7-2014

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Recommended Citation
Hill, C., Hunter, A., Johnson, L., & Coustasse, A. (2014). Medicare fraud in the United States: Can it ever be stopped? Health Care Manager, 33(3), 254-260.

Medicare Fraud In The United States: Can It Ever Be Stopped?

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Abstract

The majority of the United States (U.S.) healthcare fraud has been focused on the major public program, Medicare. The yearly financial loss from Medicare fraud has been estimated at about $54 billion. The purpose of this research study was to explore the current state of Medicare fraud in the U.S., identify current policies and laws that foster Medicare fraud, and to determine the financial impact of Medicare fraud. The methodology for this study was a literature review. Research was conducted using a scholarly online database search and government websites. The number of individuals charged with criminal fraud increased from 797 cases in Fiscal Year 2008 to 1,430 cases in Fiscal Year 2011—an increase of more than 75%. According to 2010 data, of the 7,848 subjects investigated for criminal fraud, 25% were medical facilities and 16% were medical equipment suppliers. In 2009 and 2010 the Health Care Fraud and Abuse Control Program recovered approximately $25.2 million dollars of taxpayers' money. Educating providers about the policies and laws designed to prevent fraud would help them to become partners. Many new programs and partnerships with government agencies have also been developed to combat Medicare fraud. Medicare fraud has been a persistent crime and laws and policies alone have not been enough to control the problem. With investments in governmental partnerships and new systems the U.S. can reduce Medicare fraud but probably will not stop it altogether.

Key Words: Medicare, fraud, health care, Affordable Care Act, claims

Introduction

The United States (U.S.) had the highest per capita annual spending on health care among developed countries in 2010.[1] The U.S. health system's performance has been worse than 19 other developed countries, ranking in last place in prevention of mortality, and much of the money has been spent unnecessarily.[2] The majority of the healthcare fraud focus has been on the major public program, Medicare, which expanded more than $400 billion in public funds in 2006.[3] Medicare fraud has been partly responsible for the unnecessary spending. The yearly financial loss due to Medicare fraud has been estimated to be more than $54 billion.[4]

The Centers for Medicare and Medicaid Services (CMS) have defined fraud as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist.[5] Examples of Medicare fraud include, but are not limited to: billing for services not furnished, billing for services not necessary, misrepresenting the diagnosis to justify payment, and upcoding.[6]

It is a felony to defraud federal government programs.[7] There are also civil penalties that can be attached or charged in some cases; for instance revealing personal patient information such as name and birthday is only a misdemeanor. Criminal penalties for Medicare fraud have reflected serious harm and the need for appropriate and aggressive prevention.[5] Those convicted of fraud have faced imprisonment and millions of dollars in fines. In 2011, The Department of Justice convicted 323 defendants of Medicare fraud who collectively billed the Medicare program more than $1 billion.[7]

Medicare fraud laws and policies have been in effect since 1965, the year marking the beginning of the Medicare program. The False Claim Act (FCA) and its whistleblower provisions has been at the center of the government's and President Barack Obamas anti-fraud

campaign by making individuals liable for knowingly submitting false claims.[8] The FCA was enacted in 1863 by Congress to prevent fraud during the Civil War. This act made it illegal to submit a false claim to the federal government.[8] Since enacted, the act has been amended many times. In addition to the civil penalty of the FCA, Civil Monetary Penalties have been added to violators based upon the type of violation and can range up to $50,000 for each violation.[6] This penalty has increased since 2006, and with the implementation of the Patient Protection and Affordable Care Act (ACA) of 2010, civil penalties can range up to $250,000.[9]

The ACA contains several provisions to strengthen laws combating fraud by adding increased force and promoted new payment and delivery models.[10] The ACA also has allocated more funding to help combat fraud. In 2011, $95,000,000 was allocated. In 2012, that number was nearly cut in half to $55,000,000. For each Fiscal Year 2013 and 2014, $30,000,000 will be allocated and finally in 2015 and 2016 $20,000,000 will be allocated.[9] Medicare providers have been required to establish internal compliance programs to educate employees and to establish reporting mechanisms for fraudulent activity.[10]

Laws alone do not solve Medicare fraud. Since the Clinton administration Medicare fraud has been identified as a problem and partnerships have been established within governmental agencies as a prevention effort.[3] The Department of Justice and the Department for Health and Human Services created the Health Care Fraud Prevention and Enforcement Action Team (HEAT). The HEAT's mission has been to reduce fraud and recover tax payer dollars.[11] These partnerships have strengthened the prevention efforts. In fiscal year 2012, the partnerships recovered $4.2 billion of taxpayer dollars from Medicare fraud. For every dollar spent on fraud investigations from 2010, the government has recovered $7.90.[12]

On June 30, 2011, CMS implemented a new system of analyzing every single incoming claim to reduce fraud.[13] Data mining conducted by Zone Program Integrity Contractor analysts has provided the Center for Program Integrity a better tool to promote the integrity of Medicare.[13] Data mining techniques supported by algorithmic approaches, such as classification, outlier detection, and visualization, have been used in extracting suspicious claims.[14] The classification technique is the process of identifying a set of features and models that describe data classes, while the outlier technique measures the distance between data objects. The third and final technique of visualization converts data characteristics into clear patterns for users to view.[14] These techniques have helped to convert complicated data into clear patterns and view relationships between data.

Provider audits have used two models based upon clustering ZIP code regions. These audits have permitted discovery of relationships among the data. The first model created a homogenous group to detect outliers using regression analysis.[15] The second model was based upon distances that beneficiaries traveled from the center of their ZIP code to the provider's ZIP code. Based upon the data impractical distances were established and provider's filing these claims were flagged.[15]

The purpose of this research study was to explore the current condition of Medicare fraud in the U.S., identify current policies and laws that attempted to defraud Medicare, and to determine the financial impact of Medicare fraud.

Methodology

The methodology for this study was a literature review. Research was conducted using a scholarly online database search. Databases included EbscoHost, PubMed, ProQuest,

LexisNexis, and Google Scholar. Key terms searched included 'Medicare' and 'fraud', or 'healthcare fraud', or 'Medicare laws.' Federal agency websites such as the Center for Medicare and Medicaid Services, the Department of Health and Human Services, the U.S. Government Accountability Office, the Department of Justice, and the National Health Care Antifraud Association were used. The search was limited to sources written in the English language and published 2006 through September 2013 so as to keep the research current with recent changes in the healthcare field and additional governmental regulations. Primary and secondary data were included from original articles, reports, research studies, and reviews. The findings were categorized by individual case studies.

Results

The aging population has continued to expand and has steadily increased the enrollment in Medicare. The past four years have seen a steady growth of approximately one million 65 years or older enrollees per year.[16] The 65 year old or older population is the main reason Medicare enrollees have increased. Disabled enrollees have decreased by 100,000 individuals from 2008 to 2009, but experienced a larger increase of 300,000 enrollees from 2009 to 2010.[16] From the data reported by CMS, it can be predicted that this number will continue at a steady increase of approximately one million new enrollees every year. By the year 2014 enrollees could easily total more than 51,000,000. The increase can mostly be attributed to the increase of aging baby boomers. (Table 1)

Insert Table 1 about here

More enrollees could overwhelm the Medicare system and lead to more fraud. The number of individuals charged with criminal fraud has/have increased from 797 cases in Fiscal Year 2008 to 1,430 cases in Fiscal Year 2011—an increase of more than 75 %.[17] The ACA was implemented in 2010. With the passage of the ACA federal sentencing guidelines for healthcare fraud have increased by 20%-50%.[17] The ACA also has invested more money into combating fraud in the years 2010 and 2011and more investment is projected for Medicare fraud reduction efforts for each year until 2016 (see Figure 1).

Insert Figure 1 about here

In 2010 the U.S. Department of Justice arrested and charged 28 people for a 25-state scheme to defraud Medicare.[18] Those involved in the fraudulent activity gained more than $35 million for filing wrongful claims before being caught. The evidence that led to the arrests involved bills from ophthalmologists for bladder tests.[18]

According to 2010 data, of the 7,848 subjects investigated for criminal fraud, 25% were medical facilities and 16% were medical equipment suppliers. However, most of the subjects investigated were not pursued. The government tends to only pursue fraud cases if it is believed the outcome will be in their favor, that is, if the likelihood of the government recovering money from those convicted is high. Of the 1,086 charged, 85% were found guilty.[19] The majority of convictions involved individuals with no affiliation, medical facilities, and durable medical equipment suppliers. (Table 2)

Insert Table 2 about here

Civil fraud cases investigated 2,339 subjects with hospitals accounting for nearly 20% of individuals and medical facilities accounting for 18% of cases.[19] Civil fraud is of lesser impact than criminal fraud, but it still contributes to the overall problem. In some cases, without the civil fraud the criminal fraud would not be possible. Cases pursued amounted to 1,087 subjects with 27% being hospitals and about 17% were medical facilities. Approximately 53% of the subjects investigated were not tracked due to lack of resources or funding.[19] (Table 3)

Insert Table 3 about here

The Health Insurance Portability and Accountability Act established the Health Care Fraud and Abuse Control Program (HCFAC). This program coordinated with the federal, state, and local law enforcement to reduce health care fraud.[20] Although, HCFAC is a separate government organization from the HEAT organization, efforts are coordinated as needed. In 2009 and 2010 the HCFAC recovered approximately $25.2 million of taxpayers' money. The majority of the settlement came from two hospitals: Our Lady of Lourdes Health Care Services, and Mercy Health System of Southeastern Pennsylvania. Charges ranged from receiving outlier payments and misleading Medicare about charges to charging for services not rendered. (Table 4).

Insert Table 4 about here

Discussion

Physician Education

Most physicians have earned the respect of both payers and patients after their long journey through four years of medical school and three or more years in residency and

fellowships. Unfortunately, medical schools do not usually include education about fraud in their curricula.[21] Educating physicians about policies and laws designed to prevent fraud would help them to become partners in the mission to keep money from being lost due to Medicare fraud. The Office of Inspector-General of the Department of Health and Human Service created an educational resource that summarizes the main federal fraud laws and provides tips on how physicians should comply with these laws.[21]

Increased Claims Monitoring and Provider Screening

Fraudulent claims have escalated into millions of dollars. A team of forensic accountants could search Medicare databases using Computer Assisted Audit Techniques for: suspicious billings, reimbursements to post office boxes, reimbursements for treatments performed subsequent to death of patients or providers, and dates on which one physician performed more procedures than would be possible to perform in a single day.[22]

The findings of this study suggest that additional provisions and stronger laws combating fraud have been implemented. Not only do those convicted face steep fines but also lengthy prison sentences. Many new programs and partnerships with government agencies have also been developed to combat Medicare fraud such as the HEAT, HCFAC, and provisions in the ACA. Physicians and other healthcare personnel are now being held more accountable with the tougher laws and penalties.

On the other hand, Medicare fraud in the U.S. is costing the government more than $54 billion each year. The government has to bear to cost of fraudulent Medicare claims as well as providing resources to fight the fraud.

Study Limitations

Medicare fraud has often gone undetected, therefore it is under-reported and thus the cases presented represents only a small percentage of the true amount involved Medicare fraud. Researcher bias also cannot be excluded from this study. The search strategy was also limited in this study as only a select few databases were utilized to collect articles. Search terms were limited to gathering the most relevant articles. Publication bias may also be present; many of the studies found were from government agencies as opposed to independent research studies.

Practical Implications

This research has shed light on a gigantic issue facing the U.S. healthcare industry. With the massive amount of healthcare fraud taking place more resources need to be allocated to help eliminate this issue. Increased monitoring of Medicare claims could help decrease some of the fraudulent charges Having forensic accounting teams monitoring incoming claims could decrease fraudulent Medicare charges.. Educating physicians and other healthcare personnel on eliminating healthcare fraud could raise awareness of the issue and reduce fraudulent charges. Teaching healthcare providers the importance of honesty and integrity in reporting claims has the potential to drastically decrease fraud. Making sure providers know the repercussions of Medicare fraud could make some think twice about committing fraud. Medical schools could also start educating physicians on healthcare fraud laws and policies so that physicians are familiar with them after they graduate. Further research must be conducted to expose the true extent to which healthcare fraud exists and to develop potential solutions to the problem.

Conclusion

Medicare fraud has been a persistent crime, and laws and policies themselves have not been enough to control the problem. Further investments in governmental partnerships and new detection systems can reduce Medicare fraud but probably will not eliminate it altogether. It will require continuing vigilance to “keep a lid on” the problem.

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Table 1: Medicare Enrollment by Year 2006-2010 and number of Disabled Individuals

Year	Medicare Aged and Disabled Enrollees	Persons Aged 65 or older	Disabled Persons
2006	43,252,055	36,255,198	6,996,857
2007	44,009,68	36,674,382	7,335307
2008	45,517,331	37,762,265	7,755,066
2009	46,121,666	38,496,923	7,624,743
2010	47,242,711	39,319,157	7,923,554

Source: (CMS, 2012)[16]

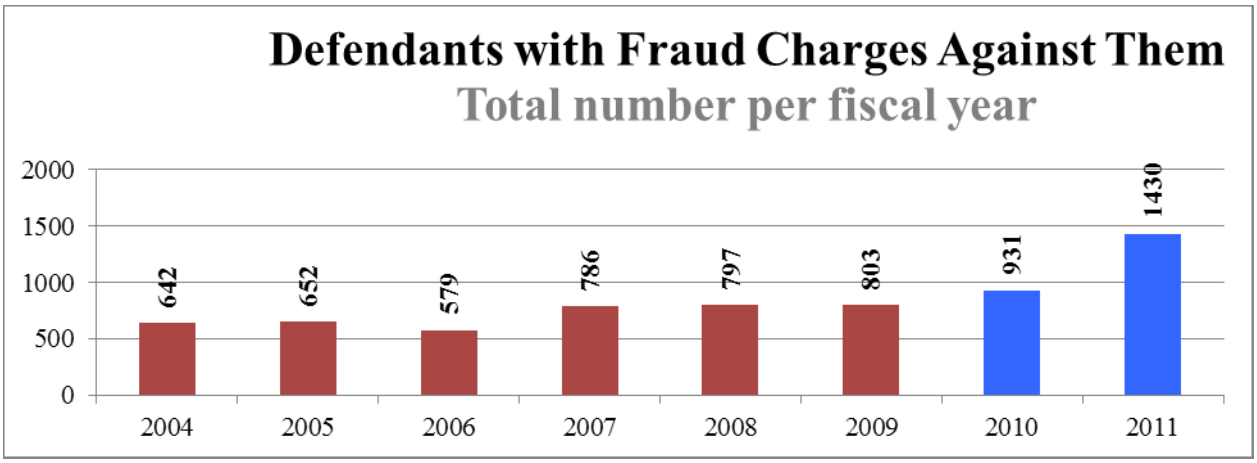

Figure 1: Number of Defendants with Fraud Charges (The White House, 2012)[17]

Table 2: Number and Percentage of Criminal Health Care Fraud Subjects That Were Found or Pled Guilty or No Contest by Provider Type, 2010

	Number of subjects that were found or plead guilty or no contest	**Percentage of total number of subjects that were found or pled guilty or no contest**
Medical facilities Medical centers or clinics Medial practices	 130 43	18.7%
Durable medical equipment suppliers	171	18.5%
Other centers, clinics, or facilities	58	6.3%
Other	49	5.3%
Home health agencies	42	4.5%
Pharmacies	40	4.3%
Management service providers	33	3.6%
Nursing homes	14	1.5%
Medical transportation companies	14	1.5%
Pharmaceutical manufacturers or suppliers	9	1.0%
Mental health centers, clinics, or facilities	9	1.0%
Medical supply companies	8	0.9%
Insurance companies	5	0.5%
Dental clinics or practices	4	0.4%
Government employees, contractors, or grantees	3	0.3%
Hospitals	2	0.2%
Unknown affiliation Individuals Health care providers Data unavailable	 220 52 19	31.6%
Total	925	

Source: (King, 2012)[19]

Table 3: Number and Percentage of Subjects in Civil Health Care Fraud Cases with Judgment for Government, Settlement, or Both by Provider Type, 2010

	Number of subjects that were found or plead guilty or no contest	**Percentage of total number of subjects that were found or pled guilty or no contest**
Medical facilities Medical centers or clinics Medial practices	 35 65	16.6%
Durable medical equipment suppliers	25	4.2%
Other centers, clinics, or facilities	41	6.8%
Other	5	0.8%
Home health agencies	34	5.6%
Pharmacies	13	2.2%
Management service providers	21	3.5%
Nursing homes	26	4.3%
Medical transportation companies	11	1.8%
Pharmaceutical manufacturers or suppliers	19	3.2%
Mental health centers, clinics, or facilities	5	0.8%
Medical supply companies	3	0.5%
Insurance companies	15	2.5%
Dental clinics or practices	21	3.5%
Government employees, contractors, or grantees	2	0.3%
Hospitals	165	27.4%
Unknown affiliation Individuals Health care providers Data unavailable	 4 34 58	 15.9%
Total	602	

Source: (King, 2012)[19]

Table 4: Health Care Fraud and Abuse Control Hospital Fraud Annual Report

Company	Date	Settlement	Details
Our Lady of Lourdes Health Care Services Inc.	December 2009	$7.9 million	FCA allegations of defrauding Medicare and wrongfully received excessive outlier payments
Brookhaven Memorial Hospital Medical Center	February 2010	$2.92 million	Mislead Medicare program about the costs of care
Lourdes Medical Center	November 2009	$1.2 million	Scheme to seize excessive Medicare outlier payments
Helene Fuld Medical Center	November 2009	$750,062	Scheme to seize excessive Medicare outlier payments
Mercy Health System of Southeastern Pennsylvania	July 2010	$7.9 million	Billed Medicare for one-day hospital inpatient admissions that should have been coded outpatient visits
Kaiser Foundation Hospitals	December 2009	$3.7 million	Billed for outpatient services performed by a resident when teaching physicians was not physically present
SCCI Hospitals of America, Inc.	October 2009	$830,166	Improperly admitted patients to long term acute-care and held patients who did not need hospitalization to increase Medicare reimbursement

Source: (Parver & Goren, 2011)[20]