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Medicaid Fraud, Abuse and Waste

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Anna Ellis

Medicaid Waste, Abuse and Fraud

Murray State University

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About the Author

I am Anna Lee Spence, academically know as Anna Ellis. I am recently married to my husband, Drew, whom I share our home with and our wonderful four legged, furry children. Over the last few years I have made several moves professionally, educationally, and personally. Born and raised in Madisonville, Kentucky, relocated to Phoenix, Arizona with my family at the age of fifteen, graduated high school to pursue a higher education in Lexington, Kentucky at the University of Kentucky. After completing two years at UK, I made the personal decision to transfer to Murray State University at the Madisonville Community College Campus where I could enjoy my roots as well as the process of furthering my education. I am pending graduation in May of 2018 with a Bachelor's Degree in Healthcare Administration. My pursuit for this degree came from a professional change when I accepted my first healthcare position in mid 2016. Working with the public of Madisonville, the patients and gaining a respect for customer service in healthcare inspired me to focus my education on healthcare administration.

While I have currently open my own small, home-based business, I hope to put my administration skills into effect immediately after graduation. Some of my future goals include growing my own business to a state wide known brand. I hope to one-day welcome my business to the Madisonville Chamber of Commerce and relish in the glory of Madisonville, Kentucky's small business developmental efforts. My husband and I hope to grow our family in the near future, pending graduation, and enjoy our small town lives in Western Hopkins County.

Abstract

The following information has been collected and reviewed over a four-month period surrounding the efforts to better control insurance fraud, particularly involving federally funded programs such as Medicaid, Medicare and TRICARE. The information allows for a better understanding of how healthcare programs came to be, teaches the history and effects of the Affordable Care Act and reflects on Medicaid eligibility and reimbursement factors.

In this document, several cases of medical insurance fraud will be examined. Forms of prosecutions as well as the analyzing of white-collar crime will be discussed. The education of fraudulent activity across health care is to be stressed by the information presented in this document. The conclusion consists of two models of suggested solutions in hopes that the government will continue all efforts to minimize Medicaid fraud, abuse and waste in America.

Introduction

Over the last several months, and with the help of several senior level, college courses, a wide variety of information pertaining to the waste, fraud and abuse of the Medicaid and Medicare systems has been obtained. The research has been spread out over this length of time to ensure the most balanced display of information to the reader in hopes to educate the audience on this large scale issue within the American health insurance system. The purpose of the following research is to educate the American population on the severity of insurance fraud taking place in the government insurance programs. The layout of this research is presented first with an intense background on what Medicaid/Medicare is followed by what these social programs cover, in detail. A special government funded program known as TRICARE will be covered next. In the following section, the Affordable Care Act (ACA) will be described as well as the implications on healthcare the ACA has had as well as a balanced debate on its overall success. With a solid grasp of basic information surrounding Medicaid and Medicare, the discussion of insurance fraud will begin with several explanations of how fraud is carried out by physicians and patients alike. By the conclusion of the listed research, the reader should be able to recall the security of Medicaid and Medicare boundaries and be blooming with ideas on how to secure these so called borders with the help of some possible solutions.

The creation of health insurance has been an inevitable, necessary protection for all Americans since the early twentieth century. It was not until 1965 when President Lyndon B. Johnson signed the Social Security into law that Medicaid and Medicare became a blanket protection for Americans needing health insurance. Health insurance itself has a long history in the making to get to where it is today. As America was growing as a country, people were working long, hard hours and needed to protect their families from poverty if the working

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individual of the home fell sick. Overseas, “sickness insurance” came to be known as the monetary protection the families could use in these situations. However, Americans began to implement their own “sickness insurance” and realized the cost of paying the individual their usual salary was much more expensive than covering their medical bills. Considering America was far behind many other countries when it came to establishing healthcare, the transformation from “sickness insurance” to health insurance was changing rapidly. The door for health insurance was wide open. Companies starting reimbursing their employees for their medical bills rather than paying them their usual wages during the time spent out of work. Unfortunately, the majority of these companies were struggle with growth and success and could only offer these benefits to their employees, not their families or children. From here, a spin off began what we know as Worker’s Comp insurance and paid time off. This created an opportunity for private health insurances companies to pave the way to a healthier America.

Creating Medicaid

It was not until the early nineteen fifties that the true foundation of health insurance became concrete. It took the deficit of the Great Depression and the Second World War to fuel the movement towards creating a national health insurance plan. There were many trail and errors through this decade, including the fact that most insurance plans did not cover individuals who worked in agriculture or who were self-employed, which at the time was about 60% of the American population. By the start of 1961, every presidential candidate was using national health insurance as their winning platform, including John F. Kennedy. At this point the goal was to come to an agreement with private health care providers and form a reimbursement standard. Medicare soon blossomed from the trial and errors of these efforts from both political parties and

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the healthcare industry. While Medicare was being played as a political move, in summary, its purpose was to keep elderly covered for primary medical services and reimburse the private health care providers for a list of covered service (Berkowitz, 2005).

While the debate over Medicare was still heavy, the idea of Medicaid was not completely secure either. During the 1960's Congress was hoping to gain State's rights to provide covered health care to those on welfare and with disability, as well as protecting the elderly of their covered health care services. Initiatives such as the Kerr-Mills program fought to bring equal access to healthcare for dependent women and children as was available to the elderly. In 1965 Medicaid was officially signed into law and was on the brink of changing the finance structure of healthcare as we know it today.

As the number of insured Americans climbs, so does the supply and demand side of financing the healthcare industry. The Federal Government was still looking for ways to remain involved in this growing process. The Hill-Burton program that began in 1946 helped create what was known as the medical infrastructure which including supplying the states with the appropriate grants to help build hospitals and supply them with the adequate amounts of doctors and staff to provide the best care for the area's patients. Not only were the physical hospitals and clinics being supported, but so were research ideas such as teaching hospitals and medical education grants to pursue the longevity of a driving healthcare field. The federal government saw this as a way to further health insurance entirely. Without hospitals and places to provide care, social programs like Medicaid and Medicare could not refund the physicians and patients as they were created to do so.

It is impossible to judge Medicaid and Medicare of their security and strength without first understanding the process in which these social programs underwent to be what they are

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today. Without funding from the federal government and without good intentions of the private healthcare providers, Medicare and Medicaid alike could have been tossed aside or driven down an entirely different path, one that did not include the well-being of Americans. Even after so many years of transformation, each health insurance initiative will have its doubts. It is time now to gain understanding on what these programs were designed to satisfy, from the patient point of view- the covered services.

Services Covered by Medicaid

The government Medicaid website has an exceptionally easy-to-follow, bulleted list of mandatory and optional coverage benefits. The following services describe the benefits that states must offer to their Medicaid covered individuals as well as optional benefits they may include. According to their website Medicaid offers mandatory benefits including, but not limited to:

- Inpatient hospital services
- Outpatient hospital services
- Early and Periodic Screening
- Diagnostic and Treatment Services
- Physician services
- Rural health clinic services
- Laboratory and x-ray services
- Family planning services
- Family nurse practitioner services
- Medical transportation
- Federally qualified health center services

The list of optional benefits, that states may or may not cover through their Medicaid programs are: prescription drug coverage, clinic services, physical therapy, occupational therapy, speech, hearing and language disorder services, respiratory care services, hospice, chiropractic services, eyeglass, prosthetics and many more (Medicaid.gov, 2018).

Eligibility Requirements

The above benefits are offered to a particular demographic of patients that will be briefly described in this section. This information is not designed to be discriminatory or degrading to those individuals who qualify for government assistance or government medical programs. “Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government (Medicaid.gov, 2018).

The quote listed above and the following information is public information that can be found on the Medicaid’s website. When considering the qualifications of an individual for Medicaid, “eligibility” requirements include financial dependability. This information and the website are tools used to help those in need determine whether or not they qualify for these assistance programs. Many of these qualifications are outlined and enforced by the Affordable Care Act, which will be discussed later. A patient’s Medicaid eligibility is based upon the Modified Adjusted Gross Income (MAGI), these same rules do not apply to those individuals who qualify for Medicaid (disabilities and of the age of 65 or older). These patients are determined using a system known as Supplemental Security Income (SSI) programs. Financial eligibility for Medicaid by the MAGI process relies solely on the taxable income of a particular

household. However, there are a few non-financial qualifications that must be met before a patient is considered “covered”. These qualifications can be as simple as being a lawful citizen of the United States and holding permanent residence within the state of application.

Medicaid Reimbursement

It is important to understand the basics of the revenue cycle within a physician’s office to fully understand how it is possible to falsify claims. The revenue cycle as well as basics of Medicaid Reimbursement will be illustrated in this section. When a patient walks into a physician’s office, their insurance information is collected and verified in a number of ways. Registration specialists verify the insurance eligibility by calling or faxing the insurance company to request a proof of insurance. The most common way to verify insurance is with a real time verification system that verifies the patient’s eligibility as well as details regarding coverage and benefits. The registration specialists collect payment based on this information given from the insurance company and the patient is confirmed to see the physician.

After the physician has seen the patient and the office visit is over, the physician then charts the specifics of the visit and applies codes to the patient’s bill. Each

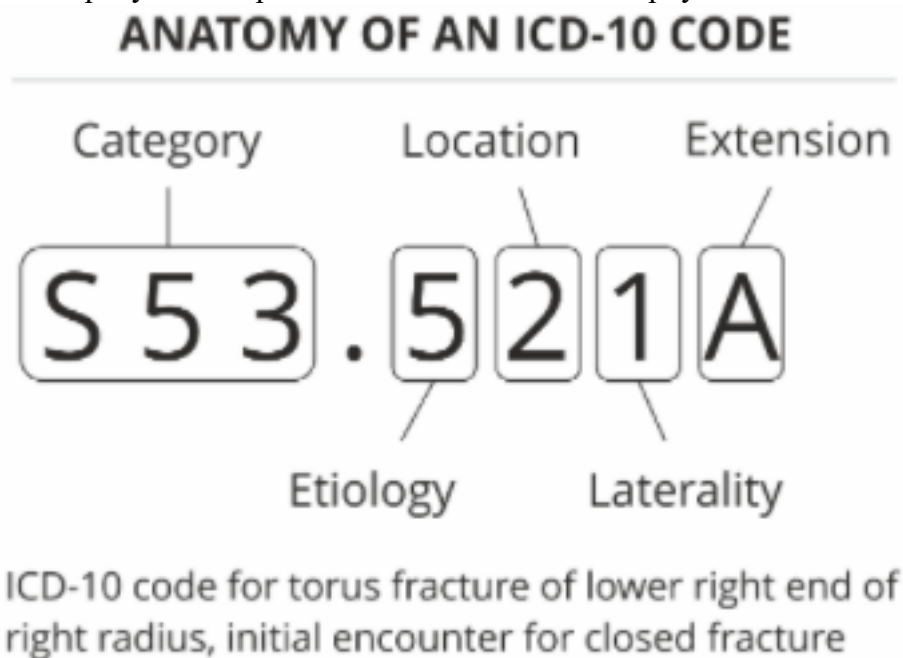


Figure 1 <https://doctors.practo.com/icd-10-codes-important-doctors/>

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visit, for new or established patients, requires at least an Evaluation and Management Code (E&M Code). The patient's visit history will determine the weight of the E&M code and the dollar amount associated with it. There are a few other specifics involved in the total calculation of a patient's bill, such as an ICD-10-CM code, explained in Figure 1.

“For example, the code that's currently in use in the United States is ICD-10-CM.

This means it's the 10th revision of the ICD code. That “-CM” at the end stands for “clinical modification.” So the technical name for this code is the

International Classification of Diseases, Tenth Revision, Clinical Modification.

The clinical modification is a set of revisions put in place by the National Center for Health Statistics (NCHS), which is a division of the Center for Medicare and Medicaid Studies (CMS) (Medical Billing & Coding Certification, 2018).

Once the patient's chart is closed, it sent to the responsible party for payment. The person(s) responsible for payment of the claim can include the patient, Medicaid or Medicaid or a private insurance company. This is the portion of the revenue cycle that is most vulnerable to insurance fraud. It is extremely important that the receiver of the claim verifies all information provided for financial and legal purposes. If a claim seems falsified, it can be sent back to the physician's office for review. In many cases, office visits, procedures and exams are incorrectly coded, but that does not mean they are necessarily fraudulent. This is a harmless mistake, with no fraudulent intentions, that can easily be rectified.

Affordable Care Act

In the early 2000s it became very obvious to much of the world, the Health Care Crisis that was underway in the United States. More Americans than ever before were uninsured and in

need of healthcare coverage for primary care services as well as specialty services. “On March 23, 2010, sweeping health care legislation, in the form of the PPACA, was signed into law by President Barack Obama,” coining this bill and insurance plan as “Obamacare” (Meltzer, 2011). The sole purpose of the Affordable Care Act of 2010 (ACA) was to “improve quality and access” to healthcare for every demographic of patients, including the financial needy in

Table 1. Characteristics of the Study Sample.*

Variable	Respondents (N = 420,449)	Unweighted No. of Respondents
Mean age (yr)	41.1	NA
Male sex (%)	50	220,137
Race or ethnic group (%)†		
White non-Hispanic	63	288,629
Hispanic	15	44,640
Black non-Hispanic	10	33,708
Asian non-Hispanic	2	8,390
Other	8	33,028
Do not know or declined to answer	2	12,054
Household income (%)		
≤138% of FPL	14	36,102
139–400% of FPL	58	217,338
>400% of FPL	28	167,009
Currently employed (%)	71	306,153

combination of lowering the cost of healthcare for all types of demographical patients. Another large key of the ACA was that beginning in June of 2010, insurance companies could no longer deny incoming patients “on the basis of pre-existing health conditions for children,” while these provisions for adults were not amended until 2014.

ACA Mandated Changes

Each new year brings new policies and changes to the ACA. Some of the major changes to health insurance brought by the ACA will be listed and described in this section. A form of research used for this information was designed to determine whether or not the changes of covered individuals actually aligned with the efforts of the ACA and secondly, if there were any true changes in access to care. The below information captures the research found by healthcare professionals of The New England Journal of Medicine (Sommers, 2014).

Medicaid Waste, Abuse and Fraud

With the open enrollment period in 2014 for Medicaid came a steady decrease in the rate of uninsured Americans. The Gallup–Healthways Well-Being Index (WBI) was used in this research in efforts to discover the correlation between the open enrollment period of Medicaid in 2014 and the number of newly covered Americans. The second approach to this research method was to identify the main demographics affected by the ACA mandates. Lastly, the search was for “an association between survey-reported coverage changes and state-level marketplace and Medicaid enrollment statistics from the Department of Health and Human Services.” The following research was collected in the form of a rapid-response survey system.

Figure 1.1 illustrates the demographics of individuals tested in this research period. The demographics allow us to visualize which groups of people are interested enough in this research to offer their information in regards to their personal changes in healthcare coverage. The “characteristics of the study sample” allow us to have a basic understanding of the sample data before digesting the remaining information. The greatest success demonstrated within this information is that of the responders, “20% were without insurance in September of 2013, right before the beginning of the open enrollment period.” However, as of April 2014, one month after the open enrollment period, rates of uninsured dropped to 16.3%. This held true until June 2014.

In conclusion of research done on the ACA mandated changes, the ACA has proven significant drops in the uninsured. The changes within ACA eligibility greatly affected those of lower income homes who fell below 138% of poverty. These eligibility gains were most popular amongst young adults and Hispanics, who were primarily uninsured prior to the open enrollment period. The researchers strongly believe that their suspicions and results align with the data given by the Gallup-Healthways WBI and find the ACA to be a beneficial bill to most Americans.

Regaining Focus

However, the focus of this overall research must not be forgotten. The boundaries of Medicaid and Medicare are to be tested and proven faulty in this information given. The purpose of the above information in total is to give the reader a better understanding of what Medicaid has become up to this point. Within the upcoming pages the reader should be able to identify weaknesses within the Medicaid and Medicare system that allow for fraud and abuse. These thoughts and questions should remain in the back of the mind until this information resurfaces.

Private Insurance Policies and the ACA

Understanding where the ACA had pushed Medicaid today will help identify some of the loop holes in these social programs. The ACA has had great success, as outlined above. However, the form of research provided does not discuss to provisions to private insurance policies and the individuals who pay out of pocket for their insurance coverage. One particular group of authors, of the Health Affairs Research Journal, help illustrate the advantages the ACA had on young adults, less than 26 years of age. These particular individuals were not able to remain a dependent of their parent's private insurance policies. Young adults are often caught with "high debt burden, but low wages". Whether these debts are from continuing their education or from an extensive healthcare record, the dependent coverage act of the ACA 2010, protects millions of Americans from being uninsured (Busch, 2014).

The dependent coverage act in only one subgroup of the whole Affordable Care Act. Research on the topic is endless. The information illustrated in this particular research is adequate for a basic understanding of the act and how it has affected Medicaid, Medicaid patients, and those who participate in private insurance policies for healthcare coverage. The

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point of this information is to help the reader dissect the boundaries of Medicaid and understand the intensity of such fraud and abuse taking place in the offices of physicians, nationwide.

TRICARE

This section of information reports on the structure of TRICARE, who it covers and what it does and how it relates to governmental insurance fraud. The majority of this information is essential to understanding TRICARE, credited to either the Military Health System or the Deputy Director of Health Care Policy. The following information is fact based and not of the opinion or credit of the author of this research. According to their website TRICARE is “the health care program for uniformed service members and their families around the world.

TRICARE provides comprehensive coverage to all beneficiaries, including: health plans, special programs, prescriptions and dental plans. Most TRICARE health plans meet the requirements for minimum essential coverage under the Affordable Care Act. TRICARE is managed by the Defense Health Agency under leadership of the Assistant Secretary of Defense (Health Affairs) (Military Health System, Tricare, 2018).

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The official website of the Military Health System reports an average of covering 9.4 million beneficiaries. Demographics range from active duty service members to retired service

Type of Beneficiary	Approximate Number of Beneficiaries (Total: 9.4 million)
Active Duty Service Members	1.4 million
Active Duty Family Members	1.8 million
Survivors of Deceased Active Duty Family Members	605,000
National Guard and Reserve Members (includes active and inactive members)	331,000
Family Members of National Guard and Reserve Members	527,000
Retired Service Members	2.2 million
Family Members of Retired Service Members	2.6 million
Others	52,000

members and their survivors. The above graphic explains TRICARE beneficiary demographics for the purpose of a better understand of who TRICARE serves.

As outline in the graphic above, TRICARE serves many active duty members, their families and retired service members as well. The goal of this “self-funded, self-administered” insurance programs is to alleviate the worry of financial burden to active duty members by provided them with second to none care for little to no out of pocket costs. TRICARE members are eligible for their benefits for a lifetime unless otherwise specified due to personal implications. The following information explains the components of TRICARE and was taken directly for the Deputy Director of Health Care Policy:

“TRICARE has four main benefit plans: TRICARE Prime, TRICARE Standard, TRICARE Extra, and TRICARE for Life (TFL). The TRICARE Pharmacy Benefits Program, the TRICARE Dental Program, and the Extended Care Health Option (ECHO) provide supplemental benefits to the main plans.” The above benefit plans will be outlined and briefly

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explain in the following section, along with their importance and relation to insurance fraud, waste and abuse (Hayes, 2015).

TRICARE Prime

“TRICARE Prime essentially functions as a health maintenance organization (HMO) plan, where beneficiaries have a designated primary care provider (PCP) who manages care and facilitates referrals to specialists. There is no annual deductible, but there is an annual enrollment fee (similar to a premium); this fee is applied to the annual catastrophic out-of-pocket limit. For FY2015, the fee is \$278 for individuals and \$556 for a family. Active duty service members—who are required to use TRICARE Prime—and their families are exempt from paying the annual enrollment fee. Active duty family members using TRICARE Prime also receive care at no cost, unless using the Point-of-Service (POS) option” (Hayes, 2015).

TRICARE EXTRA

“TRICARE Extra is a preferred provider network plan available to TRICARE Standard-eligible beneficiaries. It also has no formal enrollment requirements. In-network providers receive a reduced payment from TRICARE compared with out-of-network providers and must file all claims for participants. Beneficiaries using preferred providers are still responsible for meeting their deductible as applies under the TRICARE Standard benefit, but the cost sharing is reduced by 5 percent” (Hayes, 2015).

TRICARE for Life

“TRICARE for Life (TFL) is a supplemental Medicare plan for Medicare-eligible retirees. TFL functions as a secondary payer to Medicare and covers out-of-

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pocket costs for medical services covered under Medicare for beneficiaries entitled to Medicare Part A benefits. Beneficiaries must enroll in and pay premiums for Medicare Part B, but there is no TFL enrollment cost and cost-sharing is limited. TFL may cover additional services that Medicare does not cover, similar to a Medicare Advantage plan. More than 2 million retirees and their family members are enrolled in TRICARE for Life” (Hayes, 2015).

Extended Care Health Option

“Another program which supplements TRICARE is the Extended Care Health Option (ECHO). ECHO provides benefits not covered by TRICARE that are typically needed by individuals with special physical or educational needs. Eligibility for ECHO is generally limited to family members of active duty service members or activated National Guard/Reserve members. An eligible individual must have a qualifying condition and enroll in the Exceptional Family Member Program (EFMP) in order to receive ECHO benefits. There is no enrollment fee, but monthly cost-sharing based on the service member’s pay-grade must be paid by the beneficiary. The total government cost share for ECHO benefits, excluding the ECHO Home Health Care benefit, is capped at \$36,000 annually per beneficiary” (Hayes, 2015).

Pharmacy Benefits Program

“The Pharmacy Benefits Program allows all TRICARE beneficiaries to obtain prescription drugs through MTFs, retail pharmacies, or a national mail order plan. Prescriptions filled at MTFs are done so at no cost to the beneficiary. However, while MTFs are required to stock a subset of the Uniform Formulary, non-formulary drugs are generally not available at MTFs. Beneficiaries may also fill

prescriptions at retail pharmacies or through mail-order; copayments are required when filling prescriptions outside an MTF, except for generics filled through mail-order. Active duty service members receive full reimbursement after they file a claim. DOD requires prescriptions be filled with generics, when available, and pharmaceuticals, as of 2008, are subject to federal pricing standards, established under the Veterans Health Care Act of 1992, which require a minimum 24 percent discount off non-federal average manufacturer prices” (Hayes, 2015).

TRICARE Patient Visits

It is important to understand what patients are being seen for when they are using their TRICARE benefits. Whether they are active duty members themselves, family members of active duty members or retired members or veterans. Understanding these principles of TRICARE will raise awareness of the opportunity for fraud and abuse. The men and women who currently serve and have served our country are an exceptional group of individuals that do not deserve to be used in schemes such as health insurance fraud, yet it is happening day after day all across the nation. The information in this section will explain why TRICARE beneficiaries need the solidarity and peace of their health insurance.

Research shows that the majority of TRICARE beneficiaries seek for primary care, physical therapy and mental health therapy. The majority of TRICARE beneficiaries are growing families who seek primary care for their family members and children. Primary care for TRICARE beneficiaries is provided on base for active duty members and with a specific list of physicians described by your benefits package. TRICARE is very strict about the physicians in which are considered in network. Reason being, this will help elevate falsified claims and restrict the patient from continuously changing providers. Family practice, also known as primary care

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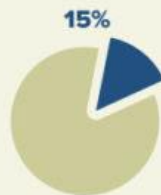
creates a large opportunity for medical insurance fraud and abuse. These are the physicians in which the patient sees most regularly and can easily over charge for prescriptions or bill the insurance for excessive testing and unnecessary procedures.

Retired military service men and women are often seeking physical therapy and chiropractic care due to the high amounts of physical activity through their career. These are two specialties in which it is uncommon to see fraud and abuse, however it is not impossible. Phantom billing would be an accessible form of committing insurance fraud for both physical therapist and chiropractors due to the high number of privately run offices among these specialties.

Mental health is a growing specialty that will only increase in importance with TRICARE beneficiaries. It is so incredibly important that we take care of the mental health of our veterans and active duty members. Post-Traumatic Stress Disorder (PTSD) is a rising mental health disorder that veterans everywhere are suffering from. The following image was taken from the website of Family Coaching, LLC of Phoenix, Arizona about the mental health of the U.S. Military.

FACTS ABOUT MILITARY MENTAL HEALTH: HELP US DO BETTER FOR OUR VETERANS!

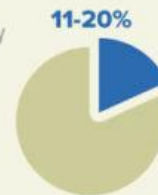
PTSD AFFECTS A SIGNIFICANT PERCENTAGE OF OUR NATION'S VETERANS:



15%
Approximately 15% of Vietnam veterans are currently diagnosed with PTSD and it is estimated that approximately 30% will experience PTSD in their lifetimes.



12%
Approximately 12% of Gulf War (1990-91) veterans experience PTSD in a given year.



11-20%
11-20% of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans, the two most recent conflicts in Iraq and Afghanistan, experience PTSD in a given year.

ACCORDING TO THE NATIONAL CENTER FOR PTSD, MANY VETERANS EXPERIENCE HIGHLY INTRUSIVE THOUGHTS OR EXTREME GUILT ABOUT EXPERIENCES THEY HAD IN COMBAT. THESE THOUGHTS MAY OVERPOWER A VETERAN'S ABILITY TO COPE, WHICH MAY CONTRIBUTE TO A HIGH RATE OF VETERAN SUICIDES.



AN ESTIMATED 22 VETERANS COMMIT SUICIDE EACH DAY.



A VETERAN COMMITS SUICIDE APPROXIMATELY **EVERY 65 MINUTES** IN THE U.S.



Despite making up only about 10% of the population, veterans account for roughly 20% of all suicides in the U.S.

OUR MOST RECENT COMBAT VETERANS FACE MANY CHALLENGES UPON THEIR RETURN.

Iraq and Afghanistan veterans rank suicide as the most important issue facing veterans.

30%
of all veterans have considered suicide.

37%
of Iraq and Afghanistan veterans know a veteran who has committed suicide.

Among male veterans under 30, there was a 44% increase in the rate of suicides between 2009 and 2011.



Among female veterans under 30, there was an 11% increase in the rate of suicides between 2009 and 2011.



REMOVING THE STIGMA OF SEEKING MENTAL HEALTH CARE WILL HELP SAVE VETERANS' LIVES

Of the approximately 22 veterans who commit suicide per day, only about five are in the VA Health Care System. Getting help does matter. **Treatment does work.**

Brought to you by **GoodTherapy.org**

SOURCES: Iraq & Afghanistan Veterans of America Survey 2013 | <http://avaa.org/files/2013survey/VA/MemberSurvey2013.pdf> / National Center for PTSD, U.S. Department of Veterans Affairs | <http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp> / Stars and Stripes | <http://www.stripes.com/report-suicide-rate-spikes-among-young-veterans-1.261283> / U.S. Department of Veterans Affairs | <http://www.goyourway.org/GOYOURWAY/DOCUMENTS/VETERANS/VA%20Suicide%20Prevention%20Fact%20Sheet.pdf> / U.S. Department of Veterans Affairs | <http://www.va.gov/opa/docs/suicide-data-report-2012-final.pdf>

TRICARE beneficiaries are entitled to covered mental health care, as it is not taken lightly. The sacrifice these individuals make in their career to protect our country is

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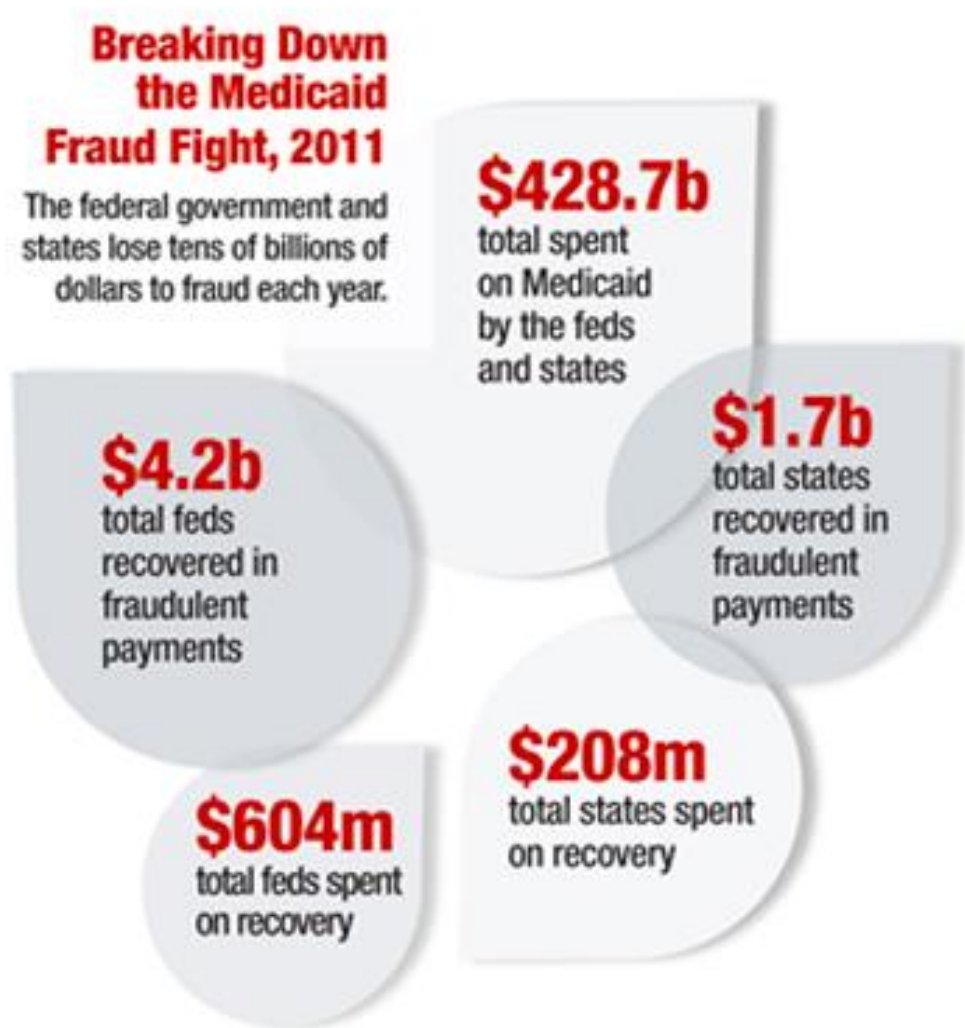
extraordinary in comparison to the care they deserve. Unfortunately, this is one specialty that is at a high risk for medical insurance fraud. Drug substitution, upcoding, phantom billing, and even misdiagnosis for the purpose of costlier medical claims are all forms of fraud that can effect mental healthcare. The struggle that arises for the rest of our country when medical fraud is being committed against TRICARE, is the risk of TRICARE overpaying for unnecessary medical claims, and having to make cutbacks to their medical coverage for the rest of their beneficiaries. The active duty members of the United States Military and the veterans of the United States deserve a secure, federally endorsed insurance plan they can count on. That cannot be delivered without the restructuring and evaluation of medical claims.

Medicaid Waste, Fraud, and Abuse

With every good intention comes the possibility for deception and abuse. Like all good social programs, Medicaid and Medicare have become subject to waste, fraud and abuse both from patients and physicians. When research on this topic began, patient abuse was the majority of the focus. It did not take long to realize the truth within physician Medicaid abuse and the destruction it has on states and individual tax payers. The following pages will outline the level of abuse and the loop holes within the Medicaid and Medicare boundaries.

Fraud by Physicians

“The inauguration of federally financed Medicare and Medicaid programs created new opportunities for fraud and abuse by members of the medical profession. Physicians has been beguiled into accepting the federal benefit programs- though as a group



they kicked and screamed along the way- because they presumed they could control the direction the programs would take” (Geis, n.d.) The first form of fraud created by physicians is the ordering and performing of unnecessary procedures or labs in order to gain a larger reimbursement from Medicaid, this is known as falsifying claims. Physicians saw this loop hole in the system and began using it to their advantage as early as the 1980s, not even 20 years after the national health programs has been signed into effect. Examples of this include “submitting bills for X rays done without film, blood and urine specimens that were never analyzed, and

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treatments much different- and more expensive- from those actually carried out.” Regardless of whether physicians were doing this as a part of a power trip against the federal government or not, there are nearly 200 physicians each year that are expelled from the use of these programs due to fraudulent and abusive practices.

There are several forms of fraud that can be performed by a practicing physician. According to the law offices of Robert David Malove, a Board Certified Criminal Trial Lawyer, physicians can perform medical insurance fraud by “phantom billing.” This is a process where the physician and their teams create claims for a visit that did not take place. Double billing is a form of insurance fraud that occurs when both Medicaid and the patient, or another insurance company are billed for the same services. Drug substitution is when a physician bills Medicaid for a top of the line, name brand prescription when in reality the patient was prescribed a generic, more cost efficient form of the drug. As explained later in this information, physicians will also coerce others into helping them perform insurance fraud by offering them kickbacks, which are any type of incentive used to benefit the physician’s practice. This can include, but is not limited to, money, gifts and vacations for referring patients to the physicians or partaking in the fraud itself, such as presenting falsified symptoms or reason for visit. Unbundling is when the physician bills services separately at a higher cost that could have been billed together at a lower cost. This causes for a higher reimbursement rate and a large medical bill for the patient. Upbilling is not to be forgotten, this is the practice of billing a more expensive code or service than necessary, or one that was not performed at all (Robert Malove Law, 2017).

The physicians are not the only to blame in the carrying out of massive insurance fraud against the federal government. In order to pull this off, it requires participation from all “office staff, recruiters, managers, billers, and money launders.” (Rober Malove Law, 2017). As recent

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as December, 2017, a massive insurance fraud case was finally broken in New York City. Four local doctors were among the many prosecuted for fraudulently abusing Medicaid and Medicare. In this instance, the physicians and their staff were approaching low-income areas and offering to pay people to visit their clinics for unnecessary visits and procedures. Therefore, the claims being sent to Medicaid and Medicare were authentic, however the patients intentions were not. The fraud had been carried out over three years with over thirty individuals and companies involved. The money from this scandal was used to purchase lavish vehicles, vacation homes and apartments for the practicing physicians. All involved will be prosecuted and any medical licensing will be revoked.

Again in 2017, the Justice Department released information in regards to a \$1.3 billion health care fraud, this time in relation to opioid prescription drugs. More than 50 physicians were

Type of Violation	Description
Overcharging Government Health Programs	Inflating the average wholesale price (AWP) of products, failing to give the lowest market price to government health programs, or failing to pay required rebates to any government health program
Unlawful Promotion	Off-label promotion of drug products or other deceptive marketing practices (e.g., downplaying health risks of a product)
Monopoly Practices	Unlawfully attempting to keep monopoly patent pricing privileges on products, or collusion with other companies undertaken with the purpose of increasing the market share of a particular product
Kickbacks	Kickbacks (e.g., monetary payments) to providers, hospitals, or other parties to influence prescribing patterns in favor of the company
Concealing Study Findings	Concealing results of company-sponsored studies from either the federal or state governments
Poor Manufacturing Practices	Selling drug products that fail to meet FDA standards or specifications (e.g., contaminated or adulterated products, or products that fail to meet size or dosage specifications)
Environmental Violations	Clean Air Act and Clean Water Act violations, or failing to meet federal emissions standards
Financial Violations	Accounting or tax fraud, or insider trading
Illegal Distribution	Distributing an unapproved pharmaceutical product

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sending claims to both Medicaid and Medicare for prescriptions that were never purchased.

Unlike the previous example, this scandal was using the act of falsifying claims, obtaining the reimbursement, and reselling the prescription drugs for cash. The high number of prescriptions for controlled substances is what threw these physicians under the bus. It is reported that “one doctor wrote more prescriptions in a single month than the local hospital did in that time” (Ruiz, 2017). Attorney General Jeff Sessions commented “This even again highlights the enormity of the fraud challenge we face.” It is interesting to see how these physicians gain such popularity in these cases. The answer is: preying on the weak. The last example would recruit low income individuals from local food banks and job fairs, while as the physicians running the prescription drug scandal would target “Alcoholics Anonymous meetings and crack motels to persuade people to move to South Florida to help him. He offered kickbacks in the form of gift cards, plane tickets, trips to casinos and strip clubs as well as drugs.” All while the federal government and tax payers’ money pay for the fraudulent claims sent to Medicaid and Medicare. As for all parties involved, the outcome is no better than the last. Jail time, revoked licensing and so on. However, the \$1.3 billion that was stolen from the government and tax payers’ pocket does not get reimbursed. The above table is a list and description of ways in which pharmaceutical companies have been known to violate the federal laws in coordination with Medicaid.

Insurance companies are now reigning in on the fraud and educating their customers and patients on how to protect themselves. An article recently published outlines five examples of Medicaid and Medicare fraud that “everyone pays for.” The most common assessment used for Medicaid fraud is sending falsified claims to Medicaid for reimbursement. This includes “one dentist who thought he could get away with filing 991 claims in ONE day.”

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An example of upbilling is the attempt to defraud Maryland federal health insurance plans of more than \$850,000 performed by allergy specialist Dr. Sampson Sarpong. According to the Department of Justice and the U.S. Attorney's Office, District of Maryland, he was indicted on 20-counts of performing unnecessary allergy tests when the patient did not present with symptoms proven to be medically necessary for further testing and examination. For a six-year period, Dr. Sampson Sarpong was almost double his salary due to this federal insurance scam. Additionally, Dr. Sarpong was charged for billing for procedures and testing that were never rendered, as mentioned above this is known as phantom billing (District of Maryland, DOJ, 2018).

Fraud by Patients

Patient's secured health information and the performance of health insurance fraud go hand in hand. Often times physicians who are aware of insurance fraud are faced with the decision of whether or not to report the patient to the insurance company, or protect the patient's personal information. Patients are just as responsible for committing insurance fraud as are physicians in many cases. The types of patient fraud and the attitudes of physicians about patient insurance fraud will be examined in this section.

Insurance fraud by patients can be done in numerous ways. One of the most common ways, and the ways in which have already briefly been touched on is the use of "kickbacks". A kickback is any form of reward offered to a patient, by a physician, in order to help the physicians, perform insurance fraud. In most cases, this is a large part of what causes the physicians to be turned in and prosecuted for their crimes. Forms of kickbacks include monetary benefits, vacations, gifts and in some cases even vehicles or homes. In return the patient is

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required to partake in the physician's form of insurance fraud whether it be creating an unnecessary visit with false complaints, agreeing to unnecessary testing and procedures and much more.

Medical Identity Theft

However, there are times when the physician is not the culprit, but rather stuck between a rock and a hard place. Most of the time this is when physicians observe patients using someone else insurance as their own, more or less in the form of identity theft. Each individual's insurance plans are correlated with their social security number, making it very difficult to use a family member or friend's insurance card. When an individual's identity is stolen for the purposes of insurance fraud, it poses a great threat to their overall physical safety. Blood types, allergies and medical history can be changed when there are two different people reporting under the same name, date of birth and social security number. According to an NPR article written in 2010, a local hospital in Springfield, Missouri reports nine identity theft cases in the last twelve months. In order to identify possible identity theft, hospitals and healthcare facilities across the country are encouraged to have their patients voice their personal information to staff members rather than vice versa for their own protection. It is common that if a person is committing identity fraud they may slip up or provide incorrect information. Patients are also encouraged to shred personal documents that may contain any personal information, not just medical records and health information. For the documents that must be kept should be kept in a private, secure location inside the home to prevent theft. Any personal information is valuable information to someone seeking to commit medical identity theft (Moore, 2010).

Companies are now cashing in on the rising level of identity theft for the insurance fraud purposed. I quick google search will leave you with several suggestive plans as to how to protect

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yourself from this form of fraud, especially the elderly. Safety plans include companies such as LifeLock, Experian ID Theft Protection and Identity Theft Insurance. However, there are some to be suspicious of and according to research done in 2012 by Eastern Illinois University Medical students “there are two agencies that primarily provide security for consumers’ medical information. One of those agencies is the United States Department of Health and Human Services (DHS). The other agency is that of the Federal Trade Commission (Betz, Walter, 2012).

The federal government is also raising its plans to ensure the safety of patients everywhere. The national Coalition Against Insurance Fraud is geared to educating Americans on the importance of personal information safety and how to keep yourself from falling victim to medical identify theft. According to their website they encourage everyone to be aware of “illegal and bogus treatments, addictive drugs, and so called free treatments.” The Coalition Against Insurance Fraud claims that being involved in medical identity theft can cause “ruined credit, loss of health insurance, inaccurate records, legal troubles and higher health premiums.” Ways to protect yourself from medical insurance fraud include examine your explanation of benefits (EOB), monitor your insurance benefits, check your medical records, appeal refusals, protect your credit, and correct inaccurate medical records.” The Coalition Against Insurance Fraud suggestion filing a police report against any assumed medical identity theft or insurance fraud (Coalition Against Insurance Fraud, 2018).

In the end, it is up to physicians and their healthcare facilities to determine how to go about reporting insurance fraud. Ultimately, the reviews seem to be fairly mixed on how to handle such cases and whether or not the physician feels it is ethically wrong. One particular case study mailed a set of questionnaires to 367 physicians and the findings are as follows:

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“Sixty-three respondents (20.7%) indicated that physicians should report all the patients presented in the vignettes, while 45 (14.8%) indicated none should be reported; the rest indicated that the decisions to report should be based on the characteristics presented, with acute vs terminal illness ($P<.001$), history of fraud ($P<.001$), and wealth of the patient ($P<.001$) all causing physicians to be more likely to report the patient to the health insurance carrier. Multivariate analysis demonstrated that type of practice ($P=.04$) and respondents' experiences with insurance fraud ($P=.03$) had significant effects on the willingness to report patients (Farber, Berger, Davis, 1997).

Fraud in TRICARE

As mentioned before, pharmaceuticals are often used in ways to commit insurance fraud. The following case refers to the fraud taking place within TRICARE and the vulnerability of TRICARE beneficiaries. According to the DOJ and U.S. Attorney's Office of Southern District of California, “two doctors, Carl Lindblad and Susan Vergot, pleaded guilty in federal court...admitting that they had participated in a health care fraud scheme that bilked TRICARE-out of more than \$65 million by prescribing thousands of exorbitantly expensive compound medications to patients that they never saw or examined” (DOJ of Southern District of California, 2018). There's a combination of phantom billing and drug substitution taking place in this healthcare fraud case.

According to the DOJ's press release of this case,

“Compounded medications are specialty medications mixed by a pharmacist to meet the specific medical needs of an individual patient. Although compounded drugs are not approved by the Food and Drug Administration (FDA), they are

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properly prescribed when a physician determines that an FDA-approved medication does not meet the health needs of a particular patient, such as if a patient requires a particular dosage or application or is allergic to a dye or other ingredient.” (DOJ of Southern District of California, 2018).

TRICARE beneficiaries are a rather vulnerable demographic of patients and can be easily targeted for phantom billing and drug substitution. The reason being, all of their beneficiaries including active duty members, family members of active duty, and even retired veterans are vulnerable to mental health disorders and require specialized treatment by mental health facilities and physicians, as well as combination drug therapy. As for TRICARE, claims for these types of visits are very common and can often be overlooked when used in large amounts such as this case in California.

The two Californian physicians who pleaded guilty to the above charges saw this window of opportunity and used it against the most selfless men and women of our country. This is where insurance fraud, waste and abuse hit home. Everyone in American should feel threatened and taken advantage of when they learn of the severity of this issue in the American healthcare system. The following graphic lists the details of the case and prosecutions.

<u>DEFENDANTS</u>	Case Number 18-cr-0432-JLS	
Carl Lindblad	Age: 53	Cleveland, TN
Susan Vergot	Age: 31	Cleveland, TN
<u>SUMMARY OF CHARGES</u>		
Conspiracy to Commit Health Care Fraud – Title 18, U.S.C § 1349		
Maximum penalty: 10 years’ imprisonment and fine of higher of \$250,000 or double loss amount		
<u>AGENCY</u>		
Defense Criminal Investigative Service		
Naval Criminal Investigative Service		
IRS Criminal Investigation Division, Gulfport, MS		
Federal Bureau of Investigation - Jackson, MS Field Office		
*The charges and allegations contained in an indictment or complaint are merely accusations, and the defendants are considered innocent unless and until proven guilty.		

Waste and Abuse

Medical Identity Theft is unfortunately not the only form of insurance fraud a patient is capable of committing. The next form can be considered debatable and that is the order in which a perfectly healthy individual truly believes they are ill. According the Merriam-Webster dictionary, a hypochondriac is “a person who is often or always worried about his or her own health (Merriam-Webster, 2018). The term is most commonly used in a derogatory way about someone who finds illness in health. A majority of unnecessary office visits spawn from this sort of condition and create borderline fraudulent healthcare claims, again, putting the treating

physician between a rock and a hard place as they determine the legitimacy of the labs, procedures and claims they submit for said patients.

According to an article written by Haider Javed Warraich, a cardiovascular disease physician of Duke University Medical Center, approximately one fifth of patients fall into what he calls the “worried well” category of being an exceptionally healthy individual with an unnecessary level of anxiety about their well-being. His article is quoted as follows:

“Physicians have to balance their responsibility to both alleviate anxiety and also avoid unnecessary testing, procedures and hospital visits that will only multiply concerns that patients may have. But that can be a difficult argument to make, especially when someone is feeling aggravated and desperately seeking answers. In fact, there is evidence that up to a third of physicians would yield to ordering expansive unwarranted MRIs based on patient expectation and pressure. Interesting, data shows that patients who end up being most satisfied with their care are on more medication, stay in the hospital longer, incur high costs and ultimately die more often. While medicine as a whole is coming increasingly patient-centric, the medical consumer is unlike any other. As the Affordable Care Act comes into effect, policy makers are increasingly trying to identify opportunities to cut healthcare costs. The influx of millions of erstwhile uninsured has to be counterbalanced by adequate cost cutting in areas where waste is accumulating. The key to managing worried well is increased patient engagement and increased patient education.”

So there lies the solutions, the answer from a physician himself on how to cut the waste and abuse of insurance while still satisfying the patient. It is to be understood from the above

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information that insurance waste is also including in this research and can be deemed insurance fraud when elaborate, unnecessary procedures and testing is performed for a healthy patient, especially when said patients are using social programs such as Medicaid and Medicare to support their constant worries and doctor visits (Warraich, 2013).

Consequence of Performing Fraud

The fraud is obvious, but what are the punishments and what keeps people from defrauding tax payers and the federal government? Research has been obtained on the current federal and state penalties for large scale insurance fraud. The overwhelming majority of cases deal with white collar crime and their penalties, criminal records and possible jail time. The following information, obtained from a variety of lawyers and state's websites, will explain just how unsecure the boundaries of Medicaid are without proper enforcement of federal and state law.

Federal and state law both punish Medicaid fraud with jail time in coordination with fines, severity of punishment differs by state. According to the Medicaid Fraud Control Unit of the state of Ohio,

“Medicaid fraud is a crime. If the fraud involves sums greater than \$150,000, it is third-degree felony with maximum penalties of 36 months in prison and \$10,000 in fines. Fraud involving sums of more than \$7,500 but less than \$150,000, is a fourth-degree felony with maximum penalties of 18 months in prison and \$5,000 in fines. Fraud involving sums of more than \$1,000, but less than \$7,500 is a fifth-degree felony with maximum penalties of 12 months in prison and \$2,500 in fines. Any fraud involving sums under \$1,000 is a misdemeanor of the first

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degree with a maximum penalty of 180 days in jail and \$1,000 in fines. (Ohio State Bar Association, 2016).

All fifty states have federal Medicaid Fraud Control Units that work together to investigate every allegation of Medicaid fraud and abuse, both physician and patient performed. “The unit’s staff of more than 100 individuals includes special agents, analysts, nurses, paralegals and attorneys.”

The research included in this section is used to question whether or not the justice system is serving justice to those committing any scale of Medicaid fraud. According to The Department of Health and Human Services and The Department of Justice’s Health Care Fraud and Abuse Control Program Annual Report of 2016, “the Federal Government won or negotiated over \$2.5 billion in health care fraud judgments and settlements.” This report is provided by the Section 1817(k)(5) of the Social Security Act. The programs created are defined as “a far-reaching program to combat fraud and abuse in health care, including both public and private health plans.”

The Department of Justice (DOJ) reports that nearly 1,000 “criminal health care fraud investigations” were opened in the Fiscal Year of 2016, nearly 400 more cases than the year prior. These cases returned approximately \$3.3 billion to either the Federal Government, Medicaid and Medicare programs or private individuals. The fairly recent report strongly supports the actions of the DOJ in efforts to control and prosecute the actions of Medicaid fraud, nationwide (Department of Health and Human Services, DOJ, 2017).

Solutions

The first solution to the increasing Medicaid fraud, waste and abuse comes from two students of New York State University Students on initiatives to better detect insurance fraud by the insurance companies themselves. These students practiced and measured the rates of insurance fraud with their very own algorithms used to validate insurance claims. The students proposed the idea of a five step plan to help health insurance companies detect fraud from both physicians and patients. Reasoning comes from the rise of covered individuals and the cost of health insurance, which causes an increased amount of fraudulent health insurance claims submitted by both parties, the physicians and the patients. The further support their methodology with explanations of how healthcare is paid for using healthcare insurance. Patients and/or their employer pay the insurance companies a monthly premium who then pay the healthcare provider the appropriate amount demanding on procedures and codes listed on the claim. The insurance company and the healthcare provider agree on an allowable amount, insurance covers all, or their portion of the bill and the rest is sent to the patient. However, with a rise in insurance premiums, it can be difficult for a patient to pay to remainder of their medical bills.

For the purpose of a review, fraud performed by the provider can be done in a variety of ways. The healthcare provider can bill for services that were not given, they can bill insurance twice for the same procedure, add unnecessary charges and so on. One of the main sources of fraud from providers is called upcoding, which is almost exactly what it sounds like. It is adding a medical code that receives hired reimbursement than that of the procedure that was actually performed. Upcoding can even include adding medical codes to an insurance claim of a procedure that was not even done. Create what the authors call a “ghost patient” is also a way of falsifying insurance claims by sending a claim on an imaginary patient created by the physician.

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This is all in hopes to increase their reimbursement rate and bring more money into their practice. In efforts to detect this fraudulent behavior, the students have created a way to classify providers and watch those more carefully whom may be more likely to submit fraudulent claims. This section goes into great detail on how the authors and their researchers suggest classifying providers. This form of research differs from that already available because they examine the mathematical equations and risk factors involved in fraud detection.

The methodology begins with profiling providers, which involves looking at their location, patient demographics, and distance from competitors. The next step is to investigate the patient's demographics, then look into the amount of claims a particular provider or patient has. Stage 4 and 5 deal with risk management and protecting health insurance companies from fraudulent claims. Each step is identified with mathematical equations and reasoning. The equations are reviewed in section 4 of the article using the sample data created by the creators. With the sample data they used, their methodology showed an accuracy rate of 86% across five different specialty physicians. It has not been proved that any one specialty physician is more likely to commit federal insurance fraud than the other, but it is nice to understand that this potential solution has a wide range of control over the detection process and allow for customization and versatility (Nagarur, Johnson, 2015).

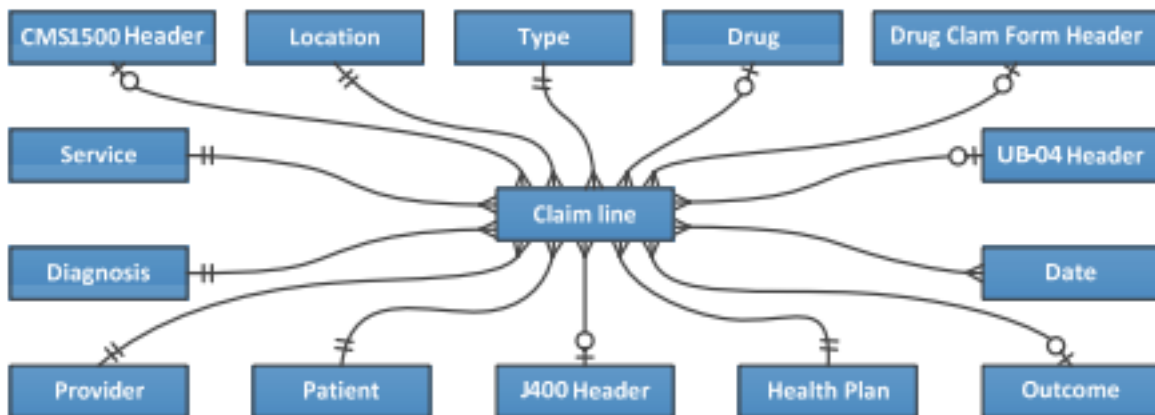
The second and final suggested solution is as follows:

“Medicaid providers use four different claim forms to submit claims to the source system: CMS1500 for outpatient professional services, J400 for dental services, UB-04 for institutional claims, and the Drug Claim Form for pharmacy claims.

These claims vary slightly in the information collected by purpose, but the general data structure is similar, defining who did what to whom when and why. To

maintain the data granularity and specificity, four different claim types: inpatient, long term, pharmacy and professional will be introduced. It should be noted that, as the data is specific to the type of service provided, most commercial insurance claims follow a similar template” (Thornton, 2013).

The solution proposed above is not about catching every falsified claim once it comes through, it is to serve as a schematic that will calculate the likelihood of falsified claims and who they may be coming from. Preparedness is the key for protecting Medicaid against fraud in this solution and it is further explained by the image below.



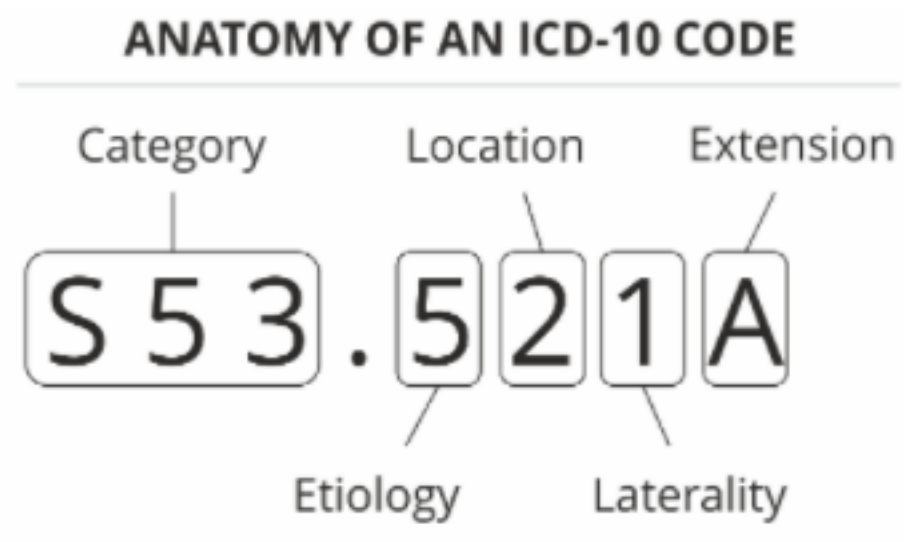
Conclusion

To conclude, a recap of the above information is necessary in order to take away the important pieces of this research development. The road to creation was not easily paved for the federal insurance programs, nor the creation of health insurance all together. The trials and tribulations that these programs have seen speak volumes of the credibility and security they deserve. Without Medicaid, Medicare, TRICARE and the Affordable Care Act, millions of Americans would be left uninsured and left responsible for the rising cost of healthcare. Those that are dependent on the governmental resources are either physically or financially in need of

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these services and deserve the lasting care they were promised. If fraud of these programs continue, health insurance could drastically change and so many Americans would be left without. Whether its phantom billing, upcoding, unbundling and drug substitution, the millions of dollars being wasted by fraudulent activity must be stopped in order to protect the benefits of Americans neediest. As mentioned in the beginning of this research, by no means is the description of Medicaid and Medicare beneficiaries meant to be disrespectful. This information is being brought forth in order to help those beneficiaries and fight for what's deserves. The white-collar crime taking place behind pharmacy counters and in physician's offices is to blame for the wasting of millions of dollars of the government's and tax payer's monies. The concluded research suggests that either proposed model will be beneficial to government insurance companies to regulate claims and determine the likelihood of fraudulent activity. Moving forward, the desire to lower fraud and increase healthcare benefits and access continues to fuel the education on Medicaid fraud, abuse and waste.

Figure 1



ICD-10 code for torus fracture of lower right end of right radius, initial encounter for closed fracture

Figure 2

Table 1. Characteristics of the Study Sample.*		
Variable	Respondents (N = 420,449)	Unweighted No. of Respondents
Mean age (yr)	41.1	NA
Male sex (%)	50	220,137
Race or ethnic group (%)†		
White non-Hispanic	63	288,629
Hispanic	15	44,640
Black non-Hispanic	10	33,708
Asian non-Hispanic	2	8,390
Other	8	33,028
Do not know or declined to answer	2	12,054
Household income (%)		
≤138% of FPL	14	36,102
139–400% of FPL	58	217,338
>400% of FPL	28	167,009
Currently employed (%)	71	306,153

Figure 3

Type of Beneficiary	Approximate Number of Beneficiaries (Total: 9.4 million)
Active Duty Service Members	1.4 million
Active Duty Family Members	1.8 million
Survivors of Deceased Active Duty Family Members	605,000
National Guard and Reserve Members (includes active and inactive members)	331,000
Family Members of National Guard and Reserve Members	527,000
Retired Service Members	2.2 million
Family Members of Retired Service Members	2.6 million
Others	52,000

Figure 4



Figure 5

Breaking Down the Medicaid Fraud Fight, 2011

The federal government and states lose tens of billions of dollars to fraud each year.

\$428.7b

total spent
on Medicaid
by the feds
and states

\$4.2b

total feds
recovered in
fraudulent
payments

\$1.7b

total states
recovered in
fraudulent
payments

\$604m

total feds spent
on recovery

\$208m

total states spent
on recovery

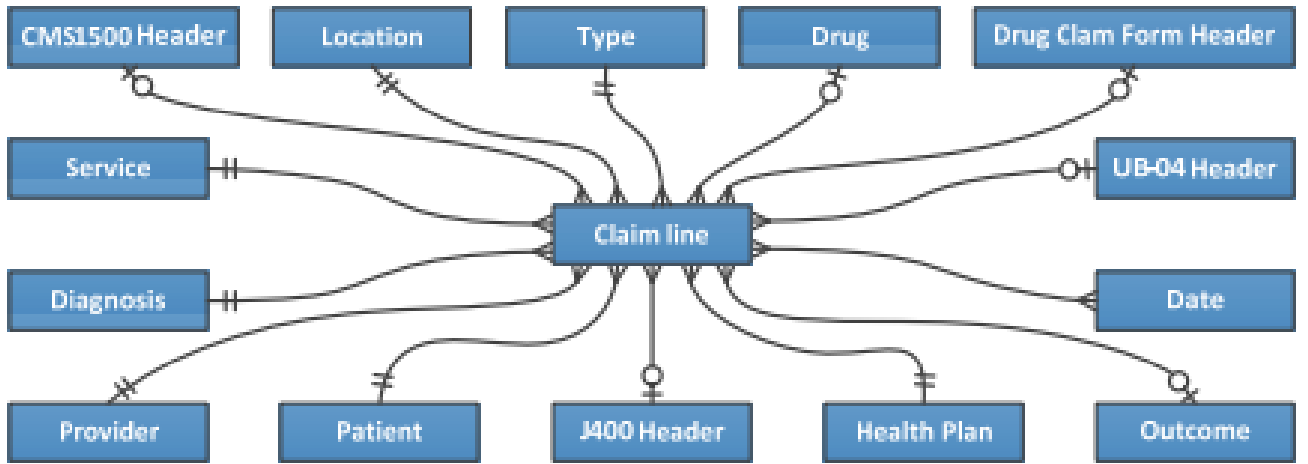
Figure 6

Type of Violation	Description
Overcharging Government Health Programs	Inflating the average wholesale price (AWP) of products, failing to give the lowest market price to government health programs, or failing to pay required rebates to any government health program
Unlawful Promotion	Off-label promotion of drug products or other deceptive marketing practices (e.g., downplaying health risks of a product)
Monopoly Practices	Unlawfully attempting to keep monopoly patent pricing privileges on products, or collusion with other companies undertaken with the purpose of increasing the market share of a particular product
Kickbacks	Kickbacks (e.g., monetary payments) to providers, hospitals, or other parties to influence prescribing patterns in favor of the company
Concealing Study Findings	Concealing results of company-sponsored studies from either the federal or state governments
Poor Manufacturing Practices	Selling drug products that fail to meet FDA standards or specifications (e.g., contaminated or adulterated products, or products that fail to meet size or dosage specifications)
Environmental Violations	Clean Air Act and Clean Water Act violations, or failing to meet federal emissions standards
Financial Violations	Accounting or tax fraud, or insider trading
Illegal Distribution	Distributing an unapproved pharmaceutical product

Figure 7

<u>DEFENDANTS</u>	Case Number 18-cr-0432-JLS	
Carl Lindblad	Age: 53	Cleveland, TN
Susan Vergot	Age: 31	Cleveland, TN
<u>SUMMARY OF CHARGES</u>		
Conspiracy to Commit Health Care Fraud – Title 18, U.S.C § 1349		
Maximum penalty: 10 years' imprisonment and fine of higher of \$250,000 or double loss amount		
<u>AGENCY</u>		
Defense Criminal Investigative Service		
Naval Criminal Investigative Service		
IRS Criminal Investigation Division, Gulfport, MS		
Federal Bureau of Investigation - Jackson, MS Field Office		
*The charges and allegations contained in an indictment or complaint are merely accusations, and the defendants are considered innocent unless and until proven guilty.		

Figure 8



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