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No One Statute Should Have Too Much Power: How Electing Not to Amend 42 U.S.C § 1320(a)–7(b) May Frustrate the Purpose of the Patient Protection and Affordable Care Act

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No One Statute Should Have Too Much Power: How Electing Not to Amend 42 U.S.C § 1320(a)–7(b) May Frustrate the Purpose of the Patient Protection and Affordable Care Act

Amber C. Dawson*

The over breadth of the Federal Anti-Kickback statute as amended by the Patient Protection and Affordable Care Act (PPACA) holds dangerous implications for the future of the health care marketplace. When a statute permits criminal, civil and administrative punishment for an overbroad category of innocuous actions, such a statute must also take into account the specific, rather than general, intent of the actor, or the ensnaring of innocents is ultimately likely to result. Historically, the statute required a finding of specific intent to be found to uphold a violation of the statute. With the passing of Greber v. US and the Federal Anti-kickback statute's amendment by the PPACA to encompass almost any act not enumerated as a safe harbor, prosecutors have been given remarkable power to decide when and who to prosecute, and almost anyone participating in the health care marketplace may find their self at risk of violating the law. Prosecutors have also been given the remarkable power to decide what constitutes genuine patient protection as we enter into a new chapter of American health care.

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I. INTRODUCTION

Imagine suffering from a debilitating disease for decades before finally finding a physician or health care specialist able to meet your medical needs to your personal level of satisfaction. Then, imagine traveling to that medical care provider’s office for your next appointment only to find it completely vacant with a padlocked front door. After calling the office several times attempting to understand and make sense of the situation, the phone never stops ringing. In fact, the voice mailbox has been turned off, and you, the sick and vulnerable patient, are left without answers. On the news later that night, a story breaks that your physician was arrested for allegedly committing health care fraud.

In the latest era of American health care under the Patient Protection and Affordable Care Act (hereinafter “PPACA” or “the Act”), combating health care fraud has been an extremely high priority of the federal

government¹, which has caused many patients to face the predicament described above. One of the federal government's most powerful weapons in combatting health care fraud and abuse has been the federal anti-kickback statute² (hereinafter "the Statute") as amended by the PPACA³.

This comment will discuss how one immensely powerful, constantly amended, and overly broad statute possesses the ability to frustrate major purposes of the PPACA in the health care marketplace. Part II of this comment summarizes and explains the historical development of the federal anti-kickback statute and the impact that the Statute has on frustrating major end-goals of the PPACA, which call for the Statute's amendment. Part III of this comment will discuss the Statute's ability to set the national tone concerning what constitutes acceptable patient protection practices and acceptable methods by which the government may achieve affordable health care in the American health care marketplace. Part IV addresses potential methods by which the federal government may restrict the federal anti-kickback statute's power to frustrate major purposes of the PPACA, while simultaneously allowing the Statute to aid law enforcement in the fight against health care fraud.

II. STRUGGLING WITH THE TRANSLATION OF REFERRAL REMUNERATIONS

A. The Federal Government's Fight to Kick Back Against Health Care Fraud

Understanding the current impact of the federal anti-kickback statute on the government's ability to combat health care fraud under the PPACA requires an understanding of the historical development of the Statute as well as the PPACA's purpose, and how the Act changed the Statute. The federal anti-kickback statute was enacted under the Social Security Amendments of 1972 as a misdemeanor criminal statute.⁴ When enacted, the primary concern of the government was "outlawing health care

¹ See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6402(f)(2), 124 Stat. 119, 759 (2010).

² See 42 U.S.C. § 1320a-7b (2006); see also 42 C.F.R. § 1001.952. (2010).

³ See § 1320a-7b; see also § 1001.952.

⁴ See Shannon Barnet, *20 things to know about the Anti-Kickback Statute*, BECKER'S HOSPITAL REVIEW (Sept. 5, 2014), <http://www.beckershospitalreview.com/legal-regulatory-issues/20-things-to-know-about-the-anti-kickback-statute.html>; see also *State v. Harden*, 938 So.2d 480, 486-90 (2006) (citing Social Security Amendments of 1972, Pub. L. No. 92-603, § 242(b), 86 Stat. 1329, 1419 (1972)).

referrals that were considered unethical or inappropriate.”⁵ The original language of the Statute stated:

w]hoever furnishes items or services to an individual for which payment is or may be made under this title⁶ and who solicits, offers, or receives any: 1) kickback or bribe in connection with furnishing of such items or services or making or receipt of such payment; or 2) rebate of any fee or charge for referring any such individual to another person for furnishing of such items or services shall be guilty of a misdemeanor and shall be fined not more than \$10,000 or imprisoned for 1 year or both.⁷

In 1977, as Medicare and Medicaid fraud continued to drive up the costs of health care,⁸ Congress passed the Medicare-Medicaid Anti-Fraud and Abuse Amendments.⁹ The 1977 amendments increased the severity of the criminal penalty for a violation of the Statute from a misdemeanor to a felony, punishable by up to five years of imprisonment and/or a fine of \$25,000,¹⁰ and broadened the existing language of the Statute in order to promote deterrence.¹¹ Instead of centrally focusing on kickbacks, rebates and bribes as the original language of the Statute had,¹² the language of the 1977 version of the Statute focused on remuneration generally, given directly or indirectly, overtly or covertly, in cash or in kind.¹³ The change in the language of the Statute resulted from complaints by federal prosecutors who were pursuing health care fraud cases and who had complained to Congress that the previous language of the statute was “unclear and needed clarification”¹⁴ to ensure successful prosecution.

⁵ See *Harden*, 938 So.2d at 488-90. (citing Social Security Amendments of 1972, Pub. L. No. 92-603, § 242(b), 86 Stat. 1329, 1419 (1972)).

⁶ See 42 U.S.C. § 1395nn(b)(2) (2006).

⁷ *Harden*, 938 So.2d at 488. (citing Social Security Amendments of 1972, Pub. L. No. 92-603, § 242(b), 86 Stat. 1329, 1419 (1972)); 42 U.S.C. § 1395nn(b)(2); Social Security Amendments of 1977, Pub. L. 95-142, 91 Stat. 1175 (1977).

⁸ Social Security Amendments of 1977, Pub. L. 95-142, 91 Stat. 1175 (1977).

⁹ See Shannon Barnet, *20 things to know about the Anti-Kickback Statute*, BECKER'S HOSPITAL REVIEW (Sept. 5, 2014), <http://www.beckershospitalreview.com/legal-regulatory-issues/20-things-to-know-about-the-anti-kickback-statute.html>.

¹⁰ *Id.*

¹¹ *Id.*

¹² See Social Security Amendments of 1972, Pub. L. No. 92-603, § 242(b), 86 Stat. 1329, 1419 (1972).

¹³ See Social Security Amendments of 1977, Pub. L. No. 95-142, 91 Stat. 1175 (1977).

¹⁴ See *United States v. Greber*, 760 F.2d 68, 71 (3d Cir. 1985), cert. denied, 474 U.S. 988 (1985) (citing H. Rep. No. 393, Part II, 95 Cong., 1st Sess. 53, reprinted in 1977 U.S. CODE CONG. & AD. NEWS 3039, 3055).

Although the Statute had always imposed criminal liability, the Statute did not require a finding of criminal intent until it was amended in 1980.¹⁵ As amended, the Statute required the government to prove beyond a reasonable doubt that an individual or entity “knowingly and willfully” violated the Statute before he, she or it could be convicted of violating the Statute.¹⁶ Courts immediately struggled trying to interpret what actions would constitute a knowing and willful violation of the statute and what exactly constituted remuneration¹⁷. In 1985, the Supreme Court clarified what degree of criminal conduct is required to successfully convict an individual for violating the Statute.¹⁸ In *Greber*, the Court established the “one purpose” test, holding that so long as one purpose of giving, receiving, offering or soliciting any remuneration was to induce referrals for services payable by a federal health care program, the anti-kickback statute is violated, even if the remuneration was also intended for another subject purpose.¹⁹ In short, any remuneration given or received where one purpose of the remuneration was to induce referrals for health care items or services payable in part or in full by a federal health care program violated the Statute and subjected both the referee and the referrer to criminal liability.²⁰

Years later, “[t]he OIG was given authority to issue civil penalties in addition to the already authorized criminal penalties . . . under The Medicare and Medicaid Patient and Program Protection Act of 1987.”²¹ This meant that the overly broad, constantly changing, and complex criminal Statute could lead to health care providers, and any other person for that matter, being found both criminally and civilly liable for actions that either party may not have been aware would be considered illegal remunerations under the law.

While referrals historically play a large role in many professional industries and the offering and soliciting of referrals were perfectly legal practices in industries outside of the health care industry,²² referrals became felonious criminal activity within the health care industry.²³ And still, health care providers had no definitive answers as to what exactly

¹⁵ See *Barnet*, *supra* note 4.

¹⁶ *See id.*

¹⁷ *Id.*

¹⁸ See *Greber*, 760 F.2d 68 (3d Cir. 1985), *cert. denied*, 474 U.S. 988 (1985).

¹⁹ *See id.* at 72.

²⁰ See *Barnet*, *supra* note 4.

²¹ *Id.*

²² *Id.*

²³ *Id.*

constituted giving or receiving remuneration for a referral given the broad language of the Statute.²⁴

In light of the broad scope of the Statute at the time, the Office of the Inspector General (OIG) was mandated under the Medicare and Medicaid Patient and Program Protection Act of 1987 to create regulatory safe harbors.²⁵ The safe harbors were intended to provide health care providers with protection from liability where their actions may have otherwise earlier resulted in a violation of the Statute. Meeting every requirement of a safe harbor would ensure an individual or entity could not be found in violation of the Statute for a specific practice which completely complied with an anti-kickback statute safe harbor, and would protect the individual or entity against liability and future criminal prosecution.²⁶ The OIG's initial set of proposed anti-kickback statute safe harbors was first announced in 1993 and finalized in 1999.²⁷

Because many individuals involved in the business of health care were still confused by the anti-kickback statute and what practices constituted a violation, the OIG continued to propose and enact a total of what are currently 25²⁸ safe harbors that are acceptable and would not violate the Statute.²⁹ The OIG, however, still had not clarified whether the government had to prove general intent or specific intent to sustain a conviction for a violation of the Statute in situations where a safe harbor was not met.³⁰

While issues sustaining convictions did not arise in cases where defendants clearly intended to engage in gross conduct in violation of the Statute and were well aware of the legal consequences of such conduct, issues arose in situations where individuals alleged that they were completely unaware that their actions violated the law and that their payment practices constituted remuneration under the Statute. The federal government saw the issue as one where a broad interpretation was necessary:

Medicare, Medicaid and other government health care programs depend on physicians and other health care professionals to exercise independent judgment in the best interests of patients. Although monetary and other

²⁴ See Harden, 938 So.2d at 488-90.

²⁵ See Pub. L. No. 100-93, 101 Stat. 680 (1987) § 3.

²⁶ *Id.*

²⁷ See Medicare and State Health Care Programs: Fraud and Abuse; OIG Anti-Kickback 56 Fed. Reg. 35932 (July 29, 1991).

²⁸ See 42 C.F.R. § 1001.952 (2010).

²⁹ See *id.* (explaining which payment practices do not constitute a violation of the federal anti-kickback statute).

³⁰ *Id.*

incentives tied to referrals are commonly accepted and legal in many businesses, such acts can corrupt the health care industry and harm federal programs. When a physician refers a patient to a provider because of some financial self-interest, the physician is not necessarily making the decision in the patient's best interests. Unfair competition results when honest providers must compete with those who unlawfully pay to generate business. This systematic corruption of federal health care programs defrauds the public.³¹

The problem remained, though, that while the government's overall goal of curbing fraud was a desirable one, innocent health care providers could become ensnared by the Statute's overarching reach.³²

B. What Is Fraud and What Is Fair in the New Era of Affordable Health Care?

The PPACA, also known as the Affordable Care Act, or Obamacare, was passed under President Barack Obama on March 23, 2010.³³ In an effort to reform the American health care system, the PPACA, for fraud purposes, aimed to make health care affordable for all Americans,³⁴ to improve "the quality and efficiency of health care,"³⁵ and to eliminate the impact of fraudulent, abusive and wasteful health care practices of providers on the high costs of health care.³⁶ But how would the government eliminate the impact of fraud on the high costs of health care? To realize the end goals of the PPACA, the federal anti-kickback statute, now entitled "Criminal Penalties for acts involving federal health care programs" under the PPACA, was amended "to provide that claims submitted in violation of the [S]tatute automatically constitute false claims

³¹ Scott Oswald, Esq., and David Scher, Esq., *Health care law expands False Claims Act liability under the Anti-Kickback Statute*, EMPLOYMENT LAW GROUP, 3-4, (last visited Jan 2, 2016 10:30 AM), <https://www.employmentlawgroup.com/wp-content/uploads/AntiKickback-Statute-False-Claims-Lawyers.pdf>.

³² Scott Oswald Esq., and David Scher, Esq., *Health care law expands False Claims Act liability under the Anti-Kickback Statute*, Employment Law Group, 3-4 (last visited Jan. 2, 2016, 10:30 AM), <http://www.employmentlawgroup.com/wp-content/uploads/AntiKickback-Statute-False-Claims-Lawyers.pdf>.

³³ *See id.*

³⁴ *Affordable Health Care for America*, THE HOUSE COMM. ON WAYS AND MEANS, ENERGY AND COMMERCE, AND EDUC. AND LABOR (Jan. 4, 2016, 12:01 PM), <http://housedocs.house.gov/energycommerce/SUMMARY.pdf>

³⁵ *Id.* at 2-3.

³⁶ *Id.*

for purposes of the False Claims Act.³⁷ Congress also added a new section that eliminates the requirement that a person have actual knowledge of the law or specific intent to commit a violation of the statute.³⁸ Because of these two significant changes, health care providers and other individuals who had no knowledge of the Statute can no longer argue that they lacked the intent to “knowingly and willfully” violate the Statute as a defense to criminal and civil liability under both the Statute and the False Claims Act.³⁹ Notable is the fact that there are separate, severe penalties for every violation of both the Statute and the False Claims Act.⁴⁰ As the Statute currently exists, a single violation, including the filing of a single false claim for medical items or services paid in part or in full by a federal health care program, constitutes a felony punishable by a fine of up to \$25,000 and/or up to five years of imprisonment.⁴¹ In addition to the criminal penalties, anyone involved in the business of health care who is convicted under the Statute as it currently exists is also subject to civil monetary penalties,⁴² to potential exclusion from the Medicare and/or Medicaid programs, and to administrative penalties.⁴³

Despite the Statute’s broad definition of remuneration and elimination of its specific intent requirement, the long-term impact that the federal anti-kickback statute may have on the PPACA actually being able to ensure patient protection and make health care affordable remains unanswered. Moreover, the meaning of “knowingly and willfully”⁴⁴ exchanging remuneration can encompass behaviors so innocuous that even courts have issues discerning when and why the Statute has been violated.⁴⁵ When the courts are unsure whether an individual’s actions constitute a violation of the Statute, it seems commonsensical that a lay juror or potential violator would find it difficult to determine what actions constitute a violation as well. As such, the overly broad Statute has essentially been broadened even further by the PPACA, allowing the government, as well as private individuals bringing claims under the False Claims Act, the discretion to go after the deepest pockets in the health care business, both criminally and civilly.⁴⁶

³⁷ Oswald & Scher, *supra* note 31 at 3.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ See 42 U.S.C. § 1320a-7b (2012).

⁴² See *Id.*

⁴³ *Id.*

⁴⁴ See *id.*

⁴⁵ See Harden, 938 So.2d at 487-89.

⁴⁶ See, e.g., Heather Stauffer, *Lancaster County hospital among many that will pay to settle false billing allegations*, LANCASTER ONLINE (Dec 20, 2015, 1:06 PM), <http://lancas>

III. THE THREATENING LEGAL IMPACT OF FEDERAL HEALTH CARE FRAUD: PROSECUTORS' FAVORITE TOOL ON COMBATING FRAUD

The government's ability to choose between prosecuting or monetarily settling with health care providers and entities who violate the Statute calls into question how important patient protection actually is to the federal government when allegedly fraudulent, wealthy providers are able to bypass criminal prosecution and felony convictions by reaching monetary settlements with the government.⁴⁷ The government's philosophy seems simple. When health care entities and individuals choose to settle in lieu of prosecution, a large portion of the settlement funds are funneled back into federal health care programs in order to increase the funds available to Medicare and Medicaid patients and make health care more affordable.⁴⁸ Simultaneously, the government is given the broad discretion to choose which medical providers (many of whom may or may not be aware they have committed crimes) it will and will not pursue. The government's ability to arbitrarily pick and choose which wealthy providers who violate the Statute will pay the costs to make American health care more "affordable" also calls into question what methods Americans are willing to find as acceptable means of funding a health care system for all.

A. Where Is the Patient Protection?

The government's reliance on the powerful federal anti-kickback statute as amended under the PPACA poses several issues that may impact the ability of the PPACA to achieve its goal of greater patient protection. The potent impact of the Statute as it currently exists calls for its amendment yet again given its potential impact on the future of patient protection in the American health care system. First, the Statute allows for the immediate arrest and future criminal prosecution of individuals and entities involved in the business of health care; yet the PPACA provides no guidelines for patients as to how they should respond in instances when their medical care providers are either imprisoned or incarcerated. Second, the PPACA also provides no guidelines on how other medical care providers should view the validity of incoming patients' medical history and records documented by health care providers who have been convicted under the Statute. Third, the PPACA provides no means or methods by

teronline.com/news/local/lancaster-county-hospital-among-many-that-will-pay-to-settle/article_b39b0b26-a5ac-11e5-8a43-63c3febc16f2.html.

⁴⁷ *Id.*

⁴⁸ See *Affordable Health Care for America*, THE HOUSE COMM. ON WAYS AND MEANS, ENERGY AND COMMERCE, AND EDUC. AND LABOR (Jan. 4, 2016, 12:01 PM), <http://housedocs.house.gov/energycommerce/SUMMARY.pdf>

which patients whose health care providers are convicted under the Statute can obtain their past medical records once the providers are convicted and incarcerated. Further, the PPACA does not require health care providers who have been indicted, accused, or are awaiting trial for violating the Statute to disclose those facts to their existing or past patients. Without notice, patients may not be aware that they may need to start searching for an affordable, competent health care provider until they learn of their potentially fraudulent provider's conviction. Despite these problems, the federal anti-kickback statute has been one of the most powerful and frequently used tools of law enforcement in the fight against health care fraud—another goal of the PPACA. Consequently, while the Statute does have the power to combat health care fraud and eliminate fraudulent providers,⁴⁹ it also has the potential to decrease patient protection. This is the harsh reality that exists on the opposite end of the patient-protection spectrum, and these are the reasons the Statute must be amended yet again to better ensure the patient protection purpose of the PPACA is not frustrated.

B. The Current Costs of Making Health Care Affordable for All

Not only does the government's reliance on the Statute and the Statute's broad applicability to the business of health care frustrate the end goal of patient protection, but its reliance also may frustrate the objective of making health care affordable through the best potential means. Given its overly broad nature and absence of actual knowledge or specific intent requirement for an individual or entity to be convicted for its violation,⁵⁰ the government has wide latitude when choosing against whom the Statute will be enforced. Since even the most innocuous of business arrangements, including business arrangements perfectly legal in other business industries, may violate the Statute,⁵¹ the government can theoretically choose to target certain groups of health care providers and arbitrarily enforce the law.

The government also has the ability to drop criminal charges and pursue False Claims Act civil litigation against entities with deeper pockets, and to use the Statute's criminal penalties as leverage to incentivize individuals and entities in the health care business to settle and avoid jail time. Notably, the government has a significantly lower burden

⁴⁹ See 42 U.S.C. § 1320a-7b (2012); see also Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6402(f)(2), 124 Stat. 119 (2010).

⁵⁰ See 42 U.S.C. § 1320a-7b (2012).

⁵¹ See, e.g., Lisa A. Estrada, *Physicians Face Increased Anti-Kickback Enforcement Focus*, HEALTH CARE LAW TODAY (June 23, 2015), <https://www.healthcarelawtoday.com/2015/06/23/physicians-face-increased-anti-kickback-enforcement-focus/>.

in a civil case as opposed to a criminal case, which disadvantages the accused.⁵² Threatened into choosing between fighting a felony criminal prosecution, which can carry immense legal fees and up to five years of imprisonment per violation, or settling with the federal government for millions of dollars civilly, some providers may feel the latter is the most affordable and least risky of the two alternatives—even when they do not admit guilt and honestly believed that they were complying with the law.⁵³ Thus, innocent health care providers may end up settling for millions of dollars not only to avoid crushing attorney’s fees, but also because they feel it is their best alternative to potential imprisonment.⁵⁴ The Statute thus creeps into the innocuous business practices of innocent individuals and leads them to turn over their hard-earned funds in order to fund the Medicare and Medicaid health care programs.

Undoubtedly, there are cases so egregiously unethical and deplorable that they should result in the accused forfeiting illegally received funds to federal health care programs as reimbursement.⁵⁵ In those cases, the government should be able to capitalize on the power of the federal anti-kickback statute and restore illegally obtained funds to federal health care programs and impose severe terms of imprisonment.⁵⁶ But, funding federal health care programs by taking away the hard-earned money of some of our nation’s brightest, life-saving, and potentially innocent health care providers is an unacceptable means of making health care affordable for all Americans.

When innocent Americans can become entangled in innocuous situations that threaten penalties and punishments as severe as those imposed under the current version of the federal anti-kickback statute, it is completely natural for said individuals not to have alarm bells going off in their heads given that they are supposed to be the patients the government aims to protect under the PPACA. In fact, they shouldn’t have alarm bells going off in their heads. The alarm bells should be going off in the heads of our elected legislators, alerting them to existing problems with the Statute as it currently exists post-PPACA amendments, and causing them to realize that the Statute needs to be amended to ensure patient protection while making health care affordable, rather than increasing patient frustration and making health care affordable by unscrupulous means.

⁵² See generally 42 U.S.C. § 1320a-7b (2012).

⁵³ See, e.g., Stauffer, *supra* note 46.

⁵⁴ *Id.*

⁵⁵ See, e.g., *Detroit Area Doctor Sentenced to 45 Years in Prison for Providing Medically Unnecessary Chemotherapy to Patients* (2015), <http://www.justice.gov/opa/pr/detroit-area-doctor-sentenced-45-years-prison-providing-medically-unnecessary-chemotherapy> (last updated July 10, 2015).

⁵⁶ *Id.*

Though innocent health care providers may not always be the targets of criminal charges following a violation of the Statute, the position in which these providers find themselves gives prosecutors the arbitrary latitude to threaten them with prosecution in exchange for testimony against individuals who are not innocent or blatantly guilty. The broad language of the Statute also gives prosecutors discretion to go after certain health care providers and agencies. As a result, making large amounts of money may no longer be the goal of many providers, and the quality of care they provide may also no longer be as important when they are forced by the government to provide services to more individuals at a lower cost or face punishment.

V. THE DAMAGED AMERICAN HEALTH CARE SYSTEM: HOW ARE WE GOING TO FIX IT?

To allow the PPACA's major purposes to be realized and to reasonably decrease U.S.C. § 1320(A)-7(B)'s ability to have such controlling weight over the future of the American health care system, several approaches are available to the government to curtail the Statute's power by amendment.

A. The Patient Protection Focus Requires Patient Protecting Notice

As U.S.C. § 1320(a)-7(b) and the PPACA are currently drafted, no provision of either law provides for a notice requirement for victims of health care fraud.⁵⁷ Therefore, there are no requirements that an individual such as the person identified in the opening hypothetical be made aware when their health care providers have been arrested for, or convicted of, violating U.S.C. § 1320(a)-7(b). The absence of a notice provision for health care fraud victims in these situations leaves patients unprotected when they are most vulnerable, and that circumstance may result from one simple unintended violation of U.S.C. § 1320(a)-7(b).⁵⁸ One way to ensure that patient protection is realized under the PPACA is for Congress to amend the PPACA to require that health care providers provide notice to their previous and existing patients when they have been arrested or convicted of health care fraud.

One way of understanding the necessity of a notice requirement can be demonstrated through health care fraud cases involving physical risk to

⁵⁷ See 42 U.S.C. § 1320(a)-7(b) (2012); see also Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6402(f)(2), 124 Stat. 119 (2010).

⁵⁸ See 42 U.S.C. § 1320(a)-7(b) (2012).

patients.⁵⁹ In some instances of fraud which violate U.S.C. § 1320(a)-7(b), health care providers have subjected patients to medical procedures that can be dangerous, unnecessary, and oftentimes, deadly.⁶⁰ The National Health Care Anti-Fraud Association demonstrated the necessity of providing notice to patients when they have been victims of fraud through the following case:

In June 2002, . . . a Chicago cardiologist was sentenced to 12-1/2 years in federal prison and was ordered to pay \$16.5 million in fines and restitution after pleading guilty to performing 750 medically unnecessary heart catheterizations, along with unnecessary angioplasties and other tests as part of a 10-year fraud scheme. Three other physicians and a hospital administrator also pleaded guilty and received prison sentences for their part in the scheme, which resulted in the deaths of at least two patients . . . The physicians and hospital induced hundreds of homeless persons, substance abusers, and elderly men and women to feign symptoms and be admitted to the hospital for the unnecessary procedures. How? By offering them incentives such as food, cash and cigarettes. 'There were 750 people who had needles stuck into their hearts purely for profit, not because they needed it,' said one of the federal prosecutors.⁶¹ (quotations removed)

Given that many of the patients in this case were homeless individuals, many of them may never have been informed that the procedures they endured had potentially deadly side effects and were essentially performed for profit.

Patients faced with cases of egregious health care fraud, such as the vulnerable victims in this Chicago case, deserve to be provided with answers. They deserve to be provided with notice of their rights, and they deserve to be provided with guidelines as to what steps they may take to ensure their current and future personal health and safety, as well as to ensure justice. Therefore, Congress should amend the PPACA to provide a notice provision for patients who are victims of fraudulent health care

⁵⁹ See *The Challenge of Health Care Fraud*, NAT'L HEALTH CARE ANTI-FRAUD ASS'N, 2-3, (Nov. 29, 2015, 10:30 AM), <http://www.nhcaa.org/resources/health-care-anti-fraud-resources/the-challenge-of-health-care-fraud.aspx>.

⁶⁰ *Id.*

⁶¹ *Id.*

providers, as well as provisions outlining any necessary or appropriate steps victims may take in these instances.

B. Outlining the Impacts of Health Care Fraud on Patient Medical History Records

False billing and overbilling are two major ways by which health care fraud takes place in the American health care system.⁶² In some health care fraud schemes, this takes place in the form of health care providers deliberately misdiagnosing patients and performing procedures that could potentially remain in their patients' medical histories for the rest of their lives.⁶³ Though U.S.C. § 1320(a)-7(b) in connection with the PPACA provides for available punishments against fraudulent providers in these instances, the PPACA neglects to take into account the validity and reliability of the medical histories of patients who have been the victims of fraudulent providers.⁶⁴ This may lead to patients feeling unprotected and unsure of the reliability and validity of their medical records and histories, as well as necessary doctor's visits to validate or verify their health statuses after they've become aware that they may be a victim of health care fraud.

Fraudulent providers can also create severe problems for individuals by creating false records despite never having provided care. Examples of these lingering injustices for victims of health care fraud have been shown by the National Health Care Anti-Fraud Association in a Consumer Alert about the impact of health care fraud on patients.⁶⁵ The Consumer Alert provided the following real-life case:

A Boston-area psychiatrist . . . forfeited \$1.3 million and was sentenced to several years in federal prison following his late-1990s conviction on 136 counts of mail fraud, money laundering and witness intimidation related to his fraudulent billing of several health insurers for psychiatric therapy sessions that never took place—using the names and insurance information of many people whom he actually had never met, let alone treated. (He also went so far as to write fictitious longhand session notes to ensure phony backup for his phony claims.) . . . In fabricating the claims, the psychiatrist also fabricated diagnoses for those

⁶² *Id.* at 1-2.

⁶³ *Id.*

⁶⁴ *See id.*; *see also* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 6402(f)(2), 124 Stat. 119 (2010).

⁶⁵ NATIONAL HEALTH CARE ANTI-FRAUD ASS'N, *supra* note 59.

“patients”—many of them adolescents. The phony conditions he assigned to them included ‘depressive psychosis,’ ‘suicidal ideation,’ ‘sexual identity problems’ and ‘behavioral problems in school.’⁶⁶

Notably, both U.S.C. § 1320(a)-7(b) and the PPACA also neglect to outline and describe how much credit and/or weight a patient’s future health care providers should give to the medical records and histories of patients who are victims of fraudulent health care providers.

Since U.S.C. § 1320(a)-7(b) is broad enough to hold providers accountable for an endless list of technically, though not willfully, fraudulent practices, and broad enough to create victims out of those providers’ patients, more patients may also be at risk of their health care providers being accused or convicted of fraud. Congress can better ensure patient protection and alleviate this issue (which is clearly an undesirable potential impact of the PPACA) by amending the PPACA to outline how medical fraud victims’ medical records and histories should be viewed by their future health care providers, and by providing guidelines for victims of fraud to follow should they find themselves in such a predicament.

C. Making the Punishment Fit the Crime: Variations in Sentencing Between Specific Intent and General Intent Violators

Undoubtedly, health care fraud is an issue of national concern. Considering the health care industry is one of the largest and fastest growing in America,⁶⁷ it is no surprise that individuals specifically target the health care industry with the intent to commit fraud.⁶⁸ However, given the broad language of U.S.C. § 1320(a)-7(b), it is possible that many innocent individuals and entities entering the industry may take actions in violation of the Statute completely unaware that their practices may be considered illegal and that they may be subject to felony prosecution.⁶⁹ In those instances, courts have historically found that ignorance of the law is

⁶⁶ *Id.* (quotations omitted).

⁶⁷ Dan Diamond, *Healthcare Jobs Just Grew at Fastest Pace Since 1991*, FORBES, (Jun. 5, 2015, 10:30 AM), <http://www.forbes.com/sites/dandiamond/2015/06/05/hospitals-jobs-growth-is-suddenly-booming/#5f0fa4983bce> (last visited Nov. 10, 2016).

⁶⁸ See e.g., *Detroit Area Doctor Sentenced to 45 Years in Prison for Providing Medically Unnecessary Chemotherapy to Patients*, *supra* note 55; see also *Medical Director and Three Therapists Sentenced for Their Roles in \$63 Million Miami Health Care Fraud Scheme*, U.S. DEPARTMENT OF JUSTICE, <https://www.fbi.gov/miami/press-releases/2015/medical-director-and-three-therapists-sentenced-for-their-roles-in-63-million-miami-health-care-fraud-scheme> (last visited Jan. 1, 2016).

⁶⁹ See, e.g., Meredith Cohn, *Justice Department settles with hundreds of hospitals, 10 in Maryland, over defibrillators*, THE BALTIMORE SUN (Oct. 30, 2015, 7:55 PM), <http://www.baltimoresun.com/health/bs-hs-hospitals-settle-20151030-story.html>.

no excuse. This strict enforcement view can be understood given the devastating impact health care fraud has had on the American economy over the years, as well as by examining some of the most egregious cases.⁷⁰

In FY 2014, the federal government recovered \$1.9 billion more in fraudulently obtained health care funds than it had in FY 2013.⁷¹ The year 2014 saw the recovery of \$5.7 billion in fraudulently obtained health care dollars,⁷² which if unrecovered, would drive up the costs of health care for all Americans. The severity of punishment for a single violation of the statute makes sense in terms of cracking down on fraudulent providers.⁷³ Since 2007, the government has charged over 2,300 accused health care fraudsters with collectively billing Medicare and/or Medicaid for over \$7 billion in fraudulent claims.⁷⁴ The need for the government to be able to effectively fight health care fraud to ensure patient protection and affordable care for all, as well as law enforcement's eagerness to rely on the Statute to combat fraud can be easily understood in light of some of the largest health care fraud cases of 2015.

In Michigan, a state where health care fraud has been a serious problem, Dr. Farid Fata, M.D. pleaded guilty not only to conspiring to pay kickbacks, but also to conspiring to receive kickbacks.⁷⁵ Chief Richard Weber, of the Internal Revenue Service, called the case of Dr. Fata "the most egregious case of fraud and deception" that he'd seen in his entire career.⁷⁶ According to the Department of Justice, Dr. Fata was a licensed medical doctor who owned and operated a cancer treatment center through which he admitted to "prescribing and administering unnecessary aggressive chemotherapy, cancer treatments . . . and other infusion therapies to patients in order to increase his billings to Medicare and other health insurance companies."⁷⁷ Chief Richard Weber perfectly summed up

⁷⁰ See, e.g., *Detroit Area Doctor Sentenced to 45 Years in Prison for Providing Medically Unnecessary Chemotherapy to Patients*, *supra* note 55.

⁷¹ Eric Pianin, *Billions in Medicare Fraud Still Rampant Despite Federal Crackdown*, THE FISCAL TIMES, (Dec. 18, 2015), <http://www.thefiscaltimes.com/2015/12/18/Billions-Medicare-Fraud-Still-Rampant-Despite-Federal-Crackdown> (last visited Nov. 9, 2016).

⁷² See *Id.*

⁷³ See, e.g., *Medical Director and Three Therapists Convicted in \$63 Million Health Care Fraud Scheme* (2015), <http://www.justice.gov/opa/pr/medical-director-and-three-the-rapists-convicted-63-million-health-care-fraud-scheme> (last visited Jan. 10, 2016); see also Estrada, *supra* note 51.

⁷⁴ See *Medical Director and Three Therapists Convicted in \$63 Million Health Care Fraud Scheme*, *supra* note 73.

⁷⁵ See *Detroit Area Doctor Sentenced to 45 Years in Prison for Providing Medically Unnecessary Chemotherapy to Patient*, *supra* note 55.

⁷⁶ *Id.*

⁷⁷ *Id.*

the needs for better patient protection overall and for the government to recover illegally obtained funds as demonstrated by Dr. Fata's case:

Dr. Fata not only defrauded the government out of millions of dollars, but he lied to his patients about their health and intentionally put their lives at risk. In fact, because of his lies, some of those patients who he was entrusted to care for likely died as a result of his actions. This defendant greedily cared more about his own financial well-being than the lives of his patients. This disgusting and diabolical scheme has hurt hundreds of patients and their families and stolen from them something that no punishment from the court can do to make them whole.⁷⁸

Unfortunately, specific intent-based violations of health care fraud laws such as Dr. Fata's are not at all uncommon; especially in South Florida, where some of the largest health care fraud schemes have taken place.

In August 2015, a formal medical director and three therapists were convicted in a health care fraud scheme where a total of 22 defendants were charged after the now defunct mental health care center they allegedly worked for submitted⁷⁹ "approximately \$63.7 million in false and fraudulent claims (also considered kickbacks) to Medicare, and received payments" amounting in around \$28 million paid out by Medicare for claims of services that in some instances were never even provided.⁸⁰ In addition to paying kickbacks to assisted living facility owners and operators in Miami for Medicare patient referrals, health care providers at the mental health clinic also fabricated medical records "to support false and fraudulent claims for partial hospitalization program services that were not medically necessary and often never provided."⁸¹ "Notably, in that case, the victims were elderly mental health patients suffering from Alzheimer's and dementia who were unaware of any existing scheme and the fact that they were actually being defrauded."⁸² Here, the need for patient protection was undeniable. In the Government's Consolidated Sentencing Memorandum in the case, Allan Medina, trial attorney, United States Department of Justice Criminal Division, Fraud

⁷⁸ *Id.*

⁷⁹ *See Medical Director and Three Therapists Convicted in \$63 Million Health Care Fraud Scheme, supra note 73; see also Medical Director and Three Therapists Sentenced for Their Roles in \$63 Million Miami Health Care Fraud Scheme, supra note 68.*

⁸⁰ *See Medical Director and Three Therapists Sentenced for Their Roles in \$63 Million Miami Health Care Fraud Scheme, supra note 68.*

⁸¹ *See Gov't Consol. Sentencing Brief, at 1-3.*

⁸² *Id. at 2.*

Section, explained why the egregious conduct of the defendants called for serious patient protection:

[T]he fraud at Health Care Solutions Network, Inc. (“HCSN”) victimized Medicare and Medicaid and the very patients the Defendants and their co-conspirators purported to help. For years – not days, weeks, or months – the Defendants took advantage of some of society’s most vulnerable people – individuals suffering from dementia, Alzheimer’s disease, mental retardation and other debilitating psychiatric conditions, as well as individuals that may have desperately needed, but never received, legitimate PHP treatment. HCSN was a criminal enterprise built on lies and deceit, and these Defendants played a vital role in its assembly line of fraud⁸³ . . . Without a doubt, the fraud at HCSN would not have flourished without Rousseau, as he was HCSN’s Medical Director from day one. For more than six years, he blindly signed HCSN medical records and recruited others to fuel the fraud, including other doctors—Dr. Villamil and Dr. Manley—and an intake assessment specialist from a hospital in South Florida—Francisco Pabon—who agreed to sell patients to HCSN in exchange for cash payments and gift cards. Patients who may have needed medical attention were beside the point; the patients at HCSN were commodities, and Rousseau allowed unlicensed professionals, such as Dana Gonzalez, to play doctor in his stead.⁸⁴

As egregious as these cases may undoubtedly be, the majority of serious health care fraud is committed by a minute fraction of money-hungry health care providers consciously acting both knowingly and willfully with the specific intent to defraud the government for their own personal gain.⁸⁵ However, not all violations of health care fraud are so egregious. In the cases of general intent violators, the dominating use and effect of U.S.C. § 1320(a)-7(b), which essentially forces health care professionals to settle with the federal government for millions of dollars though they may have not knowingly and willfully violated the law, calls into question how much power the federal government should have over the health care industry under a single statute.

⁸³ *Id.* at 2.

⁸⁴ *Id.* at 4.

⁸⁵ See NATIONAL HEALTH CARE ANTI-FRAUD ASS’N, *supra* note 59.

In a recent case, more than 130 hospitals agreed to a settlement with the federal government which will cause them to pay more than \$105 million to resolve allegations that the hospitals submitted Medicare claims for medically unnecessary procedures,⁸⁶ each of which was technically a separate and distinct violation of U.S.C. § 1320(a)-7(b). A spokeswoman for one of the hospitals said in a statement that “[e]ven though there were no findings of wrongdoing or liability, we agreed to the settlement to avoid the delay, uncertainty, inconvenience and expense of protracted litigation in a case that has been pending since 2008,”⁸⁷ raising the troubling possibility that the hospital settled because settlement was the safest solution, and not because the hospital intended to break the law.

In another recent case which alleged fraudulent hospital medical practices in 43 of the 50 states, a record-breaking 457 hospitals reached a \$250 million settlement with the federal government.⁸⁸ In that case, the Department of Justice alleged that the hospitals performed procedures placing implantable cardioverter defibrillators in patients too soon after bypass surgery, angioplasty or heart attacks.⁸⁹ In cases like this, the question arises of whether a medical service provider should be punished for making the decision to perform procedures he or she may honestly believe are in the best interest of his or her patients merely because the government disagrees about the medical necessity of said procedures.

Essentially, every single procedure where a health care provider implanted a cardioverter defibrillator in a Medicare or Medicaid patient when the health care professional truly believed the procedure was medically necessary and billed Medicare for that procedure constituted a violation of U.S.C. § 1320(a)-7(b), and subjected that health care provider to potential felony charges.⁹⁰ In this case, as in many others, the accused hospitals involved did not accept liability by the terms of the settlement, and many officials for the hospitals “maintain they gave their patients proper medical care but settled allegations to avoid further litigation.”⁹¹ A spokeswoman for another hospital which is also tied to the University of Maryland stated, “While the government’s focus was on the billing criteria, our primary focus has always been to ensure that our patients are

⁸⁶ Stauffer, *supra* note 46.

⁸⁷ *Id.*

⁸⁸ See Susan Morse, *457 hospitals settle for \$250 million over improper implantable cardioverter defibrillator surgeries*, HEALTHCARE FINANCE (Nov. 3, 2015), <http://www.healthcarefinancenews.com/news/457-hospitals-settle-250-million-over-improper-implantable-cardioverter-defibrillator-surgeries>.

⁸⁹ *Id.*

⁹⁰ Cohn, *supra* note 69.

⁹¹ *Id.*

provided with appropriate care, and we are satisfied that appropriate care was, in fact, provided to our patients.”⁹²

Under The Centers for Medicare and Medicaid Services’ rules, defibrillators of the type at issue here “can only be implanted 40 days after a heart attack and 90 days after bypass surgery or angioplasty. The rules are designed to give patients’ heart function time to improve, possibly negating the need for a defibrillator, and were developed based on clinical trials and input from specialists, manufacturers and patient advocates.”⁹³ However, the rules do not take into account what rights health care professionals have in times of emergency, nor what rights they have when their opinions of what procedures are medically necessary conflict with Medicare’s rules. In these instances, health care professionals are forced to choose between what they truly believe is right for their patient and doing only what is considered medically necessary and covered by their patients’ insurance.⁹⁴ In the words of Dr. Alan Cheng, a cardiologist and associate professor of medicine at the Johns Hopkins University School of Medicine, who was not involved in the settlement:

[T]here are times when it doesn’t make sense to wait, such as when a patient’s heart function is so poor he’s scheduled for a defibrillator implant but has a heart attack before surgery. Other times a patient has a heart attack and function isn’t likely to improve, and doctors want to implant both a pacemaker and a defibrillator immediately. In that case, the patient would have to have two procedures to comply with the defibrillator rule.⁹⁵

As evidenced by these cases, in some instances, health care professional violators truly believe they are innocent, and the Statute as it currently exists does not require the government to prove actual knowledge or specific intent to sustain a conviction. Still, their actions are technically in violation of the law and subject them to felony punishments. To rectify the controlling power of U.S.C. § 1320(a)-7(b)’s in these instances of general intent-based violations, Congress must amend the Statute’s provisions to provide for a differentiation between general and specific intent-based violations in terms of the severity of punishment and penalties available for violators of the law. Doing so would allow the government the ability to continue successfully prosecuting all violators of the Statute while recovering fraudulent funds and making health care

⁹² *Id.*

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.*

more affordable. For the less culpable offenders, this legislative action would allow them to avoid the severity of U.S.C. § 1320(a)-7(b)'s potential wrath where there is no specific intent to defraud, and for the specific-intent violators, justice may rightly be served. Variations in punishments between specific and general intent violators can be made in the classification of their offenses as misdemeanors or felonies as well as in the severity of civil penalties available for the government to pursue.

D. A Call For One Final Amendment: Preserving the Good SEEDS For Flourishing While Eliminating the Bad Seeds

While one possibility is to amend U.S.C. § 1320(a)-7(b)'s provisions allowing for a differentiation in the severity of penalties available for general and specific intent violations, perhaps the better solution would be to make any violation of the Statute a specific intent-based crime. The government would most likely argue that the government needs to be able to effectively enforce the law, and specific intent-based crimes are harder to prove beyond a reasonable doubt than are general intent-based crimes. Perhaps it should be harder for law enforcement to prove that our nation's brightest individuals who have dedicated their lives to improving the American health care system are genuine criminals, given the message that that actuality would send to future generations of health care patients about the amount of protection they can expect as health care patients and about the trustworthiness of their health care professionals.

If deterrence and the elimination of fraudulent providers are the goals of our government, why punish those individuals or entities who unknowingly violated the law when they've dedicated their entire lives to patient protection and treatment? Shouldn't actual knowledge be a prerequisite to find guilt in these cases? In theory, deterrence involves punishing criminals so that future potential criminals are discouraged from committing the same wrongful and illegal acts. But when the alleged criminals were not even aware their actions were wrongful, U.S.C. § 1320(a)-7(b) should not be able to destroy their reputations in the medical community forever. The patient protection focus of the PPACA is frustrated when those who devote their lives to protecting patients—our nation's best and brightest health care providers—can face felony criminal charges for doing just that: protecting their patients.

If the government aims to eliminate fraudulent providers, it should do just that. As noted in the cases of Dr. Fata and the mental health care professionals in Miami, specific intent to violate the Statute can be proven, and exposing those who specifically intend to defraud and eliminating them from our health care industry does ensure better patient protection in the future and does restore Medicare funds, making health care more

affordable. However, those health care providers who are potentially innocent or engage in conduct that only constitutes a violation of U.S.C. § 1320(a)-7(b) because of the Statute's over-broadness, should not be viewed in the same light nor legally treated in the same way as the clearly money hungry, fraudulent providers. Instead, they should be respected based on their merits and achievements in the field of medicine. They should be celebrated as well as appreciated for the hard work they do. They should be able to make determinations of what the best decisions are concerning medical treatments for their patients. And, they should be able to perform these actions without the fear of being criminally prosecuted, facing jail time, and facing endless attorney's fees for violating an overly broad statute in the name of protecting their patients. For these reasons, society would benefit far greater from making U.S.C. § 1320(a)-7(b) a specific-intent-based statute despite the fact that the government would undoubtedly recover more Medicare funds by not requiring specific intent nor actual knowledge to sustain a felony conviction under U.S.C. § 1320(a)-7(b).

The majority of health care fraud is intentionally committed by a minority of bad seeds.⁹⁶ Inevitably, one bad seed can tremendously frustrate the ability for a garden to grow by the right means. Removing these bad seeds from our American Health Care System Garden and disallowing them the ability to devastate our Garden is of benefit to all Americans. But in order for our Garden to flourish, we need our metaphorical good seeds to continue working for the right reasons and to continue being encouraged to provide the best patient protection that they can. To realize patient protection and help make health care affordable for all Americans as envisioned under the PPACA, we as a nation need to call to our Congress' attention the potential effects of this overly broad Statute on the ability of our good seeds to flourish. Otherwise, uncertainty exists as to which direction our Garden may grow. The best way to achieve this reality is by making a violation of U.S.C. § 1320(a)-7(b) one that requires a finding of specific-intent.

VI. CONCLUSION

There are several ways by which Congress can amend the current federal anti-kickback statute to better ensure patient protection under the PPACA and make health care affordable by means more reasonable for all. Some of the ways by which this can occur are by including guidelines in the PPACA which will provide victims of health care fraud with guidance of what steps to take and what rights they have when their health

⁹⁶ NATIONAL HEALTH CARE ANTI-FRAUD ASS'N, *supra* note 59.

care providers are accused of, charged with, or convicted of health care fraud; providing a notice requirement in the PPACA which requires health care providers to provide notice and the availability of potential rights to their current and past patients when charged with or convicted of violating health care fraud laws; allowing for a differentiation in the degree and/or level of U.S.C. § 1320(a)-7(b) violations in instances of general intent versus specific intent; or, making a violation of U.S.C. § 1320(a)-7(b) a specific-intent based crime requiring a showing of actual knowledge before guilt can be found.

Whether Congress is actually willing to amend U.S.C. § 1320(a)-7(b) to take into account its effect on the practicability of the PPACA may not only impact the future public opinion concerning the trustworthiness of American health care providers, but it also may frustrate key reasons of why the PPACA was enacted in the first place. Patient protection and affordable care will always come at a cost. But a large percentage of that cost should be paid by the bad seeds, while the good seeds are left to grow not only their professional medical practices, but also left a stronger, healthier American nation.