

Medicare Billing Risk Perceptions of Hospitals Operating Under Corporate Integrity Agreements

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Since the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Office of Inspector General of the Department of Health and Human Resources (OIG/HHS) significantly has increased its compliance and enforcement efforts aimed at reducing fraud in federally-sponsored healthcare programs.¹ One of the most common types of fraud perpetrated against Medicare, Medicaid, and other federal healthcare programs involves filing false claims for reimbursement. False claims submission is perhaps the single biggest risk factor for hospitals and other healthcare providers participating in these programs (HHS/OIG 2007, p. 19; HHS/OIG 2005, p. 4859). The False Claims Act (31 U.S.C. §§ 3729-3733) (FCA) is one of the primary tools the Office of Inspector General of the Department of Health and Human Resources (HHS/OIG) and the Department of Justice (DOJ) use to detect and penalize fraudulent billing practices. Individuals who knowingly submit false claims for federal funds are liable for three times the government's loss plus a civil penalty of \$5,000 to \$11,000 for each false claim (HHS/OIG 2007). From 1987 to 2006, the federal government recovered \$18.1 billion in settlements under the False Claims, of which \$11.5 billion or 63 percent arose from settlements in the healthcare industry.

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¹ Among other provisions, HIPPA established the Health Care Fraud and Abuse Control (HCFAC) Program funded through an account within Medicare. Under the joint direction of the United States Attorney General and the Secretary of Health and Human Services, HCFAC provided a management structure to coordinate the efforts of numerous federal, state, and local government agencies involved in fighting healthcare fraud. HIPPA also established a stable source of funding for federal government agencies to use in antifraud and abuse activities.

HHS/OIG has issued a series of compliance program guidelines for hospitals (OIG/HHS 1998 and 2005) and nine other segments of the healthcare industry to help healthcare providers develop compliance programs voluntarily and reduce their risk exposure to fraudulent billing practices and FCA violations.² In addition to its aggressive use of the False Claims Act to combat fraud and abuse, HHS/OIG may bar individuals and entities from participation in federal healthcare programs that have submitted false or fraudulent claims for reimbursement.³ During fiscal year 2007, HHS/OIG barred a total of 3,308 individuals and entities from participating in Medicare, Medicaid and other federal healthcare programs (HHS & DOJ, November 2008, p. 25).

When HHS/OIG negotiates a settlement to resolve potential liability under the False Claims Act, it also requires the provider to comply with a Corporate Integrity Agreement (CIA), usually lasting five years. The restrictive and onerous terms of the CIA are designed to sensitize the provider to unacceptable behavior and make sure the provider does not engage in fraudulent billing activities again. Since the mid-1990s, HHS/OIG has entered into more than 1,000 CIAs and similar agreements as part of the resolution of healthcare fraud cases (OIG

² In addition to hospitals, OIG/HHS published compliance program guidelines for nine other segments of the healthcare industry: Pharmaceutical Manufacturers (2003); Ambulance Suppliers (2003); Individual and Small Group Physician Practices (2000); Nursing Facilities (2000); Medical + Choice Organizations (1999); Hospices (1999); Third-Party Medical Billing Companies (1998); Home Health Agencies (1998); and Clinical Laboratories (1998).

³ Section 1128 of the Security Act (42 U.S.C. § 1320a-7) authorizes provides several grounds for excluding individuals and entities from participation in Medicare, Medicaid, and other federal healthcare programs. Exclusions are required for Individuals and entities convicted of the following types of criminal offenses: (1) Medicare or Medicaid fraud; (2) patient abuse or neglect; (3) felonies for other healthcare fraud; and (4) felonies for illegal manufacturer, distribution, prescription, or dispensing of controlled substances. OIG has the discretion to excludes individuals and e on several other grounds, including misdemeanors for other healthcare fraud (other than Medicare and Medicaid); for illegal manufacture, distribution, prescription, or dispensing of controlled substances; suspension or revocation of a license to provide healthcare for reasons bearing on professional competence, professional performance, or financial integrity; provision of unnecessary or substandard services; submissions of false or fraudulent claims to a federal healthcare program; or engaging in unlawful kickback arrangements (OIG 2007, p. 59).

2006a, p. 38). In May 2007, HHS/OIG was monitoring nearly 460 entities operating under CIAs. OIG does not list individual hospitals affiliated with medical centers operating under CIAs.

Previous studies of HHS/OIG's compliance program guidelines have focused primarily on describing the components of voluntary compliance programs (Pariser and Brooks; Pariser and Amoruso; Fedor; Lovitky and Ahern; Sigg and Fiorelli; Pelliccioni). Pariser and Abbott (2004) explored management risk perceptions of Medicare fraud billing schemes, and found significant differences in risk perceptions between senior hospital management across five hospital size categories based on number of beds. In general, they show that senior managers of larger hospitals are more sensitive to Medicare billing fraud risk factors. Empirical research is lacking on whether managements of hospitals operating under a CIA are more likely to identify unacceptable (i.e., risky) billing schemes compared to managements of hospitals not operating under a CIA. This article attempts to fill this gap.

The primary purpose of this article is to determine the extent to which senior managers of hospitals operating under a CIA are more likely to identify unacceptable (risky) billing schemes than senior managers of hospitals not operating under a CIA. This issue has important implications for internal auditors and fraud investigators who conduct risk assessments of hospitals and other entities in the healthcare industry. If empirical evidence indicates that operating under a CIA appropriately sensitizes management to unacceptable billing schemes, then internal auditors and fraud investigators should scrutinize those hospitals not operating under Corporate Integrity Agreements. That is, hospitals not operating under a CIA may be less likely to perceive certain billing schemes as risky. Thus, taking a hospital's compliance status

into consideration could help internal auditors and fraud investigators achieve a more efficient allocation of scarce resources in assessing a hospital's risk exposure to billing schemes.

This article is organized as follows. Section II of this article provides an overview of the HHS/OIG's compliance guidelines for hospitals. Section III discusses the key elements of Corporate Integrity Agreements (CIA) that HHS/OIG imposes on healthcare providers who allegedly have submitted false or fraudulent claims for payment and are liable for monetary damages under the False Claims Act. Section IV describes eight billing fraud schemes identified in HHS/OIG compliance guidelines. These eight billing schemes are a part of the survey of hospital compliance programs discussed in the next section. Section V presents our analysis of a survey of 242 hospitals which have implemented compliance programs in accordance with HHS/OIG compliance guidelines. Thirty-one of the 242 responding hospitals were operating under involuntary CIAs, and 203 were not operating under CIAs. Eight hospitals did not provide this information and were excluded from the sample. Respondents were also asked to rank the riskiness (i.e., the risk of violating applicable federal healthcare laws) of eight billing scheme on a scale of 1 to 5 (1 = low risk; 5 = high risk). The purpose of the survey was to determine whether hospitals operating under a Corporate Integrity Agreement were more likely to identify unacceptable (risky) billing schemes than hospitals not operating under Corporate Integrity Agreements. Concluding comments and opportunities for future research are presented in Section VI.

I. The False Claims Act and HHS/OIG Voluntary Compliance

False Claims Act

The Federal False Claims Act was enacted in 1863 in response to rampant fraud in federal defense contracting during the Civil War. Today, the False Claims Act is government's favorite tool for detecting and prosecuting perpetrators of health care fraud and abuse. Congress amended the False Claims Act in 1986 to make it a more effective tool for combating fraud and abuse in government-funded programs. The 1986 amendments established the *Qui Tam* or A *whistleblower* provision which allows a private individual, referred to as a *qui tam realtor*, to bring a civil action in the name of the United States against a person or entity for filing a fraudulent claim.

Whistleblowers are awarded a percentage of the amount recovered, possibly as high as 30 percent. If the government joins in a *qui tam* suit, 15 percent to 25 percent of the amount recovered by the government may be awarded to the whistleblower. However, if the government does not join the *qui tam* suit, 25 to 30 percent of the amount recovered may be awarded to the whistleblower, but the whistleblower must pursue the case without the assistance of the government. If the plaintiff wins, the defendant must pay the plaintiff's legal expenses. This provision makes it easier for a plaintiff to bring an action even when the potential reward is small.

As Table 1 (See Appendix A, Table 1) shows, the federal government recovered \$18.1 billion from settlements and judgments under the False Claims Act from 1987 to 2006. Sixty percent, or \$11 billion, of the \$18.1 billion were recovered in suits brought by whistleblowers under the False Claims Act's *qui tam* provisions during the period. (See Appendix A, Table 1).

The penalties for violating the False Claims Act are onerous, making the Act one of the government's favorite tools to combat fraud and abuse in government-funded programs. Due to the way healthcare services are billed, it does not take long for the penalties to reach substantial amounts (Krause, p. 66). According to Krause, most healthcare providers generate a bill for each occasion of services rendered to each patient, resulting in the submission of thousands of small claims a years (Krause, p. 66). A person who violates the law must pay three times the amount of losses suffered by the government plus a mandatory civil penalty of at least \$5,500 and no more than \$11,000 per claim (USC Sec 3729 (a)(7)). For example, a healthcare provider who knowingly submits 50 false claims of \$25.00 each to Medicare is liable for between \$253,750 $[(\$1,250 \times 3) + (50 \times \$5,500)]$ and \$553,750 $[(\$1,250 \times 3) + (50 \times \$11,000)]$ in damages under the False Claims Act.

To encourage health care providers to voluntarily develop compliance programs that are capable of detecting and preventing fraudulent billing practices, HHS/OIG has issued voluntary compliance program guidelines for hospitals and nine other segments of the healthcare industry. HHS/OIG's compliance guidelines for hospitals were published in the *Federal Register* in February (Vol. 63, No. 35, pp. 8987-8998). In 2005, HHS/OIG published "Supplemental Compliance Program Guidance for Hospitals" in the *Federal Register* (Vol. 70, No. 19, pp. 4858-4876). Although these guidelines are not mandatory, the HHS/OIG may consider voluntary compliance efforts as a mitigating factor when sanctioning providers who have been accused of engaging in fraudulent or abusive practices (Morris 2001, p. 5).

Elements of an Effective Compliance Program

The HHS/OIG compliance guidelines for hospitals, issued in 1998, include seven elements. The seven elements of the HHS/OIG guidelines for hospitals are listed and described below.

Written Standards of Conduct. The HHS/OIG (1998a, p. 8989-8990) recommends that an organization should establish a written code of conduct and distribute it to all employees. The guidelines state that adherence to the code of conduct should be a factor when evaluating the performance of employees. According to HHS/OIG, an organization's code of conduct should address potential fraud and abuse risk areas, such as those leading to the eight billing fraud schemes discussed earlier later in this section.

Designation of Compliance Officer and Committee. With regard to this element, the HHS/OIG (1998a) recommends that an the organization hire or appoint a compliance officer who is responsible for the development and implementation of policies, procedures, and practices designed to ensure compliance with federal health care program requirements. The compliance officer should be a member of senior management and report on compliance issues to the governing body on a regular basis. The duties of the compliance officer will vary with the size and resources of the organization (HHS/OIG 1998a, p. 8993). In addition, the organization should establish a compliance committee. This committee should be chaired by the compliance officer and include other officers in the organization.

Education and Training. Hospitals that fail to train and educate their staff adequately risk liability for the violation of federal healthcare fraud and abuse laws (HHS/OIG 2005, p. 4875). HHS/OIG compliance guideline requires employees to have at least one to three hours of basic training in compliance areas annually; more is required in high risk areas such as billing

and coding (HHS/OIG 1998a, p. 8995). Furthermore, the HHS/OIG (1998a) recommends that employees attend and participate in these training programs as a condition of their employment and be a factor in their annual performance evaluation. The HHS/OIG notes that these programs are particularly relevant to financial and marketing personnel because the pressure to meet the organization's goals may make them especially vulnerable to engaging in unethical and prohibited behavior (HHS/OIG 1998a, p. 8995).

Auditing and Monitoring. The HHS/OIG compliance guidelines recommend that hospitals maintain an internal audit function that is responsible for auditing and monitoring operations for compliance with federal health care regulations. HHS/OIG recommends that the internal auditors be independent of the operations that they audit; have access to all relevant personnel and records; and communicate their findings and recommendations for corrective action in writing to the CEO, the governing body and the members of the compliance committee on a regular basis.

Whistleblower and Complaints Processes. The HHS/OIG (1998a) believes that whistleblowers should be protected against retaliation, a concept embodied in the provisions of the False Claims Act. HHS/OIG encourages the use of hotlines (including anonymous hotlines), e-mails, written memoranda, newsletters, and other forms of exchange to maintain open lines of communication. All allegations of substantial non-compliance should be documented and investigated promptly (HHS/OIG 1998a).

Discipline and Enforcement. The HHS/OIG suggests that an effective compliance program include written policies governing the range of disciplinary actions imposed on employees who fail to comply with the organization's compliance standards.

Response to Detected Offences. Violations of a hospital's compliance program threaten a hospital's status as a reliable, honest and trustworthy provider capable of participating in federal healthcare programs. Under federal law, HHS/OIG has the authority to exclude individuals and organizations from participating in federal health care programs (HHS/OIG 1999). An individual or organization excluded from participation is called an "ineligible person," and includes any individual or entity that is currently excluded or suspended from participating in federal health care programs. According to the HHS/OIG (1998a, p. 9896), a provider participating in a federal health care program should not hire or engage any ineligible person. An excluded individual or entity that submits a claim for reimbursement to a federal health care program may be subject to a civil penalty of \$10,000 for each item or service submitted for payment (USC 1320a). To avoid employing ineligible persons, the HHS/OIG urges providers to compare current and prospective employees and contractors against the General Services Administration's List of Parties Excluded from Federal Programs as well as the HHS/OIG List of Excluded Individuals/Entities.

The HHS/OIG expects health care providers to police themselves, detect and correct underlying problems, and be willing to work with the government in resolving fraud and abuse matters. To encourage health care providers to self-disclose violations of the False Claims Act and other fraud and abuse laws to the government, HHS/OIG established a Self-Disclosure Protocol to encourage health care providers to voluntarily report suspected fraud ((HHS/OIG 1998b).). If a provider discovers fraud, the HHS/OIG's Self-Disclosure Protocol explains how to assess and report the extent and financial impact of the fraud (HHS/OIG 1998b).

II. Corporate Integrity Agreements

As mentioned earlier, HHS/OIG has the authority under 42 U.S.C.1320a-7(b) (7) to exclude healthcare providers from participation in federal healthcare programs that have engaged in fraudulent and abusive activities. During fiscal year 2006, the HHS/OIG excluded 3,425 individuals or entities (HHS 2007). When the HHS/OIG investigates individuals and entities that allegedly have violated the False Claims Act, it often enters into a settlement with the provider in exchange for not excluding the provider from future participation in federal health care programs (HHS/OIG 2001). In the mid-1990s, HHS/OIG began to require providers settling civil healthcare fraud cases to enter into Corporate Integrity Agreements as a condition for OIG not pursuing exclusion (OIG 2006a, p. 38). Since that time, HHS/OIG has entered into more than 1,000 CIAs and similar agreements as part of the resolution of healthcare fraud cases (OIG 2006a, p. 38).

The terms of a CIA require each provider to implement a compliance program with restrictive provisions and onerous penalties if the provider fails to comply with the terms of its CIA. Table 2 (See Appendix A, Table 2) presents some hospitals that have entered into CIAs with the HHS/OIG, along with the amount recovered by the government under the False Claims Act, and the description of the billing violation. Copies of CIA documents negotiated between HHS/OIG and health care providers can be accessed from the HHS/OIG's website (<http://www.oig.hhs.gov/fraud/cia/index.html>). Although the HHS/OIG website lists the names of individual hospitals and medical centers, it does not indicate whether a medical center includes a hospital. To determine the average number of hospitals operating under CIAs, we reviewed HS/OIG's Corporate Integrity Agreement website on four different dates (April 2000, July 2004, September 2005, and May 2007). For each of these dates, we counted the number of

hospitals listed and determined the number of listed medical centers with affiliated hospitals. An average total of 426 entities were listed these four dates, and the number that were hospitals or medical centers with affiliated hospital averaged 126 over the four dates, or 30 percent of the average total number. (See Appendix A, Table 2).

Most CIAs are in effective for a period of five years; however the actual term may be shorter or longer. The typical CIA obligates the provider to devote substantial resources to compliance activities, including potentially expensive engagements with independent parties to review Medicare billings, cost report submissions, and quality of care (Ramsey). Although CIAs have many of same elements as voluntary compliance programs discussed earlier, they also include other restrictive provisions. For example, CIAs include five reporting requirements that are not part of a voluntary compliance program. These five reporting requirements are: (1) an implementation report; (2) an annual report; (3) a report of probable violations of law; (4) annual report on a provider's billing practices, conducted by an independent review organization (IRO); and (5) annual report, conducted by an IRO, evaluating the provider's compliance with the requirements of the CIA. In addition, providers are liable for substantial monetary if they fail to comply with the terms of their CIAs. The five reporting requirements and financial penalties are discussed below.

Reporting Requirements under a Corporate Integrity Agreements. The HHS/OIG requires providers operating under a CIA to submit an implementation report within a specified time frame subsequent to the effective date of the CIA, typically 120 days. Providers must also file an annual report with the HHS/OIG. In addition, providers must retain an IRO to prepare two separate reports: a report on billing practices and a report on the provider's compliance system.

Implementation Report. Providers must submit a report to the HHS/OIG summarizing their progress in implementing the CIA. In addition to identifying the compliance officer and members of the compliance committee, the report must also include a copy of the organization's code of conduct; a summary of compliance policies and procedures; a description of required training programs, targeted audiences and schedule of training sessions; a description of the confidential disclosure program; the identity of the IRO, and the proposed start and completion dates for the initial IRO engagements. In addition, the implementation report should include a summary of personnel actions taken with regard to the employment of ineligible persons.

Annual Report. Providers are required to submit a written Annual Report that includes the status and findings of the compliance program. The Annual Report should include a copy of the code of conduct as well as a summary of material deficiencies reported over the last year and the total amount of overpayments discovered and returned to federal health care programs. When reporting overpayments, they must be categorized as Medicare, Medicaid, or other federal health care programs. The Annual Report should also include a copy of the confidential disclosure program and a description of program activities. A copy of the reports prepared by the IRO (discussed below) is also included in the Annual Report as well as the provider's responses to any deficiencies uncovered by the IRO. The Annual Report must also include a description of personnel actions taken regarding ineligible persons, a summary of any ongoing investigations or legal proceeding involving the provider, and any corrective action plans addressing such investigations or proceedings.

Annual Billing Practices Analysis. The HHS/OIG requires providers to conduct an annual billing practices analysis for the duration of the CIA. This analysis must be performed by an IRO (or the provider's internal auditor, if permitted by the HHS/OIG). The billing analysis

must include a review of a statistically valid sample of claims. The sample must provide a 90 percent confidence level and a 25 percent precision level. The IRO must use a random number generating program to select the sample. In addition, the IRO must use the HHS/OIG's Office of Audit Services Statistical Sampling Software.

The billing analysis report must indicate the methodology used, the overall error rate detected as well as the nature of those errors (e.g., assignment of incorrect codes, no documentation, inadequate documentation). The report should also document the procedures a provider uses to correct inaccurate billing/coding, as well as the steps the provider takes to prevent those errors from occurring in the future. A complete copy of the billing analysis report must be included in the Annual Report, discussed above.

If the IRO discovers overpayments stemming from any material deficiencies in billing, coding or other practices, the provider must notify the payer (e.g., Medicare) within 30 days of becoming aware of the deficiencies. Moreover, the provider must take remedial action within 60 days to correct the problems and prevent similar deficiencies from occurring in the future.

Annual Evaluation of Compliance with CIA. An evaluation of a provider's compliance with its CIA must be performed annually by an IRO (or the provider's internal auditor, if permitted by the HHS/OIG) for the duration of the CIA. This evaluation is conducted by accountants in accordance with standards set forth in Statement of Position 99-1 (SOP 99-1) issued by the American Institute of Certified Public Accountants. SOP 99-1 is called "Guidance to Practitioners in Conducting and Reporting on an Agreed-Upon Procedures Engagement to Assist Management in Evaluating the Effectiveness of its Corporate Compliance Program." An agreed-upon procedures engagement report includes specific findings to assist HHS/OIG to

evaluate a health care provider's compliance with the requirements of its CIA (AICPA 1999, Para 3).

Reporting Misconduct, Overpayments and Material Deficiencies. Providers operating under a CIA must report any probable violation of civil, criminal, or administrative law to the HHS/OIG within 30 days of discovery. Such reports must include the nature of the probable violation, any actions taken to correct the probable violation, and steps the provider plans to take that will prevent the probable violation from reoccurring. As indicated above, the reporting requirements for organizations operating under a CIA are onerous. Currently, the HHS/OIG is exploring ways to reduce the financial impact of complying with a CIA, without compromising effectiveness (Rehnquist 2001).

Breach and Default Provisions. The typical CIA expects the provider to fully and timely comply with all of its CIA obligations. The "Breach and Default Provisions" section of the CIA sets forth the penalties if the provider fails to comply with these obligations. Failure to comply may lead to the imposition of the following monetary penalties:

1. A \$2,500 penalty for each day the provider fails to establish and implement any of the following obligations: a Compliance Officer, a Compliance Committee, a written code of Conduct, written Policies and Procedures, training of "Covered Persons," a Disclosure Program, ineligible persons screening and removal requirements, notification of government investigation or legal proceedings.
2. A \$2,500 penalty for each day the provider fails to engage an IRO.
3. A \$2,500 penalty each day the provider fails to submit the Implementation Report or the Annual Report to OIG.
4. A \$2,500 penalty for each day the provider fails to submit the annual Arrangement Review Report and any other required Review Report.

5. A \$1,500 penalty for each day the provider fails to grant access to required information or documentation.
6. A \$5,000 penalty for each false certification submitted by or on behalf of the provider as part of its Implementation Report, Annual Report, additional documentation to a report required by OIG.
7. A \$1,000 penalty for each day the provider fails to comply fully and adequately with any obligation of the CIA. OIG provides notice to the provider stating the specific grounds for its determination that the provider has failed to fully and adequately comply with the CIA obligations at issue and the steps the provider must take to comply. This penalty begins to accrue 10 days after the provider receives notice from OIG of the failure to comply.

HHS/OIG may exclude the provider from participating in Medicare and all federal healthcare programs for “Material Breach” of the CIA. OIG defines a material breach to include the following:

- Failure to report a reportable event, take corrective action, and make the appropriate refunds;
- Repeated or flagrant violation of the obligations of the CIA.
- Failure to respond to a Demand Letter concerning the payment of penalties.
- Failure to engage and use an IRO.

If the OIG determines that the provider has materially breached the CIA and that exclusion is the appropriate remedy, OIG will notify the provider of its material breach and OIG’s intent to exercise its authority to impose exclusion. The provider will be given the opportunity, 30 days from the date of notification, to demonstrate that it is in compliance with the CIA and that the alleged material breach has been cured. If, at the end of the 30-day period, the provider fails to satisfy the requirements of the CIA, OIG may exclude the provider from participation in federal healthcare programs. OIG must notify the provider in writing of its determination to exclude the provider. The exclusion goes into effect 30 days after the date of

the provider's receipt of the Exclusion Letter. The exclusion will be national and apply to all other federal procurement and non-procurement programs. Reinstatement to program participation is not automatic. After the end of the exclusion period, the provider apply for reinstatement by submitting a written request to OIG in accordance with 42 C.F.R. §§ 1001.3001-.3004.

III. Medicare Billing Fraud Schemes

Healthcare fraud is the intentional misrepresentation of a fact on a health care claim in order to receive reimbursement from a health plan. Healthcare providers that engage in billing fraud schemes do so with the intention of submitting false claims to Medicare and other federal healthcare program to receive payments in excess of the amount they are entitled to receive. HHS/OIG's compliance guidelines for hospitals describe eight billing schemes which HHS/OIG has identified through its investigative and audit functions (OIG 1998a, p. 8990). The eight billing schemes are: (1) providing and billing for medically unnecessary services, (2) billing for services not rendered, (3) upcoding, (4) duplicate billing, (5) unbundling, (6) submission of false cost reports, (7) billing for discharge in lieu of transfer, and (8) over-utilization. They are described below and are also a part of the survey of hospital management risk perceptions discussed in the next section of this paper.

Providing and Billing for Medically Unnecessary Services. A claim requesting payment for medically unnecessary services intentionally seeks reimbursement for a service that is not warranted by the patient's current and documented medical condition. Medicare regulations prohibit reimbursement for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness, injury, or to improve the functioning of

the patient's body. On every reimbursement claim form, the provider must certify that the services were medically necessary for the health of the beneficiary.

Billing for Services Not Rendered. Providers who bill Medicare for services they never performed. Billing for services not actually rendered involves submitting a claim that represents that the provider performed a service all or part of which was simply not performed. According to HHS/OIG, this form of billing fraud occurs in many healthcare entities, and represents a significant part of the HHS/OIG's investigative caseload.

Upcoding. Upcoding reflects the practice of using a billing code that provides a higher payment rate than the billing code that actually reflects the service furnished to the patient. Upcoding has been a major focus of the HHS/OIG's enforcement efforts. The Health Insurance Portability and Accountability Act of 1996 added another civil monetary penalty to the HHS/OIG's sanction authorities for upcoding violations. .

Duplicate Billing. Duplicate billing occurs when the hospital submits more than one claim for the same service or the bill is submitted to more than one primary payer at the same time. Although duplicate billing can occur due to simple error, systematic or repeated double billing may be viewed as a false claim, particularly if any overpayment is not promptly refunded.

Submitting False Cost Reports. According to HHS/OIG, the submission of false costs reports is usually limited to in-patient providers, such as hospitals, skilled nursing facilities and home health agencies, which are reimbursed in part on the basis of their self-reported operating costs. For example, an HHS/OIG audit report on the misuse of fringe benefits and general and administrative costs identified millions of dollars in unallowable costs that resulted from providers' lack of internal controls over costs included in their Medicare cost reports. In addition, the HHS/OIG is aware of practices in which hospitals inappropriately shift certain costs

to cost centers that are below their reimbursement cap and shift non-Medicare related costs to Medicare cost centers.

Unbundling. Unbundling is the practice of submitting bills piecemeal or in fragmented fashion to maximize the reimbursement for various tests and procedures that are requested to be billed together and therefore at a reduced cost.

Billing For Discharge in Lieu of Transfer. Under the Medicare regulations, when a prospective payment system (PPS) hospital transfers a patient to another PPS hospital, only the hospital to which the patient was transferred may charge the full DRG; the transferring hospital should charge Medicare only a per diem amount.

Over-utilization. Over utilization is defined as improper or excessive utilization of medical care and services that are not medically necessary. Healthcare providers participating in Medicare and State Medicaid programs must comply with federal “Over utilization Control” regulations (42 CFR 456). Regarding utilization of medical services, over utilization occurs when a healthcare provider orders an inappropriate service or an inappropriate level of service for a patient in excess of established practice parameters and protocols of treatment. With regard to the utilization of drugs, the regulations defines over-utilization as “use of a drug in a quantity, strength, or duration that is greater than necessary to achieve a desired therapeutic goal or that puts the recipient at risk of a clinically significant undesirable effect, or both” (42 CFR 456.702). For example, utilization of medical services in treating a patient over a three-month period that exceed the following parameters constitute over-utilization of medical services under the regulations: (1) use of three or more drugs in the same therapeutic category, (2) use of three or more pharmacies, and (3) use of sixteen or more prescriptions (State of Colorado).

V. Survey Methodology and Data

Data for the study were collected through an anonymous survey questionnaire on hospital compliance programs mailed to a sample of 1,200 Chief Executive Officers of hospitals in the United States randomly selected from a list of 5,390 hospitals, ranging in bed size from 0 to 1,815 beds. The list of hospitals and their CEOs was acquired from Acxiom Corporation. A systematic random sample procedure was used to select a sample of 1,200 hospitals from this list of 5,390 hospitals.⁴ The random starting point on the list was selected by using a table of random numbers, and then every 4th hospital was selected for the sample. The cover letter was addressed to the CEO of each hospital, and requested the CEO or the Compliance Officer to complete and return the questionnaire. The survey questionnaire did not ask respondents to identify their organizations or if they were a CEO or a Compliance Officer. Although we acknowledge this as one limitation of the questionnaire, individuals participating in pre-testing the questionnaire indicated that omitting this information would increase the response rate substantially.

A total of 242 surveys were returned. Eight incomplete questionnaires were excluded, leaving 234 usable survey instruments (a response rate of 20 percent) which corresponds to about 5 percent of the total number of hospitals in the United States. The questionnaire asked respondents to indicate if they were, or were not, operating under a Corporate Integrity Agreement. As shown in Table 3 (See Appendix A, Table 3), of the 242 responses 31 hospitals were operating under a Corporate Integrity Agreement while 203 of the sample hospitals were not operating under a CIA. This represents approximately 12.8 percent of the sample as operating under a CIA. While the OIG list of entities operating under involuntary CIAs does not

⁴ For a description of systematic random sample, see Douglas A. Lind, William G. Marchal, and Robert D. Mason, *Statistical Techniques in Business & Economics*, 11 edition (McGraw-Hill/Irwin, 2001), p. 268.

identify individual hospitals controlled by the entity (e.g., HCA controls 173 hospitals), by looking at individual hospital affiliations we estimated that 574 hospitals, representing 10.7 percent of the 5,390 hospitals listed in the Acxiom database were operating under an involuntary CIA. (See Appendix A, Table 3).

Risk Rankings and Hypothesis Testing

In its compliance guidelines for hospitals, HHS/OIG lists several billing fraud schemes it has identified through its investigative and audit functions. From this list, we selected eight billing fraud schemes that have been frequently cited in settlements and judgments arising from violations of the False Claims Act. A section of the survey questionnaire asked hospital senior management (CEO/Compliance Officer) to rank these eight Medicare billing fraud schemes on a Likert scale of 1 to 5 (1 = low risk; 5 = high risk).

Table 4 presents a comparison of the mean risk-rankings scores of the 31 hospitals operating under CIAs with the 203 hospitals operating under voluntary compliance programs and respective anova test statistics for the difference in means. A discernible pattern exists in the mean risk-ranking scores shown in Table 4 (See Appendix A, Table 4). That is, hospitals operating under CIAs assign a higher risk ranking to each of the eight Medicare billing fraud schemes than hospitals operating under voluntary compliance programs. Further, the differences in mean risk-rankings are statistically significant for six of the eight billing fraud schemes.

An important research question is whether the differences in hospital mean risk-ranking scores for the eight billing fraud schemes are due to compliance status (CIA vs. voluntary compliance) or to chance occurrences. To answer this question statistically, we used Analysis of

Variance (ANOVA) to test the null hypothesis that the difference in mean scores is zero ($H_0 = \mu_{\text{CIA}} - \mu_{\text{Non-CIA}} = 0$). The alternative hypothesis is that the difference between the means is statistically greater than zero ($H_1 = \mu_{\text{CIA}} - \mu_{\text{Non-CIA}} > 0$).

Providing and billing for medically unnecessary services ranked highest for both groups, with the involuntary CIA group scoring significantly higher. Billing for items or services not rendered was the next highest concern for non- CIA hospitals near the level of concern for the CIA group of hospitals (Likert scores at 2.93 and 3.12, are not significantly different, p value 0.4563). However, the hospitals in the CIA group were significantly more concerned with upcoding (3.29), and over-utilization (3.225) as compared to non CIA hospitals with the Likert scores at 2.77 and 2.745 for these schemes. Duplicate billing was a lower concern for both categories of hospitals and not significantly different. The lowest concern for both categories was submission of false cost reports, however, it was perceived to be a significantly larger risk by the hospitals operating under involuntary CIAs (p value 0.0426). (See Appendix A, Table 4).

According to the ANOVA results reported in Table 4 (See Appendix A, Table 4), the difference in mean risk-ranking scores of the two groups of hospitals are statistically significant (at the 5% level) for six of the eight billing fraud schemes. These six billing fraud schemes are:

- 1. Providing and billing for medically unnecessary services,**
- 2. Upcoding,**
- 3. Over-utilization,**
- 4. Unbundling,**
- 5. Billing for discharge in lieu of transfer of patient, and**
- 6. Submission of false cost reports.**

The p-value shown in Table 4 (See Appendix A, Table 4) is the observed level of significance in the differences in mean ranking scores for each billing fraud scheme. That is, the p-value is the smallest level of significance at which the null hypothesis H_0 can be rejected for a given set of data. The p-value is considered the actual risk of rejecting the null hypothesis for a given set of data when the null hypothesis is true (Type I error). When using the p-value, the null hypothesis is rejected when the p-value is less than the chosen level of significance. Conversely, the null hypothesis is accepted when the p-value is greater than the chosen level of significance. For example, the p-value of 0.0319 associated with the “upcoding” billing fraud scheme is the probability of falsely rejecting the null hypothesis and accepting the alternative hypothesis when the null hypothesis is true. At the 5% level of significance, the null hypothesis is rejected and the alternative hypothesis is accepted.

The observed higher scores for hospitals operating under CIAs indicate that the managers are acutely aware of the possibility of being penalized for non-compliance with the terms of the CIA, in addition to being financially penalized under the False Claims Act as discussed earlier. Knowingly submitting false or fraudulent claims to Medicare and other federal health care programs while operating under an involuntary CIA attracts greater scrutiny, and significantly higher penalties, including possible exclusion from future participation in all federally funded healthcare services. A large number of settlements and judgments under the False Claims Act between the government and healthcare providers have resulted in substantial penalties being levied. For example, in 2006, Tenet Healthcare Corporation paid \$900 million to the United States government to settle False Claims Act allegations of illegal Medicare billing practices. Table 2 (See Appendix A, Table 2) presents some healthcare providers that have entered into

Corporate Integrity Agreements with HHS/OIG in settlements under the False Claims Act, along with the settlement amounts and alleged billing practice violations.

VI. Concluding Remarks and Future Research Opportunities

The survey results discussed in this paper indicate that senior management of hospitals operating under involuntary Corporate Integrity Agreements, on the average, assign higher risk-ranking scores to Medicare billing fraud schemes than senior management of hospitals operating under voluntary compliance programs. For six of the twelve billing fraud schemes, the differences between the risk perceptions of the two groups of hospital managers are statistically significant at the 5% level. The six billing fraud schemes identified as most risky by the managers are, billing for medically unnecessary services, upcoding, over utilization, unbundling, billing for discharge in lieu of transfer of patient, and submission of false cost reports.

The survey findings suggest that hospitals operating under Corporate Integrity Agreements are likely to be more sensitive to billing fraud risks than hospitals operating under voluntary compliance programs. Managers of entities operating under CIAs are facing severe consequences for non-compliance, including possible exclusion from all federal healthcare programs.

An important implication of these findings is that healthcare fraud investigators and internal auditors should benchmark management risk perceptions and take compliance status into account when planning investigations and developing audit programs. Management of hospitals not operating under involuntary CIAs may need to be sensitized to the possibility of these fraud schemes and the associated penalties so that they do not become complacent.

We observe that larger, multi-tiered healthcare providers have been penalized severely for their infractions (See Appendix A, Table 2). Future research may be useful in identifying the significance of the relationship between organizational structure and the propensity for fraud or risky behavior for healthcare providers. Longitudinal studies of entities operating under involuntary CIAs at the inception of the CIA and the expiration of the CIA would be useful to observe the changes in organizational behavior and evolution of compliance activities. These studies could provide a greater understanding of the interplay between the financial incentives for cheating (e.g. submitting false claims) and the effectiveness of regulatory penalties.

References

- American Institute of Certified Public Accountants (AICPA). 1999. *Statement of Position 99-1 Guidance to Practitioners in Conducting and Reporting on an Agreed-Upon Procedures Engagement to Assist Management in Evaluating the Effectiveness of its Corporate Compliance Program*. Jersey City, NJ: AICPA.
- Danninger, Lyn. 2000. New Law Facilitates Whistle-Blowing Over False Medical Claims. *Pacific Business News*. 38 (20): 23.
- Fedor, Frank. 2000. "Cost-Effective Compliance for the Small Provider." *Healthcare Financial Management* (July): 56-60.
- Health Insurance Portability and Accountability Act (HIPAA). 1996. P.L. 104-191 (Title II)
- Huntington, 2001. Fraud Probes Raise New Healthcare Risks. *National Underwriter/Property & Casualty Risk & Benefits*. 105 (2): 13-14.
- Krause, Joan H. 2003. "A Conceptual Model of Health Care Fraud Enforcement." *Journal of Law and Policy*: Vol. 12, No. 1: 55-147.
- Mangano, Michael. 2001. Health Care Financing Administration's Communication with Medicare Providers and Contractors. *Testimony Before the House Energy and Commerce Subcommittee on Health and Oversight and Investigations*. Office of Inspector General, U.S. Department of Health and Human Services. April 4.
<http://HHS/OIG.hhs.gov/testimony/manganotestimony.htm>
- Levinson, Daniel. 2006. *An Open Letter to Health Care Providers*. Office of Inspector General (HHS/OIG) of the United States Department of Health and Human Services. April 24.
<http://www.oig.hhs.gov/fraud/openletters.html>
- Lovitky, Jeffery A. and Jack Ahern. 2002. "Using the OIG Model Compliance Programs to Fight Fraud," *Healthcare Financial Management*. (March): 56-64.
- Morris, Lewis. 2001. *Testimony Before the US Senate Special Committee on Aging*. Office of Inspector General, U.S. Department of Health and Human Services. July 26.
- National Health Care Anti-Fraud Association. 2001. Estimated Financial Loss To Fraud. Website: http://www.nhcaa.org/factsheet_impact_loss.htm.

- Office of Inspector General of the United States Department of Health and Human Services (HHS/OIG). 1998a. The Office of Inspector General's Compliance Program Guidance For Hospitals. *Federal Register*. 63 (35): 8987-8998. February 23.
- Office of Inspector General of the United States Department of Health and Human Services (HHS/OIG). 1998b. Self-Disclosure Protocol. *Federal Register*. 63 (210): 58399-58403. October 30.
- Office of Inspector General of the United States Department of Health and Human Services (HHS/OIG). 1999. Special Advisory Bulletin: The Effect of Exclusion From Participation in Federal Health Care Programs. September.
[Http://HHS/OIG.hhs.gov/fraud/docs/alertsandbulletins/effectd.htm](http://HHS/OIG.hhs.gov/fraud/docs/alertsandbulletins/effectd.htm)
- Office of Inspector General of the United States Department of Health and Human Services (HHS/OIG). 2001. Corporate Integrity Agreements. <http://HHS/OIG.hhs.gov>
- Office of Inspector General of the United States Department of Health and Human Services (OIG). 2005. OIG Supplemental Compliance Program Guidance for Hospitals. *Federal Register*. 70 (19): 4858-4876. January 31.
- Office of Inspector General of the United States Department of Health and Human Services (HHS/OIG). 2006a. *Protecting Public Health and Human Services Programs: A 30-Year Retrospective*. <http://www.oig.hhs.gov/publications/retrospective.html>
- Office of Inspector General of the United States Department of Health and Human Services (HHS/OIG). 2006b. *OIG News*. "OIG Excludes Miami Hospital from Participation in Federal Health Care Programs." March 10.
<http://www.oig.hhs.gov/publications/docs/press/2007/PRSouthFlorida.pdf>.
- Office of Inspector General of the United States Department of Health and Human Services (HHS/OIG). 2007. HHS OIG Semiannual Report to Congress: October 1, 2006-March 31, 2007.
<http://www.oig.hhs.gov/publications/docs/semiannual/2007/SemiannualFirstHalf07.pdf>
- Pariser, David B. and Richard C. Brooks. 2003. "Government Compliance Initiatives in Fraud and Abuse in Federal Health Care Programs." *Journal of Forensic Accounting*. Vol. IV, No. 1 (June): 77-94.
- Pariser, David B. and Ashok B. Abbott. 2004. "Hospital Senior Management Risk Perceptions on Medicare Billing Fraud Schemes: A risk Assessment Tool for Internal Auditors." *New Perspectives on Healthcare Risk Management, Control and Governance*. Volume 23, Number 4 (Fall), pp. 24-29.
- Pariser, David B. and Anthony J. Amoruso. 2005. "Survey Results on the Design and Implementation of Hospital Compliance Programs." *New Perspectives*

on Healthcare Risk Management, Control and Governance. Volume 24, No. 3 (Summer): 20-25.

Pelliccioni, Lori and Jung Lee. "First Empirical Analysis of Healthcare Compliance Effective Identifies Key Indicators." PricewaterhouseCoopers. Retrieved from the PricewaterhouseCoopers Web site: <http://www.pwchealth.com/cgi-local/hcregister.cgi?link=doc/ces.html>

Ramsey, Robert B. 2002. Corporate Integrity Agreements: Making the Best of a Tough Situation. *Healthcare Financial Management*. Vol. 56, Issue 3 (March): 58-62.

Rehnquist, Janet. 2001. *An Open Letter to Health Care Providers*. Office of Inspector General (HHS/OIG) of the United States Department of Health and Human Services. November 20.
<http://www.oig.hhs.gov/fraud/openletters.html>

Sigg, Carolyn and Paul Fiorelli. 2002. "7 Steps to Health-Care Compliance: COSCO and the US Department of Health and Human Offer Guidance on Creating Strong Internal Controls." *Internal Auditor* (February): 35-39.

State of Colorado, State Medicaid Regulations. States Rules: 10 CCR 2505-10, Section 8.075, "Recipient Overutilization/Restriction of Benefits."
<http://www.chcpf.state.co.us/HCPF/StateRules/indexT.asp>.

United States Code. 31 USC Section 3729 to 3733. *The Federal False Claims Act*.

United States Code. 42 USC Section 1320a-7b(b). *The Anti-Kickback Statute*.

United States Department of Health and Human Services (HHS). 2001. HHS Press Office. Press Release. *Reducing Payment Errors and Stopping Fraud in Medicare*. May 2.
<http://www.hhs.gov/news>

United States Department of Health and Human Services & United States Department of Justice. 2006. *Health Care Fraud and Abuse Control Program Annual Report For FY 2005*. U.S. Government Printing Office, Washington, DC. August.

United State Department of Justice. 2006. Press Release. *Justice Department Recovers Record \$3.1 Billion in Fraud and False Claims in Fiscal Year 2006*. November 21.
http://www.justice.gov/opa/pr/2006/November/06_civ_783.html.

United States General Accounting Office (GAO). 2000. *Medicare Improper Payments While Enhancements Hold Promise for Measuring Potential Fraud and Abuse, Challenges Remain*. GAO/AIMD/OSI-00-281. Washington, DC: US General Accounting Office. September. <http://www.gao.gov>

United States General Accounting Office (GAO). 2001. *CMS Faces Challenges in Safeguarding Payments While Addressing Provider Needs*. GAO-01-1014T. Washington, DC: US General Accounting Office. July 26.

United States Government Accountability Office (GAO). 2006. *False Claims Act Litigation*. GAO-06-320R. January 31.

United States Department of Health and Human Services & United States Department of Justice. November 2008. *Health Care Fraud and Abuse Control Program Annual Report For FY 2007*. <http://www.usdoj.gov/dag/pubdoc/hcfacreport2007.pdf>

United States Office of Management and Budget (OMB). 2001. *Analytical Perspectives FY 2002*. Washington, DC: US Government Printing Office.

United States Sentencing Commission. 2000. *Guidelines Manual*. Washington, DC: US Sentencing Commission. November.

Appendix A

Table 1
False Claims Act Settlements and Judgments
1987-2006

	Non-Whistleblower Settlements	Whistleblower Settlements (Whistleblower Share in Parentheses)	Total (Percent of Total in Parentheses)
Department of Health & Human Services (HHS)	\$ 3,612,431,955	\$ 7,941,539,679 (15.8%)	\$ 11,553,971,634 (63.5%)
Department of Defense (DOD)	2,168,272,831	1,716,584,369 (18.4%)	3,884,857,200 (21.4%)
Agencies Other than HHS and DOD	1,339,962,518	1,404,627,254 (16.1%)	2,744,589,772 (15.1%)
Total, all agencies	\$7,120,667,304	\$ 11,062,751,302 (16.3%)	\$ 18,183,518,606

**Source: Taxpayers Against Fraud Education Fund. <http://www.taf.org/stats-fy2006.pdf>.
Based on fraud statistics compiled by the United States Department of Justice, Civil Division.**

Table 2
Some Health Care Providers That Have Signed
Corporate Integrity Agreements

Health care Provider	Settlement	Settlement Year	Alleged False Claims Act Violation	Term
Tenet Healthcare Corporation ¹	\$900 million	2006	Illegal Medicare billing practices	5 yrs.
The Healthcare Corporation (HCA). Formerly known as Columbia/HCA ²	\$790 million	2001	Billing Medicare for medically unnecessary lab tests, upcoding, unbundling lab tests	8 yrs.
Merck & Company ³	\$650 million	2008	Failure to pay proper rebates to Medicaid and other government health care programs; paid illegal remuneration to health care providers to induce them to prescribe the company's products..." The allegations were brought in two separate lawsuits filed by whistleblowers under the <i>qui tam</i> , or whistleblower, provisions of the False Claims Act.	5 yrs.
Saint Barnabas Health Care System ⁴	\$265 million	2006	Inflating of Medicare billing	6 yrs.
Quorum Hospital Group ⁵ Quorum's Quorum's successor, Triad Hospitals, Inc, also entered a comprehensive 5-year CIA)	\$87.5 million	2001	Fraudulent cost reporting practices Medicare claims and cost reports	5 yrs.
Abington Memorial Hospital ⁶	\$4.2 million	2005	Submitting more than 70,000 false claims for clinical laboratory tests to Medicare over a nine-year period.	5 yrs.
Simi Valley Hospital and Health Care Services ⁷	\$3.6 million	2005	Submitting false claims to Medicare for excessive payments for upcoding.	3 years

¹ Department of Health and Human Services, Office of Inspector General. 2006. *OIG News*. "OIG Executes Tenet Corporate Integrity Agreement Unprecedented Provisions Include Board of Directors." September 26. <http://www.oig.hhs.gov/fraud/docs/press/Tenet%20CIA%20press%20release.pdf>.

² United States Department of Health and Human Services & United States Department of Justice. 2002 *Health Care Fraud and Abuse Control Program Annual Report For FY 2001*. U.S. Government Printing Office, Washington, DC. April. <http://www.oig.hhs.gov/reading/hcfac/HCFAC%20Annual%20Report%20FY%202001.htm>.

³United States Department of Justice. 2008. *Press Release*. “Merck to Pay More Than \$650 Million to Resolve Claims of Fraudulent Price Reporting and Kickbacks.” February 7, 2008.

⁴United States Department of Justice. Press Office. 2006. “Largest Healthcare System in New Jersey to Pay U.S. \$265 Million to Resolve Allegations of Defrauding Medicare.” June 15.
<http://www.usdoj.gov/usao/nj/press/files/pdffiles/stba0615rel.pdf>.

⁵Department of Health and Human Services, Office of Inspector General. 2001. *Semiannual Report to the Congress*. April - September. p. 13. <http://hhs.gov/oig>.

⁶Department of Health and Human Services, Office of Inspector General. 2005. *Semiannual Report: April 1-September 30, 2005*. p. 20. <http://oig.hhs.gov/publications/docs/semiannual/2005/SemiannualFall05.pdf>.

⁷United States Department of Justice. 2005. *Press Release*. “Simi Valley Hospital Pays Over \$3.6 Million to Resolve Allegations of Fraudulent Billing Practices.” July 19.
<http://www.usdoj.gov/usao/cac/news/pr2005/105.html>.

Table 3

**Voluntary vs. Involuntary Compliance Program
Status of Sample Hospitals**

Compliance Status	Number of Sample Hospitals	Percent of Sample Hospitals
Hospitals Operating Under Involuntary Corporate Integrity Agreements	31	13%
Hospitals Operating Under Voluntary Compliance Programs	203	84%
Non-respondents	8	3%
Total Sample	242	100%

Table 4

**Mean Scores of Risk Rankings of Medicare Billing Fraud Schemes
on a Scale of 1 to 5 (1 = low risk, 5 = high risk)**

Number of Respondents in Parentheses

Billing Fraud Type	Hospitals Operating Under Corporate Integrity Agreements	Hospitals Not Operating Under Corporate Integrity Agreements	F-value	p-value
Providing and billing for medically unnecessary services.	3.4839 (31)	3.0049 (203)	3.90	0.0494
Upcoding	3.2903 (31)	2.7734 (203)	4.66	0.0319
Over-utilization	3.2258 (31)	2.7450 (202)	6.26	0.0107
Billing for items or services not rendered.	3.1290 (31)	2.9360 (203)	0.56	0.4563
Unbundling	3.0968 (31)	2.5396 (202)	5.588	0.0189
Billing for discharge in lieu of transfer of patient	2.8710 (31)	2.4100 (200)	4.270	0.0399
Duplicate billing	2.8065 (31)	2.5419 (203)	1.42	0.2344
Submission of false cost reports	2.710 (31)	2.1921 (203)	4.16	0.0426

The opinions of the authors are not necessarily those of Louisiana State University, the E.J. Ourso College of business, the LSU Accounting Department, or the Editor-In-Chief.