

# HCCH Health Care Compliance LETTER

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## Council sets strategies, priorities for patient-centered research

Recommendations for how the HHS Office of the Secretary will spend \$400 million in funds for patient-centered research, also known as comparative effectiveness research (CER), were released by the Federal Coordinating Council for Comparative Effectiveness Research (FCC-CER). The report, mandated by the American Recovery and Reinvestment Act (ARRA) (PubLNo 111-5), is designed to help the Secretary and lawmakers improve the quality of care for patients, and provide patients and doctors the best information possible to make health care decisions.

The council focused on: (1) developing a definition, establishing prioritization criteria, creating a strategic framework, and identifying priorities that lay the foundation for CER; (2) fostering optimum coordination of CER conducted or supported by relevant federal departments; and (3) formulating recommendations for investing the \$400 million appropriated to HHS.

**Definition of CER.** The council defined CER as: "...the conduct and synthesis of research comparing the benefits and harms of different interventions and strategies to prevent, diagnose, treat and monitor health conditions in 'real world' settings." The purpose of this research is to improve health outcomes by developing and disseminating evidence-based information to patients, clinicians, and other decision-makers, that respond to their expressed need to know about which interventions are most effective for which patients under specific circumstances.

To provide this information, CER must assess a comprehensive array of health-related outcomes for diverse patient populations and subgroups. Comparisons of defined interventions may include medications, procedures, medical and assistive devices and technologies, diagnostic testing, behavioral change, and delivery system strategies.

**Criteria.** The council's second step was to establish minimum threshold and prioritization criteria for scientifically meritorious research and investments. The minimum threshold criteria is that the research (1) be included within statutory limits of ARRA and the council's definition of CER; (2) have potential to inform decision-making by patients, clinicians, or other stakeholders; (3) be responsive to the expressed needs of patients, clinicians, or other stakeholders; and (4) be feasible.

The prioritization criteria include: (1) the potential impact; (2) the potential to evaluate comparative effectiveness in diverse populations and patient subgroups and engage communities in research; (3) an uncertainty within the clinical and public health communities regarding management decisions and variability in practice; (4) addressing a need unlikely to be addressed through other organizations; and (5) the potential for multiplicative effect.

**Strategic framework.** After completing the draft definition and criteria for prioritization of potential CER investments, the council developed a strategic framework for CER activity and investments to categorize current activity, identify gaps, and inform

decisions on high-priority recommendations. The types of CER investments fall into four major categories: (1) research, (2) human and scientific capital, (3) CER data infrastructure, and (4) dissemination and translation of CER. Investments or activities related to a specific theme can cut across one or more of these categories and may include: (1) conditions, (2) patient populations, and (3) type of intervention.

**Priority recommendations.** In developing its recommendations for how to invest the \$400 million in ARRA funding, the council advised that, among the four major activities and three cross-cutting themes in the CER framework, the primary investment for this funding should be data infrastructure. Data infrastructure could include linking current data sources to enable answering CER questions, development of distributed electronic data networks and patient registries, and partnerships with the private sector. Secondary areas of investment are dissemination and translation of CER findings, priority populations, and priority types of interventions.

**Long-term outlook.** This report and an Institute of Medicine report entitled "Initial National Priorities for Comparative Effectiveness Research" provide the priority-setting process for CER-related funding. The most immediate next step will be the development of a specific plan, which will be submitted by July 30, 2009, from HHS for the combined \$1.1 billion of ARRA CER funding. ■

*Federal Coordinating Council for Comparative Effectiveness Research Report to Congress, June 29, 2009*

### NIH research funds create opportunities for small businesses

Opportunities exist for small businesses to participate in National Institutes of Health (NIH) research programs funded by the American Recovery and Reinvestment Act (ARRA) (PubLNo 111-5) the Deputy Director for Extramural Research at the National Institutes of Health (NIH), Sally Rockey, Ph.D., told the Senate Committee on Small Business on June 22, 2009.

Funds provided to the NIH under ARRA are exempted from the statutory set-aside requirements for the Small Busi-

ness Innovation Research (SBIR) and Small Business Technology Transfer (STTR) programs. The NIH, therefore, is not required to provide a set amount of its ARRA funds to those programs. Rockey noted, however, that NIH is committed to the small business community and small businesses have and will receive NIH ARRA funds.

Rockey stated that during the past few months, NIH has released several small business funding opportunity announcements (FOAs) that were supported by ARRA. These include:

■ **Challenge Grants in Health and Science Research.** This opportunity focuses on specific knowledge gaps, new technologies, data generation or research methods and would benefit from an influx of funds to quickly advance the area in significant ways.

■ **Research and Research Infrastructure "Grand Opportunities."** This opportunity focuses on developing and implementing critical research innovations to advance research enterprises, stimulating future growth and investments, and advancing public health and health care delivery.

■ **Recovery Act Limited Competition: Biomedical Research, Development, and Growth to Spur the Acceleration of New Technologies Pilot Program.** This FOA is a pilot program that focuses on the funding gap between promising research and development and transitioning to the market by contributing to the critical funding needed to pursue the next appropriate milestone(s) toward ultimate commercialization.

■ **Recovery Act Limited Competition: Small Business Catalyst Awards for Accelerating Innovative Research.** This opportunity specifically targets the SBIR research community and focuses on accelerating innovation through high risk, high reward research and development that has the commercial potential and is relevant to the NIH mission.

In March 2009, NIH offered three administrative supplement and competitive revision opportunities for those with active research project grants. The supplements provided additional funding to accelerate

the tempo of scientific research on active grants. Revision awards support a significant expansion of the scope or research protocol of approved and funded projects. Administrative supplements also were offered to provide summer research experiences for students and science educators. In addition, the paylines at various NIH institutes and centers have been extended to reach more meritorious research grants. ■

*Statement by Deputy Director for Extramural Research at NIH to Senate Committee, June 22, 2009*



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### Incentives for adoption of HIT aimed at small health care practices

The Administration's health information technology (HIT) activities and how they will impact small health care practices was the focus of Dr. David Blumenthal, the National Coordinator, Office of the National Coordinator for Health Information Technology (ONC), testimony before the House Small Business Subcommittee.

**HITECH Act.** The Health Information Technology for Economic and Clinical Health Act, or HITECH Act includes \$2 billion in funding to ONC to lay the groundwork for adoption and meaningful use of HIT through infrastructure programs. It also includes an estimated \$44.7 billion in incentive payments for Medicare and Medicaid providers that are meaningful users of certified electronic health record (EHR) technology.

Physicians, including those in solo or small practices, can receive up to \$44,000 in incentive payments under the Medicare program for being meaningful users of certified EHRs. The HITECH Act includes grant programs as well as education and technical assistance opportunities to help providers, especially those in small practices, overcome barriers to adoption. Funds will be distributed through Medicare and Medicaid incentive payments to eligible professionals, physicians, and hospitals that are "meaningful EHR users." Meaningful users will become eligible for incentive bonuses in 2011. Beginning in 2015, Medicare eligible professionals and hospitals that fail to demonstrate meaningful use of certified EHRs will be subject to penalties.

**Qualifying for incentives.** According to Blumenthal, the qualification criteria for incentives are still in development, and will be defined through regulation and additional guidance materials. HHS, however, generally expects that under Medicare, "meaningful EHR users" would demonstrate: (1) meaningful use of a certified EHR; (2) using the electronic

exchange of health information to improve the quality of health care; and (3) reporting on clinical quality and other measures using certified EHR technology. CMS, in close coordination with ONC, intends to publish a proposed rule in late 2009 to propose a definition of meaningful use of certified EHR technology and establish criteria for the incentive programs.

**Grant programs.** In addition to the incentive payments from Medicare and Medicaid, the HITECH Act authorizes grant programs that ONC can implement to help providers and communities adopt and become meaningful users of EHRs. Three of these authorized grant programs include: (1) HIT Regional Extension Centers; (2) State Grants to Promote Health Information Exchange, or HIE; and (3) Developing IT Professionals in Health Care.

**HIT Extension Program.** The HITECH Act authorizes a HIT Extension Program to make assistance and education available to all providers, but with priority given to: (1) individual or small group practices that are primarily focused on primary care; (2) public or not-for-profit hospitals or critical access hospitals; (3) federally qualified health centers; and (4) entities located in rural and other areas that serve uninsured, underinsured, and medically

underserved individuals. According to Blumenthal, HHS has received comments from various stakeholders emphasizing the importance of offering technical assistance to solo and small practices in selecting and implementing EHRs.

**Interoperable HIT.** In addition to providing technical assistance to health care providers, the HITECH Act requires HHS to develop and implement a program to promote the electronic exchange and use of health information among organizations. This program includes planning and implementation grants targeted specifically towards developing capacity for widespread and sustainable health information exchange to enable the meaningful use of EHRs.

The HITECH Act also requires HHS to provide assistance to institutions of higher education to establish or expand health informatics education programs, including certification, undergraduate, and masters degree programs, for both health care and IT students, to ensure the rapid and effective utilization and development of health information technologies. ■

*Statement by David Blumenthal, National Coordinator of the Office of Health Information Technology, HHS, to the House Small Business Subcommittee, June 24, 2009*

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# Inside Criminal Minds, Part II

by Allan P. DeKaye, MBA, FHFMA

*Part I of Inside Criminal Minds discussed individuals who have committed fraud, and the characteristics that may have led to their criminal behavior. It also defined the varying degrees of greed, as behavioral traits common to the criminal mind.*

Part II of the article examines: (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, (3) the way we screen new hires and re-evaluate existing staff to see if lapses or loopholes exist that threaten to exploit vulnerable areas, and (4) related perspectives and vantage points to address compliance concerns.

## Detection, Deterrents, Safeguards and Cultural Retooling

Prosecutors contend that regardless of the reason, bad actors, whether in health care or other industries, need to be brought to justice. While the hierarchy of greed seeks to provide some level of classification and insight into those who become these bad actors, it also may provide the industry with some additional ways to detect and deter fraud, waste and abuse from occurring in the first place. In this section, some of these approaches will be presented, along with a discussion of other factors conveyed by those with different vantage points.

### The Cost of Drilling

For most hospitals, health systems and health care corporate entities, compliance plans and training seem to be the first line of defense against fraud, waste and abuse. But how effective are these programs? This author's own experience in providing training and education suggests that compliance topics are presented, but that retention of fact and practical application often falls short of obtaining a passing grade.

While stuck in traffic, I had a recollection of my military days (many years ago); however, I was able to recite closely (but not verbatim), the U.S. Army's three General Orders: (1) "I will guard everything within the limits of my post and quit my post only when properly relieved; (2) I will obey my special orders and perform all of my duties in a military manner; and (3) I will report violations of my special orders, emergencies, and anything covered in my instructions to the commander of the relief."<sup>25</sup>

Sound familiar? With a few substitutions, it could read like a standard compliance plan. Why could this subject content be recalled almost some 40 years after first hearing it? Perhaps the answer lies in the same way we remember the Multiplication (Times) Tables. Drilling! Whether in the public school

systems, or in Basic Training at Fort Campbell, Kentucky.

In attempting to curtail or limit the urge or need for the undisciplined level of greed, the sneak-a-peak mentality, health care providers will need to "drill" the core precepts of corporate compliance training into staff with the same military precision and warning: that your life depends on it – or in today's terms – your job depends on it! The cost of such repetitive and frequent training, however, is high. Revisiting the training curriculum to ensure that even shorter, more frequent reminders of core principles (whether in classroom, staff meetings, newsletters, or online vehicles, etc.) would be more beneficial than simple annual compliance retraining sessions that may be embedded in other organizational training (e.g., fire safety, etc.).

### Finding and Training Better Actors

In discussing this and other training phenomenon with Ken Kruger, President and CEO, Healthcare Human Resources Consulting Consortium, LLC (White Plains, New York), he cited that pre-hiring competency and behavioral assessment as being important measures health care organizations should use in hiring, especially for deterring the "opportunistic level of greed." He went on to add that leadership skills assessments are now being introduced with more frequency. He said that these assessments helped organizations find team players, good decision-makers, and spokespeople.

Kruger also indicated that behavioral interviewing gave management a better indication of how an individual would handle work related situations. Criminal background checks and drug-testing were becoming more prevalent in health care, and that these steps would help deter and prevent corporate greed.

He spoke favorably of employee assistance programs, but also noted that in large organizations, you find employee's personal issues are often associated with bad behavior. From his own vantage point in Human Resources leadership and consulting, he found activities like loan-sharking and drug problems were to be found. He noted that the use of cameras not only helped guard against patient care issues, and facility perimeter security, but often led to detection of criminal activity, arrests, and prosecutions.

Prosecutors confirmed that in the medical arena, arrests for corporate greed and schemes were often linked to personal problems, whether financial, marital or drug-related, to mention a few. They also indicated that individuals may be subjected

to fear of losing their job in situations in which supervisory or leadership personnel pressures staff into committing fraudulent activities as they act out corporate greed. While this ties back to Maslow's need for safety and (job) security, the effectiveness of compliance training (and drilling) should prevent employees from being victimized. Understanding their "duty to report" is essential to combating internal and external threats.

### CSI: Health Care

In mounting its counterattack on health care fraud and abuse, the federal government is marshalling its resources from across all of its criminal fighting divisions. One tool that it is using with great success is data mining. By analyzing vast amounts of claim data, federal task forces in Miami and Los Angeles have been able to tackle schemes and organized greed in DME and infusion therapy fraudulent billing activities.

Health care providers also are using advanced data mining to find internal areas of weakness and potential for abuse. While many systems may send an alert if an unauthorized individual is attempting to gain access to a medical record, other organizations are going further.

In some instances, health care systems track the usage of those individuals who have legitimate business reasons for accessing patients' accounts and medical records. They have added different algorithms and tracking protocols to compare volumes and patterns of usage an individual may have. For example, an Admitting Registrar ordinarily might have reason to access 100 patient records a day to perform his or her assigned tasks; however, the safeguards detect when "150" or "500" records are accessed in timeframes outside of the norm. Department heads then receive these reports, and must satisfactorily explain these variances in very short time frames. These types of protocols can provide a line of defense to prevent undisciplined and opportunistic greed from occurring or progressing to more serious situations.

### Raising the Red Flag

The health care industry was included in the Federal Trade Commission's (FTCs) "Red Flag" rules designed to combat identity theft. While the types of advanced data mining protocols described above can help health care organizations prevent and detect internal and external influences, the red flag approach helps organizations guard against patient perpetrated fraud. The rules also can help organizations shore up their data defenses from weaknesses caused from within.

Although some health care organizations have wrestled with designing and implementing such a policy and procedure, it would seem important to consider several of the following approaches to assure that the patient being treated is who he or she claims to be.

(1) **Requesting a Driver's License** – A seemingly benign request for a driver's license is often met with resistance. The Joint Commission (Joint Commission on the Ac-

creditation of Healthcare Organizations) requires that two forms of identification (ID) be provided (one of which is a picture ID) to promote patient safety. The driver's license (or a state issued nondriver's license), passport, or other form of government or picture identification provides vital demographic data necessary to retrieve the patient's medical record on subsequent visits or admissions, as well as to permit proper billing to insurance companies.

- (2) **Obtaining the Social Security Number (SSN)** – Obtaining the SSN perhaps may be more difficult and of concern given the level of identity theft that occurs. Many hospital information systems, however, use the SSN as a record key to more easily retrieve a patient's medical record when returning for subsequent care. All too often, failure to obtain the SSN results in that specific data field being filled with the ubiquitous "000-00-0000" or "999-99-9999," depending on the choice of default value. As a result, patients with the same name, as well as those with similar names sounding the same, hospitals have a universal problem with the same patient registered more than once with duplicate medical record numbers.
- (3) **Duplicate Medical Records** – Duplicate medical records by their very nature should prompt a "red flag" warning. They prevent clinicians from obtaining a complete medical history and provide a pathway for the undisciplined, opportunistic, or schemer to find a reservoir of personal and financial information for purposes of medical identity theft that may go undetected and unreported.
- (4) **Credit Scoring and Data** – Credit scoring and data is controversial, but is being used by some facilities nonetheless. Similar to the authority (the FTC) that indicates that health care providers are covered by red flag rules, the Fair Credit Reporting Act (FCRA) and the Equal Credit Opportunity Act (ECOA) indicates that because health care providers extend credit, they have "permissible purpose" to use credit data and reporting. It can be a helpful indicator to access, in addition to patient provided information, other factors that may support an application for financial assistance, charity care or Medicaid. This type of data also can provide fraud alerts such as: the person is deceased, the SSN was never issued, or the SSN was issued to someone who is deceased, etc. Credit files also contain aliases, previous addresses, and access to other data sources that can help establish and confirm identity.
- Health care organizations are reticent about using credit scoring and data, and often cite the Health Insurance Portability and Accountability Act (HIPAA) concerns for not using some or all of this data. This seemingly selective invocation of HIPAA suggests that if a facility cannot safeguard patients' financial information (e.g., credit file data), then how capable is it in safeguarding patients' medical data, and other protected health information. Failure to protect either leaves health care providers vulnerable to the various forms of greed described throughout this article.

### “To err is human, to forgive divine”<sup>26</sup>

There'll be no forgiveness in health care fraud – the federal government is turning up the HEAT. In a May 20, 2009 press release, the new administration's Attorney General and HHS Secretary announced the formation of a new interagency effort, the “Health Care Fraud Prevention and Enforcement Action Team (HEAT).” HEAT will expand the Medicaid Fraud Strike Forces now in operation in South Florida and Los Angeles to Detroit and Houston.<sup>27</sup>

While the schemes and organized greed will be in the HEAT crosshairs, health care provider organizations will need to do more to protect themselves from corporate greed. Gregory J. Naclerio, Esq., health law partner at Ruskin Moscou Faltischek, PC (Uniondale, New York) and Co-Chair of the firm's White Collar Crime and Investigations Group, used the “misguided altruism” case of the seven New York State Hospitals noted above to remind hospital executives and boards of trustees, “that even if their best intentions were to serve the needs of the community and hospital their due diligence needs to peel back the multiple layers of contracts to detect possible violations.” Naclerio, himself a former Director of the Long Island Regional Office of the Deputy Attorney General for Medicaid Fraud Control, indicated that greed often starts out small, and then grows. He cited that boards of trustees had to become more engaged in the process of safeguarding their institutions to better fulfill their fiduciary responsibility.

In describing the increased responsibility trustees of health care organizations have, Jeffrey Blumengold, FHFMA, CPA, partner and practice leader, Healthcare Services Group, WithumSmith+Brown, PC, indicated that, “New Jersey hospital Trustees are now required to complete a formal Trustee Training program, which must be approved by the Health Commissioner and is believed in the view of the state to be necessary for Trustees to ‘keep pace with best practices for governance, monitoring of quality and efficiency and financial oversight,’ and which should help those governing hospitals in that state to become more aware of their responsibilities and also the complex conditions which can lead to fraud, waste and abuse.” Blumengold, whose firm provides health care organizations with a full-range of audit, tax, and consulting services in the New Jersey, New York, and Pennsylvania region, notes that regulations often aren't simply black and white and that federal and state regulations, at times, are at odds with one another. He suggests that this “grey matter factor” can be a contributing element to the conditions typically present for fraud or abuse to occur. Moreover, while Professional Accounting Standards require that audit teams “brainstorm,” looking for ways fraud may be committed during the audit planning process that is conducted prior to a health care audit, he cautions that in the end, “Pressure/Incentive,” “Opportunity,” and “Rationalization” are essential ingredients in completing the fraud triangle. Thus, having both management and its trustees ever vigilant, on the lookout for questionable behavior or actions, is essential in serving to deter, detect, and ultimately prevent fraud.

While Congress is likely to continue its pressure on hospital providers through a more focused look at executive compensation,

intended more to ensure that these facilities meet their community benefit obligations, the corporate greed that continues to be found in the for profit sector may require forensic accountants to consider how the timing of financial statements may mask more alarming greed. In a paper, “Is There a Relationship Between Management Compensation and Revenue Management,” the authors suggest studies have been inconclusive in drawing a connection between management compensation and misstatements of revenue. They conclude that instead of measuring compensation variables during or at the end of a misstatement period, they examine the time period immediately prior to the beginning of the misstatement period. “This technique ensures that our measures reflect whether compensation may have led to misstatement, rather than capturing how the misstatement itself may have affected the compensation.”<sup>28</sup>

In a case of life imitating art, “Earnings Management: The Game,” describes a game that was developed to identify corporate dishonesty. It's used as part of a Master of Accountancy program, and is based on this precept: “Forensic accountants must identify environmental variables that encourage or inhibit management dishonesty. This paper describes a game used to help students understand that information asymmetry exists between managers and the public, and that public information may be misstated to increase management wealth.”<sup>29</sup>

The game creates a series of outcomes associated with dealing cards and rolling dice to determine if the students (read managers) need to reveal earlier predictions about the cards and dice truthfully. Perhaps the introduction of these types of games into the hiring process, at board presentations or conference calls with stock analysts would have a sobering impact: to tell the truth.

## What Were They Thinking?

### Five Headlines for Five Levels of Greed

“Another Day, Another Celebrity's Hospital Record Breached”<sup>30</sup> (Undisciplined Greed); “Reports: Hacker Demands \$10 Million for Records”<sup>31</sup> (Opportunistic Greed); “FL Health System Settles Medicare Fraud Charges”<sup>32</sup> (Corporate Greed); “Three People Indicated for Defrauding Medicare Through Billing Scheme...”<sup>33</sup> (Scheme Greed); “Does Healthcare Fraud Tie into Organized Crime, Illegal Immigration and...Corporations?”<sup>34</sup> (Organized Greed).

There were certainly more headlines from which to choose, and there may well be more than the five levels of greed as defined in this article. But the question that should keep gnawing at us – is why?

Perhaps opportunistic greed could be explained in part by a conclusion of the Association of Certified Fraud Examiners (ACFE), when ACFE President, James Ratley, noted: “The message to Corporate America is simple – desperate people do desperate things. Loyal employees have bills to pay and families to feed. In a good economy, they would never think of committing fraud against their employers.”<sup>35</sup> This is reminiscent of Maslow's need for safety and security gone awfully wrong.

The comments by Byron Hollis, Esq., CFE, AFHI, however, seem to draw a different conclusion, “Health care fraud has been with us for as long as we have had health-care insurance programs.

Fraud is driven by a basic human weakness. We are all tempted by greed and we all are intrigued by the idea of getting something for nothing. Unfortunately, some people succumb to the temptation at the expense of others.<sup>36</sup> This thinking would support the notion that greed can occur in any of the five levels.

Another popular belief is that scheme and organized greed are advanced by career criminals and organized crime groups. "In the North Carolina Medicare case, three subjects residing in North Carolina traveled to Florida where relatives taught them how to anonymously file false Medicare claims. They returned to North Carolina and began filing such claims. Unless people in your state don't have any connections to people in other states, chances are, somebody is using a sophisticated scam that they learned elsewhere."<sup>37</sup> Prosecutors will concur with this premise calling health care fraud: "regional and viral."

### Bad Actors, Bad Plays

"The plays the thing wherein I'll catch the conscience of the King."<sup>38</sup> Prosecutors talk about "bad actors" as the culprits in health care fraud. They also cite the inherent weaknesses in the Medicare and Medicaid systems ("the plays") that leave them vulnerable to attack. That leaves "conscience" as the remaining variable that can influence the outcome of events.

Lest we forget, the False Claims Act has its origins dating back to the Civil War. Perhaps it is inherent human characteristics that shape and define bad behavior that is not only found in health care, but in other industries, too. Recognizing that behavioral traits, economic concerns and opportunities may be "triggers" of the hierarchy of greed, then remedies and preventive actions can be tailored to limit the rash of fraud, abuse and waste that exists today.

If it were only that simple that we could treat celebrity data breach or identity theft with a dose of penicillin, we might be issuing a prophylactic dose to those in high risk areas. The examples of those losing their jobs, or facing stiff monetary penalties or incarceration may finally begin having a deterrent effect to limit recurrence. More involved and educated boards using stronger data-mining, and other protective layers and more effective training may further insulate organizations from corporate greed. New legislation pending in Florida, which will soon require DME and other type entities to post bonds (proposed to be about \$500,000) before obtaining their provider numbers is expected to cut down on the fly-by-night billing frauds that are found in scheme and organized greed. Even federal audits of the Medicare and Medicaid program point out that government contractors need to tighten and improve their review and payment processes to close those areas of vulnerability.

We hear a lot today about auto insurers offering "accident forgiveness," and that good drivers won't have their premiums raised if they have an accident. Given the level of audits, ranging from Recovery Audit Contractors (RACs) to state Office of the Medicaid Inspector General (OMIG), perhaps organizations that consistently pass these audits with stellar outcomes should be given this same dispensation either from future audits or an easement in the event of some accidental (not fraudulent) occurrence. We should consider that for good actors, there should be something other than the absence of a penalty.

With the prospect that health care reform legislation might be enacted sometime in the near future, we could hope to expect stronger internal and external controls. New regulations may help pave the way for it. There are, however, often unintended consequences that can emanate from legislation and regulation. Nationally, many jurisdictions have installed red-light cameras to promote intersection safety. While the number of red-light runners are reported down (and revenues up for violators), there has been concern with the number of rear-end collisions increasing in these situations. Behavioral changes need to occur, and training and re-education over time will be needed to fully realize the expected benefits.

If the hierarchy of greed can help explain in some way what is inside criminal minds, then it is possible that the remedy lies in the precision of the laser beam (e.g., task forces, data mining, and education, etc.) being trained and focused on the diseased portions of the brain (e.g., levels of greed) to remove the various lesions. It would be ironic to conclude that the scalpel might be mightier than the sword.

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<sup>25</sup> Army General Orders (For Boot Camp), presented at: <http://usmilitary.about.com/od/armyjoin/1/blbasicgenorder.htm>.

<sup>26</sup> Pope, A., "An Essay on Criticism."

<sup>27</sup> HHS News Release, Attorney General Holder and HHS Secretary Sebelius Announce New Interagency Health Care Fraud Prevention and Enforcement Action Team," May 20, 2009, available at: <http://www.hhs.gov/news/presw/2009pres/05/20090520a.html>.

<sup>28</sup> Du, H., Cullinan, C.P., and Wright, G.B., "Is There a Relationship Between Management Compensation and Revenue Misstatements," *Journal of Forensic Accounting (Article Abstract)*, Vol. VIII (2007) at 119.

<sup>29</sup> Lovata, L.M., Earnings Management: The Game," *Journal of Forensic Accounting (Article Abstract)* Vol. VIII (2007) at 227.

<sup>30</sup> Headline in: Security, Privacy and The Law, April 4, 2009, available at: <http://www.securityprivacyandthelaw.com/2009/04/articles/medical-information/another-day...>

<sup>31</sup> Headline in: Health Data Management, May 6, 2009, available at: [http://www.healthdatamanagement.com/news/breach-28169-1.html?type=printer\\_friendly](http://www.healthdatamanagement.com/news/breach-28169-1.html?type=printer_friendly).

<sup>32</sup> Headline in Fierce Healthcare, Dec. 19, 2006, available at: <http://www.fiercehealthcare.com/node/4505/print>.

<sup>33</sup> FBI Press Release: (Los Angeles Division), May 24, 2007, available at: <http://losangeles.fbi.gov/pressrel/la052407.htm>.

<sup>34</sup> Headline at: Blogger News Network, Feb. 14, 2008, available at: <http://www.bloggernews.net/113782>.

<sup>35</sup> Kostigan, T., "When going gets tough, the help embezzles," *MarketWatch*, May 29, 2009, available at: <http://www.marketwatch.com/story/story/print?guid=B7ECC957-371F-407F-95EA-4N98E>.

<sup>36</sup> "Health-care fraud drains lifeblood from patients, systems," *Fraud Magazine*, March/April 2006, at 2, available at <http://www.acfe.com/fraud/view-content.asp?ArticleID=542>.

<sup>37</sup> Mathias, R., "Health Care Fraud Schemes Committed by Career Criminals," *Mathias Consulting*, April 10, 2003, presented at: <http://mathiasconsulting.com/node/79/print>.

<sup>38</sup> Shakespeare, W., *Hamlet*, Act 2, scene 2, 603-605.

### Strike Force brings indictments for billing fraud

The Medicare Fraud Strike Force has brought charges against physicians, medical assistants, patients, company owners, and executives in Detroit, Michigan, and Miami, Florida.

The actions of the joint Department of Justice and Medicare Fraud Strike Force in Detroit is phase three of a targeted criminal, civil, and administrative effort against 53 individuals and health care companies that fraudulently billed the Medicare program. The Strike Force identified two primary areas, infusion therapy and physical therapy providers, in which schemes allegedly were orchestrated.

The health care providers allegedly participated in schemes to submit claims for treatments that were medically unnecessary or never provided. In addition, beneficiaries allegedly accepted cash kickbacks in return for allowing providers to submit forms saying the beneficiaries had received the treatments. Collectively, the physicians, medical assistants, patients, company owners, and executives charged are accused of conspiring to submit more than \$50 million in false claims.

In Miami-Dade County, the Strike Force has obtained indictments against eight Florida residents in connection with an alleged \$22 million Medicare fraud scheme operated out of Miami businesses purporting to specialize in home health care services. The indictments allege that ABC Home Health Care Inc. and Florida Home Health Care Providers Inc. recruited beneficiaries and paid them kickbacks and bribes for their Medicare beneficiary numbers to be used to file claims for home health care services that were not provided and were not medically necessary.

The U.S. Attorney also filed a civil complaint and obtained a temporary restraining order (TRO) freezing the assets of ABC, Florida Home Health, and certain defendants. The TRO also freezes certain financial assets of four other companies the health care providers owned or controlled and allegedly used to launder money. ■

*HHS News Releases, June 24 and 26, 2009*

## In the News

### Doctor gets 97 months for fraud scheme

Miami physician, Roberto Rodriguez, was sentenced to 97 months in prison for his role in a \$20 million Medicare fraud scheme involving HIV infusion services and ordered to pay more than \$9 million in restitution. Rodriguez admitted that he was a co-owner and practicing physician at Midway Medical Center Inc. where he and his co-conspirators routinely billed for services that were medically unnecessary or never provided. Most of the services allegedly provided were billed as treatments for low platelet counts in the blood. Rodriguez admitted that to make it appear that the patients actually had low platelet levels, he and his co-conspirators used chemists to manipulate the blood samples drawn from patients before the blood was sent to a laboratory for analysis. Rodriguez also admitted that he was medical director and practicing physician for five other Miami-area HIV infusion clinics where he engaged in similar activity.

*HHS News Release, June 29, 2009*

### State reports on cost and quality of care released

HHS Secretary Kathleen Sebelius released a series of new reports on health care cost and quality in all fifty states that the Secretary suggests highlight the urgent need for health reform across the nation. Each report includes data regarding the: (1) percent increase in family premiums since 2000, (2) hidden tax individuals and families pay as a result of subsidizing care for the uninsured, (3) percent of state residents without insurance, (4) overall quality ratings for health care in each state, and (5) the impact of failing to adequately invest in preventative measures that could prevent disease and illness. "The American people have been calling for reform, and they should not have to wait any longer," added Sebelius. "Health reform will assure quality affordable health care for all Americans, lower costs, and give more Americans the choices they deserve. The time for reform is now." The reports are available at [HealthReform.gov](http://HealthReform.gov).

*CCH Chicago Bureau, July 1, 2009*

### HHS rescinds and delays Medicaid regulations

CMS has announced that the Obama administration will rescind all or part of three Medicaid regulations and delay the enforcement of a fourth. Each of these rules had been subject to Congressional moratoria set to expire on July 1, 2009. The rescinded rules include: (1) a final rule, published December 28, 2007 (72 FR 73635), eliminating reimbursement for school-based administrative costs and costs of transportation to and from schools; (2) a rule, published November 7, 2008 (73 FR 66187), limiting the outpatient hospital and clinic service benefit for Medicaid beneficiaries to the scope of services recognized as an outpatient hospital service under Medicare; and (3) provisions of an interim final rule published December 4, 2007 (72 FR 68077), restricting beneficiary access to case management services. CMS also is delaying until June 30, 2010, the enforcement of portions of a regulation that clarified limitations on health care related tax programs so that CMS can determine whether states need additional clarification or guidance. CMS may also review the potential impact of the regulation, and give additional consideration to alternative approaches.

*CMS Medicaid News Release and Fact Sheet, June 29, 2009*