In 2013, the Department of Justice recovered $2.6 billion for violations of the Federal False Claims Act relating to healthcare fraud, making it the fourth consecutive year in which the DOJ has collected over $2 billion from organizations and individuals in the healthcare industry. The FCA remains the most powerful tool at the government’s disposal for combating healthcare fraud.

**INCREASED RISKS FOR HEALTH CARE INDUSTRY OF VIOLATING THE FCA**

The risk of violating the FCA significantly increased after the enactment of the Patient Protection and Affordable Care Act of 2010. Under the ACA and its implementing regulations, a FCA violation can be based on:

- a violation of the Anti-Kickback Statute and
- a failure to return Medicare overpayments within 60 day of identifying them.

The ACA also limited the scope of the “public disclosure” defense to FCA claims, making it easier for whistleblowers and the government to avoid a jurisdictional bar to their lawsuit.

**RECENT DEVELOPMENTS**

In a significant 2014 case now in process in the Southern District of New York, the government intervened in its first unsealed FCA case alleging violations of the “60 day overpayment rule.” The lawsuit alleges that a hospital group mistakenly overbilled Medicaid due to coding errors contained in electronic remittances.

**THE REGULATORS**

The Health Care Fraud Prevention and Enforcement Action Team (HEAT), a joint initiative between the DOJ and US Department of Health and Human Services, leads the government’s investigation of Medicare and Medicaid financial fraud. As a result of the HEAT initiative, between 2008 and 2011 there was a 75 percent increase in the number of individuals charged with criminal health care fraud.

On the federal level, HEAT acts through its Medicare Fraud Strike Force, which analyzes Medicare claims data to target geographic areas showing unusually high levels of Medicare billing. In 2013, the Strike Force filed 137 cases, charged 345 individuals, secured 234 guilty pleas and won 46 jury trial convictions.

HEAT is also assisted by state Medicaid Fraud Control Units (MFCUs) who are charged with investigating and prosecuting Medicaid fraud, as well as patient abuse and neglect in health care facilities. The MFCUs are made up of attorney-led teams of investigators and auditors.

**THE FCA AND HOSPITALS**

Last year alone, FCA settlements involving alleged violations by hospitals totaled more than 20, with the highest individual settlement amount reaching $39 million. Most involved alleged violations of the Stark Act and the Federal Anti-Kickback Statute, which restrict the financial relationships that hospitals may have with doctors who refer patients to them.
CRIMINAL PROSECUTIONS
Cases involving fraud by executives at health care providers, such as hospitals, are a high priority for the DOJ’s Criminal Division. The Division is now reviewing qui tam complaints as soon as they are filed to determine whether or not to bring parallel criminal proceedings.

TRADITIONAL RISKS FOR HOSPITALS
Hospitals are at risk of violating the FCA or its state or local equivalent for the following actions:
- Upcoding
- Unbundling/bundling
- Performing inappropriate or unnecessary medical procedures in order to increase reimbursement
- Kickbacks
- Submitting false billing cost reports or certifications to the government
- Red-lining: limiting acceptance or discouraging admission of patients who suffer from or are at risk of developing serious illnesses
- Performing procedures without the requisite level of physician supervision
- Billing for services not performed, failing to provide the full service billed for, or doubling billing
- Submitting false information to the government about the wholesale price of prescription drugs (hospital-owned pharmacies)

FCA RECOVERIES AGAINST HOSPITALS
Recent examples of FCA settlements against hospitals include:
- A hospital chain paid $265 million to settle qui tam FCA allegations that it fraudulently inflated charges for patients in Medicare in order to obtain inflated government reimbursements for “outlier” care. A hospital system paid $98.15 million to settle multiple qui tam FCA suits alleging that it knowingly billed Medicare, Medicaid and TRICARE for medically unnecessary inpatient admissions that should have been billed as outpatient or observation services and performed services in violation of the Stark Act. A hospital paid $8.5 million to the state and federal governments to settle FCA allegations that it paid kickbacks to physicians for patient referrals in violation of the Stark Act and Anti-Kickback Statute.

WHAT ABOUT STATE FALSE CLAIMS?
In 2013, states recovered $443 million for violations of state Medicaid programs.

WHAT CAN HOSPITALS DO ABOUT THEIR FCA RISK?
Under section 6401(a) of the ACA, compliance programs that contain certain “core elements” are a condition of participation in Medicare, Medicaid and Children’s Health Insurance Program. Below are key steps hospitals can take to minimize their FCA risks:

Identify the risk areas
- Identify the business areas most at risk (i.e. which areas involve government reimbursements, funds or certifications).
- Identify the types of activities most at risk for fraud. Key risk areas for hospitals include:
  - Coding and billing
  - Reasonable and necessary services
  - Government program documentation
  - Referrals and physician financial arrangements
- Identify the policies and procedures regarding the handling of the government funds

Establish internal controls
- Establish internal controls and monitoring to help prevent and identify potential fraud, abuse and corruption. Potential controls relevant to hospitals may include:
  - Documenting diagnostic codes and establishing policies and procedures on their use and how to correct errors
Establishing policies or guidelines regarding which procedures require inpatient versus outpatient care

Conducting periodic internal audits focused on determining whether fraud has occurred in identified risk areas

Conducting periodic reviews and assessments of financial agreements with physicians

Establish policies and procedures that ensure that reports of fraud are properly escalated, documented, and handled promptly and appropriately

Establish and implement guidelines and procedures regarding corrective actions. Potential corrective actions for hospitals may include:

- Return of overpayments to the government
- Submitting corrected reports to the government
- Referral of matter to law enforcement
- Termination of physician financial agreements

Conduct trainings

- Establish anti-fraud policies and conduct periodic trainings to educate employees on potential risk areas
- Determine which employee groups need training and develop tailored fraud training to fit the risk areas facing those groups

Utilize internal whistleblowers

- Establish policies and procedures which encourage internal whistleblowers to report fraud, abuse and corruption

Partner with outside counsel

- Partner with outside counsel or consultant specializing in fraud prevention to support in-house knowledge and training and ensure latest information on anti-fraud policies and controls

ABOUT US

DLA Piper is a global law firm with lawyers across the Americas, Asia Pacific, Europe and the Middle East.

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Savaria Harris is an experienced litigator with trials in state and federal courts as well as with government and internal investigations in the white collar context.

Her practice centers on providing clients with an integrated approach to addressing fraud, whistleblower and government actions under the False Claims Act and its local equivalents. She is experienced in risk assessments, internal investigations, ethics and compliance training, as well as litigation and trial representation. In addition to her practice, Savaria is an adjunct professor of Workplace Ethics at Georgetown University, a member of the Advisory Council for the Association of Certified Fraud Examiners and a member of the NYU Program on Corporate Compliance and Enforcement.