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Phone: +1 646 783 7100 | Fax: +1 646 783 7161 | customerservice@law360.com

Tenet Case Signals Shift In Health Care Fraud Enforcement

By **Demme Doufekias and Sandeep Nandivada, Morrison & Foerster LLP**

Demme Doufekias

Sandeep Nandivada

Law360, New York (November 23, 2016, 11:19 AM EST) -- Historically, the federal government has fought corporate health care fraud in two ways. First, the U.S. Department of Justice routinely intervenes in civil False Claims Act cases filed by qui tam relators. Second, the federal government typically has relied on individual U.S. Attorney's Offices to initiate and prosecute criminal health care fraud cases. Although the DOJ relied on tools such as the Medicare Fraud Strike Force to prosecute health care crimes in geographic areas that exhibited greater systemic abuse of the health care system, the focus of these efforts lay largely in individual prosecutions of Medicare fraud and abuse rather than corporate prosecutions.

This approach changed late last year when DOJ formed a separate Corporate Health Care Fraud Unit ("CHCFU") within the Criminal Division's Fraud Section. Staffed by experienced health care fraud prosecutors, the unit brings increased resources and a new, nationwide focus on the investigation and prosecution of health care fraud against corporations. The unit's prosecutors review all FCA cases filed across the country and evaluate whether the allegations support the initiation of criminal investigation and prosecution. Indeed, earlier this year, Assistant Attorney General Leslie R. Caldwell indicated in a speech that, as a result of the unit's efforts, there were over a dozen active corporate investigations. AAG Caldwell also stated that the DOJ was steering additional prosecutorial resources to this area to support fighting health care fraud through parallel civil and criminal investigations in order to "maximize the department's ability to secure the appropriate outcome in each matter — whether it be financial penalties, restitution, federal program exclusion or criminal prosecution of both corporations and individuals."

The DOJ's efforts are already bearing fruit. Last month, the DOJ announced a settlement with Tenet Healthcare Corporation that signaled a shift in policy for health care fraud enforcement. The settlement represents one of the first returns on the DOJ's investment of prosecutorial resources to combat health care fraud against corporations on a national level. No longer satisfied to focus on fraud, even large-scale

fraud, perpetuated by individual physicians, home health care providers, pharmacy owners, and medical supply company executives that were the traditional targets of the DOJ's criminal task force efforts, the Tenet settlement makes clear that the DOJ is now bringing nationwide resources and expertise to the kind of corporate investigations and prosecutions historically left to regional U.S. Attorney's Offices.

The Tenet Health Care Prosecution

On Oct. 3, 2016, the DOJ's CHCFU and the U.S. Attorney's Office for the Northern District of Georgia filed a criminal Information in the Northern District of Georgia charging Tenet and two subsidiaries, Atlanta Medical Center Inc. and North Fulton Medical Center Inc., with conspiracy to defraud the United States and to pay kickbacks and bribes in violation of the federal Anti-Kickback Statute.

The government charged that, from approximately 2000 to 2013, Clinica de la Mama, a Georgia corporation which held itself out as operating medical clinics that provided prenatal care to undocumented Hispanic women in Georgia and South Carolina, conspired with executives at Atlanta Medical and North Fulton to implement an unlawful patient referral scheme in violation of the Anti-Kickback Statute. Under the scheme, executives at Atlanta Medical and North Fulton, acting as agents of the hospitals, paid bribes and kickbacks to Clinica in exchange for Clinica referring patients to Atlanta Medical and North Fulton and arranging for Clinica patients to receive services at the two hospitals. Clinica steered patients to the hospitals by, among other things, misinforming expectant mothers that Medicaid would cover the costs of childbirth only if the mother delivered her child at Tenet hospitals. The government also alleged that Tenet executives falsified documents and records to conceal this relationship and to facilitate the further payment of bribes. Atlanta Medical and North Fulton obtained more than $145 million in Medicaid and Medicare funds as a result of this scheme. The fraud was originally brought to the DOJ's attention by an FCA relator, Ralph Williams, a former chief financial officer of a Tenet hospital in Georgia, who, as a result of the settlement, will receive $84.43 million under the FCA's whistleblower provisions.

In addition to guilty pleas from Tenet and the two subsidiaries, the DOJ entered into a nonprosecution agreement with HealthSystem Medical Inc. ("THSM"), another Tenet subsidiary and the parent company of Atlanta Medical and North Fulton. Under the NPA, the DOJ agreed not to prosecute THSM on the condition that THSM, among other things: (1) cooperate with the government's ongoing investigation; (2) enhance its ethics and compliance program and internal controls, including implementing specific measures to prevent future violations of the Anti-Kickback Act; and (3) retain an independent compliance monitor. The NPA will remain in effect for three years and may be extended for up to an additional year. Atlanta Medical and North Fulton also agreed to forfeit the $145 million obtained through the fraudulent referral scheme.

To resolve the civil claims, Tenet agreed to pay $368 million to the United States, the State of Georgia, and the State of South Carolina. Under the settlement agreement, the United States will receive over $244 million, and the two states will receive approximately $123 million and just under $1 million, respectively.

This is hardly the first time Tenet has run afoul of the FCA or the Anti-Kickback Statute. As far back as

1994, Tenet's predecessor, National Medical Enterprises, paid $324 to settle a case that also involved kickback. In 2006, Tenet agreed to pay $900 million to settle a case that alleged improper billing practices under Medicare, which, again, involved kickbacks. In 2012, Tenet paid almost $43 million to settle another lawsuit that alleged Medicare overbilling in connection with patients who improperly received treatment at rehabilitation facilities owned by Tenet. And, finally, in 2014, Tenet paid $5 million to resolve allegations that it was leasing offices to physicians at below-market rates in exchange for the physicians' referrals of patients to Tenet-owned medical facilities. Indeed, the Information plainly states that, during the period of the conspiracy charged, Tenet was already under a corporate integrity agreement for prior misconduct.

The Significance of Tenet's $513 Million Settlement

The Tenet settlement is an important development for health care companies because it demonstrates the impact of the DOJ's expanded resources and nationwide focus on combating corporate health care fraud. In particular, the Tenet settlement offers four key takeaways:

1. The DOJ is no longer satisfied to prosecute individuals alone and is now, more than ever before, actively scrutinizing corporations for both civil and criminal health care fraud.

The Tenet prosecution and civil settlement demonstrate that health care companies should not underestimate the DOJ's CHCFU. Although this case started with a qui tam relator in Georgia, it quickly garnered the attention of the CHCFU, bringing with that attention all the resources and expertise of the DOJ's Fraud Section. It is clear that the DOJ has entered the hunt for corporate health care wrongdoers of any variety. Tenet is a multinational, investor-owned health care company that operates hospitals across the United States and abroad, and the DOJ prosecuted Tenet despite certain obvious, collateral consequences, including significant harm to Tenet's business, the resulting impact on its shareholders, and the effect on Tenet's ability to provide health care services to patients across the United States and internationally. This, in no small part, is likely due to Tenet's repeated problems in the health care fraud space, including its numerous settlements to resolve kickback issues.

2. Health care companies operating in multiple jurisdictions are especially susceptible to the coordinated focus that comes with the DOJ's involvement in the prosecution of corporate health care fraud.

The Tenet prosecution was the product of extensive cooperation between the qui tam relator, the U.S. Attorney's Office for the Northern District of Georgia, and the DOJ's CHCFU. This cooperation was required, in part, because Tenet's fraudulent scheme affected individuals in Georgia and South Carolina, rendering the criminal conduct beyond the jurisdictional reach of either individual U.S. Attorney's Office. Thus, the CHCFU's involvement brought with it the ability to reach far more wide-ranging conduct and was necessary to effectively prosecute the full scope of Tenet's misconduct. This jurisdictional flexibility, in addition to the increased resources and expertise the federal government brings to any criminal investigation, demonstrates the full impact of the DOJ's intervention in health care fraud cases where the corporate target operates in multiple jurisdictions.

3. The DOJ's involvement opens the door to prosecutions in jurisdictions that do not have health care fraud expertise.

Historically, three jurisdictions — Massachusetts, Pennsylvania and New Jersey — have dominated corporate health care fraud prosecutions because of their deep expertise in this area and the proliferation of health care companies in these regions. By staffing the CHCFU with seasoned health care fraud prosecutors, the DOJ can bring its health care fraud prosecution expertise to any jurisdiction, not just those where a significant corporate health care presence has, over time, resulted in the development of expertise in investigating and prosecuting such cases. The DOJ's intervention in the Tenet case, which began in Georgia, is precisely an example of how the DOJ can deploy such expertise anywhere in the country, increasing the federal government's reach and ability to combat health care fraud in every jurisdiction, not just those that have traditionally dominated this area.

4. Corporations and individual executives alike should beware.

Well before Tenet resolved the corporate allegations, the DOJ secured pleas from two executives — Tracey Cota and Gary Lang — for their involvement in the kickback scheme. Cota and Lang each pled guilty to conspiracy to violate the Anti-Kickback Act by paying and receiving bribes in exchange for Medicaid patient referrals. Furthermore, the individual resolutions came almost a year before the publication of the Yates memo, reminding health care executives of the focus that has long existed on individual conduct in the realm of health care fraud prosecutions.

Demme Doufekias is a partner in the Washington, D.C., office of Morrison & Foerster LLP and co-leader of the firm's securities litigation, enforcement and white collar criminal defense practice group. Sandeep N. Nandivada is an associate in the firm's Northern Virginia office.

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