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HHS Plugs Payment Suspensions as Key Tool in Latest Takedown

The Medicare Fraud Strike Force's use of a pivotal ACA regulation to suspend payments during criminal investigations signals a turning point in its prosecution strategy.

On Wednesday, May 2, U.S. Attorney General Eric Holder and U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius announced the largest Medicare Fraud Strike Force operation to date, resulting in criminal charges against 107 individuals in seven cities related to allegations of $452 million in false Medicare billings. This latest round-up shows a tenacious, innovative, and coordinated law enforcement focus on entrenched organized crime enterprises in the healthcare industry. Key to the government's investigative efforts was an aggressive prepayment suspension strategy long advocated by law enforcement to stop payments and end the "pay and chase" advantage that makes the Medicare program an attractive target for organized crime.

Secretary Sebelius touted Medicare payment suspension as the newest weapon in the government's antifraud arsenal, stating in the agency's press release that "we used new authority from the health care law to stop all future payments to 52 health care providers suspected of fraud before they are ever made."[1] This signals a pivot in the government's healthcare fraud enforcement strategy. The Medicare program's failure to stop paying suspected fraudsters was a major weakness in prior Strike Force actions, but with the passage of the Affordable Care Act (ACA), HHS can now suspend payment when suspected fraud is identified. As a program integrity enhancement, section 6402(h) of the ACA expanded the authority of the Centers for Medicare and Medicaid Services (CMS) to suspend payments during an investigation into "credible allegations of fraud," removing strict time limits where suspected fraud is involved.[2] For providers caught in a scheme to defraud, this tool to protect the Medicare Trust Funds will sting. It may also potentially impact patient coverage and affect legitimate providers that have billing irregularities, both of which historically have been of concern to CMS and among the reasons why the agency has declined to implement overbroad systems protocols to stop irregular payments before there is sufficient evidence of fraud.

In the press release, HHS Office of Inspector General (OIG) Deputy Inspector General Gary Cantrell highlighted the role of the agency's forensic examiners and analysts in the operation, stating that "OIG is committed to the strike force model and will continue to use advanced data analytics along with traditional investigative methods to root out those who steal from our Medicare program."[3]

The Strike Force zeroed in on conspirators who were alleged to have made blatant cash payoffs to patient recruiters and Medicare recipients for high-end reimbursed services in home health services, mental health services, physical and occupational therapy, durable medical equipment (DME), and ambulance services. While

1. DOJ Press Statement, "Medicare Fraud Strike Force Charges 107 Individuals for Approximately $452 Million in False Billing," May 2, 2012, available at http://www.justice.gov/opa/pr/2012/May/12-ag-568.html.

2. *See* 42 C.F.R. §§ 405.370 – 405.372.

3. DOJ Press Statement, "Medicare Fraud Strike Force Charges 107 Individuals for Approximately $452 Million in False Billing," May 2, 2012, available at http://www.justice.gov/opa/pr/2012/May/12-ag-568.html.

these apparent fraudulent schemes represent the fringes in the healthcare industry, legitimate providers should take note as the "war on healthcare fraud" shows no sign of letting up and antifraud system enhancements will be the strongest protection for healthcare operations.

Health plans are often the direct victims of these blatant fraud conspiracies, as they are the ones that pay the false claims. Payors that are vulnerable to these fraud schemes should work to ensure that their claims departments and antifraud units are operating at optimal technological capacity to detect the fraud patterns before payment is made. In a recent open letter to the healthcare community, lawmakers on the Senate Finance Committee dialed up the pressure on the private sector to take charge in the fight against fraud, citing their disappointment with the "mixed record of successes and failures" of the Department of Justice (DOJ), CMS, and HHS-OIG in soliciting ideas for solutions to improve federal efforts to combat waste, fraud, and abuse in the Medicare and Medicaid programs.[4]

Morgan Lewis will monitor DOJ and OIG Medicare Fraud Strike Force activities and provide further perspective and updates on how this initiative will impact compliance strategies for the healthcare industry.

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4. Open Letter to Members of the Health Care Community from Senate Finance Committee Members Max Baucus (D-Mont.), Orrin Hatch (R-Utah), Tom Coburn (R-Okla.), Ron Wyden (D-Ore.), Chuck Grassley (R-Iowa), and Tom Carper (D-Del.), May 2, 2012, available at http://finance.senate.gov/newsroom/ranking/release/?id=d2527088-4f4c-434f-863f-5e980aaa2637.