HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM ANNUAL REPORT AND FUTURE TRENDS

Recently, the Department of Health and Human Services Office of the Inspector General ("OIG") and the Department of Justice ("DOJ") released the FY 2015 Health Care Fraud and Abuse Control Program Annual Report ("Annual Report"). The Annual Report details the enforcement actions and the monetary gains from efforts by the OIG and DOJ to fight fraud and abuse throughout the prior fiscal year. This alert will provide an overview of the Annual Report as well as guidance on current trends in fraud and abuse enforcement of which providers should be aware.

THE PROGRAM AND ANNUAL REPORT

The Health Care Fraud and Abuse Control Program ("Program") was established in order to coordinate enforcement of health care fraud and abuse across local, state and federal levels. The Program runs under the joint direction of the OIG and the Attorney General, who must submit a joint annual report to Congress including the amounts distributed to the Medicare Trust Funds. Since 1997, the Program has returned approximately $29.4 billion to the Medicare Trust Funds.

The 2015 Annual Report highlighted the fraud and abuse judgments, settlements and enforcement actions that the federal government has been involved in over the past fiscal year. For 2015, the Secretary of Health and Human Services ("HHS") and the Attorney General certified $297.7 million in mandatory funding, and Congress appropriated $672 million in discretionary funding, to the Program account (approximately $380 million more than was appropriated in 2014). Of these allocated amounts, approximately $853 million was allocated to HHS, with the most significant portions of that going to the OIG and Centers for Medicare & Medicaid Services ("CMS"). Another $119 million went to the DOJ, with the most going to U.S. Attorneys and the Civil Division.

The Annual Report estimated that settlements and judgments resulted in approximately $2.4 billion returned to both the government and private parties in 2015. The Annual Report estimated that from 2013 to 2015, the return on investment for the Program has been $6.10 for every $1.00 expended (down from the previous calculation of $7.70 for every $1.00). Further, the DOJ convicted 613 defendants, and the OIG brought 800 criminal actions against individuals and entities involved in health care fraud and abuse-related crimes. The OIG also excluded 4,112 individuals from participation in federal health care programs in 2015.

The Annual Report detailed the numerous successful criminal and civil investigations by the OIG and DOJ. These included: an $800 million settlement in which a company allegedly paid kickbacks to physicians through selling interests in exchange for referrals; a $54 million settlement by drug companies for knowingly underpaying rebates owed under the Medicaid Drug Rebate Program; a 156-month imprisonment and $1.2 million restitution payment for an individual medical supply company owner for submitting false claims to Medicare for hundreds of medical devices; a $47 million settlement by a laboratory for paying physicians kickbacks for patient referrals and billing for medically unnecessary testing; and the largest national health care fraud takedown in history charging 243 individuals, including 46 medical professionals, for alleged participation in Medicare fraud schemes for approximately $712 million in false billings.

The OIG’s audit and evaluation process found some key emerging issues in the Annual Report, including: Medicaid Home Health services; terminated Medicaid providers; access to Medicaid managed care services; payments to delinquent providers; non-emergency medical transportation services; issues in Medicare Part D; and the skilled nursing facility payment system. CMS reported that the national Medicaid improper payment rate for 2015 was 9.8 percent or $29.1 billion (an increase from the 2014 rate of 6.7 percent or $17.5 billion). Also in 2015, CMS awarded a contract for a pilot program to estimate the possible fraud in the Medicare program, specifically in the Home Health benefit. This pilot program includes a review team of health care clinicians, analysts, policy experts and fraud investigators that will review possible fraud and determine whether law enforcement should be involved.

ENFORCEMENT TRENDS

Health care entities and providers should be aware of the concentrations of the Annual Report, as many of these areas will likely remain a focus in 2016. In 2015, the DOJ Civil Division Fraud Section focused on hospitals and physicians. This trend is one that providers should watch for in the future. The DOJ stated in the Annual Report it was concerned with hospitals and physicians treating patients on an inpatient
basis when they could have been treated as outpatients. The DOJ also stated that a key area of concern was in violations of the Stark Law for physicians with ownership interest in health care entities. Further, the DOJ civil division recently has been litigating more cases that would have normally been settled in the past. This trend may continue in upcoming years.

The OIG has stated in its 2016 Work Plan that it plans to expand its concentration on alternative payment models in upcoming years, including bundled payments, value-based purchasing and coordinated care programs. These payment models have been a large part of CMS’s work in recent years and continue to garner attention from HHS as more health systems and providers move to these payment models.

Many of the recent settlements from providers have been in regards to excessive physician compensation. Several large settlements have resulted from findings of physician compensation that was in excess of fair market value, not commercially reasonable and based on the volume or value of referrals. Further, the DOJ has emphasized a recent focus on individual accountability and corporate responsibility. It is likely these trends will continue as well.

**PRACTICAL TAKEAWAYS**

Hospitals and physicians must take note of the current trends and enforcement from the OIG and DOJ as these penalties can be costly. Providers should look out for the following:

- Ensure your organization has a robust compliance program in place and that individuals are acting in accordance with that program;
- Ensure that arrangements with device and pharmaceutical companies, including relationships with their sales representatives, are appropriate and comply with the compliance program;
- Document clinical services to show they are medically necessary;
- Review policies and procedures for admitting patients to ensure they are not admitted unnecessarily;
- Document physician compensation that is in excess of collections to show community benefit justifications;
- Confirm that deals are fair market value, commercially reasonable and do not take into account the volume or value of referrals; and
- Review alternative payment models to ensure compliance with certain waivers and safeguards for such programs.

If you have questions regarding the Program’s Annual Report or other fraud and abuse concerns, please contact:

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