Lessons from Health Care Fraud Cases: Implications for Management of Health Care Entities

The Honors Program
Senior Capstone Project
Student's Name: Haley Onofaro
Faculty Sponsor: Saeed Roohani

Table of Contents

Abstract 1
Introduction 2
Literature Review 2
Internal Controls 7
Types of Fraud 9
Ethical Problems 9
Centers for Medicare and Medicaid Services 10
United States v. Anura Andradi 10
United States v. Ramon Santos 13
United States v. Ubak-Offiong 17
Donna Cain Gatch Case 20
Comparison of Cases 24
Current Laws for Health Care Entities 26
Suggestions 30
Conclusion 32
References 33

Lessons from Health Care Fraud Cases: Implications for Management of Health Care Entities
Senior Capstone Project for Haley Onofaro

Abstract

Fraud has been a major issue all throughout the health care industry. There have been many cases around the world in relation to health care fraud. There are several laws now that do try to reduce the amount of healthcare fraud, but more changes could and should be made to reduce it even more. Four different cases that have occurred within the health care industry have be analyzed in this project. It looks at the positives and negatives of each company's internal control structure and provides suggestions for how to improve these internal controls to prevent fraud from reoccurring in the health care industry. It also gives examples of other requirements that can be put in place in order to reduce the amount of fraud that occurs. Fraud is very common within the health care industry due to weaknesses within the companies' internal control systems and many improvements should be made in order to prevent fraud from continuing to occur in the future.

Introduction

Fraud can be defined as "an intentional deception or misrepresentation made by an individual or entity in order to obtain an unwarranted benefit" (Pariser & Brooks 2003). Fraud has been a major issue all throughout the health care industry. Although not each of these crimes is directly related to the financial statements of these firms, they do all eventually affect the financial stability of the companies. There have been many cases around the world in relation to health care fraud and improper controls and procedures within health care organizations. Through these cases it is possible to analyze what happened and determine where the weaknesses lie within the company based on their internal control structures. By finding the weaknesses and finding the similarities within the companies, solutions and suggestions can be made.

Health care fraud has become and will continue to be a major cost as "Medicaid and Medicare service provider fraud and errors are estimated to represent 23 percent of total expenditures or more than $140 billion annually" (Aldhizer 2009) and "health-care expenditures represent one of the fastest-growing costs in American business (Applegate 2007). It has also been found that health care fraud will continue to increase the longer people live (FBI 2005) due to the fact that the number of people who need health care will continue to rise.

There are several laws now that do try to reduce the amount of healthcare fraud, but more changes could and should be made to reduce it even more. With the amount of fraud that has occurred within the health care industry it only makes sense that there is a major concern and changes need to be made. For this reason, many laws have been put into place regarding fraud and internal controls. However, it appears that this is not enough. Fraud is very common within the health care industry due to weaknesses within the companies' internal control systems and many improvements should be made in order to prevent fraud from continuing to occur in the future.

Literature Review

Health care fraud is a major issue that has been studied and observed for many years, yet there are still many problems in relation to health care fraud and it is only expected to continue to rise as people live longer (FBI Report). Additionally the fraud schemes have become more sophisticated and complex (FBI Report). According to Goldberg & Lindquist (2005) "health care fraud is the payment of a wide variety of health care services induced by fraud" (p. 29). This fraud not only increases the costs of health care, but also allows health care companies to record more revenue than they should and sometimes even puts patients in danger. This can be proved

as one of the most significant trends observed in health care fraud is the willingness of medical professionals to put their patients in danger (FBI Report).

The number of health care fraud cases each year still appears to be a very significant number that is not decreasing as in 2010 the United States Department of Justice started 1,116 investigations involving criminal health care fraud (Parver & Goren 2011). It has also been predicted that $808 billion was spent on Medicare and Medicaid in 2010 and that number will increase to $1.5 trillion by 2020, which is almost double the amount spent in 2010 (Moses & Jones 2011). Additionally, The Centers for Medicare and Medicaid Services (CMS) ".... estimates that by 2018, health care spending will reach $4.4 trillion and will account for more than 20 percent of the gross domestic product" according to Moses & Jones (2011) (p. 51). Therefore it can be seen that until something is changed that will decrease the amount of health care fraud occurring, health care is going to continue to be a very expensive problem.

On top of the overall issue of health care fraud there also appears to be weaknesses within the health care system with regard to how things are done. For example, Medicare administrators only detect about 1% of service provider fraudulent claims (Aldhizer 2009). This shows that Medicare detection tools may need to be changed or updated to try and catch these fraudulent claims. However, there is also the problem that the Medicare administrators may not care enough to try and detect the fraudulent claims because they are typically paid a fixed percentage of the dollar amount of the claims that are processed (Aldhizer 2009). This also could be a major reason for why there is so much health care fraud occurring every year and it is only increasing by the year rather than decreasing. If they are being paid money for each claim that is processed they are only going to want large numbers of claims to be processed. This system is something that should be looked into because if this was not the case the number of fraudulent claims may be decreased as there would be no incentive for a large number of claims to be processed.

Another issue that exists within the health care system according to Aldhizer (2009) is that "...medical professionals are relied upon to perform proper procedures and to prepare appropriate supporting patient records to ensure that all invoices submitted to a Medicare administrator or Medicaid in-house claims expert are an accurate reflection of the services provided"(p. 2). It is very evident that this does not actually occur in many health care organizations as this is the major source of the fraud. Therefore, some sort of rule or law needs to be put into place to ensure that this is happening. This also relates to the fact that many health care companies do not have sufficient internal controls in place for their health care system (Cooper & Cornett 2004).

This is a major problem as internal controls are very important and "the entire organization, and each and every person who works there, should be 'tuned in' to internal control" (Cooper & Cornett 2004) (p. 37). Internal controls were created for the purpose of preventing fraud and other major issues that could go wrong within companies from happening. Every company is required to have an internal control structure in place and it is supposed to be a very strong internal control structure that will help prevent risks for the company as well as provide a plan of what needs to be done when and if these risks do occur.

There are many risks that any organization, not just health care organizations, could face and these potential risks need to be identified. In a health care company there are three major types of fraud that exist and these types of fraud consist of provider fraud, consumer fraud, and employee fraud. Provider fraud consists of many different things such as falsifying recipient identities, padding charges, upcoding medical services, billing for services not provided, performing noncovered services but billing for covered services, rolling laboratories, and kickbacks (Goldberg & Lindquist 2005). As for consumer fraud, the different types consist of misrepresentation on medical applications, fraudulent eligibility of dependents, fraudulent submission of claims, altering prescriptions, use of a covered member's card (Goldberg & Lindquist 2005).

All of these examples seem to be able to be achieved without anyone actually noticing that fraud is occurring. It is also apparent that it is not always at the fault of the people working within the health care companies as sometimes the patients are willing to also work with them and engage in the fraudulent activity as well. This is most likely why health care fraud is so common, it is probably hard to detect. However, regardless of the fact that it is difficult to detect it is still important for the different organizations that are dedicated to combating health care fraud to continue to study and analyze the issues and try to come up with more new and improved plans to fight this major issue so that one day it either may not exist or could at least be reduced greatly.

There are also many cases that have occurred which can be examined to determine where these internal controls are lacking. For example, the United States of America v. Anura Andradi case consisted of fraudulent bills being sent to Medicare and Medicaid in order for an ambulance company, Doctor's Ambulance Service, to be reimbursed. In order to be reimbursed from Medicare and Medicaid, it was required that the patients were non-ambulatory. Therefore, in order to be reimbursed, Andradi lied about many of the patients' ambulatory statuses and received $1,676,140 by doing this from March 2004 to December 2005. It was also later discovered that he submitted fraudulent bills in relation with 36 other patients and received $1,042,874 (United States v. Andradi 2009).

Another case example is the United States v. Ramon Santos case which consisted of a man who worked at Better Health Consulting Clinic Corporation as a physician's assistant (PA). While working as a PA, Santos altered blood-work results in order to bill Medicare for larger amounts of money. Therefore, he was billing Medicare for medical treatments that had not been performed. It was also later discovered that Santos did not have a PA license (United States v. Santos 2010).

Additionally, a third case is the United States of America v. Ubak-Offiong case which consisted of the owner of a durable medical equipment (DME) company submitting claims for power wheelchairs, providing less expensive scooters, and pocketing the difference (United States v. Ubak-Offiong 2008). A final example of a case that has occurred is a case involving a woman named Donna Cain Gatch who worked at Big Bend Hospice of Gadsden County in Tallahassee, Florida. What she did was fraudulently obtained controlled substances. The way that she did this was by using her patients' names and three of them were Medicaid recipients. She would then proceed to phone in the prescriptions and then pick them up herself and let the pharmacies charge Big Bend Hospice for the cost (Medicaid Fraud Report 2007).

There are many organizations and laws that are trying their best to combat the major issue of health care fraud. For example, the Health Care Fraud and Abuse Control Program (HCFAC) ".. coordinates federal, state, and local law enforcement efforts relating to health care fraud and abuse against both private and public health care programs" (Parver & Goren 2011) (p. 9). Additionally, "under [Health Insurance Portability and Accountability Act of 1996], HCFAC must release an annual report detailing its efforts to combat health care fraud, waste, and abuse" (Parver & Goren 2011) (p. 9).

There is also a team called The Health Care Fraud Prevention and Enforcement Action Team (HEAT) which uses increased resources and tools to improve the collaboration between the Department of Health and Human Services and the U.S. Department of Justice. HEAT's main focus is to fight Medicare fraud (Moses & Jones 2011). There is also a law that was passed in 2010 called The Patient Protection and Affordable care Act of 2010 and Health Care and Education Reconciliation Act of 2010 (PPACA) which will begin to expand health coverage to people who are uninsured starting in 2014 and it also increases government efforts to prevent and/or prosecute health care fraud, waste, and abuse (Moses & Jones 2011).

There are also many laws in place as well. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) contains provisions in the areas of education, expanded coverage, increased enforcement, and harsher penalties (Tomes 1998). The Anti-Kickback Statute

"…prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business" (Anti-Kickback Statute). If a person is convicted of violating the Anti-Kickback Statute, they are subject to a fine of up to $25,000, imprisonment for up to five years, and mandatory exclusion from participation in federal health care programs (Anti-Kickback Statute).

Additionally, the Stark Bill is a law that is in place that relates to the Anti-Kickback Statute. Under the Stark Bill a physician is prohibited "…from making a referral for clinical laboratory services to an entity with which the physician or an immediate family member has a relationship or compensation arrangement when the services are reimbursable under Medicare" (Tomes 1998).

The False Claims Act is another law in place that was created in order to try to prevent one of the most common types of health care fraud, submitting false claims. The act puts liability on anyone "…who submits a claim to the federal government that he or she knows (or should know) is false" (False Claims Act) or for anyone "…who knowingly submits a false record in order to obtain payment from the government" (False Claims Act). The False Claims Act also provides a whistleblower provision which is called the Qui Tam provision. What this provision does is allows a person to bring a lawsuit on behalf of the United Sates if he or she has information that someone has knowingly submitted or caused the submission of false or fraudulent claims to the United States (False Claims Act Cases).

On December 31, 2010 there was an expansion of the Recovery Audit Contractor Activities (RAC) (Amerigroup). This program expansion amends the Social Security Act to require states to enter into contracts with recovery audit contractors (RACs) for the purpose of identify and recouping Medicaid payment discrepancies" (Amerigroup). The program was also expanded to allow "…the Health and Human Services secretary to enter into contracts with RACs for Medicare parts C and D" (AmeriGroup).

The Civil Monetary Penalties Law (CMPL) is another significant law that helps to fight and prevent health care fraud. It was first enacted in 1981 and it states that significant civil money penalties may be imposed against an entity that engages in different types of fraudulent activities. Finally, the most recent change in health care law is the Patient Protection and Affordable Care Act (PPACA) which was enacted on March 23, 2010. This law touches on all of the laws that were just discussed and adds some new laws as well. Each of the laws that were talked about has been updated over time due to changes and they are described in this act.

Therefore, it can be seen that there is a lot of research being done about health care fraud. There are many statistics about the costs and amount of health care fraud occurring each year which helps to clarify the major concerns that many people have. Laws in relation to health care fraud are constantly being changed and reformed to try to find the weaknesses and add to them to help make a change. It does appear to be a slow process as the costs are only expected to increase, but with time, new laws, and technology it should be possible to decrease the amount of health care fraud that is occurring every year.

Internal Controls

Internal controls are processes that are designed to assure three main things. These consist of reasonable assurance of effectiveness and efficiency of operations, reliable reporting, and compliance with laws and regulations (Journal of Accountancy 2011). Many people believe that internal controls are only for financials. However, in order for a health care organization to ensure that patients receive the best quality care possible, internal controls need to be put in place every step of the way (Cooper & Cornett 2004).

The COSO internal control framework has been updated over time to help improve the effectiveness and efficiency of companies' internal control structures. The original COSO framework, called the 1992 COSO Report: Internal Control-An Integrated Framework, consisted of five components which were control environment, risk assessment, control activities, information and communication, and monitoring. However, in 2004 the 2004 Enterprise Risk Management (ERM) COSO Framework was introduced with some changes and some new components. The components of the ERM COSO Framework, which is the framework currently used today, are internal control environment, objective setting, event identification, risk assessment, risk response, control activities, information and communication, and monitoring. Different industries may have to apply these same internal controls in different ways and the following descriptions will give examples for the health care industry specifically.

Internal environment sets the base for how risk and control are viewed by the company. It looks at the culture of the company, the integrity of senior management, and ethics because each of these components relates to how risk and control are viewed by the company as a whole. It provides a foundation for the internal control structure. For example, the senior management needs to know their responsibilities when it comes to patient safety, billing procedures, and other major areas of problems in the health care industry. They need to be aware of all of the laws that need to be followed in order to make sure that fraud is not occurring.

Objective setting consists of setting goals that align with the company's mission and vision. Employees are required to understand the company's objectives as it relates to their position within the organization. Each person who works at the company should be aware of their direct responsibilities and what is expected of them. Therefore, if an employee is required to make sure that all bills that go through are accurate, they should understand all of the details of this responsibility and the repercussions that will be faced if they do not do their job correctly.

Event identification is looking at and analyzing different strategies that can be used to attain the objectives that are identified. These strategies can be formed using both internal and external sources. For example, things such as strong relationships with providers, rotating personnel, thoroughly checking new employees, and educating employees well would all be examples of strategies to attain objectives and prevent fraud from occurring.

Risk assessment is looking at and analyzing the potential of certain risks to occur and what their effect on the company will be if they do occur. It is important that companies are aware of the risks that they may face so that they can be prepared ahead of time. Health care companies should be aware of the fact that doctors may provide unnecessary procedures on patients and other employees may submit false claims in order to make more money. With these risks in mind, they should know exactly who is responsible for each step of the process so that they know where to look when problems occur.

Risk response is what the company does in reaction to the risk. They have to come up with a plan of what they want to do whether it is find a way out, reduce the risk, or to just accept the risk. Since risks should have already been identified they should be able to put a plan in place for each of the risks that they may be subject to. When thinking of health care fraud a lot of the risks are not something a company should want to just accept, so risk response should be a very important aspect of internal controls within the health care industry.

Control activities are the activities that have been put into place to make sure that the risk responses are carried out. Some examples of control activities are approvals and authorizations, performance evaluations, and separation of duties. These things will ensure that mistakes will be caught along the way and fraud can be caught sooner rather than later so that companies can do their best to fix the problems. If authorizations, performance evaluations, and separation of duties are not being carried out properly then this is when more mistakes and errors will be found.

Information and communication consists of delivering accurate information to the people it needs to be communicated to. This is extremely important because communication is the key to preventing problems and risks from occurring within the organization. It is also very important

that new policies and procedures are communicated to every single person throughout the organization. For example, if it has been found that some false claims have been submitted to Medicare and senior management comes up with a new procedure of how claims need to be submitted that they believe will mitigate this problem, they need to communicate this to everyone to ensure the new process is being carried out.

Finally, monitoring is making sure that all components of the ERM are functioning correctly at all levels within the organization. This is vital because it should help to make sure that all internal controls are being used effectively and correctly. If senior management finds that certain internal controls are not working correctly, it is necessary that they come up with new plans for how to improve these specific internal controls. Overall each of the components of the COSO 2004 ERM framework is supposed to prevent risks such as fraud from occurring within companies. However, as seen in the health care industry something is still lacking. Whether companies are not using the framework 100% effectively or more laws and improvements need to be put in place is what needs to be determined.

Types of Fraud

In a health care company there are three major types of fraud that exist and these types of fraud consist of provider fraud, consumer fraud, and employee fraud. Provider fraud consists of many different things such as falsifying recipient identities, padding charges, upcoding medical services, billing for services not provided, performing noncovered services but billing for covered services, rolling laboratories, and kickbacks (Goldberg & Lindquist 2005). As for consumer fraud, the different types consist of misrepresentation on medical applications, fraudulent eligibility of dependents, fraudulent submission of claims, altering prescriptions, use of a covered member's card (Goldberg & Lindquist 2005).

Ethical Problems

One of the major problems with health care fraud is the fact that it is a very different context of fraud. This is because the people who are causing this fraud are people that are supposed to be trusted. Doctors, physicians, nurses, ambulance drivers are all people who patients trust. Patients trust these people not to put their lives in danger and believe that they are always looking out for their best interests. The sad part about this is that these people cannot be trusted. Sometimes the money and what they can get out of committing the fraud is worth more to them than their patients' lives or trust.

Some people may think that criminals who commit fraud are those people who are uneducated and cannot make money so they resort to fraud. However, almost everyone within the health care industry who is committing these acts of fraud has been educated and is still willing to put themselves above others. A doctor is supposed to be someone that people can go to when they have a problem they need fixed. Whether it's mental or physical, they trust their doctors and all the other staff within the organization to do what is best for them. It is very sad to realize that one cannot even trust their own doctor who is supposed to help them in times of need.

Centers for Medicare and Medicaid Services

The Centers for Medicare and Medicaid Services (CMS) is a part of the U.S. Department of Health and Human Services. It is a federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program. CMS provides information for health professionals, regional governments, and consumers. CMS's role in fraud consists of them working together with many different groups and law enforcement agencies in order to prevent and detect Medicare and Medicaid fraud and abuse. A few examples of these different groups are the FBI, the Department of Justice, the Recovery Audit Program, and Medicare beneficiaries and caregivers. Overall CMS is an agency that helps to provide health insurance to many people and they oversee the actions of Medicare and Medicaid.

United States v. Anura Andradi

The United States of America v. Anura Andradi case consisted of fraudulent bills being sent to Medicare and Medicaid in order for an ambulance company, Doctor's Ambulance Service, to be reimbursed. Anura Andradi was the owner of Doctor's Ambulance Service which is located in Forney, Texas. This ambulance service transported non-emergency patients to dialysis appointments. In order to be reimbursed from Medicare and Medicaid, it was required that the patients were non-ambulatory. Therefore, in order to be reimbursed, Andradi lied about many of the patients' ambulatory statuses and received $1,676,140 by doing this from March 2004 to December 2005. Due to this, this case is an example of a case that is violating the False Claims Act, which will be discussed later. It was also later discovered that he submitted fraudulent bills in relation with 36 other patients and received $1,042,874. This was discovered by the FBI as they reviewed almost every submission to Medicare and Medicaid.

Andradi was the main culprit in this fraud as he owned the company as well as coordinated the fraud. Although he had partners, he was actively involved in the management of the company. In order to commit this fraud he controlled the manner in which the emergency medical technicians performed their jobs and followed the ambulances to make sure his directions were obeyed.

During the time that the fraud was being committed, three different billing personnel submitted fraudulent claims for Doctor's Ambulance Service. The claims were originally filed by an outside company and then they were filed by two people who were associated with Doctor's Ambulance Service.

When this fraud was eventually discovered, Andradi went to trial and was charged by a 44-count superseding indictment with inter alia, health care fraud and conspiracy to commit health care fraud. This was in violation of 18 U.S.C. Section 1347. He was then convicted of 40 counts of the superseding indictment and $750,000 and other assets were forfeited. He was also sentenced to 97 months in prison. Medicare and Medicaid lost over $2.5 million as a result of the fraud caused by Anura Andradi.

Since Anura Andradi was the owner of Doctor's Ambulance Service, it was part of his responsibility to ensure that a strong internal control structure was in place. However, analyzing the events of these fraudulent activities shows a lot of weaknesses within the company's internal control structure. Considering the fact that Andradi was intentionally lying about patients' ambulatory status, this shows that there was a lack of integrity and ethical values. However, this lack of integrity and ethical values may have started when Andradi saw the opportunity. Upon starting the business it is very likely that he did have an internal control system in place. When he realized that he could be making more money by causing fraudulent activities to occur, he decided to act unethically.

There also appeared to be a top-down management style as it was found that Andradi was controlling the manner in which the emergency medical technicians performed their jobs. Additionally, there was a lack of a whistleblower system implemented within the organization. From the facts of the case it seems as though Andradi was forcing every employee to commit the fraud exactly how he ordered them to. If there was a whistleblower system in place, one of the employees being told to commit the fraud may have spoken up.

The second aspect of the internal control framework is objective setting. In this situation it can be assumed that his objectives were to bring in income. It appears that his goal for the organization was to make as much money as possible, but the way that he decided to have his employees go about this was wrong. It was found during the trial that he was the person who coordinated the fraud, meaning that he directed the criminal activities. These criminal activities may have come about because the company was not making as much money as Andradi had anticipated. For example, when realizing they were not making as much money as planned, Andradi chose to take the easy way out rather than to prepare a budget or some sort of plan for

how much money he wanted the company to make and figure out what could be done in order to achieve that.

The next part of the framework is event identification. This is where things such as slow business, not having enough patients, or lack of circumstances where reimbursement is allowed comes in. If Andradi's main objective was to bring in income he needed to be aware of anything that could prevent income from flowing in. If he had considered these events that would prevent him from bringing in the amount of money he wanted, he may have had other plans in place rather than having to resort to fraud to bring in the appropriate amount of money.

It also appears that Andradi failed to apply an efficient risk assessment. In order to determine the likelihood of these events occurring he could have done research on other ambulance companies to determine how often they face the same types of risks. He also could have done some research within the area that the company would be operating in to determine the approximate amount of patients the company would be receiving. In this case it appears that Andradi did not think the risk of these events occurring was very high and that is most likely the reason why he had nothing in place to fix problems as they occurred.

As for the risk response component of the framework, Andradi evidently decided to just compensate for the risk. If the reason all of this fraud was committed is because of the fact that Andradi wanted to bring in more money for the company, the approach he took was compensating for the risk because he was making up for it by committing fraud. The risk occurred and Andradi seemed to think that the best way to make up for it was by lying about patients' ambulatory statuses so that the company could be reimbursed.

As for control activities, there may originally have been some in place, but it is very easy to see which ones were either violated or needed to be added. In this situation it is clear that there needed to be separation of duties. Since Andradi controlled how the emergency technicians performed their jobs and followed the ambulances to make sure his directions were followed, this is very evident. It should not have been just him who was giving them orders and other people should have been following the ambulances as well. It was also found that the claims were being filed by an outside company at first and then by two people associated with Doctor's Ambulance Services. There should have been more people involved with the claims process considering that is one of the most common themes in health care fraud. If more people were involved in these processes it is more likely that the fraud could have been prevented. However, since Andradi seemed to be managing every part of the business and no one was checking over his actions, the fraud continued to occur.

Information and communication also appears to be a very weak part of this company's internal control structure. This internal control is supposed to connect all parts of the framework so that risk can be minimized. However, although all information was being passed on to the manager, he was the person controlling the fraud and causing the risk. Therefore, although information may have been communicated to the correct people within the organization, this internal control would never have been effective because it was the manager's intention to cause fraudulent activities when the opportunity came about.

The final component of the internal control structure is monitoring. It is very obvious that no one was monitoring the actions of the manager himself as he was causing all of the fraud to be committed. This should be the job of other management within the organization, the auditors, or a group of internal auditors. Everyone should always be monitored no matter what position they have within the organization because when management is responsible for fraud and they are not being monitored, it may be a while before they are stopped or caught.

Overall it appears that Doctor's Ambulatory Services may have had an internal control structure in place at one time, but eventually it became very weak. Whether the company was not making enough money or Andradi just came upon the opportunity to commit fraud, it was not the right thing to do. This goes to show how people can become addicted to the money and not know when to stop. It is possible that Andradi's intention was only to submit a false claim once or twice to bring in a little extra money, but then when he realized what it was doing for himself and the company he continued to have the false claims submitted. However, if correct internal controls had been in place and they were being checked frequently, the results of this may have been different.

United States v. Ramon Santos

The United States v. Ramon Santos case consisted of a man who was convicted of one count of conspiracy to commit health care fraud in violation of 18 U.S.C. Section 1349, five counts of health care fraud in violation of 18 U.S.C. Section 1347, and one count of obstruction of justice in violation of 18 U.S.C. Section 1503. He was also sentenced to 108 months in prison. This case is another example of a violation of the False Claims Act. Santos worked at Better Health Consulting Clinic Corporation as a physician's assistant (PA), which was opened by Ana Fonseca and Felix Calas in 2004.

While working as a PA, Santos altered blood-work results in order to bill Medicare for larger amounts of money. Therefore, he was billing Medicare for medical treatments that had not been performed. For example, he would give patients infusions of vitamins B1, B6, and B12 and then

bill Medicare for more expensive treatments. It was later discovered that Santos did not have a PA license, but Fonseca claimed that Santos had shown her one. During his trial Monica Mulet, a medical assistant at Better Health Consulting Clinic, testified that Santos would tell her which medicines to put into the infusion bags. It was also found that when the medical director was not present Santos would see patients, complete paperwork, and write in the medical files.

In 2005, Fonseca opened another medical center called Mitto Health Center and she hired Santos as a PA at this medical center as well. At this clinic he performed physical exams, completed billing paperwork, and also provided infusions of vitamins B1, B6, and B12. Another PA at the clinic, Carlos Madrigal, witnessed Santos write in patient charts and fill out billing paperwork sometimes for medications that the patients were not given. The medical director at the organization, De Quesada, also believed he had seen Santos' PA license.

Then in 2006 federal agents gave both companies subpoenas for patient records. Fonseca had originally planned to close both of the clinics as a result of this, but Santos volunteered to get the records in order. While doing this he replaced pages in patient charts with fake test results and signed bills and forged the medical directors' signatures on patient charts. During the investigation the medical director was interviewed by the FBI and confirmed that claims to Medicare included medications he had not used or that he was not familiar with. As the FBI reviewed the medical records and patient files, they found charges for tests at Miami Technology Diagnostic Center on dates after the center had closed, bills for patients who had died before the listed dates of treatment, and also found that Santos has not received a license as a PA.

Additionally, it was determined that Better Health Consulting Clinic spent $15,000 on medications but billed Medicare $11 million and Mitto Health Center spent between $3,000 and $4,000 on medications but billed Medicare for $1 million. Santos later denied that he ever said he was a PA and said he never showed anyone a PA license, he claimed he was hired as a medical assistant, he admitted to giving infusions but only under the doctor's direction, and he denied falsifying documents or participating in fraud at either clinic.

In this case it is very obvious that both clinics were either lacking strong internal control structures or were just not using their internal control structures correctly. Based on the facts of the case each element of the internal control structure can be analyzed in order to determine what was missing or what could have been changed or improved. For the internal environment it does not appear that management had been lacking integrity or ethical values, it was more the element of risk consciousness that was missing. It seems as though upon hiring Santos, the management could have been a little more skeptical before allowing him to perform tasks that could only be

performed by those who were PAs. Instead of just looking at the license itself, they could have done some research and looked up if Santos actually had a valid PA license before hiring him. There also appears to be some confusion as Santos had claimed that he was hired as a medical assistant and not a PA, which are two jobs with very different responsibilities as a medical assistant is not allowed to conduct physical exams or order tests while a PA can practice medicine under the supervision of a licensed physician.

As for objective setting, it seems as though the intention was for the clinics to perform the correct procedures, but there did not appear to be any strict guidelines to follow. There was also not a very good management system in place as Santos was not even a manager and was able to commit multiple different types of fraud without being caught. If his work had been checked by a superior, as it should have been, the fraud could have been identified sooner. Also, since there was confusion to Santos about what his actual title was, there should have been strict guidelines listing out what he was allowed and was not allowed to do. This way, it would have been clearer to him what his position was and what exactly he was supposed to be doing and he would not have been able to use the defense saying he was hired as a medical assistant.

The management of these two companies was also lacking greatly in the area of event identification. They failed to consider these exact types of things from happening. Santos was able to perform medical treatments and exams, write in patient charts, and fill out billing paperwork. These tasks should have been being monitored and checked over to determine everything had been done correctly. There also should have been a system in place determining that patients were receiving the medical treatments that they actually needed. There appears to have been a very weak system of operations going on within the organizations.

There also appears to have been a weak risk assessment performed for both of the companies. Management did not seem to take into consideration the likelihood of these different events occurring or if they did they apparently did not think that the risk was that high. However, in a medical clinic those types of events should always be considered and employees' backgrounds and any licenses should be researched, analyzed, and confirmed before hiring them. Management should always be very skeptical and think of the worst events that could happen that could have either a major or minor effect on their organization. This way they can be prepared and have procedures in place for what to do when events like this begin occurring and also be able to catch these types of events earlier.

The risk response element was also weak as a result of a weak risk assessment. Since it seems as though the management did not do a very good job of determining the likelihood of certain

events occurring, they probably did not have a very good plan in place for what would be done if the events had occurred. It also appears as though the company had no idea that the events were going on until the federal agents issued the subpoenas for patient records. When this happened and Fonseca was originally planning to close down both organizations, it seems that her plan was to eliminate the risk by just shutting down the business. However, by Santos volunteering to get the patient records together he was trying to mitigate the risk, but by committing fraud so this was done in the complete wrong way.

Within both of the companies a lot of essential control activities were also missing. There absolutely should have been more separation of duties. It appeared that Santos was in charge of many different functions that should have been split up between different people. There also should have been some type of review policy in place where every step of the process was being reviewed by different people so that employees were checking each other's work. For example, if a patient only needed vitamin B1, Santos could have given that to the patient, but a different employee should have been responsible for the billing paperwork and another employee should have been checking to determine this was actually the infusion the patient needed. This way Santos would not have been charging for more expensive treatments.

There also should have been periodic assessments and evaluations so that these problems may have been identified. Additionally, when Santos got all of the patient records in order as a result of the subpoenas, a manager should have checked over what he put together. Everything in the patient charts should have been signed off and verified by the medical directors as well. This way it would have been determined earlier that Santos was forging the medical director's signature because the medical director could have identified that the procedure was never done and that he had not signed off on it. If some of these control activities had been implemented, Santos may have been caught earlier.

As for information and communication, management definitely needed to be stronger in this area. It appears that there was no manager checking over the different procedures and tasks that Santos was performing. A lot of this also seemed to occur when the medical director was not there. This should have been the medical director's responsibility to communicate with Santos and find out what went on when he was not there as well as check over everything that occurred during the day. Instead it seems as though the medical director did not ask any questions and this ended up letting Santos get away with everything he was doing without anyone even realizing it.

The monitoring aspect of the internal control structure was also very weak as it has been determined that no manager was monitoring the activities of Santos. It is also apparent that no

one was monitoring the bills or medical records of the patients. Monitoring is a very important aspect of the internal control structure because if these activities are looked over and every part of the process is looked at it is easier to identify where there could potentially be a problem.

Overall it seems as though both organizations had a very weak internal control structure in place that was lacking some of the most important elements of the framework. It almost seems as though the management had a care free attitude and put way too much trust into their employees. This allowed Santos to take advantage of that and commit the amount of fraud that he did. Although any manager wants to trust the people that they hire, it is important to be very skeptical and always check tasks over in order to prevent risk from occurring.

United States v. Ubak-Offiong

The United States of America v. Ubak-Offiong consisted of the owner of a durable medical equipment (DME) company submitted claims for power wheelchairs, providing less expensive scooters, and pocketing the difference. Ubak-Offiong was the owner of Champion Medical Supplies which was operated out of her home in Sugarland, Texas. This case is an example of a case in violation of the False Claims Act as well as the Anti-Kickback Statute. In addition, she was charged with five counts of health care fraud in violation of 18 U.S.C. Section 1347 and two counts of payment of illegal remunerations in violation of 42 U.S.C. Section 1320a-7b(b)(2)(A). However, one count of health care fraud was dismissed because the witness who was supposed to testify died before the trial.

The government found and presented documents showing that Champion submitted Medicare claims for power wheelchairs on behalf of certain beneficiaries. However, it was determined that Champion only actually ordered power scooters for those same people from its medical supplier. Therefore, the beneficiaries only needed power scooters, but Florence was submitting claims to Medicare that stated something different in order to receive more money. This is because Medicare reimbursed about $7,000 for a power wheelchair and only $1,200 for a power scooter.

The way that this was done was by inputting false information on the Certificate of Medical Necessity Form, which was needed in order to receive a power wheelchair. On this form, Florence put in the beneficiary's name and Medicare number. Then, the information about the beneficiary's need for the wheelchair was inaccurate. The physician's signature and UPIN, a unique identifying number assigned to each physician) was forged on the form. Finally a false prescription form prescribing the wheelchair with the doctor's forged signature was also submitted. Then Medicare would approve the wheelchair and reimburse the defendant. Also

during this time period it was found that Florence bought several large money orders made payable to her husband.

At the trial witnesses testified that the beneficiaries who had been sent the power scooters had not been prescribed a power wheelchair or a power scooter by their primary physicians. The physicians whose names were signed to the Certificate of Medical Necessity also testified in court and denied ever having treated the beneficiaries or prescribing the wheelchairs. The jury also heard from Special Agent Jack Green who found that Florence paid kickbacks to Emmanuel Akpan, the owner of Atbestcare Medical Equipment, and Veronica Enebong, the owner of Vision Medical Equipment, in return for the beneficiaries' patient information. He was also able to compare the invoices from Champion's medical equipment supplier, which only listed power scooters, with the invoices that were submitted to Medicare, which listed power wheelchairs. Florence was ultimately sentenced to 38 months in prison on each count to be served concurrently and three years of supervised release. She was also required to pay $1,082,332.20 in restitution and a $400 special assessment.

However, for this particular case the government also found that there appeared to be a problem with Medicare as well. In 2002 and 2003 30,000 DME providers were approved just in the city of Houston, Texas alone. Medicare approved payment of millions of dollars to these businesses without oversight as the defendant was paid for wheelchairs for people living in distant areas around the country and signed by doctors living in distant states as well. Therefore, had Medicare been doing what they were supposed to this fraud may have been identified sooner.

In this case it is pretty evident that Ubak-Offiong did not have a strong internal control structure in place, if she had one at all. However, it can still be analyzed to determine internal controls that should have been in place that would have been able to prevent her from committing all of this fraud on her own. For the internal environment it is very evident that integrity and ethical values were lacking. Also, the environment in which the company was operating was probably not the best environment. The sole owner of the company had the ability to obtain all of the information necessary to submit a false claim to Medicare in order to receive a greater payment. Also, she was operating out of her home. This most likely gave her a greater opportunity than other similar companies to commit the fraud. This is because no one else was working for her and everything was in her home so it was not possible for anyone to notice anything suspicious going on. This may be the responsibility of Medicare as they should have thought about this before approving the company as a durable medical supplier.

As for objective setting, it is clear that the goals and objectives of the organization were to provide durable medical equipment to beneficiaries. However, it also appears that the owner wanted to make additional money on top of this. This is another example of the fact that maybe this was not her intention initially, but when she realized she could obtain the information she needed and receive more money for the different scooter, she took advantage of this. However, it was her responsibility to stray away from these opportunities and submitting false claims to Medicare should never have been one of her goals or objectives.

For event identification, the opportunity to commit fraud should have been an event that was identified. Florence should have been aware that if she was opening a business on her own she would be more likely to commit fraud than if she had others working for or with her. This is because she may not have wanted others to be involved, or she could have consulted with someone first that may have been able to deter her from deciding to go through with it. She also should have identified the fact that she may not be able to make as much money as she would like to at first, so she should have had plans in place to deal with this instead of feeling the need to resort to fraud.

It is also very clear that Florence did not take the time to identify the likelihood of these events occurring. It is not likely that her only goal when starting the organization was to commit fraud. There most likely is a reason behind it and if she had assessed some of the problems that could have occurred while running the business, it may have helped her out. I believe that this is a step in the COSO Framework that Florence completely skipped over as there is nothing showing that she was prepared for these types of events occurring.

As for risk response, there was nothing in place to detect the fraud that Florence was committing. She should have had someone else to check over the claims that she was submitting and verifying the information that she was putting on the forms. There is also the possibility that she could have hired someone to fill out the forms for her so that no false information was being put on them. Other people needed to be working within the organization if she wanted anything in place to prevent fraud from being committed when things were not going as planned for the organization.

In this situation there appears to be no control activities in place whatsoever. This again relates back to the fact that Florence was running the business completely by herself. Every single thing that was done, every transaction, every form that was filled out, and every form that was submitted was done by her. This is a major issue as separation of duties is a major part of a strong internal control structure. This is something that also should have been identified by the

auditors of the company. It was in operation long enough to have been audited and the auditors should have been able to find something or determine that there was a suspicion of something especially since the company was operated by a single person.

The information and communication control does not apply in this case because again, Florence was the only person working for Champion Medical Supplies. Finally, as for monitoring, whatever controls Florence had in place for herself either did not appear to be working, she was not checking them, or she just never had any in the first place.

Overall, this is case is an example of top management committing fraud. This seems to be the case in a lot of health care fraud cases and it is a major problem because it is hard to stop the fraud from occurring as they are the people who have the final say in everything that the company does. However, in this particular case, Medicare should have been more on top of things. It appears that they were just letting this fraud occur without even considering the fact that it was occurring. There were some very obvious signs as wheelchairs were for beneficiaries out of state and signed by physicians who were also out of state. This is another thing that also should have been identified by the auditors. Overall, this fraud appears to be something that should have been identified much sooner than it had been.

Donna Cain Gatch Case

The final case that will be analyzed is a case involving a woman named Donna Cain Gatch who worked at Big Bend Hospice of Gadsden County in Tallahassee, Florida. What she did was fraudulently obtained controlled substances. These controlled substances included Ambien and hydrocodone. She was arrested by investigators from the Attorney General's Medicaid Fraud Control Unit as well as by deputies from Gadsden County Sheriff's Office.

It was determined that she obtained more than 50 unauthorized prescriptions for controlled substances. The way that she did this was by using her patients' names and three of them were Medicaid recipients. She would then proceed to phone in the prescriptions and then pick them up herself and let the pharmacies charge Big Bend Hospice for the cost.

The case was investigated by the Diversion Response Team, which is a task force of agencies that was created in order to fight the illegal trade in pharmaceutical drugs. Gatch was charged with 53 counts of obtaining controlled substances by fraud and one count of Medicaid fraud. She eventually pled no contest to twelve counts of obtaining controlled substances by fraud and one counts of grand theft. Additionally, Gatch was ordered to pay restitution to Big Bend Hospice,

costs of investigation, court costs, and fines. She was sentenced to four months in jail followed by five years of probation.

This case is an example of a situation where the owners and managers were not responsible for the fraud that was being committed, but rather an employee. Therefore, it is possible that many strong internal controls were in place, they just may not have been being operated correctly. The internal environment of this company seemed to be okay as it was not management's intention for this to happen and they did not seem to be aware of the fraud before it was discovered. The only element of internal environment this company appeared to be lacking is the risk consciousness of the business. This is because if fraud was occurring they were not conscious of the amount of risk they could face. However, they did seem to have strong integrity and ethical values, and the environment the company operates in did not appear to be a main cause of the fraud.

The next element of the framework, objective setting, also seemed to be working okay for the company as management seemed to have its goals and objectives for the company in place. They wanted to help people who had limited life expectancies. This was the main goal of the organization. Additionally, it is reasonable to assume they wanted to be able to bring in money and provide reliable services to their patients. This all appeared to be working well as even though Gatch had been fraudulently obtaining controlled substances using her patients' names it was found that no patients of the hospice ever failed to receive the medications that were prescribed for them.

The event identification element appears to be where the internal control structure of Big Bend Hospice appears to weaken. Management probably should have put a little more thought into the events that could affect their objectives especially when employees were dealing with medications, some of which were controlled substances. The identification of employees possibly trying to obtain some of these medications should have been high up on their list.

Although this could have been identified by the company, their risk assessment may not have been done as well as it could have been. Risk assessment determines the likelihood of these events occurring and the impact it will have on the company as a whole. If the risk assessment of the risk of fraud in relation to prescriptions for controlled substances had been assessed correctly it is very likely the company would have been able to have the correct responses and control activities in place in order to prevent and detect this kind of fraud from occurring sooner.

Risk response for this company appears to have been low. They apparently did not have any controls in place in order to detect this fraud, at least to detect it the way it was being committed.

Since this type of fraud should have been assessed as high, the company should have had a very strong plan for what to do if this risk occurred. Therefore, controls should have been in place to identify any type of suspicious behavior in relation to the ordering and the payment of prescriptions for controlled substances. If controls had been in place they would have been able to either eliminate or mitigate the risk when it began occurring.

As for control activities, a lot was missing from this element of the company's internal control structure. Things such as background checks on employees and separation of duties may have helped the company to identify this fraud. Although it is not known if a background check was done on Gatch or if the background check would have identified anything, it is very important for background checks to be done on all employees. This would help in the case that the employee did have any type of problems in the past that may cause them to want to commit fraud now or in the future.

As for separation of duties, Gatch was ordering and picking up the prescriptions on her own for her own patients. Different people should have been completing and checking these activities. The person who ordered the prescriptions should be different than the person whose patients they are for as well as different from the person picking up the prescriptions. This way if anything suspicious were occurring someone along the chain of activities would catch the fraud. Also, the person who was responsible for the payment of the prescriptions should have been doing a better job as it is clear that additional prescriptions were being paid for. This is known because none of the patients were missing the medications they were prescribed. There should have been more records in place for the different employees to be checking that everything was accurate and patients definitely needed the medications and amount of the medications that were being ordered for them.

Information and communication also appeared to be lacking within the organization. Management should have been talking to the nurses about their patients and questioning them about everything they needed to do. Management also should have been talking to the pharmacies where the prescriptions were being called in and picked up from so they knew exactly what was ordered and picked up and under which patient's names. Clearly, in this situation the accurate information was not being communicated all throughout the organization.

Finally, the monitoring element also appeared to be lacking. If all of the correct activities had been in place they would have been able to be monitored as well. When they were monitored management would have been able to determine which activities were not working as they should and what could be done to fix them. Had all of these elements been completed and

performed effectively the fraud that Gatch was able to commit may have never been possible. It seems as though she saw the weakness in the internal control structure and knew how she could go about getting the controlled substances without getting caught. She knew how the whole system worked and took advantage of it. Internal controls are very important and a strong structure needs to be in place in order to prevent these types of activities from ever occurring.

Comparison of Cases

Internal Control Element	U.S. v. Andradi	U.S. v. Santos	U.S. v. Ubak	Gatch Case
Internal Environment	Lack of integrity and ethical values Top-down management style Lack of whistleblower system	Lacking risk consciousness	Lacking integrity /ethical values Work environment a problem	Lacking risk consciousness Good environment Strong integrity and ethical values
Objective Setting	Bring in income Took wrong approach	Weak management system Perform correct procedures, but missing guidelines	Provide durable medical equipment, but chose to make additional money as well	Help people with limited life expectancies Bring in a profit
Event Identification	Did not identify events that may occur and cause risk	Did not perform proper event identification	No event identification for risk of fraud	Weak event identification
Risk Assessment	Did not complete risk assessment	Weak risk assessment	Did not complete risk assessment	Need stronger risk assessment
Risk Response	Compensated for the risk by committing fraud	Lacking risk response Took wrong approach to deal with risks	No responses to risk	Lacking risk response
Control Activities	Missing separation of duties	Missing separation of duties Lacking review policy Need periodic reviews/evaluations	Completely missing control activities	Missing separation of duties Missing background checks
Information and Communication	Not an effective control - manager committing fraud	Weak communication	N/A - only one person working in the company	Weak information and communication throughout organization
Monitoring	Controls not being monitored	Controls not being monitored	Controls not being monitored	Controls not being monitored frequently

From the above chart it is now possible to determine the similarities and differences between the four cases that have been analyzed. Two of these cases consisted of fraud committed by upper management, while the other two were about fraud committed by employees. Therefore, there are similarities between the cases of similar type. For the cases committed by management, the problem with the internal environment element appears to be lack of integrity and ethical values. This is because management is in control of implementing the internal control structure. Everything that gets done within the company can be viewed and approved by them and they have access to most information they will ever need. Since management was committing the fraud, it was obvious they had the intention to do so and simply disregarded any of the internal controls they may have had in place. Therefore, they were acting unethically.

As for the cases that deal with employee fraud, the problem with their control environment element seems to be the lack of risk consciousness. The management had all of the right intentions and wanted the organizations to be run correctly and smoothly, but they failed to be aware of the amount of risk that is associated with a company. For the objective setting element, the major problems here are either seeing opportunities for fraud arise or controls were missing in order for the proper objectives to be carried out. In both the Andradi and Ubak cases, the assumption is that the fraud was committed when management saw the opportunity available to them. They had other objectives in mind when starting the companies, but chose to become selfish when they had the chance. In the Santos case, the management itself had strong objectives, but they were missing the proper guidelines for how to carry out these objectives which ultimately led to being part of the reason the fraud occurred.

Event identification seems to have been a weak or nonexistent element for all four cases. These companies did not do a very good job at determining the different events that could occur and affect management's objectives and goals. Risk assessment was either weak or not completed at all in each of the four cases. This assumption was made based on the fact that fraud was able to occur without anything being done to stop or identify it. Risk response is another element that was either lacking or performed incorrectly in all four cases. Since event identification was not done correctly, this led to poor risk assessment and risk response in all four situations because they were not aware of the events that they needed to look out for.

In each situation there were many different control activities that were missing. If these different control activities had been in place it is likely that the fraud may have either not occurred or at least have been detected sooner. However, the one single control activity that was missing from all four cases was separation of duties. Clearly this appears to be a major issue in multiple companies and some sort of law should be in place about this. As for information and

communication, this element was either missing completely or was very weak. In the cases where fraud was committed by management this element was missing because it is management's responsibility to make sure all information is being communicated correctly, so if they choose to approach this differently the element is irrelevant. In the cases where fraud was committed by the employees the information and communication was weak because clearly management was not doing a good job at talking to and questioning their employees about the different activities they performed every day.

Finally, in all four cases monitoring was also missing. This is very evident simply because the fraud was being committed in the first place. If fraud was being committed, controls were lacking, meaning that the controls in place were not being monitored regularly. If they had been being monitored, the deficiencies would have been identified and fixed so that the fraud could have been detected sooner. Overall it appears that there are many similarities between the four cases, especially in the areas that were lacking greatly. This shows which elements are the most important when an internal control structure is being created. The areas that are lacking appear to be the areas that allow the fraud to be committed and go unnoticed. This provides an opportunity for changes that should be made in the law for health care companies and also in the application of the COSO ERM Framework.

Current Laws for Health Care Entities

In attempts to try and stop or reduce the amount of health care fraud that occurs, there have been many different laws put in place. These laws relate to all aspects of health care fraud, not necessarily the same types of situations from the cases that have just been analyzed. Additionally, these laws have been changed over time in order to try to include the newer types of fraud schemes that people have been coming up with. After looking at the laws that are already in place, suggestions for new policies can be thought of.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is an act that was put in place several years ago in order to fight health care fraud. However, this act is still in place today, although it is likely that many changes have been made to the act due to the changes in the industry and the changes in technology. At the time that the law was enacted, it contained provisions in four major areas. These areas consisted of education, expanded coverage, increased enforcement, and harsher penalties (Tomes 1998).

Under the education provision were things such as the Office of Inspector General is required to petition proposals from the public about modifying safe harbors or establishing new safe harbors (Tomes 1998). The Office of Inspector General is also required to request the issuance of special

fraud alerts containing suspect practices (Tomes 1998). Also, under this provision the Department of Health and Human Services (DHHS) is required to provide Medicare beneficiaries with explanations of their benefits so that they are able to identify improper billing (Tomes 1998). The DHHS was also required to set up a national data bank which would contain the names of both suppliers and providers who have committed health care fraud (Tomes 1998).

The expanded coverage provision of this act made health care fraud a federal crime and also included many new crimes (Tomes 1998). A few examples of these new crimes that were included are embezzling, stealing, intentionally misapplying money, property, or assets of a health care benefit program, and preventing or misleading communication of information or records relating to criminal health fraud to government investigators (Tomes 1998). However, there were many other crimes that were also included at the time this act was created. This provision also broadened the reach of the anti-kickback statute to extend prohibitions of the statute to all federal health care programs except for Federal Employee Health Benefits (Tomes 1998).

The increased enforcement provision "…increased funding for fraud and abuse control programs" (Tomes 1998). Additionally, the HIPAA funds the Medicare Integrity Program which allowed the "…DHHS to contract with private organizations to review and audit providers, to audit Medicare cost reports, and to audit and recover payments improperly made under Medicare secondary payer provisions" (Tomes 1998). Under the harsher penalties provision, the DHHS was now required to exclude providers who had been convicted of felony, fraud, theft, embezzlement, etc. from Medicare and Medicaid programs (Tomes 1998). Included in this act are 13 different safe harbors. However, the provider must meet each and every criterion for these safe harbors. Finally, if the act is violated, the violators are subject to felony, imprisonment and fine, and can be excluded from participation in the Medicare program (Tomes 1998).

Another law that is in place to help to prevent health care fraud is the Anti-Kickback Statute. What this statute does is "…prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business" (Anti-Kickback Statute). This is something that tends to occur quite often within the health care industry, so it is important that this law is in place and has strict penalties as well. If a person is convicted of violating the Anti-Kickback Statute, they are subject to a fine of up to $25,000, imprisonment for up to five years, and mandatory exclusion from participation in federal health care programs (Anti-Kickback Statute). In order to determine if this statute has been violated, the case United States v. Greber determined the "one purpose" test. What this says is that "if one

purpose of the payment was to induce future referrals, the Medicare statute has been violated" (Anti-Kickback Statute).

A law that is in place in relation to the Anti-Kickback Statute is the Stark Bill. Under the Stark Bill a physician is prohibited "…from making a referral for clinical laboratory services to an entity with which the physician or an immediate family member has a relationship or compensation arrangement when the services are reimbursable under Medicare" (Tomes 1998). This basically states that a physician cannot make referrals to a health care entity that he or she has a financial relationship with. The violations of this law "…can result in civil penalties, denial of payments for the services that were provided in violation of Stark, and exclusion from participation in Medicare, Medicaid, or any other federal health care program" (Stark Law).

The False Claims Act is a very important law that is in place in order to fight health care fraud. It deals with and tries to prevent one of the most common types of health care fraud, submitting false claims. On May 20, 2010, the scope of the liability under the False Claims Act was expanded when President Obama signed into law the Fraud Enforcement and Recovery Act (False Claims Act). The act puts liability on anyone "…who submits a claim to the federal government that he or she knows (or should know) is false" (False Claims Act) or for anyone "…who knowingly submits a false record in order to obtain payment from the government" (False Claims Act).

The False Claims Act also provides a whistleblower provision which is called the Qui Tam provision. What this provision does is allows a person to bring a lawsuit on behalf of the United Sates if he or she has information that someone has knowingly submitted or caused the submission of false or fraudulent claims to the United States(False Claims Act Cases). The person who brings the lawsuit to the United States must provide all evidence that they have and then the Attorney General investigates the allegations. After the allegations have been investigated the Attorney General has the choice to intervene, decline to intervene, or dismiss the complaint (False Claims Act Cases). This provision was put into place to try to get other employees within the company who may know that the fraud is going on to speak up and cause a stop to the fraud.

Additionally, on December 31, 2010 there was an expansion of the Recovery Audit Contractor Activities (RAC) (Amerigroup). This program expansion amends the Social Security Act to require states to enter into contracts with recovery audit contractors (RACs) for the purpose of identify and recouping Medicaid payment discrepancies" (Amerigroup). The program was also expanded to allow "…the Health and Human Services secretary to enter into contracts with

RACs for Medicare parts C and D" (AmeriGroup). Previously they were only allowed to enter into contracts for Medicare parts A and B. The secretary is also required to submit a yearly report on the program effectiveness (Amerigroup).

The Civil Monetary Penalties Law (CMPL) is another significant law that helps to fight and prevent health care fraud. It was first enacted in 1981 and it states that significant civil money penalties may be imposed against an entity that engages in different types of fraudulent activities. Some of these fraudulent activities consist of knowingly presenting or causing a claim for services not provided as claimed to be presented or any other type of fraud involved in the claim, knowingly giving or causing false or misleading information to influence a decision to discharge a patient, offering or giving compensation to any beneficiary of a federal health care program likely to influence the receipt of reimbursable items or services, arranging for reimbursable services from an entity that is excluded from a federal health care program, knowingly accepting compensation for a referral of a federal health care program beneficiary, and using a payment intended for a federal health care program beneficiary for another use (Civil Monetary Penalties Law). These all tie back into other laws that have been created and passed in an effort to combat health care fraud.

The most recent change in health care law is the Patient Protection and Affordable Care Act (PPACA) which was enacted on March 23, 2010. This law touches on all of the laws that were just discussed and adds some new laws as well. Each of the laws that were talked about has been updated over time due to changes and they are described in this act. The PPACA requires providers and suppliers to create and implement a compliance program. It is a condition for enrolling in Medicare, Medicaid, or Children's Health Insurance Program (CHIP) (Sevell & Shankar 2010). The act adds enhance enrollment protections consisting of things such as screening for providers and suppliers participating in these different health care programs and new providers and suppliers may be subject to enhanced oversight (Sevell & Shankar 2010). This act also gives the DHHS Secretary the power "…to impose a temporary suspension on the enrollment of new providers or suppliers…" (Sevell & Shankar 2010).

Under this law applications for enrollment in government health programs will require the disclosure of current or previous affiliation "…with a provider that has uncollected debt, has been suspended or excluded from a federal health care program, or has had billing privileges denied or revoked" (Sevell & Shankar 2010). The anti-kickback statute is amended under the PPACA. It is amended to state that a person "need not have actual knowledge of this section or specific intent to commit a violation of this section" (Sevell & Shankar 2010). This means that a

violation may be established without showing that an individual knew of the statute's details and intended to violate it (Morgan Lewis 2010).

Physicians are now prevented from having ownership or investment interest in any hospital under the PPACA (Sevell & Shankar 2010). Also, physicians who are referring patients must state in writing that the patient does not need to receive the services from the referring physician, and that they can receive it from other physicians. Additionally the physician must provide a list of suppliers for the service to the patient (Sevell & Shankar 2010).

The Civil Monetary Penalties Law is amended by the PPACA and authorizes civil monetary penalties for the following activities: (1) "knowingly making false statements in an application, bid, or contract to participate or enroll in a federal health care program" (Sevell & Shankar 2010).

Suggestions

Based on prior research done about health care fraud along with my own analysis of four different cases, I have come up with some suggestions to further combat health care fraud. However, these suggestions mainly focus on the internal control structure of these companies. First, all health care companies should be required to follow the ERM COSO Framework. This is because this is a very strong model and will work effectively when it is implemented correctly. It contains all of the elements of a strong internal control structure and with these elements in place it is very likely that it will be much harder to commit fraud without being caught right away. This is also one of the major problems within these companies is that they are not required to follow any type of internal control structure. It seems as though they are just expected to have these types of things in place in order to prevent fraud from occurring. Therefore, if the ERM COSO Framework is required to be implemented by every health care organization it is likely that there would be a reduction in health care fraud.

Secondly, there should be no single-owned health care companies. This appears to just be asking for fraud to occur especially when it is so common within the industry. Companies have to be approved before they can begin submitting claims to Medicare and Medicaid, or dealing with many other types of things within the health care industry. Therefore, this can be prevented. When one single person is operating a business there is no chance that internal controls are going to be strong. This is because there is only one person performing every task and no one to check for errors or fraud. This is a major problem because when fraud occurs in these situations the only people who can detect the fraud are people outside of the company itself. Preventing single-owned health care companies would also help to reduce the amount of health care fraud there is.

Additionally, every owner of a health care company should have to go through an intense background check. Since a large amount of health care fraud is being committed by top management, this is a necessity. Doing background checks will bring up all previous employment and anything the managers may have been in trouble for in the past. All former employers can be contacted to determine if there is anything strange that happened while the person was working there. Also, determining if he or she has been in any legal trouble in the past will determine if it can be expected to occur again. Performing intense background checks before allowing someone to start up a health care company could potentially weed out many of the people who are likely to commit fraud.

A special audit team, such as one of the organizations currently fighting health care fraud, should be formed. This team could go into all the different health care companies and check their internal controls. This should be done at the initiation of the company and then again once a year. This team could perform a typical internal control audit. They would go in and determine areas where fraud could exist. Then they could determine which internal controls should be in place to prevent these areas of fraud and test to make sure the company has each internal control. Additionally, they could ask the company for a report of all of their internal controls and test to make sure each is being performed correctly. The audit team would then report back to the company with either a pass or fail. If they failed, they would be required to fix all internal controls that were weak or missing and the audit team would be required to investigate further. This type of audit would likely catch fraud that was occurring.

Since separation of duties was the most common internal control that was missing in each of the cases analyzed, it is likely that this is a common internal control missing from a lot of health care companies. Therefore, this is something the audit team would be absolutely required to check and test for. They could do this by performing walkthroughs, which is simply walking through the company to determine what types of activities are going on. They could also observe and inquire the employees. Asking employees at different levels different types of questions to see who is in charge of which tasks within the company would likely determine if separation of duties is present.

Finally, all health care companies should be required to submit event identification, risk assessment, and risk response analyses to the audit team that would be implemented. These were the three weakest elements of the internal control structure of all four cases. Therefore, in order to prove that these steps were completed when creating an internal control structure, documentation should be recorded and submitted to prove exactly what was done for each of

these elements. This would help to strengthen the internal control structure within companies which will ultimately lead to decreasing health care fraud.

Conclusion

Health care fraud will continue to be a major issue until changes are made. New approaches need to be taken in order for these changes to take place. There have been many steps taken that are working towards new ideas for reducing the fraud, but things such as increasing penalties for these crimes does not appear to be working very well. New policies and requirements need to be put in place to reduce and eventually stop the fraud. Internal controls are a very important piece to prevent fraud from occurring within companies, so this should be one of the first things that is considered when coming up with new requirements.

After analyzing cases of four different companies who committed health care fraud it is very easy to see which areas are lacking within all four of the companies' internal control structures. Therefore, if every single health care company is required to follow the exact same internal control structure it is likely that fraud will be able to be reduced. Health care can be reduced and stopped eventually, but the internal control structures of all health care companies need to be changed in order for this to happen.

References

"2004 Enterprise Risk Management (ERM) COSO Framework." *2004 Enterprise Risk Management (ERM) COSO Framework*. N.p., n.d. Web. 5 Dec. 2012.

This article talks about the COSO ERM Framework. It talks about the changes that were made and what was added to make it different from the original COSO Framework.

309 Fed. Appx. 891; 2009 U.S. App. LEXIS 2697. LexisNexis Academic. Web. Date Accessed: 2013/04/10.

This document gives all the details of the United States v. Anura Andradi case.

364 Fed. Appx. 859; 2010 U.S. App. LEXIS 2220. LexisNexis Academic. Web. Date Accessed: 2013/04/10.

This document gives all the details of the United States v. Florence Ubak-Offiong case.

397 Fed. Appx. 583; 2010 U.S. App. LEXIS 20176. LexisNexis Academic. Web. Date Accessed: 2013/04/10.

This document gives all the details of the United States v. Ramon Santos case.

Aldhizer, George R. "Fraud and Errors: A Ticking Time Bomb That Must Be Defused." *The Journal of Governmental Financial Management* (2009): 13-16. *ProQuest*. Web. 19 Apr. 2012.

This talks about the major problems of health care fraud and then goes on to describe the different parties involved that may cause these problems to occur. It talks about each of the different types of health care fraud that exists and provides a health care specific audit approach. Finally, it gives examples of additional things that should be done in health care organizations that would help to reduce the amount of fraud that is occurring.

Amerigroup Corporation. *Recovery Audit Contractor Program Expansion*. N.d. Brief.

This brief talks about the expansion of the Recovery Audit Contractor Program. It details all the changes that will be made and what the program will consist of.

"Anti-Kickback Statutue." *Health Law Resources.* American Health Lawyers Association, 26 May 2011. Web. 9 Jan. 2013. <http://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Anti-Kickback%20Statute.aspx>.

This article talks about the Anti-Kickback Statute and how it has changed over time. It talks about everything that is considered a kick-back and what the consequences are. It also goes on to mention other laws in relation to the Anti-Kickback Statute.

Applegate, D. "An Overlooked Risk." *The Internal Auditor* (2007): 33-36. *ProQuest*. Web. 19 Apr. 2012.

This article talks about the major rising costs of health care. It goes on to say that the internal auditor should be doing more things to make sure that fraud and errors are not occurring within companies.

"Ascension Health." *Ascension Health*. N.p., n.d. Web. 9 Jan. 2013.

This article talks about the Stark Law. It discussed what it is and goes into a brief overview of the law itself.

Borchert, Robert F. "Auditing The Results Of Change, Part I." *Receivables Report For America's Health Care Financial Managers* 25.7 (2010): 4-7. *Business Source Complete*. Web. 19 Apr. 2012.

This talks about compliance within health care organizations and how to go about an audit correctly. It talks about the different types of costs associated with employees and how to make changes when there is a high turnover rate of employees. It then gives a guideline of what an organization should be thinking before getting audited.

Brocato, Lori, Lynne Byrd, and Dawn Crump. "Decoding The Alphabet Soup Of Future Audit Risks." *Hfm (Healthcare Financial Management)* 65.6 (2011): 38-42. *Business Source Complete*. Web. 19 Apr. 2012.

This paper talks about the different types of audits that health care organizations are going to have to go through. It explains what each of the types of audits what will be looking for. The audits will help to detect fraud, but also help the organization to pass each of the other audits because they can find out where things are wrong.

"Civil Monetary Penalties Law." *Health Law Resources*. American Health Lawyers Association, 8 Oct. 2012. Web. 9 Jan. 2013. <http://www.healthlawyers.org/hlresources/Health%20Law%20Wiki/Civil%20Monetary%20Penalties%20Law.aspx>.

This article describes the Civil Monetary Penalties Law and gives some details of the law.

"CMS: FAQs." *CMS: FAQs*. N.p., n.d. Web. 20 Feb. 2013.

This website gives a list of frequently asked questions about CMS and provides the answers. It helps to better understand the organization and what they do.

Cooper, Andrea, and Becky Sutherland Cornett. "Not Your Accountant's Oldsmobile: Internal Controls Today." *Journal Of Health Care Compliance* 6.6 (2004): 37-40. *Business Source Complete*. Web. 19 Apr. 2012.

This article talks about the importance of internal controls to health care organizations. It then goes on to explain what internal controls are and talks about each of them. Finally, it goes through an example of patient safety and applies each of the internal controls to this to show what can be added in each of the different internal control areas.

"Corporate Governance, Risk Management and Internal Control." *COSO Internal Control-Integrated Framework*. AICPA, n.d. Web. 19 Dec. 2012. <http://www.aicpa.org/InterestAreas/BusinessIndustryAndGovernment/Resources/CorporateGovernanceRiskManagementInternalControl/Pages/COSO_Integrated_Framework_Project.aspx>.

"The COSO Financial Controls Framework." *The COSO Financial Controls Framework*. SOX-online, n.d. Web. 5 Dec. 2012.

This article talks about the 2004 Enterprise Risk Management COSO Framework. It talks about each of the different parts of the framework and gives examples of each part.

"COSO Releases Draft of Updated Internal Control Framework." *Journal of Accountancy* (2011): n. pag. Print.

This article talks about the changes to the COSO Framework. It explains each of the parts of the 2004 Enterprise Risk Management COSO Framework.

"False Claims Act." *False Claims Act*. American Physical Therapy Association, 5 Mar. 2011. Web. 9 Jan. 2013. <http://www.apta.org/FalseClaimsAct/>.

This article describes what the False Claims Act is and what its purpose is. It then goes on to talk about the changes that have been made to this law over time.

"Financial Crimes Report 2005." *FBI*. 2005. Web. 18 Apr. 2012. <http://www.fbi.gov/stats-services/publications/fcs_report2005/fcs_2005>.

This article discusses what the FBI's role is in health care fraud. It talks about the different things they do and organizations they work with in order to try to stop health care fraud. It also talks about the different types of health care fraud that exist along with some significant health care cases that occurred in the past.

Goldberg, S. R., & Lindquist, S. C. (2005). Fighting costly health care fraud. *The Journal of Corporate Accounting & Finance, 16*(4), 29-29. Retrieved from http://search.proquest.com/docview/201616048?accountid=36823

This paper provides information about health care fraud in general and the different types of health care fraud that can exist. It also touches upon the different internal controls that should be in place in health care companies in order to prevent this fraud from occurring and provides things that should be done in an internal audit to also prevent fraud.

"Health Care Audit And Accounting Guide." *AICPA Acsec Update* 10.3 (2006): 17-21. *Business Source Complete*. Web. 19 Apr. 2012.

This article talks about the AICPA Audit and Accounting Guide Health Care Organizations which was issued in 1996. It talks about the major changes that have been made to the accounting for health care organizations.

Healthcare Reform Law: Healthcare Fraud and Abuse and Program Integrity Provisions. (2010). *Venulex Legal Summaries*, 1-6.

This paper talks about all of the different reforms that have been made to the Healthcare Reform Law as of March 31, 2010.

Jing, L., Kuei-Ying, H., Jionghua, J., & Jianjun, S. (2008). A survey on statistical methods for health care fraud detection. *Health Care Management Science, 11*(3), 275-287. doi:10.1007/s10729-007-9045-4

This article talks about health care fraud statistics and facts and then details the different types of health care fraud. In addition it provides a statistical method for detecting health care fraud.

Maginnis, J. J., & Giniat, E. J. (2010). Use a Steady Hand as You Manage Health Care Reform. *Pennsylvania CPA Journal*, *81*(2), 1-5.

This article talks about the Patient Protection and Affordable Care Act. It talks about how it relates to accounting and fraud in the health care industry and also talks about the changes that it is expected to bring.

Margolis, G L, and P R DeMuro. "Crisis Management Can Leave Residual Effects." *Healthcare Financial Management: Journal Of The Healthcare Financial Management Association* 45.10 (1991): 46. *MEDLINE*. Web. 19 Apr. 2012.

This article talks about all of the things a health care organization may face if they are having financial issues. It also gives guidance on what to do for each of the problems they may face during these issues.

"Medicaid Fraud Report." *National Association of Medicaid Fraud Control Units*. National Association of Attorneys General, Sept.-Oct. 2007. Web. 20 Mar. 2013.

This article talks about many different health care fraud cases that occurred in 2006 and 2007. They focus specifically on Medicaid.

"Medicare Fraud and Abuse: Prevention, Detection, and Reporting." *Centers for Medicare and Medicaid Services*. Department of Health and Human Services, n.d. Web. 20 Feb. 2013.

This online pamphlet talks about what Medicare fraud is and the different things that are in place to fight it. It also provides a description about how claims are supposed to be submitted.

Morris, L. "Health Care Fraud: A Primer On The Schemes And The Tools To Fight Health Care Fraud." *Journal Of Insurance Medicine (New York, N.Y.)* 25.4 (1993): 415-419. *MEDLINE*. Web. 19 Apr. 2012.

This article talks about the reasons why health care fraud occurs, the vulnerabilities to fraud in health care, and then the types of fraud health care organizations commit. It then goes on to talk about the different organizations that are trying to combat health care fraud and talks about some laws that have been put in place to try to prevent it.

Moses, R. E., & Jones, D. (2011). Physician Assistants in Health Care Fraud: Vicarious Liability. *Journal Of Health Care Compliance*, *13*(2), 51-75.

This article contains many statistics about the issue of health care fraud, but its primary focus is on the liability that physicians have due to the actions of their physician assistants. It provides guidelines for these physicians to follow that will help to prevent the physician assistants from committing fraud which ultimately becomes the liability of the physician.

Parver, C., & Goren, A. (2011). Significant Details from the 2010 Health Care Fraud and Abuse Control Program Report. *Journal Of Health Care Compliance*, *13*(3), 9-22.

This article talks about the overall issue of health care fraud and contains many statistics about the health care fraud cases that occurred in 2010. It also provides short summaries of many of the cases from 2010 and breaks these cases up by the category of the fraud. Additionally, it mentions some laws that are in place to try to fight health care fraud.

Praiser, D.B., and R.C. Brooks. "Government Compliance Initiatives in Combating Fraud and Abuse in Federal Health Care Programs." *Journal of Forensic Accounting* (2003): 77-94. *ProQuest*. Web. 19 Apr. 2012.

This paper talks about the problems of health care fraud and also the six most common types of health care fraud. It also talks about four major laws that have been put into place to try to prevent health care fraud. Finally it talks about voluntary and involuntary compliance programs some health care organizations have in place and discusses areas for future research.

Rushinek, A., and S. Rushinek. "Internet Fraud Auditing: A Simulated Health Care Industry Case Study." *Journal of Forensic Accounting* (2000): 125-33. *ProQuest*. Web. 19 Apr. 2012.

This article talks about a software fraud detection system that analyzes financial statements that are online. It red flags the major changes in differences over periods of time that need to be analyzed further to determine if there was fraud occurring. It then gives specific examples of how this software tool would work.

Sandra Walter, et al. "A Multidisciplinary Approach To Denials Prevention." *Hfm (Healthcare Financial Management)* 66.3 (2012): 108-112. *Business Source Complete*. Web. 19 Apr. 2012.

This article talks about a hospital that developed a denials process so that they would respond to denials and manage audits efficiently and effectively.

Sayther-Cunningham, Colleen. "Enterprise Risk Management: The COSO Framework." *Ethics Resource Center*. N.p., 31 Dec. 2004. Web. 5 Dec. 2012.

This article talks about the COSO Internal Control Framework, the changes that have been made to it, and what the purpose of each part of the framework is.

Sevell, R. D., & Shankar, A. (2010). Landmark Health Care Reform Legislation Significantly Expands Government's Ability to Fight Fraud, Waste, and Abuse. *Journal Of Health Care Compliance*, *12*(3), 47-72.

This article details the Patient Protection and Affordable Care Act (PPACA). It talks about a lot of the different parts of the law as well as what changes this law has made on previous laws.

Sigg, C.A., and P. Fiorelli. "7 Steps to Health-Care Compliance." *The Internal Auditor* (2002): 35-39. *ProQuest*. Web. 19 Apr. 2012.

This article talks about the Health and Human Services (HHS) Office of the Inspector General (OIG) guidelines for developing compliance for health care organization. It outlines each of these guidelines and gives examples of what should be done in these organizations in order for them to be compliant.

Tomes, J. P. (1998). The health insurance portability and accountability act of 1996: Understanding the anti--kickback laws. *Journal of Health Care Finance, 25*(2), 55-62. Retrieved from http://search.proquest.com/docview/235178950?accountid=36823

This article talks about the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It discusses many of the details of the law and also mentions a little about internal controls.

"U.S. Health Care System." *History Commons*. Web. 18 Apr. 2012. <http://www.historycommons.org/timeline.jsp?hlthcr_scandals=hlthcr_statistics_hca_inflated_cost&timeline=us_health_care_tmln>.

This article provides a short summary of the details of the Tenet Healthcare case.

United States Department of Justice. *False Claims Act Cases*. N.d. Memorandum.

This memorandum specifically talks about the qui tam provision of the False Claims Act. It goes talks about and explains the process that a whistle blower goes through when filing a complaint.

Veazie, Judy. "The Role Of Internal Audit." *Health Care Collector: The Monthly Newsletter For Health Care Collectors* 25.2 (2011): 9-12. *Business Source Complete*. Web. 19 Apr. 2012.

This article talks about what an internal audit is and how to go about performing one. It also provides the benefits a company will gain from performing an internal audit.