



**OFFICE *of* INSPECTOR GENERAL**  
NATIONAL RAILROAD PASSENGER CORPORATION

## **GOVERNANCE:**


Stronger Controls Would Help Identify Fraudulent Medical Claims Sooner and Limit Losses

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## Memorandum

**To:** DJ Stadtler  
Executive Vice President / Chief Administration Officer

**From:** Jim Morrison   
Assistant Inspector General, Audits

**Date:** December 10, 2019

**Subject:** *Governance: Stronger Controls Would Help Identify Fraudulent Medical Claims Sooner and Limit Losses (OIG-A-2020-003)*

Health care costs continue to rise nationwide, and the cost of medical expenses that Amtrak (the company) paid on behalf of agreement employees covered under its Group Health Plan (the plan)<sup>1</sup> has increased an average of about 4.4 percent annually or a total of about 18 percent since 2014.<sup>2</sup> Within one cost category of the plan, from calendar years 2014 through 2018,<sup>3</sup> the company paid about \$275 million to 30,599 non-hospital health care facilities for medical services provided. Non-hospital facilities include laboratories, substance abuse and behavioral treatment centers, durable medical equipment suppliers, emergency rooms, and ambulatory surgery centers.

Fraud losses can further increase the company's health care costs and hinder its efforts to achieve financial stability—a key goal for the company. As a self-insured company, Amtrak bears the risk of any improper medical claim payments resulting from fraud.<sup>4</sup> Since 2014, we have reported on numerous instances of health care fraud against the

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<sup>1</sup> Amtrak's group health plan covers active and retired employees and their qualifying dependents. This includes about 39,000 people. The terms and conditions of employment for agreement employees are covered by collective bargaining agreements.

<sup>2</sup> The increase in company's health care cost was below the national average of about 6 percent for the same period.

<sup>3</sup> Calendar year 2018 was the most recent year for which the company had complete data at the time of our review.

<sup>4</sup> A self-insured group health plan is one in which the employer assumes the financial risk for providing health care benefits to its employees. In practical terms, self-insured employers pay for each out of pocket claim as they are incurred instead of paying a fixed premium to an insurance carrier, which is known as a fully-insured plan. The company pays these expenses from its operating budget.

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company's plan, with a total payment in excess of \$9.5 million to the fraudulent providers, as shown in the following examples:<sup>5</sup>

- In October 2019, an acupuncturist pleaded guilty to defrauding Amtrak's health care plan. The Department of Justice estimates the total loss to Amtrak to be at least \$3.8 million.<sup>6</sup> The acupuncturist recruited company employees to visit the provider's facility and then used their identities to bill for services the acupuncturist did not provide. Ultimately, the acupuncturist billed for more than 1,000 Amtrak employees and dependents.<sup>7</sup>
- Since April 2017, a total of 17 defendants—including owners of medical centers and laboratories—pleaded guilty and 16 were sentenced collectively to 112 years in prison for conspiring to participate in a widespread kickback scheme involving fraudulent billings to insurance companies for services that were never provided. Amtrak's health plan paid more than \$2.5 million to these fraudulent providers.
- In June 2019, the Department of Justice charged the owner of a chiropractic facility—who received about \$1 million in payments from Amtrak's plan—with six counts of health care fraud for allegedly submitting claims to private insurers for services that were not provided.

Appendix B includes a more comprehensive list of our fraud investigations.

To mitigate the risk of such fraud, the company has the responsibility for ensuring that it has effective internal controls over payments for medical claims. In our prior work, we assessed the company's medical payments to individual medical providers—such as physicians, nurses, and physical therapists—against a set of indicators of fraud. We found that the company faced fraud risk and it did not have adequate controls in place to protect against this risk.<sup>8</sup>

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<sup>5</sup> We worked with the company's third-party claim administrators in investigating some of these cases.

<sup>6</sup> The acupuncturist pleaded guilty to one count of health care fraud and one count of money laundering. Department of Justice, *Acupuncturist Pleads Guilty to Charges in Scheme that Caused Millions of Dollars in Losses to Amtrak's Health Care Plan*, October 11, 2019.

<sup>7</sup> Investigation of this provider started before January 2013 when United Healthcare was the administrator of the company's group health plan for agreement employees.

<sup>8</sup> *Governance: Opportunities to Improve Controls over Medical Claim Payments* (OIG-A-2018-005), March 14, 2018.

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This report builds on our prior work and assesses the effectiveness of the company's controls to mitigate the risk of fraud in its payments to non-hospital facilities. This time, we focused on claims the company paid to the top tenth percentile of non-hospital facilities during calendar years 2014 through 2018. We also focused on medical claims submitted on behalf of agreement employees and their dependents because of their high aggregate value compared to those of management employees. Using data analytics, we identified suspicious billing patterns that could indicate potential fraud. We do not know the extent to which payments result in actual fraud, however, because this is determined through the judicial system. To assess the company's controls, we used private- and public-sector management control standards and other leading practices—particularly those addressing fraud prevention. For additional details on our scope and methodology, see Appendix A.

## **SUMMARY OF RESULTS**

Our assessment of the company's medical claim payments against a set of fraud indicators showed that the company continues to be exposed to potential fraud in its medical claim payments that it has not yet identified. This puts its funds, as a self-insured company, at risk. Based on our analysis of payments to non-hospital facilities the company reimbursed, we found 191 with billing patterns that may indicate fraud the company had not flagged for further review. We estimate that this puts at risk the \$57 million the company paid these facilities from 2014 through 2018.<sup>9</sup> Furthermore, officials from the company's third-party claim administrator told us that the company's plan is at higher risk for fraud because certain benefits within the company's plan are more generous than other plans they administer, and this makes the company's plan a greater target for fraud and abuse. This is especially true about the benefits for visiting out-of-network providers who are not limited to contracted pricing for their procedures.<sup>10</sup>

We identified a similar risk in our March 2018 report and found that its claims administrators' fraud controls were not tailored to the company's plan. We recommended that the company systematically analyze its medical claims data for

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<sup>9</sup> In conducting our work, we did not review employees' medical files, interview employees, or visit employees' medical providers; thus, we recognize that some of the claims could be appropriate.

<sup>10</sup> Aetna provides employees access to a network of medical service providers with whom it has negotiated contract rates. Employees can also seek medical services from out-of-network providers. These providers are not limited to charging contract rates.

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patterns of potential fraud and the company agreed with this recommendation. This would give the company the ability to take timely steps to mitigate risks from potentially fraudulent providers. Human Resources (HR) department officials told us they plan to implement a capability to do this, but they did not expect to have it in place until spring of 2021—three years after our report.

During this review, we also identified two additional steps that leading companies use to protect against fraud risk. One step is conducting fraud awareness initiatives with plan members, who can serve as the first line of defense against the risk of fraud—for example, by reporting suspected fraudulent providers. The second step is to use publicly available data and the results of fraud investigations to identify new patterns of fraud to monitor. Implementing these controls could further strengthen company efforts to detect and prevent potential fraud early enough to avoid improper payments.

To help strengthen the company's controls and reduce the risk of fraudulent medical payments, we recommend the company review claims paid to the 191 potentially fraudulent non-hospital facilities we identified and seek recovery of whatever portion of the \$57 million in claims it determines were improper. We also recommend that the HR department assess ways to implement proactive fraud detection procedures sooner. Furthermore, we recommend that the department implement fraud awareness initiatives. Finally, we recommend that the department gather information on fraud schemes and emerging fraud trends and use it to monitor its medical claim payments.

In commenting on a draft of this report, the company's Executive Vice President and Chief Administration Officer agreed with our recommendations and described the company's actions and plans to address them. These include reviewing the claims of potentially fraudulent providers we identified and seeking recovery of funds where feasible. The company will also take proactive measures to detect potential fraud sooner, take steps to increase employee fraud awareness, and gather information on emerging fraud schemes to inform its fraud monitoring efforts. For management's complete response, see Appendix C.

## **BACKGROUND**

The company's Executive Vice President and Chief Administration Officer is responsible for managing the company's health care programs. The company outsources the administration of its health care plan to third-party claims administrators who process and pay claims on behalf of employees and their

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dependents. Aetna processes about 97 percent of these claims.<sup>11</sup> The HR department is responsible for overseeing the work of Aetna and the other claims administrators.

As part of its overall service to its customers, Aetna's investigative unit uses a set of algorithms to identify potential fraud and works with law enforcement agencies to pursue litigation and recover funds. Under the company's contract with Aetna, the administrator's investigative unit notifies our office of any potentially fraudulent activities it detects in claims submitted under the company's plan—including overpayments, duplicate billings, or any other overall trends in medical claim fraud. Our office then considers the significance of the risk and company exposure to determine whether to investigate the claims involved.

Our prior work showed, however, that Aetna's fraud controls are not designed to assess some of the unique characteristics of the company's health care plan. Aetna officials told us that Aetna cannot develop a separate customized set of controls for individual customers.<sup>12</sup> For example, the company's plan provides for unlimited acupuncture services, whereas most other plans Aetna administers limit this benefit to 12 visits per year. Aetna's controls, therefore, are designed to stop payments for acupuncture when they exceed 12 visits in a year. To ensure that the company's employees can make full use of their unlimited acupuncture benefits, Aetna bypasses the control it has in place when processing the company's acupuncture claims. This workaround poses risks and could allow fraudulent providers to exploit this unlimited benefit.

We further reported that the company ultimately retains responsibility for the effectiveness of fraud prevention and detection controls for its medical claim payments and, as a result, we recommended that it obtain its own capability to assess its claims data for patterns of potential fraud. In this report, we provide an update of the company's efforts to obtain this capability.

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<sup>11</sup> Aetna is one of the United States' largest health care benefits companies serving its self-insured and fully-insured clients. Another contractor, Total Health Plan (Tufts), administered the remaining 3 percent of the claims paid for employees who live in Massachusetts.

<sup>12</sup> In our March 2018 report, we recommended that the company consider requiring its claims administrators to design and implement controls specifically tailored to detect and prevent potential fraud in the company's medical plan. In response, the company followed up with Aetna, but Aetna does not provide this service. Additionally, an official from United HealthCare (the company's former claims administrator) told us they do not tailor their fraud prevention controls for specific clients.

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## **BILLING PATTERNS INDICATE FRAUD RISK THAT THE COMPANY DID NOT IDENTIFY**

We continue to identify patterns of potential fraud in the medical claim payments the company made from calendar years 2014 through 2018. In our March 2018 report, we found potential for fraud from individual medical service providers that the company had not identified. Similarly, in this review, we identified suspicious billing patterns in medical claims paid to non-hospital facilities that the company did not identify.

Based on our research of industry trends in health care fraud, we identified a set of indicators of potential fraud in facilities' billing patterns. Using these indicators, we identified 200 non-hospital facilities with billing patterns that may indicate potential fraud. Aetna identified 9 of these facilities and referred them to our office. The company did not identify concerns with any of the remaining 191 suspicious facilities. We estimate that this puts the \$57 million it paid them from 2014 through 2018 at risk of fraud. This risk is substantiated in part by information we gathered from the National Health Care Anti-Fraud Association (NHCAA) that also identified 54 of these 191 companies for suspicious billing activities against other organizations.<sup>13</sup> The indicators we identified included the following billing patterns:

- **High utilization of some medical procedures.** Medical providers' utilization of certain procedures at rates significantly higher than their peers may indicate inappropriate billing, including billing for services that were not medically necessary or were not actually provided.<sup>14</sup> Of the 191 non-hospital facilities we identified that were at risk of fraud, 178 had this billing pattern.
- **High number of patients in common with other medical providers.** A high number of shared patients among a network of medical providers could indicate a coordinated effort among providers to refer patients to one another for unnecessary medical services in exchange for favors or kickbacks.<sup>15</sup> Such actions could also be an indicator of identity theft. Of the 191 non-hospital facilities we identified that were at risk of fraud, 110 had this billing pattern.

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<sup>13</sup> National Health Care Anti-Fraud Association (NHCAA) is an organization whose members include private health insurers and government entities with jurisdiction over health care fraud, and they share information on inappropriate billing activities.

<sup>14</sup> HHS OIG, *Questionable Billing for Medicare Outpatient Therapy Services* (OEI-04-09-00540), December 2010.

<sup>15</sup> HHS OIG, *Questionable Billing for Medicare Electrodiagnostic Tests* (OEI-04-12-00420), April 2014.

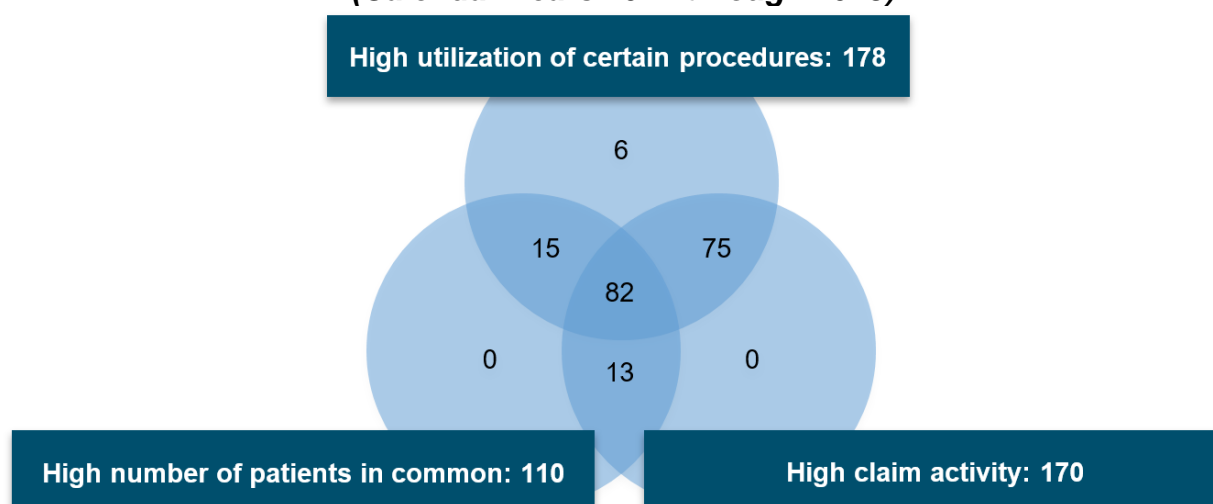


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- **High claim payment activity.** The risk of potential fraud is increased when any of the previously described billing patterns is combined with abnormally high claim payment activity because the company's financial exposure is compounded. Of the 191 non-hospital facilities we identified that were at risk of fraud, 170 had this billing pattern.

As Figure 1 shows, 82 of the 191 non-hospital facilities we identified had all three of these billing patterns.

**Figure 1. Non-Hospital Facilities  
 with Billing Patterns That May Indicate Potential Fraud  
 (Calendar Years 2014 through 2018)**



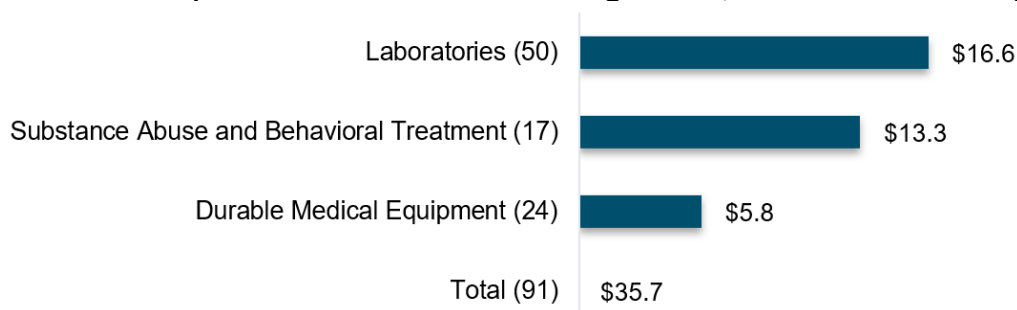
Source: OIG analysis of Amtrak health care medical claim payments

We also focused our analysis on three key specialties that industry trends show an increased risk of fraud in claims paid: laboratories, substance abuse and behavioral treatment facilities, and durable medical equipment suppliers.<sup>16</sup> Of the 191 facilities we identified, 91 were in these types of facilities. During the five years in our review, the company paid these 91 facilities about \$35.7 million, as shown in Figure 2.

<sup>16</sup> Durable medical equipment is reusable equipment used to treat a disease or injury, such as walkers and wheelchairs.

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**Figure 2. Claim Payments to Non-Hospital Facilities in Three Key Specialties with Potentially Fraudulent Billing Patterns (Calendar Years 2014 through 2018, Dollars in Millions)**



Source: OIG analysis of Amtrak health care medical claim payments

**Laboratories.** Of the 191 facilities we identified that were at risk of fraud, 50 were laboratories that the company paid a total of \$16.6 million during the five years in our review. Laboratories pose an increased risk of fraud—typically by, for instance, maintaining improper relationships with other medical facilities to optimize profits, performing medically unnecessary testing, or both.<sup>17</sup> For example, we identified a laboratory with billing patterns indicating potentially improper relationships and billing, as well as unusually high billing. The company paid this laboratory about \$1 million during the years in our review.

- **Potentially improper relationships.** This laboratory appears to be under the same ownership as nine substance abuse and behavioral treatment facilities that received about an additional \$5.6 million from the company plan. It also shared a high number of patients with 3 of these treatment facilities, which were among the 191 potentially fraudulent facilities we identified. The laboratory shared 57, 34, and 25 Amtrak patients with these three facilities, whereas other laboratories shared an average of 1 Amtrak patient with these types of facilities.
- **Potentially improper billing.** Other health care administrators identified this laboratory and four of the affiliated treatment facilities suspected of inappropriate billing activities against other medical plans. These administrators

<sup>17</sup> The Healthcare Fraud Prevention Partnership, a public-private partnership of health care payers and allied organizations, identified improper laboratory relationships and medically unnecessary testing as specific areas of concern in the billing of laboratory services. See *Examining Clinical Laboratory Services, A Review by the Healthcare Fraud Prevention Partnership*, May 2018.

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allege schemes such as billing for medically unnecessary procedures and services that they did not actually provide and submitting duplicate medical claims.<sup>18</sup>

- ***Unusually high billing.*** This laboratory billed an average of \$6,600 per patient, whereas other laboratories billed an average of about \$1,900 per patient.

**Substance abuse and behavioral treatment facilities.** Of the 191 facilities we identified that were at risk of fraud, 17 were substance abuse and behavioral treatment facilities that the company paid a total of \$13.3 million during our five-year review period. These types of facilities pose an increased fraud risk—typically by, for instance, billing for treatment and testing they did not actually provide or that was not medically necessary, as well as submitting medical claims solicited through the payment of kickbacks and bribes to patients and treatment center owners.<sup>19</sup> For example, we identified a substance abuse treatment facility with billing patterns indicating a high utilization of certain procedures, patients shared with other potentially fraudulent facilities, and unusually high billing. The company paid this facility about \$849,000 during the years in our review.

- ***High utilization of certain procedures.*** This facility billed an unusually high number of visits, drug screening tests, and group psychotherapy services per patient. It billed for 215 visits per patient compared to an average of 20, billed 70 drug screening tests per patient compared to an average of 10, and billed 63 group psychotherapy services per patient compared to an average of 13.<sup>20</sup> Other health care administrators also identified this facility as submitting excessive billing of these services and billing for services not provided.<sup>21</sup>
- ***Patients shared with other potentially fraudulent facilities.*** This facility also shared patients with seven substance abuse and behavioral treatment facilities that other health care administrators identified as submitting suspicious billing against other medical plans, including billing for services they did not actually

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<sup>18</sup> Information gathered from NHCAA also identified this laboratory and five substance abuse and behavioral treatment facilities.

<sup>19</sup> Department of Justice, *Southern District of Florida Charges 124 Individuals Responsible for \$337 Million in False Billing as Part of National Healthcare Fraud Takedown*, June 28, 2018.

<sup>20</sup> We calculated the averages using the company's medical claim payments.

<sup>21</sup> Information gathered from NHCAA also identified this substance abuse and behavioral treatment facility.

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provide.<sup>22</sup> The company paid these seven facilities about an additional \$679,000 during the years in our review.

- ***Unusually high billing.*** This facility billed an average of about \$269,000 per patient, whereas other substance abuse treatment facilities billed an average of about \$24,000 per patient.

**Durable medical equipment suppliers.** Of the 191 facilities we identified that were at risk of fraud, 24 were suppliers of durable medical equipment that the company paid about \$5.8 million during our five-year review period. Equipment suppliers pose an increased risk of fraud—typically by, for instance, submitting claims for medically unnecessary equipment they sold via telemarketing efforts that lure patients to accept free or low-fee equipment, payments of kickbacks and bribes to physicians and other intermediaries participating in the scheme, or patient identity theft.<sup>23</sup> For example, we identified an equipment supplier with billing patterns indicating excessive claims for certain equipment, as well as a high number of patients in common with other suspect providers. The company paid this supplier about \$657,000 during the years in our review.

- ***High utilization of certain equipment.*** This supplier billed for a high number of custom medical-grade compression stockings and is under investigation by another government agency for potentially substituting these stockings with an off-the-shelf product.
- ***High number of patients shared with other potentially fraudulent suppliers.*** This supplier also shared more than 200 patients with a second supplier that was among the 191 potentially fraudulent facilities we identified. Other health care administrators also identified this second supplier as submitting potentially fraudulent claims against other plans. The supplier allegedly billed for equipment—including compression stockings—after fraudulently obtaining patients’ identities and insurance information at a health fair and falsifying

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<sup>22</sup> Information gathered from NHCAA also identified these seven substance abuse and behavioral treatment facilities.

<sup>23</sup> Department of Justice, *Federal Indictments & Law Enforcement Actions in One of the Largest Health Care Fraud Schemes Involving Telemedicine and Durable Medical Equipment Marketing Executives Results in Charges Against 24 Individuals Responsible for Over \$1.2 Billion in Losses*, April 9, 2019.

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documents certifying that the equipment was medically necessary.<sup>24</sup> The company paid this second supplier about an additional \$220,000 during the five years in our review.

Aetna officials told us that the company's plan is at higher risk for fraud because certain benefits within the company's plan are more generous than other plans they administer, and this makes the company's plan a greater target for fraud and abuse. This is especially true about the benefits for visiting out-of-network providers who are not limited by contracted pricing for their procedures. Of the 191 potentially fraudulent providers we found, 76 were out-of-network providers—about 40 percent. HR officials stated that these generous benefits—including benefits for visiting out-of-network providers with minimal cost to the employees—were negotiated between the company and union representatives for agreement-covered employees.

We recognize that although these 191 non-hospital facilities' billing patterns indicate an increased potential for fraud, some facilities may have valid reasons for these billing patterns. For example, many company employees work on their feet for long periods; therefore, they may have a higher-than-average rate of medical conditions that are treated with compression stockings. The suppliers we identified, however, had suspicious billing patterns compared with others in the same specialty that probably merit extra scrutiny.

### **THE COMPANY HAS NOT OBTAINED THE CAPABILITY TO ANALYZE MEDICAL CLAIM PAYMENTS FOR POTENTIAL FRAUD**

Our work has shown that the company continues to have gaps in its controls to effectively identify and mitigate fraud risk in its medical claims. In March 2018, the company agreed with our recommendation that it needed to systematically analyze its medical claim payments to identify patterns of potential fraud, but it has not yet taken this step. Such a capability could include, for example, monthly monitoring of paid claims to identify non-hospital facilities that exhibit patterns of concern, such as those we discussed above. Identifying these patterns early would provide the company the ability to take some risk mitigation steps. For example, if the company had implemented its own capability to proactively review medical claims, it could have detected the suspicious billing trends that we identified sooner and stopped or

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<sup>24</sup> Information gathered from NHCAA identified this Durable Medical Equipment supplier for potentially inappropriate billing activities.

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mitigated some of the \$9.5 million it paid to the fraudulent providers. Public- and private-sector standards and industry experts agree that the use of proactive fraud detection procedures such as data analytics is an effective tool for identifying abnormal billing patterns early enough to stop fraudulent payments.

The HR department officials responsible for managing the company's health care plan told us that implementing fraud analytics could potentially pay for itself and that the department plans to evaluate the potential to add this capability to its current health care data analytic capability in a cost-effective manner. In fact, these officials stated that they obtained a proposal to provide fraud analytics from their current data analytics vendor, but the proposal was too high to pursue absent a competitive bid process.<sup>25</sup> The officials therefore decided to obtain multiple quotes from the marketplace but as of October 2019, the company had not yet issued a request for proposals. HR officials attributed this delay mainly to two issues. First, the officials told us that it took some time to coordinate with the Information Technology department on who would manage the procurement, and HR is assuming this responsibility. Second, these officials told us the responsibility for analyzing the company's health care data—including implementing any ability to proactively review medical claims for early fraud detection—falls to one individual. This individual also has an overall responsibility for managing the company's health care plans and benefits—and therefore has competing priorities impacting the company's ability to timely implement a data analytics capability that will identify patterns of potential fraud.

In part because of these competing priorities, the officials told us that the HR department plans to include a request for expanded fraud data analytics consultative support when the department issues a request for proposals for their existing health care analytics capability. The officials added that their goal is to choose a vendor who could provide the combined capabilities by spring 2020 with a target of implementing it in spring 2021. This timeframe, however, would be three years after we reported increased fraud risk in the company's medical claim payments. As a result, the department has not yet established the anticipated procurement in its budget or developed a request for proposals from vendors. This delay in implementation limits the company's ability to detect and address potential fraud early.

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<sup>25</sup> This vendor gathers medical and prescription claims data from the claims administrators and provides key clinical and financial performance analytic results.

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One action the company did take in response to our March 2018 report, was to engage an external auditor that specializes in reviewing medical claims to scrutinize the billings and patterns of the 500 individual medical providers we identified. Similarly, reviewing the claims paid to the 191 facilities we identified for this report would provide the company the opportunity to challenge and seek recovery of relevant portions of the \$57 million in claims it determines are improper. The company also engaged the same auditor to review the claims paid in calendar years 2017 and 2018. These efforts are underway. These reviews can help identify fraud, but they are a retroactive look at medical claim payments that are several years old. They do not allow the company to continuously monitor its medical claim payments and identify fraud early enough to avoid improper payments.

## **TWO ADDITIONAL CONTROLS COULD HELP MITIGATE FRAUD RISK**

We identified two additional steps that other companies use to protect against fraud risk that would strengthen the company's efforts to mitigate its risks. One is conducting fraud awareness initiatives with plan members, who can serve as the first line of defense against the risk of fraud. Another is to use publicly available data and the results of fraud investigations to identify any new patterns of fraud to monitor.

**Conducting fraud awareness initiatives for plan members.** Fraudulent providers frequently attempt to engage plan members in their schemes—wittingly or unwittingly. For example, a chiropractor was recently indicted for using the personal information of several individuals and their family members to generate fraudulent claims and paying these individuals cash in exchange for using their information. Five company employees allegedly participated in this scheme. The company paid this chiropractor about \$1 million since 2008.










A common practice among companies to mitigate this risk is to conduct ongoing fraud awareness initiatives to enable their plan members to better recognize and report potential fraud in their medical bills. Fraud awareness initiatives can include educating plan members to review their explanations of benefits to identify and report potential fraud. For example, the initiatives can frequently alert members of fraud indicators to monitor, such as providers offering coupons for free services or providing medical supplies their doctors did not order. Figure 3 shows some of the tips Aetna provides to its clients to help them spot wrongdoing. An Aetna official told us the administrator makes these tips available to the company's HR department but does not provide them directly to plan members. The HR official we spoke with noted that the company could

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leverage existing employee communication channels to disseminate fraud awareness information such as this one. The official also added that the HR department will assess the cost and effort in implementing outreach initiatives, such as using mailed letters to help employees be aware of potential fraud. Further, during our audit, the company included some fraud awareness information in the 2020 annual enrollment package made available to employees on the company’s intranet web portal.

**Figure 3. Aetna’s Tips to Consumers for Preventing Fraud**

**Be suspicious if providers of medical services or supplies:**

-  Bill insurance for services you don’t think were rendered
-  Bill for treatment you haven’t received yet
-  Bill significantly more than other doctors for treatment you’ve had in the past
-  Order what appear to be more tests than are necessary
-  Offer treatment while promising you won’t have to pay the balance due after insurance pays
-  Offer to bill your insurance for services that weren’t performed in order to cover your out-of-pocket costs
-  Bill insurance when you used a coupon for “free services”
-  Want you to bring other family members with you to your appointments to treat them for the same condition, even if they don’t have the same medical complaints as you
-  Call to offer you “free” medical equipment your doctor didn’t order

Source: Aetna Special Investigative Unit Brochure, *Preventing Fraud, Handy Tips to Help You Spot Wrongdoing*, December 2017

**Gathering information on fraud schemes.** Another common practice that companies use to mitigate fraud risk is to gather information on fraud schemes—particularly new or emerging schemes—to better target their fraud monitoring efforts. Meeting with plan administrators’ investigative units and OIG investigators could inform the company on the results of recent investigations and emerging risks in health care fraud. Fraud prevention standards prescribe that organizations analyze instances of detected fraud to identify potential control deficiencies and, if necessary, take corrective actions to strengthen controls in response to that analysis. An HR official told us the department would like to establish periodic meetings with our office and Aetna to have these types of discussions, but, as of October 2019, the company has not formalized these plans.



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Without these two important controls, the company's efforts to mitigate its fraud risk are not as effective as they could be in protecting its health care investment.

## **CONCLUSIONS**

The 191 potentially fraudulent non-hospital facilities we identified demonstrate that the company continues to face risk of fraud in medical claim payments. Given the significant risks we identified—with \$57 million paid to these facilities—taking timely actions to implement its own capability to analyze medical claims data to mitigate potential fraud risks could help the company better protect its employees and health care investment. In addition, implementing fraud awareness initiatives and monitoring fraud trends could help the company more effectively address this risk.

## **RECOMMENDATIONS**

To more effectively mitigate the risk of fraud in medical claims, we recommend that the Executive Vice President and Chief Administration Officer take the following actions:

1. Ensure that the HR department, to the extent that it is cost-effective and practical:
  - a. reviews the claims paid to the 191 non-hospital facilities we identified for risk of potential fraud, and
  - b. coordinates with Aetna to challenge and seek recovery of whatever portion of the \$57 million in claims it determines were improper.
2. Implement proactive fraud detection procedures sooner, such as a data analytics capability, so that the company can stop fraudulent payments earlier.
3. Ensure that the HR department develops and implements key controls consistent with fraud prevention standards, including the following:
  - a. implementing cost effective fraud awareness initiatives to enable plan members to better recognize and report potential fraud.
  - b. gathering information on fraud schemes including investigation results and emerging fraud trends to better target their fraud monitoring efforts.

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## MANAGEMENT COMMENTS AND OIG ANALYSIS

In commenting on a draft of this report, the company's Executive Vice President and Chief Administration Officer agreed with our recommendations and described the company's actions and plans to address them, which we summarize below.

- **Recommendation 1:** Management agreed with our recommendations to review the claims submitted by the non-hospital facilities we identified for risk of potential fraud and seek recovery of claims determined to be improper. The company stated it will conduct a cost-benefit analysis of the claims identified and consider directing its external auditor to review the claims based on that analysis. To the extent claims are determined to be fraudulent, the company committed to working with Aetna to seek recoveries. The target completion date is August 1, 2020.
- **Recommendation 2:** Management agreed with our recommendation to implement proactive fraud detection procedures sooner. The company stated that regularly conducting external claim audits and meeting with the claim administrators' investigative units as well as addressing issues within the plan design, in coordination with the union, will assist the company in the identification of fraudulent claims. The company also committed to performing a cost-benefit analysis to leverage additional data analytics capabilities to further mitigate the risk of fraud. We continue to believe that implementing such a capability will be an important action for the company in order to identify abnormal billing patterns early enough so that they can be addressed quickly to avoid financial losses from fraud. The target completion date is December 31, 2020.
- **Recommendation 3:** Management agreed with our recommendations to implement cost effective fraud awareness initiatives and gather information on fraud trends to inform their mitigation efforts. The company stated that fraud awareness communications will be provided to members along with information on how to report suspected fraud. It also stated that ongoing efforts to gather information on emerging fraud schemes and risks will be incorporated as part of quarterly meetings with claims administrators' investigative units and communications with external auditors. The target completion date is August 1, 2020.

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## APPENDIX A

### Objective, Scope, and Methodology

Our objective was to assess the effectiveness of the company's controls to mitigate the risk of fraud in its payments to non-hospital facilities. We performed our work from February 2019 through October 2019 in Washington, D.C.; Philadelphia, Pennsylvania; and Bethlehem, Pennsylvania.

To address our objective, we analyzed the medical claims the company paid to non-hospital facilities during calendar years 2014 through 2018 and we identified suspicious billing patterns that could indicate potential fraud. We focused on medical claims submitted on behalf of agreement employees and their dependents because of their high aggregate value compared to those of management employees. We also interviewed officials from the HR department—including the HR Benefits group—and worked with representatives from Aetna, the company's primary medical claims administrator to obtain and understand the claim data in their systems.

Our methodology for assessing the effectiveness of company's controls included comparing them with private<sup>26</sup> and public-sector<sup>27</sup> management control standards and other leading practices.<sup>28</sup> We also compared the company's practices with the Government Accountability Office's (GAO) framework for managing fraud risks in federal programs.<sup>29</sup>

Our methodology for determining whether there were potentially fraudulent payments included using a specialized data analytics tool to test the medical claim payments data we obtained from Aetna for calendar years 2014 through 2018. In our analysis, we took a risk-based approach, focusing on the claims paid to the top tenth percentile of non-hospital facilities—2,576 out of a total of 30,599 facilities who filed claims with the company during this period—because they received the highest claim payments from the company. Our analysis of the medical claims paid under the plan showed that this group received a significant portion of the total claims paid to all non-hospital

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<sup>26</sup> Committee of Sponsoring Organizations of the Treadway Commission, *Internal Control-Integrated Framework*, May 2013.

<sup>27</sup> GAO, *Standards for Internal Control in the Federal Government* (GAO-14-704G), September 2014.

<sup>28</sup> The Institute of Internal Auditors, The American Institute of Certified Public Accountants and Association of Certified Fraud Examiners, *Managing the Business Risk of Fraud: A Practical Guide*.

<sup>29</sup> GAO, *A Framework for Managing Fraud Risks in Federal Programs* (GAO-15-593SP), July 2015.

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facilities—about \$217 million, which is almost 80 percent of the approximately \$275 million the company paid to such facilities during this period. Individual payments to these 2,576 facilities ranged from \$17,252 to \$3 million during our 5-year review period.

To identify potential fraud, we assessed these facilities' claim activity across 18 risk indicators we developed based on our research on industry trends. Each indicator focused on identifying an anomaly in the aggregate claims the facilities submitted. We compared these facilities' billing patterns with all 30,599 facilities that filed claims with the company during this period. The 18 indicators fell into the following three categories:

- **High utilization of some medical procedures.** We designed six indicators to identify the largest differences in billings among facilities in the same specialty for each medical procedure by the unit price and the number of units billed, claims submitted, and patients served. Utilization of certain procedures at rates significantly higher than their peers may indicate inappropriate billing, including billing for services that were not medically necessary or were not provided.
- **High number of patients in common with other medical providers.** We designed six indicators to identify the facilities with the highest number of patients shared with other facilities. A high number of shared patients among a group of medical providers could indicate a coordinated effort among providers to refer patients to one another for unnecessary medical services in exchange for favors or kickbacks. Such actions could also be an indicator of identity theft.
- **High claim payment activity.** We designed six indicators to identify the facilities with the highest payments and the highest number of claims submitted and patients served because of the facilities' potential financial exposure to the company.

We selected only the facilities we flagged with 5 or more of our 18 indicators. We validated the reasonableness of our approach for identifying fraud risk with the Director of Advanced Audit Techniques at the Department of Health and Human Services (HHS) OIG. HHS OIG performs similar reviews of its Medicaid, Medicare, and Children's Health Insurance programs and is considered an expert in this area.

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In conducting our work, we did not review employees' medical files, interview employees, or visit employees' medical providers to determine the nature of the individual claims paid; thus, we recognize that some of the claims could be appropriate.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

### **Internal Controls**

We focused our control work on identifying the procedures the company used to manage the risk of fraud in medical claim payments. To evaluate the company's internal controls, we compared its practices with best practices and standards used in the private and public sectors described above. We did not review the entire system of controls that ensures that claims submitted by the facilities were appropriate and in compliance with the company's medical plan.

### **Computer-Processed Data**

To achieve our objective, we relied on computer-processed data from Aetna's claim adjudication systems. We validated the completeness of the data we analyzed as follows. For medical claims the company paid from calendar years 2014 through 2018, we compared the administrators' payment records with the company's financial records and found that total payments reconciled with 98.19 percent accuracy. We also compared the total claim payment amounts in the administrators' data to the claim payment amounts provided by Cotiviti, the contractor that collects and consolidates health care data from all administrators. We found that the total amount matched with 100 percent accuracy. Based on these tests, we determined that the discrepancy we found between the data sets we obtained for analysis and the company's financial records on the total payments it made for medical claims was negligible, and that the data were sufficiently reliable for meeting our objective.

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For our audit, we used only “de-identified” medical claims data as defined by the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.<sup>30</sup> Under the Privacy Rule, de-identified data that meet the standard and implementation specifications under 45 C.F.R. § 164.514(a) and (b) are not considered to be individually identifiable health information; therefore, these data are not bound by the HIPAA regulations and restrictions under 45 C.F.R. § 164.502(d). The Privacy Rule permits this standard to be met by either an expert determination or through the Safe Harbor method. We de-identified the data we used in our audit through the Safe Harbor method under 45 C.F.R. § 164.514(b)(2). We de-identified medical claims data by removing any of the specified 18 types of identifiers, such as name, social security number, and date of birth.

## Prior Reports

We reviewed the following audit reports that were relevant to our work:

- *Governance: Opportunities to Improve Controls over Medical Claim Payments* (OIG-A-2018-005), March 14, 2018
- *Governance: Controls to Avoid Duplicate Medical Payments of Agreement Employees Appear Generally Effective, but Some Payment Errors Still Occur* (OIG-A-2016-009), July 15, 2016

We also reviewed the following reports that were relevant to our work:

- *Department of Justice, Federal Indictments & Law Enforcement Actions in One of the Largest Health Care Fraud Schemes Involving Telemedicine and Durable Medical Equipment Marketing Executives Results in Charges Against 24 Individuals Responsible for Over \$1.2 Billion in Losses*, April 9, 2019.

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<sup>30</sup> The Amtrak Office of Inspector General (OIG) is not a “covered entity” under HIPAA and is not subject to HIPAA requirements, but we complied with the de-identification standards under HIPAA. 45 C.F.R. § 164.502(a). Although we did not use or analyze any protected health information during this audit, we may receive access to protected health information through our status as a “health oversight agency.” Specifically, 45 C.F.R. § 164.512(d) permits a health oversight agency such as OIG to have access to protected health information for activities authorized by law, including audits; civil, administrative, and criminal investigations; inspections; licensure and disciplinary actions; and civil, administrative, and criminal proceedings and actions; and other activities necessary for the appropriate oversight of the health care system.

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- Department of Justice, *Southern District of Florida Charges 124 Individuals Responsible for \$337 Million in False Billing as Part of National Healthcare Fraud Takedown*, June 28, 2018.
- Healthcare Fraud Prevention Partnership, *Examining Clinical Laboratory Services*, May 2018.
- Health and Human Services, Office of Inspector General, *Questionable Billing for Medicare Electrodiagnostic Tests* (OEI-04-12-00420), April 2014.
- Health and Human Services, Office of Inspector General, *Questionable Billing for Medicare Outpatient Therapy Services* (OEI-04-09-00540), December 2010.

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## APPENDIX B

### Health Care Fraud Investigative Summaries

The following are summaries of the health care fraud investigations that our office reported publicly from January 2014 through September 2019.<sup>31</sup> The company's plans paid more than \$9.5 million to the health care providers charged for fraud in these cases.<sup>32</sup> The courts have ordered restitution in 4 of these 12 cases, and 8 cases are pending for sentencing.

- *Florida Residents Plead Guilty to Health Care Fraud, July 23, 2019.* The owner of a purported substance abuse treatment facility and "sober home"<sup>33</sup> required clients to undergo excessive and medically unnecessary tests and fraudulently billed insurance providers for tests and other treatment that patients did not receive. In exchange for submission to such tests, kickbacks and bribes were provided to insured individuals who agreed to reside at the sober home and attend treatment at the substance abuse treatment facility. The owner and two other individuals who recruited patients for the treatment center pleaded guilty to conspiracy to commit health care fraud.
- *Amtrak OIG-Supported Investigation Leads to Guilty Plea in Florida Money Laundering Case, July 9, 2019.* The owner of a substance abuse treatment facility arranged to send patients' urine samples to a laboratory for drug testing in exchange for a portion of the insurance reimbursements. The laboratory owner then arranged with managers of rural hospitals in Florida to have the testing billed through the hospitals, instead of through the laboratory, taking advantage of their more favorable in-network contract billing rates. The owner pleaded guilty.
- *Medical Services Provider Pleads Guilty to Health Care Fraud, June 14, 2019.* The owner and operator of several health care facilities submitted hundreds of false and fraudulent claims to the company's plan for medical services the facilities did not provide. The owner pleaded guilty to multiple health care fraud charges.

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<sup>31</sup> Our office may issue multiple summaries on each investigative case; for example, when the provider is charged for fraud, when the provider pleads guilty, and when the provider is sentenced. For a complete list of all investigative summaries on the cases listed here, visit our website [www.amtrakoig.gov](http://www.amtrakoig.gov).

<sup>32</sup> Data used to calculate the total paid to fraudulent providers included claims paid prior to January 2014.

<sup>33</sup> Sober homes are recovery residences, operated as alcohol and drug-free living environments for individuals attempting to abstain from substance abuse.



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- *Amtrak OIG-Led Investigation Leads to Fraud Charges Against Chicago Chiropractor*, June 10, 2019. A chiropractor used personal identifying information of at least five people and their family members to generate fraudulent medical claims for medical services that were not actually provided. The chiropractor was charged with six counts of health care fraud, and judicial proceedings are pending.
- *Amtrak OIG-Supported Investigation Leads to Prison Sentence for Medical Director of Substance Abuse Treatment Facility*, March 14, 2019. The medical director of a substance abuse treatment center in Florida unlawfully distributed controlled substances. The medical director pleaded guilty to one charge of health care fraud and has been sentenced. Two individuals who owned this and other substance abuse treatment centers in Florida pleaded guilty to charges related to health care fraud for establishing illegal kickback/bribe relationships with owners of sober homes.
- *Amtrak OIG-Supported Investigation Leads to Guilty Pleas in Health Care Fraud Case*, September 7, 2018. The owner of a laboratory facility solicited bodily fluid samples from substance abuse treatment centers and conducted medically unnecessary drug testing. In exchange, the laboratory paid a portion of the insurance reimbursement for these tests to the substance abuse treatment facilities and disguised them as payments for sales commissions. The laboratory owner and five others pleaded guilty for their participation in this scheme and have been sentenced.
- *Podiatrist Pleads Guilty to Conspiracy to Commit Health Care Fraud*, July 25, 2018. A podiatrist received kickbacks from a pharmacy for prescribing unnecessary compounded medications to patients without their knowledge. The patients were not charged a co-pay and may not have reviewed or received their explanation of benefits, and therefore did not know that the pharmacy continued to use their insurance benefits even when they were no longer podiatrist's patients. Criminal judicial proceedings are pending.
- *Amtrak OIG-Supports Nationwide Health Care Fraud Enforcement*, June 29, 2018. The owner of a health and wellness company allegedly collected company employees' insurance information by misleading them about benefits offered under the company's plan. The owner of a health and wellness company conspired with the owners of a pharmacy and billed the company's plan for unnecessary prescriptions for compounded medications. In exchange,

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the pharmacy owners allegedly made kickback payments to the health and wellness owner. The company owner was charged with one count of health care fraud and one count of conspiracy to commit health care fraud.

- *Three Plead Guilty in Amtrak OIG-Supported Health Care Fraud Investigation*, April 9, 2018. An owner and two employees of several “shell companies” that purported to be laboratory marketing companies referred medically unnecessary and excessive bodily fluid tests to various clinical laboratories and rural hospitals in exchange for kickbacks. The owner and the two employees pleaded guilty for their roles in this scheme and have been sentenced.
- *Amtrak Employee and California Health Care Providers Charged in Health Care Fraud Scheme*, July 13, 2017. An acupuncturist allegedly recruited company employees to visit the provider’s facility, and then billed the company health plan for acupuncture and services the acupuncturist did not provide and laundered payments through various accounts. The acupuncturist was charged with eight counts of health care fraud and three counts of money laundering. A company employee was also involved in the scheme and was charged with two counts of health care fraud. The acupuncturist pleaded guilty to one count of health care fraud and one count of money laundering and the company employee signed a plea agreement, in which the employee admitted to committing health care fraud in furtherance of the scheme to defraud the company’s health plan.<sup>34</sup>
- *Owner Sentenced to More than 27 Years in Prison for Multimillion Dollar Health Care Fraud and Money Laundering Scheme Involving Sober Homes and Alcohol and Drug Addiction Treatment Centers*, May 17, 2017. An owner of a substance abuse treatment facility and several sober homes conspired with others to obtain patients, including dependent children of company employees, to undergo ineffective and unnecessary substance abuse treatment and testing that was fraudulently billed to the patient’s insurance. The owner also paid kickbacks and bribes to the owners of other sober home for referring their residents to the substance abuse facility. Further, to obtain residents for the sober homes, the owner provided kickbacks and bribes of free or reduced rent, gift cards, and controlled substances to individuals with insurance who agreed to reside at

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<sup>34</sup> Investigation of this provider started before January 2013 when United Healthcare was the administrator of the company’s group health plan for agreement employees.

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the sober homes, attend drug treatment and submit to regular drug testing that was fraudulently billed to the resident's insurance plans. Investigations uncovered a vast web of conspiracies involving sober home owners, medical clinic owners, doctors, and lab owners. Seventeen defendants pleaded guilty in this scheme and at least 16 were sentenced to prison terms that collectively totaled 112 years.

- *Fugitive Who Operated San Fernando Valley Chiropractic Clinic Indicted on Federal Health Care Fraud and Identity Theft Charges, September 25, 2015.* A chiropractor participated in corporate health care fairs where the provider induced employees to hand over their insurance information. The chiropractor then used this information and submitted fraudulent bills for office visits that never took place and for medical equipment that was never provided. The chiropractor was indicted for health care fraud and identity theft related to the scheme but fled the country before being arrested and remains a fugitive.<sup>35</sup>

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<sup>35</sup> Investigation of this provider started before January 2013 when United Healthcare was the administrator of the company's group health plan for agreement employees.

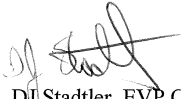

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## APPENDIX C

### Management Comments

NATIONAL RAILROAD PASSENGER CORPORATION

# Memo

Date	December 6, 2019	From	 DJ Stadler, EVP CAO	
To	Jim Morrison, Assistant Inspector General, Audits	Department	Administration	
		cc	Eleanor Acheson, EVP General Counsel Stephen Gardner, Sr. EVP Carol Hanna, VP Controller Roger Harris, EVP Jan Kelly, Director Benefits Scot Naparstek, EVP Denyse Nelson-Burney, AVP HR Dennis Newman, EVP Steven Predmore, EVP Mark Richards, Sr Director Amtrak Risk & Controls Tracie Winbigler, EVP CFO Christian Zacariassen, EVP	

Subject Management Response to **GOVERNANCE: Stronger Controls Would Help Identify Fraudulent Medical Claims Sooner and Limit Losses** (Draft Audit Report for Project No. 005-2019)

This memorandum provides Amtrak's response to the draft audit report entitled, "**GOVERNANCE: Stronger Controls Would Help Identify Fraudulent Medical Claims Sooner and Limit Losses**". Amtrak appreciates the opportunity to respond to the OIG's report and recommendations. As indicated in our responses below, we agree with the OIG recommendations and will initiate actions to address each in a timely manner.

**Recommendations:**

To more effectively mitigate the risk of fraud in medical claims, we recommend that the Executive Vice President and Chief Administration Officer take the following actions:

1. Ensure that the HR department, to the extent that it is cost-effective and practical:
  - a. reviews the claims paid to the 191 non-hospital facilities we identified for risk of potential fraud, and
  - b. coordinates with Aetna to challenge and seek recovery of whatever portion of the \$57 million in claims it determines were improper.

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*Management Response/Action Plan: Management agrees with the recommendation and currently has an audit underway for the 2017 and 2018 plan years which includes the review of potential fraud, waste and abuse in the above areas. We will conduct a cost/benefit analysis of the claims identified by and consider directing additional review of the potentially fraudulent claims identified by the OIG review based on this analysis. To the extent claims are determined to be fraudulent, we will work with Aetna to seek recoveries.*

*Responsible Amtrak Official(s): Director of Benefits*

*Target Completion Date: August 1, 2020 contingent of receipt of OIG listing of the 191 providers along with the associated claims details for the \$57 million in claims by January 2020.*

2. Implement proactive fraud detection procedures sooner, such as a data analytics capability, so that the company can stop fraudulent payments earlier.

*Management Response/Action Plan: Management believes that the implementation of regular audits via independent 3<sup>rd</sup> party vendors in combination with regular meetings with the claims administrator Special Investigation Unit will assist in more timely identification of fraudulent claims. In addition, management believes that addressing issues within the plan, in coordination with the unions and labor negotiations, will assist in strengthening protections within the plan against fraud for both the plan and plan members. Management will review and perform a cost/benefit analysis of options to add and/or leverage additional data analytics capabilities to further strengthen the plan and mitigate the risk of fraud.*

*Responsible Amtrak Official(s): Vice President of Human Resources and Benefits Director*

*Target Completion Date: December 2020*

3. Ensure that the HR department develops and implements key controls consistent with fraud prevention standards, including the following:
  - a. Implementing cost effective fraud awareness initiatives to enable plan members to better recognize and report potential fraud.
  - b. Gathering information on fraud schemes including investigation results and emerging fraud trends to better target their fraud monitoring efforts.

*Management Response/Action Plan: Management agrees with the above recommendations. Fraud awareness communications will be provided to members along with information on how to report suspected fraud. Ongoing efforts to gather information on emerging fraud schemes and risks will be incorporated as part of quarterly meetings with claims administrators Special Investigation Units as well as via 3<sup>rd</sup> party audit vendor discussions.*

*Responsible Amtrak Official(s): Director of Benefits*

*Target Completion Date: August 1, 2020*

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## **APPENDIX D**

### **Abbreviations**

GAO	U.S. Government Accountability Office
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HR	Human Resources department
NHCAA	National Health Care Anti-Fraud Association
OIG	Amtrak Office of Inspector General
the company	Amtrak
the plan	Group Health Plan

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## **APPENDIX E**

### **OIG Team Members**

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Drew Woodall, Senior Auditor-Lead

Jay McKey, Contractor

Alison O'Neill, Communications Analyst

# OIG MISSION AND CONTACT INFORMATION

## Mission

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The Amtrak OIG's mission is to provide independent, objective oversight of Amtrak's programs and operations through audits and investigations focused on recommending improvements to Amtrak's economy, efficiency, and effectiveness; preventing and detecting fraud, waste, and abuse; and providing Congress, Amtrak management, and Amtrak's Board of Directors with timely information about problems and deficiencies relating to Amtrak's programs and operations.

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[www.amtrakoig.gov/hotline](http://www.amtrakoig.gov/hotline)

or

800-468-5469

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