Oh No! What?
Another Risk Assessment?

A Fraud Risk Assessment.

H2J, Thursday April 22, 2021, 10.50-11.50a CDT

Sonal Shah, CPA, MSPA, CHC, CGMA

Former Sr. Vice President, Chief Compliance and Risk Officer

HCCA Health Care Compliance Association

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Career Responsibilities

- Risk,
- Compliance and Ethics,
- Internal Audit,
- Enterprise Risk Management (ERM),
- Privacy,
- Vendor Management,
- Conflict of Interest, and
- Investigations.

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Career Profile

- Public Accounting Firms
- Aetna

- Yale New Haven Health
- Landmark Medical Center
- Tufts Medical Center
- Hartford HealthCare
- Harvard University – School of Dental Medicine
- Stanford University
- Easter Seals Bay Area

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Disclaimer

(To prevent any misunderstanding)

- The Views in this Presentation are My Individual Views.
- And, do not necessarily reflect the Views or Policies of any of my Previous Employers.

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The Goal of our Discussion Today…

- What is Fraud?
- Learn how to conduct a Fraud Risk Assessment (FRA).
- Combine it with other Assessments.
- Design Preventive and Detective Controls.
- Explore the use of Data Analytics.
- Study three recent case studies/enforcement actions.

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Fraud

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FRAUD

What is Fraud?

Three Elements

1. Misconduct or Abuse

2. Wrongful or Criminal Deception

Intended to Result in

3. Enrichment

Financial Gain or Personal Gain

Synonyms

fraudulence · sharp practice · cheating · swindling · trickery · artifice · deceit · deception · double-dealing · duplicity · treachery · chicanery · skulduggery · imposture · embezzlement · monkey business · funny business · crookedness · hanky-panky · shenanigans · flimflam · jiggery-pokery · monkeyshines · management · knavery · trick · cheat · hoax · subterfuge · stratagem · wile · ruse · swindle · racket · scam · con · con trick · rip-off · legpull · sting · gyp · kite · diddle · fiddle · swizzle · bunco · boondoggle · hustle · grift · rort

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Cost of Fraud

Financial impact

- Direct losses
- Indirect losses
- Increased credit risk
- Cost of Fraud Management, and
- Cost of Recovery

Reputational impact

- Reliability
- Ethics

Psychological impact

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Why do People commit Fraud?

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Some people are honest all of the time.
Some people are dishonest all of the time.
Most people are honest some of the time.
Some people are honest most of the time.

-Tommie Singleton, Ph.D., University of Alabama

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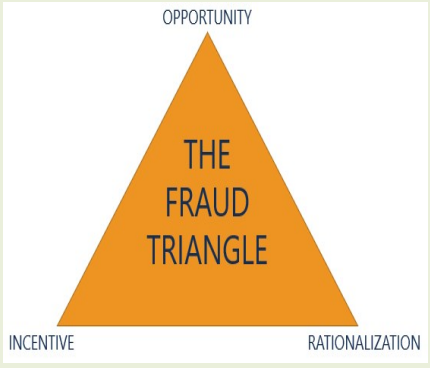
What are the Components of Fraud?

The Fraud Triangle



- **What is the Fraud Triangle?**
- The fraud triangle is a framework commonly used in auditing to **explain the motivation** behind an individual's decision to commit fraud.
- The fraud triangle outlines three components that contribute to increasing the risk of fraud:

(1) Opportunity – ability to execute plan without being caught,

(2) Incentive – financial or emotional force pushing towards fraud, and

(3) Rationalization – personal justification of dishonest actions.

Adapted from the Corporate Finance Institute (CFI) Website.

- Removal of one or more of these components will act as a **deterrent** to fraudulent activity.

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Fraud and Compliance

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Fraud as seen through "the Compliance Lens"

Promote Compliant and Ethical Behavior

Strive to Ensure:

- **Income Earned and Funds Entrusted are Used Responsibly and for their Intended Purpose.**
- **Operations and Activities are Conducted for the Intended Purpose.**

Encourage actions of a:

- **Fiscally Conscientious Nature, and**
- **Ethically Acceptable Nature.**

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U. S. Department of Justice, Criminal Division
Evaluation of Corporate Compliance Programs
Introduction

Updated June 2020

Moreover, the memorandum entitled "Selection of Monitors in Criminal Division Matters" issued by Assistant Attorney General Brian Benczkowski (hereafter, the "Benczkowski Memo") instructs prosecutors to consider, at the time of the resolution,

"whether the corporation has made significant investments in, and improvements to, its corporate compliance program and internal controls systems" and

"**whether remedial improvements to the compliance program and internal controls have been tested to demonstrate that they would prevent or detect similar misconduct in the future**"

to determine whether a monitor is appropriate.

We recognize that each company's risk profile and solutions to reduce its risks warrant particularized evaluation.

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Adapted from an Article in the Forbes Magazine:

DOJ's Updated Guidance for Evaluating Corporate Compliance Programs

Jonathan Sack, Contributor, The Insider Contributor Group

Dated June 30, 2020

First, corporate compliance programs, to be deemed genuine and effective by DOJ, **must be examined, tested and updated on a continual basis**, including (and perhaps especially) during a government investigation.

Compliance efforts should integrate **current data analytics** capabilities wherever possible.

If **deficiencies** are found, then **changes** should be made, and the 2020 Guidance makes clear that DOJ expects **regular review** of compliance efforts.

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Seven Elements of an **Effective Compliance Program**

Also, "Best Business Practices"

1. **Standards and Procedures.**
2. **Governance, Organization and Reporting.**
3. **Efforts to Include only Personnel consistent with an Effective Compliance and Ethics Program.**
4. **Training and Education.**
5. **Program Monitoring and Auditing, Evaluation of Program Effectiveness.**
6. **Performance Incentives, Consistent Enforcement/Appropriate Discipline.**
7. **Responding to Non-compliance and Modifying the Program as Necessary.**

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The pandemic has resulted in unprecedented business and financial disruption, exposing most companies to the risk of corruption, fraud and other economic crimes. In such times, it is imperative to give prompt attention to a robust anti-fraud and compliance framework to prevent, detect and remedy unethical actions.

From a White Paper of Ernst & Young, 2020, Covid -19: unravelling fraud and corruption risks in the new normal
Rupinder Malik Partner, J. Sagar Associates

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Dealing with potential fraud risks amidst limited business operations in the next three to six months.

Prioritizing fraud risk assessments

As businesses gear up and resume operations, albeit with limited capacities and workforce, organizations and their legal, risk and compliance teams should relook at identifying fraud risks. Management should reassess the company's risk quotient, state of regulatory compliance, conduct internal investigations if needed while preserving the credibility and discoverability of the evidence collected for litigation proceedings and tighten anti-fraud and compliance framework.

From a White Paper of Ernst & Young, 2020, Covid -19: unravelling fraud and corruption risks in the new normal

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Types of Health Care Fraud

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What is Health Care Fraud?

Fraud in our nation's health care system, including that in the Western District of Michigan, results in losses of millions of dollars every year from the Medicare, Medicaid, and private insurance programs.

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Beneficiaries and other recipients of health care pay for these significant losses through higher premiums, increased taxes, and reduced services.

Health care fraud occurs when an individual, a group of people, or a company knowingly mis-represents or mis-states something about the type, the scope, or the nature of the medical treatment or service provided, in a manner that could result in unauthorized payments being made.

From the Website of the United States Department of Justice, Western District of Michigan, Updated December 30, 2019

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Examples of health care fraud include:

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Billing for services not rendered or goods not provided:

- Falsifying certificates of medical necessity and billing for services not medically necessary;
- Billing separately for services that should be included in single service fees;
- Falsifying plans of treatment or medical records to justify payments;
- Misrepresenting diagnoses or procedures to maximize payments;
- Misrepresenting charges or entitlements to payments in cost reports; and
- Soliciting "kickbacks" for the provision of various services or goods.

From the Website of the United States Department of Justice, Western District of Michigan, Updated December 30, 2019

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Hospital Fraud

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What is hospital fraud?

Hospital fraud under the False Claims Act encompasses a wide variety of schemes used by hospitals to increase reimbursements from federal and state health insurance programs, such as:

- billing for unnecessary medical services,
- billing for improper patient admissions,
- improperly seeking reimbursement for costs,
- billing for more expensive healthcare services than what was provided, and
- paying kickbacks to obtain patient referrals.

Adapted from the Website of Vogel, Slade & Goldstein, LLP

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Coding Fraud

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What is medical coding fraud?

Coding fraud involves the knowing submission of claims to government insurers with incorrect:

- billing codes,
- diagnostic codes,
- units of service,
- dates of service, or
- service providers.

Adapted from the Website of Vogel, Slade & Goldstein, LLP

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Anti-Kickback and Stark Act Violations

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What are the Anti-Kickback Statute and Stark Act Violations?

An Anti-Kickback Statute violation is

- the exchange of (or offer to exchange)
- anything of value
- for the referral of federal health care program business.

Stark Act violations involve

- physician referrals for health services (covered by Medicaid or Medicare)
- to entities **with which the physicians or their family members have financial relationships.**

Adapted from the Website of Vogel, Slade & Goldstein, LLP

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Ambulance Transport Fraud

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What is ambulance transport fraud?

Ambulance transport fraud involves any scheme to get Medicare or Medicaid reimbursement for ambulance transports or services that were:

- not medically appropriate or
- were otherwise ineligible for reimbursement.

Ambulance transportation providers that commit Medicare or Medicaid fraud may face liability under the qui tam provisions of the False Claims Act.

Adapted from the Website of Vogel, Slade & Goldstein, LLP

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Device Manufacturer Fraud

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What is medical device manufacturer fraud?

Fraud by medical device manufacturers under the False Claims Act includes:

- knowingly manufacturing defective devices for use by beneficiaries of federal and state health insurance programs,
- reporting false data about medical device failures to the FDA, and
- paying kickbacks to healthcare providers to prescribe or order devices.

Adapted from the Website of Vogel, Slade & Goldstein, LLP

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Fraud by Medical Practices

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What is fraud by medical practices?

Fraud by medical practitioners under the False Claims Act encompasses a wide variety of schemes to improperly obtain payment from federal and state health insurance programs, such as:

- billing for services that were medically unnecessary or
- billing for services that were not provided,
- upcoding claims for reimbursement, and
- paying or receiving kickbacks for patient referrals.

Adapted from the Website of Vogel, Slade & Goldstein, LLP

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Home Healthcare Fraud

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What is home healthcare fraud?

Home healthcare fraud under the False Claims Act includes billing federal and state health insurance programs for:

- medically unnecessary services, or
- services that were not provided, and
- paying kickbacks for patient referrals.

Adapted from the Website of Vogel, Slade & Goldstein, LLP

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Laboratory Fraud

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What is laboratory fraud?

Laboratory fraud includes schemes where clinical laboratories:

- deliberately falsify analytical or quality assurance results, or
- falsify specific medical tests, or
- deceive doctors into ordering unnecessary tests by using deceptive requisition forms or other means.

Adapted from the Website of Vogel, Slade & Goldstein, LLP

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Long Term Care, Hospice, and Skilled Nursing Facilities Fraud

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What is long-term care, hospice and skilled nursing facilities fraud?

Fraud by skilled nursing and other long-term care facilities under the False Claims Act includes a variety of improper practices aimed at increasing reimbursements from federal and state health insurance programs, such as:

- billing for services not provided,
- billing for services that were provided but not medically appropriate, and
- paying kickbacks to providers who refer patients to the facility.

Adapted from the Website of Vogel, Slade & Goldstein, LLP

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Medically Unnecessary Services

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What are medically unnecessary services?

Health care items and services are considered "medically unnecessary," and therefore not reimbursable by Medicare or Medicaid, when they are **not**

- "reasonable and necessary for the diagnosis or treatment of illness or injury."

Adapted from the Website of Vogel, Slade & Goldstein, LLP

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Types of Risk Assessments within an Organization

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Types of Assessments Conducted within an Organization

- Internal Audit – Annual Risk Assessments.
  - Evaluate Fraud Risk
- Regulatory Risk Assessments.
- Compliance Risk Assessments.
- Enterprise Risk Assessment – where every Department/Office does its own Risk Assessment, too.
- External Auditors – Financial Statement Risk Assessment.
  - Evaluate Fraud Risk

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Fraud Risk Assessment (FRA)

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Fraud Risk – Decision
To Conduct a FRA

Triggered by:

- A concern received on the "Compliance Helpline".
- Concern Expressed by a Stakeholder via email, direct phone call, during a meeting, hard copy internal mail or U.S. mail, etc.
- Request from a Board Member, Sr. Management, etc.
- Request from General Counsel.
- Request from External Financial Auditors.
- Discomfort from Read/Analysis of Data Analytics.
- Request from Banker.

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Fraud Risk – Prevention

Tone at the Top

- The Board should be Promoting an Ethical Culture.
- Senior Management should be emphasizing Integrity.
  - •Driving Performance.

The 3 Cs – Collaboration, Communication, Coordination - between:

OPERATIONS,
Legal,
Compliance, Ethics, Internal Audit,
Privacy, Security, and
Enterprise Risk Management (ERM).

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Fraud Risk Assessment – Preparation

Management decides to Proactively undertake a Fraud Risk Assessment.

- Appoint a Senior Management Leader.
  - Which Senior Leadership Group hears Reports and Tracks Progress?
  - Which/whose Budget is to be Charged with the Expense?
- Decide on the Timeline.
- Appoint Person to spearhead the FRA.
- Question: Use in-house Resources or Hire Consultants?
- If in-house - Provide Appropriate Resources.
  - Include skill sets from various departments – Collaboration. Adjust their Work-load.
  - Called "The FRA Team".
- If decide to Hire Consultants – Use current Consulting Firm? Or Circulate RFP?
- Spread the Word – Disseminate/Communicate.
  - Employees are more likely to Support and Participate in a FRA if they understand the Purpose and Expected Outcomes.

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Fraud Risk Assessment – Preparation
Understanding Current Environment - Macro

The FRA Team should begin to gain an Understanding of the Control Environment.

- Review specific anti-fraud controls.
- Peruse Related Policies.
- Are there any known Fraud Risks?
- Study the Fraud Questionnaire filled out by External Auditors at the end of each year.
- Consider **major "Changes"** that may have occurred, e.g. mergers and acquisitions, installing a new technology platform, new incentive system, socio-economic or regulatory environment, public healthcare crisis, etc. – cause of "control gaps".
- Changes that may Affect the three components of Fraud:
  - Incentive/Pressure,
  - Opportunity, or
  - Rationalization.

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Fraud Risk Assessment – Preparation
Understanding Current Environment - Macro

- Create a "Fraud Survey".
  - Paper vs. electronic.
  - Anonymous vs. traceable to individuals.
- Disseminate the Fraud Survey.
- Conduct Interviews with:
  - Senior Management,
  - Relevant Staff – Process Owners.
  - Operating staff, too – first line of defense.
- Possibility – use Focus Groups
  - Especially when seeking information from lower-level employees.

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Fraud Risk Assessment – Preparation
Understanding Current Environment - Micro

- Conduct "Walk-throughs".
  - Take photos of evidence.
- Test Existing Controls.
  - Both Manual and Electronic.
- Inquire into Reports Produced/Data Collected.
  - Their Frequency.
- Ensure Data Analyzed by Correct Expertise.
- Inquire into Follow-up/Resolution of Outliers, Aberrations, Inconsistencies, etc.
  - Verify Process, Competence of Person Responsible, and Timeline.

- **IDENTIFY RISKS.**
- DOCUMENT - ALL.

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Fraud Risk Assessment - Management

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Factors affecting Risk Rating

Results of a Fraud Risk Assessment:

- Identification of Risks, and next,
- Rating of Risk.

- **Likelihood**
- **Significance**
- **Velocity**
  - Low Velocity – implement proactive measures to identify occurrences early.
  - High Velocity – difficult, hits hard and fast – preventive measures very important.

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Fraud Risk – Management
Prioritization

Determination of Appropriate Response.

Risk is mitigated or reduced to *a level* that is acceptable to Senior Management and the Board.

- Risk Tolerance

- Avoidance of Risk.
- Transfer of Risk.
- Mitigation of Risk.
- Acceptance of Risk.

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Fraud Risk – Mitigation
Establishing Countermeasures

What are your Internal Controls and Monitoring Mechanisms?

- Implementing Internal Controls.
  - Preventive and detective.
  - Manual and Automated.
- Embedding Monitoring Mechanisms.
- Using software. Artificial Intelligence (AI).
  - Automating Controls, where possible.

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Fraud Risk – Mitigation
Establishing Countermeasures

Do you Integrate current Data Analytics Capabilities?

- Running Data Analytics.
- Creating Reports - Dashboards.
  - Build a Risk and Control Library.
  - Create Comparative Charts – to past Organizational Data, to Similar Units within the Organization, to Industry Norms, etc.
- Harmonize controls that comply with multiple regulations and organizational needs.

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Fraud Risk – Mitigation
Establishing Countermeasures

- Reviewing and Updating Policies, as necessary.
- Strong Hiring Policy.
  - Including Background Checks, Education Verification, Credit Check, etc.
- Precise Time Off/Vacation Policy.
- Responsible Promotion Policy.
- Fraud Awareness Training.
  - Emphasize Fraud is Real – Could Happen in any Department.
- Activating/"marketing" a "Helpline".
  - Anonymous Fraud-reporting Channel – third-party?

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Fraud Risk – Mitigation
Establishing Countermeasures

- Well-enforced Conflict of Interest Policy.
  - Robust Process and Oversight.
- Objective Pharmaceutical and Device Committee.
- Establish Parameters around Sales Representatives Involvement.
- Vendor Management.
  - Third Party and Fourth Party Risk Management.
  - On-boarding,
  - Routine Monitoring, and
  - Off-boarding.

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Fraud Risk – Mitigation

Do you Review and Remediate?

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If Deficiencies are found, do you make Changes?

_____

Do you Examine, Test and Update on a "Continual" basis?

- "Regular Review".
  - The 3 Rs – Review, Reveal and Rectify.
  - Reviewing all Reports/Dashboards/Results.
- Follow-up and Remediation
  - Following up on Outliers, Aberrations, Inconsistencies.
    - **To determine if error or fraud/abuse?**
  - Make Changes - Correct/Remediate.
  - Update Internal Controls, Systems, Policies and Compliance Program.
  - Document it!

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Fraud Risk – Reporting

- Revealing Fraud, if any, to Legal, Human Resources.
  - And, Internal Management.
  - And, to External Bodies, when necessary.
- Sharing Reports with Senior Management.
  - Giving Assurance, Increasing Confidence.
  - Allowing for Better Decision-making.
  - Explaining Relevant Findings.
- Sharing Results of Fraud Risk Assessment with Board.
  - Specific Committee/s of the Board.
  - Explaining Relevant Findings.

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Fraud Risk Assessment – Combining with…

- Office of Financial Management.
  - Review of Processes and Controls.
- Office of the General Counsel.
- Office of Risk Management.
  - Internal Audit Assessments.
  - Compliance Risk Assessment.
  - Privacy Risk Assessment.
  - Security Risk Assessment.
  - Enterprise Risk Management.

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Fraud – Case Studies – Enforcement Actions

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Case Study 1: **New Jersey physician pleads guilty to role in massive telemedicine fraud scheme**

- DeCorso, a New Jersey **physician**, pleaded guilty.
- One of the largest healthcare fraud cases ever investigated by the federal government.
- He was **one of 24 telemedicine executives, medical device executives and physicians**.
- Charged in April 2019 by the DOJ in playing a role in a "complex, multi-layered scheme".
- To defraud Medicare, with losses totaling $1.2 billion to the government.
- Medical device co. paid kickbacks and bribes to physicians working for telemedicine co.
- To induce them to prescribe orthopedic braces that were not medically necessary, as per DOJ.
- Lester Stockett, **CEO** of telemedicine company AffordADoc, pleaded guilty to receiving bribes.
  - In exchange for inducing physicians working for his company to prescribe orthopedic braces that were not medically necessary.

From the Website of Fierce Healthcare, "5 legal cases against doctors that made headlines in 2019", by Joanne Finnegan, Dec 30, 2019.

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Case Study 2 – **Columbia/HCA Healthcare**, Nation's largest hospital chain - Pleaded guilty to a variety of fraud charges.

- Agreed to pay a total of $840 million in fines and penalties.
- A seven-year federal investigation.
- U.S. Attorney General Janet Reno said about the plea deal, "It's a simple message--if you overbill the U.S. taxpayer, we're going to make you pay it back, and then some."
- HCA admitted to:
  - systematically overcharging the government by claiming marketing costs as reimbursable,
  - by striking illegal deals with home care agencies,
  - by filing false data about how hospital space was being used,
  - increased Medicare billings by exaggerating the seriousness of the illnesses they were treating,
  - granted doctors partnerships in company hospitals as a kickback for the doctors referring patients to HCA,
  - gave doctors "loans" that were never expected to be paid back, free rent, free office furniture, and free drugs from hospital pharmacies.

From a Forbes Magazine Article - December 2000.

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Case Study 3: **Tenet HealthCare, Inc. – Overbilled Medicare**
Paid >$ 900 M to settle claims.

- Tenet - Operator of the Nation's second largest health care chain.
- Overbilled Medicare through use of an overstated "cost-to-charge" ratio that inflated "outlier" and other cost-based payments and paid kickbacks in exchange for patient referrals.
- Tenet will avoid prosecution if they, among other requirements, cooperate with the government's ongoing investigation and enhance their compliance and ethics program and internal controls.
- "When pregnant women seek medical advice, they deserve to receive care untainted by bribes and illegal kickbacks," said Principal Deputy Assistant Attorney General Bitkower.
- "Our Medicaid system is premised on a patient's ability to make an informed choice about where to seek care without undue interference from those seeking to make a profit," said U.S. Attorney Horn.
- "Tenet cheated the Medicaid system by paying bribes and kickbacks to a pre-natal clinic to unlawfully refer over 20,000 Medicaid patients to the hospitals. In so doing, they exploited some of the most vulnerable members of our community and took advantage of a payment system designed to ensure that underprivileged patients have choices in receiving care."

From the website of the Department of Justice – October 2016.

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Case Study 4: **Public Health Emergency (PHE)- Alleged Scam- Supply of $39M of N95 Masks**

- Feds uncover an alleged foreign criminal scheme.
  - **To fraudulently sell 39 million N95 respirator masks to US hospitals.**
- Demand - upfront payment of 40% of the total bulk purchase price.
- No masks actually existed.
- Discovered after the Service Employees International Union-United Healthcare Workers West (SEIU), California, publicly announced it had located N95 masks.
- Caught the attention of a Justice Department Task Force.
- 3M produced only 20 million N95 masks in all of 2019.
  - Yet supplier was purportedly in possession of 39 million masks from 3M.
- Supplier was identified as a man in Pennsylvania
  - Who claimed he was merely a middleman - working with two foreign companies.
  - A broker in Australia and a supplier in Kuwait.
- The two unidentified foreign entities targeted by investigators face possible wire fraud and other federal charges.

From an Article by Josh Campbell, CNN Updated April 14, 2020.

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April 2020 - LAS VEGAS (News 4 & Fox 11)

— U.S. Attorney Nicholas Trutanich and Nevada Attorney General Aaron Ford announced today the formation of the Nevada COVID-19 Task Force.

Fifteen agencies are a part of this Task Force including:

- U.S. Attorney's Office
- Office of the Nevada Attorney General
- Federal Bureau of Investigation
- U.S. Secret Service
- Internal Revenue Service – Criminal Investigation
- Drug Enforcement Administration
- U.S. Department of Health and Human Services' Office of Inspector General
- Department of Veterans Affairs' Office of Inspector General
- Department of Education Office of Inspector General
- Small Business Administration Office of Inspector General
- U.S. Postal Inspection Service
- Treasury Inspector General for Tax Administration
- Nevada's Secretary of State's Office
- Washoe County Sheriff's Office
- Las Vegas Metropolitan Police Department

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Questions?

Contact Information

Sonal Shah

sonalshah.mail@gmail.com

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