The Brave New World of Health Care Fraud and Abuse: New Civil Fraud Unit Reflects National Trends

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On January 18, 2011, the U.S. Attorney for the District of Minnesota announced the formation of a new Civil Fraud Unit in the Civil Division of the U.S. Attorney's Office. Among other focuses, the Civil Fraud Unit will combat financial fraud, including health care fraud. The Unit's proposed activities (including working closely with the Criminal Division) reflects the broad range of civil enforcement remedies available under anti-fraud laws, including civil money penalties, treble damages, and equitable and injunctive relief. These remedies are not available in most criminal actions and the Unit can take advantage of the lower burden of proof available in civil litigation.

While the Unit brings a new focus on local enforcement action by the U.S. Attorney's Office, enforcement has been in the spotlight for some time. Since 1996, the U.S. Attorney's Office for the District of Minnesota has recovered over $139 million. The new Unit's renewed focus on enforcement will only make those numbers increase.

This new emphasis at the local level on fighting health care fraud reflects an intensifying crack down occurring across the country. While fraud and abuse enforcement is hardly a new trend, recent years have seen regulators add a number of extremely powerful weapons to their already well-stocked arsenal. One of the most important developments occurred in 2009, when amendments to the False Claims Act (FCA) created the concept of "reverse" false claims. Under the 2009 amendments, the retention by a health care provider of money from federal programs to which the provider was not entitled became something that could be prosecuted as a false claim. The 2010 Affordable Care Act (ACA) raised the stakes on these "reverse" false claims dramatically. Under the ACA, any such overpayment must be returned within 60 days of the date on which it was determined to exist, with the failure to do so actionable as a false claim. This 60-day window is an extremely tight time frame for providers to identify, much less return, any overpayments.

In addition to the 60-day overpayment provision, the ACA created a slew of new enforcement tools for regulators. For example, under regulations issued this January, Centers for Medicare & Medicaid Services (CMS) is implementing a rigorous screening process under which providers perceived to pose "high" risks of fraud are subject to heightened enrollment requirements—including criminal background checks and fingerprinting—before they can participate in federal health care programs. CMS will also have authority to

suspend payments to providers for up to 18 months in the event it has "credible allegations of fraud." Depending on a provider's size and the volume of federal program beneficiaries treated, CMS' power to suspend reimbursement while an investigation drags on over this lengthy period could prove a death knell. CMS will also be using "predictive" data software intended to identify health care fraud. If this software detects fraud within a category of providers or geographic area, CMS will be able to temporarily suspend provider enrollment while an investigation occurs.

Ample Weapons; Impressive Results

With such a well-stocked array of tools at their disposal, it is no surprise that federal regulators have succeeded handsomely in their efforts to target fraud and abuse. In 2010 alone, the federal government's fraud and abuse prevention and enforcement efforts recovered more than $4 billion in improper payments for federal health care programs. This reflects the largest single-year recovery in the history of the Health Care Fraud Abuse Control (HCFAC) program, which was created in 1996 to consolidate anti-fraud measures. Since its inception, HCFAC has returned more than $18 billion to federal coffers as a result of enforcement efforts.

2010 was also a banner year for FCA cases, with over $2.3 billion recovered as a result of health care qui tam lawsuits. Under the FCA's qui tam provisions, whistleblowers, known as "relators," are able to earn a portion of any amounts recovered as a result of the fraud that they uncover. In 2010 alone, relators recovered $385 million for their efforts. Since 1986, when the FCA was amended by Congress to make it the powerful fraud-fighting tool that it is today, FCA actions have returned more than $27 billion to the federal treasury, with relators taking home an additional $2.8 billion for their efforts.

In spite of these hefty numbers, the Office of Inspector General (OIG) has often expressed concern that there are insufficient consequences for the individuals who led organizations found to have violated the Stark Law, Anti-kickback Statute, or other laws that govern the health care industry. While the agency has discretion to exclude individuals in charge of organizations that violate the law, this authority has been exercised only rarely. In late 2010, however, the agency indicated it was renewing its focus on exclusion and published guidance that it would use in deciding whether to exclude individuals who were at an organization's helm when improper conduct occurred. Among the factors that OIG will consider are the individual's role in the entity, including the level of authority held and how close the individual was to the conduct at issue, as well as what types of actions the individual took once he or she learned of the improper activities. This emphasis on excluding individuals with leadership roles at organizations found to have violated the law is currently on display in regulators' decision to impose a 12-year exclusion on the former general counsel of Purdue Pharma due to his role in Purdue's improper misbranding of the pain drug Oxycontin. Program exclusion is a devastating penalty because it essentially precludes businesses that receive any federal payments from employing or contracting with the excluded individual.

Beyond civil recoveries and enforcement actions, regulators have also proved enormously active in the criminal arena. In 2010, the U.S. Department of Justice (DOJ) opened more than 1,100 new criminal health care fraud investigations and had another 1,787 criminal probes pending. DOJ also set a record in 2010 for criminal charges, with over 930 defendants charged in health care criminal actions. More than 700 defendants were convicted of various health care fraud related crimes as a result of DOJ efforts in 2010.

What Lies Ahead?

Given the significant financial and demographic pressures facing the Medicare and Medicaid programs—and a widespread perception of fraud and abuse as pervading the health care industry—it is difficult to foresee any letup in enforcement activities. And, with the obvious political benefits from being against "fraud and abuse," politicians have little incentive to put the brakes on enforcement activities. For providers, 2011 is likely be a very challenging year.