CLOSING THE GATES ON MEDICARE BILLING FRAUD

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CLOSING THE GATES ON MEDICARE BILLING FRAUD

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Statement of the Problem

Nearly 3% of all health care spending annually, or $60 billion, is lost to fraud according to the National Health Care Anti-Fraud Association (n.d.). A large majority of this is lost through the Medicare program, America's only national health insurance program. In 2008 alone, $462 billion in benefits were paid by Medicare to medical providers within the United States (The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2009). It is unknown what percentage of these benefits were paid based on fraudulent claim submissions. The size and complexity of the Medicare program leaves it venerable to criminals, while there are very few safeguards in place from preventing fraudulent claims from being paid.

While there are the dishonest Medicare providers that use the system to their advantage, Medicare has started to attract a new type of criminal. The ease of defrauding Medicare fraud has attracted groups of criminals with ties to organized crime and no medical backgrounds to set up fake medical companies with the sole purpose of defrauding Medicare – and they have been getting away with it for too long. Medicare is in need of one single entity to protect the integrity of the Medicare program with a focus on strengthened mechanisms to catch fraudulent claims before they are ever paid.

Methods and Procedures

Secondary research data formed the bases of the methodology. Evidence from the Centers for Medicare & Medicaid Services (CMS), Federal Bureau of Investigation (FBI), Government Accountability Office (GAO) and other relevant government entities in the prevention and prosecution of Medicare fraud was used in forming recommendations for reducing the prevalence of Medicare billing fraud by implementing a unified Medicare task force. A theoretical framework for the causation of Medicare fraud and its deterrence is offered to strengthen the argument for increased sentences for those convicted of fraudulently billing Medicare. Rational choice and routine activities theories are used to explain Medicare fraud in support of establishing a dedicated Medicare task force and implementing strengthened claim pre-payment measures for identifying fraudulent claims.

Summary of Results

There is no available measure of the extent of Medicare fraud. Analysis of reports by FBI, CMS, Department of Justice (DoJ) and other relevant governmental agencies offer little data as to the extent of Medicare fraud or the efficiency of the current anti-fraud mechanisms in place. Implementing one dedicated fraud unit to operate the necessary tasks in preventing, identifying and prosecuting Medicare fraud is necessary in deterring criminals from targeting the Medicare program. The current structure of the Medicare system illustrates a need for one main entity to be at the head of anti-fraud efforts. A system that allows the viewing of all available claims data nationwide is imperative in the fight against Medicare fraud; no such system is currently in place. Increasing sentences of those convicted of fraudulently billing Medicare while excluding criminals from program participation are two necessary elements in reducing the instances of Medicare fraud.

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SECTION I: INTRODUCTION

Closing the Floodgates on Medicare Billing Fraud

Medicare fraud stands as one of the most profitable crimes in America. The National Health Care Anti-Fraud Association estimates that nearly 3% of all health care spending, or $68 billion annually, is lost to fraud (National Health Care Anti-Fraud Association, n.d.). Most often, it is a quiet, non-violent crime that victimizes the American taxpayer. A senior agent of the Medicare fraud investigation operation in Miami explains "there are entire groups and entire organizations of people that are dedicated to nothing but committing fraud [and] finding a better way to steal from Medicare" (CBS News, 2009). Medicare fraud is not a new phenomena; literature on the seriousness of the problem dates back at least as far as 1996. As the Medicare program and technology both evolve, so do the schemes utilized to perpetrate Medicare fraud.

Medicare Overview

In 1965, Congress passed legislation establishing the Medicare program as Title XVII under the Social Security Act. Medicare is a health insurance program for people age 65 or older, people under 65 with qualifying disabilities, and people of any age with end-stage renal disease (Centers for Medicare and Medicaid Services, 2009). Medicare has three major parts:

Part A: Part A is hospital insurance, which is generally paid throughout a person's life through tax withholdings on employment paychecks. Part A covers inpatient hospital stays and skilled nursing facilities for a set number of days, as well as home health services and hospice services.

Part B: Beneficiaries pay Part B separately each month, generally deducted from a person's Social Security check. For 2008 and 2009, the standard Part B premium was

$96.40 per month. Part B covers outpatient physician visits as well as other services not covered by Part A, namely physical therapy, and preventative services such as immunizations for people that are entitled to Part A, or those that are 65 and older.

Prescription Drug Coverage: Also referred to as Part D, this optional insurance is paid monthly by beneficiaries as prescription drug insurance and purchased through private insurance companies (Centers for Medicare and Medicaid Services, 2009).

Taxpayers fund Medicare Part A as a mandatory 1.45% withholding for the employee on his or her paycheck with 1.45% matched by the employer, which goes into the Medicare Trust Fund (Social Security Administration, 2009).

Statement of the Problem

Medicare, as the nation's only national health insurance program, served 45.2 million beneficiaries in 2008; of those, 37.8 million received coverage due to being age 65 or older and 7.4 million received coverage due to disability (The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2009). In 2008, there was a total of $462 billion in benefits paid by Medicare to providers (The Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, 2009). As a result, nearly every health care provider in the nation is subjected to the billing structures and regulations of Medicare. Millions of Medicare claims are submitted to the many different Medicare bill processors, or Fiscal Intermediaries, monthly. In 2007 alone, $2.26 trillion was spent on health care services in the United States, representing 16% of the Nation's Gross Domestic Product (Breuer, 2009). Nearly 4 billion health insurance claims were processed in the United States in 2007 (National Health Care Anti-Fraud Association, n.d.). A 2007 estimate by

the Federal Bureau of Investigation (FBI) found fraudulent billings to both public and private health care companies to be between 3 and 10 percent of all total health care expenditures annually (2008). The highly fragmented nature of Medicare opens the door to widespread provider fraud resulting in an estimated $60 billion or more lost to Medicare and Medicaid programs annually (Coalition Against Insurance Fraud, 2008). For example, in August 2009, 53 people from Detroit, Miami and Denver were arrested for submitting over $50 million in false Medicare claims (U.S. Department of Justice, 2009).

The defrauding of Medicare results in constantly rising health care costs nationally, while taxpayers are left paying for the fraud. The Centers for Medicare & Medicaid Services (CMS) warns beneficiaries that, "Health care fraud, whether against Medicare or private insurers, increases everyone's health care costs, much the same as shoplifting increases the costs of the food we eat and the clothes we wear" (Centers for Medicare & Medicaid Services, 2009). Aside from the financial implications of health care fraud, there are vast quality of care issues that are a direct result of providers attempting to "work" the billing and payment structure of Medicare.

Medicare fraud occurs in many facets. The most prevalent type of provider fraud includes physicians billing insurance companies for services that had not actually been rendered; up coding, a practice in which a more severe procedure code is billed than necessary, which results in a higher payment rate; submitting duplicate claims; or rendering services not medically necessary or related to the patient's symptoms because they yield a higher payment rate.

Medicare fraud is especially common in the home health sector, where Medicare pays for licensed individuals to provide services at home for the severely disabled and sick as well as among the durable medical equipment sector, which provides equipment such as wheelchairs and other health care items necessary for the disabled (United Press International, 2009). Many

durable medical equipment (DME) companies supply cheaply made or compromised equipment at the same rate of quality equipment in order to make a profit, or bill Medicare for items that are never provided at all (National Insurance Crime Bureau, 2005). On July 29, 2009, thirty-two people were indicted for schemes that involved submitting more than $16 million in false Medicare claims that billed for "arthritis kits," power wheelchairs and enteral feeding supplies that were medically unnecessary and, largely not provided (U.S. Department of Justice, 2009).

Purpose of the Study

The purpose of this study is to illustrate the prevalence of healthcare fraud (namely Medicare provider fraud), analyze how the billing and payment structure of Medicare and most other healthcare programs attributes to the ease of fraudulent activity, and identify issues that can be targeted in order to alleviate widespread provider fraud.

Medicare fraud is prevented, identified and prosecuted through collaborations between beneficiaries, the OIG, DOJ, and HHS (U.S. Department of Health and Human Services and U.S. Department of Justice, 2008). Beneficiaries are touted as a major tool in identifying fraud; OIG has the authority to impose civil penalties and exclude providers from participating in the Medicare and Medicaid programs while referring cases to the DOJ for prosecution (U.S. Department of Health and Human Services and U.S. Department of Justice, 2008).

Historically, billing fraud is so prevalent due to the nature of how providers are reimbursed on a fee-for-service basis; each service has a set rate based on locality and severity on which it is paid. Very rarely are providers reimbursed at 100% of billed charges, and most frequently only see a fraction of the amount billed to insurance companies (Centers for Medicare & Medicaid Services, 2005). There is growing evidence that Medicare billing fraud is becoming popular among organized crime members due to the ease in which it is accomplished as well as

the fact that general Medicare fraud-related sentences are substantially low in comparison to other sentences generally associated with organized crime activities (The Associated Press, 2009).

Significance of the Problem

Medicare fraud costs taxpayers of the United States millions of dollars a year while the Medicare Trust Fund dwindles, leaving an uncertain future for Medicare coverage of future beneficiaries. A recent report by the Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Insurance estimates that the Medicare Trust Fund will be exhausted in 2017 (2009). For those who have been paying 1.45% of their employment checks towards Medicare for virtually his or her whole employment life, this is clearly a problem. The Medicare Payment Advisory Commission (2009) estimates that in order to combat the climbing deficit of the Medicare Trust Fund, the Medicare payroll tax would need to increase to 6.44 percent of all earned income.

Identifying the particular areas of the billing and payment structure that allow providers to easily defraud Medicare and other healthcare programs will aid in making recommendations for fraud prevention and possible changes to the billing and payment structure. While the Medicare Task Force operations in Miami and Detroit have resulted in many arrests in cases of Medicare fraud, focusing on select regions known to be rifled with fraud does not end the fraud elsewhere – nor does it prevent those perpetrating the fraud schemes from moving their "services" elsewhere.

Assumptions

Medicare fraud has long-reaching effects – from limiting the possibility of future existence of the program, to higher overall health insurance premiums, and compromised quality of care for beneficiaries. By pinpointing exactly which facets of the Medicare program aid themselves to fraud and finding strategies to prevent against Medicare billing fraud, antifraud efforts will have a greater chance of becoming successful. Most Medicare fraud is identified only after millions of dollars have already been defrauded from the Medicare program. By implementing stronger antifraud measures and altering the way in which Medicare reimburses providers, it is quite possible to identify potential fraud cases before they reach the multi-million dollar mark.

A 1998 study sampled 1,124 random physicians within the United States indicated that a large percentage of physicians reported altering billing diagnoses in order to facilitate payment on things that would not generally be covered otherwise, and reported that they were not concerned with being prosecuted for fraud (Wynia, Cummins, VanGeest, & Wilson, 2000). It would lead that there is a necessity for stronger penalties along with strengthened preventative measures, as many providers realize that the probability of actually being caught has historically been quite low.

This outcome would benefit taxpayers and beneficiaries alike, as the money recovered through prosecution and restitution is returned to the Medicare Trust Fund. While many health care fraud cases are still pending, in fiscal year 2007 alone, $1.12 billion in restitutions, $4.4 million in recoveries, $34 million in fines, and $61.2 million in seizures were identified, according to the FBI (2008).

Methods of Approach

Secondary data provided by CMS, Federal Bureau of Investigation (FBI), Government Accountability Office (GAO) and other relevant government entities in the prevention and prosecution of Medicare fraud was used in the current research. Data was derived from CMS on the current payment and billing structure of Medicare in order to ascertain which aspects leave the program susceptible to fraudulent billing, as well as to identify current methods of prevention of Medicare fraud. Data from the FBI and GAO was utilized in order to ascertain the extent of Medicare fraud in terms of prosecution and identification of Medicare fraud.

From this data, recommendations for a permanent and centralized Medicare fraud unit were derived. The fraud unit will be created from an approach that encompasses all aspects of Medicare fraud while utilizing many of the fragmented facets in which Medicare fraud is prevented, identified, and prosecuted today. Recommendations for reducing the instances of Medicare fraud were based on rational choice, deterrence and routine activities theories. The addition of strengthened provider screening and legal requirements to obtain a Medicare provider number along with harsher penalties for those convicted of Medicare fraud will aid in targeting the entire cycle of Medicare fraud.

Limitations

Limitations of this research include the fact that most health care fraud is lumped together into a single statistic, making it difficult to completely ascertain what amount corresponds to Medicare fraud. Medicare expenditures were $431 billion in 2007, which comprised 19% of total national health care expenditures (U.S. Department of Health and Human Services, 2009). The exact scope regarding Medicare fraud is unknown and only estimates are provided as much fraud goes undetected. Further complicating matters is the highly fragmented nature in which

fraud is detected and prosecuted. Many government agencies are involved in the detection and prosecution of Medicare fraud, while CMS also contracts out to various Medicare Program Safeguard Contractors, such as Trust Solutions, LLC.

SECTION II: LITERATURE REVIEW

Literature on Medicare and health care fraud is most often contained within research on overall white collar fraud. Edwin Sutherland coined the term "white-collar crime" in 1949, defining it as a crime "committed by a person of respectability and high social status in the course of his occupation" (Sutherland, 1949). Most literature and statistics regarding Medicare fraud is included with Medicaid fraud, as the programs, while run by separate entities, are very similar in regards to the programs themselves and the prevalence of fraud. This literature review is divided into five parts. The first part looks at the characteristics of the white collar criminal as a whole. The second part provides a definition of Medicare fraud. The third part analyzes the Medicare billing and payment structure in order to identify the facets that lend to Medicare fraud. The fourth part looks at the scope of Medicare billing fraud. Finally, part five identifies important issues and initiatives in the prevention, identification and prosecution of Medicare billing fraud.

The White Collar Criminal

Simpson and Piquero (2002) argue that a need to control is a common characteristic among white collar offenders, and tend to be assertive, decisive, and active. This type of personality tends to blame failure on external factors outside of his or her control, and tend to have perceptions of control when none exists; all leading to taking higher risks than typically necessary (Bucy, Formby, Raspanti, & Rooney, 2008). Other characteristics attributed to white collar offenders include tendencies to bully others into complying with his or her demands or being charismatic and enthusiastic in order to motivate others into compliance with his or her demands. A fear of failing is often attributed to the white collar criminal as they fear losing his or her professional or financial status, and "are motivated to make unethical decisions to preserve

their material wealth, professional reputation, and institutional power" (Bucy, Formby, Raspanti, & Rooney, 2008, p. 415). While this may hold true for a physician with an illustrious career, in terms of health care fraud, most health care fraud is perpetrated in order to facilitate a higher payment than what is actually due.

White collar criminals are often explained as having a need for corporate success – the greed that leads to deceptive behavior is not for personal gains, but for corporate gains, in order for greater corporate success. Grace Duffield describes white collar criminals as being highly narcissistic; they are extremely ambitious and obsessed with power and control with a sense of superiority (as cited in Bucy, Formby, Raspanti, & Rooney, 2008). One identifying trait identified by Dittenhofer is lack of integrity, where those lacking integrity can easily justify committing a crime, whereas somebody with substantial integrity would struggle to commit the same act (Bucy, Formby, Raspanti, & Rooney, 2008).

In a study of Medicaid-provider fraud, Revco, a drug store chain, was found guilty of a double-billing scheme that defrauded Ohio $500,000 in state Medicaid funds (Vaughan, 1994). Vaughan ascertained that throughout the initial investigation, Revco assumed role of a victim, arguing that their claims were unjustly denied to begin with, and that they were owed this money by Medicaid. The legal option would have been to resubmit the claims with a pre-submission screening system, rather than devising a systematic fraud scheme. Based on this study, Vaughan developed a theory including three major elements: the competitive environment, which generates pressures upon organizations to violate the law in order to attain goals; organizational characteristics that provide opportunities to violate the law; and the regulatory environment, which is affected by the relationships between regulators and those they regulate (Vaughan,

1994, p. 126). Vaughan argues that these three elements are each related to activity leading to violation of the law, and that criminal misconduct is a result of the inter-play of each element.

Definition

Fraud is generally defined "as an intentional misrepresentation of material existing fact made by one person to another with knowledge of its falsity and for the purpose of inducing the other person to act, and upon which the other person relies with resulting injury or damage" (US Legal Definitions, n.d.).

CMS finds that the most prevalent type of fraud "arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program" (2008, Section 4.2.1). CMS simply defines Medicare fraud as "purposely billing Medicare for services that were never provided or received" (Centers for Medicare & Medicaid Services, 2009). TrustSolutions, LLC, a Medicare PSC (Program Safeguard Contractor), defines Medicare fraud as "an intentional deception or misrepresentation that the individual knows to be false or does not believe to be true, and makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person" (2008). In contrast to fraud, Medicare abuse is defined as "incidents or practices of providers, physicians or suppliers of services that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment or program payment for services that fail to meet professionally recognized standards of care or are not medically necessary" (TrustSolutions LLC, 2008).

Medicare fraud can be committed by a wide spectrum of individuals – from providers, to fiscal intermediaries that process Medicare claims, to people that steal another's Medicare number in order to receive services, to equipment suppliers. Medicare billing fraud, however,

like most white collar crime, appears to be a crime of opportunity for financial gain, perpetrated by those within the health care industry. The Coalition Against Insurance Fraud estimates that 80% of health care fraud is committed by medical providers, 10% by consumers, with the balance being perpetrated by health care insurers and their employees (2008).

The Medicare Billing and Payment Structure

The Medicare billing and payment structure is complicated, and differs depending on which type of provider or service a beneficiary sees. Providers must be approved as a Medicare provider from CMS in order to bill Medicare. When a beneficiary sees a Medicare participating physician, the physician submits an electronic claim to Medicare, utilizing ICD-9 (International Classification of Diseases, 9th Edition/Revision) or HCPCS (Healthcare Common Procedure Coding System) codes to relate the diagnosis of the beneficiary and CPT (Current Procedural Terminology) codes, which are 5 digit codes that relate what type of service was rendered (Centers for Medicare & Medicaid Services, 2009). The claim is sent electronically to a Fiscal Intermediary (FI), which has been contracted by CMS to process Medicare claims. There are 15 Medicare Administrative Contract (MAC) contracts- leading that at least 15 different entities processing Medicare Part A and B claims (NHIC Corp, 2009).

More often than not, these claims go electronically through the FI's system and are automatically paid, reimbursing the provider. If there are errors in the way the claim was billed, or certain criteria triggers the system (such as an unusual amount of units billed, services that do not make sense in relation to the age, sex, or diagnosis codes based on certain criteria that is coded into the payment program) the claims are then manually reviewed by a claims employee within the contractor, who can then deny the claims, send them back to the provider to correct, or override them to pay. Each year Medicare contractors process over 1 billion claims from over 1

million providers (Stockdale, 2008). The automated Medicare payment system emphasizes timeliness and efficiency over caution and risk control, while "the responsibilities for processing efficiency and for fraud control lie with different officials and within different organizational departments" (Sparrow, 2008). According to the Medicare Claims Processing Manual, Chapter 1, 80.2.1.1**,** "clean" claims must be paid within 30 calendar days of receipt (Centers for Medicare & Medicaid Services, 2009). Clean claims are defined as claims in which no development or investigation is needed by the FI on a prepayment basis (Centers for Medicare & Medicaid Services, 2009). While this is only a general idea of how a Medicare claim is paid, it illustrates the basic ideology of how perpetrating Medicare billing fraud can be so easy and prevalent. As long as the provider, or person submitting the claim, understands how the system works, he or she can easily send a claim through by making sure there is no conflicting or suspicious data on the claim that might trigger this automatic system – and the claim will go right through to payment (Sparrow, 2008).

There are many ways in which providers "game" the Medicare system through billing techniques. According to the Washington State Office of the Attorney General (n.d.), they include, but are not limited to:

- Billing Medicare for new equipment while providing the beneficiary with used equipment.
- Billing for services not rendered.
- Code Jamming – Putting fake diagnosis codes on the claims in order to get coverage that does not otherwise exist.
- Unbundling- Using multiple CPT codes instead of one comprehensive code that covers the two services, or submitting two separate bills for services that were rendered on the same day.
- Up Coding – Using diagnosis codes that imply that the beneficiary had more severe issues than he or she actually did in order to bill for more complicated procedures to inflate the bill.

Physicians are not reimbursed 100% for the charges they bill Medicare. There are different, distinct payment methodologies for various types of providers. Hospitals, HHAs (home health agencies), SNFs (skilled nursing facilities), DME, outpatient clinics and hospices

are all reimbursed differently, though all are based on the CPT/HCPCS codes and ICD-9 diagnosis codes billed. Age, sex, and patient status codes (whether the beneficiary is still a patient, died, was transferred or discharged) are factors that billing methodologies incorporate.

Under the traditional fee-for-service payment methodology, Medicare generally reimburses physician services based on a physician fee schedule, which is adjusted for different geographical areas based on the HCPCs, or services, billed (MedPac, 2007). A Wisconsin physician billing for an established patient outpatient visit would bill Medicare using HCPCs code 99211 – "Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services" (American Medical Association, 2009).

While the physician may bill Medicare $75.00 for the service rendered, he or she would receive $8.27 or $17.57 in reimbursement from Medicare, depending on which type of facility the service was provided in (U.S. Department of Health and Human Services, 2009). Hospital stays are paid a set amount based on a DRG, diagnostic-related group, which is calculated based on ICD-9 codes, age, sex, and discharge status. The amount paid considers the DRG number, as well as a hospital's particular negotiated standard base rate, or wage index – no matter what the billed charges may be, though there are instances where hospitals can receive higher rates of reimbursement (Blue Cross Blue Shield, n.d.). This low percentage of reimbursement is unilateral across the board, no matter what the type of particular reimbursement methodology.

Scope of the Problem

U.S. Secretary of Health and Human Services, Michael Leavitt, argues that through Medicare fraud, "The legitimate Medicare recipient is hurt- the legitimate business that's

dispensing this and serving patients is hurt, every taxpayer is hurt," while another official states that Medicare fraud is "an epidemic" as quoted in Potter (2007). Attorney Janet Reno declared health care fraud the "number two crime problem in America" in 1993; for years the DOJ has listed health care fraud as its second priority after violent crime (Sparrow, 2008).

Robert H. Hast, Assistant Comptroller General for Special Investigations, noted that a new, organized class of criminals specializing in Medicare fraud had emerged, and that many of those committing general health care fraud "have prior criminal histories for criminal activity unrelated to health care fraud— such as securities fraud, narcotics and weapons violations, grand theft auto, and forgery—indicating that the individuals have moved from one field of criminal activity to another" (U.S. General Accounting Office, 2000). The FBI notes that "All health care programs are subject to fraud; however, Medicare and Medicaid programs are the most visible" (n.d.). Chief Counsel of the Office of Inspector General Lewis Morris has testified that health care fraud is particularly attractive to organized criminals as the penalties are not as severe as those for other organized-crime offenses, schemes can be replicated easily virtually anywhere within the United states, the risk of detection is low, and "there are low barriers to entry (e.g., a criminal can obtain a supplier number, gather some beneficiary numbers and bill the program)" (Office of Inspector General, 2009). The biggest type of Medicare fraud schemes revolve around medical supplies such as wheelchairs and other materials. In an interview with CBS (Columbia Broadcasting System), one man told how he easily bilked Medicare of $20 million by setting up a fake medical supply office that did not supply medical equipment or have any real clients (2009). Literature suggests that successfully facilitating a Medicare billing scheme involves renting an office, finding somebody to obtain an occupational license, bribing a

physician or forging a prescription pad, and obtaining names and corresponding Medicare ID numbers.

While historically, Medicare fraud is perpetrated by physicians or suppliers looking for ways to increase their reimbursement, members of the mob and other violent criminals are increasingly involving themselves in Medicare fraud due to the presumably "easier money and shorter prison sentences" (The Associated Press, 2009). Medicare scammers can make $25,000 a day risking 10 years in prison if convicted, while "a cocaine dealer could take weeks to make that amount while risking up to life in prison" (The Associated Press, 2009). According to the AP (2009), federal prosecutors have been threatened, an informant has been found shot to death, and a woman was found dead, throat slit by a broken toilet seat, inside of a pharmacy that had been under investigation for fraud. Eleven members of the Bonanno family from New York were indicted in May 2009 in South Florida for stealing Medicare numbers and using them to submit false claims (The Associated Press, 2009). In order to obtain a DME Medicare license, applicants must only report whether he or she has "within the last 10 years preceding enrollment or revalidation of enrollment [been] convicted of a Federal or State felony offense" (U.S. Department of Health & Human Services, 2009). Thus, criminals are not excluded from obtaining legit Medicare licenses.

In one such case, Guillermo Denis Gonzales had spent 14 years in prison for second-degree murder; after being released in 2006 he bought a business named DG Medical in Miami, which had already obtained a Medicare DME supplier license. The license was subsequently revoked in February of 2007 because Gonzales did not respond to requests for additional information from him in regards to his business. Just two months after purchasing the company, authorities were alerted to the fact that he was submitting fraudulent claims to Medicare –

already totaling $31,000 in reimbursement for humidifiers, specialty mattresses and other DME (Weaver, 2009). Gonzales has pled guilty to defrauding Medicare and is awaiting sentencing; he has also been charged with dismembering a man in 2008, a killing in which authorities believe to be possibly related to Medicare fraud (The Associated Press, 2009). According to Los Angeles County Sherriff's Sgt. Stephen Opferman, most Medicare fraud-related murders are "typically professional hits, generally unsolved. Usually it's just a bullet in the head, nobody saw anything" (The Associated Press, 2009). In another bloody case from 2002, an Illinois podiatrist shot a wheelchair-bound patient, in the church that she worked at, six times in order to prevent her from testifying in front of a jury about his activities involving defrauding Medicare. He had submitted claims to Medicare for at least 70 surgeries on the victim that he had not performed. He was sentenced to death which the Supreme Court has subsequently upheld (The Associated Press, 2009).

The statistics regarding Medicare billing fraud are astounding, illustrating a need for strengthened anti-fraud measures. According to the U.S. Senate Permanent Committee on Investigations, from 2000 to 2007, Medicare paid deceased physicians 478,500 claims totaling up to $92 million (2008). Medicare fraud occurs nationwide, though large urban areas, such as Detroit and Miami, are particularly hot spots for fraud and have been targets for government sting operations.

A 1998 study sampled 1,124 random physicians within the United States questioning the use of exaggerating the severity of patient's conditions; changing the patients billing diagnoses, and reporting signs or symptoms that the patient did not have (Wynia, Cummins, VanGeest, & Wilson, 2000). Thirty-nine percent of the physicians reported utilizing one more of the methods listed within the past year. Reasons given included that they "believe that 'gaming the system' is

necessary to provide high-quality care today" or that they "have received requests from patients to deceive insurers" (Wynia, Cummins, VanGeest, & Wilson, 2000, p. 1858). In addition, the physicians reported that they were not worried about being prosecuted for fraud when utilizing one of the tactics and 54% reported doing it more often at the time of the survey than they had 5 years prior (Wynia, Cummins, VanGeest, & Wilson, 2000, p. 1858). In one study of occupational, speech and physical therapists, 81% of which admitted to partaking in Medicare/Medicaid billing fraud, the most common justification reasons were " claiming that everybody else does it, shifting blame to the patient or family members (for shortening sessions and the like), and denying injury (to the client)" (Gasquoine & Jordan, 2009).

As with most carefully designed fraud schemes, health care fraud schemes are virtually invisible in perpetuity, making the exact scope of the problem unknown; as with most white collar crime, the range of issues that are associated with health care fraud are undetected, unreported or underreported (Sparrow, 2008). Sparrow (2008) argues that agencies target areas in which they have found cases before (as in the Strike Force operations centered on Miami and Detroit) thus focusing control strategies on the few cases that are identified and not realizing that these cases might "represent a small and biased subset of the underlying issue, largely influenced by where and how they have looked for it in the past."

The metrics in which health care fraud is measured, whether it be the number of cases identified, number of persons involved, or total recoveries, are not absolute identifiers in the scope of health care fraud (Sparrow, 2008). If an increase in fraud is detected while billing for targeted services declines, it could suggest that detection measures have improved, or that schemers have realized that they are being scrutinized more and are being careful and have either changed their methods or areas of "specialty", or are attempting to fly under the radar, so to

speak, for the time being. Sparrow (2008) argues that "For any invisible problem, effective control begins with valid measurement" – which simply does not exist in regards to Medicare fraud or even healthcare fraud overall.

Sparrow (2008) likens health care fraud perpetrators to drug smugglers, terrorists, thieves and computer hackers, as these groups are in constant study of the relevant defenses, can adapt quickly to changes in these defenses, and thrive on novelty or surprise. Automatic claims payment systems, however, appear to cater to these types of criminals, as when a claim is automatically denied, a corresponding reason code is provided with the denial – telling the provider exactly why the claim was denied, so the provider can subsequently bill it correctly (Washington Publishing Company, 2009). Denial of multiple claims by one provider, from a fiscal intermediary view, does not correlate to suspicious activity; it may simply illustrate that the provider does not understand how to correctly bill for particular services, or reflect the fact that the field of medical billing is plagued with high turnover rates and low retention – thus it could simply be that the particular provider has new people submitting the billing who are not yet familiar with the particulars of Medicare billing, or the provider has outsourced billing to entities unfamiliar with the provider (Medical Billing, 2007).

Prevention, Identification and Prosecution

Medicare fraud, like most white collar crimes, can be difficult to identify or prove. The complexity of the rules and regulations of Medicare make it difficult for both providers and investigators to determine the correct way of billing for services. Medicare regulations change at a nearly daily rate; as of September 2009, alone, CMS has published 365 Transmittals regarding "new or changed policies or procedures that [will be incorporated] into the CMS Online Manual System" (Centers for Medicare & Medicaid Services, 2009). The nature of the ever-changing

Medicare rules and regulations may make it harder to successfully prosecute Medicare fraud; providers can claim they either did not fully understand or know of billing and reimbursement regulations – a claim that may seem logical, given the constant changes in these regulations.

CMS distributes "Medicare and You," a publication that encourages reporting of fraud and abuse each fall (Centers for Medicare & Medicaid Services, 2009). This publication as well as various other publications from CMS, informs beneficiaries that they are the "most important link in finding Medicare fraud" (U.S. Department of Health & Human Services, 2008). CMS publications urge beneficiaries to review his or her MSN, (Medicare Summary Notice), a detailed summary of services rendered, including dates of service and providers, to make sure that he or she "understands" all of the items listed, and to call the provider listed on the notice for clarifications (U.S. Department of Health & Human Services, 2008). These publications also describe a possible $1,000.00 reward for reporting "suspicious activity [that] turns out to be fraud" (Centers for Medicare & Medicaid Services, 2009). Unfortunately, MSNs are usually complex, and providers might show up that a beneficiary knows that he or she did not see, but are completely legit. A beneficiary that has a physician visit with lab work done will most likely see charges from more than one provider, as many places send blood samples or tissue samples out to an independent lab for analysis. The provider who analyzed the samples may very well show up on the MSN, even though he or she was not physically seen by the beneficiary (Ellzey, 2005).

A 1998 OIG survey of beneficiary awareness of Medicare fraud found that beneficiaries believed that Medicare fraud was a common problem, and that it was their responsibility to report (U.S. Department of Health & Human Services, 2001). In the 1998 survey, beneficiaries responded that they read their MSNs, but never received information on identifying Medicare

fraud and stated that recognizing Medicare fraud was difficult (U.S. Department of Health & Human Services, 2001). In response, a 1999 OIG outreach effort was launched in order to better educate Medicare beneficiaries; the outreach urged them to clarify unusual charges with their provider, followed by contacting their Medicare contractor, and then to contact OIG if issues remain (U.S. Department of Health & Human Services, 2001). In 2001, OIG conducted a similar survey to the 1998 version. Of a random sample of 1,498 beneficiaries, 543 beneficiaries responded (U.S. Department of Health & Human Services, 2001). The results indicated that in three years, knowledge of Medicare fraud amongst beneficiaries had increased 15%, however 85% of the beneficiaries reported not knowing about the Medicare fraud hotline, a 1% decrease from the 1998 survey (U.S. Department of Health & Human Services, 2001). Half of the respondents felt that Medicare fraud is difficult to recognize; only 40% of beneficiaries over the age of 75 remembered receiving any sort of information on Medicare fraud while 60% of beneficiaries under the age of 65% reported receiving information on Medicare fraud (U.S. Department of Health & Human Services, 2001).

There are two major mechanisms used to identify Medicare fraud cases from the government perspective: whistleblowers and data mining that detects abnormal billing patterns. The qui tam provision of the False Claims Act which rewards whistleblowers for filing suit on behalf of the government is discussed below. Since 1986 random sampling of paid Medicare claims has been legally acceptable in the investigation of suspicious billing practices (Ignatova & Edwards, 2006). Through random sampling of paid Medicare claims, billing data from individual providers is compared to billing practices regionally in order to ascertain whether there are billing inconsistencies between individuals and what the average rate is for the same

services regionally. Enforcement and prosecution of Medicare fraud is a joint effort between OIG, the DOJ, and FBI.

False Claims Act

The False Claims Act (31 U.S.C. § 3729–3733) is one of the major utilities in the prosecution of health care fraud (see Appendix A for a complete overview of the False Claims Act). The False Claims Act (FCA) imposes liability on any person or operation which submits a falsified claim to the federal government (Medicare, Medicaid, etc.) while providing that private parties can bring action on behalf of the US government in cases of knowledge of fraudulent billing (Schindler, 2009). The private third parties are known as qui tam relators, or whistleblowers, and under FCA are entitled to a percentage of recovered proceeds of FCA action – virtually anybody can prosecute a violation under the FCA. Those found in violation of the FCA are liable for a civil penalty of $5,000.00 to $10,000.00 in addition to three times the amount of damages that the Government sustains (Schindler, 2009). A successful qui tam realtor can see 25 to 30% of any recovery or 15-25% if the government intervenes (Schindler, 2009). In the first six months of 2008 the OIG reported participating in 141 civil and administrative FCA cases with expected recoveries of over $1 billion (Schindler, 2009). Some argue that the FCA offers huge incentives for disgruntled employees or patients as there is no penalty for filing false suits while the FCA protect whistleblowers from adverse treatment or discrimination as a result of their actions under the FCA.

A 2006 GAO report detailed that the Department of Justice's civil sector received 8,869 FCA cases from fiscal year (FY) 1987 through 2005 (U.S. Government Accountability Office, 2006). The Department of Health and Human Services (HHS) and the DoD agencies were most frequently named as the agencies being allegedly defrauded. The GAO analyzed 2,490 closed,

unsealed qui tam cases that had been filed in 92 U.S. district courts (U.S. Government Accountability Office, 2006). Health care and procurement fraud cases constituted 79% of all qui tam cases, of which the DOJ pursued more often than any other types of fraud cases. The median recovery in a qui tam case was $784,597.00; the median relator share was $123,885.00. Recoveries in health care fraud cases were more than recoveries in other types of cases. According to the GAO (2006), since Congress amended the FCA in 1986, the government has recouped over $15 billion from FY 1987 through 2005; $9.6 billion of this was for cases filed by whistle blowers under the FCA's qui tam provisions.

Health Care Fraud and Abuse Control Program

The Health Care Fraud and Abuse Control Program, HCFAC, was created under the Social Security Act Section 1128C(a) in order to combat fraud and abuse in health care (U.S. Department of Health and Human Services and U.S. Department of Justice, 2008). The goals of HCFAC are as follows:

- To coordinate federal, state and local law enforcement efforts relating to health care fraud and abuse with respect to health plans;
- To conduct investigations, audits, inspections, and evaluations relating to the delivery of and payment for health care in the United States;
- To facilitate enforcement of all applicable remedies for such fraud;
- To provide guidance to the health care industry regarding fraudulent practices;
- To establish a national data bank to receive and report final adverse actions against health care providers, and suppliers (U.S. Department of Health and Human Services and U.S. Department of Justice, 2008).

During FY 2007, the Federal Government received $1.8 billion in settlements and judgments relating to health care fraud; $797 million of which was repaid to the Medicare Trust Fund (U.S. Department of Health and Human Services and U.S. Department of Justice, 2008). The 2007 Annual Report on Health Care Fraud and Abuse Control program revealed that 878 criminal fraud investigations were opened in FY 2007, comprised of 1,548 defendants, while 560 people were convicted of health care fraud (see Appendix C for more details).

During FY 2008, the Federal Government either won or negotiated $1 billion in judgments and settlements, while the Medicare Trust Fund received $1.94 billion as a result of these actions (U.S. Department of Health and Human Services and U.S. Department of Justice, 2009). Throughout FY 2008, 957 new health care fraud investigations were opened involving 1,641 defendants, while 588 defendants were convicted for health care fraud throughout the year (see Appendix B for specific accomplishments) (U.S. Department of Health and Human Services and U.S. Department of Justice, 2009).

Medicare Strike Force/ Health Care Fraud Prevention and Enforcement Action Team (HEAT)

In order to combat the ever-growing problem with fraudulent billing for DME and HIV infusion therapy services, the DOJ launched a Medicare Strike Force with HHS in Miami, Florida in 2007 (U.S. Department of Health and Human Services and U.S. Department of Justice, 2008). This strike force was a combination of the DOJ criminal division with the United States Attorney's Office for the Southern District of Florida, implementing a criminal, civil and administrative attack against those fraudulently billing Medicare, lasting seven months (U.S. Department of Health and Human Services and U.S. Department of Justice, 2008). The strike force resulted in the indictment of 74 cases of 120 defendants who together billed Medicare more

than $400 million; 35 guilty pleas were negotiated with additional sentences of 21 defendants (U.S. Department of Health and Human Services and U.S. Department of Justice, 2008). The average prison sentences in these cases were 48.8 months, while the average sentence for health care fraud convictions overall is 37.4 months (Breuer, 2009). According to the Department of Justice, the charge of conspiracy to commit health care fraud carries a maximum prison sentence of 10 years, and each charged count of health care fraud carries a maximum prison sentence of 10 years (U.S. Department of Justice, 2009).

The 2007 Annual Report on Health Care Fraud and Abuse Control noted that during this strike force period, an overall reduction was seen in billings and payments for Medicare Part B compared to the same seven month period the previous year. The HCFAC report notes that this decrease can be attributed to the fact that "threat of prison time and rapid prosecution had a significant impact on those that are committing or may be inclined to commit fraud" while the elimination of Medicare payments for certain drugs that were prevalent in the fraudulent billing schemes also had a direct impact (U.S. Department of Health and Human Services and U.S. Department of Justice, 2008). From March 1, 2007 to September 30, 2007, the months during the strike force, claims submitted to Medicare for DME decreased by $1.2 billion to $661 million in comparison to $1.87 billion during the same seven-month period the preceding year (U.S. Department of Health and Human Services and U.S. Department of Justice, 2008).

Due to the success of the initial phase of two began in Los Angeles in March 2008, targeting providers suspected with submitting fraudulent DME claims to Medicare. Arrests of 11 defendants, which resulted in nine indictments of $13 million in fraudulent Medicare claims, were made as early as May 2008 (U.S. Department of Health and Human Services and U.S. Department of Justice, n.d.). Accomplishments of phase two of the Medicare Strike Force

include more than $55 million in court-ordered restitution to the Medicare program in 21 cases involving 37 defendants, two prison sentences of 54 months and 21 months, and convictions of eleven other defendants (U.S. Department of Health and Human Services and U.S. Department of Justice, n.d.). Phase three began in Detroit of March, 2009, targeting infusion therapy and physical and occupational therapy clinics for billing for services not medically necessary or provided at all (U.S. Department of Health and Human Services and U.S. Department of Justice, n.d.). Arrests in Phase three began June 24, 2009, involving two cities and 53 persons accused of submitting over $50 million in false claims (U.S. Department of Health and Human Services and U.S. Department of Justice, n.d.).

The fourth phase of the Medicare Fraud Strike Force was announced in May 2009, after operating covertly for several months (U.S. Department of Health and Human Services and U.S. Department of Justice, n.d.). The Houston operation was comprised of three teams, each led by a federal prosecutor from the U.S. Attorney's Office in Houston or the Criminal Division's Fraud Section (U.S. Department of Health and Human Services and U.S. Department of Justice, n.d.). Each team comprised of an agent from the FBI, HHS, OIG, and the Texas Attorney General's Medicaid Fraud Control Unit; the U.S. Drug Enforcement Administration, Office of Personnel Management, and Rail Road Retirement Board also had agents in place of the strike force teams. Seven indictments involving 32 defendants and $16 million in fraudulent claims were unsealed on July 29, 2009 (U.S. Department of Health and Human Services and U.S. Department of Justice, n.d.). The providers targeted in phase four submitted over $16 million in fraudulent claims to Medicare for DME supplies such as power wheelchairs, feeding supply kits and scooters, all of which were not medically necessary or never supplied to the patients (U.S. Department of Health and Human Services and U.S. Department of Justice, n.d.).

As phase four of the Medicare Task force was implemented, so was a new name for the task force activities – in May 2009 the Health Care Fraud Prevention and Enforcement Action Team (HEAT) was created (U.S. Department of Health and Human Services and U.S. Department of Justice, n.d.). HEAT is comprised of professional staff from the DOJ and Department of HHS along with law enforcement agents. The HHS and the DOJ (n.d.) provide the following mission of HEAT:

1. To marshal significant resources across government to prevent waste, fraud and abuse in the Medicare and Medicaid programs and crack down on the fraud perpetrators who are abusing the system and costing us all billions of dollars.
2. To reduce skyrocketing health care costs and improve the quality of care by ridding the system of perpetrators who are preying on Medicare and Medicaid beneficiaries.
3. To highlight best practices by providers and public sector employees who are dedicated to ending waste, fraud and abuse in Medicare.
4. To build upon existing partnerships that already exist between the Department of Justice and the Department of Health and Human Services like our Medicare Fraud Strike Forces to reduce fraud and recover taxpayer dollars.

On December 15, 2009, the DOJ and HHS announced expansion of the HEAT initiative to the fifth, sixth and seventh phases to Brooklyn, Tampa and Baton Rouge (U.S. Department of Health & Human Services, 2009). Five indictments were unsealed on December 15, 2009 after 25 people were arrested in Miami, Detroit and Brooklyn for defrauding Medicare of over $61 million collectively (U.S. Department of Health & Human Services, 2009). According to the HHS (2009), since the inception of the Medicare Strike Force operations, as of December 2009, over 460 people have been indicted for fraudulently billing Medicare of more than one billion

dollars. While recoveries of one billion dollars since 2007 indicate that the Medicare Strike Force operations are successful, estimates indicate the Medicare program loses possibly $60 billion annually to fraud indicating that task force operations alone are not sufficient to combat the annual fraudulent losses to the Medicare program (see Appendix D for more details).

Senior Medicare Patrol Programs

Funded by the U.S. Administration on Aging (AoA), Senior Medicare Patrol (SMP) programs are comprised of roughly 4,000 volunteers nationwide, most of whom are retired Medicare beneficiaries (The National Consumer Protection Technical Resource Center, 2009). The goal of SMPs is to teach Medicare beneficiaries how to protect their personal identity information and how to detect fraud, abuse and waste within Medicare and other health care programs (The National Consumer Protection Technical Resource Center, 2009). In 2008, there were 57 SMPs within the United States, comprised of 4,685 volunteers, which received $9.3 million in funding from the AoA (U.S. Department of Health and Human Services Office of Inspector General, 2009). According to HHS-OIG (2009), 2008 SMPs held 6,869 group education sessions and 24,505 individual sessions as well as 785,468 media outreach events and 5,742 community outreach events. As a result of these efforts, Medicare funds recovered were $21,068, with actual savings to the beneficiaries attributable to the programs were $34,548, and total savings to Medicare, Medicaid and beneficiaries were $65,735 (U.S. Department of Health and Human Services Office of Inspector General, 2009). HHS-OIG attributes $73,006 in cost avoidance on behalf of the Medicare and Medicaid program and beneficiaries to the SMPs for 2008 (U.S. Department of Health and Human Services Office of Inspector General, 2009). While the funds recovered in comparison to the $9.3 million funded annually to SMPs may seem small, HHS-OIG emphasizes that the number of beneficiaries that have learned from SMP

programs how to detect fraud cannot be tracked; therefore, the programs may not be receiving full credit for the work they do (U.S. Department of Health and Human Services Office of Inspector General, 2009).

Medicaid Fraud Units

When analyzing the problem of Medicare Fraud, it must be recognized that fraud is largely present in the government's Medicaid program as well. Medicare and Medicaid fraud are many times interwoven in the literature, as providers that fraudulently bill Medicare are also fraudulently billing Medicaid. Medicaid relies on Medicaid Fraud Control Units (MFCU) for investigation and prosecution of Medicaid Fraud. There are 50 MFCUs in all states aside from North Dakota that are certified annually by the Secretary of HHS (National Association of Medicaid Fraud Control Units, 2010). Each MFCU receives an annual federal grant; 25% of this funding must be matched by the state government (National Association of Medicaid Fraud Control Units, 2010). Units are comprised of attorneys, investigators and auditors, though the number of each varies from state to state. As of 2008, Wisconsin's MFCU, for example, was comprised of 11 total staff members; three attorneys, three auditors, three investigators and two other staff members with a budget of $1.2 million (National Association of Medicaid Fraud Control Units, 2008). These units are intended to operate as a "strike force" (National Association of Medicaid Fraud Control Units, 2010). Unfortunately, efficiency is judged at the individual level, with no compressive statistics of the successfulness of MFCUs as a whole.

Medicare Integrity Program

The Medicare Integrity Program (MIP) was created under HCFAC; the MIP program was created as part of comprehensive legislation to combat health care fraud and abuse through the HCFAC program (U.S. Office of Management and Budget, 2009). MIP provides funds to CMS

to protect the $300 billion in program payments (U.S. Government Accountability Office, 2006). With the funding, CMS conducts audits, medical review of claims, primary payment responsibility in terms of secondary insurance (referred to as Medicare Secondary Payer), benefit integrity to address potential fraud cases, as well as provider education (U.S. Government Accountability Office, 2006). Aside from the audit and medical review portions, the provider outreach efforts are one of the most important facets of the Medicare Integrity Program. The outreach efforts include communicating with providers about Medicare policy, initiatives, and program changes that may affect billing through workshops, newsletters, and websites. In fiscal year 2005, funding for provider education was $70 million, reflecting the importance of provider education in the scope of preventing fraud, waste and abuse (U.S. Government Accountability Office, 2006).

CMS contracts out to private entities, known as Program Safeguard Contractors (PSCs) that conduct Medicare benefit integrity activities as part of the MIP. These activities include data analysis of paid claims to identify abnormal billing patterns, developing investigations on potential fraud cases, and referring these cases to HHS, OIG and the DOJ (Stockdale, 2008). Each PSC is contracted by CMS and focuses on one distinct type of claim (such as Medicare Part A or B claims, DME claims, or Home Health and Hospice claims). The purpose of PSCs is not to deter fraud, but to identify fraudulent activity and recover the improper payments to the Medicare Trust Fund. There is little data on the effectiveness of Medicare PSCs. A 2007 OIG report on PSCs reported that in 2005, 13 of 17 PSCs reported a median of 196 investigations into fraudulent Medicare Part B claims; a median of 13 of these cases were actually referred to law enforcement officials for further investigation (Office of Inspector General, 2007). Eventually the work of PSCs will be shifted to the newly implemented Zone Program Integrity Contractors

(ZPIC), which will be responsible for Medicare integrity operations for all claim types in (Kimball, 2009). The new system will be comprised of seven jurisdictions, with one ZPIC per region. ZPICs will perform the same type of investigations as the current PSCs, which are generally focused on billing abnormalities found through data analysis (Kimball, 2009). In theory, ZPICs will be more able to identify billing fraud as they cover larger areas and will have access to all types of claim information in order to detect cross-billing and relationships among healthcare providers (Kimball, 2009).

The highly fragmented nature in which the Medicare system operates presents issues for those attempting to identify fraud. Kirk Ogrosky, deputy chief for healthcare fraud in the Justice Department likens the process of identifying Medicare billing schemes to peeling an onion, due to the depth of the Medicare system (Blesch, 2009). Currently no unified system is in place to track all of Medicare's claims and payment data, though CMS is reportedly working on creating a comprehensive repository for claims and payment data from all federal health care programs with hopes to have it implemented by 2014 (Blesch, 2009). This unified system will allow for easier fraud detection by allowing agencies to access all claims data while offering the ability to pull data from multiple sources to analyze specific trends in categories of care (Blesch, 2009).

SECTION III: THEORETICAL FRAMEWORK AND ANALYSIS

Health insurance fraud has been historically considered to be a white collar crime; as such, much of the theory regarding Medicare fraud falls under the auspices of white collar crime as a crime of opportunity as a whole. In order to make recommendations on how to alleviate Medicare fraud, concrete program factors that lead to fraud and theoretical causes of the problem must be understood. Once these factors are understood, solutions based on related theory can be identified. Whether physicians, supplier companies or organized criminals commit fraud, the underlying goal is financial enrichment – a goal shared by the majority of white collar criminals.

Physicians and non-physicians alike commit Medicare fraud once they have made a conscious decision to do so. Most providers choose the honest approach while billing Medicare, while others manipulate the system to their advantage. Rational choice and routine activities theories offer that because Medicare fraud results in greater benefits than costs to criminals, fraudulent claim submission is prevalent. In order to deter Medicare fraud, the Medicare program needs a capable guardian. Most providers choose to abide by the set of rules and regulations of Medicare; it is a conscious decision for providers to bypass these regulations in order to achieve a greater monetary gain. Deterrence theory offers that stricter and swifter prosecution of Medicare fraud with strengthened preventative measures will reduce the incidence of Medicare billing fraud.

Rational Choice Theory

Rooted in the classical school of criminology, rational choice theory was developed by Cesare Beccaria in 1764 (Seigel, 2002). Rational choice theory is based upon the "expected utility" principle of economic theory, which states that people make rational decisions based on the extent to which he or she expects to maximize profits and minimize costs or losses (Akers,

1999). Building upon the traditional deterrence model, rational choice theory couples perceived benefits of a criminal act with its perceived costs (Simpson, Piquero, & Paternoster, 2002). Offending then occurs when perceived benefits outweigh perceived costs. Jeremy Bentham's (1789) Principle of Utility recognizes the role of both pain and pleasure in human life, arguing that the hedonistic value of human action is calculated by considering the intensity, duration, certainty or uncertainty and its propinquity or remoteness (Bentham, 2004). Bentham argues that human acts are motivated by the achievement of pleasure and avoidance of pain (Bentham, 2004).

Crime can be seen as both offense-specific and offender specific by rational choice theorists. Crime is considered offense-specific as offenders react to the specific characteristics of particular crimes and offender-specific as not all persons decide to engage in crime. Because crime is offense-specific, rational choice theory argues that crime prevention/reduction can be achieved through guarding potential targets, controlling the means in which crime can be committed, and monitoring potential offenders (Seigel, 2002). Offenders are more likely to avoid criminal behavior if they believe that earnings from criminal behavior will be relatively low while legal and attractive opportunities for earning income are present (Seigel, 2002). At the same time, these same offenders may be more motivated when he or she knows somebody who has made a "big score" and are overall successful at crime (Seigel, 2002). Under rational choice theory, experience and learning aid in structuring criminal behavior, along with personality and lifestyle (Seigel, 2002). According to rational choice theories, all crime is structured by the place in which it occurs, characteristics of the target, and available means (Seigel, 2002).

Rational choice theory is presented as a general and all-inclusive explanation of the conscious decision to partake in crime as well as the decision to partake, or not partake, in a

criminal career. Cornish and Clarke (1986) contend that the decisions for both are based on an offender's expected effort and reward of partaking in crime in comparison to the likelihood and severity of punishment (Akers, 1999). Once a person has made up his or her mind to engage in criminal behavior, they choose their crimes based on the opportunities to commit particular crimes and if the benefits will outweigh the costs. In a study of repeat property offenders, Tunnell (1990; 1992) found that the threat of re-imprisonment was not a deterrent in further crime commission (as cited in Akers, 1999). Rather, offenders believed that income would be gained from their crimes without being caught, believed that they would not receive a long prison term if caught, and overall, did not fear prison time (Tunnell, 1990; 1992, as cited in Akers, 1999). These findings support the principles of rational choice theory, as for these offenders, expected benefits were perceived to outweigh the expected costs of crime, leading to the decision to commit crime. For Medicare providers, the opportunity is always present, as billing Medicare is a necessity in order to be paid. The decision to engage in criminal behavior is based on a myriad of factors, including, but not limited to, temperament, self-esteem, previous criminal experience and other factors specific to the crime itself. Perceived benefits of a crime under rational choice include little required effort, low required skill, available targets, expected high yield, and low risk of apprehension (Cornish & Clarke, 1986).

Hyman (2001) argues that those that perpetrate health care fraud only do so after rationally assessing both the costs and benefits. Those engaging in health care fraud calculate the probability of being caught and severity of sanctions by taking into consideration their knowledge of the law and probabilities of detection – typical deterrence variables (Hyman, 2001). Traditional (physicians perpetrating Medicare fraud through billing mechanisms) Medicare fraud can be understood within a cost-benefit framework, akin to corporate crime.

Physicians are generally not committed to crime as a way of life; rather, they chose his or her profession to help people. Like the majority of corporate crimes, Medicare fraud can be seen as being calculated, requiring planning and foresight rather than spontaneous or driven by emotion (Simpson, Piquero, & Paternoster, 2002). Rational choice theory can account for the inclusion of organized criminals in the typically white collar crime of Medicare fraud as they perceive that the benefits (ease in which money is "made") outweigh the potential sanctions that correlate with being caught compared to those sanctions of other typical organized crimes. Under rational choice theory, Medicare fraud can be alleviated by ensuring that costs outweigh the benefits to the offender.

Deterrence Theory

The traditional deterrence model of corporate crime can comfortably be extrapolated to health care fraud; it specifies that the greater the certainty of punishment, the less the likelihood of crime and the greater the severity of sanctions, the less likelihood of crime (Paternoster & Simpson, 2004). Deterrence theory offers that people will engage in criminal behaviors if he or she does not fear being caught or punished, and people will violate the law if left unrestricted (Seigel, 2002). In order for formal sanctions to be effective in deterring crime, they must be certain, immediate and proportionate to the crime committed.

Sparrow (2009) argues that the probability of being caught and convicted are more heavily considered in the decision to commit crime than the severity of punishment as criminals tend to believe that they will not face sentencing. Deterrence mechanisms are classified into two types: general or specific. Under the rational choice perspective, motivated people will violate the law if they are left free or unrestricted (Seigel, 2002). Under the concept of general deterrence, the threat of punishment can control the decision to commit crime (Seigel, 2002).

Specific deterrence focuses on the individual, rather than overall crime prevention. Under the theory of specific deterrence, legal sanctions should be so powerful that specific criminals will be discouraged from future criminal acts (Seigel, 2002).

Piquero and Tibbetts (2002) contend that individual characteristics can condition the effects of rational choice variables, arguing that those with strong moral inhibitions were less likely to be influenced by rational choice factors than those with weak moralities. Explaining why the possibility of criminal sanctions have deterrent effects on some offenders and not others, Sherman (1993, p. 449) theorized that sanctions have "opposite or different effects in different social settings, on different kinds of offenders and offenses" and have varied effects at "different levels of analysis." Often, those involved in Medicare fraud do so for a lengthy period of time before being caught – those indicted by the Medicare Strike Force were generally charged with defrauding Medicare of millions of dollars, indicating that the fraud had been going on for lengthy periods of time. Stafford and Warr (1996) contend that it is possible that the avoidance of formal sanctions may do more to encourage crime than sanctions do to discourage it. Providers that engage in Medicare fraud for periods of time without being caught may eventually come to think that they are invulnerable. Stafford and Warr (1996) highlight the notion that criminals always experience punishment or punishment avoidance, both of which affect behavior.

One argument for the deterrability of corporate crime is the nature of the offense - like corporate crime, Medicare fraud schemes are strategic and calculated (Paternoster & Simpson, 2004). A dedicated Medicare fraud unit which is not just focused on "hot spots" of fraudulent billing patterns post-payment will increase the likelihood that providers engaging in Medicare fraud nationwide are caught, increasing the swiftness of punishment and theoretically

diminishing any thoughts of invulnerability as increasing amounts of providers are caught. It would lead that if the formal sanctions imposed on those perpetrating Medicare were swifter and harsher, mobsters and physicians alike may be more deterred than they currently are.

Phase one of the Medicare Strike Force operations in 2007, focusing on billing schemes in Miami, resulted in an overall reduction in both billings and payments for Medicare Part B services during the strike force period when compared to the same period of time a year prior. The increased threat of prosecution and conviction exhibited through the strike force activities most likely served as a general and specific deterrent to Medicare billing fraud. While phase one of the Medicare Strike force lasted only seven months (no comprehensive data is available for the following phases), a unified and dedicated Medicare fraud unit based on the success of past Medicare strike force operations would facilitate faster detection of aberrant Medicare billing patterns leading to faster detection and prosecution of fraudulent Medicare providers.

Routine Activities

Within routine activities theory are found elements of both deterrence and rational choice theories. For crime to occur, criminals, victims and targets must all be present (Akers, 1999). Cohen and Felson further identify these three variables as motivated offenders, suitable targets, and capable guardians (Cohen & Felson, 1979). Cohen and Felson (1979) argue that the rate of criminal victimization increases when there is a convergence in space and time of these three elements. Cohen and Felson assume that the motivation to commit crime and the supply offenders are constant factors, as every society is comprised of those willing to commit crime to fulfill his or her motives (Seigel, 2002). Crime rates are proportionate to the availability of suitable targets, absence of capable guardians and presence of motivated offenders. Poorly

guarded targets are more likely to be victimized when they are exposed to a myriad of motivated offenders.

Cohen and Felson (1979) argue that crime is the product of the routine activities of everyday life for both offenders and victims. Daily activities of the workplace separate people from those they trust and things they value; routine activities often bring people of different backgrounds together in the presence of tools and facilities which aid in partaking in, or desisting from, criminal activity (Cohen & Felson, 1979). Routine activities theory argues that timing of schooling, work and leisure are pertinent in explaining crime rates. In a study of hot spots of predatory crime, Sherman et al. (1989) found that most crime reports came from only three percent of all locations in Minneapolis, and that the reports of each major type of predatory crime were only concentrated in a few locations (as cited in Akers, 1999). While Sherman et al. could not determine what exactly made these locations hot spots for crime, they argued that there must be something relating to the convergence of both victims and offenders in the absence of guardians (as cited in Akers, 1999). Like these hot spots of predatory crime, Medicare fraud has shown up in hot spots nationwide, as seen in Detroit and Miami strike force activities.

The literature has illustrated how relatively easy it is for a person to submit a falsified claim to Medicare; upfront, there are virtually no capable guardians protecting Medicare from motivated offenders. The planning of Medicare fraud incorporates the presence of available targets - the Medicare reimbursement program; the absence of capable guardians – virtually no proactive safeguards on Medicare fraud from the initial billing process; and motivated offenders – Medicare fraud has been shown to be an easy and fast way to "make" money. Historically, rogue physicians and providers in the medical field have perpetrated Medicare billing fraud; billing Medicare for services provided to Medicare beneficiaries is a required regular and routine

activity of his or her profession. Programs and targets like Medicare are most likely to become victims if they are not sufficiently guarded while being exposed to motivated offenders. As long as the threat of being caught is relatively low, while payouts are fast and easy, it would seem that criminals will continue to perceive the Medicare program as being a suitable target.

Reducing the attractiveness of the Medicare program as a suitable target is required in order to reduce the prevalence of Medicare billing fraud. Tightening the restrictions on who can obtain and maintain Medicare provider numbers, or National Provider Identifier (NPI) numbers, is a basic necessity; without a valid Medicare provider number, a person cannot bill the Medicare program. Indeed, as far back as 1997, Michael Mangano, Principal Deputy Inspector General of HHS, testified before the Senate Committee on Governmental Affairs, Permanent Subcommittee on Investigations, arguing that one of the best ways to prevent Medicare fraud is to keep illegitimate providers from ever gaining access to the program (Mangano, 1997). Further, a prepayment focus on fraud detection, rather than the current post-payment methods utilized, combined with stronger penalties for fraudulent activity would act as a guardian of the Medicare program to lessen the allure of defrauding the Medicare program.

Conclusion

Medicare billing fraud results from learned behaviors by those who have made conscious decisions to improperly bill Medicare based on rational choices or routine activities of the healthcare industry. Both rational choice and routine activity theories offer that in order to reduce the incidence of Medicare fraud, it needs to be unfavorable to the would-be offender. In order to deter Medicare fraud, strengthened measures must be implemented in order to control who can obtain and maintain the provider number necessary to bill Medicare along with increased scrutiny to claims before they are ever paid. Increasing the overall swiftness, certainty

and severity of punishment of fraud will aid in deterring it, achieved through implementation of an expanded and permanent model of the Medicare Task Force.

SECTION IV: SUMMARY, RECOMMENDATIONS AND CONCLUSION

The Medicare program loses as much as $60 billion annually to fraud, despite the government's hardest efforts at combating Medicare fraud for over a decade (CBS News, 2009). In 1993, Janet Reno declared health care fraud one of the biggest crime problems in America, yet nearly two decades later the problem persists (Sparrow, 2008). Literature provides no sole solution for ending the rampant fraud affecting the Medicare program. Medicare fraud is largely detected on a post-payment basis, with very few mechanisms in place to detect fraudulent claims before they are actually paid by the Medicare contractor. Sparrow (2008) attributes widespread Medicare fraud to the highly automated claims-processing systems utilized by Medicare coupled with the fact that these systems are not created to account for fraudulent submissions. In his testimony before the Senate Subcommittee on Criminal Prosecution as a Deterrent to Health Care Fraud, Sparrow (2009) summarizes the ease in which Medicare fraud is perpetrated, "if you want to steal from Medicare...learn to bill your lies correctly. Then, for the most part, your claims will be paid in full and on time, without a hiccup, by a computer, and with no human involvement at all."

It is clear from the literature that the Medicare reimbursement program is flawed by design. There are a myriad of changes that must be made in order to make defrauding Medicare a less lucrative business for criminals and unethical providers, from pre-payment through post-payment processes. The simplest solution would require Medicare to pay beneficiaries directly, who would in turn pay providers for services actually provided. However, placing the burden on the elderly and disabled beneficiaries to make sure correct bills are obtained from their providers, submitted to Medicare, and then paid to providers is most likely not a feasible solution.

The recommendations to reduce the incidence of Medicare billing fraud must be directed at the core of the problem, as previously identified in the rational choice, routine activity and deterrence theories. Under rational choice theory, the costs of the crime must outweigh the benefit of the crime in order to mitigate Medicare billing fraud. The major costs associated with this particular crime include the probability of being caught and the severity of the sanctions associated with being caught. Like rational choice theory, deterrence theory offers, in part, that the greater the certainty of punishment and the greater the severity of sanctions, the less the likelihood of crime (Paternoster & Simpson, 2004). There is a clear need to increase the severity of sanctions imposed on those convicted of fraudulently billing Medicare fraud. To increase the probability of being caught, current claim pre-payment anti-fraud measures must be strengthened. Implementing a unified and permanent Medicare task force will aid in detecting fraudulent Medicare claims.

Under routine activities theory, crime is the result of the presence of motivated offenders, suitable targets and the absence of capable guardians (Cohen & Felson, 1979). Medicare is a suitable target due to the ease in which money can be obtained by fraudulent billing, the small chance that the criminal will be caught and convicted, and the relatively small prison sentence that would be associated with an eventual conviction. To reduce the incidence of Medicare fraud under routine activities theory, Medicare must be properly guarded through implementation of a dedicated Medicare task force. Implementation of this task force will decrease the chance of criminals seeing Medicare as a suitable target.

In his testimony before the United States Senate, Lanny Breuer acknowledged that through the Medicare Strike Force, fast apprehension and punishment of those defrauding Medicare is critical in deterring others, though is not the sole solution to stopping Medicare

fraud; criminals must be prevented from accessing federal health care programs to begin with (Breuer, 2009). The following recommendations are necessary in utilizing the current system while alleviating the widespread billing fraud found in the Medicare program.

A. Exclude criminals from participating in the Medicare program.

DME fraud is a big problem, yet CMS only requires those applying for DME supplier licenses to report whether they have been convicted of a felony offense within the past 10 years. In an effort to control widespread DME fraud, CMS has enacted a $50,000 surety bond requirement for DME suppliers, though an additional $50,000 bond amount may be required if the supplier has had an adverse action, including any felony conviction, imposed against it within the past 10 years (Centers for Medicare & Medicaid Services, 2009). For the determined criminal, the $50,000 to $100,000 bond may not be much of a deterrent, while those already in the process of defrauding Medicare could simply choose not to continue with his or her supplier status, and terminate their status as a Medicare DME supplier – and reenroll once they have met the requirements, which often include on-site visits.

Routine activities theory argues that the absence of capable guardians is necessary for criminal acts to occur (Cohen & Felson, 1979). Removing legitimate access from convicted felons to bill Medicare is one step in ensuring that Medicare is properly guarded against fraud. For a system rifled with fraud, providers with any felony convictions, no matter how long ago it may have occurred or what it was for, should be permanently barred from participating in the Medicare program.

B. Create one unified front to prevent, identify and prosecute Medicare fraud

Currently, the mechanisms in place to prevent, identify and prosecute Medicare fraud are distinct and complex. Prevention mechanisms are largely based on the education of beneficiaries through CMS and SMP activities. Medicare billing fraud is identified through PSCs, SMP assistance, whistle blowers, HEAT operations, and beneficiaries (amongst other methods) and then referred to law enforcement agencies for prosecution. Sparrow (2000, p. 211) contends that "a collection of loosely connected functional components cannot constitute a coherent fraud-control strategy." Medicare's current fraud controls are just that – loosely connected. The first Medicare Fraud Strike Force of 2007 in Miami served as a model for future Medicare fraud enforcement as the strike force operations were expanded to additional phases in additional cities. While the operation in Miami has, to date, provided the biggest numbers in regards to charges and dollars recovered, many cases from phases two and on are still pending.

To be a true deterrent, actions against those fraudulently billing Medicare must be certain and swift. Under rational choice theory, if the costs of Medicare fraud (the certainty of being caught) outweigh the benefits, fraud is less likely to occur. Statistics from the Miami strike force operations are an indication that actions against those fraudulently billing Medicare are certainly not swift, as a majority of those apprehended had already falsely billed Medicare out of millions of dollars individually (U.S. Department of Health and Human Services and U.S. Department of Justice, n.d.). Strike force activities have been focusing on one or two types of billing fraud, mostly DME and Home Health services. The success stories of arrests are widely announced in the media shortly after arrests are made, providing detailed information about the nature of the fraud and where it occurred. Therefore, somebody fraudulently billing for other types of services safely outside of the arrest area most likely would feel somewhat safe. The Medicare task force

must make it known that any provider in any location is not safe from being investigated for fraudulent claim submission. Lanny Breuer (2009) has testified before Congress, acknowledging that the current strike force model focuses resources on the regions showing the highest levels of Medicare fraud. Resources must be made available to all regions, as just because a pattern has not yet been identified does not mean there is underlying fraud occurring.

While strike force activities have helped serve as a capable guardian to the Medicare program in specific operational locations, overall, there is no distinct capable guardian to the Medicare program. Sparrow (2000) argues that in order for anti-fraud measures to be efficient, somebody has to be in control. Currently, there is no single entity overseeing the entire operation of fighting Medicare fraud. There are two major entities involved in identifying Medicare fraud; the PSCs and ZPICs, which are based on contracts awarded to companies in the private sector, and HEAT, which also works in the apprehension of those defrauding Medicare. An expansion of HEAT into a permanent model that includes the work done by PSCs and ZPICs would provide a unilateral front in the government's fight against Medicare fraud by combining prevention, identification and prosecution measures in one place, essentially serving as a guardian to the Medicare program.

Rational choice theory offers that in order to deter Medicare fraud, the risk of being identified and prosecuted must be high for criminals. When potential targets are guarded, the means to commit criminal acts are controlled, and potential offenders are monitored, crime is less likely to happen (Seigel, 2002). Implementing one unified task force that is constantly looking at the claims data and acting on inconsistencies in real time would increase the probability of violators being caught and prosecuted. A 2008 GAO report on the strike force activities in Miami-Dade County recognized that while Medicare payments in this county were

twice the national average, they were just as high in 23 counties nation-wide (2009). The OIG report merely recommends that these findings warrant additional review; in light of the massive arrests and findings of fraud in Miami-Dade County, a mere recommendation seems weak. The permanent Medicare task force would have the resources to immediately act on this information, rather than putting it aside until current operations have subsided.

C. Strengthen Pre-payment Measures

The automated way in which Medicare claims are processed, combined with the time in which they have to be paid, leaves little room for identifying fraudulent claims before money is lost to criminals. No current system is in place that allows one to view all pending or paid claims data to be viewed, though CMS estimates one will be in place by 2014 (Blesch, 2009). That simply is not soon enough. Senator Chuck Grassley of Iowa has introduced the Fighting Medicare Payment Fraud Act of 2009, which expands the time in which claims can be paid to 365 days (compared to the current 30 days) for claims in which there is a likelihood of fraud, waste or abuse (Medicare Update, 2009). Implementation of a system that provides a complete overview of all Medicare claims data nation-wide while providing more time for investigations prior to payment are both essential components of a fully-functional anti-fraud program. This system would help increase the probability of fraudulent claims being identified and investigated. As the probability of being caught is one important factor in a person's decision to partake in criminal behavior under rational choice theory, it is essential to ensure that every effort is made to enhance pre-payment methods to catch fraudulent claims before they are paid.

From the literature, it is clear that the current pay-and-chase methodology of Medicare is not working. While there are obvious constraints on implementing a fully functional system to view all claims data, the federal government has access to a vast amount of resources which need

to be utilized in order to implement this system as soon as feasibly possible. To wait another four years would be irresponsible in light of the massive amount of fraud within the Medicare system.

Further, changes must be made to the Medicare payment system's current methodology of merely denying claims when data does not match up. Claims for deceased providers or beneficiaries, incarcerated beneficiaries or that contain conflicting data are automatically denied, with a message relayed to the provider as to why the claim was denied. The provider can then make the necessary changes and resubmit the claim. Claims such as these should be immediately flagged for review for fraud rather than assuming the provider made a clerical error. It is known that those perpetrating Medicare fraud purchase lists of provider numbers and beneficiary numbers in order to falsely bill Medicare (Sparrow, 2008). It is not unreasonable for claims billed with obvious errors to be manually reviewed to consider the possibility that while 99% of a provider's claims appear to be valid, there is underlying fraud occurring. The financial implications of putting more money into manual review and investigation for fraud should not be an issue in light of the billions of dollars that are lost annually when virtually nothing is being done. The better the prevention and identification measures, the less lost in fraud.

D. Strengthen Sentences

To be a true deterrent, sanctions must be certain, swift and proportionate to the committed crime. Implementing the aforementioned recommendations will aid in assuring that sanctions are certain and swift. Strengthened sentences for those found guilty of fraudulently billing Medicare are necessary in removing the allure of Medicare as a target. Much of the literature indicates that criminals turn to Medicare due to relatively short prison sentences if caught. Those convicted and sentenced as a result of strike force activities in Miami-Dade

County received an average prison sentence of 48.8 months (U.S. Department of Health and Human Services and U.S. Department of Justice, n.d.). In comparison, the average sentence for crack cocaine offenders in 2008 was 114.5 months (United States Sentencing Commission, 2009). Rational choice and deterrence theories both offer that to deter Medicare fraud, sanctions must be severe. Increasing prison sentences for those convicted of Medicare billing fraud is necessary in deterring criminals from targeting the Medicare program while increasing the perceived costs and reducing the perceived benefits.

Conclusion

Medicare fraud is so prevalent for three reasons: it is "easy money," the risk of being caught is low, and prison sentences are shorter compared to other crimes (The Associated Press, 2009). It is imperative that the allure of the Medicare program as a target for fraud be removed in order to deter criminals. A permanent and unified Medicare fraud unit operating all anti-fraud activities would serve as a capable guardian to the Medicare program. In order to be fully functional, this unit needs access to all Medicare claims data nationwide, to include pending and paid claims, and sufficient time to allow for investigation before a claim is paid. Strengthening prepayment measures to consider questionable claims as fraudulent ones, rather than clerical errors will aid in transferring anti-fraud activities from purely post-payment to pre-payment, resulting in less dollars lost through fraudulently paid claims.

Excluding providers with any felony conviction reduces the risk of fraud to the Medicare program, while increasing penalties for those found guilty of Medicare fraud will serve as a general and specific deterrent to would-be criminals. The currently fragmented system cannot continue as is; strides must be made to repair this broken system in order to protect it from being a continued target for abuse. Implementation of these strategies are vital to the continued existence of the Medicare Trust Fund and the resulting availability of Medicare benefits for generations to come.

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APPENDIX A

The False Claims Act ("FCA") provides, in pertinent part, that:

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government;. . . or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

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is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages that the Government sustains because of the act of that person . . . .

(b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729. While the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 31 U.S.C. 3729(b).

In sum, the False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. An example may be a physician who submits a bill to Medicare for medical services she knows she has not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor who submits records that he knows (or should know) is false and that indicate compliance with certain contractual or regulatory requirements. The third area of liability includes those instances in which someone may obtain money from the federal government to which he may not be entitled, and then uses false statements or records in order to retain the money. An example of this so-called "reverse false claim" may include a hospital that obtains interim payments from Medicare throughout the year, and then knowingly files a false cost report at the end of the year in order to avoid making a refund to the Medicare program.

In addition to its substantive provisions, the FCA provides that private parties may bring an action on behalf of the United States. 31 U.S.C. 3730 (b). These private parties, known as "*qui tam* relators," may share in a percentage of the proceeds from an FCA action or settlement.

Section 3730(d)(1) of the FCA provides, with some exceptions, that a qui tam relator, when the Government has intervened in the lawsuit, shall receive at least 15 percent but not more than 25 percent of the proceeds of the FCA action depending upon the extent to which the relator substantially contributed to the prosecution of the action. When the Government does not intervene, section 3730(d)(2) provides that the relator shall receive an amount that the court decides is reasonable and shall be not less than 25 percent and not more than 30 percent.

The FCA provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

(U.S. Department of Health and Human Services, n.d.)

APPENDIX B

2008 Accomplishments of the Health Care Fraud and Abuse Control Program

- DME company owners were sentenced for conspiring to defraud the Medicare program by submitting false claims for medically unnecessary DME items and supplies, including aerosol medications and oxygen concentrators. The companies paid kickbacks to a physician previously investigated by HHS/OIG, and to several Medicare beneficiaries in order to use their Medicare numbers to submit the fraudulent claims. The 13 convicted DME company owners involved in the scheme were ordered to pay a total of more than $6.4 million in restitution and $132,000 in fines and assessments. The 13 subjects were also sentenced to various terms of imprisonment, probation, and/or home detention, the longest prison sentence for the case being 6 years and 6 months.

- An Ohio physician was sentenced to 37 months in prison after pleading guilty to conspiring to engage in a scheme to defraud Medicare and other health care benefit programs by performing medically unnecessary nuclear stress tests that involved injecting nuclear medicine into patients. During the conspiracy, the physician received at least $1.8 million in reimbursement for the medically unnecessary tests. As part of his guilty plea, the physician agreed to give up his medical license, to forfeit more than $1.8 million, and to be permanently excluded from participation in all federal health care programs.

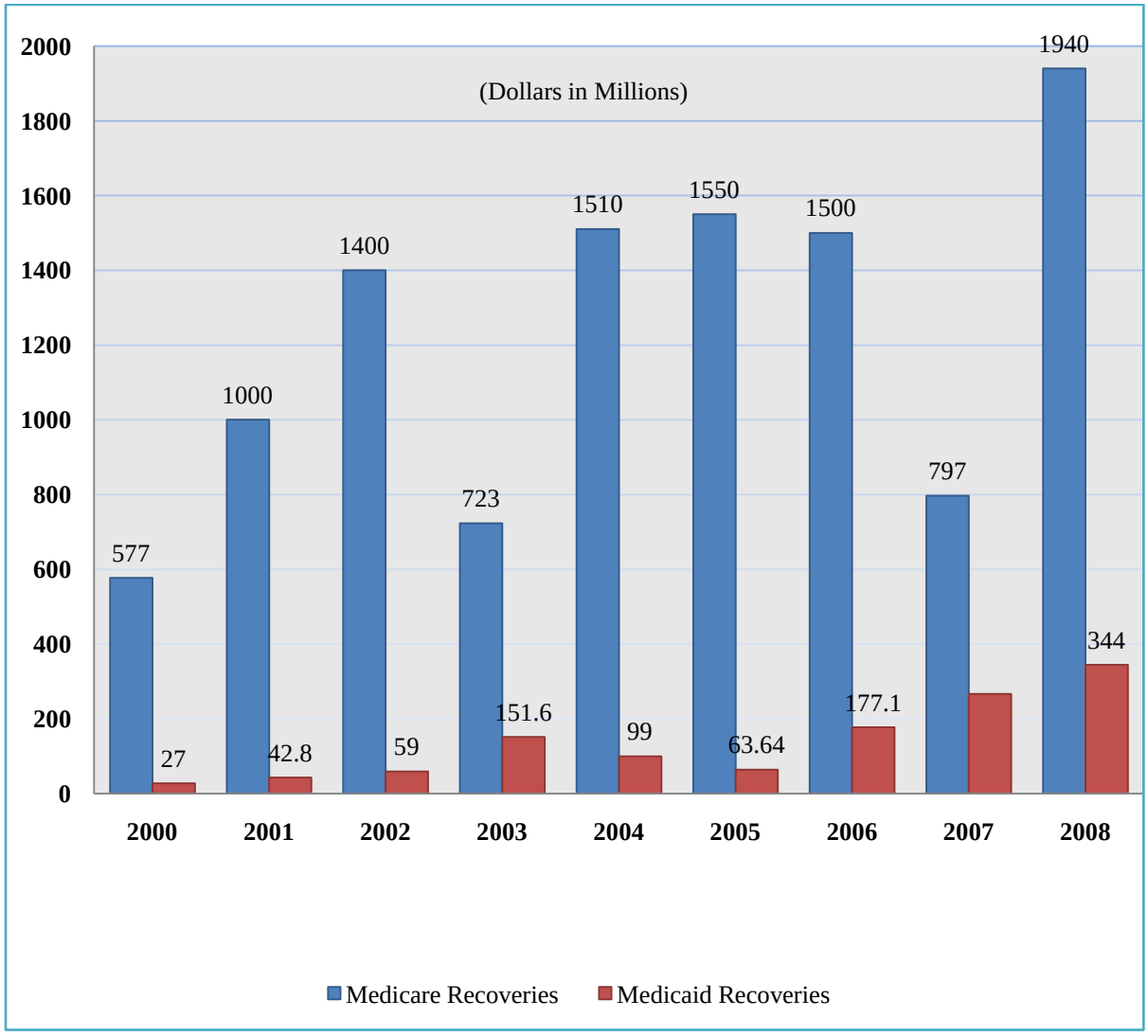
- A Federal jury in Miami convicted the owner of two DME companies for his role in a $4.6 million Medicare fraud scheme and for money laundering. The owner billed the Medicare program for negative pressure pumps, wound care supplies, and other DME. Physicians testified at trial that they never prescribed the types of equipment for which Medicare was billed in the scheme. Other witnesses testified that the defendant opened DME companies in the names of nominee owners and brokered the purchase and sale of DME companies for the purpose of "burning Medicare" by submitting high volumes of fraudulent claims submitted within a two- to three-week time period. The defendant was sentenced to a 130-month term of imprisonment and ordered to pay restitution of nearly $2 million. After being placed on home confinement with electronic monitoring, the defendant violated the terms of his post-trial release and fled the country. Another co-defendant also remains a fugitive.

- A physician's assistant pleaded guilty and was sentenced to 14 years of imprisonment for his part in $119 million HIV infusion fraud conspiracy; three other co-defendants remain fugitives. The physician's assistant admitted to training physicians at eleven fraudulent HIV infusion clinics to prepare and submit medically unnecessary HIV infusion services that were allegedly administered to Medicare patients. He also admitted to overseeing the documentation of fraudulent services to make it appear that the clinics provided legitimate services, and to knowing that the infusion treatments billed at the clinics were medically unnecessary and/or were never provided.

(U.S. Department of Health and Human Services and U.S. Department of Justice, 2008)

APPENDIX C

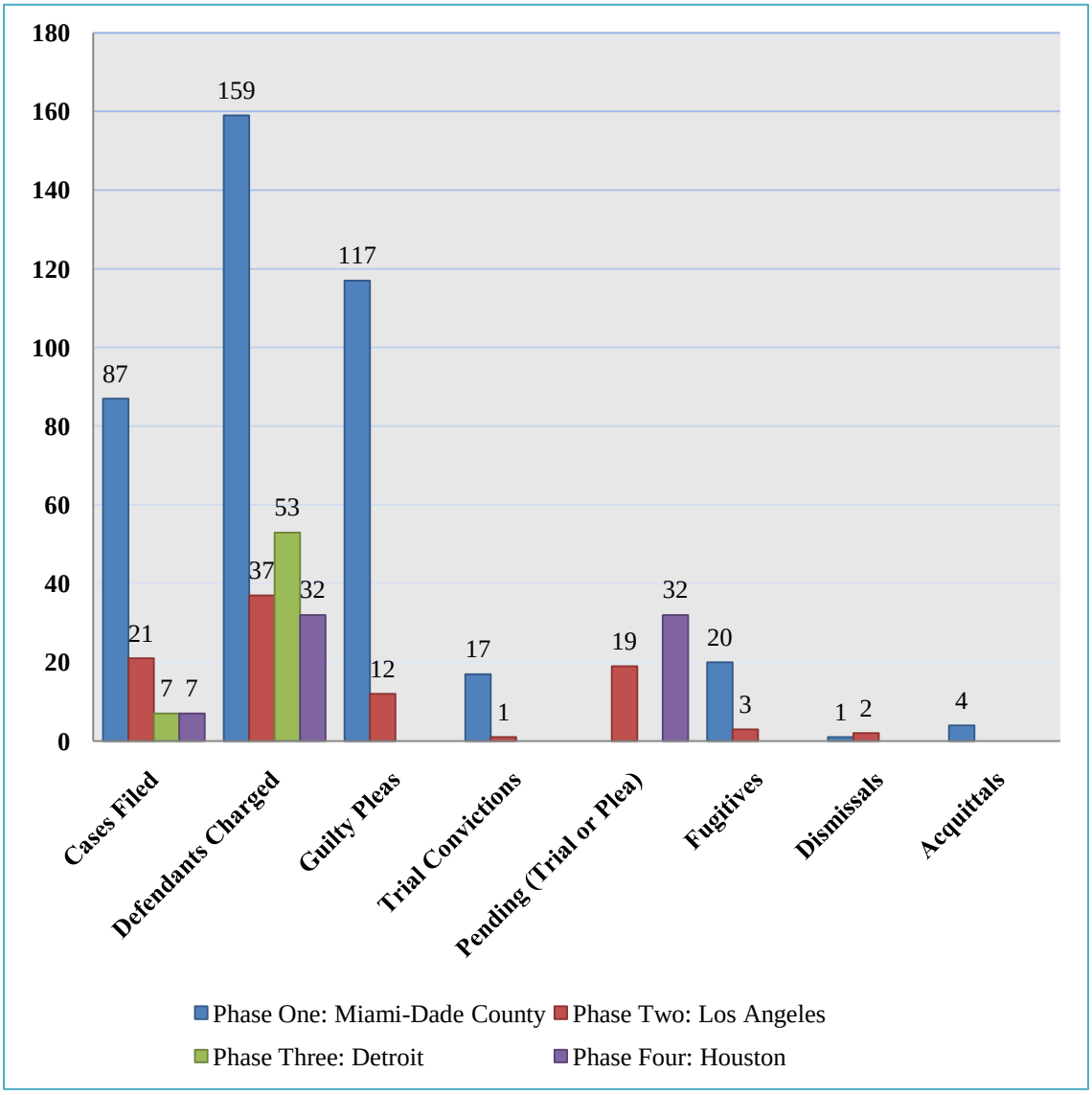
Federal Health Care Fraud and Abuse Program Recoveries by Fiscal Year[1]



[1] Chart compiled with data published in the Health Care Fraud and Abuse Control Program Reports from FY 2000-2008 available at http://www.oig.hhs.gov/publications/hcfac.asp

APPENDIX D

Key Accomplishments of Medicare Task Force: Phases One through Four[2]



[2] Chart made with data published in the HEAT Task Force Fact Sheets Phases One through Four available at http://www.stopmedicarefraud.gov/heatsuccess/

APPENDIX E

Commonly Used Terms

Acronym	Definition
AoA	U.S. Administration on Aging
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DME	Durable Medical Equipment
DoD	Department of Defense
DOJ	Department of Justice
DRG	Diagnosis-related Group
ESRD	End Stage Renal Disease
FBI	Federal Bureau of Investigation
FCA	False Claims Act
FFS	Fee For Service
FI	Fiscal Intermediary
GAO	General Accountability Office
HCFA	Health Care Financing Administration
HCFAC	Health Care Fraud and Abuse Control program
HCPCS	Healthcare Common Procedure Coding System
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHA	Home Health Agency
HHS	U.S. Department of Health and Human Services
ICD-9	International Classification of Diseases, 9th Edition/Revision
IPPS	Inpatient Prospective Payment System
MFCU	Medicaid Fraud Control Unit
MIP	Medicare Integrity Program
MSN	Medicare Summary Notice
OIG	Office of Inspector General
OPPS	Outpatient Prospective Payment System
PI	Program Integrity
PPS	Prospective Payment System
PSC	Program Safeguard Contractor
SMP	Senior Medicare Patrol Programs
SNF	Skilled Nursing Facility