



# HEALTH CARE FRAUD REPORT



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## Thieves and Beggars in an Aggressive Medicare Fraud Enforcement Climate

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**T**he Medicare and Medicaid programs are the largest purchasers of health care in the world.<sup>1</sup> By 2019 national health spending is expected to reach \$4.5 trillion and the public share of total health care spending is expected exceed 50 percent by 2012.<sup>2</sup>

It's no wonder government health care programs are seductive targets for health care fraud, particularly in light of the ease of entry, profitability, and lower criminal penalties for crimes related to health care fraud.<sup>3</sup>

The cost-balance ratio when comparing life in prison for dealing cocaine against a possible decade in prison

and fine for Medicare fraud has enticed even Mafia figures to foray into the world of Medicare fraud.<sup>4</sup>The lead attorney at the Department of Health and Human Services Office of Inspector General has been quoted as stating that “[b]uilding a Medicare fraud scam is far safer than dealing in crack or dealing in stolen cars, and it’s far more lucrative.”<sup>5</sup>

Therefore, in a bipartisan effort, Congress, the Obama administration, and law enforcement agencies, including the Department of Justice and HHS, are ramping up preventive and punitive measures to curtail fraud and abuse in public health care programs and to combat the thieves.

But while the rally cry is made against thieves, legitimate health care providers could quickly become beggars in the Medicare and Medicaid system as providers experience lower payments, increased costs, and the potential to be drawn into fraud and compliance investigations based on regulatory and reimbursement rules that are not always clear.

Consequently, as all signs point to increased scrutiny and audits, health care providers should use this opportunity to get their compliance house in order and prepare now for the enhanced scrutiny to come.

### Anti-Fraud Measures in Health care Reform

Apart from the health reform legislation that was passed recently, however, certain elements with bipartisan support continue to push forward in separate bills, such as Sen. Charles Grassley’s (R-Iowa) fraud and abuse deterrence bill, the “Strengthening Program In-

<sup>1</sup> See Stephen M. Blank, Justin Alexander Kaspisin, and Allison C. White, *Health Care Fraud*, 46 AM. CRIM. L. REV. 701 (citing A Closer Look: Inspectors General Address Waste, Fraud, Abuse in Federal Mandatory Programs: Hearing Before the House Comm. on Budget, 108th Cong. 82 (2003) (testimony of Dara Corrigan, Acting Principal Deputy Inspector Gen., Dep’t of Health and Human Services (HHS)).

<sup>2</sup> See CMS, National Health Expenditure Projections 2009-2019, available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2009.pdf> (last visited March 17, 2010).

<sup>3</sup> *OIG’s Law Enforcement Activities to Combat Medicare and Medicaid Fraud*, before the House Committee on the Judiciary, Subcommittee on Crime, Terrorism, and Homeland Security, Mar. 4, 2010. (statement of Timothy J. Menke, Deputy Inspector General for Investigations for the HHS OIG) [hereinafter Menke Statement].

<sup>4</sup> Kelli Kennedy, *Mafia, violent criminals turn to Medicare fraud*, S. F. CHRON., Oct. 6, 2009, available at <http://www.sfgate.com/cgi-bin/article.cgi?f=/n/a/2009/10/06/national/a112020D80.DTL>.

<sup>5</sup> *Id.*

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tegrity and Accountability in Health Care Act” (S. 2964), introduced Jan. 28.

This 100+ page bill, in Grassley’s words, “brings together common sense, bipartisan initiatives to fight fraud, waste, and abuse in taxpayer-sponsored health-care programs.”<sup>6</sup>

Grassley states his bill includes provisions that would: “deter fraud with enhanced screening to improve the government’s ability to keep fraudulent providers from participating in these programs from the start; limit tax dollars lost to fraud by giving the government more time to evaluate the legitimacy of Medicare providers before payment is required when fraud, waste and abuse is suspected that is allowed under the existing pay-and-chase model; strengthen the government’s ability to detect fraud with better disclosure requirements; enhance coordination among federal agencies responsible for fighting fraud, including sharing data sources; and, improve enforcement capabilities by expanding the range of activity subject to penalties and toughening existing penalties.”<sup>7</sup>

The bill includes a wide variety of very specific anti-fraud and recovery provisions. For example, Section 102 includes a requirement that overpayments should be reported and returned no later than 60 days “after the date on which the overpayment was identified or the date on any corresponding cost report is due” or else face the threat of liability under the False Claims Act.<sup>8</sup>

The bill also proposes to extend civil monetary penalties to individuals who have been excluded from a Federal health care program and who order or prescribe items in violation of their exclusion; individuals who make false claims in their enrollment applications, bids, or contracts to participate in a federal home health program; or persons who know of an overpayment and fail to return it.<sup>9</sup>

Grassley’s bill also increases funding for the Health Care Fraud and Abuse Control Account by \$10 million each year from 2011 to 2020,<sup>10</sup> and expands the RAC (recovery audit contractor) program to Medicaid and Medicare Part C (managed care) and Part D (prescription drug benefit) by December 2010.<sup>11</sup>

While no one will argue the merits of combating fraud, some of the provisions appear destined for disputes and as fodder for future case law unless there comes some common sense approach to their application.

The potential reach of a civil money penalty (CMP) to a person who knows of an overpayment and fails to return it can be very long and rife with unintended consequences. In addition, the penalties proposed with the CMPs are greater than what exists as stipulated penalties for similar conduct in some Corporate Integrity Agreements for providers who have run afoul of the program requirements.

<sup>6</sup> Senator Grassley Press Release, “Grassley fights fraud, waste and abuse in Medicare, Medicaid, CHIP” available at [http://grassley.senate.gov/news/Article.cfm?customel\\_dataPageID\\_1502=25015](http://grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=25015). (Jan. 28, 2010) [hereinafter Grassley Press Release].

<sup>7</sup> *Id.*

<sup>8</sup> S. 2964, 111th Cong. § Sec 102 (2010).

<sup>9</sup> *Id.* § 102

<sup>10</sup> *Id.* § 102.

<sup>11</sup> *Id.* § 110.

The Grassley bill serves as an example that even without comprehensive health reform legislation, certain bipartisan elements will likely live on. Hence, the health care industry can expect reincarnations of reform legislation in other forms, such as regulation, demonstration projects, stand-alone bills, and, as indicated in the President’s State of the Union address, a willingness to deploy executive orders.<sup>12</sup>

### The President’s Proposal to Combat Fraud, Abuse

The White House is also pressing health care fraud as a reason for health reform. In advance of the bipartisan health reform summit held on Feb. 25, the White House released a health care proposal which, among other things, builds on fraud and abuse elements contained in the House and Senate reform plans while also proposing additional provisions.<sup>13</sup>

Some of the key fraud and abuse provisions of the proposal include the following:

#### *Registration and Background Checks of Billing Agencies and Individuals.*

Such a measure would ensure the entities billing Medicare on behalf of providers are in good standing. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill)).

#### *Liability of Medicare Administrative Contractors for Claims Submitted by Excluded Providers.*

The President’s focus isn’t just on the providers, but also the government contractor’s paying for Federal programs. The President’s Proposal holds Medicare Administrative Contractors accountable for payment made to individuals or entities excluded from the federal programs or items or services for which payment is denied. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill)).

#### *Limiting Debt Discharge in Bankruptcies of Fraudulent Health Care Providers or Suppliers.*

The President supports limiting the ability of fraudulent health care providers from discharging amounts due to the secretary of health and human services for overpayments through bankruptcy proceedings. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill)).

#### *Illegal Distribution of a Medicare or Medicaid Beneficiary Identification or Billing Privileges.*

The President proposes to adopt hefty sanctions for individuals who knowingly, intentionally, and with intent to defraud Medicare and Medicaid, purchase, sell or distribute Medicare beneficiary identification numbers or billing privileges. These sanctions in-

<sup>12</sup> Press Release, The White House, Remarks by the President in State of the Union Address, Jan. 27, 2010, available at <http://www.whitehouse.gov/the-press-office/remarks-president-state-union-address>. (“More importantly, the cost of Medicare, Medicaid, and Social Security will continue to skyrocket. That’s why I’ve called for a bipartisan fiscal commission . . . Now, yesterday, the Senate blocked a bill that would have created this commission. So I’ll issue an executive order that will allow us to go forward, because I refuse to pass this problem on to another generation of Americans.”)

<sup>13</sup> The President’s Proposal, *Policies to Crack Down on Waste, Fraud and Abuse*, available at <http://www.whitehouse.gov/health-care-meeting/proposal/whatsnew/waste-fraud-abuse> (Feb. 22, 2010).

clude jail time. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill)).

#### *Medicaid Prescription Drug Profiling.*

The President proposes requiring States to monitor high-risk billing activity to identify prescribing and utilization patterns that may indicate abuse or unnecessary prescription drug utilization. (Source: President’s FY 2011 Budget).

#### *Modify Certain Medicare Medical Review Limitations.*

The President’s proposal wishes to modify limitations on random medical review and the application of Medicare prepayment review by Medicare Administrative Contractors prior to the payment of Medicare Part A and B claims. These modifications change the limitations placed on these types of review by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. (Source: President’s FY 2011 Budget).

#### *Use of Technology to Expand Access to Databases and Enable Real-Time Data Review.*

- o The President wishes to speed access to claims data to provide real-time data analysis and help identify potentially fraudulent payments more quickly. (Source: Roskam Amendment offered in House Ways & Means Committee markup).<sup>14</sup>
- o The President proposes expanding access to the health care integrity data bank to quality control and peer review organizations and private plans in order to improve coordination and information sharing in anti-fraud efforts. (Source: H.R. 3970, “Medical Rights & Reform Act” (Kirk bill)).
- o The President wishes to create a comprehensive Medicare and Medicaid sanctions database which allows law enforcement access to a centrally located cache of information regarding past sanctions on providers, suppliers and other related entities. (Source: H.R. 3400, “Empowering Patients First Act” (Republican Study Committee bill)).
- o The President proposes a CMS and IRS collaboration to match data regarding delinquent tax debt to help identify potentially fraudulent providers faster. (Source: President’s FY 2011 Budget).

In addition to these measures, on March 10, the President announced his intention to sign a presidential memorandum directing all federal departments and agencies to “expand and intensify their use of payment recapture audits under their current authority.”<sup>15</sup> Payment recapture audits are known for providing private auditors “bounty-hunter style” financial incentives to find improper payments made in error or through fraud.<sup>16</sup> The President anticipates that using such au-

<sup>14</sup> *Id.*

<sup>15</sup> Press Release, The White House, President Obama Announces New Effort to Crack Down on Waste and Fraud, Mar. 10, 2010, available at <http://www.whitehouse.gov/the-press-office/president-obama-announces-new-effort-crack-down-waste-and-fraud>.

<sup>16</sup> Laura Meckler and Greg Hitt, President Orders Expanded Audits, WSJ, Mar. 9, 2010 available at <http://>

dit will return at least \$2 billion over the next three years.

In sum, the Obama administration has repeatedly announced its “zero tolerance” policy for fraud and abuse in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP).<sup>17</sup> The Obama administration is trying to put its money where its mouth is: the President’s budget requests \$1.7 billion for fraud fighting at HHS.<sup>18</sup> Of this amount, \$561 million of the budget is allocated in discretionary funding for Health Care Fraud and Abuse Control—\$250 million more than the 2010 fiscal year enacted level, and almost three times the amount funded for the same program in 2009.<sup>19</sup>

These additional resources will, among other things, expand the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, increase Medicaid audits, and strengthen program oversight.<sup>20</sup>

The White House estimates that this investment in fighting fraud will supplement current resources for fighting fraud and save the government \$9.9 billion over 10 years through increased recoveries and prevention efforts.<sup>21</sup>

### **An Expanding Arsenal—The False Claims Act**

While health reform proposals remain proposals until enacted, the government nonetheless has been able to recover billions of dollars lost due to fraudulent activities by deploying an effective arsenal of commonly invoked federal statutes, including: the False Claims Act (FCA), the anti-kickback statute, the Stark law, program-related civil penalties, criminal penalties, and exclusions.<sup>22</sup>

Easily one of the most effective tools in the government’s cache, the DOJ recovered \$2.2 billion under the FCA in 2009.<sup>23</sup> One of the key provisions in the FCA is the use of whistleblowers to report and assist in pursuing alleged violations. In exchange for their efforts, the whistleblowers are entitled to share in any bounty recovered by the government.

[online.wsj.com/article/SB10001424052748704784904575112483453768298.html](http://online.wsj.com/article/SB10001424052748704784904575112483453768298.html).

<sup>17</sup> President’s Budget Make Fraud Fighting a Top Priority Funds Programs That Will Result in Billions in Savings Over 10 Years, available at [http://www.stopmedicarefraud.gov/healthcarefraud\\_factsheet.html](http://www.stopmedicarefraud.gov/healthcarefraud_factsheet.html) (last visited Mar. 17, 2010).

<sup>18</sup> HHS Press Release, “HHS Budget Makes Smart Investments, Protects the Health and Safety of America’s Families,” Feb. 1, 2010, available at <http://www.hhs.gov/news/press/2010pres/02/20100201a.html> [hereinafter HHS Press Release].

<sup>19</sup> Budget of the United States Government, Fiscal Year 2011, Section on Department of Health and Human Services, available at <http://www.whitehouse.gov/omb/budget/fy2011/assets/health.pdf>; President’s Budget Make Fraud Fighting a Top Priority Funds Programs That Will Result in Billions in Savings Over 10 Years, available at [http://www.stopmedicarefraud.gov/healthcarefraud\\_factsheet.html](http://www.stopmedicarefraud.gov/healthcarefraud_factsheet.html) (last visited Mar. 17, 2010); HHS Press Release, *supra* note 19.

<sup>20</sup> *Id.*

<sup>21</sup> HHS Press Release, *supra* note 19.

<sup>22</sup> Jennifer Staman, Health Care Fraud and Abuse Laws Covering Medicare and Medicaid: An Overview, Jan. 25, 2010, CRS Report for Congress, Congressional Research Service RS22743.

<sup>23</sup> DOJ Press Release, Remarks for Attorney General Eric H. Holder Jr. National Health Care Fraud Summit, available at <http://www.stopmedicarefraud.gov/innews/holderremarks.html> (last visited Mar. 17, 2010) [hereinafter DOJ Press Release].

Violations of the FCA can expose a health care provider to treble damages as well as penalties up to \$11,000 per false claim. In addition, other sanctions, such as exclusion, are also at risk in a FCA case. For a health care provider who submits thousands of claims, the damages and penalties can add up quickly. Consequently, the high stakes in the FCA cases often push providers to resolutions.

Last year, the FCA was upgraded by the Fraud Enforcement and Recovery Act of 2009 (FERA).<sup>24</sup> The amendments expanded the liability and the reach of the FCA. In fact, some of the revisions were focused on reversing case decisions that limited the scope of the FCA.

Among other things, the FERA amendment increases liability to providers by eliminating the presentment requirement and redefining “claim” to include claims not presented directly to the government. Previously, false claims needed to be “presented” to the government for payment.

Under FERA the definition of “claim” now includes claims made to “a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government’s behalf . . .”<sup>25</sup> The FERA amendment also establishes liability for the retention of an overpayment, even if an overpayment is not obtained fraudulently.

In sum, FERA expands both theories of liabilities under the FCA as well as the government’s ability to investigate and prosecute fraud. The expansion of the FCA coupled with the penalties and sanctions that follow violations will continue to make the FCA a favorite tool of the government and the plaintiff’s bar.

### Fast and Focused: HEAT Strike Force Teams

In addition to the civil enforcements, the DOJ continues to pursue and augment its criminal enforcement activities. In 2009, the DOJ charged more than 800 health care fraud defendants and obtained more than 580 convictions.<sup>26</sup> Attorney General Eric Holder attributes much of this success to Medicare Fraud Strike Force teams, consisting of federal prosecutors, FBI agents and agents from HHS’s Office of Inspector General (OIG).

Strike Force teams, described as the “core” of HEAT’s law enforcement mission, were introduced to Miami in 2007 and have since expanded to Los Angeles; Detroit; Houston; Brooklyn, N.Y.; Baton Rouge, La.; and Tampa Bay, Fla. Further expansion of the program is contemplated by the White House, DOJ, and HHS.<sup>27</sup>

These interagency teams find fraud by identifying suspect billing patterns using sophisticated technology and data-driven models.<sup>28</sup> The speed of Strike Force teams can be partially attributed to their collaborative approach, as well as their focus on high-risk and high-

concentration fraud targets.<sup>29</sup> Their subjects typically commit 100 percent fraud—in other words, they are “not providing any legitimate services to beneficiaries.”<sup>30</sup> Whereas traditional investigations can take up to three years; Strike Force cases are typically fully adjudicated within about a year.<sup>31</sup>

Not only have the Strike Forces captured over 270 convictions and obtained more than \$240 million in court-ordered restitutions, fines, and penalties, these teams have also had a fraud-deterrent effect as well.

“We believe that our strike forces have a marked sentinel effect” Timothy J. Menke, deputy inspector general for investigations for the HHS OIG, stated before the House Committee on the Judiciary, Subcommittee on Crime, Terrorism, and Homeland Security, on March 4.<sup>32</sup>

The discussion about HEAT Strike Forces was also ongoing at the Jan. 28, “National Summit on Health Care Fraud,”—a collaboration between the DOJ and HHS.

The attorney general outlined a road map for the ongoing fight against fraud: a reinforced effort on strengthening HEAT, an expansion of Medicare Fraud Strike Forces to other geographic areas, budgetary investments to properly fight fraud, regulatory reform in order to prevent and deter fraud and the continued inclusion of the private sector in anti-fraud efforts.<sup>33</sup>

### Compliance Efforts Will Be Critical

With the fraud and abuse focus in all health reform proposals, the expansion of the False Claims Act, and the increase in HEAT activities, Congress, the White House, and enforcement agencies could not be clearer that providers and suppliers should prepare for increased scrutiny and enforcement in the coming years.

However, while no one disputes the need and valor in combating the thieves who would steal the Medicare trust funds, one has to wonder about the unintended consequences that a potentially unbridled approach may have on legitimate health care providers. In the fervor to catch the wrongdoers, honest providers may find themselves swept up in the wide net being cast.

At some point, legitimate health care providers may be driven from the industry or may opt out of Medicare and Medicaid. Health care providers can quickly become beggars in the Medicare system where payments are decreased, costs are increased, and providers are subjected to the uncertainty of continuous auditing and review.

Physicians, hospitals, and other providers should prepare now to strengthen their compliance and internal auditing efforts. Providers should aggressively assess risks; conduct routine audits; assess billing and compliance processes, policies, and procedures; track overpayments; and continue to educate their workforce on compliance matters.

By preparing now, providers will be in a better position to avoid undue scrutiny and to respond to any inquiries that may come from enforcement agencies and government contractors as a result of the latest install-

<sup>24</sup> Fraud Enforcement and Recovery Act of 2009 (FERA), Pub. L. 111–21 (2009).

<sup>25</sup> *Id.* § 4.

<sup>26</sup> DOJ Press Release, *supra* note 24.

<sup>27</sup> *Id.* Budget of the United States Government, Fiscal Year 2011, Section on Department of Health and Human Services, available at <http://www.whitehouse.gov/omb/budget/fy2011/assets/health.pdf>; *President’s Budget Make Fraud Fighting a Top Priority Funds Programs That Will Result in Billions in Savings Over 10 Years*, available at [http://www.stopmedicarefraud.gov/healthcarefraud\\_factsheet.html](http://www.stopmedicarefraud.gov/healthcarefraud_factsheet.html); HHS Press Release, *supra* note 19.

<sup>28</sup> Menke Statement, *supra* note 3.

<sup>29</sup> *Id.*

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> DOJ Press Release, *supra* note 24.

ment of the government's serial effort to crackdown on fraud.