Is the FCA Effectively Fighting Healthcare Fraud?

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by Sue Prophet, RHIA, CCS, CHC

How effective has the False Claims Act (FCA) been in reducing healthcare fraud? A recent six-month study conducted by New Directions for Policy for Taxpayers Against Fraud sought to determine just that.[1] What the study found is that the FCA is very effective in fighting fraud and should not be amended as previously suggested.

Healthcare fraud cases currently comprise more than half of all FCA cases, which is why the study was conducted. The study methodology involved a comprehensive literature search pertaining to the FCA amendments and healthcare fraud cases and interviews with government officials, healthcare attorneys and consultants, hospital and laboratory industry representatives, and those involved in a few of the major FCA cases.

What Is the False Claims Act?

The FCA ensures that federal contractors do not fraudulently divert taxpayer dollars by establishing liability for contractors that commit fraud by submitting false or fraudulent claims for reimbursement to the federal government. Under the law, whistleblowers can sue companies or individuals that commit fraud against the federal government and employers are prohibited from retaliating against whistleblowers.

Amendments made in 1986 to the FCA revived the whistleblower's role. Whistleblowers are now guaranteed a role in an FCA suit even if the government intervenes. When the government intervenes, the whistleblower may recover from 15 to 25 percent of any recovery funds resulting from the action and between 25 and 30 percent in cases when the government chooses not to intervene. The government can bring lawsuits under the FCA on its own initiative, but most FCA cases today are filed by whistleblowers.

The Act Hits Hard

Fighting Crime Pays Off

As of fiscal year 2000, **the federal government has recovered almost $7 billion** in improperly paid funds from contractors accused of fraud (all fraud, not just healthcare) since the enactment of the 1986 amendments to the FCA. In fiscal year 2000 alone, the government recovered $1.2 billion, which is close to one percent of all spending for the Medicare program.

The federal government is getting a **direct monetary return of at least $8 for every $1** it invests in health-related FCA enforcement activities. The direct benefits take the form of treble damages and the collection of civil monetary penalties per false claim submitted for defrauding the government. There is also evidence that the federal government is receiving benefits of reduced fraud against healthcare programs (such as a deterrent effect on healthcare providers and improvements in federal reimbursement rules and regulations) that cannot be quantified, but are likely to be substantially larger than the direct monetary benefits. These indirect benefits result in lower government outlays under government healthcare programs.

The number of pending criminal matters involving healthcare fraud has increased substantially, rising from 343 in 1992 to 1,939 in 2000.

Whistleblowers Key to Progress

Forty-one percent of the total civil fraud recoveries are from health-related FCA cases. Almost half of the total *qui tam* cases (cases filed by whistleblowers) filed to date are health-related cases. *Qui tam* cases account for 57 percent of the

total civil fraud recoveries since 1986. In 2000, 80 percent of the total fraud recoveries stemmed from *qui tam* lawsuits.

Whistleblowers are vital to uncovering fraud under the FCA. Whistleblowers play a crucial role in identifying complex and obscure fraudulent billing practices, which often elude both an entity's auditors and federal regulators. The government relies on such information from whistleblowers, as well as their particular knowledge of a company's operations and billing practices, in investigating and prosecuting many FCA cases.

FCA Deters Criminals

The Medicare error rate fell to 7 percent in 2000 from 14 percent in 1996. (The error rate measures improper payments due to fraud, waste, and abuse.) This is due to the federal government's efforts to reduce healthcare fraud and billing errors, including enforcement of the FCA. The crackdown on healthcare fraud, in conjunction with other government efforts to prevent fraud, ensures compliance with Medicare's reimbursement rules and makes changes in the healthcare financing system. This has also contributed to a slowdown in Medicare spending increases in the past decade. While total Medicare outlays increased by an average of 11.5 percent per year from 1991 through 1995, the rate of growth fell from 7.9 percent to 1.5 percent over the 1996 to 1998 period.

Medicare spending actually declined in 1999 and then rose by 3 percent in 2000. Most of the decline in Medicare spending between 1996 and 1999 can be attributed to the government's efforts to ensure stricter compliance with Medicare reimbursement rules. By plugging "leakages" of federal funds previously siphoned into fraudulent or erroneous payments, the government is able to recover funds that can be redeployed to provide government services or returned to taxpayers. Some of the regulatory and administrative improvements that have been made are most likely due to FCA enforcement because some FCA cases have identified loopholes in Medicare reimbursement rules that have facilitated improper payments.

The 1986 amendments to the FCA have created a powerful deterrent to fraud among healthcare contractors conducting business with the federal government. There have been substantial efforts by the healthcare industry to uncover questionable or illegal billing practices and the overall level of healthcare fraud has been significantly reduced. Further, there have been industry-wide changes in behavior, largely as a result of FCA cases. These behavioral changes, such as a heightened level of compliance with federal rules and regulations, are attributed to several factors. These factors include: increased corporate and provider knowledge, awareness of the FCA and actual FCA cases, the threat of lawsuits by whistleblowers, heightened regulatory oversight (via stringent reporting requirements in corporate integrity agreements that are imposed on providers in most FCA settlements), and mandatory compliance programs imposed as part of corporate integrity agreements.

FCA cases appear to have **significantly reduced the more egregious and blatant forms of fraudulent billing** in certain sectors of the healthcare industry, although other undesirable forms may persist. Examples of types of fraudulent billing practices that appear to have diminished include hospitals keeping two sets of financial records to mislead auditors and giving physicians "charge sheets" with only the highest-paying codes to encourage upcoding. However, some types of fraudulent billing practices continue to persist, such as providers taking advantage of confusing and complex government regulations to "stretch the rules."

Providers, Patients Feel the Heat

Providers are concerned that federal prosecutors sometimes **improperly equate billing mistakes with fraud**. Many healthcare providers feel that the government uses its deep pockets, the threat of a lawsuit, and a presumption of liability to force settlements from providers who believe they have followed the law. Some providers may have become extremely sensitive to their vulnerability to FCA liability and that "hyper-compliance" on the part of providers has led some to be overly cautious in ordering tests and authorizing services.

As a result, patients may not always receive all the healthcare services they need. The federal government believes that the FCA only imposes liability on providers who knowingly submit false claims, that most providers would not agree to large financial settlements unless they believed they had engaged in some wrongdoing, and any excesses in enforcement that may have occurred in the 1990s have been curbed.

Study: Keep FCA Strong

Based on the study's findings, New Directions for Policy offered the following recommendations:

The FCA should not be weakened. It is a very effective fraud-fighting tool. It should not be amended, as has been suggested, to exempt certain industries or providers who do business with the federal government, nor should it be amended to reduce the effectiveness of the *qui tam* provisions of the 1986 amendments in identifying and deterring fraud.

The government should continue to enforce the FCA in a fair and effective manner. Effective enforcement should include adequate investigation and review of the facts and a consideration of allegations of fraud on a case-by-case basis. Providers should focus on complying with the law rather than attempting to change it because they perceive it as being applied unfairly. The ultimate goal of the FCA is to prevent fraud through voluntary compliance with reimbursement rules.

The FCA should not be used to police suspected overpayments to large numbers of providers or contractors in specific sectors of the healthcare industry. Federal investigators and prosecutors should not use the FCA to do the job of the Centers for Medicare and Medicaid Services' (CMS) auditors. CMS should strengthen its review and analysis of cost reports and other documents submitted by providers, which would diminish the need for FCA lawsuits.

The ultimate conclusion of the study was that the government is getting an excellent return on investment in fighting fraud through FCA enforcement. And when direct recoveries are combined with indirect cost savings that might be attributable to FCA actions, the government, and ultimately the taxpayers, are getting a real bargain.

Notes

1. New Directions for Policy is a firm that works to promote more effective operation of the health system and to aid in the development of sound public policy on healthcare and welfare reform issues. For more information, go to www.ndpolicy.com. Taxpayers Against Fraud, The False Claims Act Legal Center, is a nonprofit public interest organization dedicated to combating fraud against the federal government through the promotion and use of the False Claims Act. For more information, go to www.taf.org.

Reference

New Directions for Policy. "Reducing Healthcare Fraud: An Assessment of the Impact of the False Claims Act." Prepared by Jack A. Meyer and Stephanie E. Anthony. October 1, 2001. Available on the Taxpayers Against Fraud Web site, www.taf.org.

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