CARLTON FIELDS

Healthcare Fraud Initiatives in 2015

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In order to predict what 2015 will look like in the war against health care fraud, it is necessary to quickly review what happened in 2014. In 2014, the government's health care fraud prevention and enforcement efforts recovered $3.3 billion in taxpayer dollars from individuals and companies that attempted to defraud federal health proms, including programs serving seniors, persons with disabilities or those with low income. The government claims that for every dollar spent on health care related fraud and abuse investigations in the last three years, the government recovered $7.70. HHS Secretary, Sylvia M. Howell, announced in March 2015, that "[e]liminating fraud waste and abuse is a top priority for the Department of Health and Human Services." Attorney General Eric Holder echoed these remarks, stating "...with these outstanding results, we are sending the unmistakable message that we will not waver in our mission to pursue fraud, to protect vulnerable communities, and to preserve the public trust." The extraordinary successes in 2014 are the result of a two pronged approach adopted by the government. First, under the new authorities granted by the affordable care act, the government has been able to implement enforcement programs that move away from the "pay and chase" model that was traditionally followed. These new programs target fraudsters and try to stop the fraud from its inception. Second, is due to the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a joint initiative between the United States Department of Health and Human Services (HHS), the Office of Inspector General (OIG), and the Department of Justice (DOJ). It is no secret that the HEAT task force has been hugely successful. The HEAT task force has changed the way the

government fights health care fraud. Specifically, it is investigates cases using real-time data analysis in lieu of prolonged subpoena and account analysis, which has resulted in shorter periods between fraud identification, arrest, and prosecution. We can expect these time periods to continue to shorten in 2015 as data is mined quicker and more efficiently. The Medicare Fraud Strike Force - a key component of HEAT - which consists of an integrated group of OIG analysts, investigators, and prosecutors who target emerging or migrating fraud schemes has been critical to HEAT's success. The Medicare Fraud Strike Force has a conviction rate of 95%. As a result, the strike force has been expanded to ten territories that are considered hot beds for healthcare fraud - Miami, Los Angeles, Detroit, Houston, Brooklyn, New York, southern Louisiana, Tampa, Chicago, and Dallas. In 2014, the Medicare strike forces efforts yielded 924 new criminal health care fraud investigations opened by the DOJ. Additionally, prosecutors filed criminal charges in 496 cases involving 850 defendants - all related to health care fraud. The federal government has also been exercising its civil enforcement powers to combat health care fraud by intervening and bringing federal False Claim Act ("FCA") cases. In 2014, the Civil Division of the Justice Department and the United States Attorneys' Office obtained $2.3 billion in settlements and judgments from civil cases involving fraud and false claims against federal health care programs such as Medicare and Medicaid. The 2014 FCA activity seemed to touch on every corner of the health care provider industry, including hospitals, home health providers, clinics, skilled nursing and rehabilitation facilities, pharmacies, and billing service providers among others. Hospitals and home health services providers paid the most to resolve FCA cases in 2014. Specifically, Community Health Services, a hospital, paid $98 million to settle an FCA case. Amedisys a home health provider paid $150 million to settle a case. The most common allegation in 2014 FCA cases was billing for unnecessary or unreasonable services followed by violations of the Anti-Kickback Statute ("AKS") and the Stark law. In addition, 2014 saw aggressive enforcement of HIPAA violations by OCR. In March 2014, Skagit County, Alaska became the first local government to be fined for HIPAA violations. Two months later, the Government reached a $5 million settlement with Columbia University and New York and Presbyterian hospital to resolve HIPAA claims. This settlement amount is the largest documented HIPAA related settlement to date. In 2014, a HIPAA violation also prompted criminal charges against an employee in the case of *United States v. Joshua Hippler.* Mr. Hippler allegedly obtained private health information with the intent to sell, transfer, or use the data for personal gain. In the *Hippler* case, the government alleged an intentional effort to profit from private and personal data. Hippler plead guilty in August 2014. **What can we expect in 2015?** ***Criminal Prosecutions and FCA cases***

In her remarks to the Taxpayers Against Fraud Education Fund Conference on September 17, 2014, Assistant Attorney General for the DOJ Criminal Division Leslie Caldwell announced that all new *qui tam* civil complaints will be shared with the Criminal division for review to determine whether parallel criminal proceedings will be opened. This is an indication that larger corporate providers are at risk of facing criminal prosecutions. Thus far, we have seen prosecutions, guilty pleas, and convictions of doctors, nurses, pharmacist, home health agency owners and others. This seems to be an indication that the HEAT strike force is not slowing down. With the incentive of a potential thirty percent share of recovery on claims, whistleblowers and their lawyers are more motivated than ever to litigate FCA

cases. These cases show no signs of slowing down in 2015. At the end of 2014, approximately nineteen health care related qui tam cases were unsealed. All nineteen cases were filed in federal court and five of the nineteen unsealed in the Middle District of Florida. The government declined intervention in ten of the nineteen cases. A potential area of concern for healthcare providers are reverse FCA claims. Experts are watching the ongoing litigation involving the affordable care act's 60 day overpayment rule in *United States ex rel. Kane v. Health First, Inc.*, Case no. 11-cv-02325 (S.D.N.Y.). In *Health First, Inc.*, the government intervened against several New York hospitals and managed care organizations alleging that the defendants failure to repay Medicaid overpayments under the 60 day rule requirements constituted a reverse false claim violation. This case presents an aggressive stance by the government. If the government is successful, there will surely be more of these cases this year. ***OIG's priorities for 2015***

OIG announced its 2015 Work Plan in the Fall of 2014. The work plan gives the greatest insight as to what will be the key focus of Government enforcement efforts in 2015. Hospitals seem to be the focus of several of OIG's 2015 initiatives. In regards to Hospitals, OIG intends to, among other things: (1) scrutinize the national incidence of adverse events in long term care hospitals; (2) scrutinize the accuracy of wage data that hospitals report to OIG will also be reviewed; (3) review the billing practices of off campus clinics owned by hospitals; and (4) focus on HIPAA requirements and whether hospitals and other entities have created contingency plans for storage and safekeeping of protected information. The OIG's focus on data security is consistent with the government's overall interest and focus on data security. Pharmacies and prescription drugs is another area of focus. While the OIG did not announce any new initiatives, it did announce it will continue combat prescription drug fraud. It is a twofold process. OIG will continue to target questionable billing practices. More importantly, OIG will target overprescribing of controlled substances which can lead to patient harm. Of particular concern to the OIG are doctor shopping cases that can lead to death of the patient. Further, OIG will continue its keen oversight of home based services which have traditionally been a hot bed for fraud. Additionally, the security of electronic data and the use and exchange of health information technology is another point of concern. In 2015, OIG intends to review independent evaluations of information systems security programs of Medicare fiscal intermediaries, carriers, and Medicare administrative contractors. OIG will also examine whether CMS oversight of hospital security controls over networked medical devices, including dialysis machines, radiology systems, and medication dispensing in systems integrated with electronic medical records, is sufficient to effectively protect electronic health information under HIPAA. ***Other health care fraud issues in 2015***

OCR will continue its aggressive enforcement of HIPAA violations. OCR Chief Regional Counsel, Jerome Meites, has announced that OCR intends to focus on "high impact cases" to send a strong message about the importance of data security. Additionally, the Obama administration has joined with private insurers, states, and associations in the health care fraud prevention partnership (HFPP). The HFPP has been exchanging information and best practices across public and private sectors in an effort to combat healthcare fraud. This partnership will surely lead to an increase in cases alleging fraud within the insurance exchange. **Conclusion**

The DOJ and OIG continue to signal their commitment to enforcing laws and regulations that govern the conduct of providers. As such, the pace of civil and criminal investigations against providers show no signs of slowing down in 2015. **Republished with permission by the American Bar Association**

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