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CRIMINAL PROSECUTION AS A DETERRENT TO HEALTH CARE FRAUD

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIME AND DRUGS

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

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WEDNESDAY, MAY 20, 2009

U.S. SENATE,
SUBCOMMITTEE ON CRIME AND DRUGS,
COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 2:30 p.m., in room SD–226, Dirksen Senate Office Building, Hon. Arlen Specter, Chairman of the Subcommittee, presiding.

Present: Senators Specter, Klobuchar, Kaufman, and Sessions.

OPENING STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Chairman SPECTER. The hour of 2:30 having arrived, we will proceed with this hearing of the Subcommittee on Crime and Drugs of the Committee on the Judiciary of the U.S. Senate.

The subject today focuses on the use of tough sanctions, criminal penalties instead of fines, to hold down costs on Medicare and Medicaid fraud as a key part of the effort to have health care reform this year. President Obama has identified health care reform as the No. 1 item on his agenda for the year 2009. There is no doubt of the need for reform, with some 47 million-plus Americans either uninsured or underinsured. One of the big issues is going to be how we are going to pay for it.

In an extended floor statement earlier this week, I outlined a number of lines to accomplish that. One is increased funding for the National Institutes of Health. What better way to hold down the costs than to prevent illness? The increase from $12 to $30 billion through the leadership of Senator Harkin and myself has provided, I think, a causal relationship on reducing fatalities in strokes and various forms of cancer and heart disease. The issue of exercise and diet offers the prospect for holding down health care costs. Early intervention, with coverage for all Americans, offers the prospect for holding down costs of chronic illness by interceding at an early date. The use of advance directives is an item which will be very, very helpful with very substantial Medicare costs in the last few hours, few days, few weeks of a person's life. And today's focus, as I said, is on the use of jail sentences, tough criminal sanctions to reduce the incidence of Medicaid fraud and Medicare fraud.

From my own experience as District Attorney of Philadelphia, I saw firsthand the assistance of jail sentences holding down white-collar crime. If you deal with a domestic dispute or you deal with

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a barroom knifing, that kind of an emotional matter, spur of the moment, unaffected really by sentencing. But white-collar criminals are thoughtful, and that has real potential.

Let me thank Senator Kaufman for coming and yield to him for an opening statement.

STATEMENT OF HON. EDWARD E. KAUFMAN, A U.S. SENATOR FROM THE STATE OF DELAWARE

Senator KAUFMAN. Thank you, Mr. Chairman. I am finding this job—you know, change is always hard in dealing with it, and I am still getting used to being a Senator, and I am getting very used to and very, very happy about having our Chairman be our Chairman. And talk about hit the ground running in terms of getting right on to the business of the people, and I think this is a great hearing, Mr. Chairman, and I want to thank you for holding it.

Chairman SPECTER. Thank you, Senator Kaufman, and my thanks to Senator Durbin, who generously yielded his gavel for me to chair this Subcommittee, and my thanks to Senator Reid, the Majority Leader, for the approval and Senator Leahy, the Chairman, for his acquiescence in my taking on the chairmanship.

Mr. Breuer, if you would stand to be sworn. Do you solemnly swear that the testimony you will give before this Subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. BREUER. I do.

Senator SPECTER. I begin by thanking you for rearranging your schedule to come here on short notice. We know you have a signing ceremony in the White House, and we will get you to the White House, also known as the "church," on time.

Mr. Breuer comes to this position after undergoing rigorous confirmation hearings in that chair, questioning by the probing members of this Judiciary Committee. He began his career as an assistant district attorney in Manhattan, where he prosecuted a wide variety of cases. My own personal view is that is the best experience of all. People ask me what the best job I ever had was—Senator or district attorney. I say assistant district attorney. That is where you get to question witnesses and really dig into the tough trial work, which is great to experience.

In 1989, he joined Covington & Burling, becoming a partner in 1995, co-chair of the white-collar defense and investigations practice group, specialized in white-collar crime, complex civil litigation, internal corporate investigations, congressional investigations, and antitrust cartel proceedings. From 1997 to 1999, he served as special counsel to President Clinton. He has been recognized by numerous publications as a leading litigator and a fellow of the American College of Trial Lawyers. Excellent academic background with a bachelor's degree from Columbia and a law degree from Columbia.

Thank you for coming, Mr. Breuer, and the floor is yours.

STATEMENT OF LANNY A. BREUER, ASSISTANT ATTORNEY GENERAL, CRIMINAL DIVISION, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, D.C.

Mr. BREUER. Thank you so much, Mr. Chairman, for having me, and Senator Kaufman. Thank you for giving the Department of Justice the opportunity to appear before you today to discuss the Department's efforts to fight and deter health care fraud.

Health care fraud is one of the Department's top enforcement priorities, as the Chairman just noted. We firmly believe that greater investment in enforcement will pay significant dividends in our efforts to deter fraud and safeguard the billions of dollars in Federal health care spending each year.

As you know, health care fraud is an enormous problem. Federal and State spending on Medicare and Medicaid exceeds $800 billion per year and is expected to double in the next 10 years. According to various estimates, somewhere between 3 and 10 percent of this spending is lost to waste, fraud, and abuse. Even at the low end, that amounts to $25 billion lost in 2008 alone. We must—must—staunch the bleeding, and we are committed to doing so.

Indeed, the Department has been vigorously fighting health care fraud for years. Since 1997, working with our enforcement partners in the Department of Health and Human Services, the Department's civil and criminal enforcement efforts have returned more than $14 billion to the Federal Government, and resulted in more than 5,000 criminal convictions and exclusions from Federal health care programs.

In just the first 8 months of the fiscal year, we have recovered almost $1 billion under the civil False Claims Act. In addition, in 2008 alone, Department prosecutors obtained over 500 convictions in health care fraud cases, an all-time high for the Department.

In part, this success in our criminal enforcement efforts is due to a new strategic approach to health care fraud prosecutions: our Medicare Fraud Strike Forces. In May of 2007, the Departments of Justice and Health and Human Services announced an interagency effort to prosecute durable medical equipment suppliers, infusion clinics, pharmacies, and other individuals and entities who blatantly steal from Medicare by billing unnecessary or non-existent services.

The Medicare Fraud Strike Forces represent an innovative approach to health care fraud prosecutions. They are data-driven, community-based, real-time prosecutions. Coordinated teams of investigators and prosecutors analyze Medicare claims data to target specific geographic areas showing unusually high levels of Medicare billing, all in an effort to combat ongoing crime by the worst offenders.

This approach to health care fraud prosecutions has proven to be a powerful weapon in the fight against fraud in our Federal health care programs. To date, Medicare Fraud Strike Forces in Miami and Los Angeles have obtained 129 guilty pleas and 18 trial convictions, resulting in 113 sentences with an average length of 45 months in jail, approximately 1 year longer than the national average for health care fraud prosecutions. Seven of those sentences were 10 years or more, including one sentence of 30 years for a doc-

tor in Miami who fraudulently billed Medicare for $11 million in unnecessary HIV/AIDS infusion therapy.

We are seeing tangible results from these efforts. The work of the Medicare Strike Force in Miami alone contributed in the task force's very first year of operation to a $1.75 billion drop in claims submitted and a $334 million decrease in claims paid by Medicare. These results were achieved in a single county in South Florida, proving that targeted enforcement works and that investment in health care fraud enforcement is worth every penny.

Indeed, our combined civil and criminal enforcement efforts have returned almost $4 to the Medicare Trust Fund for every dollar of funding that Congress has provided to Federal law enforcement agencies.

Of course, despite these accomplishments, there is always much more to be done, and just today, the Departments of Justice and Health and Human Services took some additional significant steps to ramp up our prevention and enforcement efforts even further.

Approximately an hour ago, the Attorney General and Secretary Sebelius announced the formation of a senior-level task force designed to bring together the leadership of their Departments to tackle health care fraud across the country. This task force, to be named the Health Care Fraud Prevention and Enforcement Action Team, or HEAT, will increase coordination, intelligence sharing, and training among our investigators, agents, and prosecutors.

As a top priority, the task force will look at how we can better share real-time intelligence data on suspected fraud by closely monitoring claims payment data, identifying problematic billing patterns immediately, and investigating those suspected of stealing. This enhanced coordination between the two agencies will provide a vital link in our ongoing efforts. The Attorney General also announced today that we have expanded our strike force operations into Detroit and Houston.

As we saw in the example from Miami that I described a few minutes ago, targeted enforcement, now also aimed at Detroit and Houston, offers immediate and sustained benefits. We urge Congress to support the administration's request for additional funding to support these efforts. With additional funding, we can deploy additional strike forces to target emerging and migrating fraud schemes in other areas across the country.

In closing, let me assure you that the Department of Justice will remain steadfast in its pursuit of health care fraudsters. We look forward in the months and years ahead to working with Congress to identify and pursue legislative and regulatory reforms focused on the prevention, deterrence, and prosecution of health care fraud.

Mr. Chairman, thank you for allowing me to share the Department's views today on this important issue, and I welcome any questions.

[The prepared statement of Mr. Breuer appears as a submission for the record.]

Chairman SPECTER. Thank you very much, Mr. Breuer.

We have been joined by Senator Klobuchar. Would you care to make an opening statement?

STATEMENT OF HON. AMY KLOBUCHAR, A U.S. SENATOR FROM THE STATE OF MINNESOTA

Senator KLOBUCHAR. Well, Mr. Chairman, I want to welcome you as our new Chair.

Chairman SPECTER. Thank you.

Senator KLOBUCHAR. And thank you for having your first hearing on this very important topic. As a former prosecutor that also in my civil role as a county attorney represented the biggest emergency care hospital in our State, I have always been especially interested in this issue of waste and abuse in our health care system. I think we all know the figures about our rising health care costs, and we know it is not all attributable to fraud and abuse. But if we can do anything to weed out the fraud and abuse with some estimates being that it is at least 3 to 10 percent of the total amount of money that we spend on health care, I think we should do it.

So I want to thank Mr. Breuer and Attorney General Holder and the HHS Secretary for setting up this new group that is going to pursue these fraud cases. I think it is a very important endeavor, and I look forward to talking with you more about it.

Chairman SPECTER. Thank you very much, Senator Klobuchar.

Mr. Breuer, later this afternoon, as I mentioned earlier, you are going to a legislation signing ceremony at the White House on the Fraud Enforcement and Recovery Act of 2009. That legislation provides for an additional $165 million for fiscal years 2010 and 2011 for the FBI, U.S. Attorneys, and the Criminal Division of the Department of Justice. What do you expect to do with that money focused specifically on the subject of today's hearing, and that is, to get tough on health care fraud with jail sentences?

Mr. BREUER. Mr. Chairman, the FERA legislation—and I want to thank you and your colleagues for passing that legislation—will enable us in the Criminal Division and the United States Attorneys to have more prosecutors. What our goal is, specifically with respect to the topic of today, that we will have, we hope, more strike forces throughout the country, and we are going to dedicate our lawyers from the Criminal Division in greater numbers——

Chairman SPECTER. Well, where you say "hope," what do you expect to do specifically?

Mr. BREUER. Well, today what we have said is in Houston and Detroit, we are expanding already into Houston and Detroit, Mr. Chairman, and there specifically what we are going to do is, working with the data that we receive from CMS, our goal is very quickly to identify aberrant billing patterns and to go after providers very quickly and bring cases very quickly. And the goal here is not to have long investigations, but to identify those who are abusing the system, to shut them down immediately, to take their past conduct for sentencing purposes and increased enhancements; and then after Houston and Detroit, to continue as much as we can to go into other cities in the way that we have already done it in Miami and Los Angeles.

Chairman SPECTER. What are the practices of your Division with respect to making recommendations to the court on sentencing?

Mr. BREUER. Well, what we will do is we are going to take all of the conduct that is involved in these cases and make that available to the court. So, for instance, what we will do is we will bring

the case, and then we will look at the past conduct of the person and make that available to the court.

In a situation, for instance, where there was a significant sentence that I mentioned before, where there was unnecessary HIV infusions, if we think that risks—if there are health risks involved, we are going to make sure the court knows that, and we are going to bring that so that the sentences will be——

Chairman SPECTER. Aside from information, do you make it a practice to make recommendations on sentencing?

Mr. BREUER. We do. We do, Mr. Chairman.

Chairman SPECTER. Do you meet with any resistance as a generalization from judges thinking it is their sole province as opposed to standing for a prosecutor to make a recommendation?

Mr. BREUER. Mr. Chairman, I have not, in all candor, in my first month taken a national poll. I think candidly from my 1 month, the judiciary runs the gamut, and there are some courts that are more receptive to our recommendations, and there are some that are probably less. On the whole, though, I do not think that has been a significant issue, and we——

Chairman SPECTER. May I make a suggestion to you? When I became District Attorney of Philadelphia, the standard procedure was leaving it to the discretion of the court. That is what was said by the assistant. And I changed the policy to specific recommendations. And for a while, the judges were very unreceptive.

There has been a very different view of victims' rights in the intervening years, and when the victim is the U.S. Government, and when we know the cost of health care fraud, I think we have real standing.

I would urge you to give consideration to a policy in the Department of Justice. You are the man. The Attorney General is going to have to sign off on a policy of this sort. But it would be your recommendation as to what would be done. And I would urge you to adopt a policy of recommending sentences. And after a while, the judges became used to it, but it was tough for a time.

I would petition for reconsideration of sentences. I was once held in contempt of court when a dealer in a case called *Commonwealth of Pennsylvania* v. *Arnold Marks*, 6 ounces of pure uncut heroin worth several hundred thousand dollars—this is a long time ago—got 6 months in jail. And I petitioned for reconsideration of sentencing and pressed very hard. But I think if it is a uniform policy, if it comes out of Main Justice, has the sanction of the Attorney General, implemented by the Assistant Attorney General in the Criminal Division, it would carry a lot of weight.

There are a lot of sentences that I could reference here, but picking out just one case, there was a prosecution against Lutz and Health Visions, defrauded TRICARE of over $100 million. The sentence was 5 years in jail. How do you respond to that kind of a sentence with that kind of money involved?

Mr. BREUER. Well, Senator, I absolutely agree that it is essential that those who are defrauding the Medicare or Medicaid systems and defrauding the taxpayers need to have harsh sentences, and we are going to seek harsh sentences.

I agree that viscerally sometimes some of these sentences appear, without knowing more, to seem somewhat low, and I do not know

the specific facts of that case so I cannot comment. But I am in complete agreement that we need to have prison sentences for those who are responsible. They need to be substantial because it goes to the very foundation of deterrence, and we are committed to doing that.

Chairman SPECTER. Well, I request that you report back to the Subcommittee within 3 months as to what you intend to do about a policy of recommending sentences and some indication as to guidelines that you are going to instruct your Assistant United States Attorneys and to what extent the amount of the dollar figure is calculated in the sentencing recommendation so that the Subcommittee and the full Committee will have an idea as to how you are treating this subject, and let us see it on health care fraud. But this is something we are going to be taking a look at on other lines. It is a common practice, which I have seen in the past, where the fines, while they appear to be substantial, are not really substantial compared to what dollar figure is involved, and they really amount to a license to do business; whereas, if you put people in jail, that is a big, big difference. So we will look forward to your report there, and we will have oversight not only on health care fraud but on other cases as well. But we will ask you, as I say, in the next 3 months just to look to health care.

We have been joined by the distinguished Ranking Member of the full Committee. That has always been an important position, and our practice is to alternate. You just sat down. Would you care to exercise your time now?

Senator SESSIONS. Thank you, Mr. Chairman.

Chairman SPECTER. I take it this is an election to exercise your time now.

Senator SESSIONS. All things considered, Chairman is better than Ranking Member. It is great to be with you——

Chairman SPECTER. It depends on whether it is the full Committee or the Subcommittee where you are.

[Laughter.]

Chairman SPECTER. But we will work seniority out.

Senator SESSIONS. I appreciate your questions, Senator Specter, because you understand these issues very well as a proven prosecutor.

Mr. Breuer, I would just like to ask a few things, and I am going to look at this because when I was a United States Attorney, I tried to make sure we were earning the taxpayers money.

Now, for the health care fraud abuse, the Department of Justice gets $50 million a year just for that, outside your normal DOJ budget. Is that correct?

Mr. BREUER. Yes, the entire Department, that is correct, Senator.

Senator SESSIONS. And I remember—it started in 1996, this official account, but I remember, gosh, around the early 1990's that we were encouraged to form health care fraud task forces, and every time this has been done—I guess that was 7 or 8 years later—we had this $50 million. And everybody promises to do better. But just looking at the Administrative Office of the Court's statistics, which I think are pretty accurate—a lot of times agencies put forward cases that they recommended prosecution, and if they do not get prosecuted, they count it as a case of something. So you have got

to watch data. But in 2003, the Department of Justice commenced 238 health care fraud cases, and in 2007, it had edged up to 261. I do not know exactly what the funding levels are, what kind of increases you got. But that is not a whole lot of cases nationwide. Some of them may be very expensive and very prominent and time-consuming, and some could be a guilty plea right off the bat.

Have you looked at those numbers? Do you have any feel for what kind of cases are being brought and whether or not for your basic budget plus the $50 million this is sufficient production for the taxpayers?

Mr. BREUER. Senator, I think that we have done well, but we need to do better. And by that, one of the examples I give is the strike forces, those that, for instance, have been already very successful in Miami and Los Angeles. There in a very limited time, Senator, we really have provided a good number of convictions. I think just since 2007, if you look at Miami and Los Angeles, there have been some 125 or so guilty pleas. There have been people going to jail, perhaps on average not as long as the Chairman thinks but, still, at least a year more than had traditionally been the case for health care fraud.

And what we are doing in those, of course, is targeting in very real time with the data, while people are doing it, and we are bringing those cases. And if——

Senator SESSIONS. Well, wait a minute. I like that. Now, that should tell you something, which is a focused team approach in which you have interagency commitment, computer information for rapid sharing from the HCFC, whoever the Federal health department agency is, can help identify fraud early and move forward on it.

Are you satisfied that you have that kind of sophisticated, coordinated effort in all your districts? And wouldn't that be a good idea?

Mr. BREUER. It would be a great idea. I do not want to represent to you that we have it yet. What I can tell you is just today the Attorney General and the Secretary of Health and Human Services together announced the formation of a new commitment. We understand that CMS will be sharing its data in very real time with our prosecutors, and so the commitment from the very top of the Cabinet and from the President suggests to me that, as we go forward, you will see a very dynamic approach.

We are very committed to addressing and stopping the fraud that we think is obviously far too great.

Senator SESSIONS. Well, that is what they have been saying for 20 years, everyone that sat in that chair, wouldn't you say, Senator Specter? We are going to step it up. But there are still pretty weak numbers, if you ask me, considering the hundreds of billions of dollars spent on health care in America. But I am not arguing. I am just warning you that everybody has said that. But with your kind of leadership, I believe you can produce a little more.

Now, there is another thing that we have had, and I had a number of meetings with health care providers over the years, and I think for the most part they were too nervous, and I have told them that. But running a big hospital is a big thing, and every error in some billing code that occurred is not necessarily a crime. And while we want you to aggressively pursue those who are will-

fully acting to violate the law and defraud the taxpayers, would you recognize that when you have on a yearly basis thousands and thousands of claims coming through, many by young clerks who may have miscoded this or that, it does not necessarily mean that the hospital lacks integrity. Maybe they need to tighten up. Maybe they are civilly liable. But do you see the concern there that some good physicians and hospitals and providers have when we talk about health care prosecutions?

Mr. BREUER. Absolutely, Senator. I actually think that Secretary Sebelius today talked about simplifying some of these methods, and let me be clear here. We are not going to be targeting those who make mistakes. But if you look at, for instance, the Medicare Task Force, what it does is it looks for extraordinary aberrations in the numbers. So if in Miami we see certain providers who in certain areas are billing at astronomical numbers compared to what should be the norm around the country, those are the people we are going to go after. And we are not just going to go after them criminally; we are going to go after them civilly. And really, the Department of Justice has shown great success in that. Through our civil colleagues right now, I think it is fair to say that for every dollar that has been appropriated, we have returned $4, much of it through, of course, the False Claims Act, which has been an extraordinary civil hammer. But for those doctors out there who are doing their best, the 90 or 99 percent of the people involved, of course, who are acting in good faith, we want them to continue to provide their medical care.

Senator SESSIONS. Well, thank you. I appreciate your approach. I believe you have the ability to make this happen and count me a supporter.

Mr. BREUER. Thank you, Senator.

Chairman SPECTER. Thank you, Senator Sessions.

Mr. Breuer, you are surrounded by ex-prosecutors.

Mr. BREUER. I know.

Chairman SPECTER. Maybe I should not say "ex-prosecutors," just surrounded by prosecutors. But you are one of the clan, so you know what we are looking for. Now I yield to a Senator, instead of an ex-prosecutor, Senator Klobuchar.

Senator KLOBUCHAR. Thank you very much, Mr. Chairman. And good to see you again, Mr. Breuer. I was interested in your focus, the mention of Miami, and I was reading this article about the task force today about how estimates in Miami alone might have saved $334 million in fraudulent medical equipment claims and more than $1.7 billion in phony Medicare billings. And the reason I bring that up is I have often used the statistic about geographic disparity in Medicare spending that the studies have shown that the same Medicare services in Minnesota, in the Twin Cities, cost about $7,000 and they are $15,000 in Miami. And it is startling to me, and it is nothing—the cost of living is a very small fraction of that. And so perhaps some of it is this fraud, so I appreciate your efforts.

The FBI's Financial Crimes Report for fiscal year 2007 said that one of the most significant trends observed in recent health care fraud cases includes the willingness of medical professionals to risk patient harm in their schemes, and they focused on unnecessary

surgeries, prescribing dangerous drugs, and engaging in abusive care practices.

I have to tell you, being from my State where we have one of the highest quality rankings for health care in the country, I know those 99 percent, 99.59 percent, whatever it could be, of doctors who would never do anything like this. But this trend that we are seeing, I have always thought about this as a rip-off of taxpayers when you have medical fraud, and if it goes unchecked, really you can create a culture where people are lying on billings and things like that. But I have never thought of it as much in terms of patient risk. Do you want to comment on this trend at all?

Mr. BREUER. Absolutely. And, Senator, for that minority of fraudsters out there, first, it is completely unacceptable to defraud the taxpayers, and we are going to go after those people. But for those who are so greedy that they are actually willing to put people's lives at risk by either providing them with medical care that they do not need or what is even more dastardly, knowing exactly what they do need but not giving it to them and convincing them to do something else, we are just going to have to prosecute them to the full extent of the law. It is completely unacceptable, and those people are going to face extraordinarily long sentences.

Senator KLOBUCHAR. You mentioned to Senator Sessions using civil remedies sometimes instead of criminal. How do you make those determinations? As you and I both know, there is a different burden of proof in proving these things.

Mr. BREUER. Sure. Well, in some cases, I do not think we have to make the choice. I have talked a lot with my counterpart, the Assistant Attorney General in the Civil Division, Tony West, and I know the Deputy and the Attorney General agree that what we are going to do is we are going to have a comprehensive approach, and we are going to use the full force of the Department of Justice. So for entities or for those who do this, we are going to pursue it criminally. But given that there is a different standard of proof and, of course, in False Claims Act cases, there are treble damages, we will do whatever we need. I do not think we are going to have to decide, necessarily. Instead, I think we may use both remedies.

Senator KLOBUCHAR. Okay. Another trend that we are seeing is more technological issues and tools of technology that are meant to be very good, used for ill-begotten gain. And certainly we actually—I remember when I was a prosecutor, we saw identity theft going on in hospitals, things like that. And, obviously, one of our big pushes right now is to computerize medical records. But one of the thing that comes with that is that sometimes the crooks are able to use more sophisticated systems than those of us who are trying to catch them.

Could you comment on the role technology will play in the work that you are going to be doing in the health care area?

Mr. BREUER. Well, clearly, obviously, to the degree we can have more and more state-of-the-art technology, it will help our ability. I think our friends at HHS are, I am hopeful, at the cutting edge and understand it well. With our own Medicare Task Force and the leadership of one of the people in the Division, Kirk Ogrosky, we have been able to look at data, and sometimes it frankly has not

required the most sophisticated of means. We have just looked at the data and gone with it.

And so I want to be clear, even with what we have, we can do more, and we will. But you are absolutely right that fraudsters out there are more and more using more sophisticated means, and one of our goals is going to be to keep up with them. And to do that, I think we just need to have dedicated prosecutors and dedicated investigators and those at CMS following this as closely as we can.

Senator KLOBUCHAR. Have you thought about, as you go ahead here and try to prevent this as well as prosecute it, developing some best practices? And maybe the American Hospital Association does that, or others. But I just remember some cases where no one would have waned this to happen, but, you know, patient's Social Security numbers, while locked in a computer appropriately, someone had written them on a card and put them in a filing cabinet that someone who went to work there then just simply got these cards and used them to apply for credit cards. This is very different from what you are talking about, the Medicare billing, necessarily. But it just made me think at that time if there must be some best practices that could be developed across the board for health care providers.

Mr. BREUER. Senator, I agree, and I think that is really why today having the Attorney General and the Secretary of Health and Human Services together is so special: one, it shows their commitment from the top, but, second, it really shows that partnership, because HHS are the real experts in the best practices, and I think they can really provide that kind of education. I think they are doing that and will continue to do that.

And then, of course, by providing us the data, we can take care of that law enforcement piece by pursuing it both civilly and criminally. So I think you are absolutely right. With our renewed law enforcement commitment has to be a renewed effort in teaching and ensuring that best practices go forward.

Senator KLOBUCHAR. Finally, the FBI report said that the FBI provides assistance to various regulatory and State agencies that may seek exclusion of convicted medical providers from further participation in the Medicare and Medicaid health system. This seems incredibly important to me that we do not let these same providers abuse the system again. Has there been a problem of this in the past of not keeping the bad apples out after they have been prosecuted the first time?

Mr. BREUER. I think there have been challenges in keeping the data, and, of course, anytime you have a Federal-State-local partnership, there are going to be gaps.

I think one of the goals for us is to ensure that that does not happen, that there is swift and certainty of punishment, and that exclusion is much more likely to occur. I think it has occurred a lot, but I think probably we can always improve it, and we are going to have to.

Senator KLOBUCHAR. Thank you very much.

Mr. BREUER. Thank you, Senator.

Chairman SPECTER. Thank you very much, Senator Klobuchar. And thank you, Mr. Breuer. We got you out on time to make your

bill signing. Thank you for taking on this very important public job, and thank you for your testimony.

Mr. BREUER. Thank you for the hearing, Mr. Chairman.

Chairman SPECTER. We will now call Professor Sparrow, Ms. Farrar, and Commissioner Dilweg. Would the three of you take your positions and raise your right hands, please. Do you solemnly swear that the testimony you will give before this Committee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. SPARROW. I do.

Ms. FARRAR. I do.

Mr. DILWEG. I do.

Chairman SPECTER. Thank you. You may be seated.

We will start with you, Professor Sparrow, Professor of the Practice of Public Management at Harvard's Kennedy School, 10 years with the British Police Service, a master's degree in mathematics from Cambridge, a Ph.D. in applied mathematics from Kent University at Canterbury. Thank you very much for joining us, and the floor is yours.

STATEMENT OF MALCOLM SPARROW, PH.D., PROFESSOR OF PRACTICE OF PUBLIC MANAGEMENT, MALCOLM WIENER CENTER FOR SOCIAL POLICY, JOHN F. KENNEDY SCHOOL OF GOVERNMENT, HARVARD UNIVERSITY, CAMBRIDGE, MASSACHUSETTS

Mr. SPARROW. Good afternoon, Chairman Specter, Senator Sessions, and distinguished members of the Committee. My name is Malcolm Sparrow, and I teach regulatory and enforcement policy at Harvard's John F. Kennedy School of Government. I have worked on the practical challenges of fraud control in a number of different industries. With your permission, my prepared written testimony, which I would like introduced——

Chairman SPECTER. Without objection, that will be made a part of the record.

Mr. SPARROW. If I could just highlight a few key points from that testimony.

Chairman SPECTER. Thank you.

Mr. SPARROW. In 1993, I was working with the IRS on a tax fraud problem, and the Commissioner introduced me to Attorney General Janet Reno. It was about the time that the Attorney General had named health care fraud the No. 2 crime problem in America, which is an extraordinary status for a white-collar crime. There was little academic research on the subject at the time, and after my conversation with her, I took a research grant from the National Institute of Justice, and my job was to assess the state-of-the-art in health care fraud controls and try to explain why this was such a persistent and pernicious problem.

My first book on the subject, which is now out of print, I can summarize it for you in a sentence or two. It said that the controls in the health care industry are weakest with respect to the most outrageous crimes. Outright criminal fraud requires a verification, not just processing accuracy. And the systems in place did relatively well on the grayer, middle-ground issues such as policy coverage and pricing and processing accuracy. But criminals who are

prepared to lie need only to learn how to bill their lies correctly, and they will on the whole be paid automatically, without any human involvement, by computers, and without a hiccup.

Deterrence theory says that the magnitude of a deterrent effect will depend on three things in the mind of a would-be perpetrator: first of all, their perception of the likelihood of being caught; second, their perception of the probability of being convicted if their activities are once detected; and, third, the severity of the punishment if they are eventually convicted.

I appreciate that this Committee is very much interested in the effects of the third, severe punishment. I would urge you to consider the situation with respect to the first two as well, because I think the most visible weaknesses in health care fraud control may lie in these areas.

To emphasize two points about the current situation, I believe that resources available for fraud detection and control in the health care industry are not only inadequate, they are of the wrong scale. We do not know how much we are losing in these programs, and in the absence of clear knowledge about loss rates, investments in control remain pitifully small.

Spending on program integrity functions across the industry as a whole runs on the order of one-tenth of 1 percent of funds paid out. Medicare is slightly ahead of that at the moment. But with estimates of the loss rate of 3 percent, 10 percent, 20 percent, 40 percent in some segments, one-tenth of 1 percent seems like a drop in the ocean. Meanwhile, the small investments that are made pay off handsomely. The Inspector General has just reported a return ratio of $17 for every $1 spent. That can be interpreted as evidence of an efficient investigative system. But an economist would say that is also an indication that investments are nowhere near optimal, and that a system should continue adding marginal dollars until the marginal return comes much closer to 1:1. If investment resources are terribly small and the problem is huge, it is a little bit like standing in a lake. It is a very easy thing to scoop up a bucket of water and show everybody what you found.

I believe it is possible that 10 percent or even 20 percent could be saved from the Medicare and Medicaid budgets, but it would take spending of a different order to do that, maybe 1 percent of the funds paid out, not one-tenth of 1 percent.

I realize that it is politically inconceivable that you would have a tenfold increase in the level of attention to this problem, at least politically inconceivable while the loss rate remains uncertain. And that is why I put a lot of emphasis in my writings and today in my testimony on the importance of adequate and reliable measurement of the loss rate.

Chairman SPECTER. Professor Sparrow, your time is up so let me interrupt you with a question or two.

Mr. SPARROW. Yes, please do.

[The prepared statement of Mr. Sparrow appears as a submission for the record.]

Chairman SPECTER. Where would you direct that additional spending?

Mr. SPARROW. The additional spending would be spread all across the board: first in improved detection technology; second, in

a much greater willingness to take cases to court. The reviews of control operations that I have conducted reveal, for instance, post-payment utilization review units——

Chairman SPECTER. Well, I agree with you—I agree with you that certainty of apprehension is a big factor in sentencing because if you do not think you are going to get caught, you do not worry as much about the sentence. I did not quite follow all your statistics. How do you make your computation of what the return is on expenditures? Would you repeat that?

Mr. SPARROW. The Office of Inspector General in their annual report has reported that they——

Chairman SPECTER. The Inspector General of HHS?

Mr. SPARROW. Yes, sir.

Chairman SPECTER. OK.

Mr. SPARROW. Returned $17 for every $1 spent. They report the trend over time that that ratio has been increasing, even while—and they also report that the number of cases and the number of complaints at the same time is increasing.

Chairman SPECTER. $17 returned for every $1 which is spent.

Mr. SPARROW. Yes. Yes, sir. One of the areas that I feel is of great concern at the moment is we have fake billing scams all around the country, in some regions concentrated. I believe that the response that CMS and the OIG are recommending when these fake billing scams are discovered does not end up in criminal prosecution. In fact, I believe that the response recommended at the moment actually makes life easier for those that would just bill these programs. I can give you some examples of that.

Chairman SPECTER. How do they make life easier?

Mr. SPARROW. Well, I have a big pile in my office of reports talking about categories of patients that ought not to show up in Medicare claims data, paid Medicare claims data. I have a few of them here: Medicare payments for patients that were already dead at the time when the services were delivered, and it is not just rentals that ran on past death but new diagnoses and entirely new——

Chairman SPECTER. And there is knowledge that there were charges for those who had already died?

Mr. SPARROW. Yes, and the Office of Inspector——

Chairman SPECTER. And nothing was done?

Mr. SPARROW. No, something is done. The Office of Inspector General, through analysis, is able to identify by cross-matching with Social Security records Medicare claims paid——

Chairman SPECTER. Was there any enforcement action taken?

Mr. SPARROW. No. The approach that they recommend, not only with respect to dead patients but deported patients who ought not be in the country, imprisoned patients who should be covered by different health care insurance. And the final insult which came to light last year through the work of——

Chairman SPECTER. So what was done, Professor Sparrow?

Mr. SPARROW. They recommend that CMS——

Chairman SPECTER. What was done by way of enforcement?

Mr. SPARROW. Very little in most cases.

Chairman SPECTER. Anything?

Mr. SPARROW. I am sure something was done in a few cases, but——

Chairman SPECTER. Well, it sounds like Philadelphia voting the graveyard.

Mr. SPARROW. So the general strategy is to treat it as a processing error. In other words, get the information about dead patients and deportations into CMS' processing systems and bounce those claims back to the people that submit it, auto-rejection——

Chairman SPECTER. Well, we will pursue that. Do you have anything else that juicy?

Mr. SPARROW. Well, the only thing that would make that a little more juicy is what it might indicate. If you ask the question what kind of business practices could produce bills that are completely implausible—dead patients, dead doctors, people not in the country—the most obvious answer is that these are fake billing scams and that somebody is billing off a Medicare list without providing any medical treatment at all. And in that case, what is happening is that there are just a few patients on the list who might be dead, very small numbers compared with——

Chairman SPECTER. Well, we have covered the dead patients. How do you make the determination that they did not treat those patients if they are alive? If they are dead, it is pretty conclusive.

Mr. SPARROW. And my view is that if you submit 100 claims and one of your patients happens to be dead and the other 99 are alive, the chances are your claims for the 99 are no better.

Chairman SPECTER. Okay. You fulfilled the requirement. We are going to pursue that further, and we will take it up with the agency.

Mr. SPARROW. Thank you, Senator.

Chairman SPECTER. We will now turn to you, Ms. Farrar. Born in McCook, Nebraska—was Senator Nelson born in McCook? You do not know all the people who were born in McCook. You probably do not even know all the people who died in McCook, even those who have Medicare payments. Well, you have had a very distinguished career, Ms. Farrar: a special agent with the FBI, February 1992, Assistant Special Agent in Charge of the Detroit office; in 1994, lots of crime in Detroit; and since June of 2004, working for the Health Care Service Corporation in Chicago.

Thank you for coming in to testify, and we look forward to your testimony. Your full statement will be made a part of the record.

STATEMENT OF SHERI FARRAR, EXECUTIVE DIRECTOR, SPECIAL INVESTIGATIONS DEPARTMENT, HEALTH CARE SERVICE CORPORATION, CHICAGO, ILLINOIS

Ms. FARRAR. Thank you. Mr. Chairman, on behalf of the National Health Care Anti-Fraud Association and Health Care Service Corporation, thank you for providing this opportunity to share our views on the important role of criminal prosecution as a deterrent to health care fraud and specifically the role that information sharing plays in fraud investigations.

Health Care Service Corporation is the largest customer-owned health insurance company in the Nation, serving more than 12.4 million members through our Blue Cross/Blue Shield plans in Illinois, New Mexico, Oklahoma, and Texas. As a non-investor-owned company, we view anti-fraud efforts as vital to protecting our members and the communities we serve.

In my role as the Executive Director in the Special Investigations Department, I oversee the anti-fraud program for all four of our Blue Cross/Blue Shield plans. In addition to that position, I serve on the Board of Directors of the National Health Care Anti-Fraud Association, the only national association devoted exclusively to the fight against health care fraud.

The highest priorities of our Investigative Division are to identify and investigate high-impact health care fraud schemes and refer for criminal prosecution individuals and companies who defraud or attempt to defraud our company and its customers. Our primary means of identifying the most costly health care fraud cases are through effective data analysis and liaison with law enforcement and other health plans.

Our staff participate in all of the federally sponsored health care fraud task forces and working groups in our respective States. Through these associations, we routinely discuss new and emerging health care fraud schemes and share information concerning known perpetrators of health care fraud.

By sharing information, the losses attributed to the activities of one subject can be aggregated to enhance the prosecutorial potential of the case. On average, we refer approximately 40 percent of our cases to law enforcement, to include Federal, State, and local agencies. Three of these cases are detailed in my written testimony.

Health care fraud cases are some of the most complex white-collar crime cases handled by prosecutors, necessitating dedicated staff who develop an expertise in understanding how health claims are processed and understanding the intricacies of proving the necessary criminal intent. In many jurisdictions, limited prosecutorial resources impact the ability to dedicate staff accordingly. Additionally, health care fraud cases compete with other investigative programs that are deemed higher priority.

Staying one step ahead of those who are intent on committing health care fraud requires continual information sharing and collaboration among the various law enforcement and prosecutorial agencies, regulatory agencies, and private health insurers. As a result, in addition to our ongoing liaison with law enforcement in our respective States, we maintain effective information-sharing relationships with law enforcement in other States and with other private insurance plans through our corporate membership in the National Health Care Anti-Fraud Association.

The NHCAA, which has 81 corporate members representing 200 health plans and 70 Federal, State, and local law enforcement and regulatory agencies, routinely and voluntarily shares information through a variety of methods. Those perpetrating fraud against the health care system do so indiscriminately across the range of Government health care programs and private health plans.

Too often, however, information sharing in health care fraud cases is a one-way street with the private sector regularly sharing vital information with the public sector—either voluntarily or through mandate—without reciprocal information sharing to bolster our fraud-fighting efforts.

In many circumstances, the Government representatives believe that they do not have the authority to share information about

fraud investigations with private insurers. However, guidelines developed for the operation of the Coordinated Health Care Fraud Program established by HIPAA provide a strong basis for information sharing. Those principles outlined in the program recognize the importance of a coordinated program, and we believe that they should be reemphasized or reincorporated and clarified in new legislation to ensure that the goal of an effective and coordinated health care fraud program can be developed.

We also encourage the Government to incorporate the losses of private insurers into integrated settlement agreements involving health care providers who have defrauded both public and private programs.

My written testimony expands on our recommendations to enhance the collaboration between Government and private insurers that I hope you will consider. The NHCAA and the Health Care Service Corporation are committed to working with Congress to address health care fraud, and we hope that you will consider us resources and partners in this fight.

Thank you for the opportunity to appear before you today, and I look forward to answering your questions.

[The prepared statement of Ms. Farrar appears as a submission for the record.]

Chairman SPECTER. Well, Ms. Farrar, after you have gotten all that information, what prosecutions have worked out?

Ms. FARRAR. Well, I did describe three of them in my testimony. As I said, we refer about 40 percent of our cases for prosecution. Not all of them get prosecuted due to——

Chairman SPECTER. Do many of them get prosecuted? How many?

Ms. FARRAR. It is very difficult to give you an exact answer on that because we just really started in our company to focus on prosecution——

Chairman SPECTER. Well, I am not interested in an exact answer. I would just like an answer. What I am looking for here is what response you are getting when you go to the district attorney or the U.S. Attorney and say there is fraud here. And what I am looking for are instances where nothing happens, because we could exert a little pressure.

Ms. FARRAR. Well, we do have a problem with delayed prosecutions. We get excellent response from the law enforcement agencies.

Chairman SPECTER. Well, can you give us some specific cases so we could take a look at it and press somebody? Those generalizations do not do a whole lot of good. We knew that before you said it.

Ms. FARRAR. Well, I will tell you that of the cases we have referred in 2005 and 2006, only a handful have yet been prosecuted.

Chairman SPECTER. That does not tell much. How big is your hand? See if you can provide the Subcommittee with more specific information. When you talk about information sharing, sure, we are all for information sharing. But what are we going to do with it?

In some jurisdictions, I hear that the insurance companies get together and subsidize assistant DAs. I do not think that is particu-

larly, necessarily a good idea because a DA is quasi-judicial. But they ought to do their job without the subsidy.

Ms. FARRAR. We do not do any of those subsidizing arrangements in our State.

Chairman SPECTER. Well, what do you do by pressing the public prosecutors to act?

Ms. FARRAR. Well, we meet with them on a regular basis to review the cases and offer to do whatever additional investigation we can do. The difficulty is in the lack of prosecutors who get the cases before the grand jury. They seem to stall out.

To give you exact numbers, we have had three cases prosecuted in Chicago this year. Those were cases that were referred about 18 months ago to law enforcement, and that is relatively quick.

We just finished a case in Chicago involving ten defendants that had been on the docket for 6 years.

Chairman SPECTER. Well, when you talk about Chicago, you are talking about a lot of competition for prosecutions.

Ms. FARRAR. That is exactly right. You are right, sir.

Chairman SPECTER. They did not even put your cases ahead of the Governor's prosecution?

Ms. FARRAR. Probably not.

Chairman SPECTER. Thank you very much, Ms. Farrar.

We turn now to Commissioner Sean Dilweg, State of Wisconsin; he has been in that position since January 1st of 2007, holds a Master's in Public Administration from Lafollette Institute of Public Affairs at the University of Wisconsin and a B.A. in English from Lawrence University in Appleton.

Thank you for coming in, Commissioner Dilweg, and we look forward to your testimony.

STATEMENT OF SEAN DILWEG, COMMISSIONER OF INSURANCE, STATE OF WISCONSIN, MADISON, WISCONSIN

Mr. DILWEG. Thank you for the opportunity, Chairman Specter. I commend you and the Committee for taking the lead in examining fraudulent activity in the health care marketplace.

Health care consumers have in the past and continue today to be harmed by health care fraud and regulatory gaming. State insurance regulators have fought a decades-long battle against fraudulent and near-fraudulent health care plan schemes. Such Ponzi-like schemes range from bogus health care plans that leave millions in unpaid claims to more sophisticated schemes designed to circumvent rating and other restrictions to protect less healthy, less fortunate consumers.

As you examine and study the prevention of billing and provider and other fraud that increase the costs of health care delivery affecting Medicare and Medicaid, it is just as critical that Federal legislative proposals include measures to prevent schemes designed to directly harm consumers. I urge you to examine and look at what we see occurring in our marketplace. As we look at health care reform, we advocate for areas that allow confidential coordination of inquiries and investigations among State and Federal regulatory and law enforcement agencies, create a coordinating council in the U.S. Department of Justice, and give regulatory flexibility to

adapt to the changing face of fraudulent and regulatory gaming schemes.

This congressional session may be a turning point in the history of our country's health care financing system. Great care must be taken to ensure that these proposals do not inadvertently expose consumers, our families and friends, to fraud or leave them unprotected from unscrupulous schemes. Now is the time to enact measures that encourage communication and coordination among Federal and State regulatory and law enforcement jurisdictions, as well as set firm boundaries in the law to prevent schemes that abuse consumers.

There have been other such turning points in our history. The enactment of the Federal Employee Retirement Income Security Act of 1974 is an example. ERISA was a major step toward protecting workers against fraud and abuse in the private pension system. It also was the unintended door opener to fraudulent health care insurance schemes. After enactment, unscrupulous and innovative operators set up multiple employer trusts to provide bogus health care coverage. These operators used the cover of ERISA's preemption of State regulatory authority over insurance to set up such fraudulent health insurance plans.

The history of this criminal health coverage fraud is documented extensively in congressional records and studies. A 2004 GAO study reported that in the period from 2000 to 2002, 144 unauthorized entities provided bogus health plan coverage to 15,000 employers——

Chairman SPECTER. Commissioner Dilweg, let me interrupt you. What was done with that information? Were there any prosecutions?

Mr. DILWEG. There was, and you are dealing—what you are dealing with is quite a connection between the State regulator, the Federal Department of Justice, Health and Family Services, and what we have done since then to address these what I term kind of Ponzi-like schemes is to try and provide the information ahead of time, to try and educate consumers. I have some specific recommendations that I assume will be put into the record that would also enhance some of the criminal penalties on these activities.

I know this gets—I was asked to respond to these issues. I know it gets outside of Medicaid provider billing issues, but it does get into a serious area as you look at national health care reform issues.

Chairman SPECTER. Well, when you mention the criminal conduct, the question that comes to my mind——

Mr. DILWEG. It is forwarded on—from my perspective, as we see something like that, it is my role to forward it on to either my Attorney General or my U.S. Attorney.

Chairman SPECTER. What has happened with it?

Mr. DILWEG. We have had cases in the Wisconsin Western District that have been taken to court, and people have been put in jail because of it. In that GAO report, it shows a specific survey of the States, and reflects the activities where there was criminal prosecutions carried forth.

Chairman SPECTER. Do you think it has had any deterrent effect?

Mr. DILWEG. It has. This tends to be a problem as you have increasing health care costs that we are seeing today and that you had in the late 1990's and early 2000.

Chairman SPECTER. Well, but has it dissuaded people from engaging in that kind of criminal conduct?

Mr. DILWEG. It has in the past. We lay out seven areas that could help further coordinate the agencies and directly prosecute these criminal entities as we see them, to give the tools so that we can take the confidential information that we are seeing and convey it to the U.S. Attorneys or the——

Chairman SPECTER. Well, I interrupted your testimony when you had 2 minutes left.

Mr. DILWEG. We are covering basically the issues that I would have touched upon.

[The prepared statement of Mr. Dilweg appears as a submission for the record.]

Chairman SPECTER. So often these hearings tend to be a little sterile with witnesses testifying and not a whole lot of interaction. It is like the old story of the lecture passing from the notes of the professor to the notes of the student without going through the minds of either. So that is why I interrupted you.

Mr. DILWEG. I appreciate the questions. Senator Kohl is not always so inquisitive. So those were really——

Chairman SPECTER. How about Senator Feingold?

Mr. DILWEG. Senator Feingold is very inquisitive.

Chairman SPECTER. How about Senator Proxmire?

Mr. DILWEG. I have a good Proxmire story, but I can——

Chairman SPECTER. Go ahead.

[Laughter.]

Mr. DILWEG. Well, Senator Proxmire, as you know, was a very active campaigner throughout Wisconsin, and the trick that he——

Chairman SPECTER. He spent $163 on one of his 6-year campaigns.

Mr. DILWEG. The trick that he learned, he would go to every State fair, every summerfest, and he would stand at the gate. And then when he would run into somebody, they would say, "Oh, I remember seeing you last year at the State fair." And he said, "Oh, yes, that is right. At the gate."

[Laughter.]

Mr. DILWEG. So that was one of his tricks, Senator.

Chairman SPECTER. Senator Proxmire made a speech every day on genocide. Every day. He had a seat at the rear row on the aisle, and every day he went over and made a speech. This is before television. And he repeatedly collected for going home to Wisconsin, saying his residence was Washington. Senator Stevens found out about that 1 day and just blew up that any Senator would stoop so low as to say Washington was his home so that he could collect for travel going back to his home State.

So we have covered Kohl. You brought Senator Kohl up. I brought Senator Feingold up. I brought Senator Proxmire up. Now, let's see, I guess that takes us to Senator Joe McCarthy. You have to have more than just a big smile.

Mr. DILWEG. I was not a fan of Senator McCarthy's, Senator.

Chairman SPECTER. Anybody in the room a fan of Senator Joe McCarthy?

[Laughter.]

Chairman SPECTER. I wonder if he operated out of this Judiciary Committee room. That brings to mind the Army-McCarthy hearings. He was against the Army, 1954. I listened to those hearings on the radio driving back and forth from law school.

Do you have further testimony, Commissioner?

Mr. DILWEG. I really had just three points on this area that I would like to conclude with. It is really recommendations that, as health care reform is looked at, you consider.

Chairman SPECTER. The show has gotten dull. People are leaving. Go ahead.

Mr. DILWEG. I know. Establish a privilege and statutory structure for the confidential coordination and exchange of information among Federal agencies and State insurance regulators; provisions reaffirming State insurance regulators' authority to protect consumers under any Federal health care reform legislation; provisions establishing a coordinating body in the Federal Department of Justice to focus on health insurance fraud schemes and schemes to exploit regulatory gaps that will pull in all the various State and Federal entities; and then criminal and civil penalties for operators, and those who assist operators of a health plan that falsely represents itself as exempt from State insurance regulation.

Thank you, Senator.

Chairman SPECTER. Thank you very much. Without objection, we will put into the record Senator Leahy's statement and the excellent opening statement prepared by my staff, which I did not read.

Anybody have anything they would like to add?

[No response.]

Chairman SPECTER. Thank you all very much.

[Whereupon, at 3:39 p.m., the Subcommittee was adjourned.]

[Questions and answers and submissions for the record.]

QUESTIONS AND ANSWERS

BlueCross BlueShield of Illinois

February 4, 2010

VIA ELECTRONIC AND U.S. MAIL

The Honorable Patrick J. Leahy
Chairman, Committee on the Judiciary
c/o Ms. Julia Gagne, Committee Hearing Clerk
United States Senate
224 Dirksen Senate Office Building
Washington, DC 20510

Re: Response to the Committee's January 13, 2010 Request for Information

Dear Chairman Leahy:

Please find enclosed my response to a written question submitted by Sen. Ron Wyden in connection with testimony I provided on May 20, 2009 to the Committee at the hearing entitled "Criminal Prosecution as a Deterrent to Health Care Fraud."

Please accept my apologies for the inadvertent delay in responding to Sen. Wyden's question. I did not receive the written question, or any further correspondence from the Committee other than the May 29, 2009 transmittal of my hearing transcript, until my receipt this week of your January 13, 2010 letter (attached). In light of this, to the extent any formal notice of non-response was entered into the record as advised in the attached letter, I respectfully request that the record be corrected to indicate the circumstances above, as well as my prompt compliance with your request upon its receipt.

Thank you for your consideration in this matter.

Sincerely,

Sheri A. Farrar
Executive Director, Special Investigations Department
Health Care Service Corporation,
a Mutual Legal Reserve Company

Enclosure
cc: John Gleason, Executive Director, Government Relations & Public Policy

300 East Randolph Street • Chicago, Illinois 60601-5099 • (312) 653-6000 • www.bcbsil.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Hearing: "Criminal Prosecution as a Deterrent to Health Care Fraud"
Question from Senator Ron Wyden

Response of Sheri Farrar, Executive Director of the Special Investigations Department ("SID") of Health Care Service Corporation, a Mutual Legal Reserve Company

Question: *Toll free fraud report lines are impersonal and it is not easy to get a call through, especially if you're elderly or disabled. It seems to me that done right, reporting of suspected health care fraud and waste by consumers and providers could assist government oversight efforts and could even prevent the pay-and-chase dynamic. How might we better engage consumers and healthcare providers to increase reporting and "watchdog" efforts?*

Response:

I agree that increasing the awareness of our consumers and providers to potential fraudulent and/or abusive billing practices and educating them on how best to respond to suspicions of such activity are vital to enhancing antifraud efforts.

Some suggestions to better engage consumers and providers may be:

1. Mailing of regular explanation of benefit reports to people receiving services from all government and private health insurance programs to provide consumers with the ability to review and evaluate the services for which the government is issuing payments. The reports should provide easily identified telephone or email contact information so that concerns can be reported.

2. Ensure adequate staffing of contact telephones and email mailboxes with qualified personnel skilled in responding to the inquiries/concerns of callers. Many times calls are actually customer service issues which can be quickly resolved by knowledgeable personnel. When callers receive timely and accurate assistance with customer service inquiries, they may be more likely to report fraudulent and/or abusive suspicions. Trained personnel to staff fraud hotlines are often used by private insurers to enable 7-day per week/24-hour coverage, with foreign language capabilities.

4. Consider public service announcements/advertisements/website information which provide information about health care fraud and common fraud schemes, as well as how to report suspected fraud and abuse. Public-private partnerships with non-profit groups whose membership/audience are likely to be beneficiaries of Medicare and Medicaid may also be helpful in disseminating this important information.

5. Develop checklists for providers (perhaps in partnership with the AMA or other medical associations) to enable them to reduce their risk to health care fraud schemes such as information on medical identity theft, warnings concerning seminars which promote ways to enhance income, etc.

55465.002

Hearing: "Criminal Prosecution as a Deterrent to Health Care Fraud"

Questions from Senator Ron Wyden

For Professor Sparrow, PhD, John F. Kennedy School of Government, Harvard University:

There must be some way to outsmart these criminals and stop spreading this virus of fraud and waste. According to your testimony in this hearing, the probability of being detected or reported weighs more heavily in the criminal mind than the severity of the punishment. If this is true, wouldn't real-time analysis of health care claims and other healthcare data better assist prosecutors in catching criminals and preventing fraud? If so, which practices in the private sector can be adapted to Medicare and Medicaid?

ANSWER: [Malcolm K. Sparrow]

I believe very strongly in the importance of real-time claims monitoring. In fact, as a mathematician, what drew me first to the field of fraud control was the apparent opportunities to develop and exploit a much broader range of analytic and detection methods than have been traditionally deployed for fraud detection. I have written extensively about this subject, and include a full chapter in my book "License to Steal" about the opportunities for improved detection systems.

In terms of private sector practices, importable to the public sector: the news here is not so encouraging. My survey of fraud control systems straddled the private, not-for-profit, and public sectors, including "payors" from all three. I was surprised to discover that the approaches to control, and the sophistication of detection systems, were very similar, and that the private sector insurers—despite the obvious underlying profit imperative—seemed to do no better at this than public programs such as Medicare and Medicaid. Much of my work on this subject has therefore sought to explain the organizational and managerial incentives that might account for the general lack of interest in improving detection, and thus increasing deterrence.

There is some good news on this front. The market for fraud-detection systems in health care, given the heightened congressional and public interest in this area, is becoming more lively and more sophisticated over time. But the private sector payors do not seem any more hungry to improve their performance on this front than public programs. Private sector technology and analysis companies are certainly now expanding the range of offerings in fraud detection, but for them it remains a difficult market as many senior executives in insurance companies express the attitude "the last thing I need right now is to discover more fraud." Many of them struggle to cope with the volume of fraud schemes already visible, having insufficient resources available to deal with them, and finding it difficult to make the case for a significant bolstering of funding for integrity controls.

I hope this is helpful.

55465.003

Hearing: "Criminal Prosecution as a Deterrent to Health Care Fraud"

Questions from Senator Ron Wyden

For the Honorable Sean Dilweg, Commissioner of Insurance, State of Wisconsin:

Congress mandated Inspectors General to fight waste, fraud, and abuse in the executive branch nearly 30 years ago, but this hearing has told the sad story that fraud and abuse are still alive and well in a time when health care costs have sky-rocketed. Paying claims for deceased or deported patients is unacceptable. How can we expedite payment systems to "auto-reject" bad claims like this in government agencies? How much will it cost and how long would it take to implement?

SUBMISSIONS FOR THE RECORD

Department of Justice

STATEMENT OF

LANNY A. BREUER
ASSISTANT ATTORNEY GENERAL
CRIMINAL DIVISION
UNITED STATES DEPARTMENT OF JUSTICE

BEFORE THE

UNITED STATES SENATE
COMMITTEE ON THE JUDICIARY
SUBCOMMITTEE ON CRIME AND DRUGS

HEARING ENTITLED

"CRIMINAL PROSECUTION AS A DETERRENT TO HEALTH CARE FRAUD"

PRESENTED

MAY 20, 2009

Introduction

Mr. Chairman, Ranking Member Graham and distinguished Members of the Subcommittee, I appreciate the opportunity to appear before you to discuss the Department of Justice's efforts to combat health care fraud and abuse. We are grateful for the leadership of your Subcommittee on this important topic and to you, Mr. Chairman, for inviting me to discuss the Department of Justice's enforcement efforts.

Crimes involving fraud – whether they involve mortgage, securities or commodities fraud, bribery of government officials in violation of the Foreign Corrupt Practices Act or health care fraud – can jeopardize our economy, threaten the integrity of our financial system and cost taxpayers billions of dollars. The Department has been, and will continue to be, committed to the vigorous investigation and prosecution of these crimes. Health care fraud, in particular, is one of the Department's top enforcement priorities given the vital role Medicaid and Medicare play in supporting our most vulnerable citizens, the rising cost of funding these programs, and the huge amounts of waste, fraud, and abuse.

HEALTH CARE FRAUD ENFORCEMENT

The Medicare and Medicaid programs serve essential roles in our nation's health care system. They serve vulnerable populations of seniors, people with disabilities, and various low-income Americans. Last week, the trustees who monitor the Medicare Trust Fund issued a report that said that hospital expenses will pay out more in benefits than Medicare will collect this year, and that the Hospital Insurance Trust Fund will be depleted by 2017. It is therefore vitally important that the Departments of Justice and Health and Human Services do everything possible to prevent, detect,

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and prosecute health care fraud and abuse in order to return stolen Medicare dollars to the Trust Fund.

The Department, along with our partners from the Department of Health and Human Services and state law enforcement agencies is committed to this effort. Last year, the Department of Justice filed 502 criminal health care fraud cases involving charges against 797 defendants and obtained 588 convictions for health care fraud offenses – record high numbers of criminal health care fraud prosecutions since Congress established the Health Care Fraud and Abuse Control (HCFAC) program in 1996. Moreover, the Department, working with our colleagues in the Department of Health and Human Services, has obtained more than $14 billion in total recoveries, including criminal fines and civil settlements, since 1997.

The Department's prosecutions have a clear deterrent effect. Our inter-agency Departments of Justice and Health and Human Services enforcement efforts in South Florida, spearheaded by the Department's Criminal Division and U.S. Attorney's Office for the Southern District of Florida through the Medicare Fraud Strike Force, contributed to estimated reductions of $1.75 billion in durable medical equipment (DME) claim submissions and $334 million in DME claims paid by Medicare over the 12 months following the Strike Force's inception, compared to the preceding 12-month period. The average prison sentence in Miami Strike Force cases was 48.8 months, which exceeded by nearly one year the overall national average health care fraud prison sentence of 37.4 months.

Our criminal and civil enforcement efforts have taught us some important lessons. In the criminal arena, we have learned to identify criminal claim trends and track systemic weaknesses so we can stop false claims before they occur. We have also learned that quick apprehension and punishment of these criminals is critical to deterring others. But we have also learned that we

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cannot prosecute our way out of this problem. Instead, we must prevent criminals from accessing Medicare, Medicaid and other health care programs in the first place.

Medicare and Medicaid are extremely large programs -- federal and state spending on both programs collectively exceeds $800 billion per year. In FY 2008, the federal government devoted $1.13 billion for program integrity activities and health care fraud enforcement. The Administration is requesting in the FY 2010 Budget that Congress provide an additional $311 million in two-year funding to enhance federal program integrity and antifraud enforcement work of which $29.8 million is designated for the Department of Justice. We ask for your support for this and future antifraud funding enhancements.

HEALTH CARE FRAUD ENFORCEMENT IS A TOP DEPARTMENT PRIORITY

National health care spending in the United States exceeded $2.2 trillion and represented 16 percent of the Nation's Gross Domestic Product (GDP) in 2007. The Federal government financed more than one-third of the Nation's health care that year; federal and state governments collectively financed 46 percent of U.S. health care costs. The National Health Care Anti-Fraud Association estimates that 3 percent of the nation's health care spending—or more than $60 billion each year—is lost to fraud. The GAO has estimated that up to 10% of health care spending may be wasted on fraudulent claims. Over the next ten years, U.S. health care spending is projected to double to $4.4 trillion and to comprise more than 20 percent of national GDP. In short, health care fraud is an enormous problem that we cannot allow to continue.

The Department is committed to prosecuting all who commit health care fraud – providers and practitioners, equipments suppliers and corporate wrongdoers. In criminal enforcement actions during 2008, Department prosecutors:

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- Opened 957 new criminal health care fraud investigations involving 1,641 defendants, and had 1,600 criminal health care fraud investigations involving 2,580 potential defendants pending at the end of the fiscal year; and
- Filed criminal charges in 502 health care fraud cases involving charges against 797 defendants and obtained 588 convictions for the year. Each of these figures represents an "all time high" count of federal criminal cases, defendants, and convictions.

Another 773 criminal health care fraud cases involving 1,335 defendants were pending at the end of FY 2008.

Despite the staggering volume of cases, the Department has succeeded because of strategic thinking about how best to address this problem. The Medicare Fraud Strike Force in Miami is one example. The Strike Force's mission is to supplement the criminal health care fraud enforcement activities of the United States Attorneys' Offices by targeting emerging or migrating schemes along with chronic fraud by criminals operating as health care providers or suppliers. The Miami Strike Force was structured in five teams with criminal prosecutors, a licensed nurse, federal HHS and FBI agents, and state and local police investigators.

In March 2008, the Department's Criminal Division expanded the Strike Force to a second site, partnering with the United States Attorney's Office for the Central District of California. That Strike Force includes four teams of prosecutors and federal and state agents to combat DME fraud in the Los Angeles metropolitan area. In Phase Two of the Strike Force, Fraud Section attorneys, working with federal prosecutors from the U.S. Attorney's Office, and FBI and HHS-OIG agents, charged 37 defendants in 21 indictments involving more than $55 million in fraudulent Medicare claims.

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The Strike Force model for criminal health care fraud prosecutions has now become a permanent component of the United States Attorneys' Office in both the Southern District of Florida and the Central District of California.

In March 2009, the Department's Criminal Division initiated a third Strike Force phase, in partnership with the United States Attorney's Office for the Southern District of Texas in the Houston area. The Department's Criminal Division is currently planning to launch a fourth Strike Force phase, using its allocation of the supplemental funding Congress provided to the Department in the Omnibus Appropriations Act of 2009.

The Strike Force model or approach is similar in some ways to "problem-oriented policing" because it is based on obtaining an understanding of local or regional fraud schemes and focusing on the geographic areas which have the greatest rates of crime in a concentrated effort to deter fraudulent claims.

Since its inception two years ago, the Strike Force, with a limited number of investigators and prosecutors, has:

- filed 108 cases charging 196 defendants who collectively billed the Medicare program more than half a billion dollars;
- taken 129 guilty pleas;
- handled 14 jury trials resulting in convictions of 18 defendants; and
- obtained 109 sentences of imprisonment, ranging from 30 years to 4 months of home confinement, with an average term of imprisonment of 48 months.

Here are several examples of the Strike Force successes:

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- After a two-week criminal trial, a Miami jury convicted a physician and the court sentenced her to serve 30 years in prison for her role in an $11 million HIV infusion fraud scheme. The physician, with the assistance of a nurse who also was convicted and sentenced to seven years in prison, ordered and then provided hundreds of unnecessary HIV infusion treatments to patients who were paid cash kickbacks of $150 per visit to accept the services so the co-conspirators could steal from Medicare.
- DME company owners were sentenced for conspiring to defraud the Medicare program by submitting false claims for medically unnecessary DME items and supplies, including aerosol medications and oxygen concentrators. The companies paid kickbacks to a physician previously investigated by the Department of Health and Human Services' Office of the Inspector General, and to several Medicare beneficiaries in order to use their Medicare numbers to submit the fraudulent claims. The 13 convicted DME company owners involved in the scheme were ordered to pay a total of more than $6.4 million in restitution. The 13 subjects were also sentenced to various terms of imprisonment, probation, and/or home detention, the longest prison sentence for the case being 6 years and 6 months.
- After a five-week trial, a Federal jury in Miami convicted three owners of two DME companies, a home health agency and an assisted living facility which conspired to defraud Medicare of more than $14 million for unnecessary medicine, DME, and home health care services. Two defendants were sentenced to 51-month terms of imprisonment, and the third was sentenced to a 31-month prison term. Patients testified at trial that they took kickbacks, were falsely diagnosed with chronic obstructive pulmonary disease and prescribed unnecessary aerosol medications, including commercially unavailable compounds. A fourth co-defendant, a dermatologist, was also convicted in a separate jury trial and was sentenced to prison for 41 months.

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As proud as we are of our Strike Force initiative, it is but one element of our comprehensive health care fraud efforts. Indeed, the Criminal Division and the U.S. Attorney's Offices bring many other significant health care fraud cases.

For example, in the Western District of Wisconsin, Thomas Arthur Lutz (Lutz), the former President and CEO of Health Visions Corporation (Health Visions), pleaded guilty to conspiracy to defraud TRICARE, the Department of Defense's worldwide health care program for active duty and retired uniformed services members and their families, and was sentenced to 5 years in prison. On behalf of Health Visions, Lutz entered into a kickback agreement with a medical provider in the Philippines, in which the provider paid 50 percent of the amount of the bills for medical services rendered to TRICARE patients referred by Health Visions, back to Health Visions. The court ordered Lutz and the corporation to pay $99,915,131 in restitution. The court further ordered the corporation to liquidate its assets, pay a $500,000 fine and forfeit $910,910.60.

CIVIL ENFORCEMENT

The Department's Civil Division, using the False Claims Act, 31 U.S.C. §§ 3729-3733, plays an enormous role in the Department's efforts to protect public funds from fraudsters. In addition, lawsuits are often brought by private plaintiffs, known as "relators" or "whistleblowers," under the *qui tam* provisions of the FCA, and the government will intervene in appropriate cases to pursue the litigation and recovery against the provider or company.

Since the False Claims Act was substantially amended in 1986, the Civil Division, working with United States Attorney's Offices, has recovered $21.6 billion on behalf of the various victim federal agencies. Of that amount, $14.3 billion was the result of fraud against federal health care programs – primarily the Medicare program. Cases involving fraud committed by pharmaceutical

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and device manufacturers have resulted in total criminal and civil recoveries of more than $9.2 billion since 1999.

The Civil Division, through its Office of Consumer Litigation, also pursues many of these cases as criminal violations of the Federal Food, Drug, and Cosmetic Act (FDCA). For example, in January of this year, OCL and the U.S. Attorney's Office in the Eastern District of Pennsylvania prosecuted Eli Lilly and Co., which pled guilty to violating the FDCA for its illegal marketing of the anti-psychotic drug Zyprexa. Zyprexa was approved by the FDA for use in treating schizophrenia and certain aspects of bipolar disorder. Eli Lilly promoted Zyprexa for unapproved uses, including the treatment of, among other conditions, dementia, Alzheimer's dementia, agitation, and aggression, and specifically directed this effort through its long-term care sales force. That sales force targeted nursing homes and assisted living facilities, even though schizophrenia rarely occurs in the elderly. Eli Lilly sought to convince doctors to use Zyprexa to treat older patients for disorders which are prevalent in this population, despite the fact that the FDA had not approved Zyprexa for those conditions. Because the unapproved uses promoted by Eli Lilly were not medically accepted indications and, therefore, were not covered by State Medicaid programs, the company's conduct caused false claims to be submitted to Medicaid. The global settlement with Eli Lilly totaled $1.415 billion, which included a $515 million criminal fine, $100 million in forfeiture, and up to $800 million in civil recoveries under the federal and state False Claims Acts.

In addition to these accomplishments, the Department's Elder Justice and Nursing Home Initiative, coordinated by the Civil Division, supports enhanced prosecution and coordination at federal, state, and local levels to fight abuse, neglect, and financial exploitation of the Nation's senior and infirm population. Through this Initiative, the Department also makes grants to promote prevention, detection, intervention, investigation, and prosecution of elder abuse and neglect, and to improve the scarce forensic knowledge in the field. The Department additionally pursues cases

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under the False Claims Act against skilled nursing homes and other long term care providers that provide services so substandard as to constitute worthless services and constitute a complete "failures of care."

CIVIL RIGHTS DIVISION

The Civil Rights Division plays a critical role in the HCFAC Program. The Special Litigation Section of the Civil Rights Division is the sole Department component responsible for the Civil Rights of Institutionalized Persons Act. CRIPA authorizes the investigation of conditions of confinement at state and local residential institutions (including facilities for persons with developmental disabilities or mental illness, and nursing homes) and initiation of civil action for injunctive relief to remedy a pattern or practice of violations of the Constitution or federal statutory rights. The review of conditions in facilities for persons who have mental illness, facilities for persons with developmental disabilities, and nursing homes comprises a significant portion of the program.

In the context of persons residing in health care institutions operated by or on behalf of a government, the Division evaluates residential placements in each of its investigations under CRIPA, in light of the requirement in the Americans with Disabilities Act that services be provided to residents in the most integrated setting appropriate to their needs. Through its CRIPA work, the Division seeks to eliminate the unjustified institutional isolation of persons with disabilities. The Division recognizes that unnecessary institutionalization is discrimination that diminishes individuals' ability to lead full and independent lives. The Civil Rights Division's CRIPA enforcement activities have enabled thousands of unnecessarily institutionalized individuals to live safely in the community with adequate supports and services.

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As part of the Department's Institutional Health Care Abuse and Neglect Initiative, the Civil Rights Division conducts reviews of conditions in health care facilities. It has found that conditions and practices at eight state facilities for persons with mental illness, two state facilities for persons with intellectual and developmental disabilities, and three nursing homes violated the residents' federal constitutional and statutory rights. The Section entered settlement agreements to resolve its investigations of one state-operated facility for persons with intellectual and developmental disabilities, and one state-operated nursing home.

INTER-AGENCY COOPERATION

The Department is not alone in the fight to combat fraud and preserve the integrity of the country's health care system. Because HHS directly administers the Medicare Program, maintains all the payment records and data submitted by providers, and oversees the Medicaid program in partnership with the states, the close cooperation between the Departments is critical to our success. Within the framework of HCFAC, we work closely with the Inspector General of the Department of Health and Human Services, as well as our colleagues at the Centers for Medicare and Medicaid Services (CMS). As a result of this cooperation:

- Our Strike Force model focuses interagency resources on those regions with the highest levels of Medicare program fraud.
- Interagency health care fraud task forces and working groups exist in a majority of federal judicial districts that consist of Assistant U.S. Attorneys, HHS and FBI investigative agents, CMS program agency personnel and Medicare Program Safeguard Contractors, Medicaid Fraud Control Units, state Attorney General staff, and some private insurer investigators.

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We also work closely with the Food and Drug Administration, including its Office of Criminal Investigations (FDAOCI), the Federal Employees Health Benefits Program (FEHBP) at the Office of Personnel Management and its Office of Inspector General, and our State law enforcement partners in their Offices of Attorneys General and Medicaid Fraud Control Units. Because health care fraud schemes frequently impact private health insurance plans, we also work with private sector health care insurance providers. These partnerships are a key to our success in stemming health care fraud and protecting the federal fisc.

MORE THAN $14 BILLION IN TOTAL RECOVERIES SINCE 1997

Working with our colleagues, during Fiscal Year 2008 alone, the Department's health care fraud litigation resulted in deposits of $1.48 billion to the U.S. Treasury, which was reimbursed to the Centers for Medicare and Medicaid Services, other Federal agencies administering health care programs, or paid to private "whistleblowers" who filed health care fraud litigation completed by the Department. The Medicare Trust Fund received transfers of nearly $1.28 billion during this period as a result of these efforts, as well as those of preceding years, in addition to $344 million representing the federal share of Medicaid money similarly transferred to the Treasury as a result of these efforts.

Since the inception of the HCFAC program in 1997, the Department has obtained, according to our preliminary estimates, more than $14.4 billion in total recoveries, which include criminal fines and Federal and State civil settlements in health care fraud matters, predominantly involving losses to the Medicare program. Of this total, $12.5 billion has been transferred or deposited back into the Medicare Trust Fund and $1.2 billion, representing the federal share of Medicaid fraud recoveries, has been transferred to the Treasury. The monetary recoveries we achieve go right back into the Medicare and Medicaid programs to help fund the health care costs of the Americans who are enrolled in these programs.

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These recoveries were made possible by the dedicated funding stream provided by the HCFAC Program, which was established by the Health Insurance Portability and Accountability Act of 1996. The HCFAC program is the principal source of annual funding for Department of Justice efforts to combat Medicare and Medicaid fraud.

FUNDING

Earlier this year, the Omnibus Appropriations Act of 2009 provided $198 million for joint HHS and Department health care antifraud programs through an allocation adjustment for new program integrity work, predominantly for the Medicare Advantage, Medicare Part D, Medicaid and Children's Health Insurance (CHIP) programs. Nearly $19 million of this new amount is designated for the Department. The Administration's FY 2010 budget seeks an additional $311 million in two-year funding to continue and enhance this new program integrity and antifraud enforcement work of which $29.8 million is designated for the Department of Justice.

In addition to our partners in the HHS Office of Inspector General, and Centers for Medicare and Medicaid Services, the Department combats the Nation's health care fraud with a total of fewer than 400 full-time equivalent (FTE) positions, and roughly 750 FBI agents and support staff. With $12.5 billion returned to the Medicare Trust Fund since the inception of the HCFAC program, the average "return on investment" for funding provided by HIPAA to all "law enforcement agencies," the figures are as follows: total transfers to Medicare Trust Fund ($3.82 to $1) and all victims ($4.41 to $1). Further, we believe that the deterrent effects from our efforts may produce far greater "returns on investment" through dramatic reductions in fraudulent billings to and payments from Medicare.

As successful as our Strike Force and other anti-fraud efforts have been, our prosecutors believe that we may be only scratching the surface. The Administration has requested additional

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resources for FY 2010 to support the Department's efforts to bolster its health care fraud enforcement activities and protection of the Medicare Trust Fund. This additional time to use these enhanced resources would permit the Department to recruit, hire, and fully train the best and brightest attorneys and investigators to conduct and enhance this very important work, especially as the Administration and Congress seek to make health care coverage available to the millions of citizens who currently lack health insurance.

CONCLUSION

Health care fraud enforcement has restored funds to the trust funds and protected our citizens from health care fraud schemes. The Department is committed to the ongoing success of the HCFAC program and will continue to marshal its resources, including those provided by the HCFAC program and its own discretionary funds, to ensure that federal health care dollars are properly expended. We are committed to prosecuting fraud and abuse in the Medicare and Medicaid programs and restoring the recovered proceeds to these programs. We look forward to working with Congress and this Committee in particular, through these efforts, to make health care available to those who have no such safety net.

Thank you for the opportunity to testify. I would be please to take any of your questions.

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Testimony of Sean Dilweg

Commissioner of Insurance

State of Wisconsin

Before the

Senate Judiciary Committee

Subcommittee on Crime and Drugs

May 20, 2009

Chairman Specter and Members of the Subcommittee on Crime and Drugs, thank you for the opportunity to testify today. My name is Sean Dilweg and I am the Commissioner of Insurance for the state of Wisconsin. I commend you and the Committee for taking the lead in examining fraudulent activity in the health care marketplace.

Health care consumers have in the past and continue today to be harmed by health care fraud and regulatory gaming. State insurance regulators have fought a decades long battle against fraudulent and near fraudulent health care plan schemes. Such schemes range from bogus health care plans that leave millions in unpaid claims to more sophisticated schemes designed to circumvent rating and other restrictions to protect less healthy, less fortunate consumers.

I applaud your efforts to study prevention of billing, provider and other fraud that increase the costs of health care delivery, including fraud affecting Medicare, Medicaid and private health plans. It is just as critical that federal legislative proposals include measures to prevent schemes designed to directly harm consumers. I urge you to make this issue your highest priority and advocate for health care reform that allows confidential coordination of inquiries and investigations among state and federal regulatory and law enforcement agencies, creates a coordinating council, and gives regulatory flexibility to adapt to the changing face of fraudulent and regulatory gaming schemes.

This Congressional session may be a turning point in the history of our country's health care financing system. Great care must be taken to ensure these proposals do not inadvertently expose consumers, our families and friends, to fraud, or leave them

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unprotected from unscrupulous schemes. Now is the time to enact measures that encourage communication and coordination among federal and state regulatory and law enforcement jurisdictions, as well as set firm boundaries in the law to prevent schemes that abuse consumers.

There have been other such turning points. The enactment of the federal Employee Retirement Income Security Act of 1974 (ERISA) is an example. The enactment of the Erlenborn amendment in 1983 to ERISA is another. The 1974 enactment of ERISA was a major step towards protecting workers against fraud and abuse in the private pension system. It also was the unintended door opener to fraudulent health care insurance schemes. After enactment of ERISA, unscrupulous and innovative operators set up multiple employer trusts to provide bogus health coverage. These operators used the cover of ERISA's preemption of state regulatory authority over insurance activity to set up such fraudulent health insurance plans. They relied on legal ambiguity, limited federal administrative agency flexibility, and gaps in communication, coordination and authority among federal and state law enforcement and regulatory agencies to run bogus health insurance scams.

The history of criminal health coverage fraud is documented in Congressional records and studies. A 2004 General Accounting Office study reported that in the period 2000 to 2002, 144 unauthorized entities provided bogus health plan coverage to 15,000 employers and left more than $250 million in unpaid claims. Most of these bogus plans relied on ERISA preemption provisions for legal cover. The GAO found that every state had at least five such plans operating at some time during this period.

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Please do not conclude that shutting down these criminal health plan schemes can be achieved by simply outlawing these arrangements. That approach has proven unsuccessful. Fraud is always creative and energetic. It will evolve. The best preventive measures are provisions for flexible, coordinated and targeted regulatory, law enforcement and consumer education tools.

The 1983 Erlenborn Amendment to ERISA took aim at fraudulent schemes, but missed. The Erlenborn Amendment closed off some avenues for schemes while offering templates for others.

After the Erlenborn amendment was enacted, health care insurance schemes became more diverse. They included operations that:

- Purported to "aggregate" small employers into a "self-funded" single large employer by "leasing" employees;
- Purported to enter into "collective bargaining" agreements with participating employers;
- Purported to establish separate single employer "self-funded" trust arrangements;
- Purported to provide only stop-loss insurance (rather than health insurance) at attachment points of $500 or less;
- Purported to be "fully insured" although only by an insurer licensed in a single state although coverage is offered in multiple states; and
- Schemes that falsely purported to be fully insured by a licensed insurer.

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This history demonstrates that legislation to prevent criminal health schemes must be flexible and provide for coordinated enforcement and education measures.

The second and equally important lesson is that fraudulent health plans often evolve from schemes to gain windfall profits at the expense of the public by exploiting regulatory gaps. The history of fraudulent health plans demonstrates that it is not uncommon for regulatory avoidance schemes to convert to criminal enterprises.

Protecting consumers from harm due to regulatory gaming also protects them from criminal fraud. The "leased employee" and the stop loss insurance schemes I described illustrate arrangements can be used to exploit regulatory gaps and to circumvent insurance regulations. These arrangements can evolve, and have evolved into criminally fraudulent operations. They circumvent insurance consumer protections that give rate stability, adjusted community rating, and guaranteed renewal and issue rights. If the arrangements are criminally operated they will also serve as schemes to defraud claimants, leaving claims unpaid.

The National Association of Insurance Commissioners has developed a set of recommendations that urge the inclusion of fraud and regulatory gaming prevention tools in any federal health care reform proposal. I worked with the NAIC to develop these recommendations, which I strongly support. A copy of the recommendations is included with my written comments. I urge you to make it a priority to include the following key points in any federal health care reform legislation:

1) Establish a privilege and a statutory structure for confidential coordination and exchange of information among federal agencies and states insurance

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regulators. The privilege and structure should safeguard the confidentiality of communications among states regulatory and law enforcement and/or with the federal government for the purpose of regulatory oversight and facilitating investigations and inquiries.

2) Provisions reaffirming state insurance regulators authority to protect consumers. The legislation should not include ERISA-like preemption provisions that provide cover for health coverage schemes or create regulatory gaps.

3) A provision enabling the federal administrating agency to issue regulations or orders establishing that a person engaged in the business of insurance is subject to the laws of the states regulating the business of insurance and to foreclosing the use of federal law, including ERISA, as cover for fraudulent health plan schemes or for schemes to exploit regulatory gaps.

4) Provisions establishing a coordinating body to focus on health insurance fraud schemes and schemes to exploit regulatory gaps. The coordinating body should include state and federal regulators and law enforcement including the U.S. Department of Labor, FBI, the U.S. Postal Inspector, the Department of Labor's Inspector General, the IRS, and the Department of Justice and the U.S. Department of Health and Human Services.

5) Criminal and civil penalties for operators, and those who assist operators, of a health plan that falsely represents itself as exempt from state insurance regulatory authority.

6) Provisions for adequate staff and funding for regulatory enforcement.

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7) Provision for adequate staff and funding for an effective consumer education program.

Your committee is right to make health care fraud a priority. I urge you to continue your attention to this important and timely topic.

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FEDERAL ACTION NEEDED TO FIGHT HEALTH INSURANCE FRAUD

- States and the Federal government have worked diligently to identify and stop fraudulent and abusive health plans, but better cooperation and confidentiality would greatly enhance our efforts.
- The number and scope of fraudulent and abusive health plans have spiked as health insurance premiums continue to rise at a double-digit pace. They have a destructive ripple effect, impacting every aspect of the health care system – consumers, employers, providers, licensed health plans, and states
- The NAIC recommends that the following changes be made at the Federal level to give state insurance commissioners and law enforcement agencies the tools they need to stop fraudulent health plans.

NAIC Recommendations:

1. Congress should enact a federal privilege and a statutory structure for coordination and exchange of information among federal agencies and the states. The privilege and structure should safeguard the confidentiality of communications among states and with the federal government for the purpose of regulatory oversight and facilitating investigations into unauthorized insurance activity.
2. Any federal legislation addressing health coverage reform should be carefully crafted to ensure it does not include ERISA-like provisions that provide cover for health coverage scams or abusive health plans.
3. Any federal legislation addressing health coverage reform should include provisions instructing and enabling the administrating agencies to issue regulations to foreclose use of ERISA or the Risk Retention Act as cover for health insurance scams or abusive health plans.
4. The Department of Labor (DOL) should be given authority to issue administrative summary cease and desist orders and summary seizures orders against plans that are in financially hazardous condition.
5. Plans should be required to file the MEWA M-1 form and the Form 5500 with the DOL prior to enrolling anyone in the plan. The DOL should be given the direction and resources to strictly enforce the Form M-1 MEWA filing requirement and to conduct investigations to verify the status of entities, and to prosecute those who fail to file.
6. DOL should be given the resources and direction to: a) issue advisory opinions promptly when requested by a state; b) make available its investigators and their findings to state insurance departments to assist in their state enforcement actions; and c) assist the NAIC and state insurance departments in a joint consumer outreach and education program.
7. There should be federal criminal and civil penalties for operators, and those who assist operators, of a plan that falsely represents itself as exempt from state regulatory authority under ERISA.
8. Congress should require the Department of Justice (DOJ) to establish a coordinating body to focus on health insurance scams and abusive health plans. The coordinating body should include state and federal regulators, the law enforcement community including the FBI, the U.S. Postal Inspector, the Department of Labor's Inspector General, the IRS, and the U.S. Attorney's office.
9. Congress should amend ERISA to: a) prevent the removal from state to federal court any state insurance department or court proceeding once it has been initiated against a purported MEWA plan; and b) make clear that plans governed by ERISA must respond to state insurance department inquiries.

NAI
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MAY 2009

TESTIMONY FOR THE SENATE JUDICIARY

SUBCOMMITTEE ON CRIME AND DRUGS HEARING:

"Criminal Prosecution as a Deterrent to Health Care Fraud"

Submitted by

Sheri Farrar

Executive Director

Special Investigations Department

Health Care Service Corporation

May 20, 2009

Mr. Chairman, Senator Graham, distinguished members of the Subcommittee — on behalf of the National Health Care Anti-Fraud Association and Health Care Service Corporation, thank you for providing the opportunity to appear before you today to share our views on the important issue of criminal prosecution as a deterrent to health care fraud and specifically the critical role that information sharing plays in fraud investigations.

My name is Sheri Farrar and I am the Executive Director of the Special Investigations Department ("SID") of Health Care Service Corporation ("HCSC") which is the largest customer-owned health insurance company in the nation, serving more than 12.4 million members through our Blue Cross and Blue Shield Plans in Illinois, New Mexico, Oklahoma and Texas. As a not-for-profit mutual company, HCSC views its anti-fraud efforts as vital to protecting our members and the communities we serve.

In my role as the Executive Director of the SID, I oversee the anti-fraud program for all four of our Blue Cross and Blue Shield Plans. The mission of the HCSC SID is to:

- Identify and investigate high impact health care fraud schemes;
- Refer for criminal prosecution individuals and companies who defraud or attempt to defraud HCSC and its customers;
- Create a deterrent effect to discourage others from committing health care fraud;
- Maintain the integrity of HCSC's provider network; and
- Recover losses through all available means including the criminal justice system.

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In addition, I serve on the Board of Directors of the National Health Care Anti-Fraud Association (NHCAA), the only national association devoted exclusively to the fight against health care fraud.

The Challenge of Health Care Fraud

The costs of health care fraud are borne by all Americans. Whether you have employer-sponsored health insurance, purchase your own insurance policy, or pay taxes to fund government health care programs, health care fraud inevitably translates into higher premiums and out-of-pocket expenses for consumers, as well as reduced benefits or coverage. For employers, health care fraud increases the cost of purchasing health care for their employees, which in turn drives up the cost of doing business. For individuals the effects are more immediate and more devastating: the increased cost of health insurance due to health care fraud can mean the difference between being able to afford health insurance or not. For governments, health care fraud means higher taxes, fewer benefits and increased budgetary challenges.

In addition to being a financial problem, health care fraud has a human face. The victims of health care fraud include unsuspecting patients who are subjected to unnecessary or dangerous medical procedures, whose medical records are falsified or whose personal and insurance information is used to submit fraudulent claims. According to the FBI:

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One of the most significant trends observed in recent health care fraud cases includes the willingness of medical professionals to risk patient harm in their schemes. FBI investigations in several offices are focusing on subjects who conduct unnecessary surgeries, prescribe dangerous drugs without medical necessity, and engage in abusive or sub-standard care practices.

FBI Financial Crimes Report to the Public, Fiscal year 2007

http://www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm#health

Moreover, it is clear that many of the same individuals and entities that perpetrate fraud against government health care programs also perpetrate these frauds against the private sector. Accordingly, any effective steps in the fight against health care fraud must address and incorporate both the public and private sectors.

HCSC's Anti-Fraud Efforts

Approximately six years ago, HCSC's anti-fraud program was reorganized from an emphasis on claim by claim review on a prepayment basis in order to limit exposure to fraudulent and abusive billing practices to a model which emphasizes identifying the most egregious health care fraud schemes and those who are utilizing those schemes and then conducting thorough investigations to build evidence sufficient to enable prosecution. Our primary means of identifying the most costly health care fraud cases are through effective data analysis and liaison with law enforcement and other health plans.

HCSC's SID has its own dedicated Intelligence Unit staffed with highly trained analysts who utilize a number of commercially developed software analytical programs. Additionally, the unit has integrated the capabilities of these programs to better enable the development of more individualized analytical programs and detection routines which

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can be modified to address new and emerging fraud schemes. As a result, HCSC's fraud and abuse activities are supported by a state-of the-art data mining solution.

Utilizing these skills and technology, the analysts "mine" our electronic data warehouse to identify potentially fraudulent or abusive billing patterns, which are referred to the investigative teams in each state for further review and investigation as warranted. This unit also utilizes its data mining capabilities to further analyze lead information which may come from other sources or to support ongoing investigations.

Each new case opened by investigators is preliminarily investigated to determine if there is sufficient information to warrant a full investigation. This preliminary review usually includes requesting a clinical review of the medical records to determine if the services being billed are, in fact, the services that were rendered by the provider who has submitted the claim. It is important to recognize that there are few types of health care fraud which can be substantiated solely on the basis of the information presented on the claim. The more complex billing schemes, and those which involve potential patient harm, require medical record review to validate or disprove allegations of fraudulent or abusive billing practices and/or the rendering of inappropriate medical care.

At the point when a preliminary review develops evidence to support the initiation of a full, or more in-depth, investigation we also evaluate the case to determine if there is sufficient evidence to prove intent to commit fraud, which is a relevant factor in a decision to refer a case to law enforcement. Since 2006, our SID has referred 169 cases to law enforcement to include Federal, state and local agencies.

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As previously mentioned, one of our sources of investigative leads is through liaison with law enforcement. Our SID staff participates in all of the federally-sponsored health-care fraud task forces and working groups in our respective states. Through these associations, both at formal meetings and through ongoing liaison, we routinely discuss new and emerging health care fraud schemes as well as share information concerning known perpetrators of health care fraud.

While we understand that law enforcement may not be able to share information on all the health care fraud cases they investigate, it is recognized that if the subject of a health care fraud case is submitting fraudulent claims to the government, they are likely also victimizing private companies and vice versa. By sharing information, the losses attributed to the activities of one subject can be aggregated to enhance the prosecutorial potential of the case. Additionally, the manner in which a subject has billed the government may be different than the subject's billing practices with a private plan, which can provide useful evidence of knowledge and intent.

Prosecution is the Best Deterrent

While not all cases of health care fraud investigated by our SID provide the basis for a law enforcement referral or prosecution, we believe that prosecution is the best deterrent. Let me share examples of a few cases where our SID has worked with law enforcement to demonstrate the value of our collaboration.

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In 2008, a Chicago cardiologist was charged in the U.S. District Court of the Northern District of Illinois with health care fraud in a criminal information alleging he received approximately $13.4 million—$8.3 million from Medicare and $5.1 million from other health insurers—in fraudulent reimbursement for the highest level of cardiac care when those services were not performed. This case was referred to our SID by the Office of Inspector General (OIG) for the U.S. Department of Health and Human Services who requested our assistance in validating the allegations. In addition to conducting interviews of our affected members, auditing hospital records, and obtaining information on bank accounts utilized by the provider not previously known to law enforcement, we were also able to provide information on the provider's pattern of delayed billing and delayed cashing of reimbursement checks which helped facilitate the recovery of substantial amounts of the fraudulent payments. This case was charged in a criminal information, and the provider is expected to plead guilty later this year.

In 2009, the billing manager for an Illinois provider pled guilty to health care fraud in association with a scheme involving his then physician wife, an allergist/pulmonologist. The Springfield, Illinois, FBI requested the assistance of our SID in an investigation alleging the provider was engaged in a series of fraudulent billing practices to include billing for services not rendered, billing for excessive units of antigen preparation, and submitting multiple claims to unbundle services that should have been paid as one service. Victims included Medicare and several private insurers. The physician had earlier pled guilty to a misdemeanor count of balance billing Medicare patients. The provider's corporation was also charged in the original indictment and pled guilty. The corporation has been ordered to pay a fine of over $1.5 million to the

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government and make restitution totaling more than $930,000. The billing manager has not yet been sentenced but faces up to a potential 10 year sentence. He has agreed to pay a separate civil penalty of $100,000.

In 2007, a Houston physician was sentenced to 135 months in federal prison and ordered to make restitution of over $11.5 million in conjunction with his conviction on 44 counts of mail fraud and health care fraud in a scheme which defrauded various insurance companies. The physician specialized in treating patients diagnosed with Hepatitis C. He billed for services not provided and misrepresented services that were actually provided. As part of the scheme, the provider dispensed medications to patients to self administer at home while billing as though the injections had been administered by the provider or his staff in the provider's office. The medications were also billed by the provider at excessive rates and were given to the patients without appropriate follow-up care, placing the patients at potential risk. This case originated from information provided by another health plan and, after preliminary investigation, was referred to the Houston FBI and the Office of Inspector General (OIG) for OPM, as there were fraudulent claims associated with the Federal Employee Health Benefits Program (FEHBP).

Even the most well-intentioned providers can be lured into inappropriate billing practices through misinformation provided by billing "consultants" who promise to increase revenue or by manufacturers who develop new "technology" which is sold to providers with misinformation about ways in which they can bill for the services provided by the technology despite the fact that most insurers and Medicare deem the

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services to be experimental and investigational. A current example of this is a series of cases under investigation by HCSC's SID in coordination with law enforcement in which several manufacturers are selling a device to chiropractors and podiatrists with the claim that it can analyze a person's gait and diagnose foot problems. This device is a mat with sensors that detect pressure points and feed the information to a computer. No physical examination is given and the whole process only requires about five to ten minutes to complete. The provider targets employee-sponsored health fairs, charity fairs and other gatherings to advertise "free boots." Individuals who have no prior complaints of foot problems are given the test at the provider's exhibit booth. The participants are told the test results indicate they would benefit from specialized footwear that will be provided "free." Insurers are billed for the testing as though it occurred in the provider's office and are also billed for the footwear despite the fact there is no apparent medical necessity and the device does not provide information that would enable such a determination to be made. Most of the employee groups targeted thus far have been labor groups. Consequently our SID is working with the OIG for the Department of Labor as well as the FBI. Since these groups are self-insured, the overpayments associated with this fraud are being borne by the employer groups. This is only one example of a health care fraud scheme that we were unaware of two years ago but that is now being employed by a growing number of providers.

Health care fraud cases are some of the most complex white collar crime cases handled by prosecutors necessitating dedicated staff who develop an expertise in understanding how health claims are processed and paid by both private insurers and the government and the intricacies of proving the necessary criminal intent. In many

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jurisdictions limited prosecutorial resources impact the ability to dedicate staff accordingly. Additionally, health care fraud cases compete with other investigative programs that are often deemed higher priority. While we continue to refer the most egregious health care fraud matters to law enforcement, we recognize that many will ultimately not be prosecuted. Consequently, our SID, like most other private insurers, looks for other ways to impact fraudulent and abusive billing activity.

Other Remedies

When resource constraints and/or the facts of a case do not support a prosecution, we seek other means to address billing practices that result in inappropriate payments to providers. Other remedies include seeking a voluntary repayment through negotiations with the provider. In these situations, we incorporate education of proper billing practices into the discussion in an effort to mitigate future risk as well as to eliminate any future defense that the provider was unaware their practices were inappropriate. In recovering overpayments, it is important to note that, as a company which has many large self-insured groups, the largest percentage of the losses due to the fraudulent or abusive billing practices are borne by the employer group and not our company. As good financial stewards, we endeavor to recover 100% of the overpayments for our self-insured and government groups for the recovery period, using the overpayments associated with our premium business as a negotiating tool.

Other remedies include evaluating the factors that enabled the fraudulent claims to be successfully paid and recommending claims processing system fixes, medical policy or processing procedure modifications, and/or contract enhancements to reduce

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our future risk to similar schemes. We also make referrals to our respective state licensing agencies and other professional regulatory agencies and boards as appropriate.

However, there is no "one fix" to address health care fraud. Health care fraud schemes are constantly changing and evolving as new medical procedures and new health care technology are developed, and as the perpetrators of health care fraud adjust their billing practices to defeat actions taken by the government and private insurers to mitigate risk.

The Importance of Information Sharing

Staying one step ahead of those who are intent on committing health care fraud requires continual information sharing and collaboration among the various law enforcement and prosecutorial agencies, regulatory agencies and private health insurers. As a result, in addition to our ongoing liaison with law enforcement in our respective states, HCSC maintains effective information sharing relationships with law enforcement in other states and with other private insurance plans through our corporate membership in the National Health Care Anti-Fraud Association (NHCAA). NHCAA was formed in 1985 by private health insurers together with government agencies responsible for the investigation of health care fraud. As a private-public partnership against health care fraud, one of NHCAA's primary purposes is to serve as a forum and catalyst for the sharing of information about health care fraud investigations and emerging health care fraud schemes.

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NHCAA's 81 corporate members (representing more than 200 health plans) and 70 Federal, state and local law enforcement and regulatory agencies routinely and voluntarily share information through NHCAA's Special Investigation Resource and Intelligence System (SIRIS) database, in-person information sharing meetings, electronic fraud alerts, and various work groups focusing on major health care anti-fraud initiatives. This information sharing is critical to the success of national health care anti-fraud efforts. Those perpetrating fraud against the health care system do so indiscriminately across the range of government health care programs and private health plans. Without effective information sharing, broad schemes targeting multiple payors of health care become nearly impossible to detect.

An excellent example of effective information sharing is a meeting NHCAA held several months ago in Florida which brought together representatives of private insurers, FBI headquarters and 10 FBI field divisions, the Centers for Medicare and Medicaid Services (CMS), HHS-OIG, the Justice Department, the Miami U.S. Attorney's Office, OPM-OIG, DOD Tricare, and local law enforcement to address the health care fraud schemes which have emerged in South Florida and are beginning to spread to other areas of the country. The details of the emerging schemes, investigatory tactics, and the results of recent prosecutions were discussed with the dual goals of preventing additional losses in South Florida and preventing the schemes from spreading and taking hold in other parts of the country.

Too often, however, information sharing in health care fraud cases is a one way street with the private sector regularly sharing vital information with the public sector—

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either voluntarily or through mandate—without reciprocal information sharing to bolster the fraud fighting efforts of the private sector. This inequity works counter to a coordinated fraud fighting effort because the private sector—whether in commercial products or for government-sponsored programs such as Medicare Part D—plays an important role in safeguarding our nation's citizens against health care fraud.

In many circumstances, the government representatives believe that they do not have the authority to share information about fraud investigations with private insurers. However, guidelines developed by the Department of Justice and the Department of Health and Human Services for the operation of the Coordinated Health Care Fraud Program established by HIPAA provide a strong basis for information sharing. "The Statement of Principles for the Sharing of Health Care Fraud Information between the Department of Justice and Private Health Plans" (http://www.usdoj.gov/ag/readingroom/hcarefraud2.htm) recognizes the importance of a coordinated program, bringing together both the public and private sectors in the organized fight against health care fraud. We believe that these Principles should be reemphasized or reincorporated and clarified in new legislation to ensure that the goal of an effective and coordinated health care fraud program can be developed.

Additionally, the government has recovered large sums in connection with various lawsuits related to health care fraud. In these cases, there has been no consistent effort to incorporate any component of private insurance money lost to fraud. While private insurers would like to see all commercial health care dollars lost to fraud incorporated into integrated settlement agreements involving health care providers who

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have defrauded both public and private programs, at a minimum the government should incorporate into their settlements the private component of federal program dollars, primarily programs such as Medicare Parts C and D, where there is a joint administration between public and private payers of a public program.

Beyond this step, the Department of Justice should include within its information sharing efforts additional information about the fraud schemes and the factual support for the ensuing investigations so that the government can assist the private entities in helping themselves in connection with these health care fraud matters.

Conclusion

The National Health Care Anti-Fraud Association and Health Care Service Corporation are committed to working with Congress to address health care fraud. We hope that this subcommittee will consider us resources and partners in this fight.

Thank you for the opportunity to appear before you today, and I look forward to answering your questions.

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Statement of

The Honorable Patrick Leahy

United States Senator
Vermont
May 20, 2009

Statement Of Senator Patrick Leahy
Chairman, Senate Judiciary Committee
"Criminal Prosecution as a Deterrent to Health Care Fraud"
Hearing Before Crime and Drugs Subcommittee of Senate Judiciary Committee
May 20, 2009

I would like to thank my longtime friend Senator Specter for chairing this hearing before the Subcommittee on Crime and Drugs to focus on our efforts to crack down on criminal health care fraud. This topic is timely and important, and I applaud Senator Specter for drawing attention to it.

I have worked hard in this Congress to combat the fraud that threatens to undermine our government's efforts to rebuild the economy and help those who are suffering in these tough economic times. Later this afternoon, President Obama will sign the Leahy-Grassley Fraud Enforcement and Recovery Act (FERA) into law. This bill is the most comprehensive legislation to combat mortgage and financial fraud in more than two decades. I introduced this legislation in February to address the growing concern that not enough had been done to protect the billions of dollars in taxpayer money being spent to stabilize our banking system and housing markets, and to make sure those who have taken advantage of vulnerable homeowners, investors, and retirees by committing fraud are held fully accountable under the law.

I want to thank the extraordinary efforts of the original co-sponsors of this bill – Senators Grassley and Kaufman – who worked tirelessly with me to pass FERA, as well as the six other members of this Committee who joined as co-sponsors: Senators Specter, Durbin, Schumer, Cardin, Whitehouse, and Klobuchar. I believe this important fraud legislation, which passed in both the Senate and the House with overwhelming support, is the kind of bipartisan achievement that the American people want and expect from Congress and from the new administration.

Now, we turn must turn from the problem of financial fraud to the growing crisis of health care fraud, and I hope we can all work together toward a similar bipartisan response. The President has called upon Congress to pass comprehensive health care reform this year, and I believe that strengthening our enforcement efforts to crack down on rampant fraud, waste, and abuse in the health care system is vital to the success of health care reform. Working with Senator Grassley, I have begun to consult with those on the Finance and HELP Committees who are crafting the health care reform legislation, and I hope this legislation will include provisions strengthening enforcement of health care fraud, just as we have done so successfully with mortgage and financial fraud. Today's hearing, which is focused on the need to use criminal prosecution as a deterrent to health care fraud, is an important piece of that overall effort.

I was encouraged today to learn that Attorney General Holder and Health and Human Services Secretary Sebelius will make health care fraud enforcement a priority as well. Today, the Attorney General and the Secretary announced the expansion of the joint-agency health care task forces to Detroit and Houston, and new coordination efforts lead by Health Care Fraud Prevention and Enforcement Teams, which will be called HEAT teams, at both agencies. The Attorney General and the Secretary also pledged to make greater efforts to use technology and data sharing to stop fraud before it starts.

Working together to fight fraud throughout government has been a hallmark of this new administration, and I applaud the Attorney General and Secretary for their early commitment to combat health care fraud with innovative and cooperative enforcement strategies. These efforts will undoubtedly help reduce the costs of health care and protect taxpayers' funds in the future, and be an important part of our overall plan to reform health care in this country.

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The scale of health care fraud in America today is staggering. Our nation spends more than $2.2 trillion dollars a year on health care, and Federal and State governments make up more $800 billion of that spending. According to conservative estimates, about three percent of the funds spent on health care are lost to fraud – that totals more than $60 billion dollars a year. For the Medicare program alone, the General Accounting Office estimates that more than $10 billon dollars was lost to fraud just last year. Unfortunately, this problem appears to be getting worse, not better.

The answer to this problem is to make our enforcement stronger and more effective. We need to deter fraud with swift and certain prosecution, as well as prevent fraud by using real-time internal controls that stop fraud even before it occurs. We need to make sure our enforcement efforts are fully coordinated, not only between the Justice Department and other agencies, but also between Federal, state, and private health care fraud investigators. Much has been done to improve enforcement since the late 1990s, but we can and must do more.

In 1997, the Clinton administration created the Health Care Fraud and Abuse Control (HCFAC) program to provide a framework for a coordinated attack on health care fraud. The HCFAC program has proven to work, having provided vital resources for the Justice Department, the Federal Bureau of Investigation, and the Inspector General's Office at HHS to fight fraud. And like so many fraud enforcement programs, HCFAC program pays for itself many, many time over, as last year it returned more than $1.8 billion to the Federal Government and led to savings of more than $30 billion in avoided health care costs and payments. We need to build upon and expand the success of the HCFAC program as we look to reform our health care system.

I also hope that we will continue to encourage whistleblowers to come forward and uncover these frauds, as I have for many years. I will continue working with Senator Grassley to strengthen even further the False Claims Act, which we bolstered in important ways in FERA, as it is one of our most potent tools for combating health care fraud.

But the task ahead is daunting. The Justice Department has more than 1,600 pending criminal health care investigations and more than 800 civil false claims case involving health care fraud. These cases involved some of the most sophisticated price schemes ever seen, and require significant expertise to discover and investigative skill to prove in court. Our enforcement efforts attacking health care fraud need to be aggressive, efficient, and creative. I look forward to hearing from all our witnesses about their recommendations for improving criminal health care fraud enforcement.

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Testimony of:

Malcolm K. Sparrow
Professor of the Practice of Public Management
John F. Kennedy School of Government
Harvard University

Senate Committee on the Judiciary: Subcommittee on Crime and Drugs

Wednesday May 20th, 2009

Hearing: "Criminal Prosecution as a Deterrent to Health Care Fraud"

Introduction:

Good afternoon Chairman Durbin, Ranking Member Graham, and distinguished members of the Senate Committee on the Judiciary, Subcommittee on Crime and Drugs.

My name is Malcolm Sparrow, and I teach regulatory and enforcement policy and operational risk control, predominantly to government regulators, at Harvard's John F. Kennedy School of Government. I have worked on the practical challenges of fraud detection and fraud control strategy with the credit card industry, with the IRS on tax fraud, and with private, not-for-profit and public insurers on health care fraud.

The units of measure for losses due to health care fraud and abuse in this country are *hundreds of billions* of dollars per year. We just don't know the first digit. It might be as low as *one* hundred billion. More likely *two* or *three*. Possibly *four* or *five*. But whatever that first digit is, it has eleven zeroes after it. These are staggering sums of money to waste, and the task of controlling and reducing these losses warrants a great deal of serious attention. One of my deep regrets is to discover that academia has paid almost no serious attention to this critical problem. I suspect this neglect is because the art of health care fraud control falls awkwardly between the traditional disciplines of health economics, health policy, crime control policy, anomaly detection and pattern recognition.

For those running our major health programs, fraud comes as the unwelcome guest. Systems carefully designed and set up to provide the best possible health care have turned out to be fabulously attractive targets for criminal fraud. So health care policymakers find themselves plunged into the crime control business, whether they like it or not. Many don't like it, and find themselves quite unprepared for it.

In 1993, while I was working with the IRS on a major tax fraud issue, IRS Commissioner Margaret Milner Richardson introduced me to Attorney General Janet Reno. It was in 1993 that Attorney General Reno declared Health Care Fraud to be the number two crime

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problem in America, second only to violent crime. That was an extraordinary position for a white collar crime to hold, and it reflected how seriously the Clinton administration viewed the problem. Attorney General Reno wanted to understand the strengths and weaknesses of the fraud controls used within the health care system, and as a result of my conversation with her, I subsequently accepted a research grant from the National Institute of Justice. My task was to study the state-of-the-art of fraud control within the health industry and, if possible, explain why health care fraud seemed so persistent and pervasive.

In 1996 I published my first book on the subject, called "License to Steal," which analyzed the industry's approach.[1] The 1996 version is now out of print, but I can briefly summarize for you it's central message. In a nutshell, the analysis showed that the health industry failed to distinguish adequately between *payment accuracy* and *crime control*. On the whole the industry did a good job using modern process improvement strategies to ensure payment accuracy—by which I mean making sure that the claims as presented were processed correctly and according to all the relevant rules. But the industry did a terrible job of crime control, with almost no procedures in place to routinely verify that the claims presented were actually true, or that services provided were medically necessary.

This basic confusion, and the resulting lopsided performance, means that the health industry's controls are weakest with respect to outright criminal fraud. By contrast the industry's controls perform reasonably well in managing the grey and more ambiguous issues—such as questions about medical orthodoxy, pricing, and the limits of policy coverage. But criminals, who are intent on stealing as much as they can and as fast as possible, and who are prepared to fabricate diagnoses, treatments, even entire medical episodes, have a relatively easy time breaking through all the industry's defenses. The criminals' advantage is that they are willing to lie. And provided they learn to submit their bills correctly, they remain free to lie. The rule for criminals is simple: if you want to steal from Medicare, or Medicaid, or any other health care insurance program, learn to *bill your lies correctly*. Then, for the most part, your claims will be paid in full and on time, without a hiccup, by a computer, and with no human involvement at all.

In 2000 I updated and reissued "License to Steal" to give an account of the progress made by the Clinton administration, but also to make clear to subsequent administrations just how much more needed to be done to properly excise the cancer of fraud from important public programs.[2]

Although I have not conducted any new field research since then, I have remained engaged with the field and have been watching developments over the last nine years with great interest and growing concern. Last month I published a summary paper analyzing recent developments, which was requested by the journal *Social Research*.[3] That paper presents an analysis of why highly automated health care payment systems invite criminal assault, and what we know and don't know about the actual fraud loss rates. The paper also provides a critical assessment of the government's response to the

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latest round of billing scams to be discovered in the Medicare and Medicaid programs. With your permission, I would like to introduce that paper into the record.

Deterrence Theory:

The magnitude of a deterrent effect depends, according to criminologists, on a potential perpetrator's assessment of three factors:

(a) the likelihood of getting caught (i.e. the probability of being detected or reported),
(b) the probability of being convicted once detected, and
(c) the severity of the punishment if eventually convicted.

This hearing clearly focuses on the third, and I certainly support the notion of effective punishment for white collar crimes, particularly those that involve an abuse of the public's trust and diversion of public funds.

But I would urge the committee in its deliberations to consider the first two factors equally seriously. The third—severity of punishment—can be set or altered by statute or by adjusting sentencing guidelines. The first two are harder to change, as they depend on the underlying capacity of the detection apparatus and the capacity of the criminal justice system to deal with cases that come to light. The most obvious weaknesses in health care fraud control lie with these first two. Criminologists argue, in fact, that the first two—the probability of detection and conviction—weigh more heavily in the calculus of would-be-perpetrators than the severity of sentences because (assuming a low enough probability of detection) criminals like to believe they will never face sentencing.

I would like to highlight for this committee two major issues that relate directly to the chances of crimes being detected and dealt with appropriately.

Determining the Appropriate Scale for Detection and Control:

The resources available for fraud detection and control in health care are not only inadequate; they are of the wrong *scale*. The credit card industry has established benchmarks for "acceptable business risk" with respect to fraud losses. Their threshold is ten basis points on transaction volume, or one tenth of one percent. By contrast, estimates of fraud losses in the health industry range from 3% to 10% to 14%, depending on who you ask. Suppose for a moment the loss rate were 10%. That would be one hundred times the acceptable business risk threshold set by the credit card industry.

Meanwhile, spending on program integrity functions all across the health industry tends to run at or just below one tenth of one percent of overall program payouts. My papers and books present a wealth of facts and figures to demonstrate that.

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These investments in control, while minimal, pay off handsomely. From year to year the Office of Inspector General (DHHS) reports return ratios per dollar spent in the region of 17 to 1. Sometimes higher. One view is that these handsome returns reveal a highly efficient operation. But any economist would tell you, conversely, that this shows the levels of investments in control are nowhere near optimal. Economists would say that one ought to keep adding controls until the marginal returns get much closer to one-to-one. Returns of the order of 20 to 1 indicate a reservoir of fraud available, and considerable ease in skimming off the more obvious cases. If you're standing in a lake, it does not take much effort to scoop up a bucket of water and hold it up for everyone to see.

Loss rates due to fraud and abuse could be 10%, or 20% or even 30% in some segments. We do not have reliable figures of the loss rates, because the overpayment rate studies the government has relied on in the past have been sadly lacking in rigor, and have therefore produced comfortingly low and quite misleading estimates.

By taking the fraud and abuse problem seriously this administration might be able to save 10% or even 20% from Medicare and Medicaid budgets. But to do that, one would have to spend 1% or maybe 2% (as opposed to the prevailing 0.1%) in order to check that the other 98% or 99% of the funds were well spent.

But please realize what a massive departure that would be from the status quo. This would mean increasing the budgets for control operations by a factor of 10 or 20. Not by 10% or 20%, but by a *factor* of 10 or 20. Such a move would be politically inconceivable unless the actual magnitude of the losses were properly measured, and the cold hard facts about loss rates put on the table. Measurement is normally step one in any effective fraud control operation. Without reliable information regarding the scope of the problem, everyone is free to guess what the loss rate might be, and they will guess high or low depending on their interests. While ambiguity persists about the size and seriousness of the problem, re-sizing the controls in such a dramatic fashion could not possibly be justified.

There have been some previous attempts to measure and report overpayment rates in Medicare and Medicaid. The most prominent of these were the "Medicare Overpayment Rate" studies, conducted by the Office of Inspector General (for Department of Health & Human Services) from FY 1996 through FY 2002. These OIG studies involved stratified random samples of recently paid Medicare claims, and retrospective audits of the claims selected for review. But the audit protocol the OIG used on these claims resembled a typical *post-payment utilization review*. These were desk-based audits, not fraud-audits. They did not involve face-to-face contact with providers, nor any contact with the majority of patients; and medical records mailed in by providers were assumed to be truthful. Thus the *overpayments* detected by these studies would not have included the majority of fraud types that are familiar to the Medicare program. This audit method would successfully capture processing *errors* (which one assumes should be few in a highly automated environment), and some cases of insufficient documentation. Despite the weak audit protocol, the first of these OIG studies, reported in 1997, showed an

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overpayment rate of 14%, equivalent to $23 billion in annual losses from the Medicare program. These findings shocked Congress, and the nation. In subsequent years the Medicare overpayment rates, measured the same way, settled down in the range 6% to 7%, providing some comfort for alarmed taxpayers.

These figures provided the basis for the outgoing Clinton administration's claim that they had correctly identified health care fraud as a problem, and had successfully cut the problem in half. Early in 2000 the GAO was asked by the Congressional House Budget Committee to examine the methodology the OIG had been using to estimate Medicare overpayment rates. The GAO, in its response,[4] reported

> "...our work shows that because the methodology was not intended to detect all fraudulent schemes such as kickbacks, and false claims for services not provided, the estimated improper payments of $12.6 billion would have been greater. How much greater, no one knows.
> ...The methodology assumes that all medical records received for review represent actual services provided."

Despite the clear admission that these studies did not capture most forms of fraud, and in particular would not capture the most obvious and central form of fraud—*false claims*—the OIG continued to use the same audit protocol in subsequent years. OIG officials argued that they had to employ the same methodology year after year in order to make the results comparable, so that any trends over time could be reliably discerned.

In January of 2003 the OIG discontinued the Medicare overpayment measurement program, leaving the Medicare agency itself (CMS) to run an equivalent annual study. The Centers for Medicare and Medicaid Services continue to use weak audit methodology in their *Claims Error Rate Testing* (CERT) program, and hence we now have no reliable indications of the overall fraud loss rates for the Medicare program.

For any *invisible* problem, effective control begins with valid measurement. For health care fraud, control breaks down at this very first hurdle. No-one knows quite how bad the situation has become, and industry practices seem to reflect a broad reluctance to find out. Exposing the scale of the problem might involve a dose of very bad news; but such bad news is easier to swallow at the beginning of an administration than at the end of one. I believe we have an important opportunity, now, to correct this defect and establish more appropriate levels of control based in a rational way on valid measurement of the loss rates.

Recent Developments: Evidence of Fake Billing Scams

My second major point relates to the extremely low probability, for criminals, of being prosecuted even when their false claims are detected. There is accumulating evidence that existing control strategies are missing important opportunities to shut down major false-billing scams.

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The last ten years has seen an extraordinary series of reports produced by the Office of Inspector General (OIG) for the Department of Health and Human Services. According to OIG reports, several different categories of patients, none of whom should be getting treatment under these programs, have been showing up in significant numbers within paid Medicare and Medicaid claims. The most obvious embarrassment involves treatments rendered to patients who were already dead on the date they were supposedly treated. In March 2000, the OIG published its investigation into provision of medical services to Medicare beneficiaries after their dates of death. They quickly found $20.6 million in such claims, paid in 1997. A significant volume of the claims showed *new* treatments for a patient, beginning more than a month after they had died.

Dead patients also showed up in Medicaid claims around the country. An OIG report in 2006 summarized findings from ten different states, revealing $27.3 million in Medicaid payments for services after death.

Patients who have previously been *deported* also show up in paid claims. INS records show patients who had been banished from the country prior to the reported treatment dates, and prohibited from returning. How did these patients manage to receive their treatments here within the U.S., and at public expense? In March 2002, the OIG reported finding 43 deported Medicare beneficiaries for whom fee-for-service claims had been received and paid after the recorded date of deportation.

Similarly, patients who are in prison generally ought not to show up in Medicare and Medicaid paid claims. Most health insurance for prisoners is provided through prison systems, not by Medicaid or Medicare.

In July 2008, another group came to light, adding to Medicare's public embarrassment. The Senate Permanent Subcommittee on Investigations revealed the presence of *dead doctors* within Medicare's paid claims. From 2000 to 2007 between $60 million to $92 million was paid for medical services or equipment that had been ordered or prescribed by dead doctors. In many cases, the doctors had been dead for more than ten years on the date they supposedly ordered or authorized treatments.

All of these reports from the Office of Inspector General basically follow the same formulaic approach. They point out that the requisite data about deaths, deportations, and incarcerations is available somewhere within government, and so the Medicare and Medicaid programs could and should do a better job of obtaining that data from the relevant agency in a timely fashion and incorporating it into the claims processing *edits and audits* so that the payment systems could "auto-reject" the bad claims.

Anytime we discover that totally implausible claims have been paid, there are two questions that should spring immediately to mind: First, how did these obviously fictional claims get generated? Second, why did we pay them? All of these OIG reports focus heavily on the second question—the issue of whether the claim should or could have been denied—and neglect the first one almost entirely. In my mind, the first

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question is potentially much more revealing, and the most striking feature of the OIG's approach to these implausible claims is that their inquiries appear to pay little or no attention to the business practices that generate fake claims. Businesses that produce such claims are not error-prone; they are fraudulent. But the strategy the OIG recommends for dealing with these various classes of implausible billings reflect more of a concern with *payment accuracy* than with *crime control.*

While the OIG focuses on process improvement and payment accuracy, the scandals that emerge all around the country are about criminal fraud. The media provide a steady stream of stories about petty crooks or organized crime groups who—without ever seeing a patient or providing any valid medical services at all—manage to bill Medicare or Medicaid or some other health insurer millions of dollars. We know from these cases that fake billing scams exist, because they sometimes come to light. When claims are submitted, and they involve dead doctors or dead patients or some other feature that renders them obviously *false*, the most obvious explanation is that these claims arise as a chance by-product of much larger fake billing scams. To understand why the government's current response to these billing issues is inadequate, even dangerous, one has to briefly contemplate what life looks like on the other side of the fence.

Let us imagine that these claims have actually been produced by Billy, the crook. Billy's goal is to steal as much as he can, as fast as possible. Billy pays a nominal fee to sign up as a Medicare provider himself, or infiltrates a billing service which submits claims on behalf of others. In order to bill Medicare, Billy doesn't need to see any patients. He only needs a computer, some billing software to help match diagnoses to procedures, and some *lists*. He buys on the black market lists of Medicare or Medicaid patient IDs. If he wants to bill for services that require a prescription or authorization, he will also need to buy, steal, or otherwise obtain lists of physician numbers (UPINs) to enter into his electronic claims submissions.

Billy is actually vulnerable because his lists are not entirely "clean." They contain just a few cases, probably no more than one in a hundred, of doctors or patients who are dead, deported, or incarcerated. And Billy doesn't know that. In fact, Billy would pay a lot, at this point, to know which patients' and doctors' numbers to avoid.

Now consider the standard governmental response to these various billing anomalies. In particular, what do the OIG's proposals mean for a fraud perpetrator like Billy? If CMS perfects its pre-payment edits, and operates them as recommended by the OIG, then Billy will receive computer-generated *auto-rejection* notices for the small fraction of his claims that are obviously implausible: "Medicare rejected this claim because, according to government records, this patient died prior to the date of service." The other 99% of Billy's claims, not involving detectable aberrances, will all be paid. From Billy's viewpoint, life could not be better. Medicare helps him "scrub" his lists, making his fake billing scam more robust and less detectable over time; and meanwhile Medicare pays all his other claims without blinking an eye or becoming the least bit suspicious.

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Even the briefest of glances over this fence enables us to see these several categories of implausible claims in quite a different light. Rather than *processing errors to be corrected* these claims represent *detection opportunities for massive fake billing scams*. Once one sees them in this light, an important question follows: just how large might these billing scams be? For that, there is no empirical evidence. But one might imagine that lists of Medicare providers and patients available to fraud perpetrators would typically contain only a few instances of people who were in fact dead, retired, deported, or incarcerated. Suppose these accounted for 1% or less of the patient list, and that the fake billing scheme used the numbers on the lists evenly. Then one might surmise that the billing scams would likely be at least 100 times as large as the volume of *dead doctor* or otherwise implausible claims that these scams would naturally generate.

So, while the OIG reports and resulting public concern focus on the several millions of dollars in obviously implausible claims that are apparently *processed and paid in error*, the underlying billing scams may well amount to hundreds of millions or billions of dollars. The implausible claims, as obvious fictions, represent important detection opportunities. But they themselves are not the real problem; they are just the detectable and visible symptoms of much larger and more sinister abuses.

By all means, CMS and their contractors should improve their capacity to detect such obviously implausible claims. Better inter-agency data exchange can facilitate this. But once such claims become visible, *auto-rejection* of the implausible claims is a feeble response. Criminals should not be able to submit fake claims with impunity. The system should bite back. All assumptions of trust should be dropped immediately. A proper fraud response would do whatever was necessary to rip-open and expose the business practices that produce such fictitious claims. Relevant methods include surveillance, arrest, or dawn raids. All other claims from the same source should immediately be put on hold. Whenever a provider submits claims for treatment *of* the dead, or treatment *by* the dead, there is almost no chance that any of their other claims—submitted in the names of the living—are any more valid.

It seems extraordinary, given the long history of health care fraud in the U.S., that the Office of Inspector General, which is centrally placed to oversee the fight against fraud, recommends such a weak and inadequate response when it comes to false claims and fake billings. Medicare officials and their overseers fail, like so many others across this industry, to properly distinguish between the imperatives of *process management* and the imperatives of *crime control.* By focusing so heavily on the first, they make life easier and safer for fraud perpetrators. One fundamental truth of the fraud-control business is this: *fraud works best when claims-processing works perfectly.*

The health care industry still acts as if it imagines that process-accuracy is the cornerstone of effective fraud control. In fact, process-accuracy (with the transparency and predictability it produces) is a large part of what makes health care payment systems such attractive targets for fraud.

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Recommendations:

I am happy to assist the committee in any way I can. I certainly support effective punishment for white collar crimes, particularly those that so clearly involve an abuse of the public trust. But I would urge this committee to consider also the following proposals, which would help to clarify the true nature and scope of the problem, and dramatically increase the likelihood that criminal activity will be detected in the first place and then pursued in an appropriately aggressive manner.

(1) As a matter of urgency, reinstate the requirement that the OIG provide an *independent audit* of the Medicare overpayment rate on an annual basis. CMS should not be left to diagnose and report on its own failings.
(2) Require the OIG, as it designs the necessary audit protocols for such overpayment measurement, to *use a rigorous fraud-audit methodology*, not the process-oriented desk-audit approach they used from 1996 to 2002. A fraud audit must include steps to verify with the patient or with others that the diagnosis was genuine and that the treatments actually too place. It should also include contextual data analysis sufficient to identify any suspicious patterns of incestuous or self-dealing patient referrals, diagnostic biases, or systematic padding of claims or treatments consistent with patterns of fraud.
(3) Require a review of the adequacy of the Medicare and Medicaid programs' operational responses to claims submitted that are clearly implausible. *Auto-rejection* of claims involving dead patients, dead doctors, or previously deported persons is a terribly weak response, and actually helps perpetrators perfect their billing scams. The detection of such claims ought to trigger a presumption of the presence of serious criminal enterprise, and that presumption should then be tested through appropriate criminal investigation and law-enforcement response.

Thank you, Mr. Chairman.

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[2] License to Steal: How Fraud Bleeds America's Health Care System, (2nd edition), Westview Press, Denver, Colorado & Oxford, England, 2000.

[3] "Fraud in the U.S. Health Care System: Exposing the Vulnerabilities of Automated Payment Systems," [invited paper] *Social Research: An International Quarterly of the Social Sciences,* Vol. 75, No. 4, Winter 2008. pp1151-1180

[4] Government Accountability Office. "Efforts to Measure Medicare Fraud." Letter to House Budget Committee Chairman, Rep. John R. Kasich. Reference: GAO/AIMD-00-69R. February 4th, 2000.

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Malcolm K. Sparrow

Fraud in the U.S. Health-Care System: Exposing the Vulnerabilities of Automated Payments Systems

IN 1993, ATTORNEY GENERAL JANET RENO DECLARED HEALTH-CARE fraud the "number two crime problem in America" after violent crime—a remarkable status for a category of white-collar crime. In 1995, FBI Director Louis J. Freeh testified that cocaine-traffickers in Florida and California were switching from drug dealing to health-care fraud. The traffickers had discovered that health-care fraud was safer, easier, and more lucrative than the drug trade, and carried a smaller risk of detection (Freeh, 1995: 2). In 1997 the *New York Times* reported that mafia families in New York City and New Jersey were abandoning their traditional lines of business (extortion and bid-rigging rackets) in favor of new criminal enterprises, including health insurance (Raab, 1997: A1, B4). In 2003, Columbia HCA, America's largest hospital chain, finalized a $1.7 billion settlement with the U.S. Department of Justice, the largest in history, following 10 years of investigation into an array of whistle-blower allegations (Department of Justice, 2003). In July 2008, Abner and Mabel Diaz, a couple in Miami Lakes, Florida, pleaded guilty to fraud, admitting they had submitted to Medicare $420 million in false claims for medical equipment (Weaver, 2008: 1).

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All sorts, apparently, find attractive opportunities in health-care fraud. But why steal from the health-care system? Perhaps because, at least in the United States, that's where the money is! No other nation on earth spends as much on health care as the United States, where health care expenditures for 2006 (the last year for which reliable figures are currently available) reached $2.1 trillion (CMS, 2006: 1). Projections for calendar year 2008 put total costs at $2.4 trillion, equivalent to $7,868 per person or 16.6 percent of GDP (CMS, 2007, table 1). The future of American health care looks even more expensive, with costs projected to outpace economic growth by an average of 1.9 percent per year, so that by 2019 health care will account for 19.5 percent of GDP (CMS, 2007: 1). Current spending levels for the United States are roughly double the average for other Organization for Economic Cooperation and Development (OECD) countries, and several countries (for example, the United Kingdom, Holland, Denmark, Japan) enjoy significantly better medical outcomes spending less than half as much.

Health-care economists, in their attempts to explain how America spends so much compared with others yet fares worse in medical terms and leaves roughly 16 percent of the population without health insurance coverage, pay little attention to the possibility that fraud contributes substantially to these costs. Scandals abound in which a person or business is discovered to have stolen millions of dollars from health insurers without supplying any legitimate medical care at all. Nevertheless, reliable data regarding the underlying extent of the problem does not exist. Each scandal can be interpreted as evidence of "a few bad apples, thankfully detected, amidst an otherwise sound system," or as "the tip of an invisible iceberg." Each stakeholder group can choose whichever interpretation it prefers, and the majority prefer *not* to consider the possibility that the integrity of major public programs—such as Medicare and Medicaid, each of which now consume more than $400 billion in public funds each year—has been severely undermined by criminal enterprise.

STRUCTURAL FEATURES OF THE U.S. HEALTH SYSTEM

The financial and operational structure of any given health-care system profoundly affects the types of fraud liable to emerge within it.

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Transparency International's *Global Corruption Report* for 2006, focusing on corruption in health care, presents a wonderfully broad survey of health-system structures worldwide, and the distinctive patterns of corruption that emerge within them (Transparency International, 2006).

The following structural features of the American system help to account for the distinctive nature of the major fraud types that appear here:

- Fee-for-Service structure: Reimbursement for medical providers is mostly on a fee-for-service basis. Bills are presented to insurers by health-care providers, their staff, or billing agents; and the veracity of these claims is generally assumed, in the absence of any obvious indication to the contrary.
- Private-Sector Involvement: Private-sector entities provide the majority of health-care services. The insurers can be for profit, not for profit, or public. Purchasers of health-care insurance can be individuals, corporations, unions, associations, or public entities. For the majority of working Americans, the purchaser of their health-care insurance (that is, their employer), their insurance company, and their health-service providers are all nongovernmental entities.
- Highly Automated Claims-Processing Systems: The majority of health-care claims are now submitted electronically and processed automatically by computerized, rule-based systems. If the claims satisfy the criteria encapsulated within the *edits and audits* built into the system, then automatic payment follows, generally without any human involvement. Most claims paid, therefore, are not subject to any human scrutiny.
- Processing Accuracy Emphasized Over Verification: Claims-processing systems, designed with honest but possibly overworked and error-prone physicians in mind, do little or nothing to check that services billed were actually provided, or necessary, or that patients' diagnoses are genuine. Controls serve to ensure that claims are presented correctly and processed accurately: rule-based software checks that the prices charged are within appropriate

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limits, that the treatments lie within the bounds of policy coverage, and that the combinations of diagnoses and procedure codes represent orthodox medical practice. The implications for fraud perpetrators, who may choose to submit claims that are totally unwarranted or fictitious, is that they must take great care to submit their bogus claims *correctly*. Provided they learn to make the claims appear normal, then they remain free to lie. They can fabricate entire medical episodes and submit the resulting bills without the patient's knowledge.

- Postpayment Audits Focus on Medical Appropriateness, Not Truthfulness: A small proportion of claims paid may be selected later by insurers for *postpayment utilization review* (PPUR). Fraud perpetrators can generally beat such audits by taking the simple precaution of fabricating medical records to match their fictitious claims. Prevailing audit practices at the PPUR stage involve mailing requests for copies of the relevant medical record to providers. A medical record, once received, is then reviewed and compared with the claim or claims it is supposed to justify. Providers have plenty of time (typically 90 days) to prepare and provide such medical documentation, and the subsequent "desk-audit" accepts the documents provided as true, and uses them primarily to test the orthodoxy and appropriateness of the provider's treatment patterns. Fraud perpetrators subject to such reviews may therefore be required to lie twice, and consistently, in order to pass these audits. All but the least sophisticated perpetrators routinely generate matching medical records at the same time they produce their fraudulent claims, just in case anyone ever asks to see them.

The predominant forms of fraud, given this combination of factors, consist of overprovision of services based on false or exaggerated diagnoses, and billing for services that were not actually provided. Claims involving some material misstatement or deception are broadly termed *false claims*. The deception may relate to the diagnosis for the patient, or to the treatments provided, or both. Diagnoses and proce-

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dures may be exaggerated (which is called "upcoding"), or totally fictitious. The false claims problem remains the most blatant, extensive, and poorly controlled fraud issue within the health system.

The false claims problem is not the only fraud problem, of course. In the last five years significant attention has been paid to the behavior of pharmaceutical companies—in particular, to aggressive and deceptive advertising practices, off-label promotion of drugs (promoting uses not approved by the Food and Drug Administration), price manipulation, and improper "detailing" techniques (offering illegal inducements for physicians to prescribe specific drugs).

Alternate financial structures have also been introduced within the health industry that fundamentally alter the prevailing incentives, and thus alter the types of fraud liable to appear. Managed care programs that involve *capitated payments* reimburse providers a fixed amount per patient per month, regardless of the level of service the patient consumes. Managed care organizations, receiving capitation payments, therefore acquire an incentive to deny services, or underprovide, rather than to overuse or overbill. When managed care gained a substantial foothold in the industry, many officials believed it would "structurally eliminate fraud." In fact, what happened—given that as the structure changed many of the same bad actors remained in place—was that those inclined to cheat and steal quickly adapted to the new incentives. Fraud, under managed care, involves denial of services, substandard care, and construction of a daunting array of logistical and administrative obstacles for patients to navigate in order to be served. The resulting patterns of abuse involve diversion of resources away from frontline health-care delivery, and bring serious consequences for patients' health, sometimes death. Within the managed-care arena, as fraud became more dangerous to patient health, it also became harder to detect and to prosecute. (Sparrow, 2000: 98-113)

The advance of managed care has slowed somewhat over the last five years, and even slipped into reverse in parts of the country. In 2008, fee-for-service payments still account for the majority of health-

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care spending within the United States, and the false claims problem remains the most pressing uncontrolled fraud issue.

The majority of cases brought against major corporations involve false claims of one kind or another, and most are revealed through the actions of whistleblowers rather than the operation of routine detection systems. Most whistleblowers are employees of the offending company, and thus well placed to report the business policies and practices at issue. Over the last decade, the *qui tam* provisions of the federal False Claims Act have emerge as a principal tool in the government's efforts to protect public programs from fraud. In 1986 the federal False Claims Act amended the original civil war version of the act to extend its reach beyond defense procurement fraud and into the health care arena. Health-care cases now routinely dominate the caseload of *qui tam* (or whistleblower) suits filed with the Department of Justice under the False Claims Act. There is apparently no other area of federal spending so vulnerable to fraud, and so deeply infected.

UNDERLYING CHARACTERISTICS OF THE HEALTH CARE FRAUD PROBLEM

Putting aside the particularities of the American setting for a moment, health-care fraud more generally exhibits several properties, some generic to white-collar crime and some particular to the health-care setting, which complicate the task of controlling the risk. The combination of these several properties makes health-care fraud an extraordinarily intractable problem, and may help account for its persistence and scale.

Invisible by Nature

Well-designed fraud schemes remain invisible in perpetuity, and hence the underlying scope of the problem remains unknown. The class of invisible risks is familiar within the field of criminology, and includes a range of problems that generally pass undetected, or unreported, or seriously underreported. White-collar crime and corruption generally fall in this category, as do consensual crimes such as drug-dealing,

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bribery, illegal gambling, and prostitution; also underreported crimes such as domestic violence, date rape, and child abuse (Sparrow, 2008: 181-198).

The task of controlling such invisible problems is complicated by the underlying uncertainty about the pervasiveness of problem, and about the ways in which it might or might not be concentrated. Authorities' knowledge of the issue derives from the small proportion of cases detected or reported, and investments in control are pegged to the magnitude of this visible sliver. Low levels of investment result in continuing low levels of detection, which provide false assurance through a paucity of cases. Underinvestment in the control enterprise becomes a circular trap, perpetuating itself. For invisible problems, significant underinvestment remains the norm. Targeting may also suffer from circularity, as authorities pay more attention to areas in which they have found cases before. In their efforts to understand the underlying problem, control strategies rely too much on the few cases that come to light, not realizing that these may represent a small and biased subset of the underlying issue, largely influenced by *where* and *how* they have looked for it in the past.

Available metrics—such as the number of cases detected, or volume of claims denied, or total value of settlements obtained—are all ambiguous too. If the level of detected fraud doubles, this could mean detection has improved or that the fraud situation had deteriorated dramatically. In the absence of measures unambiguously reflecting the underlying level of the problem, changes in the readily available metrics remain open to diverse interpretations.

In relation to insurance fraud, reliable metrics can be obtained. Standard measurement techniques demand rigorous audit of a random or representative sample of claims, followed by extrapolation of the sample's overpayment rates to the universe of transactions. Some forms of overpayment are easier to discover than others. Errors—either committed by the submitter or by the processing operation—are generally easier to detect than fraud. To be useful as a fraud-measurement tool, audit protocols used on such a sample must be rigorous enough to

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uncover all the known types of fraud, and preferably thorough enough to reveal novel forms as well.

Few attempts have been made within the health-care field to generate any reliable estimates of fraud-loss rates. Several studies have been conducted to measure "error rates" or "overpayment rates" within various programs; but the audit protocols involved are generally too weak to uncover most types of fraud—even the familiar types.

Best known, perhaps, have been the "Medicare Overpayment Rate" studies, conducted by the Office of Inspector General (OIG) (for the Department of Health and Human Services) from fiscal year (FY) 1996 through FY 2002. These involved statistical valid samples of recently paid claims in the Medicare program (a federally operated program covering beneficiaries who are either over 65 years old, chronically disabled, or suffering from end-state renal disease—that is, dialysis patients). The OIG studies employed an audit protocol resembling a typical postpayment utilization review. These desk-based audits did not involve any face-to-face contact with providers, no contact at all with the majority of patients, and medical records mailed in by providers were assumed to be truthful. Thus the overpayments detected by the studies would not have included the majority of fraud losses, except for those cases where a fraudulent provider refused to mail in supporting (and suitably fabricated) medical records. Nevertheless, the first of these OIG studies, reported in 1997, showed an overpayment rate of 14 percent, equivalent to $23 billion in annual losses from the Medicare program. These findings shocked Congress, and the nation. In subsequent years, the measured overpayment rates came down (see table 1), providing some comfort for alarmed taxpayers.

These figures provided the basis for the Clinton administration's claim (which left office at the end of 2000) that it had correctly identified health-care fraud as a problem, and had cut the problem in half during its time in office. But the weakness of the audit protocols employed in these studies make available a range of other plausible explanations for the observed decline:

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Table 1. Medicare Overpayment Rates (by Fiscal Year)

Financial Year	Point Estimate	Extrapolated Loss Rate
1996	14%	$23.2 billion
1997	11%	$20.3 billion
1998	7.1%	$12.6 billion
1999	7.97%	$13.5 billion
2000	6.8%	$11.9 billion
2001	6.3%	$12.1 billion
2002	6.3%	$13.3 billion

Note: Figures reported annually by the Office of the Inspector General, Department of Health and Human Services.

a) the overpayments captured consisted mostly of processing and documentation errors, and increased automation of the claims process naturally reduced these categories of errors over time.

b) fraud perpetrators who happened to be caught in these samples learned, over time, that if they did *lie twice*—by supplying a fabricated medical record to match the fabricated claims—then the authorities would make no further inquiry into the matter and deem the claim payment "correct." So their initial reluctance to send in fabricated medical records (reflected in low response rates at the outset) diminished over time as they became more familiar with the limited extent of the audit.

Early in 2000, the General Accounting Office (GAO) was asked by the congressional House Budget Committee to examine the methodology the OIG had been using to estimate Medicare overpayment rates. In a letter to the committee chairman, Representative John R. Kasich, the GAO reported:

> Overall, our work shows that because the methodology was not intended to detect all fraudulent schemes such as kickbacks, and false claims for services not provided, the estimated improper payments of $12.6 billion would have been greater. How much greater, no one knows. . . .

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> It was not designed to identify or measure the full extent of levels of fraud and abuse in the Medicare program. The HHS OIG testified [in July, 1997] that the estimate of improper payments did not take into consideration numerous kinds of outright fraud such as "phony records" or kickback schemes. The methodology assumes that all medical records received for review represent actual services provided (GAO, 2000).

Despite the clear admission that these studies did not capture most forms of fraud, and in particular would not capture false claims, which are the most obvious and central form of fraud, the OIG continued to use the same audit protocols in subsequent years. The OIG argued that it had to employ the same methodology year after year in order to make the results comparable, and for any trends observed to be meaningful.

In January 2003 the OIG discontinued the Medicare overpayment measurement program, asking the Medicare agency itself to run an equivalent annual study. The Centers for Medicare and Medicaid Services (CMS) continues to use weak audit methodology in its Claims Error Rate Testing (CERT) program, and hence nobody has any reliable indication of overall fraud loss rates for the Medicare program.

Medicaid programs (which serve the poor and are administered by the states rather than by the federal government) display greater variability in policies and procedures than the centrally administered Medicare program. Several states have designed and conducted Medicaid overpayment measurement studies in recent years, similar in character to the Medicare studies. In general, these tend to use valid sampling techniques, but fairly weak audit protocols. The federal government, through its Payment Accuracy Measurement project (CMS, 2004), has sought to encourage broader use of loss-measurement by state Medicaid agencies, but does not push the states to use the kind of rigor necessary to capture fraud.

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One might imagine that private sector insurers, driven by their bottom-line and fiduciary responsibility to shareholders, would do a much better job of exposing and dealing with fraud than their public and not-for-profit counterparts. In fact, private insurers almost *never* conduct valid loss-rate studies. They defend this particular omission with a set of familiar arguments as to why measurement is either impossible (and therefore should not be attempted), or undesirable. The most frequent justifications given for this failure are as follows:

- Rigorous audits on a random basis are fundamentally unfair, and not an appropriate way to treat medical providers.
- We do not have the time or the money to waste conducting "academic" research.
- All available audit and investigative resources are consumed following leads, and it would be irresponsible to impede the progress of investigations by diverting resources.
- We get better return on investment focusing all of our audits on known high-risk areas and high-risk players. It is wasteful to apply such techniques on a random basis.
- No audit protocol could possibly capture all the possible types of fraud, and therefore it is impossible in any case to measure fraud in any reliable way.
- Fraud involves a state of mind and requires criminal intent. No study could ever determine that.

The antidote to all such arguments, of course, lies in the potential value of the information that rigorous measurement studies might produce. Reliable information about loss rates would give authorities the chance to resolve the otherwise persistent ambiguity about the scope and nature of the problem. Such information could lead in turn to the possibility that investments in control might be pegged in some more sensible way to scientifically or statistically valid estimates of fraud losses.

For any *invisible* problem, effective control begins with valid measurement. For health-care fraud, control breaks down at this very

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first hurdle. No one knows quite how bad the situation has become, and industry practices seems to reflect a broad reluctance to find out. Exposing the scale of the problem, after all, might involve a dose of very bad news; and news of major breaches in the integrity of health programs tends to alarm shareholders, drive down stock prices, reveal past failures, and alarm the public.

Conscious Opponents

Fraud also belongs within the class of risks that involve conscious opposition: risks that have a *brain* behind them. Many classes of risk, such as occupational and transportation hazards, as well as most environmental threats, do not have a brain, as such, behind them; and thus these risks do not exhibit adaptive behavior designed to circumnavigate control initiatives or enhancements. Eliminate a specific occupational hazard, for instance, and it does not go searching for another way to kill you.

In this regard, fraud perpetrators belong more naturally with drug smugglers, terrorists, computer hackers, and thieves. Such groups constantly study the relevant defenses, adapt quickly to changes in those defenses, and thrive on novelty and surprise.

The presence of adaptive opposition complicates the challenge of control. The controllers must engage in a game of intelligence and counterintelligence. They must take pains to learn what the opposition is thinking, or what they *might* be thinking. They must respond quickly to the opponents' initiatives, and hassle them out of the fray by forcing them to adapt often. They must seek out and exploit specific vulnerabilities of the opponents' strategies, using such points of vulnerability as resource-efficient opportunities to sabotage their enterprise. They must retain an air of mystery and unpredictability, and vary their detection methods so the opposition can never be sure where, or how, they are looking (Sparrow, 2008: 199-216).

One does not often hear health-care authorities speaking this language, or thinking in these ways. Claims-payment systems, by design, are utterly predictable and transparent. If a claim for payment

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is denied, helpful computer-generated explanatory notices explain the reasons for the denial so that the claim submitter can get it right next time. Everything is geared toward the honest physician, possibly error-prone, but basically well intentioned. The result, from the perspective of fraud perpetrators, is a target that exhibits all of their favorite qualities: it pays fast, because it is required to by law. It is perfectly predictable (so if it pays one claim without a hiccup, then it will reliably pay 10,000 similar claims for other patients exactly the same way). If a fraud perpetrator bills "incorrectly" and receives a denial, then the system explains the mistake and teaches how to fix it. And even when the system denies a lot of claims from one provider, it does not become suspicious. Provided the claims submitted are fashioned to reflect medical orthodoxy, then there is very little risk of encountering a human being at all, let alone a criminal investigator.

Health industry practices tend to miss or underestimate the significance of the fact that they confront opponents, sometimes quite sophisticated ones. Insurers place too much trust in the latest and most comprehensive rule-based software packages, imagining that once they have put these in place, their system is properly protected. They underestimate the extent to which the opposition immediately begins testing and trying the new controls, and just how quickly they will determine its parameters and locate its vulnerabilities.

Postpayment claims review operations similarly undervalue any broad or exploratory casting-about by which they might discover emergent problems never seen before. Instead, like fishermen of habit, they fish in the same waters day after day and month after month, because that is where they have caught fish before. One known high-risk area can dominate their thinking and consume their time to such an extent that authorities can remain completely oblivious of entirely new patterns of fraud, which can therefore grow to significant proportions within other industry segments completely out of sight.

The health industry, in addressing fraud, confronts conscious and adaptive opposition, with the following implications:

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- Historical experience provides unreliable guidance in identifying risk areas for the present and for the future. Those responsible for fraud control should expect and anticipate novelty from the opposition, and they must design analytic, audit, and investigative strategies with that in mind.
- Fraud controls should include routine use of intelligence-gathering techniques such as surveillance, undercover shopping for medical services, development of informants within corrupt networks, and making deals with convicted perpetrators in exchange for information and intelligence about fraudulent practices.
- Insurers and investigators should incorporate a counterintelligence mindset in their control operations, concealing parts of their detection capabilities, altering thresholds and focus areas constantly, and incorporating degrees of randomness and unpredictability so their methods cannot be reverse-engineered by the opposition.
- Those operating automated claims-processing systems should place less faith in state-of-the-art, but static, rule-based systems and software packages. Instead, they should invest in analytic versatility, and stress nimbleness and rapid response to emerging patterns. Rather than technology-driven control systems, they should develop human-driven, but technically sophisticated, *intelligence* operations.

It takes committed fraud perpetrators at most a few weeks to fathom the nature of new controls, and to redesign their scams accordingly. It takes at most a few months for these newly adapted fraud methods to spread across the country. But it can take authorities *years* to make the legislative, policy, or system changes necessary to suppress specific fraud threats. Health-care payment systems, as targets for fraud, are not only fat and rich, but tend to be *very* slow moving indeed.

Risk Control in a Hostile Setting

Risk control, and crime control in particular, is easier to do when the control function lies within an agency set up to do precisely that. But

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when risk control functions appear as ancillary or peripheral to an organization's core enterprise, then those responsible for control may find the general culture and assumptions of the organization somewhat at odds with, or even hostile to, their purposes and methods. Classic examples of such cultural discomfort include the task of providing security in an academic environment, or controlling embezzlement within a charitable organization, or dealing with the risk of child or sexual abuse within a religious community. The prevailing organizational assumptions of trust, and the preference for guidance as the primary method for influencing behaviors, often seem at odds with the less charitable assumptions and harsher methods required for effective crime control.

The core task of health-care systems is to deliver health care, not to carry out fraud control. The crime control imperative comes along later as an uninvited guest, and the rest of the system would rather not hear about it, or hear from it, at all. The awkwardness of the fraud control setting is particularly acute within the health-care industry, for a variety of reasons.

First, insurance companies and government health programs do not generally engender much sympathy as victims of fraud. Their own conduct (for example, in relation to the payment of legitimate claims), often criticized as substandard or unethical, makes defrauding them seem more socially acceptable. Segments of the public view stealing from insurers as a natural form of revenge, either against ruthless and heartless businesses, or against wasteful, inefficient, or incompetent government agencies. Of course, the view that fraud actually hurts the insurers misses the point that—assuming the fraud remains invisible, and the insurers can therefore pass on the cost to those who pay premiums—the real victims of fraud turn out to be the patients, subscribers, and taxpayers.

Second, society holds medical practitioners in high esteem, recognizing the rigor and intensity of their training. Professional judgments made by physicians cannot generally be critiqued, except by another qualified physician. Medical associations fight vigorously

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to prevent their members' judgments from being assessed or second-guessed by anyone else on administrative or financial grounds. And if by chance fraud investigators should come sniffing around, medical professionals tend to adopt a haughty position, pointing out that these investigators have no medical training and are therefore not qualified to understand, or render judgments about, diagnostic or treatment decisions. Investigators frequently encounter medical practitioners as arrogant and condescending, counting on their professional status to afford them protection or immunity. Even when investigators persist and make their case, prosecutors may be reluctant to pursue cases that rely in any material way on questions of medical appropriateness or necessity.

Third, medical professionals display an extraordinary reluctance to condemn the most egregious acts of their peers. Even when a physician or other provider is convicted of outright criminal fraud, and even when their actions have had profound adverse consequences for patients' health, their professional associations scarcely ever speak out against their conduct. One has to wonder why it would not be in the interests of the profession, and professional associations, to step forward and explain to the public, quite deliberately, that this person was genuinely one bad apple, and that the rest of this profession abhors what they did. But this almost never happens.

One plausible explanation for this failure relates to the range of possible malfeasance. The spectrum of misbehaviors available to medical providers is rather long, continuous, and not easily divided. At one end lie minor forms of code manipulation designed to compensate for unfairly low reimbursement levels; or a little diagnosis-substitution for the sake of the patient, so that treatments required can be covered by the insurance policy. Such actions contravene the rules but seem to have some plausible social justification. At the other end of the spectrum lie unambiguous, even rapacious, fraud scams that may leave in their wake a trail of victims. The difficulty, if anyone in the profession wants to condemn anything at all, lies in drawing satisfactory dividing lines between what the *criminals* did, and what *they* do, or might do someday.

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The fuzziness of the lines between fraud, abuse, waste, overutilization, helping patients circumnavigate unfair policy restrictions, and differences of opinion about medical orthodoxy make it dangerous for the medical profession to condemn anything. Who can tell where such condemnation, once mobilized, might end? Keeping quiet, or emphasizing the extraordinary difficulties under which medical professionals labor, is a much more comfortable course. As a result, those engaged in the fraud control task end up convinced that the entire industry opposes them, despises them, and has no interest in fraud control.

Fourth, societal trust in physicians extends, by association, to a broad range of ancillary provider groups not subject to the same rigor in training and not bound by stringent codes of professional ethics. Investigators see medical equipment suppliers, home health agencies, medical transportation companies, behavioral health clinics and billing agencies as businesses, run by businessmen, for profit. They regret society's assumptions—based purely on the fact that these groups operate within the health industry—that such businesses could or should be trusted to subvert their own private economic incentives to any higher-level professional or ethical obligations. Nevertheless, major payment systems within the industry treat such groups in basically the same way as physicians, accepting the claims they submit as true, and paying them on trust without any routine validation that the services billed were necessary or were actually provided.

Fifth, highly automated claims-processing environments emphasize efficiency and timeliness, not caution and risk control. The responsibilities for processing efficiency and for fraud control lie with different officials, and within different organizational departments. Culturally, the two purposes seem at odds. Process management focuses on the administrative cost of processing a massive volume of claims, and doing so in a timely manner. Fraud control is more interested in finding and examining exceptions, and holding payments up where necessary to reduce the organization's exposure.

One might imagine that the simple concept of *return on investment*, applied to investments in caution and scrutiny, would adequately

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instruct health insurers how best to integrate these two competing imperatives. Typically, every dollar spent on protecting the integrity of the system pays off handsomely, saving $10 or more in terms of funds paid out. So why do investments in control not escalate naturally to the optimal level (at which the marginal dollar spent on control returns just one additional dollar in savings or recoveries)? The answer is both legal and organizational. Seldom is one official in a position to consider the return-on-investment equation. Officials are responsible for one thing or the other, and each official—with his or her own metrics and motivations—gets in the way of the other. But processing efficiency always wins, because of the massive volumes and visible embarrassment to the organization if the system does not keep up. Moreover, savings from gains in processing efficiency are visible, concrete, calculable, and certain. By contrast, savings from fraud detection or fraud reductions, given the invisible nature of the problem, are uncertain, highly ambiguous, and cannot be guaranteed, even though they could potentially be much larger.

In the case of Medicare, the funds being paid out are actually legally distinct from the administrative costs of paying them. The payments themselves come from the Medicare Trust Fund, whereas the processing costs are drawn from general tax revenues. This legal separation makes it virtually impossible to set control investments at an appropriate level. Fraud control costs, rather than being weighed against reductions in fraud losses, form part of a zero-sum game with other administrative functions (for example, handling beneficiary enrollment, queries, complaints), all of which are completely inescapable, and all of which draw on the same general pool of administrative costs.

Even where there is no *legal* separation between claims expense and processing expense, organizational divisions of labor seem to produce the same dysfunction. Fraud control functions lose out in terms of budget, and in terms of influence over operational policies. Culturally, in a highly-automated and massive-volume environment, fraud control is just a nuisance.

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All of these factors exacerbate the cultural hostility to the fraud control function. Fraud investigators and analysts often express the frustration that even their own bosses behave as if they would rather not hear from them. Senior executives prefer no mention of fraud, because they do not know much about it, they have not been trained how to think about controlling it, and any fraud issue or case that does pop up gets in the way of an otherwise smoothly functioning business model and embarrasses the enterprise. Fraud control becomes a miserable task, unappreciated, stressful, and loaded with organizational tension. Those responsible for fraud control soon learn that, when it comes to fraud at least, no news is good news.

CRITICAL FAILURES OF CONTROL: THE MACHINERY

An examination of the machinery trusted by the health-care industry to control fraud shows it to be profoundly inadequate for the task (Sparrow, 2000: 162-182). Claims-processing systems incorporate extensive suites of rule-based checks (edits and audits) to make sure services have been billed correctly, priced reasonably, and fall within the bounds of medical orthodoxy and policy coverage; but these systems do nothing to verify truthfulness. Prepayment medical review, conducted by nurses or claim specialists, provides an opportunity for examination of selected claims in much greater detail, and by a person—but the claims for review are those picked out of the processing stream by the computerized edits and audits. So, if a fraud perpetrator learns to bill correctly and thereby beats the edits and audits, then their claims effectively bypass any chance of human inspection, and will be paid.

Postpayment utilization review provides an opportunity, later, for the aggregate billing patterns for any particular provider to be compared with their peers. Aggregate billing patterns that deviate from statistical norms for any one specialty, once observed, may trigger a broader audit of that provider's practice and billing behavior. The auditor will draw a sample of the selected provider's recently paid claims, and ask the provider—by sending them a request in the mail—to provide medical records and other relevant documentation (for exam-

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ple, test results) to support the claims. Postpayment utilization review does sometimes uncover fraud, but seldom. The PPUR function is more focused on medical orthodoxy and appropriateness; and the audit methods are quite trusting. Providers are typically given up to 90 days to supply the necessary documents, and what they supply is assumed to be genuine. If the documents match the claims, the provider will most likely pass the audit. If the provider fails to provide documentation, or provides inadequate documentation, then those particular claims may be reversed, and the payments adjusted. If the provider shows a pattern of poor documentation, most often they will be "educated" about the need for proper documentation in the future.

Perpetrators of outright criminal fraud do not much fear PPUR for a number of reasons. First, they know that PPUR only detects fraud where fraud produces anomalous billing profiles. If fraud perpetrators fashion fake billing schemes to mirror legitimate billing patterns, then PPUR will never find them. Second, PPUR units are very small, and can only pay attention to a few industry segments at a time. They look mostly where they have looked before, or where the last scandal was. Novel scams are liable to remain completely outside of PPUR's sights, and for a good long time. Third, when PPUR does examine a particular industry segment, it will select only the extreme outliers for audit. Fraud perpetrators can fashion their schemes to avoid these statistical tails, and so stay out of sight. Fourth, even when PPUR does find an anomalous billing pattern, it tends to employ soft and friendly methods, providing guidance and instruction to providers on how to correct their billing behaviors for the future. Fifth, PPUR works long after the fact, from 6 to 18 months after claims have been paid. Fraud schemes can net millions of dollars within such a window, and the operators can shut down and shift to alternate provider numbers as soon as anyone starts asking questions.

The remaining piece of a health insurer's fraud-control apparatus is the Special Investigative Unit (SIU). Most insurance markets require the existence of such units, but do not require any specific performance from them. SIUs employ former police and other investigators, and

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are therefore more fraud aware than the rest of the organization. SIUs, however, are tiny; and most of them sit passively on the end of fraud-referral systems. The referral systems from which they get their work (consisting of the other parts of the organization) are not focused on fraud, and therefore the levels of fraud detected and referred to SIUs remain extremely low. SIUs may apply professional investigative skills in a case-disposition mode, but generally do not engage in intelligence work or use investigative field craft to monitor for emerging fraud patterns and to diagnose fraud concentrations or patterns. The performance metrics for SIUs include cases opened and closed, and dollars recovered or settlements obtained as a result of specific investigations. They do not generally include anything relating to *fraud problems identified and suppressed* and their contribution to effective fraud risk-control is diminished by their reactive and case-based stance.

The health-care industry generally relies on these four standard pieces of apparatus—the edits and audits, prepayment medical review, postpayment utilization review, and special investigative units—to provide protection against fraud. What this set of functions manages to accomplish, given the typical resource levels and configuration, is to provide reasonably good protection against *seeing* fraud. Fraud perpetrators with any degree of sophistication at all can easily remain out of sight.

Critical Failures of Control: The Mindset

Even while fraud control *machinery* remains inadequate, one might hold out hope for better control in the future if the fraud control *mindset* were in good shape. If authorities understood what was needed, and knew how to make the case for it, then surely the situation would improve over time. Sadly, there is plenty of evidence that even those officials and organizations most critically placed to address health-care fraud still fail to grasp the nature of the beast, and hence fail to wrestle with it effectively.

The last 10 years has seen an extraordinary series of reports produced by the Office of Inspector General for the Department of

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Health and Human Services. The OIG is responsible for overseeing all of the federally funded programs that DHHS operates. These include the two largest public health care programs: Medicare (for the elderly) and Medicaid (for the poor). Medicare, being federally administered, receives the most scrutiny at the national level. Medicaid is funded through a combination of federal and state expenditures, and is administered by state agencies. The OIG is the primary agency responsible for overseeing the integrity of the Medicare program, and shares oversight of Medicaid programs with other state-level authorities. But both of these programs now cost more than $400 billion per year, and so there is a great deal of public concern about the need to protect the funds flowing through these programs.

According to OIG reports, several different categories of patients, none of whom should be getting treatment under these programs, have been showing up in significant numbers within paid Medicare and Medicaid claims. The most obvious embarrassment involves treatments apparently rendered to patients who were already dead on the date of treatment. In March 2000, the OIG published its investigation into provision of medical services to Medicare beneficiaries after their dates of death. The OIG audit methodology was straightforward enough: obtain up-to-date records of death from the Social Security Administration, and search the paid Medicare claims files for services delivered after death. They quickly found $20.6 million in such claims, paid in 1997 (OIG, 2000: 1). For some of these claims there was a plausible "error" story: the rental for a wheelchair or a series of monthly capitation payments had not been stopped when the patient died, and hence payments after death continued when they should have been shut off. But these cases represented a small minority, and can easily be filtered out of the analysis. A significant volume of the claims showed *new* treatments beginning for a patient, more than a month after they had died.

Dead patients also showed up in Medicaid claims around the country. An OIG report in 2006 summarized findings from 10 different states, revealing $27.3 million in Medicaid payments for services after death (OIG, 2006: 3).

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Other patient groups that also should not show up in paid claims, but apparently do so remarkably often, include patients who have previously been deported, and which US Citizenship and Immigration Services (CIS) records show had been banished from the country prior to the reported treatment dates, and prohibited from returning. How did these patients manage to receive their treatments here within the United States, and at public expense? In March 2002, the OIG reported finding 43 deported Medicare beneficiaries for whom fee-for-service claims had been received and paid after the recorded date of deportation (OIG, 2002(a): 1-2).

Similarly, patients who are incarcerated generally ought not to show up in Medicare and Medicaid paid claims. Health care for prisoners is provided through prison systems, not by Medicaid or Medicare. There are a few specific exceptions to this general rule, relating to hospital and other treatments delivered outside the prisons. The OIG has conducted investigations into both Medicare payments (OIG, 2002(c)) and Medicaid payments (OIG, 2002(b)) apparently made "in error" for patients in prison.

All of these reports from the Office of Inspector General basically follow the same logic. They point out that the requisite data about deaths, deportations, and incarcerations is available somewhere within government; therefore the Medicare and Medicaid programs can and should do a better job of obtaining it from the relevant agency in a timely fashion, and incorporate it into the claims processing edits and audits, so that such claims could be rejected up front by the payment system.

This approach typifies the prevailing government view that overpayments in health care systems represent processing errors. The cure, once an overpayment problem comes to light, is to fix the process. The OIG seems to understand that such claims—for which there can be no legitimate explanation—should not be paid; but they do not seem to understand that such claims ought never to be generated and submitted in the first place. The obvious question, for any astute observer, would surely be "How on earth did these claims get generated? What type of business practice produces such nonsense?" The most striking feature

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of the OIG reports on each of these categories of implausible claims is that they pay no serious attention to these questions. They focus on claims *payment*, not on claims *production*. They assume the problem, and therefore the solution, lies within government's technology, policies, and processes. None of these reports treat seriously the possibility that these claims result from fraudulent billing practices.

In July 2008, another group came to light, adding to Medicare's public embarrassment. The Senate Permanent Subcommittee on Investigations revealed the presence of *dead doctors* within Medicare's paid claims. The subcommittee's investigation revealed that from 2000 and 2007 between $60 million and $92 million was paid for medical services or equipment that had been ordered or prescribed by dead doctors. In many cases, the doctors had been dead for more than 10 years on the date they supposedly ordered or authorized treatments (US Senate, 2008: 1-5).

In testimony before the Senate subcommittee, the OIG presented its analysis and recommendations on the dead doctors problem. The recommendations followed the same formulaic approach they developed for dead patients, deportees, and prisoners. Medicare should fix the processing system, they propose, so that up-to-date information about the status of each Unique Physician Identification Number (UPIN) is properly available to the claims-processing system, and Medicare's processing contractors can bounce back any claims that do not have a valid UPIN in the authorization field (Vito, 2008: 5-13).

While the OIG focuses on process improvement, the scandals all around the country are about fraud. The media provide a steady stream of stories about one petty crook, or group, who—without ever seeing a patient or providing any valid medical services at all—managed to bill Medicare or Medicaid, or some other health insurer, millions of dollars. We know from these cases that fake billing scams exist since they sometimes come to light. When claims are submitted, and they involve dead doctors or dead patients or some other feature that renders them obviously false, the most obvious explanation (if only someone would ask how they could have been generated) is that these claims arise as a by-product of fake billing scams. To understand why the authorities'

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response to these billing issues is inadequate, even dangerous, one has to briefly contemplate what life looks like on the other side of the fence.

Let us imagine that these claims have actually been produced by Billy, the crook. Like so many others queuing up to attack the health-care industry's massive payment systems, Billy's goal is to steal as much as he can, as fast as possible. Billy pays a nominal fee to sign up as a Medicare provider himself, or infiltrates a billing service that submits claims on behalf of others. In order to bill Medicare, Billy does not need to see any patients. He only needs a computer, some billing software to help match diagnoses to procedures, and some lists. He buys on the blackmarket lists of Medicare or Medicaid patient IDs. If he wants to bill for services that require a prescription or authorization, he will also need to buy, steal, or otherwise obtain lists of physician numbers (UPINs) to enter on the electronic claims forms.

Billy is actually vulnerable because his lists are not entirely "clean." They contain just a few cases, probably no more than one in a hundred, of doctors or patients who are dead, deported, or incarcerated. The older the lists, the less clean they will be, as more of the patients will have had a chance to die or get deported or imprisoned, and more of the doctors will have retired, moved away, or died themselves. The impurities on Billy's lists are a problem for him, because they provide the authorities some chance to detect his false-claims scheme. The obvious implausibility of these claims, apparent if only the government had the right data in hand, provides an opportunity for the authorities to detect Billy's scam. Hence, unsure about the "cleanness" of his lists, Billy would pay a lot to know which patients' and doctors' numbers not to use, so as to avoid detection.

Now consider the standard government response to these various billing anomalies. In particular, what do the OIG's proposals mean for a fraud perpetrator like Billy? If the Medicare and Medicaid programs perfect their prepayment edits, and operate them as recommended, then Billy will receive computer-generated auto-rejection notices for the very small fraction of his claims that are obviously implausible. If he happened to use the identity of a dead patient, the

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computer-generated notice he gets back from Medicare will politely inform him: "Medicare rejected this claim because, according to government records, this patient died prior to the date of service." The other 99 percent of Billy's claims, not involving any such detectable aberrances, will all be paid. From Billy's viewpoint, life is good. Government programs, with their emphasis on process-management, help him "scrub" his lists, making his fake billing scam more robust and less detectable over time. At the same time, the government pays all of his other claims without blinking an eye, and does not become the least bit suspicious.

In relation to the dead doctors problem, the OIG also recommends that the Medicare program, through its contractors, "educate providers" about the importance of using valid physician numbers on their claims. Dedicated fraud perpetrators like Billy will be diligent and grateful students. They are quite eager to perfect their billing practices, and—unlike the legitimate providers who are busy with their patients—they have plenty of time available to incorporate the government's feedback to their advantage.

Even the briefest of glances over this fence puts all of these categories of implausible claims in quite a different light. Rather than *processing errors to be corrected* these claims represent *detection opportunities for massive fake billing scams*. Once you see them in this light, an important question follows: Just how large might these billing scams be? For that, there is no empirical evidence. But one might imagine that the average list of Medicare providers (or patients), available to fraud perpetrators, would typically contain only a few instances of people who were in fact dead, retired, deported, or incarcerated. Suppose these accounted for 1 percent of the list, and that the fake billing scheme used the numbers on the lists evenly. Then one might surmise that the billing scams would likely be 100 times the size of the dead doctor or otherwise implausible claims that these scams would typically generate.

So, while congressional and public concern focuses on the several millions of dollars in obviously implausible claims that are apparently processed and paid in error, the real problem may well be *billions of dollars* in fake billing schemes. The obvious fictions represent impor-

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tant detection opportunities; but they themselves are not the problem, but visible symptoms of it.

Insurers should by all means improve their capacity to detect such obviously implausible claims. Better interagency data exchange can facilitate this. But once such claims become visible, auto-rejection of the obviously bad claims is a feeble response. All assumptions of trust should be dropped immediately. A proper fraud response would do whatever was necessary to rip open and expose the business practices that produce such fictions. Relevant methods include surveillance, arrest, or dawn raids. Computers should be seized, and business practices examined. All other claims from the same source should be put on hold. Whenever a provider submits claims for treatment *of* the dead, or treatment *by* the dead, there is almost no chance that any of their other claims—submitted in the names of the living—are any more valid.

It seems extraordinary, given the long history of health care fraud in the United States, that even the Office of Inspector General, centrally placed to oversee the fight against fraud, displays such an obvious lack of comprehension when it comes to false claims and fake billings. Medicare officials and their overseers fail, like so many others across this industry, to properly distinguish between the imperatives of *process management* and the imperatives of *crime control*. By focusing so heavily on the first, they make life easier and safer for fraud perpetrators. One fundamental truth of the fraud-control business is this: *fraud works best when claims processing works perfectly.*

The health-care industry still acts as if it imagines that process accuracy is the cornerstone of effective fraud control. In fact, process accuracy (with the transparency and predictability it produces) is a large part of what makes health care payment systems such attractive targets for fraud.

ASSESSING FRAUD RISKS: TWO DIAGNOSTIC QUESTIONS

In order to assess the seriousness of different fraud threats—in terms of their potential to undermine the integrity of major public programs—two diagnostic questions turn out to be useful.

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First, is the fraud *invisible by its nature*? Many frauds are not invisible. Credit card frauds, of the type where perpetrators usurp the existing accounts of others, are *visible*. Cardholders will generally notice unauthorized activity on their accounts, because they are being asked to pay, and so have an incentive to check. Most such frauds will be reported, and thus those responsible for controlling the problem at least know how much of it occurs. Of course, they may learn about credit card fraud too late to find the offenders or to prevent the loss, but the system overall sees the problem. As a matter of course, visible problems tend to get controlled, eventually. But *invisible* types of fraud can grow to a significant scale without anyone knowing how much damage is being done. Sophisticated fraud schemes are not only invisible at the time of commission, but remain invisible in perpetuity. Nobody ever knows they happened. Hence the underlying scale of the problem remains unknown.

Second, is there a *business opportunity* in the fraud? This question could be asked another way: Can a small number of dishonest players do a disproportionate amount of damage? Perhaps the patients can cheat too, to some extent. They might overstate their out-of-pocket expenses, or fabricate their own medical episodes while abroad on vacation. But any patient that begins to look too expensive, from the insurer's point of view, will draw scrutiny and be pulled back into line. So any one patient can only cheat so much on his or her own account, and hence the overall economic cost of patient fraud will be constrained by the proportion of dishonest patients.

Medical providers, routinely submitting bills in the names of hundreds or thousands of patients, can certainly ratchet up the volume. Other intermediaries, such as billing services, can spread their fraudulent activities across hundreds of provider accounts as well. Hence a few bad actors, suitably placed, can steal hundreds of millions of dollars. Judging by the nature of the cases that come to light, they often do.

The most dangerous fraud risks are the ones that combine these two qualities: they are both *invisible by nature*, and there is a business opportunity in the fraud itself. The health care industry in the United

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States has constructed payment systems with a perfectly valid set of customer-service values in mind, assuming that the providers it is dealing with are delivering legitimate and necessary medical services, and can be trusted to tell the truth. The systems the industry has constructed, regrettably, turn out to be perfect targets for fraud, and criminal assault against them has run rampant. Unless authorities recognize the true nature of the fraud threat, and substantially increase their effectiveness in exposing and controlling it, there is a very real danger that fraud may end up destroying the integrity and viability of some vitally important public programs.

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