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Enforcement and regulatory concerns for hospitals in 2018

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The beginning of 2017 brought a new administration to the White House, along with some new and some familiar faces to executive agencies responsible for regulation and oversight of the hospital sector. Indeed, many positions in these agencies are still vacant or have only recently been filled. 2017 can thus be best categorized as a transition year, focused on forthcoming proposals for the significant payment and regulatory reform on the horizon in 2018.

Continued emphasis on individual accountability

The Yates Memorandum,[1] which was issued in September 2015, notified the healthcare community that there would be an increased focus on individual wrongdoers by the U.S. Department of Justice (DOJ).

The Trump Administration has not wavered from this message. Deputy Attorney General Rod Rosenstein repeatedly has emphasized that DOJ will continue to investigate and prosecute those persons responsible for significant corporate misconduct. Acting Assistant Attorney General Kenneth A. Blanco recently noted that False Claims Act (FCA) settlements and DOJ "indictments should send a clear signal to hospitals and healthcare institutions around the country that they and their management will be held accountable." [2]

One example of the Yates Memorandum in action was the April 2017 settlement by Norman Regional Health System, which involved a former hospital administrator and six physicians. The defendants were alleged to have improperly billed Medicare for services performed by radiological practitioner assistants, which required, but did not have, personal physician supervision. The administrator and physicians were forced to pay a share of the $1.6 million settlement.[3] Those in the hospital sector need to be more cognizant than ever that there may be a divergence of interests between the corporate entity and its employees during the course of a government investigation.

Significant False Claims Act enforcement expected to expand in 2018

The False Claims Act (31 U.S.C. §§ 3729 — 3733) continues to be DOJ's favorite tool for recovery of federal healthcare dollars. The government recovered $360 million from hospitals and clinics in FY 2016.

Although still often reliant on tips from whistleblowers, prosecutors are now able to harness the power of data analytics to identify healthcare fraud cases. For instance, the Fraud Section within DOJ's Criminal Division has an on-staff data analyst who is concerned "[n]ot simply [with] finding bills for dead patients or identifying the providers with the highest billings, but using her expertise to find investigative leads, identify strategic trends and corroborate fraud tips."[4]

In addition to monetary settlements, many entities also are faced with burdensome corporate integrity agreements (CIAs). Thirteen hospitals entered into CIAs in 2016. Hospitals should preemptively review their policies for compliance with the so-called "non-negotiable" terms that Health and Human Services (HHS) Office of the Inspector General (OIG) inserts into CIAs.

Improper coding

Hospitals must be increasingly careful in their use of billing modifiers. Policies should be in place to ensure that healthcare professionals and billers properly code services, and internal audits should be routine to identify any red flags that require further investigation. Self-disclosure of potential wrongdoing can go a long way toward reducing the institution's exposure. Hospitals can look to various settlements during 2017 for examples of billing practices to avoid:

- In September 2017, a South Carolina hospital, AnMed Health, entered into a settlement with DOJ for $7 million to resolve claims that it improperly billed for physician services and evaluation and management (E/M) "up-coding." The hospital allegedly received inflated reimbursements for: (1) systematically "bill[ing] a minor care clinic as if it was an Emergency Department" and (2) "bill[ing] Emergency Department services as if they were provided by a physician" when they were performed by mid-level providers.[5]
- In June 2017, the University of Rochester (UR) settled a *qui tam* action involving the improper use of a billing modifier. The action settled for just over $100,000, but it is worth highlighting that UR's self-disclosure of the improper billing procedure to the government prior to the suit being unsealed resulted in a substantially reduced settlement amount.[6]

There are sure to be more cases brought in 2018 involving improper billing and coding. Indeed, OIG's current Work Plan focuses on the Two-Midnight Rule, which permits Medicare Part A payments for Medicare inpatient admissions when the admitting provider "expected the patient to require a hospital stay that crossed two midnights and the medical record supports that reasonable expectation."[7] The rules for converting an admission to outpatient status (Code 44) are also complex and easily misunderstood. OIG has significant recommendations for Centers for Medicare and Medicaid Services (CMS) in this area, aimed at protecting patients from paying more than is necessary, while still providing the highest level of care.

Medicare Secondary Payer Act

In an area that seems ripe for enforcement in 2018, hospitals should also note potential FCA liability for claims under the Medicare Secondary Payer Act (MSP) [42 U.S.C. §§ 1395y(b)(2)(A)(i)-(iii)]. The MSP requires that if an individual has multiple sources of insurance, Medicare must be designated as the second payer (with limited exceptions). Medicare frequently withholds payment on claims related to accidents or injuries in order to determine if there is another primary insurer, such as Workers' Compensation, liability, or no-fault, such that Medicare should not be designated as the primary payer. Recent examples include:

- In January 2017, a court denied a hospital's motion to dismiss a FCA *qui tam* action that was brought by a

former hospital patient account supervisor who alleged that the hospital systematically removed or omitted accident and injury information in order to be reimbursed for claims, for which Medicare otherwise would have withheld payment. This case has not yet been decided, but it is certainly one to watch.[8]

- In March 2016, a court found that allowing an insurer's policyholders to select a "health-first" option, without verifying whether a Medicare or Medicaid plan was implicated, and the subsequent improper submission of claims to the federal government, was a sufficient FCA pleading. The court found the alleged practice to be impermissible, even if the insurer ultimately paid the government back, because it allowed the insurer to "receiv[e] an interest free loan from the government…" Despite the lack of any overpayment in the long run, this approach demonstrates the increasing sophistication of FCA claims and the importance of thinking through ramifications of relying on information obtained from individuals without first reviewing it for compliance with applicable law.[9]

In 2018, hospitals can expect to see the government bring more MSP-related FCA investigations.