PUBLICATION

Health Care Fraud Prosecutions: Strong Seas and High Winds Ahead for Individuals and Corporations [Ober|Kaler]

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"The pessimist complains about the wind; the optimist expects it to change; the realist adjusts the sails."
-William Arthur Ward

During the past nine months, the U.S. Department of Justice (DOJ) has made several significant policy pronouncements that impact health care organizations and individual providers. These directives and initiatives reflect that DOJ will continue to aggressively carry out civil and criminal health care fraud enforcement efforts.

Individual Health Care Providers

In September 2015, DOJ issued its individual accountability policy (Yates Memo), which reflects how DOJ remains focused on holding individuals accountable for corporate wrongdoing. Recent enforcement efforts against individuals reveal that DOJ's prosecutorial zeal shows no sign of abating. On June 22, 2016, DOJ, the U.S. Department of Health and Human Services (HHS), the FBI, and other law enforcement officials held a joint press conference during which they announced health care fraud charges filed against several individuals as part of the Medicare Strike Force's annual "takedown." As was the case in prior years, the DOJ touts this year's nationwide effort as being the "largest in history," in terms of the number of people charged and with respect to the dollar amounts associated with allegedly false Medicare billings.[1]

The statistics associated with this year's June 2016 dragnet merit a closer look: 301 individuals charged with mostly criminal offenses, 61 of whom were doctors, nurses, pharmacists, and other licensed medical professionals; charges filed against health care company owners; allegations of approximately $900 million in false billings submitted to Medicare for services that were medically unnecessary or never rendered; and allegations of kickbacks paid to providers for referrals that led to the provision of medically unnecessary services or equipment.

For the most part, the allegedly fraudulent schemes implicate the home health care, therapy, and durable medical equipment industries. New trends of fraud this year include cases involving the Medicare Part D program and the identify theft of physicians' personal information to further that fraud, as well as cases related to compounding pharmacy fraud.

Keeping to its investigatory methods of prior years, the Strike Force used real-time data analysis to find aberrant billing patterns and identify data outlines, which enabled them to develop investigative leads and to target "hot spots" for fraud. In another interesting aspect of this year's takedown, CMS announced it was using its suspension authority under the Affordable Care Act to immediately suspend payments to several of the criminally charged providers because of credible allegations of fraud. And, finally, at the same time that the "takedown" was announced, DOJ disclosed a False Claims Act civil settlement agreement with a residential treatment program that provided therapy services to children, as well as the fact that several individuals in 14 different states were charged in civil and criminal actions with defrauding the Medicaid programs.[2]

Health Care Entities or Corporations

Since September 2015, DOJ has emphasized that it will continue to scrutinize corporations and their compliance programs as it investigates and prosecutes fraud. In the *Yates Memo*, DOJ announced that corporations who disclose wrongdoing and want to receive "cooperation credit" must now provide *all* facts about *all* of the individuals involved in — or who approved of — the misconduct being reported.

Thereafter, in November 2015, DOJ's Criminal Division announced that it was hiring its first compliance officer. According to DOJ, the compliance officer will aid criminal prosecutors considering whether to charge a corporation with fraud by evaluating compliance programs to determine whether they are "paper programs," or whether a company does, in fact, have a culture that actually promotes compliance with the law.[3]

Next, in late 2015, DOJ's criminal Fraud Section instituted a Corporate Health Care Fraud Unit. This team of health care fraud prosecutors will review virtually all False Claims Act lawsuits filed nationwide, with an eye towards determining whether the facts and circumstances also support criminal investigation and possible prosecution. Recently, Assistant Attorney General Leslie Caldwell announced that this specialized team has more than a dozen active corporate investigations.[4]

Finally, in March 2016, DOJ, in collaboration with several state and local prosecutors (e.g., Medicaid Fraud Control Units), launched 10 regional Elder Justice Task Forces. These Task Forces are focused on investigating skilled nursing facilities that provide "grossly substandard care to their residents,"[5] with an interest in criminally prosecuting health care fraud uncovered.

Ober | Kaler's Comments

So, what does all of this recent activity mean? Are there reasonable inferences that individual providers and corporations can draw from these aggressive measures?

First, DOJ has absolutely no trepidation about zealously prosecuting doctors, pharmacists, and other medical professionals for what it believes to be medical unnecessary services or services rendered as a result of kickbacks.

Second, corporate health care entities need to understand that parallel civil and criminal prosecutions continue to be a DOJ focus. It is more important than ever for companies to work with compliance and audit personnel to strengthen their mechanisms for reporting and detecting potential Medicare and Medicaid fraud and abuse. Companies are on notice that if they find themselves under investigation, their compliance programs and culture will be scrutinized for true efficacy.

Next, companies should re-evaluate and revise their compliance plans to incorporate specific directives that take into account the *Yates Memo*'s focus on individual liability, including how complaints about alleged wrongdoing will be addressed.

Moreover, if a potential fraud or abuse issue has been detected, make sure that you thoroughly investigate the problem and, where appropriate, do not be afraid to take remedial action against all individual wrongdoers and document that action. More robust compliance training directly related to the issues uncovered is a necessity. Furthermore, if a company decides to disclose internal investigation findings to DOJ, be prepared to share all non-privileged facts to include those that identify all involved in the conduct at issue.

Finally, if you are a skilled nursing facility, do not hesitate to investigate more quickly and thoroughly complaints related to the quality of care of your residents, and be mindful of Elder Justice Act reporting requirements upon “reasonable suspicion” of a crime.

In other words, it is time to adjust the sails, and to tack and jibe where necessary.

[1] National Health Care Fraud Takedown Results in Charges against 301 Individuals for Approximately $900 Million in False Billing, DOJ News Release, June 22, 2016.
[2] Id.
[3] Assistant Attorney General Leslie R. Caldwell Speaks at SIFMA Compliance and Legal Society New York Regional Seminar, Remarks as prepared for delivery, Nov. 2, 2015.
[4] Id.
[5] Assistant Attorney General Leslie R. Caldwell Speaks at Health Care Compliance Association's 20th Annual Compliance Institute, Remarks as prepared for delivery, Apr. 18, 2016.