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COMMENTARY

Recommendations to protect patients and health care practices from Medicare and Medicaid fraud

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ABSTRACT

Fraud is defined as knowingly submitting, or causing to be submitted, false claims or making misrepresentations of a fact to obtain a federal health care payment for which no entitlement would otherwise exist. In today's health care environment, Medicare and Medicaid fraud is not uncommon. The negative impact of fraud is vast because it diverts resources meant to care for patients in need to the benefit of fraudsters. Fraud increases the overall costs for vital health care services and can potentially be harmful to Medicare and Medicaid beneficiaries. The objectives of this commentary are to describe the types and trends of Medicare and Medicaid fraud that are committed, and provide recommendations to protect patients and health care practices. Specifically, this article identifies types of Medicare and Medicaid fraud at beneficiary (patient) and provider level, and it can be intentional or unintentional. This article also describes the 3 primary laws that prohibit fraud and gives fraud case examples relevant to each law, including the False Claims Act, Anti-Kickback Statute, and the Stark Law. We also discuss currently trending and emerging areas, including opioid and pharmacogenetic testing; both have experienced heavier and higher-profile instances of fraud in today's health care landscape. Last, the article summarizes detection methods and recommendations for health care providers and patients to protect themselves against fraud. Recommended strategies to combat fraud are discussed at policy, practice, and grassroots levels. Health care practitioners, including pharmacists, can use these strategies to protect themselves and their patients from becoming victims of fraud or unknowingly committing fraud.

Medicare and Medicaid are government-sponsored insurance programs with approximately 59 million Medicare and 72 million Medicaid beneficiaries.[1,2] These programs have different eligibilities, with approximately 12.2 million people qualifying as dual-eligible in 2018.[3] In fiscal year (FY) 2017, the total expenditure for Medicare and Medicaid was $702 billion and $596 billion, respectively with estimated improper payments of $52 billion and $36.7 billion, respectively.[4,5] Medicare and Medicaid fraud is not uncommon. According to the Centers for Medicare and Medicaid Services (CMS), fraud is "knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain a federal health care payment for which no entitlement would otherwise exist."[6] Although the exact extent of improper payments in each program is difficult to estimate, the Office of Management and Budget estimates that 9% of the total health budget outlay was lost to improper payments.[7,8] During FY 2017, the Medicare Fraud Strike Force and Medicaid Fraud Control Units filed fraud charges against 478 and 1311 defendants, respectively. In FY 2017, the Office of Inspector General (OIG), U.S. Department of Health and Human Services, excluded 3244 health care providers and entities from serving federal health programs owing to fraudulent practices.[9,10] During the coronavirus disease (COVID-19) pandemic, OIG alerted the public about a fraud scheme that offered free COVID-19 tests to Medicare beneficiaries in exchange for personal information,[11] and was subsequently used to bill Medicare or for medical identity theft. Fraud increases the overall costs for vital health care services and can be harmful

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Key Points

Background:

- Medicare and Medicaid fraud is not uncommon. Fraud increases the overall costs for vital health care services and can be harmful to patients.
- Most fraud cases violate 1 or more of these 3 statutes: the False Claims Act of 1863, Anti-Kickback Statute of 1972, or the Stark Law of 1989.

Findings:

- This paper describes the types and trends of Medicare and Medicaid fraud that are committed and provide recommendations to protect patients and health care practices.
- By being vigilant around current trends surrounding opioid and pharmacogenetic-related fraud, pharmacists can safeguard the well-being of their patients as well as the security of their practice.

to patients. In fact, patients receiving medical care from health care providers who were subsequently excluded from Medicare for fraud had significantly higher rates of all-cause mortality and emergency hospitalization after risk adjustment.[12] To respond to the fraud epidemic, CMS has adopted sophisticated machine-learning methods, including a method used to identify deviations from practice norms in billing codes. In this case, it is important for providers to properly document any practice that may deviate from standard practice or from their usual billing codes.[13]

The introduction of the Health Insurance Portability and Accountability Act of 1996[14] and the Patient Protection and Affordable Care Act of 2010 (ACA)[15] expanded the oversight and enforcement of government health claim payments. Although not all improper payments are fraudulent, most fraud cases violate 1 or more of these 3 statutes: the False Claims Act (FCA) of 1863, Anti-Kickback Statute (AKS) of 1972, or the Stark Law of 1989.[16] Because Medicare and Medicaid rely on health professionals' judgment to treat patients with medically necessary services and to submit accurate claims for health care items and services, health care providers play a crucial role in protecting the integrity of these programs.[6] Therefore, the objectives of this commentary are to describe the types and trends of Medicare and Medicaid fraud that are committed and provide recommendations to protect patients and health care practices.

Types of fraud

There is no standard in how fraud is classified.[17] CMS describes 10 different types of Medicaid fraud, whereas Thornton et al[17] describe 18 different types of health care–related fraud. Medicare and Medicaid fraud can occur at the beneficiary (patient) or provider level and can be intentional or unintentional (Table 1).[18] Specifically, beneficiary-related fraud may include identity theft and Medicare/Medicaid card sharing; using, buying, or selling multiple cards; providing false information to qualify for Medicare/Medicaid; collusion with, or kickbacks from, providers; and drug diversion.[18] In addition to involvement in the aforementioned items, provider-related fraud may also include improper billing practices such as double billing, billing for services not provided, unbundling, and upcoding, potentially exposing providers to criminal and civil liability.[18] The U.S. Department of Health and Human Services and Department of Justice are working to combat these types of health care fraud through the FCA, AKS, and the Stark Law.[19]

First, the FCA imposes civil liability on any person who submits, or causes to be submitted, a false or fraudulent claim to the federal government for payment or approval, either knowingly or owing to deliberate ignorance.[16,20] Cases of identity theft, upcoding, and drug diversion fall into this category, making it critical for pharmacy personnel to be aware of correct prescription billing and record-keeping procedures. Violators may incur penalties of $5500-$11,000 per claim, plus 3 times the government's damage.[16] Furthermore, the qui tam provision under the FCA allows individuals to file lawsuits against any government contractor (including health care providers) for any wrongdoing and be rewarded with a share of the money recovered in a successful case.[16,21,22] This provision has increased the number of qui tam lawsuits invoked by competitors, employees, patients, other physicians, and federal prosecutors against false claims.[16,21] In FY 2018 alone, 645 qui tam lawsuits were filed in which the government recovered more than $2.1 billion.[23] Pharmacists should be aware of this provision to safeguard their practice.[23]

The AKS prohibits any person from knowingly or willfully offering, paying, soliciting, or receiving remuneration for making a referral to, or inducing business from, a federally reimbursed health care program.[16,24] When remuneration is paid or received for patient referrals, or anything of value is offered in return for purchasing, leasing, ordering, arranging, recommending the purchase, lease, or ordering of any item or service that is reimbursable by a federal health care program, the AKS is violated.[16,21] An example may include a pharmacy offering a gift card for transferring prescriptions or getting vaccinated; in this case, the AKS would be violated if the retail value of the gift card is more than $10 or totaling $50 or more within a year.[25] Anyone violating this statute may be subject to up to 5 years' imprisonment, a fine of up to $25,000, or both, and exclusion from all federal health care programs.[16,21] It should be noted that, under the safe harbor regulations, some payment and business practices are not treated as offenses.[26]

Last, the Physician Self-Referral Law (Stark Law) prohibits physicians from making referrals to certain designated health services paid for by Medicare or Medicaid. Specifically, referring patients to an entity in which the physician or immediate member of his or her family has ownership or investment interest or with which he or she has arranged compensation is regarded as a violation of the Stark Law.[19,27] Pharmacists should be aware of this law; referrals cannot be made in exchange for financial profitability. Violators are subject to denial of claims for affected services from CMS, a civil monetary penalty of up to $15,000 for each service, and $100,000 for each violation if the individual intentionally submitted the claim after realizing that it violated the statute.[21]

Table 1
Types of Medicare/Medicaid fraud[11,12]

Type of fraud	Provider examples	Beneficiary examples
Billing for services or items not provided, or double billing when not required for the patient	Provider deliberately claiming the bill for services or items not provided; billing multiple times for the same services or items; or billing deliberately for unnecessary services or items.	
Unbundling	Billing for multiple codes by creating separate claims for services and supplies that should be grouped together.	
Improper coding and upcoding	Billing for services and procedures more expensive than provided to patients to increase earnings.	
Identity fraud or card sharing	Intentionally claiming reimbursement for treating a person other than the eligible beneficiary, e.g., treating an uninsured individual intentionally assuming the identity of another person with insurance coverage to obtain services.	Uninsured individual using Medicare/Medicaid ID card of someone else to obtain services and items.
Collusion	Provider filing false claims in collaboration with beneficiaries such as patients, pharmaceutical companies, or diagnostic firms for reimbursement.	Supporting providers to file false claims for unnecessary tests and services.
Drug diversion	Prescribing unnecessary drugs or altering prescriptions for personal use or to resell them.	Altering prescription or going to multiple prescribers to get more drugs for personal use or to resell them.
Kickbacks	Intentionally offering, soliciting, or receiving remuneration for referrals of items or services reimbursable by Medicare/Medicaid, e.g., pharmacists filling prescriptions with a specific brand of medication that yields bonuses from pharmaceutical companies.	Receiving payment from providers for referring other beneficiaries for medical services.
Multiple cards	Knowingly accepting multiple Medicaid/Medicare ID cards from a single person for increased claims and reimbursement.	Using others' Medicaid/Medicare ID cards, or selling one's own Medicaid/Medicare ID card to someone else to use.
Program eligibility	Intentionally billing for an ineligible person.	Lying about eligibility by providing false information to qualify for Medicare/Medicaid.

Abbreviation used: ID, identification.

Current trends

It is critical for practitioners to be aware of currently trending and emerging areas experiencing heavier fraud reports in today's health care landscape. Chief among these are fraud related to opioid prescription medications and pharmacogenetic testing. Regarding the opioid epidemic, 190 million prescriptions for opioid pain relievers were written in 2017 alone,[28] and instances of drug diversion are on the rise, with 324 publicly reported drug diversion cases and investigations in 2018, 94% of which were opioid-related.[29] Most people unlawfully obtain prescription opioids from a friend or relative either by buying them, stealing them, or even for free.[30] However, diversion of prescription opioids can occur through various channels that fall under Medicare or Medicaid fraud if claims are filed with these agencies, including prescription forgery,[31] inadvertent prescribing or dispensing by a legitimate medical provider to an illegitimate patient, or purposeful prescribing or dispensing by a medical provider to an illegitimate patient.[32] These cases of drug diversion constitute fraud under the FCA and put both beneficiary and provider at risk of liability. This has both clinical and economic repercussions on the health care system, leading to the loss of 47 million medication doses and $454 million in 2018 alone.[29]

Genetic and pharmacogenetic testing has gained popularity in recent years, with more than 100 medications now incorporating pharmacogenetic information in their drug labels.[33] In light of this, pharmacists are likely to receive more questions from their patients on this topic. However, the Food and Drug Administration has not approved any direct-to-consumer testing kits that predict the outcome of an individual's drug metabolism on the basis of genetic variants.[34] Medicare only covers testing for certain genetic variants for patients who are taking (or are candidates for) specific medications, or when deemed medically necessary by a treating physician or prescriber.[35-37] Therefore, in accordance with the FCA, pharmacists must be wary of performing and filing claims with Medicare for point-of-care pharmacogenetic tests unless deemed medically necessary. Furthermore, the occurrence of fraud in this area is more prevalent among older adults; they have reported receiving unsolicited requests to receive random and high-cost genetic tests at senior centers, homes, or health fairs, and are often asked to provide their Medicare identification number to individuals who intend to use them for identity theft.[38] Pharmacists can provide valuable guidance to their older patients to protect them from fraud in these cases.

Fraud detection

There are many comprehensive efforts to detect Medicare fraud. In addition to the ACA, which has allocated funds to combat fraud, federal organizations and task forces such as the National Health Care Anti-Fraud Association and the Health Care Fraud Prevention and Enforcement Action Team have been formed for this purpose.[39] Furthermore, information technology and data sharing are now being used by many of these organizations to detect fraud, such as the Integrated Data

Repository that was established to detect waste, fraud, and abuse.[40] Data mining tools have also proved effective to detect anomalous and excessive claims.[41] Similarly, computer-aided auditing systems have been used to detect drug diversion by comparing expected to actual prescription consumption and distribution in a specified time period.[42] Along with these broad detection methods, there are specific recommendations and actions that pharmacists should take to protect themselves and their patients.

Recommendations

Prevention of Medicare and Medicaid fraud can be accomplished through several strategies at policy, practice, and grassroots levels. Efforts to curb this fraud at the policy level can be especially useful in combating identity theft and drug diversion. For example, the Medicare Access and CHIP Reauthorization Act of 2015[43] replaced patients' Social Security numbers with Medicare Beneficiary Identifiers on their Medicare cards to protect them against identity theft. New cards were disseminated to all beneficiaries last year,[44] and they were advised not to share their old or new Medicare number with unauthorized services.[45]

Efforts focused on curbing drug diversion and associated fraud related to the FCA include prescribing and dispensing regulations, insurance formulary restrictions, manufacturer quantity limits, and restricted pharmacy allotments.[46-50] For example, CMS enacted Medicare Part D opioid overutilization policies in 2019, including limiting coverage to a 7-day supply for opioid-naive patients and identification of at-risk patients from pharmacy-dispensing data on the basis of opioid use from multiple prescribers or pharmacies.[51] Although these policies aim at reducing opioid diversion—related fraud and enhancing safe opioid use, pharmacists and prescribers should remain vigilant to make sure that patients with legitimate pain have access to opioid therapy when indicated.

At the practice level, health care practitioners can guard against billing and kickback-related fraud by doing due diligence. For example, those who are looking to expand their practice and business can seek Advisory Opinions from either CMS or OIG, where practitioners can submit their detailed business arrangements for review of any possible violations of Medicare fraud at a reasonable cost.[52,53] Next, practitioners should also keep detailed records and perform self-audits periodically to meet compliance. It should be noted that it is the practitioners' responsibility to self-report any overpayments received from government health programs, and any retained overpayments may be subject to prosecution.[54] Furthermore, pharmacists must be aware of the fine line between "steering" and providing valuable advice for patients seeking help with health care—plan selection. Prescription reimbursements to a pharmacy may differ depending on patients' Medicare Part D plans, and pharmacists could violate the AKS if their advice suggests to, or persuades, a patient to enroll into a certain plan. Pharmacists can provide objective information regarding health care plans without making recommendations, properly disclose the contract the pharmacy has, and train employees to ensure compliance.[55]

Regarding drug diversion and diversion-related fraud specifically, pharmacists can report suspicious prescribing activity to the Board of Medical Examiners in their state or local law enforcement. Furthermore, protection against fraud can be facilitated using state Prescription Drug Monitoring Programs.[56] Practitioners can also help prevent fraud by establishing drug take-back programs at their practice sites. These programs came about as a result of the Secure and Responsible Drug Disposal Act of 2010 (an amendment to the Controlled Substances Act),[57] and they allow patients to safely dispose of expired or unused prescription opioids (or other medications), thus removing the potential for diversion from home.[58] Community pharmacies, clinics, or hospitals with on-site pharmacies, and opioid use disorder treatment programs are eligible to set up this program.[59,60] Interested parties should consult the Drug Enforcement Administration Diversion Control Division website and their state Board of Pharmacy for more information.[59,60]

Regarding pharmacogenetic-related fraud, pharmacists should caution patients regarding the limitations of unapproved pharmacogenetic tests and advise them to not alter their medication regimen without first consulting their health care provider. Furthermore, pharmacists should counsel patients to be wary of individuals other than their regular health care providers offering pharmacogenetic tests, even if these individuals seem to represent a legitimate company advertising its services at a community health fair or senior center.[38]

At the grassroots level, patients can protect themselves from identity theft and unauthorized medical services by reviewing their claim statements for any suspicious service(s), and contacting their provider about any questionable items. After contacting the provider, beneficiaries can report suspected fraud by contacting either CMS at 1-800-633-4227 or OIG at 1-800-377-4950.[61]

Conclusion

Medicare and Medicaid fraud is a far-reaching issue that affects both patients and providers. Beneficiaries must be wary of identity theft and unauthorized medical services reimbursed through Medicare or Medicaid. Likewise, providers and pharmacists must be aware of the regulations surrounding false claims, kickbacks, and referrals because fraud can occur, whether it is intentional or unintentional. By being vigilant around these issues, particularly current trends surrounding opioid and pharmacogenetic-related fraud, pharmacists can safeguard the well-being of their patients as well as the security of their practice.

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