

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

HEALTHCARE FRAUD IN THE UNITED STATES:  
ASSESSING CURRENT POLICY AND ITS ROLE IN FRAUD PREVENTION

A thesis submitted in partial fulfillment of the requirements  
For the degree of Master of Public Health  
in Health Education

By  
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## Dedication

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## ABSTRACT

### HEALTHCARE FRAUD IN THE UNITED STATES: ASSESSING CURRENT POLICY AND ITS ROLE IN FRAUD PREVENTION

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Healthcare fraud is a serious threat to global health outcomes, leading to financial misuse of scarce resources and negative impacts on healthcare access, infrastructures, and social determinants of health. Healthcare fraud is associated with increasing healthcare costs in the United States, especially to the detriment of federal health programs, specifically Medicare and Medicaid. Despite its importance and the legislative and administrative attentions paid to it, combating fraud remains a challenge in the United States health system. This study provides an overview of the classification and reasons for healthcare fraud, summarizes existing healthcare fraud legislation in the United States, and presents examples of how the policies have impacted the U.S. healthcare market. This thesis will then recommend new strategies on how to prevent future healthcare fraud to decrease healthcare expenditures and use resources for the benefit of the U.S. population.

*Key Words: healthcare fraud, corruption, policy effectiveness, health systems*

## **Chapter 1: Introduction**

Healthcare costs in the U.S. are much higher than those in industrial countries with similar or better health system performance (Bentley, Effros, Palar, & Keeler, 2008). This Chapter will describe why healthcare fraud is a serious problem and partly responsible for the current financial issues challenging the United States healthcare system. Possible causes of unnecessary health expenses could be corruption, fraud, and abuse in healthcare. Since these three terms are often related to describe devious actions in healthcare, a distinction is needed to better understand the difference in order to intervene and implement appropriate policy measures. In general, fraud is defined as making false statements or representations of material facts to obtain some benefit or payment for which no entitlement would otherwise exist (The Centers for Medicare and Medicaid Services, 2012). The National Health Care Anti-Fraud Association (2012), an organization of about 100 private insurers and public agencies, defines fraud as “an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party.” The broad term “corruption” is the “misuse of entrusted power for private gain” (Transparency International, 2009). Forms of corruption are comprised of bribery, embezzlement, fraud and extortion (Andvig, Fjeldstad, Amundsen, Sissener, & Søreide, 2000). Most relevant literature applies the broad term “corruption in healthcare” and “fraud in healthcare” when speaking of deceitful undertakings in healthcare. Both expressions describe an individual’s dishonest activity to the disadvantage of another party of the health system. Examples of other parties would be insurance companies, Medicare/Medicaid, healthcare facilities, the state, health professionals, or consumers.

For the purpose of this research study, the issue will generally be referred to as “healthcare fraud”, unless paraphrased otherwise. This thesis will use “fraud” to refer to “waste, fraud, and abuse,” recognizing that these are distinct, though related, problems. In the health setting, it can encompass bribery of health professionals, regulators and public officials; unethical research; theft of medicines and medical supplies; fraudulent or overbilling for health services; absenteeism; informal payments; embezzlement; and corruption in health procurement (Transparency International, 2009). The term “abuse” sometimes appears in the literature when speaking of practices that, either directly or indirectly, result in unnecessary costs to healthcare, including practices that are not consistent with the goals of providing patients with services that are medically necessary, meet professionally recognized standards, and are fairly priced. Table 1 gives an overview of potential fraud activities at the expense of Medicare/Medicaid found in the literature, listed in the order of their occurrence, from the most common to least common type of fraud.

Table 1: Examples of Medicare/Medicaid Fraud

- Misusing codes on a Medicare claim
- Billing for services not provided
- Double billing
- Billing for phantom visits
- Billing for more hours than there are in a day
- Falsifying credentials
- Substitution of generic drugs
- Billing for unnecessary services or tests
- Billing for more expensive procedures than were performed
- Kickbacks
- False cost reports

[Sources: National Association of Medicaid Fraud Control Units, 2013; The Centers for Medicare and Medicaid Services, 2012]

## **Background and Significance of the Problem**

Health systems of all countries face funding challenges, but at the same time they are expected to reduce their expenses while providing quality care and protecting the public's health (Blank & Buran, 2004). Structural challenges in the healthcare system are one of the reasons for corruption in healthcare. Healthcare fraud has an enormous adverse impact on healthcare quality and safety, while also imposing higher costs on consumers, employers and taxpayers (America's Health Insurance Plans, 2013).

The financial and operational structures of any given health care system affect the types of fraud possibly occurring in it. Researchers conclude that the fundamental reason why health systems are an attractive target of fraud is that the industry's standard detection and control systems are not aimed at criminal fraud (Sparrow, 2000). More specifically, public and private insurers pay the bills from healthcare providers usually on trust without checking any details or questioning the necessity of treatments. Although there are many dishonest participants in the health system, payment systems are not yet aimed at detecting fraud effectively (Sparrow, 2000).

Fraud is rarely detected because officials simply do not contact patients to find out if the health service charged was actually delivered. Structural features of the U.S. healthcare system include: the fee-for-service structure with its highly automated claims processing systems, post-payment audits that focus on medical appropriateness of health services, and private sector involvement for health delivery (Sparrow, 2008). Because Medicare and Medicaid serve so many people and provide a significant

portion of funding in the U.S. healthcare, they are often targeted for fraudulent behavior. The United States Government Accountability Office (GAO) has designated Medicare as a high-risk program, as its complexity and susceptibility to payment errors from various causes, coupled with its size, have made it vulnerable to fraud (Government Accountability Office, 2012).

Medical professions represent a large group of participants who deliver healthcare. In 2011 there were 11.8 million healthcare providers in the United States (The Henry J. Kaiser Family Foundation, 2013). Literature reveals examples of how physicians and other healthcare professionals take advantage of the patients' vulnerability (Sparrow, 2000). For example, some providers run excessive expensive tests, implement ineffective treatments, and recommend the use of unnecessary medical equipment while charging the expenses to the patient or the insurance company for financial gain (The Centers for Medicare and Medicaid Services, 2012). Research indicates that health systems are vulnerable to fraud and corruption activities, whether they are predominantly public or private, well or poorly funded (Vian, 2008). It is essential for private and public health insurance programs to prevent fraud and protect patients and payers in healthcare. Corruption in health weakens health systems and delivery, leads to financial waste and adverse health consequences internationally (Mackey & Liang, 2012). More precisely, corruption has a direct impact on the poor by denying them access to services and thereby jeopardizing their health (United Nations, 2011). Often through misappropriation and corruption of government funds in underdeveloped countries, corruption threatens the United Nations Millennium Development Goals 2015, in particular the three directly related to health – child mortality; improved maternal health, and the fight against AIDS, malaria and other diseases (Transparency International, 2012; United Nations,

2013). They range from “halving extreme poverty rates to halting the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015” (United Nations, 2013). The poor are disproportionately affected by corruption in the health sector because they are not able to pay bribes for fee services, and cannot afford other or private alternatives (Transparency International, 2006). Healthcare is probably the area where fraud has the most direct negative impact on human life, because people have to wait longer for treatment or they do not get the quality of care they would otherwise have had (Gee, 2009).

The statements above indicate that corruption in healthcare leads to human suffering and neglect of diseases because it can deprive people of access to proper healthcare and lead to inappropriate treatments. For instance, one serious case of healthcare fraud occurred on April 16, 2013 with a physician in the San Fernando Valley, California. This example clearly illustrates the scope of the issue (The Centers for Medicare and Medicaid Services, 2012). As some of his patients were Medicare beneficiaries, the physician obtained their beneficiary information to bill Medicare for procedures he did not perform, sometimes involving patients who were already dead. In addition to defrauding Medicare, the doctor was arrested for allegedly sexually assaulting a patient under the guise of conducting a physical examination (United States Department of Justice, 2013). Numerous other American physicians have served prison terms, paid fines, or faced other civil, criminal, and administrative penalties for accepting kickbacks, upcoding bills, or making improper self-referrals which led to the exclusion of more than 5000 physicians who are currently excluded from participation in the federal health care programs because of these types of violations (Taitzman, 2011).

Another example can also be seen in the pharmaceutical industry. In this industry, corruption has a direct and painful impact on individuals because patients have no choice but to trust in the statements of the pharmaceutical company regarding the place of origin, quality, and exact ingredients of the drugs. Traditionally, physicians and pharmacists have been trusted to provide treatments and recommend products in the best interest of the patient. Due to aggressive drug marketing some patients may now be using prescription drug items, unaware that their physician or pharmacist is being compensated for promoting the selection of a specific product (Toothman, Moore, & Lee, 2011). The consequences can be very serious, especially if the composition and content of the pharmaceutical product are harmful and is being inappropriately used to treat the wrong diseases. Transparency International (2006) confirms that the implications of counterfeit drugs that accelerate the spread of drug-resistant diseases can be deadly. The above statement demonstrates the negative effects of corruption in the pharmaceutical sector which is characterized by huge profits and influence, and thus entices corruptive activities such as counterfeit drugs, adulterated substances, misbranding, and illegal imports.

Accordingly, humans need to be protected from the risk of falling victim to fraudulent activities in healthcare which can be harmful to their health. Moreover, every dollar saved through prevention of healthcare fraud can be spent to grant individuals' access to healthcare, improve services, and save lives. As Benater, Gill, & Bakker (2011) explain, "Improved global health depends on achieving greater social justice, economic redistribution, and enhanced democratization of production, caring social institutions for essential health care, education, and other public goods" (p. 646).



The diversity of health systems worldwide, the multiplicity of parties involved, the paucity of good record keeping in many countries, and the complexity in distinguishing among corruption, inefficiency and honest mistakes make it difficult to determine the overall costs of corruption in this sector around the globe. In the United States, 15.3% of the Gross Domestic Product (GDP) is being spent on healthcare. This percentage is more than any other industrialized nation spends on healthcare. An estimated 5-10% of the two largest U.S. public health care programs, Medicare and Medicaid, are lost to 'overpayment' (Transparency International, 2012).

It is furthermore estimated that in 2011, between 21 and 34 percent of the annual costs to the U.S. health care system were wastefully spent (Berwick & Hackbarth, 2012). The 2010 Patient Protection and Affordable Care Act (ACA) provides for several different programs which intend to have a positive impact on the effectiveness and delivery of healthcare services, and quality of patient-centered care as they include new tools to prevent, detect, and take enforcement against fraud in health care (U. S. Department of Health and Human Services, 2012). Policymakers have implemented successful programs that help to reduce unnecessary healthcare costs and contribute to an affordable health care system. Data-mining, legal consequences and innovative anti-fraud-activities may reduce fraud. However, there is a lack of evidence regarding the effectiveness of interventions to combat fraud (Rashidian, Joudaki, & Vian, 2012). Additionally, the roles of participation in fraud by key actors in health care need to be examined before additional anti-fraud strategies and effective control measures can be proposed to policymakers (The University of Alabama School of Law, 2013). Overall, fraud activities in healthcare are a form of corruption that is preventable and its prevention can drastically reduce healthcare expenses and improve the population's health status.

## **Purpose of the Study**

As of time of this publication, a thoroughly conducted literature review revealed that although many studies documented the problem, no studies exist that examine the impact of anti-corruption-policies in the United States in reducing healthcare expenses and fraud.

Although the U.S. government has recovered \$10.7 billion of healthcare fraud through new policy and legislation, enhanced screening, improved technology, and resources within the last three years, the need to further reduce healthcare expenses is urgent because corruption in health care continues to grow in the United States (Saltiel-Busch, 2012; U.S. Department of Health and Human Services, 2012). Most relevant literature discusses corruption at the government level and loss of confidence in the public sector. However, these studies rarely review the health sector, and frequently focus on developing countries. There is a lack of evidence about the magnitude of healthcare fraud and the impact of anti-fraud policies on the United States health care system. There are very few studies that discuss the impact of policies of the U.S. health system on healthcare fraud and health expenses. Some studies have been conducted on the effect of anti-fraud prevention approaches, but they refer either to developing countries or they have found no evidence of the effect of the interventions (Rashidian, Joudaki, & Vian, 2012; Vian, 2008; World Health Organization, 2011). Although it is known that corruption is less likely in societies where there are well established policy and laws, the United States is still in need of more transparency, effective policies, strong accountability mechanisms, and preventive and monitoring measures (Transparency International, 2006; U.S. Department of Health and Human Services, 2012). The lack of evidence of

effectiveness and response to healthcare fraud issues is very likely because not enough attention has been given to this topic as an academic issue. Virtually no academic researchers publish on the topic of healthcare-related fraud activities, largely because - as Malcolm K. Sparrow, a prominent expert on fraud and Harvard professor on the practice of public management, testified recently - it “falls awkwardly between the traditional disciplines of health economics, health policy, crime control policy, anomaly detection and pattern recognition (United States Senate Committee on the Judiciary, 2013). Another possible explanation is that serious research on the issue is not much appreciated (Sparrow, 2000) or easy to document. Thus, further research such as the present proposed study, is urgently needed to identify ways to combat fraud and reduce health expenditures to inform policymakers with strong recommendations that eventually improve the public’s health.

## Chapter 2: Study Methodology

This research study is a content analysis of existing policy for current U.S. healthcare fraud prevention that can provide recommendations to strengthen health systems and enhance the population's health quality. Considering preceding explanations, it is becoming clear that healthcare fraud has serious consequences which require effective interventions. Training, education, increased federal enforcement of fraud, and abuse monitoring are examples of strategies to prevent fraud and abuse in health care. This research study will examine the features of the U.S. health system which make it vulnerable to corruption. As part of this paper, a systematic review methodology was used to assess the existing anti-corruption strategies and policies in the United States. As mentioned in Chapter 1, statistics reveal that corruption in health care has increased. This study aims to analyze existing policies in place to protect against fraud in the U.S. healthcare system and their influence on prevention of healthcare fraud, to provide examples of successful policies that have reduced health expenses, and to suggest new approaches on how to strengthen the U.S. health system through prevention of corruption activities in the health sector from a policy perspective.

*The proposed research study is, therefore, significant* because it provides an analysis of current policies in place. Assessing the impact of current anti-corruption approaches will help to establish the foundation from which interventions can be developed to improve fraud prevention and decrease costs. To ensure a practical, realistic, and scientifically relevant approach of the study, a content analysis of anti-

fraud policies that exist in the United States will be conducted. This research study will investigate the types of fraud in healthcare, explain who commits them, and why the healthcare system is susceptible to fraud. More specifically, the achievements and complications of current fraud policies in the United States will be examined. This study provides examples of how policy has reduced fraud activity in the U.S., and suggests new approaches for preventing health care fraud in the future.

### **Specific Aims of the Study**

This study accomplished its objectives by pursuing the following two specific aims:

*Specific Aim #1:* Identify the current state of healthcare fraud and health expenses in the U.S. to gain a deeper understanding about the frequency, severity, and consequences of corruptive activities in the U.S. health system.

*Specific Aim #2:* Identify existing anti-corruption laws and policies in the United States as well as domestic and international collaborations, and assess the impact of these approaches.

The results generated by the successful completion of this study can, therefore, be expected to provide information that will *positively impact* the economic situation of the healthcare market. The proposed study is consistent with the 2010 Patient Protection and Affordable Care Act's mission to "combat health care fraud, waste and abuse by providing critical new tools to crack down on entities and individuals attempting to defraud Medicare, Medicaid, and other health care programs" (U.S. Department of Health and Human Services, 2012).

## **Research Questions and Study Hypothesis**

The rationale for this research study was that once the current policies are known, appropriate, targeted intervention strategies and examples of effective prevention programs to reduce the healthcare costs in the United States can be suggested to policymakers, resulting in lowered fraud expenditure. By doing this, the proposed study contributes to good governance that strengthens health systems, provides insight and transparency to the issue of healthcare fraud, and supports a reduction of healthcare costs in the future.

For reasons of clarity and readability, the following information is illustrated as bullet points.

### **A. Research Questions**

1. What are the existing anti-fraud policies in the U.S. healthcare market?
2. What are some examples of how fraud policies have reduced healthcare expenditures?
3. What future strategies that would prevent healthcare fraud and decrease expenses in the U.S. can be suggested to policymakers?

### **B. Study Hypothesis**

Fraud prevention policy exists in the United States and provides a system of fiscal responsibility.

## **Methodological Approach**

This study uses a content analysis approach in an attempt to provide an unbiased, objective and systematic analysis of U.S. healthcare fraud with the goal of making valid inferences from published literature and resource documents.

Several different organizations and government and private agencies deal with the issue of healthcare fraud in the United States. The information collected for this analysis was derived from literature searches found in the Delmar T. Oviatt Library at California State University Northridge, the U.S. Library of Congress (Congressional Research Service), and through online searches in Google Scholar databases, PubMed databases (U.S. National Library of Medicine National Institutes of Health), Cochrane reviews for evidence-based healthcare, the U.S. Department of State Alumni journal article databases, as well as other governmental agencies, universities and research institutions addressing this issue. The appropriate literature included in the content analysis was comprised of books, journal articles, governmental reports, congressional hearings to the U.S. Government Accountability Office (GAO), news releases from the Department of Health and Human Services, policy briefs, memoranda, letters, and from personal interaction with concerned public agencies (Appendix A), including the U.S. Department of Justice; the Congressional Office of Representative Henry Waxman, the Federal Bureau of Investigation; the Office of Inspector General (U.S. Department of Health and Human Services), and from communication with U.S. experts on the topic whose contact data were retrieved from their journal articles.

As Marc Wolfson, Senior Public Affairs Specialist at the Office of Inspector General, confirms, “there is no central repository of healthcare fraud policies, because each agency has either proprietary (private industry) or internal work product

(government) policies that are unique to each agency” (Appendix A, personal communication, March 28, 2013). Wolfson furthermore goes on to explain that most anti-fraud policies are not published online because they could potentially highlight detection techniques to healthcare criminals. Thus, an interdisciplinary approach of using several different sources was used to compile this study. More specifically, since the available current literature to conduct this study was very limited, the searches were not only conducted on “healthcare” databases, but also relevant websites published in criminal justice or law journals, as well as books dealing with the economics and politics of corruption were additionally considered and appropriately applied to healthcare. Although some books that were included in this study were a little dated (one book older than 10 years), they were found to be very useful for inclusion. Information found in the books gave a great overview of the issue, and was actually recommended for use in this study by Dr. Taryn Vian, a leading healthcare fraud expert at Boston University School of Public Health. The “fraud related terms” used in the online search strategy focused on journal articles published in the time period from 2008 to 2013. The literature review included the terms “informal payments, kickback, transparency, corruption, global health governance, bribery, waste, fraud and abuse in healthcare, Medicare fraud, Medicare laws, regulations and rules”. The terms were used in various combinations in order to ensure high sensitivity of the results. The search strategy comprised of a combination of text words and Medical Subject Headings (MeSH) terms relating to the research questions (Appendix B). The online searches were conducted between December 19, 2012 and April 12, 2013 in the online databases mentioned above, and resulted in 976 documents. A total of 53 papers published were identified and content-analyzed. The sampled data was then used to retrieve information about the current state of



healthcare fraud policies and interventions in the U.S. Key concepts of the issue and existing policies were examined, summarized, and evaluated. Reliability and replicability of the study through other researchers, as well as validity and trustworthiness of the data collected are essential when assessing the quality of research studies. Overall, this research study based on secondary data has a widely used content analysis methodology. This methodology is often applied to health policy matters, and therefore it is considered an appropriate approach to answer the research questions of this study.

### **Public Health Implications of the Study**

According to Bell (2010), the goal of health research is to use findings to influence health policy. Bell (2010) indicates when designing research for health policy decision support, considerations of validity and credibility are crucial. The proposed study is very important to population health because fraud in healthcare has negative effects on health status and social welfare. Health disparities are largely a product of social and economic inequalities (U. S. Department of Health and Human Services, 2010). Advancing the health of communities and granting them affordable access to healthcare are important goals of the 2010 Patient Protection and Affordable Care Act (U.S. Department of Health and Human Services, 2010). However, existing empirical work on the effects of corruption in healthcare indicates that corruption threatens healthcare access, equity and outcomes in the United States (Jacobsen & Krieger, 2011). Healthcare fraud affects health outcomes and social welfare because individuals in need of care do not receive appropriate healthcare. Delay in seeking treatment can lead to serious illnesses. This is not only to the disadvantage of

individuals but also has a negative impact on the society because consequently, the medical costs increase to the disadvantage of government, patients, and insurers.

Fraud further impacts the social determinants of health for those who are challenged economically. In particular, those who are already economically disadvantaged are more affected by fraud because they are not able to access and afford healthcare due to a lack of financial means. For example, disadvantaged populations may be unable to pay inflated healthcare charges for treatment.

“Although there have been convictions for multimillion dollar schemes that defrauded the Medicare program, the extent of the problem is unknown as there are no reliable estimates of the magnitude of fraud in the healthcare industry” (testimony of King, 2012).

The health sector is characterized by the fact that a large amount of public funds are spent (Vian, 2008). A significant proportion of these funds are fraudulently transferred to private parties. Knowledge about fraud prevention in healthcare is an important factor influencing health expenses. As previously mentioned, the structure and governance of health system can contribute to corruption. There are tools to measure corruption, such as perception and expenditure surveys, qualitative data collection, control systems reviews (Vian, 2008). However, expenses related to healthcare fraud require reforms to combat corruption. Despite the adverse effects of corruption in health care, little empirical research has investigated how healthcare fraud prevention affects the cost and quality of medical care. This could possibly be due to the prevalence of a thirdparty payment systems and the sheer size of the sector (Becker, D., Kessler, D., McClellan, M., 2005). This study helps policymakers identify ways to increase accountability, transparency, detection of corruption, and to reduce monopoly power. The proposed study can help to reduce unnecessary health expenditure, and is

therefore essential for the development and cost-effectiveness of the U.S. health care system. The study does not only focus on the U.S. governmental healthcare programs Medicare and Medicaid programs but its recommendations are also valid for the private sector as this sector is greatly involved in reimbursement for health services and hence vulnerable to fraudulent activities. In addition, this study will contribute to the literature and provide a greater understanding of the impact of the understudied economic and political factors on fraud in healthcare.

### **Chapter 3: Effects of Healthcare Fraud on the U.S. Healthcare System**

The global corruption report of the World Health Organization documents corruption on a vast scale in both rich and poor countries, and its enormous cost to public health (2006). Fraud and abuse in healthcare have a negative impact on the health system of a country and its society. This Chapter will discuss the effects of healthcare fraud on the U.S. healthcare system. It is unknown how much fraud there is in the U.S. health sector. Compared to the banking industry, which knows its fraud loss almost down to the penny, the healthcare fraud transaction rate in the U.S. is 30 to 100 times greater (Simborg, 2011). Represented substantial threats are pervasive as corruption reduces the effectiveness, efficiency, and equity of health services, and leads to negative health outcomes and adverse effects on development (Carpenter, Edgar, & Dang, 2003; Vian, 2008).

#### **Healthcare Fraud from a System's Perspective**

Health system performance is an important indicator of the health state of the individuals and expresses the state of health equity. All health care systems have patients, providers, plan sponsors, and other administrative staff they work with. In addition to that, Vian (2008) claims that there are five key players in the health system: (1) government, (2) suppliers of drugs, equipments, and construction, (3) payer, e. g. social security, health insurance, (4) provider - public or private, and (5) patients. The examination of roles and relationships between them can identify

potential fraud and abuses that are likely to occur. Generally spoken, patients, hospital, physicians, pharmacies, clinics, medical equipment suppliers, nursing homes, home healthcare providers, transportation providers, hospice providers, and other healthcare providers could commit healthcare fraud. However, according to experience of experts and research, it is estimated that the vast majority of fraud and nearly all of the abuse is perpetrated by healthcare providers (Coalition Against Insurance Fraud, 2013).

### **Forms of Healthcare Fraud and Vulnerability of Health Systems to Fraud**

Healthcare fraud can have different forms; for instance, it can appear as health insurance fraud or false claims regarding provider education. Organized crime often includes healthcare fraud because the penalties are lower than those for other offenses. Furthermore, there are low barriers to entry, schemes are easily replicated, and there is a perception of a low risk of detection (Morris, 2009). Healthcare fraud can be divided into healthcare practices areas, ranked in the order of occurrence in the literature:

Table 2: Types of Healthcare Fraud

<ol style="list-style-type: none"><li>1. Hospital fraud</li><li>2. Long-term care and skilled nursing facilities fraud</li><li>3. Home healthcare fraud</li><li>4. Anti-kickback and Stark Act violations</li><li>5. Coding fraud</li><li>6. Medically unnecessary services</li><li>7. Laboratory fraud</li><li>8. Ambulance transport fraud</li></ol>
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[Source: Vogel, Slade & Goldstein, LLP, 2013]

Health care fraud typically involves false statements, cover-up strategies, and misinterpretations of value or services (Saltiel-Busch, 2012). According to Kochan

and Goodyear (2011), corruption is “the cause of deep and enduring problems in government, businesses, and civil society” (p. 1). It can happen in all areas of businesses, governments, countries, institutions. Vian (2008) also explains that examples of corruption in the health sector can occur in *service delivery* (informal payments required from patients, theft of user fees, unnecessary referrals to private practice for financial gain); in *education of health professionals* (bribes to gain place in medical school or to obtain passing grades); in *medical research* (inadequate standards of informed consent in developing countries; or in *purchasing of equipment, supplies, and drugs* (bribes and political considerations influence winners of bids, unethical drug promotion). Overall, healthcare fraud schemes often target one of the following: pursuit of money, avoidance of reliability, addiction, competitive advantage, and emotional drivers such as revenge, boredom, egoistical challenge, and self-imposed justice (Saltiel-Busch, 2012).

### **Social, Economic and Political Consequences**

Healthcare fraud threatens patient safety, reduces the quality of care, and wastes scarce healthcare money (America’s Health Insurance Plans, 2012). Although there is no precise measure of fraud and corruption in the healthcare sector and most healthcare providers are honest and well-intentioned, a minority of providers and patients are intent on abusing the healthcare system, and consequently put the health system, people’s health, and welfare at risk (European Healthcare Fraud and Corruption Network, 2013).

As the World Health Organization (2010) indicates, the latest estimate of global healthcare expenditure is \$4.7 trillion per year, whereas \$260 billion is lost

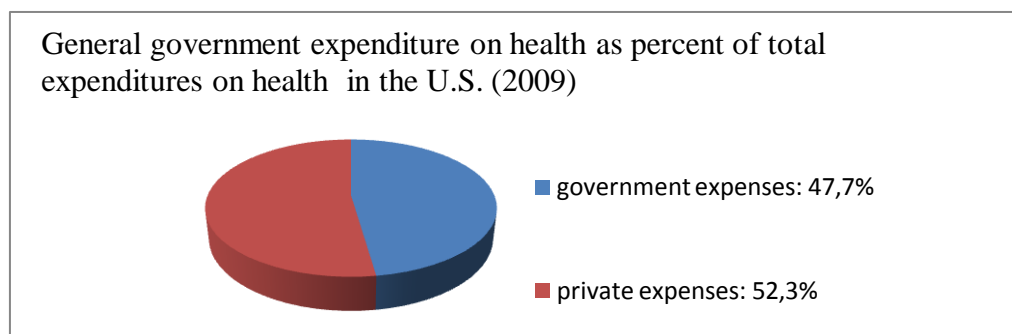
globally to fraud. Skaricic (2011) claims that these avoidable expenses caused by fraud and corruption threaten the financial management of healthcare systems globally

The latest report about Medicare fraud mirrors the negative impact of fraud on community health. According to the report, 90% of more than \$200 million in questionable billing practices at for-profit community mental health centers occurred in states that do not require the mental health centers to be licensed or certified (The Centers for Medicare and Medicaid Services, 2011). For example, in 2010, top officials at a leading chain of Florida community mental health centers were arrested in connection with a scheme involving about \$200 million in fraudulent Medicare claims (Mental Health Weekly, 2012). This example supports literature discussing the vulnerability of the health sector is to fraudulent activities. Thus, it is essential not only for maintaining the reputation of responsible mental health clinics but to ensure that patients receive necessary and appropriate treatment (Mental Health Weekly, 2012). Establishing standards to monitor provider activities, requirements for provider's education, and implementation of anti-fraud legislation will help to reduce incidence of inappropriate Medicare billing practices, decrease expenses caused by healthcare fraud, and improve community health.

According to Benatar, Gill, and Bakker (2011) governments should provide healthcare as a public duty to citizens as part of social solidarity. Health insurance is associated with better health outcomes for adults and with their receipt of appropriate care across a range of preventive, chronic, and acute care services (Harrington & Estes, 2004). Health insurance in the U.S. is being offered by different private and public organizations. Health insurance for employees of the public sector is primarily provided by the government. Other governmental U.S. healthcare programs are Medicare, Medicaid, TRICARE for uniformed services, the Children's Health

Insurance Program, and the Veterans Health Administration (Robert Wood Johnson Foundation, 2008). Figure 1 below compares the percentage of health expenditure spent by government and by private sources in the U.S. It illustrates that 47,7% of the health expenses are taken care of by the U.S. government. It actually shows how urgent interventions to address the issue of increased health expenses in both the private and public healthcare sector in the U.S. are, for example through fighting healthcare fraud. As all public healthcare programs are at risk to fraud, this statement proves how important healthcare fraud prevention is, and thus is in alignment with the hypothesis of this study that fraud policy exists in the United States and provides a system of fiscal responsibility.

Figure 1: Comparison between government and private health expenditure in the U.S.



[Source: The Henry J. Kaiser Family Foundation, 2013]

All healthcare programs are vulnerable to fraudulent actions; however Medicare and Medicaid are the most commonly affected programs (National Health Service Counter Fraud and Security Management Service, 2006). Medicare and Medicaid are government-operated healthcare programs in the United States. Medicare is a health insurance program for people age 65 or older, people under age 65 with certain disabilities, and people of all ages with End-Stage Renal Disease,



whereas Medicaid covers low-income and financially needy people, including those over 65 who are also on Medicare (The Centers for Medicare and Medicaid Services, 2012). The latest statistics (2009) reveal that as of 2012, 16% of the U.S. population were Medicare beneficiaries, and 20% of the U.S. population were Medicaid beneficiaries (The Henry J. Kaiser Family Foundation, 2013). Since between 16% and 20% of the U.S. population is covered by Medicare and Medicaid, there is a high probability of Medicare/Medicaid fraud because the major health care programs are attractive targets for fraud. Besides detrimental economic consequences, corruption hinders social growth, undermines competition in an economy and therefore affects productivity of a nation, harms the reputation of the country or state, and reduces the effectiveness of the public sector (The World Bank Group, 2011).

## Chapter 4: Combating Healthcare Fraud in the United States

This chapter will discuss some actions that government and private organizations have taken to fight healthcare fraud. It will then evaluate the impact of anti-fraud legislation on the issue. During the research for this study it was found that many different organizations made great efforts to collaborate in order to fight fraud and corruption on a national and international level. Table 3 shows which agencies play an important role in investigating and prosecuting fraud. As the table below summarizes, anti-corruption efforts can be divided into international, transnational, national, and local approaches.

Table 3: Typologies of Anti-Corruption Strategies

<b>Level of Action</b>	<b>Specific Actions</b>
<b>International</b>	World Bank and IMF policies OECD efforts to criminalize transnational bribery United Nations Development Programs and United Nations policies Transparency International's interventions
<b>Transnational</b>	USA 's Foreign Corrupt Practices Act (FCPA)
<b>National</b>	Procedures and training within state or public sector institutions 'Service culture' approaches 'Islands of integrity' Capacity-building to 'design out' corruption Legal approaches, including state funding of parties and patronage appointments Anti-corruption agencies Auditor Generals and Parliamentary oversight The police and 'Inter-agency' co-operation
<b>Local</b>	Structural reform, e.g., decentralization and deregulation New administrative procedures (e.g., overlapping jurisdictions, customerization of public services and service delivery surveys) Complaints and redress

[Sources: The World Bank, 2011; United Nations, 2013]

Table 3 confirms that although several anti-fraud policies exist in the U.S., only few address healthcare fraud, especially regarding federal healthcare programs such as Medicare and Medicaid (Evbayiro, 2009). It is noteworthy to mention that further research indicates that very few of the agencies had recent data or an emphasis on healthcare fraud despite its emerging implications on the U.S. population and its health and wealth.

### **Current Anti-Fraud Policies in the United States Healthcare System**

Some of the healthcare fraud policies in the U.S. that are directed at improper activities in the healthcare market include the False Claims Act, the Medicare and Medicaid Anti-Kickback Statute, the Physician Self-Referral Statute, the Exclusion Statute, and the Civil Monetary Penalties Law (Krause, 2004). In the U.S., healthcare fraud is addressed by national and state laws depicted in Table 4 that are part of federal policies that are directed toward poverty alleviation according to the eight United Nations Millennium Development Goals (United Nations, 2013).

Table 4: Overview of Existing Healthcare Fraud Policies in the United States (as of March 2013)

<b>Current law or policy</b> (order according to importance revealed from literature)	<b>Details</b>
Criminal Health Care Fraud Statute	<b>Year of Establishment:</b> 1996  <b>Purpose:</b> Prohibits a scheme to defraud any health care benefit program
Health Insurance Portability and Accountability Act of 1996 (HIPAA; Public Law 104-191)	<b>Year of Establishment:</b> 1996  <b>Purpose:</b> combat fraud and coordinates federal, state and local law enforcement

	<p>related to healthcare fraud including both public and private health plans</p> <p><b>Monetary or other results identified:</b></p> <p>Returned over \$23.0 billion to Medicare since 1996; in 2012 won over \$3.0 billion in health care fraud judgments and settlements</p>
False Claims Act	<p><b>Year of Establishment:</b> 1863</p> <p><b>Purpose:</b> Prevent government from damages through false claims</p>
Physician Self-Referral Law (Stark Law)	<p><b>Year of Establishment:</b> 1989</p> <p><b>Purpose:</b> Prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she has a financial relationship (ownership, investment, or compensation), unless an exception applies</p>
<p>Prevention measures under the Patient Protection and Affordable Care Act (ACA)</p> <ul style="list-style-type: none"> <li>• Swipe Card Pilot</li> <li>• Next Generation Desktop (NGD)</li> <li>• Medicaid and CHIP Business Information Solutions (MACBIS)</li> </ul>	<p><b>Year of Establishment:</b> 2010</p> <p><b>Purposes:</b></p> <p>initiative to modernize and transform the information and data exchanges with states and other key health reform stakeholders</p> <p>provide single access point that interacts with all Medicare claims processing systems and multiple other government data sources</p> <p>Medicare and Medicaid efforts to analyze all Medicare fee-for-service claims using risk-based algorithms</p>
One Program Integrity	<p><b>Year of Establishment:</b> 2012</p> <p><b>Purpose:</b> detect fraud, waste, and abuse with consistent, reliable, and timely analytics</p>
Civil Monetary Penalties (CMPs)	<p><b>Year of Establishment:</b> 1989</p>

	<p><b>Purpose:</b> based on the type of violation at issue. Penalties range from up to \$10,000 to \$50,000 per violation</p>
Anti-Kickback Statute	<p><b>Year of Establishment:</b> 1987</p> <p><b>Purpose:</b> It makes it a criminal offense to knowingly offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program</p>
Fraud Investigation Database (FID)	<p><b>Year of Establishment:</b> 2010</p> <p><b>Purpose:</b> centralized data entry and reporting system run out of the CMS Data Center that allows CMS to monitor fraudulent activity and payment suspensions related to Medicare and Medicaid providers</p>
Fraud Prevention System (FPS)	<p><b>Year of Establishment:</b> 2011</p> <p><b>Purpose:</b> Prevent payment of fraudulent health care billings; find and stop scams that cut across public and private payers</p>
Revalidation Project	<p><b>Year of Establishment:</b> 2011</p> <p><b>Purpose:</b> efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries</p>
The Command Center	<p><b>Year of Establishment:</b> 2012</p> <p><b>Purpose:</b> technology tool to revoke Medicare billing privileges and payment suspensions in order to reduce fraud and improper payments</p> <p><b>Monetary or other results identified:</b> In 2012: identified 223 action items that will lead to improvements in the fraud prevention and detection process</p>

[Sources: U. S. Department of Health and Human Services, 2013; Department of Justice, 2013; U.S. Library of Congress, 2010]

As Table 4 illustrates, there are different tools and resources for anti-fraud activities in healthcare. The scale of corruption is enormous in both rich and poor countries (Transparency International, 2009). In the U.S., anti-fraud activities are comprised of federal and state policies to improve healthcare fraud detection and investigation. Efforts are being made to improve the advancement of technologies and computer programs, and to improve collaborations of a multi-disciplinary team of experts and decision-makers to efficiently coordinate policies and case actions. Furthermore, the policies attempt to reduce duplication of efforts, and to streamline fraud investigations for more immediate administrative action (U.S. Department of Health and Human Services, 2012). In the U.S., healthcare fraud is investigated by the Federal Bureau of Investigation (FBI) and the Centers for Medicare and Medicaid Services (CMS), the U.S. Attorney General, State District Attorneys, as well as by some private sector organizations. In most cases, healthcare fraud has been exposed by whistleblowers (Shi & Singh, 2008). Table 5 summarizes the partnerships that support Medicare with fraud prevention tasks.

Table 5: Medicare Fraud and Abuse Prevention Partnerships

<b>Partnership</b>	<b>Details</b>
<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>	partners with different entities and law enforcement agencies to prevent and detect fraud and abuse
<b>Center for Program Integrity (CPI)</b>	promotes the integrity of Medicare through audits and policy reviews, identification and monitoring of program vulnerabilities, and support and assistance to states
<b>Health Care Fraud Prevention and Enforcement Action Team (HEAT)</b>	build and strengthen existing programs to combat Medicare fraud while investing new resources and technology to prevent fraud and abuse

<b>General Services Administration (GSA)</b>	maintains the Excluded Parties List System (EPLS) that includes information on entities debarred, suspended, proposed for debarment, excluded, or disqualified throughout the U.S. Government from receiving Federal contracts or certain subcontracts and from certain types of Federal financial and non-financial assistance and benefits
<b>Office of Inspector General (OIG)</b>	protects the integrity of the HHS' programs, including Medicare, and the health and welfare of its beneficiaries

[Source: U. S. Department of Health and Human Services, 2013]

Despite the collaborations listed in Table 5, more partnerships with national and international fraud experts are desirable to make progress in this important area of unnecessary health expenditure to the disadvantage of the U.S. government. As major fraud fighters in the U.S. health system, the Centers for Medicare and Medicaid Services organize their activities to reduce anti-fraud as follows: 1. Prevention, 2. Detection, 3. Transparency and Accountability, 4. Recovery (U.S. Department of Health and Human Services, 2013). Their *prevention* activities include usage of data systems to efficiently and proactively evaluate inappropriate billing, and educating entities about potential fraud, waste, and abuse. As for fraud *detection*, they identify potential overpayments, conduct complaint investigations, and provide support to law enforcement agencies for investigations of potential fraud and abuse. In summary, their fraud prevention activities are based on *transparency and accountability*, important principles of ensuring their program integrity (U.S. Department of Health and Human Services, 2013).

The fraud prevention efforts of the Centers for Medicare and Medicaid Services mentioned above as well as the partnerships confirm the hypothesis of this study which assumes that fraud policy exists in the U.S. and provides a system of

fiscal responsibility. In general, all countries can do something to improve the efficiency and equity of their health systems by setting rules and enforcing them. According to the World Health Organization (2012), most countries have reason to look critically at their current situation and should decide how they can promote good governance which is important for economic and social development. However, good governance includes reliability, predictability, accountability, transparency, and the rule of law (Transparency International, 2006).

Although Table 4 proves that anti-corruption laws and policies exist in the United States, the characteristics of good governance are missing when it comes to corruption in the health sector, a major issue yet to be solved. This means that more transparency, laws, and accountability through collaborations and examinations are necessary. Despite the essentially invisible nature of corruption in healthcare, it was considered to be such a serious issue by the Clinton Administration (based on cases revealed) that in 1993, Attorney General Janet Reno declared healthcare fraud America's 'number two crime problem', second only to violent crime (Transparency International, 2006). In the past, legislators have failed to appropriate sufficient funds to combat waste, fraud, and abuse in Medicare and Medicaid (Iglehart, 2009). The Clinton Administration (1992 - 2000) began a healthcare reform campaign and focused on preventing healthcare fraud within the Medicare and Medicaid programs. More recently, in January 2010 the Department of Health and Human Services and the Department of Justice launched a series of regional healthcare fraud prevention summits aimed at increasing awareness for health care fraud. In September 2010, a significant anti-fraud provision was signed into law by President Obama as part of the Small Business Lending Act. This anti-fraud provision requires Medicare's traditional fee-for-service program to examine bills and mark potentially fraudulent claims prior



to payment. This means that Medicare is now required to use predictive modeling techniques, such as those used by private insurers, to proactively identify health care fraud.

The effectiveness of these interventions remains to be seen. Despite all efforts, fraud prevention from a governmental perspective has been developing slowly. Statutory efforts to rein in fraud have changed over time from attempts to reclaim fraudulent payments to more aggressive actions to identify and prevent criminal activities (Robert Wood Johnson Foundation, 2012). Additionally, despite the huge amount of dollars spent in health, healthcare economists have paid little attention to this big issue. This is the case although it is one of the priority issues to be addressed in the forthcoming 2010 Patient Protection and Affordable Care Act for which President Obama announced the acceleration of government efforts to pursue healthcare fraud. According to Sparrow (2000), “The first important rule of fraud control is: What you see is not the problem. It’s what we don’t see that really does the damage” (p. 2).

This statement confirms that it is complicated to reveal fraud, and to find reliable data which can be used for the purpose of fraud prevention. It supports the goal of this study to find strategies that prevent healthcare fraud before it occurs. This study was charged with the task to examine existing policies that prevent healthcare fraud, and thus focuses only on the part of prevention of healthcare fraud. In this context, it was revealed that despite federal efforts to combat fraud, in the U.S., there is no “headquarter” fraud prevention agency for the health sector which could explain the lack of national and interdisciplinary collaborations as well as the lack of topical data. These findings led to recommendation (2) of the study findings: improved collaboration among fraud fighters that are discussed in Chapter 4 of this study.

This Chapter shows that healthcare fraud is a significant problem, but difficult to detect and prevent. It also illustrates that some of the anti-fraud legislation has been established a long time ago, yet had fighting healthcare fraud not been a priority issue until the implementation of the Patient Protection and Affordable Care Act in 2010. Overall, this chapter confirmed the study hypothesis that healthcare fraud policy is a fiscal responsibility that exists in the U.S. Now that the governmental efforts focus more on this issue, considering development of technology and necessity of research in this area and establishment of partnerships, one can expect greater success in combating healthcare fraud in the U.S. than before which helps reducing costs so that this money can be used to promote the public's health instead being wastefully spent. Hence, it is assumed countering fraud even more effectively would reduce losses and free up resources for better patient care.

### **Examples and Impact of How Policy has Reduced Healthcare Expenditures in the United States**

One can assess the impact of policy on healthcare fraud by considering the accomplishments of the federal and private sectors using them as tools to fight healthcare fraud.

Since the private health insurers and the public healthcare programs in the U.S. are working independently and are each different clearing systems, their anti-fraud-efforts are primarily focused on either the public or the private sector. Thus, the best approach to determine the impact of policies in the U.S. healthcare market seemed to be through a breakdown within this study into the impact of policy on governmental healthcare programs and on private insurance companies to ensure a realistic evaluation of the impact of existing anti-fraud policies on each sector.

Determining the effectiveness of a specific policy or law is not possible because of lack of criteria for measuring its effectiveness. Besides, policies that were recently implemented as part of the 2010 Patient Protection and Affordable Care Act do not provide sufficient information regarding their impact on health expenditure and fraud prevention, so that they do not yet enable effectiveness analysis.

## **Public Sector**

Possible ways to address the issue of fraud in healthcare are to initiate collaborations such as healthcare fraud prevention partnerships, and to identify strategies to decrease costs related to one of the major categories of waste, fraud and abuse in health care (Berwick & Hackbarth, 2012). An example of such a major collaboration is the Health Care Fraud Prevention and Enforcement Action Team (HEAT) which is a joint effort between the U.S. Department of Health and Human Services and the Department of Justice to combat health care fraud (U.S. Department of Health and Human Services, 2012). HEAT is made up of teams of analysts, investigators, and prosecutors who target fraud schemes, including fraud by criminals masquerading as healthcare providers or suppliers, using of state-of-the-art fraud detection technology (U.S. Department of Health and Human Services, 2012). As for Medicare fraud and abuse laws, the False Claims Act, Anti-Kickback Statute, Physician Self-Referral Law (Stark Law), Social Security Act, and the U.S. Criminal Code are used to address fraud and abuse in the United States. Violations of these laws may result in nonpayment of claims, Civil Monetary Penalties (CMPs), exclusion from the Medicare/Medicaid Programs, and criminal and civil liability (The Centers for Medicare and Medicaid Services, 2012). Additionally, the U.S. Department of Health and Human Services (2012) reports that in October 2012, anti-fraud

investigators conducted a data-driven analysis that led to criminal charges against 91 health care providers, which included doctors, nurses and other licensed medical professionals – for their alleged participation in Medicare fraud schemes involving approximately \$432 million in false billing from fraud in the areas of home health care, community mental health care, and ambulance transportation. Although several corruption prevention strategies to clarify the decision-making process through policies and to strengthen the information systems have been described in the literature, their impact is uncertain.

To summarize the successes of the anti-fraud efforts so far, the government recovered a historic \$4.1 billion in 2011, resulting in more than \$10 billion recovered since 2008 (The Centers for Medicare and Medicaid Services, 2012).

In its first year of implementation, the Centers for Medicare and Medicaid's Fraud Prevention System generated leads for 538 new fraud investigations, provided new information for 511 existing investigations, triggered 617 provider interviews and 1,642 beneficiary interviews. The 50 state Medicaid fraud control units recovered \$2.9 billion from civil and criminal cases during fiscal year 2012 which represents a return on investment of \$13.48 for every dollar spent by federal and state governments for medical fraud units operations (Centers for Medicare and Medicaid Services, 2012). Additionally, Medicare Strike Force's charges against 91 individuals for their alleged participation in Medicare fraud schemes involved approximately \$432 million in false billing (U. S. Department of Health and Human Services, 2013). Table 6 mirrors cost recoveries resulted from public anti-fraud programs.

Table 6: Cost Recoveries Resulting from Public Anti-Fraud Programs, 2008-2012

<b>Strategy Used for Success</b>	<b>Recovered Amount</b>	<b>Year(s) of Recovery</b>
New policy and legislation	\$10.7 billion	2008 to 2012
Other governmental operations	\$4.1 billion	2011
Civic and Criminal Cases	\$2.9 billion	2012

[Sources: Centers for Medicare and Medicaid Services, 2012; U.S. Department of Health and Human Services, 2013].

A number of government organizations in the United States investigate healthcare fraud, such as the U.S. Department of Justice (through the Criminal Health Care Fraud Division and the Civil Health Care Fraud Division), the Internal Revenue Service, the Department of Health and Human Services Office of Inspector General, the Federal Bureau of Investigation, and state Medicaid fraud control units. These organizations and other internal anti-fraud programs have helped to reduce fraud. However, more effective interventions such as increased transparency and accountability, improved detection and enforcement, reduced monopolies and incentives are still necessary (Vian, 2008). Successful efforts to stop fraud without burdening legitimate providers are possible. Consequently, fraud prevention requires continuous political support, more aggressive and innovative approaches, and a deep understanding about why fraud happens, where fraud happens, and what attracts individuals to corruption (Huss et al., 2011; Morris, 2009).

## Private Sector

The organization America’s Health Insurance Plans (2008) conducted a mixed method study amongst anti-fraud professionals that included both quantitative data collection and open-ended questions. The study allowed anti-fraud professionals to describe their views and challenges, views of fraud and abuse claims, detection strategies, and to report savings related to anti-fraud efforts of insurance companies with small, medium size and large plans from 2006 to 2008 (America’s Health Insurance Plans Center for Policy and Research, 2011). In total, responding companies had 95 million enrollees. Study results show that among the large companies in the survey, estimated net savings from anti-fraud operations (savings less costs) were over \$3 per enrollee, resulting in an estimated total net savings of nearly \$300 million in 2008 (Table 7). Generally, the 2010 Patient Protection and Affordable Care Act brings about important changes to the private health insurance market. Anti-fraud policies apply to the public as well as to the private sector. The private sector has plans to improve its anti-fraud efforts. In order to do so, exchange of information about fraud schemes and more collaboration between private and public sector are needed (America’s Health Insurance Plans Center for Policy and Research, 2011).

Table 7: Estimated Cost Savings Resulting from Private Anti-Fraud Programs, 2008

<b>Company Size</b>	<b>Combined Enrollment</b>	<b>Plans’ Estimated Net Savings per Enrollee</b>	<b>Cost per Enrollee</b>	<b>Savings per Enrollee</b>
<b>Large Plans</b> (more than 5 million enrollees)	84,086,643	\$3.45	\$0.25	\$3.70

<b>Medium Plans</b> (1 million to 5 million enrollees)	9,143,786	\$1.05	\$0.65	\$1.70
<b>Small Plans</b> (fewer than 1 million enrollees)	1,949,182	\$2.70	\$1.30	\$4.00

[Source: America's Health Insurance Plans, 2011]

### **Overall Evaluation of Impact of U.S. Healthcare Policies**

National health spending has been growing at historically low levels, by 3.9% each year from 2009 to 2011. This is the lowest rate of growth since the federal government began keeping such statistics in 1960 (The Henry J. Kaiser Family Foundation, 2013). This begs the question whether this slowdown of health expenditures is a result of economic factors, structural changes in the health system including policy changes, or a combination of the two. It may be difficult to associate cost saving as being an outcome of national healthcare fraud prevention policy. However, it can be determined that since the 2010 Patient Protection and Affordable Care Act which does have a healthcare fraud prevention program, national health spending has been growing at lower levels than before. As mentioned earlier, the government recovered a historic \$4.1 billion in 2011, resulting in more than \$10 billion recovered since 2008 (The Centers for Medicare and Medicaid Services, 2012). For every dollar spent on health care-related fraud and abuse investigations in the last three years, the government recovered \$7.90 which is the highest three-year average return on investment in the 16-year history of the Health Care Fraud and Abuse (HCFAC) Program (U. S. Department of Health and Human Services, 2013). Thus,

one can assume that healthcare fraud measures and laws have been contributing to this positive financial development.



## **Chapter 5: Future Directions and Conclusion**

### **Policy Implications**

Unless scandal hits, the management of an organization does not pay much attention to fraud control (Sparrow, 2000). Fraud control is little developed, and as mentioned earlier, there is little research done on this topic. Thus, effective fraud policy is difficult because there is little instruction from academia, or expert guidance in the field available. Furthermore, policymakers may have the desire to improve health and prevent healthcare fraud but ultimately they must take action within the financial and time constraints imposed by a pressured policy environment (Lin & Gibson, 2003). The policymakers do not have time to explore data bases and seek out research relevant to their work so they rely not only on their legislative aides, but also on researchers from the field who provide evidence-based research to help implement appropriate anti-fraud actions in the U.S. healthcare system.

### **Recommendation of Appropriate Fraud Prevention Strategies for Future Use**

In order to improve healthcare fraud prevention programs in the U.S., additional efforts to prevent healthcare fraud are needed. Overall, current literature suggests a strong focus on eliminating opportunities for fraud and on prevention before healthcare fraud takes place. The following table lists recommendations for future prevention of healthcare fraud in the U.S., based on issues discussed in the literature, and supported by experts' opinions. The *four recommendations* offered for policymakers' consideration are (1): physician's education, (2): improved

collaborations among fraud prevention experts, (3): increased claims monitoring and provider screening, and (4): enhanced healthcare fraud policies and law enforcement. Table 8 represents a summary of the four recommendations. It is proposed that recommendations 2 and 3 work best if they are tied together, assuming they would not be very effective without each other. Recommendation 4 (enhanced healthcare fraud policies and law enforcement) can work most effectively if recommendations 2 and 3 are in place.

*Recommendation (1): Physician's Education*

Educating physicians about the implications of healthcare fraud and how to prevent it can help them to recognize the importance of the issue. Their awareness of the implications of healthcare fraud can support them and their staff to avoid billing errors and thus can help to ensure quality care and cost-containment in the U.S. health care system. While medical school curriculum reform is desired, in the meantime, it is recommended that the American Medical Association continues to include fraud education as part of their list of Continuing Medical Education (CME) activities. It is understandable that physicians do not want to spend too much time and efforts on administrative issues and billing matters. However, since the business of reimbursement is part of a physician's responsibilities, teaching fraud and abuse in medical school curriculum is crucial to help physicians prevent violations of existing billing practices and laws (The Centers for Medicare and Medicaid Services, 2012).

*Recommendation (2): Improve collaboration among fraud fighters*

As discussed previously, the U.S. does not have an established "headquarters" anti-fraud agency for the health sector. Thus, private and public entities might not be

aware of new research and tools to fight healthcare fraud. It is essential that the expertise of fraud prevention experts from the public and private sector are brought together to prevent future healthcare fraud. A national agency which coordinates collaboration and supports strong working relationships among fraud prevention experts from both the private and the public sector in the U.S. is desirable. Consequently, the experts could share information and experiences about fraud schemes, billing codes, and geographical hotspots to help each other combat healthcare fraud before it occurs (America's Health Insurance Plans, 2012; Waxman, 2012).

*Recommendation (3): Increase claims monitoring and provider screening*

The system lacks routine monitoring and control procedures, making the current system vulnerable to fraudulent attacks (Shi & Singh, 2008). Making efficient use of all available tools, both human and technological, will contribute to fraud prevention through predictive modeling, data mining, relationship analytics, and other technology based approaches in preventing and detecting fraud (The Centers for Medicare and Medicaid Services, 2012).

*Recommendation (4): Enhance healthcare fraud policies and law enforcement*

It has been proven throughout this paper that consistent implementation and application of law can contribute to fraud prevention and detection and help to contain fiscal costs (Department of Justice, 2013). As the examples mentioned in Chapter 4 reveal, clear healthcare fraud policies and rigid law enforcement are necessary actions to continue to address this issue in the future.

Table 8: Recommendations for Improving Fraud Prevention in Both Private and Public Healthcare Programs

Intervention to prevent healthcare fraud	Examples	Mechanisms
	<b>Recommendation (1): Physician´s Education</b>	
A. Physician´s education and awareness aimed at changing knowledge, attitudes or beliefs about healthcare fraud; developing skills to address issue	Physician´s guide on legal and morale behavior; education through medical schools and medical associations	Improve knowledge and changes in attitudes could change perceptions and reduce motivation to commit fraud. It can lead to improved competency to identify and do something about fraud
	<b>Recommendation (2): Improve collaboration among fraud fighters</b>	
A. Establish an independent global working agency to coordinate anti-corruption activities	Global healthcare fraud prevention agency with primary function of centralized leadership, coordination or implementation of anti-corruption activities	Leadership and coordination could help to ensure that effective anti-corruption policies are implemented
B. Collaboration between the public and private sectors	Data-sharing both internally and externally can promote information sharing between the private and public sectors	Enhancing anti-fraud cooperation between private and public entities is crucial to the success of fraud prevention efforts
	<b>Recommendation (3): Increase claims monitoring and provider screenings</b>	
A. Improving pre- and post-payment review of claims	Monitor payments more closely to ensure that timely detection and prevention of fraud through improved claims review takes place	Effective detection techniques such as usage of automation, data-mining and other proactive techniques can help prevent and detect fraud

B. Improve screening of suppliers and providers	Highlight key relationships among suppliers, providers, and individuals when receiving their healthcare claims to possibly identify groups working unlawfully together	Use of sophisticated technology, for example for provider relationship analysis to detect collaborative fraud activities among providers
<b>Recommendation (4): Enhanced healthcare fraud policies and law enforcement</b>		
A. Increase implementation and enforcement of laws	Increase sentences for healthcare fraud and apply stricter law enforcement actions	Improve clarity regarding healthcare fraud policies and implement rigid law enforcement to prevent fraud from happening in the first place and allow for tough measures against perpetrators

### **Study Limitations**

This study has some limitations worth mentioning. First, it relies on secondary data such as anti-corruption laws, reports, journal articles, books, and health policy briefs. Possible future policies that are in its preparation phase may not be identifiable to include in this research since they are not publicized and not accessible to the researcher yet. Thus, new suggested anti-corruption approaches identified in the scope of this research study might already be in preparation of being implemented. For example, during the time period of conducting this research study, some anti-fraud rules, such as for example “Medicare Program; Reporting and Returning of Overpayments” launched on February 16, 2012 to reduce healthcare fraud, were proposed. Since they have not yet become a policy and their effectiveness is unknown, they are not considered in this study. Future studies could examine the impact of this

rule, and determine if overpayments of Medicare were returned through providers and suppliers.

Next, the content of this study addresses a very sensitive issue. This means that another study limitation is bias related to self-reported documented data that might lead to inaccurate documented results in the content analysis. Thus, an additional limitation of this study could be the reliability of data which is oftentimes based on estimations since corruption is such a “hidden” phenomena but also due to the lack of criteria to measure the effectiveness of governmental policies.

As for reliability of the study, there is a risk of bias due to qualitative nature of the study. Although objectivity is a challenge, it is noteworthy that the study was objectively conducted since it was based solely on literature and not on personal opinions or estimation. The recommendations for future prevention of healthcare fraud are based on issues discussed in the literature, and supported by experts’ opinions. This means that another researcher, following identical procedures, with similar data can arrive at a similar conclusion and at similar recommendations for policy implementation.

Lastly, another limitation is that the recommendations do not include an implementation plan, but could serve as a future research study.

### **Recommendations for Future Research**

This study implies opportunities for future research that can be used to support policy work. It provides a basis for understanding healthcare fraud and a foundation for evaluating the impact of healthcare fraud policies. This thesis conveys that healthcare fraud is a complex problem which threatens healthcare access, equity and

outcomes. It proves that healthcare fraud policies in the U.S. exist and have contributed to slower increase of health expenditure. Policymakers and leaders in the health sector are increasingly recognizing the necessity to address this complex issue more effectively to strengthen the U.S. health system. The study also reveals that healthcare fraud policies are still in the development process and applied practically since the implementation of the 2010 Patient Protection and Affordable Care Act. Time and future research on this topic will reveal the effectiveness of healthcare fraud policies addressing fraud detection, prevention, and law enforcement.

As for future research, it would be worthwhile to assess the effectiveness of new regulatory requirements as a result of the 2010 Patient Protection and Affordable Care Act. At first, future research should make efforts to determine how much healthcare fraud exists. As aforementioned, this issue of corruption is a hidden phenomena making it difficult to get reliable data. But through good documentation, timely bill review, and through tireless fraud prevention and persecution, it is possible to improve future data collection and data analysis. Finally, future research should assess the impact and effectiveness of particular policies on healthcare fraud by defining suitable criteria and frameworks to assess the effectiveness of healthcare fraud policies from a federal and state point of view. Because of the lack of reliable data and information on the subject of healthcare fraud, policymakers are at a disadvantage in preventing future waste and fraud in the U.S. health care system. Future researchers may want to develop in-depth analyses of U.S. healthcare fraud prevention strategies and the impact of training and education of fraud prevention.

Although the recommendations made for future prevention of healthcare fraud refer to the U.S. only, it did not create an implementation plan. Future research could

create a global anti-fraud collaboration framework that addresses global health corruption and actually implements the recommendations made in this thesis. Once the U.S. has established firm policies that respond to healthcare fraud, it should focus on developing this global anti-fraud collaborative framework. This framework can lead to improved global collaboration across public and private agencies, to more research and guidance on healthcare fraud prevention, and to effective use of anti-fraud investment. Thus, resources can be used for the improvement of population health.

## **Conclusion**

The goal of this research study was to assess the impact of anti-fraud policies in the United States. In particular, it evaluated to which extent existing policies have been helpful to prevent healthcare fraud. In summary, this study has answered the posed research questions, has led to a greater understanding of the issue, and attempted to advance the existing literature about healthcare fraud in the U.S. This study illustrates that healthcare fraud is a large contributing factor contributing to the growing cost of healthcare in the United States. It has also confirmed the study hypothesis that fraud policy exists in the United States and that it provides a system of fiscal responsibility. If healthcare fraud is not effectively addressed, more individuals will be unable to afford the healthcare that they need. It is crucial that the U. S. government takes more effective steps to identify and prevent fraud to decrease health expenditures. As the information shared in this study revealed, it is essential to focus on the causes and rationale of healthcare fraud for effective prevention. It is therefore important to allow for preventive measures that contribute to reduce the opportunities for healthcare fraud. In this context, Sparrow (2010) emphasizes that effective fraud-



control systems have to consider a well-educated audience of sophisticated criminals, some of them medically or technologically qualified. Thus, state and local legislators and policymakers, law enforcement agencies, prosecutors, health care administrators and insurers, and researchers need to collaborate by exchanging knowledge and sharing experiences. This will ensure that the experts from multiple disciplines who aim to combat fraud will be informed about fraud schemes and can constantly make efforts to prevent, detect and persecute fraudulent activities. It is certain that fraud prevention is less costly to the public compared with persecution of detected cases (Baggott, 2000). Overall, it remains to be seen how the implementation of additional anti-fraud legislation and enforcement will promote accountability and transparency, and how they will affect healthcare expenditures.

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Appendix A: Email from Marc Wolfson, Office of Inspector General, Department of Health and Human Services, Washington D.C.

Public Affairs <Public.Affairs@oig.hhs.gov>

Thu, Mar 28, 2013 at  
4:53 PM

To: fabienne.lorenz.307@my.csun.edu

Ms. Lorenz,

I am writing in response to your Email of March 27, 2013 sent via the Stop Medicare Fraud website.

There is no central repository of healthcare fraud policies, because each agency has either proprietary (private industry) or internal workproduct (government) policies that are unique to each agency.

Obviously, most anti-fraud policies are not published online because they could potentially highlight detection techniques to healthcare criminals.

However, there are some broad sources of information that may be useful:

1. Most recent HCFAC Report: <https://oig.hhs.gov/reports-and-publications/hcfac/index.asp>
2. National Healthcare Anti-Fraud Association: <http://www.nhcaa.org/>
3. AHIP: <http://www.ahip.org/Issues/Fighting-Health-Care-Fraud-and-Abuse.aspx>
4. AMA: <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/regulatory-compliance-topics/health-care-fraud-abuse.page?>
5. CMS: [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud\\_and\\_Abuse.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf)

Additionally, there are a number of white papers available through the Internet (with a simple Google search) showcasing the use of data analytics to detect health care fraud. Most of these white papers are written by vendors but they often contain useful information.

I hope you find this information useful & wish you much success in your research and studies.

Regards,

Marc Wolfson  
Senior Public Affairs Specialist  
Office of External Affairs  
Office of Inspector General  
Department of Health and Human Services  
Washington, DC 20201

## Appendix B: PubMed Online Databases Search Strategy

Database: PubMed (U.S. National Library of Medicine National Institutes of Health)

(United States of America\*[ad]) AND healthcare fraud\* [mh] OR corruption\* [tw]  
OR informal payments\*[tw] OR kickback\*[tw] OR transparency\*[tw] OR global  
health governance\*[mh] OR bribery, waste, fraud and abuse in healthcare\*[tw] OR  
medicare fraud\*[mh] OR medicare laws\*[mh] OR regulations and rules health  
systems\*[tw] OR National Health Programs\*[mh] OR policy [mh])

Publication dates 2008 to 2013

Languages: English, German