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## ABSTRACT

*In 2014, the U.S. spent approximately $3 trillion on health care. Medicare accounted for $554 billion of these costs and around $60 billion were squandered due to incorrect billing methods, abuse, and fraud. Types of fraud included: kickbacks, up coding, and organized fraudulent crimes. To reduce the financial burden associated with these activities, the U.S. has created various fraud prevention programs. The purpose of this study was to identify methods of Medicare fraud, examine the various programs implemented by the U.S. government to combat fraud and abuse, and determine the effectiveness of these programs. While fraud prevention strategies have proven to be effective, the furtherance of these strategies is imperative in order to continually combat rising healthcare expenditures in the U.S. Benefits of increased fraud prevention and detection are discussed in detail.*

## INTRODUCTION

In 2014, the United States (U.S.) spent more on health care than any other country in the world, approximately $3 trillion or $9,543 per person with the publically funded Medicare program accounting for roughly $554 billion of these costs; around $60 billion or 10% of the total cost of Medicare expenditures in 2014 was spent on unnecessary payments (GAO, 2015a). These unwarranted costs have been attributed to incorrect billing methods, abuse, and fraud. In an effort to reduce the financial impact of these activities, the government has expanded upon existing healthcare fraud legislation, implemented new laws, and created specialized fraud prevention programs (CMS, 2014a).

**Methods of Fraud**

Medicare Part D, which provides prescription drug benefits, has been specifically targeted for fraudulent activity. This activity has resulted from actions of patients as well as physicians and in the form of kickbacks from pharmaceutical companies (Maruca, 2006). Regrettably, the Centers for Medicare and Medicaid Services (CMS) have not created a dependable system for expense authentication (Toothman, Moore and Lee, 2011). In the event a patient has exhausted coverage limits for prescription medications, healthcare providers have been known to write prescriptions for the patient's spouse or family member who has not met coverage maximums or altered medical diagnoses in order to ensure prescription coverage under insurance plans (Maruca, 2006).

Kickbacks are another type of fraud that has prompted legislatures to enact numerous laws, such as the Anti-Kickback Statute and the Physicians Self-Referral Law or "Stark Law" (OIG, 2016). Although kickbacks have been an acceptable practice by other industries, it is illegal to receive or provide rewards of any type for referrals in federal healthcare programs (OIG, 2016). Physicians, other healthcare providers, medical suppliers, pharmaceutical companies, and even patients have been involved in these types of scams (Phillips and Cohen LLP, 2016). Specific examples of kickbacks have included physicians receiving payments for referring patients to specific dialysis centers, medical companies providing grants or free medical equipment to physicians that utilize their products, and pharmaceutical companies providing incentives or hosting seminars at luxurious resorts for physicians that agree to prescribe their drugs (Phillips & Cohen LLP, 2016).

A third type of fraud is up coding, or provider billing for a more complex service or procedure than was actually rendered, and/or diagnosing the patient with a costlier condition than was present (CMS, 2015b). An analysis of data collected between 2001 and 2010 by the Department of Health and Human Services (DHHS) and the Office of Inspector General (OIG) revealed, due to up coding for evaluation and management visits, Medicare payments

increased by 48% or approximately $10.8 billion (Levinson, 2012). A 2013 report released by CMS concluded $965 million was improperly dispersed for established patient visits in 2012 as a result of inaccurate billing practices (CMS, 2013). Since the requirement for electronic health records (EHR) and electronic medical billing practice, the incidence of up coding has become more prevalent (FORE, 2005). Reasons for this trend have been attributed to the overall structure of the EHR which has allowed physicians to simply point and click boxes that satisfy coding-complexity requirements (Pitts, 2012). A specific feature of EHR that has been potentially linked to the increase in up coding has included the ability to select templates created to ensure billing is at the highest possible level (Pitts, 2012).

Healthcare fraud may also be classified as organized crime (Morris, 2009). This type of fraud often involved either the stealing of patient lists from health care providers' offices or healthcare identity theft. Healthcare identity fraud has been defined as the theft of an insured individual's identity by an uninsured person, with the intent to use the personal information to receive medical services at little to no cost (Thornton et al., 2015). In contrast, when patient records have been stolen from a healthcare facility, the information has been typically sold to others for profit. The purchasers of this information have then proceeded to submit false claims to insurance companies in order to receive payment (Morris, 2009).

The purpose of this study was to identify methods of Medicare fraud, examine the various programs created by the U.S. government to combat fraud and abuse, and determine the effectiveness of these programs.

## METHODOLOGY

The primary hypothesis of this study was: The U.S. government and citizens are not efficiently and effectively utilizing available resources to prevent and combat Medicare fraud, waste, and abuse.

The methodology for this study was a literature review. Electronic databases Ebscohost, Health Source: Nursing/Academic Edition, LexisNexis, ProQuest, and PubMed provided by Marshall University's online library were employed as well as Google Scholar. Google search engine was employed when articles could not be located through the previously mention databases. Other respectable websites used were The U.S. Department of Health and Human Services (DHHS), Centers for Medicare and Medicaid Services (CMS), U.S. Government Accountability Office (GAO), Office of Inspector General (OIG) and U.S. Department of Justice (DOJ). Key words utilized for literature retrieval included "Medicare fraud" or "abuse" and "Integrated Data Repository" or "up coding" or "predictive modeling" or "whistleblower" or "fraud task force" or "organized crime" or "physician kickbacks" or "Affordable Care Act". Research discovery was limited to works published between 2003 and 2016. A total of 43 articles and websites were reviewed in the English language. Primary and secondary data was integrated from scholarly articles and reputable government publications. The search was completed by JM, LS, CT, and KV with validation by AC who also acted as a second reader and verified literature met inclusion criteria.

## RESULTS

### Legislation Against Medicare Fraud

The Affordable Care Act (ACA) has implemented additional funds to help eliminate fraud associated with Medicare and Medicaid fraud (Chang, 2013). The focus has been moved from a "pay-and-chase" model to prevention (Ruggio, Hurd and McIntee, 2013). Changes that have been initiated by the ACA include creating rigorous screening processes for Medicare and Medicaid providers, authorizing payment termination in cases of suspected fraud, increasing allocation of funds for the prevention and fighting of fraud, stricter penalties for health care fraud offenders, and incorporating new data sharing technologies (CMS, 2011a). In an effort to achieve these changes, a total of $350 million has been allotted between 2011 and 2020 to aid in the fight against Medicare fraud and criminal sentencing guidelines for healthcare fraud related crimes have been increased by 20%-50% for crimes that have involved monetary losses greater than $1 million (DHHS, 2016a).

The ability to identify all Medicare claims containing up coding or fraudulent billing has been difficult considering Medicare processes over 1 billion fee-for-service claims annually, only about 2% of which have been audited each year (CMS, 2014b). Considering the vast quantity of claims, whistleblowers have become an important tool in fraud detection by informing the government of witnessed Medicare fraud (Barger, 2016). The False Claims

Act (FCA) contained a provision known as *qui tam* which allowed whistleblowers to act on the government's behalf in relation to fraudulent claims, and collect a financial reward if the case proves successful (Stumphauzer, 2013). One of the largest profiting whistleblower cases in U.S. history involved Hospital Corporation of America (HCA) which faced a whistleblower lawsuit under the FCA (DOJ, 2003). HCA was forced to pay a total of $1.7 billion between 2000 and 2003 for fraudulent claims filed against Medicare. The whistleblowers received more than $151 million of the settlement (DOJ, 2003). In the 2015 Fiscal Year, the Department of Justice recovered $1.9 billion came from companies and individuals in the health care industry for allegedly providing unnecessary or inadequate care, paying kickbacks to health care providers to induce the use of certain goods and services, or overcharging for goods and services paid for by Medicare, Medicaid, and other federal health care programs; since 2009, the department has recovered nearly $16.5 billion in health care fraud (DOJ, 2005).

**Governmental Task Forces Utilization**

An important method that has been used to combat healthcare fraud has involved employment of an effective strategy that encompasses fraud prevention and detection as well as identification of waste and abuse (Byrd, Powell and Smith, 2013). The U.S. has formed federal committees and organizations in an effort to decrease and ultimately eliminate Medicare fraud (Byrd et al, 2013).
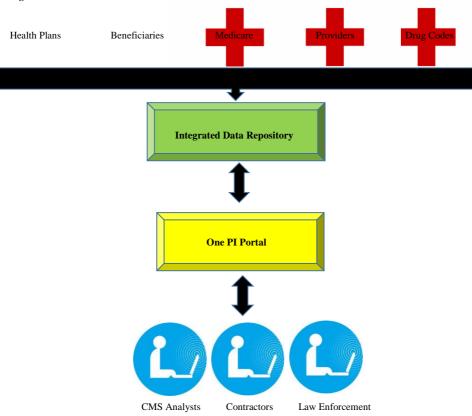
One federal program formed to combat Medicare fraud was the National Health Care Anti-Fraud Association (NHCAA). The purpose of the organization was to provide essential computer analysis programs designed to detect fraud and abuse in the healthcare system (Byrd, Powell and Smith, 2013). Lou Saccoccio, executive director of the NHCAA, recommended that government programs should be motivated to protect themselves by ensuring thorough background checks on new providers, engaging in anti-fraud information sharing, and holding provider payments in the event that fraud was suspected (Jones and Jing, 2011).

In 2009, a task force titled Health Care Fraud Prevention and Enforcement Action Team (HEAT) was established. HEAT is a joint effort by the Department of Health and Human Resources (HHS) and Department of Justice (DOJ) with the goals of decreasing healthcare costs by identifying and preventing Medicare fraud, emphasizing the practices of providers so as to eliminate waste, and strengthening relationships with other state and federal fraud prevention agencies; it charged more than 1,400 defendants who have falsely billed Medicare more than $4.1 billion in 2011 (DHHS, 2014a).

**Information Technology and Data Sharing used Against Medicare Fraud**

Fraudulent insurance claims have been problematic in both the public and private health arenas (DOJ, 2012). In September 2006, CMS launched the Integrated Data Repository (IDR) in an effort to heighten detection of waste, fraud, and abuse (GAO, 2011). The report indicated, at the time of launch, the project was anticipated to provide $21 billion in financial benefits by utilizing information technology to compile and examine data related to improper claims reimbursement. Officials planned to have all necessary and required data assimilated into the system by Fiscal Year (FY) 2010 (GAO, 2011). However, as of 2012, critical pieces of data had not been uploaded into the IDR (Budetti, 2012). In conjunction with the IDR, CMS developed One Program Integrity (One PI), a system application that provided contractors, data analysts, and law enforcement with access to the repository for further investigation of information (CMS, 2011b). The relationship between these components is depicted in Figure 1. Implementation of these programs has allowed for visualization of real-time claim submissions, access to records, and tracking of payment history (GAO, 2011).

**Figure 1: Interaction within the IDR and One PI Environment**

Health Plans          Beneficiaries          Medicare          Providers          Drug Codes

**Integrated Data Repository**

**One PI Portal**

CMS Analysts          Contractors          Law Enforcement

Source: Government Accountability Office, 2011

In 2012, to combat all categories of insurance fraud, the Obama administration created the Healthcare Fraud Prevention Partnership (HFPP). This partnership was composed of several federal government offices, state government organizations, private insurance companies, and professional organizations (DOJ, 2012). HFPP has allowed data to be shared between both private and public insurance sectors that have been used to identify unknown fraudulent schemes and possible prevention strategies (CMS, 2016a).

Predictive modeling is a relatively new technology, however it has been successfully implemented in various financial fields for fraud prevention and by insurance carriers to determine reimbursements and future premiums (White, 2011). Due to the success of the technology, Medicare has incorporated this technological advancement into claims processing as a tool for fraud prevention (Parente et al., 2012). Predictive modeling has used advanced methods to evaluate claims by assigning a score based on sets of characteristics frequently associated with inappropriate claims and fraud, and high scoring claims are then manually evaluated for validity (Lewin Group, 2009).

Since the July 20, 2016 release of CMS's *Annual Report to Congress on the Medicare and Medicaid Integrity Programs*, it has become apparent that great strides have been made to improve information technology and data sharing related to fraud prevention, detection, and abuse. The report estimated that program integrity strategies and

activities had saved Medicare $21.1 billion in FY 2013 and $18.1 billion in FY 2014. These figures had also indicated a 2-year return on investment of $12.4 to 1 (CMS, 2016b). The information has been further categorized by type of savings, as displayed in Table 1.

**Table 1: Medicare Saving by Program Integrity**

| Type of Medicare Savings | FY 2013 Savings in millions | FY 2014 Savings in millions |
|---|---|---|
| **Prevention Savings (Estimated)** | | |
| Prepayment Review | $ 12,913.5 | $ 11,859.7 |
| Provider Enrollment | $ 701.3 | $ 700.7 |
| Suspensions | $ 43.2 | $ 52.2 |
| Systematic Edits | $ 738.9 | $ 744.7 |
| **Total Estimated Prevention Savings** | **$ 14,396.9** | **$ 13,357.3** |
| **Post Payment Recovery Savings (Estimated)** | | |
| Law Enforcement Referrals | $ 129.3 | $ 102.7 |
| Recovery Auditors | $ 3,654.9 | $ 2,455.2 |
| Reviews and Audits | $ 2,881.9 | $ 2,207.1 |
| **Total Estimated Post Payment Recovery Savings** | **$ 6,666.1** | **$ 4,765.0** |
| **Total Estimated Medicare Savings** | **$ 21,063.0** | **$ 18,122.3** |

Source: Centers for Medicare and Medicaid Services, 2016

## DISCUSSION

**Legislation Against Medicare Fraud**

The ACA had strengthened federal efforts to eliminate healthcare waste, abuse, and fraud by granting greater authority to regulatory organizations in regards to their fraud combatting endeavors (Iglehart, 2010). In 2011, a total of 1,430 individuals were charged with healthcare fraud, a 75% increase from 2008 (Hill et al., 2014). During Fiscal Year (FY) 2011, the DOJ, CMS, and OIG's combined efforts led to 977 new investigations of civil health care fraud, 743 criminal convictions and the largest monetary recovery in a single year totaling $4.1 billion. In addition, future fraudulent acts against Medicare have been eliminated by revoking the billing privileges of 4,850 Medicare suppliers and providers (Goldman, 2012). This has produced a promising outlook on the ACA's influence on Medicare fraud prevention, however still is a long term project as in 2014 it was estimated by the GAO $60 billion in fraudulent Medicare payments from just of this fiscal year alone (GAO, 2015b).

Changes the government has made to the FCA to protect whistleblowers has encouraged more individuals to report fraud. This has been evidenced by the increase in whistleblower cases from 300-400 cases between 2000 and 2009 to more than 700 cases during 2014 (DOJ, 2014). Nearly 86% of the $3.5 billion recovered by the DOJ in FY 2015 was attributed to cases filed under the *qui tam* provision of the FCA (DOJ, 2015). The total amount paid by the government to whistleblowers who had risked their careers in these lawsuits, totaled $597 million in FY 2015 (DOJ, 2015). Although whistleblowers may fear retaliation in the form of loss of job and/or professional reputation

(Lachman, 2008), these potentially large financial incentives should help to provide encouragement for others to report witnessed fraud.

**Information Technology and Data Sharing used Against Medicare Fraud**

The specific task forces mentioned were just a few of many different committees and organizations that have been developed to help identify fraud and recover monetary losses. In order to determine the effectiveness of these task forces, tools and strategies have been evaluated to reveal strengths and weaknesses, as well as areas in need of improvement. According to the DOJ (2016), HEAT has recovered a total of more than $8.9 billion in false claims, and has charged more than 2,900 individuals. On June 22, 2016, it was announced that the Medicare Fraud Strike Force, a subsection of HEAT, had discovered the largest Medicare fraud operation in history (DOJ, 2016). This encounter led to a total of 301 individuals arrested and charged for approximately $900 million in fraudulent billing. These results, compared to the $1.9 billion that was recovered between 2009 and 2011, demonstrate that HEAT has been improving its performance and effectiveness.

An important aspect to consider when searching for solutions to increase productivity of current Medicare fraud task forces has been to exam the amount of federal funding allocated to accomplish this mission. In 2008, the government invested $1.13 billion in an effort to combat fraud (Iglehart, 2009). After dividing this budget between agencies including Medicare, Medicaid, and other private health insurance providers, it has been estimated that Medicare was able to dedicate less than 0.2% of its total budget to fraud prevention and detection. In 2015, the Congress appropriated about $864 millions in the Medicare Integrity Program for Medicare and Medicare Fraud detection. This has been quite a good investment it has been "won or negotiated" in FY 2015 about $1.9 billion in anti-fraud efforts. (DHHS/DOJ, 2016). In addition to increasing financial support, these programs could have also increased data sharing efforts. By collaborating with other anti-fraud organizations, the limited funding could have been better managed to increase productivity.

As of February 2016, eight studies have been conducted by the HFPP that have included data provided from all involved partners. After CMS analyzed the article titled "Misused Codes and Fraud Schemes" incorporated the findings of this literature to improve fraudulent payment detection methods, $187.7 million in savings had been reported to the Medicare Trust Fund "This partnership has continued to add partners from both private and public healthcare sectors and has planned to continue this trend (DHHS/DOJ, 2016) (HFPP Board, 2013). Although savings reports from the other studies have not been published, based on the reported savings from the first HFPP study, it can be concluded that this program has been successful. Since its creation in 2012, this partnership has captured nearly half of the $350 million originally allotted by the ACA for fraud prevention (DHHS/DOJ, 2016b). By continuing to add partners to this program, it can be assumed additional amounts of data will be provided that could be utilized in combatting fraud and recovering losses.

A 2011 study by the U.S Government Accountability Office reported the lack of ongoing assessment in relation to goal progression of the IDR and One PI was disheartening. Continual evaluation of objective progress should be paramount with a project of such magnitude. It was not until one year after the IDR and One PI implementation deadline of 2010 that the government acknowledged the program's failure to meet initially established goals (GAO, 2011). The inattention to continuing program appraisal was abysmal considering the initial investment of $832 million for fraud detection efforts (GAO, 2006). Fortunately, as a result of this report and findings of several other federal hearings, significant changes to the program were proposed in an effort to correct inefficiencies.

<div align="center">CONCLUSION</div>

Within the past seven years, the U.S. government and citizens have been working more efficiently to combat Medicare waste, fraud, and abuse. Although the breadth of fraudulent activity remains unknown, the success of current strategies has undoubtedly provided the crucial first steps necessary to further fraud prevention, detection, and monetary recovery. Further increase in national healthcare spending is foreseeable if Medicare fraud is not effectively controlled.

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