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by Allan P. DeKaye, MBA, FHFMA

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Obama addresses AMA on health care reform

On June 15, 2009, President Barack Obama addressed the Annual Conference of the American Medical Association (AMA) on health care reform. According to President Obama, there is widespread agreement on the steps necessary to make the health care system work better, including (1) upgrading our medical record keeping from a paper to an electronic system, and (2) investing more on preventive care. But as important as these investments are, Obama recognized they are, "... just preliminary steps. They will only make a dent in the epidemic of rising costs in this country."

In an effort to preempt critics of his health care reform proposals, particularly the public option, the President emphasized that the first thing he plans to do is protect what is working in our health care system. As a result, no matter how health care is reformed, Obama promised that if you like your doctor(s) and health care plan you will be able to keep them. "No one will take them away, no matter what. Fix what's broken and build on what works...that's what we intend to do."

Accounting for rising costs. Obama described our health care delivery system as "a system where we spend vast amounts of money on things that aren't necessarily making our people any healthier; a system that automatically equates more expensive care with better care." Obama identified two primary reasons for this. First, we have "a model that rewards the quantity of care rather than the quality of care." The solution requires "reforming the way we compensate our providers." According to Obama, these reforms should include: (1) bundling payments so that doctors are not paid for a single treatment, but for how well they treat the overall disease; (2) creating incentives for doctors to team up to provide care; (3) bonuses for good health outcomes; (4) addressing the rising costs of a medical education; (5) rewarding medical students who choose a career as a primary care doctor; and (6) rewarding doctors who choose to work in underserved areas.

The second structural reform recommended by Obama is improving the quality of medical information making its way to doctors and patients. According to Obama, too many doctors and patients are making decision without the latest research. "Less than one percent of our health care spending goes to examining what treatments are most effective...And even when that information finds its way into journals, it can take up to 17 years to find its way to an exam room or operating table." Obama expressed his support for figuring out what works and encouraging rapid implementation.

Medical malpractice. Obama recognized that it will be hard for doctors to order less tests and treatments if "they're constantly looking over their shoulders for fear of lawsuits." Obama, however, refused to advocate caps on medical malpractice awards, which he personally believes "can be unfair to people who've been wrongfully harmed." Instead, Obama would like "to explore a range of ideas about how to put patient safety

first, how to let doctors focus on practicing medicine, and how to encourage broader use of evidence-based guidelines.”

Health Insurance Exchange. For individuals who don't like their present health care coverage or don't have any insurance at all, the administration is proposing a Health Insurance Exchange, which will provide one-stop shopping from a number of health care plans that offer different packages, benefits and price comparisons between plans, and a chance to choose a plan — the same way federal employees, postal workers, and members of Congress do. The president recognized as “legitimate” the concerns of the AMA that, given today's Medicare rates, the cost savings in the public option will come off the backs of doctors, but he dismissed as “illegitimate” concerns that the exchange option is a Trojan horse for a single-payor system.

Hardship waiver. Because Obama is confident that the public exchange plan will provide insurance at an affordable rate, he is “open to a system where every American bears responsibility for owning health insurance — so long as we provide a hardship waiver for those who still can't afford it as we move towards this system.” This hardship waiver also would apply to employers, according to Obama. “While I believe every business has a responsibility to provide health insurance for its workers, small businesses that can't afford it should receive an exemption.” Under the waiver, small business workers and their families will be able to seek coverage in the exchange if their employer is not able to provide it.

Price tag. Obama conceded that expanding coverage to all Americans will not come without cost. He stated, however, that the costs “will not add to our deficits. I've set down a rule...[that] health care reform must be, and will be, deficit-neutral in the next decade.” He admitted this reform package will cost \$1 trillion over the next 10 years, but he believes the price tag can be met.

According to Obama, proposed administration cuts will not only produce \$950 billion toward the \$1 trillion price tag, but will actually extend the life of the Medicare Trust Fund by seven years and reduce

premiums for Medicare beneficiaries by \$43 billion over the next 10 years. Obama also anticipates that long-term savings from reforms like medical information technology and increased investment in prevention will make up the balance.

President Obama's Remarks to the American Medical Association, June 15, 2009

Health reform markup status; BPC and GOP centrists reveal plans

Senate Finance Committee Chairman Max Baucus (D-Mont.), told reporters on June 17 that he would not have his health care reform markup ready by the end of the week, and raised doubts that he would hold a markup prior to the July 4 recess. Finance Committee Democrats have been scrambling to find ways to bring down the cost, estimated by the Congressional Budget Office at nearly \$1.6 trillion.

CBO estimates. Baucus initially downplayed the CBO figures, saying they were based on a plan that was two weeks old and has undergone significant changes. He emphasized that he plans to look for more savings through medical spending reductions and other offsets, rather than raising revenue. But mounting pressure from Republican opponents to reduce the cost and find ways to make sure that more people are covered has left Baucus with the difficult task of trying to forge an agreement that will gain the approval of his party and GOP critics.

HELP committee markup. As Baucus retreated from his initial deadline, Sen. Chris Dodd (D-Conn.), Acting Chairman of the Health, Education, Labor and Pensions (HELP) Committee, began marking up that Committee's partially completed bill, the Affordable Health Choice Act. That measure also has proved controversial as CBO estimates pegged the price so far at well over \$1 trillion for the 2010-2019 period and noted that it would only provide coverage for an additional 16 million individuals out

of an estimated 46 million uninsured. The mark remains incomplete, with scant language addressing how it will be paid for.

BPC recommendations. Meanwhile, a health care reform proposal offered June 17 by Bipartisan Policy Center (BPC) advisors and former Senators Howard Baker, Tom Daschle, and Bob Dole, received high praise from



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Requests for information about article submission and comments from readers are welcome and should be directed to Susan Smith at susan.smith@wolterskluwer.com, Tel. 847-267-2780, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

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Trends (cont.)

Baucus and Senate Finance Committee ranking member Charles E. Grassley (R-Iowa). "The proposal not only helps identify areas of clear agreement, it addresses critical reforms, such as tackling cost concerns and ensuring quality coverage while holding insurance companies' feet to the fire," said Baucus. "It should encourage current members of Congress that former leaders of both political parties were able to find a compromise on even the most controversial health care issues and

demonstrate that bipartisan reform may be achievable," said Grassley

Centrist GOP plan. Finally, Reps. Mark Kirk (R-Ill.) and Charlie Dent (R-Penn.) and members of the centrist Tuesday Group, have released details of the "Medical Rights and Reform Act," a comprehensive health care reform proposal designed to lower costs and expand access without compromising the doctor-patient relationship, jeopardizing the quality of American medicine or raising taxes on the American people. To lower

health care costs, the Act provides for: state innovation through insurance market reforms, high-risk pools, community health networks, and new association options for small businesses; lawsuit reforms; upgrades and acceleration of health information technology programs; strong standards and processes to target waste, fraud and abuse; targeted prevention and wellness programs; and greater tax incentives for individuals and small businesses to buy health insurance. ■

CCH Washington Bureau, June 17, 2009

Fraud & Abuse

Supreme Court clarifies FCA appeal deadline

The U.S. Supreme Court has resolved a conflict among circuit courts of appeals regarding deadlines for filing in False Claims Act (FCA) cases brought by whistleblowers. The extended deadline of 60 days for filing a Notice of Appeal applies to *qui tam* cases only if the federal government has intervened and participated in the litigation. When the government has declined to intervene, the ordinary deadline of 30 days applies.

Qui tam cases under the FCA are brought by private individuals in the name of the U.S. These "whistleblowers" claim that another party has cheated the federal government by filing false claims. If they win, most of the recovery goes to the government, but the whistleblower receives up to 25 percent.

The federal government must be notified before the case is filed; it has the right to intervene; participate in, and control the litigation. If the government does not intervene the private party is responsible for the litigation.

In this case, the government chose not to intervene. The whistleblower filed an appeal 54 days after the dismissal by the district court.

Second Circuit's decision On appeal to the U.S. Court of Appeals for the Second Circuit, the parties addressed the timeliness of the ap-

peal. The whistleblower argued that the 60-day deadline applied because the case was brought on behalf of the U.S., which would receive most of any recovery. The provider argued that the 30-day deadline applied because the government had not intervened. The Second Circuit held that the 30-day limit applied and affirmed the dismissal because the U.S. was not a party unless it intervened.

Supreme Court's reasoning. While other federal circuits have ruled that the 60-day deadline applies in this situation, based on what they termed a literal reading of the rule, the Supreme

Court rejected that view. The Court also rejected the argument that the U.S. should be designated a party in all FCA actions irrespective of its decision to intervene. The Court cited the definition of "party" in Black's Law Dictionary: "one by or against whom litigation is brought." The legal term "intervention" is defined as becoming a party to litigation, often with permission of the court. Finally, the Court noted that in decades of litigation under the FCA, few cases involved confusion concerning the deadline for appeal. ■

United States ex rel. Eisenstein v. City of New York, U.S., June 8, 2009

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Inside Criminal Minds, Part I

by Allan P. DeKaye, MBA, FHFMA

Fraud! Settlements! Restitution! Jail time! All headlines ripped from industry trade journals and newsletters. The unsettling fact is that these same headlines have appeared with regularity over the last 15 years, or at least since Health Care Fraud has become a target of investigation at the federal, state and local levels.

Inside Criminal Minds, presented in two parts, takes a closer look at those who have committed fraud, and examines the characteristics that may have led to this criminal behavior. It also will look to define varying degrees of greed, as behavioral traits common to the criminal mind. In addition, the article will examine: (1) the way many compliance structures work to detect and prevent fraudulent activities to see if it provides sufficient safeguards, (2) the more sophisticated data models used to guard against identify theft and record breaches, and (3) the way we screen new hires and reevaluate existing staff to see if lapses or loopholes exist that threaten to exploit vulnerable areas. Finally, the article will present related perspectives and vantage points to address compliance concerns.

The Hierarchy of Need

History has a way of repeating itself: climate, war, disease, crimes and behavior, to mention a few illustrations. In 1954, Dr. Abraham Maslow introduced the “Hierarch of Needs.”¹

In this classic work, Maslow identifies five needs: physiological, safety, social, esteem, and self-actualization. In its purest sense, Maslow’s approach contends “...Humanists do not believe that human beings are pushed by mechanical forces, either of stimuli and reinforcements (behaviorism), or of unconscious instinctual impulses (psychoanalysis). Humanists focus upon potentials. They believe that humans strive for an upper level of capabilities...”²

Over the years, Maslow’s “needs” theory has been expanded and adapted. For example, the need for “safety” can be translated to include “...our urges to have a home in a safe neighborhood, a little job security, and a nest egg ...and so on.”³ With this in mind, another adaptation states: “If Maslow’s theory is true, there are some very important leadership implications to enhance workplace motivation.” To allow workers to reach Maslow’s self-actualization level, “...[the workplace needs to] offer challenging and meaningful work assignments which enable innovation, creativity and progress according to long-term goals.”⁴

“Maslow’s concept of self-actualization relates directly to the present day challenges and opportunities for employers and organizations – to provide real meaning, purpose and true personal development for their employees. For life – not just for work.”⁵ While Maslow provides one model for understanding what individuals need, then we need to examine where in the workplace either needs are not being met, or additional behavioral characteristics can be identified to determine if an early warning to predisposition to criminal behavior is possible.

While a psychosocial profile might define a potential criminal from an accounting profile, other characteristics also might be identified. In the Accounting Department at Louisiana State University (LSU), students of Professor D. Larry Crumbly, CPA, Cr.FA, CFFA, FCPA, have compiled a series of papers that address these characteristics as part of their studies in Forensic Accounting.

In Lisa Eversole’s paper, “Profile of a Fraudster,” “egotistical, risk taker, rule breaker, under stress, financial need and pressured to perform” were among the characteristics identified. In a review of criminally prosecuted health care fraud cases, these same conditions similarly were mentioned. She went on to observe: “The gains from the fraud can be direct (receipt of money or property) or indirect (reward or promotions, bonuses, power or influence).”⁶ In the next section, a system to classify these behaviors will be introduced.

The Hierarchy of Greed

Maslow’s Hierarchy of Need is often represented as a pyramid, with physiological needs at the bottom and self-actualization at the top. In researching this topic, five levels of greed have been used to similarly classify health care’s “Hierarchy of Greedsm.”⁷ Using a pyramid, these five types of greed are: undisciplined, opportunistic, corporate, scheme and organized. A definition and discussion of each follows.

Undisciplined Greed – is typified by an individual(s) whose inquisitive mind(s) lead them to “sneak a peek” at celebrity medical records – more out of curiosity than for profit; but nonetheless, a serious breach of medical data security.

Opportunistic Greed – adds an “opportunity” factor to undisciplined greed and parlays it into a motive by selling

that information for personal gain. This category also includes individuals who commit fraud against insurance companies.

Corporate Greed – raises the bar from the staff levels usually found in undisciplined and opportunistic greed, and involves organizational leadership. The notion of “loophole exploitation” is introduced to see how much of a factor it plays when corporate greed is examined in the context of not-for-profit vs. for profit entities.

Scheme Greed – The very sound of the word connotes evil wrongdoing, and is most often exemplified by an outright plan to steal information to profit by its use in defrauding governmental insurance plans.

Organized Greed – Yes, it can involve organized crime; but more often provides an expansive base from which schemes are hatched, expanded from within a familial circle, and copycatted by others looking to profit from ill gotten gains.

When taken together, these five factors cover a wide-range of health care fraud and abuse. While not necessarily a perfect classification system, it allows for type casting the bad actors that have been disciplined, fined, or incarcerated; and provides some insight into the factors that influenced these bad behaviors. As a result, some additional safeguards can be considered. These discussions follow.

Crimes and Punishment

“Don’t do the crime, if you can’t do the time!”⁸ In cases of health care fraud and abuse, penalties can range from payment restitution to criminal incarceration. In instances in which internal hospital medical records are breached, punishment ranges from reprimands to dismissal, with civil and criminal proceedings possibly based upon the extent of the infraction, and consequential damages caused by the actions.

The EMR isn’t Facebook

“Friend me; tweets, and text messaging” have become commonplace; but all too often that commonplace activity also occurs in the workplace. After a recent mass transit accident in Boston, a trolley driver admitted to “texting while operating the vehicle” while rear-ending another trolley in front of it.⁹ While the case will no doubt look to place future sanctions and prohibitions on carrying and using cell phones, personal digital assistants (PDAs) and the like by transit employees, you need only look around any hospital setting (or for that matter, any office setting) to see this common occurrence.

Surprisingly, after reading two Internet postings (there are probably more), the health care industry will need to brace for the impact of “Twitter Surgery – In the Operating Room,”¹⁰ and the “4 Things You Shouldn’t Do While Texting” including circumcision and surgery),¹¹ which may portend an even greater risk than celebrity data breaches.

The sanctity of the medical record, whether the traditional hard-copy variety, or the newer electronic medical record (EMR) that is

dotting the landscape in ever increasing numbers, is vulnerable to the “sneak a peak,” also known as celebrity data breaches. “Our society’s insatiable desire to know everything about celebrities, especially the private details of their lives, has reached a new low with recent news out of Los Angeles. Also at a new low here: patient confidentiality. The UCLA Medical Center is moving to fire 13 employees and disciplining 12 others, for peaking at the confidential patient history of pop star Britney Spears, the Los Angeles Times reports.”¹²

These are not isolated events, although they may have a geographic locus on the East and West coasts. “When a famous Hollywood actor is suddenly admitted to your hospital, some employees will likely be tempted to take a peek at the heartthrob’s medical records. But when the hospital in question later suspends more than two dozen employees without pay for allegedly violating privacy rules, those involved are bound to question whether ‘the punishment fits the crime,’ and to what extent the hospital could have better protected its celebrity patient.”¹³

These instances of “undisciplined” behavior may be rooted in celebrity viewing, but in another episode at UCLA Medical Center in which celebrity breaches of such notables as Farrah Fawcett and California’s First Lady, Maria Shriver, have occurred, the same individual who viewed Fawcett’s records, also viewed 61 other patient records—including those of noncelebrities.¹⁴ While undisciplined actions seem to attract attention and notoriety associated with celebrities, the impact tends to be localized, as long as the data breach is contained and not exploited for profit and gain, as shown in the next section.

Identity Crisis

Whether watching television or surfing online, the airwaves and cyberspace are filled with offers and advertisements to check your credit report, and prevent financial identity theft. Far less evident in the literature, and almost certainly absent from the media glare is the matter of medical identity theft. Though the two types of theft are rooted in the same premise that something personal has been stolen, the extent of the impact, the detection timeframe and the consequences and prevention techniques are in need of tightening in the health care industry.

The “undisciplined” persona noted above turns greedier when it becomes “opportunistic,” and it is no longer a voyeuristic event, but one where data is stolen and sold. For example, while medical data breaches at UCLA Medical Center were discussed above, an employee at the same facility pleaded guilty to selling patient medical information to tabloid publications in 2007.¹⁵

While tabloids are one avenue to entice the opportunistic individual, another more sinister plot unfolds when staff with access to data can be compromised to sell patient information to unknown third parties. In the incident involving New York-Presbyterian Hospital/Weill Cornell Medical Center, a staff member was arrested for selling data to persons who approached the individual offering money for information.

The reported payments of \$750 and \$600 for at least two sets of 1,000 patient data files seems small compared to the risk of losing one's job and likely facing criminal prosecution. The potential damage resulting from the misuse of this data, however, could cause financial and medical identity theft affecting very large patient populations.¹⁶

Financial identity theft seeks to impersonate an individual by accessing their credit cards, bank accounts and personal data. Medical identity theft, while borrowing some of the same key demographics that make up one's "protected health information," results when another individual improperly poses as the patient, or one's insurance identification is improperly used. These errant entries in the medical record may go undetected for long periods of time and become difficult to correct.

"Medical identity theft is a crime that can cause great harm to its victims. It also is the most difficult to fix after the fact because victims have limited rights and recourses. Medical identity theft typically leaves a trail of falsified information in medical records that can plague victims' medical and financial lives for years."¹⁷ Medical identity theft is caused in large part by the type of schemes that involve theft of patient and physician information resulting in billing fraud that will be discussed in more detail. Because of its striking similarity to financial identity theft, however, these two problem areas are grouped together and classified as opportunistic greed.

While a good portion of the undisciplined and opportunistic health care fraud is associated within the framework of organizational entities, individuals commit health care fraud against their own insurance companies. This may take the form of submitting personal claims that are false or erroneous. In instances in which these individuals are caught, their defenses range from ignorance to everyone is doing it, to the insurance company won't miss a few dollars."¹⁸ Prosecutors often cite nongovernmental health insurers in having better systems and resources to detect and prevent claim fraud than do the federal government's Medicare and Medicaid programs.

"Someone Always Playing Corporation Games"¹⁹

"Corporate Greed" is listed third on the hierarchy of greed. In the first two categories: undisciplined and opportunistic, the individual tends to be a staffer and not a department head or executive. In corporate greed, we start the climb that may take us into the "C-suite." The perplexing question is why?

Many "not-for-profit" organizations find themselves with large settlements, corporate integrity agreements, and in some cases incarceration for fraudulent acts. On the surface, it may appear more obvious that in the "for profit" health care sector there might be more corporate greed, given higher salaries, bonuses, and stock options that serve as the motivating factors. Those successful in the not-for-profit sector, however, often use their accomplishments as a springboard to the more lucrative for profit sector. Then again, the increasing levels of executive compensation in the not-for-profit sector have risen to such heights that congressional investigations have taken a closer look, especially as the voluntary not-for-profit organizations struggle to deliver services and meet the community benefit needs during increasingly difficult reimbursement and regulatory periods.

With these conditions as a backdrop, three other factors warrant consideration as possible precursors to criminal activities: ego, misguided altruism, and loophole exploitation.

- (1) **Ego** – Bragging rights may have something to do with this. Hospitals are ranked in national publications, and even have mortality and other measures becoming commonplace on state health department websites. Additionally, in "Profit of a Fraudster," Eversole said "the perpetrator may be scornful of obvious control flaws...and beating the organization [or system] is a challenge and not a matter of economic gain alone."²⁰
- (2) **Misguided Altruism** – By most accounts, hospitals nationwide have been operating on razor thin margins – with those in New York State (NYS) often on no margin at all. This makes the case of the seven NYS hospitals named in a \$50 million lawsuit alleging kickbacks, billing for unnecessary services, and providing treatment without a license,²¹ a possible case of misguided altruism gone badly. Interestingly, in another article it was reported that "No criminal actions are alleged in the complaint. But the attorney general had harsh words for those named in the complaint."²²
- (3) **Loophole Exploitation** – In a good many instances, the use of civil remedies tend to be applied to what is here termed, "loophole exploitation." While it may be called "gaming the system" or "pushing the envelope," cases for erroneous billing whether associated with outliers, diagnosis-related group (DRG) code assignment, cost reporting, kickback, or various types of billing therapies, these cases generate considerable negative publicity, and often result in steep fines and penalties being levied.

While inexcusable in the eyes of the law, the motives behind these vehicles seem more rooted in misguided altruism, rather than the egregious behavior that is discussed in the next two behavioral levels of greed. Although the types of corporate greed discussed above were centered in the hospital and health system and physician arenas, corporate greed has new frontiers in the pharmaceutical and pharmacy segments, with many cases being brought both civilly and criminally.

Some prosecutors see less behavioral causation, and instead believe its economic risk that weighs as a more significant contributing factor. They emphasize that it is the choices that management often makes in deciding in favor of one project or another determines whether management evaluates economic gains vs. risks. Citing more recent examples of hospital settings vs. pharmaceuticals, they conclude that "pharma" has become more "risk aware and risk averse" after years of being penalized significantly and substantially. Additionally, there has been more restraint as a result of having the overall number of companies reduced in size, and specifically because the companies' boards will directly hire and fire the chief executive officers. In contrast, hospitals and health systems will (still) get it wrong when competing projects pit the general good of the hospital vs. the good of individual and competing departments. Too often, the "actors" don't have the full frame of reference and incomplete knowledge from which to make objective and legally correct recommendations.

When Strategies Becomes Schemes

The literature talks about "schemes," particularly as they relate to those individual(s) who steal Medicare and Medicaid identi-

fication numbers and unique physician identification numbers to bill fraudulently. The most prominent schemes are found today in the Durable Medical Equipment (DME) and infusion therapy services.

Surprisingly, many of these crimes are perpetrated by individuals or small groups of people often related to each other. In dissecting the backgrounds of these schemes, prosecutors report that ethnicity and barriers to workforce entry of those in lower socio-economic rankings make for a recipe to enter criminal enterprises. So rampant has this phenomenon become that federal task forces have been formed in an all-out effort to dismantle these illegal activities and prosecute the guilty parties. Medicare is a trust-based system, and prosecutors have found over the years that schemers have found ways to take advantage of its thinly reinforced protective barriers. Now with this all-out effort to add manpower and data and analytic prowess, prosecutors hope to derail these current schemes; although they are wary that further vulnerabilities are simply one schemer away from starting over again.

The Sopranos Meet Health Care

At the top of the Hierarchy of Greed pyramid is “organized greed.” “Health care fraud is not just committed by dishonest health care providers. So enticing an invitation is our nation’s ever-growing pool of health care money that in certain areas - Florida, for example - law enforcement agencies and health insurers have witnessed in recent years the migration of some criminals from illegal drug trafficking into the safer and far more lucrative business of perpetrating fraud schemes against Medicare, Medicaid, and private health insurance companies.”²³

It may not be too difficult to see how the opportunistic behavior associated with financial and medical identity theft, and the individual scheming characterized by ethnicity and lower economic standing has led to organized crime seeking a foothold in health care fraud. Pam Dixon, Executive Director, World Privacy Forum, said: “...there have been cases involving Russian organized crime and identity theft rings that are buying health clinics and billing the government for services.”²⁴

While it’s been noted that organized crime may find health care fraud less likely to be detected, and that its penalties less harsh, a review of more recent convictions and penalties suggests otherwise. The joint strike forces that are now operating in Miami and Los Angeles bring all of the power of the federal government to bear. This is particularly noticeable when the convictions appear on the Internal Revenue Services web site where penalties appear to increase exponentially for the added charges of tax evasion and money laundering. When mail fraud also is evident, penalties also increase. The government is trying to combat the problem with an increasingly large arsenal of weapons at its disposal.

Conclusion

Part I of this article has examined those who have committed fraud and the characteristics that may have led to their criminal behavior. It also has defined varying degrees of greed, as behavioral traits common to the criminal mind. Part II will examine

the way many compliance structures work to detect and prevent fraudulent activities, sophisticated data models used to guard against identify theft and record breaches, the screening of new hires and the reevaluation of existing staff to see if lapses exist that threaten to exploit vulnerable areas, and related perspectives and vantage points to address compliance concerns. ■

Allan P. DeKaye is President and Chief Executive Officer of DEKAYE Consulting, Inc. His firm assists health care clients with financial, compliance and operational issues. He is a frequent speaker at national conferences, and is author/editor of The Patient Accounts Management Handbook (Aspen). Mr. DeKaye also is a member of the CCH Health Care Compliance Editorial Advisory Board. For more information: call: (516) 678-2754; write: dkconsult1@aol.com, or visit: www.dekaye.com

- ¹ Maslow, A., *Motivation and Personality*, (1954).
- ² Simons, J.A., Irwin, D.B., Drinnien, B. A, *Psychology – The Search for Understanding*, West Publishing Company, New York, 1987, as excerpted in: Maslow’s Hierarchy of Needs, found at: <http://honolulu.hawaii.edu/intranet/committees/FacDevCom/guidebk/teachtip/maslow.htm> at 1.
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- ⁴ “Abraham Maslow’s Hierarchy of Needs Theory;” as discussed at: http://www.envisionsoftware.com/Management/Maslow_Needs_Hierarchy.html.
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- ⁶ Eversole, L., “Profile of a Fraudster;” as presented at: <http://www.bus.lsu.edu/accounting/faculty/lcrumbley/fraudster.html> at 1.
- ⁷ Healthcare’s “Hierarchy of Greedsm” is a service mark of DEKAYE Consulting, Inc.
- ⁸ Lyric from: “Baretta’s Theme Keep You Eye on the Sparrow.” Words and Music by: Morgan Ames and Dave Grusin.
- ⁹ Valencia, M.J. and Bierman, N., “MBTA: Conductor in Boston trolley crash was texting his girlfriend;” Boston Globe, May 8, 2009.
- ¹⁰ Found at: <http://stanford.wellsphere.com/healthcare-industry-policy-article/twitter-surgery-in-the-oper...>
- ¹¹ Found at: <http://southcoasttoday.com/apps/pbcs.dll/article?AID=20090514/SC2470105/90513> (Jason Perry, southcoast247.com, assistant editor).
- ¹² “Celebrity Medical Records Accessed Without Authorization;” April 8, 2008 at 1, as reported at: <http://identitytheft911.org/alerts/alert.ext?sp=10439>.
- ¹³ “HIPAA Compliance Strategies: Alleged Breach of George Clooney’s Health Information Leads to Suspension of 27 Staffers at N.J. Medical Center;” published at: http://www.aishhealth.com/Compliance/Hipaa/RPP_Geroge_Clooney_PHI.html.
- ¹⁴ *Supra* n. 12 at 1-2.
- ¹⁵ “Former Hospital Employee Gave National Enquirer Celebrity Medical Records;” as presented at: <http://www.hulig.com/2623/73906/former-hospital-employee-gave-national-enquirer-celebr...>
- ¹⁶ “NYC Hospital Worker Charged with Stealing Patient Info;” as presented at: http://www.1010wins.com/print_page.php?contentID=1873268&contentType=4.
- ¹⁷ Dixon, P., “Medical Identity Theft: The Information Crime that Can Kill You;” The World Privacy Forum, May 3, 2006, at 5.
- ¹⁸ “Who Commits/Reports Healthcare Fraud;” available at: http://www.deltadentalnj.com/fraud/who_commits_fraud.shtml.
- ¹⁹ Lyric from “We Built This City;” Jefferson Starship. Words and Music by: Bernie Taupin, Martin Page, Dennis Lambert and Peter Wolf.
- ²⁰ *Supra* n. 6 at 2.
- ²¹ Mason, J., “Hospital Accused of Medicaid Fraud;” The Daily Mail, Jan. 5, 2009, available at: <http://webmail.aol.com/4291/aol/en-us/mail/PrintMessage.aspx>.
- ²² Minissale, J., “Cuomo sues CMH for fraud;” Indenews.com, Jan. 1, 2009, available at: http://www.midhudsoncentral.com/site/printerFriendly.cfm?brd=248&dept_id=462341&n...
- ²³ “The Problem of Health Care Fraud;” National Health Care Anti-Fraud Association, at 3., available at: http://www.nhcaa.org/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_center&wpsc.
- ²⁴ McKay, J., “Identity Theft Steals Millions from Government Health Programs;” Feb. 13, 2008, at 2., available at: http://www.govtech.com/gt/print_article.php?id=260202.

FTC charges IPA with price fixing

The Federal Trade Commission (FTC) has issued a Proposed Consent Order with Alta Bates Medical Group, Inc. (ABMG) charging that ABMG violated Section 5 of the FTC Act by fixing prices charged to those offering coverage for health care services (payers) and refusing to deal with payors except on a collectively determined basis.

Legitimate activities. ABMG is a multi-specialty independent practice association (IPA) comprised of multiple, independent medical practices in the Berkeley and Oakland, California area. ABMG has negotiated group contracts with payors under which it receives capitated (per member per month) payments for each enrollee. This type of contracting is a form of financial integration, so for antitrust purposes, the IPA is treated as a single entity and not as a group of competing physicians.

Challenged activities. ABMG, however, also contracts on behalf of its member physicians with health plans to provide fee-for-service (FFS) medical care. Under these arrangements, the payor compensates physicians or group practices for services rendered pursuant to agreed-upon fee schedules. In the absence of financial risk-sharing or clinical integration on the part of providers, the IPA members are competitors for purposes of antitrust analysis.

Terms of the consent order. The proposed Consent Order prohibits ABMG from entering into or facilitating any agreement between or among any health care providers: (1) to negotiate on behalf of any physician with any payor; (2) to refuse to deal, or threaten to refuse to deal with any payor; (3) regarding any term, condition, or requirement upon which any physician deals, or is willing to deal, with any payor, including, but not limited to price terms; or (4) not to deal individually with any payor, or not to deal with any payor other than through ABMG.

The FTC has requested comments on the proposed consent order by July 6, 2009. ■

FTC Proposed Consent Order, 74 FR 28246, June 15, 2009, Health Care Compliance Letter, ¶1760,333

In the News

GE offers no interest loans for HIT system

General Electric Co. has announced, as part of its \$6 billion healthymagination initiative to increase access to technology and reduce cost, the launch of a new program, Stimulus Simplicity, which offers doctors and hospitals assistance in adopting a electronic medical records (EMR) system. This program, a joint offering of GE Healthcare and GE Capital, contains (1) a commitment to ensure the EMRs are certified (which is a prerequisite to federal stimulus reimbursement eligibility) and (2) an interest-free loan with deferred payments. The program is designed to address provider uncertainty regarding future EMR standards and interim funding to cover the capital investment. GE asserts that under its program physician offices and hospitals that invest in GE's EMR products, such as, GE Centricity® EMR and Centricity Enterprise solutions, will maximize the potential benefits of the increased focus on EMRs under the HITECH Act, contained in the American Recovery and Reinvestment Act (PubLNo. 111-5). GE Capital expects to make about \$100 million available for the program.

GE Reports, June 15, 2009

Medco to strengthen limited English assistance

Medco, the nation's largest pharmacy benefit management company, plans to improve access to its services for limited English proficient (LEP) members in 2009. Following an investigation of a complaint filed on behalf of a Spanish-speaking member with HHS' Office for Civil Rights, Medco plans to (1) expand its pool of bilingual customer service representatives who speak Spanish and (2) revise its systems to enhance its ability to route Spanish-speaking members who need help with prescription drug questions directly to bilingual staff, including pharmacists. A critical improvement in Medco's internal computer systems will flag language preference on an ongoing basis to aid effective communication with LEP persons. Medco also will review how best to notify LEP members that language assistance services are available. Medco staff will be assessed as to language proficiency, and interpreters will be assessed for competency. Medco will train all relevant staff on these system changes and will monitor the results of these efforts through periodic assessments. (See the On The Front Lines article: "Title VI of the Civil Rights Act: A Compliance Primer for Health Care Providers" in the May 19, 2009 newsletter).

HHS News Release, June 15, 2009

OIG issues semiannual report to Congress

During the reporting period from October 1, 2008, to March 31, 2009, the activities of the HHS Office of the Inspector General (OIG) included audits and investigations resulting in: (1) total savings anticipated recoveries of nearly \$2.5 billion, (2) exclusions of 1,415 individuals and entities for fraud and abuse involving federal health care programs, (3) 293 criminal prosecutions for crimes against HHS programs, and (4) 243 civil actions, including False Claims Act cases, unjust enrichment suits, civil money penalties law settlements, and administrative recoveries related to provider self disclosure matters. Issues of recent focus included oversight of Medicare Part D; the weakness in the appeals process; the prevalence of adverse events; the handling of conflicts of interest and ethics issues at the Food and Drug Administration and the National Institutes of Health; and improper Temporary Assistance for Needy Families payments.

OIG Semi-Annual Report, Spring 2009, Health Care Compliance Letter, ¶1530,728