

Health Care Fraud

Sara Rosenbaum^a JD
Nancy Lopez^b JD MPH
Scott Stifler, JD (2010)

October 27, 2009

Funded with a Grant from the Robert Wood Johnson Foundation

This analysis was written in collaboration with the National Academy for State Health Policy (NASHP), an independent academy of state health policy makers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. For more information about NASHP, please visit www.nashp.org

^a Hirsh Professor and Chair, the George Washington University School of Public Health and Health Services, Department of Health Policy.

^b Senior Research Scientist, the George Washington University School of Public Health and Health Services, Department of Health Policy.

Introduction

Adequate safeguards against health care fraud are essential to the proper functioning of any health care system. This analysis examines health care fraud in the U.S., and its findings underscore the importance to national health reform of comprehensive anti-fraud protections covering both public and private health insurance industry.

This analysis examines health care fraud in a national policy context. Its findings underscore two critical points. First despite strong evidence that fraud is system-wide and affects the cost of health care in both public and private insurance, national reporting systems on health care fraud fail to capture private sector fraud. As a result, current evidence on the scope of fraud fails to present the full magnitude of the problem, because it tends to focus on public insurance fraud.

Second, existing information on health care fraud tends to conflate evidence of fraud with evidence of payment errors. While payment errors in public insurance programs pose a serious problem, the tools for remedying errors differ significantly from those used to address fraud.

Addressing these challenges in health reform is extremely important, not only because of the systemic nature of health care fraud but because, with rapid advances in health information technology, the potential for fraudulent schemes to move rapidly across all payers grows.

Following a brief overview, the analysis reviews the law and examines ongoing state and federal government efforts to combat fraud.

Overview

As with any very large enterprise, the U.S. healthcare industry is susceptible to fraud and abuse in both private and public programs alike. Evidence drawn from fraud studies suggests that fraud generally tends to disproportionately target vulnerable populations such as the poor and the elderly. Furthermore, public programs operate under strict reporting requirements, thereby creating a situation in which the most commonly available information concerns public programs such as Medicaid and Medicare. Fraud can be committed by individual consumers and patients, but the most serious health care fraud is not the result of small schemes, but instead flows from large-scale misconduct by major industry actors, including insurers and health care providers and corporate suppliers. The vast majority of fraud prosecutions emanate from the health care industry itself; indeed, a feature of fraud prosecutions involving patients can be the exposure of criminal enterprises designed by corrupt health care providers who in turn induce patients into participating in fraudulent schemes.

In 2007, the U.S. spent nearly \$2.3 trillion on health care; that year public and private insurers processed more than four billion health insurance claims.¹ The National Health Care Anti-Fraud Association (NHCAA) has estimated that conservatively, 3% of all health care spending—or \$68 billion—is lost to health care fraud. Other estimates by government and law enforcement agencies place fraud-related losses as high as 10% of annual health care expenditures.² At this rate, losses to fraud -- over \$220 billion in 2007 alone – would be enough to generously support coverage for all uninsured Americans.

Fraud schemes are not specific to any geographic area and are found throughout the entire country.³ Certain types of fraudulent schemes (e.g., stealing patient ID numbers and falsely billing for care) tend to be more common. Also, it has been found that consumers are more susceptible to fraud if they are older and/or poor, thus health care fraud, much like mortgage fraud, would tend to be more common in poorer communities because of the greater vulnerability of their residents.⁴

Certain aspects of health care increase the risk of fraud. Patients' dependence on their health care providers may mean that unscrupulous providers can engage in activities that patients may not understand or to which they may acquiesce without a full appreciation of the consequences, such as having patients sign forms affirming that they in fact received care and services never furnished. The sheer volume of insurance transactions, coupled with their complexity, serves to increase system vulnerability to fraud.⁵

Experts in the field of fraud suggest that health care fraud perpetrators consider their conduct to be a low-risk crime, with both public and private insurers offering easy targets. Insurers' payment operations are geared toward rapidly processing massive amounts of claims, with a focus on coding, not fraud.⁶ Moreover, the commercial insurance industry itself, as revealed in a recent and widely publicized investigation by New York Attorney General Andrew Cuomo, has (not for the first time) used the complex nature of its own business to commit fraud, in this case by systematically

¹ National Health Care Anti-Fraud Association. *The Problem of Health Care Fraud*. Consumer Alert. Available at:

http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centra&wpscode=TheProblemOfHCFraud. Accessed on October 15, 2009.

² *Id.* See also Federal Bureau of Investigation, (2008). *Financial Crimes Report to the Public, Fiscal Year 2007*. Available at: http://www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm

³ Clarke M. "The Control of Insurance Fraud: A Comparative View," *The British Journal of Criminology*, 30(1) (Winter 1990), pp.1-33.

⁴ Lee J., Soberon-Ferrer H. Consumer vulnerability to fraud: influencing factors. *Journal of Consumer Affairs*. 1997;31(1):70-89.

⁵ Managed Healthcare Executive, (2004). *Healthcare fraud and abuse remains a costly challenge*. October 1. Available at:

<http://managedhealthcareexecutive.modernmedicine.com/mhe/Analysis+&+Indications/Healthcare-fraud-and-abuse-remains--a-costly-chall/ArticleStandard/Article/detail/127451>.

⁶ *Id.*

underpaying health insurance claims, thereby exposing patients (and providers) to sizable unreimbursed costs that should have been covered under their plan terms.⁷

Even as they improve quality and efficiency, electronic data exchange and other technological advances can create further fraud exposure. This is because electronic claims transactions both increase the volume of claims and allow large enterprises to use technology to engage in fraud while avoiding computer fraud detection systems.⁸

Numerous government agencies have found that no segment of the health care delivery system is immune from fraud, and⁹ government investigations have uncovered fraud in all industry sectors.¹⁰ Indeed, the failure to systematically and routinely measure the scope of fraud has been reported to be a characteristic of the insurance industry worldwide.¹¹

The financial consequences of healthcare fraud are far-reaching. Whether the health care financing comes from an employer-sponsored plan, the individual market, or public insurance programs, the health care system as a whole bears the burden of fraud. Health care fraud translates into higher costs for insurers and consumers alike. Fraud also leads to reduced benefits or coverage as policies are tightened as a strategy to avoid fraud.¹² Indeed, it has been reported that the overall rise of health care costs is in part due to fraud.¹³

Because Medicare and Medicaid are government-sponsored programs, efforts to reduce fraud tend to be more publicly visible, particularly since the federal government now issues regular reports across all healthcare sectors. But since 1995, 90% of all private insurers have launched anti-fraud campaigns.¹⁴

⁷ See ¶16 of the *Assurance of Discontinuance Under Executive Law §63(15)* entered into between UnitedHealth Group and New York Attorney General at http://www.oag.state.ny.us/bureaus/health_care/HIT2/pdfs/United%20Health.pdf.

⁸ *Id.*

⁹ Health Care Fraud, (1995). Hearing before the Senate Select Comm. On Aging." 104th Cong., 1st sess. (March 21) (prepared statement of FBI Director Louis J. Freeh).

¹⁰ GAO, (1992). *Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse*. (GAO-T-HRD-92-29). May 7. Available at <http://archive.gao.gov/t2pbat6/146578.pdf>

¹¹ Clarke, *supra* note 3.

¹² National Health Care Anti-fraud Association, (2009). *Fighting Health Care Fraud: An Integral Part of Health Care Reform*. June. Available at:

http://www.nhcaa.org/eweb/docs/nhcaa/PDFs/Member%20Services/Fighting%20Health%20Care%20Fraud_NHCAAJune2009.pdf

¹³ *Id.* See also National Health Care Anti-fraud Association, *supra* note 1.

¹⁴ Cohen EL, Cesta TG. Evolution of nursing case management in a changing health care system. In: Cohen EL, Cesta TG, eds. *Nursing case management: from essentials to advanced practice applications*, 4th Ed. St. Louis, MO: Mosby; 2004:399.

Fraud Defined

In General

Black's Law Dictionary defines fraud as "a knowing misrepresentation of the truth or concealment of a material fact to induce another to act to his or her detriment." Improper payments or overpayments may not involve fraud at all if a payment simply was made or claimed in error, unless an individual knew or should have known that the claim was erroneous. At its heart, the law equates fraud with an intent to conceal or deceive, an effort to generate unjust enrichment, or acting in a manner that conveys a reckless disregard for the truth of one's claims.

In the context of health insurance, fraud may manifest itself as deceiving a public or private health insurer into paying claims that are not owed or recklessly submitting claims. Insurers also, as noted, have been found to have engaged in fraud by conspiring to overcharge sponsors and plan members in relation to the benefits that were promised in their contracts. Both provider and insurer fraud are essentially an intentional manipulation of the claims payment process for financial gain through bribes, kickbacks, and racketeering. The essence of fraud is concealment, misrepresentation, mis-stating the truth, withholding information that would allow the truth to be known, or engaging in practices that will mislead others. A fraudulent representation need not be the sole inducement to act; the essential dimension is that without the representation, the injured party would not have acted.¹⁵

Fraud must be distinguished from improper payments under public programs, which must be publicly reported as a matter of federal law.¹⁶ An improper payment can arise from simple errors in documentation, coding, reporting, verification, and other technical matters related to the administration of public programs. Improper payments are reported annually by federal agencies under the Improper Payment Improvement Act of 2002 (IPIA).¹⁷ In recent years, as agencies increasingly have implemented the law, the amount of reported improper payments has risen. Along with better reporting have come efforts to correct the underlying program administration standards and procedures that give rise to improper payments.¹⁸

Fraud is different because of the knowledge or reckless disregard for truth that is present. Translating these concepts into examples in health care fraud reveals the types of practices about which much has been written: Fraud against the Medicare program happens when hospitals "upcode" their claims in order to get more payment than their care is worth. Fraud against private health insurers occurs when a physician files claims for phantom patients by buying lists of Social Security numbers. Fraud

¹⁵ Dobbs DB. *The Law of Torts*. St. Paul, MN: West Group, 2000:1343-59.

¹⁶ Call to Action Health Reform 2009. *Reforming America's Health Care System: A Call to Action*. Senate Finance Committee Chairman Max Baucus white paper. Available at: <http://finance.senate.gov/healthreform2009/finalwhitepaper.pdf>

¹⁷ P.L. 107-300 (107th Cong., 1st sess.).

¹⁸ Government Accountability Office (GAO). *Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments* (GAO-09-628T), April 22 (2009).

against health plan members happens when an insurer conceals information about what a service actually costs so that expenses are pushed back onto members or plan sponsors. Fraud can also occur when a health benefits plan or insurer systematically denies or delays certain types of claims or rescinds insurance coverage once claims begin to come in.

In each case, the perpetrators of the fraud are using their superior information – about the procedures furnished, the patients served, or the true cost of care – to enrich themselves to the detriment of others. For this reason, insurers and health care providers alike have been sued using a variety of legal theories, ranging from the violation of the common law of good faith and fair dealing¹⁹ to general or health care specific fraud statutes addressing false claims, the most common type of health care fraud.²⁰

The Law of Fraud

Common Law Fraud

As noted, the common law (the body of judge-made law that forms the foundation of the American legal system) classifies as fraud knowingly or recklessly making false representations or concealing the truth.²¹ Liability for fraud depends on proof that the person committing the fraud knowingly or recklessly has made a materially false representation with the intent of creating reliance and causing financial injury.²²

Federal Fraud Laws

A significant body of federal law to address fraud has developed over the past 25 years; a brief overview of such laws is provided here.

Federal False Claims Act (FCA). The FCA imposes liability on a person who knowingly submits a false claim to obtain federal funds. The United States can prosecute violators for \$5000 to \$10,000 per false claim as well as treble damages (three times the government's loss).²³

In addition to applying to claims submitted with fraudulent intent²⁴, the FCA also applies to claims submitted with “reckless disregard”²⁵ or “deliberate ignorance”²⁶ of

¹⁹ See, e.g., *Wohlers v. Bartgis* 969 P. 2d 949 (1999); *Bass v. California Life Ins Co and Variable Protection Administrators, Inc.* (1991), 581 So. 2d 1087; 1991 Miss. LEXIS 352; *Niver v. Travelers Indem. Co. of Illinois*, 412 F. Supp. 2d 966, 968-72 (N.D. Iowa 2006).

²⁰ *United States ex rel. Bledsoe v. Cmty. Health Sys.*, (6th Cir. 2007) 501 F.3d 493; 2007 U.S. App. LEXIS 21260. *People v. Orzame*, No. 194566, 224 Mich. App. 551; 570 N.W.2d 118; 1997 Mich. App. LEXIS 254(1997).

²¹ *Derry v. Peek* (1889) 14 App Cas 337 at 374.

²² *Tice v. Tice*, 672 P.2d 1168, 1171 (Okla. 1983).

²³ False Claims Act, 31 USC § 3729(a) (2009).

²⁴ False Claims Act, 31 USC § 3729(b)(1) (2009).

their falsity. For example, a physician who bills for health care rendered to dozens of patients in a day – far beyond what a reasonable practice might entail -- is presumed under the law either to have intentionally filed false claims or to have ordered his untrained bookkeeper to submit the bills with total disregard for the accuracy of her work.²⁷

In addition to allowing the United States to sue on its own behalf, the FCA permits private persons, referred to as "qui tam plaintiffs" or "relators"—or colloquially, "whistleblowers"—to sue on the government's behalf as well as their own.²⁸ The Deficit Reduction Act of 2005 incentivized qui tam litigation by encouraging states to enact state false claims laws with qui tam provisions for use in Medicaid fraud suits.²⁹ States that enact such laws receive a bounty in the form of a 10% reduction in the amount owed by the state to the federal government in the event of a recovery. In order to qualify for this special statutory bounty, a state's law must be a "qualifying" false claims law.³⁰

Legislation enacted in 2009, the Fraud Enforcement and Recovery Act (FERA),³¹ further strengthened the FCA by broadening the range of conduct that can be subject to false claims prosecution by including the presentment of a false claim (even if not paid) and the knowing use of false records or statements "material to a false or fraudulent claim."³² In addition, under FERA's expanded definition of what constitutes a "claim," the false invoice or statement no longer must be presented directly to the federal government in order to establish liability; it is sufficient merely if "the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest."³³

Racketeer Influenced and Corrupt Organizations Act (RICO). RICO allows both criminal and civil prosecution if a "pattern" of criminal activity is found.³⁴ A pattern consists of at least two related predicate acts (types of conduct that evidence fraud) that "amount to or pose a threat of continued criminal activity."³⁵ The predicate acts must affect interstate commerce and must be one of the 35 crimes listed in the statute.³⁶ Mail and wire fraud (e.g., the electronic submission of fraudulent claims) are the most common alleged predicate acts.³⁷ Under RICO, it is unlawful for any person who has

²⁵ False Claims Act, 31 USC § 3729(b)(3) (2009).

²⁶ False Claims Act, 31 USC § 3729(b)(2) (2009).

²⁷ *U.S. v. Krizek*, 111 F.3d 934 (D.C. Cir. 1997).

²⁸ False Claims Act, 31 U.S.C. § 3730(b) (2009).

²⁹ Deficit Reduction Act. Pub. L. 109-171, §§ 6031-33 (2006) codified at 42 U.S.C. § 1396h(a).

³⁰ *Id.*

³¹ Pub L No. 111-21, 123 Stat 1617(2009).

³² Pub L No. 111-21 (2009), amending 31 U.S.C. §3729(c).

³³ Pub L No. 111-21 (2009), amending 31 U.S.C. §3729(a); *Allison Engine Co., Inc. v. United States ex rel. Sanders*, 128 S. Ct. 2123 (U.S. 2008).

³⁴ Racketeer Influenced and Corrupt Organizations Act (RICO), 18 U.S.C. §§ 1961-1968 (2008).

³⁵ *H. J. Inc. v. Northwestern Bell Tel. Co.*, 492 U.S. 229, 239 (1989).

³⁶ RICO, 18 U.S.C. § 1961 (2008).

³⁷ Joseph GP. *Civil RICO: A Definitive Guide*. Chicago, Ill: Section of Litigation, American Bar Association, 2nd ed. 2000;p 82.

participated directly or indirectly in a pattern of racketeering to use any money derived from those activities to invest in, acquire, maintain control in, or participate in the conduct of an “enterprise.”³⁸

The Anti-Kickback Statute. Codified at §1128B of the Social Security Act, the law makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program.³⁹ The definition of remuneration is broad and includes any kickback, bribe, or rebate.⁴⁰ The statute is violated if remuneration is paid purposefully to induce or reward referrals of items or services payable by a federal health care program (e.g., if a hospital makes payments to a medical practice to incentivize referrals of its Medicare business). The statute itself has several exceptions⁴¹ and the Department of Health and Human Services has promulgated safe-harbor regulations shielding certain activities such as employment relationships, investment interests, certain referral services, and other types of payments that are not considered remuneration for the purpose of the Act.⁴²

The Stark Statute. Often referred to by the name of the Representative who was its chief sponsor, the legislation, codified at §1877 of the Social Security Act, was enacted to “address the strain placed on Medicare Trust fund by the overutilization of certain medical services by physicians who, for their own financial gain rather than their patients' medical need, referred patients to entities in which the physicians held a financial interest.”⁴³ The Act, which contains certain limitations and exceptions, prohibits physicians from referring patients to entities that furnish “designated health services” (“DHS”) in situations in which there exists a financial relationship between the entity and the physician or an immediate family member.⁴⁴

The Health Insurance Portability and Accountability Act (“HIPAA”). HIPAA federalized the crime of health care fraud by making it illegal for anyone to knowingly and willfully defraud any health care benefit program (public or private) or to obtain by means of false representations any money or property of a health care benefit program⁴⁵, make false or fictitious statements “in any matter involving a health care benefit program,”⁴⁶ embezzle, convert, or steal any funds, property, or assets of a health care benefit program,⁴⁷ or obstruct, delay, prevent, or mislead the investigation of federal health care offenses.⁴⁸ HIPAA also requires the establishment of the Health

³⁸ RICO, 18 U.S.C. § 1962 (2008).

³⁹ 42 USC § 1320a-7b (2007).

⁴⁰ 42 USC § 1320a-7b(b)(1) (2007).

⁴¹ 42 USC § 1320a-7b(b)(3) (2007).

⁴² 42 CFR 1001.952 (2009).

⁴³ *Am. Lithotripsy Soc’y v. Thompson*, 215 F. Supp. 2d 23, 26 (D. D.C. 2002).

⁴⁴ 42 USC § 1395nn (2007).

⁴⁵ 18 USC § 1347 (2008).

⁴⁶ *Id.*

⁴⁷ 18 USC § 669 (2004).

⁴⁸ 18 USC § 1518 (2008).

Care Fraud and Abuse Control Program, which coordinates federal, state, and local law enforcement programs to control fraud and abuse.⁴⁹

Federal Oversight and Administration of Health Care Anti-Fraud Efforts

Although the Federal Bureau of Investigation is the primary investigatory agency involved in health care fraud, the successful resolution of anti-fraud efforts involves the combined investigative efforts and resources of the HHS Office of the Inspector General (OIG), Department of Justice (DOJ), Medicaid Fraud Control Units (MFCU), and other law enforcement agencies.

OIG shares enforcement responsibility under the anti-kickback statute with the DOJ, which prosecutes criminal cases on behalf of the United States. OIG investigates allegations of illegal kickbacks and works with DOJ and the United States Attorneys to prosecute criminal cases. In addition, OIG supports DOJ's civil prosecutions under the False Claims Act. Under joint direction of the Attorney General and the Secretary of the Department of Health and Human Services, the national Health Care Fraud and Abuse Control Program (HCFAC) is designed to coordinate federal, state and local law enforcement activities with respect to health care fraud.⁵⁰ The Centers for Medicare & Medicaid Services (CMS) is also engaged in combating Medicaid provider fraud, waste, and abuse through the Medicaid Integrity Program (MIP).⁵¹

State Fraud Laws

In addition to common law fraud and general fraud statutes, states have enacted specific laws aimed at health care fraud, which typically are part of the implementation of federal law.⁵² State fraud laws vary; some are of general application while others specifically target health insurance and Medicaid fraud. Fraud violations can result in concurrent or subsequent federal sanctions, and state sanctions can be more serious than their federal counterparts.⁵³

False Claims Acts

Prior to the federal False Claims Act ("FCA") amendment, no state had a false claims act with qui tam provisions.⁵⁴ Currently, 23 states and the District of Columbia have adopted qui tam statutes. (Table 1).⁵⁵ Although modeled after the federal FCA,

⁴⁹ 42 U.S.C. 1320a-7c (2007).

⁵⁰ Department of Health and Human Services and The Department of Justice (2008). *Health Care Fraud and Abuse Control Program Annual Report For FY 2007*. November 2008.

⁵¹ 42 USC 1396u-6; See also Centers for Medicare and Medicaid Services. Medicaid Integrity Program Overview. Available at: <http://www.cms.hhs.gov/MedicaidIntegrityProgram/>

⁵² Fleps C. *Health Care Fraud & Abuse Compliance Manual*. Aspen Publishers; 2002: Part 1 § 2.

⁵³ *Id.*

⁵⁴ Broderick CO. *Qui Tam Provisions and the Public Interest: An Empirical Analysis*, 107 Colum. L. Rev. 949, 956: 2007.

⁵⁵ <http://www.taf.org/statefca.htm>

state false claims acts show some state-to-state variation.⁵⁶ Among states whose false claims acts contain qui tam provisions, 17 states and the District of Columbia incorporate these provisions into a general false claims law that does not solely target Medicaid. California was the first state to adopt a qui tam statute,⁵⁷ and the California law resembles the federal FCA, imposing liability for, among other acts, knowingly presenting a false claim and conspiring to present a false claim.⁵⁸ New York's false claims act is also similar to the federal FCA; unlike the federal FCA, however, the New York law specifically excludes local governments as well as the state government from liability.⁵⁹

The remaining five states whose laws contain qui tam provisions have enacted laws that are specific to the Medicaid program (see Table 1).⁶⁰ The Texas false claims law includes prohibitions on knowingly or intentionally making false statements to obtain Medicaid benefits, failing or concealing facts that affect the right to Medicaid, and making false claims to Medicaid.⁶¹ Nine additional states have general false claims acts that do not contain qui tam provisions (Table 1).

The Deficit Reduction Act (DRA) of 2005⁶² incentivizes the state enactment of false claims laws by permitting states to retain up to 10% of amounts that otherwise would be repaid to the federal government in the event of a fraud recovery.⁶³ This bounty provision works to incentivize states to “enact compliant false claims acts.”⁶⁴ In order for a state to qualify for the FMAP recovery incentive, its false claims act must meet the following requirements: (1) the law must establish “liability to the State for false or fraudulent claims described in [the FCA] with respect to any expenditures related to State Medicaid plans described in §1903(a) of the Act”⁶⁵; (2) the law must contain “provisions that are at least as effective in rewarding and facilitating qui tam actions for false or fraudulent claims as those described” in the FCA⁶⁶; (3) the law must contain “a requirement for filing an action under seal for 60 days with review by the State Attorney General;”⁶⁷ and (4) the law must contain “a civil penalty that is not less than the amount of the civil penalty authorized under” the FCA.⁶⁸

⁵⁶ Fleps, *supra* note 52 at Part 7 §5.

⁵⁷ Boese JT. *Civil False Claims and Qui Tam Actions*, 3rd ed. Aspen Law & Business, New York, NY: 2003: §6.01.

⁵⁸ *Id.*

⁵⁹ *Id.*

⁶⁰ <http://www.taf.org/statefca.htm>

⁶¹ Tex. Hum. Res. Code Ann. §§ 36.001-36.117.

⁶² Pub L No. 109-171 §§6031-6033 (2005).

⁶³ Grady A. *Congressional Research Service Report for Congress, Medicaid: The Federal Medical Assistance Percentage (FMAP) 2009*, Available at: http://assets.opencrs.com/rpts/RL32950_20090202.pdf.

⁶⁴ 48 N.H.B.J. 6, 11.

⁶⁵ 42 USC § 1396h(b)(1) (2007).

⁶⁶ 42 USC § 1396h(b)(2) (2007).

⁶⁷ 42 USC § 1396h(b)(3) (2007).

⁶⁸ 42 USC § 1396h(b)(4) (2007).

The HHS Office of the Inspector General reviews state false claims laws to determine if they satisfy the FMAP reduction requirements.⁶⁹ Currently, OIG has determined that 14 states have false claims acts that meet the DRA requirements (Table 1).⁷⁰ Of the 10 states with the largest Medicaid populations,⁷¹ 6 have enacted false claims acts meeting federal requirements. Florida's law has not been deemed to meet federal standards, and 3 states (North Carolina, Ohio, and Pennsylvania) have failed to enact legislation.⁷² Figure 1.

Figure 1. False Claims Act Laws Meeting Federal Requirements in the Ten Largest Medicaid States

California	√
Florida	
Georgia	√
Illinois	√
Michigan	√
New York	
North Carolina	
Ohio	
Pennsylvania	
Texas	√

Anti Kickback Laws

Thirty-seven states and the District of Columbia have anti-kickback laws (Table 1).⁷³ These laws are either general in application or Medicaid specific.⁷⁴ State anti-kickback laws are “typically applicable to all payers” while the “federal anti-kickback statute only applies to payments related to items and services provided under a federal health care program.”⁷⁵ States’ anti-kickback statutes vary widely, are usually not modeled after the federal law, and often lack the intent requirements of the federal law.⁷⁶ Medicaid-specific anti-kickback laws, by contrast, typically are modeled after federal law, although there can be variation, both among states and within a state, by service.⁷⁷ State laws vary in the extent to which they include the types of safe harbor

⁶⁹ 42 USC § 1396h(b) (2007).

⁷⁰ State False Claim Act Reviews, <http://oig.hhs.gov/fraud/falseclaimsact.asp>

⁷¹ California, Florida, Georgia, Illinois, Michigan, New York, North Carolina, Ohio, Pennsylvania, and Texas.

⁷² <http://www.taf.org/statefca.htm>.

⁷³ Fabrikant R, Kalb PE, Hopson MD, Bucy PH (2002) *Health care fraud: Enforcement and Compliance*. New York: Law Journal Press; 2002; §2.03.

⁷⁴ Tully WB. *BNA Fraud & Abuse Compliance Portfolio 1500: Federal Anti-Kickback Law*. Bna Books; 1996: § 8(C)(1).

⁷⁵ Steiner J. *Health Law and Compliance Update, 2008 Edition* § 5.02(c) (2008).

⁷⁶ Fabrikant, *supra* note 73.

⁷⁷ Fabrikant, *supra* note 73.

provisions found in the federal statute.⁷⁸ For example, the federal Anti-Kickback statute exempts remunerations paid by an employer to a bone fide employee,⁷⁹ on the other hand, Florida's anti-kickback statute does not.⁸⁰ The relatively broad nature of many state anti-kickback laws makes state level enforcement a "much easier pursuit requiring less proof than would be needed to prove a violation of the federal statute."⁸¹ However, at least one state court has held that a state anti-kickback law is preempted by federal anti-kickback law.⁸²

Self-Referral Laws

Often referred to as "mini-Stark" laws,⁸³ thirty-four states have enacted laws restricting self-referral by health care providers (Table1).⁸⁴ Laws vary by jurisdiction, but in general they fall into three main categories: 1) laws that are nearly identical to Stark laws applied to state programs; 2) laws that prohibit all self-referrals; and 3) laws with a disclosure requirement of financial interests to patients.⁸⁵ In a number of cases, state mini-Stark statutes simply incorporate the terms of the federal law by reference.⁸⁶

In the case of state laws that ban all self-referrals (thereby establishing standards more stringent than the federal self-referral statute), physicians are banned from any ownership interest in hospitals or other facilities to which they refer their patients.⁸⁷ State statutes requiring only disclosure vary widely across the states, but most require disclosure in writing to the patient.⁸⁸

Whatever forms the state self-referral laws take, some state statutes may reach self-referrals not covered by the federal prohibition. Of particular interest, state law may extend to "referrals paid for by payors other than Medicare and Medicaid, referrals by practitioners other than physicians, and referrals for services other than those designated by the federal law."⁸⁹ In contrast, other state laws are more flexible than the Stark laws in providing broader exceptions to prohibitions on referrals.⁹⁰

State Oversight: Medicaid Fraud Control Units

State oversight of health care fraud has expanded considerably over the past two decades, spurred on by the fraud problem and by federal reforms.

⁷⁸ Steiner, *supra* note 75.

⁷⁹ 42 USC §1320a-7b(b)(3)(B).

⁸⁰ Fla. Stat. § 409.920(2)(e) (2000).

⁸¹ *Id.*

⁸² See *State v. Harden*, 938 So. 2d 480 (Fla. 2006).

⁸³ Steiner, *supra* note 75.

⁸⁴ Fabrikant, *supra* note 73.

⁸⁵ Bethard R. *Physician Self-Referral: Beyond Stark II*, 43 Brandeis L.J. 465, 474 (2005).

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ Gosfield AG. *Medicare and Medicaid Fraud and Abuse*. §3.30; 2008 ed. Eagan (MN): Thompson/West; 2008.

⁸⁹ *Id.*

⁹⁰ *Id.*

The Medicaid and Medicare Anti-Fraud and Abuse Amendments of 1977⁹¹ provide 90% matching funds over a three-year time period to states that established Medicaid Fraud Abuse and Control Units (MFCUs) meeting certain requirements.⁹² The federal funding became permanent three years later, providing federal contributions of 90% toward the establishment of a MFCU and 75% federal contributions thereafter.⁹³ The Omnibus Budget Reconciliation Act of 1993 required each state to establish a MFCU or obtain a waiver from the federal government.⁹⁴ Currently 49 states and the District of Columbia have MFCUs;⁹⁵ only North Dakota operates without a MFCU and with a federal waiver.⁹⁶

MFCUs are usually located within the office of the state Attorney General⁹⁷ and have responsibility for both the detection and investigation of fraud and fraud prosecution oversight. In addition, the MFCUs oversee instances of nursing home abuse and fraud in program administration.⁹⁸ The MFCUs investigate their cases based on local policies⁹⁹ and bring the cases in state courts using state laws.¹⁰⁰ Part of the National Association of Attorneys General, the National Association of Medicaid Fraud Control Units links the individual state MFCUs and seeks to “improve the quality of Medicaid fraud investigations and prosecutions.”¹⁰¹

⁹¹ Medicaid and Medicare Anti-Fraud and Abuse Amendments of 1977, Pub L No. 95-142.

⁹² Department of Health and Human Services Office of Inspector General (2003). *State Medicaid Fraud Control Units Annual Report Fiscal Year 2003 1*, available at <http://oig.hhs.gov/publications/docs/mfcu/MCFU2003.pdf>.

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ <http://www.namfcu.net/states>.

⁹⁶ <http://www.namfcu.net/about-us/about-mfcu>.

⁹⁷ Fleps, *supra* note 52 at Part 7 §2.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ Blank SM, Kaspisin JA, White AC. (2009). *Health Care Fraud*, Am. Crim. L. Rev. 2009; 46:701, 757.

¹⁰¹ http://www.naag.org/medicaid_fraud.php.

Table 1: State Fraud Laws (2009)

State	False Claims Act ✓ FCA with <i>qui tam</i> provisions + Act applies to Medicaid Only *meets DRA requirements • FCA without <i>qui tam</i>	Anti Kickback Laws	Self-Referral Laws
Alabama	-	✓	-
Alaska	-	-	-
Arizona	-	✓	✓
Arkansas	+	✓	✓
California	✓*	✓	✓
Colorado	•	✓	-
Connecticut	-	✓	✓
Delaware	✓	✓	-
District of Columbia	✓	✓	-
Florida	✓	✓	✓
Georgia	✓+*	-	✓
Hawaii	✓*	-	✓
Idaho	-	-	-
Illinois	✓*	✓	✓
Indiana	✓*	✓	-
Iowa	-	-	-
Kansas	•	✓	✓
Kentucky	-	✓	✓
Louisiana	✓+	✓	✓
Maine	-	-	✓
Maryland	-	-	✓
Massachusetts	✓*	✓	✓
Michigan	✓+*	✓	✓
Minnesota	✓	-	✓
Mississippi	-	✓	-
Missouri	•	✓	✓
Montana	✓	✓	✓
Nebraska	•	-	-
Nevada	✓*	✓	✓
New Hampshire	✓	✓	✓
New Jersey	✓	✓	✓
New Mexico	✓	✓	-
New York	✓*	✓	✓
North Carolina	•	✓	✓
North Dakota	-	-	-
Ohio	-	✓	✓
Oklahoma	✓	✓	✓
Oregon	•	-	-
Pennsylvania	-	✓	✓
Rhode Island	✓*	✓	-
South Carolina	-	✓	✓
South Dakota	-	✓	✓

State	False Claims Act ✓ FCA with <i>qui tam</i> provisions + Act applies to Medicaid Only *meets DRA requirements • FCA without <i>qui tam</i>	Anti Kickback Laws	Self-Referral Laws
Tennessee	✓*	-	✓
Texas	✓+*	✓	-
Utah	•	✓	✓
Vermont	-	-	-
Virginia	✓*	✓	✓
Washington	•	✓	✓
West Virginia	-	✓	✓
Wisconsin	✓+*	✓	✓
Wyoming	-	-	-
Total	23✓ 9• 6+ 14*	37	34

Source: Information on State Fraud Laws was obtained by a web-based search of CCH Health, Human Resources, and Labor Database accessed July 29, 2009, and Fabrikant R, Kalb PE, Hopson MD, Bucy PH (2002) *Health Care Fraud, supra* note 75 § 2.03.

How Widespread is Health Care Fraud and What Forms Does it Take?

As noted, fraud is both widespread and frequently associated with the health care industry.

Estimates are that 80% of healthcare fraud is committed by medical providers, 10% by consumers, and the balance by others, such as insurers themselves and their employees.¹⁰² According to the National Health Care Anti-Fraud Association, the majority of healthcare fraud is committed by dishonest providers.¹⁰³ The most common types of provider fraud are:

- billing for services that were never rendered; billing for more expensive services or procedures than were actually provided or performed (“upcoding”);
- performing medically unnecessary services solely for the purpose of generating insurance payments;
- misrepresenting non-covered treatments as medically necessary;
- falsifying a patient’s diagnosis to justify tests, surgeries or other procedures that aren’t medically necessary;

¹⁰² Coalition Against Insurance Fraud. *Go Figure: fraud data*. Available at www.insurancefraud.org/stats.htm. Accessed on October 19, 2009.

¹⁰³ National Healthcare Anti-Fraud Association, *supra* note 1.

- billing a patient more than the co-pay amount for services that were prepaid;
- accepting kickbacks for patient referrals;
- waiving patient co-pays or deductibles;
- over-billing the insurance carrier or benefit plan;¹⁰⁴ and
- unbundling, that is, the practice of submitting bills in a fragmented fashion in order to maximize the reimbursement for various tests or procedures that are required to be billed together at a reduced cost.¹⁰⁵

Table 2 presents an illustrative overview of the types of fraudulent conduct that have been pursued in court or reported in the press in recent years. These examples have been drawn from a systematic search of reported actions using legal search engines, as well as a review of legal journal and news articles on health care fraud-related actions.

The types of fraud recovery actions described in Table 2 might be pursued privately by health insurers as civil fraud cases, while, as noted, state Attorneys General or the United States Department of Justice also have wide-ranging powers under state and federal law to pursue health care fraud under numerous legal theories.

Table 2. Examples of Health Care Fraud across the Health Care Industry: Private Health Insurance, Medicare, and Medicaid

Private Health Insurance Medicare Medicaid

Accused Company	Industry	Type of Fraud	Recovery (Year)
UnitedHealth ¹⁰⁶	Managed Care	Underpaid consumers (10%-28%) by manipulating database it used to pay customers for out-of-network services	\$350 million (2008)
McKesson ¹⁰⁷	Pharmaceutical	Fraudulently inflated prices of approximately 450 drugs charged to insurers and consumers	\$350 million ¹⁰⁸ (2009)

¹⁰⁴ *Id.*

¹⁰⁵ Federal Bureau of Investigations. Financial Crimes Report to the Public Fiscal Year 2007. Available at: http://www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm#health.

¹⁰⁶ *American Medical Association v. United Healthcare Corp.*, 588 F.Supp.2d 432 (S.D.N.Y. 2008)

¹⁰⁷ *New England Carpenters Health Benefits Fund, et al. v. First DataBank, Inc. and McKesson Corp.*, 244 F.R.D. 79 (D. Mass. August 27, 2007)

Accused Company	Industry	Type of Fraud	Recovery (Year)
HealthNet ¹⁰⁹	Managed Care	ERISA and RICO violations by underpaying consumers in several states	\$215 million (2006)
Cleveland Clinic ¹¹⁰	Integrated Health Care System	Medical identity theft; false claims	Unknown
Tenet ¹¹¹	Hospital	False claims, Kickbacks	\$900 million (2003)
TAP Pharmaceuticals ¹¹²	Pharmaceutical	False claims, Conspiracy, kickbacks	\$ 559.5 million (2001)
St. Barnabas Hospitals ¹¹³	Hospital	False claims	\$265 million (2006)
HCA ¹¹⁴	Hospital	False claims, kickbacks	\$631 million (2003)
HealthSouth ¹¹⁵	Rehabilitative Medicine Services	False claims	\$325 million (2004)
Ciena Healthcare Management, Inc. ¹¹⁶	Nursing Home	False claims from inadequate care in nutrition and hydration, the assessment and evaluation of needs, care planning and nursing interventions, medication management, fall prevention, and pressure ulcer care, including the prevention and treatment of wounds.	\$1.25 million ¹¹⁷ (2007)

¹⁰⁸ This settlement is a preliminary court approved settlement entered on March 31, 2009 and the hearing on final approval is scheduled for July 23, 2009. Available at:

<http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aVpLVzpsq1NI>.

¹⁰⁹ *Wachtel v. Health Net; McCoy v. Health Net; and Scharfman v. Health Net*, 239 F.R.D. 81 (D. N.J. December 6, 2006).

¹¹⁰ Ronrad W. *A New Ailment: Medical ID Theft*, N.Y. Times, June 13, 2009.

¹¹¹ *United States v. Tenet Healthcare Corp.*, C. A. No. 03-206 (C.D. Cal. Jan. 9, 2003).

¹¹² *United States ex rel. Durand v. TAP Pharmaceuticals*, CA No. 00-12618-GAO (filed May 1996 in the E.D. Pa., later transferred to D. Mass, settled Sept. 28, 2001).

¹¹³ *United States ex rel. Monahan v. St. Barnabas Health Care System, Inc.*, C.A. No. 02-5702 (D.N.J. June 15, 2006).

¹¹⁴ *United States, ex. rel. Alderson, v. Columbia/HCA Corporation*, Case No. 99-3290 (RCL), part of Case No. 01-MS-50 (RCL) (D. D.C. 2003).

¹¹⁵ *United States ex rel. James Devage v. HealthSouth Corporation, et al.*, Civ. Action No. SA-98-CA-0372FB (W.D. Tex.); *United States ex rel. Manning v. HealthSouth Corporation*, (W.D. Tex.); and *United States ex rel. Brupbacher & Associates and Michael C. Freeman v. National Institutional Pharmacy Services, Inc.* (D. N. Mex.) (cases settled Dec. 30 2004).

¹¹⁶ *U.S. ex rel. Denise Hubbard v. Ciena Healthcare Management, et al.*, CV-03-60175 (E.D. Mich.).

¹¹⁷ This case involves fraud against both the Medicare and Medicaid programs.

Accused Company	Industry	Type of Fraud	Recovery (Year)
United Health Group and other insurers ¹¹⁸	Insurance	Fraud, misrepresentation, deception through use of company-owned Ingenix system to systematically undervalue its payment obligations for physician services in order to shift the cost of out-of-network coverage from the insurer to members and plan sponsors	Approximately \$100 million (2009)
Amerigroup ¹¹⁹	Insurance/Managed Care	False claims involving the treatment of pregnant women and other patients	\$225 million (2007)
Merck ¹²⁰	Pharmaceutical	False claims, Kickbacks	\$650 million (2006)
Serono Group ¹²¹ AstraZenica Pharmaceuticals ¹²² Wyeth ¹²³	Pharmaceutical	False claims, Kickbacks	\$567 million \$160 million Qui tam action pending (2000 & 2009)
Bristol-Meyers Squibb ¹²⁴ , KV Pharmaceuticals, Roxane Laboratories, Abbott Laboratories, Aventis Pharmaceutical, Teva Pharmaceuticals, Schering Plow/Warrick, Forest Laboratories, Baxter International, Dey Pharmaceuticals, Bayer Pharmaceuticals	Pharmaceutical	False Claims	\$123.75 million (2009)
Omnicare, Inc. ¹²⁵	Pharmaceutical	False claims by replacing brand-name with generic drugs or switching dosage strengths	\$49.5 million (2006)

¹¹⁸ *The American Medical Association v. United Healthcare Corporation, et al.*, 2009 U.S. Dist. LEXIS 45610 (S.D.N.Y. May 7, 2009).

¹¹⁹ *United States, ex rel. Tyson, et al. v. Amerigroup Illinois, Inc., et al.*, 2007 WL 781729 (N.D.Ill. March 13, 2007).

¹²⁰ *State of Nevada ex rel. Steinke v. Merck & Company, Inc.*, 2006 WL 1506901 (D. Nev. May 31, 2006).

¹²¹ *United States ex rel. Driscoll v. Serono Laboratories, Inc.*, C.A. No. 00-11680 (D. Mass. August 17, 2000).

¹²² *Alabama v AstraZenica*, [reported in] BNA, 18 Health Law Reporter (June 3, 2009).

¹²³ *United States, ex. Rel. Kieff v Wyeth*, C.A. No. 03-12366DPW (D. Mass.); USDOJ intervention May 18, 2009, [reported in] BNA Health Law Reporter 18:687 (June 3, 2009).

¹²⁴ *Alabama v Abbott Laboratories*, No. CV-05-219 (Ala. Cir., Ct. May 22, 2009), [reported in] BNA Health Law Reporter 18: 685 BNA (June 3, 2009).

¹²⁵ *United States et al., ex rel. Bernard Lisitza v. Omnicare, Inc.*, 01 C 7433, and *United States et al., ex rel. David Kammerer v. Omnicare, Inc.*, 04 C 2074 (N.D. Ill.).

Accused Company	Industry	Type of Fraud	Recovery (Year)
Johns Hopkins Bayview Medical Center ¹²⁶	Hospital	False Claims Act (qui tam) ²¹ by submitting false claims about patients conditions that had not been actually diagnosed or treated to Medicare, Medicaid, and TRICARE	\$2.75 million (2009)

Source: legal analysis of reported cases (Summer, 2009).

Provider Fraud: The Most Common Fraud

These cases suggest that the most common type of fraud involves systematically overcharging both private and public insurers for the cost of items and services for which payment is specified either by contract or in law. Thus, for example, many pharmaceutical companies have been pursued by Medicaid programs for failing to adhere to federal prescription drug rebate requirements, with resulting major overcharges to state agencies. (Because the Centers for Medicare and Medicaid Services have not yet reported on cases of either improper payment or fraud under the Medicare Part D program,¹²⁷ it is not possible to know the magnitude of such practices under Medicare). Similarly, hospitals have been charged with systematically upcoding Medicare claims to falsely elevate the cost of care. These cases underscore the fact that these schemes depend on intimate knowledge of the health care business, the ability to manipulate complex data, and having an insider status that comes with being a health care provider.¹²⁸ The insurer fraud cases discussed below appear to be similarly dependent on complex knowledge and insider status.

A review of cases through legal engine searches as well as review of legal journals and news articles also suggests that the majority of fraud cases involve providers. Important 2009 cases show this pattern:

- On July 10 2009, U.S. Attorney for the Eastern District of Michigan Terrence Berg announced that Geoffrey Ramseur, a chiropractor who formerly practiced in the Detroit area, was sentenced to 20 months' imprisonment on healthcare fraud charges, and ordered to pay \$121,000 in restitution to Blue Cross Blue Shield of Michigan (BC/BS-MI).¹²⁹ Ramseur pled guilty to submitting false claims to BC/BS-MI for fictitious chiropractic services that were never actually provided to patients. Ramseur admitted to engaging in this scheme over a two-year period, and as part of that scheme, paying employees of Bing Steel and

¹²⁶ *United States, ex rel. Mayer v. Johns Hopkins Bayview Medical Center*, D. Md., No. 1:07-cv-02011-WDQ, (settlement announced 6/30/09).

¹²⁷ GAO, Improper Payments: Progress Made, *supra* note 18.

¹²⁸ Dixon P. The World Privacy Forum Report (2006). *Medical Identity Theft: The Information Crime that Can Kill You*, Spring, p.36. Available at http://www.worldprivacyforum.org/pdf/wpf_medicalidtheft2006.pdf

¹²⁹ United States Department of Justice, United States Attorney Eastern District of Michigan Press Release, July 10, 2009. Florida Resident Sentenced on Health Care Fraud Charges. Available at: http://www.usdoj.gov/usao/mie/press/2009/2009-7-10_gramseur.pdf.

other large factories in the Detroit area to use their Social Security numbers and BC/BS-MI identification numbers.¹³⁰

- Joby George, a pharmacist and part-owner of a pharmacy in Greenwich, Connecticut, pled guilty to knowingly submitting false claims to the Medicaid and Medicare programs over a two-year period.¹³¹ According to plea documents, George submitted various claims to Medicaid for prescription drugs that were not actually dispensed to Medicaid recipients, and also claims for certain brand name drugs when, in fact, he dispensed less expensive generic drugs. In addition, George admitted to submitting claims to Medicare for certain prescription narcotics that he dispensed to an individual while accepting cash payments from that individual for additional quantities of those drugs. George entered into a civil settlement with the federal government under which he agreed to pay \$344,805 in restitution to the Medicare and Medicaid program.
- Also in 2009, Sam Smith Hill III, a licensed psychologist who formerly practiced in Corpus Christi, Texas, was sentenced to five years' probation and six months' house arrest for defrauding the Medicaid program out of more than \$48,000.¹³² During trial, the federal government showed that Hill billed Medicaid for psychological testing conducted by individuals with Master level degrees in psychology whom he hired to give the tests. In submitting claims to Medicaid, however, Hill falsely indicated that he had conducted the testing himself, and used the CPT billing procedure code for testing by licensed psychologists. At sentencing, Hill also was ordered to pay \$48,739 in restitution to Medicaid and a \$40,000 fine.¹³³
- On July 14, 2009, New Jersey Attorney General Anne Milgram announced that Dr. Khashayar Salartash, a surgeon, his office manager Farah Iranipour Houtan, and the treatment center they owned were indicted on charges of defrauding the Medicare and Medicaid programs as well as various private insurance companies out of more than \$8.5 million.¹³⁴ According to the indictment, over a five-year period Salartash and Houtan, through their medical center specializing in the treatment of lymphedema, submitted false claims to

¹³⁰ *Id.*

¹³¹ United States Attorney's Office District of Connecticut Press Release, July 10, 2009. Pharmacist Pleads Guilty To Health Care Fraud, Agrees To Pay \$344,085 To Settle False Claims Act Allegations. Available at: <http://www.usdoj.gov/usao/ct/Press2009/20090710.html>.

¹³² U.S. Department of Health and Human Services. Stop Health Care Fraud, In the News. Two Houston Area Doctors Charged in Conspiracy to Illegally Distribute Narcotics and Medicare/Medicaid Fraud (U.S. Attorney for the Southern District of Texas). July 20, 2009. Available at: <http://www.hhs.gov/stopmedicarefraud/innews.html>.

¹³³ *Id.*

¹³⁴ The State of New Jersey, Department of Law and Public Safety, Office of the Attorney General Press Release, July 14, 2009. Atlantic County Surgeon, Manager, and Treatment Center charged in \$8.5 Million Fraud against Medicare, Medicaid and Private Insurers. Available at: <http://www.nj.gov/oag/newsreleases09/pr20090714b.html>.

Medicare, Medicaid, and private insurers that indicated Salartash had either personally provided services or directly supervised licensed personnel who rendered services, when in fact, the services were often performed by a physical therapist or nurse with no supervision. In addition, Salartash and Houtan allegedly billed for surgery when only physical therapy services were rendered, and for services performed in an outpatient hospital facility when the procedures were performed in a physician's office.¹³⁵

- Six individuals—Alexander Levy, Zona Castellano, Aaron Bethea, Leonid Skylar, Yelena Bogatyrov, and Arthur Gutman, along with seven corporations—were indicted on charges of being involved in an elaborate fraud scheme that bilked the Medicaid program out of \$47 million over a 10-year period, announced New York Attorney General Andrew M. Cuomo on July 16.¹³⁶ Levy, the ringleader, was excluded from participation in the Medicaid program in 1997 for submitting false claims for medically unnecessary and/or never provided services. Nonetheless, Levy set up a series of corporations structured to hide his control and ownership interests in a home healthcare agency, two ambulette companies, and three medical clinics, all of which billed Medicaid for millions of dollars of services.¹³⁷

There are unusual instances in which patients themselves appear to be part of the scheme, but by far the more common scenario involves the buying of patient information without patient knowledge.

- On June 24, 2009, the United States Department of Justice indicted fifty-three people, including physicians, healthcare executives, medical assistants, and Medicare beneficiaries themselves for their alleged involvement in several schemes to submit more than \$50 million in false Medicare claims.¹³⁸ According to the indictments, the defendants were charged with participated in schemes to submit claims to Medicare for phantom and unnecessary treatments, with Medicare beneficiaries accepting cash kickbacks in return for allowing providers to submit forms saying they had received the unnecessary and not provided treatments.¹³⁹
- In *United States v. Ferrer*, Southern District of Florida, On January 24, 2007, a federal jury convicted a defendant in a case involving the theft and transfer of Medicare patient information from the Cleveland Clinic in Weston, Florida.

¹³⁵ *Id.*

¹³⁶ State of New York, Office of Attorney General Press Release, July 16, 2009. Fraudulent Medicaid Provider Allegedly Developed an Elaborate Financial Web to Steal from Medicaid and Launder the Proceeds. Available at: http://www.oag.state.ny.us/media_center/2009/july/july16c_09.html.

¹³⁷ *Id.*

¹³⁸ United States Department of Justice. Press Release #09-623 Wednesday June 24, 2009. Medicare Fraud Strike Force Operations Lead to Charges Against 53 Doctors, Health Care Executives and Beneficiaries for More Than \$50 Million in Alleged False Billing in Detroit. Available at <http://www.usdoj.gov/opa/pr/2009/June/09-ag-623.html>

¹³⁹ *Id.*

The defendant purchased the patient information from a co-defendant, a former Cleveland Clinic employee, who pled guilty on January 12, 2007 and testified against the defendant at trial. The theft resulted in the submission of more than \$7 million in fraudulent Medicare claims, with approximately \$2.5 million paid to providers and suppliers.¹⁴⁰

- In California, unscrupulous medical providers were buying Medi-Cal and Medicare patient identity numbers and were using them to get reimbursed for millions of dollars in tests and other services that were never provided. Of \$34 billion annually spent by the Medi-Cal program for health care for approximately 7 million Californians, state officials estimate that as much as \$14 billion in expenditures relate to similar fraudulent scenarios.¹⁴¹
- A 2009 GAO study reported fraudulent beneficiary conduct in relation to controlled substances. In California, Illinois, New York, North Carolina, and Texas about 65,000 Medicaid beneficiaries (1% of the Medicaid population of these five states) acquired the same type of controlled substance from six or more different medical practitioners (known as doctor shopping) during fiscal years 2006-2007. Some 400 beneficiaries were found to have visited between 21 to 112 medical practitioners to obtain the same controlled substances, a pattern that according to GAO implies drug addiction and fraudulent behavior.¹⁴²

Private Health Insurer Fraud: An Important Added Dimension

Some of the most striking examples of fraud are those that involve the private health insurance industry itself. In these cases, the deception can involve either overstating the insurer's costs in paying claims, or systematically and deceptively undervaluing the amounts owed by the insurer to a health care provider under the terms of its contract. The result is to shift increased responsibility for the cost of care to the plan member and group sponsor, thereby avoiding the insurer's obligations under the terms of its contract:

- In 2009, UnitedHealth, a leading insurance company, paid \$350 million to settle lawsuits brought by the American Medical Association and other physician groups for shortchanging consumers and physicians for medical services outside its preferred network.¹⁴³ Under the United insurers' health plans, members pay a higher premium for the right to use out-of-network

¹⁴⁰ http://www.usdoj.gov/opa/pr/2007/April/07_opa_278.html.

¹⁴¹ Testimony of Pam Dixon, Executive Director, World Privacy Forum. Electronic Health Records and the National Health Information Network: Patient Choice, Privacy, and Security in Digitized Environments Before The National Committee on Vital and Health Statistics (NCVHS) Subcommittee on Privacy and Confidentiality San Francisco, California. Tuesday, August 16, 2005.

¹⁴² GAO. Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States. (GAO-09-957) (September 2009).

¹⁴³ *The American Medical Association v. United Healthcare Corporation, et al.*, 2009 U.S. Dist. LEXIS 45610 (S.D.N.Y. May 7, 2009).

doctors. In exchange, the insurers promise to cover up to 80% of either the doctor's full bill or of the "reasonable and customary" rate depending upon which is cheaper. The Attorney General's investigation found that by distorting the "reasonable and customary" rate, the United insurers were able to keep their reimbursements artificially low and force patients to absorb a higher share of the costs. This intentional manipulation of provider payments resulted in an estimated 10% to 28% increase in members' direct financial exposure for the cost of out-of-network care.¹⁴⁴

- Humana and its affiliated private insurer was found to have intentionally misrepresented the size of its hospitals' bills to employer-sponsored plan members, thereby causing members to pay amounts for their own care that vastly exceeded the 20% copays they legally owed. Humana secretly negotiated deep discounts with its own member hospitals. As a result, plan members were actually paying the majority of the hospital bills they incurred rather than the 20% copay they were promised.¹⁴⁵

Reported Cases in States with Large Medicaid Populations

Table 3 represents similar patterns of health care fraud within the states with the ten largest Medicaid populations again showing that the majority of cases come from providers, not beneficiaries and are distributed among Medicaid, Medicare and private insurance markets alike.

Table 3: Health Care Fraud among States with the Ten Largest Medicaid Populations*

State	Insurance Market	Company	Industry	Type of Fraud	Recovery (Year)
California	Medicaid	City of Angels Medical Center, Vice President ¹⁴⁶	Hospital	False claims, kickbacks	\$4.1 million (2009)
	Medicare	Blue Cross of California ¹⁴⁷	Managed Care	false claims	\$9.25 million (2002)
Florida	Medicaid	WellCare ¹⁴⁸	Managed Care	False claims, conspiracy	\$80 million (2009)
	Medicare	University MRI & Diagnostic Imaging Centers ¹⁴⁹	Radiology	False claims, kickbacks	\$7 million (2008)
Georgia	Medicaid	King Pharmaceuticals ¹⁵⁰	Pharmaceutical	False claims	\$3.5 million (2007)

¹⁴⁴ *Id.*

¹⁴⁵ *Humana Inc. v. Forsyth*, 525 U.S. 299 (1999); 119 S. Ct. 710; 142 L. Ed. 2d 753.

¹⁴⁶ The fraud concerned both Medicaid and Medicare.

<http://www.usdoj.gov/usao/cac/pressroom/pr2009/007.html>

¹⁴⁷ *United States of America, ex rel. Vipul Vaid v. Blue Cross of California; Wellpoint Health Networks, Inc.*

¹⁴⁸ *United States v. WellCare Health Plans Inc.*

¹⁴⁹ *United States ex rel. David Clayman v. University MRI and Fred Steinberg.*

State	Insurance Market	Company	Industry	Type of Fraud	Recovery (Year)
Illinois	Medicaid	Condell Health Network ¹⁵¹	Hospital	False claims	\$2.88 million (2008)
	Medicare	Condell Health Network	Hospital	False Claims	\$33.12 million (2008)
Michigan	Medicaid	OmniCare ¹⁵²	Pharmaceutical	False claims, racketeering	\$52.5 million (2006)
New York	Medicaid	HealthFirst ¹⁵³	Managed Care	False claims, scheme to defraud, falsifying business records	\$35 million (2008)
	Medicare	Staten Island University Hospital ¹⁵⁴	Hospital	False claims	\$25 million ¹⁵⁵ (2008)
North Carolina	Medicaid	Medicaid Center ¹⁵⁶	Dentist	False claims by billing for medically unnecessary services	\$10 million (2008)
	Private	Blue Cross & Blue Shield of NC ¹⁵⁷	Managed Care	RICO	\$8.59 million (2009)
Ohio	Medicaid	Warrick Pharmaceuticals ¹⁵⁸	Pharmaceutical	fraud, unjust enrichment and violation of consumer protection laws	\$4.3 million (2009)
	Private	United Health ¹⁵⁹	Managed Care	Collusion in paying artificially low reimbursements to physicians	\$44.5 million (2006)
Pennsylvania	Medicaid	Schering-Plough Corporation ¹⁶⁰	Pharmaceutical	False claims	\$7.8 million (2004)
	Private	Pennsylvania Blue Plan Highmark Inc. ¹⁶¹	Managed Care	RICO	\$10 million (2007)

¹⁵⁰ Part of a nationwide settlement. *U.S. ex rel. Bogart v. King Pharmaceuticals, Inc.*

¹⁵¹ Condell Health Network made a voluntary disclosure of its violations in order to avoid a FCA lawsuit. http://www.usdoj.gov/usao/iln/pr/chicago/2008/pr1201_01a.pdf.

¹⁵² *Michigan v. Specialized Pharmacy Services (Omnicare Inc.)*

¹⁵³ http://www.oag.state.ny.us/media_center/2008/sep/sep3a_08.html.

¹⁵⁴ *United States and New York State ex rel. Tirado v. Staten Island University Hospital.*

¹⁵⁵ Part of a global settlement against the hospital for defrauding several government programs.

¹⁵⁶ *United States v. Michael DeRose d/b/a Medicaid Dental Center.*

¹⁵⁷ Part of a nationwide settlement. *Rick Love, M.D., et al., v. Blue Cross & Blue Shield Association, et al.*

¹⁵⁸ <http://www.ag.state.oh.us/press/09/05/pr090528.asp>.

¹⁵⁹ Aetna settle earlier for \$22 million. *Academy of Medicine of Cincinnati, et al. v. Aetna, et al.*

¹⁶⁰ Part of a nationwide settlement. *United States v. Schering-Plough Corp.*

¹⁶¹ <http://www.post-gazette.com/pg/07334/837893-28.stm> System

State	Insurance Market	Company	Industry	Type of Fraud	Recovery
Texas	Medicaid	Abbott Labs ¹⁶²	Pharmaceutical	False claims	\$28 million (2006)
	Medicare	Methodist Hospital, Houston ¹⁶³	Hospital	False claims	\$10 million (2009)

Source: Legal cases found from health fraud search on LexisNexis. State Medicaid enrollment data found at Kaiser Family Foundation, <http://www.statehealthfacts.org/comparemaptable.jsp?ind=198&cat=4>.

Anti-Fraud Enforcement and Recovery Efforts

Anti-fraud efforts have met with considerable success. The legislative expansion of anti-fraud law and its active enforcement have led to an increase in convictions and recoveries especially in the case of public health insurance programs, as well as to an increase in funding for implementation and creation of anti-fraud programs and task forces.

HIPAA established a potentially far-reaching Health Care Fraud and Abuse Control Program.¹⁶⁴ The program, covering fraud and abuse in both publicly and privately sponsored health insurance, resulted in approximately \$1.8 billion in judgments and settlements in FY 2007.¹⁶⁵ The expansion of existing Medicaid anti-fraud activities under the Deficit Reduction Act also has resulted in improved Medicaid fraud recoveries.¹⁶⁶

According to the Office of the Inspector General's semiannual report to Congress (Spring 2009), the government's enforcement efforts resulted in 222 criminal actions and 239 civil actions against individuals or entities engaged in health-care-related offenses.¹⁶⁷ These efforts resulted in \$1.6 billion in HHS recoveries, and \$540.8 million in non-HHS investigative receivables, including civil and administrative settlements or civil judgments related to Medicare, Medicaid, and other federal, state, and private health care programs.¹⁶⁸ The report also anticipates more than \$2.4 billion in expected recoveries for the first half of 2009.¹⁶⁹

Another important effort is the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative, which is designed to reduce Medicare and Medicaid fraud. Since its inception in March 2007, with a first phase in South Florida and a second phase expansion in Los Angeles, the Strike Force has obtained indictments of

¹⁶² *Texas ex rel. Ven-A-Care of the Florida Keys Inc. v. Abbott Labs. Inc. and Hospira Inc.*

¹⁶³ *United States v. Methodist Hospital*, (S.D. Texas, 2009).

¹⁶⁴ Pub L No. 104-191 (104th Cong., 2d Sess.)

¹⁶⁵ *Id.*

¹⁶⁶ Centers for Medicare and Medicaid Services. Medicaid Integrity Program Overview. Available at: <http://www.cms.hhs.gov/MedicaidIntegrityProgram/>

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

more than 250 individuals and organizations that collectively have billed the Medicare program for more than \$600 million.¹⁷⁰ In addition, HHS's Centers for Medicare and Medicaid Services, working in conjunction with the HHS-OIG, has taken additional steps to increase accountability and decrease the presence of fraudulent providers.

The Department of Justice secured \$1.34 billion in settlements and judgments in the fiscal year ending Sept. 30, 2008, pursuing allegations of fraud against the federal government.¹⁷¹ Notably, this brings total recoveries since 1986, when Congress substantially strengthened the federal False Claims Act, to more than \$21 billion. As in the last several years, health care accounted for the lion's share of fraud settlements and judgments, more than \$1.1 billion.¹⁷² This number includes both *qui tam* claims as well as claims initiated by the United States. The Department of Health and Human Services achieved the largest recoveries, largely attributable to Medicare and Medicaid recoveries. In fiscal year 2008, state Medicaid Fraud Control Units recovered more than \$1.3 billion and obtained 1,314 convictions.¹⁷³ Recoveries were also made by the Office of Personnel Management which administers the Federal Employees Health Benefits Program, the Department of Defense for its TRICARE insurance program, the Department of Veterans Affairs and others.¹⁷⁴

Table 4 shows the past decade of fraud recoveries. As the table indicates, Medicaid recoveries have increased as the laws have been toughened. As the impact of the 2006 and 2009 reforms are seen, and greater public policy attention to fraud grows, these recovery figures can be expected to increase still further.

¹⁷⁰ Federal Bureau of Investigation Detroit, Department of Justice Press Release June 24, 2009. Medicare Fraud Strike Force Operations Lead to Charges Against 53 Doctors, Health Care Executives, and Beneficiaries for More Than \$50 Million in Alleged False Billing in Detroit. Available at: <http://detroit.fbi.gov/dojpressrel/pressrel09/de062409.htm>

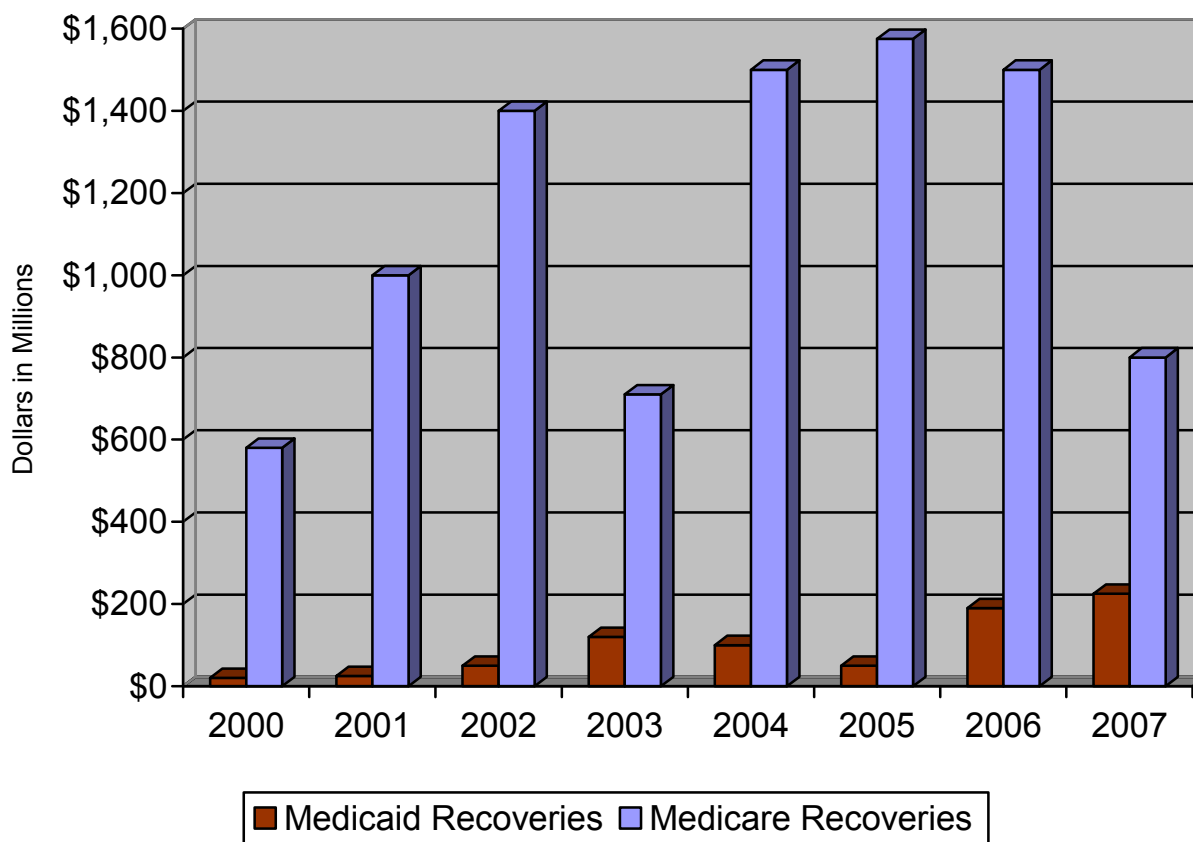
¹⁷¹ United States Department of Justice Press Release #08-992, November 10, 2008. More Than \$1 Billion Recovered by Justice Department in Fraud and False Claims in Fiscal Year 2008. Available at: <http://www.usdoj.gov/opa/pr/2008/November/08-civ-992.html>.

¹⁷² *Id.*

¹⁷³ Department of Health and Human Services Office of Inspector General, State Medicaid Fraud Control Units Annual Report Fiscal Year 2008. Available at: http://oig.hhs.gov/publications/docs/mfcu/mfcu_2008.pdf

¹⁷⁴ *Id.*

Table 4. Federal Health Care Fraud and Abuse Program Recoveries by Fiscal Year.¹⁷⁵



Source: Health Care Fraud and Abuse Control Program Reports from fiscal year 2000-07 available at <http://www.oig.hhs.gov/publications/hcfac.asp>.

Conclusion

Fraud – whether committed by health care providers, plan members, or insurers themselves – is an unfortunate but real part of the health care landscape. Medicare and Medicaid may be susceptible to fraud in part because many investigative reports on victims of consumer swindles suggest that financial fraud is not uniformly distributed across all households; instead, it disproportionately targets the elderly, women, minorities, the less educated, and the poor.¹⁷⁶ Furthermore, laws aimed at curbing fraud provide for extensive public reporting in the case of public insurance programs, a requirement that is not applicable to private insurers unless required to do so under state law.

An extensive body of fraud law exists; nonetheless overcoming fraud will remain a key challenge. The importance of continuing to strengthen these laws is reflected in

¹⁷⁵ The federal recoveries reflect the fiscal year the money was deposited into federal accounts for Medicare and Medicaid and not necessarily the year the claim was prosecuted or settled.

¹⁷⁶ Lee J, Soberon-Ferrer H., *supra* at note 4.

the fact that both the House and Senate health reform legislation focus on the issue. Important ongoing efforts to reduce fraud include extending the reach and scope of the HIPAA insurance fraud provisions of 1996 and assuring transparent reporting across all forms of coverage, including public insurance, private health insurance, and employer sponsored health plans. In addition, while a focus on provider fraud remains crucial, evidence drawn from recent prosecutions and court decisions emphasizes the importance of focusing on insurer fraud as well, including marketing and enrollment fraud, fraudulent misrepresentation of the terms of coverage and payment, provider payment fraud, violation of consumer protection laws, and other forms of conduct that may allow insurers to amass and wrongfully manipulate billions of dollars in government and private premium payments. Finally, sufficient funds must be allocated to federal and state oversight agencies in order to assure that cases of fraud are effectively detected and addressed.