BARNES & THORNBURG LLP

FALSE CLAIMS ACT: INCREASED PROSECUTIONS AND HIGHER SENTENCES

June 23, 2015 | | Department Of Justice,The GEE Blog

George E. Horn, Jr.
Partner

As Assistant Attorney General Leslie R. Caldwell warned last September, the Department of Justice has increased its "commitment to criminal investigations and prosecutions that stem from allegations in False Claims Act lawsuits." The continued rise in criminal FCA investigations, combined with substantial sentences received by those Defendants, show that Caldwell's pronouncement was not an empty promise. Recent cases exemplify a clear intent by DOJ to continue aggressive investigation and prosecution of FCA matters. When convictions are obtained, the government has sought and obtained significant sentences against both institutional and individual wrongdoers. Riverside General Hospital (Riverside) in Houston, Texas, is one of the more recent examples of this increased prosecutorial fervor toward FCA violations in the healthcare arena. On June 9, 2015, the former President of Riverside, Earnest Gibson III, was given a 45-year prison sentence and ordered to pay restitution of $46,753,180.00 for his role in a $158 million Medicare fraud scheme. Gibson's son and co-defendant, Earnest Gibson IV, received a 20-year sentence and was ordered to pay restitution of $7,518,480.00, while a co-conspirator received a 12-year prison term and a restitution order of $46,255,893,00. On May 21, a former assistant administrator of Riverside received a 40-year sentence and was ordered to pay restitution of $31,321,200.00. In total, ten individuals have pled guilty or been convicted for their involvement in the Riverside case. Last week, Hebrew Homes Health Network, Inc. (Hebrew Homes) and William Zubkoff, its former President and Executive Director, agreed to pay $17 million to resolve False Claims Act violations related to improperly paying physicians for referral of Medicare patients. The Department of Justice announced this as the "largest settlement involving alleged violations of the Anti-Kickback Statute by skilled nursing facilities in the United States." As part of the agreement, Hebrew Homes entered into a 5-year corporate integrity agreement with HHS-OIG. Since January of 2009, DOJ False Claims Act investigations have recovered a total north of $24 billion, $15.3 million of which involved fraud against federal healthcare programs. There is no sign the government intends to reduce its efforts to combat healthcare fraud. To the contrary, investigations in this area continue to increase as are the sentences being meted out to both corporate and individual defendants who run afoul of healthcare laws. To best protect against violating federal and state healthcare regulations, providers must develop, follow and enforce robust compliance programs. Such programs should contain specific "core elements", including: 1) Written Policies, Procedures and Standards of Conduct

- Identify areas most at risk for fraud, such as – coding and billing;

RELATED PRACTICE AREAS

Financial and Regulatory Litigation
Government Litigation
Securities and Capital Markets
White Collar and Investigations

RELATED TOPICS

Medicare

government program documentation; referrals and physician financial arrangements.

- Policies must be clearly written and describe expectations in detail.
- Readily available to all employees.
- Reviewed and updated on a regular basis.
- Prepare detailed “Code of Conduct” and mechanisms for reporting.
- Detailed rules and responsibilities for Compliance staff.

2) Compliance Program Oversight

- The Compliance Officer (CO) and/or Compliance Committee (CC) should oversee the program with direct reporting and accountability to the organization’s CEO/President.
- Both CO and CC handle day-to-day operation of Compliance Program.
- CO and CC responsible for Compliance Program design and structure.
- Report periodically on status of program including matters identified, investigated and resolved.

3) Training and Education

- Educate employees on fraud risks.
- Initial compliance training for new employees occurs at or near date of hire.
- Conduct refresher compliance training, on at least an annual basis, highlighting any changes or developments in the program.

4) Opening the Lines of Communication

- Establish reporting requirements – both proactive and timely.
- Establish ability to report potential compliance issues anonymously via hotline or drop box.
- Compliance issues should be reported immediately.

5) Auditing & Monitoring

- Establish system for auditing and monitoring compliance program.
- Self-test identified risk areas to ensure compliance.
- Measure overall effectiveness of compliance program on periodic basis.
- Conduct periodic reviews of financial arrangements with physicians and healthcare partners.
- Establish policies and procedures for responding to detected offenses.

6) Consistent Discipline

- Discipline issues related to compliance program must be dealt with timely and enforced consistently.
- Policies must be clearly written and widely publicized.
- Describe expectations and consequences for non-compliant, unethical, and illegal behavior.
- Review with employees on regular basis.

7) Corrective Action

- Must be taken in response to potential violations.
- Such actions may include –

Repayment of overpayments; and Disciplinary action against responsible employees.

- Submit corrected reports addressing discovered violations.

The healthcare arena is a minefield for the unwary and unprepared. Given heightened government scrutiny and the increased sentences being leveled against corporate and individual defendants, providers must establish and adhere to rigorous compliance programs. By tailoring such programs to the work done by particular providers, an effective tool against fraud can be created and maintained.