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The criminal regulatory framework

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The United States government has a plethora of agencies at its disposal to coordinate and enforce healthcare legislation. One agency, above all others, possesses the sole power to indict not only individuals, but companies that it views as having committed healthcare fraud. The Department of Justice (DOJ) is tasked with enforcing the law and defending the interests of the United States according to the law. The DOJ has recently estimated that healthcare fraud costs the United States more than $100 billion per year and growing. To that end, among the most frequently abused laws are the healthcare regulations.

To combat this fraud, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a national Health Care Fraud and Abuse Control Program (HCFAC) under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS). And, in 2009, the DOJ and investigative agencies established the Health Care Fraud Prevention & Enforcement Action Team (HEAT).

HEAT was designed to: (1) aggregate significant resources across government to prevent fraud, waste, and abuse in the Medicare and Medicaid programs; (2) reduce skyrocketing healthcare costs and improve the quality of care by ridding the system of those preying on Medicare and Medicaid beneficiaries; (3) highlight best practices by providers and public sector employees; and (4) build upon existing partnerships between DOJ, HHS and their client agencies to reduce fraud and recover taxpayer dollars.

Medicare Fraud Strike Force

The Criminal Division of the DOJ has more than 40 prosecutors assigned to healthcare fraud matters across the country, primarily through the Medicare Fraud Strike Force (MFSF). In addition to pure manpower, the MFSF employs highly advanced data analysis to identify aberrant billing levels to target suspicious billing patterns and emerging schemes. In fact, the MFSF's tools have expanded to the point where they are obtaining billing information and analyzing claims submission and reimbursement data from CMS in close to real time.

The MFSF has filed almost 1,000 cases, charging more than 3,200 defendants who collectively billed the Medicare program more than $11 billion. In 2014, the DOJ made $2.3 billion in healthcare fraud recoveries, marking five straight years it has recovered more than $2 billion in cases involving false claims against federal healthcare programs such as Medicare, Medicaid, and TRICARE. As such, the government will continue to devote growing resources to its healthcare fraud task force because, unlike other areas, healthcare fraud enforcement allows the government to recover a large portion of the money that was fraudulently obtained.

Lutemi Medical Supply

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At the early stages, the MFSF's targets were primarily low-level providers that often engaged in less complex and easier to detect frauds. For example, in July 2014, the owner and operator of Lutemi Medical Supply, a durable medical equipment (DME) supply company, was convicted of conspiracy, healthcare fraud, and money laundering in connection with an $8.3 million, 10-year Medicare fraud scheme. The evidence at trial showed that the defendant submitted fraudulent prescriptions for DME, primarily power wheelchairs and related accessories, by using street-level patient recruiters or "marketers" to find Medicare-eligible beneficiaries. The marketers then took the beneficiaries to doctors who prescribed medically unnecessary DME, and in return the defendant and her co-conspirators paid illegal kickbacks to the marketers and the doctors.[1]

This early success helped bring additional resources to the MFSF that have targeted increasingly complex frauds. Accordingly, the MFSF has been able to devote more resources to combat healthcare fraud, including increased efforts to investigate the larger, more complex healthcare frauds. Investigation and prosecution of the more complex frauds often puts hospitals, healthcare systems, and compliance professionals in the government's crosshairs. The DOJ's stated desire in prosecuting these evasive frauds is to send a strong deterrent message to the public and also to recoup payments that simply do not exist in the lower-level frauds. Below are a few examples of the government's recent trend in pursuing hospitals, healthcare systems, and compliance professionals.

Tenet Healthcare

Even though Tenet Healthcare Corporation previously agreed to pay a $513 million settlement in connection with a false claim case, it did not prevent criminal charges. In early 2017, John Holland, a former senior executive of Tenet, was indicted for his alleged role in a more than $400 million scheme to defraud the United States, and the Georgia and South Carolina Medicaid programs, by causing the payment of bribes and kickbacks in return for referring patients to Tenet hospitals. The indictment alleged that Holland concealed this scheme by circumventing internal accounting and compliance controls and falsifying Tenet's books, records, and reports. Ultimately, these alleged kickbacks and bribes helped Tenet bill Medicaid and obtain more than $149 million in Medicaid and Medicare funds based on the resulting patient referrals.[2] This case is still awaiting trial.

Additionally, two Tenet subsidiaries pleaded guilty to defrauding the United States and paying kickbacks and bribes in violation of the federal Anti-Kickback Statute (AKS), forfeiting more than $146 million. Specifically, in 2013 and 2014, the two subsidiaries were alleged to have paid bribes and kickbacks to the operators of prenatal care clinics serving primarily undocumented Hispanic women in return for the referral of those patients for labor and delivery medical services at Tenet hospitals. As a result, Tenet Health System Medical, Inc. entered into a non-prosecution agreement, requiring, among other things, an independent compliance monitor for three years.

Forest Park Medical Center

At the end of 2016, founders and investors of the physician-owned hospital, Forest Park Medical Center (FPMC) in Dallas, other executives at the hospital, and physicians, surgeons, and others affiliated with the hospital were charged in a federal indictment stemming from their alleged payment and/or receipt of approximately $40 million in bribes and kickbacks for referring certain patients to FPMC.

FPMC was an out-of-network hospital. According to the indictment, the patients referred to FPMC were primarily ones with high reimbursing, out-of-network, private insurance benefits or benefits under certain federally-funded programs. Additionally, the defendants are alleged to have attempted to sell patients with lower reimbursing insurance coverage to other facilities in exchange for cash. From 2009 to 2013, FPMC billed out-of-network insurance plans and programs well over half a billion dollars and collected more than $200 million in

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paid claims. Additionally, prosecutors allege doctors were allowed to invest in the hospital, based on the number of patients brought in, allowing them to profit from the volume of referred patients. Some of the defendants have pled guilty while the remaining defendants await trial.[3]

Merida Health Care Group

Merida Health Care Group is a collection of healthcare entities that provide hospice and home healthcare services located throughout the state of Texas. The defendants are alleged to have caused kickbacks and bribes to be paid to medical directors for the Merida Group's affiliated entities in exchange for certifying that patients qualified for services when, in fact, they did not, and for referring patients for such services. The defendants are also charged with fraudulently keeping patients on hospice services for multiple years in order to increase revenue from Medicare. This case is awaiting trial.[4]

Dawn Bentley

In June 2017, a Detroit-area medical biller was sentenced to 50 months in prison for her role in a $7.3 million healthcare fraud scheme. The jury found that Bentley, who was also ordered to pay $3.2 million in restitution, knowingly submitted fraudulent bills on behalf of physicians for services she knew could not have been rendered, and for services she knew had not been rendered as billed. In exchange, Bentley was paid 6% of the total billings paid to the physicians by Medicare.

Philip Esformes

Philip Esformes, the owner/operator of more than 30 skilled nursing and assisted living facilities (the Esformes Network), and his co-conspirators, a hospital administrator and a physician's assistant, were charged with conspiracy, obstruction, money laundering, and healthcare fraud in connection with a $1 billion scheme involving numerous healthcare providers. According to the indictment, Esformes had access to thousands of Medicare and Medicaid beneficiaries. Even though many of these beneficiaries did not qualify for skilled nursing home care or for placement in an assisted living facility, Esformes and his co-conspirators nevertheless admitted the beneficiaries to the facilities, where they allegedly received medically unnecessary services that were billed to Medicare and Medicaid.

Esformes and his co-conspirators are also alleged to have enriched themselves by receiving kickbacks in order to steer the beneficiaries to other healthcare providers who performed medically unnecessary treatments that were billed to Medicare and Medicaid. The kickbacks were often paid in cash or disguised as charitable donations. This case is set for trial.

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