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HHS OIG Annual Report Touts Increased Efforts, Investigations, Successes, and Recoveries

On February 11, 2013, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) released its Health Care Fraud and Abuse Control Program (HCFACP) Annual Report for Fiscal Year 2012. While the OIG is required under the Inspector General Act of 1978 to report its activities, including significant findings and recommendations, to the Secretary and Congress semiannually, the HCFCAP Report complies with Health Insurance Portability and Accountability Act (HIPAA) requirements that the Attorney General and the Secretary of HHS, through the HHS Inspector General, coordinate Federal, State, and Local law enforcement activities with respect to health care fraud and abuse. Thus, the HCFCAP Report focuses primarily on the results (and announced successes) of these collaborative civil and criminal efforts to reduce fraud and abuse, and specifically ties the results in terms of the funding provided for these efforts. HCFACP appropriations, which generally supplement the direct Department of Justice (DOJ) and HHS appropriations for health care fraud enforcement, are drawn from the Medicare Trust Funds from the amounts paid to Medicare in restitution or compensatory damages. In FY 2012, the Attorney General and the Secretary jointly certified $294.8 million in mandatory funding for appropriation to the HCFACP Account, while Congress appropriated an additional $309.7 million in discretionary funding. HCFACP appropriations funded approximately three-quarters of the FY 2012 appropriated budget.

This year's Report emphasizes "more" – more funds recovered, more investigations opened, more convictions obtained, more exclusions effected, and more administrative actions imposed. During FY 2012, the Federal Government won and negotiated over $3.0 billion in health care fraud judgments and settlements. The amount actually deposited with the Department of the Treasury and the Centers for Medicare and Medicaid Services (CMS), which included funds deposited based on actions in previous years, far exceeded this at $4.2 billion. Of this amount, approximately $2.4 billion was transferred to the Medicare Trust Funds, over $835 million in Federal Medicaid money was transferred separately to the Treasury, more than $375 million was returned to federal agencies, and slightly less than $285 million was paid to relators in qui tam actions. While the Report notes that the HCFACP has returned over $23.0 billion to the Medicare Trust Funds since 1997, it also highlighted that the return-on-investment (ROI) for the Program for the last three years (2010-2012) was $7.90 for every $1.00 spent on the

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Program from the Medicare Trust Funds – and that this was $2.50 higher than the average ROI since the program began in 1997.

In FY 2012, the DOJ reportedly opened 1,131 new criminal health care fraud investigations involving 2,148 defendants and brought criminal charges against 892 defendants in 452 filed cases. Through pleas and trials, the DOJ also secured the convictions of 826 defendants on criminal health care fraud charges in FY 2012. Moreover, at the beginning of FY 2013 there were 2,032 criminal health care fraud investigations pending involving 3,410 potential defendants. On the civil front, according to the Report, the DOJ opened 885 new civil health care fraud investigations and ended the fiscal year with 1,023 civil health care fraud matters pending.

In reviewing the significant HCFACP accomplishments described in the Report, it is clear that the highlighted enforcement actions shared certain characteristics. This may reflect an increasing tendency to use OIG reports as predication for opening investigations, the expansion of the Task Force approach to investigations and enforcement actions, and a consequent replication of cases throughout the country. Thus, the Report describes numerous cases involving home health care agencies, Community Mental Health Centers, partial hospitalization programs (PHPs), nursing homes, fraudulent medical clinics, and durable medical equipment (DME) companies. Similarly, the types of conduct that gave rise to the investigations included paying kickbacks and bribes to patient recruiters, falsifying and fabricating medical records for billing purposes, providing services that were medically unnecessary, and billing for services that were never provided.

During FY 2012, HHS OIG excluded 3,131 individuals from participation in Medicare, Medicaid, and other Federal health care programs. Of these exclusions, 912 were based on criminal convictions for crimes related to Medicare and Medicaid, 287 were based on criminal convictions for crimes related to other health care programs, 212 were for patient abuse or neglect, and 1,463 were because of licensure revocations.

In addition to exclusions, HHS OIG has the authority to impose civil monetary penalties (CMPs) against providers and suppliers, who engage in unlawful patient referrals and kickbacks, who fail to appropriately treat or refer patients at hospital emergency rooms, or who engage in other proscribed activities. In FY 2012, hospitals, physicians, and other centers paid more than $15,750,000 in CMPs for actions ranging from the submission of false claims to inappropriate medical care or treatment to the knowing employment of an excluded provider.

The HHS OIG has increasingly entered into Corporate Integrity Agreements (CIAs) with health care providers, whether as a result of civil or criminal settlements. By the end of FY 2012, the HHS OIG was monitoring compliance with 214 CIAs.

Finally, while the Report emphasizes the HCFACP's enforcement efforts, it includes substantial discussion of the OIG's other fraud and abuse prevention activities. Of these, audits and evaluations that examined questionable or improper conduct and recommended corrective actions received particular mention. HHS

OIG Audit Disallowances in Medicare recovered $89,677,376 for the Medicare Trust Funds in FY 2012, while the Audit Disallowances in Medicaid returned another $275,559,307.

With much riding on the recoveries from health care fraud enforcement actions, the numbers and results of these actions are of increasing interest – and can only be expected to grow further over the next several years.