Fraud-And-Abuse Enforcement In Medicare: Finding Middle Ground

Trust in the Medicare program—among beneficiaries, providers, and the government—is at stake.

by Thomas H. Stanton

PROLOGUE: Malcolm Sparrow, the former British detective and author of the influential book License to Steal: How Fraud Bleeds America's Health Care System, has called fraud and abuse in Medicare a "cancer in the system." The U.S. Department of Health and Human Services (HHS), under Donna Shalala, made detecting and eliminating fraud and abuse in Medicare one of its top priorities. The antifraud provisions of the Health Insurance Portability and Accountability Act of 1996, which authorized the Medicare Integrity Program, allowed the federal government to collect nearly a half-billion dollars in connection with health care fraud cases in FY 1999.

Amid the rhetoric and intense feelings on both sides of this issue, attorney Thomas Stanton proposes some middle ground in addressing fraud and abuse in Medicare. Stanton agrees that fraud and abuse "drain resources from Medicare at a time when resources are limited." Clearly there is the potential for savings as a result of concerted efforts to end fraud and abuse in Medicare, the author argues, but care must also be taken to address the legitimate concerns of providers caught in an aggressive antifraud net.

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ABSTRACT: Medicare fraud and abuse cost billions of dollars each year. Yet Congress is considering legislation to hamper enforcement. Providers’ anger over enforcement led to a congressional compromise several years ago to limit excesses. If providers and their advocates were to hobble enforcement, this could provoke a backlash. Instead, the existing compromise should be strengthened to accommodate legitimate provider concerns while allowing enforcement against major fraud and abuse. Government should further confine, structure, and check its discretion in applying the False Claims Act. Enhancing the Health Care Financing Administration’s capacity to ensure that contractors pay claims properly would remove additional points of friction.

On the surface it is hard to argue against law enforcement directed at Medicare fraud and abuse. Perpetrators of fraud and abuse cost the Medicare program huge amounts of money each year. Since the government began to crack down in the early 1990s, the law enforcement agencies have reported billions of dollars of annual program savings. The trustees of the Medicare Trust Funds have stated that fraud-and-abuse enforcement in recent years has helped to lengthen the period of time over which the funds can remain solvent.

On the other hand, fraud-and-abuse enforcement also has generated a substantial backlash among Medicare providers. The House of Representatives came close to passing legislation in 1998 that would have greatly weakened the False Claims Act, the government’s major legal tool for dealing with fraud and abuse. Legislation to diminish enforcement again is under consideration in the current Congress.

This is a good time to consider the virtues of finding some middle ground. If providers and their advocates succeed in hobbling fraud-and-abuse enforcement, yet another backlash—this time from those who believe enforcement is critical to the integrity of Medicare—can be expected. Taxpayers and experts both believe that health care fraud is widespread and that fraud and abuse are serious contributors to the rising costs of health care. The progression of legislation over the years to strengthen Medicare enforcement indicates that these people too have their advocates in Congress and that these issues will not go away.

The case for middle ground also rests on the fact that good ground exists. The argument goes as follows: (1) Fraud and abuse are serious matters that drain resources from Medicare at a time when resources are limited; (2) the provider backlash resulted in a congressional compromise several years ago that helped to limit the kinds of excesses that had provoked especially hospitals into anger; and (3) further steps can be taken to accommodate legitimate provider concerns while allowing enforcement to address major kinds of fraud and abuse.
Medicare Fraud-And-Abuse Laws

The search for middle ground begins with consideration of the two major laws involved in recent fraud-and-abuse enforcement actions: the False Claims Act and the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

- **False Claims Act.** The False Claims Act long predates the Health Care Financing Administration (HCFA) or Medicare. Indeed, the act became law in 1863, during the Civil War, as a tool to allow the government to deal with cheating by the defense contractors that supplied horses, munitions, and equipment to the Union Army. The False Claims Act allows the government to bring a civil action to deal with false claims that are made with actual knowledge, reckless disregard, or conscious disregard of the falsity of the claim. Thus, the term *Medicare fraud* often includes not only intentional false statements but also those that are reckless or deliberately indifferent to the truth. For criminal penalties to apply, the government must prove beyond a reasonable doubt that there has been criminal intent to defraud. This is a difficult standard to meet.

The government has been at pains to assure providers that the statutory standard is quite different from negligent errors or mistakes. The chief counsel to the U.S. Department of Health and Human Services (HHS) inspector general has written, “The False Claims Act simply does not cover mistakes, errors, or negligence.”

The act allows private citizens to sue on behalf of the government, in so-called *qui tam* (literally, “who as well”) actions, and to obtain a percentage of any recovered funds. In 1986 Congress enacted the False Claims Act Amendments that strengthened the act; clarified that the act applied to Medicare and Medicaid; and made it easier for private parties, called “relators,” to bring cases on the government’s behalf. The 1986 amendments were part of a progression of laws that Congress has enacted to strengthen fraud-and-abuse enforcement, especially as it applies to Medicare.

The False Claims Act is an unusual statute. In recent years private parties and the government have brought False Claims Act cases in a broad range of contexts, but especially against defense contractors and health care providers. To government attorneys, the act is an essential tool in the effort to crack down on fraud and abuse in Medicare and other health care programs. To providers, the act is one of the government’s most feared weapons against alleged fraud, because of the substantial potential penalties involved.

Private whistleblowers are the source of most of the government’s False Claims Act cases. Under the act, a relator begins the *qui tam* action by filing a complaint under seal (in secret) in federal court.
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and at the same time delivers a copy of the complaint and supporting evidence to the Department of Justice (DOJ). The complaint is not served initially on the respondent. The government then investigates the case, through the HHS Office of Inspector General (OIG) or the Federal Bureau of Investigation (FBI), and determines whether or not to intervene. This process can take several years. If the government intervenes, it takes primary responsibility for the litigation, although the relator remains a party. If the government does not intervene, the relator may choose to bring the action anyway. As a practical matter, it is hard for a relator to do this.

Qui tam actions offer a successful relator the prospect of potentially huge recoveries. On the other hand, the process of prosecuting a case can be painful for the relator. As a False Claims Act attorney has observed, "It is common for relators to suffer severe financial, social and/or personal consequences." 

From the perspective of a respondent, a False Claims Act case is a serious threat. Indeed, respondents have a strong incentive to settle a False Claims Act case with the government rather than fight. Under the act, a party is liable for triple damages and penalties up to $10,000 per false claim if convicted. As applied to Medicare, each false claim is an individual billing to Medicare for a specific medical service or item. The potential penalties can mount quickly. Also, the government can suspend or delay payment of later claims once a respondent is alleged to have submitted some claims falsely. The mere act of the government in bringing or taking over an action under the False Claims Act can hurt the reputation of an institution or other provider once the case becomes public.

Yet, from the enforcement agencies' perspective, resources are so limited that without settlements, the government would be unlikely to prevail in many cases, regardless of the merits. The government has been hampered in recruitment and retention of personnel by the increasing disparities in compensation between the public and private sectors. A large provider can call upon top-flight legal talent, medical expertise, and skilled support that government attorneys can only dream about.

From the perspective of the administration of justice, the inability of the government to prosecute any large number of cases in court, and the tendency of cases to settle rather than go to court for a decision, have serious consequences for the perception of legitimacy
of the process. The problem is that when the OIG or DOJ pursues a False Claims Act case, it is likely to come up with a settlement whether or not the respondent feels actually culpable. Attorneys for providers in False Claims Act cases express great resentment at being forced to settle cases for fear of the penalties, in money and potential damage to the provider’s reputation. In terms of the government’s longer-term interests, the ability to obtain a settlement in virtually any halfway reasonable False Claims Act case raises the specter that the patterns of true and expensive Medicare fraud may be different from the pattern of cases that the government settles.

HIPAA. HIPAA, also known as the Kassebaum-Kennedy Act, was landmark legislation that had a strong impact on the government’s efforts to address fraud and abuse. The law provided tougher sanctions and penalties and—most importantly—authorized the HCFA Medicare Integrity Program and a dedicated fund for fraud-and-abuse activities. HIPAA guaranteed funding from the Medicare Part A Trust Fund, through an account called the Health Care Fraud and Abuse Control (HCFAC) Account, and divided the funds among HCFA, the OIG, the Office of General Counsel, and other parts of HHS, and the FBI and other parts of the DOJ.

HCFAC expenditures for fiscal year 1999 amounted to $137.2 million. The annual HCFAC allocations supplement the direct appropriations of HHS and the DOJ that are devoted, in part, to health care fraud enforcement. Separately, the FBI received in FY 1999 an additional $66 million in funding.

On the other side of the ledger, in FY 1999, as a result of the combined antifraud actions of the federal and state governments and others, the federal government collected $490 million in connection with health care fraud cases and matters; $44.4 million of the total was paid to private persons under qui tam provisions.

HIPAA’s funding (that is, HCFAC) provisions expire after FY 2003. The large returns to the government from fraud-and-abuse enforcement under HIPAA would seem to help create a constituency for reauthorization of the HCFAC account for subsequent years and a positive financial record to support budget scoring of substantial net revenues for any reauthorizing legislation. Meanwhile, HCFA’s Medicare Integrity Program outlays amount to a large part of available funding for all administrative costs of Medicare, and health care enforcement is a top priority for the OIG, DOJ, and FBI.

Proposed Steps Toward Middle Ground

It is remarkable to contrast the progression of stronger antifraud legislation, at least until 1998, with the increasing squeeze on resources over the same period for the administration of Medicare
outside of fraud and abuse enforcement. It would seem that all parties would be better off if Congress devoted added resources to allow sound management of the Medicare program, including the institution of effective systems and administrative measures to monitor and deter inappropriate claims before rather than after they become the subject of enforcement actions. Similarly, there is a need to improve the program's design in ways that can reduce the program's vulnerability to fraud and abuse. Improved systems and design can reduce the points of friction between providers and the law enforcement process and increase the government's capacity to promptly assess fraud and abuse so that they can be contained.

**Effectively administering the claims payment process.** Despite its notable progress, and recognizing its efforts to obtain new legislation, HCFA continues to lack the capacity to administer the claims payment process effectively. There are several obstacles, including HCFA's organizational structure (one single office needs the authority and capacity to oversee performance of all carriers and fiscal intermediaries), HCFA's limited statutory powers to address performance shortcomings at carriers and intermediaries (including barriers to selecting and replacing these contractors based on merit), and limitations of the systems that the contractors use to make payments. Again, a major constraint relates to budget resources: HCFA's payments per claim to carriers and fiscal intermediaries have declined to about one-third of the amount that HCFA paid in 1975. While some of this decline relates to improvements in technology, the fact remains that carriers and fiscal intermediaries have an incentive to pay claims quickly rather than accurately. Finally, although claims payment systems are seriously out of date, HCFA lacks the financial resources to modernize its systems and the specialized capacity to implement such an effort.

So far, in terms of dealing with fraud and abuse, the government essentially has muddled through. Although the underlying systems are limited, especially because one cannot sample data easily across systems of different claims administration contractors, investigators have been able to find ways to overlay intelligent inquiries onto the old systems. Moreover, to borrow the mixed metaphor discovered by Malcolm Sparrow, "Every time the enforcers turn over another rock, they find a new can of worms."

Sparrow, a specialist in law enforcement policy, points out that much of the fraud in health care, and in Medicare in particular, is not susceptible to easy detection. Indeed, a perpetrator of fraud might take special care to submit false claims that are superficially appropriate and well documented, just to avoid triggering a review or audit. Sparrow contends that the government lacks the necessary
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cognitive map of the incidence and severity of different types of fraud and that much more work is required to gather, analyze, and evaluate quantitatively sound information about fraud. Nevertheless, the government has made definite progress. The availability of whistleblowers helps to point government officials toward serious cases of fraud. In addition, smart analysts use systems and data to make queries and flag likely improper payments. The activities of HCFA’s new program-safeguard contractors promise improved ability to pinpoint fraud and abuse in the future.

But there are costs to muddling through. One cost is that paid by the U.S. taxpayer, in increased operating costs associated with fraud. Good systems, which are now lacking, could provide the information needed to nip many fraudulent schemes at an early stage rather than letting them grow into substantial losses. (One example of such systems is the superb antifraud measures of credit card payment systems.) Weak systems limit government’s ability to direct enforcement actions to the most pressing risk-based priorities. The government has not yet constructed a data warehouse that combines data from all carriers and intermediaries and allows intelligent analysis of patterns of fraud on a timely basis at multiple levels and over the entire country, although such work is under way at HCFA. HCFA needs an improved information base so that the government can conduct the in-depth analysis, evaluation, and investigation that could be cost-effective for the program. Access to high-quality information is essential to support analyses that can influence the government’s allocation of scarce resources to investigate and deal with the most likely sources of fraud and abuse.

The second cost is that of constituency for the fraud-and-abuse enforcement program. No one expects providers to welcome government oversight. On the other hand, I have conducted interviews with providers and their advocates who express anger at what they perceive to be injustices in fraud-and-abuse enforcement. Muddling through means that the government relies too heavily on enforcement to deal with many erroneous claims that otherwise might have been denied early or flagged for administrative action through a series of filters that, in a more capable system, could be adjusted promptly to deal with the new types of misbehavior. Disinvestment in HCFA’s administrative resources has meant that too much of the bill collection process is left to law enforcement.