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Massive Criminal Takedown Is Latest Salvo in Government's Intensified Campaign Against Health Care Fraud and Abuse

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On May 2, 2012, the Justice Department and the U.S. Department of Health and Human Services (HHS) announced a nationwide takedown of 107 individuals for Medicare fraud schemes involving approximately $452 million in false billings. The wave of indictments were the culmination of the Medicare Fraud Strike Force's investigation of illegal schemes orchestrated by various health care workers, including doctors, nurses, and social workers in Baton Rouge, Chicago, Detroit, Houston, Los Angeles, Miami, and Tampa. Fifty-nine of the defendants were indicted in Miami for their involvement in a scheme to defraud Medicare of $137 million in false billings for home health care, mental health, and other services. Seven individuals were accused of submitting $225 million in false claims through two community mental health centers located in Baton Rouge—the largest-ever prosecution involving such institutions. The accused face a range of criminal charges, including health care fraud, conspiracy to defraud the Medicare program, money laundering, and violations of the antikickback statute. In addition, administrative action was taken against 52 providers pursuant to authority recently afforded by the Affordable Care Act that permits HHS to suspend payments until the completion of an investigation.

The synchronized takedown, which involved the highest amount of false billings ever targeted in a Medicare Fraud Strike Force investigation, marks the latest achievement in the federal government's efforts to make health care fraud a law enforcement priority. In 2009, President Obama launched the Health Care Fraud Prevention and Enforcement Action Team (HEAT), an interagency working group specifically engineered to combat health care fraud. Embodied within HEAT is the Medicare Fraud Strike Force, a joint effort of agents from the FBI, the DOJ, the

Office of Inspector General (OIG), and regional Medicaid Fraud Control Units, which operates in nine U.S. cities to investigate and prosecute fraudulent Medicare billings. Utilizing new legal tools, resources, and penalties provided by the Affordable Care Act, these law enforcement bodies have steadily increased the scale and scope of their activities. In fiscal year 2010, federal law enforcement secured over $4 billion in criminal, civil, and administrative recoveries. Federal health care fraud prosecutions increased in fiscal year 2011, as the DOJ opened 1,110 new criminal fraud investigations involving 2,561 potential defendants while prosecutors secured 743 convictions for health care crimes and the OIG excluded 2,662 individuals. According to government calculations, in the past three years authorities have returned an average of seven dollars for every dollar spent on health care enforcement efforts.

While the fate of current health care reform efforts remains in limbo, it is clear that the Obama Administration will be touting its intensified campaign against health care fraud and abuse as one of its cardinal achievements. This doubling down of law enforcement efforts is underwritten by broad public support and the perception that fraud is a central driver of spiraling health care costs. Through inter-agency working groups and collaboration between federal and state agencies, the government is focusing upon coordination as a means to bring its enormous leverage and resources to bear in the most potent manner. Industry observers should expect criminal prosecutions to successively increase in size and number due to the government's enhanced determination to protect federal health care expenditures.

Finally, while the recent takedown targeted blatant fraudsters, it would be unwise to presume that the government's efforts will be limited to only the most reprehensible conduct. These criminal prosecutions are in addition to—and not in lieu of—the government's other enforcement strategies that involve civil actions under the federal False Claims Act (FCA) and exclusion of individuals and entities from participation in Medicare and state health care programs. It is now well-settled that FCA suits, and the enormous penalties they can engender, may be premised on regulatory and even technical violations of antikickback statute and the Stark Law. Likewise, career-ending administrative exclusions have been increasingly meted out

on the basis of misdemeanors. At bottom, practitioners and industry stakeholders should heed Assistant Attorney General Tony West's recent pronouncement that the government will seek "to disprove the ill-advised notion that health care fraud enforcement is simply the cost of doing business."[1] By inviting criminal prosecution, civil fine, or administrative sanction, the consequence of both malfeasance and misfeasance in the health care context may prove catastrophic.

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[1] Press Release, Department of Justice, Assistant Attorney General Tony West Speaks at the 12th Annual Pharmaceutical Regulatory and Compliance Congress (Nov. 2, 2011).