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THE PATH FROM REGULATOR TO HUNTER: THE EXERCISE OF PROSECUTORIAL DISCRETION IN THE INVESTIGATION OF PHYSICIANS AT TEACHING HOSPITALS

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This article examines the economic and cultural disruption that a law enforcement initiative can have on an industry by focusing on a recent federal law enforcement health care fraud initiative, Physicians at Teaching Hospitals ("PATH"). The PATH initiative is an apt case study: it is nation-wide, was undertaken after a deliberative process among multiple federal agencies, and is focused on a limited group of health care providers regarding few legal and reimbursement issues. Part I of this article describes the PATH initiative. Part II briefly examines the arsenal of sanctions available to the government to pursue health care fraud, focusing on the False Claims Act ("FCA"), the statute utilized in the PATH initiative. Part III suggests that because the investigation and prosecution of an industry can be disruptive to an industry and those it services, care must be taken to ensure that the prosecutive initiative is warranted.

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I. THE PATH INITIATIVE

A. Background

Because of the way in which Medicare reimburses academic medical centers[1] and the teaching hospitals that they include, there has been "longstanding concern" that Medicare would pay twice for the same service: once under Part A, Medicare ("Medicare Part A") and again, under Part B, Medicare ("Medicare Part B").[2] Medicare Part A reimburses health care providers for inpatient hospital services, home health services, and certain other institutionally based services[3] for about thirty-seven million persons age sixty-five or older and certain categories of disabled persons.[4] Medicare Part A pays teaching hospitals for part of the costs of training physicians ("residents") by paying the hospitals' "direct graduate medical education reimbursement" ("DGME").[5] In 1996, Medicare Part A paid approximately $8 billion to teaching hospitals for the training of residents.[6]

Medicare Part B reimburses health care providers for physician services, outpatient services, and various other medical and health services.[7] Thus, Medicare Part B pays physicians, including teaching physicians, for services provided directly to Medicare patients.[8] Consequently, residents who may be professionally capable of rendering medical services are not eligible for reimbursement under Medicare Part B, because their salaries already have been factored into the teaching hospitals' Medicare Part A reimbursement.[9] Arguably, if Medicare Part B were to pay residents for the physician services they render to patients, Medicare is paying teaching hospitals twice for the

1. An "academic medical center" is defined as "university–based health centers that include at a minimum a hospital and associated clinics, a medical school, or one of the other health professions schools." Robert M. Carey & Carolyn Long Engelhard, *Academic Medicine Meets Managed Care: A High-impact Collision*, 71 ACAD. MED. 839, 840 (1996).

2. GENERAL ACCOUNTING OFFICE, REP. NO. HEHS-98-174, MEDICARE: CONCERNS WITH PHYSICIANS AT TEACHING HOSPITALS (PATH) AUDITS (1998) 5-6 [hereinafter GAO, CONCERNS WITH PATH].

3. 42 U.S.C. § 1395d(a) (1994 & Supp. III 1997); PAMELA H. BUCY, HEALTH CARE FRAUD: CRIMINAL, CIVIL AND ADMINISTRATIVE LAW § 1.02[2] (1996 & Supp. 1999) [hereinafter BUCY, HEALTH CARE FRAUD].

4. Memorandum from June Gibbs Brown, Inspector General, United States Department of Health and Human Services, to Bruce C. Vladeck, Administrator, Health Care Financing Administration (HCFA), March 1996, at 3 [hereinafter Brown Memorandum].

5. GAO, CONCERNS WITH PATH, *supra* note 2, at 5. DGME is based upon historic costs that include the portion of the salaries of teaching physicians related to teaching residents, residents' salaries, and other related costs.

6. *Id.*

7. 42 U.S.C. § 1395k (1994 & Supp. III 1997).

8. Brown Memorandum, *supra* note 4, at 4.

9. *Id.*

training of physicians.[10] In addition, Medicare Part B reimbursement rates are premised upon the assumption that patient services will be rendered by physicians, not by physicians in training.[11] In an effort to eliminate these problems, the Health Care Financing Administration ("HCFA"), which administers Medicare, has made clear that, with certain limited exceptions, teaching physicians billing Medicare Part B must personally provide the billed services or be physically present when the resident provides the services.[12]

Academic medical centers have claimed confusion because of ambiguous guidance provided by HCFA and the multi-faceted relationship teaching physicians have with residents.[13] Sometimes a teaching physician will be present when a resident is rendering services to a patient, while on other occasions the teaching physician will meet with the resident, review a patient's chart with the resident and provide treatment instructions which the resident carries out. Teaching physicians also provide direction to residents by discussing a patient's situation with a group of residents and other teaching physicians ("Grand Rounds").[14] In these instances, the teaching physician may have provided considerable service to the patient but has not personally seen the patient. Given this multi-faceted consultation, teaching and treatment relationship among teaching physicians, residents and patients, it is difficult for generic regulations to provide clear billing guidance.

10. As the General Counsel of the Department of Health and Human Services explained in 1997:

> [S]upervision of interns and residents by teaching physicians is reimbursed under Medicare Part A through graduate medical education (GME) payments. By this mechanism, teaching physicians are paid for taking responsibility for the hospital's oversight of its doctors in training. It would be absurd to assert that physicians could receive the significant remuneration that characterizes Part B reimbursement for supplying the same level of services that qualifies and was paid for as Part A services.

Ass'n of Am. Med. Colleges v. United States, No. SA-CV 97-862 (C.D. Cal. filed Oct. 27, 1997) [hereinafter AAMC Complaint] (citing Letter from Harriet S. Rabb, General Counsel of the Department of Health and Human Services, to Jordan J. Cohen, M.D., President of the Association of American Medical Colleges ("AAMC"), and P. John Seward, M.D., Executive Vice President of AAMC, July 11, 1997 [hereinafter Rabb Letter] (visited Jan. 18, 2000) <http://www.aamc.org/hlthcare/path/oig711.htm>). *See also* GAO, CONCERNS WITH PATH, *supra* note 2, at 5-6 (warning that Medicare will possibly have to "pay twice"); Brown Memorandum, *supra* note 4, at 4.

11. Rabb Letter, *supra* note 10, at 1-2.

12. *Id.* (noting that the standard for Medicare Part B payments to teaching physicians has been variously expressed as requiring "personal and identifiable direction," "performing the physician services," "supervision," or "being present and ready to perform").

13. AAMC Complaint, *supra* note 10, ¶ 3.

14. *See* AAMC Complaint, *supra* note 10, ¶ 17. For articles chronicling residents' and teaching physicians' reaction to PATH's impact on clinical education, *see, e.g.*, Lloyd M. Krieger, *Medicare Antifraud Initiatives: Effects on Resident Education*, 281 JAMA 1227 (1999); Joseph D. Robinson & Scott Gottlieb, *The New Face of Medical Education*, 281 JAMA 1226 (1999); Ruth SoRelle, *Tracking a Tangled PATH*, 1998 CIRCULATION 2191 (1998).

The Department of Health and Human Services' ("HHS") audit and investigation of Medicare Part B payments to teaching physicians led the Office of Inspector General ("OIG") and HHS to commence a nationwide initiative known as Physicians at Teaching Hospitals ("PATH").[15] This initiative followed a 1995 settlement between the United States Department of Justice ("DOJ") and the University of Pennsylvania ("Penn"),[16] wherein Penn agreed to pay approximately $30 million to the DOJ, without admitting guilt.[17] The DOJ's investigation focused on billings by teaching physicians on the Penn medical school faculty for services rendered to patients at Penn's hospital and on possible inflation of services rendered ("upcoding").[18] HCFA took the position that teaching physicians could properly bill Medicare for services rendered to hospitalized patients only if the physician personally rendered the services or if the teaching physician was physically present when the services were rendered by the resident.[19] Furthermore, if documentation in the patient file did not reveal that the teaching physician was physically present when the resident rendered the service, the OIG presumed that the physician was not present and that any resulting claim for reimbursement was improper.[20]

There are 1,200 teaching hospitals in the United States.[21] The OIG began its PATH initiative by selecting the 125 teaching hospitals associated with each of the nation's 125 medical schools.[22] In 1996, the OIG sent a letter to each of these 125 academic medical centers, informing them that they were subject to an audit of teaching physician Medicare Part B billings.[23] Once a teaching hospital received word that it was subject to a PATH audit, it was given two choices. The teaching hospital could consent to PATH I, whereby an OIG team would conduct, with the assistance of medical reviewers for the carrier,[24]

15. GAO, CONCERNS WITH PATH, *supra* note 2, at 1.

16. The target of the investigation was the Clinical Practices of the University of Pennsylvania ("CPUP"), which is a component of the University of Pennsylvania Health System ("UPHS"). Brown Memorandum, *supra* note 4, at 1.

17. GAO, CONCERNS WITH PATH, *supra* note 2, at 1.

18. The billings at issue were submitted from January 1, 1989 through December 31, 1994. *Id.* Although other issues also were involved, including the possibility of "upcoding," *id.* at 21-22, the dominant issue was Part B billings by teaching physicians for services possibly rendered by residents.

19. GAO, CONCERNS WITH PATH, *supra* note 2, at 7-8 (stating that "[m]edical records must contain documentation to support all services rendered.").

20. Brown Memorandum, *supra* note 4, at 5; GAO, CONCERNS WITH PATH, *supra* note 2, at 10.

21. GAO, CONCERNS WITH PATH, *supra* note 2, at 12.

22. *Id. See also* Cheryl Baacke & Lisa M. Rockelli, *IG to Audit All Hospital Academic Institutions Under PATH, Official Says*, 7 Health L. Rep. (BNA) 1118 (July 25, 1996).

23. *Id.*

24. Carriers are private groups or associations hired by HCFA to administer Part B, Medicare. 42 U.S.C. § 1395h (1994 & Supp. III 1997). Intermediaries are private groups or associations hired by the Secretary of HHS through the Health Care Financing Agency (HCFA)

an audit of the medical faculty's Medicare Part B physician billings for one year between 1990-1996.[25] Alternatively, the teaching hospital could consent to PATH II, whereby the teaching hospital could conduct the audit itself, at its own expense and under the OIG team supervision, using OIG approved auditors or consultants.[26] Most teaching hospitals apparently have opted for PATH II based upon the belief that recoupment and penalties would be less severe under PATH II than under PATH I.[27]

Within one year of announcing the PATH initiative, audits were underway at forty-nine institutions.[28] As of November, 1999, eight PATH audits have been resolved.[29] Four of the eight institutions have agreed to settlements with OIG, for a total of $64.3 million.[30] Audits at the remaining four institutions concluded with no money being owed to the government. Additional PATH audits are planned or underway at thirty-seven other institutions.[31]

B. Rules and Regulations Regarding Medicare Part B Reimbursement to Teaching Physicians

Targeted teaching hospitals have objected strenuously to the PATH initiative, arguing that the rules, regulations, and other guidance concerning Medicare Part B billings by teaching physicians are vague and that HHS, through the PATH initiative, is retroactively applying "unpublished rules, contrary to existing published rules" as a way to coerce settlements.[32] In 1997, a number of teaching hospitals filed suit seeking injunctive relief.[33] In this

to administer Medicare Part A. 42 U.S.C. § 1395u (1994 & Supp. III 1997). *See infra* notes 39-41 and accompanying text.

25. *See* AAMC Complaint, *supra* note 10, ¶ 54.

26. *Id.*

27. According to the AAMC Complaint: "[t]he OIG/DOJ team . . . either expressly threatens or implies that the outcome for the targeted faculty is likely to be less favorable and the penalty to be assessed great under PATH I than under PATH II." *See id.* ¶ 57; *see also* GAO, CONCERNS WITH PATH, *supra* note 2, at 12 n.23 (stating that "[i]n return for volunteering for a PATH II audit, the OIG advises DOJ of the institution's level of cooperation . . . [which] the DOJ may take . . . into account when resolving losses . . . from any . . . [false claims].").

28. GAO, CONCERNS WITH PATH, *supra* note 2, at 12. The OIG later dropped sixteen of its original forty-nine PATH audits. *See* GAO, CONCERNS WITH PATH, *supra* note 2, app. II, at 35.

29. The institutions included Thomas Jefferson University, Dartmouth-Hitchcock Medical Center, Yale University, the University of Virginia, and the University of Pittsburgh. *Id.* at 2, Table 1.

30. These institutions included: Thomas Jefferson University, which settled in August, 1996, for $12 million; University of Virginia, which settled in November, 1997, for $8.6 million; and the University of Pittsburgh which settled in March, 1998, for $17 million. *Id.*

31. GAO, CONCERNS WITH PATH, *supra* note 2, at 2. *See also* Sean Martin, *Teaching Physician Billing Probe Blessed by GAO*, AM. MED. NEWS, Sept. 7, 1998, at 5.

32. AAMC Complaint, *supra* note 10, ¶ 2.

33. *See generally* AAMC Complaint, *supra* note 10. This complaint was dismissed on April 28, 1998, for lack of jurisdiction. Ass'n of Am. Med. Colleges v. United States, 34 F. Supp.2d

suit, the hospitals argued that HHS deprived the hospitals of due process and violated the agency's own rule making procedures, the Administrative Procedure Act, and the Medicare Act.[34] In response, HHS maintained that the "physically present when services are rendered" requirement is longstanding, and has been clearly communicated to teaching hospitals.[35]

On at least eleven occasions between 1966 and 1995, HHS issued guidance for payment of Medicare Part B services rendered by teaching physicians.[36] HHS promulgated the first regulation in 1966 stating that a teaching physician's service was reimbursable as long it was "an identifiable service requiring performance by a physician in person."[37] In 1967, HHS issued regulations specifying that Medicare Part B reimbursement was permissible where the "physician provides personal and identifiable direction to interns or residents who are participating in the care of his patient."[38]

HHS contracts with private entities (usually insurance companies) to assist in the administration of the Medicare program.[39] These entities are designated "intermediaries" for Medicare Part A and "carriers" for Medicare Part B.[40] Intermediaries and carriers assume the responsibility to receive, screen and pay claims submitted by Medicare providers for eligible services rendered to Medicare patients.[41] In 1969, HCFA issued Intermediary Letter 372 ("IL 372") for guidance to carriers and intermediaries, noting that "there appears to be a serious need to obtain a better and more uniform understanding among carriers, providers, and physicians of the conditions under which payment may be made under Part B for services rendered to patients by supervising physicians in the teaching setting."[42] IL 372 stated that in order to bill for

1187 (C.D. Ca. 1998). AAMC appealed this dismissal on June 23, 1998. The appeal is currently pending before the United States Court of Appeals for the Ninth Circuit. The Greater New York Hospital Association, joined by several New York teaching hospitals and medical schools, filed a similar lawsuit in the Southern District of New York. *See Text of Greater New York Hosp. Ass'n. Lawsuit Against HHS* (visited Jan. 18, 2000) <http://healthcarenewsserver.com/stories/HCN1998 042400003a.shtml> (text of the plaintiffs' complaint). This suit was also dismissed for lack of jurisdiction. *See* Greater N.Y. Hosp. Ass'n v. United States, No. 98 Civ. 2741 (RLC), 1999 WL 1021561 (S.D.N.Y. Nov. 9, 1999).

34. AAMC Complaint, *supra* note 10, ¶¶ 72-82.

35. GAO, CONCERNS WITH PATH, *supra* note 2, at 3.

36. These eleven occasions are time lined in *Key Events Related to the PATH Initiative*. *See id.* app. II., at 34-35.

37. 20 C.F.R. § 405.483(a) (1966).

38. 20 C.F.R. § 405.521 (1967) (recodified as 42 C.F.R. § 521).

39. *See* 42 U.S.C. § 1395h (1994 & Supp. III 1997) (involving "fiscal intermediaries"); 42 U.S.C. § 1395u (1994 & Supp. III 1997) (involving "carriers").

40. *Id.*

41. *See id.* §§ 1395h(a), 1395u(a) (1994).

42. U. S. Dep't of Health and Human Services, Intermediary Letter No. 372 (Apr. 1969) [hereinafter "IL 372"], *reprinted in* Medicare & Medicaid Guide (CCH) ¶ 3459.33, at 1289-11 to -14 (July 17, 1997).

services under Medicare Part B, a teaching physician must "render sufficient personal and identifiable medical services to the Medicare beneficiary to exercise full, personal control over the management of the portion of the case for which a charge can be recognized."[43] "Full, personal control" required that the physician review the patient's medical history and treatment, personally examine the patient, determine the diagnosis and course of treatment, perform physician services "or supervise the treatment to assure that appropriate services are provided by interns, residents or others . . . ."[44] IL 372 also indicated that a teaching physician's services to Medicare patients should be "of the same character, in terms of the responsibilities to the patient that are assumed and fulfilled, as the services he renders to his other paying patients" to qualify for Medicare Part B reimbursement. [45]

In 1970, HHS issued additional instructions to carriers through Intermediary Letter 70-2 ("IL 70-2").[46] IL 70-2 informed carriers that they may presume that a physician rendering inpatient services personally examined a patient if the physician's signature appeared in the patient file:

> If the physician countersigned the entries in the record pertaining to the patient's history and the record of examinations and tests, it would be presumed the physician personally examined the patient and determined the course of treatment to be followed. Frequent reviews of the patient's progress by the physician would be established by the appearance in the record of the physician's signed notes and/or countersignature to notes with sufficient regularity that it could be reasonably concluded that he was personally responsible for the patient's care.[47]

In 1980, Congress enacted a statute which closely tracked IL 372's language, specifying that a carrier should not pay for teaching physicians' services unless the physicians "render[] sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which the payment is sought."[48] The legislative history accompanying this statute indicated that the House Budget Committee "strongly believes teaching physicians should personally perform or personally supervise patient services in order to qualify for fee-for-

43. *See* IL 372, Medicare & Medicaid Guide (CCH) ¶ 3459.33, at 1289-11.

44. *Id.*

45. *Id.*

46. U. S. Dep't of Health and Human Services, Intermediary Letter No. 70-2, (Jan. 1970) [hereinafter IL 70-2], *reprinted in* Medicare & Medicaid Guide (CCH) ¶ 26,076, at 9188 (1970).

47. Medicare & Medicaid Guide (CCH) ¶ 26,076, at 9193. *See also* AAMC Complaint, *supra* note 10, ¶ 28.

48. 42 U.S.C. § 1395u(b)(7)(A)(i)(I) (1994 & Supp. III 1997). According to the AAMC Complaint, *supra* note 10, Congress enacted this statute to "incorporate the medical direction standard set forth in [42 C.F.R.] § 405.521 . . . ." AAMC Complaint, *supra* note 10, ¶ 30.

service payment."[49] In 1982, when enacting legislation requiring Medicare to promulgate regulations regarding reimbursement of physician services under Part B, the Senate Finance Committee stated that physician services to hospital inpatients were reimbursable "only if such services are identifiable professional services to patients that require performance by physicians in person . . . ."[50]

In 1986, the General Accounting Office ("GAO") reviewed the requirements for Medicare Part B reimbursement by teaching physicians.[51] The GAO concluded that Medicare Part B reimbursement "required documentation in a patient's medical records that the teaching physician either personally provided the service or was present when the service was provided by a resident."[52] The GAO also found that HCFA previously had failed to adequately communicate these documentation requirements to providers.[53] At that time, the GAO recommended that HCFA "establish and enforce explicit documentation requirements" to clarify the matter for teaching physicians and hospitals.[54] On December 30, 1992, all regional Medicare administrators were informed that physicians' fees "are payable in teaching hospitals if . . . the physician personally performs an identifiable service . . . [or] the physician is physically present when the resident performs an identifiable supervised for which payment is sought."[55] The crucial question is to what extent Medicare administrators communicated this clarification to teaching physicians at academic medical centers.

On December 8, 1995—nine years later—national rules were finalized.[56] These rules limited Medicare Part B reimbursement to teaching physicians who "medically directed resident services for which the teaching physician was physically present with the resident during key portions of the billed service."[57] Further, the rules stated that the patient file must reflect the

49. H. R. REP. NO. 96-1167, at 70 (1980).

50. S. REP. NO. 97-494, VOL. 1, at 22 (1982).

51. GENERAL ACCOUNTING OFFICE, REP. NO. HRD-86-36, DOCUMENTING TEACHING PHYSICIAN SERVICES STILL A PROBLEM (1986) 20 [hereinafter GAO, DOCUMENTING SERVICES].

52. *Id.*

53. *Id.* at 21-22, 32 (observing that HCFA's instructions were not "explicit" or "clear enough").

54. *Id.* at 32.

55. Letter from Charles R. Booth, Director Office of Payment Policy, United States Department of Health and Human Services, to All Associate Regional Administrators for Medicare, December 30, 1992 [hereinafter Booth Letter].

56. *See* GAO CONCERNS WITH PATH, *supra* note 2, at 10 (acknowledging a ten year gap between its 1986 report and HCFA's resulting rules). These regulations are currently at 42 C.F.R. § 415.172 (1998).

57. *See* 42 C.F.R. § 415.172(b) (1998).

teaching physician's physical presence at the time the service was furnished.[58] To provide teaching physicians and hospitals with timely notice and an opportunity to bring practices into compliance, the 1995 regulations were not made effective until July 1, 1996.[59] Prior to July 1, 1996, HCFA issued a number of communications, generally to carriers, but also published in the Federal Register and Code of Federal Regulations[60] which, according to a 1998 GAO Report, "appear to have contributed to confusion over Medicare's enforcement policy."[61] In particular, the 1991-1996 version of HCFA Form 1500, the claim form submitted by physicians to obtain reimbursement under Part B, appeared to permit reimbursement to teaching physicians who supervised residents without requiring that the teaching physicians be physically present at the time the services were rendered.[62] Form 1500 provided:

> I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate supervision, except as otherwise expressly permitted by Medicare or [Civilian Health and Medical Program for the Uniformed Services] CHAMPUS regulations.[63]

As can be seen from the above review, over a thirty year time period some official pronouncements have required teaching physicians to be physically present when a resident rendered service (1966 regulations, 1982 legislative history, 1996 regulations)[64] while other pronouncements have required only that a teaching physician "provide direction" or "supervise" the resident who rendered the service (1967 regulations, 1969 "IL 372" to carriers and

58. *Id.* The AAMC believed that this new physical presence requirement went beyond the countersignature requirements of IL 372 and IL 70. *See* AAMC Complaint, *supra* note 10, ¶ 36.

59. *See* 60 Fed. Reg. 63,124, 63,142-43.

60. This information included the Booth Letter, *supra* note 55, and a 1995 letter from the Director of HCFA's Bureau of Policy Development. *See* GAO, CONCERNS WITH PATH, *supra* note 2, at 10. Additionally, HCFA acknowledged "wide variations and lack of consistency" in regulations and program standards, *see* AAMC Complaint, *supra* note 10, ¶ 32 (citing 54 Fed. Reg. 5948 (1989)), while later indicating that the original 1967 regulations and IL 372 could provide guidance for those seeking "a more detailed explanation of attending physician criteria." *Id*. ¶ 33 (citing 56 Fed. Reg. 59,507 (1991) (republishing 42 C.F.R. § 405.521 which set forth the "original requirements in a revised format")).

61. GAO, CONCERNS WITH PATH, *supra* note 2, at 10.

62. See AAMC Complaint, *supra* note 10, ¶ 48.

63. *Id*. HHS argues that because residents are not "employees" of the teaching physician, Form 1500 in no way permits reimbursement to teaching physicians who are not present when services are rendered to patients. Draft Comments by and Electronic Mail Communications with Lewis Morris, Assistant Inspector General for Legal Affairs, U.S. Dep't of Health and Human Services (various dates in Fall, 1999).

64. *See supra* notes 37, 50, 57-59 and accompanying text.

intermediaries, 1970 "IL 70-2" to carriers and intermediaries, 1980 legislation, 1991 HCFA claim form).[65] It is little wonder that the GAO concluded, in 1986 and again in 1998, that the physical presence requirement for teaching physicians has not been "clearly communicated or consistently enforced."[66] Interestingly, in a 1997 letter to the President and Executive Vice President of the Association of American Medical Colleges ("AAMC"), the General Counsel of HHS acknowledged that "the standards for paying teaching physicians under Part B of Medicare have not been consistently and clearly articulated by HCFA over a period of decades."[67]

C. The PATH Audit Protocol

When the OIG announced the PATH audit protocol for reviewing Medicare Part B billings by teaching physicians, they selected all teaching physicians at the 125 hospitals associated with U.S. medical schools for potential audits.[68] The OIG selected these facilities because "of the nation's 1,200 teaching hospitals, these institutions had the greatest number of residents and received the most Medicare revenue."[69] As of November, 1999, PATH audits were planned, completed or underway for thirty of these institutions.[70]

The audit protocol, whether under PATH I or II,[71] requires review of one hundred randomly selected inpatient admissions during a selected one-year period between 1994-1995.[72] Projections are made from these findings to all physician billings submitted by the physicians during the established period within the six-year statute of limitations time period set forth in the False Claims Act.[73] Teaching hospitals argue that this protocol permits claims by a

65. *See supra* notes 38-48, 60-63 and accompanying text.

66. *Id.* at 11. *See also* GAO, DOCUMENTING SERVICES, *supra* note 51, at 32 (noting that "HCFA's current [as of 1986] requirements . . . are not explicit enough" and that "enforce[ment] var[ies] substantially among carriers").

67. Rabb Letter, *supra* note 10, at 4. The General Counsel also found that some carriers had communicated billing requirements clearly and thus communicated that OIG would undertake PATH audits only where carriers issued clear explanations of the reimbursement rules. *Id.* at 5.

68. *See supra* notes 21-22 and accompanying text.

69. GAO, CONCERNS WITH PATH, *supra* note 2, at 12.

70. *Id.*

71. *See supra* text accompanying notes 24-27.

72. *See* Brief for Appellant, Ass'n of Amer. Med. Colleges v. United States, No. 98-56190 (9th Cir. filed Nov. 9, 1998) (visited Jan. 18, 2000) <http://www.aamc.org/hlthcare/path/amc brief.txt>.

> Typically, 100 inpatient admissions yields between 1500 and 2500 occasions of physician service which have been provided by a small percentage of the faculty members. By way of comparison, . . . University of Michigan faculty files an average of 350,000 claims annually. Thus, the total audit sample is less than ½ of one percent of the total claims filed for a single year.

Id. at 17 n.7.

73. 31 U.S.C. § 3729 (1994); *see infra* Part II.C.

few physicians to be the only claims reviewed and their billing errors, if any, to be projected to other physicians not included in the audit sample. Teaching hospitals further complain that the OIG auditing protocol does not permit the physicians whose claims are identified as problematic, or the teaching hospital which employs these physicians, to rebut the conclusion of wrongdoing.[74] OIG, on the other hand, maintains that "physicians are part of the audit process and have ample opportunities to bring up issue and provide additional evidence."[75]

At the outset of each PATH audit, the auditors tell teaching hospitals that the alternative to PATH I or PATH II audit participation is litigation under the FCA.[76] Penalties could be substantial, since the FCA mandates treble damages and mandatory penalties of $5,000 - $10,000 per claim.[77] As the AAMC notes: "The potential liability . . . is hundreds of millions of dollars for any faculty that averages 100,000 Medicare claims annually and experiences an error rate of even two percent . . . ."[78] The AAMC and the various teaching hospitals which filed suit for injunctive relief against the enforcement of PATH have argued that, given the possibility of severe penalties under the FCA, teaching hospitals have no choice but to settle.[79] Despite the teaching hospitals' arguments regarding the audit protocol, the GAO concluded that the OIG "followed a reasonable methodology" in conducting the audits, with one significant exception.[80] Rather than undertaking audits of all one hundred and twenty-five teaching hospitals affiliated with the nation's medical schools, the GAO concluded that OIG should have "identified institutions with suspected billing problems and then targeted its efforts accordingly."[81]

74. AAMC Complaint, *supra* note 10, ¶ 62.

75. Draft Comments by and Electronic Mail Communications with Lewis Morris, Assistant Inspector General for Legal Affairs, U.S. Dep't of Health and Human Services (various dates in Fall, 1999).

76. AAMC Complaint, *supra* note 10, ¶ 57.

77. The False Claims Act ("FCA") requires proof of "knowing" submission of false claims, which includes reckless disregard of the truth and deliberate indifference to the truth. 31 U.S.C. § 3729(b) (1994).

78. AAMC Complaint, *supra* note 10, ¶ 57.

79. As the AAMC asserts:

> The fiduciary responsibility the Trustees and managers of the [teaching] universities, hospitals and faculties have to their communities, their institutions, and the patients served by their teaching and patient care programs, make them particularly susceptible to coercion when financial risk of such magnitude is threatened, whether directly or impliedly.

Id.

80. *See* GAO, CONCERNS WITH PATH, *supra* note 2, at 23.

81. *Id*. The GAO explained that "[b]ecause PATH audits can be time-consuming and expensive for both the government and the institutions, we believe that the OIG should have had a sound basis for asking the institutions to incur these costs." *See also GAO Confirms Legal*

As already noted, teaching hospitals have felt compelled to settle a PATH audit rather than contest its findings or protocol due to their belief that failure to settle will lead to suit under the False Claims Act ("FCA").[82] With its statutorily mandated damages and penalties, the FCA is an intimidating cause of action. Yet, it is only one of numerous statutes available to the government for pursuing health care fraud. As Part II of this article discusses, liability under the FCA may be mild compared to other sanctions available to pursue fraudulent health care providers. It is the full arsenal, the FCA coupled with criminal and administrative sanctions and massive resources, that is truly intimidating.

II. RESOURCES AND SANCTIONS AIMED AT HEALTH CARE FRAUD

A. The Resources

Government resources available to combat health care fraud are formidable: far-reaching criminal statutes; civil causes of action which carry hefty, mandatory damages and penalties; forfeiture of assets; and administrative penalties of suspension and exclusion, which may be the "death penalty" for health care providers. Almost annually for the past decade, Congress has passed stricter laws aimed at health care fraud.[83] Most recently, with the passage of the Health Insurance Portability and Accountability Act ("HIPAA")[84] in 1996 and the passage of the Balanced Budget Act[85] in 1997, Congress substantially broadened the federal government's statutory authority to prosecute health care fraud. The new laws added five new health care crimes, most of which carry stiff penalties and mandatory forfeiture of assets;[86] expand the reach of federal crimes targeted at health care fraud to include fraud upon private health care insurers;[87] and broaden HHS's authority to impose

Basis for PATH, But Raises Questions About IG's Audits, 7 Health L. Rep. (BNA) 1292 (Aug. 13 1998).

82. *See supra* text accompanying notes 76-79.

83. For example, note Congress' attention to the anti-kickback statute. First passed in 1971 as a misdemeanor offense, *see* Pub. L. No. 92-603, § 242(b), 86 Stat. 1329 (1972), Congress amended the statute in 1977, *see* Pub. L. No. 95-142, 91 Stat. 1175 (1977), strengthening its provisions and making violation of it a felony.

84. Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996) [hereinafter HIPAA].

85. Balanced Budget Act of 1997, Title IV-Medicare, Medicaid and Children's Health Provisions, Pub. L. No. 105-33, 111 Stat. 251 (1997).

86. *See, e.g.*, 18 U.S.C. § 669 (Supp. III 1997) (theft involving health care programs); 18 U.S.C. § 1035 (Supp. III 1997) (false statements involving health care programs); 18 U.S.C. § 1518 (Supp. III 1997) (obstructing a health care criminal investigation); and 18 U.S.C. § 1347 (Supp. III 1997) (health care fraud).

87. *See, e.g.*, 18 U.S.C. §§ 669, 1035, 1347.

civil monetary damages[88] and exclusion.[89] Perhaps most significantly, HIPAA appropriated substantial monies for investigations of health care fraud and established a self-funding trust to finance future health care fraud investigations.[90] Under HIPAA, criminal fines and forfeitures in cases involving a "federal health care offense," civil monetary penalties imposed in health care cases, and penalties and damages recovered under the FCA in health care cases are to be deposited into the trust fund.[91] In 1998, the trust fund's second year of operation, federal and state governments collected $296 million from anti-fraud actions in health care cases.[92] Of this amount, $119.6

88. Pub. L. No. 105-33, § 4304, 111 Stat. at 383-84 (1997) (codified as amended at 42 U.S.C. § 1320a-7a(a) (1994 & Supp. III 1997)).

89. HIPAA § 211, 110 Stat. at 2003-04 (codified as amended at 42 U.S.C. § 1320a-7(a)-(b) (1994 & Supp. III 1997)).

90. HIPAA § 201(b), 110 Stat. at 1993 (codified as amended at 42 U.S.C. § 1395i (1994 & Supp. III 1997)) (establishing a "Health Care Fraud and Abuse Control Account" expenditure in the Federal Hospital Insurance Trust Fund).

91. HIPAA § 201(b)(2)(C), 110 Stat. at 1993-94.

92.

Total Transfer/Deposits by Recipient 1998	
Department of the Treasury	
HIPAA Deposits to the Medicare Trust Fund	
Gifts and Bequests	$3,000.00
Amount Equal to Criminal Fines	$2,503,298.00
Civil Monetary Penalties	$1,855,277.00
Amount Equal to Asset Forfeiture *	$0.00
Amount Equal to Penalties and Multiple Damages	$103,025,990.00
Health Care Financing Administration	$27,998,956.00
OIG Audit Disallowances - Recovered	$144,741,634.00
Restitution/Compensatory Damages	*$280,128,155.00*
Restitution/Compensatory Damages to Other Federal Agencies	$7,488,888.00
Department of Defense	$173,866.00
Office of Personnel Management	$3,125,418.00
Other	$1,270,196.00
Department of Health and Human Services - Other than HCFA	*$12,058,368.00*
Relators' Payments **	*4,344,610.00*
TOTAL *	*$296,531,133.00*

* This includes only forfeitures under 18 U.S.C. § 1347, a new federal health care fraud offense that became effective on August 21, 1996. Not included are forfeitures obtained in numerous health care fraud cases prosecuted under federal mail and wire fraud and other offenses.

** These are funds awarded to private persons who file suits on behalf of the Federal Government under the *qui tam* provisions of the False Claims Act, 31 U.S.C. § 3730(b) (1994).

million was appropriated from the fund for health care fraud investigations conducted by HHS/OIG.[93]

The full impact of these increased resources is just beginning to be felt. The Inspector General's Office of HHS currently employs a medical fraud staff of 1,143, up one-third from 1996.[94] Department of Justice attorneys and FBI Agents devoted to health care fraud matters have increased by 175% since 1993.[95] Since 1993, fighting health care fraud has been a top priority of the U.S. Department of Justice.[96] Law enforcement's focus on health care fraud has borne fruit. In the two years between 1995 and 1997, for example, criminal health care investigations increased 21.6%,[97] criminal health care fraud prosecutions filed increased 23%,[98] criminal health care fraud convictions increased 37%,[99] and pending civil matters brought under the False Claims Act increased 185%.[100] Since 1986, the DOJ has recovered $1.8 billion from matters involving health care fraud,[101] with $1.2 billion collected in fiscal year 1997 alone.[102]

B. Statutes Directed at Criminal Acts of Health Care Fraud

Over thirty federal statutes are directed at criminal health care fraud or are applicable and routinely used to prosecute health care fraud.[103] The penalties imposed by most of these statutes include possible maximum terms of prison of five years, and maximum fines of $250,000,[104] although a few statutes carry

*** Funds are also collected on behalf of state Medicaid programs and private insurance companies; these funds are not represented here.

DEPARTMENT OF HEALTH AND HUMAN SERVS. & DEP'T OF JUSTICE, HEALTH CARE FRAUD AND ABUSE PROGRAM, ANNUAL REPORT FOR FY 1998 5-6 (1999) [hereinafter HHS & DOJ FRAUD REPORT FY 1998] (visited Jan. 18, 2000) <http://www.usdoj.gov/ag/98hipaa_ar.htm>. Cited page numbers correspond to pagination of this internet source.

93. *Id.* at 7.

94. *Health Care Waste, Fraud and Abuse: Hearing Before the Subcomm. on Health of the House Comm. on Ways and Means*, 105th Cong. at 58 (1997).

95. DEPARTMENT OF JUSTICE, HEALTH CARE FRAUD REPORT 1997 13 (1998) [hereinafter DOJ FRAUD REPORT FY 1997] (visited Jan. 18, 2000) <http://www.usdoj.gov/dag/health97.html> (from 200 in 1993 to 551 in 1997). Cited page numbers correspond to pagination of this internet source.

96. *Id.* at 2.

97. *Id*. at 10 (from 1,247 in 1995 to 1,517 in 1997).

98. *Id*. (from 229 in 1995 to 282 in 1997).

99. *Id*. (from 158 in 1995 to 217 in 1997).

100. DOJ FRAUD REPORT FY 1997, *supra* note 95, at 10 (from 1,406 in 1995 to 4,010 in 1997).

101. *Id.* at 6.

102. *Id.* at 7.

103. BUCY, HEALTH CARE FRAUD, *supra* note 3, § 3.01.

104. *See, e.g.*, 18 U.S.C. §§ 286, 287, 371, 1341, 1343, 1505, 1622 (1994); 18 U.S.C. §§ 641, 1001, 1503, 1512 (1994 & Supp. III 1997); 18 U.S.C. § 1518 (Supp. III 1997).

maximum prison terms of twenty years,[105] even life imprisonment.[106] Although mandatory forfeiture of property which "constitutes or is derived from" fraud has been required in limited instances for years,[107] mandatory forfeiture authority in instances of health care fraud was expanded in 1996 with passage of HIPAA.[108] HIPAA also added five additional crimes directed at health care fraud.[109]

In addition to federal statutes and resources, the states aggressively prosecute health care fraud, usually extending their investigations to include instances of patient physical abuse. In 1977, Congress passed legislation establishing Medicaid Fraud Control Units ("MFCUs").[110] In 1983, Congress made MFCUs mandatory.[111] Most MFCUs are part of a state's Attorney General's office or other law enforcement office and are staffed with attorneys, investigators and auditors trained in health care and complex cases.[112] Currently, MFCUs have a combined staff of over 1,275 and a joint federal/state budget of $95 million.[113]

As noted throughout this section, proof of intent to commit fraud, stated in a variety of ways, is an element of every criminal offense. Ambiguous billing regulations not only make it difficult to determine whether improper bills were submitted, but also make it difficult to prove the requisite intent to defraud.

105. *See, e.g.*, 18 U.S.C. §§ 1956, 1961 (1994 & Supp. III 1997); 18 U.S.C. § 1347 (Supp. III 1997).

106. 18 U.S.C. § 1347 (Supp. III 1997) ("if the violation results in death").

107. *See, e.g.*, 18 U.S.C. §1957 (1994); 18 U.S.C. §§ 1956, 1961 (1994 & Supp. III 1997).

108. *See* HIPAA § 249(a), 110 Stat. at 2020 (codified as amended at 18 U.S.C. § 982(a) (1994 & Supp. III 1997)).

109. *See supra* note 86.

110. Medicare-Medicaid Anti-Fraud and Abuse Amendments, Pub. L. No. 95-142, § 1, 91 Stat. 1201 (currently codified at 42 U.S.C. § 1396b(g) (1994 & Supp. III 1997)).

111. Omnibus Reconciliation Act of 1993, Pub. L. No. 103-66, § 13625, 107 Stat. 636 (currently codified at 42 U.S.C. § 1396b(g) (1994 & Supp. III 1997)). A state may obtain a waiver of this requirement by demonstrating that it has a minimal amount of Medicaid fraud and that residents of facilities funded, in part, through Medicaid are protected against abuse and/or neglect. *See* 42 U.S.C. § 1396a (61).

112. 42 U.S.C. § 1396b(q)(6) (1994 & Supp. III 1997).

113. The New York MFCU, with 280 employees, is the largest MFCU; Wyoming, with four employees, is the smallest MFCU. *Hearing on Health Care Fraud Before the Subcomm. on Oversight and Investigations of the House Commerce Comm.*, 106th Cong. (Nov. 9, 1999) (testimony of John Krayniak, Director, New Jersey Medicaid Fraud Control Unit).

1. Federal Crimes[114]

a. Submitting False Claims: 18 U.S.C. § 287

Although 18 U.S.C. § 287[115] applies to any false claim made against the federal government, it is a common statute employed to prosecute health care fraud. This statute was first passed in 1863;[116] soon thereafter, it was separated into three statutes: the current § 287, a prior version of 18 U.S.C. § 1001[117] and a prior version of the civil False Claims Act.[118] The elements of § 287 are: (1) making or presenting a claim, (2) which is false, fictitious or fraudulent, (3) and material, (4) to a department or agency of the United States, (5) and, at the time the claim is made, the person presenting it knows it is false, fictitious or fraudulent.[119] Medicare claims need not violate federal law to constitute a violation of § 287; it is sufficient if the claims violate guidelines set forth in the billing manual supplied by private insurance companies which contract with the federal government to process Medicare and Medicaid claims.[120] Both § 287 and the civil False Claims Act[121] apply to almost every situation involving alleged false claims submitted to the federal government. Because § 287 and the civil False Claims Act originated in the same legislation, they share many of the same elements and courts liberally apply precedent regarding one statute to the other.[122] If physicians at teaching hospitals know that they are not to bill for patient services rendered by residents when the physician is not physically present, § 287 would be violated.

114. Portions of Part II.B.1-2 are based upon BUCY, HEALTH CARE FRAUD, *supra* note 3.

115. 18 U.S.C. § 287 (1994) provides:

> Whoever makes or presents to any person or officer in the civil, military or naval service of the United States, or to any department or agency thereof, any claim upon or against the United States, or any department or agency thereof, knowing such claim to be false, fictitious or fraudulent, shall be imprisoned not more than five years or shall be subject to a fine or both.

116. *See* Act of March 2, 1863, at ch. 67, 12 Stat. 696-99 (1863).

117. *See* discussion *infra* Part II.B.1.b.

118. 31 U.S.C. §§ 3729-3733 (1994).

119. *See* United States v. Medical Servs. Corp., 43 F. Supp.2d 499, 500 (D. Del. 1999).

120. *Id.* at 502.

121. 31 U.S.C. §§ 3729-3733 (1994). *See infra* Part II.C. For more information on the False Claims Act see JOHN T. BOESE, CIVIL FALSE CLAIMS AND QUI TAM ACTIONS (1993 & Supp. 1999) [hereinafter BOESE, CIVIL FALSE CLAIMS]; BUCY, HEALTH CARE FRAUD, *supra* note 3; SARAH N. WELLING, SARA SUN BEALE & PAMELA H. BUCY, FEDERAL CRIMINAL LAW AND RELATED ACTIONS, ch. 27 (1998) [hereinafter WELLING, BEALE & BUCY, RELATED ACTIONS].

122. *See, e.g.*, United States *ex rel.* Marcus v. Hess, 317 U.S. 537, 540 n.2 (1943); United States v. Winchester, 407 F. Supp. 261 (D. Del. 1975).

b. False Statements: 18 U.S.C. § 1001

Although 18 U.S.C. § 1001 is a generic statute, prohibiting any type of false statement or concealment within the jurisdiction of the federal government, prosecutors have used § 1001 for many years to prosecute health care fraud.[123] The elements of § 1001 are: (1) knowingly and willfully, (2) making a false, material statement *or* concealing a material fact *or* using a writing or document that is false in a material matter, (3) in any matter within the jurisdiction of any branch of the United States government.[124]

Courts tend to interpret § 1001 broadly. As the Fifth Circuit explained: "The false statement statute is necessarily couched in very broad terms to encompass the variety of deceptive practices which ingenious individuals might perpetrate upon an increasingly complex government."[125] For example, § 1001 would be violated if a teaching physician at a teaching hospital who, knowing that he could not bill Medicare for patient services rendered by residents unless the teaching physician was present, submitted records falsely indicating that he was present when the resident rendered the services.

c. Mail Fraud and Wire Fraud: 18 U.S.C. §§ 1341 and 1343

Mail fraud,[126] along with its "cousin," wire fraud,[127] is the most common statute used in the federal system to prosecute fraud, including health care

123. 18 U.S.C. § 1001 (1994 & Supp. III 1997) provides, in pertinent part:

> Except as otherwise provided in this section, whoever, in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government of the United States, knowingly and willfully —
>
> (1) falsifies, conceals, or covers up by any trick, scheme, or device a material fact;
>
> (2) makes any materially false, fictitious, or fraudulent statement or representation; or
>
> (3) makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry;
>
> shall be fined . . . or imprisoned not more than 5 years, or both.

124. United States v. Capo, 791 F.2d 1054, 1068-69 (2d Cir. 1986), *reh'g granted*, 817 F.2d 947 (1987).

125. United States v. Massey, 550 F.2d 300, 305 (5th Cir. 1977).

126. The mail fraud statute, 18 U.S.C. § 1341 (1994), provides:

> Whoever, having devised or intending to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises. . .for the purpose of executing such scheme or artifice or attempting to do so, places in any post office or authorized depository for mail matter, any matter or thing whatever to be sent or delivered by the Postal Service, or deposits or causes to be deposited any matter or thing whatever to be sent or delivered by any private or commercial interstate carrier, or takes or receives, therefrom, any such matter or thing, or knowingly causes to be delivered by mail or by such carrier according to the direction thereon. . .any such matter or thing, shall be fined not more than $1,000 or imprisoned not more than five years, or both.

127. The wire fraud statute, 18 U.S.C. § 1343 (1994), provides in pertinent part:

fraud.[128] The elements of mail fraud are: (1) devising a scheme or artifice to defraud or for obtaining money or property by means of false or fraudulent pretenses, and (2) use of the mails in furtherance of the scheme. There is no requirement of interstate use of the mails.[129] The elements of wire fraud are: (1) devising a scheme or artifice to defraud or for obtaining money or property by means of false or fraudulent pretenses, and (2) interstate use of wire, radio or television communication.[130] Courts interpret these statutes broadly. As one court explained: "Because of the statutes' broad, amorphous language, coupled with a lack of explanatory legislative history, courts have generally enjoyed considerable latitude in determining what types of schemes come within the purview of the statutes."[131]

If it can be proven that a teaching physician at an academic medical center knew that she could not bill Medicare for services provided to patients by residents when the teaching physician was not present, but submitted such bills anyway, mail fraud has been committed if the physician caused any item, which furthers this billing, to be sent through the U.S. mails, or by an interstate carrier such as Federal Express. Wire fraud has been committed in this situation if the teaching physician used or caused to be used any interstate use of wire facilities, including telephone calls or faxes.

The mail fraud and wire fraud statutes are powerful not only because of their broad scope, but also because they serve as "predicate acts" for even more powerful statutes, like RICO and money laundering.

d. Medicare and Medicaid Fraud: 42 U.S.C. § 1320a-7b(a)(1)

Making or causing false statements to be made to obtain payment from a federal health care program may be prosecuted as a violation of 42 U.S.C. § 1320a-7b(a)(1).[132] The elements of § 1320a-7b(a)(1) are: (1) knowingly and

> Whoever, having devised or intend to devise any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, transmits or causes to be transmitted by means of wire, radio, or television communication interstate or foreign commerce, any writings, signs signals, pictures, or sounds for the purpose of executing such scheme or artifice, shall [guilty of an offense].

128. Enacted in 1872, the mail fraud statute is viewed as the "first line of defense" against fraud of all kinds. *See* Jed. S. Rakoff, *Federal Mail Fraud Statute (Part I)*, 18 DUQ. L. REV. 771, 772 (1979). Prosecutors use the statute to prosecute consumer fraud, insurance fraud, public corruption, bank frauds, securities fraud and health care fraud.

129. 18 U.S.C. § 1341.

130. 18 U.S.C. § 1343.

131. *See Medical Servs. Corp.*, 43 F. Supp.2d at 501.

132. 42 U.S.C. § 1320a-7b(a)(1) (1994 & Supp. III 1997) provides that:

> Whoever knowingly and willfully makes or causes to be made any false statement or presentation of a material fact in any application for any benefit or payment under a federal health care program . . . shall be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both.

willfully, (2) making or causing to be made a false statement or representation of material fact, (3) in a claim for payment under the federal health care programs.[133] Although § 1320a-7b(a)(1) specifically applies to false statements made to obtain payments from federal health care programs, prosecutors pursuing health care fraud are not limited to § 1320a-7b(a)(1) in such instances and still may proceed under generic fraud and false statement statutes. Health care fraud in violation of § 287[134] or § 1001[135] would almost certainly be prosecutable under § 1320a-7b(a)(1).

e. Money Laundering: 18 U.S.C. §§ 1956 and 1957

Although most people think of money launderers as drug dealers, fraudulent health care providers, as well as any other white collar offender, may be prosecuted for money laundering. There are two types of money laundering offenses: reporting offenses and "transportation" offenses. Reporting offenses penalize the failure to report cash transactions.[136] Transportation offenses forbid moving illegally obtained money into, out of, or among bank accounts, or moving legally obtained money among bank accounts to avoid tax or reporting obligations.[137]

The reporting statutes include both civil and criminal penalties, while the transportation statutes only impose criminal liability. Conviction under either the reporting or transportation statutes carries mandatory forfeiture of assets involved in the offense.[138] Although money laundering statutes are lengthy and complex, prosecutors can fairly easily prove money laundering in any instance of fraud where the defendant uses the proceeds of the fraud to purchase goods or services or pay debts.[139] For example, defendants in *United*

133. United States v. Laughlin, 26 F.3d 1523, 1526 (10th Cir. 1994).

134. *See supra* notes 115-22 and accompanying text.

135. *See supra* notes 123-25 and accompanying text.

136. 31 U.S.C. § 5313 (1994 & Supp. III 1997) requires a domestic financial institution involved in a cash transaction of $10,000 or more to file a report on the transaction. 31 U.S.C. § 5324 (1994) prohibits structuring financial transactions (as in breaking the transactions into small transactions) for the purpose or evading reporting requirements. Finally, 26 U.S.C. § 7203 (1994) expands the groups of persons who must report cash transactions, requiring "all persons engaged in a trade or business" to report cash transactions over $10,000. 31 U.S.C. § 5321 (1994 & Supp. III 1997) imposes a civil penalty for violations of § 5313, while 31 U.S.C. § 5322 (1994) imposes a criminal penalty of imprisonment for not more than five years, or a fine of not more than $250,000, or both, for willful violations of § 5313.

137. 18 U.S.C. §§ 1956, 1957 (1994 & Supp. III 1997).

138. 18 U.S.C. § 982 (1994 & Supp. III 1997).

139. Excellent sources on money laundering include: United States Department of Justice, *United States Attorney's Manual* § 9-105A.000 (Money Laundering Prosecution Manual); Money Laundering Law Report (Leader Publications); Symposium, *The Anti-Money Laundering Statutes: Where From Here*, 44 ALA. L. REV. 657 (1993); Sarah N. Welling, *Smurfs, Money Laundering and the Federal Criminal Law*, 41 FLA. L. REV. 287 (1989); G. Richard Strafer, *Money Laundering: The Crime of the 90's*, 27 AM. CRIM. L. REV. 149 (1989).

States v. Suba[140] submitted false cost reports to Medicare on behalf of a home health care company, thereby obtaining reimbursement at a higher rate.[141] The defendants were convicted of money laundering, pursuant to 18 U.S.C. § 1956, because they invested the excessive reimbursement in stock, land and brokerage accounts and deposited the proceeds into company accounts from which they paid themselves.[142] Section 1957, which does not contain the stiffer intent element of § 1956, is especially broad. As the Ninth Circuit noted: "[Section 1957] is a powerful tool because it makes any dealing with a bank potentially a trap for . . . any . . . defendant who has a hoard of criminal cash derived from the specified crimes . . . . This draconian law, so powerful by its elimination of criminal intent, freezes the proceeds of specific crimes out of the banking system."[143]

Thus, for example, if a teaching physician at an academic medical center engaged in mail fraud or wire fraud arising from reimbursement claims submitted to Medicare for treatment of Medicare patients by a resident when the teaching physician was not present, *and* the physician loaned a friend money which the teaching physician received as reimbursement from Medicare because of such claims, the physician has violated § 1956 *if* she made the loan[144] with one of the following intents: (1) to promote the fraud scheme, (2) to engage in tax fraud or tax evasion, (3) to conceal the source of the funds, (4) to avoid a cash reporting requirement. As one might imagine, it would be difficult to prove that the physician made the loan with one of the aforementioned intents, and thus difficult to prove a violation of § 1956.

It would be easier to prove a violation of § 1957. If a teaching physician at an academic medical center engaged in mail fraud or wire fraud arising form reimbursement claims submitted to Medicare for treatment of Medicare patients by a resident when the teaching physician was not present, and the physician deposited an amount greater than $10,000 of Medicare reimbursement into her bank account,[145] the physician has violated § 1957. Although § 1957 carries a lighter term of imprisonment than § 1956 (ten versus twenty years), conviction of either offense requires mandatory forfeiture of property "involved in" or "traceable" to such an offense.[146] Thus, the clinic or office at which the physician saw the patients at issue would be forfeited.

140. 132 F.2d 662 (11th Cir. 1998).
141. *Id*. at 666-67.
142. *Id*. at 666.
143. United States v. Rutgard, 108 F.3d 1014, 1062 (9th Cir. 1997).
144. A loan is a "financial transaction" within the meaning of § 1956. *See* 18 U.S.C. § 1956.
145. Which is a "monetary transaction" within the meaning of § 1957. *See* 18 U.S.C. § 1957.
146. *See supra* notes 107-08 and accompanying text.

f. Racketeer Influenced and Corrupt Organizations ("RICO"): 18 U.S.C. §§ 1961-1964

Racketeer Influenced and Corrupt Organizations ("RICO"), passed in 1970,[147] creates a criminal offense and a civil cause of action.[148] The federal government serves as prosecutor if criminal liability is sought.[149] The federal government, or any person injured in his or her business or property by the RICO violation, may serve as plaintiff and bring a civil RICO action.[150] Most RICO cases are civil.[151]

Regardless of whether the RICO case is civil or criminal or the plaintiff is the government or a private citizen, the plaintiff must prove that the defendant engaged in a "pattern of racketeering activity."[152] A variety of state crimes (murder, robbery, bribery, extortion, illegal drug dealing) and over sixty federal crimes (ranging from drug dealing and gambling to white collar offenses) constitute "racketeering activity."[153] The "pattern" of racketeering activity may be shown with proof that acts were related to each other through the "same or similar purposes, results, participants, victims or methods of commission;" that there was a threat of the acts continuing; or that the "offenses are part of an ongoing entity's regular way of doing business."[154] The RICO plaintiff must show that at least one of the following types of conduct took place and that such conduct affected interstate commerce:

> (1) the defendant invested in an "enterprise," monies received through the pattern of racketeering activity;
>
> (2) the defendant acquired or maintained control of an "enterprise" through a pattern of racketeering activity;
>
> (3) the defendant, who was employed by or associated with an "enterprise," conducted or participated in the affairs of the enterprise through a pattern of racketeering activity; or
>
> (4) the defendant conspired to do any of the above.[155]

147. Organized Crime Control Act of 1970, § 901(a), 18 U.S.C. §§ 1961-1964 (1994 & Supp. III 1997).

148. *See* WELLING, BEALE & BUCY, RELATED ACTIONS, *supra* note 121, at ch. 21. Other excellent sources on RICO include PAUL A. BATISTA, CIVIL RICO PRACTICE MANUAL (2d ed. 1997) and KEVIN P. RODDY, RICO IN BUSINESS & COMMERCIAL LITIGATION (1991).

149. *See* 18 U.S.C. § 1961 (1994).

150. *See* 18 U.S.C. § 1964(b) (1994).

151. U.S. ADMINISTRATIVE OFFICE OF THE COURTS, Table C-2, Civil Cases Commenced 1994-1998; Table D-2, Criminal Cases Commenced 1994-1998.

152. 18 U.S.C. § 1961(5) (1994).

153. 18 U.S.C. § 1961(1) (1994 & Supp. III 1997).

154. H.J. Inc. v. Northwestern Bell Tel. Co., 492 U.S. 229, 240-42 (1989).

155. 18 U.S.C. § 1962 (1994).

An "enterprise" includes "any individual, partnership, corporation, association or other legal entity, and any union or group of individuals associated in fact . . . ."[156]

The penalties for violating RICO are formidable. If convicted of a RICO violation, a defendant may be imprisoned for up to twenty years and shall forfeit any interest acquired or maintained in violation of RICO and any property derived from a RICO violation.[157] If found civilly liable under RICO, a defendant faces mandatory treble damages, attorneys fees and costs.[158] In addition, courts are given broad power "to prevent and restrain" RICO violations by ordering divesture of any interest in any enterprise, or by imposing "reasonable" restrictions on future activities of a person engaged in RICO violations.[159]

Health care fraud prosecutors have used RICO to prosecute physicians who conspire with attorneys and patients to submit false claims to insurers,[160] physicians who dispense unnecessary prescriptions of controlled substances,[161] and physicians who conspire to submit false claims for medical services not rendered,[162] among others. Civilly, RICO has been used in a wide variety of instances: for example, by a home health care company suing the billing company which processed the company's bills for "fraudulently submit[ting] claims for reimbursement on [its] behalf . . . to Medicare, Medicaid, and other third-party payor insurance companies;"[163] by investors who purchased limited partnership interests in a Magnetic Resonance Imaging center and sued the sellers, alleging misrepresentations regarding ownership and leasing arrangements;[164] by an insurance company against physicians who allegedly conspired to defraud the company;[165] and by a physician against a hospital which terminated him as medical director.[166]

Through careful pleading, a RICO offense under 18 U.S.C. § 1962(c) can be proven simply by showing that a teaching physician used his office or clinic (the "enterprise") to engage in mail fraud or wire fraud (the "pattern of racketeering activity") arising from submission of reimbursement claims to Medicare for treatment by residents of Medicare patients when the teaching

156. 18 U.S.C. § 1961(4) (1994).

157. 18 U.S.C. § 1963 (1994).

158. 18 U.S.C. § 1964(c) (1994 & Supp. III 1997).

159. 18 U.S.C. § 1964(a) (1994).

160. *See, e.g.*, United States v. Console, 13 F.3d 641, 650 (3d Cir. 1993); United States v. Neely, 980 F.2d 1074, 1077 (2d Cir. 1992) (involving claims of fictitious automobile accidents).

161. *See, e.g.*, United States v. Hughes, 895 F.2d 1135, 1138-39 (6th Cir. 1990).

162. *See, e.g.*, United States v. Worthington, 698 F.2d 820, 821 (6th Cir. 1983).

163. VNA Plus, Inc. v. APRIA Healthcare Group, Inc., 29 F. Supp.2d. 1253, 1257 (D. Kan. 1998).

164. Gubitosi v. Zegeye, 28 F. Supp.2d 298, 300-01 (E.D. Pa. 1998).

165. Zenith Ins. Co. v. Breslaw, 108 F.3d 205, 206 (9th Cir. 1997).

166. Khurana v. Innovative Health Care Sys., Inc., 130 F.3d 143, 146 (5th Cir. 1997).

physician was not physically present. Under 18 U.S.C. § 1963, the office or clinic used by the physician would be subject to mandatory forfeiture.

g. Conspiracy: 18 U.S.C. §§ 371 and 286

Conspiracy is an agreement between two or more persons to commit an unlawful act.[167] The essence of the conspiracy offense is the agreement itself, not acts taken in furtherance of the agreement.[168] Conspiracy is a criminal offense when the object of the conspiracy is the commission of a crime.[169] The crime of conspiracy arises from certain planning activities that precede the actual commission of crime. Generally, three elements must be proven to show that a conspiracy exists: (1) an agreement between two or more persons to commit an illegal act, (2) an intent to commit the illegal act, (3) the commission of at least one overt act by one co-conspirator in furtherance of tile conspiracy.[170]

Some conspiracy statutes are limited to certain agreements. For example, the general federal conspiracy statute, 18 U.S.C. § 371, prohibits only conspiracies to commit an offense against the United States, either by agreeing to violate a federal criminal law or by agreeing to defraud the United States.[171] Another federal statute, 18 U.S.C. § 286, prohibits only conspiracies to submit false claims to the government.[172]

Sections 371 and 286 are the federal conspiracy offenses used most often in health care fraud prosecutions. Although the two offenses are similar, there are differences. Section 286 proscribes only certain conspiracies against the United States, those involving efforts to obtain payment for false, fictitious or fraudulent claims.[173] Section 371, in contrast, proscribes conspiracies to commit an offense against the United States or to defraud the United States.[174] Section 286 is punishable by a maximum term of imprisonment of five years, while § 371 is punishable by a maximum term of imprisonment of five years when the object of the conspiracy is a felony, but is a misdemeanor, punishable by a maximum term of imprisonment of one year when the underlying offense

167. United States v. Falcone, 311 U.S. 205, 210 (1940); Williamson v. United States, 207 U.S. 425, 447 (1908).

168. Braverman v. United States, 317 U.S. 49, 53 (1942).

169. Conspiracy may be a civil cause of action when the object of the conspiracy is a tort and the conspiracy causes proximate damage to the plaintiff. PAMELA H. BUCY, WHITE COLLAR CRIME: CASES AND MATERIALS 5 (2d ed. 1998).

170. United States v. Gold, 743 F.2d 800, 824 (11th Cir. 1984).

171. 18 U.S.C. § 371 (1994); United States v. Minarik, 875 F.2d 1186, 1187 (6th Cir. 1989); United States v. Touhey, 867 F.2d 534, 536 (9th Cir. 1989).

172. *See id.*; *see also* 18 U.S.C. § 286 (1994).

173. *Id.*

174. 18 U.S.C. § 371.

is a misdemeanor.[175] Lastly, § 286 has no "overt act" requirement, while § 371 retains such a requirement.[176] Because of these differences, the prohibition against double jeopardy does not apply if the government chooses to prosecute a defendant under both § 286 and § 381.[177]

h. Theft of Government Property: 18 U.S.C. § 641

Most federal efforts to prosecute health care fraud as theft employ 18 U.S.C. § 641.[178] Because § 641 provides one of the few misdemeanor offenses in the federal system, it can be of unique assistance to defense counsel in negotiating a plea bargain with the prosecutor.[179] Whereas a felony conviction may subject a licensed health care provider to licensure discipline (revocation, suspension, reprimand) a misdemeanor conviction may not. Misdemeanor use of § 641 will be available more often in health care fraud cases than in other types of fraud. With many types of fraud (defense fraud for example) each false statement involves a large sum of money. By comparison, although the total amount of loss per fraud scheme may be large, health care fraud usually is committed in small dollar increments ($2 per claim form, for example). This makes bringing a charge under the misdemeanor provision of § 641 a viable option in most health care cases.

Section 641 will be violated every time § 287 or § 1001 are violated, and can be used interchangeably or in addition to such charges.

175. *Id*.; 18 U.S.C. § 286.

176. United States v. Lanier, 920 F.2d 887, 892-93 (11th Cir. 1991).

177. *Id.* at 893-94.

178. 18 U.S.C. § 641 (1994 & Supp. III 1997) provides:

> Whoever embezzles, steals, purloins . . . any record, voucher, money, or thing of value of the United Sates or of any department of agency thereof . . . [s]hall be fined under this title or imprisoned not more than ten years, or both; but if the value of such property does not exceed the sum of $1000, he shall be fined under this title or imprisoned not more than one year, or both.

The word value means "face, par, or market value, or cost price either wholesale or retail, whichever is greater." 18 U.S.C. § 641. Other provisions of § 641 prohibit converting property of the United States to one's use or the use of another. Further, § 641 prohibits receiving, concealing, or retaining property obtained in one of the proscribed ways. Neither of these provisions apply to health care fraud as directly as the theft provision. *See*, *e.g.*, United States v. Marrero, 904 F.2d 251, 256 (5th Cir. 1990).

179. 18 U.S.C. § 1003 provides another misdemeanor applicable to some instances of health care fraud. Section 1003 makes it a crime to "knowingly and fraudulently demand [or endeavor] to obtain any share or sum in the public stocks of the United States." When the amount obtained does not exceed $1000, the punishment for violating § 1003 is a misdemeanor. Manocchio v. Kusserow, 961 F.2d 1539 (11th Cir. 1992).

i. Obstruction of Justice and Perjury

Counsel for defendants, targets, subjects, and witnesses should be aware of obstruction of justice and perjury statutes when advising clients during pretrial or trial stages of a case. Given the breadth of these statutes, there may be a thin line between violating the law and performing proper attorney functions such as preparing a witness for cross-examination, advising a client not to volunteer information or to answer only when certain of the facts.[180]

There are over twenty federal statutes addressing obstruction of justice and perjury. The statutes most relevant in health care fraud cases are 18 U.S.C. § 1503 (influencing or injuring an officer or juror); 18 U.S.C. § 1505 (obstructing proceedings before departments, agencies and congressional committees); 18 U.S.C. § 1512 (tampering with a witness); and 18 U.S.C. § 1622 (suborning perjury). All of these offenses are felonies, punishable by maximum terms of imprisonment of five years.[181] To protect client *and* counsel from an obstruction of justice prosecution, counsel should caution clients not to destroy evidence that is sought *or may be sought* in an investigation, and not to discuss issues under investigation since such discussions could be viewed as influencing a witness if the person is later called as a witness. Counsel should ensure that giving advice to clients is not, and is not perceived as, obstructing justice.

One obstruction of justice statute bears special attention. "Obstruction of criminal investigations of health care offenses," found at 18 U.S.C. § 1518, was created under HIPAA in 1996.[182] This statute prohibits willfully attempting to or obstructing, misleading or delaying "the communication of information or records relating to a violation of a Federal health care offense."[183] Because of HIPAA's integrated approach to health care fraud, a violation of § 1518 activates additional liability under money laundering and forfeiture statutes. Pursuant to HIPAA's amendment to the money laundering offense,[184] § 1518 is a "specified unlawful activity," subjecting those who obstruct health care fraud investigations to money laundering prosecutions if other elements of money laundering are met.[185] This is significant since money laundering offenses subject offenders to especially lengthy sentences

180. *See, e.g.*, United States v. Poppers, 635 F. Supp. 1034, 1036 (N.D. Ill. 1986).

181. 18 U.S.C. § 1503 (1994 & Supp. III 1997); 18 U.S.C. § 1505 (1994); 18 U.S.C. § 1512 (1994 & Supp. III 1997); 18 U.S.C. § 1622 (1994). However, 18 U.S.C. § 1512(c), regarding harassment of a witness, is a misdemeanor offense, and subjects the offender to a maximum term of one year imprisonment.

182. HIPAA § 245(a), 110 Stat. at 2017-18 (codified as amended at 18 U.S.C. § 1518 (Supp. III 1997)).

183. *Id.*

184. 18 U.S.C. § 1956 (1994 & Supp. III 1997).

185. HIPAA § 246, 110 Stat. at 2018 (codified as amended at 18 U.S.C. § 1956(c)(7)(F) (1994 & Supp. III 1997)).

under the Federal Sentencing Guidelines.[186] In addition, pursuant to HIPAA's amendment to the criminal forfeiture provision found at 18 U.S.C. § 982, a conviction of obstructing a health care investigation subjects one to mandatory forfeiture of property which "constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the [§ 1518]."[187]

j. Health Care Fraud: 18 U.S.C. § 1347

Created by HIPAA, 18 U.S.C. § 1347 is modeled after the mail fraud and wire fraud statutes.[188] Like the mail and wire fraud statutes, which cover fraud upon private victims, not just the government, 18 U.S.C. § 1347, through the definition of "health care benefit program,"[189] covers fraud upon private payers as well as upon public insurers. Although § 1347 requires an effect upon commerce,[190] while the mail fraud and wire fraud statutes do not,[191] it is broader than the mail fraud or wire fraud statutes in other ways. Section 1347 does not require a mailing or use of an interstate carrier as does the mail fraud offense,[192] nor does it require use of interstate wire communications as does the wire fraud offense.[193]

186. U.S. SENTENCING GUIDELINES MANUAL § 2S1.1 (1998); 18 U.S.C. § 1956(c)(7)(F) (Supp. III 1997).

187. HIPAA § 249, 110 Stat. at 2020 (codified as amended at 18 U.S.C. § 982(a) (Supp. III 1997)). *See also* text accompanying note 108.

188. HIPAA § 242, 110 Stat. at 2016 (codified as amended at 18 U.S.C. § 1347 (Supp. III 1997)). Section 1347 provides:

> Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice —
> (1) to defraud any health care benefit program; or
> (2) to obtain, by means of false or fraudulent pretense, representations, or promises, any of the 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 not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

189. The term "health care benefit program" means "any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item or service for which payment may be made under the plan or contract." HIPAA § 241(a), 110 Stat. at 2016 (codified as amended at 18 U.S.C. § 24 (Supp. III 1997)).

190. *See id.*

191. Although neither the mail fraud nor wire fraud statutes require an effect on interstate commerce as does § 1347, the mail fraud statute requires that items sent by private carrier must be sent or delivered by an *interstate* private carrier, and the wire fraud statute requires that the wire transmissions or signals be sent by an *interstate* carrier. *See* 18 U.S.C. §§ 1341, 1343.

192. *See id.*; 18 U.S.C. § 1341.

193. *See supra* note 188; 18 U.S.C. § 1343.

As with the other criminal offenses created by HIPAA, § 1347 is integrated into existing money laundering and forfeiture statutes as a "specified unlawful activity," thereby qualifying those who violate § 1347 for prosecution as money launderers.[194] As noted, conviction for money laundering subjects an offender to a substantially longer sentence than does conviction for fraud.[195] Also, pursuant to HIPAA's amendment of the criminal forfeiture provision found at 18 U.S.C. § 982, conviction of § 1347 subjects one to mandatory forfeiture of any property which "constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the [§ 1347]."[196]

k. Theft or Embezzlement in Connection with Health Care: 18 U.S.C. § 669

Created under HIPAA, 18 U.S.C. § 669 provides:

> Whoever knowingly and willfully embezzles, steals, or otherwise without authority converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title[197] or imprisoned not more than 10 years, or both; but if the value of such property does not exceed the sum of $100 the defendant shall be fined under this title or imprisoned not more than one year, or both.[198]

Although modeled after 18 U.S.C. § 641, which makes it a crime to embezzle, steal or convert property or a thing of value belonging to the United States, § 669 exceeds the scope of § 641. Through its reference to "health care benefit program," § 669 covers fraud upon private insurers as well as upon governmental programs.[199] Like § 641, however, § 669 provides a misdemeanor option for charging health care fraud.[200] Thus, it could be an important option for defendants during plea negotiations.

Like the other crimes created by HIPAA, § 669 is included as "specified unlawful activity," subjecting those who violate it to prosecution for money laundering, which carries a stiffer prison sentence than do most fraud offenses.

194. HIPAA § 246, 110 Stat. at 2018 (codified as amended at 18 U.S.C. § 1956(c)(7)(F) (Supp. III 1997)).

195. U.S. SENTENCING GUIDELINES MANUAL, *supra* note 186, § 2S1.1.

196. HIPAA § 249, 110 Stat. at 2020 (codified as amended at 18 U.S.C. § 982(a)). *See also* text accompanying note 108.

197. 18 U.S.C. §§ 3571-3574.

198. *See* HIPAA § 243(a), 110 Stat. at 2017 (codified as amended at 18 U.S.C. § 669 (Supp. III 1997)).

199. For the definition of "health care benefit program" see *supra* note 189.

200. *See* 18 U.S.C. § 669. "[I]f the value of such property does not exceed the sum of $100 the defendant shall be fined . . . or imprisoned not more than a year, or both."

Also, pursuant to HIPAA amending the forfeiture provisions,[201] conviction of § 669 subjects one to mandatory forfeiture of any "property . . . that constitutes or is derived . . . from gross proceeds traceable to commission of [§ 669]."[202]

l. False Statements Relating to Health Care Matters: 18 U.S.C. § 1035

Created by HIPAA, 18 U.S.C. § 1035 makes it a crime to make a false statement or conceal material facts in connection with the delivery or payment for health care benefits.[203] Although modeled after 18 U.S.C. § 1001, which makes it an offense to make false and fraudulent statements to the federal government, 18 U.S.C. § 1035 has two notable differences from § 1001. First, like all other new health care fraud crimes, § 1035 reaches fraud upon private as well as public insurers. Section 1001 is limited to fraud upon the federal government.[204] Second, presumably because of the clarification given to the materiality element of § 1001 in recent court decisions,[205] § 1035 (unlike § 1001) clearly sets forth materiality as an element to be proven by the government.[206]

Like the other crimes created by HIPAA, § 1035 is a "specified unlawful activity" subjecting those who commit it to money laundering prosecutions.[207] Also, pursuant to HIPAA's amendment to the criminal forfeiture provision, a conviction of § 1035 subjects one to mandatory forfeiture of property which "constitutes or is derived, directly, from gross proceeds traceable to the commission of [§ 1035]."[208]

201. HIPAA § 249, 110 Stat. 2020 (codified as amended at 18 U.S.C. § 982(a) (Supp. III 1997)). *See also* text accompanying note 108.

202. *Id.*

203. 18 U.S.C. § 1035 (Supp. III 1997) provides:

> 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 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 . . . or imprisoned not more than 5 years, or both.

204. For the definition of "health care benefit program," see *supra* note 189.

205. *See, e.g.*, United States v. Gaudin, 515 U.S. 506 (1995).

206. *See* 18 U.S.C. § 1035(a)(2) (prohibiting the knowing and willful making of "any *materially* false of fictitious statement) (emphasis added).

207. *See* HIPAA § 246, 110 Stat. at 2018 (codified as amended at 18 U.S.C. § 1956(c)(7)(F) (Supp. III 1997)).

208. *See* text accompanying note 108; HIPAA § 249, 110 Stat. at 2020 (codified as amended at 18 U.S.C. § 982(a) (Supp. III 1997)); *see also* BUCY, HEALTH CARE FRAUD, *supra* note 3, § 3.02[15][c].

m. The Anti-kickback Statute: 42 U.S.C. § 1320a-7b(b)

The federal health care anti-kickback statute, 42 U.S.C. § 1320a-7b(b), affects almost every business arrangement by and among health care providers. It is a criminal statute intended to prohibit inducements for patient referrals; violations are punishable by a maximum term of imprisonment of five years.[209] Originally, the anti-kickback statute applied only to referrals "for an item or service for which payment may be made in whole or in part under [Medicare or Medicaid]."[210] Effective January 1, 1997, however, the anti-kickback statute was expanded to reach violations related to items or services provided under all federal health care programs, notably health coverage for military personnel and their dependents through the Civilian Health and Medical Program for the Uniformed Services ("CHAMPUS").[211] In pertinent part, the anti-kickback statute prohibits any person from:

> (1) Knowingly and willfully soliciting or receiving "remuneration," directly or indirectly, overtly or covertly, in return for a referral for program-reimbursable items or services; or
>
> (2) knowingly and willfully offering or giving "remuneration," directly or indirectly, overtly or covertly, with the intent to induce referrals for program-reimbursable items or services.[212]

Controversy has surrounded the anti-kickback statute for several reasons. First, the statute prohibits what is a legitimate, if not valued, business tactic outside the health care field. Providers argue that such conduct should not be criminalized.[213] Second, court interpretations of the anti-kickback statute have lurched from expansive[214] to restrictive,[215] making it difficult for providers to conduct day-to-day business transactions without violating the statute. Third, *qui tam* relators as well as the federal government have brought actions under the False Claims Act (FCA)[216] alleging, as the falsity, violations of the anti-

209. 42 U.S.C. § 1320a-7b(b) (1994 & Supp. III 1997).

210. 42 U.S.C. § 1320a-7b(b) (1994).

211. However, federal employee health benefit plans are not included as "federal health care programs." *See* 42 U.S.C. § 1320a-7b(f)(1) (1994 & Supp. III 1997).

212. *See* 42 U.S.C. § 1320a-7b(b) (1994 & Supp. III 1997).

213. *See* BUCY, HEALTH CARE FRAUD, *supra* note 3, § 2.13[1].

214. *See, e.g.*, United States v. Greber, 760 F.2d 68 (3d Cir. 1985), *cert. denied*, 474 U.S. 988 (1985) (stating that "if *one purpose* of the payment [between providers] was to induce future referrals, the Medicare statute has been violated.") (emphasis added). *See also* United States v. Kats, 871 F.2d 105 (9th Cir. 1989) ("material purpose"); United States v. Bay State Ambulance & Hosp. Rental Serv., Inc., 874 F.2d 20 (1st Cir. 1989) ("primary purpose").

215. *See, e.g.*, Hanlester Network v. Shalala, 51 F.3d 1390 (9th Cir. 1995) (holding that the government must prove that a defendant acted with willful violation of a "known legal duty.").

216. 31 U.S.C. §§ 3729-3733 (1994).

kickback statute. Many health care providers view this coupling of the FCA and the anti-kickback statute as exceeding the scope of either statute.[217]

n. Retaining Overpayments: 42 U.S.C. § 1320a-7b(b)(3)

Under 42 U.S.C. § 1320a-7b(b)(3), it is a crime to conceal the fact that one may have received federal health care funds erroneously. This statute provides:

> Whoever . . . having knowledge of the occurrence of any event affecting . . . his initial or continued right to any . . . benefit [under a Federal health care program] . . . conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due . . . shall . . . be guilty of a felony and upon conviction be fined not more than $25,000 or imprisoned for not more than five years or both.[218]

The coverage of this statute is unclear, especially since there is no legislative history regarding it and no completed prosecutions to date under it.[219] However, its terms are broad. It appears to cover, for example, an instance where a provider learns that it was overpaid by Medicare because of incorrect billing codes accidentally submitted by the provider. If the provider fails to come forward and reveal the overpayment, is the provider guilty under this statute? Presumably so, for even if the funds originally were received through innocent mistake, once the provider decides to retain the overpayment, he has fraudulently retained the funds.

2. State Crimes

a. Conspiracy

Conspiracy is a common charge in state prosecutions of health care fraud.[220] In state prosecutions, as in federal prosecutions of health care fraud, the advantages for the government of the conspiracy charge are gaining admission of otherwise inadmissible hearsay[221] and combining far-flung actors

217. Robert Fabrikant & Glenn E. Solomon, *Application of the Federal False Claims Act to Regulatory Compliance Issues in the Healthcare Industry*, 51 ALA. L. REV. 105, 106 (2000).

218. 42 U.S.C. § 1320a-7b(a)(3) (1994 & Supp. III 1997).

219. *See* Ronald J. Nessim, *Health Care Disclosure Statute: What Does It Mean?*, CRIM. JUST. 34-39 (Winter 1999).

220. *See, e.g.*, Commonwealth v. Askin, 452 A.2d 851 (Pa. Super. 1982), *modified by* 467 A.2d 820 (1993); State v. Burnett, 556 A.2d 1251 (N.J. 1989); State v. Toscano, 378 A.2d 755 (N.J. 1977); People v. Varas, 487 N.Y.S.2d 577 (N.Y. App. Div. 1985); State v. Poganski, 257 N.W.2d 578 (Minn. 1977); State v. Lawrence, 212 S.E.2d 52 (S.C. 1974), *cert. denied*, 422 U.S. 1025 (1975); People v. Marsh, 376 P.2d 300 (Cal. 1962); People v. Chapman, 24 Cal. Rptr. 568 (Cal. Dist. Ct. App. 1962).

221. *See, e.g.*, *Chapman*, 24 Cal. Rptr. at 580.

and actions into one case.[222] As in the federal courts, proof of the agreement may be by circumstantial evidence.[223] At least some states require proof of specific intent to violate the law on the part of all conspirators.[224]

b. Medicaid Fraud

Although historically most health care fraud prosecutions have been handled by federal prosecutors, states have been active in prosecuting health care fraud for twenty years through Medicaid Fraud Control Units (MFCUs).[225] When state prosecutors bring charges against health care providers for fraud, they use a variety of statutes including Medicaid fraud, theft, larceny, obtaining money by false pretenses and forgery.[226] Medicaid fraud is the most consistent charge employed by state prosecutors[227] and a number of states have statutes specifically directed at Medicaid fraud.[228] Most such statutes are of recent vintage and contain at least the following elements: prohibition of false statements and/or false claims; prohibition of kickbacks for referrals; a dual penalty track—misdemeanor punishment when larger amounts of money are involved; required access to provider's records for governments fraud investigators; restitution; mandatory exclusion from the Medicaid program; and substantial civil penalties.

Intent is the most heavily litigated issue under the Medicaid fraud statutes and the various state statutes' intent language is considerably diverse. Some Medicaid fraud statutes explicitly require proof of a high level of intent. Louisiana, for example, requires proof of "intent to defraud the state."[229]

222. *See, e.g.*, *Toscano*, 378 A.2d at 756.

223. *Varas*, 487 N.Y.S.2d at 580.

224. *Marsh*, 26 Cal. Rptr. at 303.

225. *See supra* notes 110-13 and accompanying text.

226. Pamela H. Bucy, *Fraud by Fright: White Collar Crime by Health Care Providers*, 67 N.C. L. REV. 855, 883 (1989).

227. *Id.*

228. *See, e.g.*, ARK. CODE ANN. § 5-55-103 (Michie 1997); CONN. GEN. STAT. ANN. § 17b-99 (West 1998); D.C. CODE ANN. § 3-702 (1994); FLA. STAT. ANN. § 409.920 (1998); HAW. REV. STAT. ANN. § 346-43.5 (Michie 1999); 30 ILL. COMP. STAT. ANN. 105/5.223 (West 1993); IND. CODE ANN. § 35-43-5-7.1 (Michie 1998 & Supp. 1999); KY. REV. STAT. ANN. § 205.8463 (Michie 1998); LA. REV. STAT. ANN. § 14:70.1 (West 1997 & Supp. 1999); MD. CODE ANN., HEALTH-GEN. I § 15-123 (1994 & Supp. 1998); MICH. COMP. LAWS ANN. § 400.601 (West 1997); MISS. CODE ANN. § 43-13-201 (1993); MO. REV. STAT. § 191.900-910 (West 1996); MONT. CODE ANN. § 53-6-111 (1999); NEV. REV. STAT. § 422.540 (1997); N.H. REV. STAT. ANN. § 167:58; (1994 & Supp. 1998) N.J. STAT. ANN. § 30:4D-17 (West 1997); N.M. STAT. ANN. § 30-44-1 (Michie 1997); N.Y. SOC. SERV. § 145-b (McKinney 1992); OHIO REV. CODE ANN. § 2913.40 (West 1997); OKLA. STAT. ANN. tit. 56, § 1001 (West 1991); PA. STAT. ANN. tit. 62, § 1407 (West 1996); R.I. GEN. LAWS § 40-8.2-1 (1997); TENN. CODE ANN. § 71-5-118 (1995); UTAH CODE ANN. § 26-20-7 (1998); VT. STAT. ANN. tit. 33, § 141 (1991); W. VA. CODE § 9-7-1 (1998).

229. LA. REV. STAT. ANN. § 14:70.1 (West 1998 & Supp. 1999).

Louisiana courts hold that the statute's intent requirement requires proof of "specific intent": proof that the "offender must have actively desired the prescribed criminal consequence . . . ."[230] Michigan, by comparison, requires proof that the defendant acted "knowing[ly]."[231] Although Michigan courts claim that the statute's language requires proof of "specific intent," they appear to dilute any specific intent requirement. For example, in *People v. American Medical Centers of Michigan, Ltd.*,[232] the Michigan Court of Appeals held that "specific intent" may be shown with evidence that the defendant "was aware of his conduct and that his conduct was substantially certain to cause the intended result."[233]

c. Anti-kickback Statutes

A number of states have anti-kickback statutes,[234] most of which are modeled after the federal anti-kickback statute.[235] Some statutes include civil penalties and revocation of professional licenses as penalties.[236] Prosecution under state anti-kickback statutes may become more common if, as recent court action indicates, the federal anti-kickback statute is interpreted as requiring strong proof of criminal intent before the federal statute is violated.[237]

230. State v. Cargille, 507 So.2d 1254 (La. Ct. App. 1987). *See also* Greco v. State, 148 A.2d 164 (N.J. 1959), which typifies many courts' insistence on strong proof of intent. In *Greco*, the Supreme Court of New Jersey set aside the conviction of a physician on the ground that because of confusing regulations, the government failed to prove that the defendant "knowingly or designedly, with the intent to cheat or defraud" submitted false bills. The court counseled: "Our ultimate conclusion is based upon the firm doctrine of our criminal law that it must be shown that a defendant knew of the falsity of his representations before he can be convicted of the crime of obtaining money by false pretenses." *Id.* at 169.

231. MICH. COMP. LAWS § 400.607(2) (West 1997).

232. 324 N.W.2d 782 (Mich. Ct. App. 1982).

233. *Id.* at 792. *See also* People v. Slocum, 125 Cal. Rptr. 442, 456-57 (Cal. Ct. App. 1975) (interpreting California's Medicaid fraud statute as requiring proof of specific intent that could be satisfied with evidence that defendant submitted "false claims forms pursuant to one scheme or plan to defraud").

234. *See, e.g.*, ALA. CODE § 22-1-11(b), (c) (Michie 1997); ARK. CODE ANN. § 5-5-111(6), (7) (Michie 1997); CAL. BUS. & PROF. CODE § 650 (West 1990 & Supp. 1999); FLA. STAT. ANN. § 395.0185 (West 1998); MD. ANN. CODE art. 27 § 230B(b)(5) (1996); MICH. COMP. LAWS. ANN.§ 752.1004 (1991); MISS. CODE ANN. § 43-13-207 (1993); MO. ANN. STAT. § 198.145 (West 1996); N.J. STAT. ANN. § 30:4D-17(c) (West 1997); OHIO REV. CODE ANN. § 3999.22 (West 1995 & Supp. 1999); WIS. STAT. ANN. § 49.49(2) (West 1997 & Supp. 1998).

235. *See, e.g.*, ALA. CODE § 22-1-11(b),(c); N.J. STAT. ANN. § 30:4D-17(c); VA. CODE ANN. § 32.315(A), (B) (Michie 1997).

236. *See, e.g.*, ARK. CODE ANN. § 20-77-902(6),(7); N.M. STAT. ANN. § 61-6-15(D)(15),(E) (Michie 1999).

237. *See Hanlester*, 51 F.3d at 1400. For a discussion of *Hanlester*, see BUCY, HEALTH CARE FRAUD, *supra* note 3, § 1.04[3].

C. Statutes Imposing Civil Liability for Health Care Fraud

The False Claims Act ("FCA"), originally passed in 1863 and amended significantly since, is one of the most potent weapons available to the government to combat health care fraud.[238] The FCA gives the federal government a cause of action for damages against those who file false claims with the federal government.[239] What makes the FCA unusual, however, is that it also gives any "person" a cause of action against those who file false claims with the federal government. This private plaintiff, known as the "*qui tam*" relator, does not have to demonstrate damage or harm to himself or herself to obtain standing.[240] Rather, courts have held that the relator acquires standing through an assignment theory (the federal government as the harmed party assigns relators the opportunity to participate in the suit)[241] or a personal stake theory (the relator has sufficient interest in the lawsuit because of the portion of the judgment or costs the relator may share).[242]

The *qui tam* provision of the FCA is a "private attorney general" approach to law enforcement.[243] By offering to share a portion of its recovery from a successful lawsuit with private parties, the FCA encourages those who know about fraud, or have the ability to learn about fraud, to come forward with information. Such a rationale is well suited to fraud cases and especially well suited to health care fraud, which is complex and often known only to insiders. Industry insiders, whether employees or competitors, are in a position to see what the government is incapable of detecting or adequately investigating as an outsider.[244] The decentralization of many businesses, the complexity of applicable regulations, the challenge of following the paper trail, the many individuals within a business who may participate, even unwittingly, in a fraud, make the knowledge and assistance of an insider almost essential to a successful fraud investigation, certainly to an efficient investigation.[245]

Recognizing the value of an insider's knowledge and the risk insiders often take when coming forward with information about a fraud, the FCA rewards

238. BOESE, CIVIL FALSE CLAIMS, *supra* note 121, at 1-5.

239. *See* 29 U.S.C. § 3730(a)-(b).

240. WELLING, BEALE & BUCY, RELATED ACTIONS, *supra* note 121, § 27.9.

241. *See, e.g.*, United States *ex rel.* Milam v. University of Tex. M.D. Anderson Cancer Ctr., 961 F.2d 46, 49 (4th Cir. 1992); United States *ex rel.* Kelly v. Boeing Co., 9 F.3d 743, 748 (9th Cir. 1993), *cert. denied*, 510 U.S. 1140 (1994).

242. *See* United States *ex rel.* Kriendler v. United Techs. Corp., 985 F.2d 1148, 1153 (2d Cir.), *cert. denied*, 508 U.S. 973 (1993); United States *ex rel.* Givler v. Smith, 775 F. Supp. 172, 181 (E.D. Pa. 1991).

243. WELLING, BEALE & BUCY, RELATED ACTIONS, *supra* note 121, § 27.9.

244. *See id.* § 27.10.

245. "The billing process itself, and the paperwork necessary to monitor numerous and complex third party contracts . . . boggles the mind." BUCY, HEALTH CARE FRAUD, *supra* note 3, § 1.04[2] (citation omitted).

insiders well, allocating to relators up to 30% of the recovery in any FCA lawsuit.[246] Since the FCA was amended in 1986, over 2,900 *qui tam* cases have been filed, with the number quickly increasing, from 33 cases in Fiscal Year ("FY") 1987, for example, to 483 cases in FY 1999.[247] Since 1987, total *qui tam* recoveries have exceeded $2.915 billion; the average relator's share in *qui tam* cases where there has been a recovery is $1 million.[248] The FCA has been used increasingly in health care cases by *qui tam* relators: in 1987, only 12% of *qui tam* FCA cases involved HHS as the client agency; in 1998, 61% of *qui tam* FCA cases involved HHS as the client agency.[249]

Because of its dual plaintiff system, the procedure followed in FCA cases is unique among all federal causes of action. When a relator files an FCA complaint, the relator must file the complaint under seal and must furnish the U.S. Department of Justice ("DOJ") with a copy of the complaint and "substantially all material evidence and information" the relator possesses.[250] It is to the relator's advantage to make a thorough, comprehensive, and persuasive statement of the case to the government in this submission, so as to persuade the government to join as plaintiff. One study of all *qui tam* actions filed between 1986-1996 revealed that "the average recovery for *qui tam* cases where the government intervened [was] approximately $6 million whereas the average recovery for *qui tam* cases where the government declined to intervene was approximately $33,000."[251]

Although the FCA provides for a sixty-day sealing period,[252] the seal is often extended for eighteen to twenty-four months.[253] This sealing leaves the odd result that, for this entire time period, the defendant may remain unaware that it has been named in a lawsuit that could subject it to substantial financial penalties.[254] During the time the complaint is sealed, and before the DOJ decides whether to join the lawsuit as a plaintiff, the DOJ may conduct

246. *See* 31 U.S.C. § 3730(d)(1)-(2). If the government decides to proceed with the *qui tam* action, the relator may receive between fifteen to twenty-five percent of the total recovery from the action; however, if the government decides not to proceed, the relator may receive between twenty-five and thirty percent.

247. Taxpayers Against Fraud, *Qui Tam Statistics* (last modified Nov. 1999) <http://www.taf.org/taf/docs/qtstats99.html> (citing statistics as reported by the United States Department of Justice).

248. *Id.*

249. *Id.*

250. 31 U.S.C. § 3730(b)(2).

251. Frederick M. Levy & Gregory T. Jaeger, *The Qui Tam Provisions a Decade Later—The Case for Reform*, NAT'L INST. ON HEALTH CARE FRAUD E-19 (1997).

252. 31 U.S.C. § 3730(b)(2).

253. The government "may for good cause shown, move the court for extensions of the time during with which the complaint remains under seal . . . ." 31 U.S.C. § 3730(b)(3). *See also* BOESE, CIVIL FALSE CLAIMS, *supra* note 121, at 4-101 to 4-104.

254. *Cf.* BOESE, CIVIL FALSE CLAIMS, *supra* note 121, at 4-107.

discovery: depositions, interrogatories, and requests for production of documents, all through Civil Investigative Demands (CIDs).[255] A defendant may become aware that it has been named in an FCA lawsuit through CIDs or by virtue of a partial or full lifting of the seal, but this is not always true.[256] Even if a defendant becomes generally aware that it has been named in an FCA lawsuit, it will have no information as to the allegations or scope of the charges or the identity of the relator.[257]

As can be seen, these aspects of an FCA case resemble a criminal case. Like an FCA defendant named in a sealed complaint, a criminal defendant may be the target of a grand jury investigation, even named in a sealed indictment, without knowing of his or her status. Also by using CIDs, the government in an FCA case is able to conduct discovery unilaterally and secretly, if it chooses, prior to joining as plaintiff. This process of unilateral discovery is similar to the grand jury process, in which the government conducts secret discovery prior to filing criminal charges.

Perhaps the most unusual aspect of the FCA is its "jurisdictional bar" provision.[258] To qualify as a *qui tam* relator, a private party must overcome this bar:

> No court shall have jurisdiction over an action . . . based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or Government Accounting Office report, hearing, audit or investigation, or from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.[259]

Thus, if information regarding the allegations in the FCA lawsuit has become public before the relator files the complaint, the relator is jurisdictionally barred from proceeding with the lawsuit unless the relator can prove that he or she is the "original source" of the public disclosure.[260] Even if the relator is jurisdictionally barred, the case may continue with the federal government as the only plaintiff.[261] This provision advances the FCA's goal: *qui tam* actions are to encourage knowledgeable persons to bring to the government's attention instances of fraud against the government. If the information is already public, this goal has been achieved. However, to encourage relators to come forward and to provide information that is not yet

255. 31 U.S.C. § 3733.

256. BOESE, CIVIL FALSE CLAIMS, *supra* note 121, at 1-5.

257. *See* 31 U.S.C. § 3730(b)(2) (stating that "the complaint may not be served until the court so orders").

258. 31 U.S.C. § 3730(e)(4)(A).

259. *Id.*

260. WELLING, BEALE & BUCY, RELATED ACTIONS, *supra* note 121, § 27.10.

261. *Id.*

in the public domain, the FCA continues to reward those who can show that they were an original source of the publicity.[262]

The jurisdictional bar provision substantially complicates an FCA case involving relators. A relator must file his or her *qui tam* action prior to any public disclosure of the fraud, or if public disclosure occurs, the relator must be able to prove that her *qui tam* action is not based upon the public disclosure or if it is, that her or she was the "original source" of the disclosure.[263] To prove that he or she is an original source, the relator must prove that he or she obtained the information regarding the false claims "directly and independently" and that he or she voluntarily provided such information to the government.[264] Not only are these questions highly fact specific and thus difficult to predict, but the circuits are divided over the most basic questions of jurisdictional bar jurisprudence.[265]

Failure to master the jurisdictional bar provision can be serious and prevent a relator from participating in an FCA action. By the same token, failure to argue adequately that a case is jurisdictionally barred can spell disaster for a defendant when the relator is the only plaintiff in the FCA action (since the entire case must be dismissed otherwise) and for the government when it joins as plaintiff (and must share its recovery with a relator who otherwise would be removed from the case).

Despite the complications the FCA poses for parties, especially relators, the FCA has had an enormous impact on health care fraud for several reasons. Among white collar cases, health care fraud stands out as complex to investigate. The intricacy of applicable billing requirements, the sophistication necessary to evaluate medical procedures and services, and the large size and diffusion of duties common in many institutional health care providers make health care fraud especially difficult to detect and prove.[266] Industry insiders, whether employees, competitors or business associates, are invaluable in finding and proving such fraud. The FCA, with its large, statutory recoveries, and promise to share any recovery with relators, provides an incentive for insiders to come forward with information about fraud on Medicare and other government programs.

In addition, the damage and penalty structure of the FCA delivers a formidable punch in health care cases, more so than in cases involving many other government programs. The FCA provides for a judgment of treble damages, attorneys fees and costs, and a mandatory penalty of $5,000 -

262. BOESE, CIVIL FALSE CLAIMS, *supra* note 121, at 1-5 to 1-14; WELLING, BEALE & BUCY, RELATED ACTIONS, *supra* note 121, §§ 27.8, 27.10.

263. BOESE, CIVIL FALSE CLAIMS, *supra* note 121, at 4-29 to 4-63; WELLING, BEALE & BUCY, RELATED ACTIONS, *supra* note 121, § 27.10.

264. *Id.*

265. WELLING, BEALE & BUCY, RELATED ACTIONS, *supra* note 121, § 27.10.

266. BUCY, HEALTH CARE FRAUD, *supra* note 3, § 1.04[2].

$10,000 for each false claim.[267] Because of the billing structure for most health care services (one claim per service, per patient) even a small health care provider will submit thousands of claims each year. Thus, even if the amount of alleged fraud is a few cents per claim, rendering a minimal amount of treble damages, the mandatory penalties of a minimum of $5,000 per claim will be substantial. Considering such substantial penalties the DOJ and HHS have been especially solicitous of *qui tam* relators. As the DOJ noted: "Overall, the FCA has powerful and far reaching effects . . . . Qui tam . . . suits have dramatically increased detection of and monetary recoveries for health care fraud."[268]

The FCA has been employed in the PATH initiative. Teaching hospitals selected for audits allegedly have been told that if they choose not to participate in the audit, the "alternative is litigation under the FCA."[269] The teaching hospitals refer to the looming prospect of FCA liability as a "coercive power . . . to extract 'settlements'. . . ."[270] In addition to any the FCA, of course, is criminal liability under any number of the offenses outlined in Part II.B of this article and the administrative sanctions set forth below.

D. Statutes Providing Administrative Sanctions for Health Care Fraud

Health care providers who are found to have committed fraud, after a criminal conviction, a finding of civil liability, or an independent finding by an Administrative Law Judge of the Department of Health and Human Services, are subject to a variety of administrative sanctions[271] including assessment of penalties or exclusion from participating in Medicare and state health care programs.[272] Providers are subject to civil monetary penalties levied administratively by HHS of up to $10,000 ($100,000 in some instances) for each improper claim submitted to Medicare or state health care programs.[273] Exclusion is often referred to as the "death penalty" for providers because excluded providers cannot bill Medicare, Medicaid or any state health care program for services. For most providers, exclusion closes them down. Liability under the FCA during a PATH audit could subject a teaching hospital and any of its offending physicians to both exclusion and penalties.

267. *See* 31 U.S.C. § 3729(a).

268. DOJ FRAUD REPORT FY 1997, *supra* note 95, at 6.

269. AAMC Complaint, *supra* note 10, ¶ 57. *See also supra* notes 76-79 and accompanying text.

270. AAMC Complaint, *supra* note 10, ¶ 57.

271. For a more complete discussion of these administrative sanctions, see BUCY, HEALTH CARE FRAUD, *supra* note 3, §§ 5.01 to 5.06.

272. 42 U.S.C. § 1320a-7 (1994 & Supp. III 1997); 42 C.F.R. §§ 1001.1 to 1001.3005 (1998).

273. 42 U.S.C. § 1320a-7(a) (1994 & Supp. III 1997); 42 C.F.R. §§ 1003.100 to 1003.135 (1998).

Although exclusion is catastrophic, suspension can be worse. At least with exclusion and assessment of administrative penalties, procedures are in place for providers to obtain a hearing and an appeal.[274] However, carriers are also authorized to suspend future payments to the provider immediately and without a hearing whenever a provider has been apparently overpaid because of the filing of false claims or otherwise.[275]

In addition to the above sanctions, a provider found to have submitted false claims for reimbursement (either to public or private insurers) is subject to orders to make restitution,[276] revocation of his or her professional license, loss of staff privileges at hospitals,[277] and loss of his or her license to prescribe certain medications.[278]

III. CONSIDERATION OF CULTURAL AND ECONOMIC IMPACT

There is a large, aggressive law enforcement machine poised to pursue health care fraud. Supplied with ample resources and powerful statutory weapons including criminal statutes carrying twenty-year terms of imprisonment and mandatory forfeiture, the FCA with its huge, statutorily set monetary awards, and administrative sanctions that can demolish a health care provider.

Many businesses operate on such a thin margin that any disruption erodes their profitability, if not viability. Academic medical centers are especially vulnerable to disruptions due to recent changes in the health care industry. Before examining the general state of academic medical centers and how the PATH audit, or any large scale investigation, disrupts their existence, it may be helpful to review the PATH audit experience of one academic medical center.

The Dartmouth-Hitchcock Medical Center ("Dartmouth") underwent a PATH audit despite the fact that the OIG had no indication that Dartmouth physicians were improperly billing Medicare. In fact, the U.S. Department of Justice official credited with creating the PATH initiative viewed Dartmouth's billing guidance for teaching physicians as "the best he had ever seen."[279] Once informed that it was selected for a PATH audit, Dartmouth opted for

274. 42 C.F.R. §§ 1001.2001 to 1001.2007 (1998).

275. *See, e.g.*, 42 C.F.R. §§ 405.801 to 405.877; § 1003.127 (1998) (outlining various appeal processes).

276. *See, e.g.*, United States v. Davis, 117 F.3d 459 (11th Cir. 1997) The *Davis* defendants convicted of Medicare fraud ordered to make restitution in the amounts of $9 million and $8 million, respectively. Joint and several liability affirmed on the ground that a defendant "is liable for the foreseeable acts of co-conspirators." *Id.* at 461.

277. For a discussion of the revocation of professional licenses and loss of staff privileges, see BUCY, HEALTH CARE FRAUD, *supra* note 3, §§ 5.05 to 5.06.

278. 21 U.S.C. § 824(a)(5) (1994); 42 U.S.C. § 1320a-7(a).

279. GAO, CONCERNS WITH PATH, *supra* note 2, at 13.

PATH II, thereby conducting the audit itself, pursuant to OIG guidelines.[280] After approximately ten months, when about half of the sampled admissions had been reviewed, OIG terminated the audit, finding no billing errors.[281] By that time, Dartmouth had spent approximately $1.7 million in conducting the partial audit: $600,000 in audit expenses, $300,000 in legal fees and other costs, and $800,000 in indirect costs attributable to a delay in obtaining bond financing.[282]

The monetary costs associated with responding to a government audit, while significant, are only one expense incurred by teaching hospitals or by any business which becomes the target of a government investigation. Today, most government health care fraud audits or investigations are conducted by a team of investigators, including criminal investigators, auditors, billing specialists, and medical specialists.[283] The investigation may proceed through grand jury subpoenas for records or testimony, Inspector General subpoenas for records or testimony, Civil Investigative Demands ("CIDs") for records or testimony, search warrants, or agent interviews of employees, patients, competitors or vendors.[284] The target of such an investigation must devote massive economic and human resources to respond to this investigation. The investigative target must collect the required records, ensure that privileged records are appropriately designated and segregated as privileged, and retain adequate copies of records to carry on with business.[285] Employees who are interviewed by investigators, whether informally or through subpoenas or CIDs, may require separate counsel.[286] Often, the employer is obligated, or simply deems it wise, to pay legal fees incurred by its employees.[287] Employees and executives may be diverted from their usual duties to deal with the human, logistical, business, public relations and financial issues that arise during an investigation.[288] Employees may leave for a less stressful environment, and recruiting new staff may become difficult. As Dartmouth found, obtaining financing for expansion or even continuation of business

280. *See supra* text accompanying notes 24-27.

281. OIG concluded that Dartmouth had been overpaid by $778, but did not view this as worth collecting. GAO, CONCERNS WITH PATH, *supra* note 2, at 14. Dartmouth contested the conclusion that it had been overpaid. *Id.* at 28.

282. *Id.* at 4.

283. BUCY, HEALTH CARE FRAUD, *supra* note 3, § 6.01.

284. *Id.* §§ 6.03 to 6.06.

285. *Id.* § 6.07.

286. Separate counsel is necessary if there is a possibility of a conflict of interest with their corporate employer. *Id*. § 6.08.

287. *See generally* Pamela H. Bucy, *Indemnification of Corporate Executives Who Have Been Convicted of Crimes: An Assessment and Proposal*, 24 IND. L. REV. 279 (1991).

288. Leon Aussprung, *Federal Civil Health Care Litigation and Settlement*, 19 J. LEGAL MED. 1, 26 (1998).

during a large-scale investigation may become difficult.[289] If the target is publicly traded, stock prices may fall.

Maintaining continuity is crucial for any business, whether under investigation or not. For health care providers who treat ill patients, continuity during an investigation may become more than the financial bottom line: it may be a life or death matter. Moreover, in a financially turbulent business environment, the disruptions caused by government fraud investigations can be especially serious. It is hard to imagine a sector of the American economy which has experienced, and is still experiencing, more turmoil over the past decade than the health care industry.

Because academic medical centers provide unique services for their local communities, disruption of their mission has an unusually profound impact. The 125 teaching hospitals associated with American medical schools perform four unique functions: (1) they are the major source of biomedical research in the world; (2) they provide the largest share of indigent health care in the United States; (3) they treat unusual and complex medical problems, both nationally and globally; and (4) they educate future physicians. No other medical institution provides this combination of services. Yet, academic medical centers are "in crisis" because the changing health care marketplace has eroded their infrastructure.[290] Over the past two decades, efforts to cut health care costs have reduced revenues for virtually all health care providers. For most private physicians, this cost consciousness has led to consolidation of practices, reduced income and greater "management" of patients' health care by insurers.

For academic medical centers, the impact has been all of the above plus a threat to teaching hospitals' fundamental existence. For years these institutions have cross-subsidized their research, education and indigent care activities from patient revenues.[291] As patient revenues decrease through managed care and other cost consciousness initiatives, there is less revenue for teaching hospitals to support these multiple missions. Robbing Peter to pay Paul is no longer working.

289. GAO, CONCERNS WITH PATH, *supra* note 2, at 14 n.26 (noting that "[a]ccording to Dartmouth, investment banker and credit agency concerns about the possible outcome of the audit delayed . . . bond financing, ultimately raising the total costs of this financing.").

290. *See* Herbert Pardes, *The Future of Medical Schools and Teaching Hospitals in the Era of Managed Care*, 72 ACAD. MED. 97, 97-98 (1997). John K. Inglehart, *Rapid Changes for Academic Medical Centers: Second of Two Parts*, 332 NEW ENG. J. MED. 407, 411 (1995); David Blumenthal & Gregg S. Meyer, *The Future of the Academic Medical Center Under Health Care Reform*, 329 NEW ENG. J. MED. 1812 (1993).

291. *See* Pardes, *supra* note 290, at 98; Carey & Engelhard, *supra* note 1, at 842.

Academic medical centers are the "backbone" of American biomedical research, which is foremost in the world.[292] "[M]ost of the nation's basic and clinical research advances are made" at the 125 American academic medical centers.[293] Over half of the research grants awarded by the National Institutes of Health ("NIH") go to these centers.[294] Many of the scientific advances made by American academic medical centers reduce expenses and improve the quality of life for millions of people. For example, "[t]he annual cost of treating polio if a vaccine had not been found is estimated at $30 billion per year; [p]otassium citrate treatment for preventing recurrence of kidney stones saves an estimated $400-870 million per year; [t]he vaccine to prevent *Haemophilus influenzae* Type B (HiB) disease, the leading cause of bacterial meningitis in the United States, saves an estimated $350 million to $450 million annually; [t]he heliobacter (*H. pylori*) discovery saves $600 million to $800 million annually in the treatment of ulcers."[295] Academic medical centers also test and develop surgical and patient care procedures that are adopted world-wide.[296]

Despite its importance, the biomedical research mission of academic medical centers is under severe strain. As one expert has noted, the financial pressures currently existing in health care "could have a devastating impact on the nation's capacity to support medical research and education."[297] Studies have shown that teaching hospitals located in regions of "high managed care penetration have on average experienced a decreased rate of growth in NIH . . . [research] awards during the past 5 years, as well as relative declines in their overall ranking as awardee institutions and their market share of NIH extramural awards."[298] As the changing marketplace has emphasized direct patient care, academic physician-scientists have given up their attempt to do clinical research: the "proportion of investigators applying for clinical research grants from the National Institutes of Health (NIH) who are physicians has declined from 40% [in 1968] to 25% [in 1998]."[299] Studies also have shown

292. Pardes, *supra* note 290, at 97, 100; Jerome P. Kassirer, *Academic Medical Centers Under Siege*, 331 NEW ENG. J. MED. 1370, 1371 (1994).

293. Pardes, *supra* note 290, at 97.

294. *Id.* at 97.

295. *Id.* at 98 (citing Marc W. Kirschner et al., *The Role of Biomedical Research in Health Care Reform*, 266 SCIENCE 49-51 (1994)).

296. *Id.* at 100.

297. *Id.* at 98 (quoting a Nov. 8, 1995 communication to President Clinton from the co-chair of the President's Committee of Advisors on Science and Technology).

298. Kenneth I. Shine, *Some Imperatives for Clinical Research*, 278 JAMA 245 (1997) (citation omitted). *See also* Ernest Moy et al., *Relationship Between National Institutes of Health Research Awards to US Medical Schools and Managed Care Market Penetration*, 278 JAMA 217 (1997).

299. David G. Nathan, *Clinical Research: Perceptions, Reality and Proposed Solutions*, 280 JAMA 1427 (1998).

that publication by clinical researchers "decreased significantly in competitive markets, while the rate of publication for other faculty remained unchanged."[300] It is expected that this market competition will "encourage faculty to increase patient care activities perhaps at the expense of their research and teaching activities" and "reduce[] institutional commitment to activities such as research and teaching . . . ."[301]

The second unique service supplied by academic medical centers is their willingness to serve as the safety net for many medically indigent patients in the United States.[302] Recent studies confirm that "medically indigent patients are concentrated in major teaching hospitals."[303] In fact, "[a]cademic medical centers [AMCs] supply over 50% of the nation's care for indigents."[304] "As the ranks of uninsured Americans continue to swell and as America becomes more culturally and racially diverse, an increasing number of patients at risk of being underserved will turn to AMCs for care."[305]

There are several possible reasons for the concentration of medically indigent patients in academic medical centers: such centers tend to be located in inner cities, where most of the medically indigent reside; medically indigent patients tend to have complex medical conditions, such as human immunodeficiency virus ("HIV"), which academic medical centers are better able to treat; medically indigent persons tend to have a greater incidence of trauma injuries which academic medical centers, with their trauma centers, are better able to treat; most academic medical centers have long traditions of indigent care and "may be more willing than other hospitals to accept medically indigent patients."[306] Providing indigent care, however, comes at

300. Eric G. Campbell et al., *Relationship Between Market Competition and the Activities and Attitudes of Medical School Faculty*, 278 JAMA 222, 225 (1997).

301. *Id.* at 222.

302. "Medically indigent" patients are "patients who lack health insurance or who are covered by Medicaid programs." ASSOCIATION OF AMERICAN MEDICAL COLLEGES (AAMC), MEETING THE NEEDS OF COMMUNITIES 2 (1998) [hereinafter AAMC, MEETING THE NEEDS]. In 1994, medically indigent patients accounted for 24% of hospitalizations and 40% of outpatient visits in the United States. *Id.*

303. *Id.* at 3.

304. Pardes, *supra* note 290, at 100.

305. Ernest Moy et al., *Academic Medical Centers and the Care of Undeserved Populations*, 71 ACAD. MED. 1370, 1376 (1996). "From 1989 to 1993, the proportion of hospitalized patients at risk of being underserved increased from 49.8% to 60.9% . . . ." *Id.* at 1374. These figures are for "integrated AMCs" which are institutions that are members of the Council of Teaching Hospitals and Health Systems ("COTH") with "common ownership with a medical school or in which chiefs of clinical services also function as department chairs in the medical school." *Id.* at 1371-72. "Integrated" AMCs are most likely to be the 125 teaching hospitals selected for PATH audits since OIG chose to conduct the audits on the "major teaching hospital or faculty practice plan associated with each of the nation's 125 medical schools." GAO, CONCERNS WITH PATH, *supra* note 2, at 12.

306. AAMC, MEETING THE NEEDS, *supra* note 302, at 4.

high cost for academic medical centers. For example, in 1994 (the date of the most recent data available) "[u]ncompensated care charges incurred by . . . AMCs averaged over $14 million per AMC for bad debt and $21 million per AMC for charity care."[307]

A third unique service provided by academic medical centers is their treatment of especially complex diseases. Academic medical centers treat more complex medical conditions than do nonteaching hospitals. Consider the following examples:

- "96% of all bone marrow, liver, lung, and kidney transplants were performed at major teaching hospitals" (12% of all admissions at these hospitals);[308]
- "Major teaching hospitals are four times more likely than community hospitals to offer reproductive health services and three times more likely to provide crisis prevention services."[309]
- "Major teaching hospitals are dominant in three areas of technology-intensive services: accidents and other emergencies (e.g., burns, . . . level 1 emergency, and neonatal and pediatric ICU); new services with limited applications (e.g., PET scans); and care requiring extensive resources from multiple services (e.g., transplants)."[310]
- The medically indigent, who concentrate in major teaching hospitals, have a higher prevalence of HIV disease.[311]

Treating the sickest patients and the most complex diseases means that academic medical centers "do not fit naturally within managed care systems . . . [which] anticipate that the majority of health services will be for routine patient care in a relatively healthy population."[312] This "mis-fit" is especially serious given the dominance of managed care reimbursement in the American health care system. Academic medical centers' incompatibility with prevailing managed care reimbursement systems further destabilizes these institutions, especially vis-a-vis nonteaching hospitals that enhance their profitability under managed care reimbursement by shifting even more indigent health care to teaching hospitals. Because of their multiple missions, academic medical centers are "non-competitive in a price-sensitive

307. Moy et al., *supra* note 305, at 1372.

308. AAMC, MEETING THE NEEDS, *supra* note 302, at x (introduction by Paul F. Griner, M.D.).

309. *Id.*

310. *Id.* at 33.

311. *Id.* at 4.

312. Carey & Engelhard, *supra* note 1, at 840.

environment."[313] One recent study calculated that the "average cost of care per admission was about $6000 in teaching hospitals . . . , as compared with about $4400 in nonteaching hospitals."[314] Not surprising, "health plans avoid contracting with teaching hospitals . . . because of their higher costs"[315] and consequently "many academic institutions are overbedded, underused, and in turmoil."[316]

The last unique service performed by academic medical centers is education, not only of American medical students, residents and fellows, but also of selected physicians and scientists from around the world. Although the Medicare program pays teaching hospitals for training these individuals, the amount paid does not adequately cover the cost of medical education: "graduate training is financed largely by revenues from patient care in teaching hospitals."[317]

In short, diverting the resources, time, and human capital of an academic medical center to respond to a health care fraud investigation disrupts the already fragile balance at teaching hospitals as they attempt to continue their unique mission. Subjecting these vulnerable institutions to the disruptions of a fraud investigation is a serious matter.

There is much to learn from the PATH initiative about how to investigate suspected health care fraud. There are important advantages to employing a national initiative strategy, both for the government and for the targets of the investigation. When the suspected fraud is on a large scale, consolidation through a national initiative allows for a similarly large scale response, instead of a scattered and piecemeal approach. Consolidation promotes an efficient use of resources; almost certainly ensures that every prosecuting office and every target has the benefit of experienced prosecutors and defense counsel from offices nationwide; provides greater opportunity to systematically change the source of any fraud; and enhances the potential for meaningful dialog among the parties on almost every issue. However, as PATH has shown, the disadvantage of a national initiative is that if it is poorly focused, its destructive impact is compounded.

Ironically, one of the most innovative law enforcement tactics employed in sophisticated investigations, especially in health care fraud investigations, may be a culprit when national initiatives go awry. Parallel proceedings, through which the government employs a combination of criminal, civil and administrative sanctions to address improper conduct committed by a

313. John K. Inglehart, *Rapid Changes for Academic Medical Centers: First of Two Parts*, 331 NEW ENG. J. MED. 1391, 1392 (1994).

314. *Id.*

315. *Id.* at 1394.

316. Kassirer, *supra* note 292, at 1370.

317. Inglehart, *supra* note 313, at 1392.

defendant, have been available for years.[318] The past decade has seen a more aggressive use of parallel proceedings, however, especially in health care.[319] There are reasons for this. Intent to defraud can be difficult to prove in health care cases given the ambiguity of billing regulations and the diffusion of actual billing responsibility among personnel in many health care providers' offices.[320] Investigations that preserve the prosecutors' option of proceeding administratively or civilly on determinations that the billing errors were unintentional, or proceeding criminally when evidence of intent is present, provide needed flexibility to deal with providers who have billed insurers improperly. In addition, the complexity of billing regulations have required that criminal investigators team up with billing experts and auditors during the investigation. This inter-team communication enhances the prospects for varied and multiple levels of prosecution. Recognizing these facts, Congress has made available investigative tools, such as Inspector General subpoenas[321] and Civil Investigative Demands,[322] that enhance the ability of law enforcement officials to share information obtained during an investigation with civil and administrative members of the investigation team. Attorney General Janet Reno's 1997 directive to United States Attorneys to make greater use of parallel proceedings recognizes these advantages:

> In order to maximize the efficient use of resources, it is essential that our attorneys consider whether there are investigative steps common to civil and criminal prosecutions, and to agency administrative actions. . . . Accordingly, every United States Attorney's office and each Department Litigation Division should have a system for coordinating the criminal, civil and administrative aspects of all white-collar crime matters within the office.[323]

318. Note, *Using Equitable Powers to Coordinate Parallel Civil and Criminal Actions*, 98 HARV. L. REV. 1023, 1023 n.5 (1984).

319. Anthony A. Joseph & R. Marcus Givhan, *The New Litigative Environment: Defending a Client in Parallel Civil and Criminal Proceedings*, 60 ALA. LAW. 48, 48 (1999); BUCY, HEALTH CARE FRAUD, *supra* note 3, § 5.01; DOJ FRAUD REPORT FY 1997, *supra* note 95, EXECUTIVE SUMMARY. *See, e.g.*, United States v. Leon, 2 F. Supp.2d 592 (D. N.J. 1998) (defendant convicted on criminal charges, found liable under the Civil False Claims Act and excluded from Medicare); Seide v. Shalala, 31 F. Supp.2d 466 (E.D. Pa. 1998) (Health care provider was "prohibited from engaging in any occupation that involved Medicare or Medicaid claims for reimbursement for three years" after being convicted of Medicare fraud.).

320. BUCY, HEALTH CARE FRAUD, *supra* note 3, § 1.04[3].

321. *Id.* § 6.04.

322. *Id.* § 6.05. Before these tools were available, most fraud investigations were conducted through grand jury investigations which do not permit such sharing of information. *Id.* § 6.03; SARA SUN BEALE & WILLIAM BRYSON, GRAND JURY LAW AND PRACTICE § 7.01 (1986 & Supp. 1998); FED. R. CRIM. P. 6(e)(2) (1999).

323. Memorandum from Attorney General Janet Reno to Federal Attorneys, July 28, 1997; UNITED STATES DEPARTMENT OF JUSTICE, CRIMINAL RESOURCE MANUAL 979 (1999).

Despite the flexibility they afford, parallel proceedings can alter an investigation's dynamics. When the investigation of health care fraud is conducted so as to preserve the potential for multiple levels of liability, especially criminal liability, communication between investigators and targets during an investigation is stifled. As long as criminal charges or exclusion is a possible outcome of an investigation, investigators must be concerned about records being "lost" or destroyed, witnesses being tampered with, and files fabricated. With these concerns, the government cannot caucus with the targets of its investigation as it formulates its investigation strategy. This lost opportunity for candid dialog between regulator and regulated is unfortunate. Prior to the common use of parallel proceedings, when most billing irregularities were resolved by audit, the stakes were not as high, the concerns about the integrity of evidence were not as wide-spread and thus, early dialog between investigators and providers was more feasible.

Early dialog may well have helped focus PATH. In July, 1997, one year after the PATH initiative began, the General Counsel of HHS responded to substantial information supplied by the academic medical centers regarding PATH.[324] The HHS Counsel agreed that "the standards for paying teaching physicians under Part B of Medicare have not been consistently and clearly articulated by HCFA over a period of decades."[325] The OIG then curtailed the scope of future PATH audits.[326] Such dialog undoubtedly would have been beneficial earlier in the formulation of the PATH initiative.

Because many white collar investigations have the potential of disrupting society, the prosecutive decision to proceed with an investigation entailing potential criminal, civil or administrative liability should be undertaken with care. A formal assessment of the economic and societal impact of the prospective investigation should be part of the decision-making process. Currently, prosecutors are not hired, nor trained, to evaluate the economic, social and market impact of a large-scale fraud investigation. That should change. A plethora of governmental working groups exists to coordinate health care fraud investigations and government direction. These or similar groups should be utilized to help provide prosecutors with necessary information on industry.[327]

324. *See generally* Rabb Letter, *supra* note 10.

325. *Id.* at 3.

326. *Id.*

327. Beginning in 1993, the Executive Level Health Care Fraud Policy Group has met monthly. Its members include the HHS Inspector General, representatives from DOJ's Criminal and Civil Divisions, the Attorney General's Advisory Committee Health Care Fraud Subcommittee, the FBI and HCFA. DOJ FRAUD REPORT FY 1997, *supra* note 95, at 6-7. The National Health Care Fraud Working Group meets quarterly. Its 100 members include federal and state prosecutors and investigators. *Id.* Additionally, a health care fraud task force currently

IV. CONCLUSION

There is a large, aggressive law enforcement machine poised to pursue health care fraud. It is supplied with ample resources and powerful statutory weapons, including criminal statutes carrying twenty year terms of imprisonment and mandatory forfeiture; the FCA with its huge, statutorily-set monetary awards; and administrative sanctions that can demolish a health care provider.

The weapons available to combat health care fraud are appropriately powerful. The health care provider who has intentionally and systematically set out to defraud health care insurers and patients is a predator and should be pursued relentlessly, with the full force of all sanctions available. Because of the size and complexity of the American health care system, insurers who pay health care bills are especially vulnerable to fraud. Honesty and a good faith effort to comply with applicable billing regulations are essential for the American health care system to stay afloat. Moreover, fraudulent health care providers do more than cheat insurers of money. Their actions may harm patients, who by definition, are ill and dependent on others for the most basic of care. The health care providers who breach these fiduciary relationships deserve the condemnation of society as conveyed by our most severe sanctions, should be flushed out of the health care system, and should be held forth as examples for maximum deterrent effect. Because of their ability to efficiently address nationwide fraud practices, national initiatives are invaluable auditing and investigative strategies in detecting and deterring such health care providers.

However, as the PATH initiative has demonstrated, care should be taken in deploying the formidable weapons available to combat health care fraud. There is a danger that the health care fraud law enforcement machine that exists will take on a life of its own, where the focus becomes numbers: of investigations undertaken, convictions, fines, damages, penalties, and exclusions, rather than achieving the best health care for Americans at a fair cost. The PATH initiative is illustrative for two reasons. First, it exemplifies the difficulty of detecting fraud in a highly regulated area governed by multiple regulations. Second, it demonstrates the hardship created for targets of fraud investigations.

exists. Its members include representatives from FBI, state and local law enforcement, Inspectors General and private industry. HHS & DOJ FRAUD REPORT FY 1998, *supra* note 92, at 21.

On June 3, 1998, the Deputy Attorney General, Eric H. Holder, Jr., sent guidance to all relevant attorneys within the Department of Justice regarding national initiatives. *See* Memorandum from Eric H. Holder, Jr., Deputy Attorney General, *Guidance on the Use of the False Claims Act in Civil Health Care Matters* (June 3, 1998). This guidance is helpful and should further the appropriate exercise of prosecutorial discretion.

No one could dispute that hardship or not, fraudulent institutions should be aggressively investigated and relentlessly prosecuted. However, the internal and social costs of such investigations are high, and care should be taken so that the mystique of the health care fraud law enforcement machine does not seduce the regulator into becoming a hunter when there is no prey. Pursuit of fraudulent health care providers is only one aspect of a functional health care system; understanding when a systemic regulatory breakdown has occurred is also vital. The current emphasis on prosecuting fraudulent health care providers threatens to sweep aside this less glamorous analysis. The Departments of Justice and Health and Human Services and Congress should be just as vigilant in creating incentives for the proper exercise of prosecutorial discretion as they have been in building a well-oiled machine to combat health care fraud.