HCFAC Report 2014: After Consecutive Record Years, Recoveries and Prosecutions Take a Dip[1]

By Paul Weidenfeld

The Health Care Fraud and Abuse Control Program ("HCFAC"),[2] as the principle funding source for most of the fraud and abuse funding received by the OIG, DOJ and CMS, prepares detailed yearly reports that are sometimes viewed to be a barometer of fraud and abuse enforcement efforts. While valid conclusions can't be drawn based on small samples or on numbers alone, side by side comparisons of data sometimes does suggest trends or general directions. It will be interesting to see if that turns out to be the case as the 2014 Report, discussed below, shows a surprising drop in recoveries and cases when compared to the previous two years.

Health Care Fraud Recoveries Drop by Almost 25%

$3.3 billion in recoveries is a large sum by any standard, yet when compared to the previous two years, recoveries dropped by about 25% across the board. Total recoveries dropped from $4.2 and $4.3 billion in the 2012 and 2012, and health care fraud judgments dropped to $2.3 billion in 2014 from $3.0 billion in 2012. Medicare Trust Fund Medicaid dollars, probably the most important numbers, also sustained significant drops with Trust Fund receipts at $1.9 billion (from $2.4 and $2.85 billion), and Medicaid recoveries down from $835.7 million in 2012 to $523 million 2014. While there may be several explanations for this one year drop, it will be worth keeping an eye on the numbers to see what, if anything, it means.

DOJ Civil Numbers Were Surprisingly Lower, Though Only Slightly

It was a bit surprising to see that the number of new civil health care fraud investigations were down about 10% and 20% from 2012 and 2013 respectively and that pending fraud matters also dropped (if only slightly). Considering that cases often take four years or longer to conclude, there is not likely to be any correlation between a dip in recoveries and new cases in that same year, but these numbers, particularly the opening of new cases, are hard to understand considering the significant increase in new False Claims Act cases being brought by whistle blowers every year. This seems more likely to be an aberration than a trend, but it is still a surprise.

DOJ Criminal Numbers Were Mixed, But More Up Than Down

DOJ reported that new criminal health care fraud investigations and the number of defendants convicted of health care fraud were both slightly. On the other hand, the actual number of cases in which defendants were charged increased from 452 to 496, and FBI investigative efforts reportedly resulted in significant increases in both operational disruptions of criminal fraud organizations (from 329 in 2012 up to 605 in 2014), and in dismantling criminal hierarchies (142 in 2014 compared to 83 in 2012). These numbers may be partially explained by the HEAT program, which emphasizes criminal investigations in health care matters, and they, too, are certainly worth keeping an eye on.

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[2] The Health Care Fraud and Abuse Control Program, or "HCFAC", was created as part of the HIPAA anti-fraud legislation to coordinate Federal, State and local health care fraud and abuse enforcement.

OIG Criminal and Civil Increased Slightly; Exclusion Actions Were Considerably

The OIG reported a small increase in both criminal actions in crimes related to Medicare and Medicaid and in civil actions brought either in Federal district court or administratively, however, as the report does not reconcile these numbers or actions with those reported by DOJ, it is impossible to reach any conclusions as to their meaning. The number of individuals and entities excluded from participation in Medicare, Medicaid, and other federal health care programs actions, on the other hand, rose considerably (4,017 in 2014, up 25% from the prior two years. A breakdown of the exclusion data shows that exclusions based on convictions for crimes related to Medicare and Medicaid increased approximately 25% over the past two years, and that exclusions based on convictions for crimes relating to other health care programs showed an even greater rise (432 in 2014 up from 287 in 2012). Other major grounds for exclusion included patient abuse or neglect and licensure revocations – both of which also rose significantly. These numbers appear consistent with, and reflective of, HHS-OIG's increasing interest in exclusions and exclusion enforcement as a means of protecting the Medicare and Medicaid programs.

V. Final Thoughts

The HCFAC 2014 report may simply reflect a slightly down year. On the other hand, it might be the first indication that the numbers of the previous record years may be harder maintain and more rarely seen, as the industry embraces compliance in response to the intense enforcement efforts of recent years. Regardless of what it means, if anything, it does reflect that at least some change took place last year and that we should all stay tuned.