Title Page

**Healthcare Fraud and Abuse Implications of Medicare for All**

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**Abstract**

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Krista Grobelny Ebbert, MPH

University of Pittsburgh, 2020

**Abstract**

Healthcare fraud and abuse laws play a critical role in protecting public health through ensuring the integrity of federal healthcare programs such as Medicare and Medicaid. Moreover, these laws help to promote public health through requiring practitioners participating in federal healthcare programs to conform to certain healthcare quality and safety standards. The Medicare for All bill establishes a single payer healthcare system run by the federal government and guarantees health insurance to every person residing in the U.S. However, the bill maintains the current healthcare fraud and abuse system despite almost doubling the number of federal healthcare beneficiaries and providers. The dramatic increase in federal healthcare beneficiaries and providers will make it difficult to ensure the integrity and protection of a universal federal healthcare system under the current healthcare fraud and abuse laws. This essay theorizes that through increased healthcare fraud and abuse education, increased use of datamining by both the government and providers, increased attention to healthcare access, and the use of Integrity Agreements and increased resources from Congress, the U.S. Department of Health and Human Services could make Medicare for All work from a healthcare fraud and abuse perspective.

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# Introduction

 A Medicare for All bill has been introduced in Congress three times within the last three years by Senator Bernie Sanders and most recently, by Representative Pramila Jayapal.[[1]](#footnote-1) This paper will primarily focus on the 2019 Sanders bill. Co-sponsors of the most recent Senator Sanders 2019 bill include current and past 2020 presidential candidates Elizabeth Warren, Corey Booker, Kirsten Gillibrand, and Kamala Harris.[[2]](#footnote-2) Although Medicare for All has yet to gain congressional approval, it has become a pillar of healthcare debates during federal political elections. Moreover, it has been a controversial issue in both the 2016 and 2020 presidential elections.[[3]](#footnote-3) However, the language of the Sanders bill and the candidates promoting Medicare for All have failed to discuss how a transition to a Medicare for All health system will incorporate protections against healthcare fraud and abuse.[[4]](#footnote-4)

 Medicare for All establishes a single-payer health insurance system administered by the federal government.[[5]](#footnote-5) It is designed to cover everyone residing in the U.S.[[6]](#footnote-6) Benefits include coverage for all medically necessary services including primary care, preventative care, mental healthcare, reproductive care, vision care, dental care and prescription drugs.[[7]](#footnote-7) The bill provides coverage without premiums, deductibles, or copays and prohibits balance billing.[[8]](#footnote-8) Senator Bernie Sanders of Vermont is the most well-known champion of the bill and has been the main sponsor on two out of the three most recent Medicare for All bills.[[9]](#footnote-9)

 If passed, the Sanders Medicare for All bills would provide millions of people with a federally run, public healthcare coverage.[[10]](#footnote-10) However, the bills fail to articulate how the federal government will adapt to maintain healthcare fraud and abuse measures.[[11]](#footnote-11) In general, the U.S. Office of the Inspector General for Department of Health & Human Services (HHS-OIG) in conjunction with the Department of Justice (DOJ) and the Centers for Medicare and Medicare Services (CMS), are charged with protecting the integrity of healthcare and welfare programs including federal health insurance programs.[[12]](#footnote-12) Under the Medicare for All bills, HHS-OIG would continue to monitor and enforce healthcare fraud and abuse laws.[[13]](#footnote-13) Moreover, all of the Senate bills state that the fraud and abuse protections granted to HHS-OIG would remain the same as they are now.[[14]](#footnote-14)

# Scope

The role of this paper is to discuss whether fraud and abuse laws and policies will need to be adjusted if a Medicare for All bill is adopted and to what extent. In the last year, two Medicare for All bills have been introduced in Congress: One by 2020 Presidential candidate Bernie Sanders and another by Washington State Representative Pramila Jayapal.[[15]](#footnote-15) This paper will focus on Senator Sanders’ Medicare for All bills, which are almost identical regarding policies relating to healthcare fraud and abuse. Moreover, Sanders’ Medicare for All bills are most well-known by the American public and significantly more research analysis exists when comparing the Sanders bills to the new Jayapal bill.

 The first section will introduce the current healthcare fraud and abuse powers of HHS-OIG and discuss current healthcare fraud and abuse system. The second portion of this paper will discuss the Medicare for All bill and the overall effect that the bill will have on the U.S. healthcare system. The third part of this paper will examine the political atmosphere and perspectives of different stakeholders on healthcare fraud and abuse under the bill and the general effect of Medicare for All on healthcare fraud and abuse protections. These effects include a decrease in HHS’s power to fight healthcare fraud and abuse and increase HHS-OIG’s power to exclude healthcare practitioners from government funded programs including Medicare under the bill. Finally, this paper will analyze potential legal, policy, and budgetary strategies that HHS-OIG and Congress could implement to make Medicare for All work under a healthcare fraud and abuse perspective.

# Healthcare Fraud & Abuse Laws

The U.S. Department of Health and Human Services (HHS) defines “fraud” as knowingly submitting or causing the submission of false healthcare claims to federal government healthcare programs such as Medicaid or Medicare.[[16]](#footnote-16) Moreover, fraud can also include knowingly soliciting, receiving, offering or paying remunerations to induce payments from a federal healthcare program.[[17]](#footnote-17) For example: a doctor who submits a claim to Medicare for seeing 100 Medicare patients, but knows that she only saw 50 Medicare patients. The doctor has made a false statement and if Medicare pays the doctor for the 50 patients she did not see, then the government has been defrauded and can sue the doctor for the return of the improperly obtained money.[[18]](#footnote-18)

 HHS defines “abuse” as practices that can directly or indirectly cause unnecessary cost to federal healthcare programs.[[19]](#footnote-19) Knowledge of whether these practices cause unnecessary cost is not required for the action to be considered “abuse.”[[20]](#footnote-20) An example of a healthcare abuse law is Stark Law,[[21]](#footnote-21) which forbids doctors from giving other doctors a kickback in exchange for patient referrals. Here, there is no false statement or intent to defraud the government, but it is an abusive practice that results in the government paying more for medical services that it should.[[22]](#footnote-22) Healthcare fraud and abuse protections are integral in ensuring that federal healthcare programs are reliable and protect federal healthcare beneficiaries through establishing quality standards for healthcare providers.[[23]](#footnote-23) Moreover these laws ensure the integrity of federal healthcare programs, ensuring that taxpayer dollars are appropriately used, ensuring that federal healthcare programs have the money to maintain the healthcare program through containing and recovering healthcare costs to ensure the future of federal healthcare programs.[[24]](#footnote-24)

 Healthcare fraud and abuse laws stem from a wide variety of powers granted to HHS-OIG by Congress. These powers include collecting civil monetary penalties under the Anti-kickback statute,[[25]](#footnote-25) Stark Law,[[26]](#footnote-26) and the Emergency Treatment Medical and Labor Act (EMTALA), which are explained below.[[27]](#footnote-27) Moreover, HHS-OIG can collect financial penalties and pursue criminal action under the False Claims Act (FCA).[[28]](#footnote-28) Furthermore, HHS-OIG can pursue action under mandatory and permissive exclusion powers.[[29]](#footnote-29)

 The U.S. healthcare fraud and abuse process can be broken up into three levels: prevention, detection, and response.[[30]](#footnote-30) “Prevention” of fraud relates to stopping healthcare fraud and abuse before it happens.[[31]](#footnote-31) “Detection” of fraud involves the identification of fraud as quickly and efficiently as possible.[[32]](#footnote-32) “Response” to fraud involves retroactive actions taken to punish wrongdoers who commit fraud and in turn, prevent them from committing fraud again. All three play an integral role in the healthcare fraud and abuse framework.[[33]](#footnote-33) However, the majority of healthcare fraud and abuse laws largely fall into the “response” category.[[34]](#footnote-34)

 When prosecuting fraud and abuse cases, HHS-OIG uses a risk assessor to determine how likely a healthcare practitioner or entity is to violate a fraud and abuse law in the future.[[35]](#footnote-35) Organizations that self-disclose their fraud and abuse to HHS-OIG present the least amount of risk whereas healthcare practitioners who have lost their healthcare practice licenses or have felony convictions relating to illicit substance abuse or federal healthcare fraud are more likely to be discretionarily excluded by the agency.[[36]](#footnote-36) This is because healthcare physicians and organizations who self-disclose are generally cooperative and work with HHS-OIG to create an effective compliance program. Practitioners and organizations found to be on the middle of the spectrum may be asked to enter into corporate integrity agreements (CIA) or integrity agreements (IA).[[37]](#footnote-37) These agreements are voluntary, and act as enforceable contracts between HHS-OIG and healthcare organizations or practitioners.[[38]](#footnote-38) Under these agreements healthcare organizations will generally need to take steps to create and effect healthcare compliance programs and submit audits of federal healthcare billing to HHS-OIG.[[39]](#footnote-39)



Figure 1: HHS-OIG Risk Spectrum[[40]](#footnote-40)

## Civil Money Penalty Laws

Civil Money Penalties (CMPs) cover a wide range of healthcare fraud and abuse violations under the Social Security Act (SSA).[[41]](#footnote-41) This power allows the government to collect penalty fines when a healthcare entity provides false information to the federal government, violates EMTALA, employs or contracts with an excluded provider, or fails to provide HHS-OIG with access to audits, investigations or evaluations for HHS-OIG to perform its statutory functions. Moreover, the federal government can collect CMPs under the Anti-kickback statute and Stark Law.[[42]](#footnote-42) In general, under the SSA, HHS-OIG can collect maximum penalties between $20,000 and $100,000 per violation depending on the type of violation.[[43]](#footnote-43)

## False Claims Act and False and Fraudulent Claims under CMP laws

The False Claims Act (FCA) imposes liability on individuals and entities who defraud government programs[[44]](#footnote-44). Under the FCA, the government can prosecute offenders both civilly and criminally.[[45]](#footnote-45) With regards to federal healthcare programs, it is unlawful for healthcare practitioners or entities to submit claims for payment to Medicaid or Medicare that the provider knows or should know is false or fraudulent.[[46]](#footnote-46) For example, a physician can use a method called upcoding to increase their Medicare reimbursement.[[47]](#footnote-47) In upcoding, a physician who has a 15-minute examination bills Medicare for a 45-minute exam, knowing that she only completed the 15-minute examination. Therefore, the physician knowingly filed a false claim to the government and the when the government pays the bill for the 45-minute exam, the government was defrauded, and the physician would be liable for the fraudulent claim under the FCA.

 Filing a false claim can result in civil money penalties of up to three times the claim (“treble damages”) plus up to $11,000 per claim filed.[[48]](#footnote-48) Under the FCA, each service or item billed to Medicaid or Medicare is treated as a separate claim.[[49]](#footnote-49) For example, if a psychiatrist knowingly bills for 100 30 to 60-minute therapy sessions that require a face to face encounter to Medicare, but only sees those patients for 15 minutes that is considered a false claim under the False Claims Act. The physician received a total of $500,000 for the 100 visits. Under the law, the federal government may collect damages of $1.5 million ($500,000 x 3) plus an extra $1.1 million ($11,000 x 100).[[50]](#footnote-50)

 The federal government relies heavily on whistleblowers to report false claims and FCA violations.[[51]](#footnote-51) Whistleblowers are typically employees or other people who bring illicit activities to the attention of the federal government.[[52]](#footnote-52) Specifically, under the False Claims Act, whistleblowers have to file a *qui tam* action in court.[[53]](#footnote-53) Under a *qui tam* action the government has a right to intervene if it chooses.[[54]](#footnote-54) The government has previously denied *qui tam* claims because claims were facially lacking merit of legal theory or factual basis, *qui tam* actions were a duplicate of a pre-existing *qui tam* investigation, the FCA *qui tam* investigation would have interrupted ongoing other government litigation, the costs of government litigation would have been more expensive than what the government expected to gain, and the *qui tam* filer’s actions failed to follow appropriate *qui tam* filing and investigative procedures.[[55]](#footnote-55) If not, the whistleblower can pursue the action on their own.[[56]](#footnote-56) Between 1986 and 2018, the federal government has collected over $32 billion dollars from health fraud *qui tam* cases and received over 7,600 *qui tam* suits*.*[[57]](#footnote-57) Outside of whistleblowers HHS-OIG also performs data mining, which is the practice of using a statistics and algorithms to find patterns in Medicare and Medicaid claims data that suggests false or fraudulent billing.[[58]](#footnote-58)

## Anti-kickback Statute

The Anti-kickback Statute prohibits individual healthcare practitioners and healthcare entities from knowingly or willingly offering, paying or soliciting remuneration, either directly or indirectly, to induce referrals of federal healthcare program business.[[59]](#footnote-59) Similar to the FCA, anti-kickback violations can result in both criminal and civil penalties. The Anti-kickback Statute provides twenty-three exceptions or “safe harbors” that protect certain referrals induced by remunerations.[[60]](#footnote-60) The most common safe harbors include referral arrangements for specialty services, remunerations for physician recruitment, and price reductions offered to managed care organizations. The criminal penalty for each kickback is a maximum of $25,000 and a maximum of 5 years in prison per violation.[[61]](#footnote-61) The civil penalty for each kickback is a maximum of $100,000 per violation and a civil assessment of up to three times the amount of the kickback, however the federal government may only collect up to three times the amount of the kickback.[[62]](#footnote-62)

 For example, if an internal medicine doctor makes an agreement to refer all of his cancer patients on Medicare to one oncologist and in return the oncologist gives the internal medicine doctor $1,000 for every patient referred, that would be a violation of the Anti-kickback Statute. Assuming that no safe harbors apply, if the internal medicine doctor referred 100 patients to the oncologist and the federal government only pursued civil action then the maximum amount of civil money penalties that the government can seek is $10 million dollars from the internal medicine physician or $100,000 per patient referred. However, under the law the government may not seek any more than three times the amount of remunerations received. This means that the maximum amount that the federal government can collect from the internal medicine doctor under the Anti-kickback Statute is $300,000.[[63]](#footnote-63)

## Stark Law

Stark law prohibits physician self-referral.[[64]](#footnote-64) Specifically, it prohibits physicians from referring patients utilizing federal healthcare programs to designated health services if the physician or an immediate family member has a financial relationship with the entity.[[65]](#footnote-65) Financial relationship examples include ownership interests or compensation agreements (such as medical directorships, lease agreements, consulting arrangements, and medical service provider arrangements).[[66]](#footnote-66) These financial relationships can be between the physician or a physician’s immediate family member.[[67]](#footnote-67) Designated health services include clinical laboratory services; physical therapy, occupational therapy and outpatient speech-language pathology services; radiology services; radiation therapy services and supplies, durable medical equipment and supplies, parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.[[68]](#footnote-68)

 Unlike the FCA and Anti-kickback Statute, Stark violations are only civil claims.[[69]](#footnote-69) Penalties for a Stark violation include denial of payment for the health services provided; refund of reimbursements received by physicians and facilities; payment of civil penalties of up to $15,000 for each service that a person "knows or should know" was provided in violation of the law, and three times the amount of improper payment the entity received from the Medicare program; exclusion from the Medicare program or state healthcare programs including Medicaid; and payment of civil penalties for attempting to circumvent the law of up to $100,000 for each circumvention scheme.[[70]](#footnote-70)

 For example, an internal medicine doctor owns ABC clinical laboratory. The doctor refers 100 patients who need 1 lab test to her clinical laboratory, which is a violation of Stark Law. The physician’s clinical laboratory received $100,000 for the clinical laboratory testing done on those 100 patients from Medicare. Assuming that no Stark Law exemptions are met,[[71]](#footnote-71) the federal government can collect up to $1.5 million for all lab tests completed and $300,000 for the reimbursement from Medicare.

## EMTALA

EMTALA was designed to ensure the treatment and stabilization of all patients who enter an emergency department.[[72]](#footnote-72) This law was enacted to address an increasing problem of “patient dumping” which is the practice of refusing to provide emergency medical treatment to individuals who could not pay for it or transferring a patient before an emergency condition was stabilized.[[73]](#footnote-73) However, the courts have determined that the EMTALA statute does not require proof of improper motive and EMTALA violations have stemmed from healthcare providers’ failure to properly treat or transfer due to the patient’s race, sex, ethnic group, political affiliation, occupation , education, behavior, personal prejudice or spite.[[74]](#footnote-74) EMTALA requires (1) that emergency departments provide medical screening exams (MSE) that are appropriate to identify any possible emergency medical conditions (EMC), stabilize any EMCs within the hospital’s capabilities, provide timely hospitalization and treatment for the EMC within the capacity of the hospital, appropriately transfer unstable patients if the benefits of transfer outweigh the risks of the transfer, and report any known EMTALA violations to HHS.[[75]](#footnote-75) EMTALA is directly tied to a hospital’s ability to accept Medicare. Penalties for EMTALA violations include the termination of Medicare agreements between the violating hospital or physician and fines of up to $50,000 per violation.[[76]](#footnote-76)

 For example, a patient enters the emergency department with chest pain and shortness of breath. The patient asks to see a physician but becomes exceedingly angry when the nurse asks him why. The patient is escorted out of the emergency department by security. The patient then went to a nearby hospital but was pronounced dead within 20 minutes of arrival. This would be an example of the emergency department’s failure to perform an MSE which is a violation of EMTALA.[[77]](#footnote-77) Under the law, the federal government could terminate its Medicare contract with the hospital and seek up to $50,000 for the violation.[[78]](#footnote-78)

## Exclusion Laws

Under the SSA, HHS-OIG may exclude individual healthcare practitioners and entities from receiving reimbursement payments from federal healthcare programs for items or services provided. [[79]](#footnote-79) This applies even when the payment itself is made to another provider, supplier, or practitioner that is not excluded.[[80]](#footnote-80) Exclusions can be mandatory or permissive.[[81]](#footnote-81) Mandatory exclusions require HHS-OIG to exclude the individual for a minimum of 5 years.[[82]](#footnote-82) Types of mandatory exclusion convictions include program-related crimes, patient abuse, felony healthcare fraud, or felony convictions relating to controlled substances.[[83]](#footnote-83) The application of a permissive exclusion is determined by HHS-OIG.[[84]](#footnote-84) There are sixteen different permissive exclusion authorities including losing a state license to practice, failing to repay student loans, conviction of certain misdemeanors, or failing to provide quality care.[[85]](#footnote-85) The minimum period of exclusion is based on the type of violation. [[86]](#footnote-86), [[87]](#footnote-87)

 Exclusions are considered to be the most extreme penalty within HHS-OIG’s power because it prevents individuals and entities from collecting reimbursements from Medicare and Medicaid. Moreover, hospitals and healthcare practices that accept Medicaid and Medicare are not allowed to employ excluded individuals or they will be at risk for exclusion as well. Moreover, exclusions commonly trigger provisions in private insurance contracts that sever contracts between practitioners and private insurance providers. This makes physicians unable to collect reimbursements from any insurance company whether it’s private or federal healthcare insurance and renders excluded individuals essentially un-hirable.

# Medicare for All Bill

Senator Sanders first introduced a Medicare for All bill into Congress in 2017.[[88]](#footnote-88) The most recent Senate Medicare for All bill was introduced in 2019.[[89]](#footnote-89) Under Senator Sanders’ most current plan, the majority of health benefits would no longer be available under traditional federal government programs including Medicare, Medicaid, CHIP, the Federal Employees Health Benefits Program, and the TRICARE Program.[[90]](#footnote-90) Moreover, the bill would prohibit the sale of private health insurance, employer-based insurance, and retiree coverage that duplicates any services covered by the Medicare for All program.[[91]](#footnote-91) The plan also eliminates cost-sharing for consumers and prohibits deductibles, co-insurance, and copays for any benefits covered under the Medicare for All plan.[[92]](#footnote-92) However, HHS would be allowed to impose cost sharing under a new Medicaid long-term care program and for drugs and biologics.[[93]](#footnote-93)

 Furthermore, under Senator Sanders’ plan, every resident of the United States would be entitled to healthcare benefits under the Medicare for All plan.[[94]](#footnote-94) Upon enrollment in the Medicare for All program, each beneficiary would be issued a Universal Medicare card that is not tied to a social security number.[[95]](#footnote-95)

 The Medicare for All plan maintains the ten categories of essential health benefits established by the Affordable Care Act (ACA).[[96]](#footnote-96) Essential health benefits are specific services that health insurance plans are required to cover under the ACA, in an attempt to achieve quality and affordable health insurance.[[97]](#footnote-97) These include (1) Outpatient services, (2) Emergency medical services, (3) Hospitalization, (4) Maternity and newborn care, (5) Mental health and substance abuse disorder treatment, (6) Prescription drugs, (7) Rehabilitative and habilitative services, (8) Laboratory services, (9) Preventive and wellness services with chronic disease management, and (10) Pediatric services including oral and vision care.[[98]](#footnote-98) Moreover, other services will be covered if they have been provided pursuant to a national practice guideline that has been recognized by HHS, such as adult dental and vision services, and prescription drugs.[[99]](#footnote-99)

 Due to the ban on private insurance for covered benefits, healthcare providers are banned from contracting with private insurance companies or individually billing for covered services for any Medicare for All beneficiaries.[[100]](#footnote-100) However, providers can bill for or contract with private insurance for services not covered by Medicare for All and patients who do not qualify for Medicare for All.[[101]](#footnote-101) The plan also creates a complex process for providers to contract with consumers for healthcare services.[[102]](#footnote-102) However, providers must meet certain requirements before entering into a contract and can only do so if they will not receive reimbursement for the services under Medicare for All.[[103]](#footnote-103)

 In order for healthcare providers to participate in Medicare for All, providers must be licensed or certified practitioners, meet existing Medicare provider standards, and meet any additional minimum provider standards as established by HHS including facility quality, staffing levels for physicians and nurses, personnel training and competence, continuity of services, and patient satisfaction.[[104]](#footnote-104)

 Under Sanders’ Medicare for All plan, the bill only applies existing fraud and abuse provisions to the program.[[105]](#footnote-105) Though not outwardly related to healthcare fraud and abuse, Sanders’ Medicare for All bill establishes a national database that will contain information on providers, the cost of facilities, the quality of services, healthcare outcomes, and health equity. Using the database, HHS is required to annually report to Congress on the status of program implementation and regularly audit the information.[[106]](#footnote-106)

# Policy Analysis

The political structure and key stakeholder perspectives of those in favor of the Medicare for All law and those who disagree with Sanders’ Medicare for All Bill are essential to understanding the healthcare fraud and abuse effects of Medicare for All.

## Political Atmosphere

### Medicare for All

 The Medicare for All policy is generally associated with progressive viewpoints.[[107]](#footnote-107) Historically, progressives have aligned with the idea that the government should regulate the economy and that access to affordable and quality healthcare is a right, not a privilege.[[108]](#footnote-108) This viewpoint has become particularly prominent over the course of the political battles over the ACA.[[109]](#footnote-109) The ACA was the one of the federal government’s first successful attempts to implement federal health insurance programs for those not covered by Medicare or Medicaid.[[110]](#footnote-110) The goal of the ACA was to make affordable health insurance available to more people by creating subsidies to lower health insurance costs for households within 100% to 400% of the federal poverty level, allowing states to expand the Medicaid program to cover all adults between 19 and 64 whose income is at 138% or below the FPL, and support new healthcare delivery systems that would lower the cost of healthcare overall.[[111]](#footnote-111) The ACA was infamously coined “Obamacare” named after Democratic President Barack Obama who championed the bill and signed it into law.[[112]](#footnote-112) Highlighting the partisan divide in healthcare ideology, every Republican senator voted against the adoption of the ACA.[[113]](#footnote-113) Moreover, all of the 2020 presidential democratic candidates including Elizabeth Warren, Joe Biden, and Bernie Sanders supported the ACA bill.[[114]](#footnote-114) Pushing further into the “healthcare is a right” ideal, Bernie Sanders and Elizabeth Warren have presented similar Medicare for All plans as part of their presidential campaigns.[[115]](#footnote-115)

### Healthcare Fraud and Abuse

Increased fraud and abuse regulations align with the democratic ideology that government regulation can be used to create equal opportunity for all.[[116]](#footnote-116) This conflicts with the conservative ideology that government intervention should be limited to cases of true necessity.[[117]](#footnote-117) One challenge for HHS-OIG creating better healthcare fraud and abuse regulations is conservative President Donald Trump’s executive order 13771.[[118]](#footnote-118) Under the executive order any executive branch department or agency who plans to announce a new regulation must also propose two regulations to take away.[[119]](#footnote-119) Moreover, under the executive order, the cost of implementing the new regulation must be less than or equal to zero dollars.[[120]](#footnote-120) In guidance, the White House Office of Management & Budget (OMB) provided five exception to the order: (1) the regulation is deemed “nonsignificant” by OMB, (2) the regulation is required by statute, (3) the regulation imposes little to no cost, (4) the regulation is related to national security, and (5) the regulation is for transfer payments to beneficiaries of Federal program, such as Medicare.[[121]](#footnote-121) Thus, if HHS-OIG can meet one of these exceptions, then the “add one, remove two” rule will not apply. Moreover, Medicare for All champions and democratic presidential candidates would likely reverse this executive order, making it easier for HHS-OIG to create new regulations to support the Medicare for All policy.

## Key Stakeholders

### Medicare for All Beneficiaries

#### Medicare for All

Under Medicare for All, Medicare for All beneficiaries would likely include all people residing in the U.S.[[122]](#footnote-122) Single-payer healthcare plans, including the Medicare for All plan hold a substantial amount of public support.[[123]](#footnote-123) According to survey data, 53 percent of Americans favor the Medicare for All healthcare plan. [[124]](#footnote-124) Moreover, since July of 2017, immediately before Sanders’ first Medicare for All bill was introduced, support for Medicare for All has remained relatively consistent with about half of Americans supporting a Medicare for All plan.[[125]](#footnote-125) However, survey data has also shown that support for Medicare for All is greatly divided by political party.[[126]](#footnote-126) In a Kaiser Family Foundation poll conducted in November 2019, Democrats and Independents were more likely to favor a Medicare for All plan. Specifically, the poll found that 77 percent of Democrats and 52 percent of independents support the Medicare for All plan.[[127]](#footnote-127) Conversely, only 28 percent of Republicans support a Medicare for All plan.[[128]](#footnote-128)

The survey data also shows that Americans do not fully understand what Medicare for All entails.[[129]](#footnote-129) For example, Medicare for All bans private health insurance from covering any benefits that are already covered by the Medicare for All plan.[[130]](#footnote-130) However, 40 percent of Americans believe that private health insurance companies would still be the primary source of health insurance under the bill.[[131]](#footnote-131) Furthermore, 55 percent of Americans believe that they would be able to maintain their current healthcare plan.[[132]](#footnote-132) Moreover, Medicare for All eliminates any form of cost sharing, including premium payments.[[133]](#footnote-133) However, 54 percent of Americans believe that individuals and employers would pay premiums.[[134]](#footnote-134) Thus, while it appears that most Americans support single-payer systems and the Medicare for All bill, they do not fully understand what the Medicare for All bill entails.

#### Healthcare Fraud and Abuse

Significantly less is known about Americans’ knowledge of healthcare fraud and abuse laws. According to an extensive literature search, the most recent published public survey of Americans’ knowledge of healthcare fraud and abuse is from 1999.[[135]](#footnote-135) The survey found that 87 percent of Americans attributed high costs of Medicare to fraud, waste and abuse and that if fraud and abuse were eliminated, Medicare funding would be sufficient.[[136]](#footnote-136) Thus, Americans believe that healthcare fraud and abuse protections play a vital role in maintaining federal healthcare programs and therefore may support increased healthcare fraud and abuse regulations under the Medicare for All bill, especially because the majority of Americans support the Medicare for All bill.

### Healthcare Providers

#### Medicare for All

Healthcare providers vary in support for Medicare for All based on their role in the healthcare system. Moreover, physicians and professional physician groups have noted their concerns with a Medicare for All plan. In a poll conducted by Medscape, 49 percent of physicians, 47 percent of nurses and advance practice registered nurses, 41 percent of healthcare businesspersons and administrators and 40 percent of pharmacists support a Medicare for All plan.[[137]](#footnote-137) The majority of physicians were concerned that Medicare for All would reduce physician compensation (59 percent of all physicians surveyed).[[138]](#footnote-138) Other concerns also included there not being enough physicians and other healthcare practitioners to support the influx of patients with health insurance.[[139]](#footnote-139) Moreover, the American Medical Association (AMA) has stayed relatively silent on their support of single-payer policies.[[140]](#footnote-140) The AMA is the largest and most well-known physician group in the U.S. While AMA supports expansion and improvement of the ACA, it has not published any support of a single-payer policy.[[141]](#footnote-141)

 However, another premier physician group, the American College of Physicians (ACP), has publicly supported single-payer healthcare, including the Medicare for All bill.[[142]](#footnote-142) The ACP represents approximately 159,000 internal medicine physicians across the U.S.[[143]](#footnote-143) Noting ACP support of a universal health system, the ACP Health and Public Policy Committee and Medical Practice and Quality Committee specifically states that it is the opinion of the ACP that the U.S. should adopt a universal healthcare system that covers essential benefits and could include single-payer financing.[[144]](#footnote-144) Moreover, coverage should not be limited by residence, employment, health status, or income.[[145]](#footnote-145)

Finally, the American Public Health Association (APHA), which is comprised broadly of public health professional including medical doctors, public health researchers, nurses, those working for government and non-profit health organization.[[146]](#footnote-146) The APHA has supported has supported both the ACA as well as health reform to a single-payer healthcare system, noting that single-payer system, like Medicare for All, would increase jobs, improve the U.S. economy and improve healthcare access in the U.S.[[147]](#footnote-147) Thus, healthcare provider support for the Medicare for All bill is mixed and the tension behind providing increasing healthcare access and maintaining physician livelihood has been noted.

#### Healthcare Fraud and Abuse

Under most healthcare fraud and abuse laws, the standard of proof is that a healthcare practitioner “knew or should have known” that they were violating a healthcare fraud and abuse law.[[148]](#footnote-148) Having gone through rigorous medical training programs, the law assumes that physicians know and understand when they are committing fraud and abuse violations.[[149]](#footnote-149) While data has not been collected on whether or not physicians understand what healthcare fraud and abuse violations are,[[150]](#footnote-150) HHS-OIG found that physician education lacks teachings on healthcare fraud and abuse, noting that only 44 percent of medical schools reported providing instruction to students on Medicare and Medicaid fraud and abuse laws.[[151]](#footnote-151)

 Moreover, based on a survey of more than 8,700 physicians, physicians spent on average about 11.37 hours or 23 percent of their work time, on paperwork related to healthcare compliance regulations in 2018 and many physicians who participated in the survey commented that “government red tape” and regulations made a physician’s job harder. [[152]](#footnote-152) Furthermore, the American Hospital Association noted that hospitals and post-acute care providers spend more than $39 million on administrative activities related to regulatory compliance.[[153]](#footnote-153)Therefore it is unlikely that healthcare providers will support increased healthcare fraud and abuse regulations.

### Private Health Insurers

Under the Medicare for All bill, private health insurance will be banned with the exception of benefits not covered by Medicare for All.[[154]](#footnote-154) In 2018, total net income of the health insurance industry was $23.4 billion.[[155]](#footnote-155) The net income of the health insurance industry has steadily increased over time with net income at $4 billion in 2015, $7 billion in 2016, and $16 billion in 2017.[[156]](#footnote-156) With these dramatic increases in profit, private health insurers will likely not support a Medicare for All bill because they will lose the ability to supply most of their healthcare insurance products and have a limited market to offer other products.[[157]](#footnote-157) Moreover, private health insurers are known to not support increased healthcare regulations because of the increased burden of compliance with regulations, such as healthcare fraud and abuse regulations.[[158]](#footnote-158)

### Federal Government Healthcare Agencies

The largest issue for the federal government, including HHS-OIG and CMS will be the increased administrative burden that Medicare for All would cause, especially at the outset during the implementation period of the Medicare for All program.[[159]](#footnote-159) Under Sanders’ Medicare For All plan, HHS will be charged with creating a whole new universal healthcare plan designed to cover more than double the amount of federally covered beneficiaries (hereinafter, “beneficiaries”) that current federal healthcare plans cover.[[160]](#footnote-160) HHS will require increased resources in terms of funding and staff, have to increase communication with other related state agencies such as the IRS and will be required to work with and monitor large numbers of healthcare practitioners.[[161]](#footnote-161)

 With regards to healthcare fraud and abuse, HHS-OIG will require increased resources and staff in order to continue to enforce healthcare fraud and abuse regulations at the same level that they currently do.[[162]](#footnote-162) Moreover, HHS-OIG will need to consider changes to the implementation and enforcement of their regulations to accommodate for the increased numbers of beneficiaries and providers and balance the need for healthcare fraud and abuse protections with an increased enforcement power given to HHS-OIG through mere growth in the number of providers who accept federal health insurance and are susceptible to healthcare fraud and abuse enforcement actions. [[163]](#footnote-163)

# The Potential Problem with Medicare for All

As highlighted by the key stakeholder analysis, Medicare For All presents a number of healthcare fraud and abuse issues. Under the Medicare for All plan healthcare beneficiaries would more than double.[[164]](#footnote-164) Moreover, based on the large number of beneficiaries that have Medicare For All, health providers who accept federal health insurance would need to increase to match the increasing number of beneficiaries.[[165]](#footnote-165) Due to the increased number of beneficiaries and providers, healthcare fraud and abuse will likely increase as well, presenting a problem for the current healthcare fraud and abuse system. HHS-OIG, DOJ, and CMS will likely experience increased administrative burden and require more resources to maintain the level of healthcare fraud and abuse enforcement that the federal government maintains now.[[166]](#footnote-166)

 Based on the current law, HHS-OIG will likely also experience an influx in the amount of enforcement power that they have. Under various healthcare fraud and abuse laws, HHS-OIG is allowed to pursue enforcement action when there is a violation in relation to any federal healthcare program.[[167]](#footnote-167) This includes Anti-kickback violations, Stark violations, EMTALA, and the FCA, all of which can lead to enforcement through large civil money penalties and exclusion.[[168]](#footnote-168) With the large increase in beneficiaries and providers, HHS-OIG’s enforcement powers will expand the federal government’s powers. Thus, the government will likely need to consider other factors before exclusions such as general healthcare access in the area and the effect that the enforcement will have on the surrounding community.

 Sanders’ plan does provide for an ease-in approach where Medicare for All would be implemented in phases.[[169]](#footnote-169) This will give federal healthcare fraud and abuse agencies an opportunity to adapt to the new plan. The recommendations set out below are designed to combat these potential problems both prior to implementation of Medicare for All and during the phase-in of the bill.

#  Recommendations: Making Medicare for All Work

The healthcare fraud and abuse system can be broken down into three categories: prevention, detection, and response.[[170]](#footnote-170) The majority of powers under HHS-OIG relate to how HHS-OIG can respond to healthcare fraud violations, while relying on third party whistleblowers to detect and bring forward fraud and abuse violations.[[171]](#footnote-171) Finally, while HHS-OIG does provide some training and education to prevent healthcare fraud and abuse the main mechanism of prevention is using exclusion powers to prevent bad actors from providing services and misusing the federal healthcare system.[[172]](#footnote-172)

 As highlighted in the previous section, the implementation of Medicare for All presents new challenges for the healthcare fraud and abuse regulators. In order to maintain the current level or better of healthcare fraud and abuse protections, under Medicare for All, the healthcare fraud and abuse system will need to change to accommodate the increased amount of healthcare fraud that will result from the increased number of Federal health insurance beneficiaries and providers. Below are several recommendations targeting the three main components of the healthcare fraud and abuse system that can make Medicare for All work from a fraud and abuse perspective.

## Prevention & Detection: Increased Resources

Based on data, roughly 10 percent of U.S. healthcare spending is lost to fraud.[[173]](#footnote-173) Government officials have argued that current Medicare fraud and abuse problems highlight what is likely to happen if we convert to a single-payer plan like Medicare for All.[[174]](#footnote-174) The idea behind this statement is by more than doubling the pool of beneficiaries enrolled in federal government healthcare programs, the amount of fraud and abuse will also increase. Thus, it is plausible to say that single-payer healthcare systems will only increase the amount of taxpayer dollars lost due to healthcare fraud.[[175]](#footnote-175)

 However, Sanders’ Medicare for All plan factors in the increased costs of implementing a completely government run healthcare program.[[176]](#footnote-176) The bill does specifically outline the budget for healthcare fraud and abuse protections, but allocates budget discretion to HHS.[[177]](#footnote-177) Moreover, HHS has the discretion under the bill to allocate funds as it sees fit.[[178]](#footnote-178) Furthermore, HHS-OIG, the main healthcare fraud and abuse monitoring system, maintains its independence from HHS and the HHS secretary under the Inspector General’s Act of 1978, meaning that the HHS inspector general’s budget is approved by Congress and not by HHS.[[179]](#footnote-179) Thus, depending on Congress, healthcare fraud and abuse budgeting will be maintainable as long as Congress approves of the budget.

 Furthermore, according to a recent joint DOJ and HHS report, both agencies collectively recovered four dollars for every dollar spent on investigating and prosecuting healthcare fraud and abuse.[[180]](#footnote-180) Thus, so long as the government increases its resources to match the amount of healthcare fraud and abuse, and the agencies’ recovery remains the same under the Medicare for All program, then the program should be self-sustaining.

##  Prevention & Detection: Training for Student Practitioners & Administrators

Healthcare practitioners and administrators understanding healthcare fraud and abuse laws plays a key role in preventing these issues. However, no current law requires medical schools and other healthcare related institutions to provide instruction on compliance with Medicare and Medicaid laws aimed at preventing fraud and abuse.[[181]](#footnote-181) Moreover, only 44 percent of medical schools in the U.S. provide instruction to students on Medicare and Medicaid fraud and abuse.[[182]](#footnote-182) That number increases to 66 percent for medical residency and fellowship programs.[[183]](#footnote-183) Furthermore, no data is available on the number of other healthcare practitioner schools providing healthcare fraud and abuse training. These schools include practitioners outside physicians, who are commonly excluded from Medicare and Medicaid, such as nurses, medical assistants, nurse practitioners and physician’s assistants.[[184]](#footnote-184) No data is available setting forth the number of healthcare administration schools that offer training on Medicare and Medicaid fraud.

 Through educating both healthcare practitioners and administrators, healthcare fraud and abuse will likely decline. As noted by numerous scholars, training individuals in compliance improves overall conformity with the law or policy.[[185]](#footnote-185) Thus education plays an important role in preventing negative behavior and improving compliance.[[186]](#footnote-186)

 Based on this theory, HHS should strongly encourage that healthcare practitioner programs and healthcare administration programs teach certain healthcare fraud and abuse laws and detection methods as part of the professional coursework. By enabling healthcare practitioners and administrators to avoid, spot, and properly report healthcare fraud and abuse, the burden of detecting and reacting to Medicare and Medicaid fraud will likely be lessened. Moreover, in the case of Medicare for All where Federal healthcare beneficiaries will more than double, healthcare practitioners and administrators having proper knowledge of these laws and regulations will help to eliminate the heavy burden placed on enforcement agencies.

## Detection: Whistleblowers & Datamining

Healthcare fraud and abuse laws are generally retroactive and rely heavily on whistleblowers and self-disclosures to find healthcare fraud and abuse violations.[[187]](#footnote-187) Such reliance on whistleblowers becomes an issue when federal healthcare beneficiaries more than double. Whistleblowers are the primary identifiers of violations for the federal governmental agencies but they face unique hardships when deciding whether to alert the federal government to wrongdoing.[[188]](#footnote-188) For example, while whistleblowers are incentivized to report healthcare fraud and abuse through the promise of recovering 25 to 30 percent recovery under the False Claims Act, the whistleblower generally hires an attorney to submit a *qui tam* action with the DOJ.[[189]](#footnote-189) The requirement of needing to hire an attorney to file a *qui tam* action in order to alert the government of wrongdoing is problematic because it requires that people have access to an attorney and prevents those who cannot get an attorney from filing *qui tam* actions, limiting the number of healthcare fraud and abuse reports brought before the government.[[190]](#footnote-190)

 Moreover, the government must accept the *qui tam* action and win or settle for the whistleblower to receive recovery.[[191]](#footnote-191) If government rejects the *qui tam* action, the whistleblower can file a suit on their own against the violating organization and again hire an attorney.[[192]](#footnote-192) Due to the complicated process and the chance of employer retaliation, mere reliance on whistleblowers will not sustain a system where every resident of the U.S. is a beneficiary of the program.

 Studies have shown that through datamining, the government can efficiently find fraud and abuse violations on its own.[[193]](#footnote-193) Datamining combines automated methods and statistical knowledge to find patterns in healthcare billing that are likely related to fraudulent billing.[[194]](#footnote-194) A 2014 study conducted by the Center for Medicare and Medicaid Services reveals that data mining for Medicaid billing fraud returns $5 for each dollar spent.[[195]](#footnote-195) Due to the large increase in the number of providers and beneficiaries utilizing federal insurance if Medicaid for All becomes law, data mining will likely be necessary to oversee healthcare fraud and abuse under the program. HHS should continue to implement and increase datamining to find fraud and abuse violations. However, by increasing datamining capabilities HHS will likely also have to increase personnel and train personnel in how to datamine and find evidence of healthcare fraud and abuse within HHS.

 Moreover, researchers have suggested that under our current healthcare system, providers should implement their own datamining programs to spot possible billing errors and correct negative billing practices before they become major issues.[[196]](#footnote-196) One potential regulation that HHS,[[197]](#footnote-197) under the Medicare for All bill, could implement is a requirement that healthcare providers perform their own datamining and provide audits and reports to HHS. This regulation would standardize datamining procedures by requiring specific data be reported and verified by an unbiased outside auditing company.[[198]](#footnote-198) HHS is already tasked with developing uniform reporting requirements and standards in order to create a national database with information on providers.[[199]](#footnote-199) Through this power, HHS could require that providers perform their own datamining and audits then provide a report to the federal government. This would allow providers to catch potential fraudulent billing practices before they become large scale problems and allow providers to self-disclose fraudulent behavior to the government. Moreover, this would decrease the government’s resources used on finding healthcare fraud and abuse issues and would decrease penalty fines for providers by 1.5 times based on the False Claims Act and Self-disclosure laws.[[200]](#footnote-200)

## Response: Increased HHS Enforcement & Exclusion Power

As noted above, under healthcare fraud and abuse statutes, HHS-OIG has the power to exclude healthcare practitioners, facilities and drug companies. Depending on the violation, Medicare and Medicaid exclusion is either mandatory or discretionary.[[201]](#footnote-201) As with any discretionary law, the government must balance its power. Enforcing too few potential exclusions allows people who may be a danger to the federal healthcare system to continue to bill for services.[[202]](#footnote-202) If agency is too stringent with its enforcement, some places may be left without adequate healthcare practitioners. These considerations are exacerbated when the federal healthcare beneficiary pool more than doubles.

 One tool that HHS-OIG uses instead of excluding individuals under discretionary exclusions are integrity agreements.[[203]](#footnote-203) They generally require the organization to take steps to become compliant with fraud and abuse regulations over 1-5 years.[[204]](#footnote-204) If the organizations or practitioner refuses to enter into corporate integrity agreements (CIA) or integrity agreements (IA), then HHS-OIG will consider excluding the party instead.[[205]](#footnote-205) While generally used for corporations who qualify for exclusion under discretionary exclusions, integrity agreements can also be used for individuals.[[206]](#footnote-206) Generally, CIAs require annual reports be sent from the organization to the HHS-OIG.[[207]](#footnote-207) They usually include lists of all the activities required to hire a compliance officer, develop standards or policies to prevent future fraud and abuse violations, and report violations and potential violations to HHS-OIG and provide an annual report to HHS-OIG with an audit report from an independent, unbiased auditing company.[[208]](#footnote-208)

 IA agreements are similar, but are tailored to individual practitioners’ violations, such as a practitioner who fails to report Medicare overpayment and self-refers patients in violation of Stark law. [[209]](#footnote-209) [[210]](#footnote-210) HHS-OIG should consider using CIA and IA agreements more frequently in order to balance the increased exclusion power and allow providers who may be permissively excluded under the statute to continue to operate under the monitoring of HHS-OIG.

 Another strategy that HHS-OIG could use before using a permissive exclusion, is to perform an analysis to determine the effect that the provider’s exclusion may have, particularly in medically underserved areas.[[211]](#footnote-211) For example, if HHS-OIG contemplated permissively excluding a neurologist in a rural area, HHS-OIG should consider how many other neurologists are in the area and what impact the loss of a neurologist would have. The federal government has already made steps to consider healthcare access in areas lacking healthcare providers. For example, under the Anti-kickback statute, the federal government created safe harbors for providers and healthcare entities in medically underserved areas which are defined as being deficient in primary care providers, dental providers or mental health providers.[[212]](#footnote-212) The federal government should use this data as well as other information collected about the area to assess whether losing a physician or entity would be a detriment on the community the provider serves if excluded.

# Conclusion

Medicare for All has garnered large support among progressives in the Democratic party and the American public. However, if enacted, HHS-OIG would have to consider revamping its healthcare fraud and abuse policies and protocols to adapt to a large increase in healthcare beneficiaries and providers, continue to enforce healthcare fraud and abuse law, and protect the integrity of federal healthcare programs. Based on the analysis described above, HHS-OIG should consider increasing their datamining techniques and potentially requiring providers to perform their own datamining and provide reports to HHS-OIG. Moreover, HHS-OIG should strongly encourage a certain amount of training for healthcare practitioners to better understand healthcare fraud and abuse and be better equipped to prevent and identify it. Furthermore, HHS-OIG’s resources, such as funding and personnel, will need to be increased. Finally, HHS-OIG should consider their increased enforcement and exclusion power and consider increasing their use of CIAs and IAs and consider healthcare access and community impact before excluding providers.

Appendix Exclusion Authorities

Appendix Table 1: Exclusion Authorities[[213]](#footnote-213)

|  |  |  |
| --- | --- | --- |
| **Statute**  | **Minimum Exclusion Period** | **Description** **Exclusion based on:**  |
| ***Mandatory Exclusions*** |
| 42 U.S.C. § 1320a-7(a)(1) | 5 years | Conviction of a program related crime including crimes against Medicare and Medicaid.  |
| 42 U.S.C. § 1320a-7(a)(2) | 5 years | Conviction relating to patient abuse or neglect |
| 42 U.S.C. § 1320a-7(a)(3) | 5 years | Conviction of a felony relating to healthcare fraud |
| 42 U.S.C. § 1320a-7(a)(4) | 5 years | Conviction of a felony relating to controlled substances |
| 42 U.S.C. § 1320a-7(c)(3)(G)(i) | 10 years | Conviction of a second mandatory offense  |
| 42 U.S.C. § 1320a-7(c)(3)(G)(ii) | Permanent | Conviction of three or more mandatory exclusions |
| ***Permissive Exclusions*** |
| 42 U.S.C. § 1320a-7(b)(1)(A) | 3 years | Conviction of a misdemeanor relating to health care fraud |
| 42 U.S.C. § 1320a-7(b)(1)(B) | 3 years | Conviction relating to fraud unrelated to healthcare programs |
| 42 U.S.C. § 1320a-7(b)(2) | 3 years | Conviction relating to the obstruction of a government investigation or audit |
| 42 U.S.C. § 1320a-7(b)(3) | 3 years | Conviction of a misdemeanor relating to controlled substances  |
| 42 U.S.C. § 1320a-7(b)(4) | Determined by state licensing authority | Revocation, suspension or surrender of a healthcare practitioner license |
| 42 U.S.C. § 1320a-7(b)(5) | No less than the period imposed by federal or state healthcare program | Exclusion or suspension under a federal or state healthcare program |
| 42 U.S.C. § 1320a-7(b)(6) | 1 year | Claims for excessive charges, unnecessary services that fail to meet professionally recognized standards of healthcare, or failure of an HMO to furnish medically necessary services. |
| 42 U.S.C. § 1320a-7(b)(7) | None | Fraud, kickback or other prohibited activities  |
| 42 U.S.C. § 1320a-7(b)(8) | Same as length of individual’s exclusion | Entities controlled by a sanctioned individual |
| 42 U.S.C. § 1320a-7(b)(8)(A) | Same as length of individual’s exclusion | Entities controlled by a family or household member of an excluded individual and where there has been a transfer of ownership or control |
| 42 U.S.C. § 1320a-7(b)(9),(10), (11) | None | Failure to disclosure required information, supply requested information on subcontractors & suppliers; or supply payment information |
| 42 U.S.C. § 1320a-7(b)(12) | None | Failure to grant immediate access  |
| 42 U.S.C. § 1320a-7(b)(13) | None | Failure to take corrective action  |
| 42 U.S.C. § 1320a-7(b)(14) | Until default or obligation has been resolved | Default on health education loan or scholarship obligations  |
| 42 U.S.C. § 1320a-7(b)(15) | Same as length of exclusion  | Individuals controlling a sanctioned entity |
| 42 U.S.C. § 1320a-7(b)(16) | None | Making a false statement or misrepresentations of a material fact |
| 42 U.S.C. § 1320c-5 | 1 year | Failure to meet statutory obligations of practitioners and providers medically necessary services meeting professionally recognized standards of healthcare  |

**Appendix Table 1 Continued**

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31 U.S.C. § 3729

31 U.S.C. § 3729 (a)-(b)

31 U.S.C. § 3730 (c)

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3542 U.S.C. §1320(a)-7(b)(5)

41 C.F.R. §411.355 (b)

42 C.F.R. § 1001.2.

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55. Civil Division, Factors for Evaluating Dismissal Pursuant to 31 U.S.C. 3730(c)(2)(A), U.S. Dep’t of Justice (Jan. 10, 2018) (*citing* *U.S. ex rel. Hoyte v. Am. Nat’l Red Cross,* 518 F.3d 61 (D.C. Cir. 2008); *U.S. ex rel. Roach v. Obama,* No. 14-0470 (D.D.C. Dec. 18, 2014); *U.S. ex. Rel. Amico et. al. v. Citi Group Inc., et. al.,* No. 14-cv-4370 (CS) (S.D.N.Y. Aug. 7, 2015); *In Re Natural Gas Royalties Qui Tam Litigation,* MDL Docket No. 1293 (D. Wyo. Oct. 9, 2002); *Swift v. U.S.,* 318 F.3d 250 (D.C. Cir. 2003); *U.S. ex. Rel. Surdovel v. Digirad Imaging Solutions*, No. 07-cv-0458, 2003 WL 6178987 (E.D. Pa. Nov. 25, 2013). [↑](#footnote-ref-55)
56. *Id.*  [↑](#footnote-ref-56)
57. Civil Division, Fraud Statistics – Health and Human Servs. October 1, 1986 - September 30, 2018, U.S. Dep’t of Justice (2019), <https://www.justice.gov/civil/page/file/1080696/download?utm_medium=email&utm_source=govdelivery>. [↑](#footnote-ref-57)
58. 42 C.F.R. §1007.1 (eff. May 21, 2019) (defining “datamining” as “the practice of electronically sorting Medicaid or other relevant data, including, but not limited to, the use of statistical models and intelligent technologies, to uncover patterns and relationships within that data to identify aberrant utilization, billing, or other practices that are potentially fraudulent.”); *See e.g.* Office of Public Affairs, Dep’t of Justice, *Federal Law Enforcement Action Involves Fraudulent Genetic Testing in Charges Against 35 Individuals Responsible for over $2.1 Billion in Losses in One of the Largest Healthcare Fraud Schemes Ever Charged* (Sept. 27, 2019), <https://www.justice.gov/opa/pr/federal-law-enforcement-action-involving-fraudulent-genetic-testing-results-charges-against>. [↑](#footnote-ref-58)
59. 42 U.S.C. § 1320a-7b(b); [↑](#footnote-ref-59)
60. 42 C.F.R. § 1001.952 (2016). [↑](#footnote-ref-60)
61. 42 U.S.C. § 1320a-7b(b). [↑](#footnote-ref-61)
62. 42 U.S.C. § 1320a-7a(a)(4) (*amended by* the Bipartisan Budget Act of 2018, Pub. L. No. 115-123 § 50412 (a) (2) (2018)). [↑](#footnote-ref-62)
63. *See generally, U.S. v. Beauchamp*, 2018 U.S. Dist. Lexis 156645 (2018) (where seven physicians where found guilty of violating the Anti-kickback statute when the physicians were paid over 40 million dollars in remuneration disguised as consulting fees for referring out-of-network patients to Forest Park Medical Center. U.S Attorney’s Office for the N.D. of Tx, Seven Guilty in Forest Park Healthcare Fraud Trail, U.S. Dep’t of Justice (Apr. 10, 2019)); *U.S. ex. Rel. Lutz v. Blue Wave Consultants, Inc., 2018 U.S. Dist. LEXIS 119203 (2018)* (where the CEO and two marketing specialists paid physicians remunerations disguised as processing and handeling fees for every patient they referred to Health Diagnostic Laboratory, Inc. and Singulex, Inc. Under both the FCA and Anti-kickback statute, defendants collectively the government $114 million in damages.). [↑](#footnote-ref-63)
64. 42 U.S.C. § 1395nn (a). [↑](#footnote-ref-64)
65. *Id.*  [↑](#footnote-ref-65)
66. 42 U.S.C. § 1395nn (a)(2); Mass. Medical Society, *Making Sense of the Stark Law*, *Compliance for the Medical Practice*, Mass. Medical Society 8-13 (2005)*,* <http://www.massmed.org/physicians/legal-and-regulatory/making-sense-of-the-stark-law--compliance-for-the-medical-practice-%28pdf%29/>. [↑](#footnote-ref-66)
67. 42 U.S.C. § 1395nn (a)(2). [↑](#footnote-ref-67)
68. 42 C.F.R. § 411.351 (i)-(x) (2015). [↑](#footnote-ref-68)
69. 42 U.S.C. § 1395nn (g). [↑](#footnote-ref-69)
70. *Id.*  [↑](#footnote-ref-70)
71. For example, a common exception for laboratory testing is the “In-office ancillary service” exception. This allows for physicians to make referral within their practice as long as the services is personally furnished by the physician or another staff member affiliated with the physician practice. 41 C.F.R. §411.355 (b). Thus If the internal medical doctor referred the patients to a lab that was part of her practice group, then the physician referrals would be exempt from Stark law. [↑](#footnote-ref-71)
72. 42 U.S.C. § 1395dd (2018);Ctrs. For Medicare and Medicaid Servs., *Emergency Medical Treatment & Labor Act (EMTALA)*, U.S. Dep’t of Health & Human Servs. (March 26, 2012), <https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA>. [↑](#footnote-ref-72)
73. *See Power v. Arlington Hospital Ass’n,* 41 F.3d 851, 856 (4th Cir. 1994) (citing *Barber v. Hospital Corp. of America*, 977 F.3d 872, 880(4th Cir. 1992); *Brooks v. Maryland General Hospital,* 996 F.3d 708, 710 (4th Cir. 1993); *In re Baby K,* 16 F.3d 590, 593 (4th Cir. 1994). [↑](#footnote-ref-73)
74. *Roberts v. Galen of Virginia Inc.,* 525 U.S. 249, 251 (1999) (stating that proof of improper motive of a healthcare practitioner or organization is not required in order to prove an EMTALA violation.); *See also* Office of the Inspector General, *Semiannual Report to Congress: October 1, 2017 – March 31, 2018*, U.S. Dep’t of Health & Human Servs. (Spring 2018), <https://oig.hhs.gov/reports-and-publications/archives/semiannual/2018/sar-spring-2018.pdf> (citing examples of EMTALA violations including failure to treat a patient who could not get into the hospital doors after a nurse was made aware of the situation and a physician who transferred a patient despite the patient being in critical condition). [↑](#footnote-ref-74)
75. 42 U.S.C. § 1395dd; Nadia Zuabi et. al, *Emergency Medical Treatment and Labor Act (EMTALA) 2002-15: Review of Office of Inspector General Patient Dumping Settlements,* 17 W. J. of Emergency Medicine 245, 246 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4899053/>. [↑](#footnote-ref-75)
76. 42 U.S.C. § 1395dd (d*); EMTALA Fact Sheet*, Am. College of Emergency Physicians, <https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/> (last visited Jan. 10, 2020). [↑](#footnote-ref-76)
77. *See generally*, *Case Examples of EMTALA Violations*, The Sullivan Grp., <https://blog.thesullivangroup.com/case-examples-of-emtala-violations> (last visited Jan. 10, 2020). [↑](#footnote-ref-77)
78. *Id.;* 42 U.S.C. § 1395dd (d). *See* Andrea K. McDaniel’s & Meredith Cohn, *University of Maryland Hospital Apologizes for its Failure to Discharged Patient Found on Street in Hospital Gown*, The Baltimore Sun (Jan 11, 2018). [↑](#footnote-ref-78)
79. 42 U.S.C. § 1320a-7 (2018); 42 CFR § 1001.1901 (2017). [↑](#footnote-ref-79)
80. *Id.* [↑](#footnote-ref-80)
81. 42 U.S.C. §1320a-7. [↑](#footnote-ref-81)
82. 42 U.S.C. § 1320a-7 (a). [↑](#footnote-ref-82)
83. *Id.* [↑](#footnote-ref-83)
84. 42 U.S.C. § 1320a-7 (b). [↑](#footnote-ref-84)
85. *Id.*  [↑](#footnote-ref-85)
86. *Id.*; *see also* Office of the Inspector General, U.S. Dep’t of Health and Human Servs., Understanding Program Exclusions (2019), <https://oig.hhs.gov/compliance/provider-compliance-training/files/HandoutExclusionTips508.pdf>; Office of the Inspector General, Exclusion Authorities, U.S. Dep’t of Health and Human Servs., <https://oig.hhs.gov/exclusions/authorities.asp> (last visited Jan. 9 2020). [↑](#footnote-ref-86)
87. A full list of exclusion violations is provided in Appendix A. [↑](#footnote-ref-87)
88. S.1804. [↑](#footnote-ref-88)
89. S. 1129. [↑](#footnote-ref-89)
90. S.1804 §107; S. 1129 § 107; *See also* Katie Keith and Timothy Jost, *Unpacking the Sanders Medicare-For-All Bill*, Health Affairs (Sept. 14, 2017), <https://www.healthaffairs.org/do/10.1377/hblog20170914.061996/full/> (noting thatunder the bill the Department of Veteran’s Affairs and Indian Health Service would remain intact.). [↑](#footnote-ref-90)
91. *Id.*  [↑](#footnote-ref-91)
92. S.1804 §202; S. 1129 § 202; *See also* Keith and Timothy, *supra* note 77. [↑](#footnote-ref-92)
93. S.1804 §202 (b); S. 1129 § 202 (b); *See also* Keith and Timothy, *supra* note 77. [↑](#footnote-ref-93)
94. S.1804 §105 (a); S. 1129 § 105 (a); *See also* Keith and Timothy, *supra* note 77 (noting that under the bill the Secretary of Health & Human Services would be responsible for defining residency eligibility requirements. Moreover, they speculate that “residency eligibility” will include immigrants and undocumented individuals.). [↑](#footnote-ref-94)
95. S.1804 §105 (b); S. 1129 § 105 (b). [↑](#footnote-ref-95)
96. 42 U.S.C. § 18022 (a) (2014); S.1804 §201 (a); S. 1129 § 201 (a); Patient Protection and Affordable Care Act, Pub. L. 111-148 § 1302 (2009); *See also* Keith and Timothy, *supra* note 77. [↑](#footnote-ref-96)
97. 42 U.S.C. § 18022 (a); Ctr. For Consumer Information & Insurance Oversight, Essential Health Benefits: HHS Informational Bulletin, Ctrs. for Medicare and Medicaid Servs. (Dec. 16, 2011), <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/essential-health-benefits12162011a>. [↑](#footnote-ref-97)
98. 42 U.S.C. § 18022 (a); S.1804 §201 (a); S. 1129 § 201 (a). [↑](#footnote-ref-98)
99. S.1804 §201 (a); S. 1129 § 201 (a); *Health Care as a Human Right – Medicare for All,* Bernie2020 (2020), <https://berniesanders.com/issues/medicare-for-all/>. [↑](#footnote-ref-99)
100. S.1804 § 107 (a); S. 1129 § 107 (a); *See also* Keith and Timothy, *supra* note 77. [↑](#footnote-ref-100)
101. S.1804 § 303 (a); S. 1129 § 303; *See also* Keith and Timothy, *supra* note 77. [↑](#footnote-ref-101)
102. *Id.*  [↑](#footnote-ref-102)
103. *Id.* (the actual process of private contracts under the Medicare for All bill is complex and outside the scope of this essay.). [↑](#footnote-ref-103)
104. S.1804 § 302; S. 1129 § 302; *See also* Keith and Timothy, *supra* note 77. [↑](#footnote-ref-104)
105. S.1804 § 411; S. 1129 § 411. [↑](#footnote-ref-105)
106. S.1804 § 401 (b) (1); S. 1129 § 401 (b) (1); *See also* Keith and Timothy, *supra* note 77. [↑](#footnote-ref-106)
107. *See* Kaiser Family Found., *Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage*, Kaiser Family Found. 4, (Nov. 26 2019), <https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/> (highlighting that 74 percent of democrats either strongly favor or somewhat favor a single-payer national health plan where as 69 percent of republicans strongly oppose or somewhat oppose a single-payer national health plan.) [hereinafter *Public Opinion on Single-Payor*]; Kevin Uhrmacher et. al., *Where 2020 Democrats Stand on Healthcare*, Wash. Post (Jan. 23, 2020), <https://www.washingtonpost.com/graphics/politics/policy-2020/medicare-for-all/>; Sean McElwee et. al, *Medicare for all and Democratic Primaries,* Data for Progress (2019), <http://filesforprogress.org/memos/m4a_report.pdf>. [↑](#footnote-ref-107)
108. Ensure the Health and Safety of All Americans, Democratic Nat’l Comm. Servs. Corp., <https://democrats.org/where-we-stand/party-platform/ensure-the-health-and-safety-of-all-americans/> (last visited Jan. 20, 2020); *see also Healthcare is a Human Right – Medicare for All,* *supra* note 99; *Healthcare is a Basic Human Right*, ElizabethWarren.com, <https://elizabethwarren.com/plans/health-care>, (last visited Dec. 13, 2019); *Republican and Democratic Platforms on Healthcare*, Physicians for a Nat’l Health Plan, <https://pnhp.org/news/republican-and-democratic-platforms-on-health-care/> (last visited Jan. 16 2019). [↑](#footnote-ref-108)
109. *See* Howard Bauchner, *Healthcare in the United States: A Right or a Privilege,* 317J. Am. Medical Ass’n 29, 29 (2017), <https://jamanetwork.com/journals/jama/fullarticle/2595503>; Andrea S. Christopher and Dominic Caruso, *Promoting Health as a Human Right in the Post-ACA United States,* 17 Am. Medical Ass’n J. of Ethics 958, 958 (2015), <https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/msoc1-1510.pdf>;

Darrell G. Kirch, *High Quality, Affordable Healthcare is the Right of Every American*, Ass’n of Am. Medical Colleges (Mar. 26, 2019), <https://www.aamc.org/news-insights/high-quality-affordable-health-care-right-every-american>. [↑](#footnote-ref-109)
110. *Affordable Care Act*, Healthcare.gov, <https://www.healthcare.gov/glossary/affordable-care-act/> (last visited Jan. 10, 2020). [↑](#footnote-ref-110)
111. Patient Protection and Affordable Care Act, Pub. L. 111-148 §§ 1302, 1311, 1401 (36B) (3), 6501.( note that the Medicaid expansion mandate was later struck down in *National Federation of Independent Business v. Sebelius* 567 U.S.\_ (2012), thus making expansion optional for states.). [↑](#footnote-ref-111)
112. *See* Office of the Press Secretary, The White House, *Remarks by the President on the Affordable Care Act* (Oct. 20, 2016), <https://obamawhitehouse.archives.gov/the-press-office/2016/10/20/remarks-president-affordable-care-act>; Mike DeBonis, *The Political Price of Obamacare,* Wash. Post (Aug. 16, 2016), <https://www.washingtonpost.com/graphics/national/obama-legacy/obamacare.html>. [↑](#footnote-ref-112)
113. *Roll Call Vote 111th Congress-1st Session: On the Passage of the Bill (H.R. 3590 as Amended)*, U.S. Senate (Dec. 24, 2009), <https://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00396> (showing that all “Yea” votes were made by senators registered as democrats or independents). [↑](#footnote-ref-113)
114. *Id.*  [↑](#footnote-ref-114)
115. *Healthcare is a Human Right – Medicare for All, supra* note 99; *Healthcare is a Basic Human Right*, *supra* note 108. [↑](#footnote-ref-115)
116. *Our Party,* Democratic Nat’l Committee, <https://democrats.org/who-we-are/about-the-democratic-party/> (last visited Jan. 20, 2020); Democratic Platform Committee, 2016 Democratic Party Platform, Democratic Nat’l Committee 23 (July 8, 2016), <https://democrats.org/wp-content/uploads/2018/10/2016_DNC_Platform.pdf>; Thomas Bodenheimer, The Political Divide in Healthcare: A Liberal Perspective, 24 Health Affairs, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.24.6.1426>. [↑](#footnote-ref-116)
117. Bodenheimer, *supra* note 101. [↑](#footnote-ref-117)
118. 82 Fed. Reg. 9339 (Feb. 3, 2017). [↑](#footnote-ref-118)
119. *Id.*  [↑](#footnote-ref-119)
120. *Id.*  [↑](#footnote-ref-120)
121. Office of Management and Budget, Regulatory Policy Officers at Executive Dep’t and Agencies and Managing and Executive Directors of Certain Agencies and Commissions, Executive Office of the President, M-17-21(Apr. 5, 2017), <https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/memoranda/2017/M-17-21-OMB.pdf>; *See* Connor Raso, *How Trump’s Deregulatory Order Worked in Practice?*, Brookings (Sept. 6, 2018), <https://www.brookings.edu/research/how-has-trumps-deregulatory-order-worked-in-practice/>. [↑](#footnote-ref-121)
122. S.1804 §105 (a); S. 1129 § 105 (a). [↑](#footnote-ref-122)
123. Jonathan Oberlander, *Lessons from the Long and Winding Road to Medicare for All,* 109Am. J. of Public Health 1497, 1497 (2019) (citing *Public Opinion on Single-Payor*, *supra* note 92). [↑](#footnote-ref-123)
124. *Id.*  [↑](#footnote-ref-124)
125. S.1804 §105; Lunna Lopes *et. al.,* *KKF Health Tracking Poll – November 2019: Health Care in the 2020 Election, Medicare-For-All, and the State of the ACA*, Kaiser Family Found. (Nov. 20, 2019), <https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-november-2019/>. [↑](#footnote-ref-125)
126. Lopes *et. al, supra* note 125. [↑](#footnote-ref-126)
127. *Id.*  [↑](#footnote-ref-127)
128. *Id.*  [↑](#footnote-ref-128)
129. *Public Opinion on Single-Payor, supra* note 92. [↑](#footnote-ref-129)
130. S.1804 § 107 (a); S. 1129 § 107. [↑](#footnote-ref-130)
131. *Public Opinion on Single-Payor, supra* note 92. [↑](#footnote-ref-131)
132. *Id.*  [↑](#footnote-ref-132)
133. S.1804 §202 (b); S. 1129 § 202 (b). [↑](#footnote-ref-133)
134. *Public Opinion on Single-Payor, supra* note 92. [↑](#footnote-ref-134)
135. Jill Bernstein and Rosemary A. Stevens, Public Opinion, Knowledge, and Medicare Reform, 18 Health Affairs (Jan. 1999), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.18.1.180>. [↑](#footnote-ref-135)
136. *Id.*  [↑](#footnote-ref-136)
137. Marcia Frellick, *Healthcare Professionals Almost Equally Divided on Medicare for All Poll Shows*, Medscape (Mar. 29, 2019), <https://www.medscape.com/viewarticle/913411?faf=1>. [↑](#footnote-ref-137)
138. *Id.*  [↑](#footnote-ref-138)
139. *Id.*  [↑](#footnote-ref-139)
140. Am. Medical Ass’n, AMA: Build on the Success of ACA to Help Patients Lacking Insurance, Am. Medical Ass’n (June 11,2019), <https://www.ama-assn.org/press-center/press-releases/ama-build-success-aca-help-patients-lacking-insurance>. [↑](#footnote-ref-140)
141. *Id.*  [↑](#footnote-ref-141)
142. Robert Doherty et. al., *Envisioning a Better U.S. Helathcare System for All A Call to Action by the American College of Physicians,* Annals of Internal Medicine (Jan. 21 2020),  <https://annals.org/aim/fullarticle/2759528/envisioning-better-u-s-health-care-system-all-call-action>. [↑](#footnote-ref-142)
143. *ACP Facts*, Am. College of Physicians, <https://www.acponline.org/acp-newsroom/acp-facts> (last visited Jan. 5, 2020). [↑](#footnote-ref-143)
144. Doherty, *supra* note 122. [↑](#footnote-ref-144)
145. *Id.*  [↑](#footnote-ref-145)
146. *APHA Membership*, Am. Public Health Ass’n, (2020), <https://www.apha.org/membership>. [↑](#footnote-ref-146)
147. *Public Health’s Critical Role in Health Reform in the United State,* Am. Public Health Ass’n (Nov. 10, 2009), <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/23/11/50/public-healths-critical-role-in-health-reform-in-the-united-states>. [↑](#footnote-ref-147)
148. 31 U.S.C. § 3729; 42 U.S.C. § 1395nn; 42 U.S.C. Section 1320a-7b(b). [↑](#footnote-ref-148)
149. William J. Rudman et. al., *Healthcare Fraud and Abuse*, 6 Perspectives in Health Information Management (2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2804462/>. [↑](#footnote-ref-149)
150. While it is outside the scope of this essay, it is recommended that further research be done on physicians understanding of healthcare fraud and abuse laws to increase compliance. [↑](#footnote-ref-150)
151. Office of Inspector General, U.S. Dep’t of Health and Human Servs., *Medicare and Medicaid Fraud and Abuse Training in Medical Education,* OEI-01-10-00140 (Oct. 2010), <https://oig.hhs.gov/oei/reports/OEI-01-10-00140.pdf> [hereinafter *Training in Medical Education*]. [↑](#footnote-ref-151)
152. The Physician’s Foundation, 2018 Survey of America’s Physican Practice Patterns & Perspectives, The Physican’s Found. 10 (2018), <https://physiciansfoundation.org/wp-content/uploads/2018/09/physicians-survey-results-final-2018.pdf>. [↑](#footnote-ref-152)
153. *See* Am. Hospital Ass’n, Regulatory Overload, Am. Hospital Ass’n 4, <https://www.aha.org/system/files/2018-02/regulatory-overload-report.pdf>; *See also* Sally Pipes, *Government Policies Are Driving Doctors to Quit Health,* Forbes (Oct. 15, 2018), <https://www.forbes.com/sites/sallypipes/2018/10/15/government-policies-are-driving-doctors-to-quit-health-care/#b5099962bf36>. [↑](#footnote-ref-153)
154. S.1804 § 107 (a); S. 1129 § 107. [↑](#footnote-ref-154)
155. Nat’; Ass’n of Insurance Commissioners, *Health Insurance Industry 2018 Annual* Results, Nat’l Ass’n of Insurance Commissioners 1 (2019), <https://naic.org/documents/topic_insurance_industry_snapshots_2018_health_ins_ind_report.pdf>. [↑](#footnote-ref-155)
156. *Id.* at 2. [↑](#footnote-ref-156)
157. *See Id.*  [↑](#footnote-ref-157)
158. Am. Health Ass’n, *supra* note 131. [↑](#footnote-ref-158)
159. *See* Jodi L. Liu and Christine Eibner, *Nat’l Health Spending Estimates Under Medicare for All*, Rand Corp. (2019), <https://www.rand.org/pubs/research_reports/RR3106.html>. [↑](#footnote-ref-159)
160. S.1804 § 101; S. 1129 § 101. [↑](#footnote-ref-160)
161. S.1804 §§ 302, 303, 701; S. 1129 § 302, 303, 701. [↑](#footnote-ref-161)
162. S.1804 § 411; S. 1129 § 411. [↑](#footnote-ref-162)
163. Liu and Eibner, *supra* note 135; 31 U.S.C. § 3729; 42 U.S.C. § 1395nn; 42 U.S.C. Section 1320a-7b(b). [↑](#footnote-ref-163)
164. This is an estimate based on the fact that all people receiving employer-based insurance and uninsured people would receive coverage. Collectively this would add 58 percent of people to the 34 percent of people already coverage by federal health insurance. Furthermore, this data does not include undocumented immigrants who also be covered by federal health insurance under the Medicare for All program. *See* S.1804 § 102; S. 1129 § 102. [↑](#footnote-ref-164)
165. *See Id.*  [↑](#footnote-ref-165)
166. *See* Liu and Eibner, *supra* note 135 [↑](#footnote-ref-166)
167. 31 U.S.C. § 3729; 42 U.S.C. § 1395nn; 42 U.S.C. Section 1320a-7b(b); 42 U.S.C. § 1395dd. [↑](#footnote-ref-167)
168. *Id.*  [↑](#footnote-ref-168)
169. S. 1129 § 1011-15; *See also* Keith and Timothy, *supra* note 77. [↑](#footnote-ref-169)
170. Rashidan, *supra* note 24. [↑](#footnote-ref-170)
171. *Id.;* Civil Division, *supra* note 42. [↑](#footnote-ref-171)
172. *See* 42 U.S.C. §1320a-7a; 42 U.S.C. § 1320a-7. [↑](#footnote-ref-172)
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174. Seema Verma, *Medicare for All? Just Another Name for a Government-run, Single Payer System* Ctrs. For Medicare and Medicaid Servs. (Nov. 2, 2018), <https://www.cms.gov/blog/cms-blog-medicare-all-just-another-name-government-run-single-payer-system>. [↑](#footnote-ref-174)
175. Gov. Accountability Office, *supra* note 148. [↑](#footnote-ref-175)
176. S.1804 § 601; S. 1129 § 601. [↑](#footnote-ref-176)
177. *Id.*  [↑](#footnote-ref-177)
178. *Id.*  [↑](#footnote-ref-178)
179. Inspector General Act of 1978, Pub. L. 95-452 §5 (21)(A) (1996). [↑](#footnote-ref-179)
180. Dep’t of Health and Human Servs. & Dep’t of Justice, Healthcare Fraud and Abuse Control Program Annual Report for Fiscal Year 2018 7 (2018), <https://oig.hhs.gov/publications/docs/hcfac/FY2018-hcfac.pdf>. [↑](#footnote-ref-180)
181. *Training in Medical Education*, *supra* note 129, at 5-6. [↑](#footnote-ref-181)
182. *Id.* [↑](#footnote-ref-182)
183. *Id.*  [↑](#footnote-ref-183)
184. *The Effect of Exclusion from Participation in Federal Health Programs*, Dep’t of Health and Human Servs. (Sept. 1999), <https://oig.hhs.gov/exclusions/effects_of_exclusion.asp>. [↑](#footnote-ref-184)
185. *See* Dave Davis et. al, *Impact of Formal Continuing Medical Education,* 282J. of Am. Medical Ass’n 867 (1999), <https://jamanetwork.com/journals/jama/article-abstract/191423>; *see generally* Elaine L. Larson, *A Multifaceted Approach to Changing Handwashing Behavior*, 25 J. of Infection Control 3 (1997), <https://www.sciencedirect.com/science/article/pii/S0196655397900468>. [↑](#footnote-ref-185)
186. *Id.*  [↑](#footnote-ref-186)
187. *See* 42 U.S.C. § 1320a-7a; 31 U.S.C. § 3730 (c). [↑](#footnote-ref-187)
188. Occupational Safety and Health Admin., What is Retaliation?, U.S. Dep’t of Labor (2019), <https://www.whistleblowers.gov/know_your_rights>. [↑](#footnote-ref-188)
189. Civil Division, *supra* note 42. [↑](#footnote-ref-189)
190. *See generally, Id.*  [↑](#footnote-ref-190)
191. *Id.*  [↑](#footnote-ref-191)
192. *Id.*  [↑](#footnote-ref-192)
193. Hossein Joudaki et. al., *Using Data Mining to Detect Healthcare Fraud and Abuse: A Review of Literature*, 7 Global J. of Health Sci. 194 (2015), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4796421/>. However, it is important to note that healthcare entities in general are comprised of robust compliance programs that preform prevention & detection tasks to mitigate healthcare fraud & abuse within their organization. These tasks can include performing internal datamining and establishing internal healthcare fraud and abuse prevention and reporting policies. *See e.g., The Johns Hopkins Health System Corporation Corporate Compliance Plan*, Johns Hopkins Health System (Mar. 8, 2018), <https://www.hopkinsmedicine.org/compliance/forms/jhhs_compliance_plan.pdf>; *Hospital Compliance Program*, UNC Health Care (Sept. 2019), <https://www.unchealthcare.org/Training%20Module/presentation_content/external_files/Hospital%20Compliance%20Program.pdf>, *Jones Memorial Hospital Compliance Plan*, Univ. of Rochester Medical College (May 25, 2011), <https://www.urmc.rochester.edu/MediaLibraries/URMCMedia/jones-memorial/patients-families/documents/Corporate-Compliance-Plan-Revised-052511.pdf> [↑](#footnote-ref-193)
194. *Id.*  [↑](#footnote-ref-194)
195. Ctr. For Medicare and Medicaid Servs., Report to Congress Fraud Prevention System Second Implementation Year (June 2014), <https://www.cms.gov/About-CMS/Components/CPI/Widgets/Fraud_Prevention_System_2ndYear.pdf>. [↑](#footnote-ref-195)
196. Hossein Joudaki, *Improving Frand and Abuse Detection in General Physician Claims” A Data Mining Study*, 5 Int’l J. of Health Policy Management 165, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4770922/> (examples of negative billing practices include upcoding, charging for medically unnecessary services or services not rendered, and unbundled billing where charges for services are separated when they are supposed to be charged collectively. Nat’l Health Care Anti-Fraud Ass’n, The Challenge of Health Care Fraud, Nat’l Health Care Anti-Fraud Ass’n (2018), <https://www.nhcaa.org/resources/health-care-anti-fraud-resources/the-challenge-of-health-care-fraud/>.). [↑](#footnote-ref-196)
197. S .1804 § 401; S. 1129 § 401. [↑](#footnote-ref-197)
198. These reports will be similar to reports required by CIA and IAs, where a random sample of federal healthcare reimbursement bills are surveyed by a third-party un-bias auditing company. *See, e.g.,* Corporate Integrity Agreement between the Office of the Inspector General of the Dep’t of Health & Human Servs. And Amedisys, Inc. and Amedisys Holding, LLC (Apr. 22, 2014), <https://oig.hhs.gov/fraud/cia/agreements/Amedisys_04222014.pdf>. [↑](#footnote-ref-198)
199. S.1804 § 401 (b) (1); S. 1129 § 401 (b) (1). [↑](#footnote-ref-199)
200. *See* 42 U.S.C. § 1320a-7a [↑](#footnote-ref-200)
201. A full list of exclusion violations is provided in *Appendix A*. [↑](#footnote-ref-201)
202. For example, people who are performing medically unnecessary procedures are putting their patients at risk and are spending unnecessary government money, which puts federal healthcare programs at risk as well. *See Appendix A.*  [↑](#footnote-ref-202)
203. *See* Corporate Integrity Agreement between the Office of the Inspector General of the Dep’t of Health & Human Servs. And Amedisys, Inc. and Amedisys Holding, LLC (Apr. 22, 2014), <https://oig.hhs.gov/fraud/cia/agreements/Amedisys_04222014.pdf>.) [Hereinafter *CIA*] [↑](#footnote-ref-203)
204. *Id.* [↑](#footnote-ref-204)
205. *See* Office of the Inspector General, *Fraud Risk Indicator*, <https://oig.hhs.gov/compliance/corporate-integrity-agreements/index.asp> (last visited Jan. 5, 2020). [↑](#footnote-ref-205)
206. *CIA*, *supra* note 205. [↑](#footnote-ref-206)
207. *Id.* [↑](#footnote-ref-207)
208. *CIA*, *supra* note 205. [↑](#footnote-ref-208)
209. *Id.; See Integrity Agreement Between the Office of the Inspector General of the Dep’t of Health and Human Servs. And Ana M. Gama, D.D.S., Ana M. Gama, D.D.S., Inc.,* Health & Human Servs. (May 15, 2017), <https://oig.hhs.gov/fraud/cia/agreements/Ana_M_Gama_DDS_Ana_M_Gama_DDS_Inc_05152017.pdf>. [↑](#footnote-ref-209)
210. *Id.*  [↑](#footnote-ref-210)
211. “Medically Underserved Areas” are “areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty or a high elderly population.” *MUA Find,* Health Resources & Servs. Admin., <https://data.hrsa.gov/tools/shortage-area/mua-find#:~:text=> (last visited feb. 29, 2020). [↑](#footnote-ref-211)
212. 42 C.F.R. §1001.952 (a) (3) – (4), (n) (8), (w) (3); Medically Underserved Areas and Population, Health Resources & Servs. Admin. (June 2019), <https://bhw.hrsa.gov/shortage-designation/muap>. [↑](#footnote-ref-212)
213. Adapted from: Office of the Inspector General, *Exclusion Authorities*, U.S. Dep’t of Health & Human Servs. (last visited Feb. 29, 2020), <https://oig.hhs.gov/exclusions/authorities.asp>.(Under 42 C.F.R. § 1001.2“Conviction” means “a judgment of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether: (1) There is a post-trial motion or an appeal pending, or (2) The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;(b) A Federal, State or local court has made a finding of guilt against an individual or entity; (c) A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or (d) An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.” [↑](#footnote-ref-213)