

# **Combating Health Care Fraud in a Post-Reform World:**

## **Seven Guiding Principles for Policymakers**

A White Paper Presented by  
The National Health Care Anti-Fraud Association  
October 6, 2010



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## About the National Health Care Anti-Fraud Association

Established in 1985, the National Health Care Anti-Fraud Association (NHCAA) is the leading national organization focused exclusively on combating health care fraud. We are unique among associations in that we are a private-public partnership—our members comprise the nation’s most prominent private health insurers as well as those federal, state and local government law enforcement and regulatory agencies having jurisdiction over health care fraud.

NHCAA’s mission is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud.

NHCAA pursues this mission by:

- Maintaining a strong private/public partnership in combating health care fraud;
- Providing unparalleled learning opportunities through the NHCAA Institute for Health Care Fraud Prevention (an affiliated but separate 501(c)3 organization);
- Providing information-sharing opportunities between our private and public sector members on health care fraud investigations and issues;
- Serving as a national resource for health care anti-fraud information and professional assistance to the government, the insurance industry and the media; and
- Recognizing and advancing professional specialization in the detection and investigation and/or prosecution of health care fraud through accreditation of health care anti-fraud professionals.

NHCAA Members include 87 private-sector insurance companies representing over 200 corporate entities, 75 public-sector members representing federal, state and local government departments and agencies, and more than 400 individual members who work in health care fraud investigative units. These professionals serve as the first lines of defense against health care fraud, which *conservatively* accounts for 3 percent of national annual health care spending—or \$70 billion.

NOTE: This White Paper is not intended to represent the official view of any federal, state or local government department or agency, nor does NHCAA purport to speak in official capacity on behalf of these entities.

## Introduction

Health care fraud is a serious and costly problem that affects every patient and every taxpayer across our nation. The financial losses due to health care fraud are estimated to range from \$70 billion to a staggering \$234 billion a year. These financial losses are compounded by numerous instances of patient harm—unfortunate and insidious side effects of health care fraud. As the historic Patient Protection and Affordable Care Act (PPACA) is implemented over the next several years, we urge policymakers and other stakeholders to increase the focus given to the problem of health care fraud. Any effort to truly reform our health care system without seriously and thoughtfully addressing health care fraud will not be true reform.

PPACA includes several important reforms that will allow both government agencies and private insurers to better detect, investigate and prosecute suspected fraud. Additionally, and just as importantly, PPACA includes substantial additional funding for the Health Care Fraud and Abuse Control (HCFAC) Program. As the federal and state governments move forward to implement PPACA through the regulatory and policy making processes, or as future health care legislation is considered, it is imperative that the focus on health care fraud contained in the legislation is sustained. Consequently, it is critical that lawmakers avoid policies that could undermine health care fraud fighting efforts. In this regard, the following seven principles should guide regulators and policy makers in the months and years ahead:

1. The sharing of anti-fraud information between private insurers and government programs should be encouraged and enhanced.
2. Data consolidation and real time data analysis must be at the forefront of health care fraud detection and prevention.
3. Pre-payment reviews and audits should be increased and strengthened.
4. Public and private health plans should be allowed to protect their enrollees by barring or expelling providers suspected of perpetrating health care fraud.
5. Health care providers participating in fraud should be sanctioned by their respective state licensing boards.
6. Health care provider identifier numbers should be made more secure.
7. Investment in innovative health care fraud prevention, detection and investigation efforts and programs should be encouraged.

# I. The Impact of Health Care Fraud

## A. Economic Costs

Health care fraud is a pervasive and costly drain on the U.S. health care system. In 2008, Americans spent \$2.34 trillion dollars on health care.<sup>1</sup> Of those trillions of dollars, the Federal Bureau of Investigation (FBI) estimates that between 3 and 10 percent was lost to health care fraud.<sup>2</sup> In other words, between \$70 billion and \$234 billion is essentially stolen from the American public through health care fraud schemes annually. To put the size of the problem into perspective, \$234 billion is roughly equivalent to the Gross Domestic Product of a nation the size of Columbia or Finland.<sup>3</sup>

Moreover, because spending on health care is projected to rise rapidly over the next ten years,<sup>4</sup> the cost of health care fraud is likely to rise as well. In other words, health care fraud is already a massive problem and is only going to get worse – unless more coordinated efforts are made to prevent and minimize it.

The enormous costs of health care fraud are borne by all Americans. Whether an individual has employer-sponsored health insurance, purchases his own insurance policy, or pays 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. As Collin Wong, a former head of California's Medi-Cal fraud unit explained: "Health care fraud often gets overlooked and even trivialized, because it's seen as a victimless paper crime. . . . But, in reality, the financial burden falls on all of us. We pay for it with heightened health care premiums, increased taxes to pay for social service programs or...the reduction of services."<sup>5</sup>

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 dissuade many individuals from purchasing insurance policies, leaving them unprotected should they contract a disease or sustain an injury. In many instances, these individuals turn to local hospital emergency departments, shifting even more pressure onto already overburdened systems. For governments, health care fraud translates into higher taxes, fewer benefits and increased budgetary problems.

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<sup>1</sup> HHS, Centers for Medicare and Medicaid Services, National Health Expenditures Web Tables, Table 1; available at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.

<sup>2</sup> See Federal Bureau of Investigation, Financial Crimes Report to the Public, Fiscal Year 2007 at 9 ("FBI Report"), available at [http://www.fbi.gov/publications/financial/fcs\\_report2009/financial\\_crime\\_2009.htm#health](http://www.fbi.gov/publications/financial/fcs_report2009/financial_crime_2009.htm#health).

<sup>3</sup> World Bank GDP 2009, PPP, <http://siteresources.worldbank.org/DATASTATISTICS/Resources/GDP.pdf>.

<sup>4</sup> See HHS, Centers for Medicare & Medicaid Services, National Health Expenditure Projections ("HHS Projections"), Table 1; available online at <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf>.

<sup>5</sup> Erin McCormick, "Defrauding Medicare—No End to Flood of Schemes," *San Francisco Chronicle*, Apr. 18, 2005.

## **B. Health Endangerment and Identity Theft**

In addition to being a financial problem, health care fraud has a significant human dimension. The victims of health care fraud include unsuspecting patients who are subjected to unnecessary or dangerous medical procedures. Patients also are the victims of medical identity theft, and may have their medical records falsified to support fraudulent claims. According to the FBI's Financial Crimes Report:

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.<sup>6</sup>

Regrettably, examples of these grave human consequences are all too common:

- In June 2010, a doctor and his wife were convicted of running a “pill mill” in a small town in Kansas. Posing as a pain management practice, the clinic run by the couple was open twelve hours a day and seven days a week and illegally dispensed controlled prescription drugs; meanwhile they collected more than \$4 million from 93 different private health insurance and government health care programs. The doctor was found to be responsible for more than 100 overdoses and at least 68 deaths over a six-year period. The doctor and his wife were convicted, among other counts, of health care fraud resulting in death (sentencing is scheduled for October 19, 2010).
- In January 2010, members of an organized crime ring were sentenced in Florida for a massive Medicare fraud involving five states and perpetrated against both Medicare and Medicare Advantage plans. The ring set up a series of sham clinics which submitted false and fraudulent claims for expensive medications allegedly used to treat HIV, AIDS, cancer and other diseases. Collectively, these clinics submitted more than \$110 million in false claims. To commit this fraud, the ring set up a massive identity theft scheme that allowed them to steal the identities of hundreds of legitimate Medicare beneficiaries around the country.
- A California doctor was sentenced in 2008 to ten years in federal prison for performing more than 400 unnecessary surgeries as a scheme to defraud insurance companies. The doctor paid his patients hundreds of dollars to undergo colonoscopies and "sweaty palm surgeries" (to combat excessive perspiration), then billed insurance companies for the procedures. Prosecutors claimed that the doctor offered little pre-op consultation, no follow-up appointments for these

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<sup>6</sup> FBI, Financial Crimes Report to the Public, Fiscal Year 2009 at 9 ("FBI Report"), available at [http://www.fbi.gov/publications/financial/fcs\\_report2009/financial\\_crime\\_2009.htm#health](http://www.fbi.gov/publications/financial/fcs_report2009/financial_crime_2009.htm#health).

patients, and in several cases risked puncturing his patients' lungs. The doctor's unnecessary surgeries accounted for 70 percent of his medical practice.<sup>7</sup>

The toll of this type of fraud on patients whose life and health are risked for personal gain or whose identities are stolen is both obvious and severe. But less-conspicuous forms of health care fraud can have effects that may not manifest themselves until years after the fraud is committed. For example, if a health care provider alters a patient's medical record in order to support reimbursement for a more expensive treatment than is warranted (whether or not the treatment is actually provided), this false diagnosis becomes part of the patient's documented medical history. Such an erroneous medical history can have serious, unseen consequences: the victim may unknowingly receive the wrong medical treatment from a future provider; he may have difficulty obtaining life insurance or individual health insurance coverage; or he may fail a physical examination for employment because of a disease or condition falsely recorded in his medical record.

The effects of medical identity theft also are pernicious and can plague a victim's medical and financial status for years.<sup>8</sup> For instance, stolen medical data can allow thieves to bill thousands of dollars in medical claims to insurance companies; when the victim of the theft eventually makes a legitimate claim, he may be informed by his insurance company that he has already reached his lifetime cap on benefits.<sup>9</sup> Alternatively, people who receive medical services under stolen identities can alter the medical records of the legitimate patient, leading to incorrect information on blood types, allergies and other aspects of the patient's medical profile, thereby jeopardizing the victim's life during the course of legitimate medical treatment.<sup>10</sup>

Given the impact on individual victims—both direct and indirect—it is clear that health care fraud is not a "victimless crime." The seriousness of the threat and the enormity of the challenge posed by health care fraud cannot be overstated. The FBI has bluntly summarized the problem: "[Health care fraud] increases healthcare costs for everyone. It is as dangerous as identity theft. Fraud has left many thousands of people injured. Participation in health care fraud is a crime. Keeping America's health system free from fraud requires active participation from each of us."<sup>11</sup>

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<sup>7</sup> "O.C. Doctor Sentenced to 10 Years for Insurance Fraud," *Orange County Register*, July 7, 2008.

<sup>8</sup> Joseph Menn, "ID Theft Infects Medical Records," *Los Angeles Times*, Sept. 25, 2006, A1. This article describes the ordeal of health care identity theft victims as a "40-hour-a-week job".

<sup>9</sup> *New York Times*, "Medical Problems Could Include Identity Theft," June 12, 2009.

<sup>10</sup> *Ibid.*

<sup>11</sup> FBI, "Financial Crimes Report to the Public," FY2006

## II. Fighting Fraud in a Post-Reform World: Seven Guiding Principles

PPACA includes several important reforms that will allow both government agencies and private insurers to better detect, investigate and prosecute instances of suspected fraud. It also includes substantial additional funding for the Health Care Fraud and Abuse Control (HCFAC) Program. However, as beneficial as these reforms are, more can be done to promote effective and aggressive anti-fraud efforts in our nation's health care system. Moreover, as reform is implemented, policies which are inconsistent with, or could potentially undermine, effective anti-fraud efforts should be avoided.

The following seven principles constitute a guide for policy makers as they implement health care reform and consider where we should go from here in the fight against this complex type of fraud. Adhering to these principles will improve the prevention, detection, investigation and prosecution of health care fraud.

### **1. The sharing of anti-fraud information between private insurers and government programs should be encouraged and enhanced.**

NHCAA has stood as an example of the power of a private-public partnership against health care fraud since its inception, and we believe that health care fraud should be addressed with private-public solutions: government entities, tasked with fighting fraud and safeguarding our health system, and private insurers, responsible for protecting their beneficiaries and customers, can and should work cooperatively on this critical issue of mutual interest.

The willingness of private insurers to share information with law enforcement is well documented. For the past several years, NHCAA has conducted a biennial survey of its private sector members that aims to assess the structure, staffing, funding, operations and results of health insurer investigative units. In the most recent survey report (with data collected in 2009), 100% of respondents reported that they responded to NHCAA Requests for Investigation Assistance (RIA) from law enforcement. RIAs allow government agents to easily query private health insurers regarding their exposure in active health care fraud cases. Furthermore, 89 percent of survey respondents state that they had shared case information at law enforcement-sponsored health care fraud task force meetings.<sup>12</sup>

Likewise, NHCAA's more than 75 law enforcement liaisons, which include such entities as the FBI, the Investigations Division of the HHS Inspector General's Office, and the Medicaid Fraud Control Units, regularly participate in NHCAA information-sharing meetings with private health insurers. The FBI routinely makes use of NHCAA's RIA process. On occasion, however, some government representatives have been under the misapprehension that they do not have the authority to share information about health care fraud with private insurers, creating an unnecessary yet significant obstacle in coordinated fraud fighting efforts.

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<sup>12</sup> NHCAA Anti-Fraud Management Survey for Calendar Year 2009, National Health Care Anti-Fraud Association, June 2010.

This misapprehension runs counter to sound fraud fighting strategy, and is inconsistent with Justice Department guidelines. DOJ developed guidelines for the operation of the Coordinated Health Care Fraud Program established by HIPAA to 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” recognizes the importance of a coordinated program, bringing together both the public and private sectors in the organized fight against health care fraud.<sup>13</sup>

Health care fraud does not discriminate between types of medical coverage, so long as some entity is paying. The same schemes used to defraud Medicare migrate over to private insurers, and schemes perpetrated against private insurers make their way into government programs. Additionally, many private insurers are Medicare Parts C and D contractors or provide Medicaid coverage in the states, making clear the intrinsic connection between private and public interests. It would greatly enhance the fight against health care fraud if both federal and state agencies clearly communicate with their agents the guidelines for sharing information with private insurers, emphasizing that information sharing for the purposes of preventing, detecting and investigating health care fraud is authorized and encouraged.

Peter Budetti, M.D., J.D., Deputy Administrator and Director of the Center for Program Integrity, CMS demonstrated his recognition of the value of greater information sharing during a September 22, 2010, Congressional subcommittee hearing: “Sharing information and performance metrics broadly and engaging internal and external stakeholders involves establishing new partnerships with government and private sector groups. Because the public and private sectors have common challenges in fighting fraud and keeping fraudulent providers at bay, it makes sense that we should join together in seeking common solutions.”

PPACA mandates an expanded federal "Integrated Data Repository" that will incorporate data from all federal health care programs. This is a major step in the right direction for analyzing claims data in a way which will allow potential losses to be stemmed and emerging schemes to be identified at the earliest possible time. In the future, as this federal data repository comes together, consideration should be given for appropriately sharing the information gleaned from this data with private health plans.

## **2. Data consolidation and real time data analysis must be at the forefront of health care fraud detection and prevention.**

The U.S. health care system spends \$2.3 trillion dollars and generates billions of claims a year from hundreds of thousands of health care service and product providers. The vast majority of these providers of services and products bill multiple payers, both private and public. For example, a health care provider may be billing Medicare, Medicaid, and several private health plans in which it is a network provider, and may also be billing other health plans as an out-of-network provider. However, when analyzing claims for potential fraud, no payer has

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<sup>13</sup> See <http://www.usdoj.gov/ag/readingroom/hcarefraud2.htm>.



information about the claims being received by the other payers from this same provider. In this sense, there is no health care “all claims database” similar to what exists for property and casualty insurance claims.<sup>14</sup> The absence of such a tool limits the effectiveness with which claims can be analyzed to uncover potential emerging fraud schemes and trends.

Given the diversity of providers and payers and the complexity of the health care system—as well as the sheer volume of activity—the challenge of preventing fraud is enormous. Clearly, the only way to detect emerging fraud patterns and schemes in a timely manner is to aggregate claims data as much as practicable and then to apply cutting-edge technology to the data to detect emerging fraud trends. The “pay and chase” model of combating health care fraud, while necessary in certain cases, is no longer tenable as the primary method of fighting this crime. In recognition of this fact, many health insurers are beginning to devote additional resources to predictive modeling technology and real-time analytics and applying them to fraud prevention efforts on the front end, prior to medical claims being paid.

The federal government also has recognized the importance of real-time data analysis as a key aspect of its HEAT initiative. Appreciating the depth and scope of the health care fraud problem, in May 2009, DOJ and HHS established a joint task force to combat fraud “hot spots” in select cities nationwide. Known as the Health Care Fraud Prevention and Enforcement Action Team, or “Project HEAT,” the program’s goals include improved data sharing—including access to real-time data—to detect fraud patterns, and strengthened partnerships between public and private health sectors and among federal agencies. The Strike Forces combine all Medicare paid claims into a single, searchable database which allows them to identify potential fraud more quickly and effectively. A future goal of the Strike Forces is to improve real-time data access to help stop fraud before it takes root.

At a Congressional subcommittee hearing on September 22, 2010, HHS Inspector General Daniel R. Levinson stated, “We are committed to enhancing existing data analysis and mining capabilities and employing advanced techniques such as predictive analytics and social network analysis, to counter new and existing fraud schemes.”

Congress has demonstrated that same commitment through the Small Business Jobs and Credit Act of 2010 signed into law by President Obama on September 27. It includes language that establishes predictive analytics technologies requirements for the Medicare fee-for-service program, directing the HHS Secretary to use predictive modeling and other analytics technologies to identify improper claims for reimbursement and prevent their payment. The language describes a four-year implementation process and addresses contractor selection, qualifications, data access requirements and program evaluation. Use of predictive analytics in fraud detection shall commence by July 1, 2011, in 10 states identified by the Secretary as having the highest risk of waste, fraud, or abuse in the Medicare fee-for-service program.

PPACA also highlights the importance of fraud prevention through data consolidation and analysis by mandating a federal “Integrated Data Repository” that will incorporate data from all

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<sup>14</sup> See <https://claimsearch.iso.com>

federal health care programs. This is a major step in the right direction for analyzing claims data in a way which will allow potential losses to be stemmed and emerging schemes to be identified at the earliest possible time.

### **3. Pre-payment reviews and audits should be increased and strengthened.**

Health care fraud is able to proliferate because it exists in an environment where payment to providers is predicated on an "honor system," essentially mandating both public programs and private health insurers to pay claims quickly or face penalties. This honor system derives from a combination of federal and state law "prompt pay" requirements and the enormous volume of health care claims. While data analysis systems are improving, most claims are not reviewed until after they are paid, if at all. While hundreds of millions of dollars have been recovered in health care fraud enforcement efforts, this "pay and chase" mentality will never sufficiently address fraudulent providers, particularly the kind of "phantom providers" who simply can take their ill-gotten windfalls and disappear. Therefore, it is essential that additional leeway is given to private and public programs in resolving suspected fraudulent claims: if claims are not rushed through the payment process, auditors and investigators will have more opportunities to detect attempts at fraud before they come to fruition.

PPACA allows the HHS Secretary to suspend payments to a particular provider "pending an investigation of a credible allegation of fraud, unless the Secretary determines there is good cause not to suspend such payments." The legislation also makes a number of specific changes related to the provision of DME supplies and home health care services identified by the law as "high risk" for fraud:

- It requires a 90-day payment waiting period on initial DME claims in order to conduct enhanced oversight when the HHS Secretary identifies a significant risk of fraud. Unfortunately state "prompt pay" laws effectively pre-empt or prohibit such waiting periods for non-Medicare and non-DME initial claims, helping fraudsters to flourish in other areas.
- Providers who order DME supplies or home health care services must themselves be enrolled in the Medicare program before they can order those supplies or services for Medicare beneficiaries.
- Providers must maintain specific documentation in connection with "high risk areas," primarily DME supplies and home health services. These providers can be disenrolled from Medicare if they fail to maintain this documentation.
- "Face-to-face" encounters with patients are required before a provider can issue "eligibility certifications" for home health services or durable medical equipment.

Likewise, audits play an invaluable role in discovering providers participating in fraud schemes, especially those regarding pharmacy and durable medical equipment (DME). For example, some criminals have set up "phantom pharmacies" and submitted large volumes of false claims to Medicare over a short time period. Medicare paid more than \$1 million to one such "pharmacy" in Florida in just two months. When authorities finally arrived to investigate, the "pharmacy"

turned out to be an empty storefront.<sup>15</sup> On-site audits have revealed indications of fraud such as nonexistent pharmacies, unexplained stockpiles of controlled substances, mismatches between inventories and prescriptions and other discrepancies.

Proposed federal and state legislation that would require payers to provide providers advance warning of an audit—even in cases when fraud is suspected—would give suspects time to tamper with evidence and evade authorities altogether. We support measures that would instead protect the integrity of health care audits by giving auditors more discretion and flexibility to perform their duties.

#### **4. Public and private health plans should be allowed to protect their enrollees by barring or expelling providers suspected of perpetrating health care fraud.**

Medicare and various states require payers to accept "any willing" licensed provider into their networks, making it difficult to exclude providers suspected of fraud. For instance, when a California health insurer discovered that heart surgeons at several hospitals were performing a large volume of medically unnecessary cardiac bypass surgeries and tried to expel the offending surgeons and hospitals from its network, the insurer was sued.<sup>16</sup>

There are proposals at the federal level to allow "any willing" licensed pharmacist not convicted of a crime to participate in employer-sponsored plan networks. This low standard of admission could allow for the participation in employer networks of pharmacists who have been suspended from government programs. Even if they have records of harmful prescription errors or a high number of consumer complaints, they would still be potentially eligible in the absence of a criminal conviction. Other federal and state legislative proposals would require waiting periods before a payer can remove a provider from a network and effectively allow suspected fraud schemes to continue even after being identified.

Roughly half of the states impose "any willing" provider and/or pharmacy requirements on health insurance plans, yet these laws do not typically address circumstances where the provider has previously been charged with fraud. Instead, the laws generally obligate health plans to accept into their networks any licensed provider willing to accept their contract terms, limits and conditions. These statutes appear to work on the assumption that rigorous state licensing and oversight is already in place, whereby providers found guilty of health care fraud would lose their license and therefore be excluded from a plan's network. Sadly, this assumption does not typically hold true.

In contrast, PPACA creates the opportunity for additional and enhanced screening of providers who are participating or seek to participate in Medicare and Medicaid. Specifically, the law instructs the HHS Secretary to determine by regulation "the level of screening" for provider enrollment "according to the risk of fraud, waste, and abuse...with respect to the category of provider of medical or other items or services or supplies." This permits the Secretary to impose

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<sup>15</sup> "Medicare Fraud Costs Taxpayers More Than \$60 Billion Each Year," *ABC News*, March 17, 2010.

<sup>16</sup> "Hospital CEO Says Cardiac-Care Study Hurt His Reputation," *San Francisco Chronicle*, December 2, 2003.

additional oversight of specific health care areas in which there are significant fraud concerns such as Durable Medical Equipment (DME) suppliers, home health agencies and Community Mental Health Centers.

The proposed rule issued by CMS in September 2010 implementing these provisions of PPACA offers several prescriptive regulations aimed at aggressively addressing fraud in Medicare, Medicaid and the Children’s Health Insurance Program (CHIP). Focused on fraud prevention rather than a “pay and chase” mode of fraud fighting, the Secretary’s regulations would suspend payments to a provider once there has been a "credible allegation" of fraud that merits additional investigation. State Medicaid programs would be instructed to cease using medical providers that have been expelled from Medicare or another state's Medicaid or CHIP program. The proposed regulations also put in place additional screening procedures for provider enrollment, including mandatory licensure checks; providers who are deemed “high risk” could additionally be subject to fingerprinting, site visits and criminal background checks prior to billing Medicare, Medicaid or CHIP.

Policy makers should follow PPACA’s lead and allow for enhanced screening of health care providers by health plans as well as all government programs. “Any willing provider” laws and similar proposals run counter to this sound fraud prevention solution.

**5. Health care providers participating in fraud should be sanctioned by their respective state licensing boards.**

State medical, pharmacy and other licensing boards—intended as a frontline in the protection of patients—are inconsistent in their sanctions arising from fraudulent activities on the part of the providers they are responsible for licensing.<sup>17</sup>

One analysis revealed that over a ten-year period, only 40 percent of physicians found guilty of criminal misconduct related to the practice of medicine had their licenses revoked, surrendered, or suspended.<sup>18</sup> Furthermore, only 26 percent of physicians convicted of Medicare, Medicaid, and/or private insurance fraud had their licenses taken away over the same period.<sup>19</sup> This lag between adjudication and revocation allows unethical providers to continue to defraud these programs and place patients in harm’s way.

For example, in 2008, a New York pharmacist was convicted of running a multi-million dollar "pill mill" that filled tens of thousands of phony prescriptions for drug addicts abusing pain killers. While this conviction finally shut the fraudster down, two previous episodes of professional misconduct had resulted in only minor fines and no interruptions of his practice.<sup>20</sup>

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<sup>17</sup> Jung, Paul, et. al., "U.S. Physicians Disciplined for Criminal Activity," *Health Matrix*, Vol. 16:335, Summer 2006

<sup>18</sup> Ibid.

<sup>19</sup> Ibid.

<sup>20</sup> ABC 7 News, "Police Bust Alleged LI Prescription Drug Ring," March 22, 2007; NYED, Office of the Professions, Summaries of Regents Actions on Professional Misconduct and Discipline, March 2008.

A 1998 study examined how and if state medical boards pursued adverse licensing actions against medical providers convicted of felony charges related to insurance fraud.<sup>21</sup> The study looked at 251 providers across 12 states and classified them under the following categories of adverse board actions: warning, censure, license suspension, license revocation, and other (i.e. surrender of license, fines, probation, reprimand, etc.). Of the 251 cases, only 18 percent (46 practitioners) no longer possessed their licenses to practice as a result of committing fraud—through either license revocations (33 practitioners) or voluntary license surrenders (13). A full 57 percent of those studied, or 144 practitioners, had had no action taken against them despite a fraud conviction.

Even with a criminal conviction on their records, these providers retain the imprimatur of legitimacy as long as they hold their medical or pharmaceutical licenses. State licensing boards should be encouraged and empowered to act swiftly and boldly whenever one of their licensees is convicted of health care fraud.

## **6. Health care provider identifier numbers should be made more secure.**

The National Provider Identifier (NPI), established under HIPAA, is a unique identification number for covered health care providers. NPIs are used in claim submissions, remittances, eligibility and enrollment determinations, referrals and authorizations. This powerful, unique identifier should be considered sensitive information, yet NPIs are readily available online to anyone with internet access.<sup>22</sup> In his capacity as Chair-elect of the American Medical Association Ardis Hoven, M.D., urges greater safeguarding of provider identifiers:

"One area HHS can address relates to the growing problem of physician identity theft," said Dr. Hoven. "Physicians have no ability to control access to their National Provider Identifier (NPI), and the federal government is aware of its misuse by criminals. HHS can take immediate steps to limit access to the NPI and create a national office to help physician victims of identity theft restore their good standing."<sup>23</sup>

Other sensitive provider information, such as a provider's Drug Enforcement Administration (DEA) registration number and tax ID number (TIN), are often readily accessible on loose paper documents or unsecured on the Internet. Lack of safeguards to protect provider information allows criminals to illegally obtain controlled substances and perpetrate billing fraud.

In 2009, a physician's assistant at a Los Angeles clinic stole a physician's ID number to prescribe hundreds of motorized wheelchairs to Medicare patients who did not need them. The doctor whose identification had been stolen had never worked at the clinic, nor had he authorized

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<sup>21</sup> Coalition Against Insurance Fraud, "Licensed to Steal: Action and Inaction by State Medical Boards," October, 1998.

<sup>22</sup> See <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

<sup>23</sup> See <http://www.ama-assn.org/ama/pub/news/news/health-care-fraud-summit.shtml>.

any of the prescriptions. Investigators later discovered that, for each phony prescription, the clinic had received a kick-back from the wheelchair provider.<sup>24</sup>

Another Los Angeles doctor discovered that someone had obtained her physician identification number and had used it to bill for phony MRI exams; the thieves had recruited patients to participate in their scheme, or had created "phantom patients" to complement their phantom services.<sup>25</sup> After the doctor alerted law enforcement to these phony billings, they uncovered an organized fraud ring that had stolen an additional 19 legitimate provider identities and defrauded Medicare of nearly \$7 million.<sup>26</sup>

Medical and pharmacy provider identifications need to be treated as critical data and should be tightly and scrupulously secured. Additionally, legitimate, honest medical providers should be educated as to how best to protect their individual IDs to decrease exposure to scammers.

### **7. Investment in innovative health care fraud prevention, detection and investigation efforts and programs should be encouraged.**

Payers have found it far easier and more cost effective to prevent fraud than to investigate and prosecute it after the fact. This is especially true regarding cases of low-dollar fraud. Though there is an enormous volume of such activity, payers have little economic incentive to expend large amounts of money trying to recover an individual claim of \$40 or \$50. For these reasons, it is especially important that fraudulent patterns be detected beforehand using real-time data analysis so that investigations can proceed also in real time and fraudulent providers can be quickly identified and expelled from networks.

Additionally, health care fraud is a crime that directly affects patient safety. It is as much a quality of care issue as it is a financial issue. In his opening statement during a recent Congressional subcommittee hearing on "Cutting Waste, Fraud, and Abuse in Medicare and Medicaid," Representative Henry Waxman stated, "Health care fraud does more than cost money. It corrodes the quality of care, and weakens the Medicare and Medicaid programs."<sup>27</sup>

Submitting patients to unnecessary and sometimes dangerous procedures, diverting prescription drugs for gain and misuse, allowing unlicensed health care providers to have access to patients, and stealing patient identities all undermine the quality of our nation's health care system. Fighting health care fraud isn't just about recovering money lost to fraud; it's about protecting patients from fraud's devastating effects. The plague of health care fraud directly impacts health care quality.

Policies that set medical loss ratios that fail to recognize the direct connection between fraud and health care quality discourage health plans from investing in anti-fraud programs. Such policies

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<sup>24</sup> Department of Justice, "Jury Convicts Los Angeles Physician Assistant for Stealing Doctor's Identity and Defrauding Medicare in \$7.7 Million Scheme," July 1, 2009.

<sup>25</sup> *Los Angeles Times*, "U.S. Cracks Down on Healthcare Fraud," August 27, 2010.

<sup>26</sup> *Ibid.*

<sup>27</sup> See <http://energycommerce.house.gov/documents/20100922/Waxman.Statement.09.22.2010.pdf>.

also fail to take into account the financial importance of fraud prevention programs as compared with the recovery of dollars already lost to fraud. The more fraud a health plan prevents, the lower the insurer's payout for fraudulent claims.

Policies which impede private health insurer investment in anti-fraud programs also run counter to the direction taken by PPACA. The legislation creates significant additional funding for anti-fraud efforts. Overall, PPACA provides \$350 million in additional funding for the Health Care Fraud and Abuse Control Account between 2011 and 2020. At the same time, there is additional funding provided for the Medicaid Integrity Program, which should increase funding and expand the years for which funding is authorized.

## **Conclusion**

The Obama Administration and members of Congress from both sides of the aisle should be commended for their commitment to aggressively addressing the problem of health care fraud. But it would be a mistake to confuse this commitment with the heralding of a turning point in the war against fraud. By and large, fraudsters are mobile, elusive and innovative, coming up with new schemes and targeting different populations every year. Government authorities and private insurers, despite their best efforts, currently are only able to catch a relatively few perpetrators and recover a fraction of the monies stolen. The commitment to stopping health care fraud must be matched with sound policy decisions and sufficient resources, be they financial, technological or legal. It is our hope that policy makers are guided by the seven principles detailed in this paper so that we as a nation can truly turn the tide in this war and safeguard health care quality for all Americans.