The Miami Herald

August 6, 2012

United States: Introduction Of The Private-Public Partnership And The Future Of Fraud Claims

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The U.S. Department of Health and Human Services (HHS) and the U.S. Attorney General's Office announced that the federal government is creating a partnership with private payers and other state and private entities to attack health care fraud. Twenty-one organizations and agencies, including HHS, CMS, DOJ, FBI, Blue Cross and Blue Shield Association, Humana, and Wellpoint, have joined the partnership.

Partnership members have agreed to the unprecedented step of proactive, pre-case information-sharing about specific schemes, billing codes, and "hot" fraud locations. According to the **Coalition Against Insurance Fraud**, one of the founding partnership members, participants "will share case leads, evidence, data, and other vital information" to try to prevent fraud and to facilitate False Claims Act lawsuits and criminal prosecutions. (The partners also have committed to sharing only "scrubbed" data, to protect patient privacy.) Specific future goals of the partnership include preventing providers from billing two different insurers for the same patient care and predicting health care fraud schemes. The partnership's working groups are already meeting to structure a work plan, and its board, data analysis committee, and information-sharing committee will meet in September 2012.

The partnership arose from the Coalition Against Insurance Fraud's offer to HHS to coordinate a health care fraud summit in 2010, and is further evidence of the Obama administration's full-throttle effort to reduce fraud and abuse in health care, and to recover public and private losses in the industry.

The partnership complements, and in many ways is a natural extension of, the ever-escalating anti-fraud efforts, including increased criminal prosecutions, civil lawsuits, the recently implemented Stark Self-Referral Disclosure Protocol, and the Patient Protection and Affordable Care Act's provision for longer criminal sentences for certain categories of health care fraud.

Prosecuting fraud and abuse has been a state and federal government priority for several years, and diligent health care providers and suppliers have implemented their own anti-fraud programs and compliance plans. With growing public/private resources and fewer barriers to information-sharing, providers and suppliers should anticipate more scrutiny of all claims - whether they are sent to public or private payers. The government's best options for pursuing non-governmental health care fraud include criminal prosecutions under a variety of theories. While the government could always pursue private actors, it has sometimes been stymied by a lack of access to data, documents, and witnesses. By working with private entities, the executive branch likely hopes to expand its fraud-fighting toolkit even more. For their part, the private partners' voluntary participation is likely seen as a commitment to joining the government's battle. This partnership, especially when viewed as one more arrow in the government's quiver, suggests that all providers and suppliers - irrespective of their payer mix - will need to focus on, and obtain management buy-in for, careful monitoring to assure compliance with fraud and abuse laws. In sum, with more entities joining the fight against fraud and abuse, it may be getting harder to stay beneath the government's radar.

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Coalition Against Insurance Fraud

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