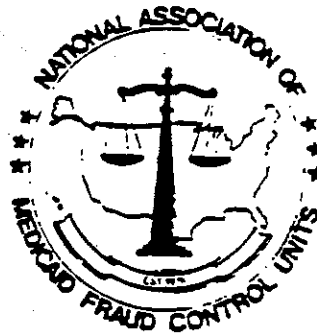


Model Health Care False Claims Act and Commentary

**MODEL HEALTH CARE FALSE CLAIMS ACT
AND COMMENTARY**



**National Association of Medicaid
Fraud Control Units**

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MODEL HEALTH CARE FALSE CLAIMS ACT

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.001 Short title. This chapter may be known and cited as the "Health Care False Claims Act".

.010 Legislative finding. The legislature finds and declares that the welfare of the citizens of this state is threatened by the submission to third party health care payers of increasing numbers of fraudulent health care claims which contribute to spiraling increases in health care costs, misallocated resources within the health care system and threaten the health and safety of patients by subjecting them to unnecessary or unsound treatments and procedures. To eliminate these practices and deter their reoccurrence requires the use of criminal sanctions and the establishment of specific penalties and prosecutorial authority to pursue and punish such conduct.

.020 Definitions. Unless otherwise specifically stated:

(1) "Claim" means any attempt to cause a health care payer to make a health care payment.

(2) "False" means wholly or partially untrue. A "false statement or representation of fact" includes, but is not limited to, the failure to reveal material facts which deceives or is intended to deceive a health care payer with respect to the claim.

(3) "Health care payment" means a payment made for, or the right under a contract, certificate, or policy of insurance to have a payment made by a health care payer for a specified health care service.

(4) "Health care payer" means any insurance company authorized to provide health insurance in this state, any health maintenance organization, any legal entity which is self-insured and providing health care benefits to its employees, any entity responsible for handling claims for health care services under the Medicare program, or any local, state or national government program making payments for health care services.

(5) "Person" means an individual, corporation, partnership, association, or any other legal or business entity.

(6) "Health care provider" means any person delivering, or authorized, or contracted to render any health service to include any employee, agent or other representative of the same.

.030 Making false claims; concealing information. No health care provider shall knowingly make or cause to be made a false statement or false representation of a material fact in order to receive a health care payment including, but not limited to:

(1) Knowingly presenting to a health care payer a claim for a health care payment that falsely represents that the goods or services for which health care payment is claimed, were medically necessary, if in fact they were not;

(2) Knowingly concealing the occurrence of any event affecting an initial or continued right under a contract, certificate, or policy of insurance to have a payment made by a health care payer for providing a specified health care service;

(3) Knowingly concealing or failing to disclose any information with the intent to obtain a health care payment to which the provider or any other provider is not entitled, or to obtain a health care payment in an amount greater than that which the provider or any other provider is entitled.

.040 **Penalty.** A person who violates this section is guilty of a class __ felony punishable under chapter _____.

.050 **Exception.** This section does not apply to statements made by a person on an application for coverage under a contract or certificate of health care coverage issued by an insurer, health care service contractor, health maintenance organization, or other legal entity which is self-insured and providing health care benefits to its employees.

.060 **Presumptions.** In a prosecution under this chapter, circumstantial evidence may be presented to demonstrate that a false statement or claim was knowingly made. Such evidence of knowledge may include but shall not be limited to the following:

(1) A claim for a health care payment is submitted with the provider's actual, facsimile, stamped, typewritten, or similar signature on the form required for the making of a claim for health care payment;

(2) A claim for a health care payment is submitted by means of computer billing tapes or other electronic means if the provider has advised the health care payer in writing that claims for health care payment will be submitted by use of computer billing tapes or other electronic means;

(3) A course of conduct involving other false claims submitted to this or other health care payers.

.070 **Restitution.** Any provider convicted of a violation of this act, in addition to any fines and/or sentences imposed by law shall be required to make restitution to a health care payer and may be responsible for the reasonable costs attributable to the investigation.

.080 **Civil action not limited.** This chapter shall not be construed to prohibit or limit any other criminal or civil action against a provider for the violation of any other law of this state.

.090 **Conviction of provider, notification to regulatory agency.** Upon conviction under this chapter of any provider, the prosecutor shall provide written notification to all appropriate regulatory or disciplinary agencies.

.100 **Severability.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

COMMENTARY

Intent of proposal - The Medicaid Fraud Control Units have more than a decade of experience, nationwide, in investigating and prosecuting providers of medical services who defraud the various state Medicaid programs. It is the experience of the Units that very often providers who defraud one payer, whether Medicaid, Medicare or private insurance, are also defrauding other third party payers. Evidences of these other health care crimes (non-Medicaid) have been reviewed and documented as part of developing Medicaid fraud prosecutions. Nationally, many successful and significant Medicaid fraud investigations have been initiated based upon information provided by health care insurance companies and the federal Medicare program when they have reason to believe that they are the victims of provider fraud. Inclusion of false health care insurance claims, false Medicare claims, and other payer false claims in state Medicaid fraud prosecutions have strengthened the impact of some prosecutions. The ability to show that a defendant/provider defrauded a number of separate payers has often defused a defense focused upon the specific Medicaid program's rules and/or their enforcement efforts. Availability of a specific state statute, such as this, would allow prosecutors to bring more comprehensive cases against unscrupulous health care providers.

Many Unit prosecutors, state's attorneys and local prosecutors have found the pursuit of health care fraud far more cumbersome and problematic because of the lack of specific criminal statutes limited only to Medicaid or Medicare fraud. The benefits of prosecuting a false claim case under a specific statute versus theft prosecutions is demonstrated by the many successes of Medicaid and Medicare fraud prosecutors, who have specific federal and state statutes to utilize, versus the infrequent number of health care theft prosecutions.

The primary differences between a false claim case (Medicaid and Medicare) and a theft case (health care insurance) are:

- 1) Theft statutes are usually graduated based upon "value" (amount alleged to have been misappropriated).
- 2) Unless the amounts misappropriated per claim can be joined together ("aggregated") the resulting crime(s) may be a series of misdemeanors or less serious offenses which do not reflect the seriousness of the defendant's acts.
- 3) If the separate amounts misappropriated can be joined and aggregated, to do so require the pleading and proof of an additional element, common scheme or plan.
- 4) Theft is a distinctive crime with different elements from a false claim prosecution. For example, to prove the crime of theft, the state must plead and prove that the defendant converted the property (monies) of another to his/her own use (he or she received the monies and used it). In some jurisdictions, it is a defense to theft that the conversion was done "openly under a valid claim of title". Theft also requires evidence that the intent to convert includes the

intent to permanently deprive the true owner of their property. This intent may be difficult to prove given the defense of intending to make up or return the money at issue.

5) The trial of a false claim case (Medicaid) joined with a theft case (insurance) often weakens the prosecution's tactical advantage (i.e. it is difficult to convince a jury why the elements of theft do not need to be proven for the false claim crimes).

Application of proposal - This "Model Act" is designed to provide states without relevant and specific laws a framework upon which to base proposed legislation. The "Act" is deliberately broad and by its nature, general. It is expected that prior to the proposal of legislation, any state would adapt the terms in this proposal to reflect those used in existing state laws and regulations.

.020 Definitions. "Claim" is given its broadest meaning to deal with false information supplied by whatever method to a health care payer. The definition of "false" relies on the same test (i.e. "material") as do the federal Medicaid and Medicare false claims act, as well as most state Medicaid and Medicare false claims act, as well as most state Medicaid fraud statutes. The federal courts have split on whether the materiality of the false information is a question of fact (jury) or law (judge). Many states have perjury statutes which specifically make the analysis of the materiality of false testimony a question of law. The most cited reason for this is to reduce the jury's potential sideshow analysis of how important ("material") the falsity was to the outcome and concentrate on the actor's knowledge of the false information. In a health care fraud prosecution, it would seem entirely appropriate to concentrate the jury's analysis on the fraud alleged as opposed to allowing an equitable defense based upon the defendant's state of mind about how important the lie he/she told was. It may, therefore, be appropriate to make the finding of materiality a question of law within the statute.

"Health care payment and payer" are defined to include HMO's, insurance companies, self-insured programs, situations of co-payments, entities who handle claims for the Medicare program (intermediaries), and local, state and federal government health care programs.

.030 Making false claims. Herein the intent is to track the alternative methods of committing the crime similar to the state and federal Medicaid/Medicare false claim acts. Subsections (2) and (3) specifically address persons, in addition to the provider, who have knowledge of false statements and/or circumstances which, if known to the payer, would make the provider ineligible for the payment. An example would be a provider who receives payment twice for the same services, knows this fact, and fails to rectify the double payment.

.040 Penalty. This section is left blank as the states will vary in the length and conditions of punishment. It is strongly recommended that the crime be a felony and that it be in the degree which is comparable to other levels of punishment in the state for similar criminal acts such as Medicaid Fraud or equivalent to the highest degree of larceny.

.050 Exception. This section specifically excludes a situation wherein an insured (customer, patient, consumer) may give false information (for example: medical condition) on his/her application for insurance coverage. The act is designed to make clear that the focus of the act is to prosecute fraudulent providers. Existing provisions of state law are assumed to be adequate to prosecute those who are the recipients of insurance benefits.

.060 Presumptions. Jurisdictions which allow presumptions (rebuttable, etc.) would use this section to specify any appropriate presumptions and their application. In a state without presumptions and with universally accepted and clear rules as to the applicability of circumstantial evidence, this section should be deleted. The listed subsections (1-3) are merely example of types of presumptions and should be augmented with appropriate presumptions under that state's laws.

.070 Restitution. Herein included as some states require a specific reference to restitution in order to empower a court upon conviction to order restitution. In states which allow statistical projections on the issue of restitution, it would be desirable to use this section to codify the same. Use of the term "shall" would underscore the legislative intent to require restitution. Also included is a reference to reasonable costs attributable to the investigation.

.090 Regulatory agency. This section would require law enforcement to notify all appropriate licensing authorities.