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Federal Health Care Fraud Statute Sentencing in Georgia and Florida, 2011-2012

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Abstract

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MBA, Samford University, 1997

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Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

The financial costs of U.S. federal health care fraud continue to increase, and as health care payments due to fraudulent claims increase, the portion of The Medicare Trust Fund available to pay for legitimate health care expenses decreases. Prosecution is one of several fraud management life cycle components that contributes to and can alter the course of increasing health care fraud; however, despite this recognition, there is a gap in the literature regarding the consistency of prosecution for federal health care fraud across different judicial districts. The purpose of this qualitative, exploratory multiple case study was to explore the federal sentencing consistency across 6 judicial districts in Georgia and Florida during 2011 and 2012 using Wilhelm's Fraud Management Life Cycle as the theoretical lens. Data consisted of publicly available records of 147 terminated federal cases in Georgia or Florida from 2011 and 2012 involving prosecutions for health care-related fraud. These data were inductively coded and analyzed using a content analysis procedure. Findings indicated physical and monetary sentencing inconsistencies when comparing the sentence delivered for similar federal health care fraud cases across judicial jurisdictions. This study promotes positive social change by demonstrating inconsistencies in federal health care sentencing and understanding that consistent sentencing will lead to greater deterrence. Prosecutors and judges will benefit from this knowledge in making more consistent sentencing decisions related to federal fraudulent health care payments.

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Dedication

My parents, Larry and Wydean Walker, instilled in me the importance of education, even though they were from a generation where a trade was more valuable than a degree. Now, it is my responsibility as a parent to pay that forward by educating my children on the value of an education.

I want to express my appreciation to my three children – Cole, McKenzie, and Sam – for respecting my school time. While we all did homework, occasionally I spent more time on mine and they respected my homework time. Last, but certainly not least, thank you Chris, for supporting me through these long years and late nights.

To my two dear friends who joined me in the path for a PhD, thank you Mary and Susan for challenging me to reach my goal. You were a support system I did not know I needed when I started this journey.

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For Dr. Milen and Dr. Wilkins, thank you for the guidance and leadership to get through this process. The journey was long and unknown, but you two helped me to see the way to my goal. When it became challenging, you gave me words of encouragement; when I needed it, you challenged me to stretch. Thank you, Dr. Matarelli, for being so efficient and precise in your feedback. It was amazing how quickly you responded and with so much constructive content.

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Chapter 1: Introduction to the Study

Introduction

The Department of Health and Human Services (DHHS) and the Department of Justice (DOJ) noted the number of Medicare and Medicaid health care fraud convictions increased from 583 in fiscal year 2009 to 826 in fiscal year 2012 (2010, 2013). Health care fraud is illegal and harms patients both monetarily and physically (Sparrow, 2008). Louis Saccoccio, the Chief Executive Officer of the National Health Care Anti-Fraud Association, testified for the United States Senate Special Committee on Aging that health care fraud was estimated to be in the tens of billions annually (United States Senate Special Committee on Aging, 2014). If a specific cost is tied to patient harm or patient death and directly attributable to health care fraud, the cost of health care fraud escalates sharply.

An important process in studying health care fraud in the United States is determining if punishment for committing federal health care fraud is being applied as expected. According to Wilhelm's (2004) fraud management lifecycle theory, doing so requires balancing deterrence, prevention, detection, mitigation, analysis, policy, investigation, and prosecution; each of these stages must align to optimize the management of health care fraud. This study specifically focused on the prosecution stage described by Wilhelm (2004), which has three aims: punish a convicted criminal, establish a reputation of fraud diligence, and repay losses.

This study focused on federal health care fraud sentencing consistency in Georgia and Florida during 2011 and 2012, but was designed to generate information that could

also be applied in other states and judicial districts. Previous research has not explored consistency in sentencing for U.S. federal health care fraud. The U.S. Constitution does not explicitly mention consistency in sentencing, but the spirit of the document is fairness and equality (Ritchie, 1936). This spirit of fairness and equity suggests that U.S. federal sentencing levels should be consistent across courts, jurisdictions, and states when someone convicted of a federal crime (Ritchie, 1936). This study promotes positive social change by expanding the body of knowledge available to judges and policy makers making changes in sentencing. This additional data on federal sentencing consistency and federal sentencing effectiveness is intended to increase fraud deterrence, which in turn is expected to decrease the amount spent by Medicare on fraudulent claims.

Background of the Problem

The U.S. Constitution guarantees a speedy trial, but makes no mention of consistency in sentencing (Ritchie, 1936). Frankel, a United States District Judge for the Southern District of New York in 1972, and researcher Johnson in 2006 voiced concerns over the lack of training and amount of discretion judges had in determining sentencing (Anderson & Spohn, 2010; Johnson, 2006). The Sentencing Reform Act of 1984 was enacted to increase sentencing uniformity and lower interjudge disparities (Anderson & Spohn, 2010). However, Anderson and Spohn (2010) found no measureable benefits in sentencing pattern changes gained from the implementation of the Sentencing Reform Act of 1984.

This study addressed a research gap on the consistency of U.S. federal health care fraud sentencing. This study is important because each United States citizen expects

equity (Ritchie, 1936). If a citizen is convicted in Georgia and Florida of the same federal health care fraud crime, they should therefore expect the same sentence. Similar to the Fair Sentencing Act of 2010, the sentence should also be comparable to the impact of the crime committed. The Fair Sentencing Act realigned the sentence guidelines to be closer to the impact of the crime committed within the ranges prescribed by the statute.

Several studies have attempted to measure the impact of health care fraud, but did not identify a definitive measurement mechanism (Federal Bureau of Investigation, 2012; National Health Care Anti-Fraud Association, 2010; Wilhelm, 2004). Wilhelm (2004) created the theoretical model for minimizing fraud used in this dissertation study. This dissertation specifically built upon the exploratory, multiple case study structure described by Yin (2014), Saldana's (2013) coding analysis, and consistent sentencing research performed by Anderson and Spohn (2010), Maguire (2010), and Krasnostein and Freiberg (2013) to analyze consistency in health care fraud sentencing. This study was designed to generate foundational data, and analysis that can be duplicated, used by policy makers, and built upon by applying to other states and jurisdictions.

Problem Statement

There is a problem with fraudulent Medicare payments within U.S. federal health programs. Despite the safeguard efforts of governmental agencies such as the Centers for Medicare and Medicaid Services (CMS), the Department of Justice (DOJ), and the Office of Inspector General (OIG), the portion of Medicare payments deemed fraudulent continues to grow (Sparrow, 2008). Kass and Linehan (2012) found that health care fraud, specifically in Medicare, has become a more significant issue in recent years, and

remains unresolved. This qualitative, exploratory multiple case study was designed to explore the consistency of U.S. federal health care fraud statute sentencing in the states of Georgia and Florida during 2011 and 2012.

This study reviewed consistency in U.S. federal health care fraud sentencing. It produced results that can be applied to other states and used by policy makers to build future federal health care sentencing guideline changes. This qualitative study explored consistency in sentencing across judicial jurisdictions and states for individuals convicted for federal health care fraud. It specifically generated information to expand the growing body of knowledge law enforcement, insurance companies, and policy makers that draw from to formulate fraud deterrence planning.

Purpose of the Study

The purpose of this qualitative study was to explore consistency in federal health care fraud statute sentencing in two geographically contiguous states, Georgia and Florida, during 2011 and 2012. Medicare health care fraud has implications across several populations: health care providers, policy makers, The Medicare Trust Fund, and most of all Medicare beneficiaries. However, U.S. federal health care fraud statutes do not specify exact sentencing for specific healthcare fraud violations, therefore leaving the sentencing decision to a wide variety of judges across the nation with varying experience in healthcare and healthcare fraud (Anderson & Spohn, 2010). The potential for variation was the focus of this study.

Consistency in prosecution sentencing is the first step in effective deterrence. In order to measure this consistency, I extracted foundational data through a document

review to code final dispositions of health care prosecutions. In order to explore the sentencing trends for health care fraud, individual convictions were collected and coded, and the relationship between the crime committed and the sentence that they received were analyzed. It was expected that this relationship between impact of the crime and the sentence received would be consistent across judicial courts and states for federal convictions. The analysis demonstrated a basis for sentencing across the judicial jurisdictions that can be expanded to jurisdictions outside of Georgia and Florida, and outside the years of 2011 and 2012. Through exploring the physical and monetary sentence imposed across six judicial jurisdictions, I was able to demonstrate sentencing consistency trends between states and judicial jurisdictions.

Primary Research Question

RQ: What variations are found in the application of sentencing for federal health care fraud across Georgia and Florida in 2011 and 2012?

Theoretical Framework

The theoretical framework of this study was based on Wilhelm's (2004) fraud management lifecycle theory. This theory describes eight stages of fraud management and was created based on evaluations of several lifecycle stage interactions from five industries with significant economic crime (Wilhelm, 2004). The eight stages of this lifecycle include deterrence, prevention, detection, mitigation, analysis, policy, investigation, and prosecution. Wilhelm (2004) hypothesized that prosecution was only one component of a larger fraud management lifecycle.

Not all researchers have concurred with Wilhelm's hypothesis. For example, Gosepath (2009) supported equality and justice as a foundational premise to successful judicial system. For prosecution to lead to deterrence is only successful when applied consistently. Bagaric and Pathinayake (2013) found parity in sentencing to be more accidental or opportunistic than methodical and planned. In order to determine if health care fraud statutes are consistently applied, research had to be performed. There was a literature gap with no analysis of health care fraud sentencing variations.

One of the eight stages of the Wilhelm fraud management lifecycle theory is deterrence. Deterrence theory is concerned with the omission of a criminal act because of the fear of sanctions or punishment (Paternoster, 2010). Paternoster (2010) stated that the decision whether or not to commit a crime, the probability of being caught, and the severity of the punishment are not well known by the offenders, and therefore would not have a great influence over the deterrence of the crime. Quackenbush (2010) tested the effectiveness of general deterrence from 1816 through 2000 with a multinomial logit model. Concluding that the perfect deterrence theory was effective.

While Beccaria (1963) agreed with Paternoster and Quackenbush on the effectiveness of deterrence, Beccaria added an additional qualification that a crime must immediately trigger a punishment to be most effective. Health care fraud could take months or years to be detected, and additional time to traverse through the judicial system to adjudication. If Beccaria's view of punishment needing to be immediate to be effective is correct, this delay in adjudication negates the full effects of any sentencing.

Paternoster (2010) supported Beccaria's position, stating that people have difficulty feeling the depth of punishment when costs are so far removed from criminal acts.

Nature of the Study

The nature of this study was to explore the consistency in federal health care fraud. Once the root cause is understood, strategies can be developed to prevent health care fraud. This qualitative, exploratory multiple case study specifically analyzed health care fraud cases adjudicated in 2011 and 2012 in Georgia and Florida for sentencing consistency. I evaluated case documents for inclusion or exclusion from the population and sample, and recorded the sentencing levels. Analysis of this data showed that certain judicial districts delivered more punitive sentences than others.

I considered and rejected using a phenomenological approach. Phenomenology uses interviews, discussions, and participant observation to gain information, and studies the experience of an individual directly from the participant's perspective. I did not have access to or direct interaction with the individuals who committed health care fraud, so I rejected using phenomenology for this study. I also rejected using a phenomenological approach because phenomenological researchers are included in their research and are not just considered unbiased observers to the topic studied. While the perspective of the individuals indicted and prosecuted for health care fraud would be interesting to explore, I choose not to engage in conversations with potentially violent individuals at this time, and to instead focus on the definitive outcome of the prosecution.

My almost 10 years of experience working in the realm of health care fraud presented potential ethical concerns related to my access to confidential information. In

particular, access to individuals who worked these cases and were instrumental in their prosecution could have been construed as an ethical issue. I took two steps to counteract those concerns: only using publicly available information, and focusing on cases that postdated my working in a health care fraud-related position.

In 2011–2012, 1,569 individuals across the United States were convicted for health care fraud. I utilized a subset of this group consisting of the individuals convicted in Florida and Georgia as the population for this study. In doing so, I included all health care-related prosecutions in these states for this period. The cases included violations of 18 USC § 1347 and 18 USC § 1349, at a minimum, and any health care fraud cases including any of the remaining related federal statutes:

- 18 USC § 371 Conspiracy to Defraud the United States and to Receive Health Care Kickbacks
- 18 USC § 1347 Health Care Fraud
- 18 USC § 1349 Attempt and Conspiracy to Commit Health Care Fraud
- 31 USC § 3729-3733 The False Claims Act
- 42 USC § 1320A-7b(b) The Anti-Kickback statute
- 42 USC § 1395 The Physician Self-Referral Law
- 42 USC § 1320a-7, 1320c-5 The Exclusion Authorities
- 42 USC § 1320a-7a the Civil Monetary Penalties Law.

Utilizing data for the entire population under study removed any concerns of representative sample size, saturation, and sample size justification (O'Reilly & Parker, 2013).

Once the population was identified, I retrieved the court case documentation, which has the charge, the patient impact, and the sentence included. These federal court case documents were retrieved from the United States District Court portal, Public Access to Court Electronic Records (PACER), where the conviction adjudication documentation was publicly available (Public Access to Court Electronic Records, 2016). These data were accessible through the individual United States District Court portals and provided the highest level of reputable source data; however, aggregating complete data for each state required accessing three different portals (Northern, Middle, and Southern) for each U.S. state in the study area.

Once I finished collecting the prosecuted federal case documentation, I coded each individual case for consistency. While the prosecution data were not anonymous, the names of the individuals prosecuted were irrelevant for the purposes of this study. The source documentation was also tied to the coded information via the case number, not the individual's name. Basic case identifiers such as case number and case name were entered into Microsoft Excel to delineate between cases and defendants, and open coding was used based upon the mix of cases convicted during 2011 and 2012 in Georgia and Florida (see Appendix A). The results were summarized using Microsoft Excel and visualized using the software program Tableau. Data stratification was completed by state, year, district court, and sentencing statute; discrepant cases were double-checked and identified as outliers in the population if they still fit within the population boundaries.

I referenced the Health Care Fraud and Abuse Control (HCFAC) Program summary reports to obtain a high-level estimate of the maximum participant pool size. The maximum potential participant pool for this study consisted of 743 defendants prosecuted nationally in fiscal year 2011 and 826 defendants prosecuted nationally in fiscal year 2012 for health care-related crimes (Department of Health and Human Services and The Department of Justice, 2011; 2012). From this, I utilized the PACER portal to select a subset consisting of all cases from Georgia and Florida states. Health care-related crimes were defined as crimes whose prosecutions that included 18 USC § 1347 Health Care Fraud or 18 USC § 1349 Attempt and Conspiracy to Commit Health Care Fraud. The decision to use this subset of prosecutions from two states was intended to make the population size and corresponding data pool more manageable. I then collected archival documentation from these prosecuted cases and coded the sentencing outcomes for easier comparison. Once coded, I analyzed the data to determine consistencies and inconsistencies between the impact of the crime and the sentence delivered. The punitive impact of the sentence was coded in terms of monetary sentence, level of jail time, and other negative actions noted such as loss of license.

Operational Definitions

The following terms were used in the following way in this research paper:

Abuse: A range of the following improper behaviors or billing practices including, but not limited to:

- Billing for a non-covered service;

- Misusing codes on a claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or
- Inappropriately allocating costs on a cost report (CMS Glossary, 2014).

Adjudicated case: A prosecution that has reached the final decision, sentence included (Office of Juvenile Justice and Delinquency Prevention, 2014).

Beneficiary: In the context of this study, an individual with the right to receive medical care and who receives such care (Aldhizer, 2009).

Deterrence Theory: A theory stating that criminal acts are omitted because of a fear of sanctions or punishment (Paternoster, 2010).

Fraud: The intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing that the deception could result in some unauthorized benefit to themselves or some other person(s) (CMS Glossary, 2014).

Federal health programs: Health programs such as Medicare and Medicaid set up and maintained by a U.S. federal agency (Centers for Medicare and Medicaid Services, 2014).

Health and Human Services (HHS): A U.S. federal department that administers many of social programs dealing with the health and welfare of the citizens of the United States. It is the parent of The Centers for Medicare and Medicaid Services. (CMS Glossary, 2014).

Indictment: A formal accusation by a grand jury stating that an individual should be put on trial for their actions (United States Health & Human Services, Food and Drug Administration, 2008).

Judicial jurisdictions: The United States has three federal district courts in Florida, and three in Georgia. The court assigned to that geographic region adjudicates cases based in the geographic region (Department of Justice, 2014).

License: An individual or a health care facility has met certain standards set by a State or local government agency (CMS glossary, 2014).

Patient harm: When a patient's health is threatened, whether intentionally or unintentionally (Ahmad & Lachs, 2002).

Prosecution: The act or process of charging a person who is accused of a crime (Department of Justice, Justice 101, 2014).

Provider: An individual who delivers health care services. Providers include but are not limited to physicians, dentists, podiatrists, hospitals, skilled nursing facilities, psychologists, pharmacists, physical and respiratory therapists, speech and language pathologists, nurses, and clinical social workers (Shah et al., 2009).

Restitution: Returning something that was lost or stolen to its owner in exchange for the damage or trouble caused (Lollar, 2014).

Sentencing: The punishment ordered by a court of law for a person convicted of a crime (Department of Justice, 2014).

Statute: A written law that is formally created by a government (Department of Justice, 2014).

Unbundling: A practice whereby practitioners or hospital personnel submit separate bills for a procedure or visit that should be billed as a single (less expensive) procedure or visit (Phillipsen et al., 2008).

Up-coding: A fraudulent billing practice in which providers use codes corresponding to higher payment rates instead of using the billing codes corresponding to the actual medical services provided (Jones & Jing, 2011).

Waste: Mismanagement, inappropriate actions, and inadequate oversight of patient care and insurance claim filing (Centers for Medicare and Medicaid Services, 2014).

Assumptions

I made the following assumptions about the sentencing of defendants charged with health care fraud. It was assumed that sentencing would be consistent within the years of the study, unless there was a judicial change altering the normal sentencing patterns (e.g., guidance from enacted laws, change in judges, or a basis on other adjudicated cases). It was also assumed that sentencing for health care fraud should be consistent across states because it is a federal matter and should not therefore be preempted by state law. For data collection, it was assumed that the federal district court databases available to the public were thorough. These assumptions were necessary support the prosecution phase of Wilhelm's fraud management lifecycle theory (2004).

Scope of the Study

In this study, I explored the consistency in sentencing individuals charged with Medicare health care fraud in the states of Georgia and Florida during 2011 and 2012.

The greatest delimiting factor of this study was the inclusion of only cases that include the use of health care fraud-related statutes as a prosecution mechanism. While there are other statutes used in the fight against health care fraud, the 147 cases included in this study were prosecuted during 2011 and 2012 for health care fraud. The other statutes focus on specific components of fraud. Delimiting factors include using only Georgia and Florida federally adjudicated cases, and termination years of 2011 or 2012.

Georgia and Florida are geographically contiguous states but are drastically different in terms of the number of health care fraud cases which they prosecute each year. While there are prosecutions initiated in other states, the geographic juxtaposition of Georgia and Florida in combination with the drastic differences in prosecution volumes could highlight a lack of experience in health care fraud prosecutions as an influencing factor on consistency of sentencing. I selected the years 2011 and 2012 to ensure inclusion of current information that had reached full adjudication and had the opportunity to appeal. From 2011 and 2012, there were 147 cases that were convicted of health care fraud-related crimes.

Limitations of the Study

The available population that was studied was limited to the number of individuals who have moved through the U.S. judicial system with a final disposition of *terminated* and with a health care fraud statute included in their prosecution. If the individuals in the judicial system were not well versed in the use of the health care fraud statutes, there may have been cases prosecuted without a statute when it should have been included. Without knowing which cases should have had a health care fraud statute

included in their prosecution, the total population was limited to only prosecutions that included health care fraud statute(s) comprising the best set of cases to explore the consistency in sentencing across states and timeframes.

Significance of the Study

This research was significant because there was no prior exploratory research of consistency in sentencing with health care fraud statutes found in searches of juried literature. Although the literature review process identified articles discussing the use of health care fraud statutes, it did not identify any articles comprising an exploratory review of U.S. health care fraud sentencing consistency in general, or any granular to sentencing consistency in Georgia and Florida during 2011 and 2012. This study is also important because it generated new information intended for use in minimizing health care fraud in the United States. Minimizing health care fraud will reduce the overall cost of health care for Medicare beneficiaries (Kass & Linehan, 2012).

Expected Social Change

Social change includes changes in rules of behavior or value systems. Policy makers will benefit from this study through exposure and understanding of sentencing disparities. If a reduction in health care fraud is achieved through the consistency of sentencing, and applying the information learned to the deterrence phase of Wilhelm's fraud management lifecycle theory will decrease the overall cost of health care. Reducing health care fraud in general and Medicare fraud in particular will help to minimize premium increases the elderly population will have to pay.

Summary

I conducted this study to explore consistency in sentencing health care fraud in Georgia and Florida by examining terminated federal health care cases from 2011 and 2012. This chapter described a related gap in research and the plan addressing this gap. Chapter 2 provides a review of literature on health care fraud, the health care fraud lifecycle, and the history of sentencing consistency. In Chapter 3, the research methodology, the data collection, and the analysis conducted are described in detail.

Chapter 2: Literature Review

Introduction

This literature review presents research for exploration of equality in federal health care fraud statute sentencing in two geographically contiguous states, Georgia and Florida, during 2011 and 2012. Despite safeguard efforts of governmental agencies such as The Centers for Medicare and Medicaid (CMS), the Department of Justice (DOJ), and the Office of Inspector General (OIG), the portion of Medicare payments deemed fraudulent continues to grow. Kass and Linehan (2012) found that health care fraud, specifically in Medicare, has become a significant issue in recent years, and remains unresolved. This problem is not unique to the United States; other countries such as China have seen similar increases in fraud (Miller, 2013). South Africa has noted a decrease in overall health care fraud, but increases in syndicate-type health care fraud (Dube, 2011; U.S. Department of Justice, 2010). While health care fraud may never be eliminated, to minimize it, the root causes must be explored and understood.

The literature search strategy section covers my approach to identifying relevant journal articles and books to support the regarding exploratory, multiple case study theory, selection of the states and time frame, federal health care sentencing consistency, and health care fraud. The remainder of the literature review is a synthesis of journal articles and books pertinent to the topics of Medicare and Medicaid history, the monetary and health impact of health care fraud, significant legal ramifications, inconsistent sentencing, and relevant theoretical foundations.

Literature Search Strategy

I searched the databases Thoreau, Sage, ProQuest, Academic Search Complete, and criminal justice and health care-related journals for relevant articles published between 2010 and 2015. The initial search included the terms: *health care fraud, fraud management lifecycle, consistency in sentencing, sentencing consistency, sentencing guidelines, deterrence theory, 18 USC § 371 Conspiracy to Defraud the United States and to Receive Health Care Kickbacks, 18 USC § 1347 Health Care Fraud, 18 USC § 1349 Attempt and Conspiracy, 31 USC § 3729-3733 The False Claims Act, 42 USC § 1320A-7b(b) The Anti-Kickback statute, 42 USC § 1395 The Physician Self-Referral Law, 42 USC § 1320a-7, 1320c-5 The Exclusion Authorities,* and *42 USC § 1320a-7a The Civil Monetary Penalties Law*. Even with the limiting period of 2010 through 2015, my search in Thoreau resulted in 279 entries for *health care fraud*. Many of the health care fraud results discussed aspects of health care fraud other than sentencing, however, such as those related to a specific illness, or private insurance fraud that was not Medicare fraud. The terms *sentencing guidelines* and *deterrence theory* also returned hundreds of articles, many of which were not related directly to health care fraud. The literature search strategy was organized in four sections: case study, selection of Georgia and Florida, sentencing consistency, and health care fraud.

Case Study

Yin (2014), Saldaña (2013), and Auerbach and Silverstein (2003) supported the appropriateness of utilizing a qualitative, multiple case study theory in exploring consistent sentencing. Yin (2003) discusses case study as being a frequently used method

in the social science fields of psychology, sociology, political science, anthropology, social work, and education. It is also used in other fields such as economics and business to explore a premise. Although most application examples I have found were in the social sciences, I applied it to the exploration of Medicare health care fraud sentencing in Georgia and Florida during 2011 and 2012.

Through case study, I created a protocol to follow and systematically collect empirical data to derive an inductively based study about a contemporary phenomenon (Yin, 2014). Case study does not test a hypothesis, but is best used when answering "how" or "why" questions (Yin, 2014). As qualitative research, grounded theory produces a theory based upon observed data gathered through discovery, and case study does not. This study gathered discrete sentencing data from archival case documentation from Georgia and Florida prosecutions during 2011 and 2012. From the observed data, exploration included the analysis of sentencing trends and consistencies between states, judicial jurisdictions and over time. A theory was not developed, therefore making case study the more applicable methodological approach used.

Individual based qualitative methods (biography, auto-biography, oral history, life history, auto-ethnography) were not the best choice to answer my research question (Leech & Onwuegbuzie, 2007). The oral history or life history methods could have been used by selecting a couple of cases such as the ones mentioned earlier. These methods could explore in-depth details about the prosecuted criminals and develop a deeper understanding of why the individuals committed the crimes. While this would have been

interesting, the greater understanding of a few cases would not deliver an overall trend in sentencing consistency across judicial districts for health care fraud.

Group based qualitative methods (ethnography, phenomenology, critical theory) could have been used to understand certain aspects of health care fraud (Leech & Onwuegbuzie, 2007). An ethnography study could have approached the cultural behaviors of white-collar criminals, or the behaviors of organized crime groups who expanded into health care fraud (Dube, 2011). With a phenomenological study, the meaning of the lived experiences of either the individuals who committed the crimes, or the Medicare beneficiaries who were harmed by health care fraud could be described. The aspects of health care fraud explored by the ethnography and phenomenological methods would be interesting, but they would not answer the research question regarding consistency in federal sentencing across Georgia and Florida.

With archival sentencing documents as the basis for my research, and a goal to explore the consistency in federal health care sentencing trends across judicial boundaries, case study was the best choice. With the geographical and years of case termination boundaries set, a specific set of federal health care fraud cases were analyzed which aligns with the case study methodology (Yin, 2014). One of the challenges associated with the traditional qualitative research is the analysis of the data. Analysis of interview data, or observations, could have caused great variability and concern over coding bias by the researcher (Gibbert & Ruigrok, 2010). The archival data found in the court documents provided sentencing information such as years of jail, amount of

restitution, and/or years/months of parole, that did not require any judgment on behalf of the researcher, eliminating potential bias.

Selection of Georgia and Florida

Understanding that exploring sentencing patterns across the entire United States would be a daunting task, I reviewed literature to determine the best boundary, to obtain a sample that would be representative of the whole, would reach appropriate saturation, and would be manageable as the researcher (O'Reilly & Parker, 2013). Health care fraud prosecutions are found in each of the 50 United States and U.S. territories, for both federal and private health care benefit plans (Public Access to Court Electronic Records, 2016). With archival, adjudicated court cases as the basis for my research, the most logical sampling boundaries were geography and judicial district court jurisdiction. Noting the largest proportion of health care fraud monetary recoveries were for the Medicare and Medicaid programs, this study focused on a geographical area with a large concentration of those two populations. Krause (2010) identified the South Florida judicial district as the leader in health care fraud prosecutions. To give the study juxtaposition, I chose to include the entire state of Florida and the geographically adjacent state of Georgia for several reasons:

1. Will Maas (2013) identified Florida as the third highest state plagued with health care fraud based upon prosecuted health care fraud cases
2. Georgia was among the top five Medicaid populated states (Feder, 2010).
3. Florida is among the top four Medicare populated states (Centers for Medicare and Medicaid Services, 2015).

4. Florida is among the top four states in overall population (U.S. Census Bureau, 2015).
5. South Florida has the largest population of Medicare beneficiaries in Florida (The Facts on Medicare Spending and Financing, 2014).
6. The first Medicare Fraud Strike Force was launched in 2007 in South Florida (U.S. Department of Health & Human Services and Department of Justice, 2015).

I also selected these states because Georgia and Florida are geographically adjacent and have large populations, high Medicare beneficiary populations, high Medicaid recipient populations, and historically high concentration of prosecuted fraud cases.

A police-deployment strategy, *hot spots* policing, was implemented in known geographical areas where health care fraud has concentrated (Durlauf & Nagin, 2011). In 2009, the Health Care Fraud Prevention and Enforcement Action Team (HEAT) combined representatives from the Department of Justice (DOJ) and the Department of Health and Human Services (HHS), selected the following cities as their hot spots to focus their health care fraud identification and prevention efforts (U.S. Department of Health & Human Services and Department of Justice, 2015).

- Baton Rouge, Louisiana
- Brooklyn, New York
- Chicago, Illinois
- Dallas, Texas
- Detroit, Michigan
- Houston, Texas

- Los Angeles, California
- Miami-Dade, Florida
- Tampa Bay, Florida

Will Maas (2013) also introduced the theory of considerably lessening Medicare and Medicaid fraud through uniform fraud enforcement, because placing "HEAT" in pinpointed places would cause the fraudsters to relocate their operations without hesitation. This further supported the selection of Georgia to be paired with Florida, because as the "HEAT" strike force makes impact in Florida, the closest state to relocate would be Georgia. One South Georgia defendant, Alfredo Felipe Rasco, admitted to opening up a new fraudulent clinic outside of Florida to avoid detection (U.S. District Court, Southern District of Georgia, Savannah Division, 2009).

The 1789 Congress divided the nation into 13 judicial districts that served as the basic organization for the federal judiciary (Federal Judicial Center, 2014). As other states entered the union, and populations grew, additional jurisdictions were added. As those jurisdictions were added, they respected the state borders, with no court jurisdictions covering multiple states (Federal Judicial Center, 2014). Both Georgia and Florida currently have three judicial districts; Northern, Middle and Southern. The number of total judgeships in Georgia increased to eighteen in 1990 and thirty-seven Florida judgeships in 2002.

Sentencing Consistency

Engraved above the Supreme Court entrance are the words, "Equal Justice Under Law." Therefore, individuals committing the same crime in any judicial district should

receive the same sentence regardless of the geographical United States location where prosecuted. Durlauf and Nagin (2011) proposed that deterrence success is dependent on the inevitability and harshness of punishment. Without the certainty of punishment and an appropriate level of punishment severity, deterrence is not effective (Durlauf and Nagin, 2011). The volume of cases, class of the defendant, gender, experience of the judges, or backgrounds of the jury members should not alter the punishment severity delivered to the defendant (Payne, Dabney, & Ekhomu, 2013; Policastro & Payne, 2013). This equal justice has also been termed uniform fraud enforcement (Will Maas, 2013).

Uniform fraud enforcement, according to Will Maas (2013), is challenging when a sentence has wide statutory limits. In order to give more consistency, sentencing guidelines applied within the statutory limits have been put in place for some sentencing groupings to replace judicial discretion (Blackwell Hofer & Ruback, 1999). In Ireland, the judges have broad sentencing discretion (Maguire, 2010). The judges delivered sentences based upon the theory that like cases were treated alike and that different cases were treated differently. Maguire (2010) referenced research by O'Malley (2000) delineating the difference between consistency, defined as treating like cases alike, and inconsistency, when like cases are treated differently with justification.

Some researchers have used inconsistency interchangeably with disparity in sentencing, even though there is an important distinction between the two (Maguire, 2010). Inconsistency in sentencing occurs when like cases are treated differently but justifiably so, whereas disparity occurs when like cases are treated differently but without

justification. Australia's judicial sentencing is based upon individualized justice and consistency (Krasnostein & Freiberg, 2013). While there is tension between the concepts of individualism and consistency, the violation of consistency erodes the public confidence in the administration of Australian justice (Krasnostein & Freiberg, 2013). With those definitions as a basis, this research explored the consistency in sentencing. In this study, when aberrancies were found without justification, then disparities were identified.

Health Care Fraud

Stealing money through health care fraud has been described as remarkably easy with a low probability of being caught, even with minimal health care knowledge (Sparrow, 2000). Even Fortune 500 companies have repaid millions of dollars because of Medicare fraud charges (Outterson, 2012). When reviewing Medicare health claims for payment, there are three main classifications of claims with errors: waste, abuse, and fraud. Waste, the least egregious of the three types of fraud, was defined as duplicate claims and unbundling claims (Krause, 2010). Unbundling claims occurs when services rendered on the same day are broken up into multiple claims for payment or broken up into multiple claims over multiple days to obtain greater reimbursement. Many procedures adjudicate as bundled payments, which is a single payment for medical procedures including both pre-procedure and post-procedure follow-ups. Abuse is best characterized by up-coding. Up-coding a claim is when a higher level of service is billed than was delivered to the patient to obtain a higher reimbursement. Fraud is delineated from waste and abuse by intent, misrepresentation of a material fact, knowledge of the

false misrepresentation, and damage to a victim (Rashidian, Joudaki, & Vian, 2012). When these types of claims are filed to Medicare or Medicaid, they are classified as false claims. False claims may be claims for service not delivered, or from someone who is not a licensed health care provider. Medical identity theft involves someone posing as a health care provider, or posing as a patient to obtain services. Medical identity theft can result in a false claim charge (Agrawal & Budetti, 2012). Because most insurance cards do not include a picture of the policyholder, family members that closely resemble each other can swap identification and insurance cards to obtain health care. Another fraud scheme classified as medical identity theft consists of an organization purchasing a list of Medicare health identifications for filing claims for services never rendered.

Medicare and Medicaid Historical Perspective

Medicare and Medicaid were enacted in 1965 as Title XVIII of the Social Security Act (42 U.S.C. § 301 *et seq.*) to offer publicly funded insurance to workers (Centers for Medicare & Medicaid Services, 2015). In 1972, Medicare was altered to cover individuals 65 years of age or older, disabled individuals, those diagnosed with ALS, and individuals with chronic kidney failure. Fee-for-service (FFS) Medicare consists of two primary parts: Hospital Insurance (Part A) and Supplemental Medical Insurance (Part B). The Medicare program authorizing statutes charge the Secretary of the Department of Health and Human Services (DHHS) with the administrative responsibility for the Medicare program. In turn, the Secretary has delegated the program authority for Medicare to the Administrator of The Centers for Medicare and Medicaid Services (CMS).

The CMS administers the Medicare program through activities such as:

1) Program policy and guidance formulation and promulgation

2) Contract execution, operation, and management

3) Utilization record maintenance and review

4) General Medicare financing (CMS, 2015)

Through the policies and guidance, the reimbursement for treatments was laid out for the providers who provide services to the patients. The CMS performs such administration through a complex set of relationships involving the private insurance industry, state and local governments, and thousands of independent hospitals, physicians, providers, and suppliers. Sections 1816(a) and 1842(a) of the Act provide that public or private entities and agencies may participate in the administration of the Medicare program under contracts or agreements entered into with CMS. These contractors are known as "Fiscal Intermediaries" (FIs) and "carriers." With certain exceptions, FIs perform bill processing and benefit payment functions for Part A of the program; carriers perform similar functions for Part B. However, the Medicare Modernization Act (MMA) required that CMS phase out these contractors under Medicare Contracting Reform and replace them with Medicare Administrative Contractors (MACs) with fraud, waste and abuse oversight by Zone Program Integrity Contractors (Centers for Medicare & Medicaid Services, 2015).

Monetary Impact

Krause (2010) presented the amount spent on health care, federal and private, in the United States as $2.5 trillion in 2009. A subset of the health care industry, the

Medicare program, currently serves over 46 million beneficiaries and processes over 1.2 billion claims annually. As the largest health care insurer in the United States, CMS is also the largest target for dishonest entities attempting to make a profit fraudulently. Feder (2010), Krause (2010), and Matos (2011) agreed that health care fraud continues to be an unresolved issue with a multi-million dollar impact, and will continue to be an unresolved issue unless different claim processing procedures or legal controls are implemented as safeguards against health care fraud. These authors disagreed on what percentage to attribute to health care fraud, varying from 3% to 10%. Over $583 billion in total Medicare benefit payments were disbursed in 2013 for the Medicare and Medicaid programs (Kaiser, 2014). Anticipated 2020 annual Medicare spending is projected to reach $686 billion, 3% of the projected Gross Domestic Product. As Medicare spending increases, so too will the total amount attributed to health care fraud without effective safeguards.

Since 1986, the Department of Justice (DOJ) has recovered approximately $1.1 billion out of the estimated $21 billion spent on fraudulent claims for health care. Using those recovery numbers, only approximately 5% of the estimated $21billion spent on fraudulent federal health care claims has been recovered. The health care focused professional organization, National Health Care Anti-Fraud Association (NHCAA), estimates health care fraud to be between 3 to 10% annually (NHCAA website, 2010). Krause referenced a 2007 Federal Bureau of Investigation (FBI) Financial Crimes report to the public in applying a rate of 10% for health care fraud. Synthesizing those estimates and applying a conservative 5% fraud estimate to health care expenditures,

health care fraud accounts for over $29 billion in 2013 and will escalate to over $34 billion in 2020 of total Medicare spending, if no changes were made in fraud detection, deterrence, and prosecution.

In order to foster a collaborative approach between federal, state and local law enforcement, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the national Health Care Fraud and Abuse Control (HCFAC) Program. The collaborative goal was to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud and abuse, and to protect Medicare and Medicaid beneficiaries (Department of Health and Human Services and The Department of Justice, 2010; 2011; 2012; 2013). As a basis for their research, Parver and Goren (2011) built research on the 2010 HCFAC report. Led jointly by the United States Attorney General and the Secretary of the Department of Health and Human Services (HHS), acting through the Office of Inspector General (OIG), the HCFAC report is produced annually. For the 2010 fiscal year, $6.9 million in HCFAC funding was allocated to the U.S. Department of Justice (DOJ) criminal division to litigate criminal health care fraud cases and coordinate health care fraud cases with other agencies. With 1,116 health care fraud investigations initiated involving 2,095 potential defendants, the DOJ filed 488 criminal cases with 931 defendants in 2010. These cases resulted in convictions against 726 defendants. Of the initiated health care fraud investigations, the prosecution rate was approximately 47%.

Florida has been described by several sources as a state with a notable health care fraud. From the 2011 and 2012 HCFAC reports, both the Middle and Southern Florida

districts are mentioned on multiple occasions with large monetary or unique health care fraud cases (U.S. Department of Health & Human Services and Department of Justice, 2011; 2012). The United States' response to the dramatic increase in fraudulent activity was to set up Medicare Fraud Strike Forces. Of the nine phases that equates to nine different cities where the strike forces were placed, Florida and Texas are the only states with two cities. Florida was the first and the seventh phase in the implementation of the strike forces. Specific instances of health care fraud in Florida were highlighted in the areas of hospital, physician, medical equipment suppliers, managed care organizations, home health providers, comprehensive outpatient rehabilitation facility, and pharmacy fulfillment (U.S. Department of Health & Human Services and Department of Justice, 2011; 2012). Other special programs such as the Enrollment Special Study and the South Florida Fraud Hot Line were created to address the higher level of fraud found in Florida. Collating these facts, Florida has a higher level of identified federal health care fraud than other states. Florida is geographically adjacent to two states, and the next most frequently mentioned state with federal health care fraud prosecutions in the HCFAC report is Texas, with four geographically adjacent states. My choice of Florida was based on the multitude of fraud references in the 2011 and 2012 HCFAC reports, the fewer number of geographically adjacent states to select from as a comparison, and the large population of Medicare beneficiaries (CMS, 2015). Georgia was a natural selection as the second state against which to compare the three Florida judicial districts. Georgia also has the larger Medicare population than Alabama, the other geographically adjacent state to Florida.

Matos (2011) noted, since Congress established the Health Care Fraud and Abuse Control program under joint direction of the Attorney General and the Department of Health and Human Services, Office of Inspector General (HHS-OIG), $15 billion has been returned to the federal government. Of the $15 billion, $13.1 billion was returned to The Medicare Trust Fund. In fiscal year 2010, the HCFAC collaborative recovered over $2.5 billion from health care fraud cases. Regardless of the percentage of health care fraud percentage estimate you chose, the recoveries do not equal the estimated monetary expenses of fraud, waste and abuse in the Medicare program.

Health Impact

Health care fraud also takes a physical toll on patients and their access to health care (Feldman, 2013). When health care providers give patients treatment for a false diagnosis to obtain an unnecessary or increased reimbursement, the patient's health may be at risk. Elder abuse comes in many forms, and from many trusted caregivers (Ahmad & Lachs, 2002). Any unnecessary procedures could cause physical harm to the patient, and be classified as elder abuse, as well as fraud. If the unnecessary procedure noted in the patient's medical record was not performed, the patient could be harmed due to changes in care based upon the previous, fraudulent diagnosis. Some insurance policies have procedure-specific lifetime maximums (Feldman, 2013). If fraudulent health care claims are filed, surpassing the lifetime maximum, the patient could be denied care later in life when the patient is sick, and those procedures are needed to save their life.

An extreme example of patient impact and health care fraud was the case against Dr. Shantha where dinitrophenol (DNP), a commercial grade week killer, was used as an

alternative cancer treatment (FDA, 2008). There was direct clinical impact on the patients. Dinitrophenol was administered in the 1930s as a weight-loss drug, and banned for use in 1938 when it was found to be toxic to the liver, kidney, and nervous system. Dr. Shantha and Bartoli were sentenced in the Northern District of Georgia after pleading guilty. Bartoli received 10 months confinement and Dr. Shantha received four hundred days of home confinement and a fine of $189,000.

Other instances of improper billing which may not directly jeopardize the patient's health include filing duplicate health care claims, unbundling services for multiple payments which should only receive one bundled payment, charging for a higher level service which was not provided, and splitting up claims over multiple days to avoid bundling (Krause, 2010). While many of these improper billings do involve direct patient clinical contact, there was no physical harm rendered to the patient, if lifetime maximums are met due to these claim billings, necessary care may be denied. The monetary amount received from each of these falsified claims is minimal and thousands of these claims would be submitted to make a substantial amount of profit.

Medical Identity Theft

Medical identity theft is another instance of health care fraud. There may or may not be direct patient, clinical contact with this type of health care fraud (Krause, 2010). For example, Oswald was sentenced for aggravated identity theft because of the hundreds of Medicare medical identities across Georgia and Florida (U.S. District Court Southern District of Georgia – Savannah Division, 2009). Oswald was allegedly the owner and Chief Executive Officer of United Therapy, with no direct physical clinical contact with

the patients. Oswald invited homeless individuals into the office for a meal and a cool place to stay during the hot summer days in Savannah, Georgia. No clinical procedures were performed on these individuals. Oswald faced a maximum statutory penalty of up to 13 months in prison, and $20,000 in fines with three years of supervised release. When comparing Oswald's sentence of 13 months in prison and Dr. Shantha's sentence of four hundred days of home confinement, it seems inconsistent knowing Dr, Shantha injected patients with commercial grade weed killer. Further inconsistencies include why was Dr. Shantha fined only $189,000 after injecting patients with weed killer while Oswald was fined $20,000, knowing Oswald never performed a medical procedure on patients. This study further explored the trends in archival cases similar to Dr. Shantha's and Oswald's to determine sentencing consistencies.

Another type of medical identity theft health care fraud focused on monetary impact is syndicate-type health care fraud. Organized crime has identified medical identity theft as a lucrative business to undertake (Dube, 2011; U.S. Department of Justice, 2010). As early as 2010, 73 members of an organized crime group were indicted for more than $163 million in health care crimes. The FBI mentioned Georgia in this indictment as one of the states where some members of this organization were located. Mimicking other organized crime structures, this health care related group included a leader or "thief-in-law," nominee owners, and runners. These groups may steal identities, or lease them from health care providers to file fraudulent health care claims. With the addition of syndicate-type groups, the population of individuals who could have been charged with health care fraud during 2011 and 2012 expands.

While there is differentiation in the monetary scale of health care fraud from up-coding to medical identity theft, there was consistency in the belief that health care fraud continues to be an issue and will continue to be an issue unless changes are made. A precise, quantitative measure of health care fraud has not been reached by any professional oversight or law enforcement agency. At the lowest NHCAA estimate of 3%, health care fraud has reached multimillion dollar proportions (NHCAA, 2010). The estimated health care fraud cost far exceeds the amount of recovered fraud expenses through adjudicated health care fraud prosecutions.

Legal Ramifications

Sentencing is based upon numerous legal statutes or laws against which crimes were committed. Some examples of punishments included in sentencing are jail time, restitution, probation, parole, license removal, and/or exclusion. Restitution is defined as the full amount of the victim's loss including any costs incurred by the victim as a result of the crime (18 US Code 2248, 2012). With good behavior during the in-jail portion of the sentence, an individual could be offered parole prior to the end of the full jail term. If offered parole, the prisoner is released prior to the end of the jail term with certain imposed restrictions. If those restrictions are violated during the parole term, parole can be rescinded and the individual will be returned to jail to serve the remainder of the sentence. Crimes found to be less egregious could end in a sentence of probation only, with no jail time. Probation is supervised release with restrictions. If the probation restrictions are violated, the courts will reevaluate the probation and could jail the individual.

Outside of physical incarceration or restriction, professional licensure can be in jeopardy. State licensing boards have a responsibility to evaluate health care provider ethics, professionalism, and ability to perform health services to the benefit of the patient. Ethical evaluations vary from more active participation in the action such as in Guantanamo Bay detainee psychological torture to a much less active participation such as white-collar crime, health care fraud (Gaskin, 2012). If the egregiousness of the crime dictates, the individual's license to practice health care would be terminated and incarcerated. Dependent on the severity of the crime, the license termination will either be for a set number of years, or permanent. Without a license, health care providers would lose the ability to file claims to Medicare and any other insurance company or program. The non-licensed individuals can participate in other aspects of the health care industry such as office management, consultation, executive level management, and other indirect positions. The Office of Inspector General (OIG) has the power under 42 USC 1320a-7(b) (15), and 1320c-5 to exclude individuals from participating in any aspect of the health care industry where health care funds would be used to cover the individual's salary, expenses or fringe benefits (Clark, 2012). Exclusion has the greatest practice restrictions on individuals who want have a future in health care.

Wide varieties of legal statute combinations are used in health care fraud related cases. Directly related statutes such as Health Care Fraud, False Claims Act, physician self-referral law, and civil monetary penalties law were enacted years ago and have been used in hundreds of criminal cases. Recently, new statutes were created to address the ever-changing health care fraud schemes. In 2004, the Identity Theft Penalty

Enhancement Act of 2004 made available the charge of "aggravated" identity theft used in a growing number of medical identity theft cases (Civic Impulse, 2015).

The health care fraud statute can be used to charge for billing for services not provided, up-coding, waiving patient co-pays to overcharge insurance companies, medical necessity, kickback arrangements, or unbundling services that should be included as a global billed service (Feldman, 2013). The health care fraud statute 18 USC § 1347 defines fraud as anyone who knowingly and willfully executes or attempts to execute a scheme to defraud any health care benefit program or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program (Civic Impulse, 2015). In violation of this statute, the defendant could be fined, imprisoned no more than 10 years, or both. If there is serious bodily injury of the patient, the defendant shall be fined, imprisoned not more than twenty years, or both. With a patient death, the defendant shall be fined, imprisoned for years or for life, or both fine and imprisonment. Individuals who work in collusion to commit health care fraud will also be charged with conspiracy to defraud the United States, found in 18 USC § 371.

The False Claims Act (31 U.S.C. § 3729-3733) is frequently used charge for Medicare payments made for fraudulent health care claims. The Qui Tam (short for *qui tam pro domino rege quam pro se ipso in hac parte sequitur*) provision, roughly translated as "he who brings an action for the king as well as for himself," was a part of the original False Claims Act, also called the "Lincoln Law" (Birkhahn et al, 2009; Schindler, 2009). During the Revolutionary War, goods or services that were agreed

upon via contract to be delivered to the government and were not delivered as promised, could be considered a False Claims Act. "Relators" work with the prosecution to deliver details surrounding the fraud committed in the False Claims Act case, and potentially testify as a witness (Chimon, Chipey, & Feulner, 2011). The relator is paid a percentage of the money returned from the case settlement. With the relator having a financial stake in the settlement of the case, this could contribute to the increase in the number of Qui Tam cases.

Introduced in 1972, the Anti-Kickback Statute 42 USC § 1320a-7b (b) was created to protect both the Medicare and Medicaid programs from fraud (Birkhahn et al, 2009). In the 1990s, it was aligned with the False Claims Act to protect against knowingly and willfully offering, soliciting, or receiving compensation to induce a referral relating to federal health care (Chimon et al, 2011). Compensation, or remuneration, was defined further as anything of value, not just restricted to cash.

To enforce the Anti-Kickback Statute, the Civil Monetary Penalties Law 42 USC § 1320a - 7a provides monetary penalties of up to $50,000 for each illegal act, charges of up to 3 times the amount of the kickback, and exclusion from participation in federal health care programs (Birkhahn et al, 2009). As an alternative to the False Claims Act, Health and Human Services administrative law judges hear Civil Monetary Penalties Law violations, and the rules of evidence are more relaxed.

The Physician Self-Referral Law, 42 USC § 1395nn, is used when a health care provider refers their patients for services in other facilities where they, or an immediate family member, have a financial interest (Chimon et al, 2011). These statutory violations

have persistently increased over the past few years (Adashi & Kocher, 2015). There has been controversy over the balance between efficient access to health care and unnecessary referrals to increase revenue. In low-population areas, one physician may be the owner of the physician office and peripheral services, such as durable medical equipment or reference laboratory. Penalties for this statute include non-payment, refund of any payments, exclusion from participation in the Medicare and Medicaid programs, and monetary fines. The maximum monetary fines range from $15,000 per violation to $100,000 for circumvention schemes.

Medical identity theft is defined by Agrawal and Budetti (2012) as the misuse of patients' or physicians' unique medical identifying information to obtain or bill public or private payers for fraudulent medical goods or services. As a growing trend, over 3,600 cases of medical identity theft were reported to the Federal Trade Commission (FTC) in 2009. Over 5,300 Medicare physician identification numbers have been compromised, with concentrations of these found in Los Angeles, Miami, and New York (Agrawal & Budetti, 2012).

With identity theft, the physician or the Medicare beneficiary can be unaware, or play an integral part in the theft. The identity of the physician and the Medicare beneficiary could be stolen with or without their knowledge (Agrawal & Budetti, 2012). The physician may participate in a job interview and complete a job application with pertinent information that is used to obtain a provider number. In this case, the health care provider may never know that a health care billing number was obtained using information that was collected for another purpose. In other situations, the provider

identity will be leased from the provider, and a kickback will be paid to the provider for the use of their provider number. While the provider is paid for the use of their medical identity, the identity may have been used in many other ways unknown to the provider. These fraudulently obtained provider medical identities have been used to open false front clinical offices. False front clinics typically never see a patient, and do not have medical equipment. Through my investigations experience, some offices only have a phone line and a fax machine to accept incoming correspondence. While there is no statute under which to prosecute medical identity theft, aggravated identity theft (18 USC § 1028A) could be used. The sentencing for this crime is 2 years of imprisonment, and probation is not allowed for any person convicted of this crime.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 offers the option of federal criminal prosecution for health care crimes (Chimon et al, 2011). While the basic sentence for health care crimes is up to ten years with financial penalties, if the fraud resulted in patient injury, the sentence could double or increase to life in prison if the patient died. The number of qui tam suits has drastically increased since the 1986 amendment, amount reimbursed went up to 30%, and protection against retaliation was strengthened (Broderick, 2007).

Money laundering is another charge that has been used in conjunction with some syndicate-type health care fraud cases. In 1986, Congress passed the money laundering statute, 18 U.S.C. § 1956 (Noonan, 2010). When large amounts of cash obtained from illegal moneymaking activities are filtered through multiple transactions and transfers to give the appearance of legitimate earnings, it is considered money laundering. Situations

which have used money laundering include drug trafficking and the mafia affiliated with illegal gambling. The difficulty in applying the money laundering statute surrounds the definition of proceeds (Noonan, 2010). Proceeds were defined as both profits and receipts in different court cases over time. With inconsistent definitions of proceeds, the money-laundering statute will continue to be applied inconsistently, rendering it less effective.

As payments were made to individuals for fraudulent claims, or fraudulent claims were submitted to the insurance company through the mail, or through electronic funds transfer, the mail or interstate wire fraud statute was applied (Chimon et al, 2011). Individuals can be charged with wire or mail fraud without being convicted of health care fraud. The wire and mail fraud provision from HIPAA could be used in health care fraud cases. Penalties include fines, and/or a maximum prison term of twenty years.

There are multitudes of penalties that can be applied to health care fraud cases dependent on the crimes committed. The gravity of the crime should dictate the level of punishment delivered. As additional groups deem health care fraud attractive for revenue enhancement and as schemes evolve, additional statutes or combinations of statutes may be utilized to deter future fraud.

Causes of Sentencing Inconsistency

There are many factors within the judicial system that could influence the consistency of sentencing. Within the Irish sentencing system, the sources of inconsistent sentencing are:

1. Individualized sentencing system – no two cases are ever the same, and circumstances of the crime and the criminal are factored in each sentence
2. Multiple sentencing aims – judges may have a deterrence, rehabilitation, or retribution stance in their overall sentencing position
3. Judicial variability – training differences, limited sentencing guidance from legislature, and appellate review in sentencing (Maguire, 2010).

Through Maguire's (2010) qualitative study using semi-structured interviews and sentencing vignettes, high variability was found in the least serious cases. With more serious cases where no guidance was provided, there was greater consistency. The choice of sentence by the Irish judges was termed "instinctual synthesis" because there were no pre-established guidelines. Similarly, Monsieurs, Vanderhallen, and Rozie (2011) found that Belgian magistrates possess wide discretion in sentencing, with no sentencing guidelines. Belgian magistrates have a positive attitude towards consistency in sentencing based through the application of non-binding guidelines.

In order to determine if sentencing guidelines reach "reasonable uniformity in sentencing," Anderson and Spohn (2009, p. 390) used hierarchical linear modeling, nesting the offenders in the judges that sentenced them to examine the sentencing decisions of federal judges in three United States District Courts. There were significant variations between judges decisions regarding appropriate sentences, and how they assigned weights to several of the legally relevant cases and offender characteristics. In Anderson and Spohn (2009) research findings there was mixed support that sentencing guidelines have produced uniformity in sentencing decisions.

Bagaric and Pathinayake (2013) argued that parity, or equality, in sentencing is unpredictable due to the large number of variables considered when deciding upon a sentence. Their findings were similar to the findings of Will Maas (2013), stating that sentencing has a considerable discretionary component, or "instinctual synthesis."

Theoretical Foundation

To explore consistencies in health care fraud sentencing, a theory was needed which addressed health care fraud, and specifically the sentencing aspect of health care fraud. There is a depth of journal articles on health care fraud, very few discussed theoretical framework. The area of financial crimes has some articles that discuss theoretical foundations. The best fit for this study was the Wilhelm's fraud management lifecycle theory (2004).

Wilhelm's Fraud Management Lifecycle Theory

Wilhelm's fraud management lifecycle theory is the theoretical framework for this research, asserting eight lifecycle stages (Wilhelm, 2004). Wilhelm built this theory from Australian National Training Authority (ANTA) competency standards, interviews, direct observations, case study responses, fraud and security publications, questionnaires, and American Association for Artificial Intelligence (AAAI) workshop papers. The fraud management lifecycle theory surpasses focusing on the criminal or the criminal activity, and was drawn from Wilhelm's attempt to describe the processes and activities surrounding the management and reduction of fraud losses. Wilhelm does not attempt to eliminate health care fraud, simply manage, and reduce. This theory evolved from the evaluation of several lifecycle stage interactions from five industries with significant

economic crime: communication, banking and finance, insurance, health care, internet merchant, and brokerage and security fraud (Wilhelm, 2004). The eight stages of this lifecycle include deterrence, prevention, detection, mitigation, analysis, policy, investigation, and prosecution.

The deterrence stage is defined as the refusal to do something for fear of the consequences (Wilhelm, 2004). In health care fraud application, an individual refusing to file a fraudulent health care claims for fear of the monetary or penal ramifications. Deterrence could also be used when evaluating how easy or hard it is to file the fraudulent claim. If the criminal has to work harder than expected or give up some piece of his identity, the repercussions may not be worth the effort expended (Wilhelm, 2004). Therefore, deterrence has dependencies on all other stages of the fraud management lifecycle. The deterrent value or difficulty component is heightened by prevention strategies, detection methods, and mitigation strategies.

The prevention stage should occur after deterrence efforts have failed and prior to the detection. Some co-mingle prevention with detection and deterrence (Wilhelm, 2004). Applying prevention in health care fraud includes keeping criminals from filing fraudulent health care claims or hindering them in the process of filing health care claims. Integrating additional protective mechanisms such as verifications, system access, and processes to follow prevents the fraud from occurring. The analysis stage provides profiles of those who are most likely to commit fraud. Those profiles are used in the prevention stage to implement additional security measures.

Identifying fraud prior to, during, and after the completion of fraud is the detection stage. Included in detection are identifying the fraud testing, unsuccessful fraud attempts, and fraud successes by criminals. Fraud testing occurs when the criminal sends through a low dollar claim to test the process, identify vulnerabilities, and determine boundaries of the system to exploit. Fraud attempts may be successful or unsuccessful. The unsuccessful attempts are as important as the successful during the detection stage. Detection occurs throughout all stages of the fraud management lifecycle, and should be used as early as possible in multiple security layers (Wilhelm, 2004).

Mitigation is enacted when a fraud occurrence has been identified or there is confirmed suspicion of fraudulent activity (Wilhelm, 2004). To mitigate a situation is to reduce the impact as quickly as possible. With health care fraud, a mitigation is a pre-pay edit added to the claims processing system to allow investigators time to review the claim(s) for accuracy. From the mitigation stage, feedback is gathered and distributed on how the fraud was not detected or stopped. This lessons-learned exercise improves future prevention efforts and evolving schemes.

Once losses have occurred despite the deterrence, detection, prevention, and mitigation stages, the analysis stage collates details of performance related to each stage (Wilhelm, 2004). Taking each stage, breaking it down into its component parts, and determining why it did not function as expected, the analysis stage attempts to determine a solution or an outcome to fix any deficiencies. As schemes evolve, this stage is important to bridge the gaps in coverage driving the evolution of detection methods, processes, and tools.

To protect customers from fraud, the situations identified in the analysis stage are used to alter or create policies mitigating any future losses. To build effective policies, the needs from operations, marketing, and accounting must be balanced. The cost of the deterrence or detection tools, or the loss caused by the fraud cannot exceed the company's profit. Policies are put in place to balance those needs, and those individuals who write the policies must understand the needs of all areas of the company (Wilhelm, 2004).

Once fraudulent activities have occurred, it is important to obtain evidence to stop future fraud, and reclaim any fraudulent payments or restitution. The investigation stage is where these activities are performed. Coordination with law enforcement could also be a component of this stage if legal statutes support the prosecution of the individual(s). Digital and physical evidence captured and documented in the case file is shared with law enforcement to build the prosecution's case. Case files typically include overall description of the fraud perpetrated, interview notes with dates and contact information, reports identifying the fraudulent activity in detail, and a report of any actions taken after the fraud was committed (Wilhelm, 2004). The investigation stage gleans information from most stages and returns information to the other stages to make the process more effective.

Pursuing legal action against someone due to the fraud they committed is prosecution. Wilhelm (2004) hypothesized that prosecution is only one component of a larger fraud management lifecycle. The prosecution stage notes having three aims:

1. punishing the defendant in an attempt to prevent further theft

2. establishing, maintaining, and enhancing the business enterprise's reputation of deterring fraud so that the community becomes aware of it
3. obtaining recovery or restitution

Wilhelm includes another aim, which some fraud investigators and law enforcement may include, the satisfaction of punishing the criminals (Wilhelm, 2004). After the case transitions to law enforcement, communication will continue as needed between the investigator and the prosecution team to adjudicate the case. Information will occasionally be returned to the investigator from the prosecution team regarding aspects of the case that were successful and not successful. While prosecution is the culmination of actions against those who commit fraud, information from this stage is returned to all other stages for learning and evolution.

Paternoster (2010) stated that the decision whether or not to commit a crime, the probability of being caught, and the severity of the punishment are not well known by the offenders, and therefore would not have a great influence over the deterrence of the crime. Quackenbush (2010) tested the effectiveness of general deterrence from 1816 through 2000 through a multinomial logit model. Quackenbush found support for the perfect deterrence theory as being effective. With that fact, consistent sentencing in the prosecution stage becomes important so offenders know the expected severity of punishment.

Beccaria proffered that the crime must immediately trigger the punishment to be most effective (Beccaria, 1963). Health care fraud could take months or years to be detected, and additional time to traverse through the judicial system to adjudication. If

Beccaria's point regarding immediate punishment is true, this would negate the full effects of sentencing. Paternoster supported Beccaria's position that people found it difficult to feel the depth of punishment when costs occur months or years from the criminal act (Paternoster, 2010).

Bagaric and Pathinayake (2013) found uniformity in prosecution sentencing to be more accidental or opportunistic than methodical and planned. Conversely, Gosepath (2009) supported equality and justice as a foundational premise to successful judicial system. For prosecution to lead to deterrence is only successful when applied consistently. In order to determine if federal health care fraud statutes are consistently applied, research must be performed. There was a literature gap with no analysis of health care fraud sentencing variations. Medicare health care fraud has implications across several populations: health care providers, policy makers, The Medicare Trust Fund, and Medicare beneficiaries.

In order to understand the root cause analysis of health care fraud, Wilhelm's fraud management lifecycle theory (2004) was derived from analysis of five industries with significant economic crime. The theory put forth that with balanced components fraudulent losses and societal costs would be minimized. The focus of this study is the prosecution stage, and consistent sentencing has direct impact on the outcomes of the prosecution stage. To be successful, Wilhelm aligned with Gosepath in believing prosecution should be consistent and equal to the injustice that has been committed. Conversely, Rashidian, Joudaki, and Vian (2012) found no evidence that interventions made a difference in the fight against fraud and abuse.

The debate to be resolved, but not resolved in this study, is whether consistent sentencing contributes to improved health care fraud deterrence. It takes more than just consistent sentencing and successful prosecutions to make the greatest impact on deterrence (Wilhelm, 2004). Influencing factors for the deterrence of health care fraud include making it difficult to file fraudulent health care claims, faster identification of fraud, policy changes, and a balanced retribution response.

Summary and Conclusions

The three major categories of literature that I collected and summarized include identifying health care fraud as an issue, the selection of Georgia and Florida as viable populations for health care fraud prosecutions, and research performed on sentencing consistency. Through multiple iterations of searches for related literature, the same literature began to reoccur. Searching in Academic Complete, Sage and Criminal Justice related juried journals for terms such as health care fraud, and the individual *health care fraud statutes, sentencing guidelines, and sentencing consistency* returned hundreds of journal articles.

Whether measured by cases initiated, cases prosecuted, or monetary recoveries, all of the researchers agreed that health care fraud continues to be a multimillion dollar issue year after year. The percent of total health care fraud expenditures varied by author between 3 and 10 percent. In order to identify a representative sample, I selected the geographically contiguous states of Georgia and Florida. As Will Maas (2013) pointed out, Florida has one of the highest Medicare beneficiary populations, one of the highest health care fraud rates, and one of the highest overall state populations. Georgia is none

of these, which makes it a good comparison juxtaposed against Florida. Sentencing with wide limitations leaves the sentence selection to "instinctual synthesis" of the judges. In Ireland, the judicial sentencing freedom provided wide variation in sentencing on lessor crimes, and less variation on more serious crimes.

The Ireland studies were not conducted in the United States and were not specific to health care fraud. This qualitative, multiple case study explored the consistency in sentencing for only health care fraud cases sentenced during 2011 and 2012. Basing this research on Wilhelm's fraud management lifecycle theory, the phases of fraud management must be managed in concert be most effective, including consistent sentencing and prosecution activities. The literature summarized in this chapter was used to support the research methodology, instrumentation, and data collection plan detailed in Chapter 3. Through a qualitative, multiple case study exploration of prosecuted federal health care fraud cases, the sentencing consistency in Georgia and Florida during 2011 and 2012 was evaluated.

Chapter 3: Research Method

The purpose of this qualitative case study was to explore consistency in federal health care fraud statute sentencing across the U.S. states of Georgia and Florida during 2011 and 2012. The U.S. federal sentencing guidelines for health care fraud statutes in place at the time of this study did not give judicial guidance in applying sentencing to cases involving such wide variation of no patient impact to patient death. It employed a multiple case study design to investigate prosecutions across the different judicial jurisdictions. This chapter discusses the multiple case study methodological framework the data collection and analysis plan, and ethical ramifications of this study.

Research Method

The primary research question guiding this study explored the consistency in sentencing for health care fraud statute prosecutions across Georgia and Florida in 2011 and 2012. The study's qualitative inquiry analyzed publicly available data on fully prosecuted cases. Although data were available for the 1,569 health care fraud cases that completed nationally during this period, the examined pool of prosecuted cases nationally was reduced to the population of prosecuted cases from Georgia and Florida during these years.

This study incorporated Wilhelm's fraud management lifecycle theory as its theoretical framework, with a focus on the concepts of parity and equality in justice. Wilhelm's (2004) fraud management lifecycle theory states that the different phases of fraud management must work in concert to be most effective. For the prosecution phase described in Wilhelm's fraud management theory to be most effective, the concept of

parity and equality in the delivery of justice must be applied (Wilhelm, 2004). According to Bagaric and Pathinayake (2013), applying the basic tenet of parity to health care fraud should result in the same federal health care fraud crime in Georgia and Florida producing the exact same sentence in both. This study explored whether or not this was the case.

I selected a multiple case study design for this study because it examined a specific set of cases, in alignment with Yin's (2014) guidelines. Collecting artifacts for further analysis paralleled the collection of prosecuted case information to determine if sentencing was consistent across judicial jurisdictions and timeframes. The case study tradition focuses solely on a specific set of cases, which in this case were included in the analysis to increase the reliability of identified trends.

Role of the Researcher

As the researcher, I was the observer collecting data. I extracted pertinent information from the court documents pertaining to these cases and code the information in a database. Once coded and saved, these data elements were sufficient for me to analyze the data and draw conclusions about the consistency in sentencing between Georgia and Florida. I also conducted a quality assurance check with an expert in doctoral research and coding, so as to confirm that my information was coded correctly and consistently, without bias.

I had previous experience with this subject matter because I worked for a company through August 2010 supporting fraud prosecutions in the state of Georgia; however, I have not worked in fraud and abuse since 2010. Terminating my employment

prior to the window from which the study data were drawn removed any professional ties to the individuals who prosecuted health care fraud cases and any potential power relationships with cases prosecuted in 2011 and 2012. During the years of 2011 and 2012, I had no involvement in the cases prosecuted for health care fraud, had no contact with anyone who was prosecuted during those years, and had no contact with the individuals prosecuting the individuals being charged.

I had no bias or power relationships that might have caused conflicts. I have supported law enforcement prosecutions prior to 2011, but not during or after. Through the exploratory, multiple case study framework, any remaining biases regarding participant influences or power relationships were null because the data which was analyzed was from public documents and no participant interaction.

The remaining potential bias is my personal passion for reducing Medicare fraud. To reduce this potential for bias, I focused my research on the collected data so that the coding for this study was objective and based upon the sentence delivered, and not on any subjective interpretations by myself. The coding was clear and reproducible, and checked by an unbiased reviewer to make sure that any bias in the coding would have been identified and revised. Another doctoral-level individual with no known bias reviewed the coding of approximately 30% (40 cases) of my data, selected through random sampling. I also journaled my reactions to the data and the analysis results so as to reduce bias, as suggested by Denzin (2011).

There were no role relationship issues. This study was not performed within my work environment, there was no contact with any investigators or prosecutors, and the

use of publicly available archival data removed any potential ethical concerns. Participant incentives were not needed because there was no contact with the study participants. Through transparency in conducting the research and following the research plan detailed in Chapters 1-3, there were no remaining ethical issues causing ethical concerns.

Methodology

Participant Selection Logic

The Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year, October 2010 through September 2011, noted that 743 defendants across the United States were convicted of health care related crimes during the year. The same report for Fiscal Year 2012 noted 826 convictions of health care related defendants during the year. For reasons of practicality and focus, the population for this study was reduced to the individuals who had terminated cases during the calendar years of 2011 and 2012 in the U.S. states of Georgia and Florida.

If the U.S. population was proportionally distributed across all 50 states, the selected population would have comprised approximately 63 cases across Georgia and Florida for the two years. In actuality, there were 147 cases, which was manageable. I performed a coding pilot of 10 ten cases to test the coding methodologies, two from each state judicial district except for the Northern Georgia judicial jurisdiction because it had zero cases meeting the study requirements. Subsequently I removed the test cases from the analysis to ensure that any potential coding issues would not skew the overall population used for data analysis.

I collected the study data by analyzing case documents from health care fraud convictions that had been made public. Only those participants convicted in the states of Georgia and Florida during 2011 and 2012 were included. Cases from other states and other years were excluded. The Office of Inspector General (OIG) Health care fraud prevention and Enforcement Action Team (HEAT) identified the following statutes as health care fraud related statutes (U.S. Department of Health & Human Services and Department of Justice, 2015). I used the same list of statutes in this study:

- 18 USC § 371 Conspiracy to Defraud the United States and to Receive Health Care Kickbacks
- 18 USC § 1347 Health Care Fraud
- 18 USC § 1349 Attempt and Conspiracy
- 31 USC § 3729-3733 The False Claims Act
- 42 USC § 1320A-7b(b) The Anti-Kickback statute
- 42 USC § 1395 The Physician Self-Referral Law
- 42 USC § 1320a-7, 1320c-5 The Exclusion Authorities
- 42 USC § 1320a-7a The Civil Monetary Penalties Law

I obtained the study data by searching the online court portals for each of the six judicial districts included in this study: three from Georgia and three from Florida. Any Georgia or Florida defendant with a terminated case within 2011 or 2012 and includes at least one of the earlier mentioned statutes, was included in the sample except those removed for the coding pilot.

Due to the use of publicly available, archival data to select the participants and determine the outcome of their case, there was no need to develop procedures to contact and/or recruit the participants. With a manageable number (147) of cases with federal convictions in the states of Georgia and Florida during 2011 and 2012, I considered all publicly available convictions a part of the sample. By utilizing the entire population in the selected area as the sample, the study reached maximum saturation.

Instrumentation

The data collection was through observation protocol, utilizing an information recording protocol similar to the *logging data* process described by Lofland and Lofland (1995, p. 66). Each prosecuted case corresponded to archived data or artifacts, and equated to one observation each. I logged these observations in an Excel database for ease of use in the data analysis plan. Each line in the Excel database signified a separate case, defendant, and charge for that defendant. This database recorded the defendant's identifying information, the case jurisdiction where the case was prosecuted, the final case disposition, and the details of the sentencing, including restitution, jail term, and license status if known.

Saldaña (2013) stated that initial or *open* coding is completed in the first cycle of coding. A single coding method cannot encompass all of the information to be captured. Saldaña (2013) described a combined methodology using attribute and magnitude was the most appropriate for this study. Attribute coding, as defined by Saldaña (2013), was used in my study to collect the defendants demographic information, state prosecuted, which district prosecuted the case, date of sentencing, judge delivering the sentence, and

prosecuting attorney. Originally, the impact on the patient was to be captured, but upon execution of the study, impact on the patient was not readily included in the majority of the cases, and not included in the analysis. Magnitude coding is shown in Table 1 as applied to patient impact. If no patient impact was discussed in the terminated case, then patient impact level 1 was be selected as the coded value. If some patient impact was noted in the terminated case file but not directly attributable deaths, level 2 would be selected. The magnitude coding striations for the level of sentencing were found ineffective due to the lack of clear patient impact information in the terminated case documentation.

Key pieces of data, such as the sentence, amount of restitution, charges and impact upon the patient(s) were extracted from the final judgment documentation from the federal courts. Final judgment documentation produced by federal courts relay the basic sentencing documentation from the health care fraud committed. Being a legal document from a United States federal court, the final judgment documentation was the best public source for information regarding each case.

Table 1

An Example of Magnitude Coding Applied to This Study's Patient Impact

Patient Impact Coding Level	Coding Definition
1	No patient deaths or patient harm were directly attributable to the health care fraud.
2	There was some physical patient harm, but no patient death directly attributable to the health care fraud.
3	There was at least one patient death directly attributable to the health care fraud.

With the sentencing collected from the archival court documents, the information necessary to answer the research question surrounding the consistency of health care fraud sentencing was collected. Utilizing the attribute and magnitude coding models helped focus the wide variety of sentencing.

Published Data Collection Instruments

Saldaña (2014) combined the research of Bazely (2003), DeWalt and DeWalt (2011), Gibbs (2002), and Lofland et al. (2006) into a cohesive description of attribute coding. Combining the research of Miles and Huberman (1994) and Saldaña presented similar information for magnitude coding methods. Saldaña applied the collation of this foundational research into a description, application, and examples demonstrating how to apply such a coding structure.

Similar to the study performed here, Krippendorff (2003), and Wilkinson and Birmingham (2003) utilized attribute and magnitude coding with content analysis to complete their research. Attribute coding was used to capture the identifying case information and the demographic information available on the defendant. Magnitude coding was used to evaluate the impact of the health care fraud. The magnitude differentiation coding changes depending on the number of patient deaths.

Content validity was reached through a detailed understanding of the content domain (Web Center for Social Research Methods, 2014). Including all prosecuted cases from Georgia and Florida during 2011 and 2012 in the study population allowed the analysis to include a wide variety of cases that should be representative of other states.

Ten cases were pulled out of the population for a pilot to test the coding. Ten cases were immaterial to the overall findings.

Procedures for Pilot Studies

To test the attribute and magnitude coding, a pilot was conducted. This pilot confirmed that the data collected, and coding performed supported the exploration of federal sentencing consistency needed to answer the research question. I selected two prosecuted cases from each federal judicial jurisdiction, excepting Northern Georgia because it had zero cases meeting study criteria, to use in a pilot to test the coding methods. The 10 cases selected for the pilot were removed from the analysis of sentencing consistency. The pilot study included enough cases to preliminarily test the coding methods and determine if the research question could be explored with the publicly available archival documents. The pilot was successful, and proved that the coding was effective to evaluate consistency in sentencing.

The Walden University IRB approval number is **09-04-15-0196620**.

Procedures for Recruitment, Participation, and Data Collection

I collected archival court documents through the district court portals. The collection of the documents spanned multiple days to retrieve all health care fraud prosecutions in 2011 and 2012 from Georgia and Florida. The data coding occurred over several days after document collection was complete. The narrative documents supplied the information used with the attribute and magnitude coding. The raw data and the coded data were stored in a Microsoft Excel spreadsheet for analysis. A sample of the Microsoft Excel data collection tool can be found in Appendix A. After the coding pilot

was complete and changes were implemented from the pilot coding outcomes, I coded the remaining cases.

In using archival documents, having too few participants is a moot issue. There were no cases in Northern Georgia and only one case in the Southern Georgia and Northern Florida judicial jurisdictions that fit the study criteria after the coding pilot cases were removed, but the state total for the year produced enough cases to be representative of the population of cases found in other states. If a judicial district did not have a large number of prosecuted cases, this was the situation in two Georgia jurisdictions and one Florida jurisdiction, so the default analysis by state and year was executed. Consistency in sentencing was explored without the necessity to analyze data at the judicial district level.

Exit strategies for participants were not needed because only archival documents were used in this study. Similarly, follow-up interviews were not be necessary. If there were aberrancies in the data, further follow-up was performed by retrieving additional documents. These additional documents would have been used to support or dispute the findings.

Data Analysis Plan

I collected data from archival documents. These archival documents consisted of final judgment documentation from federal courts. Each document used in this study was logged into a Microsoft Excel database, noting case identifying information (case number, defendant name, judge, judicial district where case was prosecuted, date of sentencing) and sentencing specifics (jail term, restitution amount, fines, etc.).

The name of the convicted individual was not redacted because the information was pulled from a public document. Copies of each court document were stored in an organized file structure by year, state and judicial jurisdiction, on a laptop which is password protected and encrypted. The back-up system I have employed consists of a detachable, password-protected hard drive with encryption, and an encrypted thumb-drive with password protection. I will store all archival data and analytical results for five years. After five years, I will destroy all data copies (hardcopy and electronic).

After the data protection mechanisms were in place and the documents were collected, I extracted the discrete data elements from the narrative documents and copied the data elements into a Microsoft Excel database.

Issues of Trustworthiness

Patton (2002) attributed study credibility to three inquiry elements: rigorous methods, credibility of the researcher and philosophical belief. This study was conducted following systematic data collection. The source of the data was PACER, the database where all cases were recorded for the courts and the judicial system for future reference and case precedence. Collection and coding of data was checked using analyst triangulation (Patton, 2002). With over fifteen years working in the health care fraud industry, my experience supported my credibility as the researcher. Additionally, I obtained two fraud certifications and have held them for multiple years. These certifications have an ethical position that I must maintain to continue holding the certification, further supporting my credibility as the researcher. Throughout years of

data analysis in my career, I appreciate the benefits of qualitative study, purposeful sampling, and inductive reasoning.

To lend greater credibility to the study and the data analysis, the entire population of federally prosecuted cases from Georgia and Florida in 2011 and 2012 were included. Ten cases were used in the pilot for coding testing, and subsequently removed from the population. The remaining population included the widest variation of possible cases and the highest saturation possible. To further the credibility of the study, the concept of triangulation was utilized.

Triangulation was used to confirm the best research methods, confirm data through different sources, confirm data and coding through using multiple data analysts, and different perspectives. Using archival data, the strongest need for triangulation surrounds confirmation of the data and coding of the data. Denzin (2009) defined data triangulation as the use of multiple sources to examine specific occurrences. My data analysis plan included triangulation of data collection and coding through reviews by multiple data analysts with experience in a similar industry. The coding protocol and the coded data was reviewed by an expert familiar with research and coding principles, but not directly involved in health care fraud. Approximately 30% of the coding data, 40 cases, were randomly sampled for review. The data analysis was reviewed by two executives with years of experience in the federal health care fraud environment. It was necessary for reviewers to have a minimum understanding of health care fraud prosecutions to effectively review the exploratory data analysis and question the outcomes.

Determining transferability of study findings instead of external validity, qualitative researchers Denzin (2011), and Marshall and Rossman (2011) found greater benefits in transferability than external validity. Understanding the distribution of the study population further added confidence to the transferability of the study sample from the states of Georgia and Florida across geographic and time delineated boundaries. Through using thick data element descriptions, readers and other researchers can determine the transferability of the data collected and the analysis performed.

Dependability in qualitative research relates to the ability to replicate or repeat the study. Denzin (2011), and Marshall and Rossman (2011) agreed that qualitative researchers demonstrate trustworthiness through the exercise of dependability instead of reliability. To replicate this study, the same data source can be used, thick data definitions were written, and the study analysis and outcomes are covered in detail in Chapters 4 and 5. To accomplish this, I organized and maintained a database of all terminated cases included in this study population. The collected data, along with the coding, was checked through analyst triangulation.

Once I confirmed the data and coding, I engaged a panel of subject matter experts to assess my analysis and findings. My panel was comprised of an expert who reviewed the data coding protocol and randomly sampled approximately 30% of the cases, which equated to 40 cases. The other two individuals on the panel were executive level management in the federal health care industry and familiar with health care fraud prosecutions and statistical analysis. Bernard (2013) agreed that panels of subject matter experts are an effective mechanism for evaluating research study outcomes. To insure

appropriate feedback from the panel, I described the case study methodology to the panel prior to their review.

In order to support confirmability, a qualitative case study research project follows systematic rigor and thoroughness from initial design, through data collection and analysis (Patton, 2002). Through analyst triangulation, consistent data collection and data coding were confirmed. The use of a subject matter expert panel as described previously provided feedback on the analysis and study findings. The doctoral individual who reviewed the coding confirmed consistent translation from the narrative documents to the Excel database and found no coding errors in the 40 cases reviewed. The executives reviewed the data analysis plan and the study outcomes in the exploratory, multiple case study methodology framework. The executives confirmed the application of case study methodology and the outcomes based upon the data analysis.

Ethical Procedures

This study was based purely on publicly available, archival court documents. Since the data was publicly available, agreements from participants to gain access to the data were not needed. I had no direct interaction with any study participant. The Walden University Institutional Review Board (IRB) study approval number is **09-04-15-0196620**. Ethical concerns in relation to data collection and participant interactions were removed because the data comes from the publicly available, archival prosecuted cases. By obtaining a log-in to each publicly available federal district court portal to retrieve the court documents, ethical concerns over access to confidential data were removed.

Once the data was retrieved, ethical concerns of whether to keep the participant's name confidential were null. Using publicly available data allowed me to keep the name of the convicted individual throughout the data collection, coding, analysis, and findings development. While the confidentiality of the participant is not an ethical concern, confidential procedures for data security were followed.

The collected data and analysis were stored on a password-protected, encrypted laptop, an external hard drive, and a thumb drive for redundancy. Identified data was shared with a peer analyst to check for data collection and coding quality. The data exchanged with my peer analyst was exchanged securely with passwords and encryption. After the peer analyst completed the analysis, the copies of the data were destroyed. The findings were shared with the expert panel. All data will be destroyed at 5 years, and at the end of 5 years, electronic data will be erased, and paper will be shredded.

Summary

Through the regimented process of a qualitative multiple case study, I explored the consistency of sentencing for health care fraud statutes across judicial jurisdictions, and calendar year boundaries. In this chapter, the reasoning behind the selection of case study framework, attribute, and magnitude coding, sampling frame, and data analysis plan were described.

Chapter 4: Results

Introduction

The purpose of this study was to analyze consistency in federal health care fraud statute sentencing in the two geographically contiguous U.S. states of Georgia and Florida, during 2011 and 2012. Through a qualitative, exploratory multiple case study of archival terminated case data, I compared the physical and monetary sentence delivered for the same charge in each of the judicial jurisdictions (Yin, 2014). At the time of this study, the U.S. federal sentencing guidelines for health care fraud statutes did not specify exact sentencing for healthcare fraud violations, therefore leaving the sentencing decision to a wide variety of judges across the nation with varying experience in healthcare in general and healthcare fraud in particular.

I pulled the foundational data through an archival document review to code final dispositions of federal health care prosecutions, in alignment with Saldana's (2013) guidelines. As mentioned previously, the source for the archival data was a publicly available database called Public Access to Court Electronic Records (PACER). This database includes federal terminated case data. The data for this study were retrieved from the PACER database by year, state, and health care related charge. The data collected included the months of imprisonment, the months of probation, the months of supervised release, amount of restitution, and amount of fines. Once collected, I analyzed the averages, minimums, and maximums for each judicial jurisdiction and state for Georgia and Florida including only cases terminated during 2011 and 2012. This chapter

provides a summary of the data demographics and the analysis, followed by a discussion of the study's evidence of trustworthiness and the results.

After approval by Walden University's IRB (Approval #: 09-04-15-0196620), I began this study with a pilot to test the data collection and coding. I originally set out to select 12 terminated cases for the pilot, consisting of two from each of the Northern, Middle, and Southern districts in Georgia and Florida that included 18 U.S. Code § 1347 health care fraud or 18 U.S. Code § 1349 attempt and conspiracy. However, there were no terminated health care cases identified in the Northern district of Georgia, so only 10 terminated cases remained in the coding pilot. Both the Southern district of Georgia and the Northern district of Florida had three terminated health care related cases in 2011 and 2012. The remaining three districts had at least fifteen cases to sample for coding. The first adjustment made during the coding pilot was having 10 available terminated cases, not 12, due to the lack of cases from the Northern Georgia judicial jurisdiction. After coding the 10 cases, I evaluated the effectiveness of the coding plan, in alignment with Saldana (2013). Of the coded cases, the only alteration of the coding plan was including each charge on a separate line of the spreadsheet for ease of analysis. The collection of the physical and monetary sentence, the monetary impact, and the entity that the fraud was committed against was completed as expected. There were no changes in the instrumentation or data analysis strategy. With the data source being archival data, there were no influences on the study participants that might have prejudiced the interpretation of study results.

Through a query of the PACER system for years 2011 and 2012, I found 147 terminated cases from Georgia and Florida that included the federal health care fraud related charges. PACER holds publicly available documentation on all cases, civil and criminal. Discrete data elements such as case number and name, filed and termination dates, assigned judges, party name, and the defendant number are all available through the PACER query. Other information such as the charges, the monetary sentence and physical restriction sentence were found in the narrative court documentation. I pulled the data elements from the narrative documentation and input into the spreadsheet, in alignment with the suggestions of Lofland and Lofland (1995). Each charge for each defendant was entered on a different line with a unique entry for months of imprisonment, months of probation, and months of supervised release. Monetary sentences, fines, and assessments were detailed at the charge level. Case level restitution was not clearly divided at the defendant and charge level, so it was repeated for each charge line within the case and was not totaled in any of the analysis. I was unable to discern patient impact in the majority of cases and therefore did not capture it in my spreadsheet.

From the 147 cases in the total population, I originally planned on selecting two cases from each judicial jurisdiction to test the coding in a pilot. One jurisdiction did not have any cases during this timeframe, however, leaving 137 cases not included in the pilot study for full data analysis in the main study. There were 19 Georgia and 118 Florida cases fitting the selection criteria after the pilot cases were removed. I noted an unusually low volume of cases found in the Northern and Southern Georgia, and

Northern Florida judicial jurisdictions. After the pilot cases were removed, Southern Georgia and Northern Florida were left with only one case each. The Northern Georgia judicial jurisdiction had zero cases that met the criteria.

One concern was the lack of Northern Georgia terminated federal health care fraud cases in 2011 and 2012, and the presence of only three in Southern Georgia and Northern Florida judicial jurisdictions. With two of the three cases in both Southern Georgia and Northern Florida jurisdictions being removed from the population for the coding pilot, I was left with only one other terminated case to base the data analysis on for each of those judicial jurisdictions. While singular cases remaining after the coding pilot cases were removed from the Southern Georgia and Northern Florida jurisdictions in the overall data, it would not have been statistically appropriate to base trends upon single instances of cases. Therefore, any judicial jurisdiction-specific analysis was based only on Middle Georgia, Middle Florida, and Southern Florida jurisdiction data.

Demographics

With 147 federal health care fraud cases terminated during 2011 and 2012 in Georgia and Florida, there were 137 left after the coding pilot cases were removed (Table 2). In Georgia, there were 23 total health care fraud cases during the study period, 19 without including the coding pilot. In Florida, there were 124 total health care fraud cases during the study period, 118 after the coding pilot cases were removed.

Table 2

Federal Health Care Fraud-Related Terminated Cases in 2011 and 2012 in Florida and Georgia, Sorted by Jurisdiction

Area	Northern	Middle	Southern	Total	Total Without Coding Pilot
Georgia	0	20	3	23	19
Florida	3	15	106	124	118
Total	3	35	109	147	137

The physical sentencing data were broken down into months of imprisonment, probation, and supervised release. Months of imprisonment ranged from 0.5 of a month to 240 months for cases terminated in Florida, and a maximum of 109 months for the cases terminated in Georgia (Table 2). Both probation and supervised release ranged from zero to 60 months. There were only 19 cases that included probation across Georgia and Florida.

In financial terms, there were two primary monetary penalties assigned to those who commit health care fraud, fines and restitution. For the cases included in this study, the six cases that included fines ranged from the lowest amount of $100 to the highest amount noted as $2,500,000. Restitution ranged from $0 to $87,533,863. For Georgia, the restitution maximum was $3,948,846, and an average restitution of $445,255 (Table 3). The maximum fine in Florida was $2,500,000, the maximum restitution was $87,533,863, and the average restitution was $16,760,209.

Table 3

Variations in Federal Health Care Fraud-Related, Terminated Cases From 2011 and 2012

Area	Minimum Months of Imprisonment per Case	Maximum Months of Imprisonment per Case	Average Months of Imprisonment per Case	Minimum Restitution per Case	Maximum Restitution per Case	Average Restitution per Case
Georgia Northern	0	0	0	$0	$0	$0
Georgia Middle	2	24	9	$2,100	$261,748	$76,456
Georgia Southern	13	109	49	$3,948,846	$3,948,846	$3,948,846
Georgia Total	**2**	**109**	**15**	**$0**	**$3,948,846**	**$445,255**
Florida Northern	30	30	30	$140,501	$140,501	$140,501
Florida Middle	6	188	48	$9,967	$7,030,932	$2,075,918
Florida Southern	0.5	240	59	$0	$87,533,863	$17,722,088
Florida Total	**0.5**	**240**	**59**	**$0**	**$87,533,863**	**$16,760,209**

I performed a focused review of two of the most common federal health care charges, 18 U.S. Code § 1347 federal health care fraud and 18 U.S. Code § 1349 attempt and conspiracy Tables 4 and 5). Specifically for the charge 18 U.S. Code § 1347 health care fraud in Georgia, the maximum months of imprisonment was 12, months of probation was 36, and months of supervised release was 36. In Florida, the maximum months of imprisonment was 188, the maximum months of probation was 60, and the maximum months supervised of release was 36 months (Table 4).

Table 4

Charge 18 U.S. Code § 1347: Health Care Fraud Defendants With Terminated Cases in 2011 and 2012

Area	Maximum Months of Imprisonment per Case	Maximum Months of Supervised Release per Case	Maximum Restitution per Case
Georgia	**12**	**36**	**$ 172,453.75**
Northern	0	0	$ 0
Middle	12	36	$ 172,453.75
Southern	0	0	$ 0
Florida	**188**	**36**	**$ 87,533,863.46**
Northern	30	36	$ 140,500.95
Middle	188	36	$ 7,030,931.83
Southern	120	36	$ 87,533,863.46

Similarly with charge 18 U.S. Code § 1349 attempt and conspiracy, the data shows great variation in each of the judicial jurisdictions maximum sentences including maximum months of imprisonment and maximum months of supervised release (Table 5). From Georgia, the maximum months of imprisonment stretched from 24 to 109 months. The monetary restitution in Georgia for charge 18 U.S. Code § 1349 fluctuated from zero dollars to $3,948,846. During the same period in Florida, the months of imprisonment varied from 37 months to 120 months, and the restitution varied from $82,766 to $87,533,863 (Table 5). The physical sentencing of maximum months of imprisonment did not correlate to the maximum monetary restitution delivered in these

cases. If the physical and monetary sentences were based upon similar patient impact decisions, the middle Georgia ($ 261,748) and middle Florida ($ 82,766) maximum restitution should be more similar since the months of imprisonment are similar at 24 and 37 months. If the middle Georgia jurisdiction maximum for months of imprisonment for charge 18 U.S. Code § 1349 is less than the middle Florida maximum months of imprisonment sentence, then the maximum restitutions should follow suit. Conversely, the middle Georgia maximum restitution was 3 times that of the middle Florida maximum restitution.

Table 5

Charge 18 U.S. Code § 1349: Attempt and Conspiracy Terminated Cases in 2011 and 2012

Area	Maximum Months of Imprisonment per Case	Maximum Months of Supervised Release per Case	Maximum Restitution per Case
Georgia	**109**	**36**	**$ 3,948,846**
Northern	0	0	$ 0
Middle	24	36	$ 261,748
Southern	109	36	$ 3,948,846
Florida	**120**	**60**	**$ 87,533,863**
Northern	0	0	$ 0
Middle	37	36	$ 82,766
Southern	120	60	$ 87,533,863

Data Themes

Moving from data summarization of descriptive statistics to discovery of themes arising from the data, I looked for correlations in the data, data alignment, and data disparity. In 2011, Chief United States District Judge Federico Moreno stated in *United States v. Armando Santos*:

> One of the major issues…is to avoid unwanted disparity in sentences because it's important. It's just not fair that X gets a much more lenient sentence because he falls before another judge or it's in another jurisdiction or even before the same judge. I mean, that's unfair. But we also have to have individualized sentencing and look at the individual, and as I'm thinking out loud for the Court of Appeals to review it here in front of a good trial lawyer and a good appellate lawyer, all the things that I'm thinking about is, what is the appropriate sentence. (*United States v. Armando Santos*, 2011, p. 30)

To reach maximum impact and the appropriate sentence, as Moreno discussed, consistency in sentencing must be reached regardless of physical location or experience of the judge with federal health care fraud. There were direct relationships between the fraudulent payments and the restitution, but not between the identified submitted charges intended for payment and restitution. There was also a disparity between the restitution amount and the years of imprisonment. The Florida average months of imprisonment of 59 months is 4 times that of Georgia's average months of imprisonment at 15 months. The average Florida restitution is $16.7 million and the average Georgia restitution is

$445,255, 37 times less than Florida. Only one case was removed because of discrepant data. This case originated in Florida, but was transferred to California prior to a sentence being delivered; therefore, I removed it from the analysis.

Evidence of Trustworthiness

Patton (2002) attributed study credibility to three inquiry elements: rigorous methods, credibility of the researcher, and philosophical belief. To support credibility in this study, I followed a systematic data collection process. The source of the data was the database where all cases were recorded for the courts and the judicial system for future reference and case precedence called Public Access to Court Electronic Records (PACER). Through analyst triangulation the collection and coding of data was checked (Patton, 2002). A minimum 30% sample of the population cases was selected. An expert in structuring doctoral level research checked the coding of the randomly selected 40 cases and no errors were found.

To increase the external validity of the study and the data analysis, the entire population of federally prosecuted cases from Georgia and Florida in 2011 and 2012 were included. Approximately 10 cases were used in the pilot for coding testing, and subsequently removed from the case population. The remaining population included the widest variation of possible cases and the highest saturation possible. External validity of the study was enhanced through the use of triangulation (Patton, 2002).

Triangulation was used to confirm the best research methods, confirm data through different sources, confirm data and coding through using multiple data analysts, and different perspectives. Using archival data, the strongest need for triangulation

surrounded confirmation of the data and coding of the data. Denzin (2009) defined data triangulation as the use of multiple sources to examine specific occurrences. My data analysis plan included triangulation of data collection and coding through reviews by multiple data analysts with experience in a similar industry. The coding protocol and the coded data were reviewed by an expert in research and coding principles, but not directly involved in health care fraud. Approximately 30% of the coding data was randomly sampled for review. Two individuals with years of experience in the federal health care fraud environment reviewed the study methodology, the data analysis, and the outcomes.

Determining transferability of study findings instead of external validity, qualitative researchers Denzin (2011), and Marshall and Rossman (2011) found greater benefits in transferability than external validity. Understanding the distribution of the study population further added confidence to the transferability of the study sample from the states of Georgia and Florida across geographic and time delineated boundaries. Through using thick data element descriptions, readers and other researchers can determine the transferability of the data collected and the analysis performed.

Dependability in qualitative research relates to the ability to replicate or repeat the study. Denzin (2011), and Marshall and Rossman (2011) agreed that qualitative researchers demonstrate trustworthiness through the exercise of dependability instead of reliability. To replicate this study, the same data source can be used, thick data definitions were written, and the study analysis and outcomes were covered in detail. To accomplish this, I organized and maintained a database of all convictions included in this

study population. The collected data and coding was checked through analyst triangulation.

Once I confirmed my data collection and coding, I engaged a panel of subject matter experts to assess my analysis and findings. Bernard (2013) agreed that panels of subject matter experts were an effective mechanism for evaluating research study outcomes. My panel was comprised of an expert to review the data coding protocol and random sample of 40 cases. The remaining two participants on the panel were from executive level management in the federal health care industry, familiar with federal health care fraud prosecutions and statistical analysis specific to health care. Insuring appropriate feedback from the panel, I described the case study methodology prior to their review, stepped them through the data analysis performed, discussed the results and my recommendations. Each member had several questions regarding the health care fraud study statistics, and the individual cases included in the case study. After absorbing the information collected and presented to the panel, each federal health care industry executive confirmed my data analysis strategy, agreed with the outcomes based upon the data delivered, and approved of my recommendations for changes and further research.

To support confirmability, a qualitative multiple case study research project follows systematic rigor and thoroughness from initial design, through data collection and analysis (Patton, 2002). Through analyst triangulation, I confirmed consistent data collection and data coding. The use of a subject matter expert panel provided feedback on the analysis and study findings. I engaged an expert to review my coding, and two

executives trained in the federal health care industry to review my case study methodology and data analysis plan.

To determine variations in the application of sentencing for federal health care fraud across Georgia and Florida in 2011 and 2012, I conducted research through multiple case study methodology and calculated the minimum, maximum, and average number of years of imprisonment and restitution ordered. As demonstrated in Table 3, the wide variation was seen in both the months of imprisonment and in the associated restitution assigned. From the cases terminated in Georgia in 2011 and 2012, the months of imprisonment ranged from two to 109, and restitution ranged from $0 to $3,978,846. For the same period, terminated cases from Florida ranged from 0.5 a month to 240 months imprisonment, and restitution from $0 to $87,533,863.

Gosepath (2009) supported equality and justice as a foundational premise to successful judicial system. With that premise established by Gosepath, it could be argued that the length of fraud, the number of fraudulent claims, or the patient impact could have impact on the variations in imprisonment or restitution per case. As a comparison, consider two cases *United States v. Albert Ayala* and *United States v. Armando Santos*. With the $87 million case against Ayala, a 120-month imprisonment sentence was delivered for one count. With the $152,664 case against Armando Santos, the sentence of 120 months of imprisonment was delivered for seven counts. With identical physical sentences, the monetary sentence varied widely. The Ayala sentence was based upon one count and received the higher monetary sentence. For further comparison, I selected five cases for in-depth review.

United States of America v. Alberto Ayala, MD

In the case *United States of America v. Alberto Ayala, MD* three companies were noted as a part of the fraud: American Therapeutic Corporation (ATC), Medlink Professional Management Group, Inc. (Medlink), and the American Sleep Institute (ASI; U.S. District Court Southern District of Florida – Miami Division, 2012, *United States of America v. Alfredo Ayala, MD.*). Willner, Gumer, and Ayala were the Florida licensed physicians in charge of directing patient care. With these three physicians, a therapist, three program directors, three marketers, and six patient brokers collected Medicare beneficiaries to attend ATC's Community Mental Health Clinics (CMHCs) and falsified medical documentation to make them eligible to receive care through a Partial Hospitalization Program (PHP).

A PHP is an intense, short-term program designed to reduce the overall costs of an inpatient stay at a hospital by offering 24-hour care through the CMHCs. These programs are offered for some mental health issues, patients in need of family counseling, therapeutic drug and biological delivery, and patients needing training or education. In this case, the claims for service payments were false and fraudulent, medically unnecessary, and never provided. Kickbacks and bribes were paid to the patient brokers and patient recruiters to find Medicare beneficiaries to receive PHP services at the ATC CMHC, and sleep studies at ASI. To conceal the conversion of checks to cash, several companies were created specifically to cash the kickback checks.

United States of America v. Sarody Milian

In the case *United States of America v. Sarody Milian (a/k/a "Alberto Fernandez") and Luis A. Perez Moreira (a/k/a "Moises")*, E&E Medical Services Corporation d/b/a Elbia's Pharmacy was established to provide prescription drugs to Medicare beneficiaries in the Hialeah, Florida area (U.S. District Court Southern District of Florida – Miami Division, 2011, *United States of America v. Sarody Milian)*. During the negotiations to purchase Elbia's Pharmacy, Milian from E&E Medical Services used an alias and never disclosed his legal name. Milian and Moreira recruited Tain (a/k/a "Emilio Hernandez") to be the nominee owner, and used that identity to protect their involvement. For less than a month (March 31, 2010 through approximately April 8, 2010), these individuals submitted approximately $776,298.98 in false and fraudulent claims to Medicare. Under the previous owners of Elbia Pharmacy, the weekly billings were approximately $1000. The evidence produced showed only a $70 payment from WellCare, out of the $776,298.98 billed. The insurance companies had not paid the majority of these claims out of concern for the validity of the charges. Three of the prescribing doctors during this time reported the fraudulently submitted claims with their names and numbers used as the prescribing physicians. To corroborate the suspected fraudulent activities, law enforcement conducted surveillance of Elbia's Pharmacy on April 8, 2010. At approximately 10:30 am, law enforcement observed a closed pharmacy with no one present. Other stores surrounding Elbia's Pharmacy noted sporadic business hours after the sale of the business to E&E Medical Services. It appeared that no patients were harmed by these fraudulent claims. Milian was charged with one count of

"conspiracy to commit health care fraud" and sentenced with 33 months of imprisonment, three years of supervised release, an assessment of $100, and $70.00 in restitution.

United States v. Alfredo Felipe Rasco, Iris Oswald, and Niurka Rasco

In the case *United States v. Alfredo Felipe Rasco, Iris Oswald, and Niurka Rasco*, their company, United Therapy, submitted over $5.6 million in false medical claims along with claims submitted from Niurka Rasco through United Medical Center, Inc. (U.S. District Court Southern District of Georgia – Savannah Division, 2011, *United States of America v. Niurka Rasco*). The Rascos billed Medicare for infusion services (*United States v. Alfredo Felipe Rasco, Iris Oswald, and Niurka Rasco*, 2011). In this phony medical clinic Medicare beneficiaries were lured to the clinic with promises of free food, transportation, and grocery gift cards. Many beneficiaries with HIV and AIDS, from the local homeless shelters and section VIII housing, came to United Therapy for non-existent services to be billed.

Over $6.5 million in fraudulent claims were billed, and over $4 million was paid before law enforcement was able to stop the fraud. For this crime, Alfredo Rasco received 133 months of imprisonment, $3,948,846.47 in restitutions, and 3 years of supervised release. Niurka Rasco received 3 years of probation and a $10 assessment. As proceeds from the fraudulent activities, they forfeited $1.3 million from their bank accounts, and a 42' powerboat named "Thank You, God." Oswald received 13 months of imprisonment, 3 years of supervised release, and a $20,000 fine.

United States of America v. Fred Dweck, MD

A medical clinic named Courtesy Medical Group, Inc. was created in Miami, Florida in April 2004 (U.S. District Court Southern District of Florida – Miami Division, 2011, *United States of America v. Fred Dweck, MD*). Dweck worked as a physician at Courtesy Medical Group, Inc. and referred beneficiaries for home health services while employed there. The Courtesy Medical referrals resulted in Medicare billing of approximately $16,605,878 and $9,806,712 in payments. For 1,279 beneficiaries for which he signed medical certifications, plans of care, signed prescriptions, and referred for home health services during this period, $40,888,474 was billed and $23,779,398 was paid for these claims.

United States of America v. Armando Santos

Santos, a registered nurse employed by a home health agency, billed Medicare for fraudulent health care claims (U.S. District Court Southern District of Florida – Miami Division, 2011, *United States of America v. Armando Santos*). Starting with signed patient assessment forms certifying that Medicare beneficiaries required home health services to weekly visit records describing the services purportedly delivered to patients, Santos falsified all documents to support the approximate $230,315.00 in Medicare claims submitted. The documented services allegedly provided included skilled nursing services, home health aide, occupational therapy, and physical therapy. These services were not medically necessary, and most were not provided. Some of the falsified services for two beneficiaries were documented to have occurred at the same time, further verifying the falsity of the records. The false claims resulted in $152,664 payments by

Medicare. Once sentenced for these crimes, Chief United States District Judge Moreno required Santos to repay $152,664 in restitution, serve 120 months of imprisonment, and 3 years of supervised release.

Table 6

Georgia or Florida Health Care Fraud-Related Case Study Examples Terminated in Either 2011 or 2012

Case	Amount of Fraudulent Billing	Payments Made From Fraudulent Billing	Restitution	Months of Imprisonment	Months of Supervised Release
United States v. Alberto Ayala	$205,000,000	*	$87,468,596	120	36
United States v. Sarody Milian	$776,298	$70	$70	33	36
United States v. Alfredo Rasco	$6,500,000	$4,000,000	$3,948,846	133	36
United States v. Fred Dweck	$16,605,878	$9,806,712	$22,142,066	24	36
United States v. Armando Santos	$230,315	$152,000	$152,664	120	36
United States v. Arsenio Leon	$1,300,000	$479,000	$443,001	97	36

*Unable to separate the payments made on behalf of Alberto Ayala from other defendants in the case.

In the majority of cases reviewed, there seemed to be a relationship between the amount paid for the fraudulent billing and the restitution assigned. In the case of *United States v. Sarody Milian*, a drastic 70,000:1 difference was noted between the fraudulent billing of over $770,000 and the $70 in total payment. With restitution set at $70, that supports the relationship between payments and restitution. Logically, the intent by Sarody Milian was to obtain over $770,000 in fraudulent payments. Due to quick

identification of those potentially fraudulent charges by the insurance companies, the payments were never made. With only $70 in payments to base restitution on, the restitution was set at $70.

The months of imprisonment had greater variability. Within the five cases highlighted, months of imprisonment ranged from 24 to 133 months. The Dweck case with 24 months of imprisonment was sentenced $22 million. The Rasco case with 133 months of imprisonment was sentenced $3.9 million. It seems incongruent that the case with the higher restitution, $22 million, would be sentenced the lower months of imprisonment, 24 months. For the $87 million case against Ayala, a 120-month imprisonment sentence was delivered for one count. With the $152,664 case against Armando Santos, the sentence of 120 months of imprisonment was delivered for seven counts. It would seem that the severity of the case would drive both monetary and physical punishments comparably and consistently across all judicial jurisdictions regardless of geography. With both defendants receiving 120 months of imprisonment, I would anticipate the monetary penalties to be similar. The difference in monetary penalties of $86.8 million between the Ayala and Santos cases could demonstrate inconsistencies in sentencing. Even differences in the number of counts could not explain the monetary sentence discrepancy. Ayala received an $87 million sentence based on one count, while Santos received a $152,664 monetary sentence for seven counts. Both of the cases had one count of 18 U.S. Code § 1349 attempt and conspiracy, which eliminates the possibility that one case included a more impactful crime than the

other case. The disparity in monetary sentencing when comparing these two cases further disproves consistent sentencing.

Summary

In summary, from the 137 terminated federal health care fraud cases from Georgia or Florida during 2011 and 2012, there were several instances drawn from the outliers where either the monetary or the physical sentencing was inconsistent. There were relationships seen between the amount of money identified as fraudulent health care claim payments and the restitution that was sentenced. There were no relationships found between the amount of money submitted on the original claim for reimbursement and restitution sentenced, even though the original submitted request for payment demonstrated intent.

The physical sentencing had similar inconsistencies. Only 19 cases out of 137 across Georgia and Florida included the physical sentence of probation. The majority of cases did include supervised release ranging from one to 60 months. Of the cases with a supervised release sentence, 85% of them received a 36-month sentence regardless of the monetary impact of the case, number of counts or the monetary sentence delivered. Next, I took the data explored to interpret the findings, detail the limitations of the study, make recommendations for future research based upon this research, review implications of this study, and conclude my research study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to analyze consistency in federal health care fraud statute sentencing in the U.S. states of Georgia and Florida during 2011 and 2012. This qualitative, exploratory multiple case study of archival terminated case data was designed to compare the sentence delivered for the same charge in each of the judicial jurisdictions. At the time of this study, the federal sentencing guidelines for health care fraud statute does not specify exact sentencing for specific healthcare fraud violations, leaving sentencing decisions to the discretion of individual judges who may have widely varying experience with healthcare and healthcare fraud cases.

A notable study finding was that there were positive relationships between payments made for fraudulent health care claims and the restitution sentenced. There was, however, no relationship found between the submitted charges for health care services submitted by the individuals committing fraud and the restitution. The submitted charges on the health care claims are the health care provider's presentation of what they intend on being paid, thus a demonstration of intent. The lack of relationship suggests that the intent demonstrated by the submitted charges does not influence the sentences delivered. There was also not a direct relationship between the restitution and physical sentence, imprisonment, or supervised release. The terms of imprisonment had a wide range of variability in comparison to the restitution. Supervised release had little to no variability even with changes in restitution.

Interpretation of the Findings

Wilhelm's (2004) fraud management lifecycle theory served as the theoretical framework for this study. The eight stages of this lifecycle include deterrence, prevention, detection, mitigation, analysis, policy, investigation, and prosecution. The deterrence stage of Wilhelm's fraud management lifecycle theory defines deterrence as the refusal to take action for fear of the consequences. The fraud management lifecycle avoids focusing on criminals or criminal activity, and was designed to describe the processes and activities surrounding the management and reduction of fraud losses (Wilhelm, 2004).

To follow the fraud management lifecycle theory's tenants to manage and reduce fraud, all stages of the lifecycle must work in unison to be most effective (Wilhelm, 2004). If one stage is ineffective, the entire lifecycle is not as effective. From the data collected and analyzed in this study, the sentences were not based on the submitted claims request for payment, and the monetary and physical sentences were not consistently delivered in comparison to the fraudulent charge. These findings suggest that the inconsistency in current sentencing practices makes the deterrence stage less effective. My recommendations for improving deterrence include changing the sentencing guidelines to be correlated with the intent of the submitted claims for payment, and proposing guidelines for consistency across monetary and physical sentences.

Limitations of the Study

Limitations for this study included the limited number of individuals who have moved through the judicial system during 2011 and 2012 in Georgia and Florida with a health care fraud statute included in their case, experience of judges with health care fraud, and media influences. After removing two cases from each judicial jurisdiction, there were several jurisdictions with either no cases for evaluation (Northern Georgia), or only one case for evaluation (Southern Georgia and Northern Florida). While the overall effectiveness of the study remained intact, I deemed the analysis by judicial jurisdiction as ineffective for those jurisdictions with zero or one case remaining.

The experience of the judges with health care fraud prosecutions remains a limitation. Judges are not formally trained in appropriate treatment protocols, insurance company coverage policies and procedures, and payment models. Judges are presented with a wide variety of cases. With the wide variety of cases, a judge cannot be an expert in every case type.

Recommendations

The recommendations that arise from this research include: extending the study to the remaining Office of Inspector General (OIG) Health Care Fraud Prevention and Enforcement Action Team (HEAT) judicial jurisdictions, analysis of health care fraud cases by judges, guidelines for sentencing consistency across judicial jurisdictions, alignment between the billed charges and sentences based upon intent, and alignment between monetary and physical punitive sentences. These recommendations align with

Chief United States District Judge Federico Moreno's call for additional sentencing guidelines in *United States v. Armando Santos*.

Conducting similar research on other HEAT jurisdictions would expand the current body of research on prosecuted federal health care fraud cases. A national analysis of prosecutions, interpreted through the lens of Wilhelm's health care fraud lifecycle theory, is expected to improve understanding of why judges deliver varying sentences could be explored. Analysis of sentences delivered by judges should be performed and the cases with unusually strict or light sentences should be analyzed for unusual circumstances.

To maximize the impact of the sentences delivered, there should be alignment between the physical and monetary sentences delivered based upon case impact and intent. As mentioned by Wilhelm in the health care fraud lifecycle theory, to be most effective, all stages, including the deterrence stage must maximize the potential effectiveness. A case that includes patient death or physical impact on patients should have a greater monetary and physical sentence than a case with lessor patient impact. Additionally, these sentences should be aligned with the billed charges on the federal health care claims instead of the paid amounts. The billed amounts presented on the claims are the amounts which providers or criminals request to be paid, therefore demonstrating intent. If health care providers submit a claim with the intent to be paid the submitted charges, the sentence should be based upon the intent not the paid amount.

Asking some judges to specialize in health care fraud cases would also improve the experience levels of judges working on these cases. The number of judges with this

specialization in each jurisdiction should be determined by the number of prosecuted health care fraud cases in that jurisdiction. With this specialization, judges experienced in health care fraud will be more able to bring consistency to the sentencing, whether or not sentencing guidelines are written into law. Specialization with health care fraud could also unnecessary overlap by reducing the number of multiple judges learning the same health care information.

Implications

Minimizing health care fraud will free funding for those who need it, especially in Medicare, which is allocated for the elderly and disabled. While legitimate health care costs rise each year due to health care innovations and the expansion of available health care procedures, costs of fraudulent health care claims cause the Medicare program to raise premiums and deductibles to supplement the tax revenue set aside for Medicare. If a reduction in health care fraud is achieved through improved consistency of sentencing, the overall cost of health care will decrease. If prosecution is swift and consistent across the United States, individuals will be less likely bill fraudulently due to the potential of a comparable monetary and physical sentence to the fraud they committed. This study ultimately promotes positive social change by informing efforts to change the behavior of criminals, which can reduce the total cost of health care for all and keep premium rates lower. With many elderly struggling with fixed incomes, a reduction in monthly expenses for health care is always welcome.

Conclusion

The purpose of this study was to explore the consistency of federal health care sentencing in the two geographically contiguous states of Georgia and Florida, during 2011 and 2012. Through qualitative, exploratory multiple case study of archival terminated case data, I compared the sentence delivered for the same charge in each of the judicial jurisdictions, and analyzed the data for consistency. Recent literature gave details regarding case examples and the application of federal health fraud statutes. Through the literature review, no articles were found to explore the federal sentencing consistency between Georgia and Florida during 2011 and 2012.

The research completed in this study identified inconsistent sentencing between jurisdictions, and between the request for payment and the monetary and physical sentences delivered. There was consistency between the amount paid for the federal health care claims and the amount of paid restitution required. Inconsistency was found in the amount of restitution, the months of imprisonment, and the months of supervised release. With inconsistent physical and monetary sentences for federal health care fraud, fraud deterrence will not be as effective. A consistent and stern message should be delivered through sentencing to anyone committing or considering the pursuit of health care fraud that will make Wilhelm's deterrence stage of the health care fraud life cycle model more effective (Wilhelm, 2004). This information is intended for use by lawmakers working on sentencing guideline reform to help those judges with little experience with health care fraud cases.

References

Adashi, E. Y., & Kocher, R. P. (2015). Physician self-referral: Regulation by exceptions. *Journal of American Medical Association, 313*(5), 457-458.

Agrawal, S., & Budetti, P. (2012). Physician medical identity theft. *Journal of the American Medical Association, 307,* 459-460. doi:10.1001/jama.2012.78

Ahmad, M., & Lachs, M. (2002). Elder abuse and neglect: What physicians can and should do. *Cleveland Clinic Journal of Medicine, 69*(10), 801-808. Retrieved from http://www.ccjm.org

Aldhizer, G. R., III (2009). Medicare and Medicaid fraud and errors: A ticking time bomb that must be defused. *Journal of Government and Financial Management, 58*(4), 12-20. Retrieved from http://www.agacgfm.org/

Anderson, A., & Spohn, C. (2010). Lawlessness in the Federal sentencing process: A test for uniformity and consistency in sentence outcomes. *Justice Quarterly, 27*(3), 362-393. doi:10.1080/07418820902936683

Auerbach, C. F., & Silverstein, L. B. (2003). *Qualitative data: An introduction to coding and analysis.* New York, NY: New York University Press.

Bagaric, M., & Pathinayake, A. (2013). The paradox of parity in sentencing in Australia: The pursuit of equal justice that highlights the futility of consistency in sentencing. *The Journal of Criminal Law, 77,* 399-416. doi:10.1350/jcla.2013.77.5.866

Baicker, K., & Chernew, M. E. (2011). The economics of financing Medicare. *New England Journal of Medicine, 365,* 1-3. doi:10.1056/NEJMp1107671

Bazeley, P. (2007). *Qualitative data analysis with NVivo.* London, United Kingdom: Sage Publications.

Beccaria, C. (1963). *On crimes and punishments.* Translated in 1819 by Edward Ingraham. Kindle edition.

Bernard, H. R. (2013). *Social research methods: Qualitative and quantitative approaches* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Berkowitz, E. (2008). Medicare and Medicaid: The past as prologue. *Health Care Financing Review. 27*(2). 11-23. Retrieved from http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/index.html

Berwick, D. M., & Hackbarth, A. D. (2012). Eliminating waste in US health care. *Journal of the American Medical Association, 14,* 1513-1516. doi:10.1001/jama2012.362

Birkhahn, R. H., Jauch, E., Kramer, D. A., Nowak, R. M., Raja, A. S., Summers, R. L., Weber, J. E., & Diercks, D. B. (2009). A review of the federal guidelines that inform and influence relationships between physicians and industry. *Academic Emergency Medicine, 16,* 776-781. doi:10.1111/j.1553-2714.2009.00460.x

Blackwell, K. R., Hofer, P. J., and Ruback, R. B. (1999). The effect of the federal sentencing guidelines on inter-judge sentencing disparity. *Journal of Criminal Law and Criminology, 90*(1), 239.

Broderick, C. (2007) Qui tam and the public interest. *Columbia Law Review,* 107. 949.

Carsten, M. K., Uhl-bien, M., West, B. J., Patera, J. L., & McGregor, R. (2010). Exploring social constructions of followership: A qualitative study. *Leadership*

Quarterly, 21, 543-562. doi:10.1016/j.leaqua.2010.03.015

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage Publications, Ltd.

Centers for Medicare & Medicaid Services. (2014). *Glossary.* Retrieved from http://www.cms.gov/apps/glossary/

Centers for Medicare & Medicaid Services. (2015). *History.* Retrieved from http://www.cms.gov/About-CMS/Agency-Information/History/index.html?redirect=/history/

Centers for Medicare & Medicaid Services. (2015). *Medicare aged and disabled by state and county: As of July 1, 2012.* Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/County2012.pdf

Centers for Medicare & Medicaid Services. (2015). *Medicare enrollment – All beneficiaries: As of July 2012.* Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareEnrpts/Downloads/12All.pdf

Clark, S. (2012). The OIG means business this time: The increasing use of strict liability in excluding pharmaceutical executives from federal health care programs. *Journal of Law, Medicine & Ethics, 40*(1), 171-175.

Denzin, N. K. (2009). *The research act: A theoretical introduction to sociological methods.* New Brunswick, NJ: AldineTransaction.

Denzin, N. K. (2011). The politics of evidence. In N. K. Denzin & Y. S. Lincoln (Eds.).

The Sage handbook of qualitative research (4th ed.) [Kindle version]. Retrieved from http://www.amazon.com

Denzin, N. K., & Lincoln, Y. S. (2011). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (4th ed.) [Kindle version]. Retrieved from http://www.amazon.com

DeWalt, K. M. & DeWalt, B. R. (2011). Participant observation: A guide for fieldworkers (2nd ed.). Lanham, MD: Rowman & Littlefield.

Department of Health and Human Services and Department of Justice. (2010, May). Health care fraud and abuse control program annual report for fiscal year 2009, Retrieved from http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2009.pdf

Department of Health and Human Services & Department of Justice. (2011, January). Health care fraud and abuse control program annual report for fiscal year 2010. Retrieved from http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2010.pdf

Department of Health and Human Services & Department of Justice. (2012, February). Health care fraud and abuse control program annual report for fiscal year 2011. Retrieved from http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2011.pdf

Department of Health and Human Services & Department of Justice (2013). Health care fraud and abuse control program annual report for fiscal year 2012. Retrieved from http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2012.pdf

Dube, J. F. (2011). Fraud in health care and organized crime. *Medicine & Health Rhode Island, 94*(9), 268-269.

Durlauf, S. & Nagin, D. (2011). Imprisonment and crime: Can both be reduced? *Criminology & Public Policy, 10*(1), 13-54. doi:10.1111/j.1745-9133.2010.00680.x

Feder, H. M. (2010). New study examines health care fraud in the United States. *Journal of Health Care Compliance*, 37-38.

Federal Bureau of Investigations. (2012). Investigating insurance fraud a $30 billion a year racket. Retrieved from http://www.fbi.gov/news/stories/2012/january/insurance_013112

Federal Judicial Center. (2014). The U.S. District Courts and the Federal Judiciary. Retrieved from http://www.fjc.gov/history/home.nsf/page/courts_district.html

Food and Drug Administration. (2008). *Chapter 6 – Office of Criminal Investigations*. Retrieved on March 18, 2012 from http://www.fda.gov/downloads/iceci/enforcementactions/enforcementstory/ucm129818.pdf

Gable, L. (2011). The Patient Protection and Affordable Care Act, public health, and the elusive target of human rights. *Journal of Law, Medicine & Ethics, 39*, 340-354. doi:10.1111/j1748-720X.2011.00604.x

Gaskin, D. (2012). Recent developments in health law. *Journal of Law, Medicine, & Ethics, 40*, 160-175. doi:10.1111/j.1748-720X.2012.00655.x

Gibbert, M., & Ruigrok, W. (2010). The "what" and "how" of case study rigor: Three strategies based on published work. *Organizational Research Methods, 13*, 710-737. doi:10.1177/1094428109351319

Gibbs, G. R. (2002). *Qualitative data analysis: Explorations with NVivo.* Maidenhead, MA: Open University Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago, IL: Aldine.

Gosepath, S. (2009). Equality. *The Stanford Encyclopedia of Philosophy.* Edward N. Zalta (Ed.). Retrieved from http://plato.stanford.edu/archives/win2009/entries/equality/

Henry J. Kaiser Family Foundation. (2014). The facts on Medicare spending and financing. Retrieved February 8, 2015 from http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/

Iglehart, J. K. (2009). Finding money for health care reform – rooting out waste, fraud, and abuse. *New England Journal of Medicine, 361,* 229-231.

Iglehart, J. K. (2010). The supercharged federal effort to crack down on fraud and abuse. *Health Affairs, 29,* 1093-1095. doi:10.1377/hlthaff.2010.0504

Johnson, B. (2006). The multilevel context of criminal sentencing: Integrating judge- and county-level influences. *Criminology, 44*(2), 259-298.

Jones, B., & Jing, A. (2011). Prevention not cure in tackling health-care fraud. *Bulletin of the World Health Organization, 89,* 858-859. doi:10.2471/BLT.11.021211

Kass, J. E., & Linehan, J. S. (2012). Fostering healthcare reform through a bifurcated model of fraud and abuse regulation. *Journal of Health and Life Sciences Law, 5*(75), 75-128. Retrieved from http://www.healthlawyers.org/JHLSL

Keehan, S., Sisko, A. M., Truffer, C. J., Poisal, J. A., Cuckler, G. A., Madison, A. J., Lizonitz, J. M., & Smith, S. D. (2011). National health spending projections through 2020: Economic recovery and reform drive faster spending growth. *Health Affairs, 30*, 1594-1605. doi:10.1377/hlthaff.2011.0662

Krasnostein, S., & Freiberg, A. (2013). Pursing consistency in an individualistic sentencing framework: If you know where you're going, how do you know when you've got there? *Law and Contemporary Problems, 76*, 265-288.

Krause, J. (2010). Following the money in health care fraud: Reflections on a modern-day yellow brick road. *American Journal of Law & Medicine, 36*(2/3), 343-369.

Krippendorff, K. (2003). *The art of the advantage.* Mason, OH: Thomson Texere.

Leech, N. L., & Onwuegbuzie, A. J. (2007). An array of qualitative data analysis tools: A call for data analysis triangulation. *School Psychology Quarterly, 22*, 557-584. doi:10.1037/1045-3830.22.4.557

Lofland, J., Snow, D., Anderson, L., & Lofland, L. H. (2006). *Analyzing social settings: A guide to qualitative observation and analysis* (4th ed.). Belmont, CA: Wadsworth Thomson.

Lofland, J., & Lofland, L. H. (1995). *Analyzing social settings: A guide to qualitative observation and analysis.* Belmont, CA: Wadsworth Publishing Company.

Lollar, C. (2014). What is criminal restitution? *Iowa Law Review, 100*(1), 93-154.

MaGuire, N. (2010). Consistency in sentencing. *Judicial Studies Institute Journal, 2*,14-54.

Marshall, C., & Rossman, G. B. (2011). *Designing qualitative research* (5th ed.). [Kindle version]. Retrieved from http://www.amazon.com

Matos, L. M. (2011). Federal prosecution of health care fraud. *Medicine & Health Rhode Island, 94*(9), 261-262.

Mello, J., & Flint, D. J. (2009). A refined view of grounded theory and its application to logistics research. *Journal of Business Logistics, 30*, 107-125. doi:10.1002/j.2158-1592.2009.tb00101.x

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Miller, A. (2013). Exposing medical fraud: "one of the last taboos in society". *Canadian Medical Association, 185*(1), 16-17.

Monsieurs, A., Vanderhallen, M., & Rozie, J. (2011). Towards greater consistency in sentencing: Findings from a survey of Belgian magistrates. *European Journal of Criminology, 8*(1), 6-16. doi:10.1177/1477370810381665

Morris, L. (2009). Combating fraud in health care: An essential component of any cost containment strategy. *Health Affairs, 28*, 1351-1356. doi:10.1377/hlthaff.28.5.1351

Muscal, R. M. (2010). Two models to investigate Medicare fraud within unsupervised databases. *Expert Systems with Applications, 37*, 8628-8633. doi:10.1016/j.eswa.2010.06.095

NHCAA website. (2010). *The problem of health care fraud, consumer alert: The impact of health care fraud on you!* Retrieved from

http://64.211.220.122/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centr&wpscode=TheProblemOfHCFraud

Noonan, W. T. (2010). Congress' failure to define proceeds and the fallout after United States v. Santos. *Journal on Criminal & Civil Confinement, 36*(1), 133-152.

O'Malley, T. (2000). *Sentencing law and practice* (1st ed.). Dublin, Ireland: Round Hall.

O'Reilly, M., & Parker, N. (2013). 'Unsatisfactory saturation': A critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research, 13,* 190-197. doi:10.1177/1468794112446106

Outterson, K. (2012). Punishing health care fraud – Is the GSK settlement sufficient? *New England Journal of Medicine, 367*(12), 1082-1085.

Patton, M. Q. (2002). *Qualitative research and evaluation methods.* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Paternoster, R. (2010). How much do we really know about criminal deterrence? *Journal of Criminal Law & Criminology, 100*(3), 765-823.

Payne, B. K., Dabney, D. A., & Ekhomu, J. L. (2013). Sentencing disparity among upper and lower class health care professionals convicted of misconduct. *Criminal Justice Policy Review, 24*, 353-369. doi:10.1177/0887403411424080

Phillipsen, N. C., Setlow, P. D., & Jacob, I. S. (2008). The most costly billing practices ever. *Journal for Nurse Practitioners, 4*, 761-765. doi:10.1016/j.nurpra.2008.09.006

Policastro, C., & Payne, B. K. (2013). An examination of deviance and deviants in the Durable Medical Equipment (DME) field: Characteristics, consequences, and

responses to fraud. *Deviant Behavior, 34*, 191-207. doi:10.1080/01639625.2012.726168

Public Access to Court Electronic Records. (2016). Retrieved from www.pacer.gov.

Quackenbush, S. L. (2010). General deterrence and international conflict: Testing perfect deterrence theory. *International Interactions, 36 i*60-85.

Rashidian, A., Joudaki, H., & Vian, T. (2012). No evidence of the effect of the interventions to combat health care fraud and abuse: A systematic review of literature. *Plos One, 7*(8), 1-8. doi:10.1371/journal.pone.0041988

Ritchie, A. C. (1936). The Constitution and the States. *The ANNALS of the American Academy of Political and Social Science,* 186, 16-21. doi:10.1177/000271623618500104

Ruth, H., & Reitz, K. (2003). *The challenge of crime: Rethinking our response*. Cambridge, MA: Harvard University Press.

Saldaña, J. (2013). *The coding manual for qualitative researcher* (2nd ed.). Thousand Oaks, CA: Sage Publications, Ltd.

Schindler, D. S. (2009). Pay for performance, quality of care and the revitalization of the False Claims Act. *Health Matrix, 19*(387), 387-422.

Shah, U. K., Johnston, D. R., Smith, G. M., Ziv, B. E., & Reilly, J. S. (2009). Penalties for health care fraud and abuse: January 2007-March 2008. *Otolaryngology - Head and Neck Surgery, 140*, 625-628. doi:10:1016/j.otohns.2008.12.032

Sitren, A. H., & Applegate, B. K. (2012). Testing deterrence theory with offenders: The empirical validity of Stafford and Warr's model. *Deviant Behavior, 33*, 492-506.

doi:10.1080/01639625.2011.636685

Sparrow, M. K. (2008). *The character of harms: Operational challenges in control* (1st ed.). Cambridge, NY: Cambridge University Press.

Sparrow, M. K. (2008). Fraud in the U.S. health-care system: Exposing the vulnerabilities of automated payment systems. *Social Research, 75*(4), 1151-1180.

Stafford, M. C. & Warr, M. (1993). A reconceptualization of general and specific deterrence. *Journal of Research in Crime and Delinquency, 30*, 123-135.

U.S. Census Bureau. (2015). State & county quick facts. Retrieved from http://quickfacts.census.gov/qfd/index.html

U.S. Code 2248, Title 18 crimes and criminal procedure, part I – Crimes, chapter 109A sexual abuse, 2248 mandatory restitution. January 4, 2012.

U.S. Department of Health & Human Services and Department of Justice. (2015). HEAT task force: Health Care Fraud Prevention and Enforcement Action Team (HEAT). Retrieved from http://www.stopmedicarefraud.gov/aboutfraud/heattaskforce/index.html

U.S. Department of Justice. (2010). Seventy-three members and associates of organized crime enterprise, others indicted for health crimes involving more than $163 million: Indictments in five states: California, Georgia, New Mexico, New York, and Ohio. *National Press Releases.* Retrieved May 16, 2013 from http://www.fbi.gov/news/pressrel/press-releases/organizedcrime_101310

U.S. Department of Justice. (2011). The False Claims Act: A primer. Retrieved from http://www.justice.gov/civil/docs_forms/C-FRAUDS_FCA_Primer.pdf

U.S. Department of Justice. (2011). Fraud detection systems: Centers for Medicare and Medicaid Services needs to ensure more widespread use (GAO Publication No. GAO-11-475). Retrieved from http://www.gao.gov/assets/330/320854.pdf

U.S. District Court Northern District of Georgia – Atlanta Division. (2007). *Guilty plea and plea agreement.* Case 1:05-cr-00612-RWS-LTW. Document 122-2.

U.S. District Court Southern District of Georgia – Savannah Division. (2009). *United States of America v. Alfredo Felipe Rasco, Niurka Rasco, Riccy Mederos and Iris Oswald.* Case 4:08-cr-00100-WTM-GRS. Document 155.

U.S. District Court Southern District of Florida – Miami Division. (2011). *United States of America v. Armando Santos.* Case 1:11-20101-CR-MORENO-1. Document 71.

U.S. District Court Southern District of Florida – Miami Division. (2011). *United States of America v. Fred Dweck, MD.* Case 1:09-21018-CR-JORDAN-1. Document 516.

U.S. District Court Southern District of Florida – Miami Division. (2011). *United States of America v. Sarody Milian.*. Case 1:10-CR-20291-PCH. Document 60.

U.S. District Court Southern District of Georgia – Savannah Division. (2011). *United States of America v. Niurka Rasco.* Case CR410-00218-001. Document 323.

U.S. District Court Southern District of Florida – Miami Division. (2012). *United States of America v. Alfredo Ayala, MD.*. Case 1:11-cr-20100-CR-SEITZ-3. Document 1226.

Will Maas, V. P. (2013). Physician Medicare fraud: Characteristics and consequences. *Internal Journal of Pharmaceutical and Healthcare Marketing, 7*(1), 8-33.

Wilhelm, W. K. (2004). The fraud management lifecycle theory: A holistic approach to fraud management. *Journal of Economic Crime Management, 2*(2), 1-38.

Wilkinson, D., & Birmingham, P. (2003). *Using research instruments: A guide for researchers* [E-book]. Ipswich, MA: RoutledgeFalmer.

Appendix A: Spreadsheet Sample

For consistent data collection, a Microsoft Excel spreadsheet was created. The columns identified in brown and with a column name starting with PACER came from a PACER query. The eight data elements provided by PACER gave a foundation of data for the analysis but did not supply all discrete data needed to answer the research question. All other data elements highlighted in green were needed to finish the analysis and were collected from the terminated case documentation narrative.

Charge	Count number	Jurisdiction	State	Health Care Related (Y/N)	PACER cs_caseid	PACER cs_case_number	PACER Case Count	PACER cs_short_title	PACER cs_date_term	PACER_pre_judge_name	PACER ref_judge_name	PACER_party	Year of Birth (UNK for unknown)	Medicare (Y/N)	Medicaid (Y/N)	Other (Y/N)	Other Charges (TEXT)	Qui Tam (Y/N)	Months Imprisonment (#)	Months Probation (#)	Months Supervised Release (#)	Assessment ($)	Fine ($)	Restitution ($)