Fraud takes no vacations: Summer vacation season brings new False Claims and health care fraud cases

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On a monthly basis we publish a roundup of recent activity involving the False Claims Act and federal health care programs, highlighting the types of conduct catching the attention of enforcement agencies to help our clients avoid the pitfalls that could lead them to be the target of a future enforcement action. These updates do not contain a full listing of all enforcement actions during the month; rather, we select a few that we believe will be of interest. This month, we focus on two recent cases: a criminal case involving the conviction of executives from a Medicaid managed care organization and a civil settlement involving medically unnecessary cardiology procedures.

WellCare Health Plans, Inc.

Our first spotlight case from May is the high-profile case involving the prison sentences handed down for several former Medicaid managed care executives convicted of fraud. On May 19, 2014, the Department of Justice announced that former WellCare Chief Executive Officer Todd Farha was sentenced to 36 months in prison and ordered to pay a $50,000 fine for defrauding the Florida Medicaid program. Farha was convicted in June 2013 of two counts of health care fraud in connection with a scheme to defraud the Florida Medicaid program involving behavioral health services.

Florida law requires Medicaid managed care organizations (MCOs) to expend at least 80 percent of the Medicaid premium for behavioral health services on providing those services and if that level of expenditure is not met, the MCO is required to remit the difference to the Florida Medicaid agency. Farha was convicted of making false statements that included inflated expenditure reports in the MCO's annual report to the Florida Medicaid agency to reduce WellCare's repayment obligation.

Also convicted and sentenced were former WellCare chief financial officer Paul Behrens, who received a two-year prison sentence, and former WellCare vice president William Kale who was sentenced to one year plus one day in prison. A fourth executive, former WellCare vice president Peter Clay, was found guilty of making false statements to federal agents and received five years of probation and a $10,000 fine.

In sentencing the former WellCare executives below what the federal sentencing guidelines would have recommended, the federal judge noted that the government's estimated loss in connection with this scheme, $30 million, was a fraction of the billions that the Florida Medicaid agency paid the company over the same period of time to manage Medicaid beneficiaries' health care. In addition to these convictions and sentences for the former WellCare executives, WellCare was previously required to pay $40 million in restitution, forfeit another $40 million to the United States and enter into a deferred prosecution agreement, in addition to paying $137.5 million to settle a civil false claims case brought by a whistleblower based on the same allegations.

The bottom line: crime doesn't pay! In this case, the government and justice system found that the fraudulent behavior started at the very top of this organization, and these former executives will not only be paying the price for many years to come but will likely never work in the health care industry again.

King's Daughters Medical Center

Our other spotlight case for May is the King's Daughters Medical Center case. On May 28, 2014, the United States announced that King's Daughters in Ashland, Kentucky, would pay nearly $41 million in a settlement to resolve allegations that it billed the Medicare and Medicaid programs for medically unnecessary cardiac procedures (specifically, coronary stents and diagnostic catheterizations) and had prohibited financial relationships with physicians referring patients to the hospital that violated the Stark Law. To settle the allegations, King's Daughters agreed to enter into a five-year corporate integrity agreement with the Department of Health and Human Services Office of Inspector General, pursuant to which King's Daughters must undertake substantial internal compliance reforms and commit to a third-party review of its claims to federal health care programs. Commenting on the settlement, U.S. Attorney Kerry Harvey stated:

> The conduct alleged in this matter is unacceptable, victimizing both taxpayers and patients. Treatment decisions motivated by financial gain undermine public confidence in our health care system and threaten vital federal programs upon which so many of our citizens rely. We will not relent in our efforts to protect the public from the sort of systematic misconduct alleged in this case.

Several months before the settlement with the United States and the Commonwealth of Kentucky was announced, about 500 former King's Daughters patients filed lawsuits against King's Daughters claiming the hospital had performed unnecessary cardiac procedures. Those cases are ongoing.

While these cases involve very different allegations, both highlight the responsibility of health care organizations and their executives to know what is going on in their facilities and to ensure that their facilities are dealing honestly with the Medicare and Medicaid programs and their program beneficiaries.

Authors