CRIMINAL HEALTH CARE FRAUD ENFORCEMENT AS A COMPONENT OF THE STRATEGY TO REDUCE MEDICARE LOSES: Achieving Deterrence through Increased Sentences for Health Care Fraud

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I. Introduction

In the forty-five years of Medicare fraud, abuse and waste enforcement, the federal government's focus on criminal enforcement has never been stronger than it is today. Recent steps to reduce fraud have federal agents and prosecutors optimistic in their outlook for the upcoming decade and positioned to expand their efforts. The law enforcement community believes, like President Harry S. Truman so bluntly said, that "[we] have never seen pessimists make anything work, or contribute anything of lasting value."[1] As concrete examples of the renewed spotlight on protecting taxpayer funds, the Health Care Fraud Prevention and Enforcement Action Team (HEAT) was unveiled, and the Fraud Enforcement and Recovery Act (FERA) was signed into law on May 20, 2009.

HEAT is the first collaborative Cabinet level organization structured to marshal resources within the federal government to both prevent health care fraud and to advance the funding of law enforcement efforts to deter fraud. A central provision of HEAT's stated mission is to expand the Medicare Fraud Strike Forces (MFSF) model of investigation and prosecution into key strategic regions. Since its announcement, HEAT has continued MFSF operations in Miami and Los Angeles, and expanded the MFSF into Detroit, Houston, New York, Tampa, and Baton Rouge. In terms of impact and deterrence, a key component of MFSF operations has been increased prison sentences for convicted defendants. This article provides an overview of recent law enforcement activity and details how the MFSF prosecutors calculate loss to achieve an average incarcerate term exceeding 45 months.

Over the next few years, law enforcement will use methodical efforts to root out fraud from our health care system. Expanding criminal enforcement across the nation, including focused MFSF operations, are but one way to reduce fraud. HEAT has engaged numerous stakeholders in open dialogue about how to prevent fraud from occurring because the law enforcement community recognizes that it cannot prosecute its way to the end of fraud. To accomplish its lofty goals, law enforcement will also rely on all honest health care providers, including doctors, nurses, pharmaceutical manufacturers, hospitals, device manufacturers, skilled

nursing facilities, academic medical centers, pharmacies, and insurers, to assist in the effort to eliminate fraud.

For law enforcement to accomplish its goals, the Omnibus Appropriations Act of 2009 provided a one-time additional $198 million for joint U.S. Department of Health and Human Services (HHS) and U.S. Department of Justice (DOJ) health care fraud programs through an allocation adjustment for new program integrity work. The President's 2010 Budget invests an additional $311 million in 2-year funding to further strengthen the anti-fraud efforts, a 50-percent increase from the 2009 Budget.

II. Scope of Health Care Fraud

In fiscal year 2009, Medicare is expected to cost the federal government $503.1 billion and Medicaid is expected to cost the federal and state governments $386 billion.[2] Under the current health care system, the Centers for Medicare & Medicaid Services (CMS) projects that federal health expenditures will double from approximately $873.2 billion in 2009 to $1.65 trillion in 2018. While there is no accurate measure of the extent of health care fraud, the Federal Bureau of Investigation (FBI) reports that estimates of fraudulent billings to public and private health care programs range between three and ten percent of total health care expenditures.[3]

Prior to the creation of the MFSF, federal health care programs operated under a "pay and chase" enforcement methodology. The government administered federal programs on a trust based operational model whereby dishonest providers were able to collect funds and disappear prior to law enforcement action. As discussed below, the MFSF presumes nothing and analyzes all claims in its key regions for medically unexplainable claims.

III. Principles for Combating Fraud, Abuse and Waste

In addition to criminal enforcement, there are many other avenues on which HEAT is focused. Within the last year, the Office of the Inspector General at HHS has put forth an integrity strategy that is both proactive in its prevention and detection of fraud, and reactive with its support of rapid investigations, prosecutions, and remedies to program vulnerabilities.

The first principle of the integrity strategy is to block criminals from becoming providers in the system. Those intent on stealing must be weeded out during pre-enrollment screening. Second, payment methodologies must be responsive, employ common sense, and eliminate facially medically unreasonable claims. Third, government programs and agencies must provide clear guidance that is instructive and uniformly enforced. Fourth, law enforcement and program administrators must work together to promote data analysis and the utilization of advanced technology. Finally, law enforcement must assure that those who elect to steal understand that they will be detected, caught and appropriately punished.

IV. The Medicare Fraud Strike Force Model

In March 2007, DOJ, HHS, and state and local law enforcement agencies, launched the Medicare Fraud Strike Force in Miami-Dade County, Florida. Its primary mission was to target

the most egregious violators and bring prosecutions as quickly as possible. While the investigations use exactly the same law enforcement tools and techniques as all fraud cases, many of the targets are identified through the analysis of claims data.

While federal health programs like Medicare and Medicaid always have been vulnerable to fraud, the MFSF has been able to identify trends in schemes and abusive practices. The MFSF has identified large numbers of individuals based on the fact that criminals are copying schemes that they have learned in their communities. These Medicare fraud schemes then replicate across communities, creating regions with high concentrations of criminal activity. The MFSF is focused on eliminating these "viral and regional" schemes by using data analysis and real-time intelligence from the target community to identify and prosecute on-going fraud before it spreads.

MFSF prosecutors seek to charge appropriate violators for engaging in criminal health care fraud conspiracies and substantive crimes. In addition, when the facts merit, prosecutors are encouraged to seek enhanced sentences for "relevant conduct" under the guidelines. As a result, the average MFSF prison sentences exceeded by twenty percent the overall national average sentence in federal health care fraud cases in 2008. Nearly 200 defendants have been sentenced to prison, with sentences ranging from four months to thirty years. The average length of sentence is 45 months.

Between March 2007, and January 2010, MFSF prosecutors brought cases against 508 defendants in 250 cases. Over 261 guilty pleas were taken and juries have returned guilty verdicts against 24 defendants. The 250 indictments contain allegations related to over $1.1 billion worth of criminal false claims. Finally, prosecutors have sought more than $425 million in court-ordered restitution to the Medicare program. As of January 2010, there have been a total of 5 acquittals out of 508 charged defendants.

The charged cases involved a number of schemes including false claims made for durable medical equipment (DME) supplies such as power wheelchairs and orthotics, "compound" medications for use with DME supplies (such as inhalers and nebulizers), HIV infusion clinics, enteral nutrition and feeding supplies, and fraudulent billing companies. Prosecutors have expanded the scope of targeted schemes to include fraudulent home health agencies, independent diagnostic testing facilities, and physical and occupational therapy clinics.

V. Achieving Appropriate Increased Sentences for Health Care Fraud Offenses

One component of MFSF operations that may be particularly relevant to white-collar practitioners is how prosecutors are seeking increased sentences for Medicare fraud offenses. The drive of the MFSF to increase punishment is based on the goal of deterring fraud before it occurs. Scientists teach that deterrence can be increased by focusing on the three factors that impact a person's decisional process. Those three factors are: (1) the person's assessment of the likelihood of detection, (2) the person's understanding of the severity of punishment if detected, and (3) the temporal relationship between the reward of the conduct and the risk of punishment. Therefore, the MFSF has sought to take calculated steps to ensure that the way we prosecute cases helps to deter crime before it occurs.

One of the key components to that deterrent effect was a significant increase in the length of incarceration for imposed sentences. During the first two and a half years of MFSF operations, the average sentence of incarceration was 45 months, which is almost a year longer than the average Medicare fraud sentence nationwide. The community knowledge of substantially longer sentences adds to the perception of punitive risk.

As with most white collar cases, the key driver of a Medicare fraud sentence when applying the advisory United States Sentencing Guidelines (the "Guidelines") is the amount of the "intended loss" under Section 2B1.1. MFSF prosecutors are required to utilize a consistent approach on how to calculate intended loss. Although the facts may vary from case to case, the way to seek an appropriate sentence is to base the loss calculation on what the individual defendant intended. In most cases, the best evidence of the defendant's intent is what he knowingly and willfully inserted in the false claims submitted to Medicare.

VI. Individualized Intent Drives Loss Calculation

One purpose of sentencing is to hold a defendant accountable for his crimes, and with respect to fraud cases, that includes what the defendant intended to accomplish with his fraudulent scheme. The best evidence of a defendant's intent is the action that he undertook. In a health care fraud case, the act of filing a claim requires that a person knowingly and willfully place an amount into the electronic or paper claim form. In most cases, this act is the best evidence of the amount the person intends to take from the Medicare program.

Under Section 2B1.1, the appropriate amount of loss "is the greater of actual loss or intended loss." USSG § 2B1.1, Application Note 3(A). The Guidelines define "intended loss" as "the pecuniary harm that was intended to result from the offense . . . and . . . includes intended pecuniary harm that would have been impossible or unlikely to occur (e.g., as in a government sting operation, or an insurance fraud in which the claim exceeded the insured value.)." *Id.*, Application Note 3(A)(ii). The Eleventh Circuit stated:

> It is not required that an intended loss be realistically possible. Nothing in [the notes to what is now labeled as Section 2B1.1] requires that the defendant be capable of inflicting the loss he intends. We do not agree . . . that an intended loss cannot exceed the loss that a defendant in fact could have occasioned if his fraud had been successful. These decisions are inconsistent with the concept that the calculation can be based on the intended loss.

United States v. Wai-Keung, 115 F.3d 874, 877 (11th Cir. 1997) (citations omitted); *see also United States v. Serrano*, 234 Fed. Appx. 685, 687 (9th Cir. 2007) ("We hold that the district court properly interpreted § 2B1.1 and that the court did not clearly err when it approximated the intended loss as the amounts Appellant submitted to Medicare and Medi-Cal for reimbursement"); *United States v. McLemore*, 200 Fed. Appx. 342, 344 (5th Cir. 2006) (unpublished) (allowing no set-off for the value of any Medicare or Medicaid services actually

rendered or products provided, and holding that the determination of the amount of loss for calculations under § 2B1.1(b)(1) requires the use of the greater of actual loss or intended loss).

In a Medicare fraud case, "actual loss" will rarely, if ever, exceed "intended loss." Actual loss is represented by the amount actually paid out by Medicare for the false claims. It is not uncommon in Medicare fraud cases for there to be numerous claims for which no money was paid out by Medicare, particularly in schemes that involve "blast billing" or instances where CMS catches on to a scheme and denies, or at least delays, payment while it investigates. Thus, the question at sentencing will be what figure – the amount billed to Medicare or the amount allowed under the fee schedules – should be used to determine "intended loss."

As discussed above, the mere fact that the Medicare fee schedules exist does not require that intended loss under the Guidelines be based on the amounts allowed under those schedules. The Guidelines specifically state that intended loss includes loss that would have been impossible or unlikely to occur. Thus, intended loss under the Guidelines is typically calculated by using the amount billed to Medicare minus the twenty percent co-payment deduction where it is established that a defendant understood the co-payment collection requirement, even though such amount may include loss in excess of the amount allowed under fee schedules.

In 2003, the Fourth Circuit directly addressed the issue of using the billed amount as evidence of intended loss. *United States v. Miller*, 316 F.3d 496 (4th Cir. 2003). In *Miller*, a doctor was convicted of mail fraud based on his submission of false and fraudulent claims to Medicaid, Medicare, and the West Virginia Workers' Compensation program. *Id.* at 496. At sentencing, the district court calculated intended loss as the difference between what Miller billed to Medicare (rather than what he actually received), and the amount to which he was legitimately entitled based upon the rendered services. *Id.* at 497.

Miller appealed his sentence, arguing, among other things, that "the court erred in using the amount he billed to Medicare and Medicaid, rather than the payments those programs allow, in estimating the amount of loss he intended because he could not have any reasonable expectation to be paid beyond what the program allows." *Id.* at 501 (internal quotation marks omitted). Miller argued, therefore, that intended loss should be limited to the allowed amount set forth in the programs' reimbursement fee schedules.

The Fourth Circuit emphatically rejected that argument, holding that "the Guidelines permit courts to use intended loss in calculating a defendant's sentence, even if this exceeds the amount of loss actually possible, or likely to occur, as a result of the defendant's conduct." *Id.* at 502. The Fourth Circuit's holding was based, in part, on the common-sense assessment that "[a]s anyone who has received a bill well knows, the presumptive purpose of a bill is to notify the recipient of the amount to be paid." *Id.* at 504.

Other courts of appeals have approved the use of the billed amount as intended loss with much less discussion than the Fourth Circuit. *See, e.g., United States v. Mikos*, 539 F.3d 706, 714 (7th Cir. 2008) ("[The defendant] billed the Medicare program for $1.8 million; that's the intended loss whether Medicare paid or not . . . ."); *United States v. Cruz-Natal*, 150 Fed. Appx. 961, 964 (11th Cir. 2005) (approving use of billed amount to calculate intended loss in Medicare

fraud case "because the intended loss is easily calculated and greater than the actual loss"); *Serrano*, 234 Fed. Appx. at 687.

In *Miller*, the court concluded that the billed amount served as *prima facie* evidence of the defendant's intended loss, unless the defendant offered contradictory evidence regarding his subjective intent. *Miller*, 316 F.3d at 504. Therefore, prosecutors may use this evidence, the amount billed, as the starting point for assessing the evidence to determine a criminal defendant intent.

The Fourth Circuit in *Miller* qualified its holding that intended loss in a Medicare fraud case should be measured by the billed amount, noting that it was possible for the defendant to offer contradictory evidence regarding his subjective intent. *Id.* at 504. In *United States v. Singh*, 390 F.3d 168, 193-94 (2d Cir. 2004), the Second Circuit found that the defendant's testimony regarding Medicare's reimbursement rules, including the fact that Medicare paid claims based on a fee schedule and not necessarily on the amount billed on the claim form, constituted sufficient evidence to rebut such an inference. Thus, the Second Circuit held that the defendant's intended loss should be based on the allowed amount, or the amount as calculated under the applicable Medicare fee schedules, where evidence established that the defendant intended to inflict such a loss.

Although use of the allowed amount may be appropriate in certain instances, particularly in cases and schemes that exist within an otherwise legitimate enterprise, use of the allowed amount to measure loss in fraudulent enterprises risks a sentencing determination that under represents criminal conduct. For instance, if a defendant only intended to take an amount allowed by the computer system and the Medicare program payment formulary, why would not the defendant submit claims for that amount? If he had knowledge of the allowed amount, could not he have easily claimed that amount? Medicare requires that the defendant collect the twenty percent co-payment from patients based on the amount billed to Medicare – did the defendant collect any co-payments? If so, what is the evidence of such collection and was it based on the allowed amount or the billed amount?

Further, did the defendant believe that the Medicare program never mistakenly pays above the fee schedule? Had Medicare paid the claimed amount, would the defendant have kept the money or returned the funds to Medicare saying they did not "intend" to take that much? These questions are particularly difficult to answer. After all, if a defendant really believed that Medicare was infallible, then he would never had submitted fraudulent claims because Medicare would not have paid.

By virtue of the fact that a defendant submitted fraudulent claims to Medicare, the defendant knew that the program had systemic payment weaknesses that made it vulnerable to fraud. Under these circumstances, is it reasonable to believe that the defendant did not intend to keep everything that he might receive as payment from Medicare, including payments over and above the allowed amounts? Even if the defendant did not necessarily expect to receive the full amount of his bills from Medicare, he most certainly would have kept the money had it been paid. *See United States v. Geevers*, 226 F3d 186, 193 (3d Cir. 2000) (the "defendant may not have expected to get it all, but he could be presumed to have wanted to").

All this is not to say that, even with respect to fraudulent enterprises, the billed amount should be unconditionally applied. It is easy to think of instances in which an amount other than that billed to Medicare could constitute the intended loss. The following hypothetical situations put forward scenarios where the claimed or billed amount may not properly constitute the defendant's intended loss:

> 1. A defendant submits claims information to a third-party billing company for preparation and transmission of the claims. In the course of submitting the bills to Medicare, the third-party company transposes numbers and bills Medicare for an amount higher than that reflected on the defendant's submission to the billing company.
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> 2. A defendant hand-writes claims for $500 into Form 1500 claim forms and the Medicare processor misreads the claims as $5000.
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> 3. A defendant has an arrangement with a third-party billing company whereby the billing company gets a percentage of the amount paid by Medicare. Also suppose that the defendant instructs his third-party billing company to bill Medicare $500 per claim for a piece of DME, but that, in order to try to get more money for itself, the company actually bills Medicare $700 per claim.

In each of these examples, and there are certainly numerous others, evidence could be presented that the defendant did not intend a loss to be the amount claimed or submitted to Medicare. But in each of these examples, the focus of the inquiry is properly on the defendant's conduct and intent.

Conversely, the generalized use of the allowed amount based on the mere existence of a fee schedule poses a risk in that a sentencing court may not be properly focused on the specific intent of the defendant. This risk is multiplied when defense counsel seeks to focus attention on the victim's programmatic rules, rather than the defendant's criminal intent. Case analysis reveals that defense counsel frequently focus on abstract, expert opinions about Medicare regulations and internal operating procedures. These have limited import on what an individual defendant intended, unless evidence is focused on the defendant's knowledge of such inner-workings. Thus, unlike the billed amount which at a minimum reflects a knowing and willful act of a defendant, the allowed amount does not, on its face, address a criminal's intent.

In addition, Medicare data from financial intermediaries often has an allowed amount of zero for unpaid claims. In this instance, is it accurate for the court, in using a summed allowed amount for all fraudulent claims, to conclude that the defendant intended to steal nothing from the Medicare program when he submitted these claims, even though they went unpaid? Of course not. So again, the question becomes, for claims in which there is no allowed amount,

what did the defendant intend? The best evidence of that intent is the amount the defendant billed to the Medicare program.

VII. Conclusion

In order to better deter health care fraud on the front end, the MFSF is seeking to: (1) do a better job of detecting health care fraud in the first instance, (2) seek consistent and appropriate punishment, and (3) move cases from identification to prosecution with greater speed. This article has attempted to explain that there is not a uniform method for setting the loss numbers. Rather, an individualized inquiry into the intent of the defendant should be used to determine the intended loss amount.

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[1] *See* Brian Burnes, *Elegant ceremony honors simple man's strong virtues,* Kan. City Star, Apr. 13, 1995, at C8.

[2] National Health Expenditure Projections 2008-2018 [Internet]. Centers for Medicare & Medicaid Services, Office of the Actuary 2007 [cited 2009 June 4]. 5 tbl. 3. Available from: http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf.

[3] Financial Crimes Report to the Public: Fiscal Year 2007 [Internet]. Federal Bureau of Investigation. 2006 Oct. 1 - 2007 Sept. 30 [cited 2009 June 4]. Available from: http://www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm#health.