



Regulatory: DOJ & HHS tout \$4.1 billion in recoveries in 2011

How to ensure corporate compliance in light of increased government scrutiny

BY [LISA NOLLER](#)

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On Feb. 14, 2011, the Department of Justice (DOJ) and the Department of Health and Human Services (HHS) sent Valentine's Day greetings by announcing that in fiscal year 2011, the agencies recovered approximately \$4.1 billion from joint enforcement efforts. The statistics demonstrate the agencies' continued commitment to combating health care fraud and abuse:

- 1,110 new criminal investigations (targeting 2,561 potential defendants) opened
- 1,873 health care fraud prosecutions (targeting 3,118 potential defendants) pending
- 489 new criminal cases (against 1,430 named defendants) filed
- 743 defendants convicted of health care-related crimes

Many criminal matters also have a parallel civil counterpart, and the FY 2011 report also noted that in the same timeframe, DOJ opened 977 new civil health care fraud investigations, adding to its 1,069 pending matters. These include *qui tam* matters and False Claims Act complaints lodged by whistleblowers. HHS also announced that in FY 2011 alone, it exercised its mandatory exclusion authority to exclude 2,662 individuals and entities from federal health care benefit programs.

Also in FY 2011, the federal government increased its commitment to its Health Care Fraud Prevention & Enforcement Action Team (HEAT), by expanding resources to two new cities: Chicago and Dallas. The HEAT teams coordinate efforts between state and local law enforcement agencies, employing sophisticated data mining technology to identify high-billing levels in certain geographic locations in an effort to reduce fraud and abuse.

The FY 2011 DOJ/HHS report announced that HEAT efforts have resulted in 323 defendants being charged in that period, resulting in 175 defendants being sentenced to an average prison term of 47 months. From 2009-2011, the return on investment for efforts to eradicate fraud and abuse was \$7.2 dollars for every dollar spent.

The FY 2011 numbers demonstrate a continued increase in health care fraud prosecutions and civil lawsuits. This likely results from an increasingly coordinated effort by law enforcement to work together and share resources. For years, those involved in the health care industry were far more knowledgeable about the regulatory framework than were prosecutors and law enforcement agents. However, with every prosecution or civil lawsuit, another government employee becomes an expert—at least in the sector at issue in his investigation.

To counter the increasing resources and successful prosecutions resulting from these government efforts, it is more important than ever for regulated entities to proactively stay on top of corporate compliance efforts. At a minimum, companies should follow four simple steps to stay ahead of the government:

1. Annually review and revise compliance programs to comport with new regulations, laws and court decisions.
2. Take immediate action to remedy any issues indicating fraud and abuse.
3. Ensure managers and board members understand, appreciate and follow the company's policies and procedures, part of the federal government's requirements for a meaningful and effective compliance program.

4. Conduct internal and routine data sampling, to identify outliers and address any potential fraud and abuse before the government learns of it.

In many instances, a data outlier is due to a system glitch or unintentional human error, rather than criminal fraud or abuse. Addressing these matters systematically and internally will save health care entities and individuals from government scrutiny or a far worse fate.

About the Author



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