Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Christino Enriquez, M.D.,	DATE: March 11, 1991
Petitioner,	
- v. -	Docket No. C-277
	Decision No. CR119
The Inspector General.	

DECISION

On June 14, 1990, the Inspector General (I.G.) notified Petitioner that he was being excluded from participation in the Medicare and State health care programs.[1] The I.G. told Petitioner that he was being excluded as a result of his conviction in a Florida court of a criminal offense related to Medicare. Petitioner was advised that the exclusion of individuals convicted of such an offense is mandated by section 1128(a)(1) of the Social Security Act (Act). The I.G. further advised Petitioner that the law required that the minimum period of such an exclusion be for not less than five years. The I.G. informed Petitioner that he was being excluded for a period of eight years.

Petitioner timely requested a hearing as to the exclusion, and the case was assigned to me for a hearing and a decision. I held a hearing in Fort Lauderdale, Florida on November 14, 1990.

I have considered the evidence introduced by both parties at the November 14 hearing. Based on the evidence and applicable law, I conclude that the eight year exclusion imposed against Petitioner is reasonable. Therefore, I

---

[1] "State health care program" is defined by section 1128(h) of the Social Security Act to cover three types of federally-financed health care programs, including Medicaid. I use the term "Medicaid" hereafter to represent all State health care programs from which Petitioner was excluded.

sustain the exclusion imposed and directed against Petitioner by the I.G.

ISSUES

The issues in this case are whether:

a. The effective date of the exclusion should be the date when payments of Medicare reimbursement to Petitioner were first suspended by the Medicare program; and

b. The length of the exclusion is reasonable.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Petitioner is a physician who has specialized in cardiology and internal medicine. Tr. at 66.[2]

2. At all times relevant to this case, Petitioner owned clinics in Fort Lauderdale and Davie, Florida, named Doctor's Gold Plus Center I and II (Center I and II). I.G. Ex. 3.

3. In or around June, 1984, Center I affiliated with International Medical Centers, Inc. (IMC). I.G. Ex. 3.

4. On or about April 1, 1985, Center II affiliated with IMC. I.G. Ex. 3.

5. IMC is a Health Maintenance Organization (HMO) which operates in Southern Florida. I.G. Ex. 3.

6. An HMO is an organization which agrees to provide medical and health services to its members in exchange for a fixed preset payment, without regard to the actual amount or cost of services provided to its members. I.G. Ex. 3.

---

[2] The parties' exhibits and transcript of the hearing will be referred to as follows:

I.G.'s Exhibits	I.G. Ex. (number)
Petitioner's Exhibits	P. Ex. (number)
Transcript	Tr. at (page)

7. At all times relevant to this action, federal law allowed Medicare beneficiaries to enroll in HMOs and have Medicare payments for the cost of their health care made directly to the HMO. I.G. Ex. 3.

8. HMOs seeking to enroll Medicare beneficiaries are required to accept for enrollment any Medicare beneficiary who wishes to enroll, without regard to the state of his or her health. I.G. Ex. 3.

9. HMOs seeking to enroll Medicare beneficiaries must qualify for and enter into contracts with the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (DHHS) under various arrangements, one kind being a "risk-based" contract. I.G. Ex. 3.

10. Under a "risk-based" contract, the HMO receives a fixed monthly payment, known as a capitation payment, for each Medicare beneficiary enrolled. I.G. Ex. 3.

11. This method of payment differs from non-HMO Medicare reimbursement in which the medical provider is paid only for services actually rendered to a Medicare beneficiary. I.G. Ex. 3.

12. Under a "risk-based" contract, the HMO may retain a certain percentage of the capitation payment as profit or absorb any extra cost as a loss when its actual cost for a patient differs from the capitation payment. I.G. Ex. 3.

13. The "risk-based" contract is intended to create incentives for the HMO to control costs and provide appropriate services in a cost-efficient manner. I.G. Ex. 3.

14. Since 1982, IMC operated a "risk-based" contract with HCFA for Medicare beneficiaries called the "IMC Gold Plus Plan" (Plan). I.G. Ex. 3.

15. The IMC Plan provided care through wholly-owned subsidiary and independently-owned affiliated provider clinics located throughout its service areas. I.G. Ex. 3.

16. Petitioner's clinics were independently-owned affiliated provider clinics under contract to IMC. I.G. Ex. 3.

17. The contract between affiliates and IMC was based on "risk-sharing". I.G. Ex. 3.

18. As an incentive to join the Plan, IMC promised to provide beneficiaries not only with all services they are entitled to receive under Medicare, but also additional benefits, such as the elimination of Medicare Part A and Part B deductible payments, no coinsurance, free prescription drugs, free eyeglasses, and routine dental care services that are not covered under Medicare. I.G. Ex. 3.

19. By letter dated May 9, 1986, Blue Cross and Blue Shield of Florida, the fiscal intermediary for Medicare, suspended payments to Petitioner for Part B assigned Medicare claims. P. Ex. 1; Tr. at 48, 60, and 61.

20. On March 5, 1987, Petitioner was indicted in the United States District Court for the Southern District of Florida (District Court) on 16 counts of mail fraud and one count of conspiracy to defraud and for obtaining money from the United States Government, through DHHS, in violation of 18 U.S.C 1341, 1342 and 1371. I.G. Ex. 3.

21. Count 1, paragraphs 1-26, alleged that Petitioner's affiliated clinics enrolled Medicare beneficiaries as HMO participants. I.G. Ex. 3.

22. Count 1, paragraphs 1-26, further alleged a scheme in which Petitioner, and his office manager, discouraged Medicare beneficiaries with serious health problems from enrolling in the HMO and encouraged disenrollment of beneficiaries who developed such health problems after initially enrolling, which is prohibited by 42 U.S.C. 1395mm(c)(3). I.G. Ex. 3.

23. On June 6, 1988, Petitioner pled guilty to one count of mail fraud (Count 5 of the indictment) and to the conspiracy count (Count 17 of the indictment). I.G. Ex. 4.

24. Count 5 of the indictment realleged and incorporated Count 1, paragraphs 1-26, of the indictment. I.G. Ex. 3.

25. In pleading guilty to Count 5 of the indictment, Petitioner admitted to having committed the acts described in Count 1, paragraphs 1-26. I.G. Ex. 3, 4.

26. Count 17 of the indictment realleged and incorporated Count 1, paragraphs 1-16 and 18-26. I.G. Ex. 3, 4.

27. In pleading guilty to Count 17 of the indictment, Petitioner admitted to having committed the acts

described in Count 1, paragraphs 1-16 and 18-26. I.G. Ex. 3, 4.

28. In pleading guilty to Counts 5 and 17 of the indictment, Petitioner admitted to devising and participating in a scheme to defraud the Medicare program of more than $100,000.00 over a period of approximately two years. I.G. Ex. 3, 4.

29. In pleading guilty to Counts 5 and 17 of the indictment, Petitioner admitted to having excluded Medicare beneficiaries from Centers I and II and shifting them to his risk-free private practice. I.G. Ex. 3, 4.

30. In pleading guilty to Counts 5 and 17 of the indictment, Petitioner admitted that his fraudulent scheme enabled him to enjoy the advantages of a risk-sharing arrangement by receiving fixed capitation payments on low-expense Medicare beneficiaries, while evading the disadvantages of such arrangement by diverting high-expense Medicare beneficiaries into his risk-free private practice. I.G. Ex. 3, 4.

31. On August 31, 1988, the District Court found Petitioner guilty, entered a judgment of conviction, and sentenced Petitioner to 18 months confinement on the conspiracy count. I.G. Ex. 4.

32. On the mail fraud count, the District Court suspended sentence and placed Petitioner on probation for five years. I.G. Ex. 4.

33. Petitioner's conditions of probation included repayment of the costs of the investigation and performance of 200 hours of community service per year for five years. I.G. Ex. 4.

34. Petitioner was convicted of a criminal offense related to the delivery of an item or service within the meaning of section 1128(a)(1) of the Social Security Act. Findings 20-28; Social Security Act section 1128(i).

35. The Secretary of Health and Human Services (Secretary) delegated to the I.G. the authority to determine, impose, and direct exclusions pursuant to section 1128 of the Social Security Act. 48 Fed. Reg. 21662 (May 13, 1983).

36. On June 14, 1990, the I.G. excluded Petitioner from participating in Medicare and directed that he be excluded from participating in Medicaid, pursuant to

section 1128 of the Social Security Act, effective 20 days from the date of the letter. I.G. Ex. 1.

37. The exclusion imposed and directed against Petitioner is for eight years. I.G. Ex. 1.

38. An exclusion in this case of at least five years is mandated by law. Findings 27-28; Social Security Act sections 1128(a)(1) and 1128(c)(3)(B).

39. Under section 1128(a)(1), the I.G. may impose and direct an exclusion of more than five years in the appropriate circumstance.

40. The remedial purpose of section 1128 of the Social Security Act is to protect the integrity of federally-funded health care programs from individuals and entities who have been shown to be untrustworthy. Social Security Act, section 1128.

41. Petitioner engaged in criminal acts that jeopardized the integrity of the Medicare trust fund. Findings 27-30; see 42 C.F.R. 1001.125(b)(2).

42. Petitioner's criminal acts damaged the Medicare program by more than $100,000.00, a substantial sum. Finding 28; see 42 C.F.R. 1001.125(b)(3).

43. Petitioner refuses to acknowledge the wrongfulness of his acts or the adverse impact that his acts have had on the Medicare program. See Tr. at 60, 75-78.

44. Petitioner, by his acts and his failure to comprehend the wrongfulness of his acts or the harm that his acts caused, has demonstrated that he cannot be trusted to deal with beneficiaries and recipients of federally-funded health care programs.

45. A lengthy exclusion is needed in this case to protect federally-funded health care programs from future misconduct by Petitioner.

46. The eight year exclusion imposed and directed against Petitioner by the I.G. is reasonable. Findings 1-45.

47. I do not have authority to change the effective date of the exclusion. Social Security Act, section 1128.

ANALYSIS

The parties do not dispute that Petitioner was convicted of a criminal offense related to the delivery of an item or service under Medicare. The I.G. has authority under section 1128(a)(1) of the Act to impose and direct an exclusion against Petitioner from participating in the Medicare and Medicaid programs. Under section 1128(c)(3)(B), the I.G. must impose a mandatory minimum exclusion of five years for individuals convicted of criminal offenses related to the delivery of items or services under Medicare and Medicaid. Therefore, the minimum exclusion which the law requires be imposed and directed against Petitioner is for five years. The I.G. excluded Petitioner for a period of eight years. The contested issues in this case are the effective date of the exclusion and the reasonableness of the eight-year exclusion which the I.G. imposed and directed against Petitioner.

1. The effective date of Petitioner's exclusion cannot be changed.

Petitioner provided evidence that payments on all assigned claims submitted by Petitioner under Part B of the Medicare Program were suspended on May 9, 1986. Petitioner argued that, as a result of this suspension of payments, he was effectively excluded from participation in Medicare for a period of over four years prior to the June 14, 1990 notification of exclusion by the I.G. Petitioner claims that an additional exclusion of eight years, after his suspension in 1986, results in a twelve-year exclusion, unless I change the effective date of his exclusion to be the date that Medicare suspended payment on the claims he submitted.

The I.G. argues that Petitioner is requesting that I retroactively backdate the commencement date of the exclusion. He contends that to give Petitioner's exclusion retroactive effect would have the bizarre result of commencing the exclusion before the date of the conviction on which it is based. The I.G. argues further that the remedies of suspension of payments and exclusion are different remedies which are intended to achieve different purposes and which have quite different effect on Petitioner's standing to claim Medicare reimbursement for his services. The I.G. contends that Petitioner is confusing the two remedies in an effort to shorten the length of the exclusion.

My authority to hear and decide cases under section 1128 does not include authority to change the commencement date of an exclusion. Samuel W. Chang, M.D., DAB App. 1198 at 9 (1990). Thus, even if I agreed with Petitioner's assertion that he has effectively been excluded for more than eight years, I would not have authority to backdate the exclusion imposed and directed against Petitioner to credit him for "time served." However, I do not accept as correct the premise that Petitioner has effectively been excluded for longer than the period imposed and directed by the I.G.

The suspension of payments imposed against Petitioner prior to the imposition of the exclusion in this case is a remedy which is different from the exclusion remedy. Suspension of payments did not bar Petitioner from claiming and receiving reimbursement for Medicare services which he provided. The suspension of payments meant only that Medicare held reimbursement to Petitioner in abeyance, pending examination of his claims for possible irregularities. In contrast, the exclusion which the I.G. imposed against Petitioner bars him from being reimbursed for any Medicare services. Therefore, Petitioner's assertion that he has effectively been excluded from participation for 12 years is incorrect.

The purpose of a suspension of payments under 42 C.F.R. 405.371(b) is to withhold payments to a provider and protect the Medicare program against financial loss during an investigation of possible program-related misconduct. David S. Muransky, D.C., DAB App. 1227 (1991). See Stanley H. Guberman, DAB Civ. Rem. C-240 (1990) This is different from the remedial purpose in section 1128 of protecting program recipients and beneficiaries from untrustworthy providers.[3]

The effect of the suspension of payments to Petitioner was to withhold payments. The suspension of payments did not prevent Petitioner from continuing to submit Part B Medicare assigned claims or treating Medicare beneficiaries. Muransky, supra. If Petitioner ceased submitting claims during the period that payments were

---

[3] The "suspension" from the Medicare program authorized in the statute and found in the regulations prior to the 1987 amendments was intended to be a different action from that contemplated by 42 C.F.R. 405.371(b). The version of the regulations in effect prior to the effective date of the 1987 amendments to section 1128 used the term "suspension" as a synonym for the term "exclusion" in the present statute.

suspended, that was a decision he was entitled to make. However, he could have continued to submit claims and, eventually, would have received payment for those claims, assuming the claims were correctly submitted for reimbursable items or services.

Petitioner is essentially asking me to credit the period of his suspension of payments against the exclusion and to retroactively start the running time for the exclusion as of the date that Medicare suspended payments to Petitioner. As I note above, Petitioner is confusing "suspension of payments" with "exclusion." The two remedies are not synonymous. The I.G. was not obligated to count the suspension of payment period as credit against the period of exclusion.

2. The eight year exclusion imposed and directed by the I.G. is reasonable.

Section 1128 is a civil remedies statute. The remedial purpose of section 1128 is to enable the Secretary to protect federally-funded health care programs and their beneficiaries and recipients from individuals and entities who have proven by their misconduct that they are untrustworthy. Exclusions are intended to protect against future misconduct by providers.

Federally-funded health care programs are no more obligated to deal with dishonest or untrustworthy providers than any purchaser of goods or services would be obligated to deal with a dishonest or untrustworthy supplier. The exclusion remedy allows the Secretary to suspend his contractual relationship with those providers of items or services who are dishonest or untrustworthy. The remedy enables the Secretary to assure that federally-funded health care programs will not continue to be harmed by dishonest or untrustworthy providers of items or services. The exclusion remedy is closely analogous to the civil remedy of termination or suspension of a contract to forestall future damages from a continuing breach of that contract.

Exclusion may have the ancillary benefit of deterring providers of items or services from engaging in the same or similar misconduct as that engaged in by excluded providers. However, the primary purpose of an exclusion is the remedial purpose of protecting the trust funds and beneficiaries and recipients of those funds. Deterrence cannot be a primary purpose for imposing an exclusion. Where deterrence becomes the primary purpose, section 1128 no longer accomplishes the civil remedies objectives

intended by Congress. Punishment, rather than remedy, becomes the end.

> [A] civil sanction that cannot fairly be said solely to serve a remedial purpose, but rather can be explained only as also serving either retributive or deterrent purposes, is punishment, as we have come to understand the term.

United States v. Halper, 490 U.S. 435, 448 (1989).

Therefore, in determining the reasonableness of an exclusion, the primary consideration must be the degree to which the exclusion serves the law's remedial objective of protecting program recipients and beneficiaries from untrustworthy providers. An exclusion is not excessive if it does reasonably serve these objectives.

The hearing in an exclusion case is, by law, de novo. Social Security Act, section 205(b). Evidence which is relevant to the reasonableness of an exclusion will be admitted in a hearing on an exclusion whether or not that evidence was available to the I.G. at the time the I.G. made his exclusion determination. Evidence which relates to a petitioner's trustworthiness or to the remedial objectives of the exclusion law is admissible at an exclusion hearing even if that evidence is of conduct other than that which establishes statutory authority to exclude a petitioner. For example, at the hearing in this case, I permitted Petitioner to offer evidence concerning the work he had performed subsequent to his conviction, because I considered that evidence to be relevant to the issue of trustworthiness.

The purpose of the hearing is not to determine how accurately the I.G. applied the law to the facts before him, but whether, based on all relevant evidence, the exclusion comports with legislative intent. My purpose is not to second-guess the I.G.'s exclusion determination so much as it is to decide whether the determination was extreme or excessive. 48 Fed. Reg. 3744 (Jan. 27, 1983). Should I determine that an exclusion is extreme or excessive, I have authority to modify the exclusion, based on the law and the evidence. Social Security Act, section 205(b).

The Secretary has adopted regulations to be applied in exclusion cases. The regulations specifically apply to exclusion cases for "program-related" offenses (convictions for criminal offenses relating to Medicare

and Medicaid). The regulations express the Secretary's policy for evaluating cases where the I.G. has discretion in determining the length of an exclusion, including exclusion periods beyond the mandatory minimum. The regulations require the I.G. to consider factors related to the seriousness and program impact of the offense and to balance those factors against any factors that may exist demonstrating trustworthiness. 42 C.F.R. 1001.125(b)(1) - (7).

Petitioner pleaded guilty to mail fraud and to having conspired to defraud the United States government. In doing so, Petitioner admitted to participating in massive fraud against the Medicare program. He acknowledged that he had conspired to steal more than $100,000.00 from Medicare over a two-year period.

I conclude that the offense which Petitioner acknowledged committing establishes him to be a highly untrustworthy individual. Petitioner not only conspired to defraud Medicare, but his fraud struck at the heart of the program's cost containment efforts. The essence of Petitioner's crime was that he agreed to participate in an HMO whose purposes included controlling Medicare costs, and then betrayed the trust placed in him by the Medicare program, by diverting patients to his own practice when that suited his purpose. Such duplicity manifests an intent to systematically steal from the program. The fact that Petitioner carried it out over a period of years underscores the calculating nature of his fraud. See 42 C.F.R. 1001.125(b)(1), (2), (3).

Petitioner asserted at the hearing that he had not intended to defraud Medicare. He acknowledged that he had diverted patients to his own practice, but asserted that he had done so in their interest, and not his own. The I.G. argued that I should not admit this testimony, contending that Petitioner was collaterally estopped from denying that which he had previously admitted. I overruled the I.G.'s objection. However, I do not consider Petitioner's testimony as probative of his trustworthiness so much as I find that it betrays a willingness to describe facts in a light most favorable to him. Petitioner's present characterization of the facts of his case evidences untrustworthiness, and not trustworthiness, as he contends.

It is a settled principle that a petitioner cannot challenge the I.G.'s authority to exclude him by denying that he is guilty of that which he has been convicted. Andy E. Bailey, C.T., DAB App. 1131 (1990); John W. Foderick, M.D., DAB App. 1125 (1990); Roosevelt A.

Striggles, DAB Civ. Rem. C-301 (1991). The I.G.'s authority to exclude a party under section 1128(a)(1) arises by virtue of that party's conviction of a criminal offense as described in the Act. A party's actual guilt or innocence is not a relevant factor to be considered in deciding whether the I.G. has authority to impose or direct an exclusion pursuant to section 1128(a)(1).[4]

However, the issue of whether an exclusion is reasonable is separate from the issue of whether the I.G. has authority to impose and direct an exclusion. A party may offer evidence at an exclusion hearing concerning that party's culpability for the offense of which he or she was convicted. That evidence relates to trustworthiness and is therefore relevant. See 42 C.F.R. 1001.125(b)(4), (6).

I conclude that in this case Petitioner's denial of culpability is additional evidence of his lack of trustworthiness. The record establishes that, when it was in Petitioner's interest to do so, he admitted to having engaged in a complex and massive conspiracy to defraud Medicare. The allegations contained in the indictment to which Petitioner pleaded were detailed and unambiguous. Petitioner was not forced to admit to these allegations. Now, Petitioner asserts that, after all, he did not really commit the acts as alleged. Such assertions are patently self-serving and not credible. Moreover, they suggest that Petitioner is willing to say what he believes will impress the fact-finder.

I am convinced from the foregoing evidence that federally-funded health care programs need to be protected from Petitioner for a lengthy period. An eight-year exclusion is reasonable in this case, because it assures that Petitioner will, for a substantial period, not be in a position to commit additional harmful acts against such programs.

In reaching my decision, I have considered evidence offered by Petitioner concerning his post-conviction public service acts and his employment by an agency of the State of Florida. I have no doubt that Petitioner is

---

[4] I do not mean by this to suggest that a party who continues to deny his or her guilt after a conviction is without recourse. That party may appeal the conviction in a court which has jurisdiction over the matter. If the conviction is overturned on appeal, then the I.G. may reinstate the excluded party. See 42 C.F.R. 1001.136(a).

presently performing socially useful work. To some extent, this evidence does suggest that Petitioner has reformed and is less of a threat than previously. However, such evidence is outweighed in this case by evidence described above which shows Petitioner to be untrustworthy.

Petitioner also argues that the exclusion in this case is unreasonable because nearly two years elapsed between the date of his criminal conviction and the date of the I.G.'s exclusion determination. At the hearing, the I.G. acknowledged that he had delayed imposing and directing an exclusion against Petitioner because the records in Petitioner's case had been administratively lost for a period of time. The I.G. argues that Petitioner was not harmed by the late imposition and direction of the exclusion. The I.G. asserts that, had he promptly excluded Petitioner, he would have excluded Petitioner for ten years, and not for the eight years that he imposed and directed. The exclusion was reduced by two years to account for its late imposition.

My authority to hear and decide cases brought under section 1128 is limited to deciding whether the I.G. has authority to impose an exclusion and whether the length of the exclusion is reasonable. There is no "statute of limitations" in section 1128. The I.G. has authority under section 1128(a) to impose and direct exclusions against a party, so long as he can establish that the party has been convicted of a criminal offense as described in that section.

The need for an exclusion of a particular duration could conceivably be affected by the date on which the exclusion is imposed. Ultimately, the question which must be asked in determining whether an exclusion is reasonable is whether it is needed to protect the integrity of federally-funded health care programs and their beneficiaries and recipients. The likelihood that a party will engage in the kind of offense which resulted in his conviction may diminish with the passage of time and intervening events. An exclusion of a given duration might be reasonable if imposed promptly upon conviction. However, an exclusion of the same duration may be unreasonable if imposed after a lengthy delay. In the latter circumstance, the excluded party may have demonstrated in the intervening period that he has become trustworthy.

I conclude that the eight-year exclusion imposed and directed in this case is reasonable despite the lapse of time between Petitioner's conviction and the imposition

of the exclusion. As I note above, Petitioner is a manifestly untrustworthy individual who, as of the date of the hearing, refused to fully acknowledge his unlawful conduct. Had the I.G. moved more promptly to exclude Petitioner, a lengthier exclusion than eight years might have been reasonable. In light of the facts of this case, including the date when the I.G. imposed and directed the exclusion, a protective period of eight years is not excessive.[5]

CONCLUSION

Based on the evidence and the law, I conclude that the eight-year exclusion which the I.G. imposed and directed against Petitioner is reasonable. Therefore, I sustain the exclusion.

/s/

Steven T. Kessel
Administrative Law Judge

[5] For the reasons described above, Petitioner was not harmed by the delay between the date of his conviction and the date of the imposition of the exclusion. During part of this time, Petitioner was incarcerated or confined in a halfway house and could not have treated Medicare patients. However, for the time Petitioner was not confined and could have treated patients, he could have claimed reimbursement from Medicare and Medicaid for any reimbursable items or services which he provided.