Risk Alert: Healthcare Fraud and Abuse at Hospital and Health Systems

While the fate of healthcare reform is far from determined, one thing is certain: many hospitals and health systems across the country have spent years planning their transition to value-based care.

This shift in how providers are compensated–based on outcomes, not quantity–has since resulted in a number of new payment models that have grown in popularity since their inception, both as a result of mandatory and voluntary compliance. According to the Center for Medicare and Medicaid Services (CMS), as of 2017, these payment models boast more than 350,000 participating clinicians and provide care to 12.3 million Medicare and Medicaid beneficiaries.

While growing in popularity, the shift to value-based care has also sparked a conversation about whether hospitals are appropriately compensated. For instance, according to data released by the American Hospital Association in December 2016, combined underpayments–the difference between the cost incurred and the reimbursement received for delivering care to patients–reached $57.8 billion in 2015. During the same period, hospitals received a payment of 88 cents for every dollar spent when treating Medicare beneficiaries and 90 cents for every dollar spent when caring for Medicaid beneficiaries.

The transition to value-based care has, not coincidentally, also driven an uptick in hospital M&A activity. In 2016, there were 102 hospital transaction announcements, up 55% from 2010. These transactions, which include mergers, acquisitions, joint ventures and joint operating agreements, are designed to cut waste, drive efficiency and decrease cost.

A Growing Financial Challenge

As providers contend with underpayments and strive to ensure they meet operational and financial benchmarks associated with M&A activity, many are questioning how they will close unsustainable revenue gaps.

In some cases, and in order to fill the hole, this pressure is driving providers to conduct and bill for unnecessary medical procedures. Beyond putting patient health at risk, this practice could expose an organization to costly medical professional and D&O liability risks.

Five Steps to Protect Your Organization

There are a number of simple steps healthcare organizations should take to reduce their exposure to healthcare fraud and abuse-related practices.

1. Ensure your corporate compliance plan aligns with the requirements set forth by the U.S. Department of Health and Human Services' Office of Inspector General (OIG). Review annually to account for new guidelines
2. Require mandatory annual compliance training for all employees, officers and agents
3. Regularly conduct risk assessments for billing, coding and physician documentation
4. Establish a confidential risk disclosure program that requires immediate reporting of any suspected or known fraudulent or criminal activity
5. Ensure that all employees who report such activity are informed that their confidentiality will be protected, to the extent possible

Why Chubb?

Medical professional liability is the largest insurance cost and source of pressure for providers. Chubb not only offers financial stability and comprehensive coverage, but also the knowledge and experience to handle the long-tail lifecycle of professional liability claims.

Similarly, litigation over the actions and decisions of healthcare organization leaders can last for years and cost millions of dollars. If an organization cannot indemnify

Healthcare Fraud and Abuse Litigation on the Rise

Over the past few years, the U.S. government has demonstrated more willingness to pursue both civil and criminal cases alleging unnecessary care and fraudulent billing practices against providers, largely as a result of enhanced data analytics and expert witnesses.

This is a shift from previous thinking where such cases were perceived as second-guessing physician decision-making and clinical processes. In fiscal year 2016, the U.S. government recovered more than $3 billion as a result of healthcare fraud judgements, settlements and additional administrative impositions in healthcare fraud causes and proceedings.

Investigations and enforcement efforts targeting fraud, waste and abuse in healthcare are expected to remain robust.

its leaders, then this financial burden can become the personal responsibility of those individuals. As the business practices and decisions of healthcare boards increasingly come under scrutiny, leaders can't afford to take any chances, and Chubb offers the D&O liability protection they need.

Our Experts:

Chubb's 25 years of experience working with healthcare providers means we've seen it all. We are uniquely equipped to protect against the emerging risks associated with today's changing healthcare landscape, while simultaneously working with providers to introduce loss control best practices to help protect against tomorrow's threat.

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