Introduction to Federal Health Care Fraud & Abuse

Presented by
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OI G-HHS
The Enforcers

- Department of Justice (DOJ)
- OIG
- Medicaid Fraud Control Units
- State Attorneys General
The Sources

- CMS and DHHS
- Whistleblowers ("Relators")
- Concerned Citizens
- Audits and Investigations
The Perpetrators

- All kinds of persons and entities involved in health care:
  - Providers and suppliers
  - Practitioners
  - Manufacturers
  - Middlemen
  - Executives
  - Consultants
Office of the Inspector General - HHS

- Criminal and Civil Investigations
- Audits
- Evaluations
- Administrative Enforcement
- Oversight of Program Integrity
Industry Guidance
- Advisory Opinions
- Compliance Program Guidance
- Fraud Alerts and Bulletins
- Regulations

Self-Disclosure Protocol

Corporate Integrity Agreements (CIAs)
- Semi-annual Reports
- Work Plans
- Audits
- Evaluations
- Listserv
Identifying Fraud & Abuse

Rule of Thumb: “Follow the Money”
Fraud & Abuse Toolbox

- False Claims Act
- Anti-Kickback Statute
- Physician Self-Referral Statute
- Civil Monetary Penalties (CMPs)
- Exclusion
Nutshell version:

“It’s illegal to submit a false claim to the Federal Government.”
Knowingly presenting or causing to be presented a false or fraudulent claim to the Federal Government

- Qui Tam provisions
- 31 U.S.C. §§ 3729-3730
Nutshell version:

“It’s a crime to buy or sell Federal health care program business.”
Federal Anti-Kickback Statute

- Felony, intent based
- Knowing and willful offer, payment, solicitation, or receipt of remuneration (anything of value) to induce Federal health care program business
- 42 U.S.C. § 1320a-7b(b)
Sanctions:
- Jail and criminal fines
- CMPs and exclusion
- False Claims Act liability

“Safe harbor” regulations
(42 C.F.R. § 1001.952)

Case-by-case evaluations
Federal Anti-Kickback Statute

Concerns:

- Over-utilization
- Increased Program Costs
- Corruption of Medical Decision-making
- Unfair competition
- Systemic Corruption
Physician Self-Referral Prohibition

Nutshell version:

“A physician can’t make referrals for ‘designated health services’ to an entity he or she owns or does business with, unless an exception applies; if the physician makes such a referral, Medicare won’t pay for the service.”
The “Stark” law

Prohibits entities from billing Medicare for “designated health services” referred to the entity by physicians with whom the entity has a prohibited financial relationship (ownership or compensation).
Physician Self-Referral Prohibition

- **Sanctions:**
  - Disallowance/Overpayments (strict liability)
  - CMPs for knowing violations
  - False Claims Act liability

- **42 U.S.C. § 1395nn**

- **Regulations:** 42 C.F.R. § 411.350
Physician Self-Referral Prohibition

Three questions:

1. Is there a referral by a physician to an entity that provides designated health services payable by Medicare or Medicaid?
2. Does the physician (or immediate family member) have a financial relationship with the entity?
3. Does the financial relationship fit in an exception?
Nutshell version:

“Misconduct that might not rise to the level of prosecution by DOJ can be subject to administrative penalties.”
Civil Monetary Penalties

- 42 U.S.C. § 1320a-7a
- Administrative proceedings
- Numerous grounds, e.g.:
  - False claims/improper billing
  - Kickbacks and Stark violations
  - Patient dumping
- Penalties vary
Nutshell version:

“We don’t do business with untrustworthy individuals and entities.”
Exclusion

- 42 U.S.C. § 1320a-7
- Administrative proceedings
- “Death knell”
- Applies to all government health care programs
- Mandatory and permissive authorities
- Exclusion list at oig.hhs.gov
Challenges

- Finding the fraudsters
- Proving intent
- Regulatory design
  - Bright lines v. flexibility
  - Aligning incentives
- Keeping up with industry changes
- Dealing with novelty
Reporting Fraud and Abuse

- OIG Regional Offices
- DOJ / USAOs / FBI
- MFCUs / AGs
- OIG hotline: 1-800-HHS-TIPS
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