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Meaningful Use Enforcement — A Texas Grand Jury Indicts a Former CFO on Allegations of EHR Meaningful Use Fraud

Providers Must Carefully Review Any Meaningful Use Attestations Made to the Federal Government

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Meaningful use enforcement is coming as concerns regarding meaningful use fraud continue to increase. Since the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act and the implementation of the electronic health record (EHR) meaningful use program, the Office of Inspector General (OIG) and others at the Department of Health and Human Services (HHS) have been concerned about the increases in claims, suggesting — even if indirectly — that such increases may be related to fraud.[1] The concerns regarding fraud are not surprising when considering that, as of February 2014, more than 355,557 eligible professionals and hospitals have been paid more than $21 billion in incentive monies.[2]

The OIG has expressed concerns in several reports that the meaningful use program is susceptible to fraud.[3] The OIG, for example, conducted an early assessment of the controls that the Centers for Medicare & Medicaid Services (CMS) had in place to oversee the meaningful use self-reports it received from eligible professionals and eligible hospitals in 2011.[4] In its 2012 report, the OIG noted that CMS "has not implemented strong prepayment safeguards" and that CMS' "ability to safeguard incentive payments postpayment is also limited."[5] The OIG recommended that CMS require supporting documentation from "high-risk professionals and hospitals" and further "bolster its current guidance by detailing the types of supporting documentation it expects professionals and hospitals to maintain for specific meaningful use measures."[6]

Most recently, the Department of Justice (DOJ) has also entered into policing alleged meaningful use fraud.

The Department of Justice Action

The DOJ charged Joe White, a former chief financial officer for the Shelby Regional Medical Center (Shelby Regional), with health care fraud violations related to falsely attesting that Shelby Regional, a now defunct 54-bed facility, met meaningful use requirements. Shelby Regional is owned by Shelby Medical Holdings, whose owner, Dr. Tariq Mahmood, was separately indicted for health care fraud in 2013.[7] On January 22, 2014, Mr. White was indicted by a federal grand jury in the Eastern District of Texas and charged with (1) making false statements to CMS, and (2) aggravated identity theft.[8]

The indictment stems from the actual attestations of meaningful use submitted by White. Allegedly, "on Nov. 20, 2012, White falsely attested to CMS that [Shelby Regional] met the meaningful use requirements for the 2012 fiscal year. However, Shelby Regional relied on paper records throughout the fiscal year and only minimally used electronic health records."[9] Further, according to the DOJ, "[t]o give the false appearance that the hospital was actually using Certified Electronic Health Record Technology, White directed its software vendor and hospital employees to manually input data from paper records into the [EHR] software, often times months after the patient was discharged and after the end of the fiscal year."[10]

With respect to the aggravated identity theft, White allegedly used another person's name and information without permission to falsely attest to the hospital's meaningful use. Relying on the false attestation, CMS paid Shelby Regional $785,655. "In total, hospitals operated by Dr. Mahmood, including Shelby Regional, were paid $16,794,462.66 by the Medicaid and Medicare EHR incentive programs for fiscal years 2011 and 2012."[11] If convicted, Mr. White faces up to five years in federal prison for making a false statement and up to two years in federal prison for aggravated identity theft.

According to a report by the Information Security Media Group, the DOJ action arose from an OIG investigation related to the submission of false meaningful use attestations.[12]

Meaningful Use Attestation and Personal Liability

When the eligible professional, eligible hospital, or a respective employee makes the necessary submission for meaningful use incentive funds, the person is required to certify and attest to a number of facts, including that the claim does not contain a misrepresentation or false statement. For example, when filing for Medicare-related EHR incentive funds on behalf of an eligible professional, the submitter must attest to the following:

> I certify that the foregoing information is true, accurate, and complete. I understand that the Medicare EHR Incentive Program payment I requested will be paid from Federal funds, that by filing this attestation I am submitting a claim for Federal funds, and that the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a Medicare EHR Incentive Program payment, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.
>
> USER WORKING ON BEHALF OF PROVIDER: I certify that I am attesting on behalf of a provider who has given me authority to act as his/her agent. I understand that both the provider and I can be held personally responsible for all information entered. I understand

> that a user attesting on behalf of a provider must have an Identity and Access Management system web user account associated with the provider for whom he/she is attesting.[13]

The attestation statements make clear that individuals making the submission may be *individually* subject to federal and state criminal and civil penalties. The attestation statement for eligible hospitals and critical access hospitals is much the same, except the statement does not include the language underlined above.[14] Nonetheless, as can be seen from the indictment against Mr. White, hospital representatives can be held personally liable.

Concluding Comments

Hospitals, providers, and those making submissions on their behalf should expect an increase in meaningful use fraud enforcement. The OIG has advised that false statements related to the incentive program are "of continuing interest."[15] The Texas case has also sparked interest from several members of Congress. On February 26, 2014, Chairman of the House Energy and Commerce Committee Fred Upton (R-MI), Vice Chairman of the Health and Oversight and Investigations Subcommittees Michael C. Burgess, M.D. (R-TX), and Chairman Emeritus Joe Barton (R-TX) sent a letter to each of CMS' Chief Administrator Marilyn Tavenner and HHS' Inspector General Daniel Levinson asking for certain details on the types of steps CMS was taking to minimize fraud as well as the recommendations that have been made by the OIG.[16] They were asked to respond by March 12, 2014.

Health care providers must carefully review any meaningful use attestations made to the federal government. The attestation is a legal statement, which may be used against both the provider and the individual to claw back monies paid under the incentive programs as well as to exclude individuals and entities from federally funded health care programs. Further, while both companies and individuals are subject to criminal penalties, only individuals can serve time in prison.

Providers do have an ongoing obligation to disclose to CMS if they believe they have been overpaid under the incentive programs.[17] Health Management Associates, Inc. (HMA), for example, repaid $31 million to CMS and the relevant state programs after discovering through an internal audit that 11 of the hospitals it had enrolled in the federal Medicare and various state Medicaid Healthcare Information Technology programs did not meet the meaningful use criteria necessary to qualify for the payments.[18] Given the possible penalties, a proactive audit is a good start for evaluating compliance.

Endnotes:

1. In a September 24, 2012 letter, for example, Attorney General Eric Holder and HHS Secretary Kathleen Sebelius, jointly warned that HHS was paying more attention to EHR-related fraud. *See* Joe Carlson, Warning Bell: Potential for Fraud Through Use of EHRs Draws Federal Scrutiny, Modern Healthcare, Sept. 29, 2012, www.modernhealthcare.com/article/20120929/MAGAZINE/309299984.
2. CMS, EHR Incentive Program Summary, Jan. 2014, *available at* www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/January2014_SummaryReport.pdf.
3. The OIG has also looked at the Medicaid EHR incentive program. *See* OIG, Early Review of States' Planned Medicaid Electronic Health Record Incentive Program Oversight, OEI-05-10-00080, July 2011. The OIG has also released reports regarding the lack of safeguards in EHRs to address fraud-related concerns as well as the lack of instructions by CMS to its contractors on investigating fraud in EHRs. *See e.g.*, OIG, Not All Recommended Safeguards Have Been Implemented in Hospital EHR Technology, OEI-01-11-00570, Dec. 2013, *available at* oig.hhs.gov/oei/reports/oei-01-11-00570.pdf; OIG, CMS and its Contractors have Adopted Few Program Integrity Practices to Address Vulnerabilities, OEI-01-11-00571, Jan. 2014, *available at* oig.hhs.gov/oei/reports/oei-01-11-00571.pdf.
4. OIG, Early Assessment Finds that CMS Faces Obstacles in Overseeing the Medicare EHR Incentive Program, OEI-05-11-00250, Nov. 2012, *available at* oig.hhs.gov/oei/reports/oei-05-11-00250.pdf.
5. *Id.* at 16.

6. *Id.* at 16 – 17.
7. *See e.g.*, Miles Moffeit, *Owner of Renaissance Hospital Terrell Faces Federal Charges on Health Care Billing Fraud*, DallasNews.com, April 23, 2013, www.dallasnews.com/news/crime/headlines/20130423-dallas-area-physician-faces-federal-charges-on-health-care-billing-fraud.ece; Bob Herman, *Shelby Regional Medical Center in Texas Closes Its Doors*, Becker's Hospital Review, www.beckershospitalreview.com/hospital-management-administration/shelby-regional-medical-center-in-texas-closes-its-doors.html, July 11, 2013.
8. Press Release, U.S. Department of Justice, U.S. Attorney's Office - Eastern District of Texas, Former Hospital CFO Charged with Health Care Fraud, Feb. 6, 2014, www.justice.gov/usao/txe/News/2014/edtx-hcf-white-020614.html [hereinafter DOJ Press Release].
9. DOJ Press Release, *supra* note 7.
10. *Id*.
11. *Id*.
12. Marianne Kolbasuk McGee, HITECH Act EHR Program Fraud Alleged - Former Hospital CFO Charged with Submitting False Documents, GovInfo Security, Feb. 22, 2014, http://www.govinfosecurity.com/hitech-act-ehr-program-fraud-alleged-a-6498 (citing n spokesman for the Department of Health and Human Services' Office of the Inspector General).
13. CMS, Attestation User Guide for Eligible Professionals, p. 71, Nov. 2013, www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/EP_Attestation_User_Guide.pdf (emphasis in original).
14. *See* CMS, Attestation User Guide for Eligible Hospitals and Critical Access Hospitals, p. 47, July 2012, www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/downloads/HospAttestationUserGuide.pdf.
15. McGee, *supra* note 12.
16. *See* House of Representatives, Committee on Energy and Commerce, Letter to Honorable Marilyn Tavenner, Feb. 26, 2014, energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/20120226CMS.pdf; House of Representatives, Committee on Energy and Commerce, Letter to Honorable Daniel Levinson, Feb. 26, 2014.
17. *See* Patient Protection & Affordable Care Act, Pub. L. 111–148, 124 STAT. 755 (2010).
18. *See* Health Management Associates, Inc., Securities and Exchange Commission Form 8-K, Nov. 5, 2013; Press Release, Health Management Associates, Inc., Nov. 5, 2013, www.sec.gov/Archives/edgar/data/792985/000090951813000221/mm11-0513_8ke991.htm.

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