HEALTH CAPITAL Topics
Volume 13
Issue 9
September 2020
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Fraud and Abuse Costs and Cases Rose in 2019

On July 22, 2020, the *Health Care Fraud and Abuse Control Program* (HCFAC) released their annual fraud and abuse report for *Fiscal Year* (FY) 2019.[1] HCFAC was established as part of the *Health Insurance Portability and Accountability Act* (HIPAA) *of 1996*, under the direction of the *Department of Justice* (DOJ) and *Department of Health and Human Services* (HHS).[2] The program's main goal is to coordinate efforts on federal, state, and local levels to reduce and prosecute healthcare fraud and abuse, including conducting investigations, facilitating regulatory enforcement, and providing education.[3] Healthcare fraud comes in many forms, most commonly including: billing for services that did not happen, for more expensive services than those provided, or for parts of a procedure as separate procedures; billing a patient more than their co-pay; waiving the patient's co-pay to over-bill their insurance; performing medically unnecessary treatments, including falsifying a patient's medical record to justify said treatments or misrepresenting non-covered procedures to insurance; and, accepting patient referral kickbacks that violate the Anti-Kickback Statute and/or Stark Law.[4] Estimates attribute between 3% and 10% of total healthcare costs (i.e., $90 to $300 billion) to fraud.[5] The HCFAC annual report, along with this data, highlights the importance, success, and value of the program and its partnerships in preventing waste and reclaiming healthcare funds lost to fraud and abuse.

In FY 2019, over 1,000 new criminal fraud cases were opened by the DOJ, with over $2.6 billion in related judgments and settlements won by the federal government.[6] Data showed a decrease in cases from 2018 but an increase in monetary collections, total convictions, and pending civil cases.[7] Over the past 22 years of reporting, data have shown dips and rises in the number of cases, with peaks in 2000, 2004, 2012, and 2018.[8] Convictions, pending cases, and the amount of collections have followed similar "*ebb and flow*" patterns since 1997.[9] However, the overall increase in indictments, convictions, and collections over the life of the program is undeniable – in 1997, the program reported 282 indictments, 363 convictions, and $1.2 trillion in collections, while in 2019, the program reported 1,060 indictments, 528 convictions, and $3.586 trillion in collections.[10] In total, the DOJ has produced over 18,000 indictments and nearly 13,000 convictions while collecting a total of over $44 trillion through HCFAC.[11]

In contrast to the ebbs and flows of these aforementioned factors, the three-year estimated *return on investment* (ROI) for the program has followed a more predictable pattern, increasing steadily from 2010 to 2013, then decreasing steadily until 2018.[12] The recently-published 2017-2019 ROI is $4.20 for every dollar expended,[13] an increase from $4.00 for the 2016-2018 period,[14] but a significant decrease from the program's peak ROI of $8.10 in the 2010-2013 period.[15]

Fraud and abuse has cost the U.S. healthcare delivery system in more ways than monetarily. A 2019 study from the *Journal of the American Medical Association* (JAMA) *Internal Medicine* found dramatic patient outcome differences between those treated by healthcare professionals who were later convicted of fraud and abuse and banned from Medicare and other federal programs versus those treated by health professionals who had not.[16] Patients treated by those excluded healthcare professionals were 14% to 17% more likely to die and 11% to 30% more likely to experience an emergency hospitalization after being treated by the provider in question.[17] These patients were also more likely to be low-income, disabled, and of a racial minority than their counterparts treated by non-excluded providers.[18] In 2013 alone, fraud and abuse was found to have likely contributed to 6,700 premature deaths, which outcomes disproportionately affected the most vulnerable patients.[19] The study's lead author said of the study's implications:

> "*While fraud has traditionally been viewed as a financial concern, our study shows that it also represents a major public health threat to patients… If we can find and remove providers committing fraud and abuse more quickly, we can save patient lives, improve health outcomes, and prevent unnecessary spending.*"[20]

Experts are concerned that fraud and abuse in healthcare will be exacerbated by the current COVID-19 pandemic. At the end of March 2020, the *Centers for Medicare and Medicaid Services* (CMS) released "*blanket waivers*" for certain aspects of the Stark Law in recognition of difficulties and extenuating circumstances during the pandemic.[21] In addition to the many consumer schemes

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that have already been prosecuted by the government, relaxed regulatory requirements for Medicare and Medicaid, including the blanket waivers, have the potential for more provider fraud.[22]

Rural hospitals becoming victims of fraud and abuse is also a growing area of concern. Rural providers have been hit disproportionately hard by the COVID-19 pandemic, with a dozen rural hospitals closing in the first half of 2020,[23] and experts are concerned about businesses buying and promising to save these desperate hospitals close to bankruptcy and later using the hospitals to commit billing and laboratory claims fraud.[24] In fact, a recent case wherein ten individuals were indicted by the DOJ involved just that – funneling $1.4 billion in fraudulent laboratory test claims through rural hospitals over almost two and a half years.[25]

COVID-19 concerns and increasing healthcare costs have only exacerbated healthcare fraud and abuse issues. On October 3, 2019, President Trump signed an executive order related to Medicare and senior health that emphasized the need to reduce and prevent fraud and pinned much of the responsibility for annual updates on this progress on CMS.[26] In response, on October 21, 2019, CMS released a five-part plan to proactively address Medicare fraud, including collaboration with other government agencies such as the DOJ for swift responses to fraud cases, a commitment to building infrastructure that prevents abuse, and diligent monitoring to catch emerging areas of fraud and abuse.[27] CMS also emphasized the need to reduce provider burden and continue to provide education so that healthcare systems understand how to stay within the limits of current legislation.[28] Finally, CMS recognized the role that analytics and *artificial intelligence* (AI) technology can play in future efforts, which potential others in the healthcare industry have also highlighted.[29] In fact, Highmark Inc.'s *Financial Investigations and Provider Review* estimates that AI generated over $260 million in savings related to fraud, abuse, and waste in 2019 alone and $850 million in total over the past five years.[30] Highmark's technology focus is also on prevention, as highlighted in CMS's statement on its plans for addressing fraud.[31] Because of its processing capabilities, AI holds tremendous potential for categorizing and analyzing data at a much faster rate than humans, and then flagging suspicious data for inspection by human workers.[32] As the number of court cases and amount of money lost to fraud and abuse seem to have grown over the years, having a method to prevent or quickly catch these schemes would be invaluable to patients, taxpayers, and the healthcare system.

There is a growing call for more to be done to prevent the fraud, abuse, and waste in the U.S. healthcare industry that is costing tens, if not hundreds, of billions of dollars each year. HCFAC's FY 2019 report highlights the heavy burden that fraud puts on the U.S. healthcare system, which could be worsened by the COVID-19 pandemic. However, there seem to be numerous measures that can be put in place to address this problem: partnerships between public and private entities to efficiently address and prevent waste; integrating technology to quickly recognize fraud and increase prevention infrastructure; and, education to prevent institutions from unknowingly committing fraud and abuse. Further, changes to the Stark Law and Anti-Kickback Statute, which are expected to be finalized in late 2020, may also aid in this effort. The proposed rules seek to streamline and update the fundamental federal fraud and abuse laws in order to increase efforts against fraud and align the law more closely with the changing healthcare environment, especially the emerging transition to value-based reimbursement.[33] These changes also aim to engender compliance and prevent fraud before it begins, a goal that could facilitate an upward trend in the number of indictments and cases prosecuted by HCFAC over the next several years, better patient outcomes overall, and significant savings for the U.S. healthcare system

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