DOJ AND OIG STRATEGIES FOR FIGHTING HEALTH CARE FRAUD

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Dallas, Texas
April 19, 2010

PROJECTED MEDICARE & MEDICAID SPENDING AND ESTIMATED FRAUD 2005-2015 ($ IN BILLIONS)

$1,500
$1,250
$1,000
$750
$500
$250
$0


Medicare & Medicaid
Medicare (Part D:+20%in'06)
GAO Fnd+10%M&M
NHCAA Fnd+3%M&M
TOP MANAGEMENT CHALLENGES FACING HHS HEALTH CARE PROGRAMS:

1. Integrity of Provider and Supplier Enrollment
2. Integrity of Health Care Payment Methodologies
3. Promoting Compliance with Program Requirements
4. Oversight and Monitoring of the Programs
5. Response to Fraud and Vulnerabilities
6. Quality of Care

PUBLIC PERCEPTION

- 20% of Americans say it’s acceptable to defraud insurers
- 40% say it’s okay to exaggerate claims to beat the deductible
- One-third of doctors say it’s necessary to “game the health care system”
- Over one-third of doctors say their patients ask them to help them obtain fraudulent coverage for services
HEALTH CARE FRAUD SPREADS LIKE A VIRUS

- Health care fraud criminals have developed a perception that there is a low probability of detection.

- This perception leads to duplication of known profitable fraud schemes. This duplication makes detection through data analysis possible.

- Opportunity exists when payers fail to analyze claims data accurately - thus, furthering the belief that the likelihood of detection is low.

- Within geographic communities, criminal conduct spreads based upon exposure to repeated outcomes – undetected and profitable criminal enterprises look rewarding to others.

- Law enforcement must address all three areas in order to deter crime: (i) better detection, (ii) more appropriate punishment, and (iii) faster arrest and prosecution.

HEAT: HEALTH CARE FRAUD PREVENTION AND ENFORCEMENT ACTION TEAM

- Cabinet-level Attention and Coordination
- Prevention -- Detection -- Enforcement
- Increased Use of Technology to Prevent and Detect Fraud
- Expansion of Medicare Fraud Strike Forces (“MFSF”) and Investigative Techniques
- Recommendations to Remedy Vulnerabilities
- National Summit on Health Care Fraud
  - Public-Private Collaboration
OIG EFFORTS INTEGRAL TO HEAT

- PREVENTION
  - Identify Fraud Vulnerabilities and Recommend Remedies
  - Promote Compliance
  - Deter Fraud through Enforcement

- DETECTION
  - Analyze Data to Identify Suspicious Billing

- ENFORCEMENT
  - Pursue Criminal, Civil, and Administrative Actions
  - Spotlight on MFSE

Medicare Fraud Strike Force:
U.S. Dept. of Justice, Criminal Division
U.S. Attorney’s Offices
HHS-OIG
FBI
Medicaid Fraud Control Units
Local and State Law Enforcement

Miami
Los Angeles
Houston
Detroit
Brooklyn
Tampa
Baton Rouge
Medicare Fraud Strike Force

- Prosecutors from DOJ Fraud and USAOs
- Investigators from HHS-OIG, FBI, MFCUs, and other law enforcement agencies
- Target highest HCF areas
- Fast acting, real time investigation and prosecution of ongoing billing schemes

WHO IS COMMITTING THE FRAUD TARGETED BY MFSF?

- Medicare Beneficiaries
- Company Owners
- Collateral Service Providers
- PAs – RNs, OTs, SLTs
- Diagnostic Testing
- Billing Companies
- Consultants
- Lawyers
- Check Cashers
- Fitters
- ALFs
THE NAME OF THE GAME: DETERRENCE

- Prison following prosecution will not stop health care fraud – we must deter crime before it occurs.

- Criminal’s Thought Process (PSR):
  i. Probability of Detection;
  ii. Severity of Punishment; and
  iii. Relationship in time of Punishment to Crime.

- The most important factor for deterrence is the criminal’s perception of the chances of detection.

- In most instances of health care fraud, the first chance you have to detect a crime is when the claim is filed. The more you detect at this level, the more you directly impact the perception of detection.

Enhanced Punishments

- Health Care Reform Law addresses need for more substantial punishments

- Increases in sentencing ranges specifically for Health Care Fraud
- In a “typical” case, enhancements could result in 1-4 years in additional prison time.
TOP FRAUD CODES AND LINKAGE

- Nonsensical Patterns
  - Single Broad-Based Diagnosis for all Patients
  - Same Treatment Regimens for all Patients
  - Treatments that are Rarely used for stated Diagnosis
  - Matching Dates of Evaluation, Treatment and Repeated Service
  - Watch for lack of follow-up care
  - Geographical Disparity
  - Inconsistent Diagnosis
  - Impossibly large number of Providers
  - Providers with impossibly large number of Patients

EXAMPLE: Miami HIV Infusion Clinics

“By 2005, the three South Florida counties accounted for 72 percent of submitted charges for beneficiaries with HIV/AIDS nationwide, though only 8 percent of such beneficiaries lived there. Most of these charges were for drugs used in infusion therapy.”
WHY INITIATE INVESTIGATIONS BY ANALYZING CLAIMS DATA?

- The process of filing claims for payment is the culmination of a series of actions for those committing crime - the goal of those actions is achieving payment.
- Unlike actors who are driven to help patients improve their health or overcome illness, many criminal defendants engage in fraud simply to steal money.
  - Claims data is the first opportunity to observe a provider's conduct.
    - People seeking reimbursement give vital information about what they are doing for the purpose of getting paid.
    - We have an obligation to fully review that information to assure that we are spending taxpayer and insurer money responsibly.
      - We are not mining public data but analyzing information that people supply so that they can get paid.
      - By intelligently reviewing claims we can do a better job of deterring crime.

MEDICAL CLAIMS, CODES AND MODIFIERS AS EVIDENCE

FOCUS ON COMMON SENSE QUESTIONS:

- Who are the patients and providers?
- What are the prevalent diseases and treatments?
  - What is medically possible?
  - What is medically likely?
  - What is medically reasonable?
  - Reverse questions: impossible, unlikely, and unreasonable
**MFSF RESULTS**

**Graph 1:** Total Medicare Fraud Strike Force Prosecutions (as of March 15, 2010)

- **Cases Filed:** 508
- **Defendants Charged:** 508
- **Trial Convictions:** 27
- **Pending (Trial or Plea):** 149
- **Guilty Pleas:** 273
- **Fugitives:** 48
- **Dismissals:** 5
- **Acquittals:** 7

**Graph 2:** Fraudulent Claims Billed and Paid in Medicare Fraud Strike Force Cases, as of March 15, 2010 ($ in Millions)

- **Total Billed/Submitted:** $1,058
- **Intusion:** $344
- **DME:** $524
- **Phys/Occ Therapy:** $43
- **Home Health:** $84
- **Pharmacy:** $49
- **Other Services:** $14
- **Amount Paid:** $427
**MFSF RESULTS**

Graph 7: DME Submitted & Paid in S/FL (Miam-Dade & Broward Cos) Since Medicare Fraud Strike Force vs Previous 12-Month Period

<table>
<thead>
<tr>
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<th>March 2006-Feb 2007</th>
<th>March 2007-Feb 2008</th>
<th>Savings During MFSF</th>
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<tr>
<td>DME Submitted</td>
<td>$2.761</td>
<td>$1.013</td>
<td>$1.747</td>
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<tr>
<td>DME Paid</td>
<td>$0.687</td>
<td>$0.353</td>
<td>$0.334</td>
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**PROSECUTIONS DOJ-wide**

Chart 2: Criminal Health Care Fraud Defendants, FYs 1997-2009
**STRIKE FORCE PROSECUTIONS**

Graph 3: Total Medicare Fraud Strike Force (All Phases) as of 3/15/2010
Cased Filed and Defendants Charged by Fiscal Year, 2007-2010

<table>
<thead>
<tr>
<th></th>
<th>FY 2007</th>
<th>FY 2008</th>
<th>FY 2009</th>
<th>FY 2010</th>
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<tr>
<td>Cases Filed</td>
<td>79</td>
<td>83</td>
<td>82</td>
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<tr>
<td>Defendants Charged</td>
<td>254</td>
<td>127</td>
<td>120</td>
<td>52</td>
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**HOT AREAS OF CRIMINAL ENFORCEMENT**

- HCF prosecutions, heightened scrutiny
  - Infusion Therapy
  - PT/OT
  - DME
  - Home Health
  - Outpatient rehab - CORF/ORF
  - Skilled Nursing Facilities
  - Physicians

- Health Care Reform Law targets DME and Home Health companies for added oversight
CIVIL AND ADMINISTRATIVE ENFORCEMENT

- Civil Actions – historically result in greatest monetary recoveries
  - Pharmaceutical Manufacturers, Pharmacies
  - Device Manufacturers
  - Hospitals
  - Nursing Facilities
- Administrative Actions – focus on individual accountability
  - Responsible Corporate Officials
  - Solicitors of Kickbacks

SYSTEMIC REMEDIES: Prevent Fraud, Increase Risk of Detection

- Investigations and evaluations identify fraud vulnerabilities and recommend remedies
- Health Care Reform – many integrity provisions consistent with OIG recommendations
  - Enhanced provider screening
  - Greater access to information
  - Increased reporting/transparency
  - Payment suspension
  - Compliance programs