

Summer 2011

The Demographics of Healthcare Fraud in South Florida

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Final Project/Thesis

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THE DEMOGRAPHICS OF HEALTH CARE FRAUD IN SOUTH FLORIDA

by

Jennifer K. Pond

A Research Project Presented in Partial Fulfillment
of the Requirements for the Degree
Master of Science in Criminology

REGIS UNIVERSITY
June 2011

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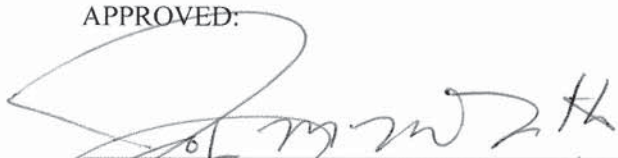
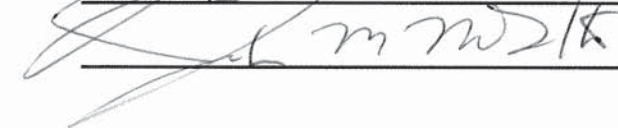
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Abstract

Health care fraud is a large problem in this country. Experts in the field estimate that 3-10% of all health care expenditures in the United States are fraudulent (National Health Care Anti-Fraud Association, n.d., Federal Bureau of Investigation, 2009). “Financial losses due to health care fraud are estimated to range from \$70 billion to a staggering \$234 billion a year” (The National Health Care Anti-Fraud Association, 2010). With this problem identified, it is important to identify and isolate possible influences and factors which perpetuate this type of fraud. Using South Florida as the subject area and health care fraud as the dependent variable, this study sets out to identify patterns and relationships between the demographic variables of ethnicity and citizenship of the perpetrators of fraud. Findings indicate that minorities with U.S. citizenship are more likely to perpetrate fraud and health care fraud than those with non-minority and non-U.S. citizen status.

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Introduction

Health care fraud remains a huge problem within the United States (U.S.). In 1993, Health care fraud was identified as the number two crime problem in America after violent crime (Sparrow, 2008). Though the social and political landscape of this nation has changed much since 1993, health care fraud remains a top priority due to the large financial implications to taxpayers. In 2008 Americans spent \$2.34 trillion on health care (Health and Human Services, Centers for Medicare and Medicaid Services, 2008). The Federal Bureau of Investigation (FBI) estimates between 3 to 10 percent of health care expenditures are lost to fraud (Federal Bureau of Investigation, 2010), resulting in approximately \$70 to \$234 billion stolen from taxpayers on an annual basis.

Health care fraud consists of several different methods or schemes. As one type of white-collar crime, health care fraud is almost always focused on the money. In the past, health care fraud was almost solely perpetrated by medical providers. However, recent trends are showing that health care fraud perpetrators are now more likely to have little to no medical experience and tend to have criminal backgrounds (Menke, 2010). Current schemes include billing for services not rendered, substituting inferior products and billing more expensive ones, performing unnecessary procedures to gain greater reimbursement, engaging in kickbacks, and prescribing narcotics for money rather than medical necessity. Victims of health care fraud may include the patients, insurance companies, and, in the case of federally funded medical benefits plans such as Medicare and Medicaid, the taxpayer.

Health care fraud is not isolated to one region of the U.S. Rather, problems with health care fraud perpetrators have influenced all corners of the country. The FBI, U.S. Department of Justice (DOJ) and the U.S. Department of Health and Human Services (HHS) indicate shared indictments of health care fraud perpetrators in forty of the fifty states and Puerto Rico (U.S. Department of Health and Human Services; U.S. Department of Justice, 2010). The hot spots of health care fraud tend to trend towards large cities with ethnic minorities and known organized crime syndicates. For example, a recent coordinated sting between the FBI, DOJ and HHS resulted in more than 100 members and associates of transnational organized crime groups being charged with offenses including health care fraud. In conjunction with this coordinated effort, six indictments were returned in the Los Angeles-area, Miami and Denver (U.S. Department of Justice, Office of Public Affairs, 2011).

Nowhere are the effects of health care fraud more evident in the U.S. than in Florida. “South Florida leads the nation in seemingly unthinkable schemes to defraud American taxpayers of billions of dollars” (Smith, 2009, p. 39). Additionally, federal officials estimate fraud in Miami alone costs the system more than \$3 billion annually, and in 2008, 245 people in South Florida were charged with Medicare fraud involving more than \$793 million in fraudulent claims (Federal Bureau of Investigation, 2010). Several factors including demographics, transient population, lack of sense of community, and geography as a gateway for imports and exports, may explain why Florida ranks high in health care fraud (Smith, 2009). Regardless of the reason, Florida remains an area ripe for fraud. Until 2009, arrests for fraud continued to grow by approximately 1,000 per year in the state of Florida as reported in the Uniform Crime Report (Federal Bureau of Investigation, 2009). While other states showed increase in these numbers, none showed such rapid growth as Florida.

Nation-wide, population over 65 years of age makes up 12.4 percent of the total population of the country. In Florida, this age group is 17.6 percent of the population, and is the highest percentage of individuals over the age of 65 among all 50 states (U.S. Department of Commerce; Economics and Statistics Administration, 2001). This gap is projected to increase, with estimates putting the percentage of individuals over the age of 65 at 27 percent in Florida in the year 2030 (U.S. Department of Commerce, 2005).

DOJ and HHS joined efforts in May 2009 creating the Health Care Fraud Prevention and Enforcement Action Team (HEAT) to focus on major risk areas of Medicare and Medicaid fraud. The first location for the joint HEAT initiative was Miami-Dade County in South Florida. Since the inception of HEAT the program has resulted in indictments of 1,000 defendants who collectively caused more \$2.3 billion in false payments (Colvin, 2011). The Attorney General identifies financial crimes, including healthcare fraud, as a top priority and mission of the Department of Justice in the coming years with increased focus on recoveries and awareness (Holder, 2011).

Purpose

With the combination of high levels of fraud and high numbers of the population over the age of 65, South Florida seems a perfect location for health care fraud to emerge. Given this, and the recent cabinet-level focus of the HEAT teams, patterns begin to emerge within the demographics of health care fraud offenders. To date, no studies have been completed that address the role of ethnicity and race in the perpetration of health care fraud. The purpose of this study seeks to identify connections between the demographic variables ethnicity and citizenship among those convicted of health care fraud in South Florida. Although patterns specific to the demographic variables are present in many large and ethnically diverse regions, South Florida

was chosen because of its history of health care fraud perpetrators and its ethnic composition. The data elements reviewed for this study are based upon the Federal judicial district in which the individuals were sentenced, therefore the focus will be on South Florida as defined by the counties covered by the U.S. Attorney's Office, Southern District of Florida (USAFLS), which are Miami-Dade, Broward, Monroe, Palm Beach, Martin, St. Lucie, Indian River, Okeechobee and Highlands (United States Attorney's Office Southern District of Florida, n.d.). Using data for the fiscal years of 2005 through 2009 on individuals sentenced to federal fraud and health care fraud violations, the ethnicity and citizenship of these individuals is examined. The data includes a sizable number of non-U.S. citizens, with the most coming from the Caribbean and South and Central America and individuals of Hispanic origin. Drawing from the history of health care fraud in South Florida and comments from experts in the field, the guiding hypothesis is that non-Caucasian ethnic groups in different municipalities within the Southern District of Florida are disproportionately committing the health care fraud.

Rationale

This project attempts to examine connections between ethnicity, citizenship and health care fraud perpetrators in the South Florida. Along with the above hypothesis this study asks three questions:

- Are ethnic minorities more likely to be convicted of health care fraud in the South Florida?
- Are non-U.S. citizens more likely to be convicted of health care fraud in South Florida?
- Do the findings mirror the same demographic percentages of ethnicity and citizenship in the geographic area of South Florida as compared to national trends?

A review of the literature identifies what is currently being done to combat health care fraud in this country as well as who is allegedly committing the fraud. Next the concept of white-collar crime is discussed, drawing ties on the theory of moral panic which addresses the concept of creating cultural scapegoats. Following the literary discussion, a quantitative review of statistics gained from the United States Sentencing Commission (USSC) specific to health care fraud convictions in the Southern District of Florida will look at the connections between the demographic factors of ethnicity and citizenship, and address the research questions posed above. Through combining results from these areas, the expected outcome is that ethnic groups in different municipalities within the Southern District of Florida are driving the health care fraud in the area. The projected benefit of these findings can then be projected on areas with similar demographic composition to identify trends and profiles of health care fraud offenders in South Florida.

Review of Literature

Though there are varying opinions within the political realm on health care, one thing that most can agree upon is the overall effect of health care fraud, especially among the federally funded programs such as Medicare and Medicaid. Experts in the field estimate that 3 to 10 percent of all health care expenditures in the U.S. are fraudulent (National Health Care Anti-Fraud Association, n.d., Federal Bureau of Investigation, 2009). HHS reported spending for the Medicare and Medicaid programs for 2009 reached \$876.2 billion (U.S. Department of Health and Human Services, 2009). Applying the conservative estimate, approximately \$26.29 billion was lost to fraud in these programs. Though private industry also loses money and resources due to fraud and abuse of their programs, they pass this cost along to their members. In public funded programs such as Medicare and Medicaid, the cost of fraud and abuse is eventually passed on to taxpayers, and therefore effects the country as a whole. This is anticipated to grow as the percentage of the U.S. budget dedicated to Medicare and Medicaid expenditures continues to grow (House Committee on Budget, 2011).

In an effort to curb fraud and abuse within this arena, the government has several tools at its disposal. In 2010 the federal government spent an estimated \$1.7 billion fighting health care fraud, waste, and abuse (Iglehart, 2010). A significantly higher amount than has been spent in previous years. Additionally, the government has the federal legislative authority of the federal anti-kickback statute, the False Claims Act and the Stark law, which all possess elements of combating health care fraud (Iglehart, 2010; Krause, 2010). Joint efforts between federal and local law enforcement have also been established to deal with the growing problem of health care fraud.

Beginning in 2007, joint agency task forces brought together federal and local law enforcement as well as judicial assistance from the Department of Justice and local jurisdictions in areas with high levels of health care fraud. Applying Cesare Becarria's (1801) classical criminological theory of deterrence, the increased focus in high risk areas such as Miami and South Florida began to lead to greater prosecutions of health care fraudsters. "Since the inception of Strike Force operations in March 2007 – Miami (Phase One) the Strike Force has obtained indictments of more than 460 individuals and organizations that have falsely billed the Medicare program for more than one billion dollars" (Department of Health and Human Services, n.d.). In May 2009, DOJ, HHS, and the Centers for Medicare and Medicaid Services (CMS) joined in the creation of HEAT, building upon the Strike Forces already in place throughout the country. These teams are focused in major risk areas and are "designed to utilize state-of-the-art technology to analyze electronic claims data for patterns that might indicate fraud" (Krause, 2010, p. 368). In fact, the mission of HEAT is four-fold and includes mandates:

to marshal significant resources across government to prevent waste, fraud and abuse in the Medicare and Medicaid Programs and crack down on the fraud perpetrators who are abusing the system and costing us all billions of dollars; to reduce skyrocketing health care costs and improve the quality of care by ridding the system of perpetrators who are preying on Medicare and Medicaid beneficiaries; to highlight best practices by providers and public sector employees who are dedicated to ending waste, fraud and abuse in Medicare; and to build upon existing partnerships that already exist between the Department of Justice and the Department of Health and Human Services like our Medicare Fraud Strike

Forces to reduce fraud and recover taxpayer dollars (U.S. Department of Health and Human Services and U.S. Department of Justice, 2010).

The anticipated outcome of this joint task force initiation is to reduce the effects and practices of health care fraud and abuse. The classical deterrence theory is highlighted by HEAT's focus on prosecution through the application of significant investigative and legislative resources dedicated to the problem. The increased prosecution efforts are a signal to the community and potential offenders that health care fraud does not pay.

While focusing on deterrence through various means such as increased funding, legislation and joint partnerships, the government continues to experience challenges in overall fight against health care fraud perpetrators. Reasons for this include a flawed structure of the U.S. health system (Sparrow, 2008), lack of collaboration between public and private sector entities (Krause, 2010; The National Health Care Anti-Fraud Association, 2010; Sparrow, 2008; Smith, 2009), and the lack of combined legislation to specifically combat health care fraud (Iglehart, 2010; Kesselheim & Studdert, 2008; Krause, 2010; Sparrow, 2008). This, added to the fact that according to authorities the face of health care fraud "has changed, and more sophisticated and costly crimes involving "cartel-type frauds" are becoming more commonplace" (Rosoff, Pontell, & Tillman, 2004), provides evidence that health care fraud remains a huge problem facing our nation.

Historically when one thinks of health care fraud perpetrators images of bad doctors or illicit distribution of drugs are conjured. Prior to the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), most health care fraud prosecutions were "limited to the illegal acquisition or distribution of controlled substances with no legitimate medical purpose or automobile accident scams involving billing for services not performed" (Daniel E. , Hubbell,

Griffith, Hair, & Van Raalte, 2011). Additionally, most perpetrators had a medical background, being doctors, nurses or professionals in the medical arena. Today health care fraud has taken on a new direction where people with little or no health care knowledge are taking advantage of systemic flaws within the Medicare and Medicaid programs. Within the current health care structure, “stealing a million dollars or more is remarkably easy, and carries with it little chance of getting caught” (Sparrow, 2008, p. 1). Additionally organized crime and street gangs are emerging among the health care fraud perpetrators. Multiple cultures are engaging in organized criminal activity around fraudulent health care claims submissions, including Armenians, Cubans, Nigerians, Russians, and Ukrainians (Trussell, 2009). This emerging phenomenon leads to viral nature of health care fraud going across the U.S., where some of these ethnic groups are actually merging to perpetuate the fraud (Menke, 2010).

The movement of organized crime syndicates to the health care fraud arena represents a shift from traditional methods of organized crime. It is a common problem of Cressey’s (1969) crime triangle which provides three sides or causes of crime: pressure, opportunity and conscience or moral integrity. Cressey (1969) indicates that most crimes are considered crimes of opportunity. Due to the inefficiencies of the current structure as discussed above, the health care system presents a lucrative opportunity for fraudsters, one with great opportunity, few severe penalties and a large arena in which to perpetrate the fraud without detection. Once the offenders are willing to risk whatever penalties might be expected, the key problem is organizing the escape from these penalties, criminal sanctions or civil recoveries that may be assessed. Organized crime syndicates provide a network of willing collaborators and/or innocent third parties to perpetrate crimes (Levi, Organized fraud and organizing frauds: Unpacking research on networks and organization, 2008).

Furthermore white-collar crime is considered less serious than traditional index crimes and, as such, comes with looser penalties (Hirshi & Gottfredson, 1995). Non-index or Part II crimes, as tracked through the FBI's Uniform Crime Reporting (UCR) Program, are considered less severe and include things such as forgery/counterfeiting, fraud, and embezzlement. These crimes are often referred to as white-collar crimes, a term coined by Edwin H. Sutherland in a speech given in December 1939. Sutherland (1949) described white collar crime as crime in the upper, white-collar class, which is composed of respectable, or at least respected, business, professional men. White collar crime is further defined as "economic offenses committed through the use of some combination of fraud, deception or collusion" (Wheeler, Weisburd, & Bode, 1982, p. 642). It can also be defined as corporate fraud (Levi, Suite revenge? The shaping of folk devils and moral panics about white-collar crimes, 2009).

Although the general public views white-collar offenses as less severe and deserving of less jail time (Schoepfer, Carmichael, & Piquero, 2007) the effects of white-collar crime can be devastating on society. With burglary, robbery or assault the victim is typically one individual and though the effects of the crime may be felt by a larger community, these events are typically isolated. However, white collar crimes such as fraud, forgery/counterfeiting, and embezzlement can have a cataclysmic effect on the financial well-being of hundreds and thousands of people, and in the case of the recent bank failures within this country, may impact the economy as a whole. Research on white-collar crime victimization suggests that "one in three Americans succumb to fraud victimization annually, but only about one-third of those victims report their victimization to authorities" (Schoepfer, Carmichael, & Piquero, 2007, p. 157). Research also indicates that fraud victims are often repeatedly victimized. This means that upwards to 103

million people are victimized by white collar crime annually per the 2009 American population estimates (Bernstein & Edwards, 2008).

Health care fraud falls under the category of white-collar crime. Prosecuted under Title 18 §1347, health care fraud is defined as

knowingly and willfully executing or attempting to execute a scheme or artifice to defraud any health care benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program (Title 18 USC 1347).

Like other non-index or Part II crimes, health care fraud has far reaching economic implications.

In the U.S.,

The financial losses due to health care fraud are estimated to range from \$70 billion to a staggering \$234 billion a year. These financial losses are compounded by numerous instances of patient harm – unfortunate and insidious side effects of health care fraud (The National Health Care Anti-Fraud Association, 2010).

Yet this problem is not isolated to the U.S.. In Europe, £50 billion is lost annually to corruption in European Union healthcare systems (Nuthall, 2010).

Levi (2009) indicates that most corporate fraudsters or white collar criminals are viewed as capitalists, and greeted with cynicism from the public because the fraudsters look like us. Though these crimes, including health care fraud, are deemed serious by society, they are not greeted with the same level of seriousness by prosecution unless external factors, such as media coverage, are pressing. Fear is not enough to bring the population to action; rather there must be external factors that heighten the issues to the forefront of societal concern. Attempts to

criminalize white-collar offenders and make the punishment fit the crime are “typically defused by the willingness of police, politicians, and regulators to treat them as issues for compensation (restorative justice) rather than punishment (retributive justice) and by the diffusion of culpability in organizational settings” (Levi, 2009, p. 63).

For labeling and crime neutralization, society is used to seeing criminals as dissimilar. If someone appears to be like *one of us*, society rationalizes and thinks that they cannot be a criminal, or a real criminal. (Levi, 1987). This plays upon the concept addressed by Veblen (1912) of the ideal delinquent, one who remains unscrupulous in the conversion of goods and persons to his own ends and callous in his disregard of the feelings of others. It also echoes the thoughts of Sutherland (1949) in that the white-collar criminal acts like the ideal delinquent while he “thinks of himself as a respectable citizen and, by and large, is so regarded by the general public” (p. 221).

Though the white-collar criminal seems like us, society maintains the need to identify a scapegoat in which to focus their frustration and criminalize the offender. Targets of moral panic, or those perpetrators which society perceives are threatening society’s collective morals, are “cultural scapegoats whose deviant conduct appalls onlookers so powerfully precisely because it relates to personal fears and unconscious wishes” (Garland, 2008, p. 15). By affixing this label to perpetrators, society is able to place them apart from themselves and demonize them because they no longer look like us. Similarly sociological research suggests that the socially disadvantaged or minority offenders are more prone to coercive treatment due to the lack of resources to resist negative labels by society, the perceived economic and social threats to the groups in power, and because sanctions are harsher when criminals are perceived to be racially

and culturally dissimilar (Liska, Logan, & Bellair, 1998; Lofland, 1969; Myers, 1987; Steffensmeir & Demuth, 2000; Turk, 1969).

By applying the concept to white-collar criminals and cultural scapegoats, society is able to set the offenders apart from their own. Bringing such topics as health care fraud to the forefront of the public mind through publications and media coverage of prosecution and settlements creates moral panic, a perceived threat to society. Through creating moral panic in this area, it helps to set the stage for classic criminological theories of deterrence and creating cultural scapegoats of the offenders. Additionally, it leads to greater focus on the issue and increases the amount of financial and societal support to the issue. This is seen through the creation of HEAT as well as the current legislative focus of the Patient Protection and Affordability Act.

The current climate in South Florida focuses on the prosecution of health care fraud criminals. Many of the offenders within the health care fraud arena in South Florida are non-U.S. citizens or immigrants. An example of this is the Benitez brothers, who were involved in an HIV infusion clinic scam in Miami which bilked the government for \$110 million in false claims (Department of Justice, Public Affairs, 2008). The Benitez brothers, Cuban immigrants who remain fugitives, engaged in fraudulent activities against social norms to increase their own profit margin despite defrauding Medicare and Medicaid. They even went so far as to engage real doctors in their scheme. These doctors are now in prison due to their involvement in the matter (Department of Justice, Public Affairs, 2008).

The concern is that with the increase of non-American nationals or immigrants involved in white-collar crime and health care fraud, these individuals do not share the same connection to societal norms within the greater community as they hold on to their own culture and cultural norms rather than assimilating to the norms within the society which they are defrauding. In this manner, “ethnic identity is the result of a dialectical process involving internal and external opinions ... i.e. what *you* think your ethnicity is, versus what *they* think your ethnicity is” (Nagel, 1994). By adhering to their own cultural norms and failing to assimilate into the greater population, the non-American nationals or immigrants appear different to the general population, and are therefore easily deemed as cultural scapegoats by society at large.

Along the same lines, social disorganization theory seeks to explain the link between areas of high crime and neighborhood ecological characteristics. Social disorganization builds upon the traditions of the Chicago School of sociology and discusses this correlation between economic disadvantage and social disorganization (Burgess, 1925). “A primary consequence of disorganization is that it renders certain areas unable to exercise social control over their residents” (Stowell, 2007, pp. 17-18). Immigration compounds this problem as immigrants with similar cultural backgrounds tend to settle in the same geographic areas, causing rapid neighborhood changes. These changes often result in elevated community concerns and higher levels of fear (Beck, 1996; Eitle & Taylor, 2008; Kelling & Coles, 1996; Skogan, 1986, 1990; Taylor & Covington, 1993; Walker, Spohn, & DeLone, 2000; Wilson & Kelling, 1982). Additionally, criminals seek out their own when help is needed in perpetrating their crime. In this manner, those with similar cultural background and even family are often enlisted to assist, spreading crime further into the community. This is seen in health care fraud, particularly with durable medical equipment and infusion center schemes which typically requires large

infrastructures of fraudsters to perpetrate the crime (Daniel E. , Hubbell, Griffith, Hair, & van Raalte, 2011).

By applying Clifford R. Shaw and Henry D. McKay's (1938) Social Disorganization theory to the problem at hand, South Florida is comprised of large Cuban immigrant communities. According to the 2000 census results, individuals identifying themselves as Cuban comprised 28.9 percent of the total population in Miami-Dade County (U.S. Bureau of the Census, 2000). This represents over 78 percent of the Cuban population in Florida. In the 2010 census, this number increased to 34.3 percent of the total population in the same area (U.S. Census Bureau, 2010). In addition, at least half of South Florida's Medicare fugitives are believed to be hiding in Cuba which leads to the thought that "the region's Cuban-connections can be playing a significant role in the region's disproportionately high propensity to commit Medicare fraud" (Lopez, 2011).

Additionally, the common held belief of federal law enforcement and government attorneys combating health care fraud is that the problem in South Florida is a Cuban problem. "Ethnic groups are perpetrating the healthcare fraud schemes. They are training each other in the schemes, which is why you see fraud focused in ethnic groups" (Neal, 2011). In South Florida where there are such a large proportion of individuals with Cuban background, it is easy to see how the health care fraud schemes in that region could be attributed to a Cuban problem. While there are numerous studies on sentencing outcomes based on ethnicity and race for index I crimes and drug offenses, recidivism among ethnic minorities, the impact of race on civil asset forfeiture and perspectives on crime in general (Murphy, 2010; Spohn & Hollaran, 2000; Steffensmeir & Demuth, 2000; Ulmer & Johnson, 2004; Walker, Spohn, & DeLone, 2000), currently there is a lack of empirical evidence and research that addresses health care fraud

specifically and supports the belief that the Cubans are to blame. This paper reviews sentencing data to determine if the belief that health care fraud in South Florida is an ethnic problem, or if this belief is just that of social disorganization and moral panic where the Cubans are the cultural scapegoats.

Methods

In reviewing the problem of health care fraud specific to South Florida the focus of this research is to address the relationship that ethnicity and nationality has with the increased presence of health care fraud in the area, and to address the questions of whether ethnic minorities and/or non-U.S. citizens are more likely to be convicted of health care fraud. The working hypothesis is that non-Caucasian ethnic groups in different municipalities within the Southern District of Florida are disproportionately committing the health care fraud. This analysis will be accomplished through looking at the demographics of convicted health care fraud offenders in South Florida and comparing that to the demographics of the population within the same area. Based on the availability of data a quantitative, secondary analysis method will be employed, blending the review of demographic data in the region with the review of fraud convictions provided by the USSC and conviction records specific to health care fraud charge Title 18 USC § 1347 obtained from the Transactional Record Access Clearinghouse (TRAC) and the U.S. Attorney's Office, Southern District of Florida (USAFLS). Because secondary analysis involves reanalyzing data collected and processed by another researcher (Babbie, 2010), existing data will be taken from the U.S. census, USSC, TRAC and USAFLS. The census data will provide general background and overview of demographic trends identified in South Florida and the U.S. Demographics captured in census data are considered to have reliability because the measures are consistent and dependable across the survey (Trochim & Donnelly, 2008).

The primary source for information regarding the demographics of offenders will come from the USSC. The USSC provides public access to non-confidential sentencing information as governed by the Sentencing Reform Act of 1984. Among its duties, the USSC is responsible for establishing "sentencing policies and practices for the Federal criminal justice system that reflect, to the extent practicable, advancement in knowledge of human behavior as it relates to

the criminal justice process” (Sentencing Reform Act, 1984). Within the mandate of the Act, the USSC also provides public access to publications and other reports. Official Commission publications are available to the public through the Government Printing Office (GPO).

The USSC data contains descriptive statistics on federal criminal cases extracted from court orders, pre-sentence reports and reports on sentencing hearings. The data file itself includes sentencing data, demographic variables, statutory information, court guideline decisions, and departure and variance information for all individuals sentenced to federal crimes (United States Sentencing Commission, 2011). In addition to the maintenance of sentencing guidelines, the USSC maintains Statement of Reason and pre-sentencing documents that contain information including the count of conviction, year of conviction, year of birth, citizenship, gender, and ethnicity. All of these data points are captured in the USSC data. This study will focus specifically on the demographic data points of citizenship and ethnicity, or race.

The dependent variable in the gathering of data is fraud conviction. The data point of fraud within the USSC data is derived from grouping similar offenses together. For example “*Fraud* includes odometer laws and regulations, insider trading, and fraud and deceit” (United States Sentencing Commission, 2011, Appendix A) or offenses identified in Title 18 of the United States Code (USC). Though health care fraud is tracked under Title 18 USC § 1347, the USSC data does not break down the fraud convictions by statute. This represents a limitation in the data. However, the Transactional Records Access Clearinghouse (TRAC) conducts monthly and annual reviews of health care fraud convictions within their white collar crime reports. This data is an integrated compilation of data points from various U.S. Federal government databases, including the primary sources of the Executive Office for U.S. Attorneys, Administrative Office of the U.S. Courts, and Census Bureau (Transactional Records Access Clearinghouse, 2011).

TRAC provides the number of individuals convicted of health care fraud by fiscal year. This data is aggregated to provide totals for the entire U.S. as well as for individual judicial districts. In addition, each judicial district keeps records of cases and convictions. The USAFLS provides data on health care fraud convictions on a monthly basis categorized by fiscal year. They capture the number of defendants, total charges and cases within their data. Combining the data points for fraud conviction under Title 18 USC obtained from the USSC with the statistics provided by the USAFLS and those gathered by TRAC provides a focused picture of health care fraud convictions in South Florida.

Due to the fact that the USSC data includes sentencing for all federal crimes nationwide, the data is voluminous. In order to limit the scope, but still provide enough length of time as to establish potential patterns or correlations in the demographic data of health care fraud convicts, the study was limited to a 5 year period covering data from FY2005 through FY2009. The research focused on data trends in South Florida and nationwide data trends for comparison purposes. Because the data set is not a sample, but rather provides complete data for all individuals receiving federal sentencing for fraud, statistical tests of significance do not apply. The data includes 36,624 unique cases for the entire universe of fraud convictions nationwide from FY2005 through FY2009 and 1,985 unique cases for fraud convictions in South Florida for the same time period.

Once compiled, the data obtained from the USSC, USAFLS and TRAC is combined and analyzed utilizing IBM SPSS. Utilizing SPSS, convictions of fraud were extracted from the total universe of data. The aggregate data for the five year period from FY2005 through FY2009 are combined to identify an overall picture of federal fraud convictions for that period. The data is also separated by fiscal year to identify trends of health care fraud offenders. This method is

applied both to the aggregate data for a nationwide picture as well as to data for the Southern District of Florida for a localized picture.

Narrowing the focus and utilizing the dependent variable of fraud conviction in the South Florida, independent variables of ethnicity and citizenship are reviewed. The demographic breakdown of ethnicity and citizenship, previously defined by the USSC, becomes the basis for comparison of these two independent variables. Following the method previously described, the data is compiled first for the Southern District of Florida and then on the larger aggregate scale for the U.S. Once this data is compiled for each of the fiscal years separately, the data was combined to show an overall trend of the ethnicity and citizenship of fraud offenders in South Florida. This trend is then compared to the ethnicity and citizenship of health care fraud offenders nation-wide.

Results

Tables 1 and 2 provide descriptive statistics for the key variables of the study, specifically race and ethnicity. Table 1 provides a picture of fraud convictions from FY2005 through FY2009 for South Florida. These statistics represent the all fraud convictions within the seven counties which make up the federal judicial district of Southern Florida. For the five year period of the study, Whites make up 26.6 of the total convictions, with Blacks accounting for 21.3 percent, Hispanics at 45.2 percent and Others (which includes Asian or Pacific Islanders, and American Indian) at 1.3 percent. In the remaining 5.6 percent of the convictions race was either not identified or missing from the data.

The same data universe is utilized to capture citizenship among those convicted of fraud. A total of 65 percent of those convicted of fraud in South Florida during the five year period are U.S. citizens, while 31 percent are non-U.S. citizens which includes both legal and illegal status. In 4.5 percent of the cases, citizenship was not captured.

The final column in Table 1 addresses the number of health care fraud convictions under Title 18 USC § 1347. This data represents those cases where the primary offense is listed as health care fraud. Within South Florida, 11.7 percent of the total fraud convictions are health care fraud related. The table also shows that fraud convictions continue in an upward pattern from FY2005 through FY2007, with a significant drop in FY2008 and a gain in convictions in FY2009. Though overall fraud convictions drop in FY2008, this represents the highest year of convictions related to health care fraud in South Florida, with 20.9 percent of the fraud convictions having the primary offense of Title 18 USC § 1347.

Table 2 provides a picture of fraud convictions within the U.S. as a whole. For the five year period of the study, Whites make up 43.4 percent of the total overall convictions, followed

by Blacks at 27.6 percent, Hispanics at 15.4 percent and Others at 5 percent. In the remaining 8.5 percent of the convictions race was either missing or not specified.

The second variable of citizenship is addressed in the second column of Table 2, and finds that 74.9 percent of the total universe of fraud convictions within the U.S. is attributed to U.S. citizens, while 20.5 percent of convictions are of non-U.S. citizens and citizenship is not addressed or captured in 4.6 percent of the total data universe.

Addressing the nexus between fraud conviction and the conviction of the specific health care fraud statute, the total number of convictions where Title 18 USC § 1347 is the primary offense is divided by the total number of fraud convictions during the five year time frame resulting in 3.6 percent of all fraud convictions within the U.S. being health care fraud related.

The five year trend for fraud convictions in the U.S. shows that convictions increased from FY2005 through FY2007, decreasing slightly in FY2008 and increasing in FY2009. Though the trend for fraud convictions follows this pattern, those convictions with the primary offense of Title 18 USC § 1347, health care fraud, stayed stable throughout the entire five year period, with the greatest deviation of 1 percent between FY2005 and FY2006, and FY2007 to FY2008.

Looking specifically at population during this same time frame, the U.S. census provided demographic data. The census data is revised every ten years, and the census data utilized represents the results of the 2010 census findings. This data is presented in Table 3 and Table 4, and includes aggregate data for the U.S., the state of Florida, and drills down to the county level. The counties which make up the Southern District of Florida include Miami-Dade, Broward, Monroe, Palm Beach, Martin, St. Lucie, Indian River, Okeechobee, and Highlands. Data from

these counties are compiled to arrive at an aggregate for the Southern District of Florida, the area of the study.

Table 3 provides a breakdown of the total U.S., Florida and Southern District of Florida by race. The first column represents the total population captured in the census. The second column represents the total population that identifies themselves as one race. Of the population that identifies themselves as one race, 78.0 percent of the total U.S. population identifies themselves as white, while 77.0 percent of the total Florida population identifies themselves as white. The aggregate for the counties making up the Southern District of Florida identifies 72.9 percent of the population as white. Those identifying themselves as Black or African American show the reverse pattern with 14.9 percent of the total U.S. population, 16.4 percent of the Florida population, and 20.8 percent of South Florida identifying themselves as Black. The census breaks down race into four additional categories, those being American Indian and Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander and Some Other Race. For comparison purposes, these categories are combined in the last column of Table 3. The Other combined category identifies 7.1 percent of the total U.S. population, 6.7 percent of the Florida population and 6.3 percent of the South Florida population identifying themselves as Other.

Table 4 provides the breakdown of population percentages for the Hispanic population. Census data allows individuals to identify themselves as Hispanic or Latin American independent of the race categories listed above. This table shows that 19.5 percent of the total U.S. population identifies themselves as Latin American, while 22.5 percent of Florida and 40.1 percent of South Florida identify themselves as Hispanic or Latin American.

Discussion

Despite the drop in FY2008, fraud convictions within South Florida are consistently trending upwards. Though the Southern District of Florida makes up only 2 percent of the total population within the U.S. (U.S. Census Bureau, 2011), it accounts for 5.4 percent of fraud convictions nationwide for this five year time period. This reflected that South Florida has a disproportionate percentage of fraud convictions. Yet, this research focuses specifically on health care fraud in South Florida. The data shows that convictions with the primary offense of Title 18 USC § 1347, the health care fraud statute, are more prevalent within South Florida. In fact, 11.7 percent of the fraud convictions within South Florida are health care related while the national average sits at 3.6 percent. This represents 3.25 times as many health care fraud convictions in South Florida than throughout the U.S.

Both data sets show a trend in fraud convictions increasing from FY2005 through FY2007, tapering in FY2008 and increasing again in FY2009. The HEAT initiative which began in May 2009 may explain the trend upward in FY2009. However, task forces in the area between HHS-IG and the FBI were prevalent prior to the formalization for HEAT which may explain the high levels in FY2005 through FY2007. The data provides no indication for why fraud convictions in both Florida and nationally dropped in FY2008.

Going back to the working hypothesis of this research, the data provides evidence that non-Caucasian ethnic groups in different municipalities within the Southern District of Florida are disproportionally committing the health care fraud. The data indicates that approximately 26.6 percent of fraud convictions within South Florida are attributed to Whites, while the remaining 67.8 percent is attributed to minorities with 5.6 percent of the total identified as missing or undeterminable. Within South Florida, the data shows that a minority is 1.4 times more the national average likely to be convicted of fraud. This mirrors other studies that also

show that minorities have a greater propensity for conviction of federal offenses (Steffensmeir & Demuth, 2000).

Addressing the first research question of whether ethnic minorities have a greater propensity to commit health care fraud in South Florida, on average the data collected suggested that there is a greater propensity for minority groups to commit and be convicted of fraud. Per census data 40.1 percent of the general population and 45.2 percent of those convicted of fraud in South Florida identify themselves as Hispanic. This would suggest that those of Hispanic decent are more likely to be convicted of fraud and points to what the experts are saying; that health care fraud is a Cuban problem. Unfortunately the data is limited in defining Hispanic therefore it is impossible to prove whether the experts are correct in their observations or if they are victims of moral panic theory by placing the blame on a dissimilar group.

Compared to the national averages, the South Florida data shows that minorities in South Florida are more likely to be convicted of fraud and health care fraud. The data indicates that approximately 43.4 percent of the fraud convictions in the U.S. are attributed to Whites, with the missing or undeterminable data making up 8.5 percent of the total population of data and the remaining 48.1 percent is attributed to minorities groups. This is compared to South Florida where the minority groups make up 67.8 percent of the total health care fraud convictions from FY2005 through FY2009. This represents nearly a 20 percent difference in convictions of minorities in South Florida versus the national average.

It is important to note that the data points presented by USSC are not fool-proof. For example, the race data point is self-reported by the offender. This presents a limitation on the study due to the fact that offenders of multiple race backgrounds may not always categorize themselves in a similar manner, and not all racial backgrounds are captured in the data points. Likewise, the offenders have the option of not reporting their race, which may limit the consistency of the data. Additionally, the statistics available through the USSC only document individuals who have been sentenced for a federal crime. It does not take into account those who have not been sentenced for their involvement in health care fraud activities or those who have been sentenced for a primary offense other than fraud. In this way, this represents a limitation of the study because it does not provide the full picture of health care fraud offenders in South Florida.

Despite the limitations, the data provided enough of a sample to gain greater insight into the potential connections between ethnicity and the sentencing of fraud offenders. Overall the data indicates that ethnic minorities in South Florida are more likely to be convicted of fraud offenses, which answers the first research question posed in an affirmative manner.

The second research question deals specifically with fraud convictions of non-U.S. citizens. Specifically, are non-U.S. citizens more likely to be convicted of health care fraud in South Florida? Table 1 addresses the statistics attributed to South Florida, and indicates that 64.5 percent of those convicted of fraud in South Florida are U.S. citizens versus 30.9 percent that are non-U.S. citizens. Compared to the aggregate U.S. data in which 74.9 percent of those convicted of fraud are U.S. citizens versus 20.5 percent that are non-U.S. citizens, the data shows that those convicted of fraud in South Florida are less likely to be U.S. citizens than the national average. This indicated that non-U.S. citizens in South Florida are slightly more likely to be

convicted of health care fraud by approximately 10 percent of the national average. Unlike race, the U.S. census does not capture data regarding non-U.S. citizens. Therefore, a comparison to the general population cannot be made.

Conclusion

Health care fraud remains a huge problem within the U.S., and will remain so until reforms of the current government health benefits plans are made. Health care and social programs remain among the largest expenditures within this country and have surpassed defense spending in FY2010 (House Committee on Budget, 2011). While the government has increased focus on deterrence and prevention of fraud, waste and abuse, including federal government expenditures of an estimated \$1.7 billion fighting health care (Iglehart, 2010), one wonders if this is too little, too late. With the growing problem of health care fraud, it is important to understand the potential causes of the problem to better develop a solution to combat the problem.

This study found that in South Florida those ethnic minorities that are U.S. citizens are more likely to be convicted of fraud than non-U.S. citizens. In South Florida, 67.8 percent of fraud convictions are individuals identifying themselves as minorities. Of the minority categories of Black, Hispanic and Others, Hispanics make up the largest portion of minority convictions and 45.2 percent. Opposed to other minority categories, individuals convicted of fraud who identified themselves as Hispanic were disproportionate than that of the general population by a difference 4.1 percent. In the case of the categories Whites, Blacks and Others, the conviction percentages were less than their representation in the general population in South Florida. Therefore the hypothesis of non-Caucasian ethnic groups in different municipalities within the Southern District of Florida are disproportionally committing the health care fraud is only true in part because the data suggests that only the Hispanics are disproportionately committing fraud in South Florida.

This aligns to a certain extent with the moral panic theory whereas blame is placed on those that are dissimilar. However, this theory would be more prevalent to outsiders looking into South Florida because the population percentages by race show that Hispanics comprise two-fifths of the population, and it is the Hispanics that are disproportionately identified in the study as being more likely to be convicted of fraud.

While it was originally assumed that non-U.S. citizens would have a higher rate of conviction for fraud related offenses, the data proved that it is U.S. citizens that are committing the majority of the fraud both in South Florida and nationwide by a difference of only 10 percent between the South Florida statistics and statistics nationwide. This supports the theory of moral panic, showing that the non-U.S. citizens are being made scapegoats by the population when in actuality they are not being convicted of the crimes at as high of a rate as U.S. citizens. More research into the comparison of the non-U.S. citizen population in South Florida versus those offenders with the same status is needed to confirm the results.

Due to the limitation of the data in identifying only those individuals convicted of the primary offense of Title 18 USC § 1347, possible future research may include looking specifically at all convictions of Title 18 USC § 1347, not just primary offense convictions, and the demographics of those offenders, including race, citizenships, age, gender and occupation to better understand the problem from a demographic detail. Such research would provide further insights specifically into health care fraud offenders, rather than providing generalizations based upon conviction numbers with the primary offense of Title 18 USC § 1347.

Along these same lines, health care fraud offenders may be charged with other related offenses beyond that of Title 18 USC § 1347. In South Florida, many of those convicted of health care fraud are convicted under Title 18 USC § 371 which addresses conspiracy against the U.S., Title 18 USC § 1349 which addresses the attempt to commit conspiracy in violation of wire fraud and mail fraud statutes, Title 42 USC § 1320(a)-7b which addresses criminal penalties for kickbacks, and Title 31 USC which addresses drug diversion. Reviewing criminal case files to identify those in which health care fraud is a related offense would provide a more robust understanding of health care fraud offenders in the area.

Expanding on this research, comparisons could be made between cities and regions with small ethnic communities to determine if this same pattern exists throughout all areas, and not just those that are composed of large ethnic communities, such as the South Florida region selected for this study. Comparison studies could also look at cities with large ethnic communities, comparing these cities to see if the same relationship between population and offender exists.

Specifically drawn from this research is the need for expansion of the time period to show a larger span of trending. This method may be important in determining if initiatives such as HEAT and increased focus on deterrence and prevention programs have a positive or negative effect on health care fraud convictions. Since HEAT officially started in 2009, this current research study does not address the outcomes of the HEAT initiative and additional focus on health care fraud matters. Additional studies could provide insight into the efficacy of such programs and findings may allow for program modification to increase efficiency.

Though this research study addresses the race and ethnicity of fraud perpetrators in South Florida and nationwide and provides an overall trend report for health care fraud convictions in those same areas, there is still work to be done. Through all of these recommendations it is apparent that more research in this area is needed to fully understand the problem and work towards solutions.

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Appendix A: Coding Factor Rubric

Name	Description	Codes
FY	Fiscal Year	05 = 10/1/2004 – 9/31/2005 06 = 10/1/2005 – 9/31/2006 07 = 10/1/2006 – 9/31/2007 08 = 10/1/2007 – 9/31/2008 09 = 10/1/2008 – 9/31/2009
CITWHERE	Identifies the defendant's country of citizenship, when citizenship is known to be not of the United States	See Appendix CITWHERE
DISTRICT	Indicates the Federal judicial district in which the defendant was sentenced	See Appendix DISTRICT
HISPORIG	Offender's ethnic origin. See MONRACE for race of the offender	0 = Information on Hispanic Origin not available 1 = Non-Hispanic 2 = Hispanic 9 = Missing, Indeterminable, or Inapplicable
MONRACE	Offender's race (self-reported to the probation officer)	1 = White/Caucasian 2 = Black/African American 3 = American Indian/Alaska Native 4 = Asian or Pacific Islander 5 = Multi-racial 7 = Other 8 = Info on Race not Available 9 = Missing, Indeterminable, or Inapplicable
NEWCIT	Citizenship of the defendant (recode of citizen for the annual report)	0 = U.S. 1 = Non-U.S. (Includes legal and illegal aliens) 9 = Missing, Indeterminable, or Inapplicable
NEWRACE	Race of defendant	1 = White 2 = Black 3 = Hispanic 6 = Other 9 = Missing, Indeterminable, or Inapplicable
OFFTYPE2	Primary offense type for case generated from the count of conviction with the highest statutory maximum (in case of a tie, the count with the highest statutory minimum is used). <i>Note that since the primary offense type is derived from statutes of conviction it may not match up logically with the primary guideline.</i>	18 = Fraud

Appendix CITWHERE

20 = Cuba
 21 = Argentina
 22 = Bahamas
 23 = Belize
 24 = Bolivia
 25 = Canada
 26 = Chile
 27 = China
 28 = Columbia
 30 = Dominican Republic
 31 = Ecuador
 32 = El Salvador
 33 = France
 34 = Germany
 35 = Ghana
 36 = Great Britain
 37 = Guatamala
 38 = Guyana
 39 = Haiti
 40 = Honduras
 41 = India
 42 = Iran
 43 = Israel
 44 = Italy
 45 = Jamaica
 46 = Jordan
 47 = Korea
 48 = Lebanon
 49 = Mexico
 50 = Nicaragua
 51 = Nigeria
 52 = Pakistan
 53 = Panama
 54 = Peru
 55 = Philippines
 56 = Russia
 57 = Thailand
 58 = Trinidad and Tobago
 59 = Venezuela
 60 = Vietnam
 61 = Afghanistan
 62 = Albania
 63 = Antigua and Barbuda
 64 = Australia
 65 = Bangladesh
 66 = Barbados
 67 = Benin
 68 = Brazil
 69 = Costa Rica

70 = Greece
 71 = Guinea
 72 = Hong Kong
 73 = Indonesia
 74 = Iraq
 75 = Ireland
 76 = Kuwait
 77 = Other
 78 = Laos
 79 = Liberia
 80 = Malaysia
 81 = Netherlands
 82 = Poland
 83 = Romania
 84 = Portugal
 85 = Spain
 87 = Syria
 88 = Taiwan
 89 = Togo
 90 = Yemen
 91 = Yugoslavia
 100 = Algeria
 101 = Andorra
 102 = Angola
 103 = Armenia
 104 = Austria
 105 = Azerbaijan
 106 = Bahrain
 107 = Belarus
 108 = Belgium
 109 = Bhutan
 110 = Bosnia and Herzegovina
 111 = Botswana
 112 = Brunei Darussalam
 113 = Bulgaria
 114 = Burkina Faso
 115 = Burundi
 116 = Cambodia
 117 = Cameroon
 118 = Cape Verde
 119 = Central African Republic
 120 = Chad
 121 = Comoros
 122 = Congo
 123 = Cote d'Ivoire
 124 = Croatia
 125 = Cyprus

126 = Czech Republic
 127 = Denmark
 128 = Djibouti
 129 = Dominica
 130 = Egypt
 131 = Eritrea
 132 = Estonia
 133 = Ethiopia
 134 = Fiji
 135 = Finland
 136 = Gabon
 137 = Gambia
 138 = Georgia
 139 = Grenada
 140 = Hungary
 141 = Iceland
 142 = Japan
 143 = Kazakhstan
 144 = Kenya
 145 = Kyrgyzstan
 146 = Latvia
 147 = Lesotho
 148 = Libyan Arab Jamahiriya
 149 = Lichtenstein
 150 = Lithuania
 151 = Luxembourg
 152 = Madagascar
 153 = Malawi
 154 = Maldives
 155 = Mali
 156 = Malta
 157 = Marshall Islands
 158 = Mauritania
 159 = Mauritius
 160 = Micronesia
 161 = Moldova
 162 = Monaco
 163 = Mongolia
 164 = Morocco
 165 = Mozambique
 166 = Myanmar
 167 = Namibia
 168 = Nepal
 169 = New Zealand
 170 = Norway
 171 = Oman
 172 = Palau
 173 = Papua New Guinea
 174 = Paraguay

175 = Qatar
 176 = Rwanda
 177 = Saint Lucia
 178 = Saint Vincent and the Grenadines
 179 = Samoa
 180 = San Marino
 181 = Sao Tome and Principe
 182 = Saudi Arabia
 183 = Senegal
 184 = Seychelles
 185 = Sierra Leone
 186 = Singapore
 187 = Slovakia
 188 = Slovenia
 189 = Solomon Islands
 190 = Somalia
 191 = South Africa
 192 = Sri Lanka
 193 = Sudan
 194 = Suriname
 195 = Swaziland
 196 = Sweden
 197 = Switzerland
 198 = Tajikistan
 199 = Tanzania
 200 = Tunisia
 201 = Turkey
 202 = Turkmenistan
 203 = Uganda
 204 = Ukraine
 205 = United Arab Emirates
 206 = Uruguay
 207 = Uzbekistan
 208 = Vanuatu
 209 = Zambia
 210 = Zimbabwe
 211 = United States (N/A)
 212 = Bermuda
 213 = Montserrat
 214 = Macedonia
 215 = St Kitts - Nevis
 216 = Tonga
 217 = Niger
 218 = Gilbert Island
 219 = Montenegro
 220 = Serbia
 221 = Kosovo
 0 = Missing

Appendix DISTRICT

0 = Maine	25 = West Virginia South	49 = Tennessee East	74 = California South
1 = Massachusetts	26 = Alabama North	50 = Tennessee Middle	75 = Hawaii
2 = New Hampshire	27 = Alabama Middle	51 = Tennessee West	76 = Idaho
3 = Rhode Island	28 = Alabama South	52 = Illinois North	77 = Montana
4 = Puerto Rico	29 = Florida North	53 = Illinois Central	78 = Nevada
5 = Connecticut	30 = Florida Middle	54 = Illinois South	79 = Oregon
6 = New York North	31 = Florida South	55 = Indiana North	80 = Washington East
7 = New York East	32 = Georgia North	56 = Indiana South	81 = Washington West
8 = New York South	33 = Georgia Middle	57 = Wisconsin East	82 = Colorado
9 = New York West	34 = Georgia South	58 = Wisconsin West	83 = Kansas
10 = Vermont	35 = Louisiana East	60 = Arkansas East	84 = New Mexico
11 = Delaware	36 = Louisiana West	61 = Arkansas West	85 = Oklahoma North
12 = New Jersey	37 = Mississippi North	62 = Iowa North	86 = Oklahoma East
13 = Pennsylvania East	38 = Mississippi South	63 = Iowa South	87 = Oklahoma West
14 = Pennsylvania Middle	39 = Texas North	64 = Minnesota	88 = Utah
15 = Pennsylvania West	40 = Texas East	65 = Missouri East	89 = Wyoming
16 = Maryland	41 = Texas South	66 = Missouri West	90 = District of Columbia
17 = North Carolina East	42 = Texas West	67 = Nebraska	91 = Virgin Islands
18 = North Carolina Middle	43 = Kentucky East	68 = North Dakota	93 = Guam
19 = North Carolina West	44 = Kentucky West	69 = South Dakota	94 = Northern Mariana Islands
20 = South Carolina	45 = Michigan East	70 = Arizona	95 = Alaska
22 = Virginia East	46 = Michigan West	71 = California North	96 = Louisiana Middle
23 = Virginia West	47 = Ohio North	72 = California East	9 = Missing, Indeterminable
24 = West Virginia North	48 = Ohio South	73 = California Central	

Fiscal Year	Race			Citizenship			Conviction of 18 USC			
	Description	Count	Percentage	Description	Count	Percentage	Count	Percentage	Count	Percentage
2005	White	97	34.5%	U.S.	173	61.6%				
	Black	61	21.7%	Non U.S.	88	31.3%				
	Hispanic	92	32.7%	Missing/Undeterminable	20	7.1%				
	Other	4	1.4%							
	Missing/Undeterminable	27	9.6%							
Totals:		281	100.0%		281	100.0%	31	11.0%		
2006	White	89	29.5%	U.S.	217	71.9%				
	Black	90	29.8%	Non U.S.	73	24.2%				
	Hispanic	107	35.4%	Missing/Undeterminable	12	4.0%				
	Other	5	1.7%							
	Missing/Undeterminable	11	3.6%							
Totals:		302	100.0%		302	100.0%	18	6.0%		
2007	White	136	29.0%	U.S.	320	68.2%				
	Black	99	21.1%	Non U.S.	126	26.9%				
	Hispanic	200	42.6%	Missing/Undeterminable	23	4.9%				
	Other	7	1.5%							
	Missing/Undeterminable	27	5.8%							
Totals:		469	100.0%		469	100.0%	23	4.9%		
2008	White	90	21.4%	U.S.	239	56.8%				
	Black	72	17.1%	Non U.S.	163	38.7%				
	Hispanic	228	54.2%	Missing/Undeterminable	19	4.5%				
	Other	6	1.4%							
	Missing/Undeterminable	25	5.9%							
Totals:		421	100.0%		421	100.0%	88	20.9%		
2009	White	116	22.7%	U.S.	331	64.6%				
	Black	101	19.7%	Non U.S.	171	33.4%				
	Hispanic	270	52.7%	Missing/Undeterminable	10	2.0%				
	Other	3	0.6%							
	Missing/Undeterminable	22	4.3%							
Totals:		512	100.0%		512	100.0%	73	14.3%		
Aggregate Totals:	White	528	26.6%	U.S.	1280	64.5%				
	Black	423	21.3%	Non U.S.	621	30.9%				
	Hispanic	897	45.2%	Missing/Undeterminable	84	4.5%				
	Other	25	1.3%							
	Missing/Undeterminable	112	5.6%							
Totals:		1985	100.0%		1985	99.9%	233	11.7%		

Fiscal Year	Race			Citizenship			Conviction of 18 USC			
	Description	Count	Percentage	Description	Count	Percentage	Count	Percentage	Count	Percentage
2005	White	3203	47.0%	U.S.	5287	77.6%				
	Black	1889	27.7%	Non U.S.	1259	18.5%				
	Hispanic	1058	15.5%	Missing/Undeterminable	263	3.9%				
	Other	379	5.6%							
	Missing/Undeterminable	280	4.1%							
Totals:		6809	100.0%		6809	100.0%	216	3.0%		
2006	White	3222	46.3%	U.S.	5598	80.5%				
	Black	2067	29.7%	Non U.S.	1088	15.6%				
	Hispanic	1069	15.4%	Missing/Undeterminable	272	3.9%				
	Other	334	4.8%							
	Missing/Undeterminable	266	3.8%							
Totals:		6958	100.0%		6958		282	4.0%		
2007	White	3322	42.8%	U.S.	5843	75.2%				
	Black	2224	28.6%	Non U.S.	1460	18.8%				
	Hispanic	1167	15.0%	Missing/Undeterminable	464	6.0%				
	Other	350	4.5%							
	Missing/Undeterminable	704	9.1%							
Totals:		7767		7767		229	3.0%			
2008	White	3138	42.0%	U.S.	5450	72.9%				
	Black	2021	27.0%	Non U.S.	1568	21.0%				
	Hispanic	1194	16.0%	Missing/Undeterminable	454	6.1%				
	Other	399	5.3%							
	Missing/Undeterminable	720	9.6%							
Totals:		7472	100.0%		7472	100.0%	292	4.0%		
2009	White	3010	39.5%	U.S.	5250	68.9%				
	Black	1925	25.3%	Non U.S.	2134	28.0%				
	Hispanic	1156	15.2%	Missing/Undeterminable	234	3.1%				
	Other	369	4.8%							
	Missing/Undeterminable	1158	15.2%							
Totals:		7618		7618	100.0%	289	4.0%			
Aggregate Totals:	White	15895	43.4%	U.S.	27428	74.9%				
	Black	10126	27.6%	Non U.S.	7509	20.5%				
	Hispanic	5644	15.4%	Missing/Undeterminable	1687	4.6%				
	Other	1831	5.0%							
	Missing/Undeterminable	3128	8.5%							
Totals:		36624	100.0%		36624	100.0%	1308	3.6%		

Geographic Area	Total Population	One race		White		Black or African		American Indian and		Asian		Native Hawaiian		Some Other Race		Other Races			
		Total Count	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	Count	Percent	
United States	258,267,944	196,817,552	78.0%	37,685,848	14.9%	2,247,098	0.9%	14,465,114	5.7%	481,576	0.2%	604,265	0.2%	17,798,063	7.1%				
Florida	18,801,310	14,109,162	75.0%	2,999,862	16.0%	214,858	0.4%	454,821	2.3%	12,286	0.1%	881,164	3.7%	1,219,709	6.7%				
Broward County	1,745,066	1,697,215	97.3%	467,519	27.5%	5,065	0.3%	56,795	3.3%	911	0.1%	64,694	3.8%	127,465	7.5%				
Highlands County	98,786	79,972	80.8%	9,263	9.6%	471	0.5%	1,439	1.5%	45	0.0%	5,401	5.6%	7,356	7.6%				
Indian River County	138,028	135,777	98.3%	116,346	85.7%	12,397	9.1%	408	0.3%	1,666	1.2%	51	0.0%	4,909	3.6%	7,034	5.2%		
Miami-Dade County	2,496,435	2,437,558	97.6%	1,841,887	75.6%	472,976	19.4%	5,000	0.2%	37,669	1.5%	675	0.0%	79,351	3.1%	122,695	4.9%		
Monroe County	73,090	71,789	98.2%	65,409	91.1%	4,194	5.8%	296	0.4%	809	1.1%	70	0.1%	1,011	1.4%	2,186	3.0%		
Okeechobee County	39,986	39,245	98.1%	31,009	79.0%	3,203	8.2%	380	1.0%	351	0.9%	29	0.1%	4,273	10.9%	5,083	12.8%		
Palm Beach County	1,320,134	1,289,862	97.7%	910,121	70.7%	228,690	17.7%	6,043	0.5%	31,100	2.4%	770	0.1%	53,138	4.1%	91,051	7.1%		
Combined Southern District of Florida	5,914,535	5,768,037	97.5%	4,206,975	72.9%	1,198,242	20.8%	17,663	0.3%	129,829	2.3%	2,551	0.0%	212,777	3.7%	362,810	6.3%		

Source: 2010 Census Redistricting Data (Public Law 94-171) Summary File

Geographic Area	Total Population	Hispanic Population	
		Count	Percentage
United States	258,267,944	50,477,594	19.5%
Florida	18,801,310	4,223,806	22.5%
Broward County	1,748,066	438,247	25.1%
Highlands County	98,786	17,157	17.4%
Indian River County	138,028	15,465	11.2%
Miami-Dade County	2,496,435	1,623,859	65.0%
Monroe County	73,090	15,071	20.6%
Okeechobee County	39,996	9,561	23.9%
Palm Beach County	1,320,134	250,823	19.0%
Combined Southern	5,914,535	2,370,183	40.1%

Source: 2010 Census Redistricting Data (Public Law 94-171) Summary