

2020

## Senior Healthcare Fraud under Investigation

Nicole Forbes Stowell

*University of South Florida St. Petersburg, nstowell@mail.usf.edu*

Martina K. Schmidt

*schmidt@mail.usf.edu*

Carl J. Pacini

*cpacini@mail.usf.edu*

Nathan Wadlinger

*University of South Florida St. Petersburg*

Follow this and additional works at: [https://digitalcommons.usf.edu/fac\\_publications](https://digitalcommons.usf.edu/fac_publications)

 Part of the [Business Commons](#)

---

### Recommended Citation

Stowell, Nicole Forbes; Schmidt, Martina K.; Pacini, Carl J.; and Wadlinger, Nathan, "Senior Healthcare Fraud under Investigation" (2020). *USF St. Petersburg campus Faculty Publications*. 4013.  
[https://digitalcommons.usf.edu/fac\\_publications/4013](https://digitalcommons.usf.edu/fac_publications/4013)

This Article is brought to you for free and open access by the USF Faculty Publications at Digital Commons @ University of South Florida. It has been accepted for inclusion in USF St. Petersburg campus Faculty Publications by an authorized administrator of Digital Commons @ University of South Florida. For more information, please contact [scholarcommons@usf.edu](mailto:scholarcommons@usf.edu).



## Senior Healthcare Fraud under Investigation

Journal:	<i>Journal of Financial Crime</i>
Manuscript ID	JFC-04-2020-0071
Manuscript Type:	Scholarly Article
Keywords:	Healthcare Fraud, Senior Fraud, False Claims Act, Anti-Kickback Statute, Health Insurance Portability and Accountability Act (HIPPA), Stark Law

SCHOLARONE™  
Manuscripts

## Abstract

**Purpose** – This study aims to increase awareness and educate the reader about healthcare fraud targeting seniors in the U.S to help stakeholders better understand, recognize, and prevent this type of fraud.

**Design/methodology/approach** – Attention is given to the statistics on the current state of healthcare fraud as it relates to seniors, an explanation of the different types of healthcare frauds committed against seniors, and a presentation of related cases and laws.

**Findings** – We find this type of fraud is highly prevalent and expected to increase. Current laws preventing this fraud from occurring are multifold and complex. While prevention strategies through law enforcement have been somewhat successful, a reduction in resources may put seniors at an increased risk in the years to come.

**Research limitations/implications (optional)** – Without additional prevention strategies, the problem will likely escalate with a growing population of older adults. This study encourages further research into effective prevention strategies and methods to fight healthcare fraud against seniors.

**Practical & social implications** – Healthcare fraud and its associated costs pose a significant threat to the society and economy of the U.S. Reducing this fraud will not only reduce the costs to the U.S. economy but will also improve the physical and mental well-being of senior victims, reduce their mortality and hospitalization rates, and improve the public trust placed in healthcare providers.

1  
2  
3 **Originality/value** – This study highlights how healthcare fraud is committed against seniors.

4  
5 With the projected trend of an aging U.S. population, educating stakeholders, increasing  
6 awareness, and applying tools to protect seniors will be important to reduce the absolute scope of  
7  
8 this problem in the future.  
9  
10

11  
12 **Keywords:** Healthcare Fraud, Senior Fraud, False Claims Act, Anti-Kickback Statute, Health  
13 Insurance Portability and Accountability Act (HIPPA), Stark Law, Opioid Crisis  
14  
15

16  
17  
18 **Paper Type:** General Review  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

## Introduction

Healthcare costs not only present a significant drain on the U.S. economy but are estimated to increase in the years to come. The economic fallout from the COVID-19 outbreak will further accelerate the challenges healthcare costs pose. Fraudsters have traditionally viewed healthcare as a lucrative field for illegal activity. Of all the healthcare fraud schemes, the ones targeting “seniors” are particularly hideous, as seniors deserve to be cared for with respect, compassion, and dignity, but are often the most vulnerable victims. Healthcare fraud already affects millions of older adults annually in the United States. Due to an expected aging of the U.S. population, healthcare fraud committed against seniors and its effects will likely present an escalating problem in years to come.

The types of crimes committed against seniors take on many forms. For example, some financial fraud cases try to exploit, trick, and/or deceive seniors into turning over their savings and often include such types of schemes as investment fraud schemes, reverse mortgage scams, mass mailing frauds, lottery phone scams, romance scams, health insurance (Medicare and Medicaid) schemes, grandparent scams, and Internal Revenue Service imposter schemes.

Healthcare fraud, which also often targets seniors, is an intentional deception or misrepresentation relating to a patient’s health or health insurance that an individual or organization makes, with the goal that the deception or misrepresentation could result in some unauthorized benefit to that individual or entity. Not surprisingly, financial fraud and healthcare fraud committed against seniors are intertwined. While many healthcare fraud cases also result in financial loss to the victims, many financial fraud cases also involve the health of the victims.

1  
2  
3 Senior financial exploitation is also related to the victims' health as it often results in shortened  
4 survival, hospitalization, and poor physical and mental health. (Burnes *et al.*, 2017).  
5  
6  
7

8  
9 The types of healthcare fraud that specifically target seniors and which are analyzed here  
10 include those that take place in the U.S. Department of Veterans Affairs, in hospice, nursing  
11 homes, and home healthcare facilities, as well as those that involve opioids and the use of  
12 durable medical equipment. The culprits may be doctors, hospitals, pharmaceutical companies,  
13 facilities offering physical therapy, urgent care centers, assisted living facilities, nursing homes,  
14 and even patients themselves, just to name a few. In order to gain a benefit, fraudsters often  
15 make false statements, misrepresent information or deliberately omit information that is critical  
16 to the determination of benefits payable, or prescribe unnecessary procedures, medical devices,  
17 tests, or drugs.  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30

31 The financial impact of senior healthcare fraud not only affects the patients and their  
32 families, but also the government and taxpayers who pay more to cover healthcare expenditures  
33 in public health plans. In addition, healthcare fraud can also erode public trust in healthcare  
34 providers (Payne, 2006) and place a patient at risk of serious physical harm or even death from  
35 unnecessary procedures, unapproved drugs, or overprescribed diagnostic tests and antibiotics.  
36  
37 As this fraud is likely to become a growing concern to the U.S. economy and society in the years  
38 ahead, educating the public and stakeholders about this threat, finding preventative measures,  
39 and allocating increased funding to fight this threat is essential and urgently needed to protect  
40 seniors in the future.  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51

52 The purpose of this paper is to increase awareness of this threat to help stakeholders  
53 better understand, recognize, and prevent this type of fraud. This study proceeds as follows.  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 First, it analyzes the scope and statistics of this fraud, as well as some of the law enforcement  
4 efforts to combat it. The study then explains the different types of healthcare fraud targeting  
5 seniors along with related recent healthcare fraud cases. Next, an analysis of the laws and  
6 policies applicable to healthcare fraud are presented. Finally, the study ends with a summary and  
7 conclusion that highlights the importance of effectively combatting this type of fraud.  
8  
9  
10  
11  
12  
13  
14  
15

### 16 **Healthcare Fraud Scope and Statistics**

17  
18 The costs associated with healthcare present a significant and increasing strain to the U.S.  
19 economy. Eighteen percent of the U.S. national economy was spent on healthcare costs alone in  
20 2018 (Peter G. Peterson Foundation, 2019). These costs are estimated to grow by an average  
21 annual rate of 5.8% between 2015 and 2025 and are projected to reach \$5.4 trillion by 2025  
22 (Centers for Medicare and Medicaid Services, 2016). Fraudsters, who view healthcare as a  
23 lucrative field for illegal activity, have caused healthcare fraud costs to reach into the tens of  
24 billions of dollars a year (Federal Bureau of Investigation, 2016; National Healthcare Anti-Fraud  
25 Association (n.d.)).  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37

38 Of all the fraud schemes, the ones targeting seniors are particularly concerning and  
39 common.<sup>1</sup> For example, financial fraud against seniors is highly prevalent, with an estimated 1  
40 out of 8 cognitively intact older adults being affected every year in the United States (Burnes *et*  
41 *al.*, 2017). The AARP reports that fraudsters have stolen billions of dollars from older  
42 Americans and programs that benefit Americans over the age of 50 (AARP, 2017).  
43  
44  
45  
46  
47  
48  
49  
50

51 Fraud against seniors is a serious and growing threat, as more and more of the baby  
52 boomer population is moving into retirement age (Federal Bureau of Investigation, 2018).<sup>2</sup> Not  
53 only is the senior population estimated to increase over time, but people live longer as well,  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 which in turn increases the demand for Medicare benefits (Federal Bureau of Investigation,  
4 2012). Fraudsters view seniors as prime targets as many older citizens have large nest eggs  
5 saved over decades and, at the same time, are generally not technologically savvy. The fraudsters  
6 also know that senior victims often do not report being victimized either because they feel guilty  
7 or embarrassed, or because they do not even realize they are being scammed due to cognitive  
8 impairment (Federal Bureau of Investigation, 2018).  
9  
10  
11  
12  
13  
14  
15  
16  
17

18 One troubling trend, which will likely increase the occurrence of and costs related to  
19 senior fraud, is the estimated increase of dementia-related diseases affecting seniors, and in  
20 particular, minorities. As the symptoms of dementia include decreased or poor judgement,  
21 confusion with time or place and memory loss (Gaugler, 2019, p.7), dementia patients are easy  
22 prey for fraudsters. In 2019, an estimated 5.8 million people were living in the U.S. with  
23 dementia (Gaugler, 2019, p. 17). Minorities are particularly affected by dementia. For example,  
24 African-Americans are two to three times more likely to get Alzheimer's disease (Barnes and  
25 Bennett, 2014). Hispanic Americans are 1.5 times more likely to get the disease  
26 (UsAgainstAlzheimer's, n.d.). By 2050, the number of dementia patients is expected to more  
27 than double to 13.5 million (Hebert et al., 2013).  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41

42 In addition, the costs of healthcare and long-term care for seniors with dementia-related  
43 illness are substantial, as dementia is one of the costliest conditions to society (Gaugler, 2019,  
44 p.43). In the U.S., total payments in 2019 alone for all individuals with dementia-related diseases  
45 were estimated at \$290 billion. Of that amount, Medicare and Medicaid were estimated to cover  
46 \$195 billion (or 67 percent) (Gaugler, 2019, p.43). Unless a cure for dementia is found by 2050,  
47 the total cost of care for Alzheimer's is projected to increase to more than \$1.1 trillion (Lynch,  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60



1  
2  
3 2018). These large sums needed to care for cognitively impaired patients will likely attract  
4  
5 fraudsters.  
6  
7

### 8 9 *Government Efforts to Combat Healthcare Fraud Costs* 10

11  
12 Due to an increase in healthcare costs and fraud, the U.S. federal government and federal  
13 and state law enforcement agencies have made efforts to prosecute healthcare fraud.<sup>3</sup> While the  
14 FBI is the primary investigative agency in the fight against healthcare fraud, it coordinates its  
15 efforts with the Health and Human Services Office of Inspector General (HHS-OIG), the Food  
16 and Drug Administration (FDA), Drug Enforcement Administration (DEA), the IRS Criminal  
17 Investigation Division, and various state and local agencies (Federal Bureau of Investigation,  
18 2012). The efforts by the federal government to investigate and prosecute healthcare fraud in the  
19 past have resulted in some successes and have led to substantial recoveries and financial  
20 settlements, as well as the incarcerations of fraudsters.<sup>4</sup>  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33

34 Some of the largest healthcare fraud financial recoveries are related to seniors as they are  
35 mostly attributable to the Medicare and Medicaid programs. Through its Healthcare Fraud and  
36 Abuse Control (HCFAC) program, for example, the federal government won or negotiated \$2.3  
37 billion in healthcare judgements and settlements in total in 2018, \$1.4 million of which was  
38 related to Medicare and Medicaid programs (Department of Health and Human Services, 2019).  
39  
40  
41  
42  
43  
44  
45  
46

47 However, despite a more focused and integrative effort by multiple government entities,  
48 the threat of healthcare fraud against seniors remains high. This is evidenced by record-setting  
49 dollar amounts in recent healthcare fraud scheme takedowns involving hospice and home health  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 companies as well as doctors prescribing opioids and other dangerous narcotics (Department of  
4  
5 Justice, 2018a & 2019).<sup>5</sup>  
6  
7

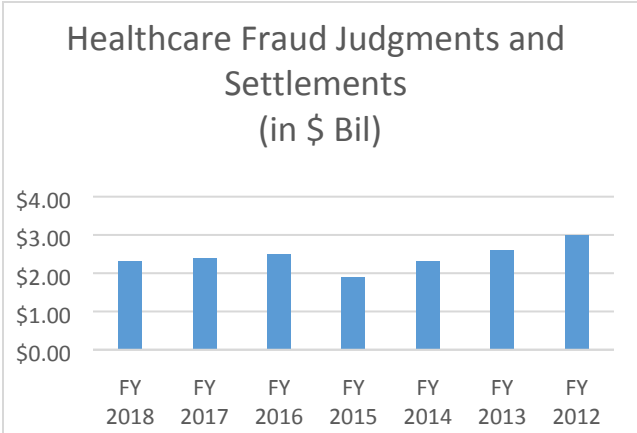
8  
9 Surprisingly, despite the successful takedown of many fraudsters in healthcare fraud  
10 cases, funding for the prosecution of healthcare fraud has decreased steadily since 2012. The  
11 Department of Justice, the FBI, and the HHS-OIG together received \$145.6 million less in  
12  
13 resources between 2013 and 2018 due to the sequestration of mandatory funding to fight fraud  
14  
15 and abuses against Medicare, Medicaid, and other healthcare programs. (Department of Health  
16  
17 and Human Services, 2013 - 2019).  
18  
19  
20  
21  
22  
23

24 This has resulted in a decrease of successful outcomes of healthcare fraud prosecutions.  
25  
26 The Department of Health and Human Service (DHHS) and the Department of Justice (DOJ)  
27  
28 report their successes with fighting healthcare fraud through their Healthcare Fraud and Abuse  
29  
30 Control Program annual reports. For example, these reports show that in 2015, the U.S.  
31  
32 Department of Justice and the Department of Health and Human Services recovered \$6.10 for  
33  
34 every dollar spent on fighting healthcare fraud (Department of Justice, 2016b); however, this  
35  
36 amount decreased to \$4.2 on average for the years 2015-2017 (Department of Health and Human  
37  
38 Services, 2018, p. 8).  
39  
40  
41  
42

43 As the following charts show, the dollar amount of healthcare fraud judgements and  
44  
45 settlements (Chart 1), the number of new healthcare fraud cases opened by the DOJ (Chart 2),  
46  
47 the number of defendants convicted (Chart 3), and the number of funds returned to the Medicare  
48  
49 Trust Funds (Chart 4) have all decreased between 2012 and 2018.  
50  
51  
52

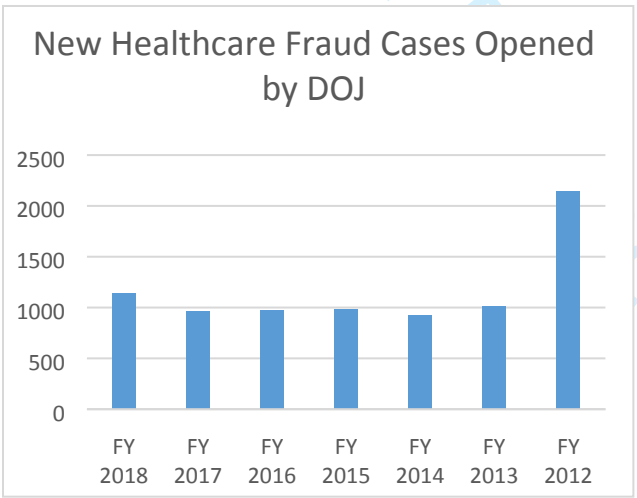
53  
54 Chart 1:  
55  
56  
57

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60



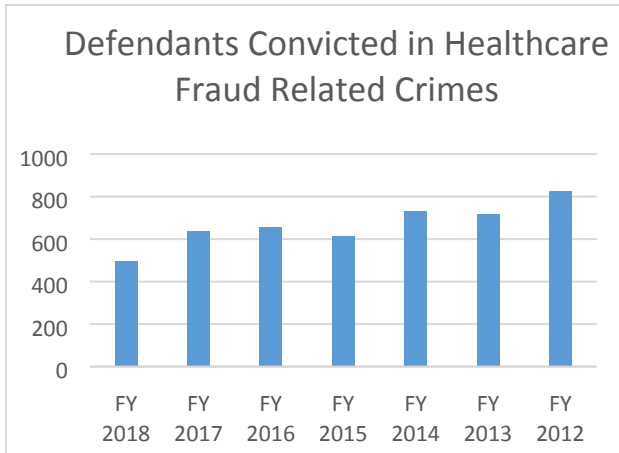
*Total dollar amount of healthcare fraud judgments and settlements won or negotiated by the Federal Government; Source: U.S. Department of Health and Human Services Office of Inspector General*

Chart 2:



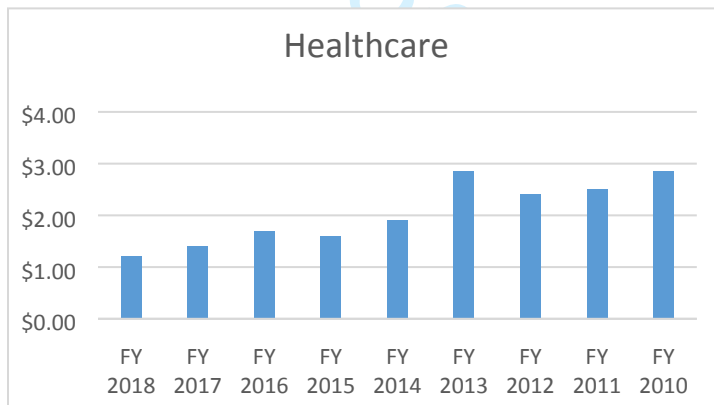
*The number of new healthcare fraud cases opened by the Department of Justice; Source: U.S. Department of Health and Human Services Office of Inspector General*

Chart 3:



*The number of defendants that were convicted in healthcare fraud-related crimes; Source: U.S. Department of Health and Human Services Office of Inspector General*

Chart 4:



*The funds that were returned to the Medicare Trust Funds through healthcare related fraud judgements and settlements initiated by the Healthcare Fraud and Abuse Control Program (HCFAC). Source: U.S. Department of Health and Human Services Office of Inspector General*

This data shows that government resources dedicated to help U.S. law enforcement agencies fight this type of fraud have not kept up with the need to combat this threat. Consequently, an improved approach to fighting and preventing senior healthcare fraud is needed. Understanding the different types of healthcare fraud is the first step in combatting this fraud.

## I. Healthcare Fraud Against Seniors

This section discusses fraud taking place in the U.S. Department of Veterans Affairs, against seniors in hospice, and in nursing homes. Also examined in this section is the use of durable medical equipment to commit fraud and the impact the opioid crisis is having on seniors. Recent cases are provided for each one of these types of fraud involving seniors.

### A. *Veterans Affairs*

The VA is a federal agency that provides near comprehensive healthcare services to eligible military veterans at VA medical centers and outpatient clinics located throughout the country; several non-healthcare benefits, including disability compensation, vocational rehabilitation, education assistance, home loans, and life insurance; and burial and memorial benefits to eligible veterans and family members at more than one hundred national cemeteries (United States Department of Veterans Affairs, n.d.a). The Department has three main subdivisions, known as Administrations. The first is the Veterans Health Administration (VHA). The VHA is responsible for providing healthcare in all its forms, as well as for biomedical research (under the Office of Research and Development), Community Based Outpatient Clinics (CBOCs), and Regional Medical Centers. The second is the Veterans Benefits Administration (VBA). The VBA is responsible for initial veteran registration, eligibility determination, and five key lines of business (benefits and entitlements): (1) Home Loan Guarantees, (2) Insurance, (3) Vocational Rehabilitation and Employment, (4) Education (GI Bill), and (5) Compensation & Pension. The third is the National Cemetery Administration (NCA). The NCA is responsible for providing burial and memorial benefits, as well as for maintenance of VA cemeteries. The first and second of these three administrations involve healthcare fraud and will be considered in this article.

1  
2  
3 The VHA is the largest integrated healthcare system in the United States, providing care at  
4 1,255 healthcare facilities, including 170 VA Medical Centers and 1,074 outpatient sites of care  
5 of varying complexity (VHA outpatient clinics) to over 9 million Veterans enrolled in the VA  
6 healthcare program (United States Department of Veterans Affairs, n.d.c).  
7  
8  
9  
10  
11

12  
13 The VA, in particular, has two interesting features that make it a magnet for various types of  
14 healthcare fraud. First, the VA is the largest integrated healthcare system. If one considers  
15 kickback schemes involving specific contracts and referrals, this can be a huge incentive for  
16 fraudsters. In one case, Anthony Lazzarino and Peter Wong agreed to make materially false  
17 statements to the VA in the course of applying for a national contract worth over \$11 million per  
18 year regarding where shoes were manufactured (Department of Justice, 2020b).  
19  
20  
21  
22  
23  
24  
25  
26  
27

28 The second interesting aspect about the VA is that much fraud committed does not purely  
29 involve healthcare benefits, but also a form of compensation related to health issues occurring  
30 during or as a result of U.S. military service. Specifically, the Compensation Service program of  
31 the VBA oversees the delivery of disability compensation, a tax-free monetary benefit paid to  
32 Veterans with disabilities that are the result of a disease or injury incurred or aggravated during  
33 active military service (Department of Veterans Affairs, n.d.b). There has been a great deal of  
34 fraud related to the Compensation Service program with two major types of fraud occurring:  
35 malingering by a veteran and stolen valor.  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47

48 In one example of a malingering veteran, a federal judge sentenced a man to three years and  
49 five months in prison and millions in restitution for claiming \$1.5 million in VA benefits while  
50 pretending he suffered extreme impairments from advanced multiple sclerosis (MS) (Monk,  
51 2016). In conducting one of the largest fraudulent single compensation claims in VA history,  
52  
53  
54  
55  
56  
57

1  
2  
3 Dennis Paulsen feigned and exaggerated the impairment resulting from his MS diagnosis.  
4  
5 According to evidence in the case, Paulsen joined the Navy in the late 1980s, hoping to become a  
6  
7 Navy SEAL. But Navy doctors determined he had MS and mustered him out. After being  
8  
9 diagnosed and discharged from the Navy in the early 1990s, Paulsen began receiving a monthly  
10  
11 VA benefit as a result of his diagnosis. Paulsen was diagnosed with 30 percent disability because  
12  
13 of MS. Unsatisfied with the amount he was receiving, Paulsen began a pattern of malingering by  
14  
15 claiming his MS rendered him unable to use his hands or feet in any respect. Still unhappy with  
16  
17 the money he was awarded, Paulsen ramped up his claims, lying to his doctors, presenting  
18  
19 himself as unable to leave his house or to move about without a wheelchair, and making false  
20  
21 claims that he required daily professional medical care to live until his benefits were increased to  
22  
23 the maximum disability payments available to a Veteran. Eventually, he received \$112,000 a  
24  
25 year in tax-free government payments. This gave him, his wife, and two sons a well-to-do life; in  
26  
27 South Carolina where he lived, the median household pretax income was around \$45,000 in  
28  
29  
30  
31  
32  
33 2014.

34  
35  
36 In 2014, a concerned citizen reported Paulsen to the VA and explained how Paulsen lacked  
37  
38 the impairments that he claimed. Upon learning that the VA was looking into his actual  
39  
40 impairment from MS, Paulsen immediately quit his baseball league and began appearing at the  
41  
42 VA again in his wheelchair, claiming to be unable to walk or use his hands. The extensive  
43  
44 investigation by the VA included undercover agents, surveillance, and photographs and video  
45  
46 footage from banks, stores, and the Columbia Metropolitan Airport. Family photographs kept by  
47  
48 Paulsen's ex-wife were also obtained showing Paulsen's many activities with his family, playing  
49  
50 baseball, and participating in a Marine Mud Run. Paulsen testified in a wheelchair for four hours  
51  
52 and called three doctors as expert witnesses in an attempt to support his claim that he was and  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 had been totally disabled. The guilty verdict reflects that the jury did not find this testimony  
4  
5 credible.  
6  
7

8  
9 While the above malingering example is egregious, stolen valor, another type of healthcare  
10 fraud in the VA, is considered despicable. In an example of stolen valor, 70-year-old Keith R.  
11 Hudson, pled guilty in federal court to defrauding the VA by receiving \$197,237 in benefits after  
12 falsely claiming to be a military veteran of combat in Vietnam (Feit, 2018). Court documents  
13 presented during the hearing established that, in 2015, Mr. Hudson applied to the VA in  
14 Charleston for benefits. He used a falsified form from the Department of Defense, called a DD-  
15 214, (“Report of Separation from Active Duty”), which is a Department of Defense form given  
16 to members of the military who are separating from service. In the form, he said that he was a  
17 veteran of the war in Vietnam. He represented that he was in the Navy and witnessed combat as  
18 a medic, suffering wounds and other trauma. He claimed that he served from August 1, 1967  
19 through October 31, 1971 and that he received two Purple Hearts.  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34

35 The investigation conducted by the Veterans Affairs Office of Inspector General (OIG)  
36 showed that the DD-214 was forged and false. For instance, Mr. Hudson’s rank was listed as HN  
37 and E-4 (in the United States Navy, HN is actually the equivalent of E-3). In the awards section,  
38 it stated that he received a Combat Medic Badge. However, this is an award only given for  
39 service in the United States Army. It also did not list the proper citation for a Purple Heart. The  
40 form also stated Mr. Hudson received the Fleet Marine Force Medal with Marine Device;  
41 however, there is no such medal. The form also had a stamp from the Alaska State Defense  
42 Force, which is suspicious as that group is not an official military organization, being comprised  
43 of volunteers. Additionally, the service branches do not permit their records to be combined with  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60



1  
2  
3 or loaned to those of other entities, including National Guard units. And, the typeset of the Social  
4  
5 Security number on the DD-214 was different from the rest of the document.  
6  
7

8  
9 In fact, Mr. Hudson never was in the military. The investigation conclusively showed that  
10  
11 there were no records in the National Personnel Records Center in St. Louis, Missouri, for him  
12  
13 from any branch of service. Additionally, employment records for him from 1967 through 1971  
14  
15 established that he worked at a variety of jobs in New York and Maine. In two of them, he  
16  
17 applied for employment and was fingerprinted. These fingerprints were still on file and matched  
18  
19 his prints. As such, he was in the United States during the years 1967 through 1971. Therefore,  
20  
21 Mr. Hudson was never in the United States Navy, nor did he ever see combat in Vietnam.  
22  
23  
24  
25

26 The investigation also revealed that he was previously prosecuted for the same scheme using  
27  
28 the same DD-214 form in 2005 in Connecticut, where he had been placed in a pretrial  
29  
30 diversionary program. He was sentenced to six months in federal prison, and six months in  
31  
32 home confinement. Hudson was also ordered to pay \$297,237 in restitution.  
33  
34  
35

### 36 *B. Hospice*

37  
38  
39

40 The hospice movement is due largely to a charismatic British nurse named Cicely Saunders,  
41  
42 who focused on addressing the spiritual, psychological, social, and practical needs of the dying,  
43  
44 as opposed to what she viewed as hospitals' traditional approach to death: never-ending,  
45  
46 intensive treatment carried to the bitter end as patients suffered and became more helpless  
47  
48 (Barger, 2016). For example, she focused on endorsing the prescription of wine, beefsteaks,  
49  
50 violin music, and narcotics, rather than aggressive medical treatments, such as chemotherapy.  
51  
52 She used an interdisciplinary team approach that put healthcare decisions in the hands of  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 patients, their families, and a team of caregivers, social workers, and clergy, rather than the  
4  
5 opinions of specialists or the convenience of nurses or the rules of hospitals, government health  
6  
7 programs, or insurance companies. The name “hospice” came from the Latin “hospes,” for  
8  
9 “both guest and host” and in honor of the hospices that sheltered members of the early Christian  
10  
11 church and pilgrims of the Middle Ages.  
12  
13

14  
15  
16 There has been a great deal of healthcare fraud related to the hospice movement, especially  
17  
18 against seniors. Many major national hospice providers have been accused of healthcare fraud  
19  
20 mainly related to false claims for payment under the Medicare Hospice benefit. In one of the  
21  
22 largest cases of Hospice healthcare fraud, on October 17, 2013, after being convened for exactly  
23  
24 one month and one day, a federal jury in the United States District Court for the Eastern District  
25  
26 of Pennsylvania returned a guilty verdict on all thirty-five counts against Matthew Kolodesh,  
27  
28 owner and operator of Home Care Hospice of Philadelphia, PA, for crimes including healthcare  
29  
30 fraud, mail fraud, money laundering, aiding and abetting, and conspiracy (Barger, 2016).  
31  
32  
33

34 Kolodesh and his co-conspirators were indicted for billing Medicare \$12.8 million for end-of-life  
35  
36 care for patients who were not at the end of their lives and another \$1.5 million for patients who  
37  
38 were dying, but for whom Kolodesh and his co-conspirators did not provide the in-home,  
39  
40 around-the-clock-care they promised. It is likely that many of the patients in this latter category  
41  
42 died alone and without care, an experience the pioneers of the hospice movement wanted ended  
43  
44 and that the federal government sought to guard against when adopting the Medicare Hospice  
45  
46 Benefit.  
47  
48  
49

50  
51 According to the indictment, Kolodesh and his co-conspirators falsified schedules to make it  
52  
53 look as though the patients were being continuously visited by hospice caregivers when, in fact,  
54  
55  
56  
57

1  
2  
3 they were all alone. Sometimes, when the phony schedules claimed they were being attended to,  
4 the patients were already dead. Medicare paid Kolodesh and his company approximately \$800  
5 per day. Before the case ended, the Department of Justice revised its Medicare losses to estimate  
6 that Kolodesh and his co-conspirators stole some \$16.2 million from the system.  
7  
8  
9  
10  
11  
12

13  
14 Federal prosecutors stated that Kolodesh used the hospice and the money it collected from  
15 Medicare as his “private piggy bank.” In their sentencing memorandum, Ercole and Vierbuchen  
16 stated that Kolodesh and his co-conspirators, including registered nurse and hospice director  
17 Alex Pugman, “orchestrated a series of fraudulent schemes that enriched [his and his co-  
18 conspirators’] bank accounts and lifestyles by millions of dollars.” “Simply put, they used  
19 [Home Care Hospice] as the vehicle to scam ... the Medicare program of \$16.2 million in false  
20 claims.” According to the prosecutors, Kolodesh’s greed not only abused the Medicare payment  
21 system, but perhaps more harmfully perverted the medical system itself, corrupting the  
22 benevolent purpose of hospice and denying the altruism behind the practice of medicine. The  
23 breach of ethics and trust by Koldesh and his co-conspirators was even more egregious, as the  
24 care of the patients was a matter of life and death. “A culture of fraud permeated [Home Care  
25 Hospice],” the prosecutors said in their sentencing memo. “It infected the field clinicians, RNs  
26 and LPNs, who provided care for patients, as well as home health aides. Kolodesh and Pugman,  
27 motivated by greed, were responsible for creating this monster.” On May 28, 2014, United  
28 States District Judge Eduardo C. Robreno of the Eastern District of Pennsylvania sentenced  
29 Kolodesh to serve 176 months in a federal penitentiary for his crimes.  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50

51 While Kolodesh’s scheme of deceiving dying patients and their families for profit at the  
52 taxpayers’ expense may be considered horrendous, unfortunately, it is not unique. Beginning in  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 2000, defendants affiliated with hospices around the nation have been forced to re-pay taxpayers  
4  
5 for similar fraud allegations under the federal False Claims Act. In the fifteen years since the first  
6  
7 settlement was announced, the United States has used the False Claims Act (discussed below) to  
8  
9 recover around \$114,565,290 of fraudulent hospice claims to Medicare, and, in some cases, to  
10  
11 bring fraudsters to justice.  
12  
13

### 14 15 16 *C. Nursing Homes* 17

18  
19 Vulnerable, senior individuals in nursing homes are, unfortunately, easy targets for Medicare  
20  
21 and Medicaid fraud. Unscrupulous nursing home workers or administrators will take advantage  
22  
23 of the vulnerability of nursing home patients to overcharge for services, perform and bill for  
24  
25 unnecessary services and tests, pay kickbacks to doctors that refer patients to the nursing home,  
26  
27 or receive kickbacks for prescribing prescription medication or devices. Nursing homes also  
28  
29 exploit their senior patients by providing more therapy services than they need – even after the  
30  
31 patient has asked for therapy to be discontinued.  
32  
33

34  
35  
36 The federal government brought a False Claims Act lawsuit accusing SavaSeniorCare, LLC,  
37  
38 SavaSeniorCare Consulting, LLC, SavaSeniorCare Administrative Services, LLC, and SSC  
39  
40 Submaster Holdings, LLC, (collectively, the “Defendants”), for improperly receiving millions of  
41  
42 dollars from Medicare for false or fraudulent claims for rehabilitation services that were not  
43  
44 medically reasonable or necessary (*United States v. SavaSeniorCare, LLC*, 2016). One  
45  
46 allegation against Defendants involved an 85-year-old female patient who was admitted to  
47  
48 Sava’s Northwest facility in Houston, Texas, to receive physical therapy, occupational therapy,  
49  
50 and speech language pathology services. Recorded for this patient’s first day were therapy  
51  
52 evaluation and treatment minutes totaling six hours and ten minutes. During the physical therapy  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 evaluation on that same day, the 85-year old patient was too weary to perform a balance test and  
4 could only endure sitting on the edge of a bed for 15 minutes. Nonetheless, Defendants billed  
5 for 60 minutes of physical therapy. This patient had a history of dementia and her progress  
6 notes stated that she said “no” to “everything.” The therapists continuously dropped or reduced  
7 her therapy goals because they were too difficult for her. Although one progress report stated  
8 that the patient was to be discharged for lack of progress, the patient continued to receive  
9 physical therapy for two additional months. Eventually, the physical therapist stopped seeing her  
10 and the patient’s physical therapy progress reports were written by an assistant. The Defendants  
11 kept the patient on therapy for two months longer than what was reasonable and necessary. As  
12 of the date of this article, the case has not been decided.

#### 23 24 25 26 27 *D. Home Health*

28  
29  
30 To qualify for home healthcare Medicare benefits, a patient must be certified by a physician  
31 that the patient is “home bound,” the patient must be under the care of a physician, and the  
32 physician must certify that the patient needs either physical therapy, occupational therapy,  
33 speech language therapy, or intermittent skilled nursing care. Often healthcare fraud is  
34 committed when no actual home health therapy is provided. The patient is asked to verify that a  
35 nurse or therapist visited the patient at his/her home and services were provided. Another  
36 variation of this fraud occurs when an unscrupulous physician certifies an individual as  
37 homebound and needing services. After the individual is certified, the fraudsters falsify home  
38 visit notes to give the appearance as though nursing services were provided and would continue  
39 to be needed.  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 In August 2018, a federal grand jury indicted three doctors and three healthcare workers with  
4 conspiracy to pay and receive kickbacks for healthcare referrals and the receipt and payment of  
5 kickbacks for healthcare referrals (Department of Justice, 2018b). The indictment alleges that  
6 three doctors, Abdelsalam Mogasbe, Jaime Cortes, and James Nickolopoulos received kickback  
7 payments in exchange for referring Medicare patients to Medics Choice Home Health, Inc. The  
8 indictment also alleges that three employees of Medics Choice Home Health, Inc., conspired  
9 with the doctors to pay, and did pay, kickbacks. Prosecutors allege that Medics Choice Home  
10 Health, Inc., received \$4.2 million from Medicare for the patient care referred by the doctors.  
11 Allegedly, the kickbacks ranged from \$250 to \$700 for each Medicare beneficiary referred to  
12 Medics Choice Home Health, Inc., while other kickbacks were paid as a flat monthly rate of  
13 roughly \$2,000 to \$3,500. Among other charges, all six defendants were charged with one count  
14 of conspiracy to pay and receive remuneration for referral of Medicare benefits, a violation of 18  
15 U.S.C. § 371, conspiracy to commit an offense against or defraud United States.  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33

#### 34 *E. Durable Medical Equipment*

35  
36  
37 Another type of fraud affecting seniors involves durable medical equipment. Durable  
38 medical equipment is equipment such as wheelchairs, walkers, canes, crutches, traction  
39 equipment, kidney machines, hospital beds, ventilators, oxygen, catheters, feeding tube supplies,  
40 monitors, lifts, nebulizers, and bili blankets and bili lights that provide therapeutic benefits to a  
41 patient because of certain medical conditions and/or illnesses. There are variations of medical  
42 equipment fraud. Sometimes, medical equipment manufacturers offer free equipment or offer to  
43 waive copayments or deductibles in exchange for a Medicare number. In other schemes, a  
44 durable medical equipment company may offer the senior a meal or food in exchange for his/her  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 Medicare number. A senior may be persuaded that “custom” diabetic shoes or therapeutic  
4 mattresses are needed. Another fraudulent spin comes about when a vendor offers to provide  
5 free healthcare screenings, lab tests, or other medical services but asks for the individual’s  
6 Medicare number. Other abusive practices include billing for equipment after it has been  
7 returned, billing before equipment is delivered, billing for unnecessary equipment repairs, and  
8 refusing to pick up equipment that is no longer needed and continuing to bill.  
9  
10  
11  
12  
13  
14  
15  
16  
17

18 A type of durable medical equipment fraud involves power wheelchairs. Here, scammers  
19 approach a senior offering a power wheelchair as a free benefit under Medicare or use scare  
20 tactics by telling the senior that Medicare is running out of money so it is best to get the  
21 wheelchair now even if it isn’t needed. In another twist on this scheme, scammers use  
22 professional recruiters, often referred to as “cappers,” to find Medicare patients or to purchase  
23 Medicare numbers from a third party (Mayer, 2015). The capper would either bribe the senior or  
24 tell the senior that the government is giving away free wheelchairs for a limited time to obtain  
25 the senior’s Medicare number. Cappers were paid a finder’s fee up to \$900 per senior, making  
26 this a lucrative business. In this scheme, seniors often feel threaten and pressured to give out  
27 their Medicare numbers or stockpile equipment for later use.  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41

42 In one case, Olufunke Fadojutimi, a registered nurse and former owner of Lutemi Medical  
43 Supply, was found guilty and sentenced to four years in federal prison for a 10-year healthcare  
44 fraud scheme of fraudulent billing to Medicare for durable medical equipment that was not  
45 medically necessary (Department of Justice, 2014). During the trial, 71-year-old Rodolfo  
46 Fernandez testified that Fadojutimi pestered him until he finally accepted her offer of a free  
47 wheelchair. Fadojutimi picked up Mr. Fernandez in a van along with other seniors for an  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 examination and in exchange for her promise of a free wheelchair, Mr. Fernandez was to provide  
4 her with his Medicare ID number. Using this scheme, Fadojutimi filed \$8.3 million in false and  
5 fraudulent claims with almost \$4.3 million being paid by Medicare.  
6  
7  
8  
9

#### 10 11 *F. Opioid Fraud*

12  
13 Opioid abuse is a leading issue that sparks a lot of debate in the United States. One of the  
14 major problems is opioid addiction is underestimated and undiagnosed in the senior community.  
15  
16 “In 2016, ‘one in three people with a Medicare prescription drug plan received an opioid  
17 prescription,’ putting ‘baby boomers and our oldest generation at great risk’” (Brown, 2018). In  
18 the medical field it can be common to misdiagnose opioid abuse as it mimics symptoms of other  
19 health disorders like diabetes, dementia, or depression which are more common for this age  
20 group (Brown, 2018).  
21  
22  
23  
24  
25  
26  
27  
28

29  
30 Opioids are prescribed for pain in an older demographic. “... [c]hronic pain conditions are  
31 more prevalent for individuals 65 years old and older, with 52.8 percent reporting that they’ve  
32 experienced some type of pain within the previous 30 days” (Aging in Place, 2019). Doctors then  
33 write prescriptions for these patients not realizing the risk of addiction can still happen at an  
34 older age. “The number of elderly patients receiving opioid prescriptions increased nine times  
35 between 1996 to 2010 according to *Psychiatric Times*. And, more than one in three (35 percent)  
36 of individuals over the age of 50 report that they have misused this particular category of drug in  
37 the last 30 days, causing the hospitalization rate for misuse to increase five-fold over the last two  
38 decades” (Aging in Place, 2019). This shows that it is not just teens popping pills but seniors  
39 with serious and chronic pain searching for relief.  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51

52  
53 With the number of prescriptions rising, it only makes it more unsafe for those of an older  
54 age. The older you get the more likely you will have “... renal function decline, prohibiting their  
55  
56  
57  
58  
59  
60



1  
2  
3 bodies from effectively clearing them from their systems” (Aging in Place, 2019). This leaves  
4 the drug and its effects in your system for longer periods of time. With that, your body builds up  
5 a tolerance as you then take more drugs to overcome that tolerance each time. This path  
6 ultimately leads to high drug use and sometimes, unfortunately, death by overdose. Opioid use  
7 by seniors also increases their constipation, “... one-half of all hospice patients on opiates (48  
8 percent) struggle with this issue” (Aging in Place, 2019). Opioids also affect respiration as the  
9 “... result is irregular or slower rates of breathing, two concerns that are especially problematic  
10 when seniors individual is sleeping as there is normally reduced sensitivity to carbon dioxide  
11 during this time already” (Aging in Place, 2019). Opioids can also have a negative effect by  
12 doing the opposite of their job called “opioid-induced hyperalgesia.” This is when the pain gets  
13 worse or the feeling of it changes compared to being eliminated by taking the drug (Aging in  
14 Place, 2019).

15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31 Given this epidemic, on October 24, 2018, President Trump signed into law the SUPPORT  
32 for Patients and Communities Act (SUPPORT Act) designed to combat the opioid crisis (H.R. 6,  
33 115<sup>th</sup> Congress, 2018). Time will tell if the implementation and enforcement of these new  
34 initiatives by the federal government will be successful.

## 35 36 37 38 39 40 41 II. Major Federal Civil and Criminal Laws that Relate to Healthcare Fraud

42  
43  
44 To bring more awareness to the legislation related to senior health care fraud, the following  
45 paragraphs discuss the different laws applicable to the prosecution of fraudsters.

### 46 47 48 49 50 A. *Federal False Claims Act*

51 In 1863, the Federal False Claims Act (FCA)<sup>6</sup> was enacted to defend the federal

1  
2  
3 government against dishonest Civil War contractors making fraudulent claims. Today, the law  
4 protects against fraudsters liable for diverting \$100 billion or more annually from federal  
5 healthcare, defense and other programs (Crain et al., 2015). “In addition to ... monetary losses,  
6 fraud also ... erodes public confidence and raises questions about the government’s ability to  
7 manage its own programs” (Phelps, 1999).  
8  
9

10  
11  
12 The current iteration of the FCA holds responsible “[a]ny person who ... knowingly presents  
13 or causes to be presented ... a false or fraudulent claim [to the US government] for payment or  
14 approval.”<sup>7</sup> The law also holds people accountable for making “false record(s) or statement(s) ...  
15 [designed] to conceal, avoid, or decrease an obligation to pay or transmit money or property to  
16 the [United States] government.”<sup>8</sup>  
17  
18

19  
20  
21 Violations of the FCA often involve submission of false information while presenting  
22 requests for payment to the federal government. *U.S. v. Rogan*<sup>9</sup> and *U.S. v. Cabrera-*  
23 *Diaz*<sup>10</sup> exemplify the types of false healthcare claims that violate the FCA. Private citizens, as  
24 opposed to government attorneys, are allowed to challenge FCA violations via a unique trait of  
25 the FCA known as a *qui tam* action.<sup>11</sup>  
26  
27

28  
29  
30 A private citizen who files a civil lawsuit on behalf of himself and the US government against  
31 one alleged to have committed fraud (against the federal government) is known as a *qui tam*  
32 plaintiff or relator, or a whistleblower.<sup>12</sup> The *qui tam* plaintiff pursuing the case is entitled to “not  
33 less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and  
34 shall be paid out of such proceeds” if the government does not pursue the action.<sup>13</sup> Further, the  
35 whistleblower is permitted to collect from the defendant reasonable attorneys’ fees and expenses  
36 from pursuing the lawsuit.<sup>14</sup> If the defendant retaliates against the whistleblower by firing them,  
37 demoting them, suspending them, harassing them, or discriminating against them in any way, the  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 whistleblower shall be entitled “to all relief necessary to make the [plaintiff] whole.”<sup>15</sup> If the  
4 federal government chooses to intervene in the lawsuit that the *qui tam* relator initiated, the  
5 relator is still entitled to “at least 15 percent but not more than 25 percent of the proceeds of the  
6 action or settlement of the claim, depending upon the extent to which the person substantially  
7 contributed to the prosecution of the action.”<sup>16</sup>  
8  
9

10  
11  
12  
13  
14  
15 Qui tam plaintiffs can often receive large sums of money, as the damages and penalty  
16 provisions of the FCA tend to lead to large settlements and judgments (Pacini and Hood, 2007;  
17 Barger, 2005). For instance, in 2013, Johnson and Johnson agreed to remit more than \$2.2 billion  
18 to the federal government to reconcile commercial and civil liability under the FCA regarding  
19 the prescription drugs Risperdal, Invega, and Natrecor (Department of Justice, 2013). Pfizer, Inc.  
20 and its subsidiary, Pharmacia & Upjohn Company, Inc., agreed to pay \$2.3 billion for violating  
21 the Food, Drug, and Cosmetic Act, which constituted one of the largest healthcare fraud  
22 settlements in history. They also agreed to pay \$1 billion under the FCA for illegally promoting  
23 drugs such as Bextra, Geodon, Zyvox, and Lyrica (Department of Justice, 2009). Glaxo Smith  
24 Kline, a global healthcare company, agreed to plead guilty and pay \$3 billion to resolve criminal  
25 and civil liability from illegally promoting certain drugs and failing to report safety violations  
26 (Department of Justice, 2012). Two of the three billion dollars resolved FCA-related civil  
27 liabilities for violations such as off-label promotion and kickbacks related to Paxil, Wellbutrin,  
28 and Avandia (Department of Justice, 2012). The settlement for the off-label promotion resolves  
29 lawsuits that were pending under the *qui tam* provisions of the FCA (Department of Justice,  
30 2012).  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49

50  
51 Two characteristics of the FCA *qui tam* provision make it a success in facilitating regulatory  
52 and external corporate governance. First, the law helps reveal inside information of fraud  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 (Phelps, 1999). Without the help of insiders with first-hand knowledge of a complex financial  
4  
5 crime, these crimes often cannot be detected (Pacini and Hood, 2007). However, it can be  
6  
7 difficult to persuade people to blow the whistle on their employer, co-workers, or partners  
8  
9 (Phelps, 1999). Second, the law provides a way for *qui tam* relators to contribute additional  
10  
11 resources towards a lawsuit, which helps government attorneys and investigators, who are often  
12  
13 working with strained resources (Barger, 2005). This resource supplement is carried out through  
14  
15 working with strained resources (Barger, 2005). This resource supplement is carried out through  
16  
17 the requisite statutory procedures or protocol.  
18

19  
20 When a private citizen sues under the FCA using the *qui tam* provision, he does so on his own  
21  
22 behalf and that of the federal government (Barger, 2005). A copy of the complaint and written  
23  
24 disclosure of the relator's material evidence and information must be filed in camera (in  
25  
26 chambers). Additionally, the DOJ must receive a copy.<sup>17</sup> "The purpose of the written disclosure  
27  
28 requirement is to provide the U.S. with enough information on alleged fraud to be able to make a  
29  
30 well-reasoned decision on whether it should participate in the filed lawsuit or allow the relator to  
31  
32 proceed alone."<sup>18</sup>  
33  
34

35  
36 Despite the fact that FCA lawsuits have grown during the past decades, the federal  
37  
38 government has chosen not to intervene in nearly two-thirds of those lawsuits (Baker, 2011).  
39  
40 Cases in which the government declines to intervene are much less likely to lead to a recovery  
41  
42 (Baker, 2011). Between 1987 and September 30, 2017, FCA recoveries amounted to over \$36  
43  
44 billion (Department of Justice, 2017a). More than \$28 billion of that amount came from cases in  
45  
46 which the U.S. government intervened (Department of Justice, 2017b). A large portion of the  
47  
48 \$36 billion involved healthcare fraud involving providers such as hospitals, nursing homes, and  
49  
50 physicians; pharmaceutical companies; medical device manufacturers, and suppliers (Farringer,  
51  
52 2018).  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 The DOJ was able to recoup more than \$4.7 billion in FCA civil cases in the fiscal year ended  
4  
5 September 30, 2016 (Department of Justice, 2016a). Of the total amount recovered, more than  
6  
7 \$2.5 billion originated from the healthcare industry (Department of Justice, 2016a). The  
8  
9 following fiscal year, the DOJ recovered more than \$3 billion.  
10  
11

### 12 *1. Qui Tam Elements*

13  
14

15 The FCA covers a broad scope of misconduct that is potentially harmful to the federal  
16  
17 treasury.<sup>19</sup> The Fraud Enforcement and Recovery Act (FERA) was enacted in 2009,<sup>20</sup> expanding  
18  
19 liability exposure under the FCA. Before Congress enacted FERA, liability did not attach under  
20  
21 §3729(a)(1) unless the alleged fraudster presented a false claim for payment or approval to an  
22  
23 “employee of the United States government or a member of the Armed Forces of the United  
24  
25 States.”<sup>21</sup> Today, as long as the federal government is providing some or all of the money to pay  
26  
27 the false claim, said claim can be presented to anyone.<sup>22</sup>  
28  
29  
30

31 Legal claims filed under §3729(a) require proof of several elements to establish a violation of  
32  
33 the FCA: (1) a “claim” must be made; (2) the claim must be made “knowingly” or with  
34  
35 “knowledge”; (3) the claim must be “false” or “fraudulent”; (4) the claim must be material  
36  
37 (while not in the statute, many courts require proof of materiality); (5) causation; and (6) the  
38  
39 claim must have resulted in damage to the federal government. We analyze below some of the  
40  
41 most important, and debatable, elements.  
42  
43  
44

#### 45 *a. “Claim”*

46  
47

48 It can be a difficult task to determine whether an actual “claim” has been made; however, it  
49  
50 has become easier due to the amendments enacted by FERA. As amended by FERA, a “claim” is  
51  
52 “any request or demand, whether under a contract or otherwise, for money or property and  
53  
54 whether the United States has title to the money or property.”<sup>23</sup> “Claim” includes any demand for  
55  
56  
57  
58  
59  
60

1  
2  
3 money or property to be utilized on behalf of the federal government or to advance a government  
4 program or interest.<sup>24</sup> In some cases, lawyers and other parties must refer to sources outside the  
5 FCA to determine whether a “claim” has been adequately established.<sup>25</sup>  
6  
7

8  
9  
10 The definition of a “claim” for payment under Medicare is set forth in regulations and  
11 statutes. Subparts of title 42 of the Code of Federal Regulations denote that the federal  
12 government will promise to pay only costs that are “reasonable and necessary.”<sup>26</sup> Therefore,  
13 requesting that the federal government pay for medical tests under Medicare without the  
14 physician supervision required under Part B equates to requesting payment for something that is  
15 not payable under part B (Al-Salihi, 2015). Lack of compliance with the rules of Part B would  
16 potentially fail the “claim” requirement under Part B (Al-Salihi, 2015).  
17  
18  
19  
20  
21  
22  
23  
24  
25

26 The FCA attaches liability to the “claim for payment or approval,” not to the fraudulent  
27 activity itself, nor to the payment made wrongfully by the government.”<sup>27</sup> In establishing that a  
28 false statement is a claim or demand for payment or approval, a court should ascertain whether  
29 the statement lead to a wrongful payment.”<sup>28</sup>  
30  
31  
32  
33  
34

35 A FCA claim is required to assert that the defendant submitted a legally fraudulent or legally  
36 false claim.<sup>29</sup> A claim is considered legally false when a person receives government funds after  
37 certifying that he has complied with a regulation or law, yet knows he has not done so.<sup>30</sup> If a  
38 person requests reimbursement for an improper list of services rendered or goods provided, this  
39 claim would be considered factually false. Further, a *qui tam* relator must be particular in stating  
40 that facts constitute fraud, according to Federal Rule of Civil Procedure (FRCP) 9(b).<sup>31</sup> As most  
41 FCA cases end in settlement (Corporate Crime Reporter, 2008), it is important to determine  
42 whether FRCP 9(b) has been met.  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52

53  
54 *b. Made “Knowingly” or “Know”*  
55  
56  
57  
58  
59  
60

1  
2  
3 Section 3729(b)(1)(A) states that the alleged fraudster satisfies the “knowledge” requirement  
4 if he or she “has actual knowledge ... acts in deliberate ignorance of the truth or falsity ... or acts  
5 in reckless disregard of the truth or falsity of the information” presented. The statute also states  
6 that “no proof of specific intent to defraud” is needed. The requisite intent is the conscious  
7 presentation of false information.<sup>32</sup>

8  
9  
10 Reckless disregard refers to indifference to the false nature of a claim despite cognizance of  
11 said falsity (Al-Salihi, 2015). However, negligence and innocent mistake are not adequate to  
12 demonstrate liability.<sup>33</sup> *U.S. v. Lorenzo*<sup>34</sup> demonstrates how reckless disregard can meet the  
13 knowledge requirement of the FCA.

14  
15 Because Congress and the judiciary do not require proof of intent to defraud, almost anyone  
16 associated with a false or fraudulent claim can be held liable. Therefore, there is a strong  
17 incentive for healthcare providers and others who submit claims for payment to the government  
18 to ensure they present their claims accurately. The knowledge requirement makes it risky to turn  
19 a blind eye to a fraudulent claim (Frieden, 1998). If the *qui tam* defendant knew a representation  
20 was false content, then the knowledge requirement has been adequately addressed (Frieden,  
21 1998). As FCA cases often involve large, multidimensional firms, some courts require that there  
22 not only be a recognition of falsity, but also a conscious presentation of that falsity to the  
23 government.

24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45 *c. “False” or “Fraudulently”*

46  
47 The FCA is not designed to address every kind of fraud perpetrated against the government.<sup>35</sup>  
48 Congress does not define the words “false” or “fraudulent” in the FCA. The U.S. Supreme Court,  
49 in *Universal Health Services, Inc. v. U.S. ex. rel. Escobar*,<sup>36</sup> has found these words to have  
50 meaning based on common law fraud concepts. For instance, a *qui tam* plaintiff does not need to  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 show that a claim is both false and fraudulent—simply one or the other—as the FCA uses the  
4 disjunctive “or” (Helmer and Popham, 2003).  
5  
6

7  
8 Most healthcare FCA cases have been related to direct “‘factually false’ claims requesting  
9 payment for more expensive categories of care than were provided or services that were never  
10 provided” (Krause, 2017). *Qui tam* relators have also taken action against “legally false” claims,  
11 in which services or items were provided but someone had falsely certified compliance with a  
12 statute, regulation, or contractual provision.<sup>37</sup>  
13  
14  
15  
16  
17  
18

19 The federal courts have endorsed two different theories of legal falsity.<sup>38</sup> A party making a  
20 false certification regarding a program condition, such as signing a false certification statement  
21 on a document, constitutes express certification.<sup>39</sup> Some federal courts have also extended legal  
22 falsity to include implied certification.<sup>40</sup> The latter requires that the claim does not merely  
23 request payment but also make specific representations about the goods or services provided and  
24 that the defendant’s failure to disclose noncompliance with material statutory, regulatory, or  
25 contractual requirements makes those representations misleading.<sup>41</sup> The U.S. Supreme Court also  
26 determined that a misrepresentation must be material to the government’s payment decision.<sup>42</sup>  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36

#### 37 38 *d. Materiality* 39

40  
41 Based on a literal reading of the FCA statute, the word “material” modifies the “false record”  
42 offered in support of a false claim, rather than the false claim itself. The false record or statement  
43 supporting the false claim has to function in a material way as a supporting document (Al-Salihi,  
44 2015). Therefore, the requirement of “materiality” pertains only to a section 3729(a)(1)(B) cause  
45 of action, not a section 3729(a)(1)(A) lawsuit or legal claim.  
46  
47  
48  
49  
50  
51

52  
53 Whatever a healthcare provider or contractor is said to be lying about does not have to be  
54 material to lead to liability under section 3729(a)(1)(A) or section 3729(a)(1)(B). A threshold  
55  
56  
57  
58  
59  
60



1  
2  
3 requirement exists that any record used to support the accuracy of a false claim must bolster that  
4 claim (Al-Salihi, 2015). While a trivial false claim can lead to liability under the FCA, some  
5 courts have judicially tacked the term “material” onto a section 3729(a)(1)(A) analysis (or  
6 claim).<sup>43</sup> This approach interprets section 3729(a)(1)(A) as signifying that a healthcare provider  
7 faces FCA liability if he or she “knowingly presents, or causes to be presented, a false or  
8 fraudulent claim for payment or approval” which “material.” In reality, section 3729(a)(1)(A)  
9 does not state this is required.

10  
11  
12 In those cases that apply “materiality” to §3729(a)(1)(A) claims, “materiality” is established  
13 when the false or fraudulent claim has a natural tendency to influence agency action or is able to  
14 influence agency action.<sup>44</sup> Contemporary courts that use a materiality standard for  
15 §3729(a)(1)(A) claims use a case-by-case, fact-intensive analysis to determine whether a  
16 particular condition of payment is material.<sup>45</sup> The insertion of materiality into a §3729(a)(1)(A)  
17 analysis muddies what is actually a clear standard (Al-Salihi, 2015).

18  
19  
20 A person found guilty of fraud under the FCA is liable to the federal government for a civil  
21 penalty of not less than \$5,000 and not more than \$10,000, plus triple the amount of damages  
22 incurred by the government as a result of the fraudulent act.<sup>46</sup>

#### 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

*B. FCA Healthcare Fraud Lawsuits Facilitated by the Affordable Care Act*

Prior to the Patient Protection and Affordable Care Act of 2010 (ACA),<sup>47</sup> as modified by  
the Healthcare Education and Reconciliation Act of 2010,<sup>48</sup> the FCA had a feature called the  
public disclosure bar, which strongly limited private citizens’ ability to file a *qui tam* lawsuit.<sup>49</sup>  
The FCA employed a two-part test to determine whether a federal court could hear a *qui tam*  
case. First, the court had to establish whether the allegations of fraud were based on publicly  
disclosed material. If so, then the court had to assess whether the *qui tam* plaintiff was an

1  
2  
3 original source of the disclosure.<sup>50</sup> The relator had to prove by a preponderance of the evidence  
4  
5 to establish subject matter jurisdiction that the lawsuit was not based upon a prior public  
6  
7 disclosure, or, if it was, that said relator was an original source of the information.<sup>51</sup> The FCA  
8  
9 described three manners in which prior public disclosure could occur: (1) in a civil, criminal, or  
10  
11 administrative hearing;<sup>52</sup> (2) in a Congressional, administrative, or GAO report, audit, or  
12  
13 investigation;<sup>53</sup> or (3) in the media.<sup>54</sup> The courts broadly determined what types of disclosures  
14  
15 were public and thus not open to *qui tam* suits, although some disputes occurred among the  
16  
17 courts (Phelps, 1999).  
18  
19  
20

21  
22 Congress lowered the disclosure bar in the ACA so that only facts that are “substantially the  
23  
24 same” as the facts revealed in the prior proceeding would lead to the bar being imposed.<sup>55</sup> Now,  
25  
26 if the information on which the *qui tam* suit is based has been disclosed in a federal proceeding  
27  
28 in which the government is a participant, then the bar is applied.<sup>56</sup> The public disclosure bar is  
29  
30 not applicable when the *qui tam* plaintiff is an “original source” of the information.<sup>57</sup> Prior to the  
31  
32 ACA, the public disclosure bar stopped many *qui tam* claims that involved public information, as  
33  
34 broadly interpreted. This alteration to the FCA has made it more powerful against healthcare  
35  
36 fraud.  
37  
38

### 39 40 C. Federal Anti-Kickback Statute 41

42  
43 The federal Anti-Kickback statute<sup>58</sup> is a criminal statute that prohibits knowingly and  
44  
45 willfully paying or receiving any compensation, directly or indirectly, in exchange for  
46  
47 prescribing, purchasing, or recommending any service, treatment, or item for which payment will  
48  
49 be received from Medicaid, Medicare, or other federally funded program (Rheiner, 2015). The  
50  
51 anti-kickback statute is broadly worded and establishes liability based not only on kickbacks and  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 bribes, but also on other economic relationships that can be more complex than a simple payment  
4 for services (Pyle III, 2007). The anti-kickback statute is intended to protect the public treasury.  
5  
6

7  
8 The Third Circuit Court of Appeals substantially expanded the scope of the anti-kickback  
9 statute in the 1985 case *U.S. v. Greber*.<sup>59</sup> The court created the “one purpose test,” holding that if  
10 one purpose of a payment was to prompt future referrals, then the anti-kickback statute was  
11 being violated. Although the anti-kickback statute does not offer a private right of action, the  
12 FCA provides a means of bringing *qui tam* actions<sup>60</sup> alleging violations of the anti-kickback law.  
13  
14 To convict a defendant under the anti-kickback statute, the government must prove beyond a  
15 reasonable doubt that the defendant: (1) knowingly and willfully; (2) solicited, received, paid, or  
16 offered to pay remuneration; (3) in return for, or to induce, the referral or generation of program-  
17 related business.<sup>61</sup> The “knowing and willful” element is met by showing that the defendant  
18 knew that his conduct was unlawful and acted voluntarily and purposefully.<sup>62</sup>  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30

31 The broad scope of the one-purpose test may create liability under the anti-kickback  
32 statute for actions that are commonly accepted commercial practices (Kirman and Wyman,  
33 2015). Parties can also be liable under anti-kickback statute even if their practices cause no  
34 perceptible harm to patients.<sup>63</sup> For example, if a hospital compensates a physician for joining its  
35 staff, intending that the doctor will refer Medicare patients to the hospital, it could be in violation  
36 of the one-purpose test.<sup>64</sup>  
37  
38  
39  
40  
41  
42  
43  
44

45 Concerned by the broad scope of potential liability under the statute, Congress enacted  
46 numerous “safe harbors” or statutory exceptions to the anti-kickback statute.<sup>65</sup> The Office of  
47 Inspector General (OIG) has enumerated more than 25 regulatory safe harbor provisions and one  
48 statutory provision<sup>66</sup> that safeguard physicians from liability under the anti-kickback statute.  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 Each behavior that falls within a safe harbor must be assessed on a case-by-case basis to  
4  
5 determine whether it amounts to an anti-kickback violation (Crain et al., 2015).  
6

7  
8 *D. False Statements to Obtain Health Benefits or Payments*  
9

10 Federal statute 42 U.S.C. §1320a-7b(a) makes it illegal to make a false statement or  
11 representation in any application or claim for benefits under a federal healthcare program. Under  
12 this statute, the federal government must prove beyond a reasonable doubt that: (1) the defendant  
13 made, or caused to be made, a statement or representation of material fact in an application for  
14 payment or benefits under a federal healthcare program; (2) the statement or representation was  
15 false; and (3) the defendant knowingly and willfully made the false statement or representation.<sup>67</sup>  
16  
17  
18  
19  
20  
21  
22  
23

24 The first element establishes that a statement or representation of fact must be material to  
25 be actionable.<sup>68</sup> Whether something is material is a question of both law and fact. The  
26 government does not have to prove that the respective federal agency actually relied on the false  
27 statement.<sup>69</sup>  
28  
29  
30  
31  
32

33 The second element of the offense requires that the defendant say or make a false statement  
34 or representation.<sup>70</sup> The false statement or representation must have been presented to the  
35 respective federal agency for payment. Some examples include billing Medicaid for procedures  
36 not actually carried out,<sup>71</sup> submitting claims for patients never examined,<sup>72</sup> submitting claims for  
37 services not personally rendered,<sup>73</sup> and submitting claims for services carried out by another  
38 party.<sup>74</sup>  
39  
40  
41  
42  
43  
44  
45  
46

47 The third element of the offense requires that the alleged fraudster “knowingly and willfully”  
48 make or cause any false representation. “Knowingly” refers to the fact that there must be proof  
49 that the accused had knowledge of the facts of the offense. The “knowing and willful” element is  
50 met if the accused is cognizant that his or her conduct is illegal without any knowledge of the  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 specific statute violated.<sup>75</sup> Further, the alleged fraudster must be aware that the statement is false  
4  
5 at the time it is made or submitted.<sup>76</sup>  
6

#### 7 8 *E. The Stark Law* 9

10  
11 As part of the Omnibus Budget Reconciliation Act, Congress enacted into law Stark I<sup>77</sup> in  
12  
13 1989 in response to the growing cost of healthcare related to physician self-referrals (Grioux et  
14  
15 al., 2018). Stark I disallowed physician referrals under Medicare for clinical lab services when  
16  
17 the referring physician has a financial arrangement with the lab unless the terms of certain  
18  
19 statutory or regulatory exceptions are satisfied.<sup>78</sup> Stark I was expanded into Stark II as part of the  
20  
21 Omnibus Budget and Reconciliation Act of 1993 (Bucy et al., 2002). Stark II applied the Stark I  
22  
23 legislation to Medicaid patients and to “designated health services” (DHS) other than clinical  
24  
25 laboratory services (Bucy et al., 2002).  
26  
27  
28

29  
30 The Stark Law (I and II collectively) and its associated regulations disallow a physician (or  
31  
32 an immediate family member) who has a “financial relationship” with a medical facility from  
33  
34 making a “referral” to that facility for certain DHS for which payment can be made by the  
35  
36 federal government.<sup>79</sup> A medical facility may not submit for payment a Medicare or Medicaid  
37  
38 claim for service provided as a result of a prohibited referral. The federal government may not  
39  
40 make payments pursuant to a forbidden claim and medical facilities must return any payments  
41  
42 that are mistakenly made by the federal government (Bucy et al., 2002).  
43  
44

45  
46 Stark I did not take effect until January 1, 1992 (Bucy et al., 2002). Enforcement of Stark II  
47  
48 began on January 1, 1995 (Bucy et al., 2002). The final regulations of Stark II came into force on  
49  
50 January 4, 2002 (Bucy et al., 2002). Published in September 2007, Phase III regulations were  
51  
52 enhanced in clarity, reducing the regulatory burden on the healthcare industry (Sutton, 2011).  
53  
54 Violation of the complex Stark law could lead to severe penalties (Sutton, 2011).  
55  
56  
57  
58  
59  
60

1  
2  
3 A multistep analysis is important in ascertaining whether a Stark law violation has occurred.  
4  
5 The first step is to determine whether the person or entity in question has made a “referral.” The  
6  
7 latter is “the request by a physician for, or ordering of, or the certifying or recertifying of the  
8  
9 need for” as well as the establishment of a plan of care by a physician involving the provision of  
10  
11 a DHS for which payment may be made under Medicare or Medicaid.<sup>80</sup> While the Stark  
12  
13 regulations do not explicitly include any DHS provided by the referring physician, they do  
14  
15 implicate referrals made within a physician’s group practice.<sup>81</sup>  
16  
17

18  
19 The second step in the analysis is to define the term “physician.” A “physician” means a  
20  
21 doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of  
22  
23 podiatric medicine, a doctor of optometry, or a doctor of chiropractic.<sup>82</sup> Nurse practitioners,  
24  
25 physician’s assistants, and physical therapists are not classified as “physicians.” Another step in  
26  
27 the analysis is specifying DHS. The latter include the following:  
28  
29

- 30  
31 1. Clinical laboratory services.
- 32  
33 2. Physical therapy services.
- 34  
35 3. Occupational therapy services.
- 36  
37 4. Radiology services, including magnetic resonance imaging (MRI), computerized  
38 axial tomography scans, and ultrasound services.
- 39  
40 5. Radiation therapy services and supplies.
- 41  
42 6. Durable medical equipment and supplies.
- 43  
44 7. Parental and enteral nutrients, equipment, and supplies.
- 45  
46 8. Prosthetics, orthotics, and prosthetic devices and supplies.
- 47  
48 9. Home health services
- 49  
50 10. Outpatient prescription drugs.
- 51  
52 11. Inpatient and outpatient hospital services.<sup>83</sup>

53 Under the Stark law, it is important to determine whether a “financial relationship” exists  
54  
55 between a physician (or an immediate family member) and the recipient of the referral. A  
56  
57

1  
2  
3 “financial relationship” can fall into one or more of three categories: (1) an ownership interest;  
4  
5 (2) an investment interest; or (3) a compensation arrangement between the physician (or  
6  
7 immediate family member) and the entity.<sup>84</sup> Stark regulations state that a financial relationship  
8  
9 may be “direct” or “indirect.”<sup>85</sup> A “direct” financial relationship exists “if remuneration passes  
10  
11 between the referring physician (or a member of his immediate family) and the entity furnishing  
12  
13 DHS without any intervening persons or entities ....”<sup>86</sup> An “indirect financial relationship” exists  
14  
15 when three criteria are met. First, an unbroken chain of persons or entities must be present  
16  
17 between the referring physician and the entity rendering DHS.<sup>87</sup> Next, the referring physician  
18  
19 must receive compensation that accounts for the volume or value of referrals or other business  
20  
21 generated by the referring physician for the entity to which the referral is made.<sup>88</sup> Third, the  
22  
23 entity providing DHS must have actual knowledge (or act in reckless disregard or in deliberate  
24  
25 ignorance of) the fact that the referring physician (or immediate family member) receives such  
26  
27 compensation.<sup>89</sup> Some exceptions do apply to the financial relationship prohibition.<sup>90</sup>  
28  
29  
30  
31  
32

33 The last step is to address the meaning of the word “entity” on the receiving end of a referral.  
34  
35 “Entity” refers to “[a] physician’s sole practice or a practice of multiple physicians or any other  
36  
37 person, sole proprietorship, public or private agency or trust, corporation ... that furnishes DHS.  
38  
39 An entity does not include the referring physician ... but does include his or her medical  
40  
41 practice.”<sup>91</sup> This definition of “entity” signifies that physicians or physician group practices that  
42  
43 perform DHS must now meet an exception to the Stark law (Sutton, 2011).  
44  
45  
46

47 When a physician has made a referral for DHS to an entity with which he or she has a  
48  
49 financial relationship, it is important to determine whether an exception to the law applies.  
50  
51 Exceptions fall into three categories: (1) exceptions applicable to both physician  
52  
53  
54  
55  
56  
57  
58  
59  
60

1  
2  
3 ownership/investment interests and compensation arrangements; (2) exceptions for ownership or  
4 investment interests only; and (3) exceptions for compensation arrangements only.<sup>92</sup>  
5  
6

7  
8 The first category of exceptions includes doctors' "services where referrals are between  
9 members of the same group practice, certain ancillary services provided within the same office  
10 of a group practice [(this is the most commonly used exception)], and certain prepaid health  
11 plans."<sup>93</sup> The second category of exceptions includes ownership interests in publicly traded  
12 securities, healthcare facilities in rural areas or Puerto Rico, and hospitals that satisfy certain  
13 requirements.<sup>94</sup> The third category of exceptions covers the rental of office space and equipment,  
14 genuine employment relationships, personal services arrangements, physician recruitment  
15 activities, and payments by doctors for certain items and services.<sup>95</sup>  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

26 Violation of the Stark law can result in severe penalties. Claims filed for services in violation  
27 of self-referrals lead to nonpayment.<sup>96</sup> Further, the money must be returned if one collects it in  
28 violation of the Stark law. Improper claims may lead to civil monetary penalties up to \$15,000  
29 per violation and inability to participate in Medicaid and Medicare programs going forward.<sup>97</sup>  
30  
31 Also, a civil penalty not to exceed \$100,000 applies to cross-referral arrangements when a  
32 physician or entity "knows or should know" that the business relationship ensures referrals by  
33 the physician to the entity.<sup>98</sup>  
34  
35  
36  
37  
38  
39  
40  
41

42 The Bipartisan Budget Act outlined changes to the Stark law in February 2018. While  
43 holdovers in personal services arrangement exceptions and equipment exceptions used to be  
44 limited to six months, they are now indefinite (Sherry et al., 2018).  
45  
46  
47  
48

#### 49 *F. Health Insurance Portability and Accountability Act (HIPAA)*

50

51  
52 In 1996, Congress passed the Health Insurance Portability and Accountability Act  
53  
54  
55  
56  
57  
58  
59  
60



1  
2  
3 (HIPAA),<sup>99</sup> which bolstered the fight against healthcare fraud in numerous ways. First, HIPAA  
4 expanded the Anti-Kickback statute to cover all federal healthcare programs.<sup>100</sup> Next, HIPAA  
5 broadened the definition of a kickback. At one time, there was controversy over whether waiving  
6 a copayment or deductible constituted remuneration to influence patients to use a certain  
7 provider (Eddy, 2000). Section 231 of HIPAA explicitly states that waiving a copayment is  
8 considered a kickback unless it is done for a documented financial need or signifies failure to  
9 collect payment after reasonable efforts.<sup>101</sup> HIPAA expands this concept to all federal healthcare  
10 programs except the Federal Employee Health Benefit Program.<sup>102</sup> Under HIPAA and the Anti-  
11 Kickback statute, remuneration includes the routine or partial waiver of coinsurance and  
12 deductibles and the transfer of items or services gratis or for less than market value.<sup>103</sup> There is a  
13 safe harbor for waivers not habitually offered.

14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

HIPAA also altered the money laundering, asset forfeiture and injunctive relief statutes to apply to “federal healthcare offenses” (Eddy, 2000). It is important to note that HIPAA changed a criminal forfeiture statute by adding a new section containing mandatory forfeiture language stating that a court “shall order the person [convicted of a healthcare offense] to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense” (Eddy, 2000). The utilization of criminal forfeiture indicates a step forward in healthcare fraud cases, but civil forfeiture would allow federal law enforcement authorities to seize the assets or funds of healthcare fraudsters sooner, limiting the opportunity for assets or funds to be moved or dissipated. HIPAA also broadened the fraud injunction statute, giving the federal government authority to bring a civil lawsuit to enjoin the commission of a federal healthcare offense and to freeze the assets of fraudsters disposing or attempting to dispose of assets acquired by fraudulent means.<sup>104</sup>

1  
2  
3 HIPAA is the first federal statute that makes it a federal crime to commit healthcare fraud  
4  
5 against private healthcare plans.<sup>105</sup> HIPAA also established four new healthcare-related felonies  
6  
7 and one misdemeanor (Grioux et al., 2018). The new crimes are: (1) healthcare fraud;<sup>106</sup> (2) theft  
8  
9 or embezzlement in connection with healthcare;<sup>107</sup> (3) false statements relating to healthcare  
10  
11 matters;<sup>108</sup> and (4) obstruction of criminal healthcare investigations.<sup>109</sup> Penalties for these crimes  
12  
13 include a maximum prison term of five to ten years (Eddy, 2000).  
14  
15

### 16 17 **Summary and Conclusions** 18

19  
20  
21 Seniors deserve to be cared for with respect, compassion, and dignity. Yet, they are  
22  
23 oftentimes the target of abuse and fraud related to their medical care. With the projected aging  
24  
25 of the U.S. population, this abuse is expected to become a growing problem. Creating awareness  
26  
27 and finding ways to protect seniors is, therefore, particularly important to reduce the scope of  
28  
29 this abuse.  
30  
31

32  
33 This article highlighted the different types of schemes that scammers use to target seniors  
34  
35 along with sample cases and laws that try to prevent this abuse from occurring in the first place.  
36  
37 Educating patients and their families, the public, as well as law enforcement personnel on how to  
38  
39 recognize, report, and protect against healthcare fraud, providing an easy way to report  
40  
41 fraudulent activities, allocating more funds to fight this problem, preventing the cognitive decline  
42  
43 of dementia patients with a focus on minorities, using vigilance, and establishing improved fraud  
44  
45 detection programs used by insurance programs, are all important methods to combat this fraud.  
46  
47 Of these methods, education might arguably be the most important one with the farthest reaching  
48  
49 impact. Further research into the creation of effective prevention strategies and methods to fight  
50  
51 healthcare fraud against seniors is needed.  
52  
53  
54  
55  
56  
57  
58  
59  
60

---

## Endnotes

<sup>1</sup> This study will be referring to any person of the age of 65 or above as an “elderly”, as most developed world countries have accepted the chronological age of 65 years as the definition of an “elderly” person (World Health Organization, 2019). The Centers of Medicare and Medicaid Services also reference the age of 65 as a defining age for an “elderly” person, as the Medicare insurance program is available to most individuals 65 years of age and older.

<sup>2</sup> The baby boomer population refers here to those born between 1946 and 1964.

<sup>3</sup> For example, Medicare Fraud Strike Forces have been in action since 2007. These Strike Forces are modeled on a cross-agency collaborative approach to investigations and resources, including a partnering of the FBI, the Department of Health and Human Services Office of Inspector General (HHS-OIG), the Centers for Medicare & Medicaid Services (CMS) Center for Program Integrity (CPI), U.S. Attorney’s offices, law enforcement agencies and sometimes the Drug Enforcement Agency and Internal Revenue Service.

<sup>4</sup> In the U.S., fraudulent healthcare related activities resulted in both criminal and civil charges and can lead to both fines and imprisonment, although the specific penalties may vary from state to state.

<sup>5</sup> On its website, <https://www.justice.gov/criminal-fraud/news-and-noteworthy>, the United States Department of Justice lists many of its charges, the number of defendants and the amount of falsely billed healthcare claims. Many of the recent cases involve home healthcare, Medicare, and opioid related cases.

<sup>6</sup> 31 U.S.C. §§3729-3733 (2018).

<sup>7</sup> 31 U.S.C. §3729(a)(1) (2018).

<sup>8</sup> 31 U.S.C. §3729 (a)(2) (2018). Sections (a)(1) and (a)(2) are the most frequently used provisions of the FCA. 3729(a) states in relevant part:

Any 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), (C), (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,

(H) Is liable to the United States Government for a civil penalty ....

<sup>9</sup> 459 F. Supp. 2d 692 (N.D. Ill. Oct. 27, 2005). This case involved alleged falsification of annual reports to Medicare.

<sup>10</sup> 106 F. Supp. 2d 234 (D.P.R. 2000). This case involved alleged false claims submitted to Medicare for anesthesia services.

<sup>11</sup> “Qui tam” is a term derived from the Latin phrase “qui tam pro domino rege quam pro se, ipso in hac parte requites,” which means, “who as well for the king as himself sues in this matter.” *Black’s Law Dictionary* 1262 (7<sup>th</sup> ed. 1999).

<sup>12</sup> “Qui tam” is a term derived from the Latin phrase “qui tam pro domino rege quam pro se, ipso in hac parte requites,” which means, “who as well for the king as himself sues in this matter.” *Black’s Law Dictionary* 1262 (7<sup>th</sup> ed. 1999).

<sup>13</sup> 31 U.S.C. §3730 (d)(2) (2018).

<sup>14</sup> 31 U.S.C. §3730 (d)(2) (2018).

- 1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60
- 
- <sup>15</sup> 31 U.S.C. §3730 (h)(1) (2018).  
<sup>16</sup> 31 U.S.C. §3730 (d) (2018).  
<sup>17</sup> 31 U.S.C. §3730 (b)(2) (2018).  
<sup>18</sup> *U.S. ex. rel. Bagley v. TRW, Inc.*, 212 F.R.D. 554, 555 (C.D. Cal. 2003)(quoting *U.S. ex. rel. Woodward v. Country View Care Center, Inc.*, 797 F. 2d 888, 892 (10<sup>th</sup> Cir. 1986)).  
<sup>19</sup> 31 U.S.C. §3729 (2018).  
<sup>20</sup> Pub. L. No. 111-21, 123 Stat. 1617 (2009)(codified as amended in 18 and 31 U.S.C.).  
<sup>21</sup> 31 U.S.C. §3729(a)(1) (2006).  
<sup>22</sup> 31 U.S.C. §3729(a)(1)(A) (2017).  
<sup>23</sup> 31 U.S.C. §3729(b)(2)(A) (2017).  
<sup>24</sup> 31 U.S.C. §3729(b)(2) (2018).  
<sup>25</sup> 42 C.F.R. §§411.15(4)(k) (2018).  
<sup>26</sup> 42 C.F.R. §§411.15(4)(k); 415.50-70 (2018).  
<sup>27</sup> 31 U.S.C. §3729(a)(1)(A) (2018).  
<sup>28</sup> *U.S. v. Rivera*, 55 F. 3d 703, 709-10 (1<sup>st</sup> Cir. 1995); *U.S. v. Richard Dattner Architects*, 972 F. Supp. 738, 746-7 (S.D.N.Y. 1997).  
<sup>29</sup> *Foglia v. Renal Ventures Mgmt. LLC*, 830 F. Supp. 2d 8, 16 (D.N.J. 2011); *see also U.S. ex. rel. Wilkins v. United Health Grp., Inc.*, 659 F. 3d 295, 305 (3<sup>rd</sup> Cir. 2011).  
<sup>30</sup> *Universal Health Services, Inc. v. U.S. ex. rel. Escobar*, 136 S. Ct. 1989 (2016).  
<sup>31</sup> *U.S. ex. rel. Conner v. Salina Reg'l. Health Ctr., Inc.*, 543 F. 3d 1211, 1217 (10<sup>th</sup> Cir. 2008).  
<sup>32</sup> *U.S. ex. rel. Hagood v. Sonoma County Water Agency*, 929 F. 2d 1416, 1421 (9<sup>th</sup> Cir. 1991).  
<sup>33</sup> *U.S. v. Oakwood Downriver Med. Ctr.*, 687 F. Supp. 302, 305 (E.D. Mich. 1988).  
<sup>34</sup> 768 F. Supp. 1127 (E.D. Pa. 1991). In that case, Dr. Lorenzo and several other dentists performed oral cancer screenings as part of routine dental examinations at nursing homes in Pennsylvania and New Jersey. The cancer screenings, after being billed to Medicaid, were then billed to Medicare as limited consultations. The evidence showed that Lorenzo knew that Medicare rules did not allow procedures during routine screenings to be deemed "limited consultations." The district court found that Lorenzo, at the very least, acted in reckless disregard of the truth or falsity of the claims made.  
<sup>35</sup> *U.S. v. McNinch*, 356 U.S. 595 (1958).  
<sup>36</sup> 136 S. Ct. 1989 (2016).  
<sup>37</sup> *U.S. ex. rel. Conner v. Salina Reg'l. Health Ctr., Inc.*, 543 F. 3d 1211, 1217 (10<sup>th</sup> Cir. 2008).  
<sup>38</sup> *U.S. ex. rel. Conner v. Salina Reg'l. Health Ctr., Inc.*, 543 F. 3d 1211, 1217 (10<sup>th</sup> Cir. 2008).  
<sup>39</sup> *U.S. ex. rel. Conner v. Salina Reg'l. Health Ctr., Inc.*, 543 F. 3d 1211, 1217-1218 (10<sup>th</sup> Cir. 2008).  
<sup>40</sup> *Universal Health Services, Inc. v. U.S. ex. rel. Escobar*, 136 S. Ct. 1989 (2016).  
<sup>41</sup> *Universal Health Services, Inc. v. U.S. ex. rel. Escobar*, 136 S. Ct. 1989, 2001 (2016).  
<sup>42</sup> *Universal Health Services, Inc. v. U.S. ex. rel. Escobar*, 136 S. Ct. 1989, 2002 (2016).  
<sup>43</sup> *U.S. ex. rel. Hutcheson v. Blackstone Med., Inc.*, 647 F. 3d 377, 394 (1<sup>st</sup> Cir. 2011)(analysis of "material" in terms of the claim itself).  
<sup>44</sup> *U.S. v. Norris*, 749 F. 2d 1116 (4<sup>th</sup> Cir. 1984).  
<sup>45</sup> *U.S. v. Sci. Application Int'l. Corp.*, 626 F. 3d 1257, 1269 (D.C. Cir. 2010).  
<sup>46</sup> 31 U.S.C. §3729 (a)(1)(G) (2012).  
<sup>47</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (amending various sections of the U.S. Code including the FCA and the Anti-Kickback statute).  
<sup>48</sup> Healthcare and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).  
<sup>49</sup> *U.S. ex. rel. Springfield Terminal Ry. Co. v. Quinn*, 14 F. 3d 645, 652 (D.C. Cir. 1994).  
<sup>50</sup> *U.S. ex. rel. Springfield Terminal Ry. Co. v. Quinn*, 14 F. 3d 645, 653 (D.C. Cir. 1994).  
<sup>51</sup> *U.S. v. Alcan Elec. & Eng'g, Inc.*, 197 F. 3d 1014, 1018 (9<sup>th</sup> Cir. 1999); *U.S. ex. rel. Biddle v. Bd. of Trustees of the Leland Stanford, Jr. Univ.*, 161 F. 3d 533, 535 (9<sup>th</sup> Cir. 1998).  
<sup>52</sup> "Hearing" encompassed both civil complaints and criminal indictments. *U.S. ex. rel. Siller v. Becton Dickinson & Co.*, 21 F. 3d 1339, 1350 (4<sup>th</sup> Cir. 1994).  
<sup>53</sup> In *U.S. ex. rel. Schwedt v. Planning Research Corp.*, 39 F. Supp. 2d 28,31,32,34 (D.D.C. 1999), an audit report prepared by the Office of Inspector General and reviewed by an outside accounting firm indicated that a government

contractor had submitted flawed products while certifying their completeness. The district court held that a qui tam suit was based upon a public disclosure and was thus barred.

<sup>54</sup> U.S. *ex. rel.* Stinson, Lyons, Gerlin & Bustamante v. Prudential Ins. Co., 944 F. 2d 1149 (3<sup>rd</sup> Cir.

1991)(construing the term “hearing” to incorporate more than just formal proceedings; it includes any information disclosed in connection with criminal, civil, or administrative litigation).

<sup>55</sup> 31 U.S.C. §3730(e)(4)(A) (2018).

<sup>56</sup> 31 U.S.C. §3730(e)(4)(A)(iii) (2018); 31 U.S.C. §3730 (e)(4)(B) (2018).

<sup>57</sup> Pub. L. No. 101-239, §6204, 103 Stat. 2236 (codified, as amended, at 42 U.S.C. §1395nn (2018)).

<sup>58</sup> 42 U.S.C. §§1320a-7b(b) (2017).

<sup>59</sup> 760 F. 2d 68, 71 (3<sup>rd</sup> Cir. 1985).

<sup>60</sup> 31 U.S.C. §3730 (d)(2) (2018).

<sup>61</sup> 42 U.S.C. §1320a-7b(b); U.S. v. Vernon, 723 F. 3d 1234, 1251-52 (11<sup>th</sup> Cir. 2013).

<sup>62</sup> U.S. v. Vernon, 723 F. 3d 1234, 1256 (11<sup>th</sup> Cir. 2013)([T]his court concluded ... the word ‘willfully’ means the act was committed voluntarily and purposely with the specific intent to do something the law forbids, that is, with a bad purpose, either to disobey or disregard the law.”) In 42 U.S.C. §1320a-7b(b) it states “with respect to violations of this section, a person need not have actual knowledge of this section as specific intent to commit a violation of this section.” Also, see *U.S. v. Mathur*, 2012 WL 4742833, at \*15 (D. Nev. Sept. 13, 2012).

<sup>63</sup> U.S. v. Jain, 93 F. 3d 436, 442-43 (8<sup>th</sup> Cir. 1996).

<sup>64</sup> Polk Cnty., Tex. v. Peters, 800 F. Supp. 1451, 1456 (E.D. Tex. 1992).

<sup>65</sup> Safe harbors protect from prosecution-specific practices that would otherwise violate the Anti-Kickback Statute. See, e.g., 42 C.F.R. §1001 (2017).

<sup>66</sup> 42 C.F.R. §1001.952(a)-(y) (2017).

<sup>67</sup> U.S. v. Laughlin, 26 F. 3d 1523 (10<sup>th</sup> Cir. 1994); 42 U.S.C. §1320a-7b (2018).

<sup>68</sup> U.S. v. Njoku, 737 F. 3d 55 (5<sup>th</sup> Cir. 2013). In *Njoku*, a company named Family Healthcare Group, Inc. did business in Houston, Texas. The company was approved as a Medicare provider in 2005. Family Healthcare provided home healthcare to individuals by skilled nurses. Family Healthcare was paid about \$5.2 million for home healthcare services between April 2006 and August 2009. Evidence at trial showed that Family Healthcare billed Medicare for services to beneficiaries who were ineligible for home healthcare, not in need of skilled nursing, or received services that were inadequate and misrepresented in the documented nursing reports. Nursing notes were subject to audit by Medicare. The jury found that the nursing notes were material.

<sup>69</sup> U.S. v. Rowe, 56 F. 2d 747, 749 (2<sup>nd</sup> Cir.1932); *Neder v. U.S.*, 527 U.S. 1 (1999).

<sup>70</sup> U.S. v. Laughlin, 26 F. 3d 1523 (10<sup>th</sup> Cir. 1994).

<sup>71</sup> U.S. v. Boesen, 541 F. 3d 838 (8<sup>th</sup> Cir. 2008). In this case, Dr. Boesen specialized in the medical and surgical treatment of the ears, nose, and throat. Between 2000 and 2002, Boesen’s clinic was regularly billing federal healthcare agencies for nasal endoscopy with debridement, cholesteatoma removal, and otoacoustic emissions tests not actually done.

<sup>72</sup> U.S. v. Larm, 824 F. 2d 780, 782 (9<sup>th</sup> Cir. 1987). In this case, Dr. Peter Larm, an allergist, was convicted of Medicaid fraud for submitting false claims for “office visits” where he neither saw or examined the patients nor personally rendered the services.

<sup>73</sup> In *Larm*, the allergist also submitted claims for administration charges for injections which the patients administered themselves.

<sup>74</sup> U.S. v. Davis, 471 F. 3d 783, 785 (7<sup>th</sup> Cir. 2006). In this case, Davis, a psychologist, billed Medicaid for psychological services provided by employees in his employ who were not qualified to deliver them.

<sup>75</sup> U.S. v. Starks, 157 F. 3d 833, 837-38 (11<sup>th</sup> Cir. 1998).

<sup>76</sup> U.S. v. Njoku, 737 F. 3d 55, 66-67 (5<sup>th</sup> Cir. 2013).

<sup>77</sup> Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, §6204, 103 Stat. 2236 (codified, as amended, at 42 U.S.C. §1395nn (2018)).

<sup>78</sup> 42 U.S.C. §1395nn(h)(6) (2018).

<sup>79</sup> U.S. *ex. rel.* Drakeford v. Tuomey Healthcare Systems, Inc., 675 F. 3d 394, 397-398 (4<sup>th</sup> Cir. 2012); 42 U.S.C. §1395nn(a)(1)(A)(2018).

<sup>80</sup> 42 C.F.R. §411.351 (2018).

<sup>81</sup> 42 C.F.R. §411.351 (2018).

<sup>82</sup> 42 C.F.R. §411.351 (2018).

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

---

<sup>83</sup> 42 U.S.C. §1395nn(h)(6)(2018).

<sup>84</sup> 42 U.S.C. §1395nn(a)(2)(2018).

<sup>85</sup> 42 C.F.R. §411.354(a)(1) & (2)(2018).

<sup>86</sup> 42 C.F.R. §411.354(a)(2)(2018).

<sup>87</sup> 42 C.F.R. §411.354 (b)(5)(i) and (c)(2)(i)(2018).

<sup>88</sup> 42 C.F.R. §411.354 (c)(2)(ii)(2018).

<sup>89</sup> 42 C.F.R. §411.354 (c)(2)(iii)(2018).

<sup>90</sup> Exceptions to the Stark law “financial relationship” element fall into three general categories: 1) all-purpose ownership and compensation arrangements; 2) ownership and investment exceptions; and 3) direct and indirect compensation arrangement exceptions. The latter are the target for critics of the statute’s complexity and focus of the statute itself (Tironi, 2010).

<sup>91</sup> 42 C.F.R. §411.351 (2018).

<sup>92</sup> 42 U.S.C. §§1395nn(b)-(e) (2018).

<sup>93</sup> 42 U.S.C. §§1395nn(b)(1)-(3)(2018).

<sup>94</sup> 42 U.S.C. §§1395nn(c)-(d) (2018).

<sup>95</sup> 42 U.S.C. §§1395nn(e)(1)-(8) (2018).

<sup>96</sup> 42 U.S.C. §1395nn(g)(1) (2010).

<sup>97</sup> 42 U.S.C. §1395nn(g)(3) (2010).

<sup>98</sup> 42 U.S.C. §1395nn(g)(4) (2010).

<sup>99</sup> Pub. L. No. 104-191, 110 Stat. 1936 (1996)(codified as amended at 42 U.S.C. §1320a-7c).

<sup>100</sup> 42 U.S.C. §1320a-b apply to anything “under a federal healthcare program.”

<sup>101</sup> 42 U.S.C. §1320a-7a(i)(6)(Supp. III 1997).

<sup>102</sup> 42 U.S.C. §1320a-7b, (f) (Supp. III 1997). The expressed definition includes “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 (other than the health insurance program under chapter 89 ....” 42 U.S.C. §1320a-7f (2018).

<sup>103</sup> 42 U.S.C. §1320a-7a(i)(6) (2018).

<sup>104</sup> 18 U.S.C. §1345 (2018); 18 U.S.C. §982(a)(7)(2018).

<sup>105</sup> Pub. L. No. 104-191, 241-247, 249, 110 Stat. 1936, 2016-2021 (1997).

<sup>106</sup> 18 U.S.C. §1347 (2018). For conviction, this statute requires the government to prove beyond a reasonable doubt that the defendant 1) knowingly and willfully executed or attempted to execute, a scheme or artifice to 2) defraud a healthcare benefit program or to obtain by false or fraudulent pretenses any money or property under the custody or control of a healthcare benefit program and 3) in connection with the delivery of or payment for healthcare benefits, items, or services. Examples include *U.S. v. Morgan*, 505 F. 3d 332 (5<sup>th</sup> Cir. 2007)(defendant convicted of twelve counts of healthcare fraud to defraud Medicare by signing a Certificate of Medical Necessity (CMN) for motorized wheelchairs for patients that the defendant did not examine and who were not medically eligible for wheelchairs); *U.S. v. Hunt*, 521 F. 3d 636, 645-46 (6<sup>th</sup> Cir. 2008)(conviction for healthcare fraud where the doctor submitted claims to Medicare for tests that had not been determined to be medically necessary since the defendant had not examined the patients); *U.S. v. Gelin*, 712 F. 3d 612 (1<sup>st</sup> Cir. 2013)(two defendants convicted of violating §1347 from making false claims to and obtaining payment from, insurers participating in Massachusetts’ no-fault auto insurance program. Congress did not limit the scope of §1347 to health insurers).

<sup>107</sup> 18 U.S.C. §669 (2018). For a conviction under this section, the government must prove beyond a reasonable doubt that the defendant knowingly and willingly embezzled, stole, intentionally misapplied, or otherwise converted any of the property or assets of a healthcare program. This statute allows federal prosecutions of embezzlements from private health plans. *U.S. v. Lucien*, 347 F. 3d 45, 52 (2<sup>nd</sup> Cir. 2003).

<sup>108</sup> 18 U.S.C. §1035 (2018). To convict a person of making false statements relating to healthcare matters, the government must prove beyond a reasonable doubt that the 1) person knowingly and willingly made false statements or representations 2) in connection with the delivery of or payment for healthcare benefits, items, or services and 3) in a matter involving a healthcare benefit program. *U.S. v. Hunt*, 521 F. 3d 636, 647-48 (6<sup>th</sup> Cir. 2008).

<sup>109</sup> 18 U.S.C. §1518a (2018). A conviction requires that the government prove beyond a reasonable doubt that the defendant willfully prevented, obstructed, misled, delayed or attempted to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a federal healthcare offense to a criminal investigator. *See U.S. v. Franklin-El*, 554 F. 3d 903, 909 (10<sup>th</sup> Cir. 2009).

---

## References

AARP (2017), "Meet the faces of fraud", available at: <https://www.aarp.org/money/scams-fraud/info-2017/elder-fraud-scams-stories.html> (accessed 25 April 2020) [perma link: <https://perma.cc/7YAG-PL4K>].

*Aging in Place* (2019), "How the opioid crisis affects seniors", available at: <https://www.aginginplace.org/how-the-opioid-crisis-affects-the-elderly/> (accessed 13 April 2020).

Al-Salihi, K. (2015), "Keeping it simple: Finding falsity under the false claims act", *Whittier Law Review*, Vol. 36, pp. 431-483.

Baker, D. (2011), "A whole new world of false-claims-act liability: The 2009 amendments and learning where to draw the line", *Catholic University Law Review*, Vol. 61, pp. 201-234.

Barger, J.F., Jr. (2005). "States, statutes, and fraud: An empirical study of emerging state false claims acts", *Tulane Law Review*, Vol. 80, pp. 465-495.

Barger, J.F., Jr. (2016), "Life, death, and Medicare fraud: The corruption of hospice and what the private public partnership under the federal False Claims Act is doing about it", *American Criminal Law Review*, Vol. 52 No.1, January 2016, pp. 6-7.

Barnes, L. and Bennett, D, (2014), "Alzheimer's Disease in African Americans: Risk factors and challenges for the future", *Health Affairs*, Vol. 33 No. 4., pp. 580-586, available at: [https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1353?url\\_ver=Z39.88-2003&rfr\\_id=ori%3Arid%3Acrossref.org&rfr\\_dat=cr\\_pub%3Dpubmed&](https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.1353?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed&) (accessed 21 April 2020).

Brown, J. (2018), "Opioid abuse and elder justice", available at: <https://heinonline.org/HOL/LandingPage?handle=hein.journals/usab66&div=124&id=&page=> (accessed 13 April 2020).

Bucy, P. et al. (2002), *Healthcare fraud: Enforcement and compliance*, 9<sup>th</sup> ed., 4.05[1] and [6].

Burnes, D., Henderson, C. R, Sheppard, C., Zhao, R., Pillemer, K., and Lachs, M. S. (2017), "Prevalence of financial fraud and scams among older adults in the United States: A systematic review and meta-analysis", *American Journal of Public Health*, Vol. 107 No. 8, e13-e21.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

---

*Centers for Medicare and Medicaid Services* (2016), “2015-2025 Projections of National Health Expenditures Data Released”, available at: <https://www.cms.gov/newsroom/press-releases/2015-2025-projections-national-health-expenditures-data-released> (accessed 21 April 2020).

*Corporate Crime Reporter* (2008), “Latham’s Lauer on Defending False Claims Act Cases,” *Corporate Crime Reporter*, Vol 2. No 8. Available at: <https://www.lw.com/mediacoverage/lathams-lauer-on-defending-false-claims-act-cases> (accessed 22 April 2020).

Crain, M., Hopwood, W., Pacini, C., and Young, G. (2015), *The Essentials of Forensic Accounting*. American Institute of Certified Public Accountants, New York, NY.

*Department of Health and Human Services* (2013), “The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program annual report for fiscal year 2012”, available at: <https://oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf> (accessed 22 April 2020).

*Department of Health and Human Services* (2014), “The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program annual report for fiscal year 2013”, available at: <https://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf> (accessed 22 April 2020).

*Department of Health and Human Services* (2015), “Annual report of the Departments of Health and Human Services and Justice Health Care Fraud and Abuse Control Program FY 2014”, available at: <https://oig.hhs.gov/publications/docs/hcfac/FY2014-hcfac.pdf> (accessed 22 April 2020).

*Department of Health and Human Services* (2016), “The Department of Health and Human Services and the Department of Justice Healthcare Fraud and Abuse Control Program annual report for fiscal year 2015”, available at: <https://oig.hhs.gov/publications/docs/hcfac/FY2015-hcfac.pdf> (accessed 22 April 2020).

*Department of Health and Human Services* (2017), “The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program annual report for fiscal year 2016”, available at: <https://oig.hhs.gov/publications/docs/hcfac/FY2016-hcfac.pdf> (accessed 22 April 2020).

*Department of Health and Human Services* (2018), “The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program annual report for fiscal year 2017”, available at: <https://oig.hhs.gov/publications/docs/hcfac/FY2017-hcfac.pdf> (accessed 22 April 2020).

*Department of Health and Human Services* (2019), “The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program annual



1  
2  
3  
4 report for fiscal year 2018”, available at: <https://oig.hhs.gov/publications/docs/hcfac/FY2018-hcfac.pdf> (accessed 22 April 2020).

7  
8 *Department of Justice* (2009), “Justice department announces largest health care fraud settlement in its history”, available at: <https://www.justice.gov/opa/pr/justice-department-announces-largest-health-care-fraud-settlement-its-history> accessed 22 April 2020).

12  
13 *Department of Justice* (2012), “Glaxo smith kline to plead guilty and pay \$3 billion to resolve fraud allegations and failure to report safety data”, available at: <https://www.justice.gov/usao-ma/file/872501/download> (accessed 22 April 2020).

17  
18 *Department of Justice* (2013), “Johnson & Johnson to pay more than \$2.2 billion to resolve criminal and civil investigations”, available at: <https://www.justice.gov/opa/pr/johnson-johnson-pay-more-22-billion-resolve-criminal-and-civil-investigations> (accessed 22 April 2020).

22  
23 *Department of Justice* (2014), “Former owner of Southern California medical supply company found guilty in a 10-year, \$8.3 million Medicare fraud scheme,” available at:  
24 <https://www.fbi.gov/contact-us/field-offices/losangeles/news/press-releases/former-owner-of-southern-california-medical-supply-company-found-guilty-in-a-10-year-8.3-million-medicare-fraud-scheme> (accessed 7 April 2020).

28  
29 *Department of Justice* (2015), “Southern California medical supply company owner sentenced to four years in prison for \$8.3 million Medicare fraud scheme,” available at:  
30 <https://www.justice.gov/opa/pr/southern-california-medical-supply-company-owner-sentenced-four-years-prison-83-million> (accessed 7 April 2020).

34  
35 *Department of Justice* (2016a), “Justice department recovers \$4.7 billion from false claims act cases in fiscal year 2016”, available at: <https://www.justice.gov/opa/pr/justice-department-recovers-over-47-billion-false-claims-act-cases-fiscal-year-2016> (accessed 22 April 2020).

39  
40 *Department of Justice* (2016b), “Fact sheet: The Health Care Fraud and Abuse Control Program protects consumers and taxpayers by combating health care fraud”, available at:  
41 <https://www.justice.gov/opa/pr/fact-sheet-health-care-fraud-and-abuse-control-program-protects-consumers-and-taxpayers> (accessed 22 April 2020).

45  
46 *Department of Justice* (2017a), “Fraud statistics - Health and Human Services”, available at: <https://www.justice.gov/opa/press-release/file/1020116/download> (accessed 22 April 2020).

48  
49 *Department of Justice* (2017b), “Justice department recovers \$3.7 billion from false claim act cases in fiscal year 2017”, available at: <https://www.justice.gov/opa/pr/justice-department-recovers-over-37-billion-false-claims-act-cases-fiscal-year-2017> (accessed 22 April 2020).

52  
53 *Department of Justice* (2018a), “National health care fraud takedown results in charges against 601 individuals responsible for \$2 billion in fraud losses”, available at:

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

---

<https://www.justice.gov/usao-edca/pr/national-health-care-fraud-takedown-results-charges-against-601-individuals-responsible> (accessed 22 April 2020).

*Department of Justice* (2018b), “Bay Area medical professionals indicted for kickback scheme”, available at: <https://www.justice.gov/usao-ndca/pr/bay-area-medical-professionals-indicted-kickback-scheme> (accessed 7 April 2020).

*Department of Justice* (2019), “Justice news: Three individuals, including a former Texas mayor, CEO and owner, found guilty in a \$154 million money laundering and health care fraud scheme”, available at: <https://www.justice.gov/opa/pr/three-individuals-including-former-texas-mayor-ceo-and-owner-found-guilty-154-million-money> (accessed 22 April 2020).

*Department of Justice* (2020a), “Justice Department recovers over \$3 billion from False Claims Act cases in fiscal year 2019”, available at: <https://www.justice.gov/opa/pr/justice-department-recovers-over-3-billion-false-claims-act-cases-fiscal-year-2019> (accessed 12 April 2020).

*Department of Justice* (2020b), “Former VA Podiatry Chief sentenced to 6.5 years in prison for healthcare fraud scheme”, available at: <https://www.justice.gov/usao-edca/pr/former-va-podiatry-chief-sentenced-65-years-prison-health-care-fraud-scheme> (accessed 12 April 2020).

Eddy, A.C. (2000), “The effect of the health insurance portability and accountability act of 1996 (HIPAA) on healthcare fraud in Montana”, *Montana Law Review*, Vol. 61, pp. 175-222.

Farringer, D. (2018), “From guns that do not shoot to foreign staplers: Has the supreme court’s materiality standard under *Escobar* provided clarity for the healthcare industry about fraud under the false claims act?” *Brooklyn Law Review*, Vol. 83, pp. 1227-1277.

*Federal Bureau of Investigation* (2012), “Federal crimes report 2010 -2011: Financial crimes report to the public”, available at: <https://www.fbi.gov/stats-services/publications/financial-crimes-report-2010-2011> (accessed 22 April 2020).

*Federal Bureau of Investigation* (2016), “What we investigate: Health care fraud”, available at: [https://www.fbi.gov/about-us/investigate/white\\_collar/health-care-fraud](https://www.fbi.gov/about-us/investigate/white_collar/health-care-fraud) (accessed 22 April 2020).

*Federal Bureau of Investigation* (2018), “Elder fraud: Law enforcement action aimed at those who victimize senior citizens”, available at: <https://www.fbi.gov/news/stories/elder-fraud-charges-announced> (accessed 22 April 2020).

Feit, N. (2018), “He lied about being a veteran and defrauded VA, but SC man gets short prison sentence”, *The State*, available at: <https://www.thestate.com/news/local/crime/article221999540.html> (accessed 12 April 2020).

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

---

Frieden, C. (1998), "Protecting the government's interests: Qui tam actions under the false claims act and the government's right to veto settlement of these actions", *Emory Law Journal*, Vol. 47, pp. 1041-1078.

Gaugler, J., James, B., Johnson, T., Marin, A., and Weuve, J. (2019), "2019 Alzheimer's Disease facts and figures", *Alzheimer's & Dementia*, Vol. 15 No. 3, pp. 321-387, available at: <https://www.alz.org/media/documents/alzheimers-facts-and-figures-2019-r.pdf> (accessed 21 April 2020).

Grioux, W., Maul, J., Delaplaine, A., Hane, F., Josephy, D., Pfeiffer, N. and Safirstein, P. (2018), "Healthcare fraud", *American Criminal Law Review*, Vol. 55, pp. 1333-1398.

Hebert, L.E., Weuve J., Scherr, P.A., and Evans, D.A. (2013), "Alzheimer disease in the United States (2010-2050) estimated using the 2010 census", *Neurology*, Vol. 80 No. 19, pp. 1778-1783, available at: <https://www.ncbi.nlm.nih.gov/pubmed/23390181> (accessed 22 April 2020).

Helmer, J.B. and J. Popham. (2003), "Materiality and the false claims act", *University of Cincinnati Law Review*, Vol. 71, pp. 839-861.

H.R. 6, 115th Congress, (2018), *SUPPORT for Patients and Communities Act*, H.R. 6, 115th Cong., 2018. Available at: <https://www.congress.gov/bill/115th-congress/house-bill/6> (accessed 22 April 2020).

Kirman, D. and Wyman, A. (2015), "Anti-kickback statute enforcement trends," *Health Lawyer*, Vol. 28, pp. 43-51.

Krause, J. (2017), "Reflections on certification, interpretation, and the quest for fraud that 'counts' under the false claims act", *University of Illinois Law Review*, 2017, pp. 1811-1845.

Lynch, M. (2018), "New Alzheimer's Association report reveals sharp increases in Alzheimer's prevalence, deaths, cost of Care", available at: [https://www.alz.org/news/2018/new\\_alzheimer\\_s\\_association\\_report\\_reveals\\_sharp\\_i](https://www.alz.org/news/2018/new_alzheimer_s_association_report_reveals_sharp_i) (accessed 21 April 2020).

Mayer, S. (2015), "Those scamming little rascals: Power wheelchair fraud and the flaw in the Medicare system", *DePaul Journal of Health Care Law*, Vol. 17, available at: <https://via.library.depaul.edu/jhcl/vol17/iss2/4> (accessed 22 April 2020).

Monk, J. (2016), "Biggest VA fraud: Blythewood man who faked illness gets prison", *The State*, available at: <https://www.thestate.com/news/local/article74306972.html> (accessed 7 April 2020).

*National Healthcare Anti-Fraud Association* (n.d.). "Consumer Info & Action: How big is the problem?" available at: <https://www.nhcaa.org/resources/health-care-anti-fraud-resources/consumer-info-action.aspx> (accessed 22 April 2020).

Pacini, C. and Hood, B. (2007), “The role of qui tam actions under the false claims act in preventing and deterring fraud against government”, *University of Miami Business Law Review*, Vol. XV, pp. 273-301.

Payne, K.P. (2006), “Problems controlling fraud and abuse in the home healthcare field”, *Journal of Financial Crime*, Vol. 13 No. 1, pp. 77-91.

*Peter G. Peterson Foundation* (2019), “Key drivers of the debt”, available at: <https://www.pgpf.org/the-fiscal-and-economic-challenge/drivers> (accessed 22 April 2022).

Phelps, J. M. (1999), “The false claims act’s public disclosure bar: Defining the law between parasitic and beneficial”, *Catholic University Law Review*, Vol. 49, pp. 247-278.

Pyle III, F.T. (2007), “The federal anti-kickback statute has no preemptive power, or does it? Florida’s supreme court holds Florida’s Medicaid anti-kickback statute unconstitutional,” *Penn State Law Review*, Vol. 112, pp. 631-658.

Rheiner, D. (2015), “Kickbacks and contradictions: The anti-kickback statute and electronic health records”, *Vanderbilt Journal of Entertainment & Technology Law*, Vol. 17, pp. 493-516.

Sherry, K., Morady, A., Compton, L. (2018), “2018 changes to the federal physician self-referral law” available at: <https://www.nelsonhardiman.com/2018-changes-federal-physician-self-referral-law-stark-law/> (accessed 22 April 2020).

Sutton, P. (2011), “The Stark law in retrospect”, *Annals of Health Law*, Vol. 20, pp. 15-48.

Tironi, P. (2010), “The ‘stark’ reality: Is the federal physician self-referral law bad for the healthcare industry?” *Annals of Health Law*, Vol. 19, pp. 235-240.

*United States Department of Veterans Affairs* (n.d.a), “About VA: History – VA history”, available at: [https://www.va.gov/about\\_va/vahistory.asp](https://www.va.gov/about_va/vahistory.asp) (accessed 7 April 2020).

*United States Department of Veterans Affairs* (n.d.b), “About VBA”, available at: <https://www.benefits.va.gov/BENEFITS/about.asp> (accessed 7 April 2020).

*United States Department of Veterans Affairs* (n.d.c), “About VHA”, available at: <https://www.va.gov/health/aboutvha.asp> (accessed 7 April 2020).

*United States v. SavaSeniorCare, LLC* [2016] 2016 WL 5395949 No. 3:11-00821 (Middle District of Tennessee).

*UsAgainstAlzheimer’s* (n.d.), “Latinos and Alzheimer’s Disease”, available at: <https://www.usagainstalzhimers.org/networks/latinos> (accessed 22 April 2020).

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31  
32  
33  
34  
35  
36  
37  
38  
39  
40  
41  
42  
43  
44  
45  
46  
47  
48  
49  
50  
51  
52  
53  
54  
55  
56  
57  
58  
59  
60

---

*World Health Organization* (2019), “Health statistics and information systems, Proposed working definition of an older person in Africa for the MDS Project”, available at: <https://www.who.int/healthinfo/survey/ageingdefnolder/en/> (accessed 11 November 2019).

Journal of Financial Crime