As health care costs have skyrocketed in recent years, the investigation and prosecution of health care fraud cases have become top government priorities. Data from the Justice Department reflects 1,235 new health care fraud prosecutions in FY 2011, equating to a 68.9% increase over the prior fiscal year. This trend has been accompanied by mounting political pressure for more severe sentences for those convicted of health care related crimes. That sentiment was reflected in the Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148 (“the Act”), which directed the Sentencing Commission to ensure that the Guidelines and policy statements “reflect the serious harms associated with health care fraud” and “provide increased penalties for persons convicted of health care fraud offenses in appropriate circumstances.”

In response to a specific directive in the Act, the Sentencing Commission amended the Guidelines effective November 1, 2011 to increase the offense level for health care fraud with losses in excess of $1 million. By statutory directive, the Guidelines now include a rebuttable presumption that the intended loss for health care offenses is derived from the “aggregate dollar amount of fraudulent bills submitted to the Government.” Prior to the newly enacted amendments, the Guidelines did not further define or clarify “intended loss” in the context of health care fraud offenses. The new Application Note now specifies that in a case involving a Government health care program, “the aggregate dollar amount of fraudulent bills” submitted to the program “shall constitute prima facie evidence of the amount of the intended loss.”

A. Offense Level Enhancements

Sentencing in fraud cases is largely driven by the amount of the loss, as reflected in the loss table in U.S.S.G. § 2B1.1. Over the years, the fraud Guideline has been amended to apply special enhancements depending upon the nature of the offense. The Guidelines now include enhancements for offenses ranging from fraud against financial institutions, to theft of property from a national cemetery, to identity theft. By virtue of the recent amendment, health care fraud now joins that list with a three-tiered enhancement that the Sentencing Commission was directed to employ under the Act. Under the new amendment, health care defendants are subject to a two-level enhancement if the loss exceeds $1 million; a three-level enhancement if the loss exceeds $7 million; and a four-level enhancement if the loss exceeds $20 million.

While the tiered structure of the new Guideline only impacts the more serious cases (losses in excess of $1 million), it substantially ups the ante in cases when the loss barely exceeds one of the new arbitrary cutoff points. For example, in cases where the loss barely exceeds $1 million, the Guideline range will now be four levels higher (rather than two levels higher) than cases in which the loss is just under that cutoff. Depending upon other applicable enhancements, that amendment has the potential to increase the upper end of the Guideline range by two years or more by virtue of the loss exceeding that arbitrary cutoff.

B. Intended Loss Determination

For purposes of Guideline calculations, “loss” is defined as the greater of the actual loss or intended loss. “Actual” loss, under the Guidelines, “means the reasonably foreseeable pecuniary harm that resulted from the offense,” whereas “intended loss” “means the pecuniary harm that was intended to result from the offense,” which includes “intended pecuniary harm that would have been impossible or unlikely to occur.” Prior to the newly enacted amendments, the Guidelines did not further define or clarify “intended loss” in the context of health care fraud offenses. The new Application Note now specifies that in a case involving a Government health care program, “the aggregate dollar amount of fraudulent bills” submitted to the program “shall constitute prima facie evidence of the amount of the intended loss.” Under the new Application Note, evidence of the billed amount is sufficient, by itself, to establish the intended loss, if not rebutted.
The new Application Note resolves a common point of contention in health care fraud cases about the methodology for calculating intended loss where a defendant bills amounts to Medicare or Medicaid that are much higher than the fixed reimbursement rates set for the billed services or procedures. Typically, the government argues that the intended loss is the total amount billed whereas defendants assert that the loss should be no greater than the amount that was reimbursable under Medicare’s schedule of approved payments. In United States v. Nachamie, 121 F.Supp. 2d 285, 293 (S.D.N.Y. Sep. 22, 2000), a Medicare fraud prosecution, the court resolved that debate in favor of the defendants by relying on evidence that the defendants “knew that Medicare always reimbursed procedures at a fixed or ‘capped’ rate per procedure,” and thus, “defendants’ intent was that Medicare reimburse them at Medicare’s capped rate.” In so ruling, the court found that the government had not proven by a preponderance of the evidence that the defendants intended Medicare to pay more than its fixed rates.11 Id. By contrast, in United States v. Mikos, 539 F.3d 706, 714 (7th Cir. 2008), the Seventh Circuit found that the intended loss was properly determined to be the full value of the $1.8 million billed to Medicare, even though some claims were not reimbursed at all, because the billed amount is “the intended loss whether Medicare paid or not.”

The new Application Note appears to adopt the approach taken by the Fourth and Fifth Circuits, which held that in health care fraud cases, the amount billed was prima facie evidence of the intended loss subject to rebuttal by the defense.12 Under the new Application Note, that principle now will be applicable in all Circuits. Although it is common practice for health care providers to bill higher amounts than they know Medicare or Medicaid will pay, a health care fraud defendant will now have the burden of proving that he only intended to receive the capped amount, not the billed amount.

C. Mitigating Role

While the overall thrust of the new Guideline amendments was to increase the penalties for health care cases, the revision of Application Note 3(A) for § 3B1.2 provides at least a glimmer of hope for less culpable defendants in multi-defendant cases. The revision pertains to defendants who are accountable under relevant conduct provisions (§ 1B1.3) for the full amount of a loss caused by their co-schemers. The revision makes clear, by way of example, that a less culpable defendant may be eligible for a decreased offense level for playing a mitigating role under § 3B1.2. The revision provides that “a defendant in a health care fraud scheme, whose role in the scheme was limited to serving as a nominee owner and who received little personal gain relative to the loss amount, is not precluded from consideration for [a mitigating role adjustment].”

The revised Application Note provides helpful language to defendants who play lesser roles in any sort of fraudulent scheme and is not just limited to health care defendants. The explicit example of a health care defendant is almost anecdotal and is more in the nature of a clarifying amendment that is unlikely to have any major impact in courts’ determinations of who does or does not qualify for role reductions under § 3B1.2.

D. Practice Tips

The increased Guideline ranges coupled with a presumptively high intended loss calculation have the potential to increase health care sentences dramatically. That said, defense practitioners need to be vigilant and creative in their sentencing advocacy to ensure that sentences in health care fraud cases are not excessive. Familiarity with some of the following issues and considerations may help mitigate the sentences imposed in health care cases.

1. The Proper Standard for Intended Loss

While the new Guideline amendment establishes that the defendant’s billing amount will serve as prima facie evidence of the intended loss, it does not change the basic definition of “intended loss” and courts still need to focus on the subjective intent of a defendant in determining intended loss. In United States v. Manatan, 647 F.3d 1048, 1050 (10th Cir. 2011), the Tenth Circuit recently clarified the concept of intended loss in holding that “intended loss” means a loss the defendant purposely sought to inflict.” The court further explained that “intended loss” does not mean a loss that the defendant merely knew would result from his scheme or a loss he might have possibly and potentially contemplated.” Thus, even under the newly revised Guideline, the calculation of intended loss remains very fact specific and is based on the defendant’s subjective intent.

The prima facie standard for intended loss is a burden shifting rule, not an absolute requirement that the billed amount is the intended loss. In situations where, for example, a defendant was an experienced Medicare
provider and knew that Medicare only reimbursed at a fixed or capped rate, evidence of the defendant’s familiarity with Medicare billing procedures can be used to rebut the presumption that the billed amount is the intended loss. A health care provider’s billing amounts can often be substantially greater than the established reimbursable amounts set by Medicare. Yet, a defendant who knows that Medicare has fixed reimbursement rates should not be tagged with an intended loss figure based on higher billing amounts that have no relation to what Medicare pays and, more importantly, do not reflect the amounts the defendant purposely sought to obtain as part of the alleged scheme.

2. Intended Loss Should be Individualized

Given the subjective nature of intended loss, one defendant’s intended loss should not necessarily control his co-defendant’s intended loss. Intended loss must be an individualized assessment. As in any fraud scheme, a defendant’s responsibility for loss and relevant conduct will be a function of many factors, including when the defendant joined the scheme and his overall knowledge and involvement in the scheme. In health care fraud schemes, under the new Guidelines, defendants may be differentiated based on their experience or familiarity with billing requirements. Thus, while it may not be possible to overcome the prima facie rule on intended loss for one defendant, if another defendant has experience as a provider and/or biller, that experience may be sufficient to overcome the presumption and allow the court to use the allowable Medicare rates as the intended loss. Ironically, under the Guideline amendment a defendant with a relatively minor role may have a more difficult time overcoming the presumption that the billed amount is the intended loss, because minor defendants often do not play a direct role in the billing process and may not have been familiar with Medicare reimbursement schedules (for example, an assistant in a doctor’s office who aids the scheme but is not in charge of billing). This type of defendant might attempt to overcome the intended loss presumption through indirect means—for example, by showing a general knowledge of the amount of money the scheme was earning that was significantly below the billed amounts relied on by the government at sentencing. In light of the increased Guideline ranges, it is critical that defense counsel consider any potential factors differentiating a client from co-schemers in assessing the intended loss.

3. Risks in Introducing Evidence to Overcome the Prima Facie Standard

The logical source of evidence to overcome the prima facie standard for intended loss is the defendant. In a case that has gone to trial, it is possible that the trial record may contain useful evidence to demonstrate that the billing amount is not the appropriate standard for intended loss. In cases that are resolved by guilty pleas, however, defense counsel need to give careful thought to what evidence is available to rebut the prima facie standard and, as importantly, any risks of presenting that evidence. A defendant who testifies at a sentencing hearing as part of an effort to rebut the prima facie standard could, of course, be subjected to an aggressive cross-examination that not only undermines the effort to rebut the intended loss, but brings out other wrongful conduct or calls into question a defendant’s acceptance of responsibility under § 3E1.1. Depending upon the circumstances, defense counsel may be well advised to consider alternative means of rebutting the intended loss amount, by introducing probative documentary evidence, such as Medicare payment records that the defendant received showing she was aware of the capped amount, or calling other witnesses who may have favorable testimony to provide, such as a provider’s billing agent. Certainly, the strategy for rebutting the prima facie standard needs to be assessed carefully so that it does not backfire and potentially result in a Guideline range or sentence more harsh than might have been imposed if the defendant had not introduced new evidence or testimony.

4. A “Downward Departure” or Variance

The new Guideline amendments may result in severe sentencing ranges based largely on “intended” loss that never occurred. Because the Guidelines define loss as the greater of actual loss or intended loss, there is the potential for defendants who caused minimal loss to face the same sentencing ranges as defendants who caused millions of dollars in losses. The use of billing amounts as the presumptive standard in health care cases increases the risk of such guideline ranges that overstate the seriousness of the offense. The Guidelines acknowledge that in some cases, the loss calculation may result in an unduly severe sentencing range. Application Note 19(C) to § 3B1.1 provides that a downward departure may be warranted in “cases in which the offense level determined under [§ 3B1.1] substantially overstates the seriousness of the offense.” In the wake of the newly enacted health care fraud Guideline amendments, defense counsel will want to place greater
reliance on Application Note 19(C), in conjunction with the sentencing factors under 18 U.S.C. § 3553(a), to advocate for sentences below the severe ranges that may be driven by “intended” loss that never materialized. The new revisions to the Guidelines raise the stakes in the sentencing of health care defendants. The new offense level enhancements and the presumptive use of billing amounts to determine the intended loss have the potential to increase Guideline ranges dramatically in large health care cases. Defense practitioners need to focus on any specific facts in a client’s case that can be used to rebut the government’s use of billing amounts as the intended loss. More generally, defense counsel need to scrutinize the government’s loss calculation to ensure that it does not overstate the amount of fraudulent billings, and to challenge whether the loss is an accurate estimate of the amount that the defendant “purposely” intended to obtain. Finally, defense counsel need to advocate forcefully for below-Guideline sentences in cases where the billing amount is far in excess of the amount that the defendant actually received as part of the scheme.

Endnotes

1 Transactional Records Access Clearinghouse (TRAC) Report dated December 14, 2011; trac.syr.edu/tracreports/crim/270
2 Section 10606(a)(3) of the Act.
5 U.S.S.G. § 3B1.2cmt.n.3(A)(2011).
7 By way of example, a defendant convicted of a $990,000 million health care prosecution stemming from a mail fraud charge would have a base offense level of 7 with an increase of 14 levels for the loss. U.S.S.G. §§ 2B1.1(a)(1) and 2B1.1(b)(1)(H). In the unlikely event that there were no other aggravating or mitigating adjustments, the offense level would be 21 with a resulting Guideline range of 37-46 months for a defendant with no criminal history. The same offender with a loss slightly in excess of $1 million would have an offense level of 25 under the new amendment, with a resulting range of 57-71 months. U.S.S.G. §§ 2B1.1(a)(1); 2B1.1(b)(1)(I); and 2B1.1(b)(8). The Guideline range disparity would be greater or less, depending upon what mitigating or aggravating factors applied.
9 Id.
10 U.S.S.G. § 2B1.1(cmt.n.3(F)(viii))(2011).
11 See also United States v. Semrau, No. 2:10-cr-10074, 2011 WL 9258, at *4 (W.D. Tenn. Jan. 3, 2011) (loss calculation properly based on reimbursed amount, rather than billed amount, where defendant’s testimony established that he was knowledgeable regarding Medicare fee schedules and the differences between what is billed to Medicare and what is reimbursed).
12 United States v. Isiwele, 635 F.3d 196, 203 (5th Cir. 2011); United States v. Miller, 316 F.3d 495, 504 (4th Cir. 2003).
13 See, e.g., Nachamie, 121 F.Supp.2d at 293.