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Health care fraud and abuse enforcement: Relationship scrutiny

Executive summary

Where is fraud and abuse enforcement headed in health care? One emerging area of interest is relationship scrutiny. Relationships can be complex in the business of health care: tracking and analyzing them is an important part of minimizing the fraud and abuse that may result from questionable relationships and improper influence.

Many organizations depend on analytics to understand their own performance. Insights and patterns within the data are often used to inform strategy and decision making. Researchers can apply analytics to identify external trends and factors that may impact businesses. To that end, Deloitte researchers used analytics techniques to examine the text of tens of thousands of federal regulations and identify emerging trends in health care fraud and abuse enforcement. The results are telling: Federal health care regulators are emphasizing relationship scrutiny in their fraud and abuse enforcement efforts. Also, discussion of health care fraud and abuse topics – including relationship scrutiny – is recurring, as evidenced by the cyclical rise and fall in frequency and relevance of keyword groups related to "enforcement," "value-based care," and "fraud and abuse." The bottom line: discussion of these topics is present; relationship scrutiny is likely here to stay.

Minimizing the risk of health care fraud and abuse doesn't have to be an impossible task. New insights can come from the application of analytics to an organization's data sets. These insights, in turn, can be used to build a fraud and abuse risk-mitigation program.

This paper examines health care fraud and abuse enforcement drivers and laws, the cyclical trend of relationship scrutiny within the regulatory discussion, and how health care organizations can build a responsive, analytics-based program to address potential fraud and abuse. An effective program will likely enable organizations to identify risks in real time, adjust to mitigate them, communicate their importance, and learn from the regulatory and legislative landscape.

Why analytics matter in fraud and abuse enforcement

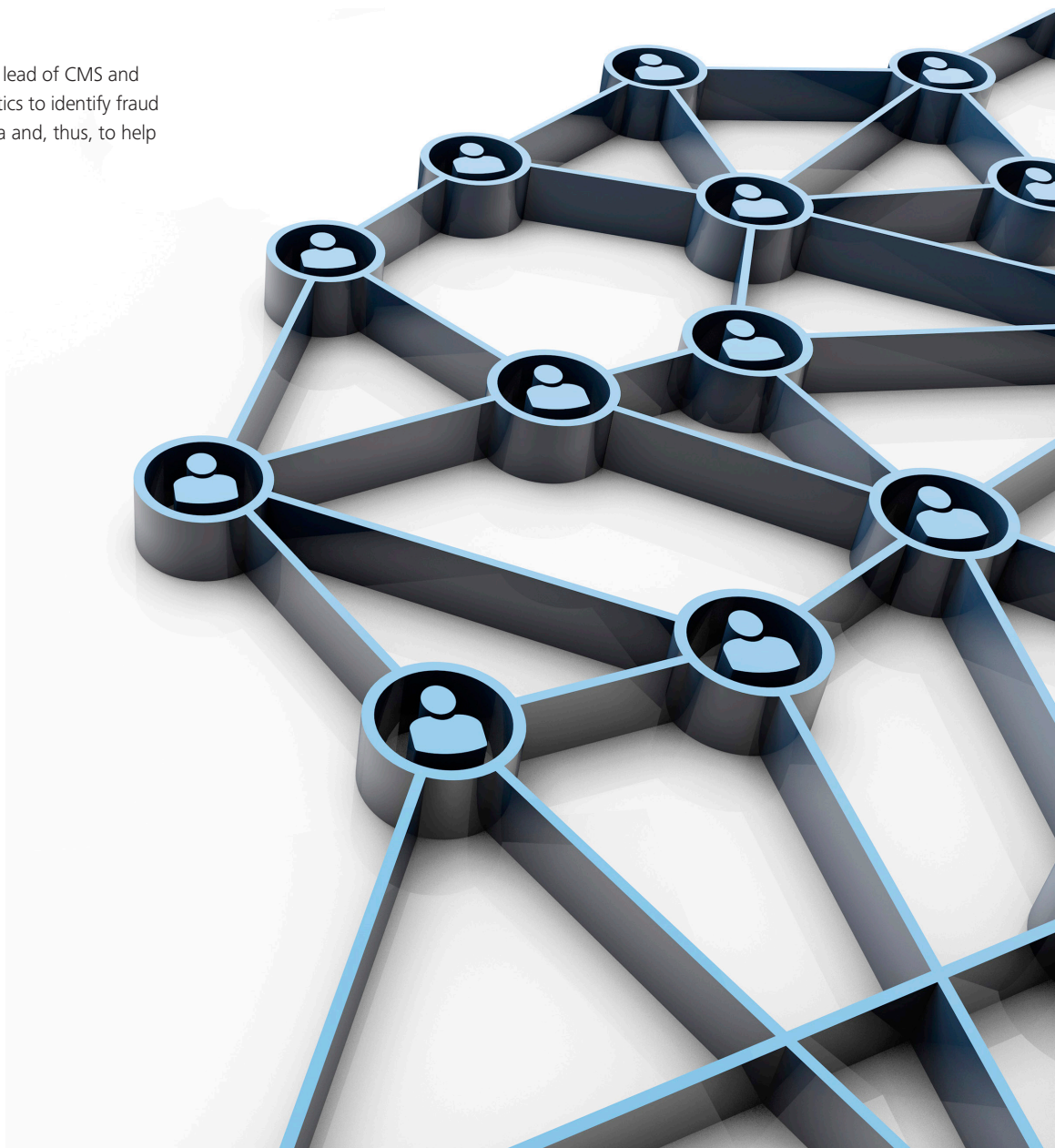
Health care fraud and abuse enforcement is a big deal: According to a US Department of Health and Human Services (HHS) and Department of Justice (DOJ) report for report for fiscal year (FY) 2014, the government recovers more than $3 billion a year in improper health care payments by enforcing laws such as the False Claims Act.[1]

Today, analytics enables government agencies including the Centers for Medicare and Medicaid Services (CMS) and others to scrutinize relationships among providers, payers, and life sciences companies. Analytics can help to expose anomalies or suspicious data patterns, verify identities, and mine data from social networks. Government investigators can use analytics to find patterns they may not have thought to look for, enabling "unknown unknowns" to be found, as well.

Health care organizations can follow the lead of CMS and other regulatory agencies by using analytics to identify fraud and abuse patterns within their own data and, thus, to help minimize their fraud and abuse risks.

What is relationship scrutiny?

We define relationship scrutiny as identifying entities within the health care system – providers, life sciences companies, beneficiaries, vendors, payers, and others – and investigating how they interact to determine whether fraud or abuse is present. Financial data, patient referral records, and even social media can provide context for studying parties' interactions.



Drivers of health care fraud and abuse enforcement

A number of health care industry drivers are increasing fraud and abuse risk:

Organizations are working more closely with one another. A potent combination of economic and regulatory forces is making health care mergers, acquisitions, and affiliations increasingly common. When organizations come together, networks of suppliers, payers, and providers can overlap in complicated ways and could result in potential conflicts of interest or problematic incentives, especially as they relate to federal health care programs. Competing interests and inappropriate influences within these relationships can result in improper payments, whether intentional or not. Also, as health care data becomes more accessible, industry relationships become open to more scrutiny. This means that organizations may increase awareness of their fraud and abuse vulnerabilities, and at the same time take steps to mitigate them. Organizations can do so by investing in analytics to support relationship scrutiny and fostering a culture that calls out potential fraud and abuse when and where it occurs.

The shift to value-based care (VBC) is spurring collaborative efforts to lower costs, improve quality, and improve outcomes. The changing financial incentives under VBC are prompting stakeholders to work together more closely on cost and quality initiatives, creating the potential for fraud and abuse. For example, sick patients could be hidden or transferred from one facility to another to boost a provider's quality scores. Relationship scrutiny could help to expose such schemes across the health care system.

Fraud and abuse increases the already high cost of health care. Recent estimates place health care fraud at up to 10 percent of national health care spending – as much as $290 million per year.[2] As overall health care spending is projected to grow, fraud-related costs could skyrocket even higher.[3] Former Attorney General Eric Holder has taken a firm stance on the issue: "We must remain aggressive in combating fraud" in health care. The DOJ will "use every appropriate tool and available resource to find, stop, and punish those" who compromise "the integrity of essential health care programs."[4]

Examples of fraud and abuse enforcement cases involving relationship scrutiny

- Four hospital executives in Florida were convicted of paying bribes and kickbacks in order to obtain Medicare patients. The executives billed Medicare for treatments for which the patients were ineligible, falsified patient charts, and administered unnecessary psychotropic medications to make the patients appear to need intensive mental health services. Relationship scrutiny played an important part in this case; it revealed that providers were taking advantage of their patients by over-treating them and billing the government.
- The owner of a home health agency in Miami was convicted of paying kickbacks to obtain Medicare patients, paying physicians kickbacks for writing false prescriptions, and submitting $40 million in claims for services provided to patients who were ineligible for and had no medical need for them. In this case, the relationship between the owner of the home health agency and patient brokers raised red flags, as did the relationship between the home health agency and the physicians writing false prescriptions for it.

Source: HHS and DOJ, Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013, February 2014 via http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf

Current analytics use in health care fraud and abuse enforcement

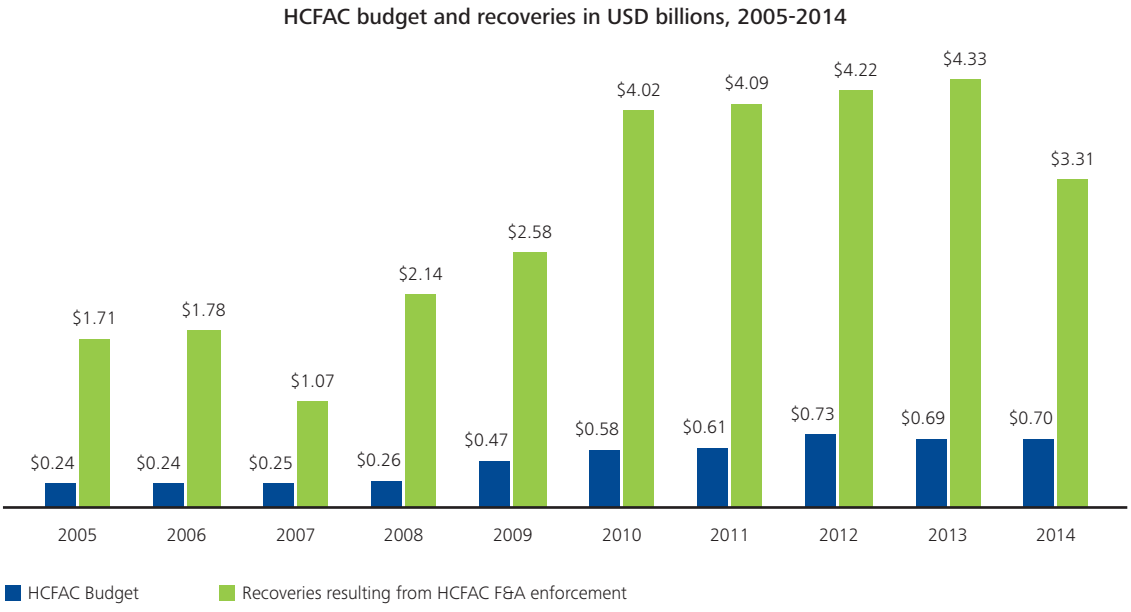
Assistant Attorney General Leslie Caldwell has placed data analytics front and center in the fight against health care fraud and abuse. She has pointed out that a great deal of useful information about potential fraud "can be gleaned from the data."[5] The Coalition Against Insurance Fraud, an insurance industry group, also has made the case for analytics. The group has proposed that analytics deserves the attention of the health care industry because they can "cut through false claims with laser-like efficiency."[6]

CMS has been using analytics to detect irregularities since the Small Business Jobs Act of 2010 required it to start using analytics to identify fraudulent payments. Offices within CMS, including the Center for Program Integrity (CPI) and the Office of Financial Management (OFM), are known for their analytics use. CMS is taking steps to advance these efforts, having established the Office of Enterprise Data and Analytics in late 2014 to help with their coordination.[7] Applying analytics to encounter data can help federal regulators discover many patterns, including anomalously high billing or prescribing rates, up-coding, and duplicative billing.

An important government initiative is the Health Care Fraud and Abuse Control Program (HCFAC), established in 1996. HCFAC is a joint DOJ and HHS effort to coordinate federal, state, and local law enforcement activities against health care fraud and abuse.[8] In May 2009, an HHS/DOJ information-sharing and collaboration initiative, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), advanced HCFAC's efforts and contributed to the success of enforcement activities.[9] Since 2005, efficiency gains have helped to increase HCFAC fraud and abuse enforcement recoveries (See Figure 1).

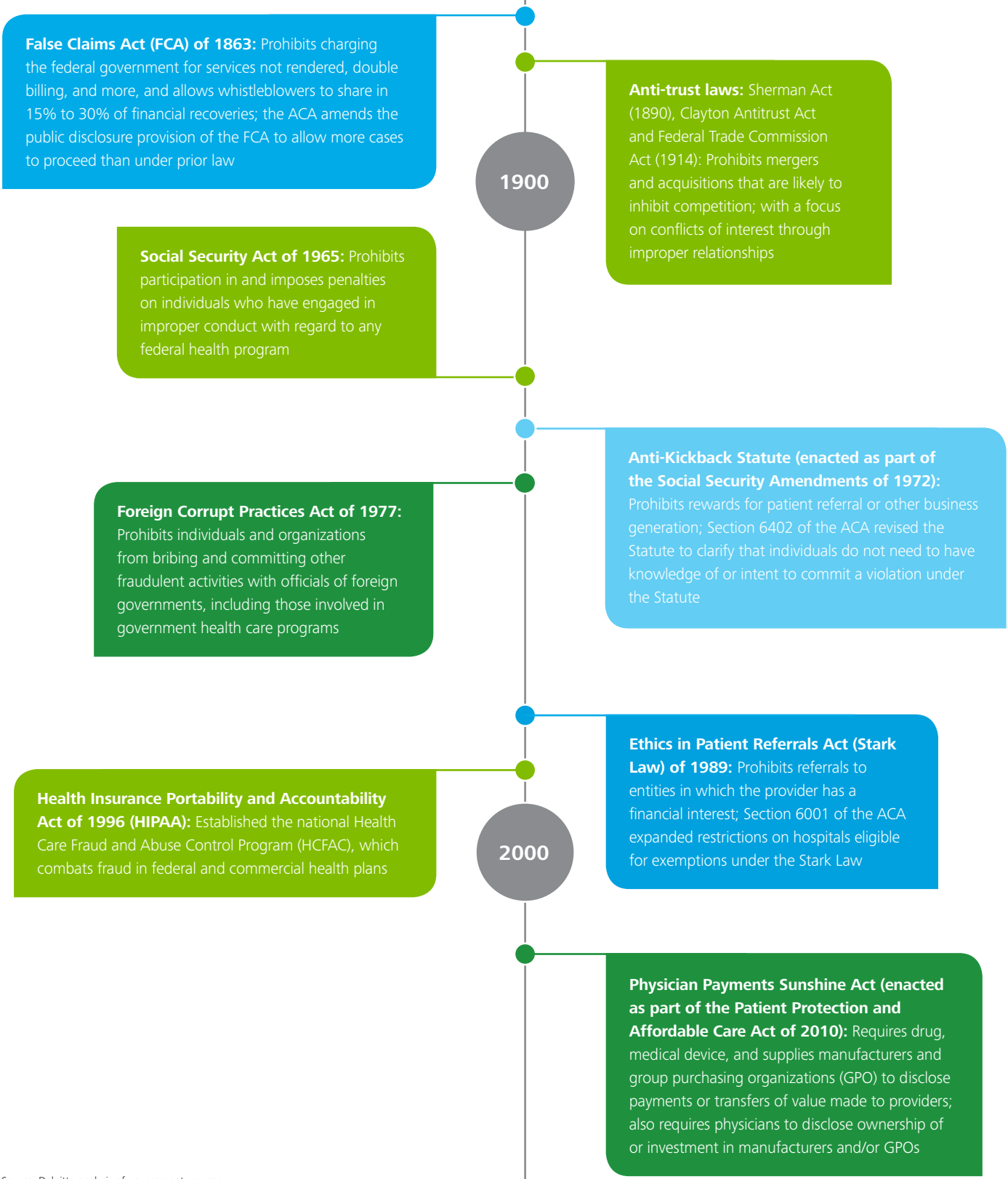
A handful of laws give multiple agencies the power to prevent and inhibit fraud and abuse from improper health care relationships (See Figures 2 and 3). To illustrate, investigations often employ the False Claims Act to prosecute against fraud and abuse claims. If kickbacks are involved, the DOJ may leverage the Anti-Kickback Statute. If investigators discover that providers have financial interests in the organizations to which they are referring patients, the DOJ can cite the Stark Law. The Federal Trade Commission (FTC) and the DOJ work together to enforce antitrust laws. Many health care fraud and abuse investigations in government health care programs are carried out by DOJ with guidance from the HHS's Office of Inspector General (OIG), using claims data to generate leads.

Figure 1. Fraud and abuse investment and recovery



Source: HCFAC Annual Reports 2006-2015

Figure 2. Laws used to fight health care fraud and abuse



Source: Deloitte analysis of government sources

Figure 3. Federal agencies that enforce health care fraud and abuse

Enforcing agency	Oversight
US Department of Health and Human Services (HHS) Office of Inspector General (OIG)	• The largest inspector general in the federal government • Oversees Medicare and Medicaid fraud and abuse prevention and detection programs • Comprises many offices, such as the Office of Audit Services (OAS), Office of Evaluation and Inspections (OEI), Office of Management and Policy (OMP), Office of Investigations (OI), and Office of Counsel to Inspector General (OCIG) • Educates the public about fraud schemes • Operates the HCFAC in conjunction with the DOJ
Centers for Medicare & Medicaid Services (CMS)	• Leads anti-fraud and abuse initiatives from the HHS OIG pertaining to Medicare and Medicaid • Leverages analytics to identify fraud and abuse patterns and detect potentially improper relationships in Medicare through the Fraud Prevention System (FPS) • Operates the Open Payments System, established by the Sunshine Act, which makes data about industry payments to providers available to the public • Oversees Recovery Audit Contractors that detect and collect overpayments made by Medicare and Medicaid
State Medicaid agencies and Medicaid Fraud Control Units (MFCU)	• State Medicaid agencies operate MFCUs in 49 states and the District of Columbia; each MFCU is certified by HHS OIG • Investigate and prosecute Medicaid provider fraud (74 percent of criminal convictions in FY2013) • Review abuse and neglect complaints against nursing home facilities (26 percent of criminal convictions in FY2013)[10]
Federal Trade Commission (FTC)	• With the DOJ, investigates potentially improper relationships in mergers and acquisitions under antitrust laws
Department of Justice (DOJ)	• Investigates health care fraud and abuse under the False Claims Act and through the HCFAC with HHS OIG • Investigates fraud and abuse under the Foreign Corrupt Practices Act with the Securities and Exchange Commission (SEC) • Investigates unfair business practices, including improper relationships, under the Clayton Act with the FTC

Source: Deloitte analysis of government sources; others as noted

Mining final rules from the Federal Register to unearth enforcement trends

Deloitte researchers sought to demonstrate through data-driven analysis that health care fraud and abuse enforcement continues to be a key industry issue. Researchers selected topics to screen for and agencies to include in the analysis and created groups of key words related to relationship scrutiny, fraud and abuse, and health care. Those groups of keywords leading the analysis are 1) "fraud and abuse" and 2) "enforcement" and "value-based care." (See Methodology for more information.)

After applying these filters, the data told an interesting story about the words and phrases that appear most often in Federal Register documents about health care fraud and abuse. The results reveal two major insights:

- The health care fraud and abuse enforcement discussion is cyclical.
- Even though the discussion is cyclical, its frequency and relevance over time is increasing.

Any number of factors may influence the frequency and relevance of health care fraud and abuse as a topic within the overall regulatory discussion. For instance, the implementation of major health care legislation may spark an increase in frequency. Conversely, a decrease in the overall volume of final rules being issued – for example, when a new administration takes office – can reduce that frequency. External events, such as large health information breaches, whistleblower cases, impactful investigative reporting, or influential oversight reports may also measurably impact discussion cycles. In short, while the discussion of health care fraud and abuse enforcement may not show a smooth line of constant growth, it persists throughout the analysis years.

Methodology: Analyzing the Federal Register for fraud and abuse trends

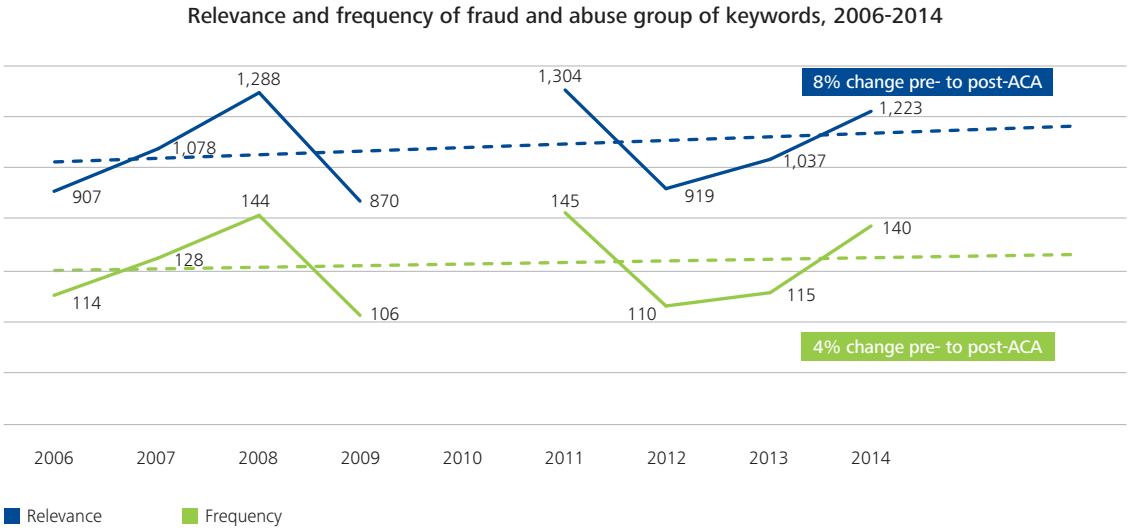
To identify trends that may indicate the future direction of health care fraud and abuse regulation, the Deloitte Center for Health Solutions teamed with the Deloitte Data Science team to analyze more than 50,000 final rules published in the Federal Register. Researchers chose the Federal Register because of its breadth and depth of information on the workings of federal agencies: the government publishes policies, guidance, notices, and regulatory changes in the Federal Register.

The set of final rules was reduced using names of departments and agencies with prominent roles in health care fraud and abuse enforcement, relevant topics from the Federal Register's own classification, and a customized list of over 150 keywords and phrases. Documents were then limited to those published between 2006 and 2014, the four years prior to and after the passage of the ACA.

The results of the analysis rest on the relevance and frequency with which groups of keywords appeared in this time period. In Figures 5 and 6, relevance is how important the term is to the overall content of the document. Frequency refers to the number of final rule documents in which words from a specific group appear.

Examining the "fraud and abuse" group of keywords shows how the topic's frequency can increase and decrease, yet continue to remain a vital part of the overall regulatory discussion (See Figure 4). Leading keywords from this group include "abuse," "bias," "corruption," and "conflict of interest." Relevance and frequency of the fraud and abuse keywords are fairly constant, on average, as the dotted trend line shows, with two- and three-year cycles of ebb and flow. Peaks in 2008, 2011, and 2014 are not much above the average, and the low points in the intervening years are similarly close to the trend line. The chart shows an overall change in relevance and frequency of eight percent and four percent, respectively, in the years before and after ACA passage, indicating the topic's relative stability and the likelihood of its continued presence in coming years.

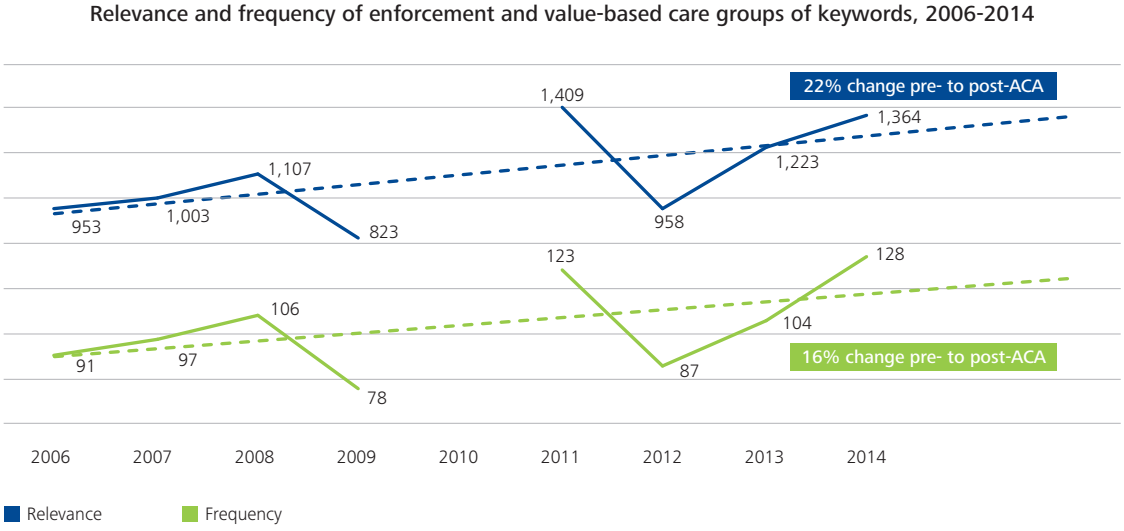
Figure 4. "Fraud and abuse" keyword group cycles



Source: Deloitte analysis of Federal Register

The importance of relationship scrutiny to fraud and abuse enforcement emerges when the "enforcement" and "value-based care" groups are combined (See Figure 5). The "enforcement" group includes keywords such as "investigation" and "irregular." The "value-based care" group includes keywords such as "managed care" and "contracting." These keywords show a greater overall increase post-ACA than the "fraud and abuse" group, with 22 percent growth in relevance and 16 percent in frequency. The takeaway from this chart is much the same as for the "fraud and abuse" group: the frequency and relevance can change from year to year, but the two keyword groups' correlation over the years of analysis indicates a topical trend that may continue to appear in the regulatory discussion.

Figure 5. "Enforcement" and "value-based care" keyword group cycles



Source: Deloitte analysis of Federal Register

Bridging the gap: From identification to an analytics-based fraud and abuse mitigation program

Deloitte researchers used analytics to confirm the regulatory and legislative focus on relationship scrutiny within health care fraud and abuse enforcement. Similarly, health care organizations can use analytics to anchor a fraud and abuse mitigation program by identifying patterns, associations, and anomalies within their own data that may warrant further attention. Here are a few ways that analytics may help investigators uncover fraud or abuse:

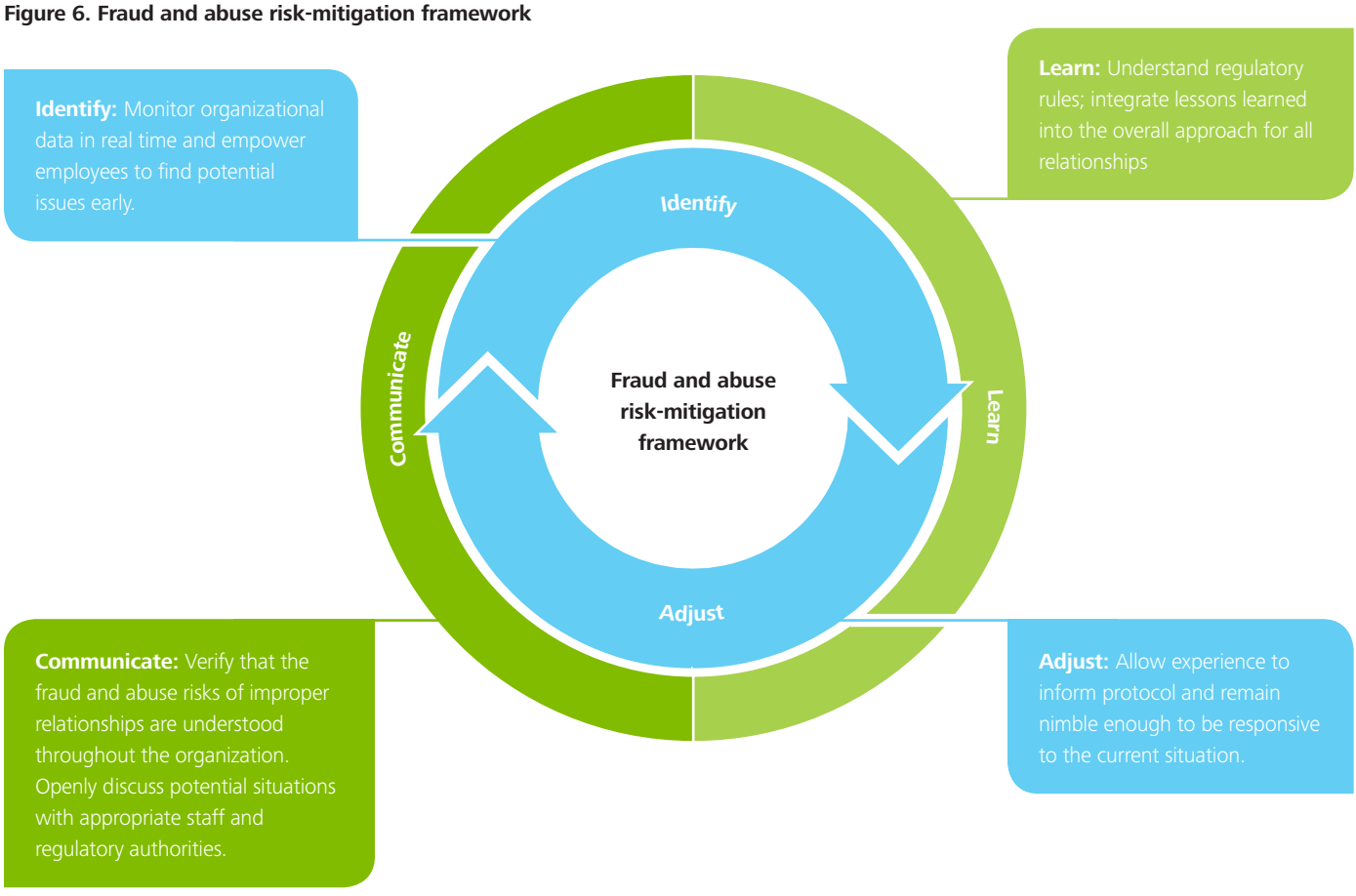
- Provider peer comparisons could reveal patterns of abnormally high or uncommonly frequent billing for similar services.
- Patterns could emerge of the same individuals making multiple visits to different providers for narcotics prescriptions.

Hospital records could reveal patterns of uncommonly high payment levels for short stays, or diagnosis-related groupings resulting in longer hospital stays than might be expected.

Addressing the challenges posed by scrutiny of improper relationships

Relationship scrutiny is likely to rise with increasing health care industry collaboration. Organizations that implement a fraud and abuse mitigation framework (Figure 6) that can identify which improper relationships may present risks could avoid the potential burdens of government investigations and enforcement actions. When implementing this framework, following leading practices may greatly improve effectiveness: setting the tone at the top, hiring and investing in the best talent, establishing a robust analytics program, investing in third-party due diligence, and staying abreast of regulatory developments are foundational elements of an effective fraud and abuse mitigation program.

Figure 6. Fraud and abuse risk-mitigation framework



Source: Deloitte Development LLC

Where the discussion may lead

Health care fraud and abuse aren't likely to disappear. But the landscape is changing. More data is being generated and collected. The tools to understand it are becoming more sophisticated. Using analytics to combat fraud and abuse will not necessarily make an organization bulletproof. Experience teaches that no amount of protocols, procedures, or preparation can prevent every potential incident, but an analytics-based monitoring program can help an organization to stay informed and adapt to changing conditions.

Leading practices for fraud and abuse risk-mitigation framework implementation

Set the tone at the top. Establish a culture that encourages identification and investigation of potential issues and a protocol for handling them. Ensure that the culture embraces change, won't sweep issues under the rug, and is willing to elevate and solve issues.

Hire the best and invest in them. Emphasize flexibility and adaptability when making the necessary human capital investments in analytics skills and regulatory compliance expertise.

Establish a robust analytics program. Invest in an analytics-based system for real-time, ongoing monitoring of potential issues. Verify that the system captures all available data, both internally and externally. Social media, financial data, vendor information, and even clinical data are all equally important to include.

Invest in third-party due diligence. Establish appropriate due diligence processes for third parties, including entities involved in complex networks such as supply chain.

Stay current on fraud and abuse enforcement trends. Monitor fraud- and abuse-related news and rulings issued by issued by HHS OIG, FTC, and DOJ. Keep informed on Congressional initiatives and legislation.

Source: Deloitte Development LLC

Appendix: Sample keywords

The Deloitte Data Science Team tracked the relevance and frequency of over 100 keywords in Federal Register final rules over a number of years. Below are a few examples.

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Endnotes

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