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Health Care Fraud: A Priority for the Trump Administration and a Trap for the Unwary

By Michael J. Engle and Kristin J. Jones*

The health care industry is caught in a tangled web of complex fraud and abuse regulations. Existing laws are intended to combat fraud perpetrated by a few bad actors who take advantage of the system. These system protections can create pitfalls for unsuspecting practitioners, but health care providers are responsible for ensuring compliance with these laws. In this article, the authors provide an overview of four important fraud and abuse laws applicable to health care providers.

The Trump administration recently announced that health care fraud will remain a high priority for the U.S. Department of Justice ("DOJ"). The announcement echoed the DOJ's focus on continuing to vigorously pursue, investigate and prosecute those who violate health care fraud prohibitions.

Acting Assistant Attorney General Kenneth A. Blanco, addressing the 27th Annual American Bar Association National Institute on Health Care Fraud,[1] stated: "For so many reasons, health care fraud is particularly egregious, and frankly, in my view, despicable. Greed resulting in the depravation of medical care for those in need is cruelty." And in many instances, this description is accurate. Some criminals take advantage of vulnerable, helpless people who are in desperate need of medical attention. However, many individuals and organizations that run afoul of the health care fraud and abuse laws are simply unaware that they are participating in arrangements that violate the law.

BACKGROUND

The health care industry is caught in a tangled web of complex fraud and abuse regulations. Both federal and state governments—as well as patients themselves—place enormous trust in health care providers. Existing laws are

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[1] https://www.justice.gov/opa/speech/acting-assistant-attorney-general-kenneth-blanco-criminal-division-speaks-american-bar.

intended to combat fraud perpetrated by a few bad actors who take advantage of the system. These system protections can create pitfalls for unsuspecting practitioners, but health care providers are responsible for ensuring compliance with these laws.

Here is an overview of four important fraud and abuse laws applicable to health care providers:

THE ANTI-KICKBACK STATUTE

The federal Anti-Kickback Statute prohibits payments for referrals of services payable under federal health care programs like Medicare and Medicaid. In its full scope, the Anti-Kickback Statute is a criminal statute that prohibits the exchange of anything of value in an effort to induce or reward the referral of federal health care program business. The law contains certain "safe harbors," which describe various practices that are not treated as offenses under the statute even though they potentially implicate the federal Anti-Kickback Statute. Nonetheless, health care providers can still violate the law when implementing seemingly acceptable payment and business practices. For example, in 2010, Rite Aid offered gift cards to patrons who transferred prescriptions, an arrangement that may be permissible in certain circumstances. Rite Aid's program triggered Anti-Kickback concerns, which Rite Aid ultimately settled for $3 million. When developing new programs, providers should always consider the Anti-Kickback Statute to ensure that the programs are structured in compliance with the law.

THE STARK LAW

Like the Anti-Kickback Statute, the Stark Law restricts payments for referrals of Medicare or Medicaid patients. The Stark Law specifically governs physician self-referrals, prohibiting physicians from referring patients to a medical practice in which the physician has a financial interest. On its face, the Stark Law prohibits physicians from entering into financial relationships that are acceptable in other industries, such as employment contracts and investment arrangements. These relationships must be carefully structured to comply with the Stark Law's exceptions, which contain a number of technical requirements that must be satisfied in order to ensure compliance. The Stark Law is a strict liability statute, and as a result, even well-intentioned providers can violate the law. Profit-sharing, productivity bonuses and referrals for in-office ancillary services are fertile grounds for inadvertent noncompliance, as the arrangements must meet all the technical requirements specified in the Stark Law's exceptions.

THE FALSE CLAIMS ACT

The False Claims Act ("FCA") makes it illegal to submit false or fraudulent claims to the federal government for payment. The FCA has both a civil and a

criminal component. A provider may violate the civil FCA by submitting claims to Medicare that are inconsistent with Medicare's comprehensive billing guidelines. The civil FCA contains a whistleblower provision that allows a private individual (e.g., a disgruntled employee, a former business partner, a competitor or a dissatisfied patient) to file a lawsuit on behalf of the federal government in exchange for a percentage of the recovery. Under the criminal FCA, a health care provider can go to prison or pay hefty criminal fines for submitting false or fraudulent claims.

STATE FRAUD AND ABUSE LAWS

In addition to federal laws, many states have their own false claims acts, anti-kickback statutes, self-referral prohibitions and more. The state laws may be broader than the federal statutes; consequently, compliance with the federal laws is not sufficient to guarantee compliance with state laws. For example, federal fraud and abuse laws are generally limited to claims payable by federal health care programs, but state laws may extend these laws to state programs, private payor arrangements or self-pay patients.

OTHER COMPLIANCE CONSIDERATIONS

In addition to the fraud and abuse laws addressed above, health care providers should ensure that their programs are in compliance with other laws, such as the Civil Monetary Penalties Law, the prohibition against patient inducements, the Exclusion Statute and more.

To protect health care providers from violating the law, a compliance plan combined with a program to implement, monitor and track compliance is a good starting point. Key personnel should also be trained to recognize and respond to potential fraud and abuse issues. These steps will help reduce the likelihood that the DOJ will have an opportunity to characterize your organization as "despicable" or "greedy" in its next health care fraud announcement.