Office of the Deputy Attorney General
Washington, D.C. 20530

November 7, 2008

Fighting the fraud and theft committed by these criminals is vital to preserving our health care system – vital to its financial solvency, as well as its integrity. The Department's attorneys and agents make up our front line in stopping those criminals, and I want to thank you for all that you do.

Attorney General Michael Mukasey
May 28, 2008

Dear United States Attorneys:

America leads the world in quality health care. Each year our government spends billions of dollars to make that care available to individuals who might not otherwise be able to afford it, including veterans, children, the elderly and the poor. But with such expansive government spending for health care comes the potential for fraud and abuse. When I was an Assistant United States Attorney for the Northern District of Illinois, I saw, as you see, how health care fraud and abuse can badly hurt the intended beneficiaries of government health care programs and drain resources we need to help the truly deserving.

The efforts of the Department of Justice to fight this fraud and abuse, led by your hard work in this area, are necessary to maintain the quality and integrity of our nation's health care system. Ensuring that abuses in the provision of health care are appropriately addressed is an important priority of the Department of Justice and its components, including the Federal Bureau of Investigation. Working with your law enforcement partners throughout federal and state enforcement agencies, you work tirelessly to bring to justice those who would prey on the vulnerabilities of government programs intended to help our most vulnerable citizens. I speak on behalf of the Attorney General and the leadership offices within the Department when I express our sincere gratitude for your efforts.

Keep up the good work. I, and your country, thank you.

Sincerely,

Mark Filip
Deputy Attorney General

Health Care Fraud Sentencing: Achieving Appropriate Loss Calculations under the United States Sentencing Guidelines

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I. Introduction

After aggressively prosecuting health care fraud for over 20 years, Department of Justice (Department) statistics establish that health care fraud, as evidenced by the number of investigations and cases, continues to increase. This increase strongly suggests that fraud cannot be eradicated and the country's limited health care dollars cannot be restored merely through investigation, prosecution, imprisonment, and restitution orders. If it could, the number of those caught committing health care fraud would be decreasing. Therefore, history has taught the valuable lesson that federal prosecutors must endeavor to deter fraud in our health care system before it occurs.

Social scientists teach that deterrence can be increased by focusing on the three primary factors that impact a person's decision process. Those three factors are:

- The person's assessment of the likelihood of detection;
- The person's understanding of the severity of punishment if detected; and
- The temporal relationship between the reward of the conduct and the risk of punishment.

Thus, although the government cannot prosecute its way out of fraud, federal prosecutors can take reasoned and calculated steps to ensure that the way cases are prosecuted helps to deter crime before it occurs.

During the past 2 years, the Department has attempted to focus resources on health care fraud to increase the ability to detect fraud through the analysis of real time claims data and to bring cases to indictment within days. A portion of these efforts are discussed below in addressing the operation of the Medicare Fraud Strike Force (the Strike Force). This article addresses a key element of this effort: uniformly achieving appropriate sentences in health care fraud cases.

According to statements from cooperating health care fraud defendants, many of the people caught committing health care fraud believe that their criminal exposure is insignificant compared to the potential monetary reward. The average term of incarceration between 1995 and 2006 for those defendants who have served time for health care fraud is approximately 30 months. For some, a single day in prison is enough deterrence. However, criminals stealing large sums from the health care system are comparing the potential health care fraud sentences against other criminal endeavors. Burglary, robbery, and narcotics crimes all pose risks of longer punishment and less monetary rewards than health care fraud. Consequently, criminals are unwittingly encouraged to turn to health care fraud.

As discussed below, the community needs to understand that health care fraud is not a

victimless crime that will be punished lightly. Health care fraud should be punished commensurate with other equally damaging crimes. This article will discuss how to ensure that defendants receive appropriate and uniform sentences in health care fraud cases.

II. Increased criminal enforcement efforts

In March 2007, the Fraud Section of the Criminal Division worked with the United States Attorney's Office (USAO) for the Southern District of Florida to establish phase one of the Strike Force. The Strike Force was conceived after a detailed review of Medicare claims data from around the nation. This claims data analysis established that Miami-Dade County, Florida had the most severe concentration of health care fraud in the country. In the simplest terms, the concept behind the Strike Force was to bring traditional law enforcement techniques to health care fraud criminal activity. The premise of the Strike Force is that traditional white collar law enforcement techniques are too slow for effective deterrence in areas that have concentrations of health care fraud centered around nonexistent providers. Delay in prosecution costs the government more as targets continue to commit fraud during lengthy investigations.

Strike Force results have been dramatic. Since the inception of the Strike Force operations in 2007 federal prosecutors have indicted 187 defendants in 104 cases in both Miami and Los Angeles, the phase two site. Collectively, these defendants fraudulently billed the Medicare program for more than one-half billion dollars. The impact of the Strike Force has been felt not only in the number of prosecutions and convictions. In Miami-Dade County alone, billing by durable medical equipment (DME) companies dropped by over $1.7 billion during the phase one operation in 2007. Thus, not only were fraudulent billings to Medicare reduced by the amounts that the Strike Force defendants would have billed but the deterrent impact was substantial. These results illustrate the success of focusing on the three key factors of effective deterrence.

One of the key components of that deterrent effect was a significant increase in the length of incarceration for convicted defendants. During phase one of the Strike Force, the average sentence of incarceration was 43 months, which is approximately 1 year longer than the average Medicare fraud sentence nationwide. Further, community awareness of substantially longer sentences achieved in phase one cases, including several in excess of 10 years, adds to the perception of punitive risk.

As with most white collar cases, the key driver of a Medicare fraud sentence under the United States Sentencing Guidelines (hereinafter Guidelines) is the amount of the "intended loss" under § 2B1.1. Federal prosecutors have not always taken consistent positions on how to calculate intended loss in Medicare fraud cases. A review of sentencing decisions in Medicare fraud cases reveals that prosecutors generally have used one of three methodologies:

- The amount billed to Medicare;
- The amount allowed under applicable Medicare fee schedules; or
- The amount actually paid by Medicare.

These various positions often appear to be based on negotiated arrangements rather than the defendant's intent. Although the facts may vary from case to case, the way to seek an appropriate sentence is to base the loss calculation on what the individual defendant intended. The best evidence of the defendant's intent in most cases is what he knowingly and willfully inserted in the false claims submitted to Medicare.

III. Defendant's individualized intent drives the appropriate loss calculation

As discussed in more detail below, the purpose of sentencing is to hold a defendant accountable for his crime. In fraud cases, that includes what the defendant intended to accomplish with his fraudulent scheme. A defendant's actions are the best evidence of his intent. In a health care fraud case, the act of filing a claim requires that a person knowingly and

willfully place an amount into the electronic or paper claim form. In most cases, this act is the best evidence of the amount the person intends to take from the Medicare program.

A. "Intended loss" includes loss that is impossible or unlikely

Under § 2B1.1, the appropriate amount of loss "is the *greater* of actual loss or intended loss." UNITED STATES SENTENCING GUIDELINES MANUAL § 2B1.1 cmt. n.3(A) (2006) (emphasis added). The Guidelines define "intended loss" as "the pecuniary harm that was intended to result from the offense . . . and . . . *includes intended pecuniary harm that would have been impossible or unlikely to occur* (e.g., as in a government sting operation, or an insurance fraud in which the claim exceeded the insured value.)." *Id.* at cmt. n.3(A)(ii) (emphasis added). As the Eleventh Circuit has stated:

> It is not required that an intended loss be realistically possible. Nothing in [the notes to what is now labeled as Section 2B1.1] requires that the defendant be capable of inflicting the loss he intends. We do not agree . . . that an intended loss cannot exceed the loss that a defendant in fact could have occasioned if his fraud had been successful. These decisions are inconsistent with the concept that the calculation can be based on the intended loss.

United States v. Wai-Keung, 115 F.3d 874, 877 (11th Cir. 1997) (citations omitted); *see also United States v. Serrano*, 234 Fed. Appx. 685, 687 (9th Cir. 2007) ("We hold that the district court properly interpreted § 2B1.1 and that the court did not clearly err when it approximated the intended loss as the amounts Appellant submitted to Medicare and Medi-Cal for reimbursement."); *United States v. McLemore*, 200 Fed. Appx. 342, 344 (5th Cir. Miss. 2006) (unpublished) (allowing no setoff for the value of any Medicare or Medicaid services actually rendered or products provided and holding that the determination of the amount of loss for calculations under § 2B1.1(b)(1) requires the use of the greater of actual loss or intended loss).

In a Medicare fraud case, "actual loss" will rarely if ever exceed "intended loss." Actual loss is represented by the amount paid out by Medicare for the false claims. It is not uncommon in Medicare fraud cases for there to be numerous claims for which no money was paid out by Medicare, particularly in schemes that involve "blast billing" or instances where Centers for Medicare and Medicaid Services catch on to a scheme and deny or at least delay payment while they investigate. Thus, the question at sentencing will be what figure—the amount billed to Medicare or the amount allowed under the fee schedules—should be used to determine "intended loss."

B. Intended loss is properly based on the amount submitted minus a co-payment deduction

The mere fact that the Medicare fee schedules exist does not require that intended loss under the Guidelines be based on the amounts allowed under those schedules. The Guidelines specifically state that intended loss includes loss that would have been impossible or unlikely to occur. Thus, intended loss under the Guidelines is typically calculated by using the amount billed to Medicare minus the 20 percent co-payment deduction where it is established that a defendant understood the co-payment collection requirement, even though such amount may include loss in excess of the amount allowed under fee schedules.

In 2003 the Fourth Circuit directly addressed the issue of using the billed amount as evidence of intended loss. *United States v. Miller*, 316 F.3d 495 (4th Cir. 2003). In *Miller*, a doctor was convicted of mail fraud based on his submission of false and fraudulent claims to Medicaid, Medicare, and the West Virginia Workers' Compensation program. *Id.* at 496. At sentencing, the district court calculated intended loss as the difference between what Miller billed to Medicare (rather than what he actually received) and the amount to which he was legitimately entitled based upon the rendered services. *Id.* at 497.

Miller appealed his sentence, arguing among other things, that "the court erred in using the amount he billed to Medicare and Medicaid, rather than the payments those programs allow, in estimating the amount of loss he intended because he could not have any reasonable expectation to be paid . . . beyond what the program allows." *Id.* at 501 (internal quotation marks omitted). Miller argued, therefore, that intended loss should be limited to the allowed amount set forth in the programs' reimbursement fee schedules.

The Fourth Circuit emphatically rejected that argument, holding that "the Guidelines permit courts to use intended loss in calculating a defendant's sentence, even if this exceeds the amount of loss actually possible, or likely to occur, as a result of the defendant's conduct." *Id.* at 502. The Fourth Circuit's holding was based in part on the common sense assessment that "[a]s anyone who has received a bill well knows, the presumptive purpose of a bill is to notify the recipient of the amount to be paid." *Id.* at 504.

Other courts of appeals have approved the use of the billed amount as intended loss with much less discussion than the Fourth Circuit. *See, e.g., United States v. Mikos*, 539 F.3d 706, 714 (7th Cir. 2008) ("[The defendant] billed the Medicare program for $1.8 million; that's the intended loss whether Medicare paid or not. . . ."); *United States v. Cruz-Natal*, 150 Fed. Appx. 961, 964 (11th Cir. 2005) (approving use of billed amount to calculate intended loss in Medicare fraud case "[b]ecause the intended loss is easily calculated and greater than the actual loss"); *Serrano*, 234 Fed. Appx. at 687.

In the *Miller* case, the court concluded that the billed amount served as prima facie evidence of the defendant's intended loss, unless the defendant offered contradictory evidence regarding his subjective intent. 316 F.3d at 504. Therefore, prosecutors may use the amount billed as the starting point for assessing a criminal defendant's intent.

C. The risks of using the allowed amount to measure intended loss

In *United States v. Singh,* 390 F.3d 168, 193-94 (2d Cir. 2004), the Second Circuit found that the defendant's testimony regarding Medicare's reimbursement rules, including the fact that Medicare paid claims based on a fee schedule and not necessarily on the amount billed on the claim form, constituted sufficient evidence to rebut an inference of intended loss. Thus, the Second Circuit held that the defendant's intended loss should be based on the "allowed amount" or the amount as calculated under the applicable Medicare fee schedules where evidence established that the defendant intended to inflict such a loss.

Although use of the allowed amount may be appropriate in certain instances, particularly in cases and schemes that exist within an otherwise legitimate enterprise, use of the allowed amount to measure loss in fraudulent enterprises risks a sentencing determination that underrepresents criminal conduct. For instance, if a defendant only intended to take an amount allowed by the computer system and the Medicare program payment formulary, why would not the defendant submit claims for that amount? If he had knowledge of the allowed amount could not he have easily claimed that amount? Medicare requires that the defendant collect the 20 percent co-payment from patients based on the amount billed to Medicare—did the defendant collect any co-payments? If so, what is the evidence of such collection and was it based on the allowed amount or the billed amount?

Further, did the defendant believe that the Medicare program never mistakenly pays above the fee schedule? Had Medicare paid the claimed amount, would the defendant have kept the money or returned the funds to Medicare saying they did not "intend" to take that much? These questions are particularly difficult to answer. After all, if a defendant really believed that Medicare was infallible, then he would never have submitted fraudulent claims because Medicare would not have paid.

By submitting fraudulent claims to Medicare, the defendant shows he knew that the program had systemic payment weaknesses that made it vulnerable to fraud. Under these circumstances, is it reasonable to believe that the defendant did not intend to keep everything that he might receive as payment from Medicare, including payments over and above the allowed amounts? Even if the defendant did not necessarily expect to receive the full amount of his bills from Medicare, he most certainly would have kept the money had it been paid. *See United States v. Geevers*, 226 F.3d 186, 193 (3d Cir. 2000) (the "[defendant] may not have expected to get it all, but he could be presumed to have wanted to").

All this is not to say that, even with respect to fraudulent enterprises, the billed amount should be unconditionally applied. It is easy to think of instances in which an amount other than that billed to Medicare could constitute the intended loss. The following hypothetical situations are scenarios where the claimed or billed amount may not properly constitute the defendant's intended loss.

- A defendant submits claims information to a third-party billing company for preparation and transmission of the claims. In the course of submitting the bills to Medicare, the third-party company transposes numbers and bills Medicare for an amount higher than that reflected on the defendant's submission to the billing company.
- A defendant handwrites Claims Forms 1500 for $500, and the Medicare processor misreads the claims as $5000.
- A defendant has an arrangement with a third-party billing company whereby the billing company gets a percentage of the amount paid by Medicare. The defendant instructs his third-party billing company to bill Medicare $500 per claim for each piece of DME, but to get more money the company actually bills Medicare $700 per claim.

In each of these examples, and there are certainly numerous others, evidence could be presented that the defendant did not intend a loss in the amount claimed or submitted to Medicare. In each of these examples, however, the focus of the inquiry is properly on the defendant's conduct and intent.

Conversely, the generalized use of the allowed amount as the intended loss based on the mere existence of a fee schedule poses a risk that a sentencing court may not properly focus on the specific intent of the defendant. This risk is multiplied when defense counsel seeks to focus attention on the victim's programmatic rules rather than the defendant's criminal intent. Case analysis reveals that defense counsel frequently focus on abstract, expert opinions about Medicare regulations and internal operating procedures. These have limited relevance to what an individual defendant intended, unless evidence is focused on the defendant's knowledge of such inner workings. Thus, unlike the billed amount, which at a minimum reflects a knowing and willful act of a defendant, the allowed amount does not, on its face, show a criminal's intent.

In addition, Medicare data from financial intermediaries often has an allowed amount of zero for unpaid claims. In this instance, is it accurate for the court, in using a sum allowed amount for all fraudulent claims, to conclude that the defendant intended to steal nothing from the Medicare program when he submitted these claims, even though they went unpaid? Of course not. So again, the question becomes, for claims in which there is no allowed amount, what did the defendant intend? The best evidence of that intent is the amount the defendant billed to the Medicare program.

D. Loss in Medicare fraud cases is not capped at "actual loss"

Finally, some misguided defense counsel have argued that intended loss in Medicare fraud cases is capped by the Guidelines based on an application note following § 2B1.1 which states as follows:

> Government Benefits.— In a case involving government benefits (e.g., grants, loans, entitlement program payments), loss shall be considered to be not less than the value of the benefits obtained by unintended recipients or

> diverted to unintended uses, as the case may be. For example, if the defendant was the intended recipient of food stamps having a value of $100 but fraudulently received food stamps having a value of $150, loss is $50.

UNITED STATES SENTENCING GUIDELINES § 2B1.1 cmt. n. 3(F)(ii) (2006).

As a preliminary matter, this section relating to receipt of "government benefits" does not apply to Medicare fraud cases. However, some defense counsel assert that the note's language precludes use of "intended loss" in a Medicare fraud case and otherwise imposes a cap on loss. This argument is not supported by the language of the application note or by the case law.

First, the language of the application note does not impose a cap on loss. Rather, the note states that in certain cases loss "shall be considered to be *not less than*. . . ." UNITED STATES SENTENCING GUIDELINES § 2B1.1 cmt. n.3(F)(iii) (2006) (emphasis added). Thus, to the extent that the application note applies to at all, it sets a *floor* on the amount of loss, not a *ceiling*. Further, Courts have rejected the argument that this note imposes a cap on loss. In *Miller*, the Fourth Circuit held that the amount billed to Medicare constitutes prima facie evidence of intended loss in a Medicare fraud case. In rejecting the argument regarding the application note, which at the time was contained in a different section of the Guidelines, the Fourth Circuit wrote as follows:

> [N]ote 8(d) simply does not speak to the issue of whether courts can use intended rather than actual loss, but instead deals with an issue altogether different from the one to which [the defendant] would have it apply. Specifically, note 8(d) directs courts to include the diversion of government program benefits as losses, even if the government funds ultimately go to eligible recipients. In other words, in cases involving government program benefits, loss is the value of the benefits diverted, as opposed to merely the value of benefits that ultimately end up in the hands of ineligible recipients, or are used for an unauthorized purpose (emphasis omitted).
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> . . .
>
> Thus, these cases make clear that note 8(d) is not meant to distinguish actual loss of government program benefits from intended loss of government program benefits, as [the defendant] would have us read it. Rather, note 8(d) clarifies that "loss" includes the amount of government program benefits diverted from intended recipients or uses, even if those funds are ultimately distributed to eligible recipients, or used for an otherwise authorized purpose.

Miller, 316 F.3d at 500-01. The Guidelines thus do not cap intended loss in Medicare fraud cases at the amount actually paid.

IV. Conclusion

In conclusion, in order to better deter health care fraud on the front end, law enforcement must:

- Do a better job of detecting health care fraud in the first instance;
- Seek consistent and appropriate punishment; and
- Move cases from identification to prosecution with greater speed.

In seeking appropriate sentences, the key question is what loss was intended by the individual defendant. In many cases, the best evidence of a defendant's intent is what he put on the claims actually submitted to the Medicare program. As discussed above, where there is evidence that a defendant has knowledge of a fee schedule or capped paid rate, then that evidence should be considered along with the claimed amount to determine what the defendant intended. This article has attempted to explain that there is not a uniformly correct method for setting the loss numbers. Rather, an individualized inquiry into the intent of the defendant should be used to determine the intended loss amount. The amount actually submitted to Medicare by the defendant is the appropriate place for this inquiry to begin.❖

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Centers for Medicare and Medicaid Services' Transition from Program Safeguard Contractors (PSCs) to Zone Program Integrity Contractors (ZPICs)

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At present, the Baltimore-based Centers for Medicare and Medicaid Services (CMS) is in the process of implementing a large-scale reorganization of its Medicare Integrity Program (MIP) contractors. This will enhance contractor effectiveness and efficiency, as well as save the government money through the streamlining of costs and consolidation of contractor activities. The reorganization will also provide tremendous benefit to the law enforcement community. They will soon be able to take advantage of a "one stop shopping" concept that will provide them with data and other information that will be more comprehensive than ever before in terms of assessing the "full picture" of potential or actual Medicare fraud, waste, and abuse scenarios.

According to the nation's newspapers, America is facing a $60 billion dollar fraud problem with respect to Medicare, the federal health-insurance program for seniors and the disabled, and Medicaid, a joint state-federal program for the needy. *See* Carrie Johnson, *Medical Fraud a Growing Problem; Medicare Pays Most Claims Without Review*, THE WASHINGTON POST, June 13, 2008, at A1; Jay Weaver, *Medicare Assailed for Extent of Fraud*, *available at* http://nl.newsbank.com/nl-search/we/Archives?p_action=doc&p_docid=122CE35CEBA4; Theo Francis, *Medicare, Medicaid Managed Care Gets Scrutiny for Fraud*, WALL STREET JOURNAL (Eastern Edition), Mar. 19, 2008 at B1. According to national newspapers, total annual Medicare spending is assessed at $429.7 billion, covering an estimated 90 million Americans. *See* Jane Zhang, *U.S. News: Medicare Ignored Its Claims Policy, Audit Says*, WALL STREET JOURNAL (Eastern Edition), Aug. 26, 2008 at A3; *see also* Theo Francis, *Medicare,*