That said, new resources alone will not be enough; Congress will need assurance that if funds are forthcoming, modernization can succeed. HCFA will need to prepare a systems modernization plan that can be implemented effectively. HCFA will not be able to reform its systems without major outside support. HCFA also will need to build substantial in-house capacity to oversee outside contractors and implement systems modernization.

**Building a stronger constituency for law enforcement.**
Medicare is one of the largest federal programs. As such, it enjoys a strong constituency among beneficiaries. Beneficiaries also are interested in fraud-and-abuse enforcement, although their benefits are designed to flow regardless of the extent to which the government deals with providers' false claims.

That many members of Congress backed the 1998 legislation to vitiate the False Claims Act stands as a warning that the officials concerned with Medicare fraud and abuse cannot assume that there will always be support for a strong law enforcement program. Many different enforcement agencies, notably the Internal Revenue Service (IRS), have learned this painful lesson.

Providers are the critical constituency that the law enforcement community must address. While providers are not likely to welcome government review of their billing, it is possible to reduce areas of unnecessary friction. This point has not been lost on HCFA, the OIG, or the DOJ. The leadership of all of these agencies has taken great pains to reassure responsible providers that they have little to fear from law enforcement.

Despite this reassurance, too many providers remain unconvinced. There are at least five reasons for this. First, any change in normative values takes time. To move, as then HCFA administrator Nancy-Ann Min DeParle said, “in just a few short years from relatively lax efforts to a zero tolerance policy on fraud, waste and abuse” requires providers to pay attention to their billing practices as they never have before.a

Second, Medicare fraud-and-abuse enforcement comes at a difficult time for many providers. Many types of providers are under financial stress and find themselves squeezed by cost cutting in Medicare reimbursement rates. Providers care about helping patients, and some may justify upcoding and other padding as an effort to maintain quality of care by protecting the funding for that care. Whatever the cause, as Sparrow amply documents, some providers appear to prefer fighting to accommodating.

Third, some early government enforcement actions in the 1990s did in fact involve “heavy-handed” approaches, as the then deputy attorney general later acknowledged. Among the most unfortunate
was the practice of some U.S. Attorneys' offices of sending out demand letters to providers before the government had investigated the case. The problem was compounded by high potential penalties of the False Claims Act that gave providers an urgent incentive to negotiate with the government, for example, in the so-called laboratory unbundling cases.

Fourth, many billing disputes involve complex and ambiguous issues. Government suffers from what economists call "information asymmetries." In other words, in many cases, and especially those involving coding, the government can find it hard to distinguish among proper billing, minor mistakes, and a deliberate effort to skim off small extra payments from a large number of claims.

Fifth, as discussed above, the False Claims Act encourages providers to settle billing disputes rather than to adjudicate them. Without adjudication by an impartial body, providers may pay to settle claims when they believe that the settlement is unfair. The issue is not whether the particular provider is right or wrong in these perceptions; the point is that the False Claims Act by its very nature builds resentment except in very clear cases of wrongdoing.

**Defining prosecutorial discretion.** Given that the False Claims Act is probably the most important legal tool available to deal with Medicare fraud and abuse, the government needs to be sure that its application is widely regarded as legitimate. It is useful here to consider applying the analytic framework proposed by Kenneth Culp Davis in his seminal work, *Discretionary Justice*.

In its reliance on settlement rather than adjudication, the False Claims Act resembles many other areas where prosecutorial discretion is perhaps more important than the letter of the law. To deal with prosecutorial discretion, Davis proposes a several-part approach. He recommends that enforcement agencies first confine their discretion—that is, articulate the types of cases that the government will enforce and, either explicitly or by implication, those cases that will not be the subject of enforcement. Second, Davis wants agencies to structure their discretion. In other words, government should articulate the ways in which different levels of violation will be addressed. Third, Davis believes that agencies should check their discretion by creating a process for review of prosecutorial judgments before actions are brought.

Consider these approaches in the context of the government's discretion to enforce the False Claims Act to deal with Medicare fraud and abuse. Given the limited resources available for law enforcement, even since HIPAA, the net result of the effort to confine, structure, and check discretion is intended to lead to more effective fraud-and-abuse enforcement directed toward cases that are more
widely perceived to be important, rather than a diminution. Again, the government in many cases already has begun to adopt some form of each of these approaches.

Confining discretion. Officials at all three organizations concerned with fraud and abuse enforcement—HCFA, the OIG, and the DOJ—have sought to articulate limits upon the application of law to deal with improper billing practices. For example, the OIG chief counsel has stated:

We are very mindful of the difference between negligent errors and mistakes on one hand and reckless or intentional conduct on the other. Even ethical physicians (and their staffs) make billing mistakes and errors through inadvertence or negligence. In part this is due to the complexity of Medicare rules. When billing errors, honest mistakes, or negligence result in improper claims, the physician may be asked to return the funds improperly claimed, but without penalties.

Another government attorney urges that providers take a close look at the cases that the government brings. In the area of alleged upcoding, for example, the government will focus on two kinds of cases: (1) where a provider consistently bills so many services in a day that it is physically impossible or at least highly improbable, and (2) where a provider, perhaps with the benefit of coding consultants, systematically engages in a high degree of upcoding. The government also will try to check with providers in the locality to obtain a reasonable baseline of practices in the area.

In interviews, advocates for hospitals and laboratories expressed two concerns in this regard: First, they contend that rules of conduct may be expressed in OIG and DOJ enforcement activity rather than beforehand in rules. Second, they say that some OIG investigators and some Assistant U.S. Attorneys may not adhere to policies that are articulated in Washington at the higher levels of the OIG and the DOJ and that a provider will settle rather than fight over a particular set of facts and allegations.

It appears that much of the first issue relates to the jolt that the provider community felt regarding the behavioral change that is taking place with respect to Medicare claims and payments. Traditionally, as noted earlier, virtually all of the players understood relevant rules of proper billing. In the contentious teaching hospital cases, for example, the rules required that there be evidence that the teaching physician was physically present while the resident provided the service.⁵ While many violations of the billing rules once had been acceptable to the government, the focus on Medicare fraud and abuse in the mid-1990s meant that some of these suddenly provided grounds for litigation under the False Claims Act.

This context of changing public values makes it difficult to address the first complaint of hospital and laboratory advocates, that
rules of conduct should be articulated in informal guidance or rule making before they become the subject of enforcement actions. The problem appears to be more subtle than that. Even if the rules of conduct are widely known, the problem seems to be that traditionally they were not enforced, even in cases that could support charges under the False Claims Act. The OIG now has taken some steps to deal with this issue by publishing “Special Fraud Alerts” and “Special Advisory Bulletins.” Also, note that some physicians object vigorously to documentation guidelines, where there has been little enforcement action.16

HCFA itself spends more than $50 million annually on provider education. One reviewer, who comes from a provider perspective, suggested that HCFA greatly increase that effort. By contrast, to warn providers expressly before bringing enforcement actions in particular areas does not seem wise. This could be resource-intensive and time-consuming. Express warnings also would favor the deliberate perpetrators of fraud, who could use the warning process to give themselves a free bite at the apple.

It may be easier for the enforcement agencies and HCFA to address the second complaint of provider advocates, that some officials may not adhere to established enforcement policies. HCFA, the OIG, and the DOJ might consider enacting rules to confine the discretion of government investigators and attorneys to help assure that they implement the major articulated policies. Including hypothetical examples can help to distinguish negligence or error from actionable conduct under the False Claims Act in ways that do not unreasonably tie prosecutors’ hands. Indeed, Davis argues that a regulation that sets forth hypotheticals may be preferable to hard-and-fast regulatory limits in areas such as Medicare fraud and abuse, where players have the potential to game any rigid set of rules. Such rule making might help to respond to the plea of some provider advocates that the top levels of the OIG and DOJ should assert more leadership over activists in their middle levels. The rule-making process itself might assist in bringing provider advocates to the table so that reasonable conversations can take place about devising hypothetical examples to deal with areas in which providers and their attorneys feel unjustly abused by the investigative process.

Structuring discretion. For Davis, the question in structuring discretion is, “How can administrators...regularize [the exercise of their discretionary power], organize it, produce order in it, so that their decisions affecting individual parties will achieve a higher quality of justice?” Davis lists seven tools for structuring discretion: open plans, open policy statements, open rules, open findings, open reasons, open precedents, and fair informal proceedings. He stresses
"Publication of settlement agreements could persuade policymakers of the legitimacy of the government's enforcement actions."

openness as an important way to prevent arbitrary action.

In structuring discretion, too, the enforcement agencies have come far since the mid-1990s. Perhaps the most impressive documents to structure discretion are the two memoranda from the deputy attorney general to provide guidance on the use of the False Claims Act in civil health matters. The DOJ memorandum of 3 June 1998, "Guidance on the Use of the False Claims Act in Civil Health Care Matters," sets forth detailed requirements that the department is supposed to follow in determining whether facts exist that would reasonably support an allegation that the act was violated.

The HHS inspector general has suggested, as a further step toward openness, that the settlement agreements that the DOJ and the OIG sign with alleged violators of the False Claims Act also should be published. When final, these settlement agreements are available under the Freedom of Information Act. Many private law firms maintain complete sets of these agreements. However, if the settlement agreements were to be published for a wider audience, it would be valuable to expand the statement of facts that is recited at the beginning of each agreement. This could help to create a growing body of information about how the government applies its discretion. Given that the respondents in these settlement agreements generally deny the allegations of wrongdoing, it seems unlikely that the government would lose much negotiating power as to remedies if it insisted on a full statement of allegations.

In structuring discretion, government attorneys have the understandable fear that new forms of fraud may emerge that provider advocates could try to shield by reference to some existing precedent that emerged from a settlement in a different context. This issue should not be minimized. Yet the government might enhance the perceived legitimacy of its enforcement actions by pointing to well-founded allegations of wrongdoing that rise to the level of a violation of the False Claims Act. The publication of settlement agreements with detailed factual allegations could help to persuade policymakers who will be deliberating the reauthorization of HIPAA's funding provisions, for example, of the legitimacy and importance of the government's enforcement actions. It also should help to discourage some of the more marginal enforcement actions that provider advocates complain about.

Checking discretion. The process of checking discretion involves a
system of institutional checks and balances. The first place to check discretion is in the supervisor's review of the case that an investigator or attorney is developing. As a practical matter, some supervisors may lack the incentive or perhaps even the confidence to advise a subordinate that a case requires more substantiation or that it should not be brought. This is especially true in False Claims Act cases, where a settlement and monetary payment are possible even for less substantiated cases.

As one provider attorney puts it, the government needs to build "some countervailing view" into its process of case development. Otherwise, the incentives to go forward even with marginal cases almost always will prevail. Again, the 3 June 1998 memorandum of the deputy attorney general and subsequent amplification stand as an excellent model of the way that a government agency can structure discretion. The DOJ has established working groups that are responsible for assuring that each part of the department complies with the guidance set forth by the deputy attorney general. In an unusual step, Congress enforced this process by requiring the U.S. General Accounting Office (GAO) to provide reports on the progress of the DOJ in complying with the guidance.

Set against this progress is the continuing complaint of provider advocates that some parts of the DOJ may not be adhering to the guidance that the former deputy attorney general issued. The DOJ's 3 February 1999 follow-up memorandum calls upon providers or their counsel to bring concerns about DOJ compliance with the guidance to higher levels at the department. However, conversations with provider advocates indicate that a fear of retaliation against their clients, whether well-founded or not, may inhibit some from doing this. Despite the impressive efforts of the then deputy attorney general, Medicare fraud and abuse remains an area in which distrust seems to come from many different sides.

Other models. Future research might look at examples of checked discretion in other fields of law to see if promising models might be adapted to the context of Medicare fraud-and-abuse enforcement. One model comes from the Federal Trade Commission (FTC). At the FTC, a Bureau of Economics that is independent from the FTC enforcement bureaus must review any case being developed. An analogous requirement in Medicare fraud-and-abuse enforcement might be to mandate active concurrence by a knowledgeable body within HCFA before a case is brought to a supervisor at the OIG or the DOJ for approval of preliminary action. (Of course, once again, this assumes that HCFA receives the necessary resources to carry out this function.) Such concurrence can help to deal with the perception of some outsiders that prosecutors lack adequate access to
sophisticated medical judgments that can provide a context for understanding a particular provider claim or activity. While the OIG does communicate informally with HCFA to determine the basis for possible new enforcement actions, the recommendation here is to make that process more formal so that HCFA plays a role in coordinating with major enforcement actions as they go forward. The 3 February 1999 deputy attorney general memorandum requires coordination between HCFA and the DOJ working groups, and this idea would bring that coordination with HCFA to bear on individual matters at an early stage of the process.

Any model that is developed needs to avoid committing the opposite mistake from the one being addressed. In other words, if the problem today is that activist investigators and attorneys may bring some marginal cases to settlement that never should have been brought at all, the opposite problem would be to create so many administrative and procedural hurdles that the perpetrators of fraud and abuse would have a field day. Achieving an appropriate balance may be difficult, but the continuing search for such a balance is essential as a way of protecting the prosecution and enforcement of Medicare fraud and abuse from any stigma of illegitimacy.

The responsible parties in government and the private sector have a stake in finding reasonable common ground so that trust is maintained in the Medicare program, among beneficiaries, providers, and the government. That common ground is likely to be found in three main areas. One is improved HCFA administration of the claims-paying process, including new funding for modernized systems and new authority to select and replace carriers and fiscal intermediaries based on merit. The government cannot afford to skimp on resources for such a major and growing program as Medicare. A second area is in efforts to redesign the Medicare program to reduce program vulnerabilities as well as points of friction. It is time to look at HCFA as an organization and to consider means of enhancing the government's institutional capacity to administer the Medicare program. Third, but not least, is through continuing progress by the OIG and the DOJ to confine, structure, and check discretion so that False Claims Act cases are accepted broadly as legitimate and worthy of increased funding when the HIPAA funding provisions come up for reauthorization in 2003.

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NOTES


4. A qui tam action is a civil, statutory proceeding brought by a third party to redress a wrong against an institution. The plaintiff sues “as well” for the institution as for him/herself.


17. Davis, Discretionary Justice, 97.