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Punishment of Health Care Fraud

Yvette M. Mastin

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THE PUNISHMENT OF “HEALTH CARE FRAUD”

YVETTE M. MASTIN¹

I.	INTRODUCTION	53
II.	THE ACT: MISTAKE OR FRAUD?.....	57
III.	HEALTH CARE FRAUD PROSECUTION	60
	A. <i>Triple Proceedings</i>	60
	B. <i>The Civil Proceeding</i>	63
	1. The False Claims Act	63
	2. Civil Penalties.....	65
	C. <i>The Criminal Proceeding</i>	66
	1. Criminal Penalties	68
	D. <i>Administrative Proceedings & Penalties</i>	73
V.	PROPOSAL.....	74
VI.	CONCLUSION.....	76

I. INTRODUCTION

Skyrocketing health care costs have remained an issue of national concern for most of this decade.² Many Americans have come to believe that one of the primary causes for the substantial increase in the cost of health care is fraud and abuse within the health care industry.³ The United States government reports that federally funded programs, such as Medicare,⁴ are fraught with fraud and abuse.⁵ The facts

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²See Jane Bowling, *AG wins grant for health fraud unit*, DAILY RECORD, Oct. 6, 1995, at 3 (reporting that the United States health care costs exceed \$1 trillion).

³See Charles J. Williams, *Toward a Comprehensive Health Care Anti-Kickback Statute*, 64 UMKC L. REV. 291 (1995) (stating that Americans believe that increased health care costs are caused by fraud).

⁴Medicare, a government sponsored health program for senior citizens, was established by Congress on July 30, 1965. See Gloria J. Banks, *Traditional Concepts and Nontraditional Conceptions: Social Security Survivor’s Benefits For Posthumously Conceived Children*, 32 LOY. L.A. L. REV. 251, 306 (1999). The Medicare program was part of the Social Security

presented by the federal government seem to support this public belief. The federal government estimates that seven percent of all billings submitted by the country's Medicare providers are fraudulent.⁶ As a result, the government believes that the Medicare program lost an estimated \$12.6 billion in 1998 due to fraudulent and improper billing.⁷

In 1995, public outcry for reform and cost-cutting measures in the federal budget led the federal government to declare "war" on "health care fraud;" Janet Reno, the Attorney General of the United States at the time, announced that the prosecution of "health care fraud" would be the number one priority of the Department of Justice [hereinafter "DOJ"] after the prosecution of violent crimes.⁸ Soon after the DOJ's declaration, in August of 1996, Congress passed the Health Insurance Portability and Accountability Act of 1996 [hereinafter "HIPAA"], which significantly strengthened enforcement efforts.⁹

Amendments to Title XVIII of the Social Security Act. *See id.* These Medicare Amendments established a health insurance system for eligible elderly and disabled individuals under which health care providers would be reimbursed directly for covered services and certain medical supplies and equipment provided to beneficiaries. *See Health Insurance for the Aged Act (Medicare Act of 1965) Pub. L. No. 89-97, tit. 1, 79 Stat. 290 (codified as amended in scattered sections of 42 U.S.C.).* This Article will focus on "health care fraud" that occurs in the Medicare program.

⁵The General Accounting Office [hereinafter "GAO"] has estimated the costs of health care fraud to be between \$80 billion and \$100 billion per year. *See* Sidney M. Wolfe, *Grim details under the headlines*, 14 (2) HEALTH LETTER (Feb. 1, 1998).

⁶*See* Rosie Mestel, *Fighting Fraudulent Health Care Charges Medicare: The government and the AARP have teamed to teach seniors how to spot bogus billing for services not rendered or needed*, L.A. TIMES, Mar. 1, 1999, at S3.

⁷*See* Peter Eisler & Barbara Pearson, *Fed triple health fraud cases: Crackdown hits Medicare billing abuses*, USA TODAY, Feb. 23, 1999, at 1A.

⁸*See* Charles Pereyra-Suarez et al., *Litigation Issues In Fraud And Abuse*, 19 WHITTIER L. REV. 51 (1997).

⁹*See* Pub. L. No. 104-191, 5701 110 Stat. 1936 (1996) (codified in scattered sections of 18 U.S.C., 26 U.S.C., 29 U.S.C. and 42 U.S.C.) (also referred to as the Kassebaum-Kennedy Act). HIPAA required the Attorney General to establish a "Fraud and Abuse Control Program" to promote the coordination and cooperation between state, federal, and local law enforcement that investigate, evaluate, inspect and audit health care providers for fraudulent practices, provide specific guidance to providers and share information. *See* 42 U.S.C. § 1320 a-7c (1998); Debra Cohn, *Health Care Fraud Legislation*, U.S. ATT'YS BULL., Apr. 1997, at 10. Along with these guidelines, HIPAA provided additional civil, criminal and administrative methods to combat health care fraud. *See id.* One of these tools was the creation of an instrument to facilitate the decision-making process within the DOJ known as an authorized investigative demand that functions like a subpoena. *See Interview with United States Attorney Lynn Bataglia, District of Maryland*, U.S. ATT'YS BULL., Apr. 1997, at 7 [hereinafter *Bataglia*]. Unlike information secured in a grand jury subpoena, which is limited in its distribution, the distribution of information gathered under an authorized investigative demand allows the Assistant United States Attorney [hereinafter "AUSA"] working on the criminal proceeding to share information with the AUSA working on the civil proceeding. *See id.* In addition to such tools, HIPAA secured financial resources to investigate and prosecute health fraud matters; initially, \$47 million was appropriated in fiscal year 1997 for FBI enforcement activities, which was to increase gradually to \$114 million by 2003. *See FBI*

The government has made a mark in its campaign against "health care fraud." In the last two years, the federal government has dramatically increased the number of health care fraud investigations initiated.¹⁰ Thus, the number of criminal prosecutions has more than tripled since the government declared "war" on "health care fraud" with health care providers going to prison in record numbers.¹¹ Additionally, federal prosecutors opened 4010 civil health care fraud matters in 1997,¹² which represented the majority of the DOJ's civil fraud workload for the first time in history.¹³ By the end of 1998, the government reported that there were 3471 civil "health care fraud" matters pending.¹⁴ Finally, more than 2700 health care providers were excluded from participation in the Medicare program in 1997,¹⁵ almost double the number of providers excluded in 1996.¹⁶ The number of exclusions continued to rise in 1998 with the government reporting that it excluded 3021 health care providers.¹⁷ These governmental efforts netted a record \$1.087 billion in judgments, settlements and fines in 1997¹⁸ and the collection of \$480

Fraud Cases Number 2800, For Seven Cases Per Agent, in FY 1999, HEALTH NEWS DAILY, Feb. 12 1999, available at 1999 WL 10483289 [hereinafter *FBI Fraud Cases*]. Additionally, HIPAA established a Health Care Fraud and Abuse Control Account in the Medicare Trust Fund, which provided \$104 million in fiscal year 1997 for health care enforcement activities as determined by the DOJ and HHS; the amount allocated to the DOJ was spent on personnel, automated litigation support, and training. See Cohn, *supra*, at 11. See also *Attorney General Highlights*, U.S. ATT'YS BULL., Apr. 1997, at 52 (reporting that funding was authorized for 166 new positions at the DOJ).

¹⁰See THE DEP'T OF HEALTH AND HUMAN SERVICES AND THE DEP'T OF JUSTICE, HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM – ANNUAL REPORT FOR FY 1997 (1998) [hereinafter 1997 ANNUAL REPORT]; THE DEP'T OF HEALTH AND HUMAN SERVICES AND THE DEP'T OF JUSTICE, HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM – ANNUAL REPORT FOR FY 1998 (1999) [hereinafter 1998 ANNUAL REPORT].

¹¹See 1997 ANNUAL REPORT, *supra* note 10. (stating that 363 defendants were convicted of health care fraud related crimes); 1998 ANNUAL REPORT, *supra* note 10 (stating that 326 defendants were convicted of health care fraud related crimes.) See also Eisler & Pearson, *supra* note 7, at 1A (explaining that 552 criminal cases of health care fraud up from 166 in 1993).

¹²See 1997 ANNUAL REPORT, *supra* note 10.

¹³See T. Jeffrey Fitzgerald, *Health Care Providers Encounter the Civil False Claims Act* 28 JAN COLO. LAW 65 (January 1999) (reporting that over sixty percent of the DOJ's civil fraud workload consists of health care fraud matters).

¹⁴See 1998 ANNUAL REPORT, *supra* note 10.

¹⁵See 1997 ANNUAL REPORT, *supra* note 10.

¹⁶See *id.*; *HIPAA's Anti-Fraud Measures Led To Dramatic Spike In Medicare Exclusions*, 6 (5) WASH. HEALTH WEEK, Feb. 2, 1998 (explaining that as a result of the enactment of HIPAA there has been a dramatic spike in the number of Medicare program exclusions).

¹⁷See 1998 ANNUAL REPORT, *supra* note 10.

¹⁸See 1997 ANNUAL REPORT, *supra* note 10.

million in 1998.¹⁹ The government states that it will maintain this return on its actions as settlements and fines are collected in future years.²⁰

Clearly, the government's "war" on "health care fraud" continues to rage.²¹ But what is "health care fraud?" How should it be defined? How "health care fraud" is defined is especially significant to health law practitioners in light of a recent case in which two Kansas lawyers were indicted in a Medicare kickback case.²² Although the federal government asserts that billions of dollars are lost to "health care fraud," these numbers include situations that result from honest mistakes.²³ The government has admitted that in its reporting of "health care fraud," it is unable to distinguish situations where honest mistakes were made from acts of intentional fraud.²⁴ In fact, the False Claims Act [hereinafter "FCA"], the most commonly utilized civil statute under which health care providers are sued for "health care fraud" includes health care providers that have merely made mistakes.²⁵

The FCA requires that the act be committed "knowingly."²⁶ However, proof of intentional wrongdoing is not required to successfully bring a civil action under the FCA.²⁷ As a result, a health care provider can be found strictly liable for an act of "health care fraud."²⁸ The government's failure to distinguish between intentional acts and mistakes in its war against "health care fraud" allows health care providers who have made mistakes to be accused of committing "health care fraud" and

¹⁹See 1998 ANNUAL REPORT, *supra* note 10, at 2.

²⁰See *id.*

²¹See *Medicare has new plan to fight fraud: The government's latest campaign enlists the help of its beneficiaries to curb wrongdoing*, STAR-TRIBUNE, Feb. 21, 1999, at 4A (reporting that on February 24, 1999, the government will increase its troops in the "war" on "health care fraud" by asking its Medicare beneficiaries to report billing errors for a \$1000 reward).

²²See Jay Christiansen, *Chairman's Corner*, THE HEALTH LAWYER, Nov. 1998, at 2. Here, Mr. Christiansen, Chairman of the Health Law Section of the American Bar Association expresses his concern about the case and its implications in regards to lawyers that practice health law. See *id.*

²³See Nancy Dickey, *Government to Grandpa: Rat out your Doctor*, WALL ST. J., Feb. 24, 1999, at A18 (describing the way the government determines fraud and abuse in health care). Nancy W. Dickey is the President of the American Medical Association [hereinafter "AMA"]. See *id.*

²⁴See *id.*

²⁵See Fitzgerald, *supra* note 13.

²⁶31 U.S.C. § 3729(a) (1996).

²⁷See *United States v. Frizek*, 111 F.3d 934, 942 (D.C. Cir. 1997) (stating that the standard is more comparable to gross negligence or "an extreme version of ordinary negligence"); 31 U.S.C. § 1329 (b)(3) (1996).

²⁸See Leon Aussprung, *Fraud and Abuse: Federal Civil Health Care Litigation and Settlement*, 19 J. LEGAL MED. 1, 8 (1998) (stating that in *United States v. Metzinger Assoc.*, No. 94-7520, 1996 WL 530002 (E.D. Pa. Sept. 17, 1996), defendants that did not cooperate ended up with settlement agreements less favorable than defendants that did).

sanctioned when in reality their conduct does not represent an act of fraud.²⁹ A definition of "health care fraud" that disregards the *mens rea* of the provider has a devastating effect on the provider's ability to deliver quality health care services to the American people.³⁰ This reckless way of defining "health care fraud" at best brings an element of adversarial tension into the patient-health care provider relationship that fosters distrust between patients and their health care providers.³¹ At worst, health care providers that have dedicated their lives to providing quality health care services will lose their ability to pursue their livelihood, their reputations amongst their peers and even their freedom.

Although the definition of "health care fraud" is only one of the numerous issues of concern to health law practitioners and health care providers, the language that defines the conduct in question is the foundation of all other concerns related to "health care fraud." This Article will demonstrate the need for a narrowly construed definition of "health care fraud." The Article begins by providing a scenario to explain how a situation involving potential "health care fraud" can arise in the delivery of health care services. The Article then addresses how "health care fraud" is defined through a discussion of the process of the applicable proceedings and the penalties that may result. The Article concludes by proposing a way to define "health care fraud" that will result in a system of sanctions that is equitable and proportional to the conduct committed by the health care provider.

II. THE ACT: MISTAKE OR FRAUD?

"Health care fraud" is predominantly discerned by the government in some form of billing practice; this fraudulent billing practice usually involves the submission of many small claims, some of which are legitimate services to the payor of the delivered health care service or product.³² The following hypothetical demonstrates

²⁹See Dickey, *supra* note 23; interview with Mr. Van Hilley, Attorney, in San Antonio, Texas (Mar. 30, 1999).

³⁰See *Medicare has new plan to fight fraud: The government's latest campaign enlists the help of its beneficiaries to curb wrongdoing*, *supra* note 21 (reporting that the leaders of the AMA met with Medicare officials to complain about the government's use of inflammatory language towards doctors because it will undermine the patient-doctor relationship); Mestel, *supra* note 6 (reporting that physicians are concerned that the government's education campaign on health care fraud amounts to "[y]ou can turn your doctor in and get a piece of the action . . . that's basically what it amounts to"). Additionally, health care providers are concerned because the Clinton administration will pay a \$1000 reward to Medicare beneficiaries for tips. See *id.*; Eisler, *supra* note 7 (reporting that health care providers are concerned that "overzealous investigations target innocent breaches of complex billing rules").

³¹See Dickey, *supra* note 23 (stating that government tactics place doctor and patients in adversarial roles causing detention in their relationship); Mestel, *supra* note 6 (expressing concern that government's campaign will undermine the doctor-patient relationship).

³²The largest purchaser of health care services is the federal government. See Press Release, Medicare, Health Care Financing Administration, Health Care Spending at Record (Jan. 13, 1998), at <<http://www.hcfa.gov/medicare/medicare.htm>>. A federal government health program pays almost fifty cents of every dollar currently spent on health care in the United States. *Id.*

how many health care providers may end up being investigated and prosecuted for activities involving health care fraud.³³

After completing nine months of employment, Dr. G terminated Nurse Black without notice from her position as program manager at the Twilight Mental Health Center [hereinafter "Center"], an outpatient psychiatric clinic for mentally ill senior citizens located in a low-income urban neighborhood. The three-year old Center, owned and operated by corporation H, is staffed by two psychiatrists, a family physician, a program manager, a clinical social worker, a licensed vocational nurse, two mental health technicians, and two clerical workers. The physicians are majority shareholders of the corporation and are on the Board of Directors. The average monthly patient census at the Center is about twenty-eight patients with ninety percent of them being funded entirely by the Medicare program.

Angry about being laid-off, Nurse Black decided to file a lawsuit for wrongful termination. During the initial consultation, she told her attorney that she believes the Center is operating in violation of federal law. She stated that when she first became aware of the Center's inappropriate business practices she did not say anything because she was afraid of losing her job. Two months before she was fired, she decided to make the medical director aware of her concerns. At the meeting with Dr. G, Nurse Black told the physician that she believed that some of the billing and referral practices of the Center did not comply with federal law and certain Medicare regulations. In addition, she told him some of the patients were inappropriately referred to the Center because they did not demonstrate a mental condition that could be successfully treated by the Center's existing clinical services. Dr. G thanked her for the information and told her that he would investigate her allegations. Nurse Black did not speak to Dr. G further about this matter. Two months later, Dr. G told her that she was being laid-off because her position was being eliminated due to budgetary constraints.

Nurse Black explained to her attorney that the Center had been inappropriately soliciting new patients for the Center by paying local family physicians a fee of \$100 for every elderly patient referred to the Center for psychiatric care, regardless of the mental status of the prospective patient. Additionally, Mrs. Black believed that approximately one third of the claims submitted to Medicare were upcoded.³⁴ Furthermore, she believed that rather than billing the services provided in the program in one daily rate, the Center was billing for each service individually.³⁵

³³The following facts are not based on any specific situation. Any similarity to a specific situation is a complete coincidence.

³⁴Upcoding is a fraudulent practice whereby the patient's situation is upgraded to a more serious category indicating the delivery of a more complex medical service where the health care provider presents a "billing for a more expensive service than that which is actually provided to the patients" to the payor for payment. See *United States v. Brown*, 988 F.2d 658, 659 (6th Cir. 1993); *Medicare Fraud or Honest Mistake*, CHI. TRIB., July 19, 1998, at 12, available at 1998 WL 2877439.

³⁵This fraudulent practice is referred to as "unbundling." See *Metzinger Assoc.*, 1996 WL 530002, at. Here, services that are usually billed as a group at a special rate under a single procedure code are billed separately under individual procedure codes, allowing providers to be paid more. See *id.* The American Hospital Association [hereinafter AHA] has challenged the DOJ's position that unbundling is fraudulent. See *Fitzgerald*, *supra* note 13. AHA states that this position is legally unfounded and abusive towards health care providers. See *id.*

Additionally, Nurse Black revealed that the other psychiatrist who usually had about thirteen patients admitted to the outpatient program would come to the Center at lunchtime and chat with all of them for about five minutes once a week. Often, the doctor would simply ask the nurse on duty how the patients were and then write psychotherapy notes in their individual charts.³⁶ For these five-minute visits and non-existent visits, Nurse Black believed that the psychiatrist billed Medicare for fifty-minute psychotherapy sessions.

After carefully considering the situation, her attorney agreed to take her case and shortly thereafter filed a formal suit against the Center and the doctors for wrongful termination. After this initial suit was filed, the attorney filed a *qui tam*³⁷ complaint in the appropriate United States District Court which remained under seal for sixty days while the DOJ determined if the cause of action was viable and whether or not DOJ would take over the prosecution of this case for Nurse Black. Four months after discharging Nurse Black, Dr. G received a letter from the DOJ informing the corporate owner that an investigation had been initiated to determine if the Center has been engaged in acts of "health care fraud."

³⁶This fraudulent billing practice is referred to as "retracting." Retracting occurs when the health care provider bills for services that were never provided. *See* United States v. Skodnek, 933 F. Supp. 1108, 1114 (D. Mass. 1996).

³⁷Although health care fraud is brought to the attention of the DOJ in numerous ways, the government has become increasingly aware of fraud and abuse situations through the reports of government informants. In 1992, there were seventeen "health care fraud" *qui tam* cases filed, while in 1998 there were 283 cases filed. *See FBI Fraud Cases, supra* note 9. The FCA establishes a private right of action for claims filed on behalf of the United States government by private parties known as *qui tam* actions. *See* 31 U.S.C. § 3730 (1996). In *qui tam* actions, private citizens are allowed to file a lawsuit in the name of the government charging false claims. *See* § 3730 (b). Statutorily almost anyone but a member of the military can file such a lawsuit. *See* § 3730. These individuals are usually fellow medical professionals. *See Bataglia, supra* note 9, at 7. The statute even encourages persons that participated in the fraud to come forward. *See* 31 U.S.C. § 3730 (D)(2) (1996). Regardless of their level of culpability, the statute always requires the plaintiff, referred to as the relator, to be someone with personal knowledge of the fraud or abuse. *See id.* *See also* Aussprung, *supra* note 28, at 9. The relator must have direct and independent knowledge of the information on which the allegations are based. *See* 31 U.S.C. § 3730(e)(4)(B) (1996). If there has been previous public disclosure, the plaintiff or relator in a *qui tam* action must be the original source of the reported information. *See* § 3730. The statute provides encouragement to the relator to report fraud and abuse through financial rewards pursuant to the statute. *See id.* The reward will amount to ten to thirty percent of the total recovery. *See* § 3730(c)(2)(d)(5)(d). The exact amount depends upon such factors as the degree of the relator's involvement in the fraud, the relator's contribution to the prosecution, and the extent of the government's intervention. *See* Adam Snyder, *The False Claims Act Applied to Health Care Institutions: Gearing Up for Corporate Compliance*, 1 DEPAUL J. HEALTH CARE L. 1, 9 (1996). Whistle blowers are important in prosecuting health fraud cases because of the difficulty investigative agents have in discerning the fraudulent conduct within extremely complex and sophisticated billing schemes. *See* David R. Olmoes, *Health Care's New Breed of Whistle-Blower*, L.A. TIMES, Feb. 17, 1998, at A1. The lawsuit is filed under seal for sixty days. *See* 31 U.S.C. § 3730(b)(4) (1996). During this time period, the DOJ determines if it will take over the prosecution of the case. *See* § 3730.

III. HEALTH CARE FRAUD PROSECUTION

A. *Triple Proceedings*

Government officials believe that “health care fraud” cases should be evaluated with the full range of remedies available to deter future fraudulent activities.³⁸ As a result, “health care fraud” defendants face criminal, civil, and administrative sanctions.³⁹ When the federal government first declared war on “health care fraud,” the government’s position was that all defrauders were going to be criminally prosecuted, a stance similar to the government’s campaign against defendants involved in the savings and loan banking crisis during the 1980’s.⁴⁰ During that period of time, the DOJ relied primarily on criminal prosecutions and put many white-collar criminals in prison.⁴¹

In that process, the government spent millions of dollars prosecuting cases and put numerous non-violent first-time offenders in prisons without recovering its losses.⁴² Initially, the DOJ approached its campaign against health care fraud in the same manner,⁴³ however, the government soon realized that banks and savings and loans are not like hospitals.⁴⁴ “The government cannot close down all the hospitals and put all the docs in jail.”⁴⁵ In response to this realization the government relies upon a process of triple proceedings in the resolution of “health care fraud” cases.⁴⁶ Any situation where health care fraud is alleged can spawn simultaneous administrative, criminal, and civil investigations and proceedings.⁴⁷ Although these separate proceedings are considered simultaneous, they have been started as much as one year apart from each other.⁴⁸

The Office of Inspector General of the Health and Human Services Department [hereinafter “OIG”] and the Federal Bureau of Investigations [hereinafter “FBI”] are the primary investigative agencies.⁴⁹ Under HIPAA, the agents of OIG were given authority to conduct criminal investigations involving health care fraud.⁵⁰ Although

³⁸See *Bataglia*, *supra* note 9, at 9.

³⁹See *id.*

⁴⁰See Interview with Mr. Ron Ederer, former U.S. Attorney, Western District of Texas, in San Antonio, Texas (Apr. 1, 1999) [hereinafter Ederer].

⁴¹*Id.*

⁴²*Id.*

⁴³*Id.*

⁴⁴*Id.*

⁴⁵See Ederer, *supra* note 40.

⁴⁶See *id.*; Geoffrey A Goodman, *Parallel Proceedings in Complex Health Care Fraud Cases: The Blue Shield of California Cases*, U.S. ATT’YS BULL., June 1997, at 8.

⁴⁷See Ederer, *supra* note 40.

⁴⁸See Hilley, *supra* note 29.

⁴⁹See Adelaide Few & Jay G. Trezevant, *Fighting the Battle Against Health Care Fraud: Federal Enforcement Actions*, 72 FLA. B.J. 34 (1998).

⁵⁰See Ederer, *supra* note 40.

the OIG agents are experts in ferreting out incidences of fraud and abuse in the health care context, there are simply not enough of them to adequately discern instances of fraud and abuse.⁵¹ This lack of manpower affects the interpretation of the discovered information and ultimately the nature of the sanctions faced by health care providers.⁵²

The number of FBI agents investigating health care fraud increased under HIPAA.⁵³ Unfortunately, these FBI agents are not specifically trained to investigate health care fraud activities.⁵⁴ While they are quite capable of investigating traditional criminal activities, they are not able to easily identify and recognize evidence needed to prove fraudulent activity or distinguish fraudulent activity from mistakes.⁵⁵ The ability to glean a pattern of intentional or mistaken fraudulent billing from a set of Medicare documents can be quite formidable for the untrained eye due to the complexity of the Medicare billing process.⁵⁶ Hence, whether the government undertakes a civil or a criminal prosecution against a defrauder will depend heavily on the quality of the evidence gathered in the investigation.⁵⁷ However, by the time the defendant is aware she is under investigation for health care fraud, the government has probably determined that the case is sufficient to proceed.⁵⁸ This governmental advantage has convinced numerous defendants to negotiate a settlement rather than finance a very expensive defense.⁵⁹

Congress has given the DOJ and OIG the authority to prosecute "health care fraud" in the Medicare Program through a number of statutes.⁶⁰ The DOJ takes the lead in determining how to proceed with prosecution of the "health care fraud" defendant.⁶¹ Whether the DOJ's decides to prosecute the "health care fraud" defendant in a criminal proceeding, or sue them in a civil proceeding, or proceed in both contexts, depends on how the government can best realize its goals in relation to the specific facts of each case. The government hopes to recover its losses and reduce incidences of fraud and abuse without undermining the delivery of health care

⁵¹*Id.* Two agents cover central and south Texas. *Id.*

⁵²*See id.*

⁵³*See FBI Fraud Cases, supra* note 9 (explaining that HIPAA increased the number of FBI agents).

⁵⁴*See Ederer, supra* note 40.

⁵⁵*See id.*

⁵⁶*See id.*; Hilley, *supra* note 29.

⁵⁷*See Ederer, supra* note 40.

⁵⁸*See* Aussprung, *supra* note 28 at 8; Pereyra-Suarez, *supra* note 8, at 64.

⁵⁹*See* Aussprung, *supra* note 28, at 8; Stuart M. Gerson, *Will New Federal Guidelines Arrest Overzealous Use of False Claims*, 4 (1) ANDREWS HEALTH CARE FRAUD LITIG. REP. 10 (stating that providers firmly believe that they must "settle or perish").

⁶⁰*See* Pamela Bucy, *Crimes by Health Care Providers*, 1996 U. ILL. L. REV. 589 (1996) (providing an exhaustive discussion of the numerous statutes available to the government for the prosecution of health care fraud in criminal proceedings).

⁶¹*See* Few, *supra* note 49.

services.⁶² Who the defendants are, their individual culpability, and the quality of the evidence against them, are pivotal issues of fact in determining how the government will proceed and the type of sanctions that could be imposed on the defendant.

Generally, where “health care fraud” is alleged, the government will initially sue any institutional defendant in a civil proceeding under the FCA because of the potential for a substantial monetary award.⁶³ Because the government is more likely to recover the alleged monetary loss of the fraud from the institutional providers than from the individual provider, institutional defendants are the primary targets in the government’s campaign against health care “fraud.”⁶⁴ Government officials believe that sanctions involving monetary considerations of tremendous magnitude will deter repeat fraudulent practices.⁶⁵

In addition to recovering substantial judgments, it is easier and more advantageous to the government to sue the “health care fraud” defendant in a civil proceeding rather than prosecute them in a criminal proceeding. In a civil action, the government’s burden of proof is the “preponderance of the evidence” standard,⁶⁶ a much lower standard than the “beyond a reasonable doubt” standard required in the criminal proceeding.⁶⁷ The government does not have to prove that the health care provider acted intentionally with knowledge of committing fraud.⁶⁸ At the end of the civil proceeding, the government has recovered its losses and has imposed substantial penalties on the defendant without having to prove intentional fraud.⁶⁹ The sanctions imposed as a result of the civil proceeding are devastating to the majority of institutional defendants.⁷⁰ With its financial goals realized, there is little incentive for the government to spend its limited resources on a criminal prosecution.⁷¹

⁶²See *Bataglia*, *supra* note 9, at 7.

⁶³See Ederer, *supra* note 40; Hilley, *supra* note 29. Bucy, *supra* note 60, at 589 (citing DEP’T OF JUSTICE, UNITED STATES ATT’YS MANUAL § 9-42.210 (1992)).

⁶⁴See *Bataglia*, *supra* note 9, at 4 (stating that many institutional providers are the subjects of criminal and civil investigations because of the prevalence of fraud that is perpetrated, primarily in the Medicare arena).

⁶⁵See *id.*; Eisler, *supra* note 7 (reporting Senator Aging’s response to claims that aggressive investigations will harm innocent health care providers).

⁶⁶See generally *Commercial Contractors Inc. v. United States*, 154 F.3d 1357, 1362 (1st Cir. 1998).

⁶⁷See generally *United States v. Abdullah*, 162 F.3d 897, 906 (6th Cir. 1998).

⁶⁸See *infra* Part III.B.(1).

⁶⁹See *id.*

⁷⁰See *Aussprung*, *supra* note 28, at 56.

⁷¹See *Bataglia*, *supra* note 9, at 7 (stating “it may be more appropriate to bring a case civilly because of its treble damages potential . . . [c]ases are driven by monetary considerations . . . that deters repeat [institutional] behavior”). In addition, no Medicare claims processing contractor had been convicted of fraud despite numerous civil investigations and huge settlements until the case against Blue Shield of California. See *Aussprung*, *supra* note 28, at 8.

If the fraudulent conduct is of such an egregious nature that the DOJ believes it must be stopped, the individual defendants are most likely to be criminally prosecuted.⁷² In order to proceed with the criminal proceeding, the DOJ must be able to prove beyond a reasonable doubt that the individual defendants committed this wrongful act intentionally. Proving the culpability of the defendants beyond a reasonable doubt to a jury is the lynchpin in the DOJ's decision to prosecute.⁷³ This means that the government must be able to prove that the wrongful conduct was committed knowingly and willfully.⁷⁴ The DOJ's ability to prove that the individual defendants acted knowingly and willfully is what makes the commitment of "health care fraud" a crime.

The remainder of this Article will demonstrate how these governmental policies and individual factors determine the government's case and the defendant's punishment in the civil, criminal and administrative contexts.⁷⁵

B. The Civil Proceeding

1. The False Claims Act

In a civil proceeding, the government is most likely to prosecute under the FCA.⁷⁶ The FCA was first enacted during the Civil War to aid the government in its prosecution of gunpowder manufacturers who sold sawdust rather than gunpowder to the government.⁷⁷ Later, this statute was revived to prosecute defense contractors who defrauded the government.⁷⁸ The FCA creates liability for defendants who act against the government by presenting or causing the presentation of a false, or fraudulent claim for payment or approval; using a false statement or record to get a false or fraudulent claim paid or approved; and conspire to defraud the government to get a false or fraudulent claim allowed or paid.⁷⁹ Health care providers can be found strictly liable under the FCA.⁸⁰ This lack of a requirement to prove a specific intent to defraud makes it extremely difficult to defend false claims cases and rather easy for the government to assert a claim of fraud successfully.⁸¹

⁷²See *Bataglia*, *supra* note 9, at 4 (stating that the government may want to prosecute criminally if it believes the behavior of the individual defendant that could further harm the community must be stopped).

⁷³See *Ederer*, *supra* note 40; *Hilley*, *supra* note 29.

⁷⁴See generally 18 U.S.C. § 1001(a) (1998).

⁷⁵See Carol S. Steiker, *Punishment and Procedure: Punishment Theory and the Criminal-Civil Procedural Divide*, 85 GEO. L.J. 775, 803 (1997) (stating that any act inflicted on another that inflicts pain can be considered punishment).

⁷⁶See 31 U.S.C. §§ 3729-3733 (1996).

⁷⁷See *Aussprung*, *supra* note 28, at 5.

⁷⁸See *id.* at 6.

⁷⁹See 31 U.S.C. § 3729 (1996).

⁸⁰See *Aussprung*, *supra* note 28, at 8.

⁸¹See *id.*

The activities that make out the act of “presenting or causing to be presented to the United States a false or fraudulent claim for payment or approval” are described in the statute in general terms.⁸² Courts have interpreted the statute to allow a broad array of actions to be considered the basis for a “submission of a false claim.”⁸³ As a direct result of this broad interpretation of the statute, the definition of “health care fraud” has broadened to include quality of care issues,⁸⁴ along with mistaken statutory interpretations made by the provider.⁸⁵ Much controversy has arisen from the latter situation as to whether or not the provider has committed an inadvertent error or whether the error actually represents a difference of opinion regarding statutory interpretation between the government and the medical community.⁸⁶ Health care providers have been prosecuted for “health care fraud” where real differences of opinion regarding statutory interpretation were present.⁸⁷

Today, it is possible to be sued in the civil context for malpractice and negligence in regards to a quality of care issue or mistake and then face further liability under the FCA for the submission of a fraudulent claim to a government insurer during the time the poor quality of care situation existed or mistake occurred.⁸⁸ The lack of

⁸²31 U.S.C. § 3729(a) (1996).

⁸³See *Aussprung*, *supra* note 28, at 32.

⁸⁴The U.S. Attorney’s Office in Philadelphia has obtained three settlements in cases where the allegations were based entirely on the provision of poor quality-of-care and that the resulting Medicare reimbursements were based on false claims only because quality-of-care violations were present. See *United States v. Chester Care Ctr.*, No. 98CV-139, 1998 U.S. Dist. LEXIS 4836 (E.D. Pa. Feb. 2, 1998); *United States v. City of Philadelphia*, No. 98-4253 (E.D. Pa. 1998); *United States v. GMS Management-Tucker, Inc.*, No. 96-1271 (E.D. Pa. 1996). Currently, there is only one reported case demonstrating judicial support of this theory. See *United States ex rel. Aranda v. Community Psychiatric Ctrs.*, 945 F. Supp. 1485 (W.D. Okla. 1996). This theory is referred to as the “implied certification theory.” See *Chester Care*, 1998 U.S. Dist. LEXIS 4836. How this theory would be accepted by trial courts is questionable considering that both the Fifth and Ninth Circuit Courts of Appeals have ruled that claims for services rendered in violation of statutes “do not necessarily constitute false or fraudulent claims under the FCA.” See *United States ex rel. Thompson v. Columbia/HCA Health Care Corp.*, 125 F.3d 899, 902 (5th Cir. 1997). See also *United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1266 (9th Cir. 1996) (stating that “violations of laws, rules or regulations alone do not create a cause of action under the FCA”). However, other AUSAs are attempting to bring such actions forward across the country. See *United States ex rel. Mckenzie v. Crestwood Hosp., Inc.*, No. 2:97cv107 (E.D. Cal., Oct. 8, 1998).

⁸⁵See *Fitzgerald*, *supra* note 13; *Ederer*, *supra* note 40; *Hilley*, *supra* note 29.

⁸⁶See *Dickey*, *supra* note 23; *Hilley*, *supra* note 29.

⁸⁷But see *Jonathan S. Shapiro*, *United States v. Ivan Namihias, M.D.: He Never Cried for Us*, U.S. ATT’YS BULL., June, 1997, at 5 (discussing case of physician who intentionally lied to the government, committing fraud).

⁸⁸See *David R. Hoffman*, *The Federal False Claims Act as a Remedy to Poor Care*, U.S. ATT’YS BULL., Apr., 1997, at 36 (stating that *United States v. GMS Management-Tucker Inc.* represented the first time that the federal government brought an action under the FCA in conjunction with the Nursing Home Reform Act to remedy a situation where health care providers received reimbursement from government funds for the provision of inadequate care). It should be further noted that as the delivery of health care services changes from a fee-for-service system to a capitated system, courts may become increasingly receptive to this

culpability on the part of the provider to commit an intentional act of fraud and the expanded definition of "health care fraud" allow health care providers to be accused of committing "health care fraud" when in reality their conduct does not represent an act of intentional fraud.

2. Civil Penalties

The DOJ has come to regard the FCA as one of its best weapons in its campaign against "health care fraud." "Health care fraud" is most frequently prosecuted under the FCA because it is relatively easy to prove the elements of the offense and because the potentially devastating nature of the penalties encourages "health care fraud" defendants to cooperate with the government to avoid them.⁸⁹ The FCA has two specific penalties.⁹⁰ First, treble damages are available for all false claims submitted.⁹¹ Second, a penalty of \$5000 to \$10,000 per false claim can be levied against the defendant.⁹² Congress intended that the assessment of damages under the FCA be "liberally measured to effectuate the remedial purposes of the Act."⁹³ While the government bears the burden of proving damages, the method of proof does not have to be scientifically exact.⁹⁴ In addition to these specific penalties, a defendant found liable under FCA may face exclusion from the Medicare program; generally, exclusion from Medicare is a discretionary matter in a civil proceeding whereas in a criminal proceeding exclusion is mandatory.⁹⁵ However, where exclusion may be for a period of years in a criminal matter, the government in the civil matter has the discretion to impose permanent exclusion from Medicare and other government funded health care programs.⁹⁶

Fearing the government's power to exclude, most providers will begin settlement discussions early in the process to avoid heavier fines or criminal prosecution for their lack of "cooperation" with the government.⁹⁷ Although the government may regain a portion of its loss, the harm sustained by the corporation as a result of the severe penalties and high legal fees will usually inflict a fatal wound to the corporation.⁹⁸

type of case theory since the incentive to commit fraud will hinge more on the provision of low-cost, poor quality services rather than billing for unnecessary services or services not performed. *See* Aussprung, *supra* note 28, at 30.

⁸⁹*See* Aussprung, *supra* note 28, at 9; Hilley, *supra* note 29.

⁹⁰*See* 31 U.S.C. § 3730(d)(2) (1994).

⁹¹*See id.*

⁹²*See id.*

⁹³*See* S. REP. 615 at 4.

⁹⁴*See* United States v. Killough, 848 F.2d 1523, 1531 (11th Cir. 1988).

⁹⁵*See* 42 U.S.C. § 1320a-7(a) (1999).

⁹⁶*See* § 1320a-7(b)(1).

⁹⁷*See* Aussprung, *supra* note 28, at 20-21 (stating that in *Metzinger* defendants that did not cooperate ended up with settlement agreements less favorable than defendants that did.)

⁹⁸*See* Hilley, *supra* note 29.

*C. The Criminal Proceeding*⁹⁹

When “health care fraud” is found to have been committed “willfully” with knowledge and intent to defraud, it is considered a crime under a number of federal statutes. Although the federal criminal code includes statutes that address criminal “health care fraud,”¹⁰⁰ federal prosecutors mostly utilize traditional generic fraud statutes to prosecute “health care fraud” because many of the situations currently subject to an indictment occurred before the enactment of these statutes.¹⁰¹ The most widely utilized criminal statute is mail fraud,¹⁰² followed by submission of false statements,¹⁰³ and criminal false claims act.¹⁰⁴ A person commits mail fraud when she schemes to defraud a victim, or obtain money or property by false or fraudulent pretenses and uses the postal service, or any private or commercial interstate carrier to accomplish this goal.¹⁰⁵

Federal officials have increasingly turned to criminal prosecutorial methods traditionally used to combat organized crime in their campaign to investigate and prosecute health care fraud.¹⁰⁶ Federal investigators of health fraud have increased the number of seizures and “freezing” of assets of those suspected of defrauding the government.¹⁰⁷ They increasingly indict health care fraud defendants for offenses such as money laundering,¹⁰⁸ crimes under the Racketeer Influenced and Corrupt Organizations Act [hereinafter “RICO”]¹⁰⁹ and conspiracy.¹¹⁰ “Health care fraud” was added as an underlying offense to money laundering with the enactment of

⁹⁹See Interview with Assistant United States Attorney Bud Paulissen, Criminal Division, Western District of Texas, in San Antonio, Texas (Mar. 12, 1999) (discussing general issues regarding prosecution of “health care fraud” from time of indictment through sentencing).

¹⁰⁰See 18 U.S.C. § 1347 (1998).

¹⁰¹See Bucy, *supra* note 60.

¹⁰²See 18 U.S.C. § 1341 (1999).

¹⁰³See § 1001.

¹⁰⁴See *Bataglia*, *supra* note 9, at 4.

¹⁰⁵See 18 U.S.C. § 1341 (1999).

¹⁰⁶See Michael E. Runyan & David Reese Jennings, *Practicing in the Field of Injunctions*, U.S. ATT’YS BULL., Apr. 1997, at 23.

¹⁰⁷See 18 U.S.C. § 1345 (1999). This is the Health Care/Bank Fraud/Wire and Mail Fraud injunction statute recently amended. *Id.* Basically, this statute provides a civil remedy for criminal conduct. *See id.* It is utilized when an AUSA asks for an injunction to “freeze” the bank accounts of those in violation of health care provisions added to § 1345. *See* Runyan, *supra* note 106, at 23; Thomas Wilder, *Unconventional Laws Used In Fight Against Fraud By Federal Officials*, NAAG HEALTH CARE FRAUD REPORT, July/Aug. 1996.

¹⁰⁸See 18 U.S.C. § 1956(c)(7)(F) (1999). This statute was recently amended by HIPAA adding health care fraud as an underlying act for the purpose of establishing a crime under the money laundering statute. *See id.*

¹⁰⁹See Daniel N. Burton & Michael S Popok, *Managed Care*, 75 FLA. B.J., 32 (1998) (describing how federal RICO and other forfeiture statutes have been expanded to include health care fraud as a predicate offense).

¹¹⁰See 18 U.S.C. §§ 286, 371 (1999).

HIPAA.¹¹¹ As a result, health care providers that commit "health care fraud" and then conduct financial transactions with the money obtained through the fraud may be laundering money.¹¹² RICO has been utilized to prosecute physicians who conspire with attorneys and patients to submit false claims to insurers and physicians who make false claims for services not rendered.¹¹³

In the criminal context, the government must prove each element of the offenses beyond a reasonable doubt. The central issue is whether or not the conduct was criminal.¹¹⁴ Here, the struggle between the defense and the prosecution is whether or not the health care provider intended to defraud or only committed an inadvertent error, due to the complexity of the Medicare billing system.¹¹⁵ Determining intent is difficult due to the extremely complicated billing process required by the government.¹¹⁶ One reason the billing process is considered problematic is because federal officials and providers disagree on the meaning of the language utilized in billing forms; this difference in interpretation has been enough to convict providers for committing fraud.¹¹⁷

Hiding behind the mire of regulations, health care providers complain that the government is unfairly prosecuting them for mistakes; however, it is important to note that the government must meet a very high burden of proof to charge a health care provider with a crime. It is highly unlikely that a federal prosecutor would indict a defendant for "health care fraud" without being able to prove her case in light of the high esteem that most health care providers are held within the community, and the political and professional consequences of losing such a case. But equally disturbing is the fact that the DOJ in many cases charges under the FCA to take advantage of the doctrines of estoppel by judgment and *res judicata*.¹¹⁸ As a result, if the federal prosecutor declines to proceed with criminal prosecution under FCA,¹¹⁹ health care providers can still be found liable for fraudulent schemes where the government cannot prove a criminal wrongdoing.¹²⁰ When the government's prosecutor cannot prove her case beyond a reasonable doubt, the government's interest of retribution for alleged wrongdoing will be vindicated through a civil action under the FCA. Unfortunately, this prosecutorial "safety-net" allows innocent health care providers to be harmed.

¹¹¹See § 1956(a)(1).

¹¹²See Bucy, *supra* note 60, at 611.

¹¹³See *id.*

¹¹⁴See Thomas A. Withers et al., *The Tao of the Health Care Fraud Trial*, U.S. ATT'YS BULL., Apr. 1997, at 19.

¹¹⁵See Dickey, *supra* note 23; Hilley, *supra* note 29.

¹¹⁶See Dickey, *supra* note 23; Hilley, *supra* note 29.

¹¹⁷See Hilley, *supra* note 29.

¹¹⁸See Kristine DeBry et al., *Health Care Fraud*, 33 AM. CRIM. L. REV. 815, 838 (1995).

¹¹⁹See 18 U.S.C. § 287 (1994).

¹²⁰See DeBry, *supra* note 118, at 838.

1. Criminal Penalties

The punishment of individuals convicted of crimes related to “health care fraud” has been accomplished by a system of determinate sentencing since the enactment of the Sentencing Reform Act of 1984 [hereinafter “ACT”].¹²¹ The ACT created the United States Sentencing Commission (within the judicial branch of the federal government), which was entrusted with developing determinate sentencing guidelines.¹²² These guidelines were created to provide uniformity in sentencing practices amongst the federal judiciary.¹²³ Congress envisioned that the guidelines remove or at least lessen sentencing disparities among defendants found guilty of similar offenses with similar criminal histories.¹²⁴ After a health care provider has been found guilty of “health care fraud,” the sentencing court determines what punishment the individual will receive within the statutory limitations.¹²⁵ In addition to being incarcerated for a period of time, the “health care fraud” defendant may also be required to pay fines and restitution and forfeit any assets acquired with the proceeds from the fraudulent conduct.¹²⁶ The majority of the federal statutes that can be applied to “health care fraud” call for terms of imprisonment not to exceed five years per violation,¹²⁷ and fines not to exceed \$250,000.¹²⁸

The trial court determines the specific punishment of each “health care fraud” offender through application of the federal sentencing guidelines.¹²⁹ The court begins this process by determining the “offense level.” To determine the offense level, the sentencing guidelines assign a sentencing range to the crime or crimes which the defendant was convicted (the base offense level), and then provide for a number of upward or downward adjustments depending on the specific characteristics of the offense.¹³⁰ If the defendant has been convicted of more than one crime, crimes which involve similar harm are grouped together and a combined score is assigned reflecting the seriousness of the harm. If the offenses are unrelated in nature, the resulting offense level will be keyed to the most serious offense.¹³¹ It is likely in a “health care fraud” situation that the prosecutor will seek to charge the

¹²¹See 18 U.S.C. §§ 3551-3742 (1994); 28 U.S.C. §§ 991-998 (1994).

¹²²See 18 U.S.C. §§ 3551-3742; 28 U.S.C. §§ 991-998.

¹²³See 18 U.S.C. §§ 3551-3742; 28 U.S.C. §§ 991-998.

¹²⁴See 28 U.S.C. § 991(b) (1994).

¹²⁵See 18 U.S.C. §§ 286, 287, 371, 1001, 1341, 1343; 42 U.S.C. § 1320a-7b (1994) (providing five or ten year maximum terms of imprisonment).

¹²⁶See 18 U.S.C. §§ 286, 287, 371, 1001, 1341, 1343 (1998); 42 U.S.C. § 1320a-7b (1994).

¹²⁷See 18 U.S.C. §§ 286, 287, 371, 1001, 1341, 1343; 42 U.S.C. § 1320a-7b (1994).

¹²⁸See 18 U.S.C. § 3571(c) (1994).

¹²⁹§§ 3551-3742; 28 U.S.C. §§ 991-998 (1994).

¹³⁰See Bucy, *supra* note 60, at 634.

¹³¹See generally, 18 U.S.C. §§ 3551-3742 (1994); 28 U.S.C. §§ 991-998 (1994).

most serious offenses possible.¹³² Federal prosecutors feel compelled to do this due to the insignificant punishment provided for crimes of fraud.¹³³

Fraud is assigned a base offense level of six.¹³⁴ Numerous upward and downward adjustments reflecting the unique nature of the particular "health care fraud" offense are applied to the base offense level.¹³⁵ In the sentencing phase, the court may consider all conduct discovered from the investigation that is proved by a preponderance of the evidence, including uncharged conduct.¹³⁶ The uncharged conduct utilized to determine sentencing includes conduct gleaned from evidence that was obtained in violation of the defendant's constitutional rights,¹³⁷ and acquitted conduct.¹³⁸ When the defendant has successfully negotiated with the DOJ to only be charged with one felony, and acquitted of other charges, the conduct reflecting the acquitted conduct will still be utilized to determine the offense level.¹³⁹

The first adjustment applied to the base offense level is an adjustment for the amount of the "loss" caused by the crime, when drafting the guidelines for economic crimes, the original Sentencing Commission made "loss" the lynchpin of the sentencing process for crimes of fraud.¹⁴⁰ Therefore, a certain number of points for any pecuniary loss over \$2000 will be added to the base offense level of six.¹⁴¹ "Loss" is determined by identifying two factors: 1) the total economic harm that resulted due to the defendant's conduct, and 2) and the relevant harm - the portion of the total harm experienced by the victims.¹⁴² Regardless of the nature of the actual

¹³²See Cedric L. Joubert, *Determining "Loss" in Medicare Fraud Prosecutions*, U.S. ATT'YS BULL., Apr. 1997, at 40.

¹³³See *id.* Crimes of fraud alone only call for an unadjusted sentencing range of zero to six months while the unadjusted sentencing range for a crime such as money-laundering, a crime often charged in conjunction with crimes of health care fraud, is forty-six to fifty-seven months. See generally U.S. SENTENCING GUIDELINES MANUAL.

¹³⁴See U.S. SENTENCING GUIDELINES MANUAL § 2F1.1 (a) (1998).

¹³⁵In determining the relevant conduct to be considered, the court will rely upon and adopt the Pre-sentence Report prepared by the U.S. Probation Department. See *United States v. Sidhu*, 130 F.3d 644, 654 (5th Cir. 1997). The defendant has the burden of producing any specific rebuttal evidence. See *id.* Without rebuttal evidence, it is proper for the court to adopt the report. See *id.*

¹³⁶See *United States v. Galloway*, 976 F.2d 414, 419 (8th Cir. 1992), *cert. denied*, 507 U.S. 974 (1993) (upholding a sentence that relied upon uncharged conduct).

¹³⁷See *United States v. McCroy*, 930 F.2d 63, 68 (D.C. Cir. 1991) *cert. denied*, 502 U.S. 1032 (1992).

¹³⁸See *United States v. Concepcion*, 983 F.2d 369, 387 (2d Cir. 1992).

¹³⁹See *Sidhu*, 130 F.3d at 654.

¹⁴⁰See Frank O. Bowman, *Guest Editor's Observations*, 10 FED. SENT. R. 3 (Nov./Dec. 1997).

¹⁴¹The amount of the loss determines the number of points that will be added to the base offense level. See U.S. SENTENCING GUIDELINES MANUAL § 2F1.1 (b) (1998).

¹⁴²See Bowman, *supra* note 140.

loss, numerous circuits have determined that if the actual loss is less than the intended loss, the intended loss may be considered for purposes of sentencing.¹⁴³

However, certain limitations have been instituted in determining “loss.” For example, the loss used to calculate the sentence must stem from the defendant’s criminal activity as opposed to civil violations.¹⁴⁴ Maintaining this distinction where parallel “health care fraud” proceedings are involved is critical in the sentencing phase of the “health care fraud” defendant. It is essential to insure that the “loss” utilized in determining the punishment of “health care fraud” defendants arises from the charged conduct. Additionally, a “loss” figure may be utilized for sentencing purposes only if the record supports by a preponderance of the evidence that the defendant intended a particular amount of loss or that a loss in that amount was probable.¹⁴⁵ A factor of specific concern in determining loss in “health care fraud” is whether or not the provision of legitimate services to a beneficiary will be considered a mitigating factor in measuring loss.¹⁴⁶ In “health care fraud” situations, several circuits have ordered the government to determine the value of the necessary services that were provided and reduce the proposed loss by this amount.¹⁴⁷ This approach to calculating loss has been sharply criticized because it tends to view the loss from the perspective of the defendant rather than the victim.¹⁴⁸ Federal prosecutors believe that this approach to determining loss does not adequately represent the risk to the victim and that it would be more equitable to give health care fraud defendants credit where benefits were received and the billing to the insurer was appropriate.¹⁴⁹ However, this strategy is not meaningful in determining punishment because the billing has already been deemed to be fraudulent by the fact-finder.

After the determination of loss has been made, the sentencing court will next consider all relevant actions committed by the defendant in furtherance of the criminal conduct.¹⁵⁰ In “health care fraud” crimes, there are certain adjustments that

¹⁴³See *United States v. Abud-Sanchez*, 973 F.2d 835, 838 (10th Cir. 1992); *United States v. Calhoun*, 97 F.3d 518, 523 (11th Cir. 1996).

¹⁴⁴See *Abud-Sanchez*, 973 F.2d at 839, 843.

¹⁴⁵See *id.* at 838. Statistical models that determine loss must have a sufficient factual basis. See *United States v. Galuzzo*, 53 F.3d 334, 336 (7th Cir. 1995).

¹⁴⁶See *Sidhu*, 130 F.3d at 654; Carol C. Lam, *Assessing Loss in Health Care Fraud Cases*, 10 FED. SENT. R. 146 (Nov./Dec. 1997).

¹⁴⁷See *United States v. Rutgard*, 116 F.3d 1270, 1271 (9th Cir. 1997); *United States v. Jackson*, 95 F.3d 500, 508 (7th Cir. 1996); *United States v. Licciardi*, 30 F.3d 1127, 1134 (9th Cir. 1996). Similarly, several circuits have found that where a defendant has obtained a fraudulent bank loan, only the amount of the loan that the defendant intends not to repay may be considered the “intended loss.” See *e.g.*, *United States v. Johnson*, 16 F.3d 166 (7th Cir. 1994); *United States v. Shaw*, 3 F.3d 311 (9th Cir. 1993); *United States v. Menichino*, 989 F.2d 438 (11th Cir. 1992); *United States v. Kopp*, 951 F.2d 521, 523 (3d Cir. 1991); *United States v. Smith*, 951 F.2d 1164 (10th Cir. 1991). For the value of services to be considered in determining loss, the defendant must provide rebuttal evidence. See *Sidhu*, 130 F.3d at 654.

¹⁴⁸See Lam, *supra* note 146.

¹⁴⁹See *id.*

¹⁵⁰See U.S. SENTENCING GUIDELINES MANUAL § 1B1.3 (1998).

are usually considered. First, a determination is made as to whether or not the fraudulent scheme involved more than minimal planning.¹⁵¹ Minimal planning is present in any case where acts are repeated over a period of time or more complex planning than would normally be done before the commission of the offence.¹⁵² Other upward adjustments to the base offense level include factors such as whether the defendant abused a position of public trust or special skill,¹⁵³ whether or not the defendant was "an organizer or leader of a criminal activity that involved five or more participant or was otherwise extensive,"¹⁵⁴ whether or not the offences impacted vulnerable victims,¹⁵⁵ and whether or not the provider obstructed justice.¹⁵⁶ One adjustment that may be applied to the offense level is a downward adjustment for acceptance of responsibility.¹⁵⁷ The earlier in the investigation that the "health care fraud" defendant decides to cooperate and enter a plea with the government the more likely the defendant will receive a two or three point reduction for his cooperation.¹⁵⁸ Although the sentencing guidelines state that going to trial will not effect the offender's ability to receive this adjustment, in practice, defendants that go to trial don't receive this adjustment to their offense level.

Once the trial court has determined the offense level as proscribed by the U.S. Sentencing Guidelines Manual it will next consider within which criminal history category the defendant falls; a separate score is calculated based on the defendant's criminal history to determine the criminal history category.¹⁵⁹ Most "health care fraud" defendants will be first-time offenders; therefore their assigned criminal history category will be category one. The scores for the offense level and the criminal history category are then applied to a sentencing table containing a grid on which both scores appear at various levels.¹⁶⁰ The point where these two scores intersect indicates the defendant's guideline range expressed in months of imprisonment.¹⁶¹

The court may choose to depart upward or downward from the sentencing guideline range if the case demonstrates certain "unusual features."¹⁶² Features that may be considered for downward departures include whether the defendant provided

¹⁵¹See § 2f1.1(b)(2).

¹⁵²See § 1B1.1, n.1 (f).

¹⁵³See § 3B1.3; *United States v. Burgos*, 137 F.3d 841, 844 (5th Cir. 1998).

¹⁵⁴See *Sidhu*, 130 F.3d at 654; U.S. SENTENCING GUIDELINES MANUAL § 3B1.1 (1998).

¹⁵⁵See *Sidhu*, 130 F.3d at 654; U.S. SENTENCING GUIDELINES MANUAL § 3B1.3 (1998).

¹⁵⁶See *Sidhu*, 130 F.3d at 651; U.S. SENTENCING GUIDELINES MANUAL § 3C1.1 (1998).

¹⁵⁷See U.S. SENTENCING GUIDELINES MANUAL § 3E1.1 (1998).

¹⁵⁸See *id.*

¹⁵⁹See U.S. SENTENCING GUIDELINES MANUAL §§ 4A1.1 – 4B1.4.

¹⁶⁰See § 5 Pt. A.

¹⁶¹See *id.*

¹⁶²18 U.S.C. § 3553(c) (1996); U.S. SENTENCING GUIDELINES MANUAL § 5K1. – 5K2 (1998).

“substantial assistance to authorities,”¹⁶³ whether the defendant was coerced,¹⁶⁴ and whether the mental capacity of the defendant was diminished.¹⁶⁵ The sentencing court would consider upward departures in situations where the defendant’s conduct resulted in harm to his victim, including extreme psychological injury, physical injury or death.¹⁶⁶ It is important to note that if the “health care fraud” defendant loses her license to practice in her specific field as part of the plea agreement, this will most likely not be a basis for a downward departure.¹⁶⁷

Despite the apparent complexity of utilizing the sentencing guidelines to determine the appropriate sentence for intentional defrauders, these defendants face insignificant amounts of prison time. For example, a first time defrauder has to defraud more than \$40,000 before any sentence of imprisonment is mandated.¹⁶⁸ A defendant whose actions caused a substantial loss of money also receives a strikingly insignificant sentence. For example, if a defrauder pleads guilty to defrauding the government of twenty to forty million dollars he would only be sentenced to a term of imprisonment between thirty-seven and forty-six months in duration.¹⁶⁹

The adoption of Organizational Sentencing Guidelines¹⁷⁰ by the United States Sentencing Commission may play a significant role in ensuring corporate compliance;¹⁷¹ however, in the health care context, their significance has yet to be realized. Under these sentencing guidelines, institutional defendants cannot be imprisoned, only fined.¹⁷² A substantial number of institutional health care providers are depleted of their assets in the civil prosecution.¹⁷³ Therefore, the possible

¹⁶³See U.S. SENTENCING GUIDELINES MANUAL § 5K1.1 (1998).

¹⁶⁴See § 5K2.12.

¹⁶⁵See § 5K2.13.

¹⁶⁶See §§ 5K2.1-.3.

¹⁶⁷See *United States v. Hoffer*, 129 F.3d 1196, 1202 (11th Cir. 1997).

¹⁶⁸The \$40,000 figure assumes a “more than minimal planning” adjustment under U.S. SENTENCING GUIDELINES MANUAL § 2F1.1(b)(2)(a) and a defendant who pleads guilty early enough in the process to receive the two level downward adjustment for acceptance of responsibility under U.S. SENTENCING GUIDELINES MANUAL § 3E1.1(a) & (b). Additionally, a first time offender must be responsible for a loss of more than \$20,000 before a judge is required to impose even intermediate conditions of confinement such as home detention or community confinement. See §§ 5F1.1-2.

¹⁶⁹This assumes that a first time offender is given a two-level enhancement for more than minimal planning under U.S. SENTENCING GUIDELINES MANUAL § 2F1.1(b)(2)(a), and a three-level acceptance of responsibility downward adjustment pursuant to § 3E1.1(a)(b).

¹⁷⁰See §§ 8A1.1-8E1.2.

¹⁷¹See *In re Caremark Int’l Inc. Derivative Litig.*, 698 A.2d 959, 969 (Del. Ch. 1996) (stating that the United States Sentencing Commission adopted Organizational Sentencing Guidelines which will play a significant role in assessing criminal sanctions on corporations, and that the guidelines provide powerful incentives for corporations to have in place compliance programs to detect violation of law, to immediately report these violations to officials when discovered and to take prompt, voluntary remedial measures).

¹⁷²See U.S. SENTENCING GUIDELINES MANUAL § 8A1.1 (1998).

¹⁷³See Hilley, *supra* note 29.

sanctions under the civil FCA alone have provided powerful incentives for corporations to have in place compliance programs to detect violation of law, to promptly report these violations to officials when discovered and to take prompt, voluntary remedial measures.¹⁷⁴

D. Administrative Proceedings & Penalties

Compliance with governmental regulations and involvement with the administrative agencies that enforce these regulations is an inherent component of almost all aspects of the health care delivery system.¹⁷⁵ The health care provider and the administrative agencies are involved in a continuous relationship where the agency promulgates regulations that the health care provider strives to meet in order to assure reimbursement from the government.¹⁷⁶ When an accusation of fraud is made, an additional administrative process is activated.¹⁷⁷

Along with being exposed to criminal and civil sanctions, the "health care fraud" defendant faces numerous administrative sanctions. One of the most feared sanctions is exclusion as a provider from the federal health care program.¹⁷⁸ A decision to exclude is discretionary in a civil proceeding but in a criminal proceeding a finding of fraud results in automatic exclusion.¹⁷⁹

In addition to exclusion from Medicare, the provider faces the possible loss of her professional license.¹⁸⁰ Although loss of licensure is not automatic, the DOJ is vigilant in informing governing boards of professionals of the fraudulent conduct committed by its members.¹⁸¹ In particularly egregious situations, the DOJ will require that the individual health care provider voluntarily surrender his license to practice as part of the negotiated plea agreement to avoid more severe consequences.¹⁸² The imposition of either of these two sanctions will mean economic and professional ruin for the provider.

¹⁷⁴But see Geri Aston, *Fed Unveil New Fraud Disclosure Policy*, AM. MED. NEWS, Nov. 9, 1998 (pagination unavailable) (reporting that the new voluntary compliance program although less burdensome could possibly be tougher treatment for providers because of its heavy-handed language). The protocols do not state what the mitigation is if a provider self-discloses. See *id.* However, the guidelines for the new voluntary compliance program do affirmatively state that self-disclosure does not obligate the OIG "to resolve the matter in any particular way." See *id.*

¹⁷⁵See Website of Health Care Financing Administration, at <<http://www.hcfa.gov/medicare/medicare.htm>> (the Health Care Financing Administration [hereinafter "HCFA"] is responsible for the administration of the Medicare program).

¹⁷⁶See *id.* (indicating that billing is submitted to HCFA for payment).

¹⁷⁷See 1997 ANNUAL REPORT, *supra* note 10.

¹⁷⁸See Goodman, *supra* note 46, at 10 (reporting that in this case the defendant argued that exclusion from Medicare was the death penalty for the institutional defendant).

¹⁷⁹See 42 U.S.C. § 1320a-7a (1999)

¹⁸⁰See *id.*

¹⁸¹See *id.*

¹⁸²See *Hoffer*, 129 F.3d at 1201.

V. PROPOSAL

Fraud is defined as the “intentional perversion of truth for the purpose of inducing another in reliance upon it to part with some valuable thing belonging to him. . . .”¹⁸³

In the legal realm only the criminally convicted can be punished.¹⁸⁴ Nevertheless, this is not the case in the prosecution of “health care fraud.” Health care providers are either being punished too severely (in civil proceedings) or not severely enough (in criminal proceedings). In part, this inequity results because “health care fraud” is broadly defined to include a variety of acts that have nothing to do with the “intentional perversion of the truth.” The words “health care fraud” have come to include a range of conduct, which includes mistakes, malpractice, and the provision of inadequate care and acts of intentional fraud.

This definition of “health care fraud” results in the inequitable prosecution and disproportionate punishment of health care providers. Health care providers that have made a mistake or have not made mistakes¹⁸⁵ are being accused and punished of committing fraud just like those that have intentionally committed fraud.

Congress, the DOJ, and health care providers recognize the need to limit the scope of what activity is identified as “health care fraud.” In response to the devastating financial effects of the FCA, and concerns of the overzealous application of the statute, health care providers joined forces lobbying Congress to pass the Health Care Claims Guidance Act [hereinafter “HCCGA”].¹⁸⁶ HCCGA provided several safe harbors with retroactive effectiveness.¹⁸⁷ However, the HCCGA was allowed to die in committee.¹⁸⁸ Instead, the Deputy Attorney General [hereinafter “DAG”] issued a memorandum to give guidance on the use of the FCA in the civil context to reduce the growing fear of health care providers that through the “unbridled prosecution” of “health care fraud” their livelihoods would be destroyed.¹⁸⁹ The DAG further noted that the purpose of his memorandum was “to

¹⁸³BLACK’S LAW DICTIONARY 660 (6th ed. 1990).

¹⁸⁴See Carol S. Steiker, *Punishment and Procedure: Punishment Theory and The Criminal-Civil Procedural Divide*, 85 GEO. L. J. 775, 803 (1997).

¹⁸⁵See Dickey, *supra* note 23.

¹⁸⁶See Rep. McCollum/AHA Health Care Fraud Bill Opposed By Justice, HHS, THE GRAY SHEET, May 11, 1998, at 1998 WL 9545914; Sean Martin, *Bill to Soften False Claims Act Gaining Steam*, AM. MED. NEWS, May, 18, 1998, at 9.

¹⁸⁷Martin, *supra* note 186, at 9 (discussing safe harbor provisions of proposed legislation). Critics of the bill stated that the real purpose of the bill was to rescue hospitals that were targets of federal investigations. See Naftali Bendavid, *Hospitals Lobby to Soften Blow of Anti-Fraud Law*, CHI. TRIB., June 24, 1998, at 1. In response, Janet Reno stated that she would encourage President Clinton to veto the bill because it would “gut our civil health care fraud program.” See *id.*

¹⁸⁸See Ederer, *supra* note 40.

¹⁸⁹See MEMORANDUM, DEP’T OF JUSTICE, OFFICE OF THE DEPUTY ATT’Y GENERAL, GUIDANCE ON THE USE OF THE FALSE CLAIMS ACT IN CIVIL HEALTH CARE MATTERS (June 1998).

emphasize the importance of pursuing civil False Claims Act cases against health care providers in a fair and even-handed manner. . . ."¹⁹⁰

The intent of the "health care fraud" defendant should be the lynchpin in determining how the government resolves the case. Prosecution of the health care fraud defendant should be limited by his intent to commit intentional fraud willfully and with knowledge. If the health care fraud was committed intentionally then both the individual and institutional defendants should be criminally prosecuted. Only acts of intentional fraud that can be proven beyond a reasonable doubt should be referred to as "health care fraud." Actual fraud should be the standard for labeling an action fraudulent rather than the almost strict liability standard currently being used regardless of intent in civil proceedings. Under this model of defining health care fraud, the words "health care fraud" would only be utilized in the context of the criminal proceeding. Thus, narrowing the scope of what is labeled "health care fraud" would allow the punishment of health care providers to correctly indicate the providers' culpability, communicating a more accurate message to the community regarding the providers' behavior in relation to billing practices and other areas of concern such as the provision of inadequate care or negligence. Utilizing this framework, conduct that is less than intentional would be prosecuted within the civil context and referred to as "health care abuse." "Health care abuse" is defined as provider practices that fall short and are inconsistent with sound practices and result in unnecessary costs or remuneration for services that do not meet professionally recognized standards for health care.¹⁹¹ Health care providers that commit "health care abuse" could be held strictly liable as most are under the FCA.

This model of reform would allow the government to fully realize its goals. The government can recover its losses and reduce fraud without disrupting the delivery of health care services. At the same time, it can send a strong message to health care fraud providers that fraudulent and reckless billing practices and other acts of fraud will not be tolerated. Although, the health care fraud defendant found guilty within the criminal context would not be sued in the civil context for the same behavior, the government could recover its losses through restitution. The sentencing court can order the individual and the corporate defendant to pay restitution.¹⁹² Restitution is not considered a part of the punishment but rather a remedial action to extinguish any harm suffered by the victim as a result of the offense.¹⁹³ States with limited resources have already chosen to ask for restitution in the criminal proceeding rather than instituting a separate civil case.¹⁹⁴ This paradigm allows the federal government to meet its goals while protecting health care providers.

¹⁹⁰*Id.*

¹⁹¹*See* 42 C.F.R. § 455.2 (1998).

¹⁹²*See* Bucy, *supra* note 60, at 638.

¹⁹³*See id.*

¹⁹⁴*See* Richard Blumenthal, *Claims For Restitution: A Viable Remedy*, NAAG HEALTH CARE FRAUD REPORT, Sept./Oct. 1997 (explaining that the Attorney General of Connecticut chose to file a claim for restitution in a pending federal criminal proceeding rather than file a separate civil claim).

VI. CONCLUSION

By combating “health care fraud,” the government hopes to recover the proceeds of fraud, punish true defrauders and deter continued fraudulent behavior while strengthening the health care delivery system. Defining “health care fraud” narrowly would subject defendants to sanctions that are just, fair, and proportional to the committed conduct. As a result, the government’s goals will be more fully realized when health care providers, no longer fearful of the consequences of being accused of fraud, can work closer and communicate more openly with government officials to clear up administrative difficulties without being disproportionately sanctioned for mistakes. Simultaneously, the government can continue to send a message that intentional fraud within the health care system will not be tolerated.