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

name redacted
Legislative Attorney

July 22, 2016

Congressional Research Service
7-....
www.crs.gov
RS22743

Summary

A number of federal statutes aim to combat fraud and abuse in federally funded health care programs such as Medicare and Medicaid. Using these statutes, the federal government has been able to recover billions of dollars lost due to fraudulent activities. This report provides an overview of some of the more commonly used federal statutes used to fight health care fraud and abuse.

Title XI of the Social Security Act contains Medicare and Medicaid program-related anti-fraud provisions, which impose civil penalties, criminal penalties, and exclusions from federal health care programs on persons who engage in certain types of misconduct. Penalties apply in circumstances where, among many other things, services were not provided as claimed, or claims were part of a pattern of providing items or services that a person knows or should know are not medically necessary.

Under the federal anti-kickback statute, it is a felony for a person to knowingly and willfully offer, pay, solicit, or receive anything of value (i.e., "remuneration") in return for a referral or to induce generation of business reimbursable under a federal health care program. The statute prohibits both the offer or payment of remuneration for patient referrals, as well as the offer or payment of anything of value in return for purchasing, leasing, ordering, or arranging for, or recommending the purchase, lease, or ordering of any item or service that is reimbursable by a federal health care program.

The Stark law and its implementing regulations prohibit physician self-referrals for certain health services that may be paid for by Medicare or Medicaid. Under the Stark law, if (1) a physician (or an immediate family member of a physician) has a "financial relationship" with an entity, the physician may not make a referral to the entity for the furnishing of these health services for which payment may be made under Medicare or Medicaid, and (2) the entity may not bill the federal health care program or any individual or entity for services furnished pursuant to a prohibited referral.

The federal False Claims Act (FCA) imposes civil liability on persons who knowingly submit a false or fraudulent claim or engage in various types of misconduct involving federal government money or property. Health care program false claims often arise in billing, including billing for services not rendered, billing for unnecessary medical services, double billing for the same service or equipment, or billing for services at a higher rate than provided ("upcoding"). Civil actions may be brought in federal district court under the FCA by the Attorney General or by a person known as a relator (i.e., a "whistleblower"), for the person and for the U.S. government, in what is termed a *qui tam* action.

Contents

Basic Civil and Criminal Penalties and Exclusions.. 1
The Anti-Kickback Statute 2
Stark Law: Physician Self-Referrals 3
False Claims Act.. 5

Contacts

Author Contact Information 6

The issue of health care fraud and abuse[1] has attracted a lot of attention in recent years, primarily because the financial losses attributed to it are estimated to be billions of dollars annually.[2] Considering that the Centers for Medicare and Medicaid Services (CMS) is the largest purchaser of health care in the United States, and that Medicare and Medicaid combined pay about one-third of the nation's health expenditures,[3] it is not surprising that these federal health programs have been considered prime targets for fraudulent activity. Accordingly, efforts to address this fraud and abuse continue to be a priority for Congress.

The federal government has an array of statutes that it uses to fight health care fraud. This report provides a brief overview of some of the key federal statutes, including program-related civil and criminal penalties, the anti-kickback statute, the Stark law, and the False Claims Act, that are used to combat fraud and abuse in federal health care programs.

Basic Civil and Criminal Penalties and Exclusions

Title XI of the Social Security Act contains Medicare and Medicaid program-related anti-fraud provisions, which impose penalties and exclusions from federal health care programs on persons who engage in certain types of misconduct.[4] Under Section 1128A of the Social Security Act, the Office of the Inspector General at the Department of Health and Human Services (OIG) is authorized to impose civil penalties and assessments on a person, including an organization, agency, or other entity, who engages in various types of improper conduct with respect to federal health care programs, including the imposition of penalties against a person who knowingly presents or causes to be presented to a federal or state employee or agent certain false or fraudulent claims.[5] For example, penalties apply to services that were not provided as claimed, or claims that were part of a pattern of providing items or services that a person knows or should know are not medically necessary.[6] In addition, certain payments made to physicians to reduce or limit services are also prohibited. This section provides for monetary penalties of up to $10,000

---

[1] Health care "fraud" has been described as an intentional attempt to wrongfully collect money relating to medical services, while "abuse" has been described as actions which are inconsistent with acceptable business and medical practices. *See* Alice G. Gosfield, MEDICARE AND MEDICAID FRAUD AND ABUSE 6 (2008).

[2] Federal Bureau of Investigation (FBI) reports estimate that fraudulent billings to both public and private health care programs make up between three and ten percent of total health care expenditures. Federal Bureau of Investigation, Financial Crimes Report to the Public: Fiscal Year 2010-2011, *available at* http://www.fbi.gov/stats-services/publications/financial-crimes-report-2010-2011.

[3] *See* Department of Health and Human Services, Centers for Medicare and Medicaid Services, Fiscal Year 2016 Justification of Estimates for Appropriation Committees, *available at* https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2016-CJ-Final.pdf at 1.

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

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

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

for each item or service claimed, up to $50,000 under certain additional circumstances, as well as treble damages.[7]

Section 1128B of the Social Security Act provides for criminal penalties involving federal health care programs. Under this section, certain false statements and representations, made knowingly and willfully, are criminal offenses. For example, it is unlawful to make or cause to be made false statements or representations in either applying for benefits or payments, or determining rights to benefits or payments under a federal health care program. In addition, persons who conceal any event affecting an individual's right to receive a benefit or payment with the intent to either fraudulently receive the benefit or payment (in an amount or quantity greater than that which is due), or convert a benefit or payment to use other than for the benefit of the person for which it was intended may be criminally liable. Persons who have violated the statute and have furnished an item or service under which payment could be made under a federal health program may be guilty of a felony, punishable by a fine of up to $25,000, up to five years imprisonment, or both. Other persons involved in connection with the provision of false information to a federal health program may be guilty of a misdemeanor and may be fined up to $10,000 and imprisoned for up to one year.[8]

One of the most severe sanctions available under the Social Security Act is the ability to exclude individuals and entities from participation in federal health care programs.[9] Under Section 1128 of the Social Security Act, exclusions from federal health programs are mandatory under certain circumstances, and permissive in others (i.e., OIG has discretion in whether to exclude an entity or individual).[10] Exclusion is mandatory for those convicted of certain offenses, including (1) a criminal offense related to the delivery of an item or service under Medicare, Medicaid, or a state health care program; (2) a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service; or (3) a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.[11] OIG has permissive authority to exclude an entity or an individual from a federal health program under numerous circumstances, including conviction of certain misdemeanors relating to fraud, theft, embezzlement, breach of fiduciary duty, or other financial misconduct; a conviction based on an interference with or obstruction of an investigation into a criminal offense; and revocation or suspension of a health care practitioner's license for reasons bearing on the individual's or entity's professional competence, professional performance, or financial integrity.[12]

The Anti-Kickback Statute

In light of the concern that decisions of health care providers can be improperly influenced by a profit motive,[13] and in order to protect federal health care programs from additional costs and overutilization, Congress enacted the anti-kickback statute. Under this criminal statute, it is a

---

[7] 42 U.S.C. § 1320a-7a(a).

[8] 42 U.S.C. § 1320a-7b(a)(6).

[9] It has been stated that exclusion from federal health care programs can be a "financial death sentence" for those in the health care industry who depend on these programs for business. HEALTH CARE FRAUD AND ABUSE: PRACTICAL PERSPECTIVES, 32 (Linda Baumann ed. 2013).

[10] 42 U.S.C. § 1320a-7.

[11] 42 U.S.C. § 1320a-7(a).

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

[13] 63 Fed. Reg. 1659, 1662 (January 9, 1998).

felony for a person to knowingly and willfully offer, pay, solicit, or receive anything of value (i.e., "remuneration") in return for a referral or to induce generation of business reimbursable under a federal health care program.[14] The statute prohibits both the offer or payment of remuneration for patient referrals, as well as the offer or payment of anything of value in return for purchasing, leasing, ordering, or arranging for, or recommending the purchase, lease, or ordering of any item or service that is reimbursable by a federal health care program.[15] Persons found guilty of violating the anti-kickback statute may be subject to a fine of up to $25,000, imprisonment of up to five years, and exclusion from participation in federal health care programs for up to one year.[16]

There are certain statutory exceptions to the anti-kickback statute. Under one exception, "remuneration" does not include a discount or other reduction in price obtained by a provider of services or other entity if the reduction in price is properly disclosed and reflected in the costs claimed or charges made by the provider or entity under a federal health care program.[17] Another exception includes, under certain circumstances, amounts paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals that furnish services reimbursable by a federal health program. In addition to these exceptions, the Department of Health and Human Services' Office of Inspector General (OIG) has promulgated regulations that contain several "safe harbors" to prevent common business arrangements from being considered kickbacks.[18] Safe harbors listed by regulation include certain types of investment interests, personal services and management contracts, referral services, and space rental or equipment rental arrangements. OIG has indicated that the safe harbor provisions are not indicative of the only acceptable business arrangements, and that business arrangements that do not comply with a safe harbor are not necessarily considered "suspect."[19]

Stark Law: Physician Self-Referrals

Limitations on physician self-referrals were enacted into law in 1989 under the Ethics in Patient Referrals Act, commonly referred to as the "Stark law."[20] The Stark law, as amended, and its implementing regulations prohibit certain physician self-referrals[21] for designated health services (DHS) that may be paid for by Medicare or Medicaid. In its basic application, the Stark law provides that if (1) a physician (or an immediate family member of a physician) has a "financial relationship" with an entity, the physician may not make a referral to the entity for the furnishing of designated health services (DHS)[22] for which payment may be made under Medicare or

---

[14] 42 U.S.C. § 1320a-7b(b).

[15] *Id*.

[16] *Id*.

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

[18] *See* 42 C.F.R. § 1001.952 for the safe harbor provisions.

[19] 64 Fed. Reg. 63,518, 63,521 (November 19, 1999).

[20] The Stark law, created as Section 1877 of the Social Security Act and codified at 42 U.S.C. § 1395nn, was created by the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, 103 Stat. 2423 (1989). The Stark law was significantly amended by the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, §13562, 107 Stat. 312 (1993) and is commonly referred to as "Stark II." Regulations for Stark II have been issued by the Centers for Medicare and Medicaid Services (CMS) and are comprehensive. *See* 42 C.F.R. §411.350 et seq.

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

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

Medicaid, and (2) the entity may not present (or cause to be presented) a claim to the federal health care program or bill to any individual or entity for DHS furnished pursuant to a prohibited referral.[23] It has been noted that the general idea behind the prohibitions in the Stark law is to prevent physicians from making referrals based on financial gain, thus preventing overutilization and increases in health care costs.[24]

A "financial relationship" under the Stark law consists of either (1) an "ownership or investment interest" in the entity or (2) a "compensation arrangement" between the physician (or immediate family member) and the entity.[25] An "ownership or investment interest" includes "equity, debt, or other means," as well as "an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service."[26] A "compensation arrangement" is generally defined as an arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity, other than certain arrangements that are specifically mentioned as being excluded from the reach of the statute.[27] The Stark law includes a large number of exceptions, which have been added and expanded upon by a series of regulations. These exceptions may apply to ownership interests,[28] compensation arrangements,[29] or both.[30]

Violators of the Stark law may be subject to various sanctions, including a denial of payment for relevant services and a required refund of any amount billed in violation of the statute that had been collected. In addition, civil monetary penalties and exclusion from participation in Medicaid and Medicare programs may apply. A civil penalty not to exceed $15,000, and in certain cases not to exceed $100,000, per violation may be imposed if the person who bills or presents the claim "knows or should know" that the bill or claim violates the statute.[31]

---

[23] While both the anti-kickback statute and the Stark law may apply to physician self-referrals, the statutes differ "in scope and structural approach." 64 Fed. Reg. 63518, 63520 (November 19, 1999). The anti-kickback statute is a criminal law that requires improper intent for a violation and has statutory and regulatory "safe harbors" that do not aim to define the full range of lawful activity. *Id.*; *see also* Linda A. Baumann, *Navigating the New Safe Harbors to the Anti-Kickback Statute*, 12 HEALTH LAWYER 1, 4 (2000). The Stark law, on the other hand, is a civil law, and a transaction must fall entirely within an exception to be lawful, regardless of the parties' intent. *Id.* Therefore, even if an arrangement is acceptable under the Stark law, it may violate the anti-kickback statute if there is improper intent to induce referrals. *Id*.

[24] *See, e.g*., 66 Fed. Reg. 856, 859 (January 4, 2001) ("Prior to enactment of section 1877 [of the Social Security Act], there were a number of studies, primarily in academic literature, that consistently found that physicians who had ownership or investment interests in entities to which they referred ordered more services than physicians without those financial relationships (some of these studies involved compensation as well). Increased utilization occurred whether the physician owned shares in a separate company that provided ancillary services or owned the equipment and provided the services as part of his or her medical practice. This correlation between financial ties and increased utilization was the impetus for section 1877 of the Act.").

[25] 42 U.S.C. § 1395nn(a)(2).

[26] *Id*.

[27] 42 U.S.C. § 1395nn(h)(1).

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

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

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

[31] 42 U.S.C. § 1395nn(g).

False Claims Act

The federal False Claims Act (FCA), codified at 31 U.S.C. Sections 3729-3733, is considered by many to be an important tool for combating fraud against the U.S. government. The FCA is a law of general applicability that is invoked frequently in the health care context. It has been reported that from January 2009 through the end of the 2015 fiscal year, the Justice Department used the False Claims Act to recover more than $16.5 billion in health care fraud cases.[32]

In general, the FCA imposes civil liability on persons who knowingly submit a false or fraudulent claim or engage in various types of misconduct involving federal government money or property.[33] Health care program false claims often arise in terms of billing, including billing for services not rendered, billing for unnecessary medical services, double billing for the same service or equipment, or billing for services at a higher rate than provided ("upcoding"). Penalties under the FCA include a penalty of $5,500 to $11,000 for each false claim filed, plus additional damages.[34]

Civil actions may be brought in federal district court under the FCA by the Attorney General or by a person known as a relator (i.e., a "whistleblower"), for the person and for the U.S. government, in what is termed a *qui tam* action. The ability to initiate a *qui tam* action has been viewed as a powerful weapon against health care fraud, in that it may be initiated by a private party who may have independent knowledge of any wrongdoing.[35] Popularity of *qui tam* actions brought under the FCA may be attributed partially to the fact that successful whistleblowers can receive between 15% and 30% of the monetary proceeds of the action or settlement that are recovered by the government.

---

[32] U.S. Department of Justice, Justice Department Recovers $3.5 Billion from False Claims Act Cases in Fiscal Year 2015, *available at* https://www.justice.gov/opa/pr/justice-department-recovers-over-35-billion-false-claims-act-cases-fiscal-year-2015.

[33] Under 31 U.S.C. § 3729, the FCA imposes liability on a person who: (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G); (D) has possession, custody, or control of property or money used, or to be used, by the government and knowingly delivers, or causes to be delivered, less than all of that money or property; (E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the government and, intending to defraud the government, makes or delivers the receipt without completely knowing that the information on the receipt is true; (F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government, 31 U.S.C. § 3729. Additional liability may also flow from any retaliatory action taken against those who seek to stop violations of the False Claims Act. 31 U.S.C. §3730(h).

[34] 31 U.S.C. § 3729(a)(1)(G). It may be noted that penalties under the FCA are set to rise, pursuant to the Federal Civil Monetary Penalties Inflation Adjustment Act of 1990. 28 U.S.C. § 2461 note. As of August 1, 2016, penalties for violations of the FCA will increase to between $10,781 and $21,562 per claim, plus additional damages. *See* 81 Fed. Reg. 42491 (June 30, 2016).

[35] HEALTH LAW, 50 (Barry Furrow 2d ed. 2000).

Author Contact Information

(name redacted)
Legislative Attorney
[redacted]@crs.loc.gov, 7-....

EveryCRSReport.com

The Congressional Research Service (CRS) is a federal legislative branch agency, housed inside the Library of Congress, charged with providing the United States Congress non-partisan advice on issues that may come before Congress.

EveryCRSReport.com republishes CRS reports that are available to all Congressional staff. The reports are not classified, and Members of Congress routinely make individual reports available to the public.

Prior to our republication, we redacted names, phone numbers and email addresses of analysts who produced the reports. We also added this page to the report. We have not intentionally made any other changes to any report published on EveryCRSReport.com.

CRS reports, as a work of the United States government, are not subject to copyright protection in the United States. Any CRS report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS report may include copyrighted images or material from a third party, you may need to obtain permission of the copyright holder if you wish to copy or otherwise use copyrighted material.

Information in a CRS report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to members of Congress in connection with CRS' institutional role.

EveryCRSReport.com is not a government website and is not affiliated with CRS. We do not claim copyright on any CRS report we have republished.