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Civil Money Penalties Law of 1981: A New Effort To Confront Fraud and Abuse in Federal Health Care Programs

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This article is intended to introduce you to the Civil Money Penalties Law of 1981.[1] This new law will more fully enable the Department of Health and Human Services (HHS) to protect the multi-billion dollar health care financing programs against unscrupulous persons and organizations who defraud or attempt to abuse these programs.[2]

On December 30, 1982, the Department of Health and Human Services published proposed regulations[3] specifying procedures for implementing the authority to impose certain civil money penalties for persons convicted of committing specified fraudulent activity as provided by section 2015 of the Omnibus Budget Reconciliation Act of 1981[4] as amended by section 137(b)(26) of the Tax Equity and Fiscal Responsibility Act of 1982.[5] The regulations will allow the Department to administratively impose civil money penalties and assessments for filing false or otherwise improper claims in the Medicare, Medicaid, or Maternal and Child Health Services Block Grant programs. This new law is expected to be fully implemented on or before June 30, 1983.

I. Background: Abuse in Health Care Programs

In late 1976, Congress enacted legislation[6] creating the Office of

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1 42 U.S.C.A. § 1320a-7a (West Supp. 1982).

2 For general statements on the scope of fraud in government benefit programs, see GENERAL ACCOUNTING OFFICE, REPORT TO THE CONGRESS OF THE UNITED STATES BY THE COMPTROLLER GENERAL OF THE UNITED STATES 9 (1978) (estimating that one to ten percent of federal funds in Medicaid, food stamps, and Defense Department spending is lost through fraud); N.Y. Times, May 17, 1982, at 11, col. 2 (fraud in benefit programs costs from $2.5 to $25 billion per year).

3 47 Fed. Reg. 58,309-14 (1982) (to be codified at 45 C.F.R. §§ 101.100-101.131). These regulations are subject to change after the comment period.

4 Pub. L. No. 97-35, 95 Stat. 357 (1981).

5 Pub. L. No. 97-248, 96 Stat. 324 (1982).

6 42 U.S.C.A. §§ 3521-3527 (West 1977).

Inspector General. This organization was designed to make a significant contribution toward eliminating fraud, waste, and abuse from nearly 300 expensive health and entitlement programs in the Department of Health and Human Services.

Today, the number one priority of the Office of Inspector General is stopping health care providers who defraud or abuse Medicare and Medicaid programs. Spending for direct health care services has grown from $5 billion in 1965 to $72 billion in fiscal year 1983. This year, the Department will spend as much every month in Medicare and Medicaid as was spent during the entire year of 1967. Americans, in contrast, will spend nearly $300 billion a year on health care, making it the nation's third largest industry.

Medicare and Medicaid together represent the second largest expenditure in the Department of Health and Human Services. These two programs constitute approximately 25 percent of the Department's expenditures and provide assistance to 29 million and 22 million beneficiaries, respectively. Medicare ($55 billion) and Medicaid ($17 billion) are major targets for both management improvement and prevention of fraud and abuse.

The dramatic growth of these two programs has been concurrent with the growth in the number of health care providers who have learned to abuse the programs by submitting false, fraudulent, or otherwise improper claims—a problem unforeseen when the legislation was in the planning stages. In fact, health care programs have grown so large and so fast that fraud and abuse have risen to epidemic proportions.

Not surprisingly, health providers convicted of fraud are rarely willing to accept the guilt of their wrongdoings. A variety of explanations and excuses are routinely offered. The following case examples illustrate the scope and magnitude of criminal activity in the health provider area.

A well-known cardiologist and author pled guilty to filing nearly $1 million in false Medicare, Social Security, and worker's compensation claims. He was sentenced to seven years' incarceration, five years' probation, and fined $300,000. In a separate civil matter, this same physician and his wife settled a false claims suit for $500,000, the largest amount under the False Claims Act in the Southern District of New York.

Many cases result from filing fraudulent Medicaid cost reports. In one case, the owner of nine nursing homes misrepresented the number of employees providing direct care to nursing home patients.

The owner kept a dual set of records and fraudulently claimed an overpayment of approximately $1.3 million. Though he agreed to repay this amount as part of the plea bargain, he was given a five year prison sentence and was fined $50,000.

In New Hampshire, a pharmacist pled guilty to five counts of Medicaid fraud. He was charged with generic substitution, unauthorized dispensing, and billing for services not rendered. The court sentenced him to five years' probation, fined him $1,000, and ordered him to repay $3,000 to the state's Medicaid program. The pharmacist was also suspended from practice.

Fraudulent cost reports are unwittingly falsified by nursing homes and hospitals because of frauds perpetrated by contractors. An Office of Inspector General surveillance of a Colorado speech therapist documented that she was not performing all the services she was reporting to her contract employer. The employer in turn billed numerous nursing homes, causing them to submit erroneous cost reports. In a plea bargaining agreement, the therapist pled guilty and agreed to repay $25,000. She was sentenced to five years' probation and fined $12,500.

For a variety of reasons, criminal prosecutions are not mandated in each and every health provider fraud case.[7] Therefore, the Office of Inspector General is taking an active role in both pursuing criminal investigations and in eliminating all administrative loopholes which foster fraud, waste, and abuse. In this new proactive role, maximum resources are directed against the civil and criminal abuses occurring in these programs.

Estimates suggest that up to ten percent of all Medicaid and Medicare claims contain false information.[8] Congressional response to the problem culminated in the administrative imposition of civil money penalties through enactment of the Omnibus Budget Reconciliation Act of 1981. President Reagan signed the Act into law on August 13, 1981.

Understanding the import of this new law is vital to the entire health care community. Until enactment of the Civil Money Penalties legislation, the federal government had to rely upon the False Claims Act or criminal proceedings in order to compel restitution of

7 For example, the United States Attorney may determine that a fraud case is unsuitable for prosecution because it increases an already crowded docket; it does not warrant the investment of time and effort to acquire the necessary expertise in Medicare-Medicaid law; or the number of counts or amount of money involved is insufficient to warrant criminal proceedings.

8 *See* note 2 *supra*.

funds falsely or improperly claimed under HHS health care financing programs. The Civil Money Penalties Law was designed to reach not only those health providers who intentionally submit false or otherwise improper claims but also those who "should have known" they were doing so. It will not be used to harass health providers who make honest mistakes.

The Civil Money Penalties Law is more than just a deterrent; it encourages health providers to check the accuracy of information on claim forms submitted by them or on their behalf by nurses, clerks, or billing services. Long-standing and extensive patterns of possible fraud can now be detected and analyzed on a much larger scale, and cases of fraud will be acted upon with greater frequency than in the past. In addition, large sums of money improperly claimed can now be recovered.

Presently, false or otherwise improper claims may be subject to a variety of criminal, civil, and administrative governmental action. False claims that are not made the subject of criminal prosecution can still be handled civilly under the Federal False Claims Act,[9] or a state equivalent. By terms of a Memorandum of Understanding with the Department of Justice, the Department of Health and Human Services will first submit cases to the Department of Justice. The Department of Justice will have the option, in each case, to seek an indictment or to file a civil action under the False Claims Act. If these options are not exercised, the Department of Health and Human Services can then begin administrative proceedings under the Civil Money Penalties Law.

The Civil Money Penalties Law contains no statute of limitations on its face. The Department intends, however, to propose penalties for a five-year period beginning with occurrence of the violation. The law also allows the Department to impose fines for false claims filed before enactment of the legislation. Since it is not a criminal statute, constitutional issues regarding ex post facto laws do not apply. However, due process considerations do apply. We intend, therefore, to follow the substantive law of the Federal False Claims Act for violations occurring before enactment of the Civil Money Penalties Law.

II. Existing Law Prior to the Civil Money Penalties Law

Prior to passage of the Civil Money Penalties Law, federal law

9 31 U.S.C. §§ 231-235 (1976).

established criminal penalties for persons convicted of committing specified fraudulent acts under Medicare and Medicaid. Such fraudulent activities included filing false claims, misrepresenting an institution's qualifications so it can qualify as a provider, and soliciting, receiving, or offering kickbacks, bribes, or rebates.[10] Such acts are punishable by a maximum fine of $25,000, five years' imprisonment, or both. Prior law also required the Secretary to suspend from Medicare any practitioner convicted of a criminal offense related to that individual's participation in the delivery of covered medical care or services. It similarly reached any institutional provider whose managing employee had been so convicted. In both cases, the state Medicaid agency was required to suspend the physician or provider from the Medicaid program.[11] The law also allowed the Secretary to exclude from Medicare individual practitioners or providers who: 1) knowingly or willfully made or caused to be made any false statements in an application for payment; 2) submitted excessive bills; or 3) furnished services in excess of need.[12]

Although the Department of Health and Human Services forwards cases of potential fraud to the Department of Justice for prosecution, many are not brought to trial. United States Attorneys frequently decline to accept Medicare and Medicaid cases for a number of reasons: the backlog of cases; a lack of sufficient expertise in Medicare-Medicaid law not warranting the investment of time and effort necessary to acquire the expertise to prosecute; or an insufficient number of counts or amount of money to warrant criminal proceedings. None of these examples imply the nonexistence of fraud or lack of culpability on the part of the alleged offender; they only indicate the United States Attorney's unwillingness to accept many cases because they appear to be unsuitable for prosecution.

Prior to the Civil Money Penalties Law, when a decision was made not to accept a case for prosecution, the only recourse for the government was attempting to recover the overpayment involved. But even if recovery was successful, the offender enjoyed penalty-free use of federal funds for a period of time. The prior law, therefore, had obvious gaps in its coverage that the Civil Money Penalties Act was intended to close.

10 42 U.S.C. §§ 1395nn, 1396h (1976, Supp. I 1977 & Supp. II 1978).
11 42 U.S.C.A. § 1320a-7(a) (West Supp. 1982).
12 42 U.S.C. § 1395y(d) (1976, Supp. I 1977 & Supp. II 1978).

III. Major Provisions of the Civil Money Penalties Law

A. *Basis for Civil Money Penalties and Assessments*

The Department of Health and Human Services derives its authority to impose a civil money penalty for improper claims from section 1128A of the Social Security Act, as supplemented by section 2105 of the Omnibus Budget Reconciliation Act of 1981, and as amended by section 137(b)(26) of the Tax Equity and Fiscal Responsibility Act of 1982.[13] In addition to being able to impose a civil money penalty of up to $2,000 for each improper claim, the Department may also assess up to twice the amount claimed against any person (including individuals, organizations, and other entities) who presents (or causes to be presented) a claim for reimbursement under the Medicare, Medicaid, or Maternal and Child Health Services Block Grant program where the claim is for an item or service that the person knew or had reason to know was false or improper.[14] Specifically, the provision applies to any claim for an item or service that was not provided as claimed, or for which reimbursement is prohibited because the person has been excluded or suspended from participation in the program, or because the services or charges were in excess of certain statutory standards. The penalty and assessment may also be imposed where a submitted request for payment violates the permissible charges in either a Medicare assignment or an agreement with a state's Medicaid agency.

The proposed regulation provision covering the circumstances which subject a person to civil money penalties and assessments is the same as the statutory provision.[15] In addition, the proposed regulations provide that, where more than one person is responsible for filing the claim, all persons may be held jointly liable for any assessment.[16] Both the statute and the proposed regulations include suspension from the Medicare or Medicaid programs as an additional sanction that may be imposed against persons who are liable for a penalty.[17]

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13 42 U.S.C.A. § 1320a-7a (West Supp. 1982). The proposed regulations specify that the Inspector General of HHS will make the initial proposal to impose a penalty, assessment, or suspension. 47 Fed. Reg. 58,312 (1982) (to be codified at 45 C.F.R. § 101.109(a)).

14 42 U.S.C.A. § 1320a-7a(a) (West Supp. 1982).

15 47 Fed. Reg. 58,311 (1982) (to be codified at 45 C.F.R. § 101.102(a)).

16 *Id.* (to be codified at 45 C.F.R. § 101.102(b)).

17 42 U.S.C.A. § 1320a-7(b) (West Supp. 1982).

B. *Hearing and Appeal Rights*

Persons against whom any of the statutory sanctions are sought have the right to a hearing and judicial review of any final HHS determination. The proposed regulations provide: an opportunity for a hearing before an administrative law judge on any issues pertaining to a proposed penalty, assessment, or suspension; an opportunity to appeal the judge's decision to the Secretary; and an opportunity to seek judicial review of a final agency determination.

The person against whom any of these sanctions are proposed would have thirty days to either accept imposition of the sanctions with or without supplying reasons for modifying them, or request a hearing.[18] The Inspector General may extend the period for good cause.[19] Unless a hearing is requested, a person would have no further appeal rights.[20] Hearings would be recorded,[21] and the parties would have the right to be represented by counsel, to present evidence and witnesses, to cross-examine witnesses, and to present oral arguments and written briefs.[22] The administrative law judge would be required to issue his decision within sixty days after either the hearing or the deadline for submitting post-hearing briefs, whichever is later.[23] The judge's decision would become final and binding on the parties thirty days after notice of the decision is received, unless a party files written exceptions to the decision within that time.[24]

Where exceptions are filed, the matter would be referred for review[25] to the Secretary or his designee. There would be no right to appear personally before the Secretary. Decisions of the Secretary or his designee would be final unless, within sixty days of being notified of the decision, the person against whom sanctions are being imposed seeks judicial review.[26] Under the statute, reviews of penalties and assessments are by the appropriate court of appeals[27] while reviews of suspension are by the appropriate district court.[28]

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18 47 Fed. Reg. 58,312 (1982) (to be codified at 45 C.F.R. § 101.109).

19 *Id.* (to be codified at 45 C.F.R. § 101.109(c)).

20 *Id.* (to be codified at 45 C.F.R. § 101.110).

21 *Id.* at 58,313 (to be codified at 45 C.F.R. § 101.122).

22 *Id.* (to be codified at 45 C.F.R. § 101.116).

23 *Id.* (to be codified at 45 C.F.R. § 101.125(a)).

24 *Id.* (to be codified at 45 C.F.R. § 101.125(d)).

25 *Id.* at 58,313-34 (to be codified at 45 C.F.R. § 101.125(j)).

26 *Id.* at 58,314 (to be codified at 45 C.F.R. § 101.125(j)(5)); 42 U.S.C.A. § 1320a-7a(d) (West Supp. 1982).

27 42 U.S.C.A. § 1320a-7a(d) (West Supp. 1982).

28 42 U.S.C.A. § 405(g) (West Supp. 1982).

C. *Calculating the Penalty, Assessment, and Length of Suspension*

The statute requires the Secretary, when determining the amount of any penalty or assessment, to take into account the nature of the claims, the circumstances under which they were presented, a claimant's level of culpability, any prior offenses, and his financial condition, as well as other matters that justice may require.[29] The proposed regulations include guidelines describing those circumstances which we would consider mitigating, resulting in a reduced penalty and assessment, and those circumstances which we would consider aggravating, resulting in a higher penalty and assessment.[30] The proposed regulation also requires that the length of suspensions takes into account the amount of the penalties and assessments.[31]

D. *Collections*

Where a person does not voluntarily pay the amount owed as a penalty and assessment, the Department may initiate a civil action in district court to recover the funds. Furthermore, the statute and regulations permit deducting the amount owed by the person from any sums owed to the person by the United States or a state agency.[32]

E. *Effective Date*

The proposed regulations would apply to any false or improper claim, regardless of when the claim was filed. However, in the case of a claim filed before the date of enactment of the Omnibus Budget Reconciliation Act of 1981, August 13, 1981, the government's burden of proof would be higher; the government would have to show that the person would have been liable for penalties under the False Claims Act.[33] These additional requirements have been added to assure that no new substantive law or standards will be applied to claims filed before August 13, 1981.

IV. Penalties and Assessments

The potential exists for imposing substantial penalties and assessments. The law calls for a civil money penalty of not more than $2,000 for each item or service falsely or improperly claimed.[34] The

29 42 U.S.C.A. § 1320a-7a(c) (West Supp. 1982).
30 47 Fed. Reg. 58,311-12 (1982) (to be codified at 45 C.F.R. § 101.106).
31 *Id.* at 58,312 (to be codified at 45 C.F.R. § 101.107).
32 42 U.S.C.A. § 1320a-7a(e) (West Supp. 1982).
33 47 Fed. Reg. 58,312 (1982) (to be codified at 45 C.F.R. § 101.114).
34 42 U.S.C.A. § 1320a-7a(a) (West Supp. 1982).

amount to be imposed will be determined initially by the Inspector General, acting on behalf of the Secretary of Health and Human Services. The amount will be fixed by the administrative law judge after a full hearing. A number of factors, both mitigating and aggravating, will be considered when determining the penalty amount.[35] Such factors include: the nature, number, and dollar size of the claims and the circumstances under which they were presented; the claimant's level of culpability, whether intentional or negligent; any prior offenses; his financial condition; and such other matters as justice may require.[36]

In addition to the penalty of not more than $2,000, an assessment may be imposed of not more than twice the amount claimed for each item or service. This assessment is in lieu of damages sustained because of similar claims by either the United States or a state agency.[37] As a general rule, the Department will seek the maximum assessment of twice the amount claimed.

Damages are generally defined as the difference between what the provider received and what he was legally entitled to receive. Determining precise damages is often difficult and always time consuming. The Civil Money Penalties Law avoids this problem by basing the assessment on the amount of the claim.

V. Cases Suitable for Civil Money Penalties Action

Presently, there is no case history interpreting the Civil Money Penalties Law. There are, however, six broad categories of fraud and abuse cases suitable for action under the law.

The first category includes cases where an investigation has been conducted but closed prior to its referral to the Department of Justice for possible criminal prosecution. Examples include cases with small overpayments not great enough to warrant criminal prosecution or cases lacking sufficient criminal intent to sustain a criminal conviction. The second group involves those cases that have been investigated and referred to the Department of Justice for criminal prosecution but declined because of the workload of the United States Attorney, the small number of potential counts, or because the amount of overpayment does not justify the cost of criminal prosecution. Third are those cases accepted by the Department of Justice for criminal prosecution but resulting in either no conviction or a con-

35 42 U.S.C.A. § 1320a-7a(c) (West Supp. 1982).

36 *See* note 30 *supra* and accompanying text.

37 42 U.S.C.A. § 1320(a)-7a(a) (West Supp. 1982).

viction on only a portion of the counts originally brought. The fourth group includes those cases where the subject is convicted of a criminal offense but the Department of Justice declines civil action. The fifth group of cases involves state court convictions for Medicaid or Title V-related offenses where the Department of Justice plans no civil action. Finally, the Civil Money Penalties Law should cover cases where a state investigation of a Medicaid or Title V case fails to produce a state prosecution, and the Department of Justice refuses to take civil action despite an indication of federal civil fraud potential.

VI. Conclusion

Since its inception, actions by the Office of Inspector General have resulted in the conviction of over 1,200 health providers. Yet, criminal convictions have not proven to be a totally effective deterrent. Rarely does a convicted health care provider have to face the likelihood of imprisonment. This is particularly true of physicians. Furthermore, prosecutions have not resulted in the total recovery of those substantial program dollars lost through fraud and abuse.

The Civil Money Penalties Law gives the Inspector General a vitally needed weapon to combat health providers who defraud or attempt to abuse the programs. It is a formidable deterrent, essential to convince a would-be criminal that the punishment outweighs the crime. The Civil Money Penalties Law will allow us to strike the crooked provider where it hurts most—in the pocketbook.