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Health Care Fraud Control Understanding The Challenge

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ABSTRACT

The study summarized here examined the fraud-control apparatus currently used within the health care industry, and assessed the assumptions, policies, and systems that constitute the industry's current approaches to fraud control. The objective was to develop a better understanding of the strengths and weaknesses of existing approaches.

Since 1992, with Health Care Reform under debate, the issue of health care fraud has received unprecedented legislative and administrative attention. Nevertheless disturbing and somewhat surprising lapses in control persist. The fraud problem shows no sign of abatement.

Background knowledge of the health care fraud issue was derived from literature searches and from four years of interaction with concerned public and private organizations. Fraud control systems, policies and procedures were examined in detail at eight field sites, representing a cross section of private, not-for-profit, and public programs. The National Institute of Justice funded the study under grant number #94-IJ-CX-K004.

This study finds the science of fraud control scarcely developed and little understood by industry practitioners. Academia has paid little attention to the problem. Within the health care industry, the task of fraud control is complicated by the social acceptability of insurers as targets, the invisible nature of most fraud schemes, the separation between administrative budgets and "funds", the respectability of the health care profession, and the absence of clear distinctions between criminal fraud and other forms of abuse.

Existing approaches to control are more effective in controlling billing errors, overutilization, medical unorthodoxy, and other forms of abuse than in dealing with criminal fraud.

The complexity of the fraud control challenge is seriously underestimated by the health care industry. Existing control systems are not targeted on criminal fraud and cannot be expected to control it. Scientific measurement of the fraud problem is a prerequisite for effective control. [J INS MED, 1996; 28:86-96]

INTRODUCTION

What proportion of the nation's trillion dollar health care budget is lost to fraud and abuse remains unknown. Conventional wisdom, crystallized in a 1992 GAO report, puts it at 10% (or roughly 100 billion dollars per year). But the 10% figure has no basis in fact. The GAO report merely says, "Estimates vary widely on the losses resulting from fraud and abuse, but the most common is 10 percent...of our total health care spending."[1] GAO got their estimate from "industry experts", and now "industry experts" get their estimates from GAO. Nobody knows the true figure, because fraud losses are not systematically measured.

Since 1992, with health care reform under debate, the issue of fraud control has received much attention. A broad range of new statutory provisions have been proposed at the federal level,[2] although most of the proposals have since died with the failure to pass health care reform legislation. During 1992 and 1993, with health care reform under debate, no less than nine separate committees within the House of Representatives held hearings dealing with health care fraud and abuse, as did a further five committees within the Senate.[3] The rash of Congressional hearings continues unabated, and seems to be accelerating, fuelled by an apparently endless supply of media stories describing fraud losses by public and private programs. Nine separate hearings relating to health care fraud were held in just the first seven months of 1995.[4]

The Clinton Administration, determined to "crack down" on fraud and abuse in the system, made Health

Care Fraud the number two priority for the Department of Justice (after violent crime). In 1992 the FBI assigned 50 agents to Health Care fraud. The Department of Justice created a health care fraud initiative, and formed a health care fraud unit within its criminal division. By the spring of 1995 the number of FBI agents assigned had risen to 250, with that number due to double again eventually. From 1990 to 1994 the General Accounting Office (GAO) produced twenty separate reports specifically relating to fraud and abuse issues or payment control inadequacies, eight of these in 1992 alone.[5]

During the 1990's the battle against health care fraud has seen many apparent successes. Coordinated actions involving federal, state and private insurers, have obtained significant settlements against major corporations. Notable cases include National Health Labs (which pleaded guilty to two criminal charges of submitting false claims to Government health insurance programs, and agreed to pay $111 million to settle the case in 1992),[6] National Medical Enterprises (which agreed to pay $362.7 million in the largest settlement to date between the Government and a health care provider[7,8]) and Caremark, Inc. (which settled a suit brought by the National Association of Medicaid Fraud Control Units for $44.5 million in 1995.[9])

The involvement of the FBI increased the level of publicity given to enforcement actions.[10] In 1994 alone, the FBI obtained 353 criminal convictions and recovered $480 million in fines, recoveries, and restitutions, representing $13.65 for each dollar spent on health care fraud investigations.[11] The state Medicaid Fraud Control Units, between them, secured 683 convictions and recovered $42.8 million in fines, restitution, and overpayments.[12] In the same year the Office of Inspector General at the Department of Health and Human Services, recouped $5.4 *billion* in fines, settlements, restitutions and other recoveries involving federal health programs.[13] HCFA Administrator Bruce Vladeck acknowledged "good reason to believe" that the $5.4 billion in recoveries during 1994, was "merely the tip of the iceberg".[14] In March 1995 Director Louis J. Freeh testified of FBI intelligence showing cocaine traffickers in Florida and California switching from drug-dealing to health care fraud (the latter being safer, more lucrative, and with a reduced risk of detection).[15] Thus health care fraud is acknowledged to be a serious national problem, which shows little sign of abatement.

Many instances of health care fraud suggest that existing control systems *do not work* the way we all imagine they should. Often the manner in which schemes are revealed suggests detection is frequently more luck than system. For example, the Miami Herald, on August 14, 1994, reported how a Florida based company, "Med EO Diagnostic", used the names of dozens of dead patients and a rented West Dade mailbox to collect $332,939 from Medicare in May and June, 1994. The operator—an unemployed tow truck operator—only got caught because he withdrew $200,000 in cash from the lab's bank account. A bank official became suspicious and called the police.[16] Another phantom company, Bass Orthopedic, comprising nothing more than two rented mailboxes and a phone number, was paid $2.1 million between November 1993 and April 1994.[17] In neither case were any medical services ever rendered.

Congressional testimony provided by GAO in 1995, on fraud in the Medicare and Medicaid programs, cited several examples of schemes that, according to GAO, ought clearly to have been detected and stopped. But these schemes came to light only through tip-offs or whistleblowers, rather than through the operation of any routine monitoring or audit. In one case, a Medicare contractor processed and paid, without question, $1.2 million in claims from one supplier, all for body jackets supplied to residents of one nursing home. The supplier's previous year total billings for the same item was just $8,500.[18] In another example, a pharmacist from California had been billing Medicaid for improbably high volumes of prescription drugs and was being reimbursed without question, despite the fact that several recipients had been receiving more than twenty prescriptions per day, each.[19] One van service billed Medicare $62,000 for ambulance trips to transport the same patient 240 times in a 16 month period.[20] For another patient, Medicaid paid for more than 142 lab tests and 85 prescriptions within an eighteen day period.[21] All these transactions turned out to be fraudulent, yet none were picked up by any routine monitoring or detection.

The persistence of disturbing (and somewhat surprising) lapses in control, despite the level of political, legislative and administrative attention paid to the fraud issue in the last four years, provides a backdrop for this research.

The study summarized here examined the fraud-control apparatus currently used within the health care industry, and assessed the assumptions, policies, and systems that constitute the industry's current approaches to fraud control. The objective was to develop a better understanding of the strengths and weaknesses of existing approaches, and to formulate hypotheses about ways in which controls could be made more effective.

Methodology:

Background knowledge of the health care fraud issue was derived from literature searches and from four years of interaction with concerned public and private organizations, including:- the Department of Justice; FBI; Health Care Financing Administration; Office of Inspector General (DHHS); Health Insurers of America Association; National Health Care Anti-Fraud Association; and the National Association of Medicaid Fraud Control Units.

Eight sites for field work were selected in consultation with an advisory committee including representatives from the above organizations, and from the National Institute of Justice. NIJ funded the study.

All eight field sites were selected in part on the basis that they were reputed to be among the very best in the industry in terms of fraud control. The reason for selecting from among the best, rather than picking a broader or more representative sample, was to be able to work from current best practice, so that any guidance ultimately offered to the industry would help advance the state of the art.

The sites were also selected so as to offer, as far as possible with only eight sites, a broad cross section of the industry. The sites examined included three Medicaid Fraud Control Units, two private insurers (one large, one much smaller), and three private corporations acting as Medicare contractors, all three of which were among the top five Medicare contractors when measured in terms of total claims volume. One of these contractors also served as a "Durable Medical Equipment Regional Contractors" (DMERC). As one of four designated "DMERC" sites, this company processes Durable Medical Equipment claims under the Medicare program for roughly one quarter of the U.S.

All eight sites selected agreed to participate in the study and to make managers and staff available for interview. A list of fifteen interview subject areas (summarized below) was provided in advance to each site, with a request that interview lists be constructed to include personnel knowledgeable in each area. The interviews themselves were not formally structured. The fifteen interview subject areas were:

(1) Statistically valid sampling procedures or scientific estimation techniques in use to measure the scope and nature of existing fraud problems.
(2) Managerial attitudes towards fraud. Levels of fraud regarded as "acceptable price of doing business".
(3) Budget for fraud control operations, and the mechanisms for setting it.
(4) Fraud control philosophy/strategy. Proactive v. reactive. How the goals of justice and cost containment are balanced. Tensions between processing efficiency and prudent controls, and mechanisms for resolving same. Distinction between "investigation" and "control".
(5) Sources of investigations (cases): range of detection mechanisms, and comparative effectiveness.
(6) Staffing/Backgrounds/Resources for fraud control operations.
(7) Use of technology for fraud detection. Existing/emerging/future systems and methods.
(8) Performance measurement for the fraud control operation. Metrics, methods in use.
(9) Nature of fraud threats: existing, emerging, anticipated.
(10) Advent of Electronic Claims Processing: effects on fraud and on fraud controls; experienced, and anticipated.
(11) Criteria used for case disposition, and for selection of administrative, civil or criminal action.
(12) Relationship with law enforcement and the criminal justice system: referral mechanisms, practices; formal & informal.
(13) Experience with managed care: how fraud differs under capitated systems, and effects on fraud control operations.
(14) Perceived constraints on effective control.
(15) Anticipated effects of various reform proposals. Industry trends and their consequences.

Summary findings:

(1) Science of Fraud Control scarcely developed.

Literature searches and practitioner interviews revealed the fact that fraud control—as a science or art—is scarcely developed and little understood. Little attention has been paid to the issue by academia.[22] Nor is there available expert guidance in the field. Guiding principles are almost impossible to find in any literature. The discipline of "Managerial Accounting" gives the subject some attention, but acknowledges the absence of generally accepted fraud audit field standards.[23] Even when accounting or audit textbooks tackle fraud, they deal with it almost exclusively from the point of view of defense against internal corruption (employee embezzlement), rather than from the point of view of institutions defending their payment systems against concerted criminal attacks from *outside*.[24] So, whoever commits to the task of controlling fraud throws themselves into an area which academic literature has virtually ignored, and where

practitioners often feel isolated and abandoned.[25]

Fraud control in any situation is a complex challenge, requiring at a minimum that the following seven harsh realities be understood.

(a) **What you see (i.e. what your detection systems show you) is never the problem.** Most white collar frauds fall in the category of "non-self-revealing" offenses. Unless they are detected close to the time of commission, they will likely remain invisible in perpetuity. Thus you see only what you detect. The danger, of course, is that organizations vulnerable to fraud lull themselves into a false sense of security by imagining that their "caseload" (i.e., what they detect) reflects the scope and nature of fraud being perpetrated against them. Often it represents only a tiny fraction, and a biased sample, of the frauds being perpetrated.[26] The number and type of fraud schemes that become visible depends as much upon the effectiveness and biases of the detection systems as upon the underlying patterns of fraud.

(b) **Available performance indicators are at best ambiguous; at worst, perverse and misleading.** If the amount of fraud detected increases, that can mean either the detection apparatus improved, or the underlying incidence of fraud increased. The resulting ambiguity pervades much fraud control reporting.[27]

Many other quantitative measures of fraud control success are ambiguous too. Reactive successes can equally be viewed as preventative failures. Some organizations boast of "record recoveries"; others say they prefer to stop the fraud up front, and regard chasing monetary recovery after the fact as a poor second best to prevention. Some organizations emphasize prevention simply to avoid having to admit that their detection systems are ineffective. To complicate things further: fraud controls usually come in a sequence of phases or stages. The phases of fraud control typically parallel various phases of the claims processing operation. Detection successes late in the sequence often represent failure at earlier points in the process.

(c) **Fraud control flies in the face of productivity and service, and competes with them for resources.** Additional fraud controls tend to slow down or complicate routine processes, and create too many categories for exceptional treatment. Officials responsible for high volume claims processes want to think about the best way to handle the whole load. The investigators or fraud analysts want to think about the best way to handle the exceptions.

The savings from processing efficiencies may be small, but they are concrete and tangible. By comparison, the potential savings from enhanced fraud controls may be massive, but they remain uncertain and invisible. Bureaucracies usually choose concrete and immediate monetary returns over longer term, uncertain ones. So processing efficiency invariably wins the battle for resources. As one senior HCFA pointed out, "of course, the cheapest way to process a claim is to pay it."

(d) **Fraud control is a dynamic game (like chess), not a static one.** Fraud control is played against opponents: that think creatively and adapt continuously, and who relish devising complex strategies. Which means that a set of fraud controls which is perfectly satisfactory today may be no use at all tomorrow, once the game has progressed a little. Maintaining effective fraud controls demands continuous assessment of emerging fraud trends and constant, rapid, revision of controls.

(e) **Too much reliance is placed upon traditional enforcement approaches.** The strength of the deterrent effect depends on the probability of getting caught, the probability of being convicted once caught, and the seriousness of the punishment once convicted. For white collar crimes all three of these are notoriously low, hence effective investigations do not necessarily translate into effective control. Many organizations fail to make the distinction between investigation (a tool) and control (the goal). Investigation focuses on disposition of detected cases, whereas the control function seeks to uncover and grapple with the invisible mass. Many organizations fail to designate anyone responsible for fraud control per se, and thus have no opportunity to develop an integrated multi-functional approach to fraud control.

(f) **Effectiveness of new fraud controls is routinely overestimated.** A false optimism is based on the hope that elimination of the types of scams most recently seen will mean elimination of the fraud problem. Unfortunately that fails to take into account the adaptability of the opponents, who take only a few days, or weeks at most, to change their tactics once they find a particular method thwarted.

(g) **Fraud control arrangements reflect the production environment within which they operate, and thus address only the least sophisticated fraud schemes.** Fraud controls are typically superimposed upon or embedded within high volume, repetitive, transaction

oriented, processes. Consequently fraud controls examine the claims or transactions one at a time, and usually in the same order in which they arrive. Whether it be humans or machines that do the monitoring, developing good quality fraud controls is, for many institutions, synonymous with having a finely adjusted set of filters or branch points embedded within the transaction processing operation.

There are two major problems with this approach. First, the fraud control game is dynamic, not static (as already discussed) so *any static set of filters* has only short term utility. Second, most sophisticated fraud schemes are devised by perpetrators *who assume the existence of transaction-level filters*, and who therefore design their fraud schemes so that each transaction comfortably fits a legitimate profile and passes through unchallenged. Fraud controls of this obvious type ("transaction-level" controls) generally detect only the casual, careless and opportunistic fraud attempts; not the serious dedicated criminal groups who quickly progress to a higher level of sophistication.

(2) Exacerbating factors in health care insurance industry.

The seven factors above suggest fraud control to be a more complex and difficult challenge than usually appreciated. Within the health care industry, a number of further factors exacerbate the problem:

(a) Insurers are regarded by significant segments of the population as socially acceptable targets for fraud, being seen as "large, rich, anonymous, and as fair game for fraud in much the same way as tax authorities."[28] With health care fraud, financial losses accrue primarily to insurance companies and to massive government bureaucracies, targets that engender little public sympathy.

(b) The majority of health care fraud schemes are "non-self-revealing". Many interviewees shared the common public assumption that "Explanations of Medical Benefits" (EOMB's) provide protection against provider fraud. But EOMBs do not have the effect one would hope, for a number of reasons. First, they are not sent at all in many circumstances. Use of EOMBs is no longer routine within the Medicaid program. Under Medicare, EOMBs are routinely sent out only when services require a copayment, or where the Medicare program refuses to cover a service. So, where services are approved and 100% reimbursed by the program, EOMBs are not usually sent; in which case Medicare beneficiaries have no way of knowing what was billed under their names. EOMBs have not been used in connection with Home Health Care services—now one of the most fraud prone categories of service—since 1981.

Second, recipients of EOMBs have little or no financial incentive to pay attention to them. They are not, as in the case of a credit card statement, being asked to pay a bill. Third, many recipients cannot decipher the strange, computer-generated, forms; and have no incentive to try. Fourth, fraudulent suppliers find innovative ways to stop patients from reading their EOMBs, such as offering to buy back unopened EOMB envelopes, or by changing patient addresses on claim forms effectively diverting the EOMBs to mailboxes under their own control. Fifth, many fraud schemes deliberately target vulnerable populations such as the elderly or alzheimer's patients who are less willing or able to complain or alert law enforcement.[29] Sixth, even when beneficiaries do call insurers to complain about bogus or questionable charges, the handling of beneficiary complaints often lacks the rigor required to uncover fraud.[30] The non-self-revealing nature of nearly all health care fraud schemes decreases the likelihood that authorities will be aware of the true scope and nature of the fraud problem.

(c) Separation between administrative budgets and "funds". Investment in adequate fraud controls suffers significantly because program administration costs are budgeted separately from *program* costs (i.e. claims paid). This budgetary separation makes it virtually impossible to consider the notion of "return on investment" in allocating resources for fraud control.

The separation is most stark under Medicare Part A. The Medicare "Trust Fund" (for Medicare payments under Part A) is sacred to the American Association of Retired Persons, and woe betide any politician who suggests taking any of it for anything resembling administrative purposes. The Medicare trust fund is maintained by the 2.9% Medicare payroll tax, paid half by employers and half by employees.[31] The Medicare program's administrative expenses, by contrast, come out of "discretionary budget" from general tax revenues. In 1995 the GAO observed that payment safeguards under the Medicare program produce at least $11 for every dollar spent; and yet, on a per-claim basis, federal funding for safeguard activities declined by over 32 percent since 1989; adjusted for inflation, by 43 percent.[32]

In other governmental and non-governmental programs the separation, whether statutory or merely administrative, is powerfully manifested in employee culture and attitudes. Most officials care a great deal *either* about the costs per claim (where their goals and incentives all relate to efficiency), *or* about payment accuracy. Which one they care about depends on their

specific functional responsibilities. Few managers find themselves in a position to act upon the important relationship between them.

(d) Respectability of the health care profession. Society places enormous trust in health care professionals, and rightly so. People need to be able to trust their doctors. But the status society accords its physicians, and the trust it places in them, make effective fraud control more difficult. Some commentators have noted the peculiar defensiveness of the medical profession,[33] and the reluctance of physicians to censure even blatantly dishonesty acts committed by their colleagues.[34] Revelations about fraud are received by medical practitioners as an attack on the integrity of the profession, and on its ability to police itself. Thus the profession and its associations tends to play down the extent and seriousness of health care fraud, and to oppose provision of additional resources for investigation and review.

The respectability of the medical profession also presents notable problems to investigators and prosecutors. Investigators, lacking medical training, feel sorely disadvantaged when questioning physicians, whom they frequently encounter as arrogant and condescending. And most prosecutors still avoid taking cases which require expert medical testimony, knowing they will be difficult, expensive, and relatively unlikely to succeed in front of a jury. Some prosecutors still display a broader reluctance to bring physicians—pillars of the community—to trial.

Health care insurers extend the same kind of professional immunity and trust to all kinds of other provider groups not bound by professional ethics of any kind—Durable Medical Equipment suppliers, Home Health Care agencies, medical transportation companies, physiological laboratories, etc. Payers accord such groups surprising latitude, paying claims on trust without any routine external verification of services provided.

(e) Absence of clear distinctions between criminal fraud and other forms of abuse. Criminal fraud is clearly enough defined, requiring a deliberate misrepresentation or deception leading to some kind of improper pecuniary advantage. If the deception is as to some objective fact (e.g. if the services were not provided as billed, or were billed as something else) then the boundaries of fraud are fairly clear. But when the deception or misrepresentation relates to the question of *medical necessity*, the distinctions between fraud and abuse become quite muddy.

Definitional ambiguities between criminal fraud and other forms of abuse produce some troublesome consequences for fraud control. First, they contribute to the medical profession's reluctance to unequivocally condemn fraudulent practice. (Nobody could be sure where along the continuum that condemnation, once mobilized, would end. Physicians may find it hard to condemn fraudulent practice amongst their peers if they cannot construct satisfactory dividing walls between what they might condemn in others, and what they do themselves.)

Second, definitional ambiguities make it much more difficult to *measure* the problem systematically, because any measurement methodology would have to establish clear outcome classifications. For practical reasons, outcome classifications would have to be based on objective, verifiable realities, none of which precisely fit legal definitions of fraud.

Third, definitional ambiguities provide an excuse for anyone who would prefer, for whatever reason, not to refer suspected "fraud" cases to an investigative unit. Many payment agencies, protective of their provider network and their program's public image, prefer to handle even quite serious cases through administrative action rather than turn them over to an investigative unit.

These impediments to effective fraud control—the social acceptability of government and insurers as targets, the invisible nature of the crime, the separation of administrative budgets from "funds", the trust placed in providers, and the difficulties of separating fraud from other behaviors—are substantial. Add them to the seven elements of the general fraud control pathology, and the task of controlling fraud seems complex, amorphous, and overwhelming.

Perhaps this helps us begin to explain why health care fraud has not gone away despite all the attention paid to it, and why strenuous political and administrative efforts to bolster defenses have failed to provide a convincing cure. Another reason, which the remainder of this paper outlines, is that the policies, systems and machinery currently in place to combat fraud cannot possibly provide effective control. They are no match for the task.

(3) Absence of Measurement

The Health care industry differs from some other fraud control environments in its ubiquitous failure to measure the problem. In 1977 the Director of the Congressional Budget Office acknowledged that the invisible nature of health care fraud made it impossible to assess the likely returns from additional investments in fraud control.[35] In 1993 the GAO admitted the same uncertainty.[36] Some legislators have bemoaned the absence of consensus regarding the size of the problem, and recognized that the uncertainty cripples efforts at control.[37] The failure to systematically and

routinely measure the scope of fraud is characteristic of the whole insurance industry—not just health care—and is not limited to the United States.[38] Measurement of fraud losses is quite feasible, and would involve standard sampling techniques backed by rigorous claims audits involving external validation procedures sufficient to identify fraud if present.[39] Success with such techniques has been recently demonstrated by the IRS in their efforts to measure and control fraudulent claims for tax refunds based on the Earned Income Tax Credit.[40,41]

Many interviewees believed that their company's quality control procedures served the measurement function. However, without exception, such programs measured procedural compliance, accepting the claim as presented, and made no attempt to check the veracity of the information in the claim itself.[42] As Clarke's 1990 study of insurance fraud pointed out, "the essence" of any fraudulent insurance claim "is to appear normal and to be processed and paid in a routine manner".[43] One of the surprising truths of the fraud control business is that *fraud works best when claims processing works perfectly.*

Resource Allocation In The Absence Of Measurement:

In the absence of scientific measurement, the health care fraud debate focuses on the size of the problem, rather than on the search for solutions. Consequent massive underinvestment in fraud control resources seems to be the industry norm.

The budget for fraud control within the Medicare program was set at $32 million in 1995. With the total Medicare budget in the region of $160 billion[44] this represents an investment in fraud control at a level below 0.02% of overall program costs.

These investments, small as they are, pay off handsomely. The Special Investigative Units at Medicare contractors all save more than they cost, several turning in savings to costs ratios as high as 14:1.

Among private insurers, the savings to cost ratios for fraud units are climbing each year. Annual surveys of anti-fraud programs, conducted by HIAA, showed the ratio of savings to budget for dedicated fraud units, aggregated across responding companies, to be 6 to 1 in 1990; 7 to 1 in 1991; and 9.5 to 1 in 1992.[45]

In the Medicaid program, with total spending in 1994 at $145.9 billion,[46] the Federal budget for the Medicaid Fraud Control Units was $62 million.[47] Adding in the states' share, total spending on the MFCUs runs at roughly 0.05% of total program budget. The Federal Government offers to pay $3 for every $1 the states invest in the MFCUs, with a cap for allowable federal reimbursement at 0.25% of the state's annual Medicaid budget. Despite the $3 for $1 offer, most states have, for many years, chosen to operate at a funding level far below the reimbursement cap.

A clear pattern emerges, spanning both commercial and public health insurance programs. The extent of fraud is never measured; merely estimated. The estimates are too soft to act as a basis for serious resource allocation decisions, so resources devoted to fraud control have to be based on something other than the perceived size of the problem. In practice control resources are budgeted incrementally, with significant increases likely only if a fraud unit were visibly drowning under its caseload.

In practice, most fraud units, however small, are not drowning. The most likely explanation—which the next section explores in detail—is that the referral mechanisms just don't work very well, and produce the merest trickle of cases (when compared to the underlying size of the problem).

(4) Assessment of fraud control systems

A central focus of the field work was to examine the units, functions, and systems which constitute existing fraud control arrangements: claims processing "edits" and "audits", claims development, pre-payment medical review, post-payment utilization review, and special investigative units. Fraud perpetrators can easily circumvent such controls by billing "correctly" and staying within the confines of medical orthodoxy and policy coverage. Such controls are extremely useful for correcting providers' honest errors, but ineffective as detection apparatus for criminal fraud. This observation was made by Joe Ford, one of the FBI's pioneers into the field of health care fraud investigation, in 1992,[48] and is borne out by detailed inspection of current operations.

(a) Claims Processing: "Edits and Audits". These audits and edits enable the system to pay the right amount to the right person for the service claimed. They serve to correct billing errors and inappropriate billing procedures. And they reject claims if one or more of the provider, the recipient, or the procedure is somehow ineligible.

Clearly such systems do not do anything to verify that the service was in fact provided as claimed, or that the diagnosis is genuine, or that the patient knows anything at all about the alleged treatment. Rather, they assume the information presented is true, and consider whether or not that information justifies payment of the claim.

Of the nine standard modules, none are targeted on fraud. Generally no attempt is made to create rules or logic which would pick out "suspicious" claims for closer scrutiny, or to detect claims containing some deception of misrepresentation. The industry does not use *fraud-specific* pre-payment edits or audits of any kind; they do not exist.

(b) Claims Examination ("Development" and Human Review): Once humans have a chance to inspect claims, the prospects for fraud detection and referral improve tremendously. Humans, given the opportunity, often notice the unusual or incongruous. The usefulness of this detection opportunity is constrained, however, by the fact that claims are suspended for review only if they trip a condition specified by the system audits. The model is "Systems Select: Humans Inspect". The basis upon which claims are selected seldom has anything to do with fraud.

(c) Pre-Payment Medical Review: This function's purpose is to establish the medical orthodoxy and necessity, and to determine whether or not the treatment is reimbursable. Often medical reviewers do spot fraud; but that is a fortuitous byproduct of the fact that they are human and are looking at the claim, not because it is their job. Medical review and fraud detection are quite separate sciences. To escape attention from medical review a fraud perpetrator has only to base their false claims on medically plausible diagnoses and procedures, and to stay comfortably within the confines of policy coverage.

(d) Post-Payment Utilization Review: Utilization review is currently the major tool used by the industry to detect fraudulent patterns of claims, with "provider-profiling" being the predominant form of analysis.

The degree to which post-utilization review turns out to be a useful device for fraud control depends upon the degree to which fraud perpetrators use anomalous billing patterns. Of course, the smart ones don't.

Once again, this is not a criticism of post-utilization review procedures *per se*. The principal purpose of utilization review is to review medical utilization patterns, both on an aggregate basis (to help formulate policy changes or provide necessary provider and recipient education), and on an individual provider basis (to eliminate medically inappropriate or unreasonably expensive treatment patterns).

As a fraud detection methodology, however, post-utilization review procedures, with their strong emphasis on provider profiling, have certain limitations which must be understood. First, they detect fraud only where it produces anomalous billing patterns, as discussed already. They are much better suited to detecting waste and abuse which does *not* amount to criminal fraud.

Second, utilization review generally leads to scrutiny of only a few extreme outliers within each provider category, leaving the bulk quite safe from detection, even if the bulk is rotten.

Third, most utilization review units prefer to inform and educate providers when they detect anomalous billing patterns, rather than investigate. So, as with pre-payment medical review, fraudulent providers remain safe from investigation provided they change tactics when warned.

Fourth, utilization review procedures come long after the fact, and are only useful in the context of a continuing relationship between payer and provider. Utilization review systems operate in batch mode, periodically processing three to six months of claims data at a time. Due to processing constraints the resulting profiles may not be available for some time after the period in question, and may then not be updated in a frequent or timely manner. The claims data forming the basis for provider profiles is usually at least three months old, and in some cases more than a year old.

Post-payment utilization review therefore comes too late to be useful in combating the increasing number of fraud schemes run by "fly-by-night" operators. Store-front businesses, which fraud investigators say are increasingly prevalent, bill fast and furious, creating extremely anomalous billing patterns, but then disappear with the money long before post-utilization review catches up with them.

To counter the threat of quick, high volume, "hit and run" type schemes, the only sure defense is *pre-payment provider profiling*--which would monitor each provider's aggregate billing patterns and acceleration rates *before* claims are paid. None of the sites visited had any form of pre-payment provider profiling, nor any (pre-payment) method of watching for sudden surges in billing from individual providers.

(e) Special Investigative Units: The investigative units sit at the end of the referral pipeline; their cases coming either from EOMB-stimulated beneficiary complaints, from data entry clerks or claims examiners, from pre-payment medical review, from post-payment utilization review, or from auditors. A small number of tip-offs from other insurers, from law-enforcement agencies, or from anonymous telephone calls augments the total referral volume.

Most investigative units work predominantly in reactive mode, just about keeping up with the work that comes to them. Whichever mechanism produced the referrals, the investigators' job is the same: to investigate, and to *make cases*. Following a traditional enforcement model, most of these units count their workload in terms of the number of incoming com-

plaints or referrals, and count their successes in terms of the number of cases made, settlements reached, aggregate dollars recovered, and convictions obtained.

Clearly, if the SIU's remain in reactive mode, fed by largely ineffective referral pipelines, they will see the truth only dimly, partially, and probably very late. Without a clear focus on the goal of *control*—which would produce a much greater commitment to proactive outreach and intelligence gathering—the contribution that SIU's can make is bounded by the effectiveness of the referral pipelines which feed them their work.[49]

(5) Lack of coordinated control strategy: Lack of functional coordination and the absence of any coordinating strategy further handicaps fraud control efforts.[50] At each of the field sites the simple question "who is in charge of fraud control?" produced bafflement, and responses of either "no-one", or "everyone". The trend within the industry, and especially within major government programs, is towards greater functional specialization. For example, the plans for the "Medicare Transaction System", now scheduled for implementation in 1999,[51] call for consolidation of processing operations into a smaller number of bigger sites. Ancillary functions such as customer services, appeals, and fraud investigation will be contracted separately. The precise extent to which these different functions will be segregated is still under discussion; but the degree of functional separation will undoubtedly increase, not decrease.

The development of modern claims processing systems—highly automated, high volume, highly efficient—seems likely to exacerbate whatever functional separations already exist, and to diminish yet further the prospects for coherent, effective, multidisciplinary fraud control strategies.

(6) Effects of Electronic Claims Processing: This research also examined the impact of electronic claims processing on fraud and fraud control. Neither the literature nor the field work can support the notion that use of the electronic medium will create significant prosecutorial difficulties. The real problem, under EDI, will be in timely fraud detection, particularly as a consequence of the following risk factors: the absence of human "common sense" in claims review; the vulnerability to computer-generated schemes involving hundreds or thousands of claims, each one designed to pass through auto-adjudication to payment; and a new vulnerability to high dollar (potentially multi-million dollar) "quick hit", or "bust-out" schemes.

This research also examined the belief—prevalent throughout the industry—that EDI can be made safe through extensive use of automated, up-front controls. This vision for "automated prevention" appears dangerously flawed when viewed against the backdrop of a more sophisticated understanding of the fraud control challenge. The vision neglects the dynamic nature of the fraud control business, seriously underestimates the sophistication and adaptability of the opposition, and overlooks the critical role that humans must play in any effective fraud control operation.

(7) Effects of Managed Care: The study also briefly considered the advent of managed care and its implications for fraud and fraud control, showing that managed care will not provide a structural solution to the fraud problem, as many had hoped. Fraud will certainly take different forms under the various types of managed care contractual arrangements.

This short paper cannot tackle this subject in any depth. It is worth observing, though, that this study identifies substantial difficulties law enforcement will face in dealing with managed care fraud, and suggests that the criminal justice system will become less and less relevant to fraud control. At the same time, the new forms of fraud—involving diversion of capitation fees and resulting in inadequate medical care—may be more dangerous to human health than the types of fraud familiar under traditional fee-for-service arrangements.

CONCLUSIONS

Most insurers, public and private, do no systematic measurement of the fraud problem. They therefore fly blind, remaining largely oblivious of the true magnitude of the problem. This study failed to locate a single insurer who makes resource allocation decisions based in any way upon valid estimates of the size of the problem. Massive underinvestment in fraud controls appears to be an industry norm.

Most insurers fail to designate responsibility for control, and many equate *control* with *investigation*. They have no one responsible for playing the fraud control game, and little prospect of effective coordination between different functional tools.

In terms of explicit strategy, many fraud units are bogged down in a reactive, case-making mode, unable to see the forest for the trees. At the other extreme, some proponents of electronic claims processing are in danger of proposing an extreme version of *prevention*, which threatens to eliminate human beings from the fraud control operation almost entirely, and which may decimate investigative and enforcement capacities. Insurers need a rational, integrating, control-oriented framework.

Most insurers, even if they believe in the value of

proactive outreach and intelligence gathering, cannot find or protect resources for it. So they operate with a distorted and fragmentary picture of fraud, as revealed by largely ineffective detection and referral systems. And most payment systems remain vulnerable to multi-million dollar quick-hit scams because they lack the necessary prepayment controls.

In order for significant progress to be made in the battle against health care fraud two things must happen. First, the complexity of the fraud control challenge needs to be grasped and understood. Second, the health care industry and the public need to learn the true extent of fraud in the American health care system. (Without that knowledge, nobody can possibly justify the cost or inconvenience associated with operating appropriate controls).

Hopefully this research will help a little with the first. Only a commitment to systematic measurement can produce the second. Until these two things happen, effective fraud control will most likely remain elusive.

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