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Assessing the Impact of The False Claims Act on Healthcare Delivery
NBER Center for Aging and Health Research: Pilot Grant Proposal

Introduction

The US federal government prosecute most health care fraud and abuse cases under a privatized whistleblowing law called the False Claims Act (FCA). Under the FCA, individuals who have private information about misreporting or overbilling to the Medicare program can sue providers directly in federal civil court. The Department of Justice participates in many successful cases, but whistleblowers can also pursue cases on their own. Since the 1986 enactment of the FCA, the FCA has produced over 7,000 healthcare whistleblower lawsuits, from which the government has recovered more than $32 Billion.[i]

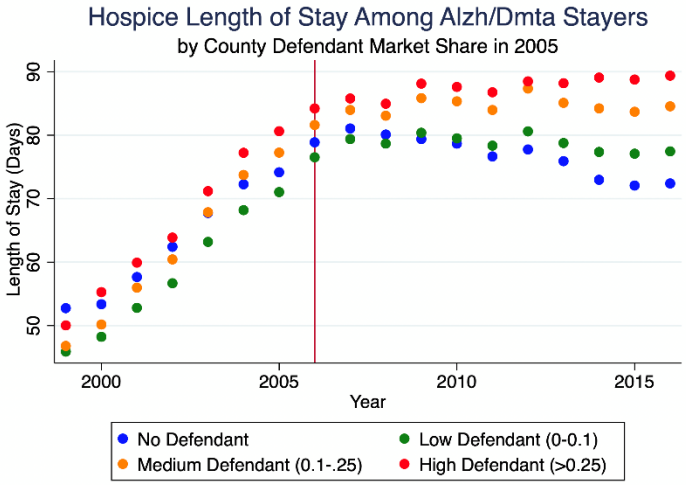
Recently, the Department of Justice and whistleblowers have used the FCA to seek civil and criminal penalties against providers accused of delivering unnecessary care. Defense lawyers argue that these cases amount to "second guessing" physicians, and argue that unnecessary care falls outside the scope of the FCA. The Supreme Court is deciding whether to take a case that resolves a Circuit court split over whether these cases should be subject to civil litigation. In light of the ongoing controversy over the reach for the FCA, this project seeks to understand the effects of that these FCA lawsuits have had on provider delivery choices and patient health outcomes.

Case Study: Hospice Care, Provider Overbilling, and Alzheimer's/Dementia Patients

A number of FCA cases have targeted hospices for admitting ineligible patients. Medicare covers hospice for patients with a life expectancy less than 6 months. In 2018, the hospice program served more than 1.5 million Medicare beneficiaries, including more than half of all decedents, spending $19.2 billion.[ii] Whistleblowers and the Department of Justice have pursued cases against many for-profit hospice chains for admitting patients who are not terminally ill, including many Alzheimer's and dementia patients. They charge that administrators pressured clinicians to admit patients and punished or fired those who refused. Long-stay patients may be particularly profitable because they require less ongoing care.

The objectives of our analysis are to 1) estimate differences in admission patterns between defendant hospices and controls and 2) estimate the impact of hospice admission for the marginal patient on life expectancy and Medicare spending. We will identify estimates based on Medicare beneficiaries geographical proximity to a defendant hospice and hospices' proximity to an annual cap on reimbursements, which is determined in-part by random variation in the length of stays of previously admitted patients.

Using data from the Department of Justice, we have identified 79 whistleblower lawsuits against hospice providers, including against the largest national hospice provider chains (Vitas, ManorCare, and Seasons Hospice). Our preliminary results show that hospice enrollment rates for Alzheimer's and dementia patients nearly tripled from 1999-2016, and average lengths of stay rose by 60%. The figure below shows the length of stay trend over time by the market share of firms eventually prosecuted for hospice fraud. We see that areas with high baseline defendant market share have seen the highest rises in length of stay. Following enforcement actions beginning in 2006, average length of stay has leveled off but not declined.



Our preliminary results also suggest that for-profit hospices spend substantially more per patient as compared to nonprofit and government hospices, indicating that long stays are not merely a feature of changes in care delivery.

Related Work and Projects

In addition to the specific example of hospice care, we plan to use our Medicare data access to explore the effects of the False Claims Act more broadly, and to complete existing projects that study the health consequences of the Act. These other assessments will help inform our understanding of the specific nature of fraud in hospice care.

One of the proposers, Jetson Leder-Luis, has studied the deterrence effects and care consequences of the False Claims Act for Medicare in his job market paper, which is currently under review. That project uses NBER Medicare data under a DUA also entitled "Assessing the Impact of The False Claims Act on Healthcare Delivery." This paper shows that False Claims Act whistleblowing has strong deterrence effects on fraudulent spending, with no health consequences to patients. Continued data access through the Center will help ensure that project can complete any revision requests it receives during the publication process.

Another of the proposers, David Howard, is studying the effect of the FCA on unnecessary inpatient admissions. A number of whistleblower lawsuits have alleged that for-profit hospital chains disproportionately and unnecessarily admit Medicare patients who sought care in the emergency department rather than treat them as outpatients. Preliminary estimates based on discharge data from Florida indicate that admission rates at Tenet and HCA hospitals are more than 5 percentage points higher than at non-profit hospitals. Access to the full Medicare sample through the NBER will facilitate a more thorough analysis that will allow for the detection of similar issues nationwide.

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[i] Department of Justice, "Fraud Statistics – Health and Human Services," 2018. Available online at: https://www.justice.gov/opa/press-release/file/1233201/download

[ii] MedPac, Report to Congress: Medicare Payment Policy, March 2020, Chapter 12, pp 325