actual events of a similar story in which drug-abuse counselors threatened pregnant women with adverse state action unless the women enrolled in a specific drug treatment center that was surreptitiously paying the counselors a kickback for each woman referred).

12. Leaman also recognizes that while Congress passed the Anti-Kickback Statute, there are several well-recognized exceptions to help guide a physician's structuring of the transaction: "The statute contains many exceptions, including but not limited to: (1) properly disclosed discounts; (2) a bona fide employee-employer relationship; (3) specific waivers of co-insurances; (4) specific arrangements between vendors and vendees; (5) certain managed care arrangements; and (6) any other arrangements exempted in the regulations." *Id.* at 23.

13. 42 U.S.C. § 1320a-7b (2012), see discussion *infra* Part II.A.1 for a further discussion of the Federal Anti-Kickback Statute and its provisions.

14. *Id.* § 1395nn. Though the Stark Law is a significant federal statute that health care practitioners and attorneys are strongly encouraged to be mindful of, it is not at the heart of this Article and, consequently, will not be evaluated in depth herein.

15. Also known as the Texas Anti-Solicitation Act or the Texas Illegal Remuneration Act. TEX. OCC. CODE ANN. § 102.001 (West 2012).

16. Compare 42 U.S.C. § 1320a-7b(b) (prohibiting remuneration for referrals and providing a violation amounts to a felony), with OCC. §§ 102.001(b)–(c) (following the language of the Anti-Kickback statute by making remuneration for solicitations an offense).

Generally, the Anti-Kickback Statute is implicated when remunerations are solicited, offered, or exchanged for referrals for services or items for which payment may be made, in whole or in part, under a Federal health care program (e.g., Medicare, Medicaid, TriCare).¹⁷ The TPSA, however, is not limited to arrangements involving a Federal health care program, but prohibits any remuneration-for-referrals arrangements, even if they involve private payors.¹⁸ The TPSA does, however, permit any arrangements and practices that the Anti-Kickback Statute permits.¹⁹

Many medical professionals and health care attorneys are intimately familiar with, and prudently observe, the provisions of the Anti-Kickback Statute and the Stark Law.²⁰ It is not apparent, however, that the TPSA is afforded the same level of deference.²¹ Presently in Texas, many health care attorneys and, consequently, their health care provider clients, are vulnerable to a disconcerting interpretation of the TPSA; to wit: it is unenforceable. More specifically, because the TPSA, as currently written, permits any remuneration arrangements that the Anti-Kickback Statute permits, it is easy to believe that the TPSA is only applicable in circumstances that implicate a Federal health care program.²² The argument proceeds that since the Anti-Kickback Statute permits any

17. 42 U.S.C. §§ 1320a-7b, 1395nn. “Federal health care program” is defined as “(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the health insurance program under chapter 89 of title 5); or (2) any State health care program, as defined in section 1320a-7(h) of [Title 42].” *Id.* § 1320a-7b(f).

18. See OCC. § 102.001(a) (prohibiting “any remuneration” (emphasis added)); see also Martin Merritt, *Texas AG Probes Physician Investment in Pharmacies*, PHYSICIANS PRAC. (Feb. 22, 2015), <http://www.physicianspractice.com/blog/texas-ag-probes-physician-investment-pharmacies> [<https://perma.cc/PTA5-AT3Z>] (“The statute is not limited to Medicare and Medicaid, but applies equally to private insurance and cash payers.”). The prohibitions will be discussed in much greater detail at Part II.A.2 *infra*.

19. See OCC. § 102.003 (“Section 102.001 permits any payment, business arrangement, or payment practice permitted by 42 U.S.C. Section 1320a-7b(b) or any regulation adopted under that law.”).

20. See, e.g., Rob Lebow, *Complying with the Stark Law Across Multiple Center Locations*, JUCM (Jan. 31, 2017), <https://www.jucm.com/complying-stark-law-across-multiple-center-locations/> [<https://perma.cc/X2WT-FBJK>] (illustrating the compliance with federal regulations and law regarding ancillary services).

21. See Kenya S. Woodruff & Jennifer S. Kreick, *Physician Investment in Compounding Pharmacies—Under Fire from Texas AG?*, HAYNESBOONE (Mar. 18, 2015), <http://www.haynesboone.com/alerts/physician-investment-in-compounding-pharmacies-under-fire-from-texas-ag> [<https://perma.cc/E6ZF-WJ7F>] (“While the Texas Anti-Solicitation Statute has been in place since 1999, a review of recent case law indicates it rarely has been enforced.”).

22. OCC. § 102.003.

arrangement that doesn't implicate a Federal health care program, then the TPSA permits the same, thus making the TPSA's proscriptions no broader than the Anti-Kickback Statute.²³

With this interpretation of the law in mind, Texas attorneys may be running the risk of counseling health care providers that the TPSA is unenforceable due to its ambiguity. Does it prohibit all remunerations made in exchange for patient referrals, or is it only concerned with arrangements involving Federal health care programs? Alternatively, counsel may suggest that the TPSA allows physicians to be less cautious when referring patients to ancillary services facilities in which the physicians have ownership stake, so long as the facilities don't bill or implicate any Federal health care program. This kind of flawed advice is caused by the erroneous reasoning and subsequent rationalization of a poorly drafted statute that jeopardizes thousands of Texas physicians.

This Article seeks not only to bring the TPSA into greater focus for Texas physicians and their legal representatives, but also to preemptively dispel a potentially viral misunderstanding of the law. In general, this Article expects to clarify the purpose, construction, and effect of the TPSA. More pointedly, this Article aims to inform Texas medical practitioners, and the attorneys who represent them, about the very serious consequences of illegal remuneration arrangements and how those consequences are appearing in greater frequency, under varying laws, and from different prosecutors—both familiar and unexpected. Finally, this Article aims to help the Texas legislature recognize the risks physicians face in misinterpreting the TPSA, and to encourage the legislature to amend and clarify its statutory language.

In Part II, this Article will briefly examine the general provisions of the Anti-Kickback Statute. This background will provide context for the proceeding thorough examination of the TPSA's purpose, legislative history, and the posited intent of the Texas Legislature in passing and amending the TPSA.

In Part III, this Article will discuss the implications of Texas physicians engaging in arrangements that may constitute illegal remuneration practices. In doing so, the discussion will review and examine recent cases

23. Compare 42 U.S.C. §§ 1320a-7b(b)(1)–(2) (2012) (providing liability for violations for any person who “knowingly or willfully” solicits or offers in connection with a Federal health care program), with OCC. §102.001 (“A person commits an offense if the person knowingly offers . . . or agrees to accept . . . any remuneration . . .” (emphasis added)), and OCC. § 102.003 (permitting any practice permitted under the Federal Anti-Kickback Statute).

of referral misconduct and additional statutes that prohibit illegal remuneration arrangements. The analysis will provide better understanding of how physicians' relationships with, and investments in, ancillary services facilities are receiving, and may continue to receive, unexpected attention from the government and other private actors. Additionally, this section will review trends in the structure of investments in ancillary facilities. That discussion will provide better insight into how a practitioner or attorney may identify suspicious business arrangements and how investment structures reveal the potential liability under illegal remuneration laws.

Finally, Part IV of this Article will suggest revisions to the TPSA's current language. The suggested amendments are intended to clarify any ambiguity, dispel contentions of the TPSA's unenforceability, and unequivocally provide physicians and their attorneys with sufficient certainty of the TPSA's prohibitions.

II. ILLEGAL REMUNERATION LEGISLATION

A. *Overview of the Federal and State Statutes*

1. Federal Anti-Kickback Statute

The Anti-Kickback Statute is a criminal statute that prohibits the knowing and willful exchange—or offer to exchange—of anything of value, in an effort to induce or reward referrals of business involving a Federal health care program.²⁴ The Anti-Kickback Statute is designed “to protect patients from inappropriate medical referrals or recommendations by health care professionals who may be unduly influenced by financial incentives.”²⁵ Its original purpose was to protect patients and Federal health care programs from fraud and abuse.²⁶

24. 42 U.S.C. § 1320a-7b(b). For purposes herein, the Anti-Kickback Statute shall refer to the provisions under 42 U.S.C. § 1320a-7b(b) and the regulations promulgated thereunder.

25. OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., SPECIAL FRAUD ALERT: LABORATORY PAYMENTS TO REFERRING PHYSICIANS 1 (2014) [hereinafter LABORATORY PAYMENTS TO REFERRING PHYSICIANS].

26. See OFFICE OF PUB. AFFAIRS, OFFICE OF INSPECTOR GEN., FEDERAL ANTI-KICKBACK LAWS AND REGULATORY SAFE HARBORS 1 (1999) [hereinafter LAWS AND REGULATORY SAFE HARBORS] (“On the books since 1972, the federal anti-kickback law’s main purpose is to protect patients and the federal health care programs from fraud and abuse by curtailing the corrupting influence of money on health care decisions.”).

The Anti-Kickback Law is triggered by, among other things, referrals for any items or services that are reimbursable by Medicare, Medicaid, TriCare, CHIP, or any other Federal health care program.²⁷ In other words, the Anti-Kickback Statute prohibits anyone from knowingly and willfully accepting, providing, or inducing illegal remuneration (e.g., kickbacks),²⁸ in cash or in kind, in exchange for referring patients, whose care is paid for in whole or in part under a Federal health care program, to another person or organization. The payment or offer of remuneration as an inducement for referrals need not be the primary purpose of the relationship between the parties.²⁹ Even if, for example, the payment compensated the referring physician for providing specific services, as long as one purpose of the payment was intended to induce referrals, the federal statute has been violated.³⁰ The law is also dual-edged in that it

27. 42 U.S.C. § 1320a-7b(b).

28. The Anti-Kickback Statute prohibits the exchange of “any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind,” for referrals implicating Federal health care programs. *Id.* §§ 1320a-7b(b)(1)–(2). One commentator adequately explained the meaning of “kickback” in this context:

A kickback is generally defined as a payment by a seller of a portion of the purchase price to the buyer to induce the purchase or future purchases. Kickbacks, like bribes, seek to buy the loyalty of someone in a position of trust. For example, a supplier of medical gauze who pays a kickback to a hospital’s purchasing agent does so to buy the loyalty and duty owed by that agent to the hospital to make purchasing decisions based on the best interest of the hospital. Anti-kickback statutes are similar to statutes prohibiting bribery, however, in that they are both directed at the form of the transaction itself, the buying of loyalty.

Charles J. Williams, *Toward A Comprehensive Health Care Anti-Kickback Statute*, 64 UMKC L. REV. 291, 293 (1995) (footnote omitted).

29. *See, e.g.*, Special Fraud Alert: Physician-Owned Entities, 78 Fed. Reg. 19271, 19272 (Dep’t of Health & Human Servs. March 29, 2013) (notice) (“The anti-kickback statute is violated if even one purpose of the remuneration is to induce such referrals.”).

30. *See United States v. Greber*, 760 F.2d 68, 72 (3d Cir. 1985) (finding the statute was violated “even if the payments were also intended to compensate for professional services” because they were partially used to induce the physician to use services in the future); *see also United States v. Borrasi*, 639 F.3d 774, 781 (7th Cir. 2011) (concluding there was persuasive authority which weighed heavily against adopting a “primary motivation” test; most would agree that the remuneration need only be one purpose in the transaction); *United States v. McClatchey*, 217 F.3d 823, 835 (10th Cir. 2000) (“[A] person who offers or pays remuneration to another person violates the Act so long as one purpose of the offer or payment is to induce Medicare or Medicaid patient referrals.”); *United States v. Davis*, 132 F.3d 1092, 1094 (5th Cir. 1998) (affirming the district court’s determination that the inducement for referrals need not be the only purpose for the payments); *United States v. Kats*, 871 F.2d 105, 108 (9th Cir. 1989) (per curiam) (agreeing with the Third Circuit in *Greber*, that “[e]ven if the physician performs some service for the money received, the potential for unnecessary drain on the Medicare system remains” (quoting *Greber*, 760 F.2d at 71)).

ascribes criminal liability to both the party who accepts or solicits the kickback and the party who furnishes or offers the kickback.³¹ Each violation of the statute constitutes a felony punishable by a maximum fine of \$100,000, imprisonment up to ten years, or both.³²

Congress recognized that the Anti-Kickback Statute implicates a broad range of potentially innocuous commercial transactions. Consequently, certain payment arrangements and practices are specifically exempted by the statute.³³ Congress also authorized the U.S. Department of Health and Human Services Office of the Inspector General (OIG) to adopt regulations as “Safe Harbors” that shield certain payment and business practices from prosecution under the Anti-Kickback Statute.³⁴ These Safe Harbor provisions specify various arrangements that will not be treated as criminal offenses under the Anti-Kickback Statute, despite the fact that they may very well be capable of inducing referrals of Federal health care program business.³⁵

Since 1991, the OIG has enacted over twenty regulatory Safe Harbor provisions developed “to limit the reach of the [Anti-Kickback Statute] somewhat by permitting certain non-abusive arrangements, while encouraging beneficial or innocuous” activity.³⁶ Practices and transactions not specifically included in the statutory exceptions, or protected under the

31. *McClatchey*, 217 F.3d at 835.

32. The Anti-Kickback statute previously provided for penalties up to \$25,000, and imprisonment up to five years; however, it was recently amended in February of 2018 to provide for increased penalties for violations. Bipartisan Budget Act of 2018, Pub. L. No. 115-123, § 50412, 132 Stat. 64, 220–21 (2018) (to be codified at 42 U.S.C. § 1320a-7b). Violations under the Anti-Kickback Statute may also serve as a basis for liability under the Federal False Claims Act, 31 U.S.C. §§ 3729–33. *Id.* § 1320a-7b(g). The False Claims Act prohibits persons from knowingly submitting false or fraudulent claims to the government for payment. 31 USC § 3729(a)(1) (2012). Convictions thereunder subject the violator to civil penalties of \$5,000 to \$10,000 plus three times the damages the U.S. Government sustains because of the violators acts. *Id.* For further discussion of the False Claims Act and liability thereunder, see *infra* notes 229–35 and accompanying text.

33. *See* 42 U.S.C. § 1320a-7b(b)(3) (providing specific exceptions such as discounts or reductions, employer payments made to employees, certain amounts paid by vendors of goods, and coinsurance provisions, among others).

34. *Id.* § 1320a-7b(b)(3)(E). These “safe harbors” are published in the Code of Federal Regulations. 42 C.F.R. § 1001.952 (2015).

35. *See* Medicare and State Health Care Programs: Fraud and Abuse; Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements and Gainsharing, 79 Fed. Reg. 59717, 59717–18 (Oct. 3, 2014) (codified at 42 C.F.R. pts. 1001 & 1003) (acknowledging the need for safe harbors because certain services may be at low risk of harming Federal health care programs if properly structured).

36. Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. 35952, 35958 (July 29, 1991) (codified at 42 C.F.R. pt. 1001).

Safe Harbors, are not necessarily *per se* violations of the Anti-Kickback Statute, but are analyzed by the OIG on a case-by-case basis to determine compliance with the statute.³⁷

What should be understood is that the federal regulations that outline the Safe Harbors “do[] not expand the scope of activities that the [Anti-Kickback Statute] prohibits.”³⁸ The 1991 OIG Anti-Kickback Provisions Final Rule clearly states that its purpose, in fulfilling the Congressional mandate under Section 14 of Public Law 100-93, was to specify various payment practices that will be protected from criminal prosecution and civil sanctions under the Anti-Kickback Statute.³⁹ The Safe Harbors, therefore, are designed to define specific practices that should not be prosecuted under the federal statute, despite the fact that those practices are potentially capable of violating the Anti-Kickback Statute.⁴⁰ Therefore, the Safe Harbor regulations only describe specifically permitted conduct—conduct exempt from the Anti-Kickback Statute. They do not describe prohibited conduct. “The [federal] statute itself describes the scope of illegal activities.”⁴¹

2. The Texas Patient Solicitation Act

a. The Health Care Preface to Legislative Action

Texas’s own illegal remuneration law, the TPSA,⁴² was the result of an abhorrent culture of abusive practices within the mental health industry at the beginning of the 1990s.⁴³ During the early 1980s, a combination of government-created-favorable-financial conditions and dramatic relaxing of state regulations on mental health treatment facilities resulted in an explosion in the number of private psychiatric hospitals across the

37. See LAWS AND REGULATORY SAFE HARBORS, *supra* note 26, at 1 (“Compliance with safe harbors is voluntary, and arrangements that do not comply with a safe harbor must be analyzed on a case-by-case basis for compliance with the anti-kickback statute. Parties who are uncertain whether their arrangements qualify for safe harbor protection may request an advisory opinion.”).

38. Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. at 35954.

39. *Id.* at 35952.

40. See *id.* at 35958 (asserting that these practices would otherwise be illegal under the provisions of the Act).

41. *Id.* at 35954.

42. TEX. OCC. CODE ANN. § 102.001 (West 2012).

43. See generally Timmons, *supra* note 10, at 325–40 (“Once the reports of abuses came to the knowledge of the general public, all branches of Texas government began to investigate the actions of private for-profit psychiatric hospitals.”).

country.⁴⁴ In Texas alone, the amount more than doubled in number, from thirty-four in 1984 to eighty-six in 1991, despite the fact that the number of total hospitals decreased nearly 7% over the same period.⁴⁵

As the late 1980s rolled in, the lax, profitable health-care marketplace had significantly increased psychiatric care costs and competition among private psychiatric hospitals.⁴⁶ Insurers responded to the increased costs of care by decreasing coverage for mental health care, restricting reimbursement for psychiatric services, and instituting the use of managed care companies.⁴⁷ Thereafter, psychiatric hospitals found their revenues falling.⁴⁸

These financial complications for private psychiatric hospitals, combined with the oversaturation of the psychiatric health care marketplace, spawned the environment of abusive practices that ultimately became “the focus of the legislative, administrative, and judicial investigations.”⁴⁹ Reports of egregious private psychiatric hospital business practices and abuses sparked all branches of the Texas government to begin industry-wide investigations.⁵⁰

44. The federal government exempted psychiatric care from the list of diagnostic related groups—“which set the limit of reimbursement under Medicare and Medicaid that it would allow for medical treatment based upon the medical diagnosis or type of surgery performed”—allowing reimbursement for those services generally at the hospital’s discretion. *Id.* at 326 (first citing Susan Gilbert, *Is America Abandoning Sick Patients*, N.Y. TIMES, Apr. 29, 1990, § 6, at 22; and then citing Susan Moffat, *Hospitals: Tactics of Psychiatric Facilities*, L.A. TIMES, Feb. 2, 1992, at A24). Additionally, Texas repealed laws that enforced “certificate of need” restrictions on building hospitals, enabling entities to build hospitals without obtaining governmental approval. Mark Smith, *Profitable Addictions: Marketing Blitz Straddles Line of Medical Ethics*, HOUS. CHRON., Sept. 8, 1991, at A21. Finally, in 1983, the Texas Legislature enacted certain licensing inspection laws that allowed newer psychiatric hospitals to never be inspected by the state. Mark Smith & Cindy Rugeley, *Profitable Addictions: New Psychiatric Hospital Law Flawed*, HOUS. CHRON., Dec. 15, 1991, at D1, 8D; *see also* Leslie Berkman, *Hospital Firm Shows It’s Not Afraid of Risks*, L.A. TIMES, Mar. 31, 1991, at D1, D7 (“David Langness, spokesman for the Southern California Hospital Council[] [said:] ‘There is a major shake-out occurring in the industry.’”). Between 1980 and 1988, private psychiatric hospitals increased in number from 17,157 to 42,615, almost doubling in size. *Id.*

45. Smith, *supra* note 44, at A21.

46. Timmons, *supra* note 10, at 329.

47. *Id.* at 329–30.

48. *See id.* at 330 (“This decrease reduced available revenue to these hospitals because they bill inpatients a certain amount per day.”).

49. *Id.*

50. *Id.* at 340. One standout abuse occurred in 1991, when employees of a private security firm apprehended a 14-year-old boy under threat of establishing a criminal record for him if he did not cooperate. *Id.* at 332. The security agents were operating under the auspices of a doctor at a private psychiatric facility, Colonial Hills Hospital, who never examined or treated the boy but

b. The Bills and the Law

The TPSA was first introduced during the state's budget crisis in 1991, as part of a sweeping landmark legislation under House Bill 7 (HB 7), discussed in the first called session of the 72nd Texas Legislature.⁵¹ Within the wide-encompassing HB 7, the TPSA was established with near parallel provisions of the Anti-Kickback Statute.⁵² The Texas law made "it a criminal offense for health-care professionals to offer to pay or agree to accept remuneration for securing or soliciting patients or patronage."⁵³ The provision sought to "prohibit[] the payment of a 'bounty' for referring patients to particular health facilities."⁵⁴

Most significantly, the TPSA was not limited in the same manner as the Anti-Kickback Statute. Unlike the federal statute, the TPSA makes no

ordered the security officers to detain him. *Id.* The boy, Jeremy, had a younger brother undergoing an evaluation at Colonial Hills, and the doctor ordered Jeremy to be detained, based on an allegation by his younger brother that Jeremy used drugs. Gordon Witkin et al., *Health Care Fraud*, U.S. NEWS & WORLD REPORT, Feb. 24, 1991, at 34, 38, 41. Under the guise of drug-use allegations, the boy was admitted to Colonial Hills on an emergency basis and held for six days. *Id.* at 38. He was released only after then-State Senator Frank Tejada assisted in obtaining a writ of habeas corpus for his release. Timmons, *supra* note 10, at 343; Witkin, *supra*, at 38. The hospital was alleged to have apprehended and detained the boy because he was fully covered for psychiatric care by CHAMPUS, the predecessor to TriCare. *Id.* at 41. A drug test during the boy's hospital stay revealed no drug use. Timmons, *supra* note 10, at 332. This incident sparked national media coverage and is credited as the impetus for the Texas legislature's passage of the TPSA. *See id.* at 333, 343 (noting the incident identified above, along with multiple other reports of abuse, resulted in legislative, administrative, and state action to remedy the abuses); *see also* STEPHEN KLAIDMAN, CORONARY: A TRUE STORY OF MEDICINE GONE AWRY 9–10 (2007) (stating that the business plan of the psychiatric company's business was "to identify and admit patients with good insurance coverage" rather than considering the need of the patient).

51. Act of Aug. 9, 1991, 72d Leg., 1st C.S., ch. 15, § 5.21, sec. 161.091, 1991 Tex. Gen. Laws 325, 325, *repealed by* Act of May 31, 1999, 76th Leg., R.S., ch. 388, § 6, 1999 Tex. Gen. Laws 1083, 2440; Bee Moorhead, *Fixes to Health and Human Services Will Keep Evolving*, STATESMAN (Nov. 19, 2014, 6:00 PM), <http://www.statesman.com/news/opinion/moorhead-fixes-health-and-human-services-will-keep-evolving/59nRpDk5OEsjCq5uI7k9OM/> [<https://perma.cc/N622-LTLY>]. Among other things, HB 7 had the purpose and effect of consolidating twelve state agencies into the singular Health and Human Services Commission, creating a task force to study consolidation and closure of mental health and mental retardation facilities, and adding new enforcement powers for child-support collection. *See* H. Comm. on Appropriations, Bill Analysis, Tex. H.B. 7, 72nd Leg., 1st C.S. (July 24, 1991) (consolidating twelve state agencies into the Health and Human Services Commission).

52. *See* GARY E. MCCLANAHAN, STATE ILLEGAL-REMUNERATION AND SELF-REFERRAL LAWS 6 (2d ed. 2005) ("Texas[s] illegal-remuneration law begins with a close paraphrase of the federal statute . . .").

53. HOUSE RESEARCH ORGANIZATION SPECIAL LEGISLATIVE REPORT: SUMMARY OF 1991 SPECIAL SESSION LEGISLATION, No. 173, 72nd Leg., 1st C.S., at 70 (1991).

54. *Id.*

reference to Federal health care programs.⁵⁵ The letter of the law, as originally codified at then Texas Health and Safety Code § 161.091 (THSC § 161.091),⁵⁶ prohibited persons licensed, certified, or registered by a Texas health care regulatory agency from intentionally or knowingly offering or agreeing to accept “*any* remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to or from any person . . . [or entity] for securing or soliciting patients or patronage.”⁵⁷ The TPSA does not require the remuneration to be tied to Federal health care programs, but instead prohibits the remuneration from any source, which would seem to include private health insurance and cash payments.⁵⁸

The TPSA does, however, articulate exceptions to its prohibitions with reference to the Anti-Kickback Statute. THSC § 161.091(f) originally read: “This section shall not be construed to prohibit any payment, business arrangements, or payments practice not prohibited by 42 U.S.C. Section 1320a-7b(b) or any regulations promulgated pursuant thereto.”⁵⁹ Facially, this provision would appear to limit the TPSA’s prohibitions to those practices prohibited by the federal statute; however, this subsection also created the potential for an ambiguous reading of the TPSA, which has the unintended potential of rendering the law unenforceable. This ambiguity will be addressed later in this Article.⁶⁰ Nevertheless, a plain reading of the Texas statute seems to intimate a set of prohibitions on illegal remuneration for referrals, unbridled by considerations of Federal health care programs.

In 1993, the TPSA underwent several amendments as a part of the Texas Legislature’s response to the findings of the Special Senate Interim Committee on Health and Human Services’ investigation into healthcare

55. Compare 42 U.S.C. § 1320a-7b(b) (2012) (limiting application to Federal health care programs), with TEX. OCC. CODE ANN. § 102.001 (West 2012) (providing that *any* remuneration is a violation of Texas’s illegal remuneration statute).

56. The Texas Illegal Remuneration Statute was originally published in the Texas Health and Safety Code, however, the 76th Legislature repealed and placed the statute into the Texas Occupations Code in 1999. Act of May 31, 1999, 76th Leg., R.S., ch. 388, § 6, 1999 Tex. Gen. Laws 1083, 2440 (codified at OCC. § 102.001).

57. Act of Aug. 9, 1991, 72nd Leg., 1st C.S., ch. 15, § 5.21, sec. 161.091, 1991 Tex. Gen. Laws 325, 325–26 (repealed 1999) (emphasis added).

58. See OCC. § 102.001 (prohibiting remuneration for “securing or soliciting a patient” but not requiring the compensation be in connection to any Federal health care program).

59. Act of Aug. 9, 1991, § 5.21, 1991 Tex. Gen. Laws at 326.

60. See Part II.B.1 *infra* (discussing the potential ambiguity in the TPSA).

abuses in 1991.⁶¹ The amendments to the TPSA were passed as a part of the 73rd Legislature's Senate Bills 210 (S.B. No. 210) and 211 (S.B. No. 211).⁶² These bills were cogs in a larger machination of proposals to reform the mental health industry.⁶³ The reforms were directed toward "strengthen[ing the] protection of patients, improv[ing the] quality of care[,] and severely penaliz[ing] those who violate[d] state laws or regulations."⁶⁴

The 1993 amendments to the TPSA primarily addressed the then existing statutory language that limited its applicability to healthcare professionals only.⁶⁵ After the 1993 amendments, the criminal sanctions of THSC § 161.091's subsection (a) were no longer limited to persons "licensed, certified, or registered by a health care regulatory agency" of Texas.⁶⁶ Thereafter, it was a crime for *any* person to offer to pay or to agree to accept remuneration for referring or soliciting patient referrals.⁶⁷

61. See Act of May 29, 1993, 73d Leg., R.S., ch. 573, § 5.01, secs. 161.091–.094, 1993 Tex. Gen. Laws 2169, 2169–72, *repealed by* Act of May 31, 1999, 76th Leg., R.S., ch. 388, § 6, 1999 Tex. Gen. Laws 1083, 2440 (removing and modifying several sections of the originally drafted 1991 Act); see also SENATE INTERIM COMM. ON HEALTH & HUMAN SERVS., PRIVATE PSYCHIATRIC SUBSTANCE ABUSE, AND MEDICAL REHABILITATION SERVICES IN TEXAS 66 (1992) [hereinafter SENATE INTERIM COMM. REPORT] (recommending that the Texas legislature amend the current statute to address several issues identified, such as prohibiting "any person" from accepting or offering remuneration); Timmons, *supra* note 10, at 343–44 ("[T]he legislature passed a myriad of initiatives designed to address the abuses in the for-profit psychiatric industry.").

62. Act of May 29, 1993, 73d Leg., R.S., ch. 706, § 1, secs. 161.091–.094, 1993 Tex. Gen. Laws 2769, 2769–73 (repealed 1999).

63. See generally Timmons, *supra* note 10, at 340–50 (discussing the large reforms that occurred in the mental health industry including judicial, administrative, and legislative responses to the abuses).

64. Letter from Senate Interim Comm. on Health & Human Servs. to The Honorable Bob Bullock, Lieutenant Governor of Texas (Nov. 2, 1992), in SENATE INTERIM COMM. REPORT, *supra* note 61. Other major mental health bills passed during the 73rd Regular Session of the Texas Legislature include Senate Bills 205 and 207. SENATE RESEARCH CTR., THE 73RD TEXAS LEGISLATURE: SUMMARY OF SIGNIFICANT LEGISLATION 58 (1993).

65. See S. Comm. on Health & Human Servs., Bill Analysis, Tex. S.B. 211, 73d Leg., R.S. (1993) (acknowledging the fact that the then current language of the statute only addressed health-related professions); SENATE INTERIM COMM. REPORT, *supra* note 61, at 65–66 ("[A] steady stream of new allegations have arisen involving individuals who are not regulated by state health care agencies and thus are not subject to the provisions of current law.").

66. See Act of May 29, 1993, § 1, 1993 Tex. Gen. Laws at 2769 (removing the limiting language from the Act).

67. TEX. OCC. CODE ANN. § 102.001 (West 2012). Part of the reason for this change was that during the Senate Interim Committee's public hearings, interviews, and investigations, a steady stream of allegations built up against individuals who were not regulated by state health care agencies—"includ[ing] probation officers, ministers, school counselors, [and] private businesses set

The 1993 amendments also re-designated THSC § 161.091(f) as § 161.091(e) to read, “This section shall *be construed to permit* any payment, business arrangements, or payments practice *permitted by*” the Anti-Kickback Statute and its regulations.⁶⁸ In other words, the language that provided certain exceptions to the TPSA was deleted. In its place language was substituted that permitted those practices that would be otherwise prohibited by the Anti-Kickback Statute.⁶⁹ This change from 1991’s limiting and excepting language, to 1993’s permissive language, with respect to the federal statute,⁷⁰ had the effect of both accomplishing SB 211’s purpose of expanding the authority of Texas’s illegal remuneration law,⁷¹ and eliminating (or at least clarifying) the potentially ambiguous reading of the TPSA.⁷²

The TPSA underwent its final revision in 1999. Pursuant to the Texas legislature’s major revision process of the 1925 Texas statutory classification scheme,⁷³ THSC § 161.091 was repealed and re-codified in the Texas Occupations Code at Chapter 102 (TOC § 102).⁷⁴ The TPSA currently remains in force in the Occupations Code with virtually no substantive changes since the 1993 Amendments.

up to recruit patients”—and thus were not subject to the prohibitions of the TPSA prior to the 1993 amendments. SENATE INTERIM COMM. REPORT, *supra* note 61, at 66. After the 1993 amendments, those kinds of actors were also punishable under the TPSA. See OCC. § 102.001 (prohibiting any remuneration from a *person* without any limitation to health care professionals).

68. Act of May 29, 1993, § 1, 1993 Tex. Gen. Laws at 2770 (emphasis added).

69. See S. Comm. on Health & Human Servs., Bill Analysis, Tex. S.B. 211, 73d Leg., R.S. (1993) (“This bill expands the authority of the existing illegal remuneration law and establishes penalties for violations of this act.”).

70. THSC § 161.091(f) originally read: “This section shall not be construed to prohibit any payment, business arrangements, or payments practice not prohibited by 42 U.S.C. Section 1320a-7b(b) or any regulations promulgated pursuant thereto.” Act of Aug. 9, 1991, 72nd Leg., 1st C.S., ch. 15, § 5.21, sec. 161.091(f), 1991 Tex. Gen. Laws 325, 326 (repealed 1999).

71. S. Comm. on Health & Human Servs., Bill Analysis, Tex. S.B. 211, 73d Leg., R.S. (1993).

72. For a further discussion of the ambiguity concerning the TPSA see Part II.B.1 *infra*.

73. See *Texas v. W. Pub. Co.*, 882 F.2d 171, 173 (5th Cir. 1989) (noting the reorganization of the major statutes then in effect by the Texas legislature in 1925). “The purpose of the [statutory revision] program [was] to clarify and simplify the statutes and to make the statutes more accessible, understandable, and usable.” TEX. GOV’T CODE ANN. § 323.007(a) (West 2013).

74. TEX. OCC. CODE ANN. §§ 102.001–.054 (West 2012). The 1999 recodification of Texas Health and Safety Code § 161.091 in the Texas Occupations Code was a set of non-substantive revisions of statutes “relating to the licensing and regulation of certain professions and business practices.” TEX. LEGIS. COUNCIL, REVISOR’S REPORT OCCUPATIONS CODE TITLE 6, 78C1 SMH–D, 77th Leg., R.S., at i (2000).

B. *Interpreting the Texas Patient Solicitation Act*

1. The Ambiguity

The TPSA has largely gone unobserved in the contemporary health care market—in legal enforcement, healthcare business practices, and in legal consultation.⁷⁵ This is likely due to the fact that the TPSA is susceptible to an ambiguous reading at TOC § 102.003.⁷⁶ As mentioned above, the illegal remuneration prohibitions of § 102.001 are limited in that the TPSA permits “any payment, business arrangement, or payment practice *permitted* by” the Anti-Kickback Statute and its regulations.⁷⁷ The Anti-Kickback Statute only prohibits remuneration for the referral of patients whose care is reimbursable by Federal health care programs.⁷⁸ It could be reasoned that, if the Anti-Kickback Statute only prohibits remuneration for referrals that implicate Federal health care programs, it does not prohibit referral remuneration arrangements that do not involve Federal health care programs, such as private insurance and cash payments.

There is a dearth of substantive legal guidance from the Texas courts and other administrative bodies—which contributes to its perceived ambiguity.⁷⁹ The specious line of reasoning is as follows: the Anti-Kickback Statute permits referral arrangements that do not implicate Federal health care programs, and the TPSA permits anything that the Anti-Kickback Statute permits. Thus, the TPSA permits those same

75. Despite the fact that there have been numerous prosecutions, lawsuits, and investigations that invoke and interpret the federal Anti-Kickback Statute, there has only been one Texas state court lawsuit that has discussed the Texas TPSA. *See infra* Part II.B.2 (discussing the only significant state court case in Texas analyzing the TPSA); *see also* Kevin Krause, *New Texas Law Seeks to Uncover Financial Deals Between Pharmacies, Physicians*, DALL. MORNING NEWS (Feb. 11, 2016), <https://www.dallasnews.com/news/news/2016/02/10/new-texas-law-seeks-to-uncover-financial-deals-between-pharmacies-physicians> [<https://perma.cc/W7PP-SZTB>] (describing physicians willingness to engage in certain “financial arrangements after being told falsely that they meet state and federal laws”); Woodruff & Kreick, *supra* note 21 (“While the Texas Anti-Solicitation Statute has been in place [at Texas Occupations Code §§102.001–.054] since 1999, a review of recent case law indicates it rarely has been enforced.”).

76. Formerly Texas Health and Safety Code section 161.091(f) prior to the 1993 amendments, and Texas Health and Safety Code section 161.091(e) thereafter. Act of Aug. 9, 1991, 72nd Leg., 1st C.S., ch. 15, § 5.21, sec. 161.091(f), 1991 Tex. Gen. Laws 325, 326 (amended 1993) (repealed 1999).

77. OCC. § 102.003 (emphasis added).

78. *See supra* notes 24–38 and accompanying text.

79. *See infra* Part II.B.2, II.B.3 (discussing relevant case law and AG Opinions which have contributed to the perceived ambiguity of the TPSA); *see also* Woodruff & Kreick, *supra* note 21 (illustrating the difficulty in understanding enforcement of fraud and abuse matters in healthcare).

referral arrangements that do not implicate Federal health care programs.⁸⁰

Stated differently, this misleading argument provides that because the Anti-Kickback Statute is silent regarding remuneration-for-referrals arrangements that do not involve Federal health care programs, the Anti-Kickback Statute does not prohibit those practices; and because the Anti-Kickback Statute does not prohibit those practices, by inference alone, the federal statute *permits* those same arrangements. Therefore, if the Anti-Kickback Statute permits remuneration for referrals involving payors that are not Federal health care programs, the TPSA permits the very same.⁸¹ The Anti-Kickback Statute does not prohibit these kinds of remuneration schemes, so conclusively the Anti-Kickback Statute must permit those schemes, thereby permitting those very schemes under the TPSA.⁸²

The above contention that the TPSA essentially prohibits no further conduct than the Anti-Kickback Statute has two potential ramifications. First, at the very least, the TPSA may be interpreted as so overly vague or ambiguous as to warrant it unenforceable.⁸³ The TPSA prohibits *any*

80. In Texas, the TPSA follows the Anti-Kickback Statute, prohibiting financial payments and rewards for patient referrals, and is known as the Texas Anti-Solicitation Act or the Texas Illegal Remuneration Act. OCC. §§ 102.001–.054. However, as noted above, Texas prohibits “any” remuneration, while the Anti-Kickback Statute prohibits remunerations in connection with a Federal health care program. Compare 42 U.S.C. § 1320a-7b(b) (2012) (prohibiting remunerations associated with referrals that may be paid “in whole or in part under a *Federal health care program*” (emphasis added)), with OCC. § 102.001 (prohibiting a person from offering or accepting “*any* remuneration in cash or in kind” (emphasis added)).

81. It is necessary to keep in mind that the TPSA permits payment arrangements permitted under the Federal Anti-Kickback Statute. OCC. § 102.003.

82. Compare 42 U.S.C. §§ 1320a-7b(b)(1)–(2) (containing limitations to federal health care programs), with OCC. § 102.003 (allowing anything permitted under the federal statute).

83. See *Ahearn v. State*, 588 S.W.2d 327, 338 (Tex. Crim. App. 1979) (“A statute is unconstitutionally vague only if persons of common intelligence must necessarily guess at its meaning and differ as to its application.” (citing *Papachristou v. City of Jacksonville*, 405 U.S. 156, 162 (1972))). For purposes of this article, “unenforceable” shall have the same meaning as “unconstitutional” when referring to a statute. The analysis for determining whether a statute is unconstitutional in Texas was clearly laid out in *Battles v. State*.

When reviewing the constitutionality of a statute, we presume the statute is valid and the legislature has not acted unreasonably or arbitrarily in enacting the statute. The burden rests on the party challenging the statute to establish its unconstitutionality. We uphold the statute if we can determine a reasonable construction which will render it constitutional and carry out the legislative intent. To pass a vagueness challenge, a criminal statute must give a person of ordinary intelligence a reasonable opportunity to know what is prohibited. Also, the law must establish determinative guidelines for law enforcement.

remuneration knowingly provided, solicited, or accepted for patient referrals in one provision; but, it seemingly excludes the remuneration arrangements permitted under the Anti-Kickback Statute in another provision.⁸⁴ This distinction means that the law may not sufficiently provide fair notice as to what conduct is made criminal.⁸⁵ Second, the TPSA may be construed as attempting to have it both ways: prohibiting non-Federal health care program remuneration while simultaneously deferring to the purview and limitations of the Anti-Kickback Statute. Under this interpretation, the TPSA runs the risk of being declared preempted by the Anti-Kickback Statute, rendering it unenforceable.⁸⁶

As mentioned at the outset, this Article contends that the TPSA is valid and enforceable; however, the TPSA has garnered very little attention and even less analysis by the courts or under state administrative consideration.⁸⁷ Nevertheless, there are several Texas judicial cases and Texas Attorney General Opinions that evaluate its purpose and applicability.⁸⁸ When considered alongside its legislative history and intent, and with the assistance of insightful case law from other jurisdictions that have considered the federal-state relationship of illegal

Battles v. State, 45 S.W.3d 694, 702–03 (Tex. App.—Tyler 2001, no pet.) (citations omitted) (first citing *Ex parte* Granviel, 561 S.W.2d 503, 511 (Tex. Crim. App. 1978) (en banc); then citing Cotton v. State, 686 S.W.2d 140, 145 (Tex. Crim. App. 1985) (en banc); then citing Ely v. State, 582 S.W.2d 416, 419 (Tex. Crim. App. 1979); and then citing Grayned v. City of Rockford, 408 U.S. 104, 108–09 (1972)).

84. Compare OCC. § 102.001 (prohibiting any remuneration), with *id.* § 102.003 (permitting anything permitted under 42 U.S.C. § 1320a-7b(b)).

85. See *Abearn*, 588 S.W.2d at 338 (requiring statutes to cater to persons of average intelligence in order to be considered constitutional, ensuring fair notice of what is prohibited); *Margraves v. State*, 996 S.W.2d 290, 303 (Tex. App.—Houston [14th Dist.] 1999, pet. granted) (“All criminal laws must give fair notice to the populace as to what activity is made criminal so that individuals have fair warning of what is forbidden.” (citing *Bynum v. State*, 767 S.W.2d 769, 773 (Tex. Crim. App. 1989) (en banc))).

86. See *Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474, 476 (1996) (per curiam) (“In a pre-emption case such as this, state law is displaced only ‘to the extent that it actually conflicts with federal law.’” (quoting *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm’n*, 461 U.S. 190, 204 (1983))).

87. Only two Texas courts and three Attorney General opinions have discussed the TPSA. *Plano Surgery Ctr. v. New You Weight Mgmt. Ctr.*, 265 S.W.3d 496, 501 (Tex. App.—Dallas 2008, no pet.); *New Boston Gen. Hosp., Inc. v. Tex. Workforce Comm’n*, 47 S.W.3d 34, 38–41 (Tex. App.—Texarkana 2001, no pet.); Tex. Att’y Gen. LO-95-041 (1995); Tex. Att’y Gen. LO-93-84 (1993); Tex. Att’y Gen. Op. No. DM-138 (1992).

88. See *infra*, Parts II.B.2, II.B.3.

remuneration laws, the TPSA's legitimate enforceability becomes more apparent.⁸⁹

2. Texas Courts

There is only one Texas state case of record that addressed the TPSA as it appeared when it was codified at THSC § 161.091.⁹⁰ That case involved a hospital appealing a decision of the Texas Workforce Commission regarding the hospital's former employee, whose contract, the hospital alleged, was unenforceable for violating the Anti-Kickback Statute and TPSA.⁹¹ The significance of that decision was that it recognized that both the federal statute and the Texas statute each have exceptions and safe-harbor provisions that exempted the conduct alleged as illegal.⁹² The court ruled that the alleged illegal conduct satisfied the exemptions under the Anti-Kickback Statute as well as its Safe Harbors⁹³ and was equally exempted under the TPSA.⁹⁴ The conduct in question was granted exemption under the TPSA because it was both: (i) specifically permitted under the federal statute, thus satisfying THSC § 161.091(f)'s federal law construction provision,⁹⁵ and (ii) independently exempted under THSC § 161.091(e)'s exemption for marketing and advertising services.⁹⁶

89. A recent set of federal cases has also considered the TPSA's applicability and enforceability in private actions. *See infra* notes 239–82 and accompanying text.

90. *New Boston Gen. Hosp.*, 47 S.W.3d at 38.

91. *Id.*

92. *Id.* at 38–39.

93. *See id.* at 38 (“[The Anti-Kickback Statute] explicitly exempts an employee and employer from [the prohibitions of] Subsections (b)(1) & (2) for any amount paid during the existence of a bona fide employment relationship.” (citing *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 938 F. Supp. 399, 403 (S.D. Tex. 1996), *aff’d in part, vacated & remanded in part on other grounds*, 125 F.3d 899 (5th Cir. 1997))).

94. *Id.* at 39 (identifying the statutory safe harbor provisions for bona fide employee-employer relationships as an exception to the Texas statute as well (citing *Columbia/HCA*, 938 F. Supp. at 403)).

95. *See* Act of Aug. 9, 1991, 72nd Leg., 1st C.S., ch. 15, § 5.21, sec. 161.091, 1991 Tex. Gen. Laws 325, 326 (repealed 1999) (“This section shall not be construed to prohibit any payment, business arrangements, or payments practice not prohibited by 42 U.S.C. Section 1320a-7b(b) or any regulations promulgated pursuant thereto.”).

96. *See New Boston Gen. Hosp.*, 47 S.W.3d at 38–39 (concluding that both statutes provide exemptions for the type of marketing undertaken by the employee in this case). Prior to the TPSA's 1993 amendments, the TPSA provided at section 161.091(e) that the TPSA:

[S]hall not be construed to prohibit remuneration for advertising, marketing, or other services that are provided for the purpose of securing or soliciting patients provided the remuneration is

Only one other Texas state court case has substantively analyzed the provisions of the TPSA.⁹⁷ Therein, the court briefly addressed a similar argument as above—whether a contract was unenforceable because it violated the TPSA.⁹⁸ The court briefly examined the same marketing and advertising exemption under the statute, found that the contract fit within the exemption, and proceeded to consider other legal issues without any further analysis of the TPSA.⁹⁹

Aside from the Texas state court cases, several federal district courts in Texas have, in varying degrees, considered the TPSA.¹⁰⁰ *DAC Surgical Partners v. United Healthcare*,¹⁰¹ stands out among these cases, as it is the one rare case comparing the purview of the TPSA with that of the Anti-Kickback Statute.¹⁰² In *DAC Surgical*, dozens of physician-owned professional associations (PAs) filed suit against the insurance company United Healthcare for wrongfully refusing to pay millions of dollars in “facility fees” for surgeries the physician owners of the PAs performed for United Healthcare’s insured at a Houston Ambulatory Surgical Center

set in advance, is consistent with the fair market value of the services, and is not based on the volume or value of any patient referrals or business otherwise generated between the parties.

Act of Aug. 9, 1991, § 5.21, 1991 Tex. Gen. Laws at 326.

97. *Plano Surgery Ctr. v. New You Weight Mgmt. Ctr.*, 265 S.W.3d 496, 501 (Tex. App.—Dallas 2008, no pet.).

98. *Id.* at 500.

99. In this civil suit for breach of contract among private persons, the defendant argued on appeal that the contract on which the suit was based violated the TPSA, “making the arrangement illegal and unenforceable.” *Id.* at 501. Determining that illegality of contract is an affirmative defense; the court ruled that the defendant waived the defense by not presenting evidence of it at trial. *Id.* at 501–02 (citing TEX. R. CIV. P. 94; *MJR Corp. v. B & B Vending Co.*, 760 S.W.2d 4, 22 (Tex. App.—Dallas 1988, writ denied)). Nevertheless, the court decided that the contract here, a letter of intent, was not facially illegal by the defendant paying the plaintiff “for ‘marketing services’ not involving the securing or soliciting of patients other than through advertising permitted by [TOC] section 102.004.” *Id.* at 502.

100. *See, e.g., Koenig v. Aetna Life Ins. Co.*, No. 4:13–CV–0359, 2015 WL 6554347, at *7 (S.D. Tex. Oct. 29, 2015) (“Aetna contends that NCMC’s ‘prompt pay discount program’ violates state law, particularly §§ 101.201, 102.003 of the Texas Occupations Code, on the basis that NCMC engaged in false, misleading or deceptive advertising.”). This Article discusses federal cases analyzing the TPSA below. *See* Part III.A.1, *infra*.

101. *DAC Surgical Partners v. United Healthcare Servs., Inc.*, No. 4:11–CV–1355, 2016 WL 7177881, slip op. (S.D. Tex. Dec. 8, 2016).

102. *See id.* at *14 (“The Federal Anti-Kickback Statute is similar to the Texas Patient Solicitation Act but applies only to referrals for services paid by federal health care programs, not by private insurers such as [Defendant].” (citing 42 U.S.C. § 1320a-7b (2012))).

(ASC).¹⁰³ United Healthcare raised counterclaims against the PAs and their physician owners.¹⁰⁴

In *DAC Surgical*, the PAs entered into facility use agreements in which the PAs would perform surgeries at the ASC and would be entitled to 50% of the facility fees that the ASC collected from insurers such as United Healthcare.¹⁰⁵ United Healthcare alleged that the PAs were merely “shell companies” who were not licensed surgical facilities.¹⁰⁶ United Healthcare claimed that the use agreements with the ASC served the sole purpose of funneling kickbacks to the physician owners of the PAs in exchange for scheduling their surgical procedures at the ASC.¹⁰⁷

United Healthcare sought declaratory judgment that the PAs' facility fee-sharing (use) agreements were void based on their illegality, thus relieving United Healthcare of liability for the PAs' claims.¹⁰⁸ Among those Texas laws that United Healthcare alleged the PAs had violated in their use agreements was the TPSA.¹⁰⁹ In a succinct comparison of the TPSA and the Anti-Kickback Statute, the court observed that both laws are similar to each other, but that the federal statute “applies only to referrals for services paid by federal health care programs, not by private insurers.”¹¹⁰

In this brief consideration, the federal court analyzed the Anti-Kickback Statute alongside the TPSA. The court cursorily, but specifically, acknowledged that the federal law is different from the TPSA, in that the federal law is limited to Federal health care programs and the TPSA is not.¹¹¹ Currently, this court's analysis is the only one to intimate that the TPSA does, in fact, prohibit referrals involving kickbacks irrespective of the source of funds, whereas the Anti-Kickback Statute is limited to those affecting Federal health care programs.

103. *Id.* at *2–3.

104. United Healthcare's counterclaims included additional professional organizations and physicians. *Id.* at *2.

105. *Id.*

106. *Id.* at *3.

107. *Id.* at *5.

108. *Id.* at *14 (“United seeks two declaratory judgments that are based on both the public policy in Texas that a party cannot recover for claims that arise from its own illegal or fraudulent conduct and plan provisions, namely that: (1) United is not liable for any of the pending charges for facility fees for services provided at [the ASC]; and (2) that the [use agreements] that the [PAs] entered into with [the ASC] are void *ab initio*.” (internal quotation marks omitted)).

109. *Id.*

110. *Id.*

111. *Id.*

3. Texas Attorney General Considerations

The Texas Attorney General (AG) Opinions provide slightly better guidance regarding the construction and disposition of the TPSA.¹¹² Unfortunately, the AG Opinions' consideration of the TPSA's applicability to Federal health care programs varies among the different attorneys general.¹¹³ The variance, however, seems to align with the changes in language of the TPSA's construction provisions. The AGs' analyses of the TPSA's relation to Federal health care programs vacillate as the language referencing the Anti-Kickback Statute changed.

The first AG Opinion evaluating the prohibitions of the TPSA came in 1992.¹¹⁴ There, the AG responded to a hospital's inquiry of whether it could compensate on-call physicians who admit emergency room patients with a flat fee or a per diem fee without violating the TPSA.¹¹⁵ The AG determined that this kind of arrangement was exempted from criminal liability under the Anti-Kickback Statute as satisfying one of the Safe Harbors.¹¹⁶ The AG concluded that because the arrangement was exempted from criminal liability under the federal statute, it was also exempted under the TPSA by virtue of then THSC § 161.091(f), which provided that the TPSA "shall not be construed to prohibit any payment . . . not prohibited by" the Anti-Kickback Statute or its regulations.¹¹⁷

112. Despite the fact that in construing a criminal statute, administrative construction, such as Texas AG Opinions, may have little persuasive influence on a court evaluating the express meaning of the legislature, a court may nonetheless consider such administrative construction of a statute. *Compare* *Shires v. State*, 191 S.W.2d 475, 476 (Tex. Crim. App. 1945) (per curiam) ("In construing a criminal statute . . . administrative construction may have but little, if any, persuasive force in reaching a judicial conclusion as to the express meaning of the legislature."), *with* TEX. GOV'T CODE ANN. § 311.023(6) (West 2013) (allowing a court to consider administrative construction, among other things, in construing a facially ambiguous statute).

113. *Compare* Tex. Att'y Gen. LO-95-041 (1995) (exempting arrangements that satisfy the regulations promulgated under the Anti-Kickback Statute as specifically permitted under the THSC), *with* Tex. Att'y Gen. LO-93-84 (1993) ("This provision is intended to prohibit only payments, business arrangements, and payments practices prohibited by the anti-kickback provision of the Medicare law, and regulations promulgated thereunder.").

114. Tex. Att'y Gen. Op. No. DM-138 (1992).

115. *Id.*

116. *Id.* The AG, however, explained that it was beyond the purview of the AG Opinion process to review the particulars of any contract to determine whether it satisfies specific statutory requirements. *Id.* The AG spoke more in hypotheticals, e.g., "[a]ssuming . . . the contracts are as you describe them," in order to surmise that the contracts would be exempted from criminal liability under the federal statute's Safe Harbors. *Id.*

117. *Id.*

This AG Opinion appears to construe the “not prohibited” provision of the pre-1993 amendments of THSC § 161.091(f) to mean “permitted.” Additionally, the AG specifically identifies a Safe Harbor of the Anti-Kickback Statute and uses that specific Safe Harbor as the exempted conduct under THSC § 161.091.¹¹⁸ In addition, the AG describes the prohibitions under the Anti-Kickback Statute as “criminaliz[ing] kickbacks in Medicare and federally-funded state health care programs.”¹¹⁹ Yet the AG broadly describes the TPSA as “prohibit[ing] health care professionals from accepting remuneration for securing or soliciting patients or patronage” with no mention of Federal health care programs.¹²⁰ This abstention from categorizing the Texas statute as a prohibition of referrals-for-remuneration schemes implicating Federal health care programs may ultimately prove instructive on whether the TPSA is enforceable.

The next AG Opinion, in 1993, similarly categorized the TPSA broadly, stating that it “prohibits licensed health care personnel from giving or receiving illegal remuneration.”¹²¹ The opinion continues, however, explaining, “This provision is intended to prohibit only payments, business arrangements, and payments practices prohibited by the anti-kickback provision of the Medicare law, and regulations promulgated thereunder.”¹²² This observation seems to intimate that the prohibitions of the TPSA only concern the same prohibitions of the federal statute or its regulations.¹²³ The AG’s language here thus supports the potential for an ambiguous reading of the TPSA.

The AG wrongly asserted that the regulations promulgated under the Anti-Kickback Statute prohibit certain conduct.¹²⁴ As previously discussed, the OIG itself has clearly specified that the Safe Harbor

118. *See id.* (“Assuming . . . that the contracts . . . do not ‘involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law,’ then persons making payments under such contracts are exempted from criminal liability . . .” (citations omitted) (quoting 42 C.F.R. § 1001.952(d)(6) (2015))). The reader should keep in mind that the Safe Harbors are defined as “payment practices [that] shall not be treated as a criminal offense” under the Anti-Kickback Statute. 42 C.F.R. § 1001.952 (2015).

119. Tex. Att’y Gen. Op. No. DM-138 (1992).

120. *Id.*

121. Tex. Att’y Gen. LO-93-84 (1993).

122. *Id.*

123. *See id.* (furthering the potential misconception of the TPSA by emphasizing that the Anti-Kickback Statute criminalizes remunerations in connection with services paid under Medicare).

124. *Id.*

regulations do not prohibit any conduct.¹²⁵ The AG's intimation here not only misconstrued the purpose of the Safe Harbor regulations, but, in the process, developed misconceived administrative guidance regarding the construction provision of the TPSA. The AG possibly contributed to any perceived or potential ambiguity in the Texas statute.

It is important to emphasize that this 1993 AG Opinion was published prior to the enactment of the 1993 amendments.¹²⁶ Therefore, a proper statutory analysis cannot summarily dismiss this AG's direct contextualizing of the TPSA in terms of Federal health care programs, particularly considering that its conclusion may very well be the genesis of an ambiguous interpretation of the TPSA. But, considering this AG Opinion was decided prior to the 1993 amendments and misconstrues the purpose of the federal Safe Harbor regulations, this AG's conclusions cannot be considered dispositive either.

An AG Opinion from 1995 may arguably be the most significant and germane of its kind in developing an understanding of the TPSA.¹²⁷ Unfortunately, while proving instructive, it also remains as incomplete and unsatisfying as other administrative guidance on the TPSA.¹²⁸ The 1995 AG Opinion addresses the question of whether the TPSA prohibits a physician from investing in, and referring patients to, a business entity "that offers monitoring services to high risk obstetrical patients."¹²⁹ Once again, the AG distinguishes the Texas and federal illegal remuneration statutes by disregarding any reference to Federal health care programs when discussing the TPSA.¹³⁰ Meanwhile, the opinion describes the Anti-Kickback Statute's prohibitions as "generally criminaliz[ing] kickbacks in Medicare and federally-funded state health care

125. *See supra* notes 38–41 and accompanying text.

126. The 1993 amendments changed the "not prohibited" language of THSC section 161.091(f) to the "permitted" language of THSC section 161.091(e), and the current construction provision at TOC section 102.003. Act of May 29, 1993, 73d Leg., R.S., ch. 573, § 5.01, sec. 161.091(f), 1993 Tex. Gen. Laws 2169, 2170 (repealed 1999).

127. *See* Tex. Att'y Gen. LO-95-041 (1995) (considering the role a physician may have in "a business entity that offers certain health care services").

128. There are various other AG Opinions in which the TPSA was at least mentioned but not considered in any worthwhile or related manner. *See* Tex. Att'y Gen. LO-94-001 (1994) (concluding there were not enough facts to conclude whether the acts in question ran afoul of the TPSA); Tex. Att'y Gen. DM-276 (1993) (referring to the TPSA to conclude there was no liability without a thorough analysis).

129. Tex. Att'y Gen. LO-95-041 (1995).

130. *See id.* (assuming the acts in question ran afoul of the Texas statute although there was no reference to a Federal health care program).

programs.”¹³¹ The business arrangements in question in the 1995 AG Opinion involved physicians referring their patients to a monitoring company in which the physicians were investors.¹³² “[T]he monitoring company [did] not directly furnish the monitoring equipment and services, [but it did] receive payments from the patient or third-party payor, such as the patient’s health insurance company.”¹³³

Despite expressly acknowledging that liability under the Anti-Kickback Statute required implicating a Federal health care program, the 1995 opinion was notably silent on such requirement when analyzing the TPSA.¹³⁴ The AG contributed to the inadequacy of valuable analysis of the TPSA, however, by concluding that the petitioners here did not provide adequate information to determine whether their business arrangement satisfied the exemptions or safe harbors of the Texas or federal statutes.¹³⁵

Nevertheless, the AG acknowledged that the monitoring company appeared to violate the TPSA “by providing an investment return to the physicians who refer the patients to the company.”¹³⁶ This interpretation may indirectly acknowledge that an illegal remuneration scheme that involves private payors (rather than Federal health care programs) may violate the TPSA. The 1995 opinion concludes that “an investment arrangement that *satisfies certain federal regulations* may be exempt from the prohibition set forth in [the TPSA].”¹³⁷ The AG intimates that if a remuneration scheme constitutes specifically protected conduct under the Safe Harbors—as opposed to merely qualifying as unspecified non-prohibited conduct (as the pre-1993 amendments of THSC § 161.091(f) and the 1993 AG Opinion, above,¹³⁸ possibly contemplate)—then such a scheme may be exempt from criminal liability under the TPSA.¹³⁹

131. *Id.*

132. *Id.*

133. *Id.* The monitoring services company in which the referring physicians were investors, “contract[ed] with a second company to provide the monitoring equipment and services to the [referred] patients.” *Id.*

134. *See id.* (lacking any reference to a Federal health care program requirement in the analysis of the potential violation).

135. *Id.*

136. *Id.*

137. *Id.* (emphasis added).

138. *See supra* notes 121–26 and accompanying text.

139. Tex. Att’y Gen. LO-95-041 (1995).

4. Case Law from Other Jurisdictions

Like Texas, many states have enacted their own state-level illegal remuneration statutes.¹⁴⁰ Several state statutes specifically implicate Federal health care programs, and some simply mirror the federal statute.¹⁴¹ Among those states, there are two leading state-level cases that discuss their respective state's statutes with regard to the Anti-Kickback Statute.¹⁴² Though these cases specifically considered whether their respective state law was preempted by the Anti-Kickback Statute, their legal analysis is relevant to understanding whether the TPSA is enforceable. Specifically, these state court analyses of federal preemption provide a better understanding of what the purpose and bounds of the Anti-Kickback Statute are with respect to state counterparts. These cases further demonstrate what conduct is prohibited under the federal statute and the reasoning behind those prohibitions.¹⁴³

The first case, *State v. Harden*,¹⁴⁴ was decided in the Florida State Supreme Court in 2006. There, ten individuals were engaged in a “pay for patients” arrangement with three corporate entities that provided dental services to children.¹⁴⁵ The alleged misconduct involved individuals soliciting Medicaid-eligible children and driving them to the corporate entities for dental treatment in exchange for a payment per each child that was treated.¹⁴⁶ The defendants argued “that the payment of wages by a Medicaid provider to its employees for the solicitation and transportation of Medicaid-eligible children to dental facilities for treatment was expressly protected by” the Anti-Kickback Statute and the Safe Harbors thereunder.¹⁴⁷ The defendants thus posited that Florida's attempt to prosecute activity expressly protected under federal statute was unconstitutional under the U.S. Constitution's Supremacy Clause.¹⁴⁸

140. See, e.g., LA. STAT. ANN. § 46:438.2 (2015) (providing similar provisions to that of the TPSA, along with specifically enumerated safe harbors, and language recognizing “[a]ny other ‘safe harbor’ exception created by federal or state law or by rule”).

141. See MCCLANAHAN, *supra* note 52, at 6–7 (explaining the several approaches states may take in promulgating state illegal remuneration statutes).

142. *People v. Guiamelon*, 140 Cal. Rptr. 3d 584, 593–96 (Ct. App. 2012); *State v. Harden*, 938 So. 2d 480, 486–93 (Fla. 2006).

143. See *infra* notes 211–15 and accompanying text.

144. *State v. Harden*, 938 So. 2d 480 (Fla. 2006).

145. *Id.* at 484.

146. *Id.*

147. *Id.*

148. *Id.*

The challenged Florida statute (Florida Kickback Statute) under which the defendants were charged made it unlawful to “[k]nowingly solicit, offer, pay, or receive any remuneration . . . in return for referring an individual to a person for the furnishing . . . of any item or service for which payment may be made . . . under the Medicaid program.”¹⁴⁹ The Florida court held that the Florida Kickback Statute was preempted by the Anti-Kickback Statute under a conflict preemption theory.¹⁵⁰ Under this theory “it is impossible to comply with both the state and federal regulations or where state law is an obstacle to accomplishing the full purposes and objectives of Congress.”¹⁵¹ The court determined the Florida Kickback Statute: (i) allowed “a lower mens rea element[,] which permit[ted a state] anti-kickback violation based on negligent behavior,” and (ii) possessed no exceptions or safe harbors.¹⁵² Consequently, the court held that the Florida Kickback Statute criminalized conduct that the Anti-Kickback Statute “specifically intended to be lawful and shielded from prosecution.”¹⁵³

The Florida Court made several key observations regarding federal law, specifically with respect to the Anti-Kickback Statute. First, there is a “presumption against federal pre-emption of a state statute designed to foster public health [and that presumption] has special force when it appears . . . that the two governments are pursuing common purposes.”¹⁵⁴ Second, “Congress was concerned that the [Anti-Kickback Statute] was so broad that ‘some relatively innocuous commercial arrangements were technically covered by the statute and therefore were subject to criminal prosecution.’”¹⁵⁵ This was essentially why Congress added the knowing and willful *mens rea* standards and directed the OIG to

149. *Id.* at 490 (quoting FLA. STAT. § 409.920(2)(e) (2000)).

150. *See id.* at 493 (“[T]he Florida anti-kickback statute is preempted because it presents an obstacle to the accomplishments of the purposes of the federal law.”).

151. *Id.* at 490 (citing *Gade v. Nat’l Solid Wastes Mgmt. Ass’n*, 505 U.S. 88, 98 (1992)).

152. *Id.* at 491, 492.

153. *Id.* at 492–93.

154. *Id.* at 486 (quoting *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 646 (2003)). The Anti-Kickback Statute was “primarily concerned with outlawing health care referrals that were considered unethical or inappropriate.” *Id.* at 487 (citing Social Security Amendments of 1972, Pub. L. No. 92-603, § 242(b), 86 Stat. 1329, 1419 (1972)).

155. *Id.* at 492 (quoting 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. 63518, 63518 (Nov. 19, 1999) (codified at 42 C.F.R. pt. 1001)).

promulgate the Safe Harbors.¹⁵⁶ The Florida Kickback Statute's lower *mens rea*, and lack of exceptions and safe harbors, meant that it stood "as an obstacle to the accomplishment and execution of the full purposes and objective of Congress."¹⁵⁷ The court, therefore, found that the Florida statute was preempted based on an obstacle preemption theory.¹⁵⁸

The second case, *People v. Guiamelon*,¹⁵⁹ took place in the California Court of Appeals in 2012, with a similar set of facts to those of *Harden*.¹⁶⁰ In *Guiamelon*, the defendant, a pediatric physician, was approached by marketers claiming they could help her increase her client base.¹⁶¹ The defendant engaged the marketers to bring patients by driving or directing them to her office.¹⁶² She paid the marketers \$20 for each referred patient who qualified for, and actually enrolled in, a Federal health care program.¹⁶³ She was convicted for offering rebates for patient referrals in violation of California's Business and Professions Code (California Kickback Statute).¹⁶⁴

On appeal, the defendant challenged the conviction, contending that the California Kickback Statute was preempted by the Anti-Kickback Statute.¹⁶⁵ She posited an obstacle preemption theory, arguing that the California Kickback Statute interfered with Congress's "objective of providing health care services to the underserved."¹⁶⁶ The defendant's argument maintained that the California Kickback Statute was preempted

156. *State v. Rubio*, 967 So. 2d 768, 773 (Fla. 2007) (citing *State v. Harden*, 938 So. 2d 480, 487–89 (Fla. 2006)).

157. *Harden*, 938 So. 2d at 485 (quoting *State v. Harden*, 873 So. 2d 352, 355 (Fla. Dist. Ct. App. 2004)).

158. *Id.* at 495.

159. *People v. Guiamelon*, 140 Cal. Rptr. 3d 584 (Ct. App. 2012).

160. Compare *id.* at 589 (discussing how *Guiamelon*, a licensed physician, paid marketers for each referred patient who qualified for, and enrolled in, a federal health care program), with *Harden*, 938 So. 2d at 484 (describing alleged misconduct involving "the payment of wages by a Medicaid provider to its employees for the solicitation and transportation of Medicaid-eligible children").

161. *Guiamelon*, 140 Cal. Rptr. 3d at 589.

162. *Id.*

163. *Id.* It is worth noting that the physician-defendant was a provider for various government health care programs for the poor, "treat[ing] primarily low-income Spanish-speaking patients." *Id.* Prior to engaging the marketers, she tried to increase her client base through seemingly innocuous marketing measures, including flier distribution, billboards, and health fairs. *Id.*

164. *Id.* at 590.

165. *Id.* at 588.

166. *Id.* at 588–89.

specifically because it punished negligent and inadvertent conduct, which was allowed under the Anti-Kickback Statute.¹⁶⁷

Unlike the Florida Kickback Statute, but similar to the TPSA, the California Kickback Statute's prohibitions do not consider whether a Federal health care program was implicated.¹⁶⁸ Like Texas, California prohibits a broader base of activity—seemingly any remuneration for patient referrals.¹⁶⁹ The California appellate court determined that the California Kickback Statute was enacted to “ensure that referrals would not be induced by considerations other than the best interest of the patient” and to “prevent patients being charged more for treatment because of an additional hidden fee imposed to recoup payment for securing the referral.”¹⁷⁰ The court found that the purpose of the California Kickback Statute was consistent with that of the Anti-Kickback Statute—“to prohibit and punish payment for referrals to medical providers.”¹⁷¹ The defendant's obstacle preemption claim consequently failed.

Of particular importance to our analysis here was the California court's discussion of its own state case law regarding obstacle preemption, to wit, the idea of state law prohibiting what federal law permits.¹⁷² In discussing whether obstacle preemption exists simply because a state statute prohibits what the federal law permits, the court borrowed a line of reasoning from a prior case of similar legal subject matter.¹⁷³ In that prior case, the appellants argued that a California penal statute prohibiting the

167. *Id.* at 604. The Anti-Kickback Statute requires a willful or knowing scienter, a higher *mens rea* standards than negligence. 42 U.S.C. § 1320a-7b(b) (2012).

168. Compare FLA. STAT. ANN. § 409.920(2)(a) (West 2013) (prohibiting remuneration in connection with a Medicaid program), with CAL. BUS. & PROF. CODE § 650 (West 2017) (making no reference to any Federal health care program), and TEX. OCC. CODE ANN. § 102.001 (West 2012) (prohibiting any remuneration with no limitation to Federal health care programs).

169. *Guiamelon*, 140 Cal. Rptr. 3d at 595 (“Section 650 . . . makes it unlawful for any physician to offer ‘any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person . . .’” (emphasis added) (quoting CAL. BUS. & PROF. CODE § 650(a) (West 2012))).

170. *Id.* (quoting 65 Op. Cal. Att’y Gen. 252 (1982)).

171. *Id.* at 604.

172. *Id.* (citing *Viva! Int’l Voice for Animals v. Adidas Promotional Retail Operations, Inc.*, 162 P.3d 569, 575 (Cal. 2007); *Bronco Wine Co. v. Jolly*, 95 P.3d 422, 454 (Cal. 2004)).

173. See generally *Viva! Int’l Voice for Animals v. Adidas Promotional Retail Operations, Inc.*, 162 P.3d 569, 583 (Cal. 2007) (“So too here: federal law does not prohibit importation of kangaroo products, while state law does. That arrangement poses no obstacle to current federal policy.”).

importation or sale of kangaroo products within California was preempted by federal law, which neither prohibited nor authorized such importations.¹⁷⁴ In other words, the party arguing for preemption contended that state law prohibited what federal law permitted, and the state law was therefore preempted.¹⁷⁵ In rejecting this argument, the court concluded that “[t]here is a difference between . . . not making an activity unlawful, and . . . making that activity lawful,” and that “it is more accurate to characterize the state statute as prohibiting . . . what the federal [regulation] *does not prohibit*.”¹⁷⁶ Federal law did not prohibit the importation of kangaroo products, while California law did.¹⁷⁷ Consequently, the state law prohibiting importation and sale of kangaroo products posed no obstacle to federal policy and was not preempted by federal law.¹⁷⁸

Employing similar principles, the *Guiamelon* court held that the California Kickback Statute’s prohibition of the arrangement between the physician and marketers, and the physician’s subsequent conviction, did not pose an obstacle to federal policy.¹⁷⁹ The fact that the California statute punished conduct that was not prohibited under the federal statute (negligent or unintentional, rather than knowing or willful, conduct), did not form a basis for obstacle preemption.¹⁸⁰ The court held that the purpose of the California Kickback Statute was consistent with the Federal Anti-Kickback Statute.¹⁸¹

174. *Id.* at 582–83.

175. *Id.* at 583 (citing *Bronco Wine Co. v. Jolly*, 95 P.3d 422, 454 (Cal. 2004)).

176. *Id.* (alteration in original) (quoting *Bronco*, 95 P.3d at 454).

177. *Id.* at 582.

178. *Id.* at 583. The court in *Vinal* reasoned:

The key here is the meaning of the word “authorized” The trial court and Court of Appeal[s] viewed a “failure to prohibit” as equivalent to “authorization.” But if that were so, there would be no room for state regulation, despite an evident federal intention that there be significant room for such regulation. Either an action would be prohibited by federal law, in which case state regulation would be superfluous, or it would not be prohibited by federal law, in which case state regulation would be preempted (in these courts’ views). . . . Instead, every action falls within one of three possible federal categories. An action may be prohibited, it may be authorized, or it may be neither prohibited nor authorized.

Id. Under this third category (neither prohibited nor authorized under federal law), the court reasoned that there was free room for the state to regulate the conduct. *Id.*

179. *People v. Guiamelon*, 140 Cal. Rptr. 3d 584, 604 (Ct. App. 2012).

180. *See id.* (“[I]he fact that a state statute punishes conduct not prohibited by federal law is not a basis for obstacle preemption.”).

181. *Id.*

C. *Coalescing the Interpretations and Addressing Enforceability*

The analysis in the previous section of this Article focused on the effect and breadth of the Texas and federal illegal remuneration statutes.¹⁸² This section is intended to focus on what activity the TPSA, in fact, addresses, and what conduct it proscribes. The prior examination of legal authorities in both Texas and foreign jurisdictions additionally demonstrated that the TPSA is not a piece of perfunctory and toothless legislation.¹⁸³ Although perhaps presently obscured in shadows, the TPSA is a potentially formidable piece of legislation capable of catching the unwary physician off guard and unprotected.

Until there is better, more definitive judicial consideration and a canon of reliable case law interpreting the TPSA, the interpretations of the TPSA will remain ambiguous and likely specious. A close perusal of the legislative records surrounding the implementation and amendments of the TPSA, however, assists in providing a more precise perspective of what the TPSA is intended to prohibit. And to the prudent practitioner and diligent counselor, a familiarity with the legislative intent also illustrates how effective a tool the statute would be for the Texas AG's office in pursuing criminal charges against physicians for engaging in remuneration-for-patient-referrals schemes.

The broad language of the TPSA, the seemingly muddled collection of Texas AG Opinions, and the paucity of meaningful analysis by the courts all contribute to the potential for physicians and their attorneys to mistakenly apprehend the TPSA as ineffectual, ambiguous, or unenforceable. Furthermore, the fact that the Texas AG has simply not utilized this statute to prosecute very many violators, if any, weakens the threat of the TPSA's proscriptions.¹⁸⁴ Additionally problematic, is the fact that if a court were required to analyze whether the TPSA is enforceable, criminal statutes must be strictly construed against the government seeking to enforce it.¹⁸⁵ Attorneys armed with knowledge

182. *See supra* Part II.B.

183. *See supra*, Part II.B.2, II.B.3.

184. *See supra* note 75 and accompanying text.

185. *See* *Townsend v. State*, 427 S.W.2d 55, 62 (Tex. Crim. App. 1968) (“[P]enal statutes are to be construed strictly in favor of the accused . . .”); *State v. Johnson*, 198 S.W.3d 795, 797 (Tex. App.—San Antonio 2006, pet. granted) (“Unless found in the Texas Penal Code, a penal statute must be strictly construed.” (footnote omitted) (citing *United States v. Granada*, 302 F.3d 421, 424 (5th Cir. 2002), *superseded by statute on other grounds*, TEX. TRANSP. CODE ANN. §§ 502.409(a)(6)–(7)

that a prosecutor must assail a strict construction of the statute might proceed less cautiously when advising their clients of the risks of participating in conduct prohibited by the TPSA.

Nevertheless, when construing a criminal statute, the Texas courts must consider the statute's context and subject matter and, if possible, discern the legislative intent.¹⁸⁶ Therefore, upon a reasonable argument that the TPSA is ambiguous on its face, a court will have the opportunity to analyze and consider the legislative intent and history of the TPSA in construing and applying the statute.¹⁸⁷ A court may only stray from the strict letter of the law, however, when there is ambiguity in the statute's wording.¹⁸⁸

The wording at TOC § 102.003, stating that "Section 102.001 permits any payment, business arrangement, or payment practice permitted by [the Anti-Kickback Statute and its regulations,]" is clearly the source of the potential ambiguity in the TPSA.¹⁸⁹ The attractive, but erroneous,

(current version at TEX. TRANSP. CODE ANN. § 502.475)), *aff'd*, 219 S.W.3d 386 (Tex. Crim. App. 2007).

186. *Cf. McLeod v. State*, 180 S.W. 117, 118 (Tex. Crim. App. 1915) (analyzing an ambiguous statute regarding the definition of "charged" in a criminal statute). The Texas Court of Criminal Appeals analyzed: "[W]e must take into consideration the entire provision and ascertain the intent of the Legislature in the use of the word, taking into consideration the context and subject matter, and, if the intent can be ascertained, it must govern over the literal import of the words . . ." *Id.* (citing *Brooks v. Hicks*, 20 Tex. 666, 667 (1858); *Ex parte Robinson*, 29 Tex. Ct. App. 186, 187 (1890); *Barkley v. State*, 28 Tex. Ct. App. 99, 100–01 (1889); *Rigby v. State*, 27 Tex. Ct. App. 55, 56–57 (1889); *Sartain v. State*, 10 Tex. Ct. App. 651, 653 (1881); *Albrecht v. State*, 8 Tex. Ct. App. 314, 314–15 (1880); *Walker v. State*, 7 Tex. Ct. App. 245, 257 (1879)).

187. *Cf. Ex parte Peede*, 170 S.W. 749, 775 (Tex. Crim. App. 1914) (Harper, J., on motion for rehearing) ("The history of contemporaneous legislation, as well as legislative debates, may in rare instances be resorted to and considered by courts in searching for the meaning of a law when the meaning is obscure, and in discovering the evils intended to be remedied when those evils are in doubt or unknown." (quoting *Van Winkle v. State*, 91 A. 385, 397 (Del. 2014))); *Ex parte Roquemore*, 131 S.W. 1101, 1104 (Tex. Crim. App. 1910) ("[I]t is a rule of construction well known that, in undertaking to fix and place meaning upon statutes, we should do so in light of contemporaneous history, and in reference to the habits and activities of our people."); *Williams v. State*, 107 S.W. 1121, 1125 (Tex. Crim. App. 1908) (providing courts with the rule of statutory construction that legislative intent may be discerned by contemporaneous legislation and irreconcilable conflicts in other rules (citing *Ex parte Neal*, 83 S.W. 831, 831–32 (Tex. Crim. App. 1904); *Ex parte Keith*, 83 S.W. 683, 686 (Tex. Crim. App. 1904))).

188. *See Sparks v. State*, 174 S.W. 351, 352 (1915) ("This court has held that it is only when a statute is ambiguous by its terms that courts may rightfully exercise the power of controlling its language, so as to give effect to what they may suppose to have been the intention of the lawmakers.")

189. TEX. OCC. CODE ANN. § 102.003 (West 2012). For further discussion regarding this potential ambiguity, see *supra* Part II.B.1.

interpretation of this provision, is that it nullifies any argument that the TPSA prohibits referral schemes involving all payors—including private insurers and cash payments—rather than government payors alone. The argument is simply that the TPSA unequivocally permits what the Anti-Kickback Statute permits. The Anti-Kickback Statute inarguably does not prohibit referral arrangements not invoking Federal health care program business.¹⁹⁰ Because the federal statute is not concerned with referrals-for-remuneration schemes not affecting Federal health care programs—such as cash payments or commercial payors—under this interpretation, the TPSA would be equally unconcerned with such schemes.

The rationale for finding ambiguity in the TPSA is alluring but clearly erroneous. Concluding that the TPSA permits what the federal statute permits requires the conclusion that the TPSA is equally unconcerned with, and does not prohibit, referral arrangements that do not affect Federal health care programs. The language of the TPSA's construction provision may allow for such a specious ambiguity argument, but its legislative history is threaded with insight into a contrary legislative intent.

In spite of the TPSA's clearly self-imposed limitations, permitting activity that the Anti-Kickback Statute itself permits,¹⁹¹ the most prominent evidence of the TPSA's intent not to be restricted to reimbursements made under Federal health care programs is the consistent silence on that very matter throughout the TPSA's life. Over the course of the TPSA's inception, implementation, amendment, and consideration by authoritative governmental bodies, the absence of any acknowledgment of the TPSA being limited to Federal health care program business should demonstrably evince the legislative intent.¹⁹² In neither the current or previous codified versions of the TPSA, nor any of the bills introducing or amending it, is Medicare, Medicaid, TriCare, or any other Federal health care program discussed as a part of the TPSA's purview.¹⁹³ The

190. See 42 U.S.C. §§ 1320a-7b(b)(1) & (2) (2012) (requiring such remunerations to be in connection with a Federal health care program).

191. OCC. § 102.003.

192. The notable exception would be the 1993 Texas AG Opinion previously discussed. See *supra* notes 121–26 and accompanying text.

193. See generally OCC. § 102.001; Act of May 29, 1993, 73d Leg., R.S., ch. 573, § 5.01, secs. 161.091–.02, 1993 Tex. Gen. Laws 2169 (repealed 1999); Act of May 29, 1993, 73d Leg., R.S., ch. 706, § 1, secs. 161.091–.094, 1993 Tex. Gen. Laws 2769 (repealed 1999); Act of Aug. 9, 1991, 72nd Leg., 1st C.S., ch. 15, § 5.21, sec. 161.091, 1991 Tex. Gen. Laws 325 (repealed 1999).

respective legislative bill analyses performed by the Texas House and Senate Committees for each bill did not yield a consideration of Federal health care programs in their reviews and synopses of the TPSA—and they certainly did not consider Federal health care programs as a limitation on the TPSA’s applicability.¹⁹⁴ Rather, those analyses reaffirm the notion that the TPSA prohibits any remuneration arrangements for patient referrals.¹⁹⁵

The 1993 amendments stand out as greater evidence of the legislature’s intent to endow the TPSA with wider reach than the Anti-Kickback Statute. The goal of SB 211 was to expand the authority of the TPSA.¹⁹⁶ The 73rd Texas Legislature intended to eliminate language within the TPSA that (1) limited the application of the statute only to violators who were health care professionals (as opposed to any person violating the TPSA),¹⁹⁷ and (2) made exceptions to the TPSA’s prohibitions.¹⁹⁸

During Senate Committee Hearings on, among other bills, SB 210 and SB 211, the then current Texas AG, Dan Morales, provided witness testimony that his office had a growing concern for psychiatric care providers’ nefarious business tactics and patient abuses done “with the objective of . . . maximizing opportunities to gain access to public and

194. *See generally* S. Comm. on Health & Human Servs., Bill Analysis, Tex. S.B. 210, 73d Leg., R.S. (1993); H. Comm. on Pub. Health, Bill Analysis, Tex. S.B. 210, 73d Leg., R.S. (1993); H. Comm. on Appropriations, Bill Analysis, Tex. H.B. 7, 72nd Leg., 1st C.S. (1991).

195. *See, e.g.*, H. Comm. on Appropriations, Bill Analysis, Tex. H.B. 7, 72nd Leg., 1st C.S. (1991) (indicating that a violation is made out when there is an offer to pay or acceptance of payment for any referral, without any reference to merely those involving Federal health care programs).

196. *See* S. Comm. on Health & Human Servs., Bill Analysis, Tex. S.B. 211, 73d Leg., R.S. (1993) (“As proposed, [SB 211] expands the authority of the illegal remuneration law and provides penalties for violations of this Act.”).

197. *See id.* (conforming the TPSA to address allegations of non-healthcare professional violations, making it a violation for any person to offer or accept a remuneration prohibited by the statute); *see also* Texas Patient Solicitation Act: Hearings on Tex. S.B. 211 Before the S. Comm. on Health & Human Servs., 73d Leg., R.S. (Mar. 16, 1993) (tape available from Texas State Library and Archives Commission) (“Senate Bill 211 relates to illegal remuneration, and, basically, it expands the law, which currently makes remuneration illegal for purposes of securing patients and prohibits the making or accepting of a payment by mental health providers—expands that law to make remuneration for patients illegal, period. We are prohibiting the payment of securing patients, period.”).

198. *See* S. Comm. on Health & Human Servs., Bill Analysis, Tex. S.B. 210, 73d Leg., R.S. (1993) (“Delet[ing] existing language providing certain exceptions to the act; permit[ing] payments, business arrangements and payment practices permitted by related federal statutes.”).

private insurance funds.”¹⁹⁹ If nothing more, Mr. Morales’s testimony intimates the Texas AG’s office was concerned, at least leading up to the 1993 amendments, about health care practices that potentially abused both public and *private* health care fund sources.²⁰⁰ The 1993 amendments, themselves, remain a steadfast defense against misapprehensions that the TPSA is so ambiguous as to be unenforceable. The 1993 amendments also help dispel erroneous assertions that the TPSA does not prohibit remuneration schemes involving reimbursements other than Federal health care programs.²⁰¹

The distinction drawn in the previous section of this Article, between Congress not making an activity unlawful as opposed to making the same activity lawful,²⁰² applies directly to how we may construe the TPSA. Considering the possibly varying interpretations of the TPSA among the different Texas AG Opinions, the significance of the difference between not making an activity unlawful and making that activity lawful becomes much more evident.

A person cannot be expected to be criminally liable for engaging in conduct that is unlawful under a state’s statute that Congress has explicitly exempted from culpability in a federal statute.²⁰³ As observed in the

199. Texas Patient Solicitation Act: Hearings on Tex. S.B. 211 Before the S. Comm. on Health & Human Servs., 73d Leg., R.S. (Mar. 16, 1993) (statement of Attorney General Morales) (tape available from Texas State Library and Archives Commission).

200. *See id.* (“Our investigation disclosed a course of activity on the part of major psychiatric care providers involving prescription of unnecessary, excessive and in some instances, forcible psychiatric care . . . all of this with the objective of . . . maximizing opportunities to gain access to public and private insurance funds.”).

201. *E.g.*, third-party private insurance or cash payments.

202. *See supra* notes 172–81 and accompanying text.

203. *See* *Cipollone v. Liggett Grp., Inc.*, 505 U.S. 504, 516 (1992) (“[I]t has been settled that state law that conflicts with federal law is ‘without effect.’ . . . In the absence of an express congressional command [of federal preemption], state law is pre-empted if that law actually conflicts with federal law . . .” (first citing *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981); and then citing *Pac. Gas & Elec. Co. v. St. Energy Res. Conservation & Dev. Comm’n*, 461 U.S. 190, 204 (1983)); *De Maio Farms & Ranches, Inc. v. Hereford Veterinary Supply, Inc.*, No. 2:14-CV-00233-J, 2015 WL 12731758, at *3 (N.D. Tex. Mar. 4, 2015) (illustrating two forms of preemption, including express and conflict preemption (first citing *Crosby v. Nat’l Foreign Trade Council*, 530 U.S. 363, 372 (2000); and then citing *Cipollone*, 505 U.S. at 516)); *Kansas City S. Ry. Co. v. Oney*, 380 S.W.3d 795, 809 (Tex. App.—Houston [14th Dist.] 2012, no pet.) (“The intent to preempt state law may be explicitly stated in statutory language or implicit in a statute’s structure and purpose. Implied preemption can be based on field preemption or conflict preemption.” (citations omitted) (citing *Cipollone*, 505 U.S. at 516)); *see also* *State v. Harden*, 938 So. 2d 480, 493 (Fla. 2006) (concluding the Florida anti-kickback statute was preempted because it “presents an obstacle to the accomplishments of the purposes of the federal law”).

California and Florida cases, this is tantamount to presenting an obstacle to Congress accomplishing its purpose under the respective federal statute. Such an obstacle results in federal preemption and invalidation of state law under the Constitution's Supremacy Clause.²⁰⁴ That being said, a federal statute that does not explicitly prohibit certain conduct does not automatically render that conduct as lawful or permitted. As the California court observed, there is a difference between not making an activity unlawful and making the activity lawful.²⁰⁵

The argument for the unenforceability of the TPSA would maintain that Congress's failure to specifically prohibit non-Federal health care program remuneration practices is equivalent to Congress's authorizing those same practices. "[I]f that were so, there would be no room for state regulation," irrespective of any potential evidence of federal intention to the contrary.²⁰⁶ Subscription to this line of reasoning means that if some conduct is prohibited by federal law, state regulation of that conduct would necessarily be superfluous (because Congress has already covered it).²⁰⁷ Alternatively, it would mean that if the conduct is not prohibited by federal law (making it "permitted" under the perspective that the TPSA is ambiguous), state regulation of the conduct would be preempted (because the federal government has already "permitted" it).²⁰⁸

The Anti-Kickback Statute does not seem in harmony with such a narrow perspective.²⁰⁹ The OIG's statements of purpose regarding the

204. See *supra* note 151 (discussing the federal conflict preemption theory in conjunction with a state law action).

205. See *supra* note 176 and accompanying text.

206. *Viva! Int'l Voice for Animals v. Adidas Promotional Retail Operations, Inc.*, 162 P.3d 569, 583 (Cal. 2007); see also *Man Hing Ivory & Imports, Inc. v. Deukmejian*, 702 F.2d 760, 763 (9th Cir. 1983) (discussing the potential conflict between state and federal statutes and concluding the "general language [of the federal Endangered Species Act regarding preemption], by its terms, does not forbid state statutes such as California Penal Code § 653*o*. Rather, it allows full implementation of section 653*o* so long as the state statute does not prohibit what the federal statute or its implementing regulations permit. The Act itself nowhere authorizes the importation or sale of African elephant products by permit or by exemption. Indeed, it prohibits the sale or import of endangered species unless such import or sale is specifically authorized or exempted" (emphasis added) (footnote omitted) (citing 16 U.S.C. § 1538(a)).

207. *Viva!*, 162 P.3d at 583.

208. *Id.*

209. In 1991, the Office of the Inspector General provided clarity as to the intent of the federal statute in relation to state law: "There is no federal preemption provision under the statute. Thus, conduct that is lawful under the federal anti-kickback statute or this regulation may still be illegal under State law. Conversely, conduct that is lawful under State law may still be illegal under

Anti-Kickback Statute's Safe Harbors illuminate a different approach.²¹⁰ Congress directed the OIG to “*permit*[] certain non-abusive arrangements,” and gave the Department of Health and Human Services the “authority to *protect certain* arrangements and payment practices under the anti-kickback statute.”²¹¹ What the Anti-Kickback Statute “permits” are those *certain* arrangements—the specific and explicitly enumerated arrangements in both the Safe Harbor regulations and the exemptions under the federal statute.²¹² These are the permitted “payment practices [that] shall not be treated as a criminal offense under” the Anti-Kickback Statute,²¹³ which the TPSA contemplates at TOC § 102.003.²¹⁴ They are not, however, merely referral remuneration schemes that do not implicate Federal health care programs—on which the Anti-Kickback Statute is silent.²¹⁵

Once again, there is a difference between not making an activity unlawful and making that activity lawful; or, for purposes here, not making a specific payment/business arrangement *prohibited*, and making that payment/business arrangement *permitted*.²¹⁶ The Anti-Kickback Statute and its Safe Harbor regulations specifically and expressly protect certain conduct.²¹⁷ The distinction of which to be mindful is that the federal law

the federal anti-kickback statute.” Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. 35952, 35957 (July 29, 1991) (codified at 42 C.F.R. pt. 1001).

210. See 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. 63518, 63518 (Nov. 19, 1999) (codified at 42 C.F.R. pt. 1001) (expressing the purpose of the safe harbors of the federal statute were to respond to concerns that certain innocuous commercial arrangements were criminalized under the originally promulgated statute); Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. at 35958 (asserting the purpose of the promulgation of safe harbors was to limit the prohibitions of the anti-kickback statute and protect certain innocuous arrangements, not to expand the regulatory reach of the statute).

211. 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. at 63518 (emphasis added); Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. at 35957 (emphasis added).

212. 42 U.S.C. § 1320a-7b(b)(3) (2012); 42 C.F.R. § 1001.952 (2015).

213. 42 C.F.R. § 1001.952.

214. TEX. OCC. CODE ANN. § 102.003 (West 2012).

215. See *supra* Part II.A.1 (discussing the Anti-Kickback Statute and the purpose of the regulatory Safe Harbors promulgated thereunder).

216. See *supra* note 176 and accompanying text.

217. The Anti-Kickback Statute, itself, specifies illegal conduct and, by virtue of its statutory exemptions at § 1320a-7b(b)(3) and its Safe Harbors, it protects specific conduct. Medicare and State

prohibits certain conduct and has in place specified protected payments and arrangements, while also being altogether indifferent to other payments and arrangements (i.e., non-Federal health care program business).²¹⁸ The Anti-Kickback Statute specifically permits certain conduct in its statutory exemptions and Safe Harbor regulations.²¹⁹ Concurrently, it does not prohibit kickbacks that do not implicate the Federal health care programs.²²⁰ And therein lies the necessary distinction between permitting certain conduct and not prohibiting other kinds of conduct. The former requires proactive measures, such as establishing Safe Harbor regulations.²²¹ The latter requires nothing more than passive silence, which the Anti-Kickback Statute certainly maintains regarding referral arrangements not reimbursable by the Federal health care programs.²²²

If, prior to the 1993 amendments, the Texas Legislature incidentally, if not unintentionally, allowed the TPSA's construction provision to mean that all non-Federal health care program arrangements are legal under the TPSA because those arrangements were not prohibited under the Anti-Kickback Statute, the legislature certainly cleared up that confusion in 1993. The change in language from "not prohibited" to "permitted" must be construed to be deliberate and intentional.²²³ The change must have

Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. 35952, 35954 (July 29, 1991) (codified at 42 C.F.R. pt. 1001).

218. 42 U.S.C. § 1320a-7b (2012).

219. See 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. 63518, 63518 (Nov. 19, 1999) (codified at 42 C.F.R. pt. 1001) ("The OIG safe harbor provisions have been developed 'to limit the reach of the statute somewhat by permitting certain non-abusive arrangements, while encouraging beneficial and innocuous arrangements.'" (quoting Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. at 35957)).

220. See, e.g., *id.* (providing the only prohibited activity under the federal act are those activities that are "reimbursable under the Federal or State health care programs," not private providers).

221. See Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback Provisions, 56 Fed. Reg. at 35957 (indicating the intent behind promulgating such provisions is to permit particular practices that are not subject to prosecution and thus are permitted by the promulgation).

222. See generally 42 U.S.C. § 1320a-7b(b) (prohibiting only remuneration available "in whole or in part under a Federal health care program," not private providers).

223. See *Ramos v. State*, 264 S.W.3d 743, 751 (Tex. App.—Houston [1st Dist.] 2008, pet granted) (stating that if the legislature "enacted into law something different from what it intended, it would amend the statute to conform to its intent" (citing *State v. Vasilas*, 187 S.W.3d 486, 489 (Tex. Crim. App. 2006))), *aff'd*, 303 S.W.3d 302 (Tex. Crim. App. 2009); see also *Tex. Mut. Ins. Co. v. Ruttiger*, 381 S.W.3d 430, 452 (Tex. 2012) ("[T]he Legislature deliberately and purposefully selects

also been intended to clarify that those precise “certain arrangements” the Anti-Kickback Statute intentionally and specifically protects and permits are the practices, business arrangements, and payment practices permitted under the TPSA.²²⁴

In order to elucidate the purpose of the 1993 amendments regarding the construction provision at TOC § 102.003, we may need to borrow some logic from the California courts again. In *Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.*,²²⁵ the California Supreme Court discussed the relationship between two state statutes.²²⁶ The court observed that California “Penal Code section 211, which defines robbery, does not make murder unlawful. Most assuredly, however, that section does not also make murder lawful.”²²⁷ This simple observation helps reinforce the argument against spurious notions that the TPSA is ambiguous or unenforceable. A flat prohibition of certain activity that allows for expressly permitted exemptions, should not be read the same as a flat allowance of certain activity with express forms of conduct being prohibited. That which is not prohibited is not automatically permitted.

III. IMPLICATIONS OF ILLEGAL REMUNERATION SCHEMES

Having established an understanding that exchanging referrals for remuneration poses genuine legal liability to physicians in Texas, this Article now turns to how engaging in such practices has further reaching implications than one may suspect. By and large, lawsuits and prosecutions of illegal remuneration arrangements have been brought under the Anti-Kickback Statute.²²⁸ In pursuing its ongoing efforts of

words and phrases it enacts, as well as deliberately and purposefully omits words and phrases it does not enact.” (citing *Tex. Lottery Comm’n v. First State Bank of DeQueen*, 325 S.W.3d 628, 635 (Tex. 2010)); *In re M.N.*, 262 S.W.3d 799, 802 (Tex. 2008) (“[T]he Legislature included each word in the statute for a purpose, and that words not included were purposefully omitted.” (citations omitted) (first citing *Eddins-Walcher Butane Co. v. Calvert*, 298 S.W.2d 93, 96 (Tex. 1957); and then citing *Cameron v. Terrell & Garrett, Inc.*, 618 S.W.2d 535, 540 (Tex. 1981))).

224. See *supra* note 178 and accompanying text (explaining the three different categories of conduct—permitted, prohibited, and silent—and reasoning that federal silence is not construed as permitting, rather it leaves it to the states to regulate the conduct).

225. *Cel-Tech Comm’ns, Inc. v. L.A. Cellular Tel. Co.*, 973 P.2d 527 (Cal. 1999).

226. See *id.* at 541 (illustrating the relationship between the California unfair competition law and California Civil Code 47, which appeared to be in conflict).

227. *Id.*

228. James G. Sheehan & Jesse A. Goldner, *Beyond the Anti-Kickback Statute: New Entities, New Theories in Healthcare Fraud Prosecutions*, 40 J. HEALTH L. 167, 167–68 (2007) (“Until recently,

combatting federal health care program financial fraud, the federal government has also found an extraordinarily potent tool in the False Claims Act.²²⁹

The False Claims Act prohibits the knowing submission of false claims for financial reimbursement from the government.²³⁰ This federal statute also contains whistleblower provisions allowing private parties to initiate lawsuits on behalf of the government and share in any recovery.²³¹ That provision provides an effective measure for ushering fraudulent schemes out of the shadows by essentially rewarding insiders for bringing the arrangements to the government's attention.²³² The government's ability to intervene thereafter (or at the inception in cases of government-instituted investigations),²³³ allows the Department of Justice to further investigate illegal conduct.²³⁴ The effectiveness of the False Claims Act is underscored by the fact that the Department of Justice has recovered more than \$17 billion under the statute since 2009.²³⁵

As healthcare business arrangements and regulations continue to develop in complexity, and the relationships between medical

prosecutions have been based almost entirely on the Medicare-Medicaid Anti-Kickback Statute . . .”).

229. 31 U.S.C. §§ 3729–33 (2012); *see also* Press Release No. 15-431, Dep't of Justice, Two Cardiovascular Disease Testing Labs to Pay \$48.5 Million to Settle Claims of Paying Kickbacks and Conducting Unnecessary Testing (Apr. 28, 2017), <https://www.justice.gov/opa/pr/two-cardiovascular-disease-testing-laboratories-pay-485-million-settle-claims-paying> [<https://perma.cc/7R88-U9VC>] (reporting on huge settlements resulting from False Claims Act lawsuits filed by whistleblowers, resulting in roughly \$50 million in settlement payments).

230. 31 U.S.C. § 3729(a)(1)(A).

231. Private persons “may bring a civil action for a violation of [the False Claims Act] for the person and for the United States.” *Id.* § 3730(b). The private person is, with certain exceptions, allowed to receive 15–25% of the proceeds of any action or settlements of claims, if the government proceeds with an action brought by the private person. *Id.* § 3730(d). The amount of proceeds such a “qui tam” plaintiff may receive depends “upon the extent to which the person substantially contributed to the prosecution of the action.” *Id.*

232. *See, e.g., id.* § 3730(d)(1) (providing payments to a person for assisting in deterring such fraudulent behavior by rewarding them with not only the *qui tam* reward but also “an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys’ fees and costs”).

233. *Id.* § 3730(c)(3).

234. *Id.* § 3730(a).

235. Press Release No. 15-233, Dep't of Justice, Fact Sheet: The Health Care Fraud and Abuse Control Program Protects Consumers and Taxpayers by Combating Health Care Fraud (Aug. 11, 2016), <https://www.justice.gov/opa/pr/fact-sheet-health-care-fraud-and-abuse-control-program-protects-consumers-and-taxpayers> [<https://perma.cc/QMR8-F7DF>].

practitioners, third-party payors, and patients consequently evolve,²³⁶ “opportunities for improper influence and fraud are increasing.”²³⁷ Consequently, prosecutors, regulators, and private litigants are responding by exploiting the variety of statutes prohibiting fraudulent activities, and positing new and unique legal theories to address the consequences of these developing relationships.²³⁸ This section will now examine some of the growing trends and specific examples of financial arrangements between physicians and ancillary services facilities that are attracting further scrutiny from lawmakers, law enforcement, and private actors. To that end, it is necessary to discuss recent referral schemes that have been a part of actual prosecutions or litigation, as well as analyze the additional legal theories under which plaintiffs and prosecutors are seeking redress.

A. *Recent Enforcement and Legal Actions against Referral Schemes*

The current legal landscape of prosecutions of referral-for-remuneration schemes features a combination of government enforcement actions and commercial payor lawsuits. Some of the more recent and prominent cases involve the public and private interests overlapping. The takeaway from the following examples is that the number of investigations and the degree of scrutiny are increasing along with the fraudulent activity they seek to suppress. Not least of which is *Aetna Life Insurance Company v. Humble Surgical Hospital*,²³⁹ the only reported court case involving private recovery based in part on a violation of the TPSA.

236. See, e.g., Emma Mata & Jonathan Ishee, *The Out-of-Network Battle Heats Up*, ABA HEALTH ESOURCE (Sept. 2014), http://www.americanbar.org/publications/aba_health_esource/2014-2015/september/out_of_network.html [<https://perma.cc/AT5N-HJNP>] (discussing the growing complexity of healthcare providers waiving or reducing of patients’ “portion of financial responsibility associated with receiving out-of-network services by the provider” and the tension such billing practices are establishing between providers and third-party payors). See generally Charles C. Dunham, *Out-of-Network Referrals and Waiver of Patient Copayments and Deductibles: The Battle Between Payors and Providers Endures and Intensifies*, HEALTH LAW., June 2013, at 18, 18–21 (discussing out-of-network provider billing practices, particularly the practice of waiving copayments and deductibles, and the resistance and push back to such practices of insurers).

237. Sheehan & Goldner, *supra* note 228, at 168.

238. *Id.*

239. *Aetna Life Ins. Co. v. Humble Surgical Hosp., LLC*, No. H–12–1206, 2016 WL 7496743 (S.D. Tex. Dec. 31, 2016), *appeal dismissed sub nom.*, 17-20123, 2017 WL 3753665 (5th Cir. Apr. 5, 2017).

1. *Aetna v. Humble*

In 2012, Connecticut-based Aetna Life Insurance Company (Aetna) sued Humble Surgical Hospital, LLC (Humble)—a five-bed hospital in Humble, Texas—for defrauding Aetna of millions of dollars.²⁴⁰ As an out-of-network healthcare provider, Humble set its own fees for services it provided to Aetna beneficiaries rather than functioning under an agreed-upon fee schedule.²⁴¹ Aetna would then pay a certain amount of Humble's fees pursuant to each of its member's policies.²⁴² The member would be required to pay more out of pocket for the balance not covered by Aetna than if the member had used an in-network hospital.²⁴³ Humble was accused of joining with over a hundred doctors in a referral scheme in which the physicians would receive 30% of the facility fees Humble collected from Aetna for the patients they referred.²⁴⁴

In an attempt to disguise the referral arrangement, the referring physicians created limited liability companies (Physician LLCs), that would pretend to assume Humble's medical billing responsibilities.²⁴⁵ In reality a third-party affiliate of Humble, K&S Consulting, LLC, would perform the billing in exchange for 5% of the fees collected from Aetna.²⁴⁶ K&S Consulting would charge Aetna, who would pay Humble Aetna's permitted amounts for each bill, and Humble would kickback the 30% of the facility fees paid by Aetna to the Physician LLCs.²⁴⁷

As an additional element of the scheme, to prevent patients from choosing cheaper, in-network hospitals, Humble promised patients that their out-of-pocket costs would be waived or reduced to be no more than they would otherwise be with an in-network provider.²⁴⁸ This particular policy was in stark contradiction to all of Aetna's insurance plans.²⁴⁹

240. *Id.* at *1–2.

241. *See id.* at *2 (“Humble is an out-of-network hospital, but it did not oblige patients to pay out-of-network amounts. Instead, it told patients that its services’ costs would be equal to or less than at an in-network facility.”).

242. *Id.* at *1.

243. *Id.*

244. *Id.*

245. *Id.*

246. *Id.*

247. *Id.* at *2.

248. *Id.* at *1. Humble also promised that if Aetna paid the bills in full, the patients may possibly be afforded a refund. *Id.*

249. Aetna's plans have three characteristics worth noting: “(a) the insurer pays a portion of the patient’s bill; (b) the insurer pays a smaller portion when the patient uses a hospital with which the insurer does not have a fee schedule, and (c) the insurer does not pay when a hospital waives the

Those plans provided that Aetna would not pay any fees if a hospital waived the patient's share of the fees.²⁵⁰ Furthermore, Aetna alleged that Humble "breached its written representations to Aetna" when submitting billing forms.²⁵¹ The form explicitly stated "that the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts."²⁵²

Aetna sued Humble under various legal theories, and the district court granted Aetna relief under a claim for money had and received.²⁵³ Under this cause of action, Aetna was required to "show that Humble ha[d] been paid money that—in equity—belong[ed] to Aetna."²⁵⁴ The court permitted Aetna to recover the amount of money Humble wrongly received from Aetna in violating Texas's prohibition of payments to doctors in exchange for patient referrals.²⁵⁵

The court determined that Humble attempted to characterize its agreements with the Physician LLCs as leases for use of the hospital.²⁵⁶ But because the Physician LLCs were not licensed under title 25 of the Texas Administrative Code, section 133.21, they could not legally lease hospitals.²⁵⁷ The court held that Humble's agreements with the Physician LLCs were not leases but referral-fee arrangements in violation of the TPSA.²⁵⁸ Consequently, the court decided that Aetna was entitled to

patient's share." *Id.* Aetna argued that, not only did Humble overcharge it, but Humble failed to charge patients in a fashion required by the plan, failed to provide the services for which it was charging, and paid kickbacks to the referring doctors—which are all in contravention to the characteristics listed above. *Id.* at *3.

250. *Id.* at *1.

251. Aetna's First Amended Complaint at 9, *Aetna Life Ins. Co. v. Humble Surgical Hosp., LLC*, 4:12-cv-01206 (Feb. 8, 2013).

252. *Id.*

253. *Aetna*, 2016 WL 7496743, at *2. Other claims included fraud, negligent misrepresentation, and relief under the Employee Retirement Income Security Act (ERISA). *Id.*

254. *Id.* (citing *Staats v. Miller*, 243 S.W.2d 686, 687 (Tex. 1951)).

255. *Id.* at *4. The court allowed Aetna to choose among three remedies: (1) recovery of \$41 million in overpayments to Humble, attributable to Humble having no right to be paid under Aetna's contracts with patients without a proper assignment to a patient's benefits; (2) recovery of \$20 million under a finding that Texas does not allow hospitals to bill patients one way and insurance plans in a different manner, and this recovery amount was the difference between what Aetna paid Humble as on out-of-network provider and what it would have paid Humble as an in-network provider (pursuant to the manner in which Humble billed the patients); and (3) \$12 million pursuant to violations of the TPSA. *Id.*

256. *Id.* at *2.

257. *Id.* (citing 25 Tex. Admin. Code § 133.21(c)(1) (2017) (Tex. Dep't of Health & Human Servs., Hospital License)).

258. *Id.*

approximately \$12 million, representing the 30% of fees it overpaid to Humble, which Humble paid to the Physician LLCs as kickbacks.²⁵⁹

While this case does not represent a physician's investment in facilities that provide ancillary health services, it does address a broader concern: kickback/referral schemes are not limited to criminal investigations and prosecutions. Private actors, specifically insurance companies, are using statutes prohibiting such conduct to buttress their claims for redress against the participants in such schemes. And despite the sparse legal reasoning for the relief granted in *Aetna v. Humble*, this federal case reflects a distinct judicial unwillingness to allow remuneration-for-referral schemes to defraud patients or the private payors responsible for the billed fees.²⁶⁰

Several other recent federal cases have considered the TPSA in regard to referral schemes; but the courts in those cases have determined that the TPSA does not grant a private right of action, or they have dismissed state-law claims under other rationales.²⁶¹ For the time being, *Aetna v.*

259. *Id.*

260. The court's reasoning and decision under *Aetna v. Humble* is notably terse and pointed, as a seeming intimation of the court's unwillingness to brook Humble's unlawful schemes or its rationales therefor; to wit, when the court considered Humble's contention that the doctrine of unclean hands applied, the court summarily dismissed the argument, merely stating, "Aetna's hands are clean. Humble is filthy up to the elbows from lies and corrupt bargains." *Id.* at *3. And in prefacing its conclusion of Aetna's entitlement to relief, the court stated, "This case has had a tortured existence, and the bulk of activity has been trying to force Humble to tell the truth. Humble has conducted guerilla warfare against this court, Aetna, the patients, and common decency." *Id.* at *4.

261. See, e.g., *Conn. Gen. Life Ins. Co. v. Elite Ctr. for Minimally Invasive Surgery, LLC*, No. 4:16-CV-00571, 2017 WL 607130, slip op. at *15 (S.D. Tex. Feb. 15) (determining that the provisions of the Texas Occupations Code do not provide a basis for a private right of action), *amended and superseded in part by* 2017 WL 1807681 (May 5, 2017). *Connecticut General v. Elite Center*, also held—contrary to *Aetna v. Humble*—that the insurance companies' claims for equitable relief under state law, specifically for money had and received and unjust enrichment, were preempted by the Employee Retirement Income Security Act (ERISA): "[A]ny state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Id.* slip op. at *11. The court concluded that recovery under a theory of money had and received required "the Court [to] determine the nature of the benefits [the insurance companies were] required to pay, which necessarily [directed the] Court's inquiry to the plans, require[d] an analysis of the plans' terms, and presumably involve[d] the calculation of payments due to members/patients under the various plans." *Conn. Gen. Life Ins. Co. v. Humble Surgical Hospital, LLC*, No. 4:13-CV-3291, 2016 WL 3077405, at *13 (S.D. Tex. June 1, 2016), *reversed and vacated in part by* 878 F.3d 478 (5th Cir. 2017). Consequently, the court in *Cigna v. Humble* determined the insurance companies' claims for equitable reimbursement under a claim for money had and received and unjust enrichment were preempted by ERISA "as they refer and/or 'relate to' the various plans." *Id.* (citing *Mayeaux v. La. Health Serv. & Indem. Co.*, 376 F.3d 420, 432 (5th Cir. 2004)). *But see Aetna*, 2016 WL 7496743, at *3 (holding that

Humble provides a current, but perhaps vague, blueprint as to how insurance companies may pursue action against participants in remuneration-for-referral schemes.

2. Testing Laboratories

Clinical laboratories are among the most prominent examples of ancillary services facilities that have been exposed to legal scrutiny for illegal kickback schemes. Physicians' investment in clinical labs to which they may regularly refer high volumes of patient specimens is an economic relationship that causes particular concern for law enforcement.²⁶² There exists a symbiosis between physicians and clinical labs that is entirely based on referrals and patient patronage. When a physician becomes involved in a financial relationship with the laboratory, the question of whether the physician is directing her patients' business to that laboratory for the physician's own pecuniary interests becomes an inherent concern in the referral arrangement.²⁶³ Among the many enforcement actions and lawsuits directed at laboratories alleged to have suspicious referral arrangements with physicians, those surrounding Sky Toxicology, Ltd. and its affiliate laboratories are particularly noteworthy.

Aetna's claims of money had and received were not preempted by ERISA because they did not seek to enforce the insurance plans, but rather sought to "recoup the money *Humble* tricked it into paying for no benefit at all to the patients; the plans are merely the context of *Humble's* fraud" and that ERISA "does not give comprehensive regulations and procedures for all eventualities that might be tangentially related to a benefit plan. . . . [and is] silent about overpayment by an insurer to a provider"). It is also noteworthy that this case involved the exact same hospital, *Humble*, during overlapping periods, but that the *Cigna v. Humble* court did not consider violation of the TPSA as justification for a claim of money had and received, as the *Aetna v. Humble* court did; rather, the *Cigna v. Humble* court denied relief under the TPSA based solely on there being no private right of action under the Texas Occupations Code. *Conn. Gen. Life Ins. Co.*, 2016 WL 3077405, at *15–16; *see also Conn. Gen. Life Ins. Co.*, slip op. at *15 (holding that the TPSA does not provide a private right of action, and the plaintiff had no right to enforce the TPSA or seek a declaratory judgment related to a violation of the TPSA).

262. *See generally* LABORATORY PAYMENTS TO REFERRING PHYSICIANS, *supra* note 25, at 1 (addressing the issue of "compensation paid by laboratories to referring physicians and physician group practices . . . for blood specimen collection, processing, and packaging, and for submitting patient data to a registry or database"); Special Fraud Alert: Arrangements for the Provision of Clinical Lab Services, 59 Fed. Reg. 65377, 65377 (Dep't of Health & Human Servs. Dec. 19, 1994) (notice) (discussing anti-kickback statutes and their relation to arrangements for the provision of clinical lab services).

263. *See* Special Fraud Alert: Physician-Owned Entities, 78 Fed. Reg. 19271, 19272 (Dep't of Health & Human Servs. Mar. 29, 1993) (notice) (noting that because of "the strong potential for improper inducements between and among the physician investors[and these] entities . . . ventures should be closely scrutinized under fraud and abuse laws" (footnote omitted)).

a. Sky Toxicology, Ltd.

In July 2015, Connecticut General Life Insurance Company and Cigna Health and Life Insurance Company (collectively, Cigna) filed a lawsuit against Sky Toxicology, Ltd., a Florida-based urinalysis lab, and its Texas-based affiliate labs (collectively, Sky Labs) for \$20 million in overpayments.²⁶⁴ In 2016, UnitedHealth Insurance Company also sued Sky Labs for \$50 million in overpayments attributable to its fraudulent operations.²⁶⁵ The pleadings alleged that Sky Labs constructed a complicated artifice to defraud private payors pursuant to an improper referral kickback scheme.²⁶⁶ The scheme induced physicians and drug treatment centers to refer their patients to its out-of-network facilities by offering ownership interests in one or more of the laboratories.²⁶⁷

The insurance companies ascribed their millions in losses in overpayments to Sky Labs' business model, which allegedly offered financial kickbacks to referring physicians and drug treatment centers in exchange for referrals of excessive and medically unnecessary urinary analysis tests.²⁶⁸ In an effort to conceal the financial inducements to the referral sources, Sky Labs allegedly contrived an investment structure in which the referring physicians and treatment centers were offered ownership interests in one or more of its labs.²⁶⁹ The physicians and

264. The other named defendants were Florida-based Sky Toxicology Lab Management, LLC, and Texas laboratories Frontier Toxicology, Ltd. and Hill Country Toxicology, Ltd. Complaint at 1, Conn. Gen. Life Ins. Co. v. Sky Toxicology, Ltd., No. 9:15-cv-80994-WJZ (S.D. Fla. July 17, 2015); *see also* Complaint at 1, UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd., No. 9:16-cv-806649-RLR (S.D. Fla. Apr. 25, 2016) (identifying the incorporated states and home offices of the same defendants in the *Cigna* case).

265. *See generally* Complaint at 44, UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd., No. 9:16-cv-806649-RLR (S.D. Fla. Apr. 25, 2016) (bringing multiple causes of action against the defendants, including \$50 million resulting from fraudulent conduct). UnitedHealthcare named numerous additional defendants, including general partners of the various limited partnership laboratories and the business entities and individuals responsible for referrals to the defendant laboratories. *Id.* at 6–13.

266. *Id.* at 23.

267. *Id.* at 23–24; *see also* Complaint at 2–3, Conn. Gen. Life Ins. Co. v. Sky Toxicology, Ltd., No. 9:15-cv-80994-WJZ (S.D. Fla. July 17, 2016) (“Sky Labs has been inducing physicians and drug treatment centers to refer patients, including, but not limited to Cigna plan members, to their out-of-network laboratories by offering the referring providers ownership interests in the entities operating the laboratories, and then paying the referring providers kickbacks in the form of ‘dividends,’ which relate to the number of specimens referred to the laboratories.”).

268. Complaint at 3, UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd., No. 9:16-cv-80649-RLR (S.D. Fla. Apr. 25, 2016).

269. *Id.*

treatment centers would refer patients to the labs for screenings, and, in exchange, the labs would remit monthly profit distributions to these interest-owning referral sources.²⁷⁰ Those distributions were based on revenues generated by the referrals. If the referrals decreased or stopped, Sky Labs was entitled, and threatened, to “redeem” the ownership interests or withhold the monthly distributions.²⁷¹

Sky Labs would also routinely waive or fail to adhere to patients' cost-sharing responsibilities, irrespective of the patients' ability to pay, and then submit claims to the insurer without disclosing the waiver practice.²⁷² These concessions served as additional inducement for patients to use Sky Labs' services and prevented the insured patients from requesting to receive laboratory services from an in-network provider.²⁷³ Finally, to artificially increase reimbursements from the insurance companies, Sky Labs purportedly required physicians to order tests that bundled panels together, rather than allowing for selection of only medically necessary individual panels for patients.²⁷⁴ The bundled panels would include extra screening tests that would inevitably drive up the cost of services Sky Labs would perform and thus, be able to bill the insurance company for payment.²⁷⁵

270. *Id.*; see also Complaint at 12, Conn. Gen. Life Ins. Co. v. Sky Toxicology, Ltd., No. 9:15-cv-80994-WJZ (S.D. Fla. July 17, 2015) (“Physicians and treatment centers that meet the referral quota receive kickbacks in the form of ‘dividends’ that are based on the profits of the laboratory, which in turn, are based on reimbursements for the referred patients.”).

271. Complaint at 3, UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd., No. 9:16-cv-80649-RLR (S.D. Fla. Apr. 25, 2016); see also Complaint at 12, Conn. Gen. Life Ins. Co. v. Sky Toxicology, Ltd., No. 9:15-cv-80994-WJZ (S.D. Fla. July 17, 2015) (“Upon information and belief, if a physician or treatment center investor does not meet the specimen referral quota, Sky Labs may repurchase or ‘redeem’ the shares from the investor.”).

272. Complaint at 3, UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd., No. 9:16-cv-80649-RLR (S.D. Fla. Apr. 25, 2016); Complaint at 13, Conn. Gen. Life Ins. Co. v. Sky Toxicology, Ltd., No. 9:15-cv-80994-WJZ (S.D. Fla. July 17, 2015).

273. Complaint at 3, UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd., No. 9:16-cv-80649-RLR (S.D. Fla. Apr. 25, 2016); see also Complaint at 13, Conn. Gen. Life Ins. Co. v. Sky Toxicology, Ltd., No. 9:15-cv-80994-WJZ (S.D. Fla. July 17, 2015) (“Sky Labs concealed the cost of its services in furtherance of its scheme to induce patients to use its services and prevent members from requesting to receive such services from an in-network provider.”).

274. Complaint at 28, UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd., No. 9:16-cv-80649-RLR (S.D. Fla. Apr. 25, 2016); Complaint at 11, Conn. Gen. Life Ins. Co. v. Sky Toxicology, Ltd., No. 9:15-cv-80994-WJZ (S.D. Fla. July 17, 2016).

275. See Complaint at 28, UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd., No. 9:16-cv-80649-RLR (S.D. Fla. Apr. 25, 2016) (“Lab Defendants, under the direction, control, and management of Individual Defendants, billed United for services not ordered by Referring

In May 2016, Cigna and Sky Labs entered into an undisclosed settlement.²⁷⁶ UnitedHealth sought leave to amend its complaint to resolve questions of federal jurisdiction after its case was dismissed in November 2016.²⁷⁷ The insurance companies' claims for relief were based mostly on tortious activity and private rights of action under state deceptive trade practices statutes;²⁷⁸ however, the insurers also predicated part of their claims on violations of Florida and Texas anti-kickback laws.²⁷⁹

The significance of these cases rests in the fact that commercial payors pursued legal actions against healthcare providers for engaging in

Defendants, and required Referring Defendants to order custom test panels, which included tests that were not medically necessary and were selected only to maximize the payments from United.”).

276. Order of Dismissal with Prejudice, *UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd.*, No. 9:16-cv-80649-RLR (S.D. Fla. Nov. 11, 2016).

277. *Compare id.* at 1–2 (disclaiming the court’s jurisdiction over the plaintiff’s state law claims and lack of standing to assert claims under ERISA), *with* Plaintiff’s Motion to Amend Order of Dismissal to Allow Leave to File an Amended Complaint Under Federal Rules of Civil Procedure 59(e) and 60(b) at 5, *UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd.*, No. 9:16-cv-80649-RLR (S.D. Fla. Nov. 29, 2016) (“ERISA relief is now limited to claims not yet paid and future conduct, and seeks no monetary judgment. Recovery for claims already paid is now sought only in United’s state law tort claims. Because United is no longer requesting ‘other equitable relief’ under ERISA in the form of restitution for amounts it paid to the Defendants, the Court’s basis for dismissal is no longer present.”). The day after UnitedHealth’s suit was dismissed in the Florida District Court, Sky Labs sued UnitedHealth in the Western District of Texas for, among other causes of action, breach of contract and claims under ERISA. Plaintiff’s Original Complaint at 12–21, *Sky Toxicology, Ltd. v. UnitedHealthcare Ins. Co.*, No. 5:16-cv-01094-FB-RBF (W.D. Tex. Nov. 11, 2016). As of February 27, 2018, Sky Labs and UnitedHealth have exchanged settlement offers and agreed to mediate their claims on or prior to December 14, 2018. Parties’ Report on Alternative Dispute Resolution and Compliance with Local Rule CV-88 at 1, *Sky Toxicology, Ltd. v. UnitedHealthcare Ins. Co.*, No. 5:16-cv-01094-FB-RBF (W.D. Tex. Feb. 27, 2018).

278. *See* Complaint 31–32, *UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd.*, No. 9:16-cv-80649-RLR (S.D. Fla. Apr. 25, 2016) (alleging the waiver of patient responsibilities was a direct violation of the Florida deceptive practices act and “caused significant economic harm to United because Lab Defendants’ fraudulent insurance claims induced United to make millions of dollars of payments that it was never obligated to make”); *see also* Complaint at 26, *Conn. Gen. Life Ins. Co. v. Sky Toxicology, Ltd.*, No. 9:15-cv-80994-WJZ (S.D. Fla. July 17, 2015) (“Sky Labs also deceived Cigna by submitting false, grossly inflated charges to Cigna that did not reflect Sky Labs’ actual charges to patients. Sky Labs’ fraudulent fee-forgiving scheme has and continues to harm Cigna’s business.”).

279. Complaint at 51, *UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd.*, No. 9:16-cv-80649-RLR (S.D. Fla. Apr. 25, 2016) (alleging that failing to disclose the “services were the direct result of a patient-referral kickback scheme[,]” which was a violation of the Florida and Texas anti-kickback statutes); Complaint at 20, *Conn. Gen. Life Ins. Co. v. Sky Toxicology, Ltd.*, No. 9:15-cv-80994-WJZ (S.D. Fla. July 17, 2015) (expressing the opinion that intentionally failing to disclose the anti-kickback scheme violated the laws of both Florida and Texas).

referrals-for-remuneration schemes that they alleged defrauded their members and insurance plans. More applicable to this Article is the fact that UnitedHealth not only named the laboratories as defendants, but that it also sought relief from the referral sources—both business organizations and individuals—as conspirators engaged in a scheme to defraud the insurer.²⁸⁰

Multimillion dollar lawsuits like those instigated by Cigna and UnitedHealth are but a reflection of the expanding breadth of liabilities that healthcare providers should be wary of in their referral relationships. Federal and state governments are not the only enforcement agents confronting illegal remuneration schemes. Aside from criminal and civil penalties under state and federal statutes, referrals-for-remuneration arrangements have an effect on private parties who will seek to protect their own interests.²⁸¹ Sky Labs illuminates the potential legal liabilities associated with referral sources owning investment interests in ancillary services providers. A different kind of kickback scenario underlies the referral scheme involving Health Diagnostic Laboratory, Inc.

b. Health Diagnostic Laboratory, Inc.

Health Diagnostic Laboratory, Inc. (HDL) was a Virginia-based laboratory specializing in blood testing for cardiovascular diseases.²⁸² Similar to Sky Labs, HDL was sued by Cigna in 2014 for a scheme in which HDL, as an out-of-network provider, submitted bills to Cigna at exorbitant rates while waiving patients' obligations to pay copayments, coinsurance, or deductibles.²⁸³ Cigna and HDL settled the \$84 million lawsuit for \$59 million.²⁸⁴ In a related suit, another insurance company,

280. See *supra* note 264 (providing a list of the named defendants in UnitedHealthcare's complaint).

281. See *infra* pp. 152–53 (explaining the wide range of actors who participate in these lawsuits, including private parties attempting to recoup losses sustained due to the violation).

282. See Plaintiffs' Amended Complaint at 2, *Conn. Gen. Life Ins. Co. v. Health Diagnostic Laboratory, Inc.*, No. 3:14-cv-01519-VAB (D. Conn. Jan. 16, 2015) (noting HDL is a provider of routine laboratory services which is considered an out-of-network provider under Cigna's plans).

283. *Id.*

284. The settlement was a part of HDL's bankruptcy proceedings, wherein Cigna has been established as a Class 4 Claim in the bankruptcy estate. Katie Demeria, *Ex-Richmond Blood-Testing Firm Settles \$59M Suit Brought by Cigna*, RICHMOND TIMES-DISPATCH (June 21, 2016), http://www.richmond.com/business/local/article_7afd33e9-5114-57d5-b4f8-b5af58b64e6a.html [<https://perma.cc/DAF5-JAUM>].

Aetna, Inc., sued on similar grounds and also procured a multimillion dollar settlement agreement.²⁸⁵

Aside from allegations of HDL's inducements to patients by waiving their copayments, the laboratory was also accused of engaging in an illegal kickback arrangement.²⁸⁶ In exchange for physicians referring their patients' blood testing services to HDL, the laboratory would pay the physicians excessive processing and handling fees for collecting blood from their patients.²⁸⁷ Medicare and private insurance companies generally permit fees of \$3 per blood draw.²⁸⁸ It was purported that HDL paid between \$10 and \$17.²⁸⁹ HDL began its legal issues with the government when it was confronted with *qui tam* (private whistleblower action) lawsuits under the False Claims Act.²⁹⁰ Thereafter the Department of Justice intervened.²⁹¹ Soon following, HDL agreed to resolve the allegations against it by settling with the government for \$47 million.²⁹²

Despite the fact that HDL's kickback scheme did not involve physician ownership in a referral entity or remuneration through ownership

285. See generally *Aetna, Inc. v. Health Diagnostic Laboratory, Inc.*, No. 15-1868, 2015 WL 9460072, at *10 (E.D. Penn. Dec. 28, 2015) (denying defendants motion to dismiss Aetna's claims on all counts). The settlement in *Aetna*, which is a purported \$77.4 million, is also a part of HDL's bankruptcy proceedings; however, Aetna is an unsecured creditor, and Aetna's settlement has been split into two categories: \$49.5 million is a Class 3 claim, and the remaining \$27.9 million, like Cigna, is a Class 4 claim. Katie Demeria, *HDL Settles \$77.4 Million Aetna Lawsuit*, RICHMOND TIMES-DISPATCH (Apr. 26, 2016), http://www.richmond.com/business/article_44294a9b-ea59-5385-8514-e42826b7e051.html [<https://perma.cc/SWN3-HZE6>].

286. See Plaintiffs' Amended Complaint at 14, *Conn. Gen. Life Ins. Co. v. Health Diagnostic Laboratory, Inc.*, No. 3:14-cv-01519-VAB (D. Conn. Jan. 16, 2015) (noting the recent OIG alert indicating that such improper payments implicate the Anti-Kickback Statute).

287. *Id.* at 24.

288. Larry Husten, *Inside the Scandal: Profit and Greed at an Embattled Laboratory Company*, FORBES PHARMA & HEALTHCARE (Apr. 21, 2015, 8:32 AM), <https://www.forbes.com/sites/larryhusten/2015/04/21/inside-the-scandal-profit-and-greed-at-an-embattled-laboratory-company/#7e6386b32789> [<https://perma.cc/33UJ-7S8P>].

289. Press Release No. 15-431, *supra* note 229; Husten, *supra* note 288. Another deviation from industry standards was the fact that for most clinical laboratories, physicians order an average of 2.2 to 2.8 tests on a single patient. *Id.* HDL performed on average 31 tests per requisition, further evincing its inducement of physicians to order medical unnecessary tests. *Id.*

290. See, e.g., *United States ex rel. Mayes v. Berkeley HeartLab Inc.*, 225 F. Supp. 3d 487, (D.S.C. 2016) (indicating Mayes *qui tam* action was one of three independent actions). "The lawsuits were filed by Dr. Michael Mayes, Scarlett Lutz, Kayla Webster and Chris Reidel under the *qui tam*, or whistleblower, provisions of the False Claims Act." Press Release No. 15-431, *supra* note 229.

291. Press Release No. 15-431, *supra* note 229.

292. *Id.*

distributions, it proves to be a poignant cautionary tale. First, HDL's incredible early success was eventually curtailed by government enforcement actions and commercial payor lawsuits.²⁹³ The aggregate toll of these financial setbacks and the reduction in HDL's business in the wake of its legal disputes ultimately landed HDL in bankruptcy.²⁹⁴

Second, in spite of the assurances physicians or HDL may have provided—that the laboratory would waive the patients' obligatory out-of-pocket payments—the patients eventually suffered. In the course of HDL's bankruptcy proceedings, HDL's bankruptcy estate recruited a Florida collection agency to pursue payments from more than 9,000 patient accounts.²⁹⁵ The bankruptcy estate has sought reimbursement from thousands of former HDL patients for “overdue bills” totaling more than \$50 million dollars.²⁹⁶ In one case, a California woman received a bill for \$2,883.80 for blood testing done two years prior.²⁹⁷ Her insurer had previously denied payment because it said the blood work was unnecessary.²⁹⁸

Third, HDL's bankruptcy trustee is actively pursuing recovery of certain fraudulent transfers made by HDL prior to filing bankruptcy.²⁹⁹ To the extent that the process and handling fees HDL paid to physicians constitute fraudulent or otherwise avoidable transfers, HDL's liquidating trustee is seeking recovery from the physicians of those remunerations.³⁰⁰

293. *Id.*

294. Demeria, *supra* note 285. Contributing to HDL's lag in business was the OIG's 2014 publication issuing guidance that paying processing and handling fees to physicians who send blood samples is an arrangement facing potential liability under the federal Anti-Kickback Statute. *See* LABORATORY PAYMENTS TO REFERRING PHYSICIANS, *supra* note 25, at 1 (“[W]e have repeatedly emphasized that providing free or below-market goods or services to a physician who is a source of referrals, or paying such a physician more than fair market value for his or her services, could constitute illegal remuneration under the anti-kickback statute.”); *see also* Husten, *supra* note 288 (warning doctors who accept remuneration will be subject to DOJ scrutiny).

295. Katy Stech, *Health Diagnostic Laboratory Patients Face Bills Years After Blood Work*, WALL STREET J. (May 16, 2016), <https://www.wsj.com/articles/health-diagnostic-laboratory-patients-face-bills-years-after-blood-work-1463428248> [<https://perma.cc/MT29-BYKJ>].

296. *Id.*

297. *Id.*

298. *Id.*

299. *See* Order Authorizing Creditors Committee to Conduct Bankruptcy Rule 2004 Examinations of the Debtors and Certain Third Parties at 2, *In re* Health Diagnostic Laboratory, Inc., No. 15-32919-KRH (E.D. Va. Oct. 27, 2015) (authorizing the committee to investigate whether there were any intentional or constructive fraudulent transfers that should be returned to the estate).

300. *See* Motion of Creditors Committee for an Order Authorizing it to Conduct Bankruptcy Rule 2004 Examinations of the Debtors and Certain Third Parties at 13, *In re* Health Diagnostic

These cases not only affect the laboratories themselves, but the investors, the referring parties, and, as in the case of HDL's bankruptcy, sometimes the patients. HDL also presents a unique wake-up call to attorneys providing legal counsel to laboratories and other ancillary services facilities. In 2015, HDL's bankruptcy trustee filed claims against the law firm LeClairRyan, rooted in legal services the firm provided HDL during its primary operation years.³⁰¹ Nearly a year later, the firm settled with the estate for \$20.375 million.³⁰² The terms of the settlement agreement were not an admission of guilt, but LeClairRyan's chief legal officer made a sobering observation: "[T]he pursuit of litigation claims against law firms has become quite commonplace as one of the ways trustees try to raise funds to pay off claimants in bankruptcy cases."³⁰³

HDL's legal proceedings demonstrate the wide breadth of legal issues, claimants, liable parties, and even victims of illegal remuneration referral arrangements involved in such schemes. Not only is the government pursuing enforcement of the Anti-Kickback Statute and the False Claims Act, but commercial payors are attempting to cover their bottom lines by going on the offensive and recouping funds they deemed illegally obtained; insiders are initiating suits against the health care providers via *qui tam* suits; and bankruptcy estates are throwing the kitchen sink into legal proceedings, attempting to recoup any and all possible funds from whomever they can rationalize a reasonable legal claim against—including seemingly innocent (if not entirely oblivious) patients and former legal counsel. Above all, the aforementioned laboratories represent the legal vulnerability of referral relationships with ancillary services facilities when some kind of compensation is involved and, just as important, the heightened scrutiny these arrangements are receiving from various government forces and private actors.

Laboratory, Inc., No. 15-32919-KRH (E.D. Va. Sept. 30, 2015) (requesting permission to examine the unlawful inducements used to cause patients to utilize the out-of-network services).

301. See Katie Demeria, *HDL Reaches \$20M Settlement with LeClairRyan*, RICHMOND TIMES-DISPATCH (Sept. 2, 2016), http://www.richmond.com/business/local/article_4e705fac-f07b-5453-9e4f-22a0dc91350f.html [<https://perma.cc/BFR5-2CB2>] (asserting HDL's claims against LeClair Ryan were "rooted in the legal services that LeClairRyan provided HDL from the Richmond-based blood testing firm's formation in 2008 until its bankruptcy filing in 2015").

302. *Id.*

303. *Id.*

3. The Growing Concern over Compounding Pharmacies

While the federal government's focus is increasingly directed toward physician-owned entities and payments for referrals, and private litigants are pursuing redress against fraudulent activity, the state of Texas does not outright prohibit physician ownership in ancillary services facilities.³⁰⁴ The current legal landscape of the state, however, displays a growing interest in physicians' relationships with, and ownership in, their referral facilities.³⁰⁵ The Texas AG has recently displayed increasing interest in physician involvement with compounding pharmacies.³⁰⁶

A recent string of investigations has delved into the relationship between compounding pharmacies and the physicians who refer business to them, particularly in the wake of a recently enacted Texas statute. Effective as of September 2015, the Texas State Board of Pharmacy (Pharmacy Board) may inspect a pharmacy's "financial records relating to the operation of the facility."³⁰⁷ The Pharmacy Board may only inspect such records in the course of investigating a specific complaint against the pharmacy, and then, "only [those] records related to the specific complaint."³⁰⁸

The last two restrictions may seem to be sterilizing provisions of an otherwise powerful law, but consider the recent fraud investigations against a Dallas area company, RXpress Pharmacy.³⁰⁹ "Disgruntled

304. Kevin Krause, *Texas Pharmacy Regulators Have New Law to Scrutinize Financial Ties to Doctors*, DALL. MORNING NEWS (Feb. 9, 2016), <https://www.dallasnews.com/news/crime/2016/02/09/texas-pharmacy-regulators-using-new-law-to-scrutinize-financial-ties-to-doctors> [<https://perma.cc/8VWU-8B7A>] (recognizing that under Texas law, "[i]t's legal for physicians to own or invest in a pharmacy . . . as long as they disclose it to patients who they refer to the business").

305. *See generally id.* ("Physician ownership and investment in compounding pharmacies is starting to get more attention and scrutiny with an expanding federal investigation of kickbacks in Texas and other states."); Woodruff & Kreick, *supra* note 21 ("Although the Texas Attorney General has investigated compounding pharmacies before, the [Civil Investigative Demands] involved here focus on physician ownership, investment, and financial relationships, which may indicate increased enforcement activity in an area that has seen relatively little scrutiny.").

306. *See* Woodruff & Kreick, *supra* note 21 (recognizing that the Texas AG is beginning to focus on physician ownership of compounding pharmacies).

307. TEX. OCC. CODE ANN. § 556.051(a)(6) (West 2012).

308. *Id.* § 556.051(b).

309. Keven Krause, *North Texas Pharmacy in Federal Probe is Accused of Paying Kickbacks to Doctors*, DALL. MORNING NEWS (Feb. 5, 2016), <https://www.dallasnews.com/news/investigations/2016/02/05/north-texas-pharmacy-in-federal-probe-is-accused-of-paying-kickbacks-to-doctors> [<https://perma.cc/83NX-QM93>] ("Federal authorities are investigating a

business partners and a pharmacy tax adviser [brought] accusations against” the pharmacy when they each filed separate lawsuits.³¹⁰ The tax adviser alleged that RXpress paid kickbacks to physician-owners in the form of investor dividends in exchange for the physicians writing prescriptions to bolster the pharmacy’s business.³¹¹ RXpress subsequently came under investigation by federal authorities.³¹² The accusations of former associates swung the door wide open for the Pharmacy Board to inspect the pharmacy’s financial records.³¹³ These records may confirm the veracity of the kickback’s allegations, and the Pharmacy Board may then pass along such information to state or federal investigators.³¹⁴

The Texas AG’s office has also made recent use of its ability to issue Civil Investigative Demands (CIDs) to several physicians who have ownership interests in the compounding pharmacy, Healthscripts of America.³¹⁵ CIDs are investigative tools that the Texas AG’s Consumer Protection Division may use in the course of an investigation under the Texas Deceptive Trade Practices Act (DTPA)—a consumer protection law that proscribes false, misleading, or deceptive acts or practices in the conduct of trade or commerce.³¹⁶ CIDs generally require the issuant to produce documentary materials the Consumer Protection Division believes the issuant may possess that are relevant to the subject matter of the DTPA investigation.³¹⁷

North Texas compounding pharmacy accused of paying illegal kickbacks to physicians for writing prescriptions . . .”).

310. *Id.*

311. *Id.*

312. *See id.* (“The FBI said it could not confirm or deny the existences of an investigation.”).

313. *See* OCC. §§ 556.015(a)(6), (b) (permitting investigation into a pharmacy’s financial records after a specific complaint has been filed against the company).

314. *See id.* (referring to “financial records” but failing to define what the term encompasses). What remains uncertain is what actually constitutes as a “financial record,” and whether those financial records would disclose the ownership records of physicians. *Id.*

315. *See* Woodruff & Kreick, *supra* note 21 (recognizing the effort of the Texas AG to combat healthcare fraud and abuse through its issuance of Civil Investigative Demands to some physician investors of Healthscripts Specialty Pharmacy).

316. *See* TEX. BUS. & COM. CODE ANN. § 17.46 (West Supp. 2017) (prohibiting deceptive trade practices); *see also id.* § 17.61 (West 2011) (allowing CIDs).

317. *See id.* § 17.61(a) (“Whenever the consumer protection division believes that any person may be in possession . . . of any documentary material relevant to the subject matter of an investigation of a possible violation of this subchapter, an authorized agent . . . may execute a writing and serve on the person a civil investigative demand . . .”).

In regard to Healthscripts, the CIDs made requests for documents “showing all prescribers who have purchased an interest [in] any compounding pharmacy.”³¹⁸ Physician investors were asked to produce documents “showing the amount of remuneration of any kind paid to these prescribers who invested money or other types of investments in any compounding pharmacy.”³¹⁹ CIDs are a common tool for the AG’s office, but it is a rare occurrence for CIDs to inquire into physician investors’ financial records and communications related to remuneration—quite obviously information that charters the waters of the TPSA.³²⁰ If anything, such a dramatic shift from standard CIDs usage provides some indication that state authorities are developing a growing interest in physician ownership interests in ancillary services facilities.³²¹

The fact that the state has an interest in the ownership records of a health care provider may very well signal Texas’s desire to pursue investigations of physician-owned entities. The statute permitting inspection of pharmacy financial records may simply be the first stop. Upon inspection of such records revealing referring physicians having ownership interests in these pharmacies, the TPSA seems to be the next logical stop, which may result in the beginning of prosecutions thereunder.

4. A Note on Investment Structures

a. Investment Structures in Ancillary Services Entities Generally

Blatant illegal remuneration arrangements like the examples in this Article’s introduction are easy situations to spot.³²² Even the HDL scheme had clear paper trails of checks written to physicians for

318. Woodruff & Kreick, *supra* note 21 (quoting Petition to Partially Set Aside Civil Investigative Demands and for Protective Order, *In re Healthscripts Specialty Pharmacy*, No. D-1-GN-15-000380 (53d Dist. Ct. Travis Cty., Tex. Jan. 30, 2015)).

319. *Id.* (quoting Petition to Partially Set Aside Civil Investigative Demands and for Protective Order, *In re Healthscripts Specialty Pharmacy*, No. D-1-GN-15-000380 (53d Dist. Ct. Travis Cty., Tex. Jan. 30, 2015)); *see also* Merritt, *supra* note 18 (noting that CIDs sought documents from individual physicians who had dealt with Healthscripts).

320. Merritt, *supra* note 18 (“While DTPA CIDs are common, it is very rare to see DTPA CIDs asking physician investors for financial records and any communications related to an investment covered by the Solicitation of Patient statute.”).

321. In addition to the attention in Texas, in January of 2016, “the FBI and other police agencies raided nine compounding pharmacies in Mississippi and seized more than \$15 million in assets.” Krause, *supra* note 309. “[S]everal Florida pharmacies also agreed [in 2015] to pay millions to settle civil allegations that they had improper financial relationships with doctors.” *Id.*

322. *See supra* notes 10–12 and accompanying text.

overcharged, unnecessary expenses.³²³ But when those arrangements are concealed within varying degrees of investment entities, such as ownership interests in limited partnerships and limited liability companies, the illegitimacy is more difficult to identify (which is likely the point). As a practical consideration, then, the structure of investments in ancillary health care facilities may help provide a glimpse into the potential liability it may cause for investors.

The attorney reviewing these investment structures may often find that the business entity that operates the ancillary services facility is broken up into two sets of owners. First, there are the investors who are capable of referring business to the facility—usually individual physicians, physician practice groups, or other business entities owned by persons who can refer patients (collectively, Referring Investors).³²⁴ On the other side of the coin are the Non-Referring Investors—persons or investment groups who may not be health care professionals and who tend to be a part of the company’s governance (Non-Referring Investors).³²⁵ The business entities often distinguish Referring Investors from Non-Referring Investors by separating them into two classes of owners (e.g., Class A Members and Class B Members).³²⁶

323. See Larry Husten, *Inside the Scandal: Profit and Greed at an Embattled Laboratory Company*, FORBES PHARMA & HEALTHCARE (Apr. 21, 2015, 8:32 AM), <https://www.forbes.com/sites/larryhusten/2015/04/21/inside-the-scandal-profit-and-greed-at-an-embattled-laboratory-company/#7e6386b32789> [https://perma.cc/33UJ-7S8P] (“The reason the company sent paper checks, according to one source, is because Tonya Mallory, the CEO, told employees that ‘doctors love to see the paper checks in their hand.’”).

324. See generally 42 C.F.R. § 1001.952(a)(1)(ii) (2015) (referencing “an investor in a position to make or influence referrals”).

325. See, e.g., First Amended Complaint at 9–10, *UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd.*, No. 9:16-cv-80649-RLR (S.D. Fla. Nov. 29, 2016) (referring to the Non-Referring Investors as the corporate officers or the various lab entities).

326. Cf. ROBERT W. HAMILTON ET AL., *THE LAW OF BUSINESS ORGANIZATIONS: CASES, MATERIALS, AND PROBLEMS* 274 (12th ed. 2014) (demonstrating the separation of investors into ownership classes is a common practice in various business ventures). Among other reasons, however, separating investors into classes based on their ability to refer business to the company is frequently done in a vain and perfunctory attempt to satisfy the Safe Harbor—an exemption from criminal prosecution under the Anti-Kickback Statute regarding returns on certain investment interests. See 42 C.F.R. § 1001.952. This Safe Harbor requires, among numerous other requirements, that Referring Investors may hold no more than 40% of the investment interests of each class of interests in a 12-month period. *Id.* § 1001.952(a)(2)(i). More importantly, this Safe Harbor requires that no more than 40% of the gross revenue of the company may come from business generated by the Referring Investors in a given 12-month period. *Id.* § 1001.952(a)(2)(vi). Ancillary services companies tend to attempt to satisfy this Safe Harbor by limiting the membership of Referring Investors to 40% of the total ownership interests. The companies inevitably fail to satisfy this Safe

Ordinarily, business organizations that are used as vehicles for medical practitioners' investment in ancillary services facilities are a part of normal, legally-permitted investment strategies. The circumstances become less legally tenable, however, when those business entities are used to funnel kickbacks to physicians for their referrals to the ancillary services facilities. In Sky Labs, we saw that the Referring Investors owned interests in one of the various business structures that operated the laboratories involved in the asserted illegal remuneration artifice.³²⁷ The allegations claimed that Referring Investors would refer business to those laboratories.³²⁸ In exchange, those investors would receive remuneration from the business entities in the form of company profit distributions that were generated by the referrals.³²⁹ The Non-Referring Investors would similarly receive company distributions from the various labs' profits.³³⁰

These entities usually have partnership agreements, limited liability company agreements, or corporate bylaws that control the governance and rights of interest owners (collectively, Bylaws).³³¹ These Bylaws seldom contain a smoking-gun provision that mandates Referring Investors refer business to the respective ancillary services facilities.³³² Instead, these governing documents provide that Referring Investor ownership interests may be owned only by persons who are actively able to make those kinds

Harbor, however, because 100% of the companies' revenues are generated by those same Referring Investors.

327. See First Amended Complaint at 2–3, *UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd.*, No. 9:16-cv-80649-RLR (S.D. Fla. Nov. 29, 2016) (alleging the physicians that refer specimens to the labs are not actually “investors” being paid “investment distributions” but actually just being paid “kickbacks” from their referrals). Sky Laboratories, Ltd. was a limited partnership, and the affiliated labs were either limited partnerships or for-profit corporations. See *id.* at 6–9 (“Defendants utilize multiple corporate entities in an attempt to shield themselves from liability for their fraudulent conduct.”).

328. See *id.* at 6 (claiming the separate entities would refer business to the labs by sending urine specimens for drug testing).

329. See *id.* at 2–3 (describing the “investment” distribution process—an “investor” sends the lab a certain number of referrals per month and then receives an “invest distribution,” typically much larger than the initial “investment”).

330. See *id.* at 6 (explaining the physicians would make money by acquiring ownership of the limited partnership labs through equity ownership in the general partner, which was typically some type of limited liability entity).

331. See, e.g., *id.* at 10 (referencing “subscription agreements” and explaining that the agreement formalized the “kickback” the Referring Investor would receive in exchange for referrals to the labs).

332. See Complaint at 11, *Conn. Gen. Life Ins. Co. v. Sky Toxicology, Ltd.*, No. 9:15-cv-80994-WJZ (S.D. Fla. July 17, 2015) (indicating the deception employed by Sky Labs in failing to disclose its cost sharing responsibilities in conjunction with its services to either patients or insurers).

of patient referrals.³³³ Further, the Referring Investors' interests are commonly subject to redemption provisions that allow for the company to repurchase or redeem the Referring Investor's interests upon the unilateral decision of the governing board.³³⁴ Referring Investors who are not complying with the company's business plan may be forced to sell their interests.³³⁵

These are all tactics that may be employed to compel Referring Investors to refer business to the ancillary services facilities in which they have invested. Simultaneously, these tactics may help shroud any company's conditions that ownership interests and the receipt of profit distributions be based on mandatory referrals. The Bylaws provisions and company policies may also assist in accomplishing a third goal of preventing the Referring Investors from free-riding the company's profits. Mandatory sales and redemption clauses allow these companies to essentially kick out Referring Investors not contributing to the scheme.³³⁶ Armed with this kind of tool, ancillary services facilities can prevent sharing profits with Referring Investors who are not actively participating in the referral-for-remuneration scheme.³³⁷

Despite these red-flag company policies, when the business entity has numerous investors, the sheer volume of investors may allow for passive

333. *See id.* at 11–12 (highlighting only those physicians who meet minimum referral requirements may participate in the ownership interest).

334. *See, e.g., id.* at 12 (“Upon information and belief, if a physician or treatment center investor does not meet the specimen referral quota, Sky Labs may repurchase or ‘redeem’ the shares from the investor.”).

335. The author has reviewed numerous prospective investor information documents that inform potential investors that their shares in the company may be redeemed if the Referring Investor, for instance, disrupts the affairs of the company or if the company's governing board solely determines that the investor has been deemed unsuitable to remain an investor for any reason or no reason. *See, e.g.,* First Amended Complaint at 43–45, *UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd.*, No. 9:16-cv-80649-RLR (S.D. Fla. Nov. 29, 2016) (redeeming investment shares upon failure to send the requisite number of specimens).

336. *See* Complaint at 12, *Conn. Gen. Life Ins. Co. v. Sky Toxicology, Ltd.*, No. 9:15-cv-80994-WJZ (S.D. Fla. July 17, 2015) (explaining penalties exist for those who do not substantially contribute to sales quotas); First Amended Complaint at 3, *UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd.*, No. 9:16-cv-80649-RLR (S.D. Fla. Nov. 29, 2016) (“If an ‘investor’ slows or stops sending specimens to a lab, the Officers threaten to rescind the ‘investment’ or withhold the monthly distributions until the specimens start flowing again.”).

337. This kind of policy, where the company is allowed to retain the right to repurchase the interests of investors upon the investor's failure to refer business to the company, is a particular characteristic the U.S. Office of the Inspector General has stated it finds highly suspicious for illegal activity. Special Fraud Alert: Physician-Owned Entities, 78 Fed. Reg. 19271, 19272 (Dep't of Health & Human Servs. Mar. 29, 1993) (notice).

Referring Investors who do not contribute significant referrals. As mentioned, targeting motivated referral sources for investment and including mandatory sales and redemption provisions in Bylaws help alleviate these kinds of free-rider concerns. Recently, however, ancillary services companies dependent on investor referrals have begun to utilize a newer investment structure to secure against free-riding Referring Investors. This investment structure seeks to accomplish all of the referral policies described above, without the red flags, in the form of the Series Limited Liability Company.

b. The Series Limited Liability Company

The Series Limited Liability Company (Series LLC) is a limited liability company (LLC) that provides for a series of members, managers, ownership interests, or assets.³³⁸ The series is not a separate domestic entity under Texas law. Rather, the series “has separate rights, powers, [and] duties with respect to specifi[c] property or obligations of the” LLC under which it is formed.³³⁹ Each series has the ability to sue and be sued, enter contracts, and hold assets separate from the broader LLC.³⁴⁰

As we saw above, all of the Referring Investors in the ancillary services company are a part of a general class of interest-owning members. Each of those members are expected to contribute to the company by referring business to the LLC. If any investors within that class do not refer patients, and the LLC still makes distributions to the class of members, the Referring Investors who did not refer may still be entitled to the distributions.³⁴¹

In the Series LLC, however, the ancillary services company can separate ownership classes into numerous series, having as few as one Referring Investor and Non-Referring Investor per series.³⁴² What this means is

338. TEX. BUS. ORG. CODE ANN. § 101.601(a) (West 2009).

339. *Id.* § 101.601(a)(1).

340. *Id.* §§ 101.605(1)–(3). The series may also grant liens and security interests in the series’ assets as well as exercise all necessary powers or privileges to conduct the series’ business. *Id.* §§ 101.605(4)–(6).

341. This is, of course, dependent on whether the non-contributing Referring Investor has been discovered and forced to sell their shares back to the company. See *supra* notes 336–37 and accompanying text.

342. See Carol R. Goforth, *The Series LLC, and a Series of Difficult Questions*, 60 ARK. L. REV. 385, 387 (2007) (“[A]n LLC that observes the statutory requirements for this new form of business can set up distinct series of ownership, management and economic rights, where each series owns and controls specific assets, and as to which liability is limited.”).

that the overarching Series LLC can conduct one business of running a laboratory, compounding pharmacy, or other ancillary services facility. Meanwhile, each Referring Investor, along with the Non-Referring Investor, would be in an individual series of the LLC. Because each series is allowed its own members, managers, liabilities and duties, distributions from company profits would not be organization-wide.³⁴³ The managers within the series (usually the Non-Referring Investor's appointees) decide when to make distributions.³⁴⁴ And then, those distributions would not come from the profits of the broader LLC, but from the profits of the respective series.³⁴⁵

Instead of simply dividing Referring Investors and Non-Referring Investors into respective classes of interest-owners within the entire *organization*, the Series LLC allows the Non-Referring Investor to be a class member separate from another class of as few as one Referring Investor in each *series*. The Series LLC, therefore, benefits the ancillary services company that depends on referrals by helping eliminate the cost of Referring Investors who are not actively referring business. If the series in which the Referring Investor(s) is, is not profitable due to fewer referrals generating fewer company revenues, the company can simply ignore that series. The series' governing authority is not obligated to distribute profits from the LLC to the individual, unprofitable series.³⁴⁶

This investment structure avoids the red-flag Bylaws provisions or mandatory referral company policies. The incidental effect of the structure, however, is that the smoking gun is no longer an explicit Bylaw provision. The smoking gun is now the tie between the profitability of each series and the number of referrals made by the Referring Investors in that series. In other words, in a regular LLC or other investment entity, free-riding referring investors who collect distributions, despite their failure to refer business, at least allow an inference that distributions from the company are not solely conditioned on referrals. But the Series LLC

343. *See id.* (stating losses incurred by one series do not impact members of another series).

344. *See id.* at 387–88 (“The series LLC provision also includes a number of subsections explaining how series are to be managed, operated, and dissolved.”).

345. *See id.* at 402 (highlighting whether the IRS and courts consider each individual series as distinct partnerships for the purposes of distributing profits).

346. *See* TEX. BUS. ORG. CODE ANN. § 101.252(1) (West 2009) (conferring management of a limited liability company's business affairs to the governing authority of the LLC according to the company agreement); *id.* § 101.613(a) (“A limited liability company may make a distribution with respect to a series.”); *id.* § 101.609(c) (discussing the powers and rights of governing persons and officers within a series).

allows an observer to recognize the direct correlation between profit distributions to Referring Investors and the number of referrals they made to the ancillary services facility. The fewer Referring Investors there are in a series, the more apparent that relationship is. A Referring Investor who fails to refer business to an ancillary services facility affects the return of distributions that a series is able to issue much more than an LLC at large.

Despite there being no explicit company policies or Bylaws provisions mandating Referring Investors to refer business to the company, the Series LLC has its own smoking gun. The direct correlation between a series' profit distributions and the business attributable to the series' Referring Investors' referrals establishes a convincing implication of an illegal remuneration scheme. It seems that, irrespective of the structure of investment in an ancillary services facility that requires its investors to refer business, there is a traceable line connecting the distributions from the company to the referrals the investors make.

B. *Additional Legal Theories Implicating Referrals for Remunerations*

Any prudent physician is capable of believing that because they have invested in a modest yet respectable toxicology laboratory or radiological imaging center, they are likely immune from prosecution under illegal remuneration laws. The physician might particularly be subdued by this notion if she has invested with the best intentions and actually does value her patients' wellbeing over her own pecuniary interests when making referrals. But despite a physician's good intentions, the relationship with the ancillary services facility may still prove to be problematic.³⁴⁷

As previously discussed, in addition to the enhanced attention government investigative authorities are paying ancillary services facilities to which physicians refer business, insurance companies are levying aggressive civil suits against physicians and other medical providers as a means of combating healthcare insurance fraud.³⁴⁸ Numerous state and federal laws that concern the financial relationships surrounding physician

347. See James J. Ferrelli, *Civil Rico Actions on the Rise to Combat Healthcare Insurance Fraud*, DUANE MORRIS HEALTH L. (Feb. 17, 2015) (on file with St. Mary's Law Journal) ("[P]laintiff insurance companies assert that the defendants—two doctors, three medical professional corporations, and the professional corporations' alleged managers—engaged in a racketeering scheme . . .").

348. See *supra* Parts III.A.1, III.A.2; see also Ferrelli, *supra* note 347 ("Over the past several years, insurance carriers have aggressively pursued civil suits against doctors and other medical providers in an effort to fight healthcare insurance fraud.").

referrals to ancillary services facilities are at the disposal of government prosecutors and private litigants.³⁴⁹ There are, however, several notable statutes in our analysis of the TPSA under which a commercial payor may pursue action against allegations of fraud. The first among those is the Federal Travel Act (Travel Act).³⁵⁰

1. The Travel Act and Commercial Bribery

The Travel Act prohibits persons from using facilities in interstate or foreign commerce (such as mail, e-mail, the Internet, facsimile or telephone) with intent to:

(1) distribute the proceeds of any unlawful activity; or (2) commit any crime of violence to further any unlawful activity; or (3) otherwise promote, manage, establish, carry on, or facilitate the promotion, management, establishment, or carrying on, of any unlawful activity and thereafter performs or attempts to perform [such unlawful activity].³⁵¹

The United States Supreme Court has held that Congress intended “unlawful activity” under the Travel Act to encompass state commercial bribery statutes.³⁵² Thus, one may violate the Travel Act by traveling in or using the facilities of interstate or foreign commerce with the intent to promote or carry on a violation of a state bribery law.³⁵³

For insurance carriers, the Travel Act can be very useful in that it can essentially transform what would ordinarily be a state-level crime into a federal felony, thus providing insurers a better bargaining chip. In the case of Texas physicians, the underlying state-level “unlawful activity” requisite for Travel Act liability is the Texas Commercial Bribery Statute.³⁵⁴ This statute establishes a criminal offense if a physician, without the consent of her patient, “intentionally or knowingly solicits, accepts, or agrees to

349. See, e.g., the False Claims Act, *supra* notes 229–35 and accompanying text, and ERISA, *supra* note 277 and accompanying text. Though these laws, among others, are noteworthy in the discussion of health care fraud, the depth of their further analysis is beyond the purview of this Article.

350. 18 U.S.C. § 1952 (2012).

351. *Id.*

352. See *Perrin v. United States*, 444 U.S. 37, 50 (1979) (holding state bribery statutes shall be included in the Travel Act as envisioned by Congress).

353. 18 U.S.C. §§ 1952(a) & (b)(1)(2).

354. See TEX. PENAL CODE ANN. § 32.43(2)(C) (West 2011) (noting physicians as a covered group for the purposes of the statute).

accept any benefit from another person [(which would include an ancillary services facility) by] agreement or understanding that the benefit will influence the conduct of the [physician] in relation to the affairs of [her patient].”³⁵⁵

Even though there are no Texas cases in which a physician's ownership interest in an entity to which the physician refers patients is challenged under the Commercial Bribery Statute, it is clear that such an arrangement falls within its purview.³⁵⁶ Distributions or dividends of profits from an investment in an ancillary services facility constitute the benefit accepted under the statute.³⁵⁷ The law's wording provides that, if the physician-investor refers a patient to a facility without disclosing her financial interest to the patient, the physician is essentially accepting a bribe under the statute.³⁵⁸

Incidentally, the TPSA and Commercial Bribery Statute overlap regarding communication with the patient. In the Commercial Bribery Statute, the key provision determining culpability is whether the physician, as fiduciary, received consent from her patient, the beneficiary, to accept the benefit of profit distributions from her ancillary services facility.³⁵⁹ Consent from the patient clearly implies notice to the patient about the financial arrangement the physician maintains with the facility. In circumstances where the remuneration arrangement is permitted under section 102.001 of the TPSA, the physician is still required to inform the patient of the arrangement in order to be free of criminal liability under

355. *Id.* § 32.43(b). The statute does not only apply to physicians and their patients, but rather prohibits the conduct of a “fiduciary” when concerning their “beneficiary.” *Id.* § 32.43(a)(2)(C). The statute defines “fiduciary” as, among other things, a physician. *Id.*

356. Incidentally, there is at least one federal case in which an insurance company sought declaratory judgment that it is not liable for unpaid facility fees charged by an ambulatory surgery center and shared pursuant to a remuneration-for-referrals scheme with numerous joined physician-owned professional association-plaintiffs, under the theory “that a party cannot recover for claims that arise from its own illegal or fraudulent conduct,” namely, the plaintiffs violations of the Texas Commercial Bribery Statute, among others. *See* DAC Surgical Partners v. United Healthcare Servs., Inc., No. 4:11-CV-1355, 2016 WL 7177881, slip op. at *14 (S.D. Tex. Dec. 8, 2016) (citing to the Texas Commercial Bribery provision for holding the referral scheme criminal in Texas).

357. PENAL § 32.43(c) (“A person commits an offense if he offers, confers, or agrees to confer any benefit the acceptance of which is an offense under Subsection (b).”).

358. *See generally id.* § 32.43(b) (“A person who is a fiduciary commits an offense if, without the consent of his beneficiary, he . . . agrees to accept any benefit from another person on agreement or understanding that the benefit will influence the conduct of the fiduciary . . .”).

359. *See id.* (detailing the importance of consent in determining whether a bribe has occurred on behalf of the physician).

section 102.006 of the TPSA.³⁶⁰ Therefore, otherwise permitted referral remuneration arrangements require disclosure to—and in the case of the Commercial Bribery Statute, consent from—the patient, regarding the physician’s ownership interest in the arrangement.

To assert that the Texas Commercial Bribery Statute and the Travel Act are potential mechanisms through which a health insurer may fight health care fraud is not to suggest that the government cannot prosecute physicians thereunder. First and foremost, a violation of the Texas Commercial Bribery Statute is a state felony.³⁶¹ In addition to imprisonment, the law authorizes a court to sentence the physician to “pay a fine in an amount fixed by the court, not to exceed double the value of” any benefit the court finds the physician gained through the commission of an offense under the Commercial Bribery Statute.³⁶² Violation of the Travel Act is a federal felony, punishable by fine, imprisonment, or both.³⁶³

The larger implication here is that a physician’s investment in an ancillary services facility may give rise to a violation of the Texas Commercial Bribery Statute. Culpability under the Commercial Bribery Statute allows the Travel Act to piggyback on the same conduct. Consequently, the illegal conduct establishing violations of the Commercial Bribery Statute and the Travel Act may arm an aggrieved insurance carrier with a more formidable means of recourse—one fraught with onerous ramifications: the federal Racketeering Influenced and Corrupt Organizations Act.³⁶⁴

2. The Effect of the Racketeering Influenced and Corrupt Organizations Act

The federal Racketeering Influenced and Corrupt Organizations Act (RICO) prohibits a person from “invest[ing] in, acquir[ing] an interest in, maintain[ing] control over[,], or conduct[ing] the affairs of, an ‘enterprise’,

360. TEX. OCC. CODE ANN. §§102.006(a)(1)–(2) (West 2012) (“A person commits an offense if: the person, in a manner otherwise permitted under Section 102.001, accepts remuneration to secure or solicit a patient . . . and does not, at the time of initial contact and at the time of referral disclose to the patient . . .”).

361. PENAL § 32.43(d).

362. *Id.* §§ 32.43(d)–(e).

363. 18 U.S.C. §§ 1952(a)(3)(A)–(B) (2012).

364. *Id.* §§ 1961(1)–(10).

by means of a 'pattern' of 'racketeering activity.'"³⁶⁵ The federal government can bring a RICO case against a physician based on the physician's violation of the Texas Commercial Bribery Statute.³⁶⁶ Similarly, insurers can, and in recent years have, become more aggressive in seeking reimbursement for funds wrongfully or fraudulently received by medical providers by filing a civil RICO claim.³⁶⁷ What makes RICO such an attractive tool for insurers, and such a threatening maneuver against physicians, is that the civil RICO claims provide victorious claimants under the statute with treble damages, attorney's fees, and costs.³⁶⁸ In recent years large insurance carriers have brought cases yielding recoveries in the millions of dollars in actual damages.³⁶⁹

Notwithstanding the fact that insurance companies may bring civil RICO claims against physicians who have clearly defrauded the company, the insurers may have another motive in mind. Managed care plans motivated by economic factors may be inclined to keep beneficiaries entirely in network, rather than allow physicians to refer specialists, diagnostic testing, or imaging services outside of the covered network. To accomplish this, an HMO, for instance, may provide in their physician contract, that physicians suffer a financial penalty for referring out of the network or for specialty consultations with whom the HMO disagrees.³⁷⁰

365. Stuart P. Green, *Official and Commercial Bribery: Should They be Distinguished?*, in MODERN BRIBERY LAW: COMPARATIVE PERSPECTIVES 44 (Jeremy Horder & Peter Alldridge eds. 2013).

366. See 18 U.S.C. § 1961(a) (specifying that an act of bribery that is chargeable under a State law constitutes as the predicate, underlying "racketeering activity" for a RICO claim). There appear to be no cases in which RICO has been used in conjunction with commercial bribery. Green, *supra* note 365, at 45.

367. 18 U.S.C. § 1964(e) ("Any person injured in his business or property by reason of a violation of section 1962 of this chapter may sue therefor..."). See generally First Amended Complaint at 506-47, UnitedHealthcare Ins. Co. v. Sky Toxicology, Ltd., No. 9:16-cv-80649-RLR (S.D. Fla. Nov. 29, 2016) (discussing the existence of viable RICO claims).

368. 18 U.S.C. § 1964(c).

369. Matthew J. Smith, *The RICO Act: How to Use the Statute to Aggressively Seek Recovery Against the Unscrupulous*, CLAIMS MGMT., Apr. 2014, at 30, 32 (citing a \$12 million award recovered by State Farm Insurance, and a \$6 million (trebled sum) award that Allstate recovered in a 2013 RICO case against a chain of chiropractic clinics and related parties); see also Allstate Ins. Co. v. Plambeck, 802 F.3d 665, 676 (5th Cir. 2015) ("RICO provides civil remedies to '[a]ny person injured in his business or property by reason of a violation of section 1962.'" (quoting 18 U.S.C. § 1964(c) (2012))), cert. denied, 136 S. Ct. 1824 (2016); State Farm Mut. Auto. Ins. Co. v. Lincow, 715 F. Supp. 2d 617, 632 (E.D. Pa. 2010) (highlighting State Farm's RICO case against health care providers attempting to defraud them), *aff'd*, 444 F. App'x 617 (3d Cir. 2011).

370. See David U. Himmelstein, & Steffie Woolhandler, *Why the US Needs a Single Payer Health System*, PNHP.ORG (2010), http://www.pnhp.org/facts/why_the_us_needs_a_single_payer_health_system.php [<https://perma.cc/83JC-DP4F>] ("HMO Payment incentives

Alternatively, managed care plans may delist, or threaten to delist, physicians for pecuniary reasons.

As a veritable “nuclear tactic,” large insurers with heavy-loaded resources may threaten a civil RICO suit against a physician practice group who owns a pharmacy to which the physicians refer their patients, but at which the insurer simply does not want coverage for its beneficiaries. In such a case, the insurer could simply threaten a lawsuit to recover the extra expenditures the physician group caused the insurer in referring beneficiaries to the pharmacy. As another option, as mentioned above, the insurer can simply file a complaint against the physicians in the physician group with the Texas AG or an overseeing administrative body (e.g., the Pharmacy Board), alleging fraudulent practices between the ancillary services facility and physicians. With respect to arrangements involving remuneration for patient referrals, it may prove to be a more prudent option to play nicely with an insurer than be delisted or run the risk of a lawsuit or invasive investigation.

IV. MOVING FORWARD

The significance and potential severity of improper patient referral arrangements is plain. The issue, however, remains that physicians and their attorneys may be reading into the TPSA limitations that are not there; and in other cases, these people may be justifying certain conduct that, while illegal under the statute, they believe cannot be prosecuted under an unenforceable law.

As discussed above, the contention that the TPSA is ambiguous or unenforceable is directly traceable to the statute’s language found in its

increasingly pressure primary care physicians to avoid specialty consultations and diagnostic tests.”). Texas, however, passed a law in 2015 that prohibits insurers from penalizing, terminating, restricting, or prohibiting, in any manner, physicians or other health care providers with whom the insurer has a provider agreement (a “preferred provider”), covering the preferred provider’s “communicat[ion] with an insured about the availability of out-of-network providers.” TEX. INS. CODE ANN. § 1301.0058(a) (West 2015). Though this law does provide that “[a]n insurer’s contract with a preferred provider may require that . . . the preferred provider inform the insured” patient, prior to referring the insured to an out-of-network provider, that: (1) the insured has a choice between an in-network and out-of-network provider; (2) the out-of-network provider may cause the insured higher out-of-pocket expenses; and (3) if applicable, “the preferred provider has a financial interest in the out-of-network provider.” *Id.* § 1301.0058(c).

construction provision.³⁷¹ The primary goal of this Article is to make physicians and their health care attorneys better informed about the proscriptions and liabilities under the TPSA. Given the potential for physicians and their attorneys to misread the TPSA detailed herein, it is imperative for the Texas legislature to take action and clarify its position on illegal remuneration arrangements. Only by amending the TPSA to clarify what conduct is permitted thereunder can the legislature protect physicians from the dangers elucidated in this Article, rather than leave them to face those dangers in court.

For these reasons, this Article suggests that the Texas Legislature amend the construction provisions at TOC §102.003 to read as follows:

Section 102.001 shall be construed to permits any payment, business arrangement, or payment practice ~~permitted that~~ 42 USC § 1320a-7b, or ~~any~~ the regulations ~~adopted under that law~~ promulgated thereunder, has expressly and specifically identified as a payment, business arrangement, or payment practice that shall not be treated as a criminal offense under Section 1128B9(b) of the federal Social Security Act or serve as the basis of an exclusion under section 1128(b)(7) of such Act, without regard as to whether that payment, business arrangement, or payment practice implicates or is reimbursable under Medicare, Medicaid, or any other state or “Federal health care program” as that term is defined under 42 U.S.C. §1320a-7b(f).³⁷²

This amendment language allows for greater specificity as to what kinds of arrangements and practices are being permitted when the TPSA references the Anti-Kickback Statute and the Safe Harbor regulations. Specifically, this suggested language eliminates the possibility of misinterpreting the TPSA to allow referral-for-remuneration arrangements that do not implicate Federal health care programs. The language would only permit those arrangements and practices that are explicitly referred to as exempt arrangements and practices under the federal statute and Safe Harbor regulations. This amendment would preclude the possibility of the erroneous inferences or assumptions discussed herein.³⁷³ This kind of

371. See *supra* notes 182–95 and accompanying text; see also TEX. OCC. CODE ANN. § 102.003 (West 2012) (“Section 102.001 permits any payment, business arrangement, or payment practice permitted by 42 U.S.C. Section 1320a-7b(b) or any regulation adopted under the law.”).

372. Portions of the current OCC. §102.003 that should be eliminated are indicated by strikethroughs, and added language is denoted by double underlines.

373. See *supra* note 20–22 and accompanying text.

clarity would help prevent physicians from investing in risky referral arrangements and would allow their health care attorneys to better counsel against such investments and structure safer, more compliant investment strategies.

V. CONCLUSION

When the Texas Legislature enacted the TPSA in 1991, it had all of the right motives in protecting patients from the corrupt business practices and eventual abuses of health care professionals whose pecuniary interests outweighed their better medical judgement. But in addressing the overwhelming maladies of the mental health industry at the time, the legislature left the state with an unclear criminal statute that many may choose to ignore. Nevertheless, the importance of that law remains today—maybe now more than ever as the health care industry changes and becomes increasingly complex and competitive.

As of the time of publication of this Article, the TPSA has received scant consideration in the courts, and other administrative bodies have provided mixed guidance at best. Nevertheless, its enforceability seems sound, as the guidance that is available has not suggested or implied that the statute may be ambiguous or unenforceable. Further, the legislative history and case law discussed in this Article intimate the TPSA's reach to be beyond that of its federal counterpart, affecting even those transactions that do not involve Federal health care programs. And not only does the TPSA present the potential for criminal punishment to violators, it also has the possibility, among other illegal remuneration statutes, of subjecting persons engaged in referral-for-remuneration agreements to significant civil liability from increasingly aggressive insurance companies.

As necessary as it is to protect Texas's healthcare patients, it is just as important to protect the physicians who treat them. Our doctors are engaged in investment ventures they have been lead to believe are harmless, meanwhile their ignorance is leaving them exposed. Providing health care professionals and their legal representatives with clear, unequivocal information that seemingly innocent, industrious conduct may actually be against public policy, will allow physicians to make well-informed, prudent, and legal decisions about their referrals, their investments, and their practices generally.

Leaving the TPSA as it currently stands would be a grave mistake and would subject some of Texas's finer doctors to the more acute austerities

of laws they are being counseled are not relevant to them. If the State of Texas is going to allow physicians to supplement their hard-won income with profits from ancillary health care services, we should make the limitations of that allowance clear and prominent enough for everyone to recognize.