

# **U.S. Efforts to Stem Health Care Fraud**

## **A CASE STUDY IN LEGALIZED TERROR**

**Presented by**

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**I. The Problem - Scope of U.S. Health Care Fraud. Prior to World War II, the American health care system was pre-modern, i.e., specialty health care was concentrated in large cities and available primarily to the wealthy, while the poor and those who lived in rural areas relied on general practitioners for their health care. During World War II, over 16 million Americans served in the armed forces where they were given access to the best health care services that the government could buy. When they returned from military service, they demanded access to the same level of care. Consequently, in the mid-1940's, Congress passed the Hill-Burton Act which pumped millions of dollars into the health care economy for the construction and equipping of premier health care facilities. Then, in the mid-1960's the government added funding for payment of health care services in the Medicare and Medicaid laws. Effectively, the government was fueling the health care industry, and not surprisingly, providers took advantage of the funding to expand facilities and raise wages. The final act in government funding of the health care system came in 1974, when congress passed the Health Maintenance Organization Act. That law encouraged a new type of health care provider, the HMO, to offer preventive care to its subscribers. Be seen early and often was the concept, and HMOs became user friendly to the point of nurses calling patients to remind them of appointments and to conduct follow up services.**

**The blush was off the bloom, however. In the same year, recognizing that the expansion of health care services fueled by the Hill-Burton and Medicare/Medicaid programs was driving up health care costs at multiples of the average consumer price index increases, Congress passed a National Health Planning Act to contain expansion of the health care system. Then in the 1980's, laws were passed to make government insurance the secondary payor to any private insurer that a patient had, and in the 1990's, both by court decision and legislation, HMO's were mandated to provide services without raising charges, and were subjected to direct liability for an HMO physician's malpractice.**

**Thus, government intervention in health care came full circle. From early infusions of cash which drove up health care costs to government clamps on health care spending. HMOs, the darlings of good health in the 1970's became the over utilizers of health care dollars in the 1990's. The result was that in 2000, health care expenditures in America exceeded \$1.3 trillion or 13% of the Gross Domestic Product. The governments answer? Clean the crooks out of health care!**

**II. The Pattern of Correction. Without looking closely at what might really constitute health care fraud, and realizing that a conviction was an easier mark of efficiency than trying to prove that government regulation was improving health care, the Congress and Administration established Draconian penalties to curb what they saw as health care fraud. These penalties fell into three general categories: Regulatory, Civil Litigation and Criminal Litigation.**

**A. Regulatory penalties include fines or forfeitures equal to three times the amount alleged to have been defrauded or \$10,000 per fraudulent claim. In addition, providers who are found to have defrauded the government will be excluded from participation in government health care programs for a minimum of five years, and on the third such finding, for life. While this may seem appropriate penalties for criminal activity, the government's definition of health care fraud includes activities which were simply good business and marketing practices only a few years ago. Two examples will illustrate my point. Providers file cost reports in which they claim health care related expenses as costs which form the basis for their reimbursement. Government auditors review the reports and routinely disallow costs that in their opinion are not fully documented or are not necessary. This is an iterative and negotiated process, since the reimbursement rules are hardly clear. Previously, the penalty to the provider was simply disallowed reimbursement. Now, the claiming of unnecessary costs is deemed to be fraud. Second, providers are routinely surveyed by government inspectors to determine if they are in compliance with the thousands of pages of government regulations. If they are not, they can be punished financially or in extreme cases, excluded from the program in which they participate. Now, however, the current government plan is that if a provider is not delivering care to the vague government standards, but is submitting normal bills for reimbursement, that too is fraud.**

**B. Civil Litigation included many of the same penalties as are contained in the regulations, but with additional twists. For example, a provider can be fined up to \$10,000 per day for failing to deliver care in accordance with standards or even for unknowingly dealing with someone who has previously be excluded from a government health care program. And carrying the example above of delivering substandard care, the claim submitted for every patient or resident in the provider's facility during the period of time that the deficiencies exist are each separately considered a false claim and subject to separate penalties of \$10,000 per "false" claim. No wonder that nearly any report of government prosecution runs into the millions of dollars.**

**A second aspect of Civil prosecution is the imposition of Corporate Integrity Programs. These are extremely restrictive agreements by which the provider pledges to give up most of its civil rights and self report any activity which may be considered to be questionable, in exchange for reduced government prosecution. Just the onset of a government investigation is enough to cause most providers to seek to settle charges to avoid the adverse publicity, as well as the thousands of man-hours required to comply with government litigation discovery requests.**

**C. Criminal Litigation follows most of the same patterns as Civil litigation except that the government must prove intent to defraud, or at least reckless disregard of the laws, and convictions can carry prison terms up to and including life imprisonment. In addition, under the American justice system, the accused has the right to remain silent in a criminal prosecution and no inference of guilt is presumed. Unfortunately, the same is not true in civil prosecution where the failure to present evidence can be considered in the jury's assessment of guilt. Consequently, the government has taken to prosecuting providers simultaneously under both civil and criminal theories to force providers to produce evidence in the civil proceeding which can be used against them in the criminal case.**

**III. The Actors. The government uses several avenues to approach catching providers that it deems have engaged in health care fraud.**

**A. Government Surveyors/Office of Inspector General. Health care providers are subject to numerous unannounced inspections of their health care facilities and practices. These surveyors have received training to root out health care fraud, even though that is not part of their primary inspection purpose. They are supposed to determine whether or not providers are in compliance with minimum standards of health care delivery. But the government's position is that these inspectors are in a position to uncover possible abuses of the health care system, and turn these cases over to government prosecutors. In addition to inspections of health care providers, The Office of Inspector General reviews the payment practices of government agencies. IN 1998, government auditors determined that payment errors to providers had decreased to only 7.5%. On payments of \$45 billion, that amounts to errors in excess of \$3,8 billion per year. The biggest difficulty is that in tallying "health care fraud", no distinction is made between government payment errors and actual fraudulent activity.**

**C. Private Citizens. The government has instituted a series of incentives to encourage private citizens to report health care fraud. The most popular of these programs involves what are known as Qui Tam Lawsuits. These are lawsuits filed by a private party, and then taken to government prosecutors to see if the government will take on the prosecution, and thereby save the original private party the cost of litigation. If the government takes on the case, the original private party can recover between 15 and 25 percent of the government recovery. With fraud lawsuits being settled in the millions of dollars, private parties are recovering "rewards" of hundreds of thousands of dollars.**

**D. Media. Finally, the government enlists the public media in its pursuit of alleged health care abusers. By releasing press bulletins which detail an investigation of a provider, the government can assure so much adverse publicity that the provider usually will cave in and settle the government's claim without ever going to court.**

**IV. The Scheme. Government prosecutors use both active and passive means of**

pursuing health care providers.

A. Active measures include investigation and prosecution as outlined above. In addition, the government collects information required to be reported by providers and uses statistical samples of that information to determine whether or not to prosecute a provider. For example, one of our clients received a threatening letter from the government stating that the length of stay of their patients was above the national average, and that therefore, the number of above average stays amounted to so many tens of thousands of dollars which the government presumed was because of fraud. Of course, in order to reach an average, some providers must be above the mean and some below, but that mathematical nicety was lost on the investigators. What's more, the courts have upheld prosecutions of providers based strictly on sampling. If 10% of a sample is incorrect, even from honest error, that percentage is applied against the total reimbursement received by the provider, and the resulting amount is deemed to be fraudulent.

B. Passive measures include the requirement that providers self-report any health care errors or fraud to the government. There is no leniency because a provider reported the act. The penalties are just as severe. In addition, government prosecutors have warned providers that even though there is no law or regulation requiring it, providers must conduct a self-assessment to see if they may have been involved in fraudulent activities and then must institute a Corporate Compliance program to prevent any fraudulent activities or errors from arising. These Corporate Compliance Programs are almost as intrusive as the Corporate Integrity Agreements outlined above, but because they are "voluntarily" adopted, they are much more insidious. In the current frenzy of health care prosecutions, providers are conducting internal witch hunts to ferret out any activity which might possibly be considered to be health care fraud, and punishing their own employees when no government agency has determined that the activities uncovered are fraudulent.

V. The Results. The government is proud to announce that its prosecutions have increased by 240% in 1998, and that it has saved the taxpayer \$38 billion since 1992.

Of course the government does not distinguish between its own payment errors and fraud in claiming those figures. In addition, the government proudly announces that it has excluded over 5700 providers, individual and institutional, from its health care programs in 1997 and 1998. Again, there is no qualitative way to determine if these exclusions were due to error or fraud. Finally, the government is pleased that 100% of its investigations started in 1999 were settled favorably to the government. With the enormous resources and the Draconian penalties available to the government it is no wonder that providers are more than willing to settle rather than risk bankruptcy from an exclusion. Government figures indicate that they have collected \$2 billion in settlements since 1986, but this is minuscule compared to the \$1.4 billion dollars that the government pays for health care each day. And again, no distinction is made in the recovery figure between fraud and payment errors.

**VI. Conclusion - strategies for success. The current atmosphere in the health care delivery system in the United States is so frenetic and filled with paranoia on the part of providers that it is a wonder that anyone continues to deliver health care services. What is needed is an even handed approach which is not antagonistic toward providers and which is based on well thought out standards. This would bring some stability into the delivery system, and permit a thoughtful approach to redesigning the payment system to match reality. Second, the government should educate providers, its own regulators and the consuming public as to what can be realistically expected from the health care system, instead of simply portraying providers as criminals. Finally, the United States needs a national policy of health care delivery. All “reform” proposals simply address reducing the payment for health care services. The United States needs leadership which will tackle the tough issues of defining what is an acceptable standard of care, and then determining how much Americans are willing to pay for it.**

**Ironically, the World Health Organization recently released a study of national health care systems. It found that the United States spends more per person on health care than any other country in the world. It also determined that the American health care system ranked 37<sup>th</sup> in performance. The sign should be clear. The United States Government needs to tackle the serious problems facing its delivery system, not simply try to put more providers out of business in order to “control” the cost of health care. What exists today in the United States is a system of health care providers who conduct their business in terror of being accused of committing health care fraud. A very unhealthy situation!**