GOVERNOR'S TASK FORCE ON

HEALTH CARE FRAUD

INITIAL REPORT

Christine Todd Whitman
Governor

Peter Verniero, Chair
Attorney General

December 23, 1996

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December 23, 1996

The Honorable Christine Todd Whitman
Governor of New Jersey
State House
CN 001
Trenton, New Jersey 08625

Dear Governor Whitman:

The Health Care Fraud Task Force, which you established by Executive Order No. 50, is pleased to submit our initial report. As you know, you charged us to look at health care fraud in New Jersey. Specifically, you asked us to identify and catalog the possible forms of health care fraud existing within the New Jersey marketplace as well as to identify the executive branch agencies involved in fraud prevention and enforcement. This initial report touches on these areas.

As you will see, we have concluded that health care fraud is a significant issue. If we accept the consensus figure that approximately ten percent of the dollars spent for health care each year go to fraud, then New Jersey's $35 billion-per-year health care market may be subject to as much as $3.5 billion dollars in fraud. These frauds range from padded bills casually submitted by claimants or providers to the systematic submission of fraudulent claims by highly organized entities formed for the purpose of engaging in improper conduct. As the health care marketplace evolves and becomes more sophisticated, so do the strategies of health care fraud perpetrators.

Our report sets forth several recommendations as well as areas identified for further study as we move into the next phase of the Task Force mission. By design, the Task Force is an ongoing entity. We intend future reports to recommend coordination strategies among Executive Branch agencies as well

as to develop measures to educate the public and health care industry. Additionally, we hope to propose ideas to reduce the opportunities for individual gain through fraudulent health care practice, as well as other solutions for your review.

Executive Order No. 50 contemplates that our next report would be due July 1, 1997. Based upon what we have learned so far, we believe that more time may be necessary before we are in a position to issue our next major report. Accordingly, we respectfully request that you modify the terms of E.O. 50 to allow us until December 31, 1997 to submit our next report.

We appreciate your leadership and support as we undertake further work on this important issue for the citizens of our State. Thank you for the opportunity to provide you with our recommendations.

Respectfully submitted,

Peter Verniero
Attorney General, Task Force Chair

Brian W. Clymer
State Treasurer

Len Fishman
Commissioner, Department of Health and Senior Services

Elizabeth Randall
Commissioner
Department of Banking and Insurance

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The Task Force appreciates the assistance it has received from all staff and from those who appeared at its public hearings. It is especially grateful for the assistance of Assistant Attorney General Robert H. Stoloff in the drafting of this report.

EXECUTIVE SUMMARY

In 1995, health care costs in this country exceeded $1 trillion dollars for the first time, representing more than 15 percent of the nation's Gross National Product. In New Jersey, the total cost is approaching $35 billion annually. In reaction to the spiraling costs in recent years, dramatic changes are being implemented in the nation's health care delivery and financing systems. The ever-changing face of health care is unfortunately mirrored by the constant development of new and innovative schemes to defraud those responsible for paying health care bills. This is hardly surprising. The size of the country's health care budget, the millions of participants involved in the health care delivery system, the complexity and variety of billing systems and the sheer volume of health care transactions all make health care an inviting target for perpetrators of fraud. Whether the payer is an insurance company, the government or an individual patient, ultimately we all pay for fraud through increased insurance premiums or increased health care bills. Even more significant are those cases where the fraud directly interferes with the delivery of legitimate health care services. Ultimately, the fraudulent diversion of scarce resources can undermine the overall quality of health care in this country. Therefore, in the ever-changing world of health care delivery and financing, it has become critical that there be dynamic organizations capable of identifying and addressing new health care fraud schemes as they emerge, while continuing to fight traditional forms of health care fraud.

Recognizing the magnitude of the problem presented by health care fraud, nationally and in New Jersey, Governor Whitman created the Health Care Fraud Task Force as the policy development body to establish a comprehensive health care fraud enforcement plan in New Jersey. The Task Force is chaired by the Attorney General and includes the Treasurer and Commissioners of Banking and Insurance, Health and Senior Services, and Human Services. The Governor's charge to the Task Force was to (1) identify and catalog the various forms of fraud in the New Jersey health care marketplace; (2) inventory Executive Branch resources which are arrayed or should be involved in the fight against health care fraud; (3) identify priority prevention and enforcement areas; (4) implement coordination strategies among all Executive Branch agencies for investigation and prosecution of civil and criminal cases involving significant health care fraud; (5) develop and recommend an Executive Branch budget for support of health care fraud prevention and enforcement from existing resources; (6) identify emerging technologies necessary for effective health care fraud prevention and enforcement; (7) develop plans to educate the public and health care industries to eliminate their tolerance of health care fraud; (8) develop methods to reduce opportunities for health care fraud; and (9) identify

statutory, regulatory and administrative changes related to health care fraud prevention and enforcement.

Because a complete understanding of this complex and broad-based problem is necessary in order to take appropriate action, the first focus of the Task Force, as reflected in this report, has been to identify and categorize forms of health care fraud, inventory State resources arrayed against such fraud and identify priority enforcement and prevention areas. In undertaking its initial effort, the Task Force held two public hearings during which it heard from legislators, members of the law enforcement community, representatives of the health care and insurance industries and concerned citizens and consumers. Task Force staff has also surveyed and met with State employees and representatives of the private sector engaged in the fight against health care fraud, as well as reviewed literature in the area. This report summarizes the Task Force's findings so far, makes some initial legislative recommendations and outlines a future course of study and review. The next report will contain additional specific recommendations for action.

A. Nature and Scope of Health Care Fraud

The Task Force's efforts confirmed the wide-ranging nature of health care fraud. Incidents of health care fraud can range from the padding of otherwise legitimate bills to large scale operations in which the mission of the enterprise is nothing more than health care fraud, the provision of health care being incidental, assuming it happens at all. Among the variety of health care fraud schemes described to the Task Force are:

1. billing for services not rendered or patients not seen;
2. billing for unnecessary or useless treatments;
3. billing for more expensive treatments than those actually rendered;
4. self referrals and kickbacks;
5. waiver of co-payments;
6. quackery;
7. forged or altered bills or prescriptions;
8. staged or intentional accidents.

The perpetrators of fraud can be career criminals or otherwise upstanding members of the community. They can include health care professionals, laboratories, drug dealers, patients, medical equipment suppliers or organized criminals. Some schemes are developed by and limited to the unscrupulous among one particular health care specialty, while other schemes may be developed to target a specific type of payer (e.g., Medicaid and auto insurance Personal Injury Protection (PIP) coverage). While the overwhelming majority of participants in the health care system are honest and law

abiding, the nature of the system results in the ability of the dishonest few to steal a disproportionate share of the health care dollar.

Whatever the scheme, much fraud is never detected because a fraudulent bill is, on the surface, virtually indistinguishable from a legitimate bill. At best, then, we can only engage in educated speculation as to the exact proportion of the problem. Estimates of health care fraud and abuse range from three to 15 percent of the total health care bill. The 10 percent estimate made by the United States General Accounting Office in 1992 has been widely used. However, even at the low end of these estimates, total health care fraud in this country would exceed $30 billion a year and in New Jersey $1 billion. Using the GAO percentage, the total amount of health care fraud in New Jersey would be $3.5 billion annually. It must also be recognized that the fraud is not evenly spread among the various health care disciplines and providers in the marketplace. For example, in recent years there has been an explosion in fraud committed in such areas as the PIP coverage provided by auto insurers and within the Medicaid program's prescription, laboratory and transportation benefits.

B. The Changing Face of Health Care and Health Care Fraud

The ever-changing fraud schemes are occurring in a dynamic environment. Of particular note in the last decade has been the rapid movement towards managed care delivery and payment systems, the parameters of which vary widely from one company to the next and within companies. Layered over the increased use of managed care is the even more recent trend of electronic data interchange in health care claims processing and payment systems. These new systems offer new opportunities to both those committing fraud and those seeking to detect and prevent fraud. As direct human involvement in the systems is reduced, care must be taken to ensure that sophisticated perpetrators of fraud do not use this new technology to increase their take from the health care system. In addition, some of the vast savings to be realized from the use of electronic claims processing must be channeled into systems to reduce the opportunities for fraud that can be inherent in such systems. Finally, the recently enacted Kennedy-Kassebaum Health Insurance Portability and Accountability Act contains a major federal initiative against health care fraud, including establishing federal responsibility to coordinate federal, state, local and private efforts against health care fraud. New Jersey can position itself to take advantage of this new federal effort.

C. Prevention and Enforcement Strategies

The most effective methods for preventing health care fraud are those which identify the fraudulent bill before it is paid, because they only impose the costs of detection on the health care system. Moreover, the fewer fraudulent bills that are paid, the less incentive there will be to commit fraud in the first place. The Task Force will be examining various means to ensure the early identification of fraud. After the bill is paid, the enforcement community has a variety of civil and criminal statutes and remedies available in the fight against health care fraud. The Task Force will be examining these laws to determine what changes are needed to address the changing face of health care delivery and payment systems and of health care fraud.

Moreover, while there are many statutes and remedies available, there are also inherent difficulties in pursuing health care fraud enforcement actions. As was already noted, it is not always evident when health care fraud has been committed. Even when fraud is identified, there can be a number of problems in meeting the State's burden of proof for such offenses. When health care fraud is committed by a health care provider, the type of fraud which the Task Force believes diverts the most dollars, the prosecution will often need to rely on patients for corroboration of the fraud. However, many patients do not want to get involved, do not feel victimized by the fraud or may in fact be participants in the fraud. Given that health care fraud by providers often requires proving a pattern over the course of thousands of transactions, the investigations and the prosecutions can be extremely time-consuming and labor-intensive. On the other hand, health care fraud committed by patients and beneficiaries of insurance plans, while significant in the aggregate, often involves small amounts of money on an individual basis. Moreover, because health care fraud is a non-violent crime, the prosecution of such matters may receive low priority from local prosecutors.

Because large scale fraud schemes are most often committed by a very small fraction of health care providers, there is a general consensus among the health care enforcement and payer communities that enforcement aimed against dishonest health care providers can have the greatest return. Attention must also be paid to a growing number of organized fraud schemes involving those outside the provider community, including beneficiaries. At the same time, it is important that there be deterrence maintained against lower level fraud committed by individual patients and beneficiaries.

Finally, it is important to recognize that the efficacy of enforcement efforts may often turn on whether the sanction sought is appropriate and realistically achievable, whether it be jail, criminal fines, civil penalties or professional licensing action. Given that none of the enforcement arms separately has all of these sanctions available, policy

direction and coordination at a high level is critical to a successful effort against health care fraud.

D. State Resources

The State resources arrayed against fraud are primarily found in the following agencies:

- Department of Banking and Insurance
  - Division of Insurance Fraud Protection
- Department of Human Services
  - Office of Quality Management and Program Integrity
- Department of Law and Public Safety
  - Division of Criminal Justice
  - Division of Consumer Affairs
    - Professional Boards
    - Enforcement Bureau
  - Division of Law

Because not all staff in these units is dedicated full-time to health fraud issues, the total resources arrayed against such fraud can only be estimated. There are approximately 130 full-time equivalent staff in the various agencies dedicated to fighting health care fraud, including approximately 80 investigators, 15 attorneys, 10 other professionals and 25 support staff.

In addition to these State government resources, there are numerous federal agencies engaged in efforts against health care fraud. Moreover, there are approximately 125 investigators in private insurance companies' special investigation units. These individuals investigate health care fraud and health care and non-health care related automobile insurance fraud.

E. Recommendations

The initial focus of the Task Force was to identify the scope of the health care fraud problem, with specific recommendations for a strategy to attack the problem to be studied in the next phase of the Task Force's work. However, the Task Force was able to make a number of recommendations at this time:

1. Require the use of standardized and serialized prescription forms on non-reproducible and non-erasable paper.

2. Amend N.J.S.A. 45:9-19.3 to permit the sharing of investigative information from the State Board of Medical Examiners' files with other governmental agencies.

3. Amend the Insurance Fraud Protection Act to apply to fraud committed against the State Health Benefits Program.

4. Revise and provide for periodic review of PIP fee schedules.

5. Amend the No-Fault Statute to allow individuals to select a managed care option for personal injury protection benefits.

6. Amend the No-Fault Statute to provide for peer review of PIP claims.

7. Amend N.J.S.A. 17:33A-11 to expressly shield insurance company representatives as well as Division of Insurance Fraud Prevention (IFP) personnel from discovery during the pendency of an investigation.

The Task Force also set a course for future study:

1. The development of recommendations for how to best coordinate health care fraud prevention and enforcement efforts in New Jersey among State agencies, the federal government and the private sector.

2. Exploration of technological developments in order to recommend necessary computer systems and training of investigative staff.

3. Study of proposed legislative and regulatory changes to enhance fraud prevention and enforcement efforts including:

- Amending criminal statutes to increase the likelihood of jail sentences for the commission of Health Care Fraud related crimes.

- Amending criminal statutes to criminalize running, the payment and receipt of kickbacks and the routine waiver of copayments.

- Better defining the responsibility of health care providers with regards to their responsibility for submitting truthful, accurate and understandable bills.

- Enhancing the ability of the State and insurance companies to take action against large-scale patterns of fraud.

- Requiring submission of fraud plans by managed care organizations.

- Creating an all payer fraud and abuse program, including facilitation of the sharing of information regarding fraud investigations.

CATEGORIES AND TYPES OF FRAUD

Health care fraud can take many forms. Simply defined, health care fraud is the use of deceit or a breach of confidence to achieve a profit in the health care arena. There are two ways in which fraud can be categorized: (1) by the type of perpetrator of the fraud (e.g., health care professionals, patient or insured, drug or equipment provider, etc.) or (2) by the type of payer for the medical services (e.g., Medicaid, health insurance, managed care organization, auto insurance, individual). Understanding these two ways of categorizing fraud may be helpful in considering the organizational structure for attacking fraud.

While most frauds can be categorized by the type of perpetrator, it is also the case that some of the most significant schemes seen in New Jersey over the last five years have been targeted to a specific type of health care payer. The enforcement community cannot help but notice that in many instances fraud is not discovered until the perpetrator has become so greedy that the fraud becomes apparent simply from the sheer volume of bills submitted. In such cases, patterns can be observed, over time, in which a dishonest provider increases the volume of fraudulent transactions, apparently growing bolder until caught. We must assume that there are a significant number of individuals who are able to temper their greed so as to avoid ever being caught. Consequently, better detection methods are also needed.

In order to understand the different types of health care fraud, an understanding of the way insurance bills are paid is essential. Traditionally, all medical

care in this country was paid on a fee-for-service basis. In a fee-for-service system, a separate fee is charged for each office visit, treatment, prescription drug, lab test or piece of medical equipment. In such an environment, the economic incentive is to increase either the number of services or goods billed or the amount billed for the services and goods provided. Providers can effect such increases either legitimately or fraudulently. This economic incentive has been identified as a significant cause of increased health care costs, because the provider of the service is not given any motivation to keep costs down. In such an environment, fraud is committed when the total number of bills or the amount of individual bills is inflated through a variety of deceptive practices.

Beginning in the 1970's, in order to control increasing health care costs, many payers of health care bills have increasingly turned to the use of "managed care." Managed care generally combines aspects of traditional fee-for-service payments together with the use of "capitation" reimbursement. However, it is important to understand that well over half of the services provided in managed care environments are still on a fee-for-service basis, with the same incentives to commit fraud as with traditional insurance.

Under capitation reimbursement, health care payers reimburse providers a set amount to provide any needed services to a particular individual for a set period of time, usually a year, rather than reimbursing based on actual services rendered. Which medical services and goods are subject to capitation and which are subject to a fee-for-service arrangement varies widely among managed care companies and managed care plans. A common model is for an individual in a managed care plan to choose a general

practitioner/gatekeeper who has general responsibility for the medical care of the individual. The gatekeeper must approve any referrals to other providers, usually specialists, for treatment. Under such a model, the gatekeeper may be an employee of the managed care company, may be paid a capitation rate or may be paid on a fee-for-service basis. In most cases, the specialists will be paid on a fee-for-service basis, as will be testing labs, pharmacies and medical goods suppliers. Where the basis for payment is capitation, the provider does not have the traditional incentive to increase the services provided or billed. Indeed, the incentive is just the opposite, to decrease services. Under capitation arrangements, the provider may not be motivated to engage in most of the traditional types of health care fraud. However, there are other frauds that may occur, as will be discussed later in this report.

A. Fraud Committed by Health Care Providers

Fraud committed by providers can range from the slight padding of what is primarily a legitimate bill to large-scale fraud where virtually all bills are totally fraudulent. In practice, where the problem is padding of otherwise legitimate bills, it can be virtually impossible to distinguish between an intent to defraud and the negligent application of billing codes and regulations. For those types of cases, criminal prosecutions are often not feasible and even attempts to impose civil remedies can be fraught with difficulties. As one moves along the continuum from the padding of bills to large scale fraud, even patterns of misused billing codes or unnecessary treatments can present difficulties for criminal prosecution. Successful civil fraud prosecutions generally

will require time consuming investigation and sophisticated analysis of the patterns of alleged fraud. As will be discussed below, fraud schemes by health care providers can take on a number of forms.

1. Billing for services not rendered/phantom patients

While not always easy to detect, once discovered, the easiest type of health care fraud cases to charge and to prove at trial are those in which the service billed for was never rendered or for which the patient was not even seen. Because of this, the vast majority of criminal prosecutions for health care fraud arise in this category. Fraud of this type is not subject to many of the standard defenses which make other fraudulent schemes difficult to prove, particularly when the burden of proof is beyond a reasonable doubt. Specifically, a doctor cannot rely on the use of professional judgment or a misunderstanding of billing codes in explaining billing for a service never rendered.

Proof of fraudulent billing for services never rendered can be established through a number of sources. First, patients are often available to testify that they never received the services billed. Moreover, providers who bill for services never rendered often do not bother to develop fraudulent patient records, so that the fraudulent nature of a patient billing can frequently be established through the lack of the usual corroborating patient records. As fraudulent perpetrators become greedier, they may also bill for more services than they can possibly render in a given time period, providing additional proof of fraud. There have even been cases where providers have billed for services allegedly

rendered while they were traveling out of the state. Even this type of fraud can be difficult to detect or prove where it involves the type of service which would often legitimately occur in high volume, where the provision of this service cannot be verified by a subsequent physical examination or where the provider will argue the propriety of nonlicensed staff applying certain modalities "under supervision." However, two of the most common defenses to claims of health care fraud, the reliance on professional judgment or on an alleged misunderstanding of billing codes, are unavailable where the fraud is for a service never provided.

2. Misrepresenting the nature of services/ "upcoding" and "unbundling"

Another common type of fraud is where a provider bills for more expensive services, procedures, equipment, tests or drugs than those actually provided (upcoding) or where providers bill for multiple services when all the services provided should have been included in a single charge, such as one for a comprehensive exam (unbundling). Such misrepresentations are often proved in a manner similar to those cases where services are not provided. However, the fraud can be more difficult to prove for a number of reasons, including that patients are less likely to be able to distinguish between different types of treatment. Moreover, when the fraud involves upcoding or unbundling, some service was actually provided, so that a review of the office logs can only be helpful where the volume was so great that it would establish the impossibility of the performance of the number of services billed for in a day. Moreover, upcoding and unbundling charges will often be defended with an explanation that there was a

misunderstanding as to billing codes or a mistake was made by office staff in issuing the bills. These defenses are particularly difficult to overcome under the criminal burden of proof of beyond a reasonable doubt. For this reason, criminal prosecutions for upcoding and unbundling are extraordinarily rare.

3. Unnecessary or useless treatments

Health care fraud is committed when a provider knowingly misrepresents that services were needed or were competently provided when they were not. This type of fraud often involves misdiagnoses or a representation that a particular service was necessary to address a medical problem. The provision of unnecessary and useless treatments is common in "fraud mills," where a single provider or group of providers can bill hundreds of thousands or even millions of dollars annually for fraudulent medical services. The difficulty in proving fraud by the rendering of unnecessary and useless treatments derives from the fact that determinations of diagnosis and treatment regimens often involve inherently subjective medical judgments. Indeed, such fraud can often be proved, if at all, only as part of a large-scale pattern. An individual case or a small number of cases of unnecessary or useless treatments may be explained away by differences of medical judgment, mistake or the result of a scheduling crush on an individual day. Because proof of fraud through the issuance of bills for unnecessary and useless treatments requires the establishment of a pattern of such actions, investigations can be labor intensive and time consuming, with a single case occupying virtually all the energies of a number of individuals.

4. Kickbacks and self referrals

A growing area of fraud relates to the referral of patients to specialists, labs, or medical equipment suppliers. Such referrals may be fraudulent where they are made in return for a payment to the referring provider (a kickback) or where they are made to an entity in which the referring provider has a substantial interest.* Such referrals have a tendency to encourage the provision of unnecessary services. Most kickback schemes are difficult to discover because they involve agreements between two participants in a fraudulent scheme, with neither the patient nor the payer being involved in the transfer of the illicit funds.

Often, kickback schemes can be related to other fraudulent schemes. For example, with the crackdown of direct fraud committed at nursing homes, a number of schemes have been discovered in which the nursing home, in return for a kickback, makes its large patient population available to other health care providers who, in many instances, provide either unnecessary services or bill Medicaid or Medicare for services not provided at all. The nursing home population makes for a particularly fruitful target for fraud because many patients in nursing homes are not able to determine what services they need or what services have been provided to them.

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*Subject to compliance with regulations, many self referrals are legal.

5. Waiver of co-payments

Many insurance policies and government programs provide benefits which include payment of only a portion of the health care provider's usual or customary charge. This percentage is often 80 percent. Under those circumstances, the patient would pay the remaining 20 percent of the bill. In order to attract patients with insurance, some providers will agree to accept an assignment of the insurance company's partial payment as payment in full. The fraudulent nature of this transaction was explained by the New Jersey Superior Court in a case entitled Feiler v. New Jersey Dental Association, 191 N.J. Super 426 (Chan., 1983); aff'd 199 N.J. Super 363 (App. Div. 1984):

> The untruth of such a dentist's statement is highlighted by a comparison. If the insurance payment were not assigned to Feiler, the patient would pay him and seek reimbursement from the carrier. If he had paid Feiler an agreed fee of $80 for a dental procedure, he could not truthfully submit to the carrier a statement that the fee was $100 in order to gain reimbursement of $80. There is no relevant difference between that case and the case in which the dentist, to whom the benefits are assigned, states his fee to be $100 when he intends to be satisfied with a payment of $80. In such a case, the insurance company has been defrauded of $16.

The impact of this kind of fraud goes beyond the amount of the co-payment waived. The purpose of deductibles and co-payments is to ensure that patients using health services participate in the payment, thereby giving them an incentive not to seek unnecessary treatment. By routinely waiving co-payments, a provider not only misrepresents his usual

and customary charges, he also eliminates the financial incentive to patients to use medical care prudently. Like many forms of health care fraud, the dollar amount of this type of fraud committed on any individual bill is quite small, whereas the repetitive nature of the violation ultimately adds up to significant fraud. In the case of Dr. Feiler, he did not collect the co-payment for 97 percent of his patients, thus resulting in thousands of dollars of fraud. This type of fraud can be difficult to discover because the patient is a beneficiary of the fraud and the fraudulent nature of the activity may not be apparent to the patient.

6. Quackery; Misrepresenting credentials or remedies

The types of fraud discussed above involve primarily the defrauding of third party payers of dollars. While the billions of dollars stolen from the health care system affect the care of patients, those effects are usually indirect or incidental. However, the oldest form of health care fraud -- quackery (who doesn't remember seeing old western movies with purveyors of fraud selling elixirs and snake oil from the back of horse drawn wagons) -- is still prevalent today and has a direct impact on the quality of care given to patients. Misrepresentations by licensed health care providers, or by individuals claiming to be health care providers, regarding their credentials or the availability of a remedy, not only defraud consumers of money but can hold out the false hope of a cure. Even worse, such misrepresentations can deter a patient from seeking treatment from a health care provider who can provide real medical benefits. Similarly, the use of "supervised"

unlicensed staff to provide treatments requiring professional expertise may also create the illusion of medical care.

While the provision of illegitimate treatments and drugs can harm the patients and steal their money, it does not have a significant impact on third party payers, except where the failure to receive legitimate care results in more costly care in the future. That is because neither insurance plans nor government programs pay for treatments not generally recognized by the provider community. A primary difficulty in enforcement actions against quackery arises in distinguishing between real medicine and quackery. Like any science, medical science is subject to constant changes. There is not always a consensus as to what constitutes legitimate attempts at innovation. One individual's innovation may be another's quackery. However, even for those actions that should be viewed rather clearly as quackery, there are always individuals who can qualify themselves as "experts" so as to make the proof of quackery quite difficult. To support a claim of quackery, the supporting expert's opinion must be clear and unequivocal. Except for situations where the remedies are obviously "bizarre," quackery can be quite difficult to prove and the prosecution of a case can be quite labor intensive.

7. Provider fraud in managed care

While there has been much literature describing the potential for fraud in the managed care environment, there has been insufficient experience, outside fee-for-service aspects of managed care, to determine the extent to which health care fraud is a significant problem in that setting. This difficulty is exacerbated by the myriad of

managed care structures, and the varying contractual arrangements that are central to the analysis of fraud. For example, in some managed care structures, the gatekeeper is responsible for managing the relations with specialists and testing labs. However, few health care providers are trained in or attuned to the fraud issue.

One thing is clear. All forms of managed care, to greater or lesser degrees, include a fee-for-service component; and when managed care uses fee-for-service as the basis for payment, it is open to all the same types of fraud as are extant in traditional indemnity insurance programs. Indeed, a review of the various types of managed care programs reveals that, while operating somewhat differently from the patient's perspective, some managed care plans operate almost exclusively on a fee-for-service basis, including compensation for primary care providers. In such cases, while the individual or employer may pay a set fee to the managed care company to provide medical care, the managed care company pays providers negotiated fees for each individual service on a contractual basis. Under such circumstances, the unscrupulous provider will have the same incentive to engage in overutilization or other fraud as exists under a traditional fee-for-service plan. Even if the primary care provider is compensated on a capitation basis, most managed care plans use fee-for-service reimbursement for specialists, labs and medical equipment. Moreover, many managed care plans permit individuals willing to make a co-payment to go outside the network, in which case the providers are paid on a fee-for-service basis. Again, wherever fee-for-service is a part

of a managed care plan, one can expect to find the same kinds of fraud as are found in traditional indemnity fee-for-service health insurance plans.

When managed care is based on a capitated rate, many of the traditional forms of fraud are less likely to be found. However, as stated in the Report of the National Health Care Anti-Fraud Association's Task Force on Fraud in Managed Care (December, 1994):

> Experience in the managed-care environment clearly contradicts the assumption that managed-care arrangements eliminate, or even minimize, the potential for fraud.
>
> Logic dictates that in any system where $1 trillion is exchanged every year, unscrupulous individuals will attempt to steal from the system, and neither managed care nor any other structure is a panacea for fraud. However, experience does confirm that the managed care environment alters the fundamental nature of some frauds, while leaving intact other, more familiar frauds.

In a capitated system, a managed care organization or health care provider will be paid a fixed rate for a patient, regardless of the amount of care provided. Therefore, there appears to be less of an incentive to bill for services not rendered, to provide unnecessary services or to describe services incorrectly. Indeed, it has been surmised that the most likely fraud to be found in a capitated system is a failure to deliver medically necessary services. Obviously, while most cost cutting is just good business and will represent the exercise of medical judgment, there is a point at which cost cutting methods can become illicit. While isolated instances of such fraud have been detected, there is currently no evidence that this fraud is occurring on a wide scale.

Examples of fraud in a capitated environment include the performance of a perfunctory examination where a comprehensive examination is required, the denial of treatment requests without regard to medical necessity, making services difficult to obtain, requiring an appeal prior to approving obviously necessary treatment, the automatic referral of certain routine treatments to a specialist or kickback arrangements for such referrals. While any of these kinds of practices might be fraud, it may be difficult to prove fraud in all but the most egregious cases. The difference between breach of contract and fraud will often turn on state of mind, a particularly difficult fact to prove in criminal cases. A critical factor in any fraud case, civil or criminal, will be the terms of the contract. Thus, the prevention of fraud must be a consideration during the drafting of managed care contracts.

Other types of illicit practices that have been observed or are under scrutiny in the managed care environment are disenrollment practices which include actions intended to disenroll high-cost patients through the deliberate delivery of poor service, deceptive marketing to attract low-cost healthy patients, false cost treatment data to support higher future capitation fees, and the misrepresentation of credentials to gain entry into the managed care network. While all of the above types of fraud may occur in the managed care environment, no large-scale trends have been reported so far in New Jersey to establish that they occur in a similar magnitude to what has been seen in the traditional insurance arena. Moreover, many of these types of fraud may best be

addressed through quality control and contractual remedies rather than through fraud enforcement.

8. Fraud Using Electronic Data Interchange

The rapid pace by which Electronic Data Interchange (EDI) is taking over claims processing and claims payment offers new opportunities for both the commission of fraud and its control and enforcement. EDI is the computer-to-computer exchange of information in an electronic format, including claims submissions by providers and claims payment by payers. Already, the Medicaid and Medicare programs process more than 80 percent of the claims to those programs through the use of EDI. While private payers have moved much slower towards the use of EDI, the recent passage of the Kennedy-Kassebaum Health Care Portability and Accountability Act, which includes a provision mandating the establishment of federal uniform standards and requirements for the electronic transmission of health care information, seems certain to drive the private sector in the same direction as public sector payers have already gone.

The drive towards the use of EDI has been motivated by the enormous administrative savings to be realized by the elimination of paper claims processing. Unfortunately, to date, EDI has largely been developed without significant input from anti-fraud professionals. To the honest provider, EDI offers transaction speed, lower costs and faster payment. It also will provide early feedback regarding whether a service is reimbursable. Unfortunately, those same advantages are available to the fraudulent provider, and can facilitate the commission of fraud.

Some administrative professionals have expressed the view that computer systems do not have the same vulnerability to fraud as exist in manual claims processing. However, as was stated in the recent book License to Steal: Why Fraud Plagues America's Health Care System by Malcolm K. Sparrow, (1996):

> Control systems may work very well in pointing out billing errors to well-intentioned physicians and may even automatically correct errors, adjust claims, and limit code manipulation. But those same systems might offer no defense at all against determined, sophisticated thieves, who treat the need to bill "correctly" as the most minor of inconveniences. Most competent fraud perpetrators study the rule book carefully -- probably more carefully than most honest providers -- because they want to avoid scrutiny at any cost. So they "test" claims carefully, making sure that they neatly pass all the established system edits and audits. Then, having found combinations of diagnoses, procedures, and pricing that "work" (i.e., trip no alarms and preferably pass through "auto-adjudication" to payment, avoiding human intervention altogether), they ratchet up the volume, carefully spreading the claims activity across different patients and across different insurers so as to avoid detection . . .
>
> Whether or not EDI offers a license to steal, it does provide a different mechanism for stealing. The important question is whether the change of mechanism effects how much thieves can steal, and how fast. (Id. at 11-12, 124)

EDI can offer the opportunity for a quick big hit. If investigations are not also conducted quickly, the perpetrators and their ill-gotten gains can be gone before the investigations are complete. Investigations into fraud committed through EDI can be complicated by the lack of a paper trail, a signature and human contact. While computers provide new tools to detect fraud, they may also lack the common sense necessary to

detect new schemes for which they have not been prepared. A particular vulnerability of EDI payment systems may be the availability of provider identification numbers to submit bills. Most payers do not conduct a site visit before they issue to a provider's business an identification number necessary to submit bills. Thus, sham operators are able to submit sham bills, so long as they know what information is necessary to avoid system edits. EDI systems are designed to pay every "clean" claim. In such schemes, providers can bill hundreds of thousands of dollars and be gone before they are even detected.

EDI also offers significant opportunities to detect and prevent fraud. As noted, once fraudulent schemes are identified computers can be programmed with edits and audits to screen out suspicious bills. If data is properly collected, computers may have the ability to identify a pattern of fraud which individual humans claims processors would never be able to identify. The standardization of claims, forms and data sets necessary for the processing of bills may also simplify fraud detection on computer systems. Both the problems and opportunities inherent in EDI demonstrate that organizations and individuals charged with investigating fraud will require new and changed skills and knowledge sets to successfully pursue their tasks.

B. Claimant/beneficiary fraud

While most of the large-scale schemes involving health care fraud are committed by providers, there are also thousands of cases of fraud committed by individual claimants, beneficiaries and related parties. Such fraud can take a number of

forms. First, there are various ways in which individuals can falsely obtain eligibility for benefits. This may include the use of another's Medicaid or insurance card, the false claiming of dependents by an employee or the false enrollment of a nonemployee. While this may be a particularly significant problem in government benefit programs, recently a number of organized schemes have been uncovered in which phantom employees have been enrolled in private employer benefit plans.

The most common type of fraud among claimants is the submission of forged or altered bills, prescriptions or other documents. With the increasing sophistication of desk top publishing resources, it is increasingly easy for anyone to create a professional looking medical bill or prescription. Not surprisingly, many dishonest claimants are taking advantage of this technology. In addition, insurance companies and the Medicaid program continue to see the more "low-tech" alteration of legitimate medical bills and prescriptions which can be effected through the use of "white out" and a copy machine. Much fraud of this type is discovered by insurance claims examiners by looking for one or more indicators of a fraudulent bill or by pharmacists scrutinizing and verifying suspicious prescriptions. Once discovered, this type of fraud is relatively easy to prove because the fraud will be relatively apparent on the face of the bill and the provider will be able to testify that the services were not rendered. Forged prescriptions usually require the testimony of the purported prescriber that he or she in fact did not write the prescription, but it may be difficult to identify the forger if someone else goes to the pharmacy to fill the prescription. The problem with criminal enforcement in this

area is that the claims are usually relatively small in size and can be a low priority for prosecutors. Even when prosecutions occur, jail time is rare so that there is little deterrence available in the criminal arena. Civil prosecutions are of limited value because individuals committing this type of fraud are often judgment proof.

In addition to the submission of false claims by individuals, it must also be recognized that the claimant or beneficiary can also be involved in many forms of provider fraud. Most often, this will occur when the provider shares a portion of the ill-gotten gains with the claimant or beneficiary. A recent example of this was an psychologist who fraudulently obtained fees with public employees whose names he used to submit the fraudulent claims. As will be discussed in more detail below, a claimant may also be a participant in a health care fraud in return for the doctor's agreement to provide necessary assistance in enhancing a claimant's personal injury claim.

C. Fraud directed at specific types of third party payers

In addition to the general types of fraud schemes discussed above, experience demonstrates that certain schemes may develop as perpetrators of fraud learn how to take advantage of specific reimbursement plans or types of insurance. The history of such schemes demonstrates both the need for a coordinated approach to prevent and punish such fraudulent conduct and to address more quickly the underlying systematic opportunities created for such fraud.

1. Personal Injury Protection (PIP) Mills

The potential for significant monetary recoveries provides ample incentive for individuals to file tort actions arising from auto accidents. For those suffering from truly significant injuries, such actions are clearly warranted. However the availability of such recoveries can provide an incentive for the unscrupulous to engage in insurance fraud, typically by fabricating or exaggerating the nature and extent of injuries suffered, by falsely claiming to be a passenger in an accident, or by "staging" accidents. In such fraudulent schemes, the accident "victim" seeks to enhance his or her permanent injury award and the "health care practitioner" seeks to maximize medical bills, whether legitimate or otherwise. The fraudulent claims for bodily injury damages (not including medical bills) by the alleged accident victims are usually quite modest (e.g., $15,000 or less), because it is difficult to fake more substantial injuries. The fraudulent providers' profits come from the high volume of such cases.

The investigation and civil prosecution of such fraud is difficult, in large part due to the assistance rendered to "accident victims" by dishonest lawyers and medical providers. In many cases, these professionals actively solicit persons involved in auto accidents and willingly participate in the fraud in order to reap financial gain. Not surprisingly, certain medical providers devote virtually all of their practice to the treatment of auto accident victims who are seeking relatively modest recoveries. The

opportunity for fraud in such operations has grown to the extent that one chiropractic enterprise billed more than $40 million in fraudulent claims in one year.

In New Jersey, medical benefits arising from auto accidents are paid under the personal injury protection (PIP) coverage of the patient's insurance policy, unless the insured elects to make health insurance coverage primary. The New Jersey Automobile Reparation Reform Act, N.J.S.A. 39:6A-1 et seq. (No-Fault Act), requires insurance companies to reimburse medical providers promptly. N.J.S.A. 39:6A-5. However, the No-Fault Act in most cases limits the ability to institute tort actions for non-economic losses to persons with certain types of injuries, i.e., injuries meeting the "verbal threshold" requirements contained in N.J.S.A. 39:6A-8. Predictably, some unscrupulous medical providers specialize in assisting patients and their lawyers in satisfying the verbal threshold requirements by rendering unnecessary treatment. They are able to do so in part because the verbal threshold is available for certain soft tissue injuries which are not subject to objective measurement. The term "PIP mill" has been used to describe the high-volume practice of practitioners whose primary mission is not the treatment of patients, but rather the objectification of their patients' symptoms (almost always for soft tissue injuries) in such a manner as to enable these patients to meet the verbal threshold requirements and file personal injury suits -- regardless of the actual extent of injury suffered by these patients. Patients who go to such mills, often at the recommendation of their lawyers, are typically involved in "fender-bender" low-impact accidents in which none of the occupants suffers significant injury. It is not uncommon to find that, in

two-car accidents, the occupants of both vehicles are treated at the same PIP mill. Many of these patients become involved in additional accidents and return to the same PIP mill for treatment.

The doctors who participate in PIP mills typically subject their patients to a battery of unnecessary but costly medical tests including, but not limited to, MRIs, thermograms, nerve conduction studies and psychological tests in order to support findings of permanency and satisfy the verbal threshold. In order to take full advantage of the economic rewards available to those who commit fraud, providers who operate PIP mills frequently have a financial interest in the companies performing these diagnostic tests. Furthermore, the diagnostic test findings, coupled with the patients' subjective complaints of pain, are used to justify a lengthy (and costly) treatment regimen. It is not uncommon for patients in PIP mills to receive "therapy" three to five times per week for periods of six months, one year or even longer. Patients rarely complain about such a lengthy course of treatment, even when the therapy is illusory, because the duration and frequency of treatment is critical to their primary objective -- a monetary settlement. It is noteworthy that the settlement amounts received for these marginal bodily injury cases are typically exceeded by the amount of medical bills generated by the providers. This factor creates a powerful incentive for insurers to offer settlements early in the course of a patient's treatment.

It is extremely difficult to establish fraud in this area when viewing an individual case in isolation, since each of the participants has a significant financial

interest at stake and, therefore, has no incentive to cooperate with investigators. For this reason, the primary means used to prove fraud is through the establishment of patterns of illusory treatments and unnecessary diagnostic tests for a significant portion of the patients at the same PIP mill. Obviously, significant efforts are required to investigate and prosecute such cases successfully. Results may not be obtained for years, and due to the heavy burden of proving fraud, a successful outcome is uncertain. For these and other reasons, insurance companies are often reluctant to pursue such matters and may, instead, prefer to pay the medical providers and settle resulting bodily injury cases for nuisance value. These limiting factors are fully appreciated by the medical providers who commit fraud and serve to encourage the continued operation (if not the proliferation) of PIP mills.

Attorneys and providers have also learned that arbitrations are an effective forum to pursue their claims. This is true whether the claims are legitimate or fraudulent. Insureds (or, through assignment of rights, their medical providers) have the option to arbitrate medical fee disputes. Arbitrations over individual claims are not conducive to the assertion of fraud defenses involving patterns of fraud. Moreover, in the event a claimant is successful, the insurance carrier is obligated to reimburse the claimant the expense of the arbitration, including reasonable attorneys fees. It does not require too many adverse arbitration results before insurance carriers determine to settle, rather than contest, questionable claims.

2. Prescription fraud

While the State's Medicaid program has always included a prescription component, the only substantial fraud detected a decade ago in this aspect of the program was committed by individuals using Medicaid eligibility identification cards to obtain controlled narcotic drugs through the use of forged or otherwise illegal prescriptions. In the late 1980's, the State began to observe the use of Medicaid numbers and identification cards as part of a growing black market in prescription drugs. Over the last decade, these schemes have mushroomed in type and magnitude.

In recent years, the New Jersey Medicaid program, the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program and the General Assistance (GA) program have fallen victim to a pervasive type of fraud which is costing these programs millions of dollars per year. This fraud involves both obtaining and distributing prescription drugs with or without the consent of legitimate prescribers, and the billing for prescription drugs never dispensed. This fraud is concentrated in certain municipalities in Essex County, especially Newark, and has spread to Hudson, Union and Passaic Counties.

Various schemes are being used to defraud the Medicaid, PAAD and GA programs, some of which are described below:

- Writing prescriptions using forged prescription blanks obtained by various surreptitious means, including:

-Prescription blanks stolen from doctors' offices, clinics and hospitals.

-Prescription blanks produced by "whiting out" the handwriting on a legitimate prescription before making multiple photocopies.

-Prescription blanks of legitimate and fictitious providers and clinics obtained from printers or produced on personal computers.

- Obtaining prescriptions from legitimate prescribers by feigning an illness, having the prescription filled at a pharmacy, then selling the medication back to various illegal markets.

- Obtaining prescriptions from legitimate prescribers for an actual illness, having the prescription filled at a pharmacy, not taking the needed medication and instead selling the medication back to various illegal markets.

- Obtaining prescriptions from prescribers who willingly write for medications that have no medical indications for the beneficiary, usually in exchange for cash or for other items of value (e.g. drawing of blood for unnecessary tests to be billed by unscrupulous laboratories, signing of multiple Medicaid claim forms to bill the Medicaid program for services never rendered or in excess of what was rendered).

- Pharmacies billing the Medicaid, PAAD, and GA programs for original and refill prescriptions never ordered and/or never dispensed.

- Pharmacies re-stocking medications when the beneficiary fails to pick up these medications which have been reimbursed by the Medicaid, PAAD or GA programs.

Recent pre-payment and post-payment monitoring of pharmacies has revealed instances where as many as two-thirds of prescriptions reviewed were forged

(i.e., the prescriber denied writing the prescriptions). The developing trends indicate the DMAHS is losing millions of dollars annually to prescription fraud and/or abuse.

Where once prescription fraud involved primarily a small cadre of beneficiaries and drug dealers, it now has extended to include dishonest pharmacists and doctors. While enforcement entities have been attacking the problem aggressively, more should be done to change the laws, particularly those making prescription forms readily available and readily subject to forgery, in order to stem this particular rising tide of fraud.

3. Transportation Fraud

In recent years the State's Medicaid program has seen increasing fraud in the area of transportation benefits provided to individuals eligible for Medicaid. Specifically, one benefit of the Medicaid program is to provide necessary transportation, even for ambulatory patients, for health-care-related purposes. Problems uncovered have included billing for trips that never occurred, billing for more miles than actually traveled, billing for multiple family members when only one member required transportation, transporting beneficiaries for nonmedical purposes, such as shopping, education and social events, and transporting patients in unsafe, uninspected or unauthorized vehicles. This problem reached its height in the early 1990's. As a result of DMAHS investigations, as well as federal and State criminal prosecutions, the State suspended close to 40 livery providers and livery-related individuals from New Jersey's Medicaid program. As a result of these and other actions, Medicaid expenditures for

livery services were reduced from over $20 million in calendar year 1993 to $5.8 million in calendar year 1994. At the same time these successes were realized, the State witnessed an explosion in expenditures for transportation services for invalid coach patients. Investigations in this area have revealed inflated mileage charges and many recipients who do not qualify for invalid coach services and who should be utilizing less expensive livery service instead.

4. Laboratory Fraud

The area of laboratory reimbursement for medical tests is particularly vulnerable to fraud. Because they bill in volume, such laboratories are largely "invisible" to the patient. They also commonly operate in locations remote from the providers who send them specimens and the patients whose specimens they test. In one case, a national testing lab added an $18 unnecessary test to hundreds of thousands of blood samples sent by providers, thus defrauding the government of tens of millions of dollars.

Another scheme involving labs demonstrates the interplay which sometimes occurs between unscrupulous providers from different disciplines. In another form of "mill," a physician will provide Medicaid eligible recipients a prescription for their drug of choice in return for a blood sample. The blood is then subjected to a battery of unnecessary tests for which the laboratory bills Medicaid.

STATE RESOURCES

The State's resources arrayed against health care fraud are primarily found in the Departments of Banking and Insurance, Human Services and Law and Public Safety, with more limited resources found in the Department of Health and Senior Services. These resources are primarily organized by the type of payer, (e.g., insurance or Medicaid). There are also licensing entities which have disciplinary authority for misconduct by licensed professionals and health care provider entities.

The Department of Banking and Insurance's Division of Insurance Fraud Prevention (IFP) is responsible for the enforcement of the Insurance Fraud Prevention Act, which includes, among other forms of insurance fraud, health care fraud committed against automobile and health insurance companies. The Office of Quality Management and Program Integrity (OQMPI) in the Department of Human Services has responsibility for prevention, detection and investigation of health care fraud and enforcement actions involving fraud in the State's four billion dollar Medicaid program, as well as the PAAD and other programs recently transferred to the Department of Health and Senior Services. The Division of Criminal Justice and Division of Law in the Department of Law and Public Safety each have units mirroring those in the Department of Banking and Insurance and the Department of Human Services to enforce the criminal and civil laws with respect to insurance, Medicaid and PAAD fraud.

One area where the State organizes its efforts by health care provider is in the Division of Consumer Affairs, also in the Department of Law and Public Safety,

which houses the professional licensing boards. The professional boards are supported by investigators in the Division of Consumer Affairs' Enforcement Bureau and by deputy attorneys general in the Division of Law's Consumer Affairs Sections. The Department of Health and Senior Services has licensing authority over some health care provider entities including hospitals and laboratories, although it has no discrete staff deployed against health care fraud, other than the assistance it receives from OQMPI by way of an interagency agreement.

Because not all staff in the various units mentioned above are dedicated to health care fraud, the State's total resources arrayed against such fraud can only be estimated. There are approximately 130 full-time equivalent staff in the various agencies dedicated to fighting health care fraud, including 80 investigators, 15 attorneys, ten other professionals and 25 support staff. In addition to the State's resources, the various county and municipal prosecutors handle health care fraud cases, including most of the criminal and disorderly persons prosecutions for Medicaid and PAAD beneficiary fraud, although no staff is solely dedicated to that effort. The federal government has also recently dedicated substantial resources to the fight against health care fraud. Thus, in addition to the State resources discussed here, federal agencies involved in the fight against health care fraud include the Justice Department, the United States Attorney's Office, the Federal Bureau of Investigation, the Department of Health and Human Services' Office of Inspector General, the Internal Revenue Service, the Drug Enforcement Administration, the Federal Food and Drug Administration, and the Postal Service (often

federal cases are based on mail fraud). Finally, the special investigation units required of every auto and health insurer in New Jersey are a significant resource in the efforts to detect, prevent and take enforcement action against health care fraud.

The increasing sophistication of perpetrators of health care fraud requires matching sophistication on the side of the enforcement community. Efforts will have to be undertaken to increase the availability of the forensic accounting, medical and computer expertise now critical to the fight against fraud. While all staff is becoming computer literate, there is a continuing need to enhance the State's ability to "search" through computer data used by the perpetrators of fraud. The more sophisticated fraud schemes today require the use of computers to manage data and issue bills. Law enforcement has found the use of undercover staff to be a particularly useful tool in attacking fraud. However, because many schemes are limited to localized communities, including some with new immigrant populations, there is an increasing need to utilize investigative staff with the necessary language skills or background.

Each of the State units dedicated to insurance fraud prevention and enforcement has developed ongoing informal and formal working relationships with each other and with the federal and private resources arrayed against fraud. While these cooperative efforts allow for the coordination of individual cases and the informal sharing of information regarding trends in health care fraud, at the State level, there is not a forum for the systematic review of cases or the provision of a broad-based policy outside of what each individual unit decides on its own.

A. Division of Insurance Fraud Prevention

The Division of Insurance Fraud Prevention (IFP) in the Department of Banking and Insurance is charged with the enforcement of the Insurance Fraud Protection Act, which provides for the imposition of civil penalties for the commission of insurance fraud. Until recently, the primary focus of the IFP was on auto insurance fraud, a component of which -- PIP coverage -- involves health care. While the Division has now added health care fraud as a primary focus, it still devotes substantial resources to auto fraud. Its efforts are divided between an extremely large volume of fraud referrals from insurance company special investigations units and the investigation of large-scale fraud involving millions of dollars. In the last year, the IFP collected $4.5 million in civil penalties as a result of approximately 870 consent orders, settlements and judgments, together with $1.5 million in restitution to insurance companies. The great bulk of those recoveries was achieved through the settlement of a large number of small cases. The IFP employs over 100 professionals, primarily investigators, and approximately 25 clerical staff. However, less than half of that staff is devoted to health care fraud.

IFP has separate units to address health and worker's compensation fraud, personal injury protection fraud, auto/property insurance fraud, as well as a unit to oversee insurance companies' compliance with their obligations to investigate fraud, and a computer systems unit to support the other units and process information and requests for information from outside sources. Its investigative staff is trained and highly experienced. It relies on insurance companies' staff where medical expertise is required.

In addition to current staff members, who are capable of undertaking undercover operations, the Division should consider training or acquiring personnel to allow for such operations in newer immigrant communities. Similar efforts should be considered to enhance the forensic accounting capabilities of the Division.

B. Division of Medical Assistance and Health Services (Medicaid)

The Office of Quality Management and Program Integrity (OQMPI) within the Division of Medical Assistance and Health Services (DMAHS) is responsible, among other things, for the prevention, detection and investigation of fraud and abuse by providers, practitioners, beneficiaries and others involved in the State's Medicaid program. That program, which is administered by the DMAHS, is designed to provide medical care to qualifying individuals, generally the underprivileged in the State. The program has approximately 700,000 beneficiaries in New Jersey, of which over 400,000 are presently served by managed care. The Fiscal Year 1997 budget for Medicaid is approximately $4 billion. Last year, the OQMPI conducted 15,000 reviews of pharmacy claims of Medicaid beneficiaries, and as a result of these and prior years' reviews 3,200 Medicaid beneficiaries were restricted to a single pharmacy in 1995. Limiting a beneficiary to a single pharmacy controls overutilization and fraud by inhibiting beneficiaries from utilizing multiple pharmacies and also deters them from going to multiple prescribers. These efforts resulted in savings of $5.5 million. In 1995, OQMPI was involved in the recovery of $4.34 million from eligibility and utilization fraud and abuse cases and imposed more than ninety suspensions, debarments and disqualifications

of providers and others from the Medicaid program. In addition, although not subject to quantification, many millions of dollars were saved through both deterrence and prevention measures recommended or put in place by OQMPI.

Of OQMPI's 80 staff, approximately 30 to 40 professional, paraprofessional, clerical and supervisory staff are dedicated to or involved in fraud and abuse detection, prevention and enforcement. In the Bureau of Program Integrity, 13 investigators are primarily responsible for detecting, investigating and/or taking action against fraud or abuse. In addition, the Bureau has recently hired 10 temporary staff to conduct prepayment and postpayment reviews of providers' claims which may be fraudulent or abusive. In the Bureau of Administrative Control, four staff members are responsible for processing cases to recover overpayments and civil penalties due to potential fraud and abuse and to exclude providers and others who engage in fraud and abuse from future participation in the program. The Bureau also monitors contractors conducting audits of hospitals and pharmacies. These audits resulted in the recovery of an additional $9 million dollars in 1995.

Finally, in the Surveillance and Utilization Review Subsystem (SURS) Unit, a staff of four is responsible for designing and developing multiple reports through the use of computers and specialized software. The analysis of the resulting data is used to identify patterns of fraud and abuse. This is an effective tool because the SURS system accesses and utilizes all Medicaid claims entered into a computer database. Much provider and beneficiary fraud is detected through the use of computers and the

identification of patterns of billings outside the norm. The unit's funding is approximately 75 percent federal and 25 percent State.

In addition to staff dedicated to fraud detection, prevention and enforcement, other staff throughout the Department of Human Services have responsibilities to assist in this area. Health care professionals and other staff employed throughout DMAHS conduct prepayment and post-payment reviews. The Department's Office of Auditing is also responsible to look for potential fraud or abuse as part of its audits of long term care facilities and federally qualified health care centers.

Unlike the other State entities charged with health care fraud prevention and enforcement, OQMPI has substantial technological capability through its own staff and the Medicaid program's fiscal agent, UNISYS, as well as Treasury's Office of Telecommunications and Information Services. Thus, it has the capacity to take advantage of computer programs for detecting fraud and putting into place measures to prevent fraud. However, the present system lacks data warehousing (the maintenance of all data in an easily retrievable form) and decision support capability, which would greatly enhance the fraud detection capacity of the SURS Unit and the Bureau of Program Integrity. Moreover, the OQMPI has no undercover capacity of its own and must rely on the Division of Criminal Justice's Medicaid Fraud Section or federal and county law enforcement agencies for such assistance. Presently, the office is seeking to augment its own resources in this regard through an outside contract. OQMPI also lacks forensic accounting capability.

C. Department of Law and Public Safety

The Department of Law and Public Safety has three distinct functions with respect to health care fraud which are handled in three different divisions -- the Divisions of Criminal Justice, Law and Consumer Affairs.

1. Division of Criminal Justice

The Division of Criminal Justice's efforts with respect to health care fraud are primarily handled by two units. The Insurance Fraud Unit investigates and prosecutes all forms of insurance fraud, including health care fraud. It is staffed by seven attorneys, ten investigators and two clerical staff and is funded through the Department of Banking and Insurance by the same assessment mechanism on the insurance industry that funds the Division of Insurance Fraud Prevention. The Medicaid Fraud Section investigates and prosecutes criminal fraud against the Medicaid Program, as well as Medicaid patient abuse. With respect to fraud, its specific mandate is to address provider fraud, although fraud by beneficiaries may be pursued where it is tied to provider fraud. The unit is staffed by three attorneys, 10 investigators and three clericals. The unit is supported by 75 percent federal funding and 25 percent State funding. Both Medicaid and Insurance fraud prosecutions against fraud rings are extremely resource intensive. As in other units, these units require staff capable of conducting undercover investigations in some ethnic communities as well as medical, computer and forensic accounting expertise.

While no other unit within the Division of Criminal Justice is specifically dedicated to health care fraud, health care fraud may be prosecuted where it is detected

in the course of investigations by other units, such as the Organized Crime Unit or the Statewide Narcotics Task Force.

2. Professional Boards/Enforcement Bureau in Division of Consumer Affairs

The Enforcement Bureau in the Division of Consumer Affairs provides investigative services for 34 professional and occupational boards, including more than 20 boards which regulate various health care professions. While fraud can occur within any of these professions, most of the fraud cases which have been handled by the Enforcement Bureau relate to a very small number of physicians, chiropractors and dentists, who are involved in fraudulent activity. While health care fraud represents a significant priority for the Enforcement Bureau, its highest priority has always been issues pertaining to professional competence and quality of care. The Bureau is staffed by 57 investigators, including supervisors, and 11 administrative support personnel. This includes five staff assigned to a fraud unit, although other staff may be called upon to assist in fraud investigations. The funding for the Enforcement Bureau comes primarily from fees assessed against the various regulated professions. Unlike some of the other entities involved in insurance fraud prevention and enforcement, the Enforcement Bureau does have some forensic accounting assistance and investigators with medical backgrounds. It should consider greater technological support, especially since its computers are not hooked up to an internal network.

3. Division of Law

Consistent with its general mission, the Division of Law's role in insurance fraud enforcement is to provide counsel and representation to other State agencies with responsibility in this area. This is principally done through the representation of the Division of Insurance Fraud Prevention, the Division of Medical Assistance and Health Services and the various professional boards. Within the Banking and Insurance Section, there are four attorneys, supported by three paralegals and two secretaries, assigned to provide counsel and representation to the IFP. The primary function of these attorneys is to seek civil penalties and restitution under the Insurance Fraud Prevention Act through the filing of civil suits. The primary focus of this unit has been the extremely large volume of small cases, most of which are brought against insureds who defraud insurance companies. The Division is seeing an increasing number of referrals involving providers. Experience tells us that the very large cases are extremely resource intensive. Given the amount of dollars at issue, the multiple instances of fraud that must be proved in order to demonstrate a large-scale fraud, and, the vigorous defense of these matters, just one case can occupy more than one attorney full time for over a year. The funding for the staff handling these matters comes from assessments on the insurance industry through the Department of Banking and Insurance.

Of the five attorneys assigned to represent the Division of Medical Assistance and Health Services, approximately one full-time equivalent attorney works

on matters related to fraud and abuse. Most cases are either resolved before referral to the Division or are straightforward enough that they are not contested. This assignment is funded through the DMAHS in accordance with the overall funding of staff to support the Medicaid program.

The Division of Law has two Consumer Affairs sections responsible for providing representation and counsel, respectively, to the various professional boards. There are 28 attorneys in those sections with responsibility for prosecuting licensing matters involving violations of professional standards, counseling the boards in their decision-making roles regarding such prosecutions and prosecuting civil matters against unlicensed practitioners. Just as the professional boards themselves focus primarily on quality of care, so do the attorneys representing the boards. It is estimated that approximately four to five attorneys are dedicated to matters involving health care fraud. As is the case with the prosecution of providers for violations of the Insurance Fraud Prevention Act, it is our experience that a large-scale fraud case can occupy a single attorney or more for long periods of time.

D. Department of Health and Senior Services

Among the responsibilities of the Department of Health and Senior Services are the licensing of hospitals, nursing homes, laboratories, ambulatory-care facilities, residential treatment facilities and home health agencies. In addition, the Department administers the $300 million hospital charity care program. The Department's regulation of licensed entities focuses primarily on quality of care and regulatory compliance.

However, in the few instances when fraud by the licensed entities has come to the attention of department staff, licenses have been revoked. Similarly, during audits of hospitals for compliance with charity care regulations, fraud or discrepancies may come to the attention of auditors. Suspected fraud has been referred to the Division of Criminal Justice. The only regulatory action taken against hospitals or beneficiaries for the few instances of fraud detected has been disallowances of the charity care claim.

E. Private Insurers' Special Investigations Unit

The final dedicated resources against health care fraud, and in many ways the front lines of the battle, are the Special Investigation Units (SIUs) within insurance companies providing auto and health insurance. Presently, by statute, auto insurers are required to have one investigator for every 30,000 policies in force and health insurers are required to have one investigator for every 60,000 lives insured. This amounts to approximately 125 fraud investigators employed by insurance companies in New Jersey. Notably, however, because there is no requirement for special investigations units within managed care organizations, the level of anti-fraud efforts within managed care organizations varies widely. There is a general contractual requirement that managed care organizations providing Medicaid services have an anti-fraud effort. DMAHS is auditing and working with managed care organizations to assure that this general requirement is met.

While the number of investigators in SIUs suggests a formidable presence, the effectiveness of SIUs often depends on the level of consciousness regarding fraud

elsewhere within insurance companies. This is true because these investigators are responsible for investigating thousands of "suspicious" referrals from within their own companies, so the speed with which fraudulent activity is identified is crucial. Carriers often pay fraudulent claims, unaware that they are fraudulent, before a provider or claimant scheme is identified as suspicious. If there is delay in discovering the fraud, by the time the investigation is commenced, claims checks may have been destroyed, records may have been misplaced or destroyed, claims examiners' memories may have faded, and the perpetrator, now aware of suspicions of the company, may have ceased that particular activity. In addition to these common difficulties, SIUs are often limited to information regarding claims against their own companies, although the fraudulent schemes at issue may be committed against many companies by the same providers or claimants. It is suggested that some perpetrators "fly under the radar" of the various payers by spreading out their fraudulent bills. In the next stage of its deliberations, the Task Force will examine means of better leveraging the resources of the SIUs and making them even more effective in their efforts against health care fraud. Among the issues to be explored are how to encourage insurance companies to take advantage of their own investigations and to bring their own enforcement actions, as is presently permitted by law. Coordination mechanisms will be necessary to avoid the possibility of private causes of action interfering with ongoing investigations.

INSURANCE FRAUD DETECTION, PREVENTION AND ENFORCEMENT TOOLS

In order to identify priority detection, prevention and enforcement methods for health care fraud, it is first necessary to understand the inherent difficulties in detecting and taking enforcement action against health care fraud. Like other white collar offenses, health care fraud is not committed in the open. The victim is almost always unaware of the crime at the time it is committed and, absent vigilant staff, may never know it has been victimized. This problem is exacerbated by the fact that significant health care fraud is not committed through a single incident of large magnitude, but is rather committed through a large volume of small scale frauds. Therefore, identification of the fraud is dependent on finding a pattern. Large scale fraud can almost never be detected by review of individual files. Indeed, on its face, a fraudulent claim may be indistinguishable from a legitimate claim. The necessity of identifying patterns makes both the detection and proof of large scale fraud time consuming and labor intensive. The proof of such fraud is also made difficult by the fact that corroboration often depends on patients who are either indifferent to the offense or were actually participating in it.

The subjective nature of medical decision making and the complexity of billing codes not only makes the identification of the fraud difficult, but can create a credible defense that apparent fraud was just a mistake by the practitioner, a difference in medical judgment or was the fault of administrative staff responsible for the billing. Moreover, the recent introduction of electronic billing eliminates a paper trail which is

often critical in proving fraud. At the same time that computer systems can provide new tools for detecting and identifying patterns of fraud, they also provide new tools for the sophisticated criminal to take advantage of the lack of human involvement in the claims review process. It is therefore critical that fraud detection and prevention be an important design criteria in the development of these systems and that human involvement be retained or introduced where necessary to provide checks against fraud.

A. Prevention and Detection

The prevention and detection of health care fraud must be the primary responsibility of the payers; that is, insurance companies, Medicaid and individual consumers. Individual consumers, who are primarily the victims of fraud by quackery, can best prevent fraud by being suspicious of claims of treatment that appear overly optimistic and by seeking verification of such claims from neutral sources.

Third party payers must design, implement and maintain systems which reduce opportunities for fraud and which detect fraud before claims are paid. Such systems may include prepayment reviews, the training of personnel to spot fraud indicators in claims, the performance of independent medical examinations and the development and use of fraud detection software, including computer edits designed to reject invalid or suspicious claims. The effectiveness of many of these techniques will also depend on the development of an institutional culture that is intolerant of fraud. Surprisingly, it is not uniformly the case that all third party payers are intolerant of fraud.

All too often, they find the payment of suspicious claims easier than taking enforcement action.

In addition to the State Medicaid agency's role as a third party payer to detect and prevent fraud, government also has a role to assist third party payers in their efforts. Thus, a legal framework must be designed to minimize opportunities for fraud. A recent example of such governmental assistance is the requirement that health care providers make prompt notification to auto insurers upon the commencement of medical services under the personal injury protection portion of an auto insurance policy. The sooner an insurance company is aware that PIP benefits are being sought, the sooner it can confirm the need for treatment and conduct its own diagnosis of the alleged victim of a car accident. In general, elected officials must be fully sensitized to the problem of insurance fraud so that they can be responsive to the need to move quickly to address new fraud schemes as they emerge. Another area where the government can help reduce opportunities for fraud is developing, and encouraging the development by the responsible organizations, of clearer billing codes and standards for service delivery by health care professionals. Finally, the State can facilitate information sharing so that all payers become aware as soon as possible of ongoing fraud schemes.

The final means of prevention of insurance fraud is deterrence and removal from the health care system of fraudulent providers. These means of prevention naturally lead to the discussion of enforcement actions against perpetrators of health care fraud.

B. Enforcement

There is a relative consensus among the enforcement community and the insurance industry that the most cost effective enforcement strategy is one that focuses on those relatively few health care providers who commit health care fraud. That is because most large-scale health care fraud schemes have providers at the center. While other parties involved in health care transactions may also commit fraud, it is much less common that those parties will commit fraud on a large scale without some provider involvement. The suggestion that an enforcement strategy should focus on health care providers who engage in fraud in no way suggests that a significant portion of the health care provider community is dishonest. To the contrary, the vast majority of health care providers are honest participants in a system which is by definition central to the well being of each and every one of us. However, the nature of health care fraud means that a very few dishonest participants in the system can improperly take a hugely disproportionate share of the health care dollars.

There are three general avenues for health care fraud enforcement: (1) criminal, (2) civil (restitution, civil penalties and administrative exclusion) and (3) licensing. The realistic threat of jail or substantial criminal penalties can be the most effective deterrence and punishment for health care fraud. However, the fact that crimes must be proven beyond a reasonable doubt makes criminal prosecution of much health care fraud more difficult. As was noted earlier, the vast majority of criminal

prosecutions for health care fraud have been for services not provided. It is currently relatively uncommon that a viable criminal case can be made out for other types of health care fraud. The difficulty in prosecuting health care fraud under the criminal standards of proof arise out of the fact that the matters can often be defended based on differences of opinion in a complex field. These issues need to be explored further to determine whether criminal prosecutions for other types of health care fraud can be made more viable. Moreover, even where a conviction is obtainable, jail time for crimes usually depends on the magnitude of the offense. Because most of the individual instances of health care are measured in the tens or hundreds of dollars, in order to prove an offense of substantial magnitude it is often necessary to prove hundreds or even thousands of individual instances of fraud. Such a prosecution can be extremely time intensive and divert resources from other important cases. The issue of sentencing for health care fraud offenses also needs further study.

Under the State's Insurance Fraud Prevention Act and Medicaid statute, civil penalties, treble damages and restitution are available against individuals committing health care fraud. Civil penalties and restitution may be sought by the IFP, whereas insurance companies may obtain treble damages along with reasonable investigation expenses, cost of suits and attorneys fees, where they can establish that a defendant has engaged in a pattern of violating the act. While the availability of treble damages would appear to be a substantial tool available to the industry against the perpetrators of health care fraud, it has been rarely used by insurance companies. All too often, the payment

of questionable claims can be viewed as a cost of doing business by some insurance companies. Moreover, while the Insurance Fraud Division has often imposed penalties under the act, a mere monetary penalty is not always an effective deterrence against health care fraud. A major advantage of civil prosecutions is that there is a lower burden of proof.

When the perpetrator of fraud is a health care professional, a licensing action may represent the most effective deterrence and punishment. In addition to having civil remedies available, including penalties and restitution, a licensing board can suspend or revoke a health care provider's license, depending on the magnitude of the fraud. In addition, the licensing boards are in a peculiarly advantageous position to deal with the common defenses of professional judgment or mistakes in the application of a billing code. Licensing boards are comprised primarily of licensed professionals, who are in a better position than a jury or even a judge to determine, after the presentation of expert testimony, whether the claimed use of medical judgment or the claimed mistake in the application of billing codes is bona fide or is merely a rationalization for fraud. Thus, while such defenses may still be viable in a licensing action, they are less likely to be effective in those situations where they are after the fact rationalizations for fraud. Moreover, a threat against a health care practitioner's license for the commission of fraud can be a greater deterrence, given its impact on the individual's future prospects, than mere monetary penalties. For these reasons, for many cases of health care fraud by health care providers, a licensing action may be the most effective way of addressing

health care fraud. Moreover, common sense dictates that a license granted by the State should be subject to forfeiture when it is used to defraud the health care system.

C. Investigative Methods

When health care fraud is suspected, there are a number of different approaches to investigating that fraud. The most common means of conducting an investigation is still through the review of documents and the interviewing of witnesses. However, experience is demonstrating that for more significant cases, other investigative tools are more effective and necessary. Specifically, given the common difficulty in obtaining corroboration from patients who either do not remember, cannot remember or do not want to remember the nature of the treatment they received, undercover investigations, followed by a search warrant (in criminal cases), document seizures or subpoenas, can provide much more effective and definitive corroboration of apparent patterns of fraud or through computer records. In theory, paper or computer records combined with expert opinions can contain sufficient evidence to prove fraud. However, it is always helpful to have a person who can testify and put a human face on what treatment was or was not received and what was specifically said by the health care provider. This is particularly true when a presentation must be made to a jury.

In addition to the ability to conduct undercover investigations, the ability to engage in the sophisticated analysis of computer information is becoming increasingly important. More and more bills are submitted electronically. Moreover, large scale providers keep many records on the computer. Even perpetrators of fraud, in order to

keep track of their fraudulent enterprise, must maintain much of their information on computers. Related to the ability to do computer analysis is the fact that the perpetrators of fraud may engage in complex schemes to disguise transactions with other participants in the scheme or in order to hide their ill-gotten gains. Therefore, the use of forensic accountants in health care fraud investigations is becoming increasingly important. More simply, the State must make sure that it develops and maintains the necessary sophistication to match the increasing sophistication of perpetrators of health care fraud.

RECOMMENDATIONS FOR LEGISLATIVE ACTION

The focus of the initial efforts of the Task Force was identifying the nature and scope of the issue of health care fraud. Specific recommendations for a strategy to attack the problem are to be studied in the next phase of the Task Force's work. However, as part of its initial efforts, the Task Force has determined that there are some proposals which have received sufficient discussion or are straightforward enough that further study by us is unnecessary.

The following proposals are, therefore, recommended for consideration and action:

1. Require the use of standardized and serialized prescription forms on non-reproducible and non-erasable paper.

Discussion. Fraud involving the use of altered or forged prescriptions has exploded in the last few years. The lack of a standardized form which is non-reproducible and non-erasable makes it easy to alter and forge prescription forms. The lack of serialization of the forms makes the origin, and number of forged, stolen, lost or improperly issued prescriptions difficult to trace.

2. Amend N.J.S.A. 45:9-19.3 to permit the sharing of investigative information from the State Board of Medical Examiners' files with other governmental agencies.

Discussion. Present law prohibits the sharing of information related to the State Board of Medical Examiners' investigations pending a final disposition of the inquiry or investigation. The only exception is for sharing the information with another governmental agency upon an application to the Superior Court with notice to the physician or surgeon who is the subject of the investigation. This inhibits coordination where investigations involve physicians. Whatever legitimate claims physicians may have to the confidentiality of an investigation does not extend to

other investigative arms of government. Moreover, no other health professional's investigations are subject to this degree of confidentiality.

3. Amend the Insurance Fraud Protection Act to apply to fraud committed against the State Health Benefits Program.

Discussion. Some have questioned whether fraudulent activity which constitutes a violation of the Insurance Fraud Prevention Act when committed against private health insurance companies violates the Act when committed against the State Health Benefits Plan. The law should be amended to eliminate any ambiguity that civil penalties and treble damages are available against those who defraud the State's Health Benefit Program.

4. Amend the No-Fault Statute to adopt the Medicare schedule at a prescribed percentage in lieu of the current PIP Medical Fee Schedule.

Discussion. Experience demonstrates that perpetrators of fraud have taken advantage of apparent confusion or even mistakes in PIP fee schedules adopted by the Department of Banking and Insurance. This would assure that the fee schedule is kept current and would remove the confusion that can occur by using more than one schedule for billing as is the practice today.

5. Amend the No-Fault Statute to allow individuals to select a managed care option for personal injury protection benefits.

Discussion. The establishment of multi-million dollar PIP fraud mills demonstrates a need to change the underlying incentives and opportunities to commit fraud. A proposal has been made to allow insureds to elect managed care for personal injury protection as an option which would reduce their auto insurance premiums. Those who would select such an option would have a greatly reduced opportunity to commit fraud upon being involved in an automobile accident. Any such amendment must be drafted so as to avoid the possibility of shifting the cost of "treatment" provided at PIP mills to State-funded health care programs such as Medicaid.

6. Amend the No-Fault Statute to provide for peer review of PIP claims.

Discussion. Again, the existence of multi-million dollar PIP mills makes clear the need for changes in the PIP statute. In many of these mills the routine provision of unnecessary or inappropriate services is common place. Subjecting the diagnosis and treatment regimen to peer review could greatly reduce the opportunity to over bill PIP claims. The review should not be permitted to take so much time as to impose any undue burden on the majority of legitimate providers. The legislation should also provide that claims for unnecessary or inappropriate care which are denied as a result of PIP peer review should not be submitted to State funded health care programs, such as Medicaid, PAAD or General Assistance.

7. Amend N.J.S.A. 17:33A-11 to expressly shield insurance company representatives as well as Division of Insurance Fraud Prevention (IFP) personnel from discovery during the pendency of an investigation.

Discussion. Most IFP investigations are the result of referrals from insurance companies. IFP investigations are presently shielded from subpoena and discovery during an investigation in order to protect the integrity of the investigation. If insurance company personnel are not similarly shielded, astute individuals may be able to undermine the integrity of investigation by getting information directly from the insurance companies.

FUTURE DIRECTION OF TASK FORCE

Having defined the scope of the problem and identified currently available resources and methods for attacking the problem, the next efforts of the Task Force will be directed at developing specific proposals to attack health care fraud in New Jersey. These efforts will focus on three areas: (1) coordination of New Jersey's prevention and enforcement efforts; (2) the development and use of technology for health care fraud prevention and enforcement; and (3) legislative and regulatory changes to enhance health care fraud prevention and enforcement efforts.

A. Coordination

This report indicates that, while there is informal communication and some bilateral arrangements for cooperation among the various State agencies with responsibility for health care fraud prevention and enforcement, most priorities and policies regarding health care fraud prevention and enforcement are set at the individual agency level. Moreover, while State agencies work with individual federal governmental agencies, the extent of cooperation and prioritization is set at the individual agency level.

Health care fraud is a multi-faceted problem which crosses the jurisdiction of various agencies. The same fraud schemes or perpetrators of fraud may attack various payers subject to the jurisdiction of different State agencies. Moreover, these individual State agencies are often left to make their individual cases for legislative changes necessary to facilitate their prevention and enforcement efforts. In order to make more

effective use of available resources, it is critical that the various units of State government are carefully coordinated and that the Executive Branch speak with a strong and unified voice regarding proposals to enhance the health care fraud prevention and enforcement effort.

Shortly after the issuance of this report, the federal government, through the United States Attorney General and the Office of the Inspector General of the Department of Health and Human Services, will be issuing its first statements regarding how the federal government will facilitate coordination among federal, state and local enforcement agencies. New Jersey will be in a better position to work with this new coordinated federal effort if its own systems for coordination are clear. In order to address this issue, the Task Force will be further exploring and ultimately making recommendations regarding how to best coordinate efforts among the various State agencies, the federal government and the private sector with regards to health care fraud prevention and enforcement responsibilities.

B. Technology

Understanding how technology is changing the face of health care and how it can be used for health care fraud prevention and enforcement will be critical to the State's efforts in this arena. As stated elsewhere in this report, attacking health care fraud is going to require new skills and knowledge sets. A subgroup of the Task Force, comprised of technical staff of Task Force members, will be established to assess the technical resources available to the State in its health care fraud prevention and

enforcement efforts. Specifically, this technical staff will be asked to look at the hardware, software and people skills available to the State. This staff will be directed to make recommendations regarding necessary computer systems, both hardware and software, and training to allow the State to take full advantage of technological developments in the fight against health care fraud. In undertaking this effort the subgroup will consult with the drafters of the Healthcare Information Networks and Technologies Report to the Legislature.

C. Legislative and Regulatory Proposals

During the course of its work, the Task Force has heard a number of proposals for legislative or regulatory changes to enhance fraud prevention and enforcement efforts. In addition to those above matters recommended for action, other proposals raise issues that require further discussion by the Task Force and affected parties. These proposals will be studied by the Task Force for its next report:

1. Criminal Law

There have been no significant changes to the criminal laws in recent years to address the changing nature and scope of health care fraud. Among the proposals heard by the Task Force are some which could enhance the effectiveness of the criminal remedy or which would criminalize fraudulent activity not clearly covered by the criminal laws today. The Task Force will be studying the following proposals:

1. Amend criminal statutes to increase likelihood of jail sentences for commission of health care fraud related crimes.

Discussion. As is noted throughout this report, health care on a large scale is most often committed through a large number of small frauds, often amounting to less than $100 each. Indeed, it is relatively infrequent that the individual fraudulent claims will exceed $1,000. Under existing law, there is no presumption of jail time for third and fourth degree criminal offenses. While a presumption of jail does attach to a conviction for a second degree crime, in order to establish second degree theft, the amount of the theft must exceed $75,000. In most health care fraud schemes, to prove a theft of $75,000 would require proving hundreds of individual cases of fraud and in some cases thousands of individual cases of fraud. This fact often makes the prosecution of a second degree offense impractical, thus making the imposition of a jail sentence difficult to obtain in health care fraud cases.

There have been a number of suggestions regarding how to address this problem. Among them are:

a. Amending the theft statute to lower the threshold for second degree theft related to health care fraud to a figure such as $20,000 or $10,000;

b. Create a new second degree crime for a pattern of health care fraud, defining a pattern as ten, twenty or thirty related commissions of health care fraud;

c. Make a pattern of insurance fraud an aggravating factor for the consideration of jail for third degree theft;

d. Eliminate the presumption of non-incarceration for third degree theft where the crime involves health care fraud;

e. Create a new crime of claims fraud.

2. Amend N.J.S.A. 30:40D-17(a) to provide for the punishment of Medicaid fraud consistent with other theft offenses.

Discussion. Presently there is a separate statute for the commission of Medicaid fraud which provides for a maximum penalty of three years in jail and $10,000 fine, regardless of the amount of the fraud. This is in contrast to other theft offenses where the amount of the fraud will enhance the degree of the crime and hence the penalty. This issue is particularly significant for large scale fraud schemes, including kickbacks.

3. Expressly criminalize "running" and the payment and receipt of kickbacks.

Discussion. Because most fraud schemes depend on a volume of "patients," fraudulent providers will often pay third parties for patients. Most commonly this occurs through "runners" who provide accident victims or alleged accident victims to health care providers and others involved in the health care field who will refer patients in return for kickbacks. Because these practices facilitate fraud and serve no legitimate purpose, it has been suggested that they be expressly criminalized.

4. Expressly criminalize the routine waiver of copayments.

Discussion. While it has been established that the waiver of copayments is fraudulent in a civil setting, the nature of the fraud is not clear enough that the existing theft by deception statute is sufficient to criminally prosecute the routine waiver of copays.

5. Amend the General Assistance statute to make the criminal and civil penalties contained in the Medicaid statutes applicable to violations involving General Assistance health care payments.

Discussion. Current statutory remedies for dealing with fraud and abuse in the General Assistance program are limited. Unlike the Medicaid and PAAD programs, which have clear provisions for civil and criminal penalties for fraud in the obtaining of health care payments, there is no similar provision in the General Assistance statute.

6. Clarify the doctor-patient privilege as it applies to health care fraud investigations.

Discussion. When a criminal prosecutor issues a subpoena to a doctor for patient files, the doctor-patient privilege is often asserted. While this is being sorted out, time is lost to the State and gained by the provider. Billing records and dates of treatment and perhaps other information should not be so "privileged."

2. Civil Enforcement

A number of suggestions were also made to enhance civil enforcement efforts against health care fraud. Among these recommendations were those intended to

address problems inherent in the detection, prevention and enforcement efforts in the civil arena. These suggestions relate to problems arising out of the scale on which fraud is committed and the types of defenses which are unique to health care fraud enforcement efforts.

1. Require health care professionals to assume responsibility for insurance claims and billing forms prepared by their staff.

Discussion. It is rather common in the civil (and criminal) prosecution of health care fraud for the health care professional to seek to avoid responsibility for fraudulent bills by blaming the billing irregularities on staff. While this defense may not be terribly credible, especially where it was the health care professional who profited from the fraud, the lack of the professional's "fingerprints" on the bill or the billing process presents a problem in the prosecution of fraud cases. This problem might be avoided by creating an irrebuttable or rebuttable presumption of the health care professional's responsibility for the bill. Perhaps a rebuttable presumption would be appropriate in the criminal context, but an irrebuttable presumption would be appropriate in the civil context. In essence, an irrebuttable presumption would just create strict liability for health care professionals for any fraud committed under their names.

2. Amend the Insurance Fraud Prevention Act to give the Department of Banking and Insurance the option of pursuing fraud claims in either the trial courts or in an administrative forum.

Discussion. When pursuing fraud committed by health care professionals, the IFP has found itself in positions where it must file suit under the Insurance Fraud Prevention Act in the trial courts while a professional board is pursuing a licensing action in an administrative forum. Clearly, it is appropriate that licensing actions be limited to an administrative forum where professional boards with professional expertise can pass judgment on their peers. However, it is not similarly clear that violations of the Insurance Fraud Prevention Act should be limited to the trial courts. In some instances, the Department of Environmental Protection has the option of pursuing its claims in either the trial courts or administrative forums. In this case, if the IFP had the option of pursuing its claims in an administrative forum, such actions could be joined with any licensing actions avoiding substantially duplicated efforts by attorneys and staff litigating two cases arising out of essentially the same facts.

3. Define "pattern of violating this act" in N.J.S.A. 17:33A-7(b).

Discussion. The Insurance Fraud Prevention Act presently allows for treble damages where an insurance company can prove a pattern of fraudulent conduct. The statute does not define what constitutes a pattern. A definition of the term should be developed.

4. Add a new subsection to the Insurance Fraud Prevention Act requiring providers to prepare an accounting with respect to all similar types of claims where a pattern of fraud is established.

Discussion. As has been noted in a number of places, one of the greatest difficulties in pursing fraud claims is the burden of proving hundreds or thousands of individual cases in order to establish a substantial case. Experience shows that many fraud schemes involve patterns. It is suggested that once a reasonable number of related fraudulent claims are established, the significant burden of proving hundreds of cases should be shifted from those trying to prove the fraud to the provider who has committed fraud. While this suggestion was made with respect to the Insurance Fraud Prevention Act, it may also be considered in the licensing and Medicaid context.

5. Provide for insurance company access to all provider treatment and financial records relative to the types of services for which the provider has submitted claims to the insurance company, with appropriate safeguards to protect patient privacy and to avoid disruption within the providers' offices.

Discussion. As noted, much fraud is only detectible as part of a pattern. If an insurance company has only received a few claims for a particular type of service, it may suspect fraud but not be able to prove it unless it can see similar bills that may have been submitted to other insurance companies. In such cases, insurance companies would be asking to see billing and treatment records for individuals it does not insure. The records would have to be redacted to exclude any information identifying the name of the individual. It has been noted that, presently, such information can only be obtained after the insurance company files a lawsuit alleging fraud. Given that such information would be obtainable after the filing of such a lawsuit, it is suggested that it would conserve resources, as well as enhance the ability to prove fraud, for insurance companies to have access to such information without filing suit.

6. Adopt a regulation or pass legislation prohibiting health care professionals from charging excessive fees.

Discussion. Among the forms of health care fraud that are particularly prevalent are unbundling a variety of individual services that should be treated as part of a single charge and upcoding by billing for a higher level service than actually provided. Often health care professionals will explain away such activity by professing confusion regarding billing codes and regulations. However, in many of those cases simple common sense makes it clear that the billing was excessive. A separate prohibition on excessive billing, like the regulations which now applies to physicians, with specific factors to be considered in determining whether a bill is excessive may help avoid this problem.

7. Adopt a statute addressing "Truth in Medical Billing" which would require disclosure in plain language of all medical bills to the patients receiving the service.

Discussion. Fraud is often facilitated by the fact that there is a third party responsible for paying medical bills. That is, while the services are received by individual patients, government benefit programs or insurance companies pay a large portion of the bills. In many cases, the patient does not even see the bill. When the patient does see the bill it may be in a form that the patient does not understand. Perpetrators of fraud may be emboldened by the fact that no one who actually knows what services were provided will actually see the bill. A requirement that patients see a copy of such bills, in language they can understand, may both deter some fraud and help in the detection of other fraud.

8. Mandate internal controls for hospitals.

Discussion. It has been suggested that many hospitals do not have even rudimentary standard internal controls and that many others have internal control systems that exist only on paper. The lack of internal controls makes hospitals particularly susceptible to fraud. A proposal was made that a commission be established to develop a standard internal control regimen for all hospitals.

9. Extend DMAHS's current authority to examine and make copies of records and inspect the premises of a provider to any party, whether or not that party is a "provider", as long as there is a direct or indirect relationship to goods or services provided under the Medicaid Act.

Discussion. Presently, DMAHS has authority to examine and makes copies of records and visit and inspect the premises of a provider. Under fee-for-service arrangements existing in the past, this was sufficient as most parties providing services to Medicaid beneficiaries were providers with direct relationships with Medicaid. However, with the advent of managed care, Medicaid now has a direct relationship with health maintenance organizations but not, in many cases, with the health care entities employed by or contracting with those HMOs.

10. Require submission of fraud plans by managed care organizations and other third party payers not presently required to submit such plans.

Discussion. By statute, auto and health insurers are required to establish special investigation units to detect and investigate fraud. This requirement does not extend to managed care organizations, workers compensation carriers and other third party payers of health care bills. While fraud may take on somewhat different characteristics in managed care organizations, there are also significant similarities. Despite this fact, we have heard that a number of managed care organizations undertake no substantial efforts, outside their normal claims review process, to detect and investigate fraud. The same may be true with other third party payers such as insurers providing workers' compensation insurance.

11. Adopt a statute expressly requiring professional license suspension or revocation upon conviction of a crime involving health care fraud.

Discussion. Although current law clearly permits licensing boards to take action on the basis of criminal conduct related to the performance of licensed activity, the process can be cumbersome and action varies from case to case and from professional board to professional board in a manner that some view as inconsistent and unjustified. It has been suggested that just as public employees are barred from public employment upon the commission of crime touching or concerning their employment, an automatic bar from participation in a profession when one is convicted of a crime touching or concerning the profession may be appropriate.

12. Provide for fines and assessments to fund the anti-fraud effort.

Discussion. As already noted, health care fraud is a multi-billion dollar industry. In many instances, effective enforcement can pay for itself many times over. However, the fight against health care fraud is manpower and resource intensive

at the same time as resources are somewhat limited. Under these circumstances, it makes sense to explore alternate means of funding the anti-health care fraud effort.

13. Amend N.J.S.A. 17:33A-7(b) to make the award of investigative expenses and attorneys fees mandatory and not discretionary.

Discussion. Under the present law when insurance companies successfully bring an action under the Insurance Fraud Prevention Act, the award of investigative expenses and attorneys fees is discretionary with the court.

14. Adopt a six year statute of limitations for insurance company actions brought under the Insurance Fraud Prevention Act.

Discussion. The Insurance Fraud Prevention Act presently has no express statute of limitations.

15. Create an all payor fraud and abuse program and permit the sharing of information regarding fraud investigations among insurance companies, subject to appropriate safeguards.

Discussion. As was noted by the Executive Director of the National Health Care Anti-Fraud Association, health care fraud is often committed against numerous payers with the perpetrator staying under the radar of each of the individual insurance companies. It may be particularly difficult for smaller third party payers to identify patterns of fraud because they do not see enough individual cases. Computer software is becoming more sophisticated in its ability to identify fraud. However, that software is only useful if the necessary information is entered into computers. The development of a central computer database for all payers could greatly facilitate the ability to identify fraud in its early stages. This issue will require a long term review given the privacy and propriety issues it raises and the substantial expense involved in developing such a program.

Finally, there is presently before the Legislature a proposal to subject insurers to the Consumer Fraud Act for failure to settle claims in a timely manner. While on the surface, the purposes of such legislation would appear to be salutary, there is a very real concern that this bill would provide just another weapon in the arsenal of

those seeking to commit fraud against insurance companies by creating a disincentive for the review of questionable claims. Existing civil law already provides substantial remedies to claimants for breach of the insurers' obligations. It is suggested that no action be taken on this bill until the Task Force has had a full opportunity to consider its ramifications with regards to health care fraud.