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Compliance | *In the News*

The Cost of Healthcare Compliance Violations

Backed by the Departments of Justice (DOJ) and Health and Human Services (HHS), the Medicare Fraud Strike Force and the Health Care Fraud Prevention and Enforcement Action Team (HEAT) recovered $1.9 billion[1] from healthcare fraud cases in 2015, and that does not include the millions paid to consumers and state Medicaid programs.

The Department of Justice is authorized to pay rewards to whistleblowers in an amount of between 15 and 25 percent (and as much as 30 percent in some cases)[2] of what it recovers. The DOJ's success in recovering settlements is a direct result of the high priority it has placed on identifying and preventing healthcare fraud before money is paid out and investigating and prosecuting violators after the fact.

Violations of the Stark Law, the Anti-Kickback Statute, and the False Claims Act are costly for taxpayers, jeopardize health outcomes for patients, and present a disturbing reality for the majority of providers who have built their reputations not only on clinical expertise, but also on integrity and trust.

Big Numbers

- The DOJ recovered nearly $16.5 billion in healthcare fraud between January 2009 and the end of fiscal year 2015 [3]
- In fiscal years 2013 and 2014, every dollar invested in the Centers for Medicare & Medicaid Services' (CMS) Medicare program integrity efforts saved $12.40 for the program [4]
- Hospitals were involved in nearly $330 million in settlements and judgments in 2015 [5]
- Some of the larger Stark Law violations in 2015 included settlements with single hospitals or systems for $115 million, $69.5 million, and $35 million [6]
- Whistleblower awards totaled $597 million in 2015 [7]
- Whistleblowers filed 638 suits in FY2015 [8]
- The DOJ recovered $2.8 billion from whistleblower suits [9]

The Stark Law

"The Stark Law is intended to ensure that physician referrals are made based on the medical needs of the patients and are not tainted by certain financial arrangements. Thus, the Stark Law generally forbids a hospital from billing Medicare for certain services referred by physicians who have a financial relationship with the hospital unless that relationship falls within enumerated exceptions." (10)

- The United States Department of Justice

Recommendations

- Regularly review all physician and vendor compensation and billing arrangements
- Avoid compensation arrangements that can influence referral patterns
- Be sure that financial arrangements do not exceed fair market value
- Ensure that agreements with physicians who are not hospital employees are in writing
- Fully understand both direct and indirect physician ownership of, or investment in, entities providing designated health services and entities for which referrals could result in compliance violations
- Consider outsourcing clinical and administrative services to an independent, nationally recognized service provider, which can offer natural protection from illegal physician-ownership arrangements
- Understand Stark exceptions

In the News

- South Carolina Hospital to Pay $17 Million to Resolve False Claims Act and Stark Law Allegations
- Manhattan U.S. Attorney Settles Civil Fraud Claims Against Westchester Medical Center Arising From Its Violations Of The Anti-Kickback Statute And The Stark Law
- King's Daughters Medical Center to Pay Nearly $41 Million to Resolve Allegations of False Billing for Unnecessary Cardiac Procedures and Kickbacks
- Does Stark Phase III Ring the Death Knell for Physician-Owned Perfusion Groups?

The Anti-Kickback Statute

"Secret sweetheart deals between hospitals and physicians, like the ones in this case, undermine patient confidence and drive up healthcare costs for everybody, including the Medicare program and its beneficiaries. This case demonstrates the United States' commitment to ensuring that doctors who refer Medicare beneficiaries to hospitals for procedures, tests and other health services do so only because they believe the service is in the patient's best interest, and not because the physician stands to gain financially from the referral. The Department of Justice is determined to prevent the kind of abuses uncovered in this case, and we are willing to take such cases to trial to protect the integrity of the Medicare program." [11]

- The United States Department of Justice

Recommendations

- Avoid arrangements that have the potential to skew clinical decision making
- Monitor activity for the potential of over-utilization or inappropriate utilization
- Monitor actions (or possibly inactions) of your allied partners to ensure they are compliant with applicable laws governing the services they provide
- Quality (or lack thereof) can be a sign of compliance issues so pay attention to your outcomes data
- Look beyond clinical services to other areas under scrutiny (e.g., credit arrangements, purchasing or leasing agreements for physical space)
- Thoroughly vet your providers to ensure a proven history of compliance and no exclusions from practice
- Be aware that The Anti-Kickback Statute applies to all federal healthcare programs
- Understand Safe Harbors

In the News

- Largest Health Care Fraud Case In U.S. History Settled HCA Investigation Nets Record Total Of $1.7 Billion
- Alabama Hospital System and Physician Group Agree to Pay $24.5 Million to Settle Lawsuit Alleging False Claims for Illegal Medicare Referrals
- Medical Device Company Agrees To Pay $8 Million To Resolve Claims It Paid Illegal Kickbacks To Physicians
- Seven High-Profile NCS Fraud Cases

The False Claims Act

"Health care fraud is not an abstract violation or benign offense—it is a serious crime. The wrongdoers that we pursue in these operations seek to use public funds for private enrichment. They target real people—many of them in need of significant medical care. They promise effective cures and therapies, but they provide none. Above all, they abuse basic bonds of trust between doctor and patient." [12]

- U.S. Attorney General

Recommendations

- Be wary of inappropriate discounts or bundled items (e.g., supplying one good/service at a reduced charge or at no charge to induce the purchase of a different good or service)
- Monitor your activities for inappropriate or unnecessary medical procedures or billing for work or tests not performed in order to increase reimbursements
- Watch for billing by providers not actually on the job, or billing for made-up hours, in order to maximize reimbursements
- Do not engage in upcoding
- Carefully vet staff members against the list of excluded individuals and entities
- Implement robust internal policies that include compliance training and confidential hotlines, and keep your documentation and policies up to date
- Make use of quality programs, such as The Joint Commission guidelines, that review compliance standards as part of the audit process
- Insist on strict adherence to coding and billing requirements
- Empower trustworthy legal counsel and compliance experts in your organization
- Make sure that your administrative and clinical partners operate under the guidance of a formal compliance office with administrative oversight

In the News

- United States Resolves $237 Million False Claims Act Judgment against South Carolina Hospital that Made Illegal Payments to Referring Physicians
- Kentucky Hospital Agrees to Pay Government $16.5 Million to Settle Allegations of Unnecessary Cardiac Procedures
- Tenet Healthcare Corporation to Pay U.S. more than $900 Million to Resolve False Claims Act Allegations
- Florida Hospital District Agrees to Pay United States $69.5 Million to Settle False Claims Act Allegations

SpecialtyCare's Compliance Program

Adhering to applicable laws and helping protect our customers from the risk of compliance violations is part of SpecialtyCare's standard process. It's integral to who we are and how we operate. Being a good steward of the business side of healthcare is a key component of our overall service model and reinforces our ability to provide customers and patients with the best possible clinical and financial outcomes. Here are some ways that our compliance program and processes help provide protection from financial and reputational damage:

- We are led by a CEO, Board of Directors, and executive leadership team that value Integrity as one of our core operating principles
- We employ an experienced Chief Compliance Officer who is responsible for maintaining and enforcing a robust compliance program
- We provide a clear and thorough Code of Conduct for our associates, along with topic-specific, detailed policies
- We provide multiple resources, including a secure and anonymous compliance hotline and a non-retaliation policy, so that every associate can feel safe reporting a compliance concern, should one arise
- We expect our managers to serve as positive role models who make ethical decisions, create an open environment for their team members, resolve or elevate compliance concerns, and prevent retaliation
- We protect the privacy and security of our associates, customers, and patients with regular HIPAA training and other programs and technical safeguards
- We train all our associates on healthcare statutes, regulations, and other compliance directives upon hire and periodically thereafter
- We are not in a position to make or directly influence referrals
- We adhere to practices that restrict offering or giving something of value in hopes of inducing referrals, or as a reward for referrals, for SpecialtyCare services
- We are certified and accredited by The Joint Commission
- We conduct exclusion list checks to ensure we do not hire or retain associates who have been excluded by federal or state organizations
- We monitor certain operations for compliance (e.g., billing to help ensure submitted claims comply with government and private payer requirements, which can help reduce the chance of false claims allegations)
- We maintain a separate compliance committee, comprised of leaders from key functional areas, to assist with: monitoring employee adherence to compliance program requirements; identifying and addressing education or training needs unique to certain functional areas; investigating compliance allegations; and, implementing corrective actions

References

(1) https://www.justice.gov/opa/pr/justice-department-recovers-over-35-billion-false-claims-act-cases-fiscal-year-2015

(2) http://www.cooley.edu/lawreview/_docs/2012/vol29/2/Hesch.pdf

(3) https://www.justice.gov/opa/pr/justice-department-recovers-over-35-billion-false-claims-act-cases-fiscal-year-2015

(4) https://blog.cms.gov/2016/07/20/42-billion-saved-in-medicare-and-medicaid-primarily-through-prevention/

(5 - 9) https://www.justice.gov/opa/pr/justice-department-recovers-over-35-billion-false-claims-act-cases-fiscal-year-2015

(10) https://www.justice.gov/opa/pr/south-carolina-hospital-pay-17-million-resolve-false-claims-act-and-stark-law-allegations

(11) https://www.justice.gov/usao-ednc/pr/united-states-resolves-237-million-false-claims-act-judgment-against-south-carolina

(12) https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-301-individuals-approximately-900