

HIPAA AND THE CRIMINALIZATION OF AMERICAN MEDICINE

Grace-Marie Turner

Waste, fraud, and abuse in federal health care programs are serious problems, but so are the federal government's efforts to combat them. There are egregious cases of fraud, and those engaged in these criminal activities should be stopped and prosecuted. But an expanding dragnet for "health care criminals" is threatening and intimidating innocent doctors as well. It is creating an unhealthy climate of fear and defensiveness that is having an adverse impact on the medical profession.

In its zeal to rid the nation's health care system of waste, fraud, and abuse, Congress has passed a blizzard of new federal criminal statutes targeting the health care industry, including those contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Congress created new "health care" laws on top of the existing mountain of rules and regulations and funded an army of enforcement agents. The statutes are being enforced by hundreds of federal agents, armed with hundreds of millions of dollars in investigatory funds. This new army of law enforcement agents has been sweeping through hospitals and doctors' offices throughout the country to investigate a new class of "health care offenders."

Mark L. Bennett Jr., an attorney with the firm of Bennett & Dillon, L.L.P. in Topeka, Kansas, says that health care has become the prosecution of choice for many U.S. attorneys: "At one point in time, drugs and drug offenders got the most attention from the authorities, then it was banking and savings and loan violations. Now . . . one of the prosecutions of choice is fraud relating to the provision of medical services. . . . That's where the money is" (Bennett 1998: 1).

Cato Journal, Vol. 22, No. 1 (Spring/Summer 2002). Copyright © Cato Institute. All rights reserved.

Grace-Marie Turner is the Founder and President of the Galen Institute.

The federal government uses the threat of prosecution and arbitrary penalties to collect excessive settlements from doctors “guilty” of clerical errors. Federal officials developed a crude system to extrapolate fines on doctors and hospitals. Any billing practice that established a physician as a financial outlier on a computer statistical analysis could lead to a payment audit. The audit may look at a fraction of the doctor’s medical records, identify a percentage that have coding or billing errors, and then extrapolate the estimated overbillings to the whole practice based upon the sample. But Medicare enforcement officials do not stop there—they then may impose penalties as great as *three times* the total amount of those estimated overbillings.¹

Many of the nation’s 650,000 physicians are living in fear that they could face armed federal agents, prosecution, and even jail time because of a dangerous new trend to criminalize the practice of medicine. “Demonizing the entire medical community with the broad brush of ‘fraud, waste and abuse’ trivializes real fraud and sets up an adversarial tension in every patient-physician encounter,” according to Nancy Dickey, M.D., former president of the American Medical Association (Dickey 1999).

HIPAA Loads New Bullets into Enforcement Guns

The national effort to target medical professionals began in earnest when the Clinton administration introduced the concept of “health care offenses” into the general public lexicon in its proposed 1993 Health Security Act. While the public rejected the draconian bill within less than one year, many of its enforcement provisions became law two years later as part of the Health Insurance Portability and Accountability Act of 1996, sponsored by Senators Edward Kennedy (D-Mass.) and Nancy Kassebaum (R-Kan.). To the surprise of strong

¹For example, if federal authorities were to audit a practice, they would analyze a sample of a practitioner’s patient charts. Let’s say they looked at 25 charts and found errors in 10 of them. That means there were errors in 40 percent of the charts. Then they have to determine how much the errors cost. Let’s say they determined that in the 10 erroneous charts, the physician had overbilled Medicare by a total of \$300, or an average of \$30 per chart. To extrapolate the full fine, federal officials next would ask the doctor how many patients he has. If the doctor has 1,000 patients, and Medicare investigators discovered “errors” in 40 percent of the sampled charts, they would assume that there would be errors in 400 of them. They then would multiply the average overbilling amount (\$30) by 400 in order to come up with their estimate of the total amount of overbillings: \$12,000. At that point, “The OIG may impose an assessment, where authorized . . . of not more than three times the amount claimed for each item or service which was a basis for the penalty” (64 *Federal Register*, No. 140 [22 July 1999], p. 39429). That means our doctor could be fined \$36,000 based upon 10 erroneous charts.

critics of the original Clinton health plan, congressional staff resurrected nearly identical language from many of the enforcement provisions in the 1993 Clinton bill and transplanted them into the Kennedy-Kassebaum legislation (see Appendix I).

HIPAA broke ground in creating a new national health care fraud and abuse control program to coordinate federal, state, and local law enforcement efforts. It also created a federal criminal statute specific to health care offenses, making it easier for authorities to prosecute. It provided generous funding for authorities to investigate and prosecute violators, and it instituted a fraud and abuse data collection program in which government agencies and health plans are required to report on “final adverse actions” against providers.²

Federal Health Care Offenses

HIPAA defines a “federal health care offense” as a violation of, or a conspiracy to violate, any of the nine current criminal statutes or any of the four new health care crimes created under the act: health care fraud, embezzlement, false statements, and obstruction.

The penalties for health care fraud are even more onerous than a similar provision contained in the Clinton Health Security Act. Under HIPAA, anyone knowingly and willfully executing a scheme to defraud any health care benefit program or to obtain falsely money or property owned by or under the control of any health benefit program faces imprisonment of not more than 10 years, a \$250,000 fine, or both. If these schemes result in bodily injury, the person responsible can be imprisoned for 20 years. If the patient dies, a life sentence can be imposed.

HIPAA’s broad provision on false statements makes anyone who knowingly and willfully falsifies or covers up material information or makes false statements in connection with the delivery of health care benefits liable for fines, jail terms, or both.

Criteria and penalties for obstruction and embezzlement are similar. One section creates a new penalty for “incorrect coding or medically unnecessary services.” There is a separate penalty for a pattern of upcoding.

Conviction on a health care fraud offense under HIPAA can easily lead to a money laundering conviction, according to the Medical Association of Georgia’s David A. Cook: “Money laundering occurs when funds gained illegally are commingled with funds earned legiti-

²42 USC Sec. 1320a-7e.

mately” (Cook 1997: 7). Since physicians usually deposit Medicare and Medicaid checks into their practice accounts, the physician may also face money-laundering charges because he or she commingled allegedly tainted funds with legitimate revenue.

Bounty System for Fraud Enforcement

HIPAA provided two major sources of new funding for federal anti-fraud programs.

The Office of Inspector General at the Department of Health and Human Services and the Attorney General jointly run the Fraud and Abuse Control Program. It is funded through a trust account, which in turn is funded by criminal fines, civil judgments, forfeitures, penalties, and damages imposed on health care providers and institutions.

This self-funding mechanism, in which money from this trust then is used to finance more fraud and abuse investigations and prosecutions, was also a provision of the Clinton Health Security Act. Politicians, who did not want to add red ink to the federal budget by adding another spending program, created instead a program in which federal health care authorities have a huge financial incentive to extract settlements and judgments from health care providers. Just as in the Clinton Health Security Act, they can seize property, sell it, and use the money to fund more health care investigators.

In addition, Congress appropriated more than \$100 million a year in taxpayer money to supplement the account. The FBI received an additional appropriation of \$47 million in 1997, increasing to \$114 million in 2002, for investigations of health care offenses through the Fraud and Abuse Control Program. HIPAA also created separate funding for a Medicare Integrity Program, enabling investigators to go after alleged violators of Medicare law even more aggressively. Program funding grew from \$430 million in 1997 up to \$710 million in 2002. The law created a private sector enforcement force by authorizing the use of private contractors.

Congress has criticized the Health Care Financing Administration (HCFA), recently renamed the Centers for Medicare and Medicaid Services, for not having been aggressive enough in awarding contracts to carry out the activities specified in law, including investigating doctors, auditing cost reports, recovery of payments, education of providers, etc. HCFA responded by aggressively stepping up its efforts. HIPAA even created an incentive plan to encourage Medicare beneficiaries and health plan employees to become “whistleblowers” and report information that leads to the collection of at least \$100.

Other Sanctions

One of the most ominous provisions of the law allows the government to exclude a provider from federal programs based simply on an indictment or “on OIG initiated determinations of misconduct, e.g., poor quality care or submission of false claims for Medicare or Medicaid payment.”³ This means that a provider need not even have been found guilty to face catastrophic damages.

HIPAA’s Health Care Fraud and Abuse Data Collection Program requires publication of judgments against medical providers, suppliers, or others convicted of health care offenses. Any health plan that fails to report “final adverse actions” against any health care professional is subject to fines up to \$25,000 per instance not reported.⁴

The Department of Health and Human Services (HHS) claimed in the explanation of its new rule that “Congress intended a broad interpretation of the terms ‘health care fraud and abuse,’ . . . including *adverse patient outcomes*, failure to provide covered or needed care in violation of contractual arrangements, or delays in diagnosis and treatment” (emphasis added).⁵

In other words, HHS can use HIPAA to enforce “quality of health care.” And doctors and hospitals are not the only ones in the sights of enforcers. In addition, HHS interpreted health care practitioners covered by the statute to include “nurses, chiropractors, podiatrists, emergency medical technicians, physical therapists, pharmacists, clinical psychologists, acupuncturists, dieticians, aides, and licensed or certified alternative medicine practitioners such as homeopaths and naturopaths.”⁶

Politicians Duck Hard Choices

Weak Data

The majority of HIPAA’s fraud and abuse provisions were passed despite the absence of good data on how much fraud and abuse there is, where it is, and how bad it is. Congress was legislating in the dark in 1996, and data on fraud and abuse have improved little since then.

In February 1999, Secretary of Health and Human Services Donna Shalala claimed that government efforts had led to a dramatic decrease in health care fraud and abuse, noting that Medicare’s \$12.6

³67 *Federal Register*, No. 52 (18 March 2002), p. 11928

⁴63 *Federal Register*, No. 210 (30 October 1998), p. 58347.

⁵63 *Federal Register*, No. 210 (30 October 1998), p. 58342.

⁶63 *Federal Register*, No. 210 (30 October 1998), p. 58344.

billion in erroneous claims in 1998 were down from \$20.3 billion in 1997. Yet the audit conducted by the Office of Inspector General at HHS revealed that the declining numbers resulted primarily from a big drop in “documentation errors”—from 44 percent of Medicare overpayments in 1996 compared to 16.8 percent in 1997. The “documentation error” decline made up \$8.7 billion of the \$10.6 billion reduction in “improper” Part A and B payments (*Part B News* 1999: 1).

An example from the audit is illustrative: “A physician was paid \$103 for an initial patient consultation, with a comprehensive history, exam, and ‘moderate’ medical decision-making. It was determined [following an audit] that documentation supported a less complex, problem-focused history and exam and \$46 was denied.” (*Part B News* 1999: 4).

As former AMA president Dr. Dickey pointed out, “The government relies on an ‘estimate’ of improper payments based upon a review of claims that were filed for 600 Medicare patients. That’s 0.0015% of Medicare’s 39 million beneficiaries. It’s from this sample that officials project that \$12.6 billion is being ripped off the system” (Dickey 1999). The sample clearly is too small to be accurate.

Many of the errors involve doctors mistakenly failing to put the correct number (drawn from thousands of billing codes) in the right box on the correct form. Nonetheless, HIPAA’s new penalties for such clerical errors are stiff: possible fines up to \$10,000 for each instance.⁷

Following Uninformed Popular Opinion

Congressional policy toward health care fraud and abuse has been fueled by political polls, which were in turn fueled by misinformation and a crude political expediency, or the vague need to “do something” about waste, fraud, and abuse. National polling data consistently show that the majority of Americans erroneously believe that high health care costs are almost exclusively the result of fraud and abuse.

Particularly in the mid- and late-1990s, both Congress and the White House used waste, fraud, and abuse in Medicare as a scapegoat. Rather than tackling the tough job of reforming the program, they implemented the original Clinton plan’s punitive regulatory regime. At the same time, political leaders failed to educate the public on the seriousness of Medicare’s financial problems. Stopping every

⁷42 USC Sec. 1320a-7a (civil monetary penalties for “incorrect coding or medically unnecessary services”).

instance of fraud and improper billing could not come close to saving Medicare from its looming insolvency.

Why Current Financial Arrangements Invite Fraud

While Congress and the Clinton Administration were engaged in a fraud and abuse vendetta, both did an abysmal job of reforming a government system that remains a greenhouse for corruption. Clearly, it is easier for politicians to point fingers at doctors than to blame themselves for the flawed public policies that created the climate for waste in the health care system in the first place.

What is it about Medicare and Medicaid that makes them such a target? The editors of the *New York Times* (1997) observed, “The truth is that the Health Care Financing Administration, the Federal oversight agency for Medicare, has neither the financial means nor the ability to tightly supervise the numbingly complex system.”

The Medicare Regulatory Fog

Dr. Robert Waller, chairman emeritus of the Mayo Foundation and former president of the Healthcare Leadership Council, told the National Bipartisan Commission on the Future of Medicare in August 1998 that Medicare’s regulatory complexity, rather than widespread fraud in the program, is the real problem.

Waller (1998a) testified that “Medicare’s complexity . . . thousands of pages of regulations, rules, manuals, instructions, letters, alerts, notices, etc. . . . has a negative impact on patient care. It steals time from patient care and scholarship . . . dilutes the value of medical records—changing them from a medical record to a billing and coding record—and . . . breeds mistakes. We must all have zero tolerance for real fraud, but differences in interpretation and honest mistakes are not fraud.”

Dr. Waller noted that the number of pages of federal health care rules and regulations his facilities must follow now totals 132,720 pages, the vast majority of which (about 111,000) govern Medicare.⁸

Physicians are increasingly lost in this Medicare fog, confused about what Medicare will or will not pay for in the course of treating

⁸Letter from Bruce M. Kelly, Director of Government Relations, Mayo Foundation, March 4, 1999. “Medicare regulations and supporting documents.” The 132,720 pages of rules include Medicare legislation and regulation, fraud and abuse regulation, the Balanced Budget Act of 1997, HCFA manuals, HCFA *Federal Register* pages, carrier manuals, coding manuals, carrier newsletters, intermediary communications, intermediary Medicare bulletins, HCFA administrator decisions, and nearly three dozen other document sets.

patients. They cannot know for sure whether Medicare will pay for a service until after the fact.

The Medical Necessity Mess

Under Medicare, bureaucrats struggle to define the meaning and application of “medically improper or unnecessary health care services.”⁹ Even among experts, there is disagreement over whether a payment will be withheld over a treatment or procedure, depending on whether or not the Medicare bureaucracy will deem it medically necessary or appropriate. The ultimate decision currently rests with the Secretary of Health and Human Services—not patients and doctors—in deciding what is medically necessary for Medicare patients.

But it is impossible for the federal government to define a term as medically ambiguous as medical necessity in a way that would get it right for every patient in every medical circumstance. In the meantime, doctors cannot be sure what the government’s definition will be in any given case. Congress should heed these words of caution: If it cannot define the standard to be applied, it should not create a legal obligation.

Examples of this medical “twilight zone” are numerous. Dr. Philip M. Catalano (1998) recounts his experience as a Florida dermatologist in trying to treat patients for actinic keratosis, a pre-cancerous skin condition:

HCFA has decided that only a limited number of actinic keratoses can be frozen within a given period of time. In other words, if a patient with severe sun damage has the upper limit done (now 15 on a single day’s session) and comes back in a couple of months with another lesion or two, the subsequent lesions can be rejected by Medicare on the grounds that they “exceed” the limits imposed by Medicare. Interestingly enough, the total number which can be done in a given time period is a secret. . . . Medicare will not tell you, they will only tell you that you exceeded the limits.

To add double jeopardy, the Medicare Private Contracting provision contained in Section 4507 of the Balanced Budget Act of 1997 could forbid the patient from paying the doctor privately to have the skin lesions removed unless the doctor gets out of the Medicare program altogether for two years.

⁹“Congress intended a broad interpretation of the terms ‘health care fraud and abuse’ . . . we believe that include(s) . . . services . . . that are medically unnecessary” (63 *Federal Register*, No. 210 [30 October 1998], pp. 58341–42).

Dr. Philip R. Alpert (1997), a California internist specializing in geriatrics, points to another absurdity of Medicare rules in governing colon cancer screens:

If a doctor orders a stool specimen to test for occult blood—which might indicate an early colon cancer—is he engaging in good medical practice or criminal behavior? Answer: It depends. If the patient doesn't have symptoms and the bill is sent to Medicare, it's a criminal offense because these preventive services are not covered benefits. Thus, billing them to Medicare is considered fraud. The absence of intent to cheat Medicare doesn't matter. Fines of up to \$10,000 per incident of fraud may be levied on the physician who simply orders the test from a lab at no personal profit.

Medicaid's Fraud and Abuse Time Bomb

The problems that plague Medicare plague Medicaid as well. The HHS Office of Inspector General acknowledged in testimony before Congress in March 1999 that the Health Care Financing Administration had no method for arriving at a national estimate of wrongfully-paid Medicaid claims in the program that pays for medical care for the poor. Further, Assistant Inspector General Joseph Vengrin said there has been a “fairly substantial” drop-off in site visits and audits of Medicaid providers “over the past few years, at least in part because of a lack of resources” (Faulkner and Gray, Inc. 1999b).

Because Medicaid is a joint federal-state program, responsibility is diffused. Auditors found that “weaknesses identified in prior years' audits were not corrected” and that there was “significantly reduced emphasis on detecting Medicaid errors and irregularities and on requiring states to devote resources to fraud and abuse collection and activity.” Vengrin told Congress the states are reluctant to work with HCFA because there is no mandate for them to do so (Faulkner and Gray, Inc. 1999b). While federal officials focus on Medicare, criminals very likely are focusing on Medicaid. It is a fraud-and-abuse time bomb waiting to explode, and it is beginning to get the attention of Congress, which is exploring the possibility of creating a Medicaid Commission to study the program and its problems.

The Real Criminals

While the great majority of doctors are honest, the structure of the Medicare and Medicaid programs leaves them vulnerable to real criminals. The serious con artists, intent on bilking the Medicare and Medicaid programs and private insurance companies, take great pains to study the rules and find ways around them. They carefully figure out how to create schemes that siphon millions of dollars through fly-by-night health care organizations.

The most common scheme is to create fake companies that seek reimbursement for fictional treatments of real patients by real doctors. Patients and doctors both can be victims, with taxpayers footing the bill. The *New York Times* described one typical fraudulent plot:

Sham companies are created which, through various schemes, get names and billing numbers for actual patients. The companies then submit claims for the real patients with fictional treatments. As a result, untold numbers of patients can be listed in insurance-company computers without their knowledge, describing ailments they never had and for which they never received treatment. Without their knowledge or authorization, criminals use real doctors' names on large numbers of phony claims. Once the fraudulent scheme is detected, insurance companies and federal agents begin investigating the innocent doctors and delay payment on their legitimate bills. By then, tax authorities also have then gone after them for evading taxes on income that they never received [Eichenwald 1998].

Of course, there is a difference in the powers of government and those of private sector companies in detecting and combating fraud. "The government can utilize powers not available to private managed care companies; namely, criminal prosecution and forfeiture of assets," says David Cook. He points out that, "Because it is so politically unpopular to address beneficiary eligibility and benefits, targeting physicians and other providers becomes an attractive alternative for policy-makers." Not only will reduced payments and the constant threat of criminal and civil sanctions fail to achieve the desired monetary savings, they will ultimately drive physicians out (Cook 1997: 2).

Flawed structures of both the private and public sector health insurance programs—where the distance between doctors and patients is lengthened by the intervention of complex third party payment systems—invite fraud, abuse, and mistakes. But rather than begin to fix the complex systems which create a climate for fraudulent schemes, politicians instead have opted to impose a wide-ranging regulatory scheme that covers all doctors and hospitals in hopes they will catch some of the criminals. While this dragnet for criminals ensnares innocent doctors in a dizzying web of paperwork, common-sense principles of public policy have yet to be employed in the serious business of reducing fraud in the Medicare and Medicaid programs.

"The basic system seems designed to enable fraud," former AMA president Daniel (Stormy) Johnson, M.D., told the author. "Why not be on the side of trying to get this fixed rather than throwing hundreds of millions of dollars at these investigations?"

The Big Business of Fraud Enforcement

The current regulatory regime is breeding a whole new industry of billing consultants, administrative specialists, technocrats, and experts on Medicare law, rules, and regulations, including lawyers and insurance agents. Among the most well attended sessions at the American Bar Association's recent meetings have been those devoted to representing doctors in fraud investigations. Given the current career-ruining regime of Medicare regulation, it is hardly surprising.

Medical malpractice insurance now routinely covers the cost of investigations. In Wisconsin, for example, the largest medical malpractice insurer has added a new benefit to policies for doctors. If the doctors have fraud compliance programs in place in their offices, they can get \$25,000 in coverage to cover the costs of a fraud investigation. The insurance company, PIC Wisconsin, said it added the benefit because "there's been a lot of activity by feds who are looking for ways to investigate and uncover billing errors" (Manning 1998: 8).

"The fear of investigations is so great among physicians that many of them have begun to submit reduced bills to Medicare in case they are audited," Wisconsin physician Sandra Mahkorn told me.

One private company is using doctors' fear of investigations as part of its marketing plan. The company disguised its marketing materials as a threatening notice from the government. The marketing letter is headlined "Fraud & Abuse Compliance Alert." It looks like a letter from a government agency and is stamped "Second Notice." The letter offers a 900-page *Fraud and Abuse Answer Book* to "explain government rules and enforcement actions in plain English." It says it provides "the most current information" on "Stark II, the Anti-Kickback Statute, HIPAA, the Balanced Budget Act, Operation Restore Trust, the False Claims Act, OIG model compliance plans and more." Further, the letter says the book "reveals how the government goes about investigating providers and furnishes crucial information on your rights." The \$248 bill for the book is printed to resemble a tax payment notice from the federal government, and payment is to be mailed to a post office box in Washington, D.C.

Nonprofits are in the game as well: The National Health Care Anti-Fraud Association (NHCAA) offers a series of training programs and "provides leading-edge information on health care fraud prevention, detection, investigation, and prosecution techniques to approximately 1,000 anti-fraud professionals representing private health payers' special investigation units and public-sector law enforcement and health care administration personnel" (NHCAA 2002).

Turning Seniors Loose on Their Doctors

Making matters worse, on top of the complex and detailed regulatory environment in which physicians are forced to operate under the existing Medicare law, Congress enacted a bounty hunter provision in HIPAA, which pays senior citizens for helping to ferret out fraud. The leadership of the AARP, a powerful interest group supporting health policy initiatives for seniors, sought to capitalize on the public's anti-fraud sentiment. After HIPAA was enacted, AARP launched an effort to turn Medicare patients into informers by providing them with a "Medicare Fraud Fighters Kit," composed of a magnifying glass and highlighter, pen, note pad, bumper sticker, and a refrigerator magnet listing the fraud-fighting 800 number. The tacit assumption is that Medicare patients will understand Medicare billing rules better than Medicare doctors. Seniors become eligible for the bounties if information on improper billing by their doctors uncovers abuses.

Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons, warned, "We hope the government will reconsider the cynical use of seniors as paid informants. Seniors may not realize a phone call to the government fraud hotline could unleash a chain of events that could destroy their doctor" (Faulkner and Gray, Inc. 1999a). Adds former AMA president Johnson, "Professional liability already says anyone who walks in the door is a potential threat to your practice" [because of medical liability]. Now, everyone over 65 is a potential whistleblower" for federal enforcement agents, he told me.

Doctors at Risk

Civil actions have become lucrative for law enforcement agencies (see Table 1). The government can seek \$10,000 in fines for each violation, plus three times the amount of the charges in question. One dispute over \$50,000 in Medicare bills wound up in a court with fines and penalties totaling \$15 million (Pretzer 1996: 57). In this inquisitorial legal climate, doctors fear their livelihoods and financial security are at risk if their office assistants happen to make errors on federal forms. Even if they can withstand the financial losses, doctors are particularly terrified of reputation-ruining fraud charges. They often feel it is safer to simply pay heavy fines than to fight the federal government.

For example, one physician, who feared having his name used, was

TABLE 1
FRAUD AND ABUSE COLLECTIONS

	1997	1998	1999	2000	2001
Judgments, settlements, fine (millions of dollars)	\$1,200 ^a	\$480	\$524	\$1,200	\$1,700
Criminal indictments filed	282	322	371	457	445
Convictions	363	326	396	467	465
Civil cases pending	4,010	3,471	2,278	1,995	1,746
Civil cases filed	89	107	91	233	188
Exclusions from Medicare/Medicaid	1,000	3,021	2,976	3,350	3,756

^aMore than \$500 million of this amount resulted from settlements in three cases involving clinical laboratory billing practices.

SOURCE: Department of Health and Human Services and Department of Justice, Health Care Fraud and Abuse Control Program, Annual Reports for FY 1997, 1998, 1999, 2000, and 2001.

challenged by federal authorities on a Medicare bill.¹⁰ He did not think that the service he provided to his patient was “covered” under Medicare rules. However, he called program administrators, and he was told that it was a covered service. He soon was paid by Medicare, but officials later changed their minds, saying that the service was not covered after all. The physician was required to reimburse Medicare. He complained and soon found federal investigators in his office demanding to audit his entire practice.

How the Regulatory Regime Impacts Patients

For nearly two decades, political leaders have been tightening the screws on health care providers in the belief that they could penalize providers and cut payments without any impact on patients. In their efforts to get control of mushrooming costs, politicians have tried to insulate beneficiaries. However, the changes ultimately cannot help but impact patients. The government increasingly is inserting itself between the physician and the patient in the most intimate decisions involving medical care. The consequences are serious.

Compromising Patient Care

Because doctors increasingly are forced to practice medicine by the bureaucratic book to avoid possible prosecutions, they are less likely

¹⁰Fear among physicians is growing to the point that few physicians would allow this author to use their names for this paper.

to be innovative and to offer newer treatments that have not yet been approved by the regulators. Among other things, says Dr. Waller (1998b), the “blizzard of Medicare billing rules . . . has a negative impact on quality of medical care, research, and education, as it steals time from direct care of the patient, from new technology development, and other scholarly activities that lead to new discoveries in diagnosis and treatment of illness.”

Doctors who are buried in government paperwork are not spending time increasing their medical knowledge. They are forced to spend so much time deciphering a mountain of rules and regulations that the time available to keep up with the latest developments in clinical practice recorded in medical journals is limited. Instead, they have to devote more and more time to paperwork exercises. For example, a prominent newsletter advertised a conference for anesthesiologists in the summer of 1999 that was entitled “Anesthesia Billing, Coding & Compliance 1999.” Sadly, anesthesiologists have a higher stake in attending such events to make sure they are not running afoul of health care laws than they do in attending a continuing medical education event on the latest advances in anesthesiology technology.

As an entire industry of consultants and paperwork specialists grows up around the bureaucratic Medicare system, the bureaucracy and its resulting paperwork are increasingly expensive and wasteful. Doctors and hospitals ultimately must pass the costs on to the public, either through higher taxes due to increased spending on federal programs or through higher health insurance costs for those in the private sector.

Washington, D.C., attorney Jonathan Emord (1998: 31) explains how the practice of medicine is being damaged by this bureaucratic system:

Physicians find it difficult to discern what medical services are covered by Medicare. . . . They must spend considerable time and money to satisfy complex and confusing Medicare regulations that are traps for the unwary, and they fear costly injuries, investigations, audits, and prosecutions by Medicare enforcement authorities. They [face] an increasingly intrusive federal regulatory establishment to interfere with their exercise of independent professional judgement and limit their freedom to serve the best interests of their patients.

Doctors are getting divorced from the practice of medicine and married to the public and private sector bureaucracies that pay their bills. They are forced to jump through an increasingly complex array of federal hoops that prescribe exactly what they can and cannot do for their patients. They order tests and treatments they otherwise

would not—or withhold them—based not upon what is best for the patient but what Medicare will approve for payment (and will not assign for prosecution as “fraud”). The individuality of the patient’s needs is lost in the government’s ever more aggressive effort to force everyone into the same one-size-fits-all box. Physicians are finding it harder and harder to work in small practices, and they are forming and joining larger groups, which offer greater legal protection but less continuity with their patients.

As Emord points out, this is “hastening the arrival of the day when physicians will be able to practice only if they are affiliated with large hospitals or managed care groups that can afford the risk managers, accountants, and lawyers needed to ensure compliance with Medicare regulations” (Emord 1998: 31).

Clinton Care on the Installment Plan

Among the many elements of the failed Clinton Health Security Act that shocked the public were its onerous enforcement provisions. The 1,342-page bill provided a cornucopia of fines and prison sentences targeting physicians, health plan employees, lawyers, pharmaceutical companies, medical suppliers, and even patients. However, these enforcement provisions were integral to a health care system that was designed by government to force everyone to play by the same set of rules. In such a system, escape hatches must be closed.

One of the biggest concerns the American people had about the Clinton bill was that government, not doctors, would decide what medical care they should get. With nearly half of the nation’s health care bill now being financed through government programs, it already is clear that the majority of those in the medical profession must comply with Big Brother’s rules.

The teeth behind those rules can be found in the multitude of criminal and civil statutes that have been enhanced by HIPAA to target health care offenses (see Appendices I and II). Law enforcement agents have powerful weapons to go after health care crime, but their indiscriminate use may harm innocent health care providers and their patients instead.

Portents for the Future

The Bush administration is mandated by federal law to continue its activities to combat fraud and abuse. CMS administrator Thomas A. Scully and assistant attorney general Robert D. McCallum, chief of the Civil Division of the Department of Justice, confirmed in a March

22, 2002 letter to Senator Charles Grassley (R-Iowa) that they are committed to working together in Medicare and Medicaid investigations and prosecutions. Scully was asked to clarify an earlier statement he made during a congressional hearing that CMS had significant legal differences regarding some Justice Department investigations (Bureau of National Affairs 2002).

However, investigations following the September 11, 2001 terrorist attacks have refocused the nation's attention on finding and prosecuting real terrorists. While government officials have a responsibility to enforce HIPAA, their verve and vigor may diminish.

Early signs already have appeared on Capitol Hill that at least some members of Congress believe they may have gone too far in criminalizing the practice of medicine. On March 5, 2001, Senator Frank Murkowski (R-Alaska) introduced legislation (S. 452, the Medicare Education and Regulatory Fairness Act) that would "ensure that the Secretary does not target inadvertent billing errors" and calls for "regulatory fairness for physicians" that would soften some provisions of HIPAA. The bill says:

The overwhelming majority of physicians and other providers in the United States are law-abiding citizens who provide important services and care to patients each day . . . [who] have trouble wading through a confusing and sometimes even contradictory maze of Medicare regulations . . . [that detract] from the time that physicians have to treat patients . . . If this trend continues, health care for the millions of patients nationwide who depend on Medicare will be seriously compromised. Congress has an obligation to prevent this from happening [Sec. 2, p. 2.]

What Members of Congress Should Do

Americans live in an era of decentralization driven by explosions in technology and information, yet the health care system, both in the public and private sectors, is lumbering along in the opposite direction. Centralized bureaucracies, both public and private, are trying to gain greater and greater control over the most minute aspects of physician-patient encounters. At some point, this effort at centralization will implode.

Under the current system, the enforcement provisions that doctors are complaining about today will only get worse. Penalties are inevitable in any program that attempts to force everyone—patients and doctors—to abide by the same set of rules. The result is a progressive loss of individual freedom. Treating doctors like criminals also cannot help but erode the quality of the medical profession. Unless support-

ers of freedom begin to enact legislation that injects the energy of free markets, competition, and individual freedom into the health care system, the erosion inevitably will continue.

Politicians are more than willing to point the finger at fraud and abuse rather than tackle the difficult questions involved in making structural reforms to public and private health care financing systems. Government bureaucracies have churned out thousands of pages of new regulations that are unlikely to stop professional criminals, but which definitely burden average doctors and make honest compliance mistakes even more likely. Many of the problems with health care crime are endemic to the third-party payment system. They would be minimized if basic structural reforms put consumers back in charge in a vibrant, competitive marketplace.

No one is suggesting that patients should be negotiating with doctors for their fees if they are laid out on a stretcher in an emergency room. But savvy American consumers, both working people and senior citizens, are perfectly capable of making decisions about the kind of private insurance arrangements they prefer in case of such an emergency, or even for routine treatment. By being closer to the cost of the insurance policy, consumers inevitably will pay more attention to the cost of the health care they receive. However, achieving this requires structural reform of the health care financing systems in both the private and public sectors to put consumers in charge of resources and choices. The only way to right the system over the long term is to decentralize its financing to allow consumers to have greater control, authority, and responsibility over resources and decisions.

Reform the Public and Private Systems of Health Care Financing

Congress must begin to tackle the tough choices and be honest about fixing the real problems in Medicare and Medicaid and the private health care financing system. Experience proves that trying to enforce cost containment with laws rather than through market dynamics is a no-win game. Fraud and abuse will never end while the programs are structured as they are.

Free-market reform would put individuals in control of their own health care decisions and would reverse the trend toward greater and greater government control of the health care system. If Americans were to have an incentive to be engaged in decisions about their health care arrangements, they would force the creation of a free health care system that is regulated by the discipline of the competitive marketplace. In a patient-centered system, people would be able

to choose health care arrangements based upon cost and quality. Providers and insurers would compete on these same criteria.

Medicare premium support in the public sector and individual tax credits for the uninsured in the private sector would begin to establish a new financing system where individual citizens gain the chance to purchase health insurance that they own and control themselves.

Review the Regulatory Impact of Existing Law

At the very least, Congress should stop passing more laws and regulations before it has had a chance to assess the impact of all of the new legislation it has enacted.

Defederalize Health Care Crime

As former attorney general Edwin Meese III and his colleagues concluded in an American Bar Association Task Force report (Meese et al. 1999: A19), enactment of federal offenses that duplicate state laws is not only unnecessary and unwise, but it also has harmful implications for the whole criminal justice system:

For most of this nation's history, federal criminal jurisdiction was limited to offenses that involved truly national matters, such as treason, counterfeiting, bribery of federal officials, and perjury in the federal courts. But in recent years . . . we federalize everything that walks, talks, and moves.

Congress should return responsibility for criminal investigations and prosecutions to the level of government where it belongs—the states.

Protect Doctors from Wrongful Government Actions

Congress should also put safeguards into place to protect innocent providers from overly aggressive enforcement agents. Emord (1998: 37) observes, "Under HIPAA, health care practitioners may be forced to spend tens of thousands of dollars, lose financial opportunities and their reputations, and yet not be able to recover damages when they are finally proven innocent of wrongdoing." Physicians who are proven innocent should have a statutory right to recoup the money they have lost as a result of wrongful investigations, audits, and enforcement actions. If a doctor or medical facility, following an investigation, has been found not guilty, the government should reimburse them for all costs associated with the legal investigation and actions that may follow.

Eliminate Medicare's Bounty Hunting System

The bounty system enacted in HIPAA creates a trust fund into which money and proceeds from the sale of confiscated property are deposited. The revenues in this trust are then used to finance more fraud and abuse investigations and prosecutions. This self-funding mechanism encourages a quota system where agents go after citizens to meet their targets to perpetuate funding for their agencies. It bypasses our constitutional system of checks and balances and eventually will generate the same public outcry that the Internal Revenue Service experienced when its collection quota system was exposed. According to Emord (1998: 32):

Rewarding those who enforce Medicare fraud and abuse regulations with more program funds creates strong institutional incentives for those enforcers to pursue as many investigations and fraud and abuse prosecutions as possible, thus increasing the risk that the innocent as well as the guilty will suffer punishment. An analogy can be made with the Internal Revenue Service. Past years have brought it to light IRS abuses that resulted from agents being rewarded for how much money they could extort from taxpayers. Thus, while the IRS is supposedly abandoning a system of perverse incentives, Congress has mandated such a system for Medicare.

This should and must be eliminated.

Apply IRS Audit Reform Standards to Federal Health Care Audits

Many doctors fear criticizing CMS and other federal fraud and abuse enforcement agencies, or their policies. That fear should be put to rest. If any federal official conducts an audit because of doctor complaints about federal policies, then the legal sanctions that currently govern IRS audits would apply to those federal audits as well. Politically motivated or retaliatory audits are a felony under IRS law. They should be a felony under Medicare law, too.

Make Federal Authorities Accountable for Distinguishing between Fraud and Clerical Errors or Mistakes

Congress should order CMS to clarify the degree to which "improper payments" are fraudulent or merely a matter of clerical error. Taxpayers currently cannot know if the government's claims of reductions in fraud are accurate, what standards the agency is using, and what can be learned for future action by Congress to combat fraud.

Provide Administrative Review

The Provider Reimbursement Review Board should be assigned to serve as an adjudicator of disputes between doctors and government over coverage and reimbursement issues.

Streamline Medicare Rules

Congress should direct CMS to simplify the complex thicket of rules and regulations that torment physicians and imperil the quality of care. CMS also should be required to correct its database, which is faulty and frail.

Target the Real Problem

Congress should monitor law enforcement efforts and curb abusive practices such as intimidation of witnesses, forcible entry, bounty hunting, use or display of deadly weapons in circumstances presenting no threat of harm to officers, knowing use of perjured testimony, and similar tactics. In addition, it should identify areas most vulnerable to fraud, determine their extent, and target resources in the most effective manner.

Conclusion

Real change in the American health care system will come only when the power to make health care decisions is taken away from politicians, bureaucrats, lawyers, consultants, and accountants, and placed into the hands of those whose lives and health depend on access to quality medical treatment. More aggressive oversight may make a difference in combating fraud and abuse. But it will come at the cost of further corrosion of the doctor-patient relationship. Every action taken by a doctor or hospital will increasingly be subject to second-guessing and third-party monitoring. Medical judgments made and services rendered will become, in retrospect, grounds for civil and criminal action. Even today, doctors and hospitals practice the art of medicine with the knowledge that even an honest billing error could set off a chain of events that could threaten their livelihoods and result in a prison sentence.

To paraphrase Friedrich Hayek, the Nobel Prize-winning economist, there are only two ways of holding men accountable: prices and prisons. Unfortunately, some of the people who get thrown in jail may have honestly misunderstood the regulation they needed to follow (Citizens Against Government Waste 1997: 27). This is not a health care system befitting America.

Appendix I: Enactment in HIPAA of Clinton Health Plan Provisions

The Clinton administration introduced the concept of a “health care offense” into the general public lexicon. While the public rejected the draconian bill proposed by President Clinton in 1993, the term and many of its enforcement provisions were enacted into law as part of HIPAA. The table below gives just a few examples from 44 pages of the HIPAA text that mirror enforcement provisions, and often exact language, from the Clinton Health Security Act. The language that is virtually identical in the two pieces of legislation is highlighted in bold type.

Clinton Health Security Act	Health Insurance Portability and Accountability Act of 1996
<i>HSA and HIPAA both set up “Health Care Fraud and Abuse Control” systems, define where the money will come from, and specify how the money will be used.</i>	
Section 5402. Establishment of all-payer health care fraud and abuse control account.	Section 201. Fraud and Abuse Control Program.
(a) Establishment. —	(1) Establishment. —
(1) . . . There is hereby created on the books of the Treasury of the United States an account to be known as the “All-Payer Health Care Fraud and Abuse Control Account” (in this section referred to as the “Anti-Fraud Account”) . The Anti-Fraud Account shall consist of such gifts and bequests as may be made . . . It shall also shall include the following:	There is hereby established in the Trust Fund an expenditure account to be known as the “Health Care Fraud and Abuse Control Account” (in this subsection referred to as the “Account”) .
(A) All criminal fines imposed in cases involving a Federal health care offense . . .	(a) There are hereby appropriated to the Trust Fund . . . such gifts and bequests as may be made . . .
	(i) Criminal fines recovered in cases involving a Federal health care offense

- (B) **Penalties and damages imposed** under the False Claims Act . . .
 - (C) Administrative penalties and assessments imposed under . . . the Social Security Act
 - (D) **Amounts resulting from the forfeiture of property by reason of a Federal health care offense.**
- (b) **Use of Funds.—**
- (1) Amounts in the Anti-Fraud Account shall be available without appropriation and until expended as determined jointly by the Secretary and Attorney General in carrying out the All-Payer Health Care Fraud and Abuse Control Program . . . and may be used to cover costs incurred in operating the Program, including—
- (A) costs of **prosecuting health care matters** . . .
 - (B) costs of **investigations** . . .
 - (C) costs of **financial and performance audits of health care programs and operations;**
 - (D) costs of **inspections and other evaluations.**
- (ii) Civil monetary **penalties and assessments imposed** in health care cases . . .
 - (iii) **Amounts resulting from the forfeiture of property by reason of a Federal health care offense.**
 - (iv) Penalties and damages obtained . . . in cases involving claims related to the provision of health care items or services . . .
- (C) **Use of Funds.—**
- The purposes described in this subparagraph are to cover the costs . . . of the administration and operation of the health care fraud and abuse control program . . . including . . .
- (i) **prosecuting health care matters** (through criminal, civil and administrative proceedings);
 - (ii) **investigations;**
 - (iii) **financial and performance audits of health care programs and operations;**
 - (iv) **inspections and other evaluations**
 - (v) provider and consumer education regarding compliance . . .

HSA and HIPAA define a “health care offense” in the same way and reference many of the same sections of existing law (although the HIPAA writers appear to have had more time to conduct their research).

Section 5402 (Continued) . . .	Section 241.
<p>(d) Federal health care offense defined. The term “Federal health care offense” means a violation of, or a criminal conspiracy to violate</p> <p>(1) sections 226, 668, 1033, or 1347 of title 18, United States Code;</p> <p>(2) section 1128B of the Social Security Act;</p> <p>(3) sections 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of title 18, United States Code, if the violation or conspiracy relates to health care fraud . . .</p>	<p>Definitions related to Federal health care offense.</p> <p>(a) As used in this title, the term “Federal health care offense” means a violation of, or a criminal conspiracy to violate</p> <p>(1) section 669, 1035, 1347, or 1518 of this title;</p> <p>(2) section 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title, if the violation or conspiracy relates to a health care benefit program . . .</p>

The language in the explanations of fraud and penalties is nearly identical in HSA and HIPAA, although HIPAA added the qualifier that doctors must “willfully” execute fraud.

Section 1347. Health care fraud.	Section 1347. Health care fraud.
<p>Whoever knowingly executes, or attempts to execute, a scheme or artifice—</p> <p>(1) to defraud any health alliance, health plan, or other person, in connection with the delivery of or payment for health care benefits, items, or services;</p> <p>(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the</p>	<p>Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—</p> <p>(1) to defraud any health care benefit program; or</p> <p>(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the</p>

money or property owned by, or under the custody or control of, any health alliance, health plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury . . . such person shall be imprisoned for life or any term of years.

money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury . . . such person shall be fined under this title or imprisoned for not more than 20 years, or both; and if violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

The False Statements language also is nearly identical.

Section 5433. **False Statements.**
[Amendment to criminal law]

Section 1033. **False statements relating to health care matters.**

(a) **Whoever, in any matter involving a health alliance or health plan, knowingly and willfully falsifies, conceals, or covers up by and trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false,**

Section 244. **False Statements.**
[Amendment to criminal law]

Section 1035. **False statements relating to health care matters.**

(a) **Whoever, in any matter involving a health care benefit program, knowingly and willfully—**
(1) **falsifies, conceals, or covers up by any trick, scheme, or device a material fact; or**
(2) **makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document**

fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

knowing the same to contain any materially false, fictitious, or fraudulent statement or entry in connection with the delivery of or payment for health care benefits, items, or services, shall be fined under this title or imprisoned not more than 5 years, or both.

... as is the language saying that doctors must forfeit their property, real or personal, if convicted.

5432. **Forfeitures** for violations of fraud statutes.

(a) **In General.—Section 982(a) of title 18, United States Code, is amended by inserting after paragraph (5) the following:**

If the court determines that a Federal health care offense . . . is the type that poses a serious threat to the health of any person or has a significant detrimental impact on the health care system, **the court, in imposing a sentence on a person convicted of that offense, shall order that person to forfeit property, real or personal, that**

(A)(i) is used in the commission of the offense; or
(ii) **constitutes or is derived from proceeds traceable to the commission of the offense . . .**

Sec. 249. **Forfeitures** for Federal Health Care offenses.

(a) **In General.—Section 982(a) of title 18, United States Code, is amended by adding after paragraph (5) the following new paragraph:**

The court, in imposing a sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that

constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

Appendix II: Non-HIPAA Criminal and Civil Statutes Targeting Health Care Offenses

Balanced Budget Agreement of 1997

Passed one year after HIPAA, the Balanced Budget Agreement (BBA) added more teeth to HIPAA, with enhanced powers to exclude providers from federal health programs. Its provisions included:

- “Three strikes, you’re out,” whereby an individual or entity, upon conviction of a second health care–related crime, will be excluded from federally-funded health care programs for 10 years, and will be excluded for life upon the third conviction.
- Authority to exclude from Medicare an entity when ownership or controlling interest is transferred to a member of the family of an excluded provider.

False Claims Act

The federal False Claims Act (FCA) was signed into law by President Lincoln in 1863 in response to allegations of widespread fraud in the Union Army. In the 1990s, the act has been used by federal law enforcement authorities to impose criminal penalties on health care providers who present a false or fictitious claim to the government in the process of seeking reimbursement for medical goods and services. Punishment for criminal conviction *on each occurrence* can be up to five years imprisonment and a fine of \$250,000 for an individual and \$500,000 for a felony conviction. Misdemeanor convictions are \$100,000 for individuals and \$200,000 for corporations.

For civil offenses, the statute also permits the assessment of treble damages plus civil penalties of \$5,000 to \$10,000 *for each instance* against persons who submit false claims. The law firm of Michaels, Wishner & Bonner, P.C., reports on the case of a District of Columbia psychiatrist who had “grossly negligent billing practices” involving \$245,392 in Medicare claims (Michaels, Wishner & Bonner, P.C. 1997: 2). An appeals court ruling noted that “the government’s definition of claim permitted it to seek an astronomical \$81 million worth of damages for alleged actual damages of \$245,392.”

The American Hospital Association has charged that the Department of Justice has been wielding the enormous potential liability under the FCA to coerce hospitals into multimillion-dollar settlements for what the industry contends are only honest billing errors in an area of highly complex rules and regulations. The General Ac-

counting Office agreed with many of those criticisms, concluding that providers should be given “a realistic opportunity to review and analyze the data in question and provide an explanation for why there may be inaccuracies before legal action against providers is either threatened or undertaken” (U. S. General Accounting Office 1998: 18).

Health care institutions and providers are especially troubled by the *qui tam* provisions of the FCA, which allow private “whistle blowers” to bring False Claims lawsuits and retain a portion of the judgment as bounty. Government auditors are bringing cases based upon information they learn as government auditors “to line their own pockets,” charged attorney John T. Boese of Fried, Frank, Harris, Shriver & Jacobson, during an American Health Lawyers Association’s health care fraud and abuse conference in October of 1998 (Bureau of National Affairs 1999: S22).

False Statements Act

Similar to the False Claims Act, the False Statements Act imposes liability on a health care provider who makes false or fraudulent statements or misrepresentations, submits false writings or documents, or who falsifies or covers up a material act. Penalties are \$10,000 or imprisonment of five years, or both, *per violation*.

Social Security Act

A number of provisions in the Social Security Act concern false statements or representations involving benefits or payments under a federal or state health care program, including Medicare or Medicaid. Other provisions of the act address kickbacks—prohibiting anyone from knowingly and willfully soliciting or receiving payment in return for referrals for medical services under a federal or state health care program. Fines of up to \$25,000, imprisonment of up to 5 years, or both can be imposed.

The “Stark” Statutes

Rep. Fortney “Pete” Stark (D-Calif.) is responsible for two controversial amendments to the Social Security Act. So-called “Stark I” was included in the Omnibus Budget Reconciliation Act of 1986. It bars a physician from referring Medicare patients to medical laboratories if that physician or a family member has a financial relationship with the lab. The penalty is \$15,000 per violation where the referral was

inadvertent and \$100,000 and exclusion from Medicare if it was intentional.

“Stark II” was included in the Omnibus Budget Reconciliation Act of 1993. It expanded self-referrals beyond laboratories to physical and occupational therapists, radiological testing and therapy, medical equipment and supplies, home health services, outpatient prescription drugs, and hospital services. If any member of a doctor’s family is employed in the health care industry, this statute puts them at risk of federal prosecution.

Federal Mail and Wire Fraud

Health care providers who use the mail or television or telephones in the process of committing a health care offense also are subject to further penalties under the Federal Mail Fraud and Federal Wire Fraud statutes. These are separate offenses and convictions are punishable by fines of up to \$1,000, and prison terms of up to five years.

Civil Monetary Penalties Law

This law establishes an administrative action that can be pursued in lieu of criminal or civil action for Medicare or Medicaid fraud. The provider does not have the right to a jury trial. Instead, an administrative law judge in the Department of Health and Human Services makes the determination of liability. Fines are \$10,000 per violation. In addition, the provider is subject to an assessment of up to three times the amount claimed for each item, and the provider can be excluded from Medicare and Medicaid.

Racketeering Influenced and Corrupt Organizations Act

This law increasingly is being used to hold managers and executives liable for the wrongdoing of the companies they run.

Civil Rights of Institutionalized Persons Act of 1990

Under the authority of this act, the Department of Justice enforces patients’ civil rights in public residential institutions. It has created a number of special task forces, including the Nursing Home Working Group. At last report, the unit had under investigation conditions in 43 residential facilities, including nursing homes and mental health

centers. Seven health care facilities settled their cases while others were dropped or still are under investigation.

State Fraud Control Statutes

Kansas and Florida are among a number of states that have enacted laws that provide an additional layer of fines, penalties, and jail terms for health care offenses. For example, the Kansas Medicaid Fraud Control Act says health care providers will be in violation of the Act if they fail to maintain adequate records for five years that disclose “fully” the nature of goods, services, items, facilities, or accommodations for which a claim is submitted or a payment received through Medicaid. The act creates a new Medicaid fraud and abuse division in the Kansas attorney general’s office. Its agents are to be allowed access to all records in the hands of the provider relating to transactions the office is investigating. No provider may refuse to provide access to the records on the grounds of privacy or privilege.

References

- Alpert, P. (1997) “Free Doctors from Medicare’s Shackles.” *Wall Street Journal* (5 November): A21.
- Bennett, M. L. (1998) “Criminal Prosecutions for Medicare and Medicaid Fraud.” Association of American Physicians and Surgeons. (www.aapsonline.org/fraud/fraud.htm.)
- Bureau of National Affairs (2002) “Scully, McCallum Respond to Grassley, Say CMS, DOJ Cooperate on Fraud Probes.” *Health Care Daily Report*, April 2, Washington, D.C.
- Catalano, P. M. (1998) Letter to Dr. Robert Moffit, the Heritage Foundation (9 September).
- Citizens Against Government Waste (1997) “Medicare Fraud: The Symptoms and the Cure.” Washington, D.C. (www.cagw.org/uploads/medicare.pdf.)
- Cook, D. A. (1997) “Fraud, Abuse, and Beyond: Costly Pitfalls for Physicians Who Serve Medicare and Medicaid Patients.” Medical Association of Georgia (29 August). (www.mag.org/content_legal/legal_news_1997_cook_paper.html.)
- Cornwall, W. (1998) “I. F. Doctors Under The Microscope.” *Idaho Falls Post Register* (1 October): A1.
- Dickey, N. (1999) “Government to Grandpa: Rat Out Your Doctor.” *Wall Street Journal* (24 February).
- Editorial (1997) “Fraud and Waste in Medicare,” *New York Times* (1 August): A26.
- Eichenwald, K. (1998) “Unwitting Doctors and Patients Exploited in a Vast Billing Fraud.” *New York Times* (6 February): A1.
- Emord, J. (1998) “Murder by Medicare.” *Regulation* 21(3): 31–39.

- Faulkner and Gray, Inc. (1999a) "Doctors Decry 'Cynical' Uses of Medicare Beneficiaries to Spot Fraud." *Medicine & Health* (1 March).
- Faulkner and Gray, Inc. (1999b) "There's No Way for Feds to Estimate Amount of Error in Medicaid Overpayments." *Medicine & Health* (29 March).
- Himali, U., et al. (1999) "Health Care Fraud." *Bureau of National Affairs' Daily Report for Executives* (26 January).
- Kelly, B. M. (1999) "Medicare Regulations and Supporting Documents." Letter from Director of Government Relations, Mayo Foundation (4 March).
- Manning, J. (1998) "Insurance Firms Cover Doctors' Legal Fees." *Milwaukee Journal Sentinel* (19 October): 8.
- Meese, E., et al. (1999) *The Federalization of Criminal Law*. American Bar Association, Criminal Justice Section. Washington, D.C.
- Meese, E. (1999) "The Dangerous Federalization of Crime." *Wall Street Journal* (22 February): A19.
- Michaels, Wishner & Bonner, P.C. (1997) "Court Rules that HCFA Form 1500, Not CPT Codes, Is A 'Claim' under the False Claims Act." *Health Law Perspectives* (10 October): 2.
- National Health Care Anti-Fraud Association (2001) "Education Training Programs and Descriptions." Washington, D.C. (www.nhcaa-institute.org/education/core_curriculum_descrp.html.)
- Part B News* (1999) "Prepay Reviews Take a Starring Role in Annual OIG Audit of HCFA." (15 February): 1-4.
- Pretzer, M. (1996) "What Washington Plans for Doctors." *Medical Economics* 73(7): 57.
- U. S. General Accounting Office (1998) "Medicare: Application of the False Claims Act to Hospital Billing Practices." GAO/HEHS-98-195. July, Washington, D.C.
- U. S. General Accounting Office (1998) "Medicare: Fraud and Abuse Control Pose a Continuing Challenge." GAO/HEHS-98-215R. Letter dated July 15, to the Honorable John Kasich.
- Waller, R. (1998a) "Administration of the Medicare Program." Testimony before the National Bipartisan Commission on the Future of Medicare (10 August). Washington, D.C.
- (1998b) "Astray in the Medicare Fraud Fog." *Washington Times* (12 August).