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Healthcare Regulatory Liability

The threat of regulatory action against healthcare providers continues to be a concern.

Background

Eliminating waste from social programs is a top priority of our government and the Trump administration's statements in 2017 have not suggested this will change. In 2016 the Justice Department recovered over $4.7B from civil cases involving fraud against the government. This is 30% higher than 2015 and is the third largest annual recovery in the history of the False Claims Act. Of the $4.7B, $2.5B came from the healthcare industry. This is the seventh year that number has exceeded $2B and it only includes civil Federal recoveries. Contracted auditors, state programs and criminal fines and penalty recoveries can add billions to that number. So far the first half of 2017 has amounted to Federal and State recoveries of nearly $1.3B and $370M in judgements. Since congress amended the FCA 30 years ago, giving whistleblowers up to 30% of the recovery, the FCA has brought in $53.1B. Sixty percent of these Federal recoveries have been received since 2009 when the Obama administration made fighting fraud a priority. The government fights fraud from companies in financial services, government procurement, and the defense industry, but nearly every year healthcare takes first place for monies recovered.

The government estimates healthcare fraud to be tens of billions each year and with a return on investment of $5 for every dollar fighting fraud, the government is not going to back down any time soon. Although pharmaceutical companies carry the lion's share of the recovery dollars in just a few settlements, there are hundreds of hospitals, laboratories, nursing homes and physicians (to name a few) that are investigated each year. If you are a provider receiving money from the government, you could receive a direct investigation or a Qui Tam lawsuit with the intent to determine fraud or abuse. Healthcare recoveries have come from allegations ranging from not medically necessary, 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, and billing and coding consultants. It is imperative that providers who receive reimbursement from the government have a robust compliance program and policies in place to prevent fraud at all levels of the corporate structure. Beazley can help provide a risk transfer solution and give insureds access to our loss control services to help prevent a claim.

Advancements in healthcare fraud enforcement

- **The Yates Memo**
  The Department of Justice has made it clear that there will be increased accountability for corporate wrongdoing. The DOJ will target individuals and seek monetary penalties.

- **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.

- **The Bipartisan Budget Act of 2015**
  As part of this act False Claims Act penalties were increased from $5,500 - $11,000 at a one time catch up in July of 2016. This doubled the FCA penalty to reflect inflation levels from 1999 to 2016. This was updated again in Feb. 2017 so that the minimum is now $10,957 and the maximum is $21,563. Stark Law penalty increased from $15,000 to $23,863 and violations of the Anti-Kickback Statute are now $73,588, an increase from $50,000.

- **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. Many states now have FCA legislation in place and are seeing recoveries along with the Federal government in most settlements.

Facts taken from:

- https://www.justice.gov/opa/pr/justice-department-recovers-over-47-billion-false-claims-act-cases-fiscal-year-2016
- http://www.gibsondunn.com/publications/Pages/2017-Mid-Year-False-Claims-Act-Update.aspx
- https://www.justice.gov/opa/press-release/file/918366/download
- http://www.dinsmore.com/a-47-billion-year--an-analysis-of-dojs-false-claims-act-recoveries-in-fy-2016-recent-trends-and-predictions-for-the-future/
- https://www.natlawreview.com/article/analysis-doj-s-false-claims-act-recoveries-fy-2016-recent-trends-and-predictions
- https://www.justice.gov/criminal-fraud/health-care-fraud-unit
- http://healthcarecounselblog.com/articles/needing-adjust-doj-and-hhs-announce-steep-increases-fca-stark-law-anti-kickback-statute-and
- https://www.bna.com/trump-budget-boost-n57982085442/

Scenarios of over-billing claims and penalties

- A not for profit nursing home chain agreed to pay $150M 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 $2.7M 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 $5.1M settlement paid by the hospital.
- A hospital chain agreed to a $1.5M 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. A sublimit for pre-claim investigation services is included on all policies where fines and penalties are purchased. Our product is available in all 50 states with limits up to $20 million.

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