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Medicare and the ACA: Shifting the paradigm of fraud detection

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ABSTRACT

Medicare fraud and abuse costs are estimated at 3%-10% of overall Medicare spending, which is expected to expand considerably until 2024 and as such the amount of fraud dollars would be expected to increase proportionally. The purpose of this research was to determine how recent reforms, especially the Patient Protection and Accountable Care Act, may affect Medicare fraud and abuse and to uncover the best strategies to combat Medicare fraud. The breadth of fraud and abuse within Medicare as well as recent reforms to fight fraud including legislative reforms, delivery system reforms, and other reforms including the formation of HEAT fraud fighting taskforces are examined. Legislative reforms are noted to be incompatible with the ACA's new P4P delivery and reimbursement reforms. Medicare fraud requires comprehensive detection and prevention measures. Benefits of implementing this dual method of fraud fighting are discussed.

INTRODUCTION

Landmark social legislation signed into law in 1965 by President Lyndon B. Johnson marked the inception of the Medicare program which provided health benefits for all Americans over age 65. In 1972 the program was expanded to include individuals under age 65 with long-term disabilities and individuals with permanent kidney failure, otherwise known as End-Stage Renal Disease (Rettig, 2011). Medicare was initially comprised of two parts, part A for hospital insurance and part B for medical or professional insurance. It has been expanded to include two part C that allows private insurance companies to administer Medicare benefits and part D for a prescription drug benefit.

The health care sector's spending growth rate is attributable to numerous cost drivers. Reimbursement methodologies that are conducive to overtreatment, fragmented delivery, administrative complexities, an aging population, sedentary lifestyles, expensive technologies, lack of transparency in pricing, and fraud, waste, and abuse are among those drivers contributing to the enormous future spending projections (BPC, 2012). Although it has occurred in the private sector as well, Medicare fraud and abuse has become increasingly visible due to taxpayers' stakeholder positions (BPC, 2012). Estimates have suggested that fraud and abuse added at least \$98 billion in spending across both Medicare and Medicaid in 2011 (Goldman et al., 2012).

The terms "fraud and abuse" refer to somewhat different concepts, but are often used as a together (Medicare Learning Network® Podcasts, 2012; Staff, 2016), a convention that will be followed in this paper, as they both result in additional costs for the Medicare program. Medicare fraud and abuse span a wide range of activities from submitting false statements to obtain payment to accepting kickbacks for referrals to misusing claim codes by upcoding or unbundling (CMS, 2014). Medicare fraud schemes have been difficult to detect as the perpetrators range from individuals to complex, organized crime rings (Schencker, 2016). Additionally, schemes may contain false billings for services or supplies that were either not rendered or delivered, false billings for services that were not deemed medically necessary, or making prohibited referrals for designated services (CMS, 2014).

Medicare fraud detection and prevention efforts were made a cabinet-level priority in May 2009 with the creation of Health Care Fraud Prevention and Enforcement Action Team (HEAT). HEAT is a joint effort by the Department of Health and Human Resources (HHS) and Department of Justice (DOJ) and has charged more than 1,400 defendants who have falsely billed Medicare more than \$4.1 billion in 2011 (DHHS, 2014a). In spite of government efforts recovering \$10.7 billion in fraud, waste and abuse since 2008, the Patient Protection and Affordable Care Act of 2010 (ACA) has provided an additional \$350 million to enhance fraud fighting efforts. Additionally, the ACA of 2010 has provided impositions for stricter rules and sentences for fraudulent activities,

enhanced screening procedures, and state-of-the-art predictive modeling technology to advance Medicare fraud strike forces (DHHS, 2014b).

The purpose of this research was to determine how the legislative changes of the ACA and other recent legislative healthcare reform will impact Medicare fraud and what steps should be taken to minimize Medicare fraud within this new legislative framework.

RESULTS

Breadth of the Problem

National health care expenditures reached \$3.0 trillion in 2014 and is projected to grow 1.1% faster than Gross Domestic Product (GDP) per year between 2014 and 2024 (NHE Fact Sheet, 2015; Projections 2014-2024, 2015). Government program expenditures continue to represent a significant portion of national health care expenditures: the Medicare program constituted 20% of health care spending in 2012 at \$572.5 billion (CMS, 2012). National health spending projections have anticipated total healthcare spending to exceed \$5.0 trillion in 2022, accounting for nearly 20% of GDP (CMS, 2013). A projected spending growth of 7.4% through 2022 for Medicare is attributed to the net impact of accelerated enrollment, increased utilization, increased illness complexities, and inflation, offset to some degree by Medicare savings mechanisms implemented in the Patient Protection and Affordable Care Act of 2010 (ACA, 201; CMS, 2013).

The Centers for Medicare & Medicaid Services (CMS) have differentiated fraud from abuse by emphasizing that fraud is intentional whereas abuse is the result of poor medical practices (CMS, 2014c). Although the difference between fraud and abuse remains important in the legal arena, in terms of monies spent on these billing inaccuracies, the result is the same. Fraud and abuse in health care are difficult to estimate, but the Federal Bureau of Investigation in 2007 estimated that 3% to 10% of billings for health care (both public and private) were fraudulent (FBI, 2007), an estimated range which has remained stable (FBI, 2010-2011) despite continued enforcement efforts and newly enacted programs. Unfortunately, Malcolm Sparrow, chair of the executive program on regulation and enforcement at Harvard's John F. Kennedy School of Government and one of the leading academics studying health-care fraud, says CMS' upper bound of 10% estimate is almost certainly low, although he's unable to determent by how much (Korten, 2011).

Unfortunately, the Director of Program Integrity at CMS, Shantanu Agrawal, believes that even the upper bound of this range is not necessarily accurate, stating that "There is no nationally accepted number or even methodology for arriving at a fraud rate" (Eaton, 2016, 17). However, healthcare fraud is projected to increase dramatically due to two factors: the large number of Baby Boomers who are not will receive Medicare benefits over the next decade and the relatively low risk for organized crime in pursuing health care fraud as opposed to other criminal activities (CLEAR for Healthcare Fraud Investigations, 2012).

A series of recent regional Medicare fraud claims has shed further light on the extent of this problem. In 2014 in Kentucky, King's Daughters Medical Center paid \$40.9 million in order to resolve allegations that the hospital had prohibited financial relationships with referring physicians and that the hospital received kickbacks secondary to unnecessary medical procedures including cardiac catheterizations and coronary stenting (DOJ, 2014b). This ruling came nearly immediately after another Kentucky hospital, St. Joseph Health System, settled a False Claims Act accusation for \$16.5 million in an eerily similar claim of providing unnecessary cardiac diagnostic procedures and surgeries (DOJ, 2014a). In 2013 a West Virginia physician was convicted of committing 22 healthcare fraud-related felonies and, although he has yet to be sentenced, faces up to 10 years in prison on each of 13 healthcare-related fraud charges and a fine of \$850,000; 8 years earlier, the same physician had agreed to pay \$310,000, and to voluntarily be excluded from all federal health care programs for 10 years after it was alleged that he submitted false claims to Medicare and Medicaid (DOJ, 2013). Meanwhile, in the national platform, an ongoing investigation into a Medicare fraud conspiracy spanning three facilities from Louisiana to Texas and resulting in the fraudulent billing of approximately \$258 million dollars over a period of 7 years for partial hospitalization program services for the mentally ill that were not indicated or never performed (DOJ, 2014c). One of the facility's owners was sentenced to almost nine years in prison, and the medical director was sentenced to seven years in prison (DOJ, 2015).

Fraud involving durable medical equipment – supplying unnecessary equipment, supplying no medical equipment, paying or receiving kickbacks or referral fees for patients, and/or upcoding the need for medical equipment – is a large component in Medicare fraud (Hesch Firm, 2013). In 2010, spending on DME by public and private payers rose 7.3%, compared with an increase in total health-care spending of 3.9% (Goozer, 2012). Medical facilities and DME suppliers were the largest healthcare industries to be investigated for healthcare fraud as in 2010, with medical facilities accounting for 25% of all investigated cases and DME suppliers accounting for another 16% in (King, 2012).

Legislative Reform

In an attempt to control healthcare fraud a number of statutes have been created and expanded over time. Of these, the following four laws have been significantly modified and expanded to more accurately address the ongoing issues with fraud: the False Claims Act (FCA), the Anti-Kickback Statute (AKS), the Physician Self-Referral Act (Stark Law), and the Civil Monetary Penalty Statute (CMP) (Lovette, 2011). The oldest of these pieces of legislation, the FCA, prohibited persons from knowingly submitting false claims and included protections for whistleblowers in its *qui tam* provisos (FCA, 1863). However, revisions to the FCA have subsequently removed the requirement that the act be committed knowingly and have added a requirement that overpayments must be returned to Medicare within 60 days or the provider may be found liable of fraud by holding the overpayment (Kass and Linehan, 2012). The AKS was enacted in 1972 and has been amended multiple times to address “kickbacks” (any compensation or financial arrangement in which a provider knowingly receives, is offered, or solicits a fiscal benefit of any kind for referrals, purchases, etc.) to physicians and, similarly to the FCA, required the statute to be broken knowingly in order to be considered fraud (AKS, 1972). In order to remain within the guidelines of the AKS providers have operated within “safe harbors” or regulatory exclusions which have been specifically addressed in the law. However, consistent with the changes to the FCA, the AKS has been recently amended by the ACA to remove the requirement that a violation be performed knowingly (Valiant, 2010). In 1992 the Stark Law was enacted to address physician self-referral but was limited to referrals to clinical laboratories. However, that law has subsequently been amended to include a multitude of diagnostic and treatment self-referrals of Medicare patients by physicians or their family members (Stark Law, 1992; AHLA, 2009). The CMP Statute prohibited any entity from filing a medical claim for a service not provided as claimed, is fraudulent, or is not medically necessary, or when such a payment provided a physician with any incentive or payment that could possibly result in decreased care of a patient (CMP, 1996). Although some minor changes were made to the CMP by the ACA, it has been noted that the CMP has never had safe harbors in its statute, unlike the AKS, and therefore any physician payment that led or could possibly lead to a decrease in the patient’s level of care is in violation of this law (Kass and Linehan, 2012).

Delivery System Reform in the ACA

Delivery system reform, as outlined in the ACA, has proposed considerable restructuring to healthcare by tying Medicare payments to integrated, transparent, quality care (ACA, 2010). Delivery system reform in the ACA put heavy emphasis on pay-for-performance (P4P) as opposed to the traditional Fee-For-Service (FFS) model of payment which inherently promoted the over utilization of services (ACA, 2010). In an attempt to move providers towards a P4P system, the ACA has outlined three alternative yet complimentary paths to delivery system reform: the formation of Accountable Care Organizations (ACOs), Bundled Payments for Care Improvement (BPCI), and the Patient-Centered Medical Home (PCMH) (Kass and Lineham, 2012).

The intent of ACO formation was to reduce silos of care and the redundancy of services to promote collaboration among providers, hospitals, and all those within the spectrum of healthcare delivery within a defined population of Medicare patients (Valiant, 2010). ACO formation was strictly regulated and included both internal and external program integrity requirements designed to minimize fraud and abuse (ACA, 2010). Internally, an ACO must have incorporated the development of a compliance plan, a written conflict of interest policy, the certification of compliance of all ACO members, maintaining continuous quality control and internal monitoring/auditing. Externally administered through CMS, ACOs are subject to the screening of ACO applicants, a prohibition of cost-shifting, as well as penalties up to and including termination of the ACO for violations that harm beneficiaries (The Mintz Levin Healthcare Group and Sternfield, 2011).

The PCMH model of care revolves around integrated care provided by a primary physician with whom the patient has a stable relationship with and in which particular attention is paid to preventative care and the meeting of positive health outcomes (Davis, Abrams and Stremikis, 2011). PCMHs are paid on a P4P, but have also received additional monies to pay for the necessary infrastructure (Davis, Abrams and Stremikis, 2011). It is hoped that PCMHs will significantly reduce long term health costs when the emphasis is placed on preventative care and that patient health outcomes such as hospital utilization and readmissions will be significantly reduced as demonstrated in a pilot study which showed a savings of \$10.3 per patient per month and a 6% decrease in hospitalization within 23 months (Reid et al., 2011). Another study (Reid et al., 2013) of PCMH found no statistically significant change in hospital admission rates, but did find a 5.1% decline in primary care office visits in early years of PCMH implementation followed by a 6.7% declines after the PCMH programs implementation year, a 123% increase in the use of secure electronic message threads, a 20% increase in telephone encounters, and declines emergency department visits at 1 (13.7%) and 2 years (18.5%). However, although there are several demonstration projects designed to evaluate the effectiveness of PCMH (e.g., the Federally Qualified Health Center PCMH demonstration which includes 500 medical practices, the Multi-Payer Advanced Primary Care Practice demonstration in eight states, and the Comprehensive Primary Care Initiative run by the Center for Medicare and Medicaid Innovation), the true value of the PCMH model has “yet to be definitively tested” (Klein, Laugesen and Liu, 2013, S88).

Predictive Modeling

Predictive modeling is the use of a fraud detection algorithm made up of multiple algorithms to determine the likelihood of an event, represented by a score of high (likely) to low (unlikely) (Parente et al., 2012). Although relatively new to the arena of healthcare fraud prevention and detection, a similar statistical model has been used extensively within the healthcare finance realm as a means of underwriting insurance claims. Furthermore, predictive modeling has been used successfully with the credit card industry to identify and verify claims that were suspected to be fraudulent (Parente et al., 2012; White, 2011).

As of June, 2011 CMS began streaming all Medicare claims through its new predictive modeling software however, CMS has neither measured, or even defined, quantifiable goals for the model, nor has it measured the benefit of the model (GAO, 2012). CMS implemented 25 different models that fall into 3 categories of predictive models: rules-based models, anomaly-detection models, and predictive models (GAO, 2012). Predictive modeling provided a way for Medicare to prospectively identify potentially fraudulent claims prior to payment, a very different model than the traditional pay-and-chase fraud recovery which requires retrospective review of charges and/or medical records (White, 2011). Parente et al. (2012) estimated that predictive modeling could save an estimated \$18.1 billion annually within Medicare Part B and another \$2.6 billion from Part A, without requiring access to in-depth medical records. Another similar study found that roughly \$65 billion could be saved from Medicare fraud between 2011 and 2019 (Lewin Group, 2009). CMS is now using a predictive analytic system which screens \$450 million in Medicare claims daily, a system which is expected to have a significant effect in identifying and reducing Medicare fraud (Fadairo, Williams and Maggio, 2015). The Fraud Prevention System has now been operational for several years, with savings, certified by the OIG, of \$210.7 million, almost double the amount identified during the first year of the program. This resulted in more than a \$5 to \$1 return on investment, an increase from the previous year's \$3 to \$1 return (CMS, 2014d).

Other Reforms

Additional entities have been recently implemented as a means to diminish healthcare fraud. In 2012, the GAO obligated \$583.6 million in order to fund the Health Care Fraud and Abuse Control (HCFAC) (GAO, 2013). Of those monies, over \$47 million funded HEAT Strike Force teams which it has been operating in nine US cities (GAO, 2013). According to the GAO, the HCFAC estimated a return-on-investment of approximately \$7.90 for every one dollar spent for fiscal years 2010-2012, an improvement from the \$4.90 for every dollar spent for the fiscal year 2006-2008 (GAO, 2013). However, critics of the pay-and-chase method of healthcare fraud purport that healthcare fraud prevention would create higher cost-savings (Parente et al., 2012). The National Health Care Anti-Fraud Association (NHCAA) has suggested several key factors to guide healthcare fraud legislation that included the use of predictive modeling and transparency of care between private insurers and government programs (NHCAA, 2010). Although development of an all-encompassing policy to prevent fraud and abuse through systematic elimination of improper payments would certainly be helpful, such a program is unlikely, given the speed at which health policy reforms historically have been adopted within the United States, and the current

polarization of political viewpoints regarding how our nation's health care system should best be reformed (Lyles, 2013).

DISCUSSION

Medicare fraud is rampant within the healthcare industry and even if rates of fraud and abuse remained stable until 2022, the pay-and-chase method of fraud detection could result in the US paying up to an estimated \$100 billion annually (or 10% of the estimated \$1.0 trillion in Medicare funds). The excessive burden posed by fraud and abuse brings into question the fiscal stability and integrity of the Medicare program as a whole. Comprehensive fraud and abuse efforts must be both preventative and detective to address the overwhelming amount of fraud and abuse adequately.

By shifting the primary focus of Medicare fraud and abuse reduction efforts from detection to prevention the US will pay out less up front to providers. Recent healthcare fraud research has suggested that implementing overall program integrity policies which utilize tactics traditionally used within the business sphere, such a predictive modeling, combined with innovative ideas like healthcare transparency results in significantly decreased levels of fraud. However, in order to implement nation-wide predictive modeling, healthcare must move further toward transparency, as exemplified by RHIOs.

Changing the reimbursement for Medicare may also reduce fraud and abuse payments as well as potentially increase quality of care for patients. Innovative payment ideas such as PCMHs, bundled payments, and ACOs promise much, but remain in their infancy. However, the legislative reforms currently in place are not cohesive with the P4P model, but instead reflect the traditional FFS model. The disconnect between these reforms creates tension in the healthcare community as they attempt to meet the ACA requirements while staying within the letter of the law. In order for reimbursement reforms to be embraced, it is necessary for the legislation to match the ACA's vision and for providers to be quickly and appropriately trained to ensure they are confident in implementation.

Although preventative measures are a major portion of healthcare fraud reform, detection and legal ramifications post-reimbursement are also important in deterring fraud. By enforcing and increasing the criminal liability it is possible that the overall rate of intentional fraud would decrease. Furthermore, investing comprehensive program integrity training and holding providers accountable for maintaining that integrity should also significantly reduce Medicare abuse or unintentional overbilling.

CONCLUSIONS

Significant, ongoing fraud and abuse within Medicare may threaten the program's viability. In order to contain costs of fraud and abuse, decisive and immediate action should be taken that encompasses both fraud prevention and fraud detection efforts. Furthermore, legislative and reimbursement reforms must be revised and made to be complimentary or providers will be wary of participating in ACOs out of fear that such participation may run afoul of legislation designed to prevent fraud and abuse.

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