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United States v. Greber and its Effect on the Medicare and Medicaid Programs

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**United States v. Greber** and its Effect on the Medicare and Medicaid Programs*

**INTRODUCTION**

The Medicare and Medicaid health care programs were created in the mid-1960s in an attempt to ensure that all Americans would receive high quality health care despite their inability to pay.\(^1\) In 1965, Medicare and Medicaid services cost $5 billion. By 1983, spending for these programs grew to $72 billion\(^3\) and is projected to have exceeded $94.3 billion in fiscal year 1986.\(^4\) The sheer magnitude of these programs has caused them to become the objects of widespread fraud and abuse. Congress has responded by enacting and revising anti-fraud and abuse statutes in an effort to curb this waste of the tax-payers’ dollars.

Initially, this Comment traces the legislative development of the current sections of the Medicare\(^5\)-Medicaid\(^6\) fraud\(^7\) and abuse\(^8\)

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* The author wishes to express his appreciation to Richard Plymale, Esquire of Brown, Todd & Heyburn for his guidance in the preparation of this Comment.

1 See infra note 10.


Medicare provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care for:

1. individuals who are age 65 or over and are eligible for retirement benefits under subchapter II of this chapter (or would be eligible for such benefits if certain Federal employment were covered employment under such subchapter) or under the railroad retirement system,
2. individuals under age 65 who have been entitled for not less than 24 months to benefits under subchapter II of this chapter (or would have been so entitled to such benefits if certain Federal employment were covered employment under such subchapter) or under the railroad retirement system on the basis of a disability, and
3. certain individuals who did not meet the conditions specified in either clause (1) or (2) but who are medically determined to

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that prohibit the solicitation or

have end stage renal disease.

Id.


The Medicaid program was adopted:

for the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.

Id.


Fraud involves an intentional deception or misrepresentation with the intent of receiving some unauthorized benefit for the individual engaged in fraud. In the health care area, examples of fraud may include: billing for services not rendered, misrepresentation of services rendered, kickbacks, deliberate duplicate billing, false or misleading entries on cost reports, and so forth.

Id.

8 Id.

[A]buse. . . includes activity wherein providers, practitioners, and suppliers of services operate in a manner inconsistent with accepted, sound medical or business practices resulting in excessive and unreasonable financial cost to either medicare or medicaid. Also included are the provisions of unnecessary health services and necessary health services in unnecessarily costly settings.

Id.

9 42 U.S.C. § 1395nn(b) provides:

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this subchapter, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this subchapter, or
receipt of kickbacks, bribes, or rebates. Second, this Comment

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to—

(A) a discount or other reduction in price obtained by a provider of services or other entity under this subchapter if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title, and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

42 U.S.C. § 1396h(b) provides:

(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this subchapter, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

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(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.
examines two periods when the courts expanded the scope of the Kickback Statutes and analyzes the effect of this expansion on the present Medicare-Medicaid programs following the introduction of a new reimbursement plan. Finally, this Comment concludes that, until the Judicial branch renders decisions consistent with the Medicare-Medicaid sections governing the methods and means of health care delivery, the Medicare-Medicaid programs will be unable to provide assistance to those persons whom the programs were designed to help.

I. LEGISLATIVE HISTORY

From their creation in 1965 under the Social Security Act, the Medicare-Medicaid programs have been the targets of many fraud and abuse schemes. Unfortunately, the Social Security Act originally contained only one penalty provision, 42 U.S.C. section 1307(a), which related solely to the making of false statements or misrepresentations of material fact. A conviction under 42 U.S.C. section 1307(a) was a misdemeanor carrying a penalty of a maximum fine of $1,000, a term of imprisonment of not more than one year, or both. Prosecutors often were unsuccessful in obtaining convictions of abuses of the Social Security Act because of the limited nature of prohibited conduct

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10 42 U.S.C. ch. 7 (1982).
12 42 U.S.C. § 1307(a) (1982) provides:
   Whoever, with the intent to defraud any person, shall make or cause to be made any false representation concerning the requirements of this chapter, subchapter E of chapter 1 or subchapter A, C, or E of chapter 9 of the Internal Revenue Code of 1939, or of any rules or regulations issued thereunder, knowing such representations to be false, shall be deemed guilty of a misdemeanor, and, upon conviction thereof, shall be punished by a fine not exceeding $1,000, or by imprisonment not exceeding one year, or both.
13 Id.
under 42 U.S.C. section 1307(a). Therefore, prosecutors began prosecuting under general federal criminal statutes. The prosecutor's task was difficult, however, because the more useful criminal statutes required not only that the prohibited conduct

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14 Yoakum, Physicians Fraud in the Medicare-Medicaid Programs: Kickbacks, Bribes, and Remunerations, 10 Mem. St. U.L. Rev. 684, 685 n.6 (1980) (citing State v. Fellman, 193 N.W.2d 775 (Neb. 1972), illustrating the difficulties of prosecution based on false pretenses due to the requirement that the state prove a specific intent to cheat or defraud).


If two or more persons conspire either to commit any offense against the United States, or to defraud the United States, or any agency thereof in any manner or for any purpose, and one or more of such persons do any act to effect the object of the conspiracy, each shall be fined not more than $10,000 or imprisoned not more than five years, or both.

If, however, the offense, the commission of which is the object of the conspiracy, is a misdemeanor only, the punishment for such conspiracy shall not exceed the maximum punishment provided for such misdemeanor.


Whoever enters into any agreement, combination, or conspiracy to defraud the United States or any department or agency thereof, by obtaining or attempting to obtain the payment or allowance of any false, fictitious claim, shall be fined not more than $10,000 or imprisoned not more than 10 years, or both.


Whoever makes or presents [claims] to any person or officer . . . of the United States, or any department or agency thereof, knowing such claims to be false, fictitious, or fraudulent, shall be fined not more than $10,000 or imprisoned not more than five years or both.


Whoever, in any manner within the jurisdiction of any department or agency of the United States knowingly and willingly falsifies, conceals or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than five years, or both.


Whoever, having devised or intended to devise any scheme or artifice to defraud or for obtaining money or property by means of false or fraudulent pretenses, representations or promises . . . for purposes of executing such scheme or artifice or attempting to do so, places in any post office or authorized depository for such matter . . . or takes or receives therefrom, any such matter or thing, or knowingly causes to be delivered by mail . . . shall be fined not more than $1,000 or imprisoned not more than 5 years, or both.
be performed "knowingly" and/or "willingly," but also that this "mens rea" be proved beyond a reasonable doubt.

When it became apparent that prosecutors were having difficulty utilizing statutes not specifically designed to prevent fraud within the Medicare-Medicaid programs, Congress added sections 1877(b) and 1909(b) (hereinafter the "original Kickback Statutes") in the Social Security Act Amendments of 1972. The

17 Mens rea is "A guilty mind; a guilty or wrongful purpose; a criminal intent." Black's Law Dictionary 889 (5th ed. 1979).
18 See, e.g., United States v. Mekjian, 505 F.2d 1320, 1324 (5th Cir. 1975). The court held that the indictment, under which the defendant was convicted of 60 counts of filing fraudulent Medicare claims, was invalid because it failed to allege that the conduct was performed "willfully." Id.
The statute uses both "willingly" and "knowingly" in defining the offense. Each encompasses a different element of the requisite mens rea, requiring different proof. "Knowingly" under sec. 1001 requires that a defendant acted "with knowledge." [citation omitted] "Willfully" under sec. 1001 requires proof that a defendant acted "deliberately," or "deliberately and with knowledge." [citation omitted] Each must be proved beyond a reasonable doubt, as the district court recognized by so instructing the jury. Id. (emphasis in original).
19 Yoakum, supra note 14, at 686. "Congress responded to the need for specific legislation to combat Medicare and Medicaid fraud in 1972 by passing penalty statutes which directly prohibited these corrupt activities." Id.

Whoever furnishes items or services to an individual for which payment is or may be made under this title and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or
(2) rebate of any fee or charge for referring any such individual to another person for the furnishing of such items or services, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than $10,000 or imprisoned for not more than one year, or both.

Id. at 1660 provides:

Whoever furnishes items or services to an individual for which payment is or may be made in whole or in part out of Federal funds under a State plan approved under this title and who solicits, offers, or receives any—

(1) kickback or bribe in connection with the furnishing of such items or services or the making or receipt of such payment, or
(2) rebate of any fee or charge for referring any such individual
original Kickback Statutes solved two problems for prosecutors by: (1) eliminating the requirement that prosecutors prove that the prohibited conduct was performed "knowingly" and/or "willingly";\(^{21}\) and (2) expanding the conduct prohibited under the Social Security Act to include the solicitation, offer, or acceptance of any kickback\(^{22}\) or bribe.\(^{23}\) A conviction under either original Kickback Statute could result in a fine of up to $10,000, a term of imprisonment of not more than one year, or both.\(^{24}\)

When the original Kickback Statutes were presented to Congress as a legislative solution to the prosecutors’ dilemma, the House Ways and Means Reporting Committee stressed that public confidence in the integrity of the Medicare-Medicaid programs had to be maintained.\(^{25}\) The adoption of the original Kickback Statutes facilitated this by providing "penalties for certain practices which have long been regarded by professional organizations as unethical, as well as unlawful in some jurisdictions, and which contribute appreciably to the cost of the Medicare-Medicaid programs."\(^{26}\) The original Kickback Statutes also were intended to facilitate the vigorous prosecution of "every person attempting by unlawful means to obtain payments not due him under the plan. . . ."\(^{27}\) Thus, cases were not to be dropped because of high prosecution costs, even if the amount of money to be recovered was small.\(^{28}\)

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\(^{21}\) Id. Note the absence of the words "knowingly" and "willingly."

\(^{22}\) A kickback is defined in Webster's Third New International Dictionary (1966) as "a percentage payment . . . for granting assistance by one in a position to open up or control a source of income" (cited in United States v. Perlstein, 632 F.2d 661, 663 (6th Cir. 1980)). See infra note 59.

\(^{23}\) A bribe has been defined as "an attempt to influence another to disregard his duty while continuing to appear devoted to it or to repay trust with disloyalty." United States v. Zacher, 586 F.2d 912, 915 (6th Cir. 1980) (citing United States v. Esperdy, 285 F.2d 341, 342 (2d Cir.), cert. denied, 366 U.S. 905 (1961)). See infra note 45.

\(^{24}\) See supra note 20.


\(^{26}\) Id.

\(^{27}\) Id.

\(^{28}\) See id.
Nevertheless, the original Kickback Statutes failed to significantly deter the illegal practices in Medicare-Medicaid programs. Prosecutors initially were reluctant to use the original Kickback Statutes because they were unfamiliar with the Medicare-Medicaid programs and because they preferred not to prosecute well-known local doctors, hospitals, and nursing homes.

Additionally, the original Kickback Statutes contained only misdemeanor penalties which were inconsistent with other federal criminal code provisions which also punished the submission of false claims or the solicitation, offer, or acceptance of a bribe or kickback as felonies. The original Kickback Statutes' failure to deter illegal practices was evident when in 1978, the Comptroller General of the United States estimated that one to ten percent (1%-10%) of federal funds spent on Medicaid were lost through fraud. The discovery of multi-million dollar fraud schemes in California, Illinois and New York in the mid-1970s is illustrative of the graft which resulted in the Comptroller's figures.


Existing law provides specific penalties under the medicare and medicaid programs for certain practices that have long been regarded by professional organizations as unethical, which are unlawful in some jurisdictions, and which contribute significantly to the cost of the programs.

Recent hearings and reports, however, indicate that such penalties have not proved adequate deterrents against illegal practices by some individuals who provide services under medicare and medicaid.

Id.

30 Plymale, Medicare and Medicaid Fraud and Abuse, HEALTH CARE SYMPOSIUM N-5 (1986).


34 See Plymale, supra note 30, at N-5. The New York Attorney General's investigation into Medicaid fraud led him to estimate that nursing homes in New York had overcharged the Medicaid system up to $70 million since 1965.
In response to this widespread fraud and abuse, Congress passed the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (hereinafter the “amended Kickback Statutes”).

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(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

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(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this subchapter, or

(B) in return for purchasing, leasing, ordering, or arranging for
These amendments further expanded the breadth of the Social Security Act by prohibiting the solicitation or receipt of remuneration, in addition to kickbacks, bribes, or rebates.36 "Remuneration," a more comprehensive term, was included to eliminate problems of proving that a kickback, bribe, or rebate took place, thus making all forms of improper payment illegal.37 Additionally, to encourage compliance, a violation of the amended Kickback Statutes was elevated to a felony, resulting

or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

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(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this subchapter, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this subchapter, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

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(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

36 United States v. Greber, 760 F.2d 68, 71 (3d Cir.), cert. denied, 106 S. Ct. 396 (1985). While citing WEBSTER's THIRD NEW INTERNATIONAL DICTIONARY (1966) definition of "remuneration" as an action "to pay an equivalent for service," the Third Circuit stated that because the statute included the terms kickback and bribe, it expanded "remuneration" to cover situations where no service is performed. Id. The court further stated that remuneration "includes not only sums for which no actual service was performed but also those amounts for which some professional time was expended." Id.

37 United States v. Stewart Clinical Laboratory, Inc., 652 F.2d 804, 806 (9th Cir. 1981). "The amendments, therefore, shift the focus of the operative distinction between the subsections from the type of payoff involved to the nature of the referred Medicare or Medicaid business—individuals or services." Id. See infra notes 45-53 and accompanying text for a discussion of the problems of proof in the original Kickback Statutes.
in a fine of up to $25,000, a term of imprisonment of not more than five years, or both.\textsuperscript{38}

The amended Kickback Statutes were intended to clarify the illegal types of financial arrangements and conduct prohibited under Medicare and Medicaid, thus facilitating their enforcement.\textsuperscript{39} Urging the passage of the 1977 amendments, Senator Robert Dole stated: "The extent of fraud and abuse in these programs is widespread. In the past, our attempts to control these problems have met with limited success. This bill provides us with an opportunity to wage a stronger battle, with stronger weapons at our disposal."\textsuperscript{40} Senator Herman Talmadge stated that these amendments were "an opportunity for the Congress to give a clear, loud signal to the thieves and the crooks and

\begin{quote}
\textsuperscript{3} See supra note 35 at 1180.

\textsuperscript{7} See supra note 7 at 3041.

The most common violations . . . include:

- (1) "ping-ponging"—referring of patients from one practitioner to another within the facility even though there is no medical reason for doing so;
- (2) "ganging"—billing for multiple services to relatives who accompany a family member who alone had sought treatment at the [facility].
- (3) "upgrading"—billing for a service more extensive than that actually provided;
- (4) "steering"—directing a patient to a particular pharmacy, a violation of the medicaid program's policy of freedom of choice; and
- (5) billing for services not rendered—either added services not performed onto an invoice carrying legitimate billings or submitting a totally fraudulent claim.

Other violations include soliciting, offering, or receiving kickbacks; billing twice or more for the same service; and billing both medicare and medicaid for the same service.

Fee splitting and percentage lease arrangements are common practices and often go hand-in-hand with medicaid mills. Percentage lease arrangements are a basic economic incentive to form these facilities. Percentage lease arrangements give the landlord a percentage of the provider's gross income in return for office, space, equipment, shared waiting rooms, laboratory services, custodial and office help, and often administrative services.

Factoring is also a very common practice associated with medicaid mills. Although factoring was outlawed under the Social Security Amendments of 1972, factoring firms have evaded statutory intent by working under a power of attorney arrangement.

the abusers that we mean to call a halt to their exploitation of the public and the public purse."

II. JUDICIAL INTERPRETATION OF THE AMENDED KICKBACK STATUTES

Although prosecutors were reluctant to vigorously pursue convictions under the original Kickback Statutes, Congress' 1977 call for a halt to the exploitation of the public purse, coupled with the recent revelations of widespread exploitation, prompted prosecutors to increase the number of investigations of fraudulent medical practices and to obtain more convictions under the amended Kickback Statutes.

The problems faced by prosecutors under the original Kickback Statutes are illustrated by United States v. Zacher, in which the Second Circuit reversed the defendant's conviction by narrowly interpreting the language of the statute. The court held that there was "no showing that 'bribe' in section 1396h(b) (1972) was intended to encompass more than at common law or in common usage. . . ." In United States v. Porter, the Fifth

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42 Plymale, supra note 30, at N-5.
43 See supra note 41 and accompanying text.
44 Fiske, supra note 11, at 288 n.1007 (citing Sept. 12, 1980 interview with Dr. Robert Wilson, Public Affairs Assistant to the Inspector General of the Department of Health and Human Services). In 1979, prosecutors obtained 288 convictions resulting from both state and federal investigations. In 1980, state Medicaid fraud control units in 31 states investigated approximately 2,100 cases of fraud. Id.
45 586 F.2d 912 (2d Cir. 1978). Zacher ran a nursing home and charged his private paying residents $29.00 per day. If a patient's insurance paid only $25.00 per day, Zacher required the patient's family to pay the $4.00 difference. Id. at 913. The Second Circuit found that, without the element of corruption, the supplemental payments did not constitute bribes. Id. at 917. The court noted that the payments to Zacher did not increase the cost to the government, decrease the quality of health care purchased, or involve a misapplication of government funds. Id. at 916. Zacher's activities occurred in 1973 and 1974. He had been convicted of violating 42 U.S.C. § 1396h(b) (1972). Id. at 913.
46 Id. at 917.
47 591 F.2d 1048 (5th Cir. 1979), aff'd, 625 F.2d 111 (6th Cir. 1980). When a doctor chose to send blood samples to certain laboratories, the court upheld the doctor's right to receive "handling fees" from the laboratory and classified the payments as legitimate and not as kickbacks. Id. at 1054. Porter's activities occurred in 1973, 1974 and 1975. He was convicted of violating 42 U.S.C. § 1395nn(b)(1) as amended in 1972. Id. at 1052.
Circuit also reversed a lower court conviction under the original Kickback Statute based on a narrow definition of the term "kickback." The court found that no kickback existed because (1) the defendants were not public officials having their judgment corrupted, (2) the funds received were not funds being returned to an earlier possessor, and (3) the defendants were not persons on whom Congress had imposed a specific duty. The Fifth Circuit reasoned that, if the 1977 amendments were necessary to clarify the language of 42 U.S.C. sections 1395nn and 1396h, "then we are hard put to say, with that degree of confidence required in a criminal conviction, that these defendants were given clear warning by that statute that their conduct was prohibited by it, thus amounting to a criminal act."  

Except for the narrow interpretations of the original Kickback Statutes in the Zacher and Porter decisions, the trend in the judiciary, between 1977 and 1980, was to support the stated intent of Congress by expanding the Kickback Statutes. A series of decisions in the Sixth and Seventh Circuits evidences this trend. The first expansionary step was to establish a broad definition of the term "kickback," thereby prohibiting more
kinds of conduct. Even gratuitous gifts, the funds for which did not originate from federal sources, were included in the definition. Ultimately, kickbacks could be payments given to persons in control of federal funds because of the potential creation of increased costs to the government.

In *United States v. Hancock*, the Seventh Circuit held that "handling fees," received for services rendered, were illegal kickbacks. The defendants in *Hancock* were doctors who prepared samples for shipment to a laboratory and received a percentage of the laboratory's Medicaid receipts for preparing the samples for testing. The laboratory billed Medicaid directly for its own services and included in its bill the cost for the services performed by the defendants. After receiving its reimbursement from Medicaid, the laboratory paid the defendants for their services. This reimbursement from the laboratory to the doctors was deemed a kickback by the court, which stated:

cert. denied, 431 U.S. 905 (1977); United States v. Bush, 503 F.2d 813 (5th Cir. 1974); United States v. Thompson, 366 F.2d 167 (6th Cir. 1966) (defendant city council members soliciting a particular architectural firm for the construction of a hospital were deemed to have requested a 1% "kickback" payment from the firms).

604 F.2d at 1001. The acceptance of "handling fees" by a doctor from a laboratory, for the actual services of obtaining, packaging, and sending specimens, was included as prohibited conduct. The court noted that "the potential for increased costs to the Medicare-Medicaid system and misapplication of federal funds is plain where payments for the exercise of such judgments are added to the legitimate costs of the transaction." *Id.*

625 F.2d at 177. In the case, defendants, nursing home operators, were paid $3.00 each month by a pharmacist, from his own private resources, for the opportunity to provide pharmaceutical services to each public aid patient in the nursing home. *Id.* at 176. Convictions for accepting kickbacks under 42 U.S.C. § 1396h(b)(1) were affirmed because the payments were made to a person in control of federal funds. *Id.* at 177.

632 F.2d 661 (6th Cir. 1980). The defendant, Perlstein, operated a nursing home primarily for Medicaid patients. For the opportunity of servicing the pharmaceutical and physical therapy needs of the residents, Perlstein demanded that the supplier of those services give him $416 worth of alcoholic beverages every month. *Id.* at 662. The defendant's convictions were affirmed because the supplier of services was selected for no other reason than that he made payments to the nursing home administrator. *Id.* at 663.

604 F.2d 999 (7th Cir. 1979).

*Id.* See infra notes 62-66 and accompanying text.
[T]he element of corruption is found in this allegation that the defendants received payments in return for their decision to send specimens to Chem-Tech. The potential for increased costs to the Medicare-Medicaid system and misapplication of federal funds is plain, where payments for the exercise of such judgments are added to the legitimate costs of the transaction.66

The definition of kickback adopted in Hancock,67 and followed in United States v. Perlstein,68 reads: "a percentage payment ... for granting assistance by one in a position to open up or control a source of income."69

The Hancock decision is an example of the unjust results which prompted Congress to acknowledge the potential for criminal prosecution of individuals whose conduct, while "improper," was inadvertent.70 Thus, in 1980, Congress amended the Social Security Act,71 again requiring that conduct be performed "knowingly" and "willfully"72 before it is deemed illegal. Ironically, one of the purposes for adopting the original Kickback Statutes was to assist prosecutors by eliminating just such a requirement.73 Therefore, although the 1980 amendment, through its silence, endorses the 1977-1980 period of judicial expansion of the amended Kickback Statutes to cover all types of economic inducement for referrals, it must also be seen as an attempt by Congress to restrict that expansion by adding the requirement that specific intent be proven in each instance.

Even though Congress obviously was attempting to rein in the application of the amended Kickback Statutes, the judiciary

66 Id. at 1001.
67 Id. at 1002.
68 632 F.2d 661, 663 (6th Cir. 1980).
69 WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY (1966) (cited in 632 F.2d at 663; 604 F.2d 1002).
70 Act of Dec. 5, 1980, Pub. L. No. 96-499, 1980 U.S. CODE CONG. & ADMIN. NEWS 5526, 5572. "This section provides that criminal penalties for solicitation or payment of kickbacks, bribes, rebates, or other remuneration in exchange for Medicare or Medicaid business apply only in cases where such conduct is undertaken knowingly and willfully." Id.
71 Id.
72 "See supra note 9.
73 Yoakum, supra note 14, at 686 n.8. Prosecutors were required to prove beyond a reasonable doubt that violations were knowingly and willingly performed.
responded only temporarily. Following the 1980 amendment, the Ninth Circuit decided the case of *United States v. Stewart Clinical Laboratory, Inc.*, in which the court adhered to Congress’ intent to restrict the application of the amended Kickback Statutes by finding that an indictment under one subsection of the amended Kickback Statutes would not support a conviction based on evidence applicable to a different subsection of the amended Kickback Statutes. After the *Stewart Clinical Laboratory, Inc.* decision, however, the Ninth Circuit issued a series of opinions which began re-expanding the scope of the Kickback Statutes as amended in 1980 (hereinafter the “existing Kickback Statutes”) by upholding convictions that would have been reversed under Congress’ more limited intent analysis, as reflected in *Stewart*.

The Ninth Circuit’s expansion of the amended Kickback Statutes following Congress’ 1980 amendment was accomplished by employing methods similar to those used successfully by the Sixth and Seventh Circuits between 1977 and 1980. The Ninth Circuit broadly defined the terms used in the amended Kickback

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74 See infra notes 75-82 and accompanying text.

75 652 F.2d 804, 806-07 (9th Cir. 1981). The Ninth Circuit read the indictment narrowly and overturned the conviction, deciding that the charge stated in the indictment did not fall within the terms of the statute. The defendants were charged with violating 42 U.S.C. § 1396h(b)(2)(A) (the payment of remuneration for the referral of an individual), but the proof offered at trial sought to establish a violation of 42 U.S.C. § 1396h(b)(2)(B) (the payment of remuneration for the referral of services, including laboratory work). *Id.* at 805.

76 *Id.* at 807.

77 See infra notes 79-83. The Ninth Circuit decided *United States v. Universal Trade and Indus., Inc.*, 695 F.2d 1151 (9th Cir. 1983) (affirmed conviction for offering remuneration in return for the referral of services); *United States v. Feki*, 650 F.2d 1044 (9th Cir. 1981) (conviction for offering 10% rebate on medicare and Medi-Cal collections affirmed due to lack of evidence to establish entrapment and because no objection was raised to the variance between indictment and proof. There was no prejudice and the error was merely in the citation); *United States v. Duz-Mor Diagnostic Laboratory, Inc.*, 650 F.2d 223 (9th Cir. 1981) (proposing a 15% rebate in exchange for the referral of medicare and Medi-Cal business meets the standard of an “offer” of a bribe or kickback as proscribed by federal statutes and the narrower contract definition of “offer” does not control).

78 See infra note 82 and accompanying text.

79 See supra note 55.
Statutes\textsuperscript{80} and broadly construed indictments so that the charged conduct qualified as conduct prohibited under the amended Kickback Statutes.\textsuperscript{81} Although not specifically reversing its holding in \textit{Stewart Clinical Laboratory, Inc.}, the Ninth Circuit later held, in a similar fact situation, that the sections of the Kickback Statutes "are not mutually exclusive and that some conduct might come within either subsection (A) or (B) of 42 U.S.C. section 1396h(b)(2)."\textsuperscript{82}

With the judicial expansion of the existing Kickback Statutes after 1980, the groundwork was laid for the prosecution of conduct deemed illegal because of its potential to create economic inducement for referrals. An example of such a case is the Third Circuit's decision in \textit{United States v. Greber}.\textsuperscript{83} The
defendant in *Greber* was a doctor who had set up a company to install monitors on heart patients. The company also removed the monitors twenty-four hours after their installation and sent reports to the referring doctors. The carrier for Medicare, Pennsylvania Blue Shield, utilized a three-part payment system for this process that consisted of payments for installation, scanning, and interpretation of the test. The referring doctors merely signed the reports and received the portion of the fee that covered the costs of interpretation. Concluding that these interpretation fees were improper, the Third Circuit stated that "the more expansive reading [of remuneration] is consistent with the impetus for the 1977 amendments. . . . If the payments were intended to induce the physician to use Cardio-Med's services, the statute was violated, even if the payments were also intended to compensate for professional services."84

Unfortunately, by focusing on the 1977 amendments, the Third Circuit disregarded not only the restrictive effect of the 1980 amendment, but also ignored changes made in the Medicaid reimbursement system in 1982 at the request of the Executive Branch.85 The previous effect of the factually similar *Hancock* case86 was merely to broaden the scope of conduct prohibited by the Kickback Statutes as amended in 1977. By disregarding post-1980 changes in legislative intent and executive policy, the Third Circuit's identical holding in *Greber* will have a radically different effect from that of *Hancock*.

III. **Effect of the Expanded Kickback Statutes After the Introduction of the Prospective Payment System**

Originally, the Medicare-Medicaid programs utilized a fee-for-service87 reimbursement system whereby health care providers,88 treating program beneficiaries, were reimbursed by private

84 *Id.* at 72.


86 See *supra* notes 60-67 and accompanying text.

87 "Whenever a program beneficiary receives a service, the provider bills for payment." Laudicina & Schneider, *supra* note 32, at 843.

88 "Health care providers" include hospitals, nursing homes, doctors, etc. *Id.*
insurers upon submission of a receipted bill for reasonable costs.\textsuperscript{89} The system was designed so that health care providers were taken at their word when they filed their claims for reimbursement.\textsuperscript{90} In addition to providing a means of fraud and abuse, this retrospective reimbursement system offered hospitals no incentive to provide cost efficient health care and significantly contributed to the increase in Medicare spending from $5 billion in 1965 to over $72 billion in 1983.\textsuperscript{91}

As an incentive to hospitals to provide more cost efficient health care, section 1886 was added to the Social Security Act, thereby creating what is known as the prospective payment system ["PPS"].\textsuperscript{92} Under PPS, hospitals are paid a fixed amount of money for each diagnosis,\textsuperscript{93} in contrast to the fee-for-service system under which hospitals are reimbursed for care given to Medicare-Medicaid in-patients.\textsuperscript{94} Because section 1886 allows the hospital to retain the difference between the fixed PPS amount and its actual costs, hospitals are encouraged to operate more efficiently.\textsuperscript{95} Thus, hospitals that reduce in-patient costs most effectively will be more competitive under PPS and will be able to offer lower rates to their privately paying patients. The Medicare-Medicaid programs also benefit because Medicaid patients, who are seen as out-patients and billed on a fee-for-service basis, will be charged less for the same services.\textsuperscript{96}

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\textsuperscript{89} Act of July 30, 1965, Pub. L. No. 89-97, 1965 U.S. CODE & CONG. ADMIN. NEWS 1943, 1949. A reasonable charge is "the customary charge for similar services generally made by the physician or other person or organization furnishing the covered services, and also the prevailing charges for the locality for similar services." Id. at 1949.

\textsuperscript{90} Plymale, \textit{supra} note 30, at N-4.

\textsuperscript{91} Kusserow, \textit{supra} note 3, at 986.


\textsuperscript{93} 48 Fed. Reg. at 39,754.

\textsuperscript{94} \textit{Id}.

\textsuperscript{95} \textit{Id}.

\textsuperscript{96} Intermediary Letter 84-9, from Richard P. Kusserow, Inspector General, Department of Health & Human Services, to Assistant Attorney General Stephen S. Trott,
In legislating the 1977 and 1980 amendments, which broadened the original Kickback Statutes to encompass more diverse types of conduct and restricted the amended Kickback Statutes by requiring that the perpetrator possess a specific intent to defraud, Congress apparently felt, in adopting the PPS, that sufficient safeguards were in place to prevent fraud and abuse. In fact, some business practices being encouraged under the PPS might have been subject to prosecution prior to the 1980 amendment. PPS reimbursement, although not completely eliminating the possibility of fraud and abuse, automatically prevents certain questionable business practices, previously controlled by the amended Kickback Statutes, from becoming devices for fraud and abuse. For example, the design of the PPS prevents a group purchasing agent from engaging in fraudulent conduct. No such built-in controls were present in the fee-for-service reimbursement system. With the fee-for-service reimbursement system relying primarily on the amended Kickback Statutes to prevent fraud and abuse and the PPS's relying on cost-saving incentives and the existing Kickback Statutes to prevent fraud and abuse, two apparently contradictory reimbursement systems are in place at the same time. Unfortunately, the courts, as demonstrated by the Greber decision, are incorrectly applying the principles and policies of the fee-for-service reimbursement system to the PPS, preventing the PPS from accomplishing the goals for which it was created. The result is that business practices authorized and encouraged by the Executive branch and adopted by the Legislative branch are being prohibited wrongfully by the Judicial branch.

An example of one major problem, yet to be adequately resolved, exists where a doctor is a limited partner in a partnership which owns a clinical laboratory or a medical supply store. If that doctor refers one of his patients to that laboratory or store and, as a result of that referral, the doctor receives a profit (notwithstanding that there is only one clinical laboratory or

[Department of Justice (dated April, 1985), [1984 Transfer Binder - Current Developments] Medicare & Medicaid Guide (CCH) ¶ 34,127.

97 A group purchasing agent is a person used by a group of hospitals to obtain agreements with vendors for the sale of a wide variety of equipment, supplies, and services to member hospitals. Id.]
medical supply store in the area), under *Greber*, an overzealous prosecutor might charge the doctor with receiving an illegal kickback and succeed in obtaining a conviction. Therefore, a doctor must either risk prosecution or refrain from referring any Medicare-Medicaid patient to any business in which the doctor has any interest. In light of the penalties, doctors must either refuse to participate in the ownership of businesses that serve Medicare or Medicaid patients or refuse to treat such patients. The latter option certainly would protect the doctor but may rob Medicare-Medicaid patients of the expertise of many qualified physicians. Also, the practices, wrongfully prohibited by the Judicial branch, could save money for hospitals, private paying patients, and Medicare-Medicaid patients.98

**CONCLUSION**

Analysis of *United States v. Greber*99 and the legislative development of the existing Kickback Statutes reveals that, after attempting for 15 years to prevent the loss of funds from Social Security, the Legislative, Executive, and Judicial branches do not agree regarding the existing Kickback Statutes’ function, operation or scope.100 A comprehensive review of the sections of the Medicare-Medicaid programs that govern the methods and means of health care delivery is needed to give doctors greater freedom in referrals and thus provide more efficient services for Medicare-Medicaid patients by eliminating barriers that often keep those patients from benefitting from these programs. That review should involve all three branches of government and should define clearly what kinds of conduct the Executive branch should prosecute and how broadly the Judicial branch should interpret the existing Kickback Statutes.

Prior to the 1980 amendment, a three year period of judicial expansion101 of the amended Kickback Statutes occurred, culminating in *United States v. Hancock*.102 Following the 1980

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51 Id.
100 See supra notes 83-85 and accompanying text.
101 See supra notes 54-69 and accompanying text.
102 604 F.2d 999 (7th Cir. 1979).
amendment, which restricted the application of the amended Kickback Statutes, a second period of judicial expansion of the existing Kickback Statutes occurred, ending with Greber.\textsuperscript{103} The first period of judicial expansion was understandable, considering the reasons for which Congress passed the original Kickback Statutes in 1977. It was clearly Congress' intent, however, in their 1980 amendments, to restrict the application of the Kickback Statutes.\textsuperscript{104} Nevertheless, the Judicial branch has disregarded the intent of both Congress and the Executive branch by continuing to interpret the existing Kickback Statutes broadly.\textsuperscript{105} Such interpretations have created a direct conflict between statutes designed to provide medical assistance to congressionally designated individuals and statutes designed to protect the Medicare-Medicaid programs from fraud and abuse.

That portion of the Social Security laws concerned with the prevention of fraud and abuse in the delivery of health care has been revised by Congress in a manner that consistently allows for our society's constantly changing social needs and policies and allows health care providers to function in a competitive and rapidly changing health care delivery system which is markedly different from that which prevailed when the Medicare-Medicaid programs were created almost two decades ago. The judiciary should follow this lead and apply the laws in that same spirit, instead of clinging to older notions which are no longer valid under the new PPS system.

\textit{Stephen C. Pierce}

\textsuperscript{103} See supra notes 83-85 and accompanying text.
\textsuperscript{104} See supra notes 70-73 and accompanying text.
\textsuperscript{105} See supra notes 77-85 and accompanying text.