



CRS Report for Congress

Health Care Fraud and Abuse Laws Covering Medicare and Medicaid: An Overview

Jennifer Staman
Legislative Attorney
American Law Division

Summary

A number of federal statutes address fraud and abuse in federally funded health care programs, including Medicare and Medicaid. These statutes include the False Claims Act, the anti-kickback statute, the Stark law, as well as additional program-related penalties and exclusions. This report provides a brief overview of these laws, including examples of prohibited conduct and penalties for violation.

The issue of health care fraud and abuse¹ has attracted a lot of attention in recent years, primarily due to the fact that financial losses attributed to it are estimated to be billions of dollars each year. Federal health care programs such as Medicare and Medicaid have been considered a prime target for fraudulent activity. This report provides a brief overview of selected federal statutes, including program-related civil and criminal penalties, the anti-kickback statute, the Stark law, and the False Claims Act, that may be used to address fraud and abuse in federal health care programs.²

Basic Civil and Criminal Penalties and Exclusions

Federal penalties for fraudulent activities in health care include civil and criminal penalties as well as permissive and mandatory exclusions from federal health care

¹ Health care “fraud” has been described as an intentional attempt to wrongfully collect money relating to medical services, while “abuse” has been described as actions which are inconsistent with acceptable business and medical practices. Charges of abuse customarily lead to civil suits, while accusations of fraud can result in either civil or criminal action.

² This report only addresses some of the more commonly invoked statutes used to address fraud and abuse in federal health care programs. It does not discuss every statute that may be invoked in connection with health care fraud or abuse cases. It is also important to note that many states have enacted fraud and abuse legislation. This report does not address state law.

programs.³ The basic Medicare and Medicaid program-related anti-fraud provisions are generally found in Title XI of the Social Security Act, 42 U.S.C. §§ 1320a-7 *et seq.*

Under Section 1128A of the Social Security Act (42 U.S.C. § 1320a-7a), the Office of the Inspector General at the Department of Health and Human Services (OIG) is authorized to impose civil penalties on any person, including an organization, agency, or other entity, that knowingly presents or causes to be presented to a federal or state employee or agent certain false or fraudulent claims.⁴ For example, penalties apply to services that were not provided as claimed, or claims that were part of a pattern of medical or other items or services that a person knows or should know are not medically necessary.⁵ In addition, certain payments to physicians to reduce or limit services are also prohibited. This section provides for monetary penalties of up to \$10,000 for each item or service claimed, up to \$50,000 under certain additional circumstances, as well as treble damages.

Section 1128B of the Social Security Act (42 U.S.C. § 1320a-7b) provides for criminal penalties involving federal health care programs. Under this section, certain false statements and representations, made knowingly and willfully, are criminal offenses. For example, it is unlawful to make or cause to be made false statements or representations in either applying for benefits or payments, or determining rights to benefits or payments under a federal health care program. In addition, persons who conceal any event affecting an individual's right to receive a benefit or payment with the intent to either fraudulently receive the benefit or payment (in an amount or quantity greater than that which is due), or convert a benefit or payment to use other than for the use or benefit of the person for which it was intended may be criminally liable. Persons who have violated the statute and have furnished an item or service under which payment could be made under a federal health program may be guilty of a felony, punishable by a fine of up to \$25,000, up to five years' imprisonment, or both. Other persons involved in connection with the provision of false information to a federal health program may be guilty of a misdemeanor and may be fined up to \$10,000 and imprisoned for up to one year.⁶

One of the most severe sanctions available under the Social Security Act stems from the authority to exclude individuals and entities from participation in federal health care

³ 42 U.S.C. § 1320a-7b(b). "Federal health care program" is defined as (1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government [not including health insurance provided to federal government employees] or (2) any state health care program, as defined in section 1128(h) [42 U.S.C. § 1320a-7(h)]. 42 U.S.C. § 1320a-7b(f). Federal health care programs include Medicare and Medicaid.

⁴ Civil penalties do not apply to beneficiaries under this provision. Under 42 U.S.C. § 1320a-7a(i)(5), a beneficiary is defined as an individual who is eligible to receive items or services for which payment may be made under a federal health care program, but excludes any providers, suppliers, or practitioners. However, it may be noted that beneficiaries still may be subject to criminal penalties under 42 U.S.C. 1320a-7b.

⁵ Several other types of prohibited conduct subject to civil penalties are specified by the statute. See 42 U.S.C. § 1320a-7a(a)-(b).

⁶ 42 U.S.C. § 1320a-7b(a)(6).

programs.⁷ Under Section 1128 of the Social Security Act (42 U.S.C. § 1320-7), exclusions from federal health programs are mandatory under certain circumstances, and “permissive” in others (*i.e.*, OIG has discretion in whether to exclude an entity or individual). Exclusion is mandatory for those convicted of certain offenses, including (1) a criminal offense related to the delivery of an item or service under Medicare, Medicaid, or a state health care program; (2) a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service; or (3) a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance. OIG has “permissive” authority to exclude an entity or an individual from a federal health program under numerous circumstances, including conviction of certain misdemeanors relating to fraud, theft, embezzlement, breach of fiduciary duty or other financial misconduct; a conviction based on an interference with or obstruction of an investigation into a criminal offense; and revocation or suspension of a health care practitioner’s license for reasons bearing on the individual’s or entity’s professional competence, professional performance, or financial integrity.⁸

The Anti-Kickback Statute

One important provision that provides for criminal penalties under Section 1128B of the Social Security Act is the federal anti-kickback statute.⁹ Under this statute, it is a felony for a person to knowingly and willfully offer, pay, solicit, or receive anything of value (*i.e.*, “remuneration”), directly or indirectly, overtly or covertly, in cash or in kind, in return for a referral or to induce generation of business reimbursable under a federal health care program.¹⁰ The statute prohibits both the offer or payment of remuneration for patient referrals, as well as the offer or payment of anything of value in return for purchasing, leasing, ordering, or arranging for, or recommending the purchase, lease, or ordering of any item or service that is reimbursable by a federal health care program. Persons found guilty of violating the anti-kickback statute may be subject to a fine of up to \$25,000, imprisonment of up to five years, and exclusion from participation in federal health care programs for up to one year.

There are certain statutory exceptions to the anti-kickback statute. Under one exception, “remuneration” does not include a discount or other reduction in price obtained

⁷ It has been stated that exclusion from federal health care programs can be a “financial death sentence” for those in the health care industry who depend on these programs for business. HEALTH CARE FRAUD AND ABUSE: PRACTICAL PERSPECTIVES, 32 (Linda Baumann ed. 2002).

⁸ See 42 U.S.C. § 1320-7a(b) for additional circumstances under which OIG has permissive authority to exclude individuals and other entities from a federal health care program.

⁹ 42 U.S.C. § 1320a-7b(b).

¹⁰ Courts have examined what “knowingly and willfully” means with regard to the anti-kickback statute and have reached varying conclusions. For example, the Ninth Circuit has found that “knowingly and willfully” means that the government must prove that defendants (1) knew their conduct was unlawful (*i.e.*, a violation of the anti-kickback statute) and (2) still engaged in the conduct with the “specific intent” to disobey the law. *Hanlester Network v. Shalala* 51 F.3d at 1400 (9th Cir. 1995). In *United States v. Starks*, the Eleventh Circuit found that the “knowingly and willfully” standard was met if defendants knew their conduct was generally unlawful, regardless of whether the defendants knew they were violating the anti-kickback statute. *United States v. Starks*, 157 F.3d 833 (11th Cir. 1998).

by a provider of services or other entity if the reduction in price is properly disclosed and reflected in the costs claimed or charges made by the provider or entity under a federal health care program.¹¹ Another exception includes, under certain circumstances, amounts paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals that furnish services reimbursable by a federal health program. In addition to the exceptions, the Department of Health and Human Services' Office of Inspector General (OIG) has promulgated regulations that contain several "safe harbors" for common business arrangements, under which the anti-kickback provision should not be violated.¹² Safe harbors listed by regulation include certain types of investment interests, personal services and management contracts, referral services, and space rental or equipment rental arrangements. OIG has indicated that the safe harbor provisions are not indicative of the only acceptable business arrangements, and that business arrangements that do not comply with a safe harbor are not necessarily considered "suspect."¹³

Stark Law: Physician Self-Referrals

Limitations on physician self-referrals were enacted into law in 1989 under what is commonly referred to as the "Stark law."¹⁴ The Stark law, as amended, and its implementing regulations prohibit certain physician referrals¹⁵ for designated health services (DHS) that may be paid for by Medicare, Medicaid, or other state health care plans. In its basic application, the Stark law provides that if a physician (or an immediate family member of a physician) has a "financial relationship" with an entity, the physician may not make a referral to the entity for the furnishing of designated health services (DHS)¹⁶ for which payment may be made under Medicare or Medicaid. A "financial relationship" under the Stark law consists of either (1) an "ownership or investment interest" in the entity or (2) a "compensation arrangement" between the physician (or immediate family member) and the entity. An "ownership or investment interest" includes "equity, debt, or other means," as well as "an interest in an entity that holds an ownership

¹¹ See 42 U.S.C. § 1320a-7b(b)(3) for additional exceptions to the anti-kickback statute.

¹² See 42 C.F.R. § 1001.952 for the safe harbor provisions. For a discussion of each of the safe harbors, see Dan McGuire and Mac Scheider, *HEALTH CARE FRAUD*, 44 *Am. Crim. L. Rev.* 633 (2007).

¹³ 64 *Fed. Reg.* 63,518, 63,521 (Nov. 19, 1999).

¹⁴ The Stark law, created as Section 1877 of the Social Security Act and codified at 42 U.S.C. § 1395nn, was created by the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, 103 Stat. 2423 (1989). The Stark law was significantly amended by the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, §13562, 107 Stat. 312 (1993) and is commonly referred to as "Stark II." Regulations for Stark II have been issued by the Centers for Medicare and Medicaid Services (CMS) in three phases. The Phase III regulations of Stark II were recently issued in September 2007.

¹⁵ "Referral," as defined by the Stark law, includes the request of a physician for an item or service, as well as an establishment of a plan of care that involves furnishing DHS. 42 U.S.C. §1395nn(h)(5).

¹⁶ A list of "designated health services" can be found at 42 U.S.C. § 1395nn(h)(6). Services include clinical laboratory services, physical therapy services, and inpatient and outpatient hospital services.

or investment interest in any entity providing the designated health service.” A “compensation arrangement” is generally defined as an arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity, other than certain arrangements that are specifically mentioned as being excluded from the reach of the statute.

The Stark law includes a large number of exceptions, which have been added and expanded upon by multiple regulations. These exceptions may apply to ownership interests,¹⁷ compensation arrangements,¹⁸ or both.¹⁹ The Stark law is a strict prohibition against self referrals; if a referral arrangement does not meet one of the exceptions, it will be considered unlawful. In September of 2007, CMS issued Phase III regulations, which will go into effect in December 2007. CMS has noted that no new exceptions have been added by the Phase III rules, but that it contains refinements to certain areas that would permit, or in some cases require, restructuring of certain business arrangements.²⁰

Violators of the Stark law may be subject to various sanctions, including a denial of payment for relevant services and a required refund of any amount billed in violation of the statute that had been collected. In addition, civil monetary penalties and exclusion from participation in Medicaid and Medicare programs may apply. A civil penalty not to exceed \$15,000, and in certain cases not to exceed \$100,000, per violation may be imposed if the person who bills or presents the claim “knows or should know” that the bill or claim violates the statute.²¹

False Claims Act

Though laws aimed to protect against health care fraud cover a wide variety of conduct, a large number of criminal prosecutions, civil recoveries, and other cases brought against federal health care program providers involve false claims.²² These cases

¹⁷ Exceptions applicable to ownership arrangements include arrangements involving rural providers, hospital ownership, and ownership of publicly traded securities and mutual funds. See 42 U.S.C. § 1395nn(c) and implementing regulations.

¹⁸ Exceptions applicable to compensation arrangements include office space and equipment rental arrangements, physician recruitment, as well as bona fide employment relationships. See 42 U.S.C. § 1395nn(e) and implementing regulations.

¹⁹ Exceptions applicable to both types of financial relationships under the Stark law include physician services performed by another physician in the same group practice, in-office ancillary services, and certain services performed under a prepaid plan. See 42 U.S.C. § 1395nn(b) and implementing regulations.

²⁰ Press Release, Centers for Medicare and Medicaid Services, CMS Issues Final Rule Prohibiting Physician Self-Referral (Aug. 27, 2007).

²¹ For additional information on the Stark law and description of each of the Stark law exceptions, see CRS Report RL32494, *Medicare: Physician Self-Referral ('Stark I and II')*, by Jennifer O'Sullivan.

²² HEALTHLAW, 44 (Barry Furrow 2d ed. 2000). It should also be noted that the government may be able to bring an action for a false claim under several statutes other than the False Claims Act. See, e.g., note 6 and accompanying text; see also 18 U.S.C. § 1347.

may be brought under the False Claims Act (FCA),²³ a law of general applicability that is invoked frequently in the health care context. Under the FCA, any person who “knowingly presents or causes to be presented ... a false or fraudulent claim for payment or approval” to the U.S. government may be subject to civil penalties. Health care program false claims often arise in terms of billing, including billing for services not rendered, billing for unnecessary medical services, double billing for the same service or equipment, or billing for services at a higher rate than provided (“upcoding”).

Under the FCA, a defendant is liable to the U.S. government if the defendant knowingly presents a false or fraudulent claim to an officer or employee of the U.S. government for payment, or if the defendant knowingly makes or uses a false record or statement to get a false or fraudulent claim paid.²⁴ “Knowingly,” as defined under the FCA, means that the defendant must have had actual knowledge of the falsity of the information furnished to the government, acted in deliberate ignorance of the truth or falsity of the information, or acted in reckless disregard of the truth or falsity of the information.²⁵ It should be noted that a claim may be actionable under the FCA even if the claim is made against a party other than the government if the payment of the claim would eventually result in a loss to the United States.²⁶ Penalties under the FCA include treble damages, plus an additional penalty of \$5,500 to \$11,000 for each false claim filed.

Civil actions may be brought in federal district court under the False Claims Act by the Attorney General or by a person known as a relator (*i.e.*, a “whistleblower”), for the person and for the U.S. Government, in what is termed a *qui tam* action. The ability to initiate a *qui tam* action has been viewed as a powerful weapon against health care fraud, in that it may be initiated by a private party who may have direct and independent knowledge of any wrongdoing.²⁷ Popularity of *qui tam* actions brought under the FCA may be attributed partially to the fact that successful whistleblowers can receive between 15% and 30% of the monetary proceeds of the action or settlement that are recovered by the government.²⁸

²³ 31 U.S.C. §§ 3729-3733.

²⁴ 31 U.S.C. § 3729(b). For additional discussion of the False Claims Act, see CRS Report RL30463, *Constitutional Aspects of Qui Tam Actions: Background and Analysis of Issues in Vermont Agency of Natural Resources v. United States ex rel. Stevens*, by T.J. Halstead.

²⁵ *Id.*

²⁶ S.Rept. 345, 99th Cong., 2d Sess. 10 (1986).

²⁷ HEALTH LAW, 50 (Barry Furrow 2d ed. 2000).

²⁸ Prosecution under the FCA may also be more attractive for the government. It has been pointed out that the terms of the act are relatively simple and straightforward, and can be applied generally to all types of healthcare providers. See Dayna Bowen Matthew, AN ECONOMIC MODEL TO ANALYZE THE IMPACT OF FALSE CLAIMS ACT CASES ON ACCESS TO HEALTHCARE FOR THE ELDERLY, DISABLED, RURAL AND INNER-CITY POOR, 27 Am. J. L. and Med. 439 (2001). Further, because it is a civil statute, there is an easier burden of proof to meet (“preponderance of the evidence”) as opposed to a criminal statute (“beyond a reasonable doubt”). *Id.*