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Healthcare Regulatory Liability

The threat of regulatory action against healthcare providers for over-billing Medicare and Medicaid is of growing concern.

Background

Eliminating waste from social insurance programs is a top government priority. In 2009 the U.S. Department of Justice (DOJ) and Department of Health and Human Services (HHS) joined forces to create the Health Care Fraud Prevention and Enforcement Action Team (HEAT). Since then the government's enforcement actions against healthcare providers have skyrocketed. Since 2009 the DOJ has recovered $22.75B in fines which is over half all funds recovered since the False Claims Act was brought back to life in 1986. The federal government recovered nearly $5.7B in civil settlements and judgments under the False Claims Act in YE2014 with $2.3B in healthcare fraud. 2015 is shaping up to be another banner year with nearly $2B in recoveries within the first six months,and healthcare is leading the charge with nearly $862M.

The government estimates healthcare fraud to be tens of billions each year and with a return on investment of $7.70 for every dollar fighting fraud, the government is not going to back down any time soon. Qui Tam cases are on the rise with whistleblowers being by far the largest initiator of DOJ investigations. Whistleblower cases have exceeded 700 for the second year in a row. With the relator award being 15-25% of the government recovery this isn't expected to slow down anytime soon.

Healthcare recoveries have come from allegations ranging from medical necessity, services not provided, upcoding, double billing, bundling or unbundling, unqualified personnel and improper referral arrangements. The process of responding to such investigations can be extremely onerous, both in terms of time and cost. A provider can easily spend hundreds of thousands of dollars a year dealing with defense costs, forensic auditor fees, medical expert costs, billing and coding consultants. Beazley can help provide a risk transfer solution and give insured's access to our loss control services to help prevent a claim.

Trends in healthcare fraud investigations

- **RAC**
  Recent Recovery Audit Contractors (RACs) in 2013 recovered $3.75B. Over 94% of these overpayments are from inpatient hospital claims. New 5 year contracts for the 4 RAC contractor regions will be announced in 2015.

- **Formal Self Disclosure Protocol**
  This is a delicate process that providers should enlist outside legal advice to resolve. There are still damages and fines and penalties assessed even though the provider is coming forward voluntarily. Stark violations are disclosed to CMS and all others are disclosed to the OIG. The process was started by the OIG and HHS in 1998.

- **State False Claims Recoveries**
  Deficit Reduction Act of 2005 – authorizes states to receive in addition to their own recoveries, 10% of the federal government's share of recovered Medicaid funds if their FCAs are at least as robust as the federal FCA. States are now making their statutes even broader incorporating qui tam provisions and broadening the circumstances under which companies can be found liable for violations. Many states now have FCA legislation in place and are seeing recoveries along with the Federal government in most settlements.

Facts taken from:

- http://www.gibsondunn.com/publications/Pages/2015-Mid-Year-False-Claims-Act-Update.aspx
- 2014 Year End Health Care Compliance and Enforcement Update – Jan. 15th 2015
- Justice Department Recovers Nearly 6B from False Claims Act Cases in Fiscal Year 2014 – Nov. 20, 2014
- State False Claims Act Enforcement Explodes in 2014 Law 360 May 29, 2014
- CMS Centers for Medicare & Medicaid Services – Recovery Auditing in Medicare for Fiscal year 2013
- Understanding The False Claims Act April/May2014 Weil, Gotshal & Manges LLP

Scenarios of over-billing claims and penalties

- A not for profit nursing home chain agreed to pay $150 million for a variety of falsifications, including falsification of nursing logs to make it appear that the nurses delivered a disproportionately higher number of hours of nursing care to Medicare patients in the “Medicare distinct” beds, when in fact they were attending to Medicaid and indigent or private pay patients.

- A public hospital district agreed to pay $2.7 million settlement because of its up-coding fraud. The hospital was submitting claims for a complex form of pneumonia when the correct diagnosis indicated a simpler form that is reimbursed at a lower rate. In addition, the hospital agreed to pay $562,201 for other up-coding, including false claims for septicaemia, a blood infection.

- A Psychiatric physician group agreed to pay $3.4M to the government to settle charges that it defrauded the Medicare program. The group billed Medicare for unqualified patient visits between February 2004 and October 2009. The US attorney’s office said the company billed for outpatient treatment for patients who rarely attended, failed to get proper approvals for treatment and did not get physician orders for tests.

- A not for profit hospital gave free office space to a psychiatric services management company and inflated management and director fees to induce it to funnel patients to the hospital. This kickback scheme violated the Stark Law and resulted in costly defense and a $5.1 million settlement paid by the hospital.

- A hospital chain agreed to a $1.5 million settlement of a qui tam lawsuit in which it was alleged that the hospital billed under physician provider numbers when, in fact, the services were rendered by nurses rather than physicians. Nursing services are reimbursed at a lower rate than physician services, so the hospital used the physician numbers to achieve a higher reimbursement rate.

- A jury awarded $28M in fines against a nursing home for fraudulently billing Medicare and Medicaid. $19 million of the fine was attributable to 1,700 false or fraudulent claims. The whistleblowers who originated the Qui Tam lawsuit after witnessing fraudulent billing practices for substandard care received roughly 25% of the verdict.

How regulatory liability cover can help

Beazley’s Healthcare Regulatory Liability product is designed to respond to the growing risk of actions being brought by or on behalf of governmental entities and commercial payers for billing errors and omissions. Beazley’s policy is designed to provide coverage for defense reimbursement, external forensic audit expenses and civil fines and penalties as covered damages. Our product is available on surplus lines in all 50 states with limits up to $10 million.

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