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BNA's
Health Care Fraud Report™

Enforcement

Government Recovered $4.2 Billion In FY 2012 Due to Health Fraud Enforcement

The federal government's health fraud enforcement and prevention efforts recovered $4.2 billion in fiscal year 2012, a record amount, the departments of Justice and Health and Human Services said Feb. 11.

The departments a year ago said they had recovered $4.1 billion in FY 2011 (16 HFRA 136, 2/22/12).

In addition, the departments said that the Health Care Fraud and Abuse Control (HCFAC) program, which is 16 years old, has returned more than $23 billion to the Medicare trust funds. HCFAC coordinates federal, state, and local law enforcement activities to fight health care fraud.

The departments said that in FY 2012, DOJ opened 1,131 criminal health care fraud investigations involving 2,148 potential defendants, and a total of 826 defendants were convicted of health fraud-related crimes during the year. In addition, the two departments opened 885 civil investigations in FY 2012.

The departments also released a report on HCFAC that said the return-on-investment (ROI) for the program over the past three years (2010-2012) is $7.90 returned for every dollar spent.

''This is $2.50 higher than the average ROI for the life of the HCFAC program since 1997,'' the report said. HHS and DOJ said that because the annual ROI can vary from year to year, depending on the number of cases that are settled or adjudicated during that year, DOJ and HHS use a three-year rolling average ROI for results contained in the report.

Potential End to Large Recoveries. Kirk Ogrosky, an attorney with at Arnold & Porter in Washington and the former head of criminal health care enforcement at DOJ, told BNA that he does not see ''mega-billion dollar'' recoveries continuing.

Ogrosky said that is because the quantity of qui tams is increasing while the quality is decreasing.

''If you take a hard look under the numbers for the past few years, it is clear that the $4.2 billion is tied directly to the work of the United States Attorneys' Office in Boston that handles cases against large companies,'' he said.

Ogrosky said most of the recoveries in the HCFAC report are from FCA settlements, entered into by real providers who are concerned about compliance and their relationship with the government.

''Thus, the numbers that were released are not a reflection of enforcement progress but are the sums extracted from legitimate providers,'' Ogrosky said.

However, Ogrosky said that fraud savings could top $50 billion a year if DOJ and HHS emphasized a strategy to fight crime before it occurred, and Congress funded it, and there would be no need for an annual report on recoveries.

''In a well run system, CMS would be timely and efficient, DOJ and OIG would be proactive, and fraudulent claims would be identified when submitted and never paid,'' Ogrosky said.

Overall, Ogrosky said the HCFAC report showed some signs of progress in terms of the number of criminals indicted and convicted, but he said DOJ still lacks adequate funding.

''The current budgeting process doesn't provide for the kinds of administrative, civil, and criminal enforcement that is needed to police almost one sixth of the US economy,'' Ogrosky said.

''Most of the enforcement people are not trained in health care, and it is difficult to find doctors, nurses, and clinicians who are willing to work for government salaries in the enforcement fields,'' he said.

Ogrosky said shifting DOJ and HHS resources from FCA work to criminal enforcement could significantly improve enforcement and improve relations between industry and the government.

''If Congress really wants to stop fraud, they would adequately fund enforcement for the long haul and let the programs plan and grow,'' he said.

Joint DOJ-HHS Investigations. The success of the joint Justice and HHS effort was made possible by the Health Care Fraud Prevention and Enforcement Action Team (HEAT), which was created in 2009 to enhance an anti-fraud collaboration between the two agencies, the departments said.

prevent fraud, waste, and abuse in the Medicare and Medicaid programs and to crack down on individuals and entities that are abusing the system and costing taxpayers billions of dollars, the departments said.

In addition, the departments said their efforts to reduce fraud ''will continue to improve with new tools and resources provided by the Affordable Care Act.'' ACA helps fight fraud, the agencies said, by providing for enhanced screenings and provider enrollment requirements; increased data sharing across the government; expanded recovery efforts for overpayments; and greater oversight of private insurance abuses.

In FY 2012, the Centers for Medicare & Medicaid Services began screening all 1.5 million Medicare-enrolled providers through a new Automated Provider Screen-

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ing system, which quickly identifies ineligible and potentially fraudulent providers and suppliers prior to enrollment or ''revalidation'' to verify their data, the departments said.

''As a result, nearly 150,000 ineligible providers have already been eliminated from Medicare's billing system,'' the departments added.

DOJ also noted that its enforcement of the civil False Claims Act and the Federal Food, Drug and Cosmetic Act have produced record-breaking results.

Strike Force Takedown. The agencies said they have increased the number of Medicare Fraud Strike Force teams to nine. The strike force concept was originally implemented in 2007 in Miami and uses advanced data analysis to find high-billing levels in health care fraud hotspots so that interagency teams can target ''emerging or migrating schemes,'' as well as the fraud perpetrated by criminals masquerading as providers.

The strike force coordinated a takedown in May 2012 that involved the highest number of false Medicare billings in the history of the strike force program, DOJ and HHS said. The takedown involved 107 individuals, including doctors and nurses, in seven cities, who were charged for their alleged participation in Medicare fraud schemes involving about $452 million in false billings.

As a part of the 2012 takedown, HHS also suspended or took other administrative action against 52 providers using authority under the health care law to suspend payments until an investigation is complete, the agencies said.

The strike force operations in the nine cities where teams are based resulted in 117 indictments, informations, and complaints involving charges against 278 defendants who allegedly billed Medicare more than $1.5 billion in fraudulent schemes.

The departments said that during FY 2012, 251 guilty pleas and 13 jury trials were litigated, with guilty verdicts against 29 defendants, in strike force cases. ''The average prison sentence in these cases was more than 48 months,'' it said.

False Claims Act, Big Pharma. The departments said they continued their success in civil health care fraud enforcement during FY 2012. DOJ's Civil Division Fraud Section, working with U.S. attorneys' offices throughout the country, obtained settlements and judgments of more than $3 billion in FY 2012 under the False Claims Act.

''These matters included unlawful pricing by pharmaceutical manufacturers, illegal marketing of medical devices and pharmaceutical products for uses not approved by the Food and Drug Administration, Medicare fraud by hospitals and other institutional providers, and violations of laws against self-referrals and kickbacks,'' the departments said.

The biggest such case was in July 2012, when GlaxoSmithKline paid $3 billion, plus interest, to resolve its criminal and civil liability arising from the company's ''unlawful promotion of certain prescription drugs, its failure to report certain safety data, and its civil liability for alleged false price reporting practices,'' the report said. About $2 billion of that $3 billion from GSK was a civil FCA settlement.

This marked the third straight year that more than $2 billion has been recovered in FCA health care matters, according to DOJ and HHS.

Additionally, the DOJ Civil Division's Consumer Protection Branch, working with U.S. attorneys' offices, obtained nearly $1.5 billion in fines and forfeitures, and obtained 14 convictions in matters pursued under the Federal Food, Drug and Cosmetic Act, the departments said.

HIPAA Enforcement. Among the activities detailed in the report is enforcement of the Health Insurance Portability and Accountability Act.

In December 2011, a Georgia man was sentenced to more than five years in prison and ordered to pay $1 million for health care fraud and criminal HIPAA violations.

According to the report, the defendant persuaded numerous practicing physicians to bill Medicare, Medicaid, and private insurers under their own provider numbers for allergy-related care provided by him. The defendant, Matthew Paul Brown, pleaded guilty in fall 2011. ''The defendant had never been licensed in Georgia as a physician, physician assistant, nurse practitioner, or clinical nurse specialist.''

BY BRIAN BRODERICK

The HCFAC annual report is at http://op.bna.com/hl.nsf/r?Open=bbrk-94tl9g.

More information on the joint DOJ-HHS strike force activities is at http://www.StopMedicareFraud.gov/.

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