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Senior Healthcare Fraud under Investigation

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Senior Healthcare Fraud under Investigation

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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.

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Originality/value – This study highlights how healthcare fraud is committed against seniors. With the projected trend of an aging U.S. population, educating stakeholders, increasing awareness, and applying tools to protect seniors will be important to reduce the absolute scope of this problem in the future.

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

Paper Type: General Review

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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 COIVD-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.

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

The types of healthcare fraud that specifically target seniors and which are analyzed here include those that take place in the U.S. Department of Veterans Affairs, in hospice, nursing homes, and home healthcare facilities, as well as those that involve opioids and the use of durable medical equipment. The culprits may be doctors, hospitals, pharmaceutical companies, facilities offering physical therapy, urgent care centers, assisted living facilities, nursing homes, and even patients themselves, just to name a few. In order to gain a benefit, fraudsters often make false statements, misrepresent information or deliberately omit information that is critical to the determination of benefits payable, or prescribe unnecessary procedures, medical devices, tests, or drugs.

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

The purpose of this paper is to increase awareness of this threat to help stakeholders better understand, recognize, and prevent this type of fraud. This study proceeds as follows.

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First, it analyzes the scope and statistics of this fraud, as well as some of the law enforcement efforts to combat it. The study then explains the different types of healthcare fraud targeting seniors along with related recent healthcare fraud cases. Next, an analysis of the laws and policies applicable to healthcare fraud are presented. Finally, the study ends with a summary and conclusion that highlights the importance of effectively combatting this type of fraud.

Healthcare Fraud Scope and Statistics

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

Of all the fraud schemes, the ones targeting seniors are particularly concerning and common.[1] For example, financial fraud against seniors is highly prevalent, with an estimated 1 out of 8 cognitively intact older adults being affected every year in the United Sates (Burnes *et al.*, 2017). The AARP reports that fraudsters have stolen billions of dollars from older Americans and programs that benefit Americans over the age of 50 (AARP, 2017).

Fraud against seniors is a serious and growing threat, as more and more of the baby boomer population is moving into retirement age (Federal Bureau of Investigation, 2018). [2] Not only is the senior population estimated to increase over time, but people live longer as well,

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

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

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

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2018). These large sums needed to care for cognitively impaired patients will likely attract fraudsters.

Government Efforts to Combat Healthcare Fraud Costs

Due to an increase in healthcare costs and fraud, the U.S. federal government and federal and state law enforcement agencies have made efforts to prosecute healthcare fraud.[3] While the FBI is the primary investigative agency in the fight against healthcare fraud, it coordinates its efforts with the Health and Human Services Office of Inspector General (HHS-OIG), the Food and Drug Administration (FDA), Drug Enforcement Administration (DEA), the IRS Criminal Investigation Division, and various state and local agencies (Federal Bureau of Investigation, 2012). The efforts by the federal government to investigate and prosecute healthcare fraud in the past have resulted in some successes and have led to substantial recoveries and financial settlements, as well as the incarcerations of fraudsters.[4]

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

However, despite a more focused and integrative effort by multiple government entities, the threat of healthcare fraud against seniors remains high. This is evidenced by record-setting dollar amounts in recent healthcare fraud scheme takedowns involving hospice and home health

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companies as well as doctors prescribing opioids and other dangerous narcotics (Department of Justice, 2018a & 2019).[5]

Surprisingly, despite the successful takedown of many fraudsters in healthcare fraud cases, funding for the prosecution of healthcare fraud has decreased steadily since 2012. The Department of Justice, the FBI, and the HHS-OIG together received $145.6 million less in resources between 2013 and 2018 due to the sequestration of mandatory funding to fight fraud and abuses against Medicare, Medicaid, and other healthcare programs. (Department of Health and Human Services, 2013 - 2019).

This has resulted in a decrease of successful outcomes of healthcare fraud prosecutions. The Department of Health and Human Service (DHHS) and the Department of Justice (DOJ) report their successes with fighting healthcare fraud through their Healthcare Fraud and Abuse Control Program annual reports. For example, these reports show that in 2015, the U.S. Department of Justice and the Department of Health and Human Services recovered $6.10 for every dollar spent on fighting healthcare fraud (Department of Justice, 2016b); however, this amount decreased to $4.2 on average for the years 2015-2017 (Department of Health and Human Services, 2018, p. 8).

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

Chart 1:

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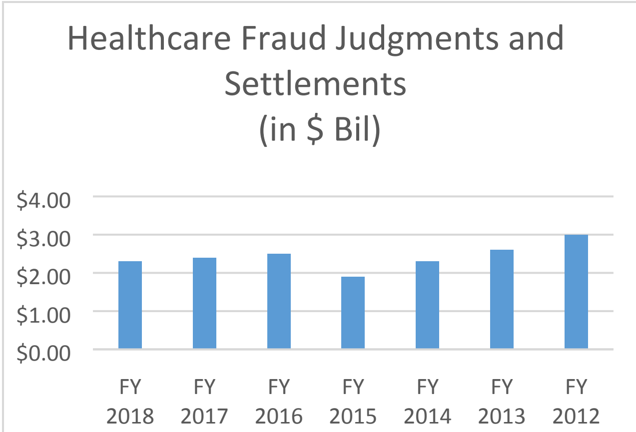
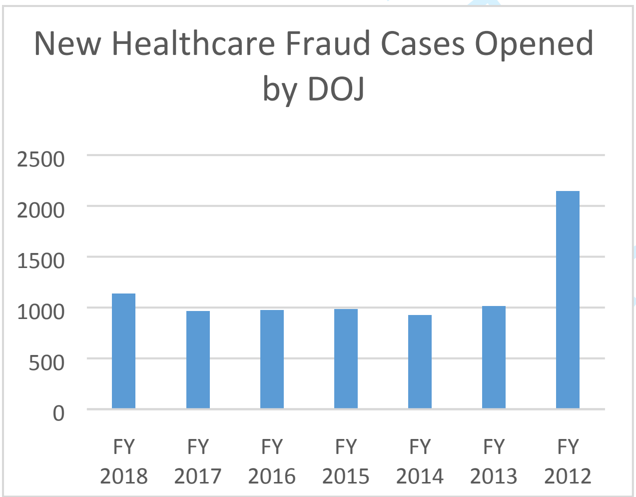


Total dollar amount of healthcare fraud judgments and settlements won or negotiated by the Federal Government; Source: U.S. Department of Health and Human Services Office of Inspector General

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:

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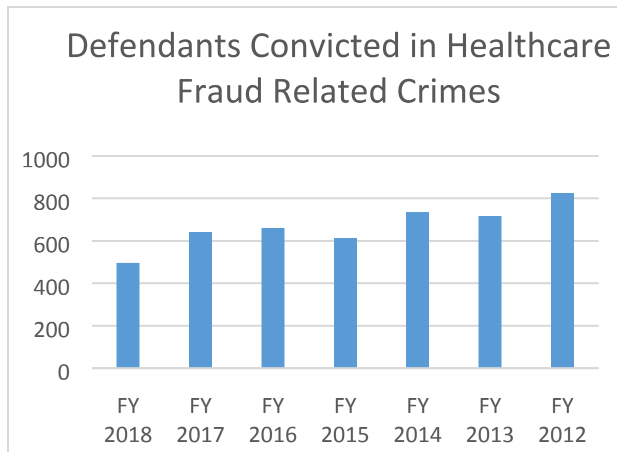
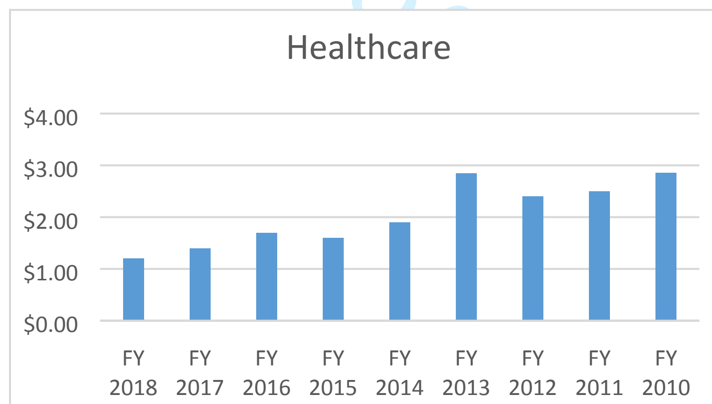


The number of defendants that were convicted in healthcare fraud-related crimes; Source: U.S. Department of Health and Human Services Office of Inspector General

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.

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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.

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

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

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

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

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

In 2014, a concerned citizen reported Paulsen to the VA and explained how Paulsen lacked the impairments that he claimed. Upon learning that the VA was looking into his actual impairment from MS, Paulsen immediately quit his baseball league and began appearing at the VA again in his wheelchair, claiming to be unable to walk or use his hands. The extensive investigation by the VA included undercover agents, surveillance, and photographs and video footage from banks, stores, and the Columbia Metropolitan Airport. Family photographs kept by Paulsen's ex-wife were also obtained showing Paulsen's many activities with his family, playing baseball, and participating in a Marine Mud Run. Paulsen testified in a wheelchair for four hours and called three doctors as expert witnesses in an attempt to support his claim that he was and

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had been totally disabled. The guilty verdict reflects that the jury did not find this testimony credible.

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

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

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

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

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

B. Hospice

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

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patients, their families, and a team of caregivers, social workers, and clergy, rather than the opinions of specialists or the convenience of nurses or the rules of hospitals, government health programs, or insurance companies. The name "hospice" came from the Latin "hospes," for "both guest and host" and in honor of the hospices that sheltered members of the early Christian church and pilgrims of the Middle Ages.

There has been a great deal of healthcare fraud related to the hospice movement, especially against seniors. Many major national hospice providers have been accused of healthcare fraud mainly related to false claims for payment under the Medicare Hospice benefit. In one of the largest cases of Hospice healthcare fraud, on October 17, 2013, after being convened for exactly one month and one day, a federal jury in the United States District Court for the Eastern District of Pennsylvania returned a guilty verdict on all thirty-five counts against Matthew Kolodesh, owner and operator of Home Care Hospice of Philadelphia, PA, for crimes including healthcare fraud, mail fraud, money laundering, aiding and abetting, and conspiracy (Barger, 2016). Kolodesh and his co-conspirators were indicted for billing Medicare $12.8 million for end-of-life care for patients who were not at the end of their lives and another $1.5 million for patients who were dying, but for whom Kolodesh and his co-conspirators did not provide the in-home, around-the-clock-care they promised. It is likely that many of the patients in this latter category died alone and without care, an experience the pioneers of the hospice movement wanted ended and that the federal government sought to guard against when adopting the Medicare Hospice Benefit.

According to the indictment, Kolodesh and his co-conspirators falsified schedules to make it look as though the patients were being continuously visited by hospice caregivers when, in fact,

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they were all alone. Sometimes, when the phony schedules claimed they were being attended to, the patients were already dead. Medicare paid Kolodesh and his company approximately $800 per day. Before the case ended, the Department of Justice revised its Medicare losses to estimate that Kolodesh and his co-conspirators stole some $16.2 million from the system.

Federal prosecutors stated that Kolodesh used the hospice and the money it collected from Medicare as his "private piggy bank." In their sentencing memorandum, Ercole and Vierbuchen stated that Kolodesh and his co-conspirators, including registered nurse and hospice director Alex Pugman, "orchestrated a series of fraudulent schemes that enriched [his and his co-conspirators'] bank accounts and lifestyles by millions of dollars." "Simply put, they used [Home Care Hospice] as the vehicle to scam ... the Medicare program of $16.2 million in false claims." According to the prosecutors, Kolodesh's greed not only abused the Medicare payment system, but perhaps more harmfully perverted the medical system itself, corrupting the benevolent purpose of hospice and denying the altruism behind the practice of medicine. The breach of ethics and trust by Koldesh and his co-conspirators was even more egregious, as the care of the patients was a matter of life and death. "A culture of fraud permeated [Home Care Hospice]," the prosecutors said in their sentencing memo. "It infected the field clinicians, RNs and LPNs, who provided care for patients, as well as home health aides. Kolodesh and Pugman, motivated by greed, were responsible for creating this monster." On May 28, 2014, United States District Judge Eduardo C. Robreno of the Eastern District of Pennsylvania sentenced Kolodesh to serve 176 months in a federal penitentiary for his crimes.

While Kolodesh's scheme of deceiving dying patients and their families for profit at the taxpayers' expense may be considered horrendous, unfortunately, it is not unique. Beginning in

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

C. Nursing Homes

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

The federal government brought a False Claims Act lawsuit accusing SavaSeniorCare, LLC, SavaSeniorCare Consulting, LLC, SavaSeniorCare Administrative Services, LLC, and SSC Submaster Holdings, LLC, (collectively, the "Defendants"), for improperly receiving millions of dollars from Medicare for false or fraudulent claims for rehabilitation services that were not medically reasonably or necessary (*United States v. SavaSeniorCare, LLC,* 2016). One allegation against Defendants involved an 85-year-old female patient who was admitted to Sava's Northwest facility in Houston, Texas, to receive physical therapy, occupational therapy, and speech language pathology services. Recorded for this patient's first day were therapy evaluation and treatment minutes totaling six hours and ten minutes. During the physical therapy

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

D. Home Health

To qualify for home healthcare Medicare benefits, a patient must be certified by a physician that the patient is "home bound," the patient must be under the care of a physician, and the physician must certify that the patient needs either physical therapy, occupational therapy, speech language therapy, or intermittent skilled nursing care. Often healthcare fraud is committed when no actual home health therapy is provided. The patient is asked to verify that a nurse or therapist visited the patient at his/her home and services were provided. Another variation of this fraud occurs when an unscrupulous physician certifies an individual as homebound and needing services. After the individual is certified, the fraudsters falsify home visit notes to give the appearance as though nursing services were provided and would continue to be needed.

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In August 2018, a federal grand jury indicted three doctors and three healthcare workers with conspiracy to pay and receive kickbacks for healthcare referrals and the receipt and payment of kickbacks for healthcare referrals (Department of Justice, 2018b). The indictment alleges that three doctors, Abdelsalam Mogasbe, Jaime Cortes, and James Nickolopous received kickback payments in exchange for referring Medicare patients to Medics Choice Home Health, Inc. The indictment also alleges that three employees of Medics Choice Home Health, Inc., conspired with the doctors to pay, and did pay, kickbacks. Prosecutors allege that Medics Choice Home Health, Inc., received $4.2 million from Medicare for the patient care referred by the doctors. Allegedly, the kickbacks ranged from $250 to $700 for each Medicare beneficiary referred to Medics Choice Home Health, Inc., while other kickbacks were paid as a flat monthly rate of roughly $2,000 to $3,500. Among other charges, all six defendants were charged with one count of conspiracy to pay and receive remuneration for referral of Medicare benefits, a violation of 18 U.S.C. § 371, conspiracy to commit an offense against or defraud United States.

E. Durable Medical Equipment

Another type of fraud affecting seniors involves durable medical equipment. Durable medical equipment is equipment such as wheelchairs, walkers, canes, crutches, traction equipment, kidney machines, hospital beds, ventilators, oxygen, catheters, feeding tube supplies, monitors, lifts, nebulizers, and bili blankets and bili lights that provide therapeutic benefits to a patient because of certain medical conditions and/or illnesses. There are variations of medical equipment fraud. Sometimes, medical equipment manufacturers offer free equipment or offer to waive copayments or deductibles in exchange for a Medicare number. In other schemes, a durable medical equipment company may offer the senior a meal or food in exchange for his/her

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Medicare number. A senior may be persuaded that "custom" diabetic shoes or therapeutic mattresses are needed. Another fraudulent spin comes about when a vendor offers to provide free healthcare screenings, lab tests, or other medical services but asks for the individual's Medicare number. Other abusive practices include billing for equipment after it has been returned, billing before equipment is delivered, billing for unnecessary equipment repairs, and refusing to pick up equipment that is no longer needed and continuing to bill.

A type of durable medical equipment fraud involves power wheelchairs. Here, scammers approach a senior offering a power wheelchair as a free benefit under Medicare or use scare tactics by telling the senior that Medicare is running out of money so it is best to get the wheelchair now even if it isn't needed. In another twist on this scheme, scammers use professional recruiters, often referred to as "cappers," to find Medicare patients or to purchase Medicare numbers from a third party (Mayer, 2015). The capper would either bribe the senior or tell the senior that the government is giving away free wheelchairs for a limited time to obtain the senior's Medicare number. Cappers were paid a finder's fee up to $900 per senior, making this a lucrative business. In this scheme, seniors often feel threaten and pressured to give out their Medicare numbers or stockpile equipment for later use.

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

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examination and in exchange for her promise of a free wheelchair, Mr. Fernandez was to provide her with his Medicare ID number. Using this scheme, Fadojutimi filed $8.3 million in false and fraudulent claims with almost $4.3 million being paid by Medicare.

F. Opioid Fraud

Opioid abuse is a leading issue that sparks a lot of debate in the United States. One of the major problems is opioid addiction is underestimated and undiagnosed in the senior community. "In 2016, 'one in three people with a Medicare prescription drug plan received an opioid prescription,' putting 'baby boomers and our oldest generation at great risk'" (Brown, 2018). In the medical field it can be common to misdiagnose opioid abuse as it mimics symptoms of other health disorders like diabetes, dementia, or depression which are more common for this age group (Brown, 2018).

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

With the number of prescriptions rising, it only makes it more unsafe for those of an older age. The older you get the more likely you will have "... renal function decline, prohibiting their

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

Given this epidemic, on October 24, 2018, President Trump signed into law the SUPPORT for Patients and Communities Act (SUPPORT Act) designed to combat the opioid crisis (H.R. 6, 115th Congress, 2018). Time will tell if the implementation and enforcement of these new initiatives by the federal government will be successful.

II. Major Federal Civil and Criminal Laws that Relate to Healthcare Fraud

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

A. Federal False Claims Act

In 1863, the Federal False Claims Act (FCA)[6] was enacted to defend the federal

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government against dishonest Civil War contractors making fraudulent claims. Today, the law protects against fraudsters liable for diverting $100 billion or more annually from federal healthcare, defense and other programs (Crain et al., 2015). "In addition to … monetary losses, fraud also … erodes public confidence and raises questions about the government's ability to manage its own programs" (Phelps, 1999).

The current iteration of the FCA holds responsible "[a]ny person who … knowingly presents or causes to be presented … a false or fraudulent claim [to the US government] for payment or approval."[7] The law also holds people accountable for making "false record(s) or statement(s) … [designed] to conceal, avoid, or decrease an obligation to pay or transmit money or property to the [United States] government."[8]

Violations of the FCA often involve submission of false information while presenting requests for payment to the federal government. *U.S. v. Rogan*[9]and *U.S. v. Cabrera-Diaz*[10]exemplify the types of false healthcare claims that violate the FCA. Private citizens, as opposed to government attorneys, are allowed to challenge FCA violations via a unique trait of the FCA known as a *qui tam* action.[11]

A private citizen who files a civil lawsuit on behalf of himself and the US government against one alleged to have committed fraud (against the federal government) is known as a *qui tam* plaintiff or relator, or a whistleblower.[12] The *qui tam* plaintiff pursuing the case is entitled to "not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds" if the government does not pursue the action.[13] Further, the whistleblower is permitted to collect from the defendant reasonable attorneys' fees and expenses from pursuing the lawsuit.[14] If the defendant retaliates against the whistleblower by firing them, demoting them, suspending them, harassing them, or discriminating against them in any way, the

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whistleblower shall be entitled "to all relief necessary to make the [plaintiff] whole."[15] If the federal government chooses to intervene in the lawsuit that the *qui tam* relator initiated, the relator is still entitled to "at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim, depending upon the extent to which the person substantially contributed to the prosecution of the action."[16]

Qui tam plaintiffs can often receive large sums of money, as the damages and penalty provisions of the FCA tend to lead to large settlements and judgments (Pacini and Hood, 2007; Barger, 2005). For instance, in 2013, Johnson and Johnson agreed to remit more than $2.2 billion to the federal government to reconcile commercial and civil liability under the FCA regarding the prescription drugs Risperdal, Invega, and Natrecor (Department of Justice, 2013). Pfizer, Inc. and its subsidiary, Pharmacia & Upjohn Company, Inc., agreed to pay $2.3 billion for violating the Food, Drug, and Cosmetic Act, which constituted one of the largest healthcare fraud settlements in history. They also agreed to pay $1 billion under the FCA for illegally promoting drugs such as Bextra, Geodon, Zyvox, and Lyrica (Department of Justice, 2009). Glaxo Smith Kline, a global healthcare company, agreed to plead guilty and pay $3 billion to resolve criminal and civil liability from illegally promoting certain drugs and failing to report safety violations (Department of Justice, 2012). Two of the three billion dollars resolved FCA-related civil liabilities for violations such as off-label promotion and kickbacks related to Paxil, Wellbutrin, and Avandia (Department of Justice, 2012). The settlement for the off-label promotion resolves lawsuits that were pending under the *qui tam* provisions of the FCA (Department of Justice, 2012).

Two characteristics of the FCA *qui tam* provision make it a success in facilitating regulatory and external corporate governance. First, the law helps reveal inside information of fraud

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

When a private citizen sues under the FCA using the *qui tam* provision, he does so on his own behalf and that of the federal government (Barger, 2005). A copy of the complaint and written disclosure of the relator's material evidence and information must be filed in camera (in chambers). Additionally, the DOJ must receive a copy.[17] "The purpose of the written disclosure requirement is to provide the U.S. with enough information on alleged fraud to be able to make a well-reasoned decision on whether it should participate in the filed lawsuit or allow the relator to proceed alone."[18]

Despite the fact that FCA lawsuits have grown during the past decades, the federal government has chosen not to intervene in nearly two-thirds of those lawsuits (Baker, 2011). Cases in which the government declines to intervene are much less likely to lead to a recovery (Baker, 2011). Between 1987 and September 30, 2017, FCA recoveries amounted to over $36 billion (Department of Justice, 2017a). More than $28 billion of that amount came from cases in which the U.S. government intervened (Department of Justice, 2017b). A large portion of the $36 billion involved healthcare fraud involving providers such as hospitals, nursing homes, and physicians; pharmaceutical companies; medical device manufacturers, and suppliers (Farringer, 2018).

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The DOJ was able to recoup more than $4.7 billion in FCA civil cases in the fiscal year ended September 30, 2016 (Department of Justice, 2016a). Of the total amount recovered, more than $2.5 billion originated from the healthcare industry (Department of Justice, 2016a). The following fiscal year, the DOJ recovered more than $3 billion.

1. Qui Tam Elements

The FCA covers a broad scope of misconduct that is potentially harmful to the federal treasury.[19] The Fraud Enforcement and Recovery Act (FERA) was enacted in 2009,[20] expanding liability exposure under the FCA. Before Congress enacted FERA, liability did not attach under §3729(a)(1) unless the alleged fraudster presented a false claim for payment or approval to an "employee of the United States government or a member of the Armed Forces of the United States."[21] Today, as long as the federal government is providing some or all of the money to pay the false claim, said claim can be presented to anyone.[22]

Legal claims filed under §3729(a) require proof of several elements to establish a violation of the FCA: (1) a "claim" must be made; (2) the claim must be made "knowingly" or with "knowledge"; (3) the claim must be "false" or "fraudulent": (4) the claim must be material (while not in the statute, many courts require proof of materiality); (5) causation; and (6) the claim must have resulted in damage to the federal government. We analyze below some of the most important, and debatable, elements.

a. "Claim"

It can be a difficult task to determine whether an actual "claim" has been made; however, it has become easier due to the amendments enacted by FERA. As amended by FERA, a "claim" is "any request or demand, whether under a contract or otherwise, for money or property and whether the United States has title to the money or property."[23] "Claim" includes any demand for

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money or property to be utilized on behalf of the federal government or to advance a government program or interest.[24] In some cases, lawyers and other parties must refer to sources outside the FCA to determine whether a "claim" has been adequately established.[25]

The definition of a "claim" for payment under Medicare is set forth in regulations and statutes. Subparts of title 42 of the Code of Federal Regulations denote that the federal government will promise to pay only costs that are "reasonable and necessary."[26] Therefore, requesting that the federal government pay for medical tests under Medicare without the physician supervision required under Part B equates to requesting payment for something that is not payable under part B (Al-Salihi, 2015). Lack of compliance with the rules of Part B would potentially fail the "claim" requirement under Part B (Al-Salihi, 2015).

The FCA attaches liability to the "claim for payment or approval," not to the fraudulent activity itself, nor to the payment made wrongfully by the government."[27] In establishing that a false statement is a claim or demand for payment or approval, a court should ascertain whether the statement lead to a wrongful payment."[28]

A FCA claim is required to assert that the defendant submitted a legally fraudulent or legally false claim.[29] A claim is considered legally false when a person receives government funds after certifying that he has complied with a regulation or law, yet knows he has not done so.[30] If a person requests reimbursement for an improper list of services rendered or goods provided, this claim would be considered factually false. Further, a *qui tam* relator must be particular in stating that facts constitute fraud, according to Federal Rule of Civil Procedure (FRCP) 9(b).[31] As most FCA cases end in settlement (Corporate Crime Reporter, 2008), it is important to determine whether FRCP 9(b) has been met.

b. Made "Knowingly" or "Know"

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Section 3729(b)(1)(A) states that the alleged fraudster satisfies the "knowledge" requirement if he or she "has actual knowledge … acts in deliberate ignorance of the truth or falsity … or acts in reckless disregard of the truth or falsity of the information" presented. The statute also states that "no proof of specific intent to defraud" is needed. The requisite intent is the conscious presentation of false information.[32]

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

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

c. "False" or "Fraudulently"

The FCA is not designed to address every kind of fraud perpetrated against the government.[35] Congress does not define the words "false" or "fraudulent" in the FCA. The U.S. Supreme Court, in *Universal Health Services, Inc. v. U.S. ex. rel. Escobar,*[36] has found these words to have meaning based on common law fraud concepts. For instance, a *qui tam* plaintiff does not need to

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show that a claim is both false and fraudulent—simply one or the other—as the FCA uses the disjunctive "or" (Helmer and Popham, 2003).

Most healthcare FCA cases have been related to direct "'factually false' claims requesting payment for more expensive categories of care than were provided or services that were never provided" (Krause, 2017). *Qui tam* relators have also taken action against "legally false" claims, in which services or items were provided but someone had falsely certified compliance with a statute, regulation, or contractual provision.[37]

The federal courts have endorsed two different theories of legal falsity.[38] A party making a false certification regarding a program condition, such as signing a false certification statement on a document, constitutes express certification.[39] Some federal courts have also extended legal falsity to include implied certification.[40] The latter requires that the claim does not merely request payment but also make specific representations about the goods or services provided and that the defendant's failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading.[41] The U.S. Supreme Court also determined that a misrepresentation must be material to the government's payment decision.[42]

d. Materiality

Based on a literal reading of the FCA statute, the word "material" modifies the "false record" offered in support of a false claim, rather than the false claim itself. The false record or statement supporting the false claim has to function in a material way as a supporting document (Al-Salihi, 2015). Therefore, the requirement of "materiality" pertains only to a section 3729(a)(1)(B) cause of action, not a section 3729(a)(1)(A) lawsuit or legal claim.

Whatever a healthcare provider or contractor is said to be lying about does not have to be material to lead to liability under section 3729(a)(1)(A) or section 3729(a)(1)(B). A threshold

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

In those cases that apply "materiality" to §3729(a)(1)(A) claims, "materiality" is established when the false or fraudulent claim has a natural tendency to influence agency action or is able to influence agency action.[44] Contemporary courts that use a materiality standard for §3729(a)(1)(A) claims use a case-by-case, fact-intensive analysis to determine whether a particular condition of payment is material.[45] The insertion of materiality into a §3729(a)(1)(A) analysis muddies what is actually a clear standard (Al-Salihi, 2015).

A person found guilty of fraud under the FCA is liable to the federal government for a civil penalty of not less than $5,000 and not more than $10,000, plus triple the amount of damages incurred by the government as a result of the fraudulent act.[46]

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

Prior to the Patient Protection and Affordable Care Act of 2010 (ACA),[47] as modified by the Healthcare Education and Reconciliation Act of 2010,[48] the FCA had a feature called the public disclosure bar, which strongly limited private citizens' ability to file a *qui tam* lawsuit.[49] 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

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original source of the disclosure.[50] The relator had to prove by a preponderance of the evidence to establish subject matter jurisdiction that the lawsuit was not based upon a prior public disclosure, or, if it was, that said relator was an original source of the information.[51] The FCA described three manners in which prior public disclosure could occur: (1) in a civil, criminal, or administrative hearing;[52] (2) in a Congressional, administrative, or GAO report, audit, or investigation;[53] or (3) in the media.[54] The courts broadly determined what types of disclosures were public and thus not open to *qui tam* suits, although some disputes occurred among the courts (Phelps, 1999).

Congress lowered the disclosure bar in the ACA so that only facts that are "substantially the same" as the facts revealed in the prior proceeding would lead to the bar being imposed.[55] Now, if the information on which the *qui tam* suit is based has been disclosed in a federal proceeding in which the government is a participant, then the bar is applied.[56] The public disclosure bar is not applicable when the *qui tam* plaintiff is an "original source" of the information.[57] Prior to the ACA, the public disclosure bar stopped many *qui tam* claims that involved public information, as broadly interpreted. This alteration to the FCA has made it more powerful against healthcare fraud.

C. Federal Anti-Kickback Statute

The federal Anti-Kickback statute[58] is a criminal statute that prohibits knowingly and willfully paying or receiving any compensation, directly or indirectly, in exchange for prescribing, purchasing, or recommending any service, treatment, or item for which payment will be received from Medicaid, Medicare, or other federally funded program (Rheiner, 2015). The anti-kickback statute is broadly worded and establishes liability based not only on kickbacks and

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

The Third Circuit Court of Appeals substantially expanded the scope of the anti-kickback statute in the 1985 case *U.S. v. Greber.*[59] The court created the "one purpose test," holding that if one purpose of a payment was to prompt future referrals, then the anti-kickback statute was being violated. Although the anti-kickback statute does not offer a private right of action, the FCA provides a means of bringing *qui tam* actions[60] alleging violations of the anti-kickback law. To convict a defendant under the anti-kickback statute, the government must prove beyond a reasonable doubt that the defendant: (1) knowingly and willfully; (2) solicited, received, paid, or offered to pay remuneration; (3) in return for, or to induce, the referral or generation of program-related business.[61] The "knowing and willful" element is met by showing that the defendant knew that his conduct was unlawful and acted voluntarily and purposefully.[62]

The broad scope of the one-purpose test may create liability under the anti-kickback statute for actions that are commonly accepted commercial practices (Kirman and Wyman, 2015). Parties can also be liable under anti-kickback statute even if their practices cause no perceptible harm to patients.[63] For example, if a hospital compensates a physician for joining its staff, intending that the doctor will refer Medicare patients to the hospital, it could be in violation of the one-purpose test.[64]

Concerned by the broad scope of potential liability under the statute, Congress enacted numerous "safe harbors" or statutory exceptions to the anti-kickback statute.[65] The Office of Inspector General (OIG) has enumerated more than 25 regulatory safe harbor provisions and one statutory provision[66] that safeguard physicians from liability under the anti-kickback statute.

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

D. False Statements to Obtain Health Benefits or Payments

Federal statute 42 U.S.C. §1320a-7b(a) makes it illegal to make a false statement or representation in any application or claim for benefits under a federal healthcare program. Under this statute, the federal government must prove beyond a reasonable doubt that: (1) the defendant made, or caused to be made, a statement or representation of material fact in an application for payment or benefits under a federal healthcare program; (2) the statement or representation was false; and (3) the defendant knowingly and willfully made the false statement or representation.[67]

The first element establishes that a statement or representation of fact must be material to be actionable.[68] Whether something is material is a question of both law and fact. The government does not have to prove that the respective federal agency actually relied on the false statement.[69]

The second element of the offense requires that the defendant say or make a false statement or representation.[70] The false statement or representation must have been presented to the respective federal agency for payment. Some examples include billing Medicaid for procedures not actually carried out,[71] submitting claims for patients never examined,[72] submitting claims for services not personally rendered,[73] and submitting claims for services carried out by another party.[74]

The third element of the offense requires that the alleged fraudster "knowingly and willfully" make or cause any false representation. "Knowingly" refers to the fact that there must be proof that the accused had knowledge of the facts of the offense. The "knowing and willful" element is met if the accused is cognizant that his or her conduct is illegal without any knowledge of the

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specific statute violated.[75] Further, the alleged fraudster must be aware that the statement is false at the time it is made or submitted.[76]

E. The Stark Law

As part of the Omnibus Budget Reconciliation Act, Congress enacted into law Stark I[77] in 1989 in response to the growing cost of healthcare related to physician self-referrals (Grioux et al., 2018). Stark I disallowed physician referrals under Medicare for clinical lab services when the referring physician has a financial arrangement with the lab unless the terms of certain statutory or regulatory exceptions are satisfied.[78] Stark I was expanded into Stark II as part of the Omnibus Budget and Reconciliation Act of 1993 (Bucy et al., 2002). Stark II applied the Stark I legislation to Medicaid patients and to "designated health services" (DHS) other than clinical laboratory services (Bucy et al., 2002).

The Stark Law (I and II collectively) and its associated regulations disallow a physician (or an immediate family member) who has a "financial relationship" with a medical facility from making a "referral" to that facility for certain DHS for which payment can be made by the federal government.[79] A medical facility may not submit for payment a Medicare or Medicaid claim for service provided as a result of a prohibited referral. The federal government may not make payments pursuant to a forbidden claim and medical facilities must return any payments that are mistakenly made by the federal government (Bucy et al., 2002).

Stark I did not take effect until January 1, 1992 (Bucy et al., 2002). Enforcement of Stark II began on January 1, 1995 (Bucy et al., 2002). The final regulations of Stark II came into force on January 4, 2002 (Bucy et al., 2002). Published in September 2007, Phase III regulations were enhanced in clarity, reducing the regulatory burden on the healthcare industry (Sutton, 2011). Violation of the complex Stark law could lead to severe penalties (Sutton, 2011).

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A multistep analysis is important in ascertaining whether a Stark law violation has occurred. The first step is to determine whether the person or entity in question has made a "referral." The latter is "the request by a physician for, or ordering of, or the certifying or recertifying of the need for" as well as the establishment of a plan of care by a physician involving the provision of a DHS for which payment may be made under Medicare or Medicaid.[80] While the Stark regulations do not explicitly include any DHS provided by the referring physician, they do implicate referrals made within a physician's group practice.[81]

The second step in the analysis is to define the term "physician." A "physician" means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a doctor of chiropractic.[82] Nurse practitioners, physician's assistants, and physical therapists are not classified as "physicians." Another step in the analysis is specifying DHS. The latter include the following:

1. Clinical laboratory services.
2. Physical therapy services.
3. Occupational therapy services.
4. Radiology services, including magnetic resonance imaging (MRI), computerized axial tomography scans, and ultrasound services.
5. Radiation therapy services and supplies.
6. Durable medical equipment and supplies.
7. Parental and enteral nutrients, equipment, and supplies.
8. Prosthetics, orthotics, and prosthetic devices and supplies.
9. Home health services
10. Outpatient prescription drugs.
11. Inpatient and outpatient hospital services.[83]

Under the Stark law, it is important to determine whether a "financial relationship" exists between a physician (or an immediate family member) and the recipient of the referral. A

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"financial relationship" can fall into one or more of three categories: (1) an ownership interest; (2) an investment interest; or (3) a compensation arrangement between the physician (or immediate family member) and the entity.[84] Stark regulations state that a financial relationship may be "direct" or "indirect."[85] A "direct" financial relationship exists "if remuneration passes between the referring physician (or a member of his immediate family) and the entity furnishing DHS without any intervening persons or entities …."[86] An "indirect financial relationship" exists when three criteria are met. First, an unbroken chain of persons or entities must be present between the referring physician and the entity rendering DHS.[87] Next, the referring physician must receive compensation that accounts for the volume or value of referrals or other business generated by the referring physician for the entity to which the referral is made.[88] Third, the entity providing DHS must have actual knowledge (or act in reckless disregard or in deliberate ignorance of) the fact that the referring physician (or immediate family member) receives such compensation.[89] Some exceptions do apply to the financial relationship prohibition.[90]

The last step is to address the meaning of the word "entity" on the receiving end of a referral. "Entity" refers to "[a] physician's sole practice or a practice of multiple physicians or any other person, sole proprietorship, public or private agency or trust, corporation … that furnishes DHS. An entity does not include the referring physician … but does include his or her medical practice."[91] This definition of "entity" signifies that physicians or physician group practices that perform DHS must now meet an exception to the Stark law (Sutton, 2011).

When a physician has made a referral for DHS to an entity with which he or she has a financial relationship, it is important to determine whether an exception to the law applies. Exceptions fall into three categories: (1) exceptions applicable to both physician

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ownership/investment interests and compensation arrangements; (2) exceptions for ownership or investment interests only; and (3) exceptions for compensation arrangements only.[92]

The first category of exceptions includes doctors' "services where referrals are between members of the same group practice, certain ancillary services provided within the same office of a group practice [(this is the most commonly used exception)], and certain prepaid health plans."[93] The second category of exceptions includes ownership interests in publicly traded securities, healthcare facilities in rural areas or Puerto Rico, and hospitals that satisfy certain requirements.[94] The third category of exceptions covers the rental of office space and equipment, genuine employment relationships, personal services arrangements, physician recruitment activities, and payments by doctors for certain items and services.[95]

Violation of the Stark law can result in severe penalties. Claims filed for services in violation of self-referrals lead to nonpayment.[96] Further, the money must be returned if one collects it in violation of the Stark law. Improper claims may lead to civil monetary penalties up to $15,000 per violation and inability to participate in Medicaid and Medicare programs going forward.[97] Also, a civil penalty not to exceed $100,000 applies to cross-referral arrangements when a physician or entity "knows or should know" that the business relationship ensures referrals by the physician to the entity.[98]

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

F. Health Insurance Portability and Accountability Act (HIPAA)

In 1996, Congress passed the Health Insurance Portability and Accountability Act

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

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.[104]

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

Summary and Conclusions

Seniors deserve to be cared for with respect, compassion, and dignity. Yet, they are oftentimes the target of abuse and fraud related to their medical care. With the projected aging of the U.S. population, this abuse is expected to become a growing problem. Creating awareness and finding ways to protect seniors is, therefore, particularly important to reduce the scope of this abuse.

This article highlighted the different types of schemes that scammers use to target seniors along with sample cases and laws that try to prevent this abuse from occurring in the first place. Educating patients and their families, the public, as well as law enforcement personnel on how to recognize, report, and protect against healthcare fraud, providing an easy way to report fraudulent activities, allocating more funds to fight this problem, preventing the cognitive decline of dementia patients with a focus on minorities, using vigilance, and establishing improved fraud detection programs used by insurance programs, are all important methods to combat this fraud. Of these methods, education might arguably be the most important one with the farthest reaching impact. Further research into the creation of effective prevention strategies and methods to fight healthcare fraud against seniors is needed.

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Endnotes

[1] 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.
[2] The baby boomer population refers here to those born between 1946 and 1964.
[3] 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.
[4] 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.
[5] 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.
[6] 31 U.S.C. §§3729-3733 (2018).
[7] 31 U.S.C. §3729(a)(1) (2018).
[8] 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 ….

[9] 459 F. Supp. 2d 692 (N.D. Ill. Oct. 27, 2005). This case involved alleged falsification of annual reports to Medicare.
[10] 106 F. Supp. 2d 234 (D.P.R. 2000). This case involved alleged false claims submitted to Medicare for anesthesia services.
[11] "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 (7th ed. 1999).
[12] "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 (7th ed. 1999).
[13] 31 U.S.C. §3730 (d)(2) (2018).
[14] 31 U.S.C. §3730 (d)(2) (2018).

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[15] 31 U.S.C. §3730 (h)(1) (2018).
[16] 31 U.S.C. §3730 (d) (2018).
[17] 31 U.S.C. §3730 (b)(2) (2018).
[18] 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 (10th Cir. 1986)).
[19] 31 U.S.C. §3729 (2018).
[20] Pub. L. No. 111-21, 123 Stat. 1617 (2009)(codified as amended in 18 and 31 U.S.C.).
[21] 31 U.S.C. §3729(a)(1) (2006).
[22] 31 U.S.C. §3729(a)(1)(A) (2017).
[23] 31 U.S.C. §3729(b)(2)(A) (2017).
[24] 31 U.S.C. §3729(b)(2) (2018).
[25] 42 C.F.R.§§411.15(4)(k) (2018).
[26] 42 C.F.R. §§411.15(4)(k); 415.50-70 (2018).
[27] 31 U.S.C. §3729(a)(1)(A) (2018).
[28] U.S. v. Rivera, 55 F. 3d 703, 709-10 (1st Cir. 1995); U.S. v. Richard Dattner Architects, 972 F. Supp. 738, 746-7 (S.D.N.Y. 1997).
[29] 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 (3rd Cir. 2011).
[30] Universal Health Services, Inc. v. U.S. *ex. rel.* Escobar, 136 S. Ct. 1989 (2016).
[31] U.S. *ex. rel.* Conner v. Salina Reg'l. Health Ctr., Inc., 543 F. 3d 1211, 1217 (10th Cir. 2008).
[32] U.S. *ex. rel.*Hagood v. Sonoma County Water Agency, 929 F. 2d 1416, 1421 (9th Cir. 1991).
[33] U.S. v. Oakwood Downriver Med. Ctr., 687 F. Supp. 302, 305 (E.D. Mich. 1988).
[34] 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.
[35] U.S. v. McNinch, 356 U.S. 595 (1958).
[36] 136 S. Ct. 1989 (2016).
[37] U.S. *ex. rel.* Conner v. Salina Reg'l. Health Ctr., Inc., 543 F. 3d 1211, 1217 (10th Cir. 2008).
[38] U.S. *ex. rel.* Conner v. Salina Reg'l. Health Ctr., Inc., 543 F. 3d 1211, 1217 (10th Cir. 2008).
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[40] Universal Health Services, Inc. v. U.S. *ex. rel.* Escobar, 136 S. Ct. 1989 (2016).
[41] Universal Health Services, Inc. v. U.S. *ex. rel.* Escobar, 136 S. Ct. 1989, 2001 (2016).
[42] Universal Health Services, Inc. v. U.S. *ex. rel.* Escobar, 136 S. Ct. 1989, 2002 (2016).
[43] U.S. *ex. rel.* Hutcheson v. Blackstone Med., Inc., 647 F. 3d 377, 394 (1st Cir. 2011)(analysis of "material" in terms of the claim itself).
[44] U.S. v. Norris, 749 F. 2d 1116 (4th Cir. 1984).
[45] U.S. v. Sci. Application Int'l. Corp.., 626 F. 3d 1257, 1269 (D.C. Cir. 2010).
[46] 31 U.S.C. §3729 (a)(1)(G) (2012).
[47] 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).
[48] Healthcare and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).
[49] U.S. *ex. rel.* Springfield Terminal Ry. Co. v. Quinn, 14 F. 3d 645, 652 (D.C. Cir. 1994).
[50] U.S. *ex. rel.* Springfield Terminal Ry. Co. v. Quinn, 14 F. 3d 645, 653 (D.C. Cir. 1994).
[51]U.S. v. Alcan Elec. & Eng'g, Inc., 197 F. 3d 1014, 1018 (9th Cir. 1999); U.S. *ex. rel.* Biddle v. Bd. of Trustees of the Leland Stanford, Jr. Univ., 161 F. 3d 533, 535 (9th Cir. 1998).
[52] "Hearing" encompassed both civil complaints and criminal indictments. U.S. *ex. rel.* Siller v. Becton Dickinson & Co., 21 F. 3d 1339, 1350 (4th Cir. 1994).
[53] 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

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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.

[54] U.S. *ex. rel.* Stinson, Lyons, Gerlin & Bustamante v. Prudential Ins. Co., 944 F. 2d 1149)(3rd 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).

[55] 31 U.S.C. §3730(e)(4)(A) (2018).

[56] 31 U.S.C. §3730(e)(4)(A)(iii) (2018); 31 U.S.C. §3730 (e)(4)(B) (2018).

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

[58] 42 U.S.C. §§1320a-7b(b) (2017).

[59] 760 F. 2d 68, 71 (3rd Cir. 1985).

[60] 31 U.S.C. §3730 (d)(2) (2018).

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

[62] U.S. v. Vernon, 723 F. 3d 1234, 1256 (11th 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).

[63] U.S. v. Jain, 93 F. 3d 436, 442-43 (8th Cir. 1996).

[64] Polk Cnty., Tex. v. Peters, 800 F. Supp. 1451, 1456 (E.D. Tex. 1992).

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

[66] 42 C.F.R. §1001.952(a)-(y) (2017).

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

[68] U.S. v. Njoku, 737 F. 3d 55 (5th 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.

[69] U.S. v. Rowe, 56 F. 2d 747, 749 (2nd Cir.1932); Neder v. U.S., 527 U.S. 1 (1999).

[70] U.S. v. Laughlin, 26 F. 3d 1523 (10th Cir. 1994).

[71] U.S. v. Boesen, 541 F. 3d 838 (8th 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.

[72] U.S. v. Larm, 824 F. 2d 780, 782 (9th 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.

[73] In *Larm,* the allergist also submitted claims for administration charges for injections which the patients administered themselves.

[74] U.S. v. Davis, 471 F. 3d 783, 785 (7th 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.

[75] U.S. v. Starks, 157 F. 3d 833, 837-38 (11th Cir. 1998).

[76] U.S. v. Njoku, 737 F. 3d 55, 66-67 (5th Cir. 2013).

[77] 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)).

[78]42 U.S.C. §1395nn(h)(6) (2018).

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

[80] 42 C.F.R. §411.351 (2018).

[81] 42 C.F.R. §411.351 (2018).

[82] 42 C.F.R. §411.351 (2018).

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[83] 42 U.S.C. §1395nn(h)(6)(2018).
[84] 42 U.S.C. §1395nn(a)(2)(2018).
[85] 42 C.F.R. §411.354(a)(1) & (2)(2018).
[86] 42 C.F.R. §411.354(a)(2)(2018).
[87] 42 C.F.R. §411.354 (b)(5)(i) and (c)(2)(i)(2018).
[88] 42 C.F.R. §411.354 (c)(2)(ii)(2018).
[89] 42 C.F.R. §411.354 (c)(2)(iii)(2018).
[90] 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).
[91] 42 C.F.R. §411.351 (2018).
[92] 42 U.S.C. §§1395nn(b)-(e) (2018).
[93] 42 U.S.C. §§1395nn(b)(1)-(3)(2018).
[94] 42 U.S.C. §§1395nn(c)-(d) (2018).
[95] 42 U.S.C. §§1395nn(e)(1)-(8) (2018).
[96] 42 U.S.C. §1395nn(g)(1) (2010).
[97] 42 U.S.C. §1395nn(g)(3) (2010).
[98] 42 U.S.C. §1395nn(g)(4) (2010).
[99] Pub. L. No. 104-191,110 Stat. 1936 (1996)(codified as amended at 42 U.S.C. §1320a-7c).
[100] 42 U.S.C. §1320a-b apply to anything "under a federal healthcare program."
[101] 42 U.S.C. §1320a-7a(i)(6)(Supp. III 1997).
[102] 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).
[103] 42 U.S.C. §1320a-7a(i)(6) (2018).
[104] 18 U.S.C. §1345 (2018); 18 U.S.C. §982(a)(7)(2018).
[105] Pub. L. No. 104-191, 241-247, 249, 110 Stat. 1936, 2016-2021 (1997).
[106] 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 (5th 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 (6th 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 (1st 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).
[107] 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 (2nd Cir. 2003).
[108] 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 (6th Cir. 2008).
[109] 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 (10th Cir. 2009).

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