Medicare Fraud And Abuse

The Medicare program, which began in 1965 was a long-awaited solution for seniors that did not have proper health insurance coverage. Until that time, I read that less than half of all seniors had any insurance coverage at all, which is terrible. As the number of older Americans grew, the Medicare program kept expanding. Statistics for 2019 show that Medicare now covers over 60 million people, and that number keeps increasing every day. With its large number of people enrolled in the program and the enormous amount of money spent, unfortunately it left the Medicare program particularly vulnerable to fraud and abuse.

Medicare fraud is defined by the Centers for Medicare and Medicaid (CMS) as intentionally giving false or misleading information to Medicare for your own personal gain. Examples of fraud include billing for services not performed, misrepresentation of the type or level of service provided, billing for services not medically necessary, and altering medical records to justify payments. Fraud is considered a serious criminal offense under laws such as the False Claims Act and health care professionals can be fined up to $50,000 per claim, they can be given jail time, and even be suspended from the Medicare program. As opposed to fraud, abuse is unintentional and the provider has not knowingly misrepresented the facts in order to obtain payment. Examples of abuse include billing and coding errors. Abuse is taken very seriously, but is considered a lesser offense and usually the only penalty is fines.

The United States spends more than 2 trillion on health care every year and Medicare accounts for approximately 20% of that. The FBI estimates that fraud, waste, and abuse accounts for up to 10% of all health care money spent annually, so stopping any activity that wastes this precious resource has become extremely important to the government. *****

Prevention is one of the keys to control fraud and abuse. I read an article about how the OIG and CMS recommend the use of compliance programs, especially for providers by themselves or in small group practices to help reduce the chance of sending “improper claims” to Medicare. To me, it seems like these improper claims that are being labeled fraud for wasting money are nothing more than careless errors. However, the government takes a different stance. According to the article, in 2016, there were $40.4 billion in payments to Medicare that was improper. This is obviously a big problem that needs to be addressed, and I agree with using education and not just severe penalties to help discourage these careless errors from happening. Therefore, with the use of their guidelines, especially performing self-audits regularly and providers reviewing their policies on how to properly perform billing and coding, things like billing errors, which are often innocent mistakes, would not happen.

The ability to detect fraud can sometimes be very easy, but in other cases it can be very difficult through layers and layers of data. The Patient Protection and Affordable Care Act of 2010 (ACA) provided $350 million to help fight fraud, along with establishing a new set of fraud and abuse enforcement tools. Stricter rules and harsher sentences were created as a deterrent, to force compliance with requirements of the law. Current advances in technology have also made it easier to identify fraud. The article I read on “Big Data” talked about how every year CMS releases a number of Medicare datasets. There is an enormous amount of data in health care and each dataset can identify fraud in specific areas. If you combine all three datasets, it has

been shown to be very effective at detecting what is hidden.

Controlling fraud is accomplished by not just with the prevention and detection of it, but by laws and harsh civil and criminal penalties. My opinion on the penalties for fraud and abuse is that sometimes they are too severe, thanks to the ACA imposing stricter rules and harsher sentences for those accused of it and do not take into consideration the whole picture of what is going on. Yes, people do try and trick the government and should be caught and punished, but for everyone else making innocent mistakes or providers just doing their job to the best of their ability, I do not agree with how they are being punished. The article I read about providers being accused of fraud for the overtreatment of their patients, based on the government's definition, proved my point exactly. In the litigious society that we live in, providers have had no choice but to practice defensive medicine in order to prevent lawsuits. Ordering more tests and doing more for patients, even if it is not medically necessary, increases spending, but lowers the chances of something bad happening to their patients from lack of care. If it came down to a lawsuit, doing more can provide evidence that the provider did all they could for the patient. There are no incentives for providers to reduce this health care spending when the real threat of a lawsuit increases if they do so. So, with the government aggressively targeting providers that overtreat patients, in their opinion, still practicing this defensive medicine, accusing them of committing fraud, it puts providers in a difficult position. It is great that the government is trying to identify waste and cut costs, but turning this into a witch-hunt is wrong.

In conclusion, Medicare fraud and abuse has presented significant financial challenges in America. It effects patients, health care providers, taxpayers, and our government. Despite all of the laws, the enforcement tools, stricter rules, and harsher sentences, it has still not been enough. If enrollment keeps increasing along with the program's growing costs, no one knows for sure what the future of the Medicare program is. Based on current studies, nothing that the government comes up with will never completely eliminate fraud because there will always be somebody out there who will try it.