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The Coming Wave of Health Care Fraud and Abuse Prosecutions

Efforts include increase in enforcement resources and interagency coordination.

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IN THE REAL-LIFE story behind the film, "The Perfect Storm," the crew of a small commercial fishing boat, the Andrea Gail, is tragically placed in grave danger when a cold front, a hurricane, and a Great Lakes gale come together to create a nor'easter with waves 10 stories high and winds topping 120 miles per hour.

This rare confluence of weather factors is evocative of the possible "perfect storm" brewing in New York when it comes to health care fraud and abuse investigations and prosecutions. Accordingly, white-collar defense counsel should be forewarned of this storm front and be prepared properly to respond when their clients' storm hits.

The government has been focused, to varying degrees, on health care fraud and abuse cases on the federal and state levels since around 1997. However, as a result of a number of developments all coalescing at the same time, health care fraud and abuse prosecutions have been and will continue to increase in frequency in the months and years ahead.

These developments include (1) new and amended legislation that provide prosecutors with more tools, and (2) increased enforcement resources for the prosecution of such cases. Each one has its own ability to cause rough waters, but the combination guarantees that practitioners who navigate these seas must develop a level of expertise not just with the substantive legal, compliance and regulatory issues, but also with the relationships between all of the different prosecuting agencies and the ramifications for the health care professionals who are the targets of these prosecutions.

New and Amended Legislation

By 2005, Governor George E. Pataki had continually shrugged off the Legislature's repeated attempts to enact a New York state False Claims Act as nothing more than light precipitation. But in July 2005, the rain became torrential when The New York Times, after a yearlong investigation, published a string of articles rebuking state authorities for losing billions to Medicaid fraud and abuse due to lax regulation and inadequate policing of New York's Medicaid program.[1] Moreover, the Times noted that although New York's Medicaid budget was the largest in the nation, the number of fraud investigators had declined by 50 percent in five years.

Just two days later Mr. Pataki appointed Paul Shechtman, a former federal prosecutor, to help overhaul the state agencies that pursue Medicaid fraud, and the Legislature subsequently created the Medicaid Inspector General's Office (OMIG) in January 2006, to take over the responsibility of coordinating and pursuing Medicaid fraud.

Ironically, then-Attorney General Eliot Spitzer also fell under criticism in The New York Times articles for the perceived lackluster performance of his Medicaid Fraud Control Unit, although he had continually championed the enactment of a New York state False Claims Act in order to give his office the proper tools to vigorously pursue such prosecutions.[2]

New False Claims Act

In April 2007, Governor Spitzer followed through on his promise to make Medicaid fraud enforcement a top priority and signed the New York False Claims Act (NY FCA) into law. The NY FCA is modeled after its federal counterpart (federal FCA), and contains the key component, a whistleblower provision that permits "qui tam" actions by whistleblowers to reap up to 30 percent of the recovered monies.[3] Moreover, the NY FCA is immediately effective, and thus, entities having

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any interaction with New York's Medicaid programs are immediately potential targets of lawsuits brought privately or in conjunction with the state.

The federal FCA has been very effective and has enabled the federal government to recover billions of dollars and "$13 back for every dollar it spends on investigations, litigation, and whistle-blower awards."[4] For instance, in July 2006, Tenet Healthcare agreed to pay the government $900 million over a four-year period for alleged health care fraud.[5] Thus, if the federal FCA is any indication, the NY FCA will be a powerful weapon to help deter and prevent fraud and abuse of the New York Medicaid program, and we can expect New York to reap significant returns from large health care providers.

But broad sweeping legislation, coupled with significant monetary incentives for whistleblowers, is also likely to produce many frivolous claims by unscrupulous and opportunistic employees motivated to cash in on their share of the take, which means not only more false claims act cases but a very high cost to named health care organizations since the government investigates all false claims case filings.

Frivolous 'Qui Tam' Actions

Using Department of Justice (DOJ) data on the federal FCA from 1987 to 2004, a recent empirical study has suggested that 72 percent of all "qui tam" actions brought under the federal FCA are frivolous—defined as actions that are ultimately dismissed or where the Attorney General refuses to intervene.[6] According to the study, 4,704 "qui tam" actions have been brought under the federal FCA since 1987 and of those, the Attorney General joined in 809 cases (22 percent). Further, an additional 6 percent of the cases survived when the "qui tam" plaintiff continued with the suit after the Attorney General refused to intervene.

There is no doubt that the federal FCA deters and/or recoups money spent as a result of Medicaid waste, fraud and abuse. So the point for this discussion is not whether the number of federal FCA actions ultimately determined to be frivolous speaks to the effectiveness of the statute, and is thus indicative of what to expect with the NY FCA but rather, since the government investigates all "qui tam" filings, we must be certain that many of those filings will generate active criminal investigations. Lawyers must therefore be versed in the "qui tam" procedures and process so as to mitigate the high cost to the respective health care organizations in defending such investigations.

To make the stormy seas even more dangerous, we can expect these numbers to increase even further as a result of new legislation requiring health care providers to educate their employees about federal and state false claims laws and the whistleblower protections.

Federal Deficit Reduction Act

The federal Deficit Reduction Act of 2005 (DRA) was signed into law on Feb. 8, 2006,

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and §6032 of the DRA became effective Jan. 1, 2007. Specifically, §6032, "Employee Education about False Claims Recovery," amends the Social Security Act, 42 USC §1396(a), by inserting a new paragraph (68), that requires health care organizations (receiving $5 million or more in annual Medicaid reimbursement) to implement written policies that provide "detailed" and "specific" information about federal and state laws regarding false claims including the respective whistleblower protections, as well as the organization's own policies and procedures to detect fraud and abuse. Moreover, complying with §6032 is a condition of continued Medicaid reimbursement.

The Office of the Medicaid Inspector General has already interpreted the DRA amendment and moved aggressively in requiring that each affected New York health care entity certifies its DRA compliance to the OMIG no later than Oct. 1, 2007.

The OMIG's guidance[7] states that the health care entity must certify that it has established and disseminated detailed written policies regarding:

- the federal False Claims Act;
- the New York False Claims Act;
- the specific statutory and regulatory provisions named in §1902(a)(68)(A) of the Social Security Act;
- any other applicable state civil or criminal laws and state and federal whistleblower protections; and
- the health care entity's policies and procedures for detecting and preventing waste, fraud and abuse.

These policies must be distributed to all employees (including management), contractors or agents of the health care entity. Furthermore, if the health care entity has an employee handbook, then the handbook must include (1) a specific discussion of the laws described in the written policies, (2) the rights of employees to be protected as whistleblowers and (3) a specific discussion of the health care entity's policies and procedures for detecting and preventing fraud, waste, and abuse. But if no handbook currently exists then there is no requirement to create one.[8]

Thus, health care organizations and counsel already trying to stay afloat given the substantive issues surrounding the NY FCA and the associated "qui tam" program must also become well versed in DRA compliance in order to guide their clients past the three-month deadline as well as periodic audits and investigations.

There does not appear to be any sign of clear skies on the horizon. Governor Spitzer and Attorney General Andrew Cuomo have recognized that to implement such an effort, a significant increase in resources and interagency coordination is needed to handle the coming waves of claims, investigations and prosecutions.

Enforcement Resources

Although the renewed focus on New York's Medicaid program began at the end of Mr. Pataki's term, both Mr. Spitzer and Mr. Cuomo have been very aggressive in increasing enforcement resources and revising the leadership dedicated to prosecuting Medicaid fraud. Moreover, they are also in the process of forming a new operating model in which multi-agency investigation teams work proactively together with the Attorney

General's Office, county law enforcement officials, and other officials responsible for combating Medicaid fraud.

As previously mentioned, the OMIG was established following The New York Times articles criticizing authorities for the lack of action regarding the billions of taxpayer funds lost to Medicaid fraud and abuse. Previously, the job to preserve the integrity of the Medicaid program was handled by the Department of Health along with the Attorney General's Medicaid Fraud Control Unit.

Now the OMIG coordinates the Medicaid fraud, waste and abuse control activities of the state, working with the Department of Health and the Attorney General's Medicaid Fraud Control Unit. And the governor has not been shy about allocating the resources necessary for this effort as he has provided for an additional 157 new positions for the OMIG and 100 new auditors in the 2007 state budget.[9]

In April, the state hired James G. Sheehan as the New York State Medicaid Inspector General.[10] Mr. Sheehan is a nationally recognized health care fraud prosecutor with expertise coordinating large joint health care fraud investigation teams and over 26 years of experience as an assistant U.S. attorney. The new auditors are going to be put to use by Mr. Sheehan, as he has the task of recovering $1.6 billion by 2011 or risk losing promised federal aid.[11]

Medicaid Fraud Control Unit

A perceived lackluster performance by this state's Medicaid Fraud Control Unit (MFCU) was also a target of The New York Times investigation, and Mr. Cuomo has made overhauling the unit a top priority in order to work effectively with the OMIG.

On Jan. 5, 2007, Mr. Cuomo asked Brooklyn District Attorney Charles S. Hynes to thoroughly review the functions, technology and overall effectiveness of the MFCU.[12] Eleven days later Mr. Cuomo announced the creation of a first-ever joint task force with Nassau County authorities to collaborate on the identification and prosecution of Medicaid fraud cases,[13] and in support of that objective, the Nassau County District Attorney's Office received state funding of $750,000 for the creation of its own Medicaid Fraud Unit.[14] Mr. Cuomo stated that instead of each government unit waiting to become involved in a case of suspected fraud, this new alliance would allow the counties and district attorneys to act in concert with the Attorney General's Office.

The state subsequently hired Heidi Wendel as the new deputy attorney general for Medicaid Fraud Control.[15] Ms. Wendel is also experienced in health care fraud investigation and most recently served as health care fraud coordinator for the U.S. Attorney's office for the Southern District of New York.

Given this interagency cooperation, New York can expect more efforts like the recent one in Florida. In that state, the MFCU, the U.S. Attorney's Office, the Drug Enforcement Administration, the Defense Criminal Investigative Service and the Florida Department of Law Enforcement conducted a joint federal/state investigation and prosecution. The defendant physician was convicted of 94 indicted counts including health care fraud, mail fraud and unlawfully dispensing controlled substances resulting in death, and ordered to pay over $2 million in restitution.[16]

There are indications that the storm has already begun, with one example being the nursing home initiative being conducted by the Attorney General's MFCU. In June, the former owner of two Bronx County nursing homes was facing 2 to 6 years in prison for defrauding the Medicaid program and was ordered to pay $6 million in restitution.[17]

The Attorney General's MFCU has also been using hidden video surveillance to uncover patient neglect and falsification of records in nursing homes. In Cortland's Northwoods Rehabilitation and Extended Care facility, three nurses have pled guilty and await sentencing of up to 4 years in prison, and the case against Northwoods' owner, Highgate LTC Management, LLC, is pending.[18] This follows the arrest of nine employees, including the physician medical director, of Hollis Park Manor Nursing Home in Queens, where a secret camera revealed evidence of widespread patient neglect and falsification of patient records.[19]

Conclusion

Between the new New York False Claims Act, the employee education requirement of the federal Deficit Reduction Act (and the fast approaching certification of compliance), and the impressive array of resources aligned by the state to investigate and prosecute Medicaid fraud, lawyers who navigate these waters must be familiar not just with the substantive crimes being charged, but also with the relationships between all of these prosecuting agencies and the intricacies of medical billing and coding, cost reporting methodologies, which set Medicaid and Medicare rates, and licensing ramifications for the health care professionals who are the targets of these prosecutions. Otherwise, much like the Andrea Gail, they may find themselves upside down and sinking in a roiling sea.

1. Clifford J. Levy and Michael Luo, "New York Medicaid Fraud May Reach Into Billions," The New York Times, p. A1 (July 18, 2005), available at 2005 WLNR 11224654.

2. See http://www.oag.state.ny.us/press/2007/jun/jun12a_07.html.

3. New York State Fin. Law §187 (McKinney 2007); see also, New York Law Journal, "New York's New False Claims Act," p. 4 (April 23, 2007).

4. New York Law Journal, "New York's New False Claims Act," p. 4 (April 23, 2007).

5. See http://www.usdoj.gov/opa/pr/2006/June/06_civ_406.html.

6. Christina Orsini Broderick, "Qui Tam Provisions and the Public Interest: An Empirical Analysis," 157 Colum. L. Rev. 949 (2007).

7. See http://www.omig.state.ny.us/data/images/stories/dra_employee_education_requirements.pdf.

8. Id.

9. http://www.ny.gov/governor/press/0401074.html.

10. See http://www.ny.gov/governor/press/0436071.html.

11. See Gale Scott, "Top cop targets health care fraud," Crain's New York Business, p. 2, (June 25, 2007). This includes a target of $644 million for 2011 as compared to $243 million in the most recent fiscal year.

12. See Brooklyn District Attorney Charles S. Hynes Report http://www.oag.state.ny.us/press/2007/apr/MFCU_Hynes_ExecutiveSummary.pdf.

13. See http://www.oag.state.ny.us/press/2007/jan/jan16b_07.html.

14. See http://www.nassaucountyny.gov/agencies/DA/NewsRelease/2007/04-19-07.html.

15. See http://www.oag.state.ny.us/press/2007/apr/apr17a_07.html.

16. National Association of Medicaid Fraud Control Units, "State Medicaid Fraud Control Units: Enforcement Developments," 17th Annual National Institute on Health Care Fraud, p. 21, (May 16, 2007); See United States v. Williams, No. 3:03 cr59-MCR (N.D. Fla. 2004), aff'd, 445 F.3d 1302 (11th Cir. 2006).

17. See http://www.oag.state.ny.us/press/2007/apr/apr12a_07.html.

18. See http://www.oag.state.ny.us/press/2007/jan/jan26a_07.html.

19. See http://www.oag.state.ny.us/press/2006/nov/nov22a_06.html.

Speech therapist arrested

Bronx-employed pathologist falsely billed for sessions not provided

Rose Gill Hearn, Commissioner of the New York City Department of Investigation (DOI), announced the arrest of Donna M. Tillman, a licensed New York State Speech Pathologist, for allegedly falsely billing and receiving $62,000 between 2002 and 2004 for remedial therapy sessions that she never provided to approximately 59 developmentally disabled infants and toddlers in need of the therapy.

Tillman, 58, of New Rochelle, New York, has been arrested for grand larceny in the second degree, a class C felony. If convicted, she faces up to 15 years in prison.

Tillman was employed as an independent contractor for several providers in the Bronx that are contracted with the New York City Department of Health and Mental Hygiene (DOHMH) Early Intervention Program (EIP). DOHMH oversees the EIP in New York City. EIP is a comprehensive, interagency program that supports infants and children with developmental delays in their effort to realize their full potential and receives funds from the State, City and Federal governments.

Gill Hearn said, "These allegations show the tangible reality of corruption. In this case, the alleged scheme meant that children with developmental delays and disabilities did not get much-needed services through the City's Early Intervention Program. These allegations are even more troubling because they involve a state-licensed professional who had been entrusted with aiding some of the most vulnerable in our City."

DOI's investigation was prompted by the complaint that Tillman was defrauding EIP by allegedly submitting false bills and receiving payments for services she never rendered. DOI's investigation found that Tillman falsely claimed to have been providing speech therapy to children at two or three different locations in the Bronx, on the same date and time. DOI's investigation determined that approximately 940 therapy sessions overlapped and that Tillman was paid $62,000 for sessions she did not hold with children, even though they were in need of them.

The investigation was conducted under the supervision of DOI's Inspector General for DOHMH, Christopher Staackmann, and members of his staff, including Deputy Inspector General Stephan Zander, Assistant Inspector General Bradley Howard, and Confidential Investigator Salvatore Mazzone. Assistant District Attorney Jessica Lupo of the Bronx District Attorney's Office is prosecuting the case, under the supervision of Bureau Chief Tom Kapp.