LEGAL MATTERS

Dispatches From a Takedown

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In 2013, the Department of Justice started a new summer tradition: the healthcare fraud "takedown." Each summer since, the Department of Justice's Medicare Fraud Strike Force has coordinated its summer enforcement actions, bringing hundreds of cases on a single day in the hopes of gaining the most possible public attention.

This year's takedown, predictably, was the "largest health care fraud enforcement action in Department of Justice history." On Thursday, July 13, 2017, the Strike Force charged 412 defendants in 41 federal districts (of the 94 that exist), including 115 doctors, nurses, and other licensed medical professionals, for participating in about $1.3 *billion* in allegedly fraudulent billings. Almost half of these actions clustered around the Strike Force's nine field offices in Miami, Los Angeles, Detroit, Michigan, Southern Texas, Brooklyn, Southern Louisiana, Tampa, Chicago, and Dallas.

As in previous years, this year's takedown had a theme, focusing on opioid and prescription drug abuse. Still, although opioid abuse dominated the headlines, only about a third of the takedown's enforcement actions actually involved opioid abuse. Most of the cases, including those against home healthcare and hospice providers, involved more general allegations of fraud, with no apparent connection to opioid or prescription drug abuse. The government simply waited to bring these cases until the takedown date to boost its numbers and media impact.

The home healthcare and hospice cases stuck to the basics, targeting alleged payments to recruiters and physicians made in return for bogus referrals. In one Illinois case, a group of registered nurses with Care Specialists allegedly conspired with others to cause home health claims to be submitted for beneficiaries who did not need skilled care (Justice.gov, 2017a). In another Illinois case (note the proximity to a strike force field office in both of these cases), three administrators at Sure Care Home Health were charged with offering bribes and kickbacks to a pair of doctors who accepted them and who were also charged with referring Medicare beneficiaries in return (Justice.gov, 2017b). These prosecutions are fully in keeping with the government's general scrutiny toward home healthcare providers' referral sources.

The Strike Force also continued its emphasis on using big data to detect fraud. One Nevada doctor was charged with fraud relating to several hospice companies he owned (Justice.gov, 2017c). The indictment noted that one of those companies, West Coast Hospice, had a 66% discharge rate for patients who were supposedly terminally ill.

This 66% discharge rate is exactly the sort of statistic that a provider should at this point *expect* to have scrutinized by the federal government. Prudent providers owe it to themselves this winter to monitor their own referral sources and statistical profiles for hallmarks of fraud using the government's handy guide (United States Office of Inspector General, 2016), and to investigate and be prepared to explain any red flags. Because just like fireworks, BBQs, and warm beer, there will be a healthcare fraud takedown next summer. And it will likely be the "largest health care fraud enforcement action in Department of Justice history."

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