The Persistence of Fraud and the False Claims Act

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ABSTRACT


Title: The Persistence of Fraud and the False Claims Act.

The focus of this thesis will be to evaluate the False Claims Act (FCA) and in particular its Qui Tam provisions. A closer look will be taken at the emergence of a very lucrative type of fraud in the United States. This type of fraud has only been on the scene for less than twenty years. However, it has drawn incredible attention from both the criminal and anti-criminal factions. This fraud is Health Care Fraud and although the FCA was not originally intended in the use of fighting fraud in this area, it has been the weapon of choice. However, there are still some loopholes and problems that are interfering with the effectiveness of the FCA as a fraud fighting tool. Because of the rapid growth in health care fraud, it is considerably important that all Americans are informed about this widespread fraud.

As indicated in this thesis, the United States government has recovered large amounts of money due to whistleblowers,
however they are still losing out on lots of money because of the revolving door of fraudulent activities. The FCA has been effective in fighting health care fraud in some aspects, but as Senator Grassley believes, the FCA has a long way to go before it can efficiently and effectively fight fraud.

Advisors: Lisa Jaeger, Dorothea I. Wolfson, Ph.D. and Dan Guttman
Reason for writing this thesis:

This thesis is written to provide a historical and policy evaluative perspective on the topic of the False Claims Act and it's Qui Tam provisions. The False Claims Act is a fairly old Act, dating back to 1863. The Act was first enacted to fight procurement fraud but in recent years the focus has turned to health care fraud. This thesis will seek to determine whether or not the False Claims Act and it's Qui Tam provisions are an effective tool in fighting fraud, in particular health care fraud.

Group that will benefit from reading this thesis:

This thesis is written for policy makers, health care providers and patrons, False Claims Act supporters and non-supporters.

Scope of this thesis:

This thesis covers the effectiveness of the False Claims Act in fighting fraud. It will inform the reader on how big a problem fraud is in the United States, specifically health care fraud. The thesis will provide an historical background of the Act, examples of large fraud cases and a
discussion on the False Claims Act’s effectiveness as a tool for fighting fraud.
Acknowledgements

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Chapter I

Introduction
The focus of this thesis will be to evaluate the False Claims Act (FCA) and in particular its Qui Tam provisions. A closer look will be taken at the emergence of a very lucrative type of fraud in the United States. This type of fraud has only been on the scene for less than twenty years. However, it has drawn incredible attention from both the criminal and anti-criminal factions. This fraud is Health Care Fraud and although the FCA was not originally intended in the use of fighting fraud in this area, it has been the weapon of choice. However, there are still some loopholes and problems that are interfering with the effectiveness of the FCA as a fraud fighting tool. Because of the rapid growth in health care fraud, it is considerably important that all Americans are informed about this wide spread fraud. Health care fraud and abuse have grown steadily, both in government and amongst the public.

The False Claims Act (FCA), also known as "Lincoln's Law", was first enacted March 2, 1863 to address the rampant fraud that the country witnessed during the Civil War. The False Claims Act was designed to entice whistleblowers to come forward by offering them a share of the money that the
government recovered. Even though this Act was enacted to combat military contractor fraud, it was pertinent to all government contractors, federal programs and any other instances involving the use of federal revenue.

Health care fraud affects millions and is estimated to cost somewhere between eighty billion dollars and one hundred seventy billion dollars per year.\(^1\) Besides the fact that fraud is a criminal activity and that taxpayers and government agencies are affected, human factors additionally are compelling enough for health care payers to take this issue seriously and develop proactive approaches to fraud detection.

Billing for services never rendered and charging for more expensive procedures are just two ways that fraudulent health care providers affect patients. The fact remains that health care providers have also been known to perform unnecessary medical services for the sole purpose of collecting insurance payments. In addition, fraudulent providers falsify medical treatment histories or diagnoses of medical conditions and use up a patient’s health care

\(^1\)National Health Care Anti-Fraud Association
benefits, putting people's lives at risk. The possibility
to drain a patient's private insurance benefits means that
when the insurance might be legitimately needed, a patient
may not have access to the appropriate insurance amounts
required for adequate treatment. If a patient's medical
insurance is depleted, that may affect future treatments
and in serious cases lead to premature death.

President Abraham Lincoln strongly advocated passage of the
False Claims Act. The Act contained "Qui Tam" provisions
that allowed private citizens to sue, on the government's
behalf, companies and individuals that were defrauding the
government. "Qui Tam" is short for a Latin phrase, "Qui Tam
pro domino rege quam pro se ipso in hac parte sequitur,"
which means "he who brings an action for the king as well
as for himself". When first enacted, the False Claims Act
assessed wrongdoers double damages and a 2,000 dollar civil
fine for each false claim submitted. Those who filed
lawsuits, known as "relators," were entitled to receive
fifty percent of the amount the government recovered as a
result of their cases.

During the second World war in 1943, Congress revisited the
Act and adopted amendments to address some abuses of the
statutory scheme. Following decades of growth in federal programs and burgeoning fraud problems, Congress revisited the act again in 1986 to address judicial interpretations of the Act that Congress viewed as too restrictive and to make the statute more effective. The amendment provided that if the Government had prior knowledge of the allegations, the relator had no jurisdiction over the lawsuit even if the relator had independent and direct knowledge of the allegations.\(^2\)

When amending the False Claims Act in 1986, Congress realized that health care fraud would be one of the areas in which the False Claims Act would become useful.\(^1\) Since that time, the health care industry has slowly become the largest source of cases under the False Claims Act. Between 1863 and 1986, very few people took advantage of the law primarily because of many complex obstacles built into the Act that whistleblowers had to overcome in order to be successful and many judicial rulings making it difficult to enforce the law. Furthermore, a problem for anyone who preferred to file a lawsuit under the 1863 Act, was the


provision that all relators had to bear all the costs of the lawsuit and the Government could take over the suit at any time, at its discretion.⁴

The Act was initially directed towards addressing defense procurement fraud, but was never limited to that purpose and has been applied to fraud involving a wide range of government programs. In recent years, the health care field has seen the most rapid growth of litigation under the Act. False Claims Act cases have been initiated to address fraud against the government in other areas, including environmental programs, scientific research, and financial services industry. As the act has made its effects felt, policymakers have begun to consider whether the Act’s model holds promise for addressing problems other than fraud and if it is achieving the initial goal that was set forth by Congress.

Health care fraud is a big issue in the United States, and the significant use of fraud in this sector by health care providers is making this issue more prominent when it comes to the False Claims Act. A carrier will often pay a claim

from an entity that is unknown and for a service that is unknown. This is because the government has legislated that the claim must be paid within thirty days, therefore the carrier is mandated to pay out this large amount. As a result, large amounts of money are lost to fraudulent claims paid without scrutiny by the carrier.

All Americans suffer from health care fraud through higher out-of-pocket costs, higher taxes needed, and reduced real wages or layoffs when employees bear the cost of health care by passing it along to other employees. As the health care industry becomes a profit seeking industry, it has attracted all kinds of elements including criminal. Health Care fraud is such an easy target for these reasons and many others.  

Congress and the Executive Branch have sought to adopt law and implement them to check the growing area of fraud. This thesis will highlight the use of the False Claims Act and demonstrate that the government continues to fall short of

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6 Sources used in this thesis present potential bias on the subject matter. However, these known potential biases are used to give a variety of insight on the discussed topic.
the goal of reducing health care fraud. This thesis will conclude with a critical assessment of the False Claims Act as the tool of choice to combat health care fraud and provide some recommendations for improvement.
Chapter II

History and Current Application of the False Claims Act
The False Claims Act 1863

During the Civil War, outraged by extensive fraud against the Government by army contractors, Congress enacted the False Claims Act. A key component of the Act was the Qui Tam provision, which sought to enlist the resources of private citizens to supplement the government’s effort to combat fraud. Over a period of time, Congress has modified the Act to respond to problems that have arisen with its implementation.

Although there were a small number of Qui Tam False Claims Act cases during the early part of this century, over a period of time, one type of Qui Tam action grew to be a very difficult one. Because the Act provided no exception for suits based on information already in the government’s possession, a group of extremely parasitic suits arose by parties having no information of their own to contribute, but who merely plagiarized information in indictments, newspaper stories or congressional investigations.  

During the fifty years following the passage of the Act, a number of cases were filed under the Qui Tam provisions. In the 1930s, with the inception of the New Deal and the

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7 The False Claims Act: Fraud Against The Government, Claire M. Sylvia, Thomson West, c2004
spectacular growth of the federal government, the number of Qui Tam actions increased at a proportionate rate. Many of these suits merely parroted the allegations that appeared in criminal actions brought by federal prosecutors. In these actions the relator was entitled to share in the recovery by the government when it had provided information not already known to the government.

The False Claims Act 1943

The statute remained virtually unchanged until 1943 when Congress radically altered the Qui Tam provisions. The changes included a drastic cut in the relator’s reward, so there was less of an incentive for people to report fraud. This change was a provision that prohibited Qui Tam lawsuits based on evidence or information already in the possession of the Federal Government. This provision effectively prevented whistleblowers from filing a Qui Tam

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9 The Center of False Claims. 2007.15 Aug 2007 (http://www.center4falseclaims.com/FCA.html)

10 The Center of False Claims. 2007.15 Aug 2007 (http://www.center4falseclaims.com/FCA.html)

lawsuit if any government employee had received a tip about
the fraud or if any information about the fraud was
contained in any government file, even if the government
was not investigating the matter or trying to stop the
fraud, and even if the whistleblower was the source of the
government’s knowledge.\textsuperscript{12}

In 1943, the Department of Justice sought to persuade the
Supreme Court of the United States in the case of Marcus v.
Hess.\textsuperscript{13} In the case of Marcus v. Hess the relator had
allegedly copied the complaint’s allegations from a
criminal indictment and filed a Qui Tam action based upon
those allegations. The Attorney General argued that the
False Claims Act did not authorize such suits, but the
Supreme Court rejected the argument, concluding that “there
are no words of exception or qualifications such as we are
asked to find”.\textsuperscript{14}

The Supreme Court let the relator proceed even though he
copied a criminal indictment verbatim into his Qui Tam
complaint.\textsuperscript{15} Congress amended the FCA to prevent such abuse,

\textsuperscript{12} Slyvia, M. Claire. The False Claims Act: Fraud Against the

\textsuperscript{13} Marcus v. Hess, 317 U.S. 537 (1943).

\textsuperscript{14} Slyvia, M. Claire. The False Claims Act: Fraud Against the

\textsuperscript{15} Id. at 546-48.
but those amendments ended up barring meritorious Qui Tam suits. In United States ex rel. State of Wisconsin v. Dean, \(^{16}\) the Seventh Circuit refused to allow the State of Wisconsin to act as relator even when it had investigated Medicare fraud.\(^{17}\) In rejecting its suit for having relied upon publicly available information, the Seventh Circuit stated that "if the State of Wisconsin desires a special exemption to the False Claims Act because of its requirement to report Medicaid fraud to the federal government, then it should ask Congress to provide the exception".\(^{18}\) In response, Congress loosened restrictions on Qui Tam pleading in the 1986 amendments to the FCA. But even while seeking to encourage relators to investigate and share their information with the government, Congress remained concerned about parasitic suits like Marcus v. Hess. Teetering between these two competing goals, Congress enacted the FCA's Public Disclosure Bar, \(^{19}\) which bars actions based upon a public disclosure, unless the relator was the original source of the information.

\(^{16}\) 729 F.2d 1100 (7th Cir. 1984).

\(^{17}\) Id. at 1102.

\(^{18}\) Id. at 1106-07.

\(^{19}\) 31 U.S.C § 3729(e)(4).
The 1943 FCA amendments made a number of significant changes to the Act. First, the amendments gave the Department of Justice the right to take over cases initiated by the relator. The amendment required the relator to submit all of their supporting evidence to the Department of Justice at the time of the complaint and gave the department sixty days to decide whether to intervene and take exclusive control of the suit. If the government intervened, the relator had no role in ensuing litigation. Second, the amendments deprived courts of jurisdiction over any Qui Tam actions "that were based upon evidence or information in the possession of the United States, or any agency, officer or employee, thereof, at the time suit was brought". Also the relators share of any recovery from a suit was reduced and they were not assured of a minimum recovery. If the United States government prosecuted the suit, the court could award the informer "fair and reasonable compensation, not to exceed ten percent of the total proceeds". If the United States government did not intervene, the informer's reward could not exceed twenty five percent of the proceeds, rather than the fifty percent that the original 1863 FCA awarded.


For years it has been unclear whether the 1943 amendments were intended to preclude all suits based on information already known to the United States government. At some point in time some members of the United States Senate were under the impression that the amendments precluded only suits by informers who provided no new information. Senator Van Nuys, who was the chairman of the Senate Judiciary Committee, assured other members that the "honest informer, the bona fide informer is protected under the bill".

After 1943, Qui Tam actions under the False Claims Act became rarely viable. The 1943 amendment's in combination with various judicial interpretations were unfavorable to the Qui Tam relator, and significantly reduced the number of Qui Tam actions being filed. The congressional changes barred use of information in the public record causing the

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23 "Fraud and Abuse: Reno Willing to Work with the Hospitals to nsure Proper Use of False Claims Act". 2006:6HCP261.
As a result, until Congress changed the law in 1986, few Qui Tam cases were filed.

The False Claims Act 1986

During the 1980's defense buildup, the growing magnitude of fraud against the Government, and increased reports of widespread fraud against the government, Congress was lead to take a look at the Act. At this time it was evident that the False Claims Act was no longer an effective tool against fraud. Defense contractor practices were receiving the greatest media attention. In part, this was due to the vastly increased defense spending spurred by the Reagan administration's response to the Cold War.

The public was reading a steady stream of stories describing outrageous billing practices, such as the Navy paying 435 dollars for an ordinary claw hammer and 640 dollars for a toilet seat. In 1985, the Department of

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Defense reported that forty five of the largest one hundred defense contractors, including nine of the top ten were under investigation for multiple fraud offenses.\textsuperscript{28} Government enforcement agencies, meanwhile, complained that their efforts to investigate and stop fraud were hamstrung by insufficient resources, a lack of adequate legal tools and the difficulty of getting individuals with knowledge of fraud to speak up for fear that they would lose their jobs.

Frustrated with the government's inability to respond effectively to outrageous charges and other improper billing behavior by government contractors, Congress decided to revise the False Claims Act to encourage more whistleblowers to come forward and to create incentives for private attorneys to use their own resources to investigate fraud.\textsuperscript{29} Congress sought to create a partnership between public institutions and private citizens in keeping with former President Reagan's promise of greater privatization


of government functions and the use of market forces to enhance government services.  

Senator Charles Grassley, a Republican from Iowa, and Representative Howard Berman, a Democrat from California, sponsored the amendments to the False Claims Act, which received wide bipartisan support and former President Reagan signed the bill into law on Oct. 27, 1986. The 1986 Amendments had the most wanted effect of significantly strengthening the Act and its enforcement.

The 1986 Amendments considerably increased the penalties. From the enactment of the Act in 1863, until 1986, the Act provided for the recovery of double damages and 2,000 dollars per false claim. Now companies and other entities that defraud the government are liable for treble damages and a 5,000 to 10,000 dollar penalty for each false claim.

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Under the 1986 Amendments, a Government contractor submitting one hundred false claims and over billing the Government by 1,300,000 dollars, may be liable for as much as one million three hundred thousand dollars.\textsuperscript{34} Similarly, significant changes were made to the Qui Tam provision. These changes evidenced Congress's intent to expand upon the rights of Qui Tam relators to encourage the filing of more private actions under the Act.\textsuperscript{35} Prior to 1986, the Act provided that a successful Qui Tam relator was entitled to up to 25 percent of the proceeds to the Government in an action prosecuted by the relator.\textsuperscript{36} The 1986 amended False Claims Act provided that complainants who brought successful cases were entitled to fifteen percent to thirty percent \textsuperscript{37} of the government’s recovery, and their attorneys were guaranteed payment of their regular hourly fees by the defendant.

Some additional amendments may sound like minor procedure, yet they dramatically enhance a relator's ability to

\textsuperscript{34} The Center of False Claims. 2007.15 Aug 2007 (http://www.center4falseclaims.com/FCA.html)

\textsuperscript{35} The Center of False Claims. 2007.15 Aug 2007 (http://www.center4falseclaims.com/FCA.html)


successfully prosecute a case under the Act. The 1943 bar regarding information in the possession of the government was eliminated and replaced with language that permits such cases to be brought so long as the relator is an independent source of the allegations in a complaint. The Amendments also clarified the level of intention necessary to establish a violation. Since the Amendments, it is not essential that a defendant be proven to have intentionally defrauded the Government. Rather, it is sufficient to establish that the defendant acted with reckless disregard for the truth of the information in its claim or in deliberate ignorance of the information provided. The Amendments also clarified that the burden of proof is the same as in a typical civil action, the preponderance of the evidence, and not the higher burden of clear and convincing evidence, as some courts had ruled. The 1986 Amendments also contained whistleblower protection. This protects an employee from reprisal by his employer in the event that the employee becomes involved in the filing or investigation of an action against his employer. In the

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38 The Center of False Claims. 2007.15 Aug 2007 (http://www.center4falseclaims.com/FCA.html)


41 The Center of False Claims. 2007.15 Aug 2007 (http://www.center4falseclaims.com/FCA.html)
event an employer retaliates, the Act provides for the employee’s reinstatement, double the back pay plus interest, and any special damages.42

As more people have become aware of the False Claims Act, the number of lawsuits has jumped tremendously. The 1986 Amendments made it easier for Qui Tam relators to file claims and increased the rewards for doing so. Both the number of Qui Tam actions filed and the amounts recovered have increased dramatically. In 1987, thirty three Qui Tam cases were filed across the country and 200,000 dollars was recovered by the Government. In 2000, 366 Qui Tam cases were filed and the Government recovered 1.2 billion dollars. This represents nearly a 10,000 fold increase in recoveries.43 More than 3,000 Qui Tam cases have been filed since 1986.

The FCA is broadly applicable to almost any situation where federal dollars are involved. Given the Act’s current structure, it seems that categories of Qui Tam cases will grow limited only by the Qui Tam plaintiff’s tenacity and


ingenuity. This possibility is reflected in the many categories of cases resulting in Qui Tam recoveries including, but not limited to, failures to report fraud education grants, housing programs, emergency relief programs, fraudulent pre-selection of beneficiaries for Federal programs, defense contracting, agriculture support programs, false certifications of compliance with environmental laws, vehicle parts suppliers, and, Medicare/Medicaid fraud.

Initially, the FCA was used to fight defense contractor fraud, but it was soon applied to other areas of government spending, including Medicare and Medicaid. In 1988, medical fraud recoveries, using the Qui Tam provisions, totaled one percent of the total Qui Tam recoveries and the majority were defense related. By 1993, that total had grown to forty six percent and has remained over one third of total Qui Tam recoveries ever since.

Provisions of the Act

Under 31 U.S.C. § 3730(a), the U.S. Attorney General is empowered to institute a civil action against persons that submit claims in violation of 31 U.S.C. § 3729. Section 3729 states that while the False Claims Act imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false. A person who acts in reckless disregard or in deliberate ignorance of the truth or falsity of the information, also can be found liable under the Act. 45

Section 3730(b) contains the Qui Tam provision which provides for "a person" to bring a civil action on the government's behalf for violations of § 3729. Any person or entities with evidence of fraud against federal programs or contracts may file a Qui Tam lawsuit. In order to be eligible to recover compensation under the False Claims Act, a person must file a whistleblower Qui Tam lawsuit. Simply informing the Government about the false claims is not enough. Unless the relator bringing the Qui Tam lawsuit is the "original source" of the information, he will not

45 31 U.S.C. § 3729
have standing to bring a claim. To be an original source, the relator must have "direct and independent knowledge of the information on which the allegations are based".

Furthermore, the relator must have "voluntarily provided the information to the Government before filing the action." If the government or a private party has already filed a False Claims Act lawsuit based on the same evidence, one cannot bring a lawsuit. The False Claims Act imposes liability on any person who submits a claim to the federal government that he or she knows (or should know) is false. The Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government.

The statute of limitations (the maximum amount of time that can lapse after something happens for it to be taken to court) is defined under § 3731(b). The Act states that a claim must be brought within six years from the date on which the violations of § 3729 were committed or three years after the date when facts material to the right of action are known or reasonably should have been known by the United States official charged with the responsibility to act in the circumstances, but not more than ten years after

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the date of the violation, whichever occurs last. A relator is not required to file suit as soon as he or she uncovers the false claims. However, the reward may be reduced by the court if the relator unreasonably delays bringing the action.

A Qui Tam action must be filed in federal district court in accordance with the Federal Rules of Civil Procedure. A copy of the complaint, with a written disclosure statement of substantially all material evidence and information in the plaintiff's possession, must be served on the U.S. Attorney General and the U.S. Attorney General for the district in which the complaint is brought. An action under the False Claims Act must be filed, in camera and under seal. Under the False Claim Act, whistleblower protection is included and one's identity is kept a secret to all but the Court and the Government. At some point, generally years later, typically after the Government investigation is completed or the Judge will no longer give the Government extensions of time regarding the seal, the lawsuit will be made public. The name of the claimant will be open to disclosure to the Defendant when the lawsuit is unsealed.

The complaint and its contents must be kept confidential until the seal is lifted. If the plaintiff violates the provisions of the seal, his or her complaint could be dismissed.\(^{48}\) A relator may receive compensation only if, and after, the Government and relator recover money from the defendant as a result of the lawsuit. Just the act of filing the lawsuit is not enough. A Qui Tam action may be brought in any judicial district in which the defendant can be found, resides, transacts business, or in which the false claim occurred. Under § 3732(a), the federal courts may also have jurisdiction over state whistleblower claims if they arose from the same transaction or occurrence that triggered the federal Qui Tam action. This is important in states such as Ohio, Florida, and California, which have their own whistleblower statutes.

\(^{48}\) It is only the filing of a whistleblower Qui Tam lawsuit and a successive settlement or favorable verdict resulting in a recovery, which enables a private party to receive a reward under the False Claims Act. The relator's standing (the prerequisite characteristics for bringing a case into the judicial system as prescribed in the U.S. Constitution; the courts will only hear controversies between parties where one party has directly suffered a wrong at the hands of the other party) is not an issue when the U.S. government intervenes or when the relator has suffered actual damages due to actions taken by his or her employer. Giving the information to the government does not bar one from filing an action.
III

Health Care Fraud
What is Health Care Fraud?

Health care fraud in the United States remains a serious problem that has an impact on all health care payers, and affects every person in this country. Health care fraud cheats taxpayers out of billions of dollars every year. Health care fraud schemes have been investigated and prosecuted in every part of the country, in urban and rural areas, and in rich and poor areas. As health care options and the reach of federal programs have expanded, so have the boundaries of health care fraud. This section will give an overview of how big of a problem health care fraud is in the United States.

Health care fraud has put a burden on the nation due to enormous financial cost and the effect it has had on health care. Over the past ten years, health care fraud has exposed widespread theft and has placed health care providers at the top of the most wanted list. The size and complexity of the health care industry present a considerable challenge for the government and industry.

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fraud investigators. The size of the health care industry makes it an easy target which in turn makes it difficult to accurately determine the extent of the fraud. Health care fraud can take many forms, reach all areas of the health care industry, and can be perpetrated by person’s both within and outside of the industry.  

Vulnerabilities to fraud exist throughout the entire health care system, and patterns of fraud are so persistent that universal criminal activity is accepted as a "way of doing business" in many segments of the health care industry.  

The United States Department of Justice provides this description of the scope of the problem: "Fraud has been perpetrated by individual physicians and large publicly traded companies, medical equipment dealers, contract carriers, labs, hospitals, nursing homes and home health care agencies. In addition to health care providers, individual scam artists prey on the United States health care programs as well. Fraudulent health care schemes put billions of dollars in the pockets of individuals and providers who cheat the health care system, while the

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United States is steadily struggling with finding drugs to fight diseases such as Aids.\textsuperscript{53}

Health care fraud is an increasing problem that impacts almost everyone as patient, provider, taxpayer, employee or employer. Health care fraud involves the theft of thousands to even millions of dollars, and the damages reach further than just financial losses. It is the natural exploitation of individuals and their insurance information that are the basis for falsified claims.\textsuperscript{54} Dealing with health care fraud whether prosecuting it, trying to avoid it or defending those accused of it requires a thorough understanding of the areas of law and policy.\textsuperscript{55} For economic reasons health care fraud has increased in recent years.\textsuperscript{56} At more than one trillion dollars per year and being expected to double this year, health care is a huge business.\textsuperscript{57}

\textsuperscript{57} United States Department of Justice. Health Care Fraud: Scope and Nature of Problem. 1998.

\textsuperscript{54} National Health Care Anti Fraud Association


Fraud in the Health Care sector involves a variety of conduct which includes over-billing or upcoding, fraudulent cost reporting by providers, billing for services not provided, and failure to provide required quality of work.\textsuperscript{58} Most health care providers and suppliers contract either directly or indirectly with the federal government to provide services or supplies.

In addition to becoming the largest source of False Claims Act cases, the health care sector has also been the largest source of recoveries for Qui Tam actions.\textsuperscript{59} Industry representative have stated that the False Claims Act was initially never intended to be used against health care providers and critics believe that it will undermine the provision of health care services by requiring health care providers to spend excessive time complying with technical requirements.\textsuperscript{60}


The first very large health care fraud settlement was in the amount of a 111 million dollar settlement with National Health Laboratories in 1992. Other giant settlements have been reached with companies such as SmithKline Beecham Clinical Laboratories for improper bundling of lab services in the amount of 325 million dollars, Blue Cross and Blue Shield of Illinois for improper processing of Medicare claims for 140 million dollars, National Medical Care for billing for unnecessary tests in the amount of 375 million dollars, and Beverly Enterprises, the nation’s largest operator of nursing homes, for inflating the costs of treating Medicare patients in the amount of 170 million dollars.  

A Health Care Fraud case which involves the FCA allows the Department of Justice to bring civil actions while seeking damages and penalties against providers who knew that fraudulent or false bills were submitted. The purpose of the False Claims Act in the health care industry is to point out those providers who allow fraudulent billing to occur and continue.  

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illustrate the types of fraudulent activities taking place. Efforts to prosecute and recover losses from those involved in the schemes are costly and convictions often do not result in recovery of losses. Ranging from simple schemes to very thought-out conspiracies, some frauds have even put lives at risk.  

Why Health Care Fraud is easy to commit

The health care fraud problem is due to fraudulent providers billing insurers with ease. In the Medicaid system errors can occur in two levels. These levels are at the provider level, where a provider mistakenly enters the wrong code for a service that was not performed or at the carrier/intermediary level, where, the intermediary (the company which handles Medicare claims for a geographic area) incorrectly approves a service that was performed or approves an incorrect service. These errors are usually human errors and are not intended to defraud the Medicare/Medicaid system and any other government program.

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63 Health care fraud and abuse is complex and often counterintuitive. The penalties for violation of Health Care Fraud laws are severe. Because these fraudulent schemes may impact many areas of the health care system when they go undetected, they can cause incredible damages.

As error can occur in many sectors of health care, so can fraud. Fraud in health care has become a very big issue and can in many cases be more costly minor and or major errors.

In addition, fraudulent schemes can be imitated throughout the health care system. Fraudulent schemes are changing and becoming more sophisticated. Dishonest people and companies can be found in every segment of the health care industry, and fraudulent schemes targeting health care patients, providers, and plans have occurred in every part of the country and involve a wide array of medical services and products. While the vast majority of health care providers are law-abiding, some providers are taking advantage of federal health benefits programs.

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Types of Health Care Fraud and Scope of Problem

Fraud in the Medicaid and Medicare programs has grown tremendously in states such as Florida, and California. Medicare, a federal health insurance program for people of age sixty five and older, allows for certain people under sixty five with disabilities and certain people with kidney disease to participate. Medicaid, which is administered by the states, is a program of health coverage for certain people with low income or very high medical bills. Eligibility for Medicare depends on age or disability only; eligibility for Medicaid depends on age, disability or family status and on an individual’s (or family’s) income and resources. Medicare covers inpatient care, in hospitals, skilled nursing facilities and other institutions, outpatient services, physician services, medical supplies and equipment. While Medicare covers many health care services required by its beneficiaries, it does not cover certain types of care that are important to older people and people with disabilities. Because these services cover a wide array of individuals, it is a considerable target for fraudulent activity.

Medicare fraud, a 368 billion dollar federal program, is an attractive target for perpetrators and continues to be a
growing problem. Federal law defines abuse, under the Medicare program, as incidents or practices by providers, which although not usually considered fraudulent, are inconsistent with accepted sound medical, business or fiscal practices, that directly or indirectly create unnecessary costs to the Medicare program. When it comes to abuse in the system, it involves items and services when there is no legal entitlement to that payment for items or services and the provider has no knowledge of misrepresentation of the fact to obtain payment. 66

In areas such as South Florida, this fraud arena is very high and is replacing drug trafficking and is becoming a way that perpetrators can get rich quickly. For many drug dealers, Medicare fraud has become their new career focus. Drug dealers have been interviewed by FBI agents and have stated that they are moving from cocaine to wheelchairs and walkers. Malcolm Sparrow of Harvard's Kennedy School of Government says that "former drug dealers give three reasons for switching their career focus. These reasons are that "There's more money, there's much less chance of being caught and if I do get caught, being treated like a white-collar criminal, not like a drug dealer. There's also a

fourth reason and that is that they're less likely to be killed in a drive-by shooting". 69

"Fraudulent Medicare claims estimated at between 300 million and 400 million dollars and were prosecuted in just two South Florida counties in the past year. Those are just the cases that have drawn the attention of the courts. Estimates of total losses range as high as ten times that much". 70 Medicare fraud often involves the use of durable medical equipment, which includes items such as wheelchairs, back braces, canes, walkers, electric beds and shower-transfer tubs. Perpetrators use such items to defraud the federal government’s Medicare program.

The white collar crime program in Miami Florida, which is run by Tim Delany and twenty seven other agents, spent a lot of time on the issue of Medicare fraud. When a new Medicare Strike Force program went into operation in Miami, many people had been charged. "Many of those arrests are


for scams involving durable medical equipment."  

Delaney says "It's a field where you can be a relatively recent immigrant new to America and not know anything about the health-care system and open up your own company and start billing."

Start up fraudulent companies bill the government for tens of thousands of dollars a month for equipment and services that Medicare beneficiaries never receive.

Medicare fraud is also attracting perpetrators to new arenas in health care fraud. The new arenas involve "clinics that administer drugs intravenously to people with HIV and AIDS. Investigators call that infusion-therapy fraud".  

Single treatments for HIV and Aids can end up costing the federal government thousands of dollars. New fraudulent activity by perpetrators involves billing the government for the expensive drugs, then administering only saline solution or nothing at all to AIDS and HIV patients. In recent cases patients blood samples were

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modified by lowering the platelet counts to convince medical personnel that an expensive AIDS drug was needed. In the majority of these scams, the patients are aware of what is going on and in some cases are even involved in the acts.

Patients are involved in the schemes are often paid kickbacks as a payment for their participation. The amounts are hundreds of dollars just for these patients to sit and take these injections. "In many cases Medicare beneficiaries are the victims, not the perpetrators of the fraud. In one case, an employee at the Cleveland Clinic in Naples, Fl. stole billing records for more than 1,000 patients. Before long, one of those patients received a notice from Medicare about treatment he had supposedly received. It was for wound treatments and the treatments were never performed". The reimbursement for this supposed treatment was 6,000 dollars. In that case, the two people involved were cousins and in many Medicare fraud cases acquaintances and family members are often involved.

Medicaid Fraud

Under the Medicaid program, taxpayer dollars are used to provide health care to low-income individuals. It is fundamental that these dollars be efficiently spent to help those in need. A small percentage of Medicaid providers and recipients engage in various forms of fraud and abuse.\textsuperscript{76}

Advocates for change point out that Medicaid and private insurance companies are also encountering a fraud problem and that there are a few factors that make it almost a perfect target. One is that it is a trusting system, "set up to serve honest physicians with few safeguards designed to weed out false claims. Also, most claims are paid automatically, so there's little or no person to person contact".\textsuperscript{77}

There are numerous types of Medicaid fraud committed by providers or recipients. These types are:


• "Loanng his/her Medicaid Identification card to another person;

• Forging or altering a prescription or fiscal order;

• Using multiple MA ID cards;

• Intentionally receiving duplicative, excessive, contraindicated or conflicting health care services or supplies; and

• Re-selling items provided by the Medicaid program".78

A small number of recipients are involved in fraudulent behavior and abuse in regards to their Medicaid privileges. The United States Health and Human Service's Office of Medicaid Management oversees a recipients use and investigates other charges of fraudulent behavior in order to take proper actions. Some types of recipient fraud, such as forging prescriptions, "are subject to prosecution and will be referred to the appropriate authorities. A small number of Medicaid providers engage in fraudulent activities. The Office of Medicaid Management reviews provider billing and other activities and investigates

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charges of fraudulent behavior in order to take appropriate actions".79

Medicaid provider fraud happens in a number of forms. These forms include:

- "Billing for services that were not provided, e.g., a chest x-ray that was not taken.
- Duplicate billing which occurs when a provider bills Medicaid and also bills private insurance and/or the recipient.
- Requiring the recipient to return to the office for more visits when another appointment is not necessary.
- Taking unnecessary x-rays, blood work, etc.
- Upcoding, e.g., providing a simple office visit and billing for a comprehensive visit.
- Having an unlicensed person perform services that only a licensed professional should render, and bills as if the professional provided the service.
- Billing for more time than actually provided, i.e., counseling, anesthesia, etc.

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• Billing for an office visit when there was none, or adding additional family members' names to bills.

• Accepting payment from another provider, including sharing in the reimbursement paid by the Medicaid program, as a result of referring a patient to the other provider".\(^\text{80}\)

"The vast majority of physicians, providers, and suppliers who serve people with Medicare/Medicaid are committed to providing high quality care to their patients and to billing the programs only for the payments they have earned. However, there are a few individuals who are intent on abusing or defrauding Medicare/Medicaid, cheating the program out of millions of dollars annually. Medicare/Medicaid fraud takes a lot of money every year from the Medicare/Medicaid program, and people with Medicare pay for it with higher premiums".\(^\text{81}\)

The illegitimate proceeds of schemes typically amount to very significant amounts of money. In cases involving individual fraudulent providers, it is common to see


\(^{81}\) U.S. Department of Health & Human Services Medicare Fraud Overview
schemes in which the perpetrators have ranged from a few hundred thousand dollars to several million dollars in a relatively short period prior to their detection. In November, 2001, an Arlington, Texas chiropractor was sentenced to five years in prison after pleading guilty to masterminding a broad-based scheme responsible for submitting 5.7 million dollars in false claims. In this, 3.2 million dollars was paid to a variety of health insurers over a five-year period.

In institutional cases, involving such fraud committers as hospital chains, national laboratory companies, transportation, pharmaceutical and medical equipment companies, the totals in various federal criminal and civil fraud cases of recent years have ranged from tens of millions to hundreds of millions of dollars.\textsuperscript{2} Several recent high-profile fraud cases involving hospital chains and pharmaceutical companies have resulted in criminal and/or civil settlements ranging from six hundred million to eight hundred fifty million dollars. Regrettably, the use of anti-fraud education has not put a halt to fraud in this industry.

\textsuperscript{2} National Health Care Anti Fraud Association
A Boston-area psychiatrist, forfeited 1.3 million dollars and was sentenced to several years in federal prison following his conviction on 136 counts of mail fraud, money laundering and witness intimidation related to his fraudulent billing of several health insurers for psychiatric therapy sessions that never took place using the names and insurance information of many people whom he actually had never met nor treated. In fabricating the claims, the psychiatrist also fabricated diagnoses for those patients many of them, whom were adolescents. The conditions he assigned to them included depressive psychosis, suicidal ideation, sexual identity problems and behavioral problems in school. 

Privately insured patients typically have lifetime caps or other limits on benefits under their policies. Every time a false claim is paid in a given patient’s name, the dollar amount counts toward that patient’s lifetime or other limits. Part of the abovementioned psychiatrist’s fraud involved routinely billing for the maximum number of therapy sessions covered by patient’s health insurance,

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81 National Health Care Anti Fraud Association

82 National Health Care Anti Fraud Association
even if they had seen them only a handful of times.\textsuperscript{85} Some patients discovered the fraudulent claims only when treatment by different psychiatrists was denied on the basis that they had already used all of their available benefits.\textsuperscript{86} The perpetrators of some types of fraud schemes deliberately and unsympathetically place their trusting patients at significant physical risk, illustrating vividly why federal law provides for longer potential prison terms in health care fraud cases that result in a patient’s injury or death.\textsuperscript{87}

In June, 2002, a Chicago cardiologist was sentenced to twelve and a half years in federal prison and was ordered to pay 16.5 million dollars in fines and restitution after pleading guilty to performing 750 medically unnecessary heart catheterizations, along with unnecessary angioplasties and other tests as part of a ten year fraud scheme.\textsuperscript{88} Three other physicians and a hospital administrator also pleaded guilty and received prison sentences for their part in the scheme, which resulted in

\textsuperscript{85} National Health Care Anti Fraud Association
\textsuperscript{86} National Health Care Anti Fraud Association
\textsuperscript{87} National Health Care Anti Fraud Association
\textsuperscript{88} National Health Care Anti Fraud Association
the deaths of at least two patients. The physicians and hospital induced hundreds of homeless persons, substance abusers, and elderly men and women to feign symptoms and admitted them to the hospital for unnecessary procedures, by offering them such incentives as food, cash and cigarettes.\textsuperscript{89}

**Pharmaceutical fraud**

Pharmaceutical fraud is currently accounting for the largest False Claims Act recoveries by the United States and Qui Tam relator whistleblowers.\textsuperscript{90} With the initiation of the Medicare prescription plan, even more federal tax dollars will flow into the pockets of large drug companies illegally.

Pharmaceutical fraud can take on many forms. These form include:

- "charging for drugs not used and returned to pharmacy providers;"

\textsuperscript{89} National Health Care Anti Fraud Association

• marketing promoting, and selling drugs for uses other than those approved by the FDA;
• marketing drugs to physicians through illegal means, such as providing financial or other benefits, like expense-paid consulting trips to doctors and providers who participate in drug marketing promotional meetings;
• charging prices to the Government that are higher than is allowable by law". 91

In general Pharmaceutical fraud creates a massive problem for the whole healthcare industry. In addition to the threat to patient's safety, fraud negatively impacts the reflection, integrity and financial well-being of pharmaceutical companies that are dependent on the management of their products and how they manage their problems.92 "With the rapid growth of on-line pharmacies, with the potential to bypass safeguards, together with increasingly sophisticated technologies, fraud and counterfeiting is no longer just a problem in developing countries. However, with the help of novel technologies and the implementation of a number of practical management

92 Combating Pharmaceutical Fraud Counterfeiting 2003; SMi Group
strategies, there seems to be potential to drastically cut the huge number of open cases of fraud, diversion, tampering, smuggling and parallel importing reported by the authorities world-wide". 93

Overall, those who commit fraud in the health care sector have all the necessary tools with which to commit ongoing fraud. These tools include but are not limited to:

- The entire population of insured patients to attract and exploit;
- The entire range of potential medical conditions and treatments on which to base false claims; and
- The ability to spread false billings among many insurers simultaneously, increasing their fraud proceeds while lessening their chances of being detected by any one insurer. 94

Fraud and abuse affects everyone from the recipients of care, to the taxpayers who pay for it and a greater part of providers who provide quality care.

93 Combating Pharmaceutical Fraud Counterfeiting 2003; SMi Group

94 National Health Care Anti Fraud Association
Chapter IV

Government Response
Contemporary statements by program administrators and law enforcement personnel suggested that there was a desperate need for more accountability in the health care. Bruce Vladeck, the former administrator of the Health Care Financing Administration, wrote in the Journal of the American Medical Association" that there was "an enormous increase in health care fraud and program abuse, considerable temptations are cropping up for those unable to resist the quick buck".⁶

In a medical billing system errors are likely to occur. Many times the errors that occur are human errors, likely occurring when wrong codes are punched in. It is very difficult to catch these errors and if someone is stuck with a large medical bill and their insurance company refuses to pay all of it they may find themselves in a lot of confusion. Even the simplest medical procedure can cost tens of thousands of dollars. One error could add several thousand dollars to an already hefty bill. Even if the insurance does cover the entire bill the excess cost will be passed along to the patient eventually in the form of higher insurance premiums so it's in everyone's best


interest to detect and correct hospital billing errors. Some of the errors may be more difficult to identify and the item may be valid even if the amount billed for it is not. Overcharges are one of the most common billing errors. Duplication is another common billing mistake. If there is the same charge listed more than once then there is usually a problem.

In 1998, there were 322 criminal health care fraud cases filed under the FCA in addition to 3,471 health care fraud matters pending and on 107 civil cases being filed. In addition, the Department of Justice had recovered 2 billion dollars in matters involving alleged fraud in the health care sector. Over half of the money that was recovered by the Department of Justice in health care fraud cases that year involved judgments and settlements related in some sort to allegations of Qui Tam cases.

Currently there are many Qui Tam cases that are either pending or under seal that involve a variety of fraudulent

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pharmaceutical activities. Currently the pharmaceutical industry is facing their biggest challenge. "Whistleblowers have exposed and continue to expose fraudulent practices ranging from pricing issues to sales and marketing practices at a rate never anticipated by either the pharmaceutical industry or the Department of Justice. Settlements and jury verdicts have been headline grabbing and large, attracting the attention of pharma, regulators, Congress and taxpayers. The Qui Tam pharmaceutical fraud cases settled since 2000 alone have amounted to over 3.5 billion dollars, representing various patterns of fraud. It is expected to see some new patterns as time goes by". 99

Most criminal and civil prosecutions and penalties for health care fraud and abuse involve false claims. Many federal laws authorize the criminal and civil prosecution of fraud. Civil false claims cases can involve large recoveries against defendants in health care fraud cases. In addition to other health care issues such as Medicaid and Medicare, the False Claims Act separates and increases the penalties and can be assessed under the Program Fraud and Civil Remedies Provisions, which the False Claims Act

99 Pharmaceutical-kickbacks.com: visited on 12/13/07
provides civil penalties and treble damages in cases that an individual is found liable for filing a false claim.\textsuperscript{103}

The United States War on Health Care Fraud

The government's war on health-care fraud began in 1993 when the Attorney General announced that combating the fraud would be a top priority for the Department of Justice.\textsuperscript{101} Through using the law aggressively, the government has obtained huge settlements and paid sizable amounts to private individuals who have brought fraud to the attention of the government in the health care sector.\textsuperscript{102}

Health Care Fraud is particularly covered in section 287 of the False Claims Act. This section is frequently used in prosecuting Medicare and Medicaid fraud. It is favored among prosecutors because of its success as a deterrent. Section 287 prohibits "knowingly making or presenting any


\textsuperscript{101} Slade, Shelley R. "Health Care Fraud: How Far Does the False Claims Act Reach?" Health Care Fraud. (2000).

\textsuperscript{102} Slade, Shelley R. "Health Care Fraud: How Far Does the False Claims Act Reach?" Health Care Fraud. (2000).
false, fictitious, or fraudulent claims to any department or agency of the United States." In this the federal government must prove three elements to obtain a conviction for health care fraud under the False Claims Act. These elements include the defendant presenting a claim (demand for money or property) to the government seeking reimbursement for medical services or goods; the claim was false, fictitious, or fraudulent; and the defendant had both knowledge of the claim's falsity and the intent to submit it.

In addition to a criminal action, under the FCA the government may also bring a parallel civil action seeking relief in health care fraud cases. For the purposes of proving health care-related fraud under the FCA, the federal government can demonstrate that the defendant presented a claim directly seeking payment from the government for either services or for equipment. The government's use of the False Claims Act in some instances by critics appears to be effective in deterring health-

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related fraud. When the New York Times reported in 1999 that "Medicare spending had dropped for the first time in the history of the program, the paper noted that federal efforts to "rein in fraud" have been at least partially responsible for the decline". 106

The Department of Justice in regards to civil cases, receives referrals from private whistleblowers bringing Qui Tam actions, along with other informants, and federal and state agencies. The Justice Department carefully examines each referral to determine the liability of the health care provider and encourages providers to brief the responsible government attorney on any factors that may be relevant to the case. 107 Qui Tam suits have drastically increased detection of monetary recoveries for health care fraud. The Qui Tam provisions in general provide strong financial incentives to expose fraudulent activities, which has been an incentive for health care fraud as well. 108


Under the FCA negligence, mistakes, and inadvertence do not constitute a false claim, and the Department of Justice will not bring an action under the False Claims Act if it is against doctors and hospital for honest billing errors. The Federal government has a way of tracking the errors that are made in Medicare/ Medicaid but often overlooks that fraud detection. These errors are due to overlooking of paper work errors. Error when it comes to Medicare/Medicaid refers to a mistake without intent to deceive. 109

When the federal government suspects health care fraud it can bring a charge under a number of statues other then the FCA. These statues include the Social Security Act, False Statements Act, criminal fraud statues, specific Medicaid and Medicare fraud statues, and HIPAA. 110 In response to fraudulent activity in the health care sector, Congress in 1996, enacted HIPAA which has been widely used as a tool against fraud. HIPAA specifically established health care fraud as a federal criminal offense, providing additional enforcement tools, with the basic crime carrying a federal prison term of up to ten years in addition to significant

109 The Department of Justice GAO Report 2008
financial penalties. ¹¹¹ When Congress passed HIPAA, the focus of attention was portability. The portability provisions of the Act have had relatively little impact on the portability of health care benefits, while the drive for accountability has resulted in an unprecedented number of civil and criminal enforcement actions; the transfer of billions of dollars from providers and insurers to the federal government and whistleblowers; the expenditure of tens of millions of dollars on lawyers, accountants, consultants, and compliance programs; and vehement protests by providers. ¹¹²

This Act has many titles, however Title II is the most important for accomplishing the governments anti-fraud goals. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers.

¹¹¹ United States Code, Title 18, Section 1347.

The Administration Simplification provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the US health care system, which will aid in ending future fraudulent activity in the health care system.

Following the mandate of HIPAA, the Department of Justice and the Department of Health and Human Services issued guidelines for implementing the anti-fraud program created by the legislation. The guidelines provide a broad outline of how law enforcement looks to proceed with the coordinated anti-fraud program mandated by HIPAA. In addition to setting forth general law enforcement priorities, the guidelines also look at the creation of a federal database of anti-fraud sanctions, provisions for health care provider guidance on fraud statutes and regulations and privacy provisions. Large portions of the Guidelines indicate how federal law enforcement will conduct investigations concerning federal health care programs. "While these Guidelines necessarily represent a preliminary outline of this program, they provide a useful

starting point for developing a more effective overall anti-fraud program. 114

From the perspective of private payers, the HIPAA section entitled Coordination and Exchange of Information is the most important section of the guidelines when it comes to health care fraud. This section sets new rules on how information should be exchanged between all health care fraud investigators, public and private. 115 The Guidelines state that each health plan should establish policies to ensure that relevant information on health care fraud is provided to law enforcement and to other health plans. The specific categories of information that are provided should include information on potential fraud violations, information requested by law enforcement authorities and information that will assist in the identification of potential cases, including surveys, quality assurance programs, provider profiles or other like forms of information. 116 Pursuant to this section, each plan should


establish such procedures or any penalties if a plan fails to create such policies."117

The guidelines also set forth that each federal, state and local law enforcement agencies acting as part of this coordinated program "should establish policies for the exchange of the following categories of information with health plans, to the extent such exchange is permitted by law and where disclosure would not jeopardize ongoing law enforcement activities".118 The categories of information include, but are not limited to, information that will help in the investigation; audit, or evaluation, information that could assist health plans in establishing and maintaining appropriate controls; information or evidence discovered in the course of an investigation, including periodic updates on the status of the investigation or related proceedings; information to be conveyed to victims of health care crime; and information discovered in the course of an investigation or proceeding which indicates an ongoing quality of care problem".119


Although HIPAA provides for participation by private payers in anti-fraud efforts, the private payer's role in fighting fraud has gone unnoticed, by law enforcement, health care providers and even some payers themselves. HIPAA creates significant opportunities for payers, ones that should not be overlooked. "While private payers are not the focus of the extensive HIPAA anti-fraud provisions, the fundamental premise of the HIPAA anti-fraud plan is that all entities involved in fighting health care fraud should work more collectively, due to the problem that fraud affects all health plans, public and private". The statute mandates the adoption of a coordinated anti-fraud program, which involves law enforcement and private payers, in addition to increasing sharing of information between public and private fraud fighters.

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The States Response

A complicated interlocking array of health-care-specific civil, criminal, and administrative anti-fraud laws and regulations were enacted by states and the federal government, along with multiple levels of investigative and enforcement agencies. In addition to the Federal False Claims Act, states such as California, Delaware, Florida, Hawaii, Illinois, Louisiana, Massachusetts, Nevada, Tennessee, Texas, and the District of Columbia, have enacted State False Claims Acts and Qui Tam laws. Whistleblowers in those places can recover money from companies and individuals who defraud state and local government's. The civil False Claims Acts in these states focus on health care fraud, but few have modeled their statutes after the federal False Claims Act itself. States have a responsibility to ensure the integrity of the activities conducted within the health care programs. Oversight by state administrators is the first line of prevention against health care fraud and abuse in many states. In their role as administrators, states are required to address provider enrollment, claims review and case referrals.

Many states are engaged in enforcing the goals of HIPAA. HIPAA requires states to:

- collect and verify basic information on potential providers, including whether the providers meet state licensure requirements and are not prohibited from participating in federal health care programs,

- have an automated claims payment and information retrieval system, intended to verify the accuracy of claims, the correct use of payment codes, and patient’s medical eligibility—and a claims review system intended to develop statistical profiles on services, providers, and beneficiaries to identify potential improper payments, and

- refer suspect overpayments or over utilization cases to other units in the Medicaid agency for corrective action, and potential fraud cases to law enforcement—generally to the States Medicaid Fraud Control Unit for investigation and prosecution.

State agencies are required to conduct preliminary investigations when they identify questionable practices or receive complaints of suspected fraud or abuse. CMS’s role has been largely one of support to the states. In most states the function of investigating and prosecuting
provider's for fraud falls to the state Medicaid Fraud Control Unit (MFCU) is typically located within the state attorney general's office. Forty-eight states and the District of Columbia have established MFCUs.

In recent years states such as California and Florida have had a tremendous growth in the amount of fraud in the health care sector. As enforcement officers and the government fight against these activities they are also establishing task forces to control and eliminate the problem. Large amounts of money continues to be lost do to fraudulent actions in these states and many others.

The Effectiveness of the Response

Over the past decade, the health care community has witnessed dramatic changes in government efforts to enforce fraud and abuse laws. \(^{123}\) Overall the FCA along with HIPAA have powerful and far reaching effects. Sen. Grassley of Iowa, who is a sponsor of the 1986 FCA Amendments and who introduced the False Claims Correction Act of 2007, which will be discussed later in this thesis, says that “With

billions of dollars of profits at stake in the health care industry, more must be done to stop the perception that fraud settlements are the cost of doing business with the federal government. Taxpayers can’t continue to subsidize those drug companies that rely on ill-gotten profits. That’s why I’m urging all the major drug companies to launch meaningful anti-fraud programs, with informing all employees about the False Claims Act as the centerpiece”.

HIPAA has been a very effective tool in the United States efforts to prevent fraud in the health care sector, however, the FCA is the oldest and main initiative in preventing fraud. The FCA is a more mature statute. Although the statute has received criticism in its interpretation and effectiveness, it has been responsible for recovering millions of dollars from fraudulent health care cases each year. “A major factor in the government’s stride to combat health care fraud is the financial incentives for whistleblowing established by provisions in the False Claims Act that permits private persons to bring cases on behalf of the United States and to share in the government’s recovery”. "When private whistleblowers bring


fraud to the attention of the government, they can receive large amounts of money equaling millions of dollars. Publicity concerning these awards motivates otherwise reluctant informants to bring additional fraud to light, and increases public awareness concerning the reach of the False Claims Act".\textsuperscript{126}

Author Shelley R. Slade has compiled a list of examples of sizable recoveries by whistleblowers. These examples are:

- Louis Mueller receiving, 678,584 dollars, from a 1999 settlement with Walgreen Company, the retail pharmacy chain, after Mueller filed a False Claims Act case reporting that Walgreen billed Medicaid the full amount for prescriptions that were only partially filled.

- As part of a 1998 settlement, Francine Mettevelis and Rhea Jones received 903,899 dollars for reporting that Charter Behavioral Health Systems - Orlando billed Medicare for medically unnecessary psychiatric care for elderly patients with severe dementia, Alzheimer's disease and other organic brain disorders.

\textsuperscript{126} Slade, Shelley R. "Health Care Fraud: How Far Does the False Claims Act Reach?" Health Care Fraud. (2000).
• The estate of Teresa Semtner received 3.2 million dollars after Semtner brought a suit against Emergency Billing Services, disclosing the company’s practice of upcoding the claims of its clients.

• George Denoncourt received approximately 4 million dollars as part of the settlement of his allegations that the State of New York was overcharging the federal government under various Social Security Act programs, including Medicaid.

• Donald McLendon, the former Vice President of Olsten Corp., received 9.8 million dollars as part of a 1999 settlement of his allegations that Olsten charged Medicare for unallowable, sales and marketing costs.

• As part of a 140 million dollar civil settlement with Health Care Service Corporation, the private plaintiff was paid more than 21 million dollars for exposing that this Medicare carrier had submitted false information to the Health Care Financing Administration, failed to process claims in accordance with HCFA's guidelines, and failed to process correspondence and reviews in a timely manner.

• In 2002, Eckerd Corporation, a national retail pharmacy chain, paid the United States 5.87 million dollars to resolve allegations that Eckerd dispensed partial prescriptions due to insufficient stock, but billed for the full quantities prescribed for
beneficiaries of Medicaid and other government health insurance programs.

The health care anti-fraud landscape is critically different today than it was years ago. Health care fraud is higher on the list of priorities for federal law enforcement than it has ever been. Government settlements demonstrate the power and monetary impact of active fraud investigations. To aide in this battle, legislation provides new law enforcement investigative tools and additional resources in fighting Health Care.\textsuperscript{127} "Legislation has created substantial new opportunities for payers with aggressive fraud-fighting skills and the expanded emphasis on fraud-fighting at all levels of law enforcement also means new risks for payers in conducting their primary business activities".\textsuperscript{128}

The issue of False Claims act has not only gotten legislative attention, it has also been an issue in the Supreme Court. In the recently decided case of Allison Engine Co. v. United States on June 9, 2008, which will be discussed in detail later in this thesis, the U.S. Supreme


Court's decision curtailed the Sixth Circuit's expansive reading of the False Claims Act. It imposes on plaintiffs the significant burden of proving that a false statement or record was intended to be material to the Government's decision to pay. Subcontractors working on a Government project still may be exposed to liability under the Act, even if they do not submit statements directly to the Government, provided a plaintiff can prove the requisite intent.

The Court has made it clear in this case that FCA liability does not extend to situations where the link between a defendant's false statement and the government's decision to pay is attenuated beyond foreseeable limits. This decision by a unanimous Court narrows FCA liability from the widest potential claim to focus on what is reasonably foreseeable. This case insures that the False Claims Act remains a remedy for fraud, but narrows the scope of liability.129 The impact health care fraud is yet to be seen.

Chapter V

Case Examples
Fraud happens every day in every healthcare system. The majority of fraud remains undetected and thus invisible. Because most fraud is invisible, the United States can benefit greatly from whistleblowers who assist the U.S. and States to overcome the difficulty of detecting fraud. The cases in this chapter were chosen to give an overview of the wide variety of methods of operations in health care fraud schemes and a demonstration of the usefulness of the Qui Tam provisions as a means to detect fraud and prosecute its perpetrators. The cases in this chapter were selected to give a broad overview of how large a problem fraud is in the health care sector and additionally were chosen based on the following criteria that are useful in explaining and addressing the effectiveness of the FCA:

- Amount of money recovered
- Geographic area in which activity occurred
- Time period from whistleblower complaint to outcome favorable to government
- Amount lost in comparison with amount recovered
- Civil cases turned criminal, and
- Cases leading to other recoveries.

There are hundreds of cases pending involving the health care and pharmaceutical industries and often involve Medicare and Medicaid funds.
From among the hundreds of cases, four cases will be highlighted here. The first Medicare case is one of the largest fraud cases committed by a company. The second Medicare case discussed is the largest fraud case committed by a single person. The final two cases give an example of how one recovery can lead to others, and how offices other than the United States Department of Justice aide in the recovery of fraud. These cases give an example of how broad fraud is in the health care sector. Additionally, these cases take place in geographical areas in which fraud is likely to occur. The cases outlined in this chapter have returned sizable amounts to relators as in those cases listed in Appendix C, giving insight as to how much whistleblowing is an incentive to a relator for reporting fraud.

Case #1 (Medicare Fraud) Columbia/HCA

In 2001, the Department of Justice joined a lawsuit alleging that Columbia/HCA Healthcare Corporation and Quorum Health Group, which are two national hospital chains, defrauded the Medicare program and other federally
funded health insurance programs.\textsuperscript{110} Columbia owns approximately 320 hospitals, while Quorum owns and operates about 250 hospitals. In this case there were more than 200 hospitals and approximately thirty seven states that served as defendants. According to the complaint, beginning around 1984, Columbia/HCA and Quorum made false statements to various fiscal intermediaries, the companies that process Medicare cost reports for the government, in their annual cost reports, claiming that they should receive reimbursement of costs that the hospitals knew were unallowable.\textsuperscript{111}

In this lawsuit, it was claimed that Columbia/HCA and Quorum prepared reserve cost reports, internal documents which included certain unallowable costs contained in their filed cost reports, and kept those reserve cost reports hidden from government auditors.\textsuperscript{112} The lawsuit additionally


alleged that the purpose for accounting purposes to reserve funds and repaying the government in the event that the unallowable costs were eventually discovered by the government.\textsuperscript{113} The suit, brought against these two companies came after years of investigation into allegations of fraud occurring at the companies. The suit says that the hospitals routinely overstated expenses in reports to the Government to increase their compensation from the Federal Medicare program. \textsuperscript{114} Another Company that was named in the suite was Healthtrust, a for-profit hospital chain now owned by Columbia, and Quorum Health Resources, a subsidiary of Quorum that is the country's largest manager of not-for-profit hospitals.

The lawsuit, which was unsealed in Federal District Court in Tampa, Florida., was originally filed in 1993 by a corporate whistle-blower. The suit was then reviewed and investigated by the Justice Department, which filed a motion to join the litigation. The Government had previously brought criminal charges against four Columbia


executives who had been involved in the preparation of cost reports for one Florida hospital in earlier years.\textsuperscript{15} Quorum, which had been under investigation at the time of the case, for possible irregularities in its cost reports, was part of the Hospital Corporation of America (HCA) until the late 1980’s; afterwards Columbia bought HCA in 1994. This litigation is just a reminder of the Federal cost-reporting system, and equals billions of dollars in reimbursements by the Government to hospitals and other health care providers.\textsuperscript{16} Through this reporting system, portions of costs associated with patient care are reimbursed by programs like Medicare at different rates.\textsuperscript{17} The Government in this case contended that the companies intentionally misrepresented costs to increase the reimbursement rate or receive payment for costs that were not eligible for reimbursement.\textsuperscript{18} Although the lawsuit does


\textsuperscript{17} Department of Justice. Immediate Release. April 23 2001.

\textsuperscript{18} Department of Justice. Immediate Release. April 23 2001.
not specify the amount the Government was seeking from the two companies, it says that through the scheme, federal health programs "have been damaged in the amount of many millions of dollars". 139

Much of the government’s supporting evidence was based upon second sets of cost reports and work sheets maintained at the hospitals that contained significantly lower expenses than those in reports submitted to the government. 140 Large portions of that information was confiscated by the government during a civil investigation into the two companies cost-reporting practices. 141 In an internal statement to its employees, Columbia said "that the issues raised in the suit were not new. But the statement added that the Government’s action could well be an important step in bringing an end to the dispute. "We anticipate that the Government joining of this lawsuit will facilitate our ability to reach a resolution of these issues". 142 The President and chief executive of Quorum, James R. Dalton


Jr., stated that "the company had always striven to submit honest claims to the Government. Throughout Quorum's existence, we have tried our very best to follow all the applicable rules. Quorum is very proud of the rigorous honesty and the highest ethical values that we believe our people -- from management to all of our associates -- exhibit every day".

The lawsuit was filed under seal by James F. Alderson, who is the former chief financial officer of North Valley Hospital in Whitefish, Mont., managed by Quorum. Alderson's lawyer issued a statement in regards to the case, saying that "their client was ordered to file aggressive cost reports with the Government, and establish a second document called a reserve report". 143 In the second set of court documents there is a statement stating that the reports in fact did contain accurate information about the true expenses. When Mr. Alderson refused to follow those instructions, the lawyers said in their statement, he was dismissed. Lawyers involved in the case said that the investigation had obtained large amounts of evidence

proving the fraud and that the final claim against the companies would be huge.

Each of the corporate defendants was at one point owned by or was a owner of the Hospital Corporation of America, one of the original for-profit hospital chains. The thirty three page case complaint details a wide range of methods it contends were used to misrepresent costs and defraud federal health programs. For example, the complaint contends that the companies improperly misrepresented operating expenses, which are reimbursed at a low rate, as being highly compensated capital costs. Then, the suit says, the companies established short-term reserves in the event that the misrepresentation was later caught by Government auditors, which would result in a requirement for the companies to repay the money.

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Additionally, the suit stated that the companies misidentified capital costs for projects that begun before 1990 as having been incurred after that date.\textsuperscript{147} Under the law, the newer costs are reimbursed at a higher rate than the one for the older costs.\textsuperscript{148} Those costs were correctly characterized in the reserve reports of this case. In addition to increasing the reimbursable amounts for some costs, the suit alleged that the companies often misrepresented expenses in their reports that were unrelated to patient care and were not reimbursable.\textsuperscript{149} For example, the suit says that the companies included costs associated with marketing, physician recruitment and even hospital televisions. Each of those costs was misrepresented in the filed cost reports, according to the lawsuit, but identified correctly in the second set of reports. The companies also manipulated certain reimbursement calculations by misrepresenting statistics such as time and square-footage.\textsuperscript{150} But in the reserve reports, those statistics were recorded accurately.

\textsuperscript{147} Department of Justice. Immediate Release. April 23 2001.


\textsuperscript{149} Department of Justice. Immediate Release. April 23 2001.

\textsuperscript{150} Department of Justice. Immediate Release. April 23 2001.
In 2001 this case was considered the largest government investigation of Medicare fraud ever. Quorum paid 85.7 million dollars to settle the whistleblower lawsuit in 2001. A judge awarded Alderson twenty four percent of the recovery. HCA later paid in unrelated cases 631 million dollars to settle three Qui Tam lawsuits, including Alderson’s and one brought by John Schilling, another whistleblower.

This case is an example of how long it can take before the United States government intervenes once a claim is brought under the FCA. This case was brought to the government’s attention in 1993, however it was not until 2001 that a reward was recovered. If these companies had previous criminal investigations, then why wouldn’t the Department of Justice monitor their activity very closely? One of the biggest questions raised in this case, which will be discussed more in detail later in this thesis, is why it took the Department of Justice so long to intervene and whether or not less money would have been lost if they would have intervened earlier.

The area in which this activity occurred is another major indicator as to how easily fraud is committed in the
Florida area. The size and complexity of a company is also a deciding factor as to how much money had been defrauded from the federally funded program. Because of the companies' size and the amount of partnerships they had with other hospitals and health care companies, the amount of money that was defrauded is greater than that of companies that singly defraud the government and their federally funded programs, which becomes a major problem for the Department of Justice and ultimately a problem for tax-payers, because of the risk of paying higher health care premiums.

Case #2 (Medicare Case) Rita Campos Ramirez

Under the Medicare program, taxpayer dollars are used to provide health care to low-income individuals. It is essential that these dollars be effectively spent to help those in need. Unfortunately, there are Medicare providers and recipients who engage in various forms of fraud and abuse.

Florida, as mentioned previously, in recent years has been a high traffic area for health care fraud, specifically in the Medicare sector. The Medicare Fraud Strike Force, a
multi-agency team of federal, state and local investigators in south Florida, was designed specifically to combat Medicare fraud in south Florida. In another Medicare case, a high school dropout named Rita Campos Ramirez orchestrated from her Mediterranean-style townhouse, what is currently known as the largest health-care fraud scheme by one person. Over a four year span, she electronically submitted more than 140,000 Medicare claims for unnecessary equipment and services.

Rita Campos Ramirez, owner of a Medicare billing company named R and I Medical Billing Inc., was charged in a two-count criminal information with conspiracy to commit health care fraud and submission of false claims to the Medicare program, stemming from a scheme to defraud Medicare of 170 million dollars. From October 2002 through April 2006, Campos was employed as a medical biller for roughly seventy five Miami-based health clinics that alleged to provide HIV infusion services to Medicare eligible beneficiaries. As part of the scheme, HIV clinic owners would provide Campos with bills stating that HIV patients were being infused with expensive HIV medications in amounts that Campos knew were medically impossible. In most instances, the Medicare program was being billed for the same HIV medications and services at each of the seventy five HIV clinics. During
the approximately four year, Campos submitted 170 million dollars in fraudulent medical bills to the U.S. Department of Health and Human Services on behalf of the seventy five HIV clinics. Of the 170 million dollars in fraudulent bills submitted by Campos, about 105 million dollars was paid to the HIV clinics. Campos received a fee in the region of five percent of all claims paid by Medicare.

After pleading guilty in August 2007 to filing false claims, she has helped authorities, by becoming a whistleblower, win indictments against more than half a dozen doctors and patients who allegedly accepted kickbacks for pretending to receive costly HIV drug therapy. She was also sentenced to forfeit 207,000 dollars, her three homes and an automobile; and pay 105 million dollars in restitution to the U.S. Department of Health and Human Services. With cooperation from Campos Ramirez, PBI agents have arrested three Miami-area men who, the government alleges, “financed sham clinics that billed the government more than 100 million dollars”. Sentenced to 10 years, Campos Ramirez may reduce her prison term by helping authorities close down “the large web of medical clinics, doctors, nurses, money laundering companies and HIV clinic

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financiers who participated in this massive fraud. Rita Campos Ramirez was sentenced in the Southern District of Florida to 10 years in prison and three years of supervised probation.

In addition to the area in which the activity occurred, this case was also chosen based on its recovery amount and it leading to the recovery of other Medicare fraudulent activity. As indicated earlier, this case is the largest scheme committed by a single person in the United States. This fact alone exemplifies how big a profit can be made by a person acting alone, demonstrating that the fraud problem is not limited to major corporations.

Case #3 (Medicaid Fraud) Bristol-Myers Squibb

Indiana Attorney General Steve Carter’s Medicaid Fraud Control Unit (MFCU) investigators recovered 14 million dollars for the Medicaid Program in 2007. Bristol-Myers Squibb (BMS), paid Indiana 5.8 million dollars as part of a multi-state settlement over illegal marketing and pricing

\[^{152}\] Medical Fraud a Growing Problem, Carrie Johnson. The Washington Post, June 13, 2008
practices including the antipsychotic drug Abilify, and the anti-depressant Serzone.

The Government alleged that, from approximately 2000 through mid-2003, BMS knowingly and willfully paid illegal compensation to physicians and other health care providers to induce them to purchase BMS drugs.\textsuperscript{153} BMS paid the illegal compensation in the form of consulting fees and expenses to physicians and other health care providers to participate in various consulting programs, advisory boards, and preceptorships. Some of these programs involved travel to luxurious resorts. The Government also alleged that, from 1994 through 2001, the company knowingly and willfully paid illegal compensation such as stocking allowances, price protection payments, probates, market share payments, and free goods in order to induce its retail pharmacy and wholesaler customers to purchase its products.\textsuperscript{154} In the case, the Government suspected that, by paying this illegal compensation to physicians and others, BMS knowingly caused the submission of false and fraudulent claims to the federal health care programs.

\textsuperscript{153} Indiana Business New Press Release March 27, 2008

\textsuperscript{154} Indiana Business New Press Release March 27, 2008
From 2002 through the end of 2005, BMS knowingly promoted the sale and use of Abilify, an atypical antipsychotic drug, for pediatric use and to treat dementia-related psychosis, both off-label uses. The Food and Drug Administration has approved Abilify to treat adult schizophrenia and bi-polar disorder, but has not approved the use of Abilify for children and adolescents or for geriatric patients suffering from dementia-related psychosis. The FDA has mandated that the package for Abilify should carry a black box warning concerning its use in the treatment of dementia-related psychosis. BMS directed its sales force to call on child psychiatrists and other pediatric specialists, and the sales force then urged physicians and others providers to prescribe Abilify for pediatric patients. BMS also created a specialized long term care sales force that called almost entirely on nursing homes, where dementia-related psychosis is far more common than schizophrenia or bipolar disorder.

The Government also alleged that BMS set and maintained fraudulent and inflated prices for a wide assortment of oncology and generic drug products with the knowledge that federal health care programs established reimbursement rates based on those prices. By reporting false and

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United States Department of Justice Immediate Release; Bristol-Myers Squibb to pay more than $515 million to resolve allegations of illegal drug marketing and pricing; September 28, 2007.
fraudulent prices that were considerably higher than commonly and widely available prices in the marketplace, BMS created a spread between the reimbursement rates for federal health care providers and the actual prices for the drugs charged to its customers.\textsuperscript{156} The larger the spread on a drug, the larger the profit or return on investment for the provider.\textsuperscript{157} Because reimbursement from federal programs was based on the fraudulent, inflated prices, the United States alleged that BMS caused false and fraudulent claims to be submitted to federal health care programs. Finally, the Government alleged that BMS knowingly misreported its best price for the anti-depression drug, Serzone. Under the provisions of the Medicaid Drug Rebate Statute, BMS was required to report to Medicaid the lowest, or best price, for Serzone that it charged its commercial customers.\textsuperscript{158} In making its mandatory best price reports, BMS knowingly failed to include the low prices at which it sold private-label Serzone to Kaiser Permanente.\textsuperscript{159} As a result, BMS denied the Medicaid program and certain Public Health

\textsuperscript{156} United States Department of Justice Immediate Release; Bristol-Myers Squibb to pay more than $515 million to resolve allegations of illegal drug marketing and pricing; September 28, 2007.

\textsuperscript{157} Indiana Business New Press Release March 27, 2008

\textsuperscript{158} United States Department of Justice Immediate Release; Bristol-Myers Squibb to pay more than $515 million to resolve allegations of illegal drug marketing and pricing; September 28, 2007.

\textsuperscript{159} United States Department of Justice Immediate Release; Bristol-Myers Squibb to pay more than $515 million to resolve allegations of illegal drug marketing and pricing; September 28, 2007.
Service entities the benefit of the lowest price in the marketplace.

Out of the settlement amount, the federal recovery was over 328 million dollars, of which over twenty five million dollars constituted disgorgement of profits under the Food, Drug and Cosmetic Act resulting from BMS's illegal promotion of Abilify.160 BMS also paid over 187 million dollars to the Medicaid participating states, and 124 thousand dollars to certain Public Health Service entities. This settlement resolves in part allegations made in other Qui Tam actions brought under the False Claims Act against BMS by whistleblowers, Richardson, Piacentile, Forden, Cokus, Barlow, and Ven-A-Care of the Florida Keys, Inc.

Bristol-Myers Squibb agreed to pay 515 million dollars to settle allegations brought in the Qui Tam cases involving pricing and promotional activities (including kickbacks to doctors) for more than fifty drugs, including thirteen drugs with a combined 2007 sales of 10.7 billion dollars -- a total of sixty nine percent of Bristol-Myers' 2007 pharmaceutical revenue.161 Drugs included in this settlement

160 Indiana Business New Press Release March 27, 2008

161 United States Department f Justice Immediate Release; Bristol-Myers Squibb to pay more than $515 million to resolve allegations of illegal drug marketing and pricing; September 28, 2007.
include the blood thinner Plavix, antipsychotic Abilify, the cholesterol treatment Pravachol, the cancer therapy Taxol, and the antidepressant, Serzone. Of the 515 million dollars, approximately three hundred twenty eight million dollars were paid under the Federal False Claims Act, with the state getting a total of one 187 million dollars.

Bristol-Myers Squibb entered into a Corporate Integrity Agreement with the Office of Inspector General of the Department of Health and Human Services that requires the company to report accurate average sales prices and average manufacturer prices for its drugs covered by Medicaid and other federal health care programs. "Illegal drug marketing schemes and deceitful pricing by manufacturers will be vigorously pursued by OIG," said Daniel R. Levinson, HHS Inspector General. "We are committed to ensuring that beneficiaries participating in federal health care programs are not taken advantage of by those engaging in unscrupulous practices". This case is one of the largest settlements in Medicaid to date.

\[^{162}\text{United States Department of Justice Immediate Release; Bristol-Myers Squibb to pay more than $515 million to resolve allegations of illegal drug marketing and pricing; September 28, 2007.}\]
"Those that cheat the Medicaid system hurt the patients they serve and increase healthcare costs over the long run. This latest success builds upon the successes by the Unit over the last several years. Since 2004 the unit has recovered thirty four million dollars for the State. We will continue to work with federal, state and local law enforcement to pursue justice against those that would commit fraud against patients and the public healthcare program", said Attorney General Steve Carter.

This case is an example of the volume of cases that can come out of one. After this case was settled it resulted in a number of Qui Tam settlements under the FCA involving the same company and the same activities. Additionally, this is an example of how effective the FCA has been in recovering money in more than one case at a time. Although that might be the case, the investigation period is still lengthy one. As it may seem, the Government is recovering the amount of money lost over the years, but the tax-payers are still in the hole making up for the fraudulent activities by these companies.
Case #4 (Pharmaceutical Fraud) Boehringer Ingelheim Corp.

In 2005, attorney General Abbott won ten million dollars in a Medicaid fraud case. The attorney General of Texas won this case against a major drug company. This was one of the last lawsuits in a series against several drug companies, amounting in almost fifty six million dollars in recoveries for the state of Texas. The prolonged whistleblower litigation exposed drug-pricing schemes designed to enrich the companies while systematically defrauding the state Medicaid system.\(^{163}\) In the settlement, Boehringer Ingelheim Corp. of Connecticut and its subsidiaries agreed to pay the state ten million dollars in damages to dismiss the lawsuit, which was originally filed in September 2000 after whistleblower Ven-a-Care revealed the fraud to the state.\(^{164}\) The Government intervened after alleging that the drug company engaged in a "scheme to report fraudulent and inflated prices for several pharmaceutical products, knowing that federal health care programs established reimbursement rates based on those reported prices".\(^{165}\) The Attorney General’s suit claimed that the companies

\(^{163}\) www.oag.state.tx.us: visited 1/16/08

\(^{164}\) www.oag.state.tx.us: visited 1/16/08

\(^{165}\) www.oag.state.tx.us: visited 1/16/08
falsified the wholesale prices of several dozen
prescription drugs, particularly inhalants, causing the
Texas Medicaid program to overpay the companies for these
drugs.\textsuperscript{166} "We will not tolerate big pharmaceutical companies
that ignore the laws of Texas and bill Texas taxpayers in
the race for profits.\textsuperscript{167} We will make sure these companies
pay for their wrongdoing and give back money that
rightfully belongs to Texas".\textsuperscript{168}

From at least on or before January 1, 1996, the company
reported prices that were more than 1,000 percent the
actual sales prices on certain drugs it manufactures. The
United States alleged that Medicare and Medicaid have
reimbursed the companies' customers in excess of 500
million dollars for the drugs which were the subject of the
complaint.

The settlement with Boehringer and its subsidiaries -
Roxane Laboratories Inc., Boehringer Ingelheim
Pharmaceuticals Inc. and Ben Venue Laboratories Inc.

\textsuperscript{166} \url{www.oag.state.tx.us}: visited 1/16/08

\textsuperscript{167} Attorney General Abbott: Texas

\textsuperscript{168} \url{www.oag.state.tx.us}: visited 1/16/08
returned money to the state that the companies pocketed over time as they falsely reported their wholesale drug prices to the Medicaid program. The relationship between these companies and the parent company made the schemes very easy, the companies marked up prices by as much as 500 percent to wholesalers, distributors, pharmacies, group purchasing organizations, home health care providers and others delivering prescriptions to Medicaid patients.

The settlement represents the finish of thousands of hours of effort from both the Attorney General and the Vendor Drug Program of the Texas Health and Human Services Commission. The litigation, additionally has resulted in the recovery of millions of dollars for the state and the discovery of the false pricing from Boehringer Ingelheim, Roxane and the other companies and in significant changes in the way that Texas reimburses pharmacists and physicians. In addition, the Attorney General’s Office has shared information with many other states working to

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169 www.oag.state.tx.us: visited 1/16/08
170 www.oag.state.tx.us: visited 1/16/08
171 www.oag.state.tx.us: visited 1/16/08
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recover funds wrongfully paid, as well as to preempt future losses.\textsuperscript{173} Attorney General Abbott's office has also assisted the U.S. Department of Justice and Congress in their efforts to eliminate this fraud. These efforts have and are expected to continue to result in a wholesale change in the way drugs will be reimbursed by Medicaid across the country, which could result in savings of billions of dollars in the future.\textsuperscript{174} Attorney General Abbott successfully concluded other lawsuits through this settlement that over the past years has grown out of the original Ven-a-Care's lawsuit. Dey Inc. which settled for 18.5 million dollars in 2003, and Schering-Plough Inc. and its subsidiaries which settled in 2004 for twenty seven million dollars.\textsuperscript{175}

"Every dollar lost to fraud or abuse is one less dollar available to help the most needy citizens of our state".\textsuperscript{176} "The Office of the Insurance Fraud Prosecutor is committed to fighting healthcare fraud and returning much needed dollars to victims of insurance fraud including Medicaid,

\textsuperscript{171} www.oag.state.tx.us: visited 1/16/08

\textsuperscript{174} www.oag.state.tx.us: visited 1/16/08

\textsuperscript{175} www.oag.state.tx.us: visited 1/16/08

\textsuperscript{176} Insurance Fraud Prosecutor Greta Gooden Brown
Medicaid, Pharmaceutical, insurance companies and taxpayers”. ¹⁷⁷

Concluding Observation

As the Medicare and Medicaid programs advance, so will the amount of fraud committed in these programs. Violations of Medicare and Medicaid laws also constitute violations of the False Claims Act. The False Claims Act has been the weapon of choice when fighting fraud in these sectors, and has been responsible for the many recoveries and convictions of fraud in the health care sector. From the cases discussed in this chapter, it may seem as if the FCA is an effective tool in fighting fraud in the health care sector. As measured by amounts recovered in these other successful FCA cases, the False Claims Act and its whistleblower provisions have been effective in the fight against Medicare fraud. In a six-month study conducted by Taxpayers Against Fraud (TAF) in 2001, TAF found that anti-fraud efforts returned nearly 1.9 billion dollars to the Medicare Trust Fund over the period of FY 1997-FY 2000, and that a significant portion of these recoveries was attributable to FCA cases. Their study also found that, over this four-year period, the federal government was getting a direct monetary return of at least eight dollars.

¹⁷⁷ Division of Criminal Justice Office of the Insurance Fraud Prosecutor for the State of New Jersey
for every one dollar invested in health-related FCA enforcement activities. Based on an analysis of data for the five-year period FY 1997-FY 2001, TAF concluded that the U.S. taxpayers are continuing to get an excellent return on their dollars invested in fighting fraud against the Medicare program. TAF believes that the initiatives already set forth are great in fighting health care fraud but there are still major problems that need to be addressed. The FCA and its whistleblower provisions are central to the federal government's anti-fraud efforts. They provide the federal government with the inside information it needs to uncover complex business fraud against Medicare and the influence it requires to recover stolen funds.

Opinions vary on what is the most successful way to end fraud, while maintaining the reliability of the medical professions and the Medicare and Medicaid programs. The federal Office of Inspector General (OIG) believes that incarceration and extensive fines work best. However, administrators in the federal and state departments that regulate Medicaid and Medicare have concerns that stiff penalties may isolate health care providers to the point that they may cut back or altogether restrain their participation in government programs, plummeting access and quality of services further.
There still remain significant questions, loopholes and doubts in the FCA’s effectiveness. One might raise the following questions when analyzing these cases:

- Why does the Government take so long to intervene;

- Why is the government not monitoring the health care sector very closely, if it is known that fraud is easily committed in that arena;

- What is done to make up for the loss of tax payer dollars during the fraud period;

- Why aren’t companies with prior criminal activity monitored more closely; and

- Instead of whistleblowers going directly to the Department of Justice, why not go to the State Attorney General first.

As will be explored in the next chapter, over the years the FCA has undergone many changes through legislative amendments to the FCA, judicial decisions, and programs now dealing with specific fraud related issues. These improvements notwithstanding, abusers of the health care
fraud system seem to continue to be one step ahead of government regulators and enforcement officials.
Chapter VI

Recent FCA Developments
The drafters of the False Claims Act, both initially and in 1986, made a conscious effort to encourage private enforcement actions under the statute. As an incentive to file the lawsuit, the Act now awards successful relators not only attorney's fees, expenses, and costs, but also a generous amount of money, even if the United States chooses to intervene in the case. Since Congress amended the Federal False Claims Act in 1986, the Act's Qui Tam provisions have become a force in the fight to recover fraudulently obtained federal tax dollars. Qui Tam plaintiffs help return hundreds of millions of dollars to the federal treasury each year. In spite of celebrated successes, health care fraud continues to increase calling into doubt the effectiveness of the FCA as an effective tool against the abuse of fraud.
Legislation

Congress has dealt with the legislation of the FCA many times, in an attempt to make it more effective. In order to further combat health care fraud and abuse, Congress enacted FCA- related provisions as part of the Deficit Reduction Act of 2005 (DRA). These provisions slow mandatory spending in Medicare and Medicaid. Additionally, the DRA includes a provision, § 6032, "that requires health care entities to address fraud and false claims within the

In addition HIPAA provided a solid foundation on which to build program integrity activities. Former President Clinton proposed a number of additional fraud and abuse proposals in his FY98 Budget. In March of 1997, President Clinton presented an additional set of legislative proposals entitled the "Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997". Some of these proposals were built on the provisions enacted in HIPAA. Others sought to close loopholes or weaknesses in the Medicare statute that allowed providers to take advantage of Medicare payments. The provisions required insurance companies to report the insurance status of beneficiaries to ensure that Medicare pays appropriately.

S. 1932 [109th]: Deficit Reduction Act of 2005

Medicaid system”. Section 6032, entitled "Employee Education About False Claims Recovery,” “requires entities receiving or making payments of more than five million dollars annually in Medicaid reimbursement to establish policies and disseminate information to employees about the False Claims Act and anti-fraud compliance”. These DRA provisions are not required for fraud within the Medicare system.182

Most recently, Senators Grassley and Durbin are sponsoring new legislation in response to recent federal court decisions that threaten to limit the scope and applicability of the False Claims Act. The False Claims Act Correction Act of 2007 has the support and co-sponsorship of Senate Judiciary Committee Chairman Leahy and Ranking Member Specter. Senator Grassley was a sponsor of the 1986 amendments to the False Claims Act. It has been demonstrated time and again that without the courage and motivation of these individual citizen whistleblowers, the federal government would not have known what was going on or been able to pursue successful cases against those who defrauded the government, including contractors and state and local governments, as stated by Senator Grassley. “The


successful settlements have returned tens of billions of dollars that would otherwise be lost. The new legislation proposed would work to make sure recent court decisions won’t wane the government’s ability to recover tax dollars lost to fraud, whether it’s in health care another areas of spending”.

This legislation is as significant today as it was when it was enacted during the Civil War in 1863. There ought to continue to be combating of fraud and abuse of government programs and the wasting of taxpayer dollars. One proposed way to do that is to promote and protect employees who come forward to identify fraud. This legislation would ensure that the law continues to do both, as noted by Senator Specter.

The 1986 updates to the FCA are today the government’s weapon against fraud. The False Claims Act Correction Act of 2007 would make the following corrections to the False Claims Act as presented by Sen. Grassley:

• Makes corrections to 31 U.S.C § 3729 removing the requirement that false claims be presented to a government employee. This section corrects longstanding problems with the requirement that false claims be presented directly to
government employees, instead applying liability directly to any false claim regarding government money or property. This correction ensures that any government money lost to fraud, waste, or abuse can be recovered using the FCA regardless of whether the individual making the false claim directly represents such a claim to a government employee. This problem arose following the D.C. Circuit Court of Appeals decision in U.S. ex rel. Totten v. Bombardier Corp, 380 F.3d 488 (2004) which held that false claims to government grantees (here Amtrak) were not presented to a government employee and barred government recovery of government funds lost to fraud. It was finally resolved by the Supreme Court in 2008;

- Amends the FCA to clarify the dismissal of parasitic claims filed based upon publicly disclosed information. Commonly referred to as the public disclosure bar, the FCA currently allows for the dismissal of FCA cases brought based upon publicly disclosed information unless the relator is the original source of the public information. This correction also clarifies it is the exclusive right of DOJ to dismiss relator claims on public disclosure grounds, and not a jurisdictional defense of those who defraud the government;
Clarifies that false or fraudulent claims against non-U.S. Government funds under the trust and control of the U.S. Government are subject to recovery under the FCA. This clarification would ensure funds administered by the U.S. Government on behalf of third party nations or other entities are protected from fraud, waste, or abuse by extending FCA liability to those funds;

Clarifies a split between Circuit Courts of Appeal as to when a government employee may act as a Qui Tam relator under the FCA. This clarification would explicitly state in statute the original legislative intent of the 1986 amendments to the FCA allowing government employees to act as Qui Tam relators in limited circumstances when they have reported activities up the chain of command, to the Inspector General, to the Attorney General, and only if no action was taken after 12 months; and

Makes technical and clarifying amendments to the statute of limitations in FCA cases, as well as technical edits to the Civil Investigative Demands authorized under the current FCA.
Allison Engine Co. v. United States\textsuperscript{123}

The Supreme Court recently decided a case that would change the interpretation of the False Claims Act. In 1985, the U.S. Navy contracted with two shipyards for the production of a new fleet of destroyers. Both shipyards subcontracted with other companies to acquire necessary parts. Among the necessary parts were generators to supply electricity. The shipyards ordered Gen-Sets from the Allison Engine Company, which then outsourced some of the work to the General Tool Company ("GTC"), which further subcontracted with Southern Ohio Fabricators ("SOFCO"). None of these companies billed the federal government, but billed the company directly above them in the chain of production. The company directly above them did not include these bills when submitting documentation for payment from the government.

As former employees of GTC, Roger Sanders and Roger Thacker worked on the Gen-Set assembly teams and suspected the Gen-Sets to be defective. They filed two FCA actions against their former employee GTC and other government subcontractors Allison, GM and SOFCO in 1995.

\textsuperscript{123} ALLISON ENGINE CO., INC., ET AL. v. UNITED STATES EX REL. SANDERS ET AL. 553 U. S. ___ (2008)
The False Claims Act has a number of subsections under which contractors may be found liable for defrauding the federal government. Contractors may be found liable under subsection (a)(1) only if someone presented a fraudulent bill to the federal government. Subsections (a)(2) and (a)(3) do not spell out the same presentment requirement in explicit terms. At issue was whether these subsections still include a presentment requirement that there be proof that a false bill was sent to the government, or is it enough to show that the fraudulent bill was paid with federal funds? The Supreme Court held that under a narrowing interpretation of the FCA, that subcontractor claims never submitted to the government could not be the basis of a Qui Tam claim.

The Court concluded that the Allison Engine case effectively limits the False Claims Act to cases dealing with actual fraud on the government, instead of a wide variety of actions between private parties in which funds can be traced back to the government. The Supreme Court decision is very important, however critics say that the importance of this case will be short lived if congress passes the False Claims Correction Act of 2007, that was proposed by Senator Grassley.
Administrative and Law Enforcement Programs

There are many initiatives and programs set forth by the Federal Government to stop and prevent fraud. Programs that are being used to specifically fight fraud in the health care sector include:

Medicare Integrity Program (MIP)

This program authorizes the HHS Secretary to promote the integrity of the Medicare program by entering into contracts with eligible entities to carry out program integrity activities such as audits of cost reports, medical and utilization review, and payment determinations. MIP provides a stable source of funding for HCFA's program integrity activities, and provides the authority to contract for these activities with any qualified entity, not just those insurance companies that are currently fiscal intermediaries or carriers.  

Operation Restore Trust (ORT)

The Operation Restore Trust (ORT) project was the first comprehensive effort in collaboration between HCFA and law enforcement agencies. This two-year demonstration project, which was launched in May 1995 and concluded on March 31,

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1997, was designed to demonstrate new partnerships and new approaches in finding and minimizing fraud in Medicare and Medicaid.\textsuperscript{185} As a demonstration project, ORT targeted four areas of high spending growth: home health agencies, nursing homes, DME suppliers, and hospices. Since more than a third of all Medicare and Medicaid beneficiaries are located in New York, Florida, Illinois, Texas, and California, ORT efforts were targeted at these five states.\textsuperscript{186}

\textbf{Fraud and Abuse Control Program}

The program integrity activities of the Medicare contractors initiates many of the cases later developed by the Office of Inspector General and Federal Bureau of Investigation, and support their prosecution by the Department of Justice. Using the money made available through the Fraud and Abuse Control Fund, established in HIPAA, the success of ORT has expanded using the State survey agencies to be the eyes and to report back to the contractors whether providers are meeting Medicare billing as well as quality requirements.\textsuperscript{187}

\textsuperscript{185} Smith, Andrew. "Combating Health Care Fraud and Abuse in Medicare: Legislative Action and New Programs". (April 1998).

\textsuperscript{186} Smith, Andrew. "Combating Health Care Fraud and Abuse in Medicare: Legislative Action and New Programs". (April 1998).

Chapter VII

Recommendations and

Conclusion
Fraud is a very serious crime that should concern all parties of the U.S. health care system and is a costly reality that the government cannot overlook. The Federal Bureau of Investigation is spending large amounts of its budget to catch health care fraud. Special units have been formed to help the FBI Crimes Section find these perpetrators and take them to court for prosecution. Crimes are being committed by both providers and insurance companies on a daily basis. Their patients and subscribers are being punished with improper coverage and over-priced medications.\footnote{Slyvia, M. Claire. The False Claims Act: Fraud Against the Government. MA: Thompson, 2004.} Until the root of the health care fraud problem can be found the future of fraud in that sector will remain and fraud will continue to occur at an increasing rate.

Health-care experts say that the effortlessness of the Campos Ramirez's scheme outlined in chapter five, underscores the scope of the growing fraud problem and the need to devote more resources to theft prevention. Law enforcement authorities estimate that health-care fraud costs taxpayers more than sixty billion dollars each year. The South Florida region bills Medicare more than two billion dollars each year for injectable HIV medications. That figure is twenty two times as high as the amount of
similar claims in the rest of the country, and is far out of line with demographic data in a population of two million people in Miami-Dade County, NHS statistics show.\textsuperscript{189}

In the meantime, the FCA is viewed as a valuable means to address this area of fraud yet, the False Claims Act in fighting health care fraud is similar to the Washington DC crime problem. It is known that a problem exists in certain areas, but it seems as though programs and detection efforts are only being enforced when the problem arises. Similarly in ways, as the crime issue becomes bigger and bigger in Washington DC, as does health care fraud in the state of Florida, the tactics to stop the activity are becoming less useful. Violators in both instances have become immune to the detection devices and so educated on the tactics used, that they now know how to get through the loopholes in law enforcement. If the United States does not look at the smaller issues leading to the bigger issues, we will continue to face a fraud problem in the health care arena, such as Washington DC and its continuous crime wave.

\textsuperscript{189} Medical Fraud a Growing Problem, Carrie Johnson. The Washington Post. June 13, 2008
Recommendations

The overall recommendations of this thesis are as follows:

- Companies should be required to report accurate average sales prices and average manufacturer prices for its drugs covered by federal health care programs.
- An informed and engaged public will aide in the fight against health care fraud.
- Alternative avenues should be established for filing a claim under the FCA Qui Tam provisions in order to better manage the work load of the Department of Justice.
- A monitoring and evaluation process should be established in order to avoid replicating problems with the FCA legislation and interpretations.
- Fraud prevention should be made a priority to support FCA implementations.
- Agency oversight should be monitored more closely.
- There should be continued administrative improvements.

The US could make some changes to the FCA and to its approach to health care fraud that would support the successful application of the FCA. Scholars say that "a critical aspect of the problem is that Medicare automatically pays the vast majority of the bills it receives from companies that possess federally issued
supplier numbers. Computer and audit systems now in place to detect problems generally focus on over-billing and unorthodox medical treatment rather than fraud. Congress should make its intent explicit by either amending the False Claims Act to include states within the definition of person, or by pursuing conditional funding measures that would require states to waive their False Claims Act defenses. Everyone should be involved in the fight against health care fraud, government and state. While not all fraud can be prevented, patients can be educated on how to protect themselves from fraud. Websites such as www.whistleblower.com and www.taf.com obtain valuable information in regards to health care fraud and the False Claims Act. An informed public and a properly funded FBI will go a long ways in the overall fight of health care fraud.

As apart of the problem with how long it takes for a false claims case to reach its final stage, a July Washington Post article pointed out that there are 900 cases that are languishing in a backlog at the Department of Justice, this number representing the active cases under

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191 National Health Care Anti-Fraud Association

192 National Health Care Anti-Fraud Association
investigation by the Justice Department. New cases being investigated under the Federal False Claims Act are processed instantaneously before earlier cases are completed, resulting in the Department of Justice resolving approximately 350 cases per year, which in turn amounts to the same number of cases brought in. The amount of cases that come in are about the same amount of cases that are resolved.

The Department of Justice is considerably overloaded with these false claims cases and the Civil Division that deals with these cases is understaffed as well. The litigation branch in charge of processing these cases only processes about 100 case investigations per year, and devotes their time to processing approximately 425 cases annually, leaving 300 cases rolling over to the next fiscal year.

As stated by Gregory G. Katsas, Attorney General for the Civil Division for the Department of Justice, "the implication that the department is not acting diligently in handling fraud cases is belied by the 20 billion dollars in recoveries since the False Claims Act was amended in 1986, nearly 7 billion dollars of which has been recovered since fiscal 2005. Of the 20 billion dollars, 12 billion dollars has been collected in whistle-blower cases that have been
aggressively pursued by Justice Department attorneys with the assistance of whistle-blowers and their attorneys, and more than 2 billion dollars in rewards have been paid to those who brought cases under the False Claims Act.

But is this enough? Yes the Department of Justice is recovering large amounts of money each year, but it still does not eliminate the fact that fraudulent activities are still committed. Regardless of how diligently the department is working in fraud cases, that hard work is over-shadowed by the amount of fraud cases that the Justice Department initiates per year. That is an indicator that there are some loop holes either in the False Claims Act or in the Department of Justice investigation process. The issue is drawing new interest among lawmakers and nonprofit groups because many of the cases involve rising health-care payouts, and privatization of government functions, all of which offer rich new opportunities to defraud tax-payers.

Since 2001, 300 to 400 civil cases have been filed each year by employees charging that their companies defrauded the government. But under the troublesome process that governs these cases, Justice Department lawyers must review them under seal, and whistle-blowers usually wait 14 months
or longer just to learn whether the department will get involved. The government dismisses about three-quarters of the cases it receives, saying that the vast majority have little merit. As a result disputes can stay hidden for years more while the government investigates the allegations.\textsuperscript{153} In a statement, Justice spokesman Charles Miller said that career lawyers and supervisors base their determinations on merit, not on political sensitivities. "Our decisions to intervene or decline in cases are entirely consistent with our record in whistle-blower cases generally," he said.\textsuperscript{194} "Even if no new cases are filed, it might take 10 years for the Department of Justice to clear its desk. Cases in the backlog represent a lot of money being left on the table," said Patrick Burns, a spokesman for Taxpayers Against Fraud which advocates for Justice to receive more funding to support cases by whistle-blowers and their attorneys.

Critics argue that the delays are at least partly the result of foot-dragging by Justice and the federal agencies

\textsuperscript{153} Backlog of Cases Alleging Fraud Whistle-Blower Suits Languish at Justice; Washington Post Staff Writer Carrie Johnson; Wednesday, July 2, 2008; Page A01A

\textsuperscript{194} Backlog of Cases Alleging Fraud Whistle-Blower Suits Languish at Justice; Washington Post Staff Writer Carrie Johnson; Wednesday, July 2, 2008; Page A01A
whose position it represents, especially in the area of suppliers that may have over-billed the government for equipment, food and other items. Help from Justice greatly enhances the chances that a complicated fraud scheme can be unraveled, lawyers from the Justice Department say. And department statistics show that cases that the Justice Department turns away win trivial, if any, financial recoveries.155

"Whistle-blowers are the key to the secrets locked in closets throughout the federal bureaucracy and government contractors," said Sen. Charles E. Grassley "These patriotic Americans stick their necks out, against all odds, to help the federal government pursue fraud and save taxpayers tens of billions of dollars that would otherwise be lost". In June of 2008, Deputy Assistant Attorney General Michael F. Hertz told Congress that "the number and increased complexity of the fraud schemes presented to the department, combined with the volume of cases now under review, certainly present challenges". 196

155 Backlog Of Cases Alleging Fraud Whistle-Blower Suits Languish at Justice; Washington Post Staff Writer Carrie Johnson; Wednesday, July 2, 2008; Page A01A

196 Backlog Of Cases Alleging Fraud Whistle-Blower Suits Languish at Justice; Washington Post Staff Writer Carrie Johnson; Wednesday, July 2, 2008; Page A01A
The Department of Justice is overwhelmed with whistleblower claims and therefore there should be an alternative for claims to be brought when the department has a very high case load or either there should be a process of evaluating the claims before they reach the Department of Justice. A recommendation that should be made is that claims should be brought to the State Attorney General’s office for processing. As seen in the previous chapter with the case involving the Indiana Attorney General, cases brought to this office can lead to a sizable recovery, and even the recovery of other fraud cases. If this recommendation is implemented this could change the amount of time the passes from claim to recovery. Attorneys General for each state should be responsible for the claims brought in their designated areas. The case would be referred to the attorney general, who could take over the suit, dismiss it, settle it or allow the whistleblower to prosecute it on the States behalf. A guilty party would pay the state treble damages plus additional fines, and could be barred as a government contractor. The amount of money the whistleblower gets would depend on the value of the information provided, and the time and expense spent on the lawsuit.197

197 The New York Times; Fraud Busting Begins at Home; By MARK GREEN; January 29, 2006
As the False Claims Act grows in popularity there should be someone or an agency that measures the effectiveness of the government’s tools in fighting the war on health care fraud. Although recent successes in some way or another prove that the FCA has been effective there are still some effective measures that need to be determined. As cases are being successfully investigated there still remain large number of cases that arise each year that are not investigated. Additionally, because in the years following the enactment of the FCA there have been many amendments to the Statute, the government should make sure that there are no replications in the legislation and that those areas that were amended are not repeated in future legislation. Fraud should be seen as a major crime problem and not just an FCA problem, and other crime prevention techniques should be used in conjunction with the FCA to eliminate the problem. As stated by former Mayor of New York, Rudy Giuliani, every single little thing leads to bigger things, and the US should take that into account when using the FCA as a fraud fighting tool. Those little things that might not seem important and that might get overlooked, might ultimately be the key to cracking down on the problem. For companies that have prior criminal activity, the United States should use a special system in monitoring their activity to insure that fraud does not occur.
In the long haul, tax-payers have lost large amounts of money due to health care fraud, and because of that have been left with the burden of paying higher premiums and higher co-payments. When the government recovers money from Qui Tam actions, none of the tax-payers defrauded money is returned and as fraud continues to rise so will the amount of money that tax-payers are losing. Often times, the whistleblowers receive large amounts of money for their role in the cases. A clause should be added to the False Claims Act that allows for tax-payers to be reimbursed in one way or another to encourage a broader range of users of the health care system to participate in combating fraud. The amount of money recovered shows the success of the FCA, but the growing health care fraud problem shows the opposite. That is even with the FCA the government is still losing the war on health care fraud.

**Conclusion**

This thesis has explored the Federal False Claims Act and its effectiveness in overcoming health care fraud. Although the FCA was not intended for the use of fighting fraud in the health care arena, it has been the reason for large amounts of recoveries under its Qui Tam provisions.
However, when money is recovered from fraudulent claims, the relator receives a sizable amount. This raises another question that should be taken into account by the Department of Justice, and that is whether the relators bringing these claims are abusing the Qui Tam whistleblower provisions of the FCA because they know that they will receive large amounts of money as seen in Appendix C. To avoid this issue, the money rewarded to the relator should be split with tax-payers and rewarded to taxpayers in a way that they can benefit from the money they lost due to high co-pays. As fraud continues to grow in areas such as Florida, much more needs to be done to eliminate the attraction of these fraudulent activities and even to detect them before they even happen. As indicated in this thesis, the United States government has recovered large amounts of money due to whistleblowers, however they are still losing out on lots of money because of the revolving door of fraudulent activities. In conclusion the FCA has been effective in fighting health care fraud in some aspects, but as Senator Grassley believes, the FCA has a long way to go before it can efficiently and effectively fight fraud. This long journey will take time. However, if the US takes into account the recommendations of this thesis along with the current tactics and initiatives, this goal can be met.
## Appendix B

### Fraud Statistics - Health & Human Services

<table>
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<tr>
<th>Year</th>
<th>New Matter</th>
<th>Out of Total</th>
<th>New Matter</th>
<th>Out of Total</th>
<th>New Matter</th>
<th>Out of Total</th>
<th>New Matter</th>
<th>Out of Total</th>
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<td>50</td>
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</tr>
</tbody>
</table>

**Notes:**
- The data is presented in the order shown, except where indicated otherwise.
- Total cases refer to the total number of cases handled by the program.
- New matter refers to cases that are new to the program in the given year.
- Out of total refers to the percentage of new cases out of the total cases handled.
- The data reflects the program's efforts in combating fraud in the health and human services sector.

The table above illustrates the program's performance in handling cases over the years, focusing on the percentage of new cases relative to the total cases handled.
# Appendix C

Qui Tam Settlements
Source: U.S. Dept of Justice

<table>
<thead>
<tr>
<th>Defendant</th>
<th>Time of Settlement (or Judgment)</th>
<th>Amount</th>
<th>Relator's Share (if known)</th>
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<tr>
<td>Tenet Healthcare Corporation</td>
<td>June 2006</td>
<td>$900 Million</td>
<td></td>
</tr>
<tr>
<td>HCA</td>
<td>December 2000</td>
<td>$731.4 Million</td>
<td></td>
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<tr>
<td>Merck &amp; Co</td>
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<td>$650 Million</td>
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<tr>
<td>HCA</td>
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<td>The Boeing Company</td>
<td>June 2006</td>
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<td></td>
</tr>
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<td>Tap Pharmaceuticals Products Inc</td>
<td>October 2001</td>
<td>$550 Million</td>
<td>$95 Million</td>
</tr>
<tr>
<td>Schering-Plough Corporation</td>
<td>August 2006</td>
<td>$435 Million</td>
<td></td>
</tr>
<tr>
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<td>July 2003</td>
<td>$490 Million</td>
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<td>National Medical Enterprises</td>
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<td>Gambro Healthcare</td>
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<td>Care of Georgia</td>
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<tr>
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[Source: Federal fraud content settlements.htm](http://federalfraud.com/content_settlements.htm)
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http://federalfraud.com/content_settlements.htm

3/19/2008
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<td>----------------------------------</td>
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<td>--------------</td>
</tr>
<tr>
<td>University of Medicine and</td>
<td>March 2005</td>
<td>$1.4 Million</td>
<td></td>
</tr>
<tr>
<td>Dentistry of New Jersey</td>
<td></td>
<td></td>
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<tr>
<td>University Medical Center of</td>
<td>May 2002</td>
<td>$1.1 Million</td>
<td>$162,000</td>
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<td>Southern Nevada</td>
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<td>Kaiser Foundation Health Plan Inc.</td>
<td>April 2005</td>
<td>$1 Million</td>
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<td>RightCHOICE Managed Care</td>
<td>January 2007</td>
<td>$975,100</td>
<td>$165,000</td>
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<td>Columbia Hospital Corp</td>
<td>December 2004</td>
<td>$560,100</td>
<td>$160,000</td>
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<td>CVS</td>
<td>August 2005</td>
<td>$895,100</td>
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<tr>
<td>Snap-on Incorporated</td>
<td>December 1996</td>
<td>$891,100</td>
<td></td>
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<tr>
<td>Rubbermaid</td>
<td>January 1995</td>
<td>$887,000</td>
<td>$185,000</td>
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<td>The University of Colorado</td>
<td>March 2005</td>
<td>$755,272</td>
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<td>Hospital</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Electrolux Home Products</td>
<td>October 2002</td>
<td>$687,000</td>
<td></td>
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<tr>
<td>County of Fresno, California</td>
<td>February 2005</td>
<td>$653,100</td>
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<tr>
<td>Hospital of St. Raphael</td>
<td>May 2005</td>
<td>$632,000</td>
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<td>North American Pipe Corporation</td>
<td>June 2000</td>
<td>$590,100</td>
<td>$401,000</td>
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Source: [federalfraud.com/content/settlements.htm](http://federalfraud.com/content/settlements.htm)
Curriculum Vitae

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Birth Information:

October 12, 1984
Takoma, Maryland

EDUCATION

May 2006 to May 2009
M.A. Government
Johns Hopkins University

August 2003 to May 2006
B.S. Criminal Justice
University of Maryland Eastern Shore

HONORS AND AWARDS

2004-2007 Delegate Scholarship Recipient

2004-2007 Senatorial Scholarship Recipient

ASSOCIATION MEMBERSHIPS

National Counsel of Negro Women
Delta Sigma theta Sorority, Inc.
Phi Alpha Delta
Alpha Phi Sigma
THESES


PROFESSIONAL EXPERIENCE

Jan. 2007 to present
Operations Assistant, Wiley Rein LLP.

July. 2001 to Aug. 2006
EEO Assistant, United States Department of Agriculture.

COMMITTEE MEMBERSHIPS

April. 2008 to present
Member, Prince Georges County Alumnae Chapter of Delta Sigma Theta Sorority, Inc. Social Action Committee.