

LIFT PERSPECTIVE

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Health Care Fraud

Health care fraud is defined by the National Health Care Anti-fraud Association (NHCAA) 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 party¹. In 1998 it was estimated that three to five percent of all health care expenditures were the result of fraudulent claims. Therefore, \$3.5 billion in Texas and \$55 billion nationally were misspent. With costs for health care increasing yearly, it is prudent to look at the issue of fraud both as a means to control the cost of health care for the individual covered by private insurance, and as a means for cutting costs where the government is the purchaser of health care.

Medicare

A Morass of Rules and Regulations

The Office of the Inspector General of the U.S. Department of Health and

includes estimates of the cost of payments based on fraudulent claims as well as improper payments attributable to errors.² In 1997, federal investigators revealed that unjustified payments, a category that includes both billing errors and outright fraud and/or abuse, accounted for approximately \$23 billion in overcharges to the Medicare program in 1996--or 14 percent of all program expenditures.³

Key Issues:

- Fraud should be rooted out and vigorously prosecuted.
- Fraud should be distinguished from the honest mistakes made by individuals.
- Policy makers should beware of efforts to fight fraud through the creation of a centralized database to be used in conjunction with a unique health identifier.
- Efforts to model the Medicare system after private health insurance provider operations could be beneficial and promote individual liberties.

The federal Medicare program is comprised of a complex combination of central planning and price controls administered through the Health Care Financing Administration (HCFA). The scope of this agency's regulatory authority encompasses virtually every aspect of the financing and delivery of health care services to America's retirees. According to the Mayo Foundation, of the 132,729 pages of federal healthcare regulations, laws, rules, guidelines, and related paperwork, over 110,000 are related to the Medicare program. Congress and the executive branch continue to add to the regulatory

Human Services (HHS) estimates that Medicare improperly paid \$12.6 billion in medical claims in 1998. This figure

burden. For example, the Balanced Budget Act of 1997 required the HCFA to implement approximately 335 separate regulations, reports and other administrative actions.⁴

The Government Accounting Office (GAO), after reviewing HHS data from 1997, concluded that the portion of improper payments "attributable to fraud" is unknown.⁵ Dr. Nancy Dickey, a past president of the American Medical Association, points out the weaknesses of the federal government's data on fraud and abuse:

The government relies on an "estimate" of improper payments based upon a review of claims that were filed for 600 Medicare patients. That's 0.0015 percent of Medicare's 39 million beneficiaries. It's from this sample that officials project that \$12.6 billion is being ripped off the system.⁶

Because the government's assessment of unjustified Medicare payments is an estimate and does not distinguish clearly between outright fraud and honest billing mistakes by doctors or other providers, it is not possible to quantify clearly the magnitude of the problem produced by fraudulent claims. It appears certain that a significant portion of improper payments arise from clerical errors and confusion regarding regulations. As Dr. Robert Waller, Chairman Emeritus of the Mayo Foundation, explains:

The public has been led to believe that the Medicare program is riddled with fraud, when, in reality, complexity is the root of the problem. This has contributed

to the continuing erosion of public confidence in our health care system. We must all have zero tolerance for real fraud, but differences in interpretation and honest mistakes are not fraud.⁷

Systemic Issues

As more instances of Medicare fraud have surfaced, it has become apparent that many problems are inherent in the system. Since 1993, six Medicare contractors have been the targets of federal civil and criminal actions because of conspiracy, obstruction of federal audits, falsification of documents and false statements to HCFA auditors. In July 1999, the Justice Department announced that two more Medicare contractors had pleaded guilty to criminal activity related to Medicare.⁸ These contractors are the private insurance carriers in each state that administer the Medicare program for the federal government. They are the very entities, which are charged with assisting the HCFA in rooting out fraud and abuse.

The GAO stated in 1999 that the HCFA's oversight of Medicare contractors is poor. Among the complaints by the GAO were charges that the HCFA seldom validated Medicare contractors' internal controls, set few performance standards for contractors, conducted uneven and inconsistent reviews and lacked a structure that assured accountability.⁹

The Texas Perspective

In 1997 the Texas Legislature passed legislation (SB 30) that provided a package of reforms intended to improve the state's ability to combat fraudulent acts committed against publicly funded programs. Among other things, SB 30

mandated the consolidation of staff from the Sanctions Department of the Health and Human Services Commission (HHSC), the Utilization and Assessment Review Section at the Texas Department of Human Services, the Policy Analysis and Claims Review Sections at the Texas Department of Health into the Office of Investigations and Enforcement (OIE). The OIE has three primary operating functions:

- Medicaid Program Integrity (MPI) - responsible for investigating allegations or complaints of Medicaid fraud, abuse or misuse.
- Utilization Review (UR) - responsible for monitoring utilization review activities in Medicaid contract hospitals. UR is also developing and implementing a statewide effective and efficient nursing home case mix assessment review program.
- Compliance Monitoring and Referral (CMR) - responsible for monitoring and reviewing Medicaid claims processing to ensure compliance with federal regulations and the Medicaid state plan requirements.

SB 30 also provided for the use of a new Medicaid Fraud and Abuse Detection System (MFADS) designed to use learning or neural network technology to identify discrepancies in Medicaid claims. Neural network technology relies on mathematical algorithms to analyze substantial amounts of Medicaid claims data to identify situations in need of further investigation by the OIE. In the first two months of operation, using only 3 out of

22 existing algorithms, MFADS produced 244 suspects and identified \$623,096 in overpayments in a 63 county database. OIE reports recovering between \$8 and \$10 for every dollar spent on fraud, misuse and abuse detection. Once suspected fraud is identified by the OIE the case is referred to the Office of the Attorney General for prosecution.

Private Insurers

Insurance fraud in the private sector drives up the cost of health care for everyone through increased premiums. While the incidence of insurance fraud in the private sector is costly, it is not as prevalent as in government programs. Figures indicate that 14 percent of Medicare payments were the result of fraud, abuse or improper payments, while private insurers report their losses in the 3 to 5 percent range.⁹

Conservative Note

Fraud, whether in Medicare or in the private sector, should be rooted out and vigorously prosecuted. Fraudulent behavior, however, should be distinguished from the honest mistakes made by individuals trying to work within this most burdensome and confusing of bureaucratic systems. It does not appear to be possible at this time to clearly differentiate, within that estimated total amount of improper Medicare payments, between simple errors and intentionally fraudulent acts. However, it does seem reasonable to assume that the nature of this vast and burgeoning bureaucratic system actually contributes to the problem by making both accountability and efficiency difficult to attain.

In the private sector, a direct exchange between buyer and seller in a

free market is the financial transaction that is least susceptible to fraud and abuse, primarily because the costs and benefits of that transaction are transparent. Instead of a large bureaucratic system with third-party administrators processing hundreds of millions of claims for payment at taxpayers expense, private carriers in a competitive system would have a direct stake in rooting out waste, fraud or abuse in claims processing because the extra costs incurred from poor accounting methods would undercut their competitive market position.

Additionally, policy makers should beware of efforts to fight fraud through the creation of a centralized database to be used in conjunction with a 'unique health identifier.' (See LIFT Perspective, *The Invasion of Medical Privacy, January 21, 2000*). The rules currently proposed by Health and Human Services (HHS) would allow for the disclosure of personal information without patient consent during a fraud investigation. Such disclosure is not generally necessary.

Fraud cases can often be developed without having to refer to specific patient information. For example, in investigating a hospital's billings for particular procedures, individual patient files need not be the starting point of the investigation. Fraud investigators can look at hospital billing records and data which list particular procedures that were performed and how they were billed on an aggregate basis, comparing such data with that of other hospitals in the area to determine if there is anything unusual in the hospital's billing practices. This can be done without having to obtain individual patient files. Former employees that have knowledge

of a doctor's billing practices may provide similar aggregated information.

It is clear that law enforcement officials and insurers can minimize privacy concerns by first seeking types of information other than private medical records in building fraud cases - and by postponing any efforts to seek information that identifies specific patients until necessary, if at all. When that information is necessary, it should be obtained through a standard judicial process.

Conclusion

Efforts to encourage the Medicare system to more closely emulate health insurance provider operations in the private sector could yield measurable benefits. Such efforts would promote the conservative principles of limited government and free enterprise. Likewise, requiring a standard judicial process to obtain the release of information without patient consent would promote individual liberties.

¹ National Health Care Anti-fraud Association "guidelines to Health Care Fraud," http://nchaa.org/factsheet_guideline.htm;

² U.S. General Accounting Office, *Medicare Fraud and Abuse Control Pose a Continuing Challenge*, GAO/HEHS-98-215R, letter to Representative John Kasich, July 15, 1998.

³ Representative Thomas Bliley (R-VA), opening statement in an inquiry into the effectiveness of Medicare's anti-fraud efforts for the Subcommittee on Oversight and Investigations, Committee on Commerce, U.S. House of Representatives, 106th Cong., 1st Sess., July 14, 1999, p. 1. Chairman Bliley stated that the real figure for Medicare waste, fraud and abuse is probably higher than the official HHS estimates cited here is.

⁴ Representative Pete Stark (D-CA), statement on the funding requests of the Health Care Financing

⁵ U.S. General Accounting Office, *Federal Health Programs: Comparison of Medicare, the Federal Employees Health Benefits Program, Medicaid, Veterans' Health Services, Department of Defense Health Services, and Indian Health Services*, a report to the Honorable William M. Thomas, U.S. House of Representatives, GAO/HEHS-98-231R, August 7, 1998, p. 23.

⁶ Nancy Dickey, M.D., "Government to Grandpa: Rat on Your Doctor," *The Wall Street Journal*, February 24, 1999.

⁷ Robert Waller, M.D., in testimony to the National Bipartisan Commission on the Future of Medicare, August 10, 1998.

⁸ Robert Pear, "Major Audit of Medicare Finds \$23 Billion in Overpayments," *The New York Times*, July 17, 1997, p. A1.

⁹ U.S. General Accounting Office, *Medicare: HCFA Oversight Allows Contractor Improprieties to Continue Undetected*, statements of Leslie Aronovitz, Associate Director Health Financing and Public Health Issues, and Robert H. Hast, Acting Assistant Comptroller General for Special Investigations, before the Subcommittee on Oversight and Investigations, Committee on Commerce, U.S. House of Representatives, GAO/T-HEHS/OSI-99-174, September 9, 1999.