Why Medicare & Medicaid are Vulnerable to Fraud
Executive Summary

The Government Accountability Office estimates that about 10% of Medicaid and Medicare expenditures are attributed to fraud, waste, and abuse. That equates to about $120 billion annually, more than the total federal budget for science, energy, and the environment. While fraud is prevalent throughout the entire healthcare system, Medicare and Medicaid programs have some basic characteristics that make them especially vulnerable. This paper explores Medicare and Medicaid program demographics, claims volumes, reimbursement complexities, budget constraints, stakeholder considerations, and other factors that contribute to the programs' vulnerability to fraud and abuse.
Medicare and Medicaid Program Overview

In 1965, Congress passed Title XVIII and Title XIX of the Social Security Act establishing the Medicare and Medicaid programs. Medicare was established to support the health care needs of the elderly and later coverage was added for persons with certain disabilities and kidney disease. Medicaid was established to provide medical services to individuals and families with low incomes and resources.

The Centers for Medicare & Medicaid Services (CMS) has oversight for both programs. CMS administers the Medicare program on a federal level and state governments administer Medicaid as a state level program. In the past decade, there has been a significant shift by both programs to a managed care model, changing how the programs are delivered and financed. In 2015, 27% of Medicare recipients were enrolled in Medicare Advantage plans, and 71% of Medicaid recipients were enrolled in Medicaid Managed Care plans.¹

Today, the Medicare and Medicaid programs cover more than 113 million people—over 55 million in Medicare and over 58 million in Medicaid.² Total expenditures for the programs are in excess of $1 trillion annually ($597 billion for Medicare and $476 billion for Medicaid).³
Fraud, Waste, and Abuse in Medicare and Medicaid

Improper payments made by the Medicare and Medicaid program are estimated to equate to 10% of total expenditures. Some of the common types of fraud and abuse include medical identity theft, billing for services not delivered, known as phantom billing; billing for unnecessary services; upcoding; unbundling; and kickbacks.

While a small portion of improper payments is eventually recovered, the vast majority is never recouped. The financial loss from improper payments is obvious, albeit alarming, for these government healthcare programs and the taxpayers who fund them. What are less obvious are the impacts to other program stakeholders such as providers, recipients and government staff. These Medicare and Medicaid constituents are subject to resource drain, financial costs and even risk of harmful medical treatments as a result of fraud, waste, and abuse.

Impacts of Fraud, Waste, and Abuse on Medicare and Medicaid Stakeholders

Medicare & Medicaid Providers
- Compliant providers subject to onerous audit programs
- Poor health outcomes due to medical record errors and overlays
- Financial cost to correct records and treatments

Medicare & Medicaid Recipients
- Disruption in service and accessibility to care
- Harmful treatment due to medical records errors
- Erroneous medical bills and impact to credit history

Law Enforcement & Government Staff
- Audit and investigation costs
- Cost to correct data and records
- Costs to deal with stakeholder abrasion

Why Medicaid and Medicare are Vulnerable to Fraud
Medicare and Medicaid Vulnerabilities to Fraud, Waste, and Abuse

There are a multitude of reasons why Medicare and Medicaid are vulnerable to fraud, waste, and abuse. Some of the more prevalent factors are the programs’ volume and complexity, limits on the amount and depth of claims reviews, recipient characteristics, and their fraud risk-reward profile. We will examine each of these factors in detail.

Volume and Complexity
Medicare and Medicaid are the largest healthcare programs in the country. The sheer volumes of claims processed, 4.5 million claims daily for Medicare alone, provides a ripe environment for improper payments to pass through the system. We have all heard the stories of high volume fraud cases, including one reported by the New York Times where a Brooklyn dentist earned $5.4 million from Medicaid in less than two years, with specific incidences where she billed for 991 procedures in one day and 9,500 for the month.

Volume alone is not Medicare and Medicaid’s only vulnerability related to claims processing; complexity opens the door to errors and difficulty in capturing all improper payment submissions. Compliance with changing state, federal and local regulations and exceptions, ICD-10 implementations, and managing dual-eligible populations also make the claims process highly complex, fostering an environment fraught with errors & risk.

Limits on the Amount and Depth of Claims Reviewed
The enormous claims volumes in Medicare and Medicaid make it impossible to review most claims in depth. This volumetric impact coupled with the fact that budgets for audit programs and audit resources are limited results in gaps in claims compliance oversight. Further, both the Medicare and Medicaid programs are concerned about the audit burden on the providers who serve their constituents. Medicare and Medicaid typically pay lower rates for services than commercial health plans, yet recipient enrollment is massive. To retain providers in the program, Medicare and Medicaid remain cognizant of the cost and resource impact that audit programs have on these stakeholders, and often place limits on the depth and volume of audits faced by any single provider. For example, CMS’ Medicare Recovery Audit program places limits on medical records and other documents (Additional Documentation Requests, or ADRs) that an auditor can request to complete the review a provider’s claims. The baseline ADR Limit is set...
at one half of one percent (0.05%) of the provider’s total number of paid Medicare claims for the past 12-month period, meaning that less than 1% of a provider’s Medicare claims can be reviewed using the necessary provider documentation. This ADR Limit is risk adjusted in future periods using the provider’s denial rate. This risk-adjusted ADR Limit ranges from 0% of the provider’s total Medicare claims to a maximum of 5% of the provider’s Medicare claims for a 12-month period for providers who have a high denial rate.9

Medicare and Medicaid Recipient Characteristics

One of the checks and balances on healthcare fraud, waste, and abuse are the patients themselves, who often have the ability to review charges on their behalf to check for accuracy. Unfortunately, some of the characteristics of Medicaid and Medicare recipients limit this verification function. For example, there is a high churn rate in Medicaid, meaning that individuals go on and off the program at high frequency. This coupled with a high percentage of transience make it difficult to both track individuals as well as provide information about services delivered on their behalf. Further, the fact that there are often no copays, especially for Medicaid services, makes patients less likely to scrutinize their bills or summaries.

Other characteristics of Medicaid and Medicare recipients, including portions of the aged and disabled populations, may make them more susceptible to fraud and medical identity theft. This is a growing threat for government healthcare programs as health benefit cards are more lucrative for criminals than credit card numbers.

Favorable Risk-Reward Profile for Criminals

As mentioned, there is a growing market for obtaining Medicare and Medicaid recipient numbers for illegal use. Criminals use the numbers to submit phantom bills for services and equipment; to obtain medical services or prescriptions; or to sell the recipient cards on the black market. Government healthcare fraud has a favorable risk-reward profile as compared with several other types of common crimes. For example, the illegal drug trade is more physically dangerous and has steeper penalties for convictions. Credit card fraud has become more difficult to perpetrate as the financial sector gets increasingly sophisticated in stopping cybercrimes in a timely fashion. This makes the per transaction gain from stealing a credit card less profitable than the gain from stealing a medical identity.

These are some of the many factors impacting Medicare and Medicaid’s vulnerability to fraud, waste, and abuse. Some other factors include antiquated claims processing systems, lack of robust data sharing requirements, and certain gaps in prior authorization and utilization review programs.
There are numerous ongoing efforts to combat fraud, waste, and abuse in Medicare and Medicaid. Many of these initiatives have made inroads into identifying and recovering improper payments and prosecuting fraudulent actors. Medicare Zone Program Integrity Contracts, Medicare Recovery Audit Contracts, Audit MIsCs (Medicaid Integrity Contracts) and a host of other initiatives led by CMS, the Health and Human Services Office of the Inspector General, the Department of Justice, Medicaid Fraud Control Units, and other government agencies at the federal, state, and local level continue efforts to contain improper payments in government healthcare programs.
Bending the Medicare and Medicaid Cost Curve

In recent years, government healthcare programs have turned their interest to exploring ways to prevent fraud, waste, and abuse before it occurs. Stopping erroneous services, equipment, or prescriptions from being delivered will eliminate a significant portion of improper payments and will have the added benefits of:

1. Preserving audit and investigative resources to target the most egregious problem areas
2. Reducing provider audit burden
3. Protecting patients from harmful medical care due to medical record errors
4. Reducing claims volume and complexity

One of the ways that CMS is trying to prevent fraud is by identifying fraudulent providers when they apply for the program. The automated provider-screening program assigns levels of risks based on a variety of factors including provider type and historic instances of fraud or improper payments. Based on the risk score, the provider will be subject to different levels of screening including unannounced site visits, licensure checks, and other investigations.

The private sector has also been developing technology solutions to prevent fraud before it occurs. To address the problem of medical identity theft and phantom billing, technology that accurately verifies a patient’s identity and their presence at the point of care, assures providers and payers that the right person is being treated and no medical identity theft or phantom billing has occurred. These technologies link government identification databases to a biometric identifier, providing a significant advancement over a patient showing a Medicare or Medicaid card alone.

Other prevention technologies detect patterns between members and providers and benchmark like-providers to identify potential high fraud risks. Once adopted more broadly, these technology solutions will help curtail Medicare and Medicaid fraud, waste, and abuse by both catching bad actors as well as by providing a deterrent to would-be criminals wanting to defraud the programs.
Conclusion

Medicare and Medicaid remain vulnerable to fraud, waste, and abuse; especially as recipient populations grow, claiming becomes more complex, and government healthcare continues to be seen as having an attractive risk-reward profile versus other types of fraud. The limitations of current fraud, waste, and abuse audit and review programs require government programs to focus more on prevention efforts in order to contain improper payments. New technologies are emerging that can bend the improper payments cost curve and act as a deterrent to fraudulent actors.

Sources:
1. Kaiser Family Foundation, kff.org, Medicare Advantage Fact Sheet June 29, 2015; Medicaid Managed Care Trend Data 2013.
5. CMS.gov, Common Types of Fraud Fact Sheet, September 2015.

MedicFP® is a healthcare technology company that has created the only solution to actually prevent fraud before care. MedicFP’s solution addresses growing healthcare concerns related to medical identity theft, medical identity sharing, and phantom billing by enabling payers and providers to verify a patient’s identity, eligibility, and presence before a medical service is delivered.

For more information about how to reduce healthcare fraud vulnerabilities, contact us at: contact@medicfp.com

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