The Affordable Care Act Has Improved the Way the Federal Government Fights Health Care Fraud, But the Rate of Return on the Investment is Still Being Measured

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As times change, so do the tactics of people who wish to make a living by committing fraud. As criminals change their tactics, law enforcement must quickly adapt their methods in order to counter and prosecute the criminal's evolving scams. The ever-growing health care industry offers plenty of opportunities for criminals to make money by gaming the system. And once again, the government has changed its tactics to keep up with the evolving efforts of criminals who bilk money from the system.

Specifically, the Patient Protection and Affordable Care Act (ACA) has changed fraud detection in the health care industry from a system of "pay and chase" where the government would chase after people who were suspected of committing fraud, into a much more complex proactive system of information-technology platforms and comprehensive data mining.[1] While the ACA continues to be a highly controversial piece of legislation, one thing most people will agree with is that the ACA has significantly increased efforts to fight against health care fraud. While the level of success in fighting health care fraud that can be attributed to the ACA is being debated, the statistics released by the Department of Health & Human Services (HHS) and the Department of Justice (DOJ) show an increase in the amount of money recovered through antifraud proceedings after the ACA was signed into law in 2010.

For example, in 2007 the federal government won or negotiated approximately $1.8 billion in judgments and settlements.[2] The following year, the government only collected $1 billion.[3] In 2009, the recovery was approximately $1.63 billion.[4] In 2010, Congress passed the ACA, and that same year, the federal government won or negotiated approximately $2.5 billion from health care fraud judgments and settlements.[5] In 2011, the federal government negotiated approximately $2.4 billion in health care fraud judgments and settlements.[6] During the 2012 fiscal year, that number jumped to over $3 billion.[7] For the 2013 fiscal year, the government won or negotiated over $2.6 billion in recoveries.[8] During the 2014 fiscal year, the government made a $2.3 billion recovery.[9] Finally, 2015 saw a $1.9 billion recovery.[10]

Other examples of perceived success with the new antifraud measures came with an announcement on June 22 by Attorney General Loretta E. Lynch and HHS Secretary Sylvia Mathews Burwell of an unprecedented nationwide sweep by the Medicare Fraud Strike Force in 36 federal districts.[11] The sweep led to civil and criminal charges filed against 301 individuals for their alleged participation in health care fraud, which resulted in approximately $900 million in false billings.[12]

As part of the changes brought by the ACA, the DOJ was able to increase its efforts to combat health care fraud, opening 1,131 new criminal investigations and an additional 885 new civil investigations.[13] Of course, the changes in the way the government fights health care fraud under the ACA cannot take *all* the credit for the apparent success. Indeed, the DOJ and the HHS were fighting health care fraud long before the ACA was even an idea brewing in Washington, D.C. For example, in 2015 the DOJ and HHS announced that since 1997, the federal government has recovered $27.8 billion from its efforts to crack down on health care fraud.[14]

Outside of increased funding and better coordination between law enforcement agencies, the ACA also changed the laws to make it easier for the DOJ to prosecute alleged perpetrators of fraud. Specifically, the federal government has many tools at its disposal to fight against health care fraud. Three of the most important laws are: (1) the False Claims Act; (2) the Anti-Kickback Statute; and (3) the Physician Self-Referral Law (which is more commonly referred to as the Stark Act).[15]

The False Claims Act prohibits someone from knowingly submitting, or causing the submission of, a false or fraudulent claim to the government for payment or approval.[16] For each violation, or in other words each time a false or fraudulent claim is submitted, the government can impose a civil penalty of between $5,500 and $11,000, plus treble damages.[17] In 2012, the False Claims Act was the government's primary weapon of fighting health care fraud.[18]

The ACA amended the False Claims Act, providing additional protections for whistleblowers who report fraudulent acts.[19] Specifically, § 1558 of the ACA offers protection to whistleblowers by prohibiting employers from firing or discriminating against an employee who reports health care fraud.[20] These amendments are often credited with the False Claims Act's increasing effectiveness, but it's often difficult to accurately measure just how much of an impact the amendments truly have or whether the apparent success can be attributed to other causes.

One possible way to measure the success of these amendments is through number of *qui tam* actions, which are the government's primary tool used to prosecute defendants for false claim liability.[21] In 2012, the majority of False Claim Act cases originated as *qui tam* actions.[22] The following year, the number of *qui tam* actions increased by more than 100 claims.[23]

The ACA also made changes to the Anti-Kickback Statute, which criminalizes payments made in exchange for referrals.[24] Specifically, the Anti-Kickback statute "bars the knowing or willful solicitation, receipt, or payment of 'any remuneration (including any kickback, bribe, or rebate)' that is exchanged 'directly or indirectly, overtly or covertly, in cash or in kind' under the umbrella of a federal health care program for referrals, services, goods, facilities or even 'recommending' the same."[25]

Prior to the ACA, the Anti-Kickback Statute was subject to a circuit split that severely undermined enforcement of the statute. Specifically, in *Hanlester Network v. Shalala*, the Ninth Circuit interpreted the "knowing" or "willful" elements of the Anti-Kickback Statute to require the prosecution to prove the defendant: (1) knew the Anti-Kickback Statute prohibited the offering or payment of compensation in order to induce referrals, and (2) the defendant engaged in the "prohibited conduct with the specific intent to disobey the law."[26] Requiring the prosecution to prove the *mens rea* element of this statute set a very high, and often unrealistic, standard for the prosecution to meet.

By comparison, in *United States v. Jain*, the Eighth Circuit took a softer approach in interpreting the "knowing" or "willful" elements of the Anti-Kickback Statute. In *Jain*, the Eighth Circuit held that the statute only required the prosecution to prove the defendant knew their conduct was "wrongful" as opposed to violation of "a *known* legal duty."[27]

A good example of how drastically this circuit split could affect enforcement of the Anti-Kickback Statute can be found in the analogy used by Jeffrey B. Hammond in an article published in the *Stetson Law Review*. Theoretically, Hammond explains, a medical provider in California could engage in a transaction in which he offers or accept payments for making referrals that result in claims paid under Medicare and, as long as the medical provider did not know about the Anti-Kickback Statute, the medical provider would not be committing a crime.[28] However, if that medical provider engaged in the exact same transaction in Iowa, they could ultimately be convicted of a felony.[29]

The ACA modified the intent requirement of the Anti-Kickback Statute to specify that a defendant does not need actual knowledge of the Anti-Kickback Statute, nor does the defendant have to possess the specific intent to violate the statute.[30] By eliminating the availability of a good faith defense, the ACA greatly increased the government's ability to prosecute violators under the Anti-Kickback Statute.[31] Violators who are prosecuted under the Anti-Kickback Statute face up to five years of imprisonment and up to $25,000 in fines.[32]

Finally, the ACA also made changes to the Stark Act in an effort to beef up the government's ability to fight health care fraud. The Stark Act is meant to fight the conflicts of interest that arise among medical providers.[33] Under the Stark Act, physicians cannot refer patients to entities in which the physician or the physician's immediate family members have a financial interest.[34] Unlike the Anti-Kickback Statute, the Stark Act is a strict liability statute where the intent of the perpetrator is totally irrelevant.[35] The ACA improved the Stark Act with mechanisms that allow for the self-reporting of potential violations.[36] The amendments to the Stark Act offer incentives for health care practitioners to report their actions by reducing the penalties for self-reported violations.[37]

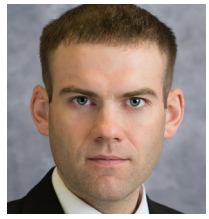
The federal government reports that in the last three years, for every $1 spent on health care-related fraud and abuse investigations, the administration recovered $7.70 in revenue, which is up by $2 since the Health Care Fraud and Abuse Control Program was created in 1997.[38] However, the ACA's true measure of success in fighting fraud is still very much in debate. In fact, some have called into question just how economically effective the new methods of fighting fraud truly are when their levels of success are measured in terms of a cost verses return analysis. For example, in June 2016, the American Hospital Association reported that in the 2016 calendar year alone, six of 10 claims reviewed by the Medicare Recovery Audit Program did not have an overpayment, despite having previously been flagged as overpaid.[39]

There are other unintended consequences that must also be considered. For example, according to the report from the American Hospital Association, as more and more Medicare reimbursements are flagged for improper payments, the hospitals appeal nearly half of all claim denials.[40] This appeals process is very expensive, and in the first quarter of 2016 alone, 43 percent of hospitals claimed to have spent more than $10,000 overseeing the appeals process.[41] Other drawbacks from the antifraud provisions implemented by the ACA is the fact that, in order to avoid expensive fraud investigations, medical providers have to divert more resources to focus on compliance with medical billing requirements.[42] This naturally drives up the cost of health care, which is already an expensive commodity that has caused both economic and political fallout.

While the amount of money saved and recovered from the federal government's crackdown on health care fraud is something that most people can get enthusiastic about, the true levels of success are still very much in debate. More importantly, while the billions of dollars

recovered from the efforts to fight health care fraud are impressive, the savings does not come close to paying for the overall sticker price of the ACA, which some researchers anticipate will increase the federal deficit by at least $340 billion over 10 years.[43]

Regardless of all the debate over the success and future of the ACA, one thing that is certain is the ACA's effect on the way the federal government combats health care fraud has been a benefit to the entire country. For the people who make their living by gaming the system, the risks associated with committing health care fraud have never been higher. The new antifraud provisions brought under the ACA has put criminals in the tough situation of having to decide if the ever-increasing risks and penalties associated with prosecution are worth the potential rewards of their fraudulent acts. No matter how effective or efficient law enforcement becomes, health care fraud will never completely be eradicated. However, the ACA is making it much more difficult to commit fraud and is putting health care criminals in prison or driving them into other less risky enterprises. Whether you support the ACA or not, the prevailing view is the ACA's enforcement provisions have been effective in combating health care fraud. ⊙



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Endnotes

[1]Jeffrey B. Hammond, *What Exactly Is Healthcare Fraud After the Affordable Care Act?,* 42 Stetson L. Rev. 35, 36-37 (2012).

[2]Dep't of Health & Human Servs. & Dep't of Justice, Ann. Rep. for FY 2007, at 1 (Nov. 2008).

[3]Dep't of Health & Human Servs. & Dep't of Justice, Ann. Rep. for FY 2008, at 1 (Sept. 2009).

[4]Dep't of Health & Human Servs. & Dep't of Justice, Ann. Rep. for FY 2009, at 1 (May 2010).

[5]Dep't of Health & Human Servs. & Dep't of Justice, Ann. Rep. for FY 2010, at 1 (Jan. 2011).

[6]Dep't of Health & Human Servs. & Dep't of Justice, Ann. Rep. for FY 2011, at 1 (Feb. 2012).

[7]Dep't of Health & Human Servs. & Dep't of Justice, Ann. Rep. for FY 2012, at 1 (Feb. 2013).

[8]Dep't of Health & Human Servs. & Dep't of Justice, Ann. Rep. for FY 2013, at 1 (Feb. 2014).

[9]Dep't of Health & Human Servs. & Dep't of Justice, Ann. Rep. for FY 2014, at 1 (Mar. 2015).

[10]Dep't of Health & Human Servs. & Dep't of Justice, Ann. Rep. for FY 2015, at 1 (Feb. 2016).

[11]Press Release, Dep't of Justice Office of Public Affairs, National Health Care Fraud Takedown Results in Charges Against 301 Individuals for Approximately $900 Million in False Billing (June 22, 2016) (on file with author), *available at* https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-301-individuals-approximately-900.

[12]*Id.*

[13]Randy M. Mastro & Lee G. Dunst, *Business and Commercial Litigation in Federal Courts* 3d, 10 Bus. & Com. Litig. Fed. Cts. § 112:38 (Nov. 2015).

[14]*Id.*

[15]*Id.*

[16]*Id.*

[17]*Id.*

[18]*Id.*

[19]*Id.*

[20]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1558, 124 Stat. 119, 261 (2010); *see also* David J. Marshall & Colleen E. Coveney, *Whistleblower Protections in the Affordable Care Act*, Katz, Marshall & Banks LLP (May 9, 2013), at 5, http://www.kmblegal.com/publications/whistleblower-protections-in-the-affordable-care-act; *see also* OHSA, Filing Whistleblower Complaints under the Affordable Care Act (2014), https://www.osha.gov/Publications/whistleblower/OSHAFS-3641.pdf (last visited Nov. 25, 2016).

[21]Hammond, *supra* n. 1, at 51.

[22]Mastro, *supra* n. 13, at §112:30.

[23]*Id.*

[24]*Id.*

[25]*Id.* (quoting 42 U.S.C.A. § 1320a-7b(b)(1)-(2)).

[26]*Hanlester Network v. Shalala*, 51 F.3d 1390, 1400 (9th Cir. 1995).

[27]*United States v. Jain*, 93 F.3d 436, 441 (8th Cir. 1996) (emphasis added).

[28]Hammond, *supra* n. 1, at 62-63..

[29]*Id.* at 63.

[30]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10606, 124 Stat. 119, 1008 (2010); *see also* Mastro, *supra* n. 13, at § 112:38.

[31]Mastro, *supra* n. 13, at § 112:38.

[32]*Id.*

[33]*Id.*

[34]*Id.*

[35]*Id.*

[36]*Id.*

[37]*Id.*

[38]Press Release, U.S. Dep't of Health & Human Servs., *Department of Justice and Health and Human Services announce over $27.8 billion in returns from joint efforts to combat health care fraud* (Mar. 19, 2015) (on file with author), *available at* http://www.hhs.gov/about/news/2015/03/19/departments-of-justice-and-health-and-human-services-announce-over-27-point-8-billion-in-returns-from-joint-efforts-to-combat-health-care-fraud.html.

[39]Jacqueline Belliveau, *How the Affordable Care Act Impacted Health care Revenue Cycle*, RevCycle Intelligence (Aug. 18, 2016), http://revcycleintelligence.com/news/how-the-affordable-care-act-impacted-healthcare-revenue-cycle.

[40]*Id.*

[41]*Id. See also* Jacqueline Belliveau, *60% of RAC Reviewed Claims Showed No Medicare Overpayments*, RevCycle Intelligence (June 10, 2016), http://revcycleintelligence.com/news/60-of-rac-reviewed-claims-showed-no-medicare-overpayments.

[42]*Id.*

[43]Hammond, *supra* n. 1, at 39.