U.S. Recovers $3.3 Billion in Federal Health-Care Fraud

Obama administration steps up efforts to prevent Medicare fraud, not just uncover it

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WASHINGTON--The government recovered $3.3 billion in fiscal 2014 from individuals and companies that tried to defraud federal health programs, part of an effort by the Obama administration to improve enforcement and prevent abusive billing practices.

The administration recovered $7.70 for every dollar spent investigating health-care-related fraud and abuse in the past three years, according to a report to be released Thursday by the Health and Human Services Department and Justice Department. That marks the third-highest return on investment since the antifraud program was launched nearly two decades ago, the report said.

“These impressive recoveries for the American taxpayer demonstrate our continued commitment to this goal and highlight our efforts to prosecute the most egregious instances of health-care fraud and prevent future fraud and abuse,” HHS Secretary Sylvia Mathews Burwell said in a statement.

The Obama administration has been intensifying its focus on fraud and waste by preventing abuse and cutting the time from when fraud is identified and an arrest is made. The recoveries, while substantial, are small compared to the estimated fraud in the system.

The attempt to move away from chasing fraud to preventing it is based in part on a predictive analysis program called the Fraud Prevention System, which scans the fee-for-service claims for unusual behavior. That spawned leads for 469 investigations in fiscal 2013 and identified or prevented $211 million in improper payments; that was nearly

double the amount in the first year of the system a year earlier, according to an earlier Wall Street Journal report.

More than $27.8 billion has been returned to the Medicare Trust Funds since the fraud and abuse program began in 1997, the U.S. report said. The money was recovered from companies and providers who attempted to defraud federal health programs such as Medicare and Medicaid serving seniors, people with disabilities and those with low incomes.

Fraud recovery presents a formidable challenge. About 4.5 million claims funnel through the system each day, and in 2013 alone, Medicare spent some $583 billion.

The Wall Street Journal's continuing investigation into Medicare fraud and abuse found that recouping money from providers who engage in billing fraud is difficult even in the face of convictions or guilty pleas. Fraud accounts for as much as 10% of Medicare's yearly spending—which would amount to about $58 billion in bogus payments in the 2013 fiscal year, according to law-enforcement officials involved in the crackdown. Yet the U.S. government recovered just $2.86 billion in Medicare funds that year.
The recoveries reflect a two-pronged strategy to tackling abuse. The administration has been moving away from chasing down fraudsters, and instead is focusing more on preventing abuse. For example, the administration in 2014 expanded the Centers for Medicare and Medicaid Service's authority to remove doctors and other providers from the federal program for abusive government billing, and the agency can now revoke billing privileges of doctors and other providers who have a pattern of inappropriately billing the government.

The agency has also taken steps to help ensure that only legitimate providers are in the program. The Affordable Care Act required the agency to revalidate all 1.5 million Medicare suppliers and providers under new screening requirements. CMS has since halted billing privileges for 470,000 and revoked privileges for nearly 28,000 others.

Cases are also being investigated faster. The Justice Department and HHS's inspector general's office are using real-time data analysis instead of more time-consuming subpoenas and account analysis.

"With these outstanding results, we are sending the unmistakable message that we will not waver in our mission to pursue fraud, to protect vulnerable communities, and to preserve the public trust," Attorney General Eric Holder said in a statement.
The Medicare strike force, buoyed by increased funding from the administration and Congress, has expanded into nine territories including Miami, Los Angeles, Houston and Chicago.

In fiscal 2014, which ended on Sept. 30, the Justice Department opened 924 new criminal health-care-fraud investigations. Federal prosecutors filed criminal charges in 496 cases involving 805 defendants. A total of 734 defendants were convicted of health-care fraud-related crimes during the year, according to the report.

In November, owners of Miami-based Trust Care Health Services Inc. and other home health-care companies were sentenced for their roles in a fraud scheme with losses of about $50 million, the report said. Facility owners paid kickbacks to patient recruiters in return for referring patients. Defendants were each sentenced to prison terms of up to 120 months, and collectively ordered to pay more than $25 million in restitution.

In March 2014, the owner of Merfi Corp., a Miami health-care clinic, was sentenced to 108 months in prison for her role in health-care fraud schemes with estimated losses of more than $20 million, according to the report. Documentation was used to fraudulently bill Medicare for physical therapy and other home health-care services, based on the report.

The amount the agencies collect fluctuates from year to year depending on the number and type of settlement cases that are in the pipeline. Dollar amounts of recoveries may decrease as the agencies shift more focus to preventing fraud in the first place.

“I feel very positive,” said Dr. Shantanu Agrawal, deputy administrator for program integrity at CMS. “The efforts are having a great return on investment for taxpayers. Clearly, our work isn’t done. I’m very happy but by no means do I think we’re done.”

—Christopher S. Stewart contributed to this article.