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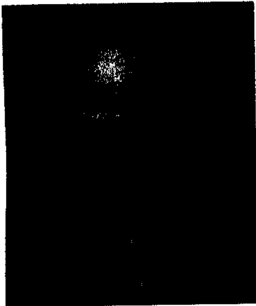
SENTENCING

Tough New Sentencing Guidelines on Health Care Fraud Need Revisiting



BY JAMES E. FELMAN

Responding to a directive from Congress in the Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148,[1] the U.S. Sentencing Commission recently submitted its proposed amendments to the U.S. Sentencing Guidelines for health care fraud offenses.[2] There are two critical aspects of the new amendments: (1) increases in the offense levels for offenses involving losses of more than $1 million and (2) a new application note shifting the burden of proof regarding the loss enhancement from the government to the defendant as to the value of services legitimately rendered.

Increases in Offense Levels For Loss Amounts Above $1 Million

The congressional directive to the commission was the functional equivalent of a direct legislative amendment to the text of the guidelines. It required the guidelines to provide a two-level increase for health care frauds causing losses of between $1 million and $7 million, a three-level increase where the loss is between $7 million and $20 million, and a four-level increase where the loss exceeds $20 million.[3] Neither Congress nor the commission has provided any justification for the amendments in terms of *why* health care frauds are so much more serious than other frauds[4] or why the existing penalties for health care frauds were insufficient.[5] These increases expand penalties in tandem with the new burden-shifting application note discussed below.

Defendants Now Bear Burden Of Disproving Intended Loss

A second change the commission made to the guidelines pursuant to a specific "word-for-word" directive from Congress in the Patient Protection Act was to provide that "the aggregate dollar amount of fraudulent bills submitted to the Government health care program shall be prima facie evidence of the amount of the intended loss by the defendant." The guidelines enhancements for loss from economic crimes are driven by the greater of actual or intended loss.

The new amendment is significant in several respects. First, it effectively shifts the burden of proof from the prosecution to the defense regarding the value of any legitimate services provided. In a case where no services are provided—the "wholesale" fraud—the actual loss will typically be the total amount the health care program paid the defendant. But where some legitimate services are provided and the billing for them is fraudulent only as to a portion of the amount claimed or as to other certifications of payment prerequisites

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[1] These amendments did not result from independent empirical study or initiative by the Sentencing Commission. See *Kimbrough v. United States*, 552 U.S. 85 (2007). Congress did not conduct any hearings regarding the matter or present any empirical basis for its directives to the commission.

[2] See Amendments to the Sentencing Guidelines, Amd. 1, April 28, 2011, at http://www.ussc.gov.

[3] The increases apply to defendants convicted of a federal health care fraud offense involving a government health care program, which the commission defined to mean "any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by federal or state government."

[4] The impact of the amendment is that a defendant who defrauds a government health care program of $20 million will be sentenced in the same manner as other defendants who cause losses of $200 million to any other government agency, including the Department of Defense, or to any private individual or organization, such as a disaster-relief-aid nonprofit.

[5] As discussed below, the existing penalties for these offenses were already so high that they were the subject of extreme criticism in the courts.

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not directly tied to amounts claimed—the "partial" fraud—the loss is an amount less than the amount paid. In such cases, the loss is instead the amounts paid for services that either were not medically necessary or were not rendered at all.[6]

Prior to the amendment, the government bore the burden of proving this figure. After the amendment, the defendant will bear that burden. This will present circumstances in which courts should be prepared to appoint expert accounting assistance to indigent defendants pursuant to the Criminal Justice Act.

The second significant aspect of the new amendment concerning the loss definition is that Medicare frequently pays only some percentage of the amount billed. The amendment appears aimed at shifting the burden to defendants to prove their specific awareness of such payment practices should they wish to contest the amounts they billed as the amount of their intended loss.

The amendment's impact should be limited to altering the allocation of the burden of proof as discussed above. It should not be construed to alter the substantive law of loss and the need to distinguish on policy grounds the sentencing of "wholesale" versus "partial" frauds.

Combined Impact Of New Amendment

The real-world impact of the change to the burden of proof regarding loss, coupled with the new increases to the base offense levels in high-loss cases, means that a hospital executive unable to affirmatively rebut a $20 million loss from fraudulent billing would likely face the following guidelines calculation:

Base offense level: 7

$20 million loss: +22

New health care fraud amendment: +4

Sophisticated means: +2

Role in the offense: +4

Total offense level: 39

Sentencing range for first offender: 21.8 to 27.25 years' imprisonment

Even without the new amendment, the total offense level would have been 35, yielding a sentencing range of 14 to 17.25 years for a first offender. The new amendment thus increases penalties in such cases by roughly eight to 10 years, or roughly 60 percent. It also results in effectively multiplying the loss by a factor of 10—i.e., a $20 million health care fraud will now be treated in the same manner as a $200 million fraud of any other variety.

These increases are especially difficult in light of the wide array of forms of health care fraud, ranging from the billing for services that were simply not rendered, at one extreme, to properly billing for services actually rendered but accompanied by a false anti-kickback certification, near the other.[7] Cases in the middle of this range include "upcoding"—billing for a more expensive procedure than the one actually performed. The overall impact of the new intended loss application note will be to treat more cases that are in fact different as though they were the same—as if no services were provided.

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It will be interesting to see how the courts will consider the new higher ranges in an advisory sentencing guidelines regime, given that some courts are already expressing criticism in rather stark terms of the economic crime guidelines as a whole. One district court recently referred to them as "so run amok that they are patently absurd on their face."[8] Another district court called the guidelines "a black stain on common sense,"[9] while a third court, more charitably, referred to them as "of no help."[10] A number of courts have granted significant variances from the sentences advised by the high-loss economic crime guidelines.[11] Indeed, the Department of Justice,[12] the American Bar Association,[13] and others have called on the commission to conduct a complete review of the guidelines for high-loss economic crimes as a whole.[14]

The ABA has specifically urged the commission to complete a rigorous and comprehensive assessment of the guidelines for all economic crimes—especially those involving high-loss amounts—to ensure that the guidelines for such crimes are proportional to offense severity and adequately take into consideration individual culpability and circumstances. The ABA has suggested that the commission re-evaluate the emphasis on both monetary loss and multiple specific offense characteris-

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[6] *United States v. Medina*, 485 F.3d 1291 (11th Cir. 2007).

[7] Bills submitted to federal health care programs routinely require the provider to certify that it has not paid any "kickbacks" to obtain the referral of the services. See 42 U.S.C. § 1320a-7b(b).

[8] *United States v. Adelson*, 441 F. Supp.2d 506, 515 (S.D.N.Y. 2006).

[9] *United States v. Parris*, 573 F. Supp.2d 744, 754 (E.D.N.Y. 2008).

[10] *United States v. Watt*, 707 F. Supp.2d 149 (D. Mass. 2010).

[11] See, e.g., *United States v. Ovid*, No. 09-CR-216 (JG), 2010 WL 390724 (E.D.N.Y. 2010); *United States v. Ferguson*, No. 3:06-cr-00137-CFD (D. Conn. 2009); *United States v. Stinn*, No. 07-CR-00113(NG) (E.D.N.Y. 2009); *United States v. Turkan*, No. 4:08-CR-428 DJS (E.D. Mo. 2009).

[12] June 28, 2010 letter to William K. Sessions, Chair of the U.S. Sentencing Commission, from Jonathan Wroblewski, Director, Office of Policy and Legislation.

[13] Recommendation 104C, Midyear 2011; Testimony of James E. Felman on behalf of the American Bar Association before the U.S. Sentencing Commission, February 16, 2011, available at http://www.ussc.gov.

[14] James E. Felman, "The Need to Reform the Federal Sentencing Guidelines for High-Loss Economic Crimes," 23:2 FED. SENT'G REP. 138 (2010).

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tics that, in combination, tend to overstate the seriousness of some offenses. The ABA resolution calls on the commission to place greater emphasis on mens rea and motive in relation to an offense, the defendant's role in the offense, whether and to what extent the defendant received a monetary gain from the offense, and the nature of the harm suffered by victims of the offense. The commission has indicated it intends to conduct such a review, and hopefully it will include at least an after-the-fact assessment of the need for and potential impact of these new congressionally directed sentencing increases for health care offenses.

The 2011 amendments to the U.S. Sentencing Guidelines are at http://pub.bna.com/cl/USSGamend2011.pdf.