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Health Care Fraud Across Time and Delivery Systems: Assessing the Legal Impact of the Affordable Care Act

Dana Kay Bonnell

A Thesis Submitted to the Graduate Faculty of

GRAND VALLEY STATE UNIVERSITY

In

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Abstract

Health care fraud is a crime that costs the United States billions of dollars each year. Health insurance fraud against government programs such as Medicaid and Medicare make up the majority of false claims. Government health care programs are particularly susceptible to fraud for three reasons: (a) high volume of claims; (b) recipient characteristics; and (c) a favorable ratio of reward to risk. Modes of fraud commission change depending on the health care delivery and payment model in use. In part, the Patient Protection and Affordable Care Act of 2010 sought to dramatically reduce health care fraud. The Affordable Care Act and related documents were analyzed using a qualitative, inductive approach that involved aspects of legal impact study and grounded theory methodology. The principles of Cressey's Fraud Triangle Theory were applied with the goal of generating new hypothetical understanding about how the law influences pressure, opportunity, and rationalization in terms of the way the legislation was intended as well as its real world application. The Act decreases pressure by awarding grants and providing funding and incentives to institutions and individuals, thus improving their financial stability. In a small number of cases, the Act may increase pressure on specific entities by imposing financial penalties, although the purpose of these sanctions is to coerce compliance with requirements of the law. The Act has the strongest effect on opportunity through increased regulation and oversight, linking payment with quality and outcomes, reporting requirements, use of alternative payment methods, and innovative demonstration projects. The Act addresses rationalization by consistently endorsing a consensus-based, multi-stakeholder approach when it comes to the creation of operating rules and standards. Emphasis is also placed on public reporting of performance data and information related to safety and quality standards. This was found to have a culture changing effect in ways that discourage favorable definitions of trust violation. The

study concludes that linking provider payment with performance and outcomes is the optimal way to control costs while safeguarding patient health and deterring fraud, waste, and abuse. Future studies should explore the impact of the Act after it has been fully implemented.

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Health Care Fraud Across Time and Delivery Systems:

Assessing the Legal Impact of the Affordable Care Act

Background of the Problem

Corporate crime. Corporate crime has been defined as, "offenses committed by corporate officials for their corporation and the offenses of the corporation itself" (Clinard & Yeager, 1980, p. 189). The Federal Bureau of Investigation (FBI) has adopted a more focused definition of corporate criminality; "those illegal acts which are characterized by deceit, concealment, or violation of trust and which are not dependent upon the application or threat of physical force or violence" (Barnett, n.d., p.1).

Compared to conventional crime (street crime), corporate crime exacts a much higher financial and social price. According to Clinard and Yeager (1980), the most economically significant crimes are also the least publicized, investigated and punished. Reiman (2007) calculated the cost of conventional crime versus that of corporate crime. Whereas property crime in 2003 cost the U.S. $17 billion, corporate crimes cost $419 billion (Reiman, 2007). In terms of the cost of white collar and corporate crime to society in general, "corporate crime is dysfunctional because it lacks the social opprobrium necessary to foster solidarity" (Brown & Chiang, 1995, p. 33). Corporate crime undermines the social structure by violating public trust which generates cynicism toward the law and destroys the hope of an egalitarian society (Brown & Chiang, 1995). "The corporation acts as a separate entity and makes the contracts, pays the taxes, incurs the debt and protects the individuals involved from being personally liable for the consequences of business activity" (Nelson, 2002, p. 1).

There are many differences between corporate crime and conventional crime. Compared to conventional crime, corporate offending occurs within the organizational context and is often

carried out for organizational as opposed to individual ends (Simpson, 2002). This sets corporate crime apart from other forms of conventional crime. Corporations are comprised of "hierarchical, diverse, and often highly specialized positions" (Simpson, 2002, p. 8). The people that make up a corporation work both autonomously and in teams. Corporations are also made up of subunits and these subunits develop their own cultures and subcultures in which employees are socialized into organizational norms and goals, some of which may include illegal behavior. Unlike conventional crime, in which an individual offender can be identified, charged, tried, and punished, the complexity and anonymity with which corporate crime is often carried out presents problems in terms of detection, investigation and prosecution.

Health care fraud and Medicaid. Health care fraud is just one form of corporate crime. According to a recent FBI publication, national health care expenditures exceeded $3 trillion in 2014 and of this, an estimated 3% to 10% was lost to fraud and abuse (FBI, 2015; Morreale, 2008). Health care fraud is often complex and comes in many forms. One type of health care fraud, health insurance fraud, occurs when an organization or an individual defrauds a private insurance company or government health care program such as Medicaid. Of all the different types of insurance fraud in the United States (U.S.), fraud against Medicaid and Medicare make up the vast majority of all false claims (Healthcare Business & Technology, 2014).

Medicaid provides free or low-cost health coverage to low-income people, families and children, pregnant women, the elderly, and the disabled. As of 2011, the cost of this coverage was $427 billion with $21.9 billion (or about 5% of the total cost of the program) lost to fraud and abuse (CMS, 2014a). The Centers for Medicare and Medicaid Services (CMS, 2014b) define health care fraud as "an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other

person" (p. 3). In health care, every diagnosis, procedure, service, and piece of equipment is assigned an alphanumeric code by medical professionals for billing purposes. The totality of an encounter between a patient and a physician is broken down into codes, which are then submitted in the form of a bill to Medicaid, Medicare, or a private insurer in the form of a claim. Codes and bills can be manipulated in ways that do not accurately represent what transpired during a medical event. When individuals and organizations stand to profit from such misrepresentations it constitutes health care fraud. Types of fraud against the Medicaid program include medical identity theft; billing for unnecessary items or services; billing for items or services not provided; upcoding; unbundling; billing for non-covered items or services; kickbacks (bribery); and beneficiary fraud. Perrin (2016) cites three primary reasons why government programs such as Medicaid are targets of fraud, waste, and abuse. First, as the financial industry is becoming more sophisticated in terms of fraud prevention and detection, those intent on committing fraud turn to health care to steal identities and submit false claims. Lack of pre-authorization in government programs means a fraudulent claim can be submitted and paid with little threat of detection. Second, the high volume of claims make it difficult for all claims to be audited in a meaningful way. "For law enforcement and program integrity reviewers the targets keep moving, as criminals often abandon schemes and locations for new types of cheats before they are caught or prosecuted" (Perrin, 2016, p. 1). Third, Medicaid patients tend to move in and out of the program on a regular basis. They also tend to be somewhat transient, changing addresses and locations frequently. With this type of population, medical identities can be easily exchanged or stolen. In terms of Medicare, elderly and disabled individuals are vulnerable to fraud schemes in which their medical identities are used without their knowledge or consent (Perrin, 2016).

In order to understand how fraud can be perpetrated against the Medicaid program, one

must first understand the various ways the Medicaid program is administered, as these present different opportunities for fraud commission. Some Medicaid enrollees are served through a fee-for-service (FFS) delivery system in which providers are paid for each individual service. The states determine their reimbursement rates for the provision of Medicaid based on factors such as the cost of the service, what commercial payers pay in the private market, and a percentage of what Medicare pays for equivalent services. CMS then reviews the state plans to ensure reimbursement practices are in accord with federal guidelines. In a FFS system, the incentive is there for physicians to provide more services than are necessary because payment depends on the quantity of care as opposed to the quality of care. Reimbursement occurs retrospectively, after the treatment has been provided and there is little incentive to consider the cost of treatment, thus overutilization occurs. Under FFS delivery systems, common forms of fraud are billing for services never provided, billing for more expensive services than those provided, unbundling, and upcoding; essentially practices that will increase the amount of Medicaid reimbursement.

Fraud and managed care. Managed care came about in response to what was perceived as the health care cost explosion of the 1960s (Hackey, 1999; Virk, 2007). The broad goal of managed care is cost control. Managed care organizations (MCOs) are responsible for the financing, insurance, delivery, and payment of health care services. States contract with MCOs to deliver care through networks and pay providers on a monthly capitation payment rate. According to Medicaid, approximately 80% of all current Medicaid enrollees are served through managed care delivery systems.

Capitation, in the context of health care, is defined as "a fixed "per capita" amount that is paid to a hospital, clinic or doctor for each person served" (MedicineNet, 2012, p. 1). In capitated arrangements the burden of financial risk is shifted to the providers and thus the

incentive to utilize fewer health care services is created. Whereas FFS arrangements are characterized by overutilization, managed care arrangements are characterized by underutilization. Underutilization means not providing enough tests, medicine, or other services for the purpose of retaining profits. Underutilization has negative implications for patient health; however, MCOs are unlikely to tolerate providers who attempt to defraud the plans by altering or falsifying documentation, as this would cost the plans money and thus stand counter to their cost control purpose. For this reason, fraud commission under managed care is less likely to be carried out by providers, and shifts to the MCO itself (Sparrow, 1996a).

Previous Research

Malcolm Sparrow is one of the leading international experts on the subject of health care fraud and fraud control. In his book, *License to Steal: How Fraud Bleeds America's Health Care System*, Sparrow (1996a) conducted interviews with a variety of public and private insurers as well as Medicaid Fraud Control Unit (MFCU) personnel from three different MFCUs from three states in order to gain an understanding of the ways fraud is perceived by payers and regulators under managed care. Sparrow's (1996a) study revealed several forms of fraud specific to managed care such as:

> the embezzlement of capitated funds paid by the state; excessive salaries and fees to owners and their close associates; bid rigging by state personnel; self-dealing by state and county employees (awarding contracts to friends and relatives); improper enrollment practices such as attracting good risks and refusing bad risks; improper disenrollment practices such as persuading or forcing sicker patients to leave the plan; and extortion, bribery, conspiracy, and tax evasion (p. 148).

These findings are supported by the Office of the Inspector General (OIG) for the Department of Health and Human Services (DHHS) in a 2011 report that identified six areas of concern: managed care contract procurement; marketing and enrollment; underutilization of services; claims submission and billing procedures; FFS payments within managed care; and embezzlement and theft. According to a 2009 statement by Lewis Morris, chief counsel of the OIG, DHHS, "although we cannot measure the full extent of health care fraud in Medicare and Medicaid, everywhere we look we continue to find fraud in these programs" (Inglehart, 2010, p. 304). The time was right for an enforcement crackdown and President Obama and his administration claimed to place a high personal priority on combatting health care fraud.

The Affordable Care Act

The Patient Protection and Affordable Care Act, or Affordable Care Act, was signed into law by President Barack Obama on March 23, 2010 and represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. As of this writing, the program is in its sixth year of rollout and is expected to be fully implemented by the year 2020. The Act was enacted to increase the quality and affordability of health insurance, lower the uninsured rate by expanding public and private insurance coverage, and reduce the costs of healthcare for individuals and the government. It introduced mechanisms like mandates, subsidies, and insurance exchanges (Pear, 2012). The law requires insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of pre-existing conditions or gender. Additional reforms include increased competition, regulation, and incentives to streamline the delivery of healthcare.

The Affordable Care Act mandates that all Americans obtain health insurance by yearly deadlines or be subject to a tax penalty. Subsidies are provided to low-middle income families

for the purpose of affording insurance by taxing some health care providers and high income families. For those without insurance, the states and the federal government have partnered to operate health insurance exchanges; places online where people can compare different plans to find what suits their needs and budget. For the most part, those who already have health insurance prior to the mandate are able to keep it. Those who cannot afford health insurance may qualify for monthly tax credits, reduced co-payments and deductibles, or be eligible for Medicaid.

In addition to a host of other changes, the Affordable Care Act expanded Medicaid eligibility to include individuals and families with incomes up to 133% of the federal poverty level, including adults without disabilities and without dependent children (Kaiser Family Foundation, 2013). The law also provides for a 5% "income disregard", making the effective income eligibility limit for Medicaid 138% of the poverty level (DiPietro & Kingenmaier, 2013). However, the Supreme Court ruled that states may opt out of the Medicaid expansion, and several have done so. As of February, 2015 the Department of Health and Human Services (DHHS) estimates that Medicaid covers nearly seventy million people, or one in five Americans (Leonard, 2015).

The Act and Fraud Triangle Theory

According to Amadeo (2015), major health care reforms such as those contained in the Act were needed in the U.S. due to several reasons. First, health care costs are skyrocketing. Second, quality of care in the U.S. is the worst in the industrialized world. Third, approximately 25% of Americans have no health insurance to cover their costs. When providers treat patients who cannot pay, the high costs of treatment are then passed on to everyone in the form of higher health care costs. Lastly, health care reform was needed to curtail the economic costs of health

care fraud.

The Affordable Care Act has impacted health care fraud in many ways. The U.S. Department of Justice (DOJ) states that the government has claimed an unprecedented $10.7 billion in recoveries from health care fraud in the last three years. The DOJ attributes this to features like tougher sentences built into the Act, enhanced screening for providers and suppliers, state of the art predictive modeling technology, and the channeling of financial resources toward anti-fraud efforts.

The Affordable Care Act has focused increased scrutiny and resources on health care fraud and it is common for external auditors to help organizations prevent and detect it (Kassem & Higson, 2012). Detecting fraud is an extremely difficult task and requires thorough knowledge of the health care and insurance industries, why it is committed, and how it is committed and concealed. Where health care fraud is concerned, "offenders are reasonable decision makers, exercising some degree of planning and foresight and adapting their behavior to take account of proximal and distal contingencies" (Cornish & Clark, 1986, p. 13). The concept of why people commit fraud was first examined by Donald Cressey in 1953. He interviewed prison inmates who accepted positions of trust and went on to violate that trust. He concluded that in order to commit fraud, three factors must be present: (a) the individual must conceive of themselves as having a non-shareable financial problem that creates the pressure or motivation to violate their position of trust; (b) they must have the opportunity to commit the trust violation; and (c) they must be able to rationalize their trust-breaking behavior (Kassem & Higson, 2012).

Pressure, opportunity, and rationalization make up the three key elements of Cressey's Fraud Triangle. Pressure can be real, such as medical bills or mortgages, or perceived, such as the need to gain or maintain social status. Other examples include pressure for certain

performance results at work, gambling addiction, or drug addiction (The Certified Accountant, 2009). In any case, the problem must cause the individual fear and shame to the extent that they feel they must solve it independently and secretly.

Opportunity is the ability of the trust violator to commit fraud. Opportunity is the element over which organizations have the most control, therefore it is imperative that companies limit opportunities for fraud commission (The Certified Accountant, 2009). Trust violators do not wish to be caught so if they chose to commit fraud they do so under the assumption that their behavior will go undetected. Opportunity is created by weak internal controls, lack of management oversight, or abuse of one's position and authority. Failure to establish adequate procedures to detect fraudulent activity also increases opportunities for fraud.

Rationalization deals with the trust violator reconciling their actions with socially acceptable notions of decency and trust (The Certified Accountant, 2009). According to the Association of Certified Fraud Examiners (2015), most trust violators are otherwise law abiding citizens with no criminal past and therefore do not view themselves as criminals. Instead, they view themselves as good people caught up in a bad set of circumstances. This attitude allows the trust violator to justify their behavior in a way that makes it acceptable in their own mind. Examples of common rationalizations include the trust violator feeling as though they are entitled to the money, they are only borrowing the money, or they had to steal in order to provide for their family. As Cressey's (1953) theory illustrates, learning why and how individuals commit fraud is a complex task in which societal laws, values, and economic structure must be considered.

The Current Study

This research seeks to explore the ways in which the Affordable Care Act influences pressure, opportunity and rationalization; thus increasing or decreasing the capacity for fraud commission at the individual and organizational level. Analysis of the Act itself, along with related literature, will provide a speculative understanding of the legislation as it was intended as well as administered. This research is a qualitative legal impact study in the sense that the opinions and experiences of those impacted by the law will be critical to understanding its influence on human thought and behavior. Fraud Triangle Theory is appropriate in this study because the law impels human behavior, while theory provides a reasoning behind and explanation for the behavior. An inductive approach will be used to present theoretical findings about the nature of health care fraud since the inception of the Act.

The subsequent chapter provides an in depth analysis of Cressey's (1953) study followed by a review of the literature surrounding Medicaid, the evolution of payment systems, the Affordable Care Act, and how fraud and fraud control have changed over time with the dawn of new technology and enforcement strategies.

Review of Literature

Expanding on the Fraud Triangle

In *Other People's Money*, Cressey (1953) interviewed hundreds of inmates imprisoned for embezzlement throughout the U.S. to examine the psycho-social factors that led to the violation of their positions of trust. What emerged from his interviews has come to be known as the Fraud Triangle, or Fraud Triangle Theory. The first aspect of which is pressure in the form of a "non-sharable" financial problem, which is necessary and precedes fraud. In all the cases Cressey (1953) encountered, subjects described having some sort of financial issue that they were ashamed to share with others and this shame prevented them from getting help. The source of the shame came from the status-seeking or status-maintaining behavior of the perpetrators, which led to role conflict and ultimately a sense of cognitive dissonance. They were trying to "keep up a good front" (Cressey, 1953, p. 50) in the eyes of their peers but were aware, in their own minds, of their dishonesty and inadequacy. These feelings of failure made it seem supremely important to somehow solve the financial problem independently and secretly. Again, in all cases Cressey (1953) found that, due to problems leading up to the illegal act, "the approval of groups important to the trusted person had been lost, or a distinct feeling that present group approval would be lost if certain activity were revealed, isolated the trusted person from others who could assist him with solving problems arising from that activity" (p. 66).

Pressure

Six types of non-shareable financial problems became evident throughout the course of Cressey's (1953) study. The first relates to what Cressey (1953) termed "ascribed obligations;" they are non-financial in nature but rather deal with the social and behavioral expectations of one in a position of trust. For example, most trusted individuals and employers of trusted individuals

assume that being initially deemed worthy of the position implies that the individual is honest, behaves in a proper manner, and refrains from indecorous behavior. “Just as individuals in trusted positions have obligations not to violate the trust by taking the funds, they also have obligations to refrain from what may loosely be described as riotous living, and maintain an enviable position in the community” (Cressey, 1953, p. 36). If one believes they are not supposed to gamble and loses all their money, for example, the resulting financial problem could be viewed as non-shareable because admission of the loss would equal an admission of unworthiness of their coveted social status. These “secret debts” are incompatible with the other roles one embraces, such as those of spouse, parent, or trusted person.

Perhaps worse than problems associated with ascribed obligations are problems rooted in feelings (real or perceived) of personal failure. Cressey (1953) found subjects were afraid of losing their status if they were to admit to someone else that their financial problems were a result of their bad judgment, own fault, or stupidity. This was typically observed when the trusted person went against the wishes of their intimate associates, the decision turned out unfavorably, and the trusted person was left in a position of shame at the thought of having to tell the associates their money was lost.

Business reversals, problems stemming from legitimate economic downturns, can also be classified as non-shareable financial problems. While the trusted individual may not have contributed personally to their financial failure, the social and psychological consequences of such an event are much the same as if the person had made a foolish decision. Furthermore, they are structured as problems which cannot be shared with associates (Cressey, 1953). Cressey (1953) uses the example of how bankers embezzled funds from trust accounts during the Great Depression rather than reveal to their communities that the banks were failing. The fact that

subjects had experienced success previously created in them a sense of pride in their ability to handle difficult situations, take risks and come out ahead. Resignation and admitting failure would hurt that pride. There is also the fact that, if one's business fails, the livelihoods of associates are also negatively impacted. Cressey (1953) found some subjects who claimed they did not have intent to cheat anyone, but only a strong desire to save their business, their investment, and that of their stockholders. "Values in regard to success and profit-making are such that some individuals cannot even think of revealing a shaky business condition to anyone" (Cressey, 1953, p. 50). In these cases, admission of defeat is viewed as impractical or impossible, as the trusted person feels they have a responsibility to solve the financial problem through any means necessary.

Physical isolation was another problem Cressey (1953) found to precede fraud commission. This form of pressure is somewhat different from the others because the trust violator is not afraid or ashamed to share it, but is physically isolated from associates with whom they could share it.

> Often the individual has taken steps of a non-financial nature which are not approved of by his associates, with the result that he is physically isolated from them, or he has been physically separated in some other way from persons to whom he could turn for help in meeting what he considers cogent obligations and needs (p. 52).

One case involved a man who moved away from his home town due to a family problem and ran into financial difficulties. Due to the fact that he had no family support and did not know anyone in his new town, he turned to fraud as a solution. His financial problem became non-shareable

because he had no one to turn to for help; in fact, he may not have turned to crime at all in the presence of social support.

As was previously mentioned, many non-shareable financial problems are rooted in status-gaining or status-maintaining behavior on the part of the trusted person. Cressey (1953) observed problems related to status-gaining less frequently than problems related to status-maintaining, and noted that these perpetrators typically embezzled lesser amounts. The trusted person realizes they do not have the financial means necessary to continue associating with others of a desired status level. On the surface, it appears to be a case of "extravagant tastes" or "living beyond ones means" but that alone was not found to be a causal factor in fraud commission. According to Cressey's (1953) theory, "what makes such behavior a significant event in the process which results in trust violation is the fact of its becoming non-shareable" (p. 54). This occurs because the trusted person does not want to renounce their wish to be accepted as part of the status group, nor can they obtain the finances or "prestige symbols" (Cressey, 1953, p. 54) necessary for membership through legitimate means. An excerpt from one of Cressey's (1953) interviews illustrates the nature of this problem in layman's terms:

> I've got too much pride to wear ragged clothes but I don't have enough money to wear anything else so I go into debt to buy new clothes. That's false pride – I have the clothes, but there is nothing to back it up. We all have a certain amount of it, but some of us have too much of it – we go dishonest to keep up the pride. If you do something to keep up with the neighbors and you have to steal something to do it, that's false pride. A man can keep up with the neighbors and if he has the money to do it, that's all right, but if he borrows or goes dishonest to get enough to do it, that's false pride (p. 56).

The final problem Cressey (1953) identified dealt with employer-employee relations. The trusted person came to resent their status within the organization in which they were employed. They felt underpaid, overworked, or mistreated in some manner involving finances. It was not enough to simply be mistreated because those who feel mistreated can quit and find other work. Trust violators in this particular situation felt they must carry on in service to their organizations and this was what made their problem non-shareable. It was their perception that, were they to make suggestions for improvement or request a raise or promotion, they would be at risk of losing their actual or desired status within the organization. Cressey (1953) found that this type of non-shareable problem was usually combined with another form because "the person's associates both outside the organization where he is employed and within that organization will, to a large extent, determine whether he feels underpaid" (p. 57). There were also undercurrents of retaliation and rebelliousness associated with this type of problem. Subjects felt they would not have committed the trust violation if they had been treated properly in the first place. To quote another of Cressey's (1953) subjects, "this time there was a reason beside the money – those people weren't treating me right. You might say it was the spirit of retaliation. I figured it was a good way out of a bad situation that I didn't like" (p. 59).

Cressey (1953) also made a point of noting the absence of non-shareable problems among non-violators; that is, when non-shareable problems were not present, fraud did not occur. Each interview subject was viewed as his own "control" because each had been non-violating up until the time a non-shareable problem presented itself and each had held various positions of trust before committing the particular violation for which they were caught. To test this hypothesis, Cressey (1953) posed a hypothetical problem to a portion of subjects that, by most standards, would be considered shareable, but was at least as severe as the problem they faced in

their own cases. Of the subjects answering the question, 57.7% answered that they would "just work it out somehow" (Cressey, 1953). While this tends to support his hypothesis, there are other aspects of the Fraud Triangle to take into account.

Opportunity

It has been stated that opportunity, the second aspect of the Fraud Triangle, is the facet organizations have the most control over, or need to have control over, in terms of preventing fraud commission. It is common knowledge among trusted persons and non-trusted persons alike that positions of trust can be and are violated, as stories of this nature are widely publicized (Cressey, 1953). Furthermore, many individuals within an organization (trusted and non-trusted) possess the knowledge and skills necessary to execute a trust violation, were they to perceive the trust violation as a secret solution to a non-shareable problem. If ones position does not offer a solution to the problem, no trust violation will occur. Similarly, if one is ignorant to the means by which to commit the trust violation, the violation cannot occur. According to Cressey (1953),

> the perception of the connection between the non-shareable problem and the illegal solution is a product of the interrelated intellectual processes of "knowing" and "rationalizing" that the problem can be and may be alleviated by violation of the position of trust (p. 78).

There are various ways an individual can learn the knowledge and skills required for fraud commission. Cressey's (1953) subjects described unintended means of it being communicated to them through training and indoctrination processes, and by the simple act of being bonded. As one subject stated, "they said I was a trusted employee, but I wasn't – I was bonded for $100,000 so they couldn't have trusted me very much" (Cressey, 1953, p. 80). Another employer told a subject who was an ex-con that he expected him to steal but that he

could not "get away with all of it" (Cressey, 1953, p. 80). A small minority stated they were simply criminal minded. More commonly, observation of the dishonest behavior of other associates informed the subjects as to how they might violate trust.

Logically, being in the position of trust, by nature of knowing ones job, means one is trained in how that trust may be violated. Other times, the means by which trust may be violated are learned through school or some other source. Accountants, for example, are trained to identify embezzlement when they see it and therefore, in knowing how to spot it, also know how to commit it. In other words, in some cases, the knowledge and skills necessary for fraud commission are learned "on the job" and other times they are brought to the job. Regardless, Cressey (1953) points out that trusted individuals violating their positions do not deviate from their daily routines. "The trust violator follows routine procedures because he has the technical skills and general information about converting funds in this capacity" (Cressey, 1953, p. 85). When organizational weaknesses are known and there is an awareness that one's trusted position can be used for the purpose of secretly solving a non-shareable financial problem, the stage is set for fraud.

Rationalization

Rationalization is the third and most important aspect of the triangle. Rationalizations are essential to the commission of fraud; in fact, they are the "green lights" for fraud commission. Knowledge and skill are part of the setting for fraud because they, with rationalization, "enable trusted persons to respond to non-shareable problems as if they were stimuli to violation" (Cressey, 1953, p. 85). The trusted person must believe that their act will produce the desired result (solve the problem) with little threat of detection, otherwise it is not worth the risk. Therefore, a rationalization must also precede the violation.

Rationalizations, or "vocabularies of adjustment" as Cressey (1953) called them, allow the violator to mentally frame the relationship between their non-shareable problem and the illegal solution in a way that is either "non-criminal, justified, or part of a general irresponsibility for which he is not accountable" (p. 93). The interview subjects did not simply use rationalizations to excuse their thoughts and actions; they also used them to excuse their decisions to carry out their actions. In all the cases Cressey (1953) encountered, rationalization preceded the criminal act; in fact, after the crimes were committed, his subjects abandoned their rationalizations and did not use them to justify their actions.

It was of interest to Cressey (1953) how subjects' vocabularies of adjustment were learned and how they differed between prisoners of varying social status. In much the same way opportunities for fraud commission are learned by observing the trust violating behavior of others, rationalizations for fraud are also learned from others with prior experience with trust violation. "Before being internalized by the individual they exist as group definitions in which crime is appropriate" (Cressey, 1953, p. 96). This notion that others view the trust violating behavior as acceptable helps the individual contemplating fraud resolve the inner conflict they feel between the knowledge that fraud is a crime versus the possibility that it may solve their problem.

On a deeper level, this is a conflict of one's ability to view oneself as moral and acceptable to a society that values trustworthiness, honesty, and integrity and expects these things from those in positions of trust. In order to do so, the violator disassociates from themselves, objectifies their actions, and takes on the role of the "generalized other" (Cressey, 1953, p. 98). This involves putting themselves in the place of another person or group and hypothesizing their reaction upon learning of the trust violation. Essentially, the violator is

asking, “if I was someone else, what would I think of me?” In order to soften the psychological blow, it is at this point that the violator employs a rationalization in order to conceive of themselves as anything but criminal (i.e. “everybody does it…I was in a tight spot”) because society’s, and therefore their own when serving as the generalized other, reaction to the conception of one as “pressed” is more empathetic than society’s reaction to the conception of one as “criminal.”

From the outside, society defines the perpetrator as a criminal but they define themselves as something else in order to go through with the trust violation. In Cressey’s (1953) study, that definition was highly dependent upon the socio-economic status of the trust violator, as people from different echelons of society framed their rationalizations in very dissimilar ways. Cressey (1953) observed two broad categories of employed people who violated trust; those who were in business for themselves and diverted funds entrusted to them for a specific purpose and those who were employed by someone else and diverted funds belonging to their employer or employer’s clients. Within these two groups Cressey (1953) differentiates between three subgroups he terms “independent businessmen,” “long-term violators,” and “absconders;” all of whom have diverse attributes and opposing vocabularies of adjustment.

Independent businessmen. Independent businessmen tended to rationalize their trust violation by convincing themselves that they were either borrowing the money or that it was somehow actually theirs. Cressey’s (1953) subjects had an “everybody does it” type of mentality in which the trust violating individual assumed their behavior, perhaps unethical but never criminal, was the accepted way of conducting business and this opinion only served to reinforce their misconception. An example could be that of spending the profits of a business negotiation before the deal was closed. Cressey (1953) found it very common for trust violators to believe it

was “usual business practice to accept deposits on goods and then, before the goods are actually delivered, to use part of the money to be deposited, on the assumption that before the delivery date enough money for the purchase of the goods will be secured elsewhere” (p. 108). Trust violators would use the diverted money to solve their own non-shareable problem and would fail to account for the money, thinking that it belonged to them. Problems arose when the violator was not able to cover the diverted money, in the event that it needed to be returned or the deal needed to be completed earlier than expected. Since this type of trust violator believes what they are doing is the norm, once caught they feel that the situation was atypical as opposed to their reasoning and consequent behavior. Independent businessmen tended to blame situational factors beyond their control for their decisions; an unusual business trend or a poor economy had produced the crime. None of the independent businessmen could view themselves as criminals, rather they were the unlucky ones who had been caught and made examples of when a situation caused them to act out of desperation, even though they were only doing what everyone else in the business does every day. “Because they could not admit defeat, none of them would share the tragic state of their business until it got entirely out of control” (Cressey, 1953, p. 113).

Long term violators. As a group, long term violators provided a unique opportunity for Cressey (1953) to study the consequences of their crimes as well as the entirety of their thought processes. Long term violators were similar to independent businessmen in that, they too, rationalized they were merely borrowing the diverted money, however in these cases it was common for subjects to also add they were “embezzling to keep their families from shame, disgrace, or poverty, that theirs was a case of necessity, or that their employers were cheating them and were dishonest, so that trust violation seemed justified” (Cressey, 1953, p. 114). At first, most long term violators began by diverting small amounts of money and would keep track

of how much they were taking with the intention of paying it back. After time however, the amounts stolen increased and when it was realized their actions were going undetected the violators came to look upon the source of ill-gotten gains "as a rather general pool or pot from which they can readily abstract funds at will" (Cressey, 1953, p. 119). Accountants, for example, also pointed out that it was much more difficult to restore funds to an account without detection than it was to divert funds in the first place so this made it difficult for violators to reconcile paying the money back, as they would rather remain unnoticed.

At some point, perhaps several years later, the violator becomes conscious of the fact that they are committing a criminal act. For example, they may read about a case of fraud or embezzlement in a newspaper and recognize that the behavior of the person in the story mirrors that of their own. They quickly realize that they've been "kidding themselves" (Cressey, 1953, p. 120) in terms of their ability and intent to pay back the money. The rationalization of borrowing the money simply allowed the violator to carry on with their job duties as they normally would, without the need to abscond or commit another type of crime in order to solve their non-shareable problem.

Upon the realization that their actions are criminal, however, the long term violator condemns themself for their wrongdoing. Their immediate reaction is to repay the money but they know that would ruin them. Their primary fear is being ostracized from a society that condemns embezzlers and stigmatizes criminals. They fear losing their social position – the very position they resorted to crime to preserve – as well as having their non-shareable problem exposed. The mind rebels as the notion that they are, in fact, criminals sinks in and they begin to behave strangely. Cressey (1953) related how subjects were irritable, moody, and unhappy during this time. Some became reckless and went on gambling sprees in an attempt to recoup

what they had stolen. Others carelessly diverted larger amounts more frequently, indicating they now somewhat identified with their new criminal self, while others could not and absconded or even committed suicide. One thing was always certain; once the pretense that they were borrowing the money fell away, the subjects divided into two groups: those who re-adopted the values of the group with which they identified prior to the trust violation and those who adopted the values of the criminal group to which they now belonged.

Curiously, Cressey (1953) found the criminal group to most sincerely regret their actions. These subjects expressed the idea that their perceived non-shareable problem would probably have cleared up on its own and would not have led to such a dismal outcome as prison. Some stated that, in going to prison, they had merely traded one non-shareable problem for another (Cressey, 1953). From a psychological perspective, it was determined that what predisposed one to be of the criminal group was the experience of "getting in too deep" (Cressey, 1953, p. 127) and being forced to face the error of their logic. "If the amount of the peculations does not get to the point where the individual feels he can no longer handle it, he never does look upon himself as a genuine criminal, even if he has been incarcerated for his behavior" (Cressey, 1953, p. 127)

Absconders. Absconders provide a very different perspective on trust violation from those of independent businessmen and long term offenders. Most striking is the finding that absconders tended to not view their crimes as trust violation at all, but rather as a form of stealing. Whereas independent businessmen and long term offenders claimed it was the loss of control over a situation that served as the impetus for their crimes, absconders claimed to have lost control over themselves. High socio-economic status offenders rarely consider absconding due to the presence of moral and social obligations (i.e. family, career, homeownership), whereas absconders rarely consider diverting small amounts of money over time. Cressey (1953)

describes absconders as having an "at the end of the world" (p. 132) attitude, characterized by feeling fed up with their situations and seeing no other way out except to disappear with stolen funds.

Cressey (1953) found absconders to typically be of a lower socio-economic status and have few, weak primary group relationships. All the subjects interviewed echoed similar sentiments; they had tried to live honest lives but found it futile, all had a general disregard for what happened to them, and all felt they possessed an inherent sense of criminality over which they had little control. Their perception that criminality was "in" them coupled with an overall attitude of not caring what happened to them provided them with an easily accessible rationalization that allowed them to feel unaccountable for their actions. Being of low socio-economic status and having few primary group relationships caused seemingly commonplace problems to appear non-shareable. Furthermore, without primary group relationships the absconder has no one to define appropriate goals and the means by which to achieve those goals or provide informal social control by imposing prescribed rules (Cressey, 1953). The absconder has a minimum of legitimate obligations so it is easy to rationalize that they "don't care" (Cressey, 1953, p. 129) should a non-shareable problem present itself and they have no honest way of solving it.

Whereas trust violators of a higher socio-economic status will structure their rationalizations in a manner that make it seem at first that their actions are innocent, absconders structure their situation in a way that whatever moral values they previously held no longer have meaning for them. They fully recognize their behavior as criminal, but since they feel unable to control what is happening to them, they feel justified in relinquishing all control of what is happening within them, sever any pro-social ties, and abandon responsibility for their behavior.

When caught and removed from the situation, the absconder again becomes mindful of the rejected values and decides they were wrong to believe they held no meaning. Unable to provide a rational explanation for their trust violating behavior, they resort to the conclusion that criminality is an intrinsic aspect of their personality and the rationalization is reinforced.

Summation of the Fraud Triangle

To summarize his findings, Cressey (1953) presented a list of shared characteristics, or informal profile, of trust violators. First, they were all in a psychological state of frustration, conflict, and tension at the time of their crimes. They were not mentally ill, irrational, or illogical to the point of being unable to make choices but they were experiencing a heightened state of mental stress which made them more likely to structure problems as non-shareable (Cressey, 1953).

Second, trust violators tended to be slightly older, be of a higher socio-economic status, and have more ascribed obligations. While not a direct causal factor, they also had greater propensities toward gambling, excessive alcohol consumption, and extravagant living as these tendencies were shown to lead to problems perceived as non-shareable.

Third, they "informally assimilated definitions of situations in which trust violation is sanctioned, and when they perceive that the situation in their own case is included in the general category of situations in which trust violation is sanctioned, they violate the trust" (Cressey, 1953, p. 148). Similarly, the trust violators in the study seemed to have an excess of contacts with definitions favorable to criminal behavior.

Fourth, all trust violators went through a gradual modification of values in regard to deceit, trustworthiness, honesty, and respectability which ultimately culminated in fraud commission. All had to formulate rationalizations to sidestep the ideal of honesty.

Fifth, Cressey (1953) found:

> the fact that many trust violations were perpetrated by employees who had been in their positions for several years indicates that the learning of rationalizations necessary to trust violation took place while the person was in the position of trust, and an over-balancing of the ratio in favor of criminal behavior must have taken place (p. 150).

In other words, the individual was aware of the opportunity for fraud, but it was not until a non-shareable problem presented itself (coupled with exposure to definitions favorable to criminal behavior) that the individual began contemplating rationalizations for executing the illegal act. When the individual discovered a rationalization that was able to reconcile honesty and criminality, the decision to violate trust was psychologically approved.

This leads to both the conclusion of the shared characteristics of trust violators as well as a restatement of Cressey's (1953) central thesis. In order for an individual to commit fraud, three conditions must be present; pressure, opportunity, and rationalization. All trust violators were faced with pressure in the form of a problem they perceived as non-shareable, an awareness of the opportunities that their position of trust offered a possible solution to their problem, and a rationalization favorable to the violation of their position of trust. Much like the workings of a clock, the laws of our society, our politics, our economic system, and our criminality are inter-related. The Fraud Triangle illustrates this because when one aspect of it is affected, the other parts are similarly set into motion. The Fraud Triangle derives its significance from these influences in society that incite individuals to act and from its succinct ability to explain the psychology behind their decisions.

While it is important to understand the aspects of the Fraud Triangle and how they relate to fraud commission, it is also critical to gain an understanding of health care delivery systems, state and federal programs, and the health insurance infrastructure. The following section traces the evolution of health care entitlement programs and their complex relationship with health spending, cost control measures, and fraud.

Inception of Government Health Care Programs

The Medicaid and Medicare programs were signed into law on July 30, 1965 by President Lyndon Johnson. Medicare was established to provide health care to the elderly and Medicaid was established to provide health care to the poor, with an emphasis on dependent children and their mothers, the disabled, and the elderly in nursing facilities. Prior to the passage of Medicaid, health care services for the indigent were provided primarily through a patchwork of programs sponsored by state and local governments, charities, and community hospitals (U.S. Department of Health & Human Services, 2000).

Each state operates its own Medicaid program within a broad set of federal guidelines. As a result, Medicaid eligibility and benefits vary from state to state. Medicaid is an "entitlement" program, meaning that anyone who meets eligibility requirements has the right to enroll in the program. It also means that states have guaranteed federal funding for a portion of the cost of their Medicaid programs. According to the Center on Budget & Policy Priorities (2013), states must cover certain mandatory populations in order to receive federal funding: children under six in families with income below 133% of the federal poverty line ($25,975 for a family of three in 2013); children aged six to eighteen in families with income below the poverty line; pregnant women with income below 133% of the poverty line; parents whose income is within the state's eligibility limit for cash assistance that was in place prior to welfare reform; and most

seniors and persons with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program. States also may receive federal funds for covering optional populations such as pregnant women, children, and parents with income above mandatory coverage income limits; seniors and persons with disabilities with income below the poverty line; and "medically needy" people, those whose income exceeds the state's regular Medicaid eligibility limit but who have high medical expenses that lower their disposable income below the eligibility limit.

Medicaid does not provide health care directly, but rather reimburses hospitals, physicians, nursing homes, managed care plans, and other health care providers for services they deliver to enrollees. It is important to note that health care providers are not required to participate with Medicaid and not all do. Federal rules require state Medicaid programs to cover certain mandatory services such as: physician, midwife, and certified nurse practitioner services; inpatient and outpatient hospital services; laboratory and x-ray services; family planning services and supplies; rural health clinics, federally qualified health center services; nursing facility and home health care for adults over twenty-one; and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under twenty-one (Center on Budget & Policy Priorities, 2013). States may also cover services like prescription drugs, dental care, vision services, hearing aids, and personal care services for the frail elderly and people with disabilities, as meeting these needs are also critical to the health of the Medicaid population. The states have the discretion to determine their own restrictions on the amount, duration, and scope of coverage provided under their Medicaid programs, thus Medicaid varies significantly from state to state.

States can decide whether they want to pay providers who accept Medicaid through a FFS or managed care arrangement. In a FFS arrangement, providers are paid directly for their

services. In a managed care arrangement, states contract with organizations to deliver care through networks and pay providers. According to Medicaid (n.d.) data "approximately 80% of Medicaid enrollees are served through managed care delivery systems, where providers are paid on a monthly capitation payment rate" (p. 1). A state can change their payment method by submitting an amendment to CMS for approval, which CMS (n.d.) then compares to the Social Security Act and other federal regulations to assure that:

> payments are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area (p. 1).

The Medicaid program is funded jointly by the federal government and the states. The federal government pays states for a portion of Medicaid expenditures, called the Federal Medical Assistance Percentage (FMAP). According to Medicaid, the FMAP varies by state based on criteria such as per capita income. The regular average state FMAP is 57%, but ranges from 50% in wealthier states up to 75% in states with lower per capita incomes (the maximum regular FMAP is 82 %).

The Affordable Care Act and Medicaid expansion. Provisions of the Affordable Care Act expanded Medicaid to all Americans under sixty-five whose family income is at or below 138% of the federal poverty level as of January 1, 2014. As the law was initially written, states failing to participate in the expansion risked losing their entire federal Medicaid allotment (Hansen, 2014). This provision of the Act led to challenges that went all the way to the Supreme Court in National Federation of Independent Business v. Sebelius, 132 S. Ct. 2566 (2012) in which the court ruled that Congress may not make a state's entire existing Medicaid funds

contingent upon the state's compliance with the Act's Medicaid expansion (Hansen, 2014). This decision gave states the option to not expand their Medicaid programs (or explore alternatives), despite that fact that the federal government will cover 100% of the costs of the states' Medicaid expansion from 2014 to 2016 and 90% from 2020 and beyond. FamiliesUSA conducted a 2014 study showing which states have expanded Medicaid and which have not, as well as the projected impact on the populations in both regions. For example, twenty-nine states have expanded Medicaid, including Michigan. According to the study, the expansion of Medicaid in Michigan will now make health care accessible to approximately 443,000 low-income, uninsured residents. Conversely, nineteen states have not expanded their Medicaid programs, including Alabama. According to the study, this decision has barred approximately 254,000 low-income, uninsured Alabama residents from accessing health coverage.

Reimbursement and its relationship to care. The expansion of Medicaid has not come without a down side. Many authors (Galewitz, 2015; Hurtubise, 2014; Kliff, 2012; Millman, 2014; Sack, 2010) state that, to compensate for the roughly 9.1 million new Medicaid enrollees since the inception of the Affordable Care Act, the program has had to make drastic cuts to the amount of reimbursement paid to providers. A temporary reimbursement bump to participating Medicaid providers, included in the Act, expired at the end of 2014 and brought about an average payment cut of 43% to Medicaid primary care doctors. This has had a negative impact on providers and patients alike. For example, a Flint, Michigan obstetrician receives $29.42 from Medicaid for a visit that would bill $69.63 from Blue Cross Blue Shield of Michigan. She receives $842.16 from Medicaid for a Caesarean delivery, compared with $1,393.31 from Blue Cross. If she takes too many Medicaid patients, she cannot afford overhead expenses like staff

salaries, the office mortgage and malpractice insurance that will run $42,800 annually (Sack, 2010).

Add to this an ever-increasing amount of burdensome paperwork imposed by Affordable Care Act regulations. A 2014 study by Harvard Medical School found that the average doctor spent 8.7 hours per week, or 16.6% of their working time, on administration. This does not include patient-related tasks such as writing chart notes, communicating with other doctors, and ordering lab tests. Not only does this detract from the time a physician could spend with a patient building the kind of relationship that leads to quality care, it is also surprisingly costly. The researchers estimated that the total cost of physician time spent on administration in 2014 amounted to $102 billion. One of the stipulations of the Act was that providers switch to the use of electronic medical records. It was assumed that this would increase efficiency but the Harvard study found the opposite to be true. “Physicians who used electronic health records spent more time (17.2% for those using entirely electronic records, 18% for those using a mix of paper and electronic) on administration than those who used only paper records (15.5%)” (Tate, 2014, p. 2).

Ubel (2013) cites a study in which physicians were surveyed about their concerns with accepting Medicaid patients. The study found their main concerns to be lack of acceptance of referrals by specialists; low reimbursement rates; complexity of patient needs compared to other patients; time spent on paperwork; long time waiting to receive reimbursement; lack of patient acceptance of treatment options; and length of patient visits compared to other patients. In essence, many doctors are finding the costs (financial and otherwise) of treating Medicaid patients exceed the benefits and put their livelihood at risk.

Hurtubise (2014) cites a survey of Medicaid acceptance rates which found that just 45.7%

of physicians are now accepting Medicaid patients in the U.S.'s largest fifteen cities. Low-income people with Medicaid who are unable to find a family doctor will instead go to emergency rooms where treatment is expensive and not focused on prevention. This is supported by Siegel (2014) who cited a recent study of Medicaid patients in Oregon. The study found that new Medicaid enrollees were 40% more likely to use the emergency room than the uninsured. This has negative implications because it suggests Medicaid expansion may not reduce uncompensated care, thus keeping health care costs high.

Reluctance on the part of physicians when it comes to providing care to those on Medicaid is not a new phenomenon unique to the implementation of the Affordable Care Act. Dissatisfaction with reimbursement rates and the time it takes to receive payments has been a point of contention between providers and the government since the beginning. It has also been, in the minds of some providers, a justification for committing fraud.

Fee for service versus capitation. As was previously mentioned, most people on Medicaid are enrolled in a managed care plan. There are three primary types of managed care plans; the Health Maintenance Organization (HMO), the Preferred Provider Organization (PPO), and the Point of Service Plan (POS). In managed care plans, managed care organizations (MCOs) may pay a participating provider a fixed salary or a system of discounted fees. In a system of discounted fees, the MCO negotiates a discount for the provider based on services billed. For example, if a provider bills a patient $1000 the MCO may pay 70% of the bill (Virk, 2007). Another payment arrangement is a system of capitation. Capitation, in the context of health care, is defined as "a fixed "per capita" amount that is paid to a hospital, clinic or doctor for each person served" (MedicineNet, 2012, p. 1). These fixed amounts exist in the form of premium payments paid by managed care plan enrollees to the MCO. These payments are then paid to the provider for every managed care enrolled patient per month. In capitated

arrangements the burden of financial risk is shifted to the providers and thus the incentive to utilize fewer health care services is created.

The goal of managed care was and is to control health care costs. In a FFS system, provider income is directly linked to the quantity and quality of services delivered. In a competitive market, providers may engage in overutilization. Overutilization is defined as "the consumption of resources, the cost of which is in excess of the value or benefit generated by that consumption" (Long, 1991, p. 1). In other words, providers can bill insurance companies for excessive services, services never rendered, medically unnecessary services, etc., and reap the financial reward while the insurance companies pass these costs to patients in the form of higher premiums (Virk, 2007). While overutilization is health care fraud, patients are not typically physically harmed, although financially all consumers suffer.

In response to the perception that health care costs were growing out of control (no doubt in part to overutilization on the part of providers), the Health Maintenance Organization Act of 1973 was passed in the hope that capitated payments would create the incentive for decreased health care utilization. "Physicians initially resisted the introduction of managed care but the growing clout of MCOs and weakening financial position of hospitals curbed their resistance" (Virk, 2007, p. 1). MCOs set out to negotiate lower fees with providers and hospitals "in exchange for a steady flow of patients, developing standards of treatment for specific diseases, requiring clinicians to get plan approval before hospitalizing a patient, and encouraging physicians to prescribe less expensive medicines" (Encyclopedia of Surgery, n.d., p. 1).

Cost control mechanisms of managed care. To elaborate, what follows is a brief discussion of the various cost control methods used by MCOs, the first of which is utilization review. During utilization review, MCOs use efficiency experts to "deny claims of services

which they think are unnecessarily provided and attempt to find the most cost effective methods for health care delivery" (Virk, 2007, p. 3). MCOs also use providers as gatekeepers to control the number of referrals to specialists. Providers are often given incentives to limit the number of referrals they make. MCOs limit the providers from which an enrollee can seek treatment (Virk, 2007). Managed care plans require that enrollees only seek treatment from participating providers. Some plans allow enrollees to visit physicians outside of the provider network, but the enrollee pays an increased premium or higher out of pocket costs as a consequence.

Another cost control mechanism employed by MCOs is the use of case managers for enrollees with complex health problems (Virk, 2007). These case managers work in conjunction with specialists, providers, rehabilitation, or long term care facilities in an attempt to maximize cost effectiveness in terms of that patient's care. Similarly, primary care case management is a form of managed care in which a state Medicaid agency contracts with a primary care provider. The provider is paid a monthly contracting fee in addition to FFS reimbursement in return for approving and monitoring the care of enrolled Medicaid beneficiaries (Rawlings-Sekuda, Curtis, & The Neva Kaye National Academy for State Health Policy, 2001).

While the intent of MCOs was to decrease costs, the financial incentives used to accomplish this are potentially detrimental to patient health. For example, "many plans offer financial incentives to clinicians who minimize referrals and diagnostic tests, and some even apply financial penalties on those considered to have ordered unnecessary care" (Encyclopedia of Surgery, n.d., p. 1). Whereas FFS arrangements were characterized by overutilization, managed care arrangements are characterized by underutilization. Underutilization means not providing enough tests, medicine, or other services for the purpose of retaining profits.

The rise of managed care in recent decades has drastically altered the practice of

medicine in both positive and negative ways. “It has reignited the focus on preventive health care, introduced outcomes measurement and evidence-based medicine, and incorporated cost accountability and control in health care delivery” (Virk, 2007, p. 3). On the other hand, managed care has presented new problems such as “increased administrative overhead for providers, restricted choice of lab service vendors, and occasional interference with treatment protocols” (Virk, 2007, p. 3). In terms of increased administrative overhead for providers, MCOs require that physicians provide detailed documentation pertaining to what diagnosis was given and what course of treatment was provided. In other words, participation with the MCO may cost a provider time and money as a result of the paperwork involved in justifying treatment decisions. MCOs are unlikely to tolerate providers who attempt to defraud the plans by altering or falsifying documentation, as this would cost the plans money and thus stand counter to their cost control purpose. For this reason, fraud commission under managed care is less likely to be carried out by providers, and shifts to the MCO itself (Sparrow, 1996a).

The Emergence of Fraud in Medicaid Managed Care

During the recession of the mid 2000s, the incentives for fraud specifically within Medicaid managed care networks stemmed from the fact that increasing numbers of people were turning to Medicaid for health insurance coverage, coupled with the fact that states were increasingly contracting their Medicaid programs out to MCOs. Spitz (2007) cites three reasons why the number of Medicaid enrollees rose so dramatically during this period. The first deals with the fact that health care costs increased much more rapidly than income or inflation. “This has been a long term trend but now the per capita expenditures are so large that rampant increases in medical costs are having an immediate impact, particularly on those with modest incomes” (Spitz, 2007, p. 403). The second relates to increases in the cost of employer-provided health insurance. “As a result of increases in medical costs, employer-based premiums increased

at two to four times the rate of increases in worker wages" (Spitz, 2007, p. 403). Employers shifted more of the costs of health insurance onto workers making it difficult for many workers to afford workplace insurance. Many newly uninsured workers earned below the poverty level and therefore qualified for Medicaid. Similarly, a third reason for increased Medicaid enrollment was due to the fact that, in general, America became more impoverished (Spitz, 2007). "Between 2000 and 2004, the percentage of people living at or below the poverty line increased from 31.6 million individuals to 37 million" (Spitz, 2007, p. 404). As more people came to live in poverty, more people became eligible for, and turned to Medicaid.

Due to the unique nature of the Medicaid population (primarily low income women and children, disabled persons, and the elderly), Medicaid managed care initiatives have historically experienced more problems than private (commercial) managed care (Gold, Sparer, & Chu, 1996). This is supported by Hurley and Somers (2003) who suggest that early Medicaid was plagued by challenges with financing and coverage, provider participation, and access to quality care for beneficiaries. During the early 1990s, Medicaid costs increased as a result of federally mandated eligibility expansion and health care inflation. At the same time, commercial HMOs were attaining significant savings for private purchasers who moved their employees into health plans (Hurley & Somers, 2003). In order to stay viable, Medicaid looked to the managed care model for help curtailing costs and provisioning services and became reliant on the managed care marketplace over time.

While one of the main goals of managed care is cost reduction through capitation, partial capitation or FFS is used in regions in which the tax base cannot support full capitation, or where providers cannot support the financial risk (Gold et al., 1996). In these cases, overutilization was common. Fraud was typified by an exaggeration of services, the padding of claims, and other

behaviors associated with FFS arrangements. “Participating providers were not paid or were paid lump sums that they could not associate with services, leaving them dissatisfied, especially those who were paid FFS” (Gold et al., p. 162). Arrangements like these present opportunities for fraud as providers cannot match money with services thereby opening the door for overutilization, and rancor is created between Medicaid and providers who perceive reimbursement schedules as untimely or inadequate (Hackey, 1999). Disgruntled providers participating in partially capitated or FFS managed care are presented with both the motive and opportunity to defraud Medicaid via their Medicaid patients. Providers may also experience resentment toward their Medicaid patients as it is these patients that place them into reimbursement relationships that are dissatisfactory.

It may be an incorrect assumption that Medicaid managed care plans always reduced costs and improved access to and quality of health care. Spitz (2007) found the opposite to be true in terms of quality and access and inconclusive in terms of cost savings:

> In terms of cost, the expectations of between 5 and 10% savings on those enrolled in managed care based on early studies did not materialize and managed care did not translate into dramatically slower growth in program cost per beneficiary (p. 386).

Originally, a federal regulation that has since been repealed required capitation rates to be less expensive than the costs enrollees would have incurred under FFS (Spitz, 2007). According to Spitz (2007), MCOs may have produced significantly higher costs than FFS in some states. This is attributed to variations in the costs of different health care delivery systems. For example, a more expensive urban state has higher costs than a rural state (Spitz, 2007). Spitz (2007) posits that some states are paying more to cover managed care clients than they would if the clients had

stayed in FFS because Medicaid MCOs have fewer opportunities to reduce their costs compared to private MCOs.

> Medicaid HMOs are unable to extract significant rate discounts from providers because Medicaid FFS rates are often much lower than commercial rates. Because fewer providers participate in Medicaid, HMOs have less leverage to demand rate discounts than in the commercial market. Also, most Medicaid programs used prior authorization and other utilization controls in their FFS system prior to shifting to Medicaid managed care, therefore the savings associated with those controls were built into the FFS base (Spitz, 2007, p. 387).

Effects on patient health. Several studies exist that reveal that managed care, particularly for-profit managed care, has the potential to harm patient health. For-profit corporations are intended to benefit their owners, whereas non-profit corporations are intended to further a purpose (Nelson, 2002). As of 2005, there were approximately 300 managed care plans participating with state Medicaid programs, many of which were under for-profit ownership (Long, 2008). Long (2008) studied differences in terms of access between for-profit and non-profit MCOs and found evidence of problems of access to care among for-profit MCOs.

Enrollment in a for-profit Medicaid plan was associated with a lower probability of health care use and greater probability of unmet need relative to a non-profit plan. Medicaid enrollees in for-profit plans were significantly less likely to have a visit to a doctor or other health professional in the year prior to the study (Long, 2008). "For-profit health plans may have an incentive to restrict access to care in an effort to ensure profits for shareholders, whereas non-profit plans may be motivated by other goals (i.e. maximization of output, charity care, or quality of care)" (Long, 2008, p. 638). Long (2008) asserts that administrators at non-profit plans are

prohibited from sharing surplus revenues and therefore may have fewer incentives to solely attempt to generate profits.

This is supported by Mariner (1995) who sought to distinguish good MCOs from bad ones based on the extent to which the corporations created incentives to withhold beneficial care from patients. Mariner (1995) found that good MCOs were typically "well established, non-profit organizations that encouraged coordinated care, including preventive services, in long term personal relationships between patients and primary care givers" (p. 236). Bad MCOs were found to be newer, investor owned, for-profit corporations operated by insurance companies and managers. "With little or no experience in health care delivery, such organizations may focus on cutting costs and on ensuring an adequate return on investments to their shareholders" (Mariner, 1995, p. 236).

In order to obtain a better understanding of how providers respond to the financial incentives MCOs set before them, Quast, Sappington, and Shenkman (2008) studied the ways quality of care varies depending on the form of provider compensation employed while paying particular attention to the experiences of Medicaid enrollees. The authors examined the effect of the form of provider compensation on both a health care service that increases the revenue of a FFS provider (well child visits) and a service that has the potential to reduce expenditures for capitated providers (asthma medications). Quast et al. (2008) found that financial incentives seemed to affect the preventive care provided to Medicaid enrollees. Preventive care that increases the revenue of FFS providers (well child visits) was provided more frequently, whereas care that has the potential to reduce future visits (asthma medications) was observed more frequently in health plans that used capitation. In other words, if a well patient goes to a FFS provider the incentive is to conduct tests, prescribe medications, etc. in order to generate profit.

If a sick patient goes to a provider who is paid via a capitated arrangement, the incentive is to offer the minimum amount of services possible in an attempt to conserve profit. This withholding of needed services, however, comes at the price of patient health.

To illustrate this point, Aizer, Currie, and Moretti (2007) studied the impact of the transition to Medicaid managed care on a sample of pregnant women. The authors compared birth outcomes between pregnant women with FFS Medicaid and those with Medicaid managed care. Under managed care, women sought less prenatal care and managed care was associated with low birth weight, prematurity, and neonatal death (Aizer et al., 2007). Aizer et al. (2007) concluded that "healthcare providers responded to managed care incentives to reduce costs by limiting care, and suggest that these limitations in care had negative effects on infant health" (p. 398).

Studies illustrate that managed care has negative implications for patients, as provider behavior is influenced and altered by financial pressures and incentives. Fossett, Goggin, Hall, Johnston, Plein, Roper, and Weissert (2000) examined the extent to which states realized managed care's potential for improving accountability. Fossett et al. (2000) argue that "the contractual relationship between states and managed care organizations (MCOs) makes it possible for states to enforce standards for accessibility and quality of care for which the contractor can be held accountable and sanctioned if standards are not met" (p. 37). Fossett et al. (2000) examined the states' oversight routines and processes in the areas of financial reporting and performance, quality assurance and improvement, access and network capacity, and consumer relations. The authors found that states collected performance data but little was done with the findings. They also found few explicit performance standards in state managed care contracts even though states had a wide array of contractual sanctions available to them, from

including requirements for corrective action plans, to freezing enrollments or payments, to terminating contracts (Fossett et al., 2000). States have been reluctant, "frequently for sound political or market reasons, to use these sanctions, preferring to rely on more informal solutions" (Fossett et al., 2000, p. 45). Thus, states cannot be counted upon to hold MCOs to high standards of care. It could have been that states were turning a blind eye to any negative findings in order to maintain managed care, especially if it was the primary health care delivery system for a majority of people in the state. This notion is supported by the findings of Jesilow, Geis, and Harris (1995) who argued that government entities were placating MCOs in order to garner their participation in the health care system as well as the political process. "State regulators do not want to jeopardize provider enrollment in Medicaid, they want them to stay in the program" (Taylor, 2007, p. 56). In terms of health care system participation, the government and regulators realized that Medicaid is essential to society, as it serves as a health care safety net for millions.

Pellegrino (1999) argues that health care is not and should not be a commodity. The author states that to need health care but lack access to treatment denies one the fulfillment of his or her human potential as well as the power to direct one's life (Pellegrino, 1999). "If we treat health care like any other commodity, then we are prone to sell it like any other commodity, that is, by creating a demand among those who can pay" (Pellegrino, 1999, p. 255).

Medical ethics versus business ethics. Physicians pledge to put the interests of their patients first, however, two aspects of managed care place providers in an ethical dilemma. These aspects include "paying physicians in ways that impose conflicts of interest on them; and regulating clinical judgment, decision making, and behavior" (McCullough, 1999, p. 78). Some MCOs withhold a portion of a provider's salary and then pay it back depending on performance. It can be reasonably argued that the act of capitation itself creates a conflict between a provider's

moral obligation to serve the needs of patients and a provider's self interest in income and job security (McCullough, 1999). "In a capitalist economy almost everyone will respond to well designed, strong economic incentives that put income and security at risk" (McCullough, 1999, p. 79). In his assessment of the ethical statements of professional medical organizations, McCullough (1999) came to the conclusion that MCOs should be morally similar to hospitals and less like insurance companies of "the bygone era of FFS medicine" (p. 93). Both providers and MCOs should adopt the roles of co-fiduciaries of populations of patients (McCullough, 1999), meaning that both the MCO and the provider are entrusted with money and power intended for the benefit of large groups of people and should behave in a manner worthy of that trust.

Mariner (1995) explored the difficulties associated with developing ethical standards for MCOs. "The ethical principles that promote free and fair competition are quite different from the ethical principles that preserve the integrity of the physician-patient relationship and specifically those that protect patient welfare, and these principles can lead to quite different outcomes" (Mariner, 1995, p. 236). It may be possible to reach an agreement that MCOs should adopt ethical standards and should see the organization as a co-fiduciary of patients, but market survival may make it difficult to live by those standards. Functioning as an economic enterprise, an MCO values economic efficiency, product quality, and fair competition. Problems arise for providers and patients when achievement of the corporation's mission to provide medical care conflicts with its obligation to preserve its assets. "If an MCO's financial goals conflict with its service methods, little in the field of business ethics argues for giving subscribers priority" (Mariner, 1999, p. 239). The issue boils down to regulating the health care system by eliminating marketplace standards that conflict with equitable access to care.

> Were all companies required to enroll individuals regardless of their medical conditions, MCOs would be free to compete on quality of care, including patient satisfaction. Universal coverage would undoubtedly reduce the feasible profit margin for all companies, but the pressure to sacrifice patient welfare for cost control would be substantially diminished (Mariner, 1995, p. 242).

Under such circumstances, MCOs would be encouraged to adopt and adhere to ethical standards that promote patient welfare because higher quality care would enhance the market position of the corporation. Mariner (1995) calls for a market regulated in a way that removes or reduces incentives for MCOs to compete based on profits.

Evidence suggests that many providers resisted the threat to their autonomy presented to them by MCOs. Ulrich, Soeken, and Miller (2003) studied the ethical conflicts faced by nurse practitioners (NPs) working under managed care. The authors found that 67% of the NPs surveyed felt that patient needs were being overridden by the business decisions of MCOs. Ulrich et al. (2003) also found that 78% of the sample perceived that they were becoming agents for the health plan instead of agents for their patients with more than 78% indicating their concern for the potential of unethical practices associated with this system of care. As if to illustrate this point, "over a quarter of the sample indicated that it was sometimes necessary to ignore one's clinical judgment and follow the directions of insurance guidelines regarding patient care" (Ulrich et al., 2003, p. 172). More than half of the NPs stated that they were often put into positions in which they were forced to weigh the best interests of the patient with the interests of the MCO (Ulrich et al., 2003). The findings of this study indicate both ethical concerns associated with managed care and a need for regulation of managed care practices that

emphasize patient needs, otherwise in order to serve patients in a manner that is morally congruous with their beliefs, providers will be forced to resort to deception.

Bogardus et al. (2004) reviewed past studies that have examined the reasons providers have cited for the use of deception against third party payers. The authors focused on third party payers because it is these entities that have the power to influence provider behavior and have considerable influence over the cost of health care in the U.S. Several authors (Bogardus et al., 2004; Ulrich et al., 2003) found that physicians whose practices include larger numbers of Medicaid or managed care patients seem more willing to deceive third party payers than are other physicians. In a random sample of 720 physicians, 39% reported manipulating reimbursement rules to help patients secure coverage for needed treatment in the year before being surveyed. In another study, out of a random sample of 1617 physicians, 16% expressed a willingness to misrepresent the facts to an insurance company to obtain coverage for a patient (Bogardus et al., 2004). "Other studies based on hypothetical vignettes suggest that 60 to 70% of physicians report willingness to use deception depending on circumstances" (Bogardus et al., 2004, p. 1842). Not only did the physicians studied claim that it was necessary to game the system in order to provide high quality medical care, but many also claimed to have been asked by their patients to deceive insurers. The reasons cited for deception included "the unreasonableness of insurance companies and the strength of physician's obligations to their patients, also diagnostic uncertainty, problems with reimbursement, concerns about patients' future ability to get insurance, concerns over stigma and patient request" (Bogardus et al., 2004, p. 1842). As long as providers have a fiduciary relationship with their patients there will be deception because of the fact that a physician's first loyalty is to the patient (Bogardus et al., 2004). Society as a whole, however, should be concerned about a system that places providers in

such difficult positions. Technically, these providers are committing fraud, albeit what they perceive as necessary fraud.

At the root of this duplicity is the fact that "the provider has the medical expertise that the health plan may lack, yet the health plan controls the resources the practitioner may distribute" (Ulrich et al., 2003, p. 169). In many cases, when it comes time to make a medical (and ethical) decision, the provider knows what needs to be done and does it, even though such deception places the provider at significant risk. "Commission of fraud by physicians would make physicians expensive to the plans, and the plans are not of a mind to tolerate physicians that become expensive for any reason" (Sparrow, 1996a, p. 149). Physicians caught utilizing more resources than plan guidelines allow can be discharged from the plan, often in ninety days or less.

Fraud among corporate actors. Sparrow (1996a) conducted interviews with a variety of public and private insurers as well as Medicaid Fraud Control Unit (MFCU) personnel from three different MFCUs from three different states in order to gain an understanding of the ways fraud is perceived by payers and regulators under managed care. At the time the data were collected, many of the payers expressed the sentiment that managed care would largely do away with the fraud problem as capitation would eliminate provider incentives for overutilization (Sparrow, 1996a). In the course of his study, however, Sparrow (1996a) found that health care fraud is not eliminated under managed care, but merely changes form. Sparrow (1996a) found that under managed care, "the predominant nature of fraud will involve diversion of capitated fees, resulting in underutilization" (p. 144).

Of the three MFCUs Sparrow (1996a) interviewed, two had experience with fraud under managed care. One of the MFCUs operated in a state in which 80% of Medicaid clients were

enrolled in managed care and the state Medicaid agency paid providers capitated fees. One case of fraud involved two doctors who had formed a corporation "that won a contract for managed care provision under the state Medicaid program" (Sparrow, 1996a, p. 144). After operating for two years, front line providers participating with the plan began to complain that they were having trouble obtaining reimbursement from the plan. It turned out that the two doctors had been paying themselves "huge salaries and management fees" (Sparrow, 1996a, p. 145) of about 24% of all revenue whereas the state expected plans to only retain about 5% of revenue for profit. The doctors, operating as the managed care plan, also owned seven other corporations which served as subcontractors, but did not report any of these third party transactions to the state Medicaid agency (Sparrow, 1996a). "There was not a false claim, as such. Just an intricate web of corporate arrangements designed to siphon resources away from the Medicaid patients" (Sparrow, 1996a, p. 145). The MFCU investigator who related this anecdote stated that schemes like these were typical of what unsophisticated fraudsters do and that "the sophisticated ones can create much more complex schemes, even harder to detect and prosecute" (Sparrow, 1996a, p. 145).

One thing that Sparrow (1996a) points out is the fact that, while the proportion of funds and the manner in which they are paid to providers is a critical issue in managed care, plan managers can use related party contracts to "insert themselves into the food chain again at the provider level" (p. 145). One investigator relayed a case in which a vulnerable population did not receive necessary services due to fraud. The investigation revealed that the state's mental health program had not been paying providers, not providing needed services to children, and assigning multiple case managers to a single beneficiary (Sparrow, 1996a). The program had also created "bureaucratic obstacles designed to deter patients from obtaining treatment" (Sparrow, 1996a, p.

146). Other practices used by managed care plans that are destructive to the provision of adequate health care include:

> the arbitrary exclusion of identifiable groups of beneficiaries from service; regularly denying treatment requests without regard to legitimate medical evaluation; establishing policies that require an appeal before treatment will be given; failing to notify beneficiaries of their rights, yet retaining capitation payments; failing to procure health practitioners, so no service is ultimately provided; retaining exorbitant administrative fees, leaving inadequate provision for services; and assigning unreasonably high numbers of beneficiaries to providers, making adequate service impossible (Sparrow, 1996a, p. 149).

All of these actions were carried out for the singular goal of retaining profits. At the time of the study, managed care plans especially did not want to cover chronically ill patients, as such patients would utilize the most health care services causing the MCO to not retain any or much of the premium payment. In essence, any health care service utilization on the part of enrollees equals money drawn away from a MCO's profit margin. This list of harmful activities carried out by MCOs illustrates that some corporations are more than willing to cut access to and quality of care in the hopes of retaining profits.

Sparrow (1996a) concluded his study of fraud under managed care with an ominous prediction. Whereas fraud under FFS typically involved unnecessary or fictitious services and a padded claim, "under managed care, fraud will claim lives" (Sparrow, 1996a, p. 156). At the time Sparrow (1996a) conducted his study, capitation rates were relatively high and close to historical FFS costs; however, of concern was the fact that competition within the health care industry might drive capitation rates down. Due to the fact that MCOs compete in the market

based on profits as opposed to care quality, in order to remain competitive MCOs may reduce the amount of capitated fees paid to providers in an attempt to retain more of the money for the corporation. “Once the fees paid more accurately reflect the cost of providing reasonable service, and once the opportunities for favorable selection diminish, then there will be far less room for fraud” (Sparrow, 1996a, p. 156).

Past issues with fraud control. The form fraud takes and the locus for fraud commission under managed care is different from that under FFS. The issue becomes one of whether there are sufficient fraud controls and quality controls in place to prevent fraud under managed care so that patient health is not jeopardized and MCOs are sufficiently deterred. Sparrow (1996a) argues that under managed care, the locus for fraud control shifts to the corporate managers. The responsibility for fraud control resides with the insurer (in this case, the MCO and/or Medicaid) and this has led some states to delegate the task of fraud detection to the MCO under the assumption that, for managed care plans, cost control equals fraud control. If providers attempt to defraud the managed care plans, this costs the corporation money and therefore the corporation does have a valid incentive to monitor provider behavior. What is missing from this equation is the incentive on the part of the corporation to increase revenue via fraud commission. States and Medicaid decrease their oversight of managed care plans, effectively “leaving the fox watching the henhouse” (Sparrow, 1996a, p. 150).

Sparrow (1996a) relates the experience of one MFCU to illustrate this point. The state in which the MFCU operated had contracted most of its Medicaid program out to MCOs and was “winding down” (Sparrow, 1996a, p. 150) its internal fraud section. Managed care plans were told to refer any fraud they detected to the MFCU, which was comprised of only three staff

members. Not required to have any fraud control apparatus in place, the MCOs made no referrals to the MFCU.

This tendency for states to leave the responsibility for fraud control in the hands of MCOs and decrease regulatory oversight was also noted by Jesilow, Geis, and Harris (1995). The authors interviewed Medicaid enforcement officials in an attempt to understand what third party payment programs like managed care would mean for state fraud control entities. Jesilow et al. (1995) concluded that, in the future, "enforcement agents will face a sizeable increase in the number of providers they are required to scrutinize and a small likelihood that they will be granted sufficient, if any, additional resources" (p. 129). One MFCU official stated that personnel in his unit had been cut because state officials concluded that the MFCU would become less necessary as the state continued to contract its Medicaid program out to managed care plans (Jesilow et al., 1995). At the time of this and Sparrow's (1996a) study, MFCUs and other regulatory entities were being excluded from fraud control.

Sparrow (1996a) and Jesilow et al. (1995) agree on many of the ways managed care was predicted to cause difficulties for regulatory agencies with respect to detection, investigation, and prosecution. One concern dealt with the fact that investigators will experience a "lock out" (Sparrow, 1996a, p. 152) to the extent that, with MCOs in charge of policing themselves and participating providers, MFCUs and other enforcement agencies will have no way in. At the time Sparrow's (1996a) study was conducted, MFCU personnel did not possess the required knowledge of the complex contractual arrangements MCOs and their providers utilize. "Investigating fraud under managed care will demand a range of skills and a degree of sophistication never previously required in the traditional FFS environment" (Sparrow, 1996a, p. 153).

It was (rightly) predicted that fraud under managed care would reveal itself through patterns of behavior as opposed to single claims. At the time, Sparrow (1996a) found prosecutors reluctant to take on cases involving MCOs. This was because proving fraud under managed care depended on the ability of the courts to assess the significance of broad patterns of behavior. The legal system was accustomed to cases dealing with fraud under FFS, and therefore prosecutors "wanted a false claim" (Sparrow, 1996a, p. 154). If a case involving a MCO went to court, the determination of patterns was dependent on encounter data as opposed to claims data, and this data was unreliable because it was generated by the MCO and could be of poor quality, late or falsified (Jesilow et al., 1995; Sparrow, 1996a).

Historically, investigators and prosecutors have faced tremendous difficulty proving fraud within MCOs because both lack the medical expertise needed to answer crucial questions related to medical necessity and quality (Jesilow et al., 1995; Sparrow, 1996a). Securing a conviction meant proving a "systematic and conscious failure to provide adequate medical care – with the money being improperly diverted" (Sparrow, 1996a, p. 155). Without medical knowledge, investigators and prosecutors find it hard to distinguish between fraudulent provider activity and poor quality care. Criminal diversion of funds is difficult to distinguish from "inflated administrative overhead" (Sparrow, 1996a, p. 155). It is difficult for investigators without specialized knowledge of the profits and expenditures that MCOs typically deal with and the way these financial transactions are carried out to discern whether a corporation is utilizing funds in illegal ways or not. Considering that MCOs are in a position to generate their own financial statements and data, it is very difficult for any outsider to determine if money is set aside for legitimate corporate expenditures or is fraudulently diverted. Ambiguities like this

illustrate the difficulty associated with proving guilt beyond a reasonable doubt and criminal intent.

Changes in anti-fraud technology. In the mid-2000s the government as well as insurers began to recognize the problem that health care fraud presents. According to Galimi (2005) there are several factors that contribute to health care fraud. These include "an ever increasing volume of transactions, antiquated procedures that were not established to assume that fraudulent claims would be made, and complex and multiple reimbursement methodologies that open insurers to the risk of inappropriate claim payments because of fraudulent and abusive billing practices" (Galimi, 2005, p. 40).

What Galimi (2005) describes is a retroactive or "pay and chase" (Taylor, 2007, p. 56) approach. Sparrow (1996a) predicted that effective fraud detection under managed care would identify patterns of behavior as opposed to individual claims. Indeed, the mid 2000s saw a shift in fraud detection to the prospective approach (Galimi, 2005). "The pattern matching system is good at looking for aberrations in claims by comparing a provider with a peer group" (Galimi, 2005, p. 40). Major and Riedinger (2002) explain how the newer fraud detection systems of the time compared categories of behavioral heuristics such as "the flow of dollars, whether a medical situation would normally happen, the frequency of treatments as well as the place, time, and sequences of activities, and how a provider presents themselves to an insurer" (p. 313). The program "red flagged" outliers who did not fit in with the behavior typical of peer providers. The problem with these early electronic fraud detection technologies, however, was the fact that sophisticated fraud perpetrators learned how to fit in with the bulk of claims.

Anti-fraud Legislation

In addition to new fraud detection technologies, several pieces of legislation geared toward combating health care fraud have been passed, beginning with the False Claims Act of 1863. Broadly, the False Claims Act established liability when any person or entity improperly receives from or avoids payment to the federal government. This involves knowingly presenting, or causing to be presented a false claim for payment or approval and knowingly making, using, or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the government. There have been numerous amendments to the False Claims Act since 1863, for example in 1986 and 2009, and most recently in 2010 with the passage of the Affordable Care Act.

There are four main changes that the Affordable Care Act has made to the False Claims Act that have bolstered fraud control in recent years. The first establishes that a violation of the Anti-Kickback Statute can be the basis for a false and fraudulent claim (Rhoad & Lui, 2012). The change in the statute now means a person need not have knowledge or intent to commit a violation of that section of the law. The second change imposes False Claims Act liability on any provider who receives Medicare or Medicaid overpayments (accidentally or otherwise) and fails to return the money to the government within sixty days. The third relates to changes in the public disclosure bar that was previously in place. Under the previous version of the False Claims Act, cases filed by private individuals (or relators) could be barred if it was determined that such cases were based on a public disclosure of information arising from certain proceedings, such as civil, criminal or administrative hearings, or news media reports. As a result, defendants frequently used the public disclosure bar as a defense to a plaintiff's claims and grounds for dismissal of the same. The Affordable Care Act amended the language of the

False Claims Act to allow the federal government to have the final word on whether a court may dismiss a case based on a public disclosure. Lastly, the Affordable Care Act modified the original source requirement which now only requires a relator to have "knowledge that is independent of and materially adds to the publicly disclosed allegations," which omits the prior requirement that the knowledge be "direct and independent of the information on which the allegations are based" (Rhoad & Lui, 2012, p. 30).

Earlier anti-fraud initiatives included the 2005 Deficit Reduction Act. The Deficit Reduction Act was intended to encourage the states and whistleblowers to report and prosecute health care fraud in much the same way that the False Claims Act had (Taylor, 2007). The Deficit Reduction Act created incentives for states to pass False Claims Act laws as tough as or tougher than the federal laws. In return for doing this, the federal government agreed to give states a larger portion of Medicaid fraud settlement recoveries. An amendment to the Deficit Reduction Act states that health care organizations that receive more than $55 million annually from Medicaid must educate their staffs on both state and federal laws as they relate to health care fraud (Taylor, 2007). Similarly, the 2002 Improper Payment Information Act "required federal agencies paying more than $10 million in claims to study and reduce payment errors" (Taylor, 2007, p. 56). The Improper Payments Information Act also required federal agencies to identify programs that are susceptible to significant improper payments, estimate the amount of overpayments, and report these figures annually to Congress as well as the steps being taken to reduce such payments (Grady, 2008). Determining the amount of overpayments and where they are coming from involves the annual selection of a sample of states which are then reviewed using a random sample of claims and eligibility determinations to gauge Medicaid error rates (Grady, 2008). The states must then submit a corrective action plan and reimburse the federal

government any overpayment. The Department of Health and Human Services (DHHS) estimated improper payments of approximately $13 billion in 2007 (Grady, 2008). The Deficit Reduction Act "established a Medicaid Integrity Program with an appropriation reaching $75 million annually for audits, identification of overpayments, education with respect to payment integrity and quality of care, and other purposes" (Grady, 2008, p. 4).

Taylor (2007) argued that there was a downside to the influx of anti-fraud initiatives at that time. "Before there would be a single state with a MFCU and an underfunded integrity program. Now there are multiple federal agencies and their contractors and better funded state regulators" (Taylor, 2007, p. 56). The increased numbers of regulators in the field, however, led to confusion as to which agency was responsible for what. State regulators warned CMS not to replicate audits because to do so cost the government unnecessary money and frustrated providers. The bottom line, however, is that, while new anti-fraud initiatives cost providers and health plans time and money, the purpose behind these efforts was to force those in the health care industry to expand their Medicaid compliance programs in order to satisfy the new federal regulations. "Providers will need to invest in at least some new personnel to oversee who's asking for what and where that information is going" (Taylor, 2007, p. 58). This prediction came true, as a myriad of authors (Baker, 2014; Fodeman, 2015; Moeller, 2013; Moffit, 2013; Siegel, 2014; Tate, 2014; Woodward; 2013) cite increased regulation and paperwork as a main source of provider frustration, not only with Medicaid but also with the Affordable Care Act as a whole.

Quality Assurance and Accreditation

In addition to increased attention paid to health care fraud on the part of the government, the National Committee for Quality Assurance (NCQA) evaluates and accredits MCOs based on quality and accountability. According to Gosfield (1997) the power of accreditation lies in its

link to purchasing opportunities. When local, regional, and national firms mandate accreditation before a plan can be offered to the subscriber population, "plans will move to make themselves more accountable by seeking accreditation" (Gosfield, 1997, p. 35). Many of the fraudulent behaviors observed by Sparrow (1996a) seem to be addressed by the evaluation standards of the NCQA, in addition to the fact that the NCQA bridges the gap between marketplace competition and quality of care. Some of the broader areas in which MCOs are evaluated include quality management and improvement; utilization management; credentialing and re-credentialing; members' rights and responsibilities; standards for member connections; Medicaid benefits and services; and rigorous performance measures (NCQA, 2015).

The accreditation requirements are designed to improve the quality of health care services that MCOs provide to enrollees, and while it is encouraging that accreditation is favored by firms because it provides a market incentive for MCOs to behave ethically, it remains unclear if these quality controls automatically reduce fraud. Perhaps, as Clinard and Yeager (1980) argued, the most effective way to ensure corporate compliance is by bringing ethical constraints and motivations in line with economic constraints and motivations, and it appears as though efforts like those of the NCQA have managed to achieve this, at least in terms of eradicating some corporate behaviors that were destructive to adequate medical care.

The fact that the government and socially conscious organizations have taken measures to bolster fraud control and quality is promising. At the time of his study, Sparrow (1996b) found that, while underinvestment in fraud control has traditionally been the industry norm, even small investments pay off. While most regulatory agencies estimate losses to fraud as being between 3 and 10% of annual health care spending, this estimation has remained constant while spending increases from year to year. Sparrow (1996b) asserted that the true extent of health care fraud is

not known because it is not systematically measured. “Fraud control, as a science or an art, is scarcely developed and little understood” (Sparrow, 1996b, p. 88).

Changes in Fraud Control Due to the Affordable Care Act

Sparrow’s (1996a) study, now nearly twenty years old, brought the issues of a failing fraud control system to the fore. In more recent years, the government and enforcement entities have acknowledged the incredible toll health care fraud takes on the health care system, the economy, and society as a whole. The Affordable Care Act has channeled funding, resources, and manpower into combatting health care fraud in a manner that is unprecedented. There are five main areas in which provisions in the Act have focused anti-fraud efforts: providing more funding to prevent and fight fraud; facilitating means for better screening and compliance; new penalties to deter fraud and abuse; increased data sharing to identify fraud; and scrutiny and compliance strategies for high risk sectors (Ruggio, Hurd, & Reimers-McIntee, 2013).

The Affordable Care Act is providing approximately $350 million between 2011 and 2020 to strengthen fraud control; this includes the hiring of enforcement officials and agents trained to prevent and detect health care fraud. CMS is now allowed to conduct background checks, site visits, and other enhanced oversight measures to identify fraudulent providers before they can bill Medicaid. For example, states are required to screen providers to determine if they have a history of defrauding government programs. Providers with a history of fraud are subject to more intense screening and heightened scrutiny. Providers and suppliers must now undergo mandatory licensure checks, fingerprinting, site visits, and criminal background checks before they can begin billing Medicaid (Ruggio et al., 2013). Alternately, payment can be withheld to any Medicaid provider or supplier against whom a credible allegation of fraud has been made or if an investigation is pending.

Penalties for fraud have also been stiffened as a result of the Affordable Care Act. The Office of the Inspector General (OIG) now has the power to impose stronger civil and monetary penalties on fraudsters; for example, $50,000 for a false statement or misrepresentation of a material fact and $50,000 or triple the amount of the claim for providers who know of an overpayment but fail to return it. The Act has also increased federal sentencing guidelines for fraud offenses by 20% to 50% for crimes that involve more than $1 million in losses (Ruggio et al., 2013).

The Affordable Care Act has expanded the CMS Integrated Data Repository (IDR) and One Program Integrity (One PI) to incorporate data from all federally funded health care programs. The IDR has been in use since 2006 and is essentially a storehouse for CMS data. One PI is a web-based portal that provides an access point to the data contained in the IDR as well as tools for analyzing that data. All providers are issued a National Provider Identifier which they must use on all applications and claims. More detailed claims data is now required from programs like Medicaid, Medicare, the Veteran's Administration, and the Social Security Disability Insurance program. Information from these and other programs is "centralized, thereby making it easier for agency and law enforcement officials to identify criminals and prevent fraud on a system-wide basis" (Ruggio et al., 2013, p. 22). The goal of having all this information in one place is to be able to observe patterns of utilization, prescribing, billing, and business arrangements that may be fraudulent.

In order to help reduce the risk of health care fraud, the Affordable Care Act makes provisions to enhance scrutiny in sectors historically known to be high-risk. Notoriously fraud-prone sectors include durable medical equipment (DME), home health care, hospice, Medicare Advantage, and nursing facilities. In terms of DME for example, the Act requires a provider to

have a face-to-face encounter with an individual before issuing a certification for DME. This eliminates many of the opportunities for "false front" providers who bill for medical equipment not needed or requested by the patient, submit duplicate bills, offer "free" equipment to the patient but bill the program, offer a generic product but bill for a more costly product, or even submit a bill for a deceased patient (Nebraska Senior Medicare Patrol, 2009).

Impact on fraud. Despite the frustrations of providers, and perhaps an increasing unwillingness on the part of providers to accept new Medicaid patients in the wake of the Affordable Care Act, there seems to be little doubt that, in terms of fraud control, the Act has been successful. In March of 2013 the Obama administration announced that it had recovered an unprecedented $4.2 billion in fraudulently billed charges to government health care programs (Knowles, 2013). In fact, over President Obama's first four years in office, his administration was able to recover $14.9 billion in health care fraud from government programs, compared to the $6.7 billion recovered in the last four years of President George W. Bush's term.

According to the Justice Department, the government recovered $3.3 billion in 2014, over $1 million less than the previous year. The lower recovery amount may be an incredibly promising sign; "the government may collect fewer actual dollars because it's doing a better job of targeting potential fraudsters before they are able to abuse the system for extended amounts of time" (Schencker, 2015a, p. 1). The National Health Care Anti-Fraud Association (NHCAA) released their Heath Care Fraud and Abuse Control Program (HCFAC) Report for 2014. Among many other findings, this report states that OIG investigations resulted in 867 criminal actions against individuals or entities that engaged in crimes related to Medicare and Medicaid (NHCAA, 2014). The OIG also excluded 4,017 individuals and entities from participation in Medicare, Medicaid, and other federal health care programs. Among these, 1,310 were

exclusions based on criminal convictions for crimes related to Medicare and Medicaid (NHCAA, 2014). The report stated that the return on investment (ROI) for the HCFAC program is $7.70 for every $1.00 spent.

In addition to strengthened laws, increased funding and manpower, and stiffer penalties, in recent years the government and enforcement agencies have moved away from the "pay and chase" model of fraud control and have become more proactive; choosing to prevent health care fraud instead of catch it after it occurs. The Justice Department credits the Health Care Fraud Prevention and Enforcement Action Team (HEAT) for the large recoveries of recent years. HEAT is run jointly by the Department of Health and Human Services (DHHS) and the Department of Justice (DOJ). Overall, the sole purpose of HEAT is to fight fraud in the Medicaid and Medicare programs by cracking down on individuals and organizations that defraud the government, prevent fraud and spread awareness, highlight best practices for combatting fraud, and build upon existing agency partnerships to strengthen enforcement efforts (DHHS & DOJ, 2015). Since 2008, HEAT actions have led to a 75% increase in individuals brought forward on charges of health care fraud. "In 2011, HEAT coordinated the largest-ever federal health care fraud takedown involving $530 million in fraudulent billing" (HHS & DOJ, 2015, p. 1).

HEAT, as well as the OIG and other enforcement entities, has access to new technology such as advanced predictive modeling to detect and investigate health care fraud. The Fraud Prevention System (FPS), in use since 2011, is the cornerstone of this new technology and incorporates both the IDR and One PI. Billions of records and data points can be analyzed to identify trends, geographical hot spots, emerging schemes, and providers of concern (OIG, 2015). On a large scale, patterns of data are analyzed to assess fraud risks across services, providers, and regions and deploy resources in an efficient manner. On a small scale, virtually

real-time data is used to identify suspicious activity and conduct effective investigations. While the quantitative value of this technology can be measured in dollars, the qualitative value can be measured in terms of changes in provider behavior. Since 2011, CMS (2014) has observed:

> a significant reduction in provider billing after administrative actions are taken such as suspension of payments; providers reduce their billing in specific regions where a combination of program integrity activities, such as FPS models, HEAT activity, and policy changes occur; and providers reduce unnecessary orders and referrals for services (p. 17).

Summary of Related Literature

The goal of this chapter was to provide an in-depth historical perspective of not only how health care delivery and payment systems have evolved, but also why they have had to evolve with the changing characteristics of American society throughout the latter half of the 20th century and beginning of the 21st century. Medicaid and Medicare were created to more efficiently deal with the issue of providing care to underserved populations. Lower reimbursement rates and problems related to provider participation, however, have seemingly always plagued these programs despite repeated government expansions. To reduce costs, ration services, and take advantage of already established markets, federal programs like Medicaid joined forces with managed care organizations. These arrangements led to a shift away from traditional FFS payment toward capitated models, which served their cost control purpose but, without quality standards in place, proved harmful to patient health and placed providers in a precarious ethical position.

Managed care opened up new avenues for fraud by taking the opportunity for fraud commission away from providers and shifting it to the plan managers. Under

managed care, corporate managers have been observed diverting funding and resources away from Medicaid patients, making both providers and patients the victims. Managed care organizations historically faced little oversight because they were believed at the time to be the answer to the problem of fraud and also because states relied so heavily on their participation to care for their Medicaid populations. As a result, government regulatory entities have faced problems with acquiring sufficient funding and personnel.

To complicate matters, moving away from FFS to capitation caused a change in the way fraud was detected, investigated, and prosecuted. The cumulative dishonest behavior of corporate actors was very different from a provider filing a single false claim. For investigators, new and sophisticated knowledge became necessary in order to identify patterns of illegal behavior and distinguish them from usual business practices. Prosecutors and judges were reluctant to pursue fraud cases based on their complexity. Detection systems were also forced to keep up with the changing nature of fraud. Retroactive, "pay and chase" models gave way to predictive models that examined overall configurations of claims and behavior.

The Affordable Care Act rewrote the story of twenty-first century health care by making broad and sweeping changes to almost every feature of the system. The task at hand was how to promote free and fair market competition within health care while also maintaining high quality standards. Anti-fraud legislation had been piecemeal prior to the Act and quality assurance and accreditation was something a health plan could choose to participate in but was not highly prioritized in the minds of many plans or consumers. From a fraud control perspective, the Act provided a holistic boost on all fronts. Strengthened laws, increased funding and personnel, reporting requirements, use of new

technology, and government oversight decreased opportunity immensely. Evidence of this was seen as anti-fraud efforts yielded strong returns on investment and numbers of investigations, convictions, and recoveries spiked in the years immediately following the passage of the Act, leading to tangible changes in submitted claims and provider behavior.

With an understanding of how the current health care system came to be and Fraud Triangle Theory as a means of explaining and interpreting human reasoning and conduct, this study now turns its focus on the Affordable Care Act itself to determine how the law influences pressure, opportunity, and rationalization. The following chapter lays out how this will be accomplished through an inductive, qualitative process involving aspects of legal impact study, document analysis, and grounded theory methodology.

Methodology

Introduction to the Qualitative Approach

Qualitative research does not depend on statistical quantification but rather attempts to capture and categorize social phenomena and their meanings in context. “Quantitative research examines observable, measureable, independent facts whereas qualitative research examines socially constructed facts that have no independence beyond the meaning ascribed to them by people” (Webley, 2010, p. 928). Quantitative and qualitative methodological traditions have historically adhered to opposing epistemologies. A deductive approach involves the formulation of a hypothesis posed prior to data collection and the subsequent analysis of data aims to prove or disprove the hypothesis. An inductive approach seeks to develop common themes and patterns from the data collected as the research progresses. Grounded theory is simultaneously a theory of research, a data collection method, a mode of data analysis, and a means of generating theory. It involves the collection and analysis of data in a way that creates theory from sources by means of constant comparison. It requires the researcher to revisit descriptions of phenomena to examine whether they have continued validity or require modification.

This study is qualitative in nature and will employ an inductive approach as well as the grounded theory methodology. Analysis of existing documents related to the Affordable Care Act, as well as the Act itself, will be conducted and compared to one another to identify emergent themes. In addition, repetitive themes will be analyzed in the context of Cressey’s (1953) Fraud Triangle to theorize whether aspects of the law have increased or reduced the predilection for health care fraud. When the Affordable Care Act is deconstructed and its impact on health care fraud is assessed utilizing the principles of Cressey's (1953) Fraud Triangle Theory, conclusions will be reached as to whether the policy has been more or less successful at

reducing fraud. Specifically, which aspects of the Affordable Care Act increase and reduce fraud? Since the program is only midway through its roll out, any areas appearing to produce positive results should be maintained in the future.

Legal Impact Research

Legal impact research can be thought of as a research method within the broader practice of policy analysis, defined as "determining the causes and consequences of public policies" (Horney & Spohn, 1990, p. 167). Specifically, legal impact research is a form of policy analysis that focuses on the magnitude of statutory modifications and attempts to outline the social, economic, and political effects of these modifications.

Legal impact studies typically involve one central comparison; "the comparison between actual behavior patterns in jurisdictions having the law in question and the behavior patterns which would have existed in those same jurisdictions had the law in question never been enacted" (Lempert, 1966, p. 111). In this case, such a comparison cannot be made, however one way around this problem is to deconstruct the Affordable Care Act and conjecture which aspects of it, based on Cressey's (1953) theory, impact fraud commission. This process will take the form of an inductive document analysis aimed at uncovering new theoretical knowledge about the nature of health care fraud in the wake of the Act.

Document Analysis in Grounded Theory

The grounded theory methodology was first introduced by Strauss and Glaser in their 1967 book *The Discovery of Grounded Theory*. The exact definition of grounded theory is debatable; it can be argued that it is not a research method at all, but rather a mode of examining data for theories contained within the data. "A grounded theory is one that is inductively derived from the study of the phenomenon it represents" (Corbin & Strauss, 2008, p. 23). Theory is

generated during data analysis and the validity of the theory is "grounded" as the data supporting it increases. This approach is unique from other methodologies in that data collection and data analysis occur almost simultaneously. As new data is collected and analyzed, it is constantly checked and re-checked against the emergent theory to ensure accuracy.

Before data can be analyzed, it must be selected through a process referred to as theoretical sampling. Theoretical sampling involves examining a phenomenon from all angles. Data must be all inclusive to avoid possible gaps in the research. How gaps are identified and filled is a data-driven process. Antecedent conditions or causal conditions are factors that impact the primary phenomenon and their influence must be taken into account. The Affordable Care Act and health care fraud are not phenomena that exist in a vacuum. Economic factors, political factors, provider behavior, patient behavior, issues with Medicaid, bureaucracy, and technology are just some of the elements that play a part in telling the story.

Webley (2010) states there are three stages of data analysis within grounded theory methodology. The first of which is referred to as open coding and involves analyzing documents to formulate initial, basic codes. This step is very broad in nature as the researcher skims the documents line by line and notes anything that stands out. Over time, however, ideas are refined through a process of thorough reading of documents and synthesizing information, retaining replicable concepts and discarding concepts not sustained in later documents.

In the second stage, known as axial coding, relationships between progressively specific concepts are grouped into theoretical categories. While some researchers feel that true grounded theory requires the researcher to take their lead from the data rather than try to impose a particular theoretical approach on the process (Glaser, 1992), others argue that this phase should be undertaken in the light of a certain pre-existing theory; in this case, Fraud Triangle Theory.

In the third phase, known as selective coding, the theoretical categories are combined with the pre-existing theory to develop a new core concept, theory, or conclusion. Each stage leads to a higher level of abstraction from the original data (Webley, 2010). Continuous comparisons take place until the researcher considers that no more refinements can be made, nothing more can be added, rejected, and the theory has crystallized.

Advantages and disadvantages of document analysis. According to Bowen (2009), document analysis has several advantages that outweigh the potential disadvantages. It is a very efficient research method that is less time consuming and more cost effective than other methods. It is a process of data selection as opposed to data collection, as data contained in documents has already been collected and simply needs to be evaluated by the researcher. Many documents are in the public domain and are available over the internet free of charge.

Documents are unobtrusive and non-reactive; they are not affected by the research process. Similarly, documents are stable, as the presence of the researcher does not alter what is being studied. Lastly, documents have the potential to cover a broad range of topics spanning long periods of time, many events, and numerous settings. Often, they are our only accessible link to history (Cajote, 2014).

Bowen (2009) concedes that while document analysis can have limitations, these are merely potential flaws rather than major disadvantages. One issue with documents relates to irretrievability; some may be difficult to procure, access may be blocked, while others may not be retrievable at all.

Another concern with documents is the possibility for insufficient detail. Documents are frequently produced for purposes other than research and consequently do not always provide enough detail to answer a research question. They may explore only one side of an issue, be an

opinion piece, or exhibit bias. According to Cajote (2014), when conducting document analysis, one must critically evaluate each source of information. External criticism refers to the authenticity of a document; who wrote the document? For what purpose was it written? When and where was it written? Do different versions exist? Internal criticism refers to the accuracy of the information contained in the document; is the author competent to describe the event? Was the author present at the event? Was the author a participant or observer at the event? Does the language of the document suggest any bias? Do other versions of the event exist?

Biased selectivity, in this context, refers to an incomplete collection of documents, or a collection of documents aligned with the researcher's (or the institution's) point of view on the topic. This particular problem can be countered by something Bound (2011) refers to as "the identification of epoche," which he defines as "the identification of the researcher's bias prior to beginning a research project" (p. 8). Researchers claim to bury their personal bias or that no bias exists, but Bound (2011) argues that in order for a subject to interest someone to the point that they would conduct a study on the topic indicates they must have some knowledge of and feelings about the matter. Identifying epoche up front adds credibility to the research because recognizing one's own bias allows one to avoid short sightedness and bias-based conclusions.

Issues with legal impact studies. According to Lempert (1966), there are three major threats to the validity of legal impact studies; history-selection interaction, distinguishing the law as it appears on the books from the "law in fact" (p. 118), and history. Law functions as both a regulatory device and an expression of the people's feelings about an issue. History-selection interaction becomes a threat when an entire nation is being studied in isolation, as is the case with this study. Care must be taken to ensure that the law is more than a manifestation of the popular will of the people and that their behavior would be different in the absence of the law.

The U.S. is the only developed nation in the world that lacks universal health care (Fisher, 2012) and as a result, there is no jurisdiction to serve as a control group. In addition, the anti-fraud provisions contained the Affordable Care Act apply nationwide, making it impossible to conduct state by state comparisons.

While legislators write the laws, it is up to administrative and regulatory agencies to interpret and enforce the laws. This is the difference between the law as it appears on the books versus the "law in fact." In cases court decisions may have altered laws from their original form or judges may have applied their personal prerogative. Different enforcement agencies may use dissimilar tactics and philosophies and this can have a tremendous impact on outcomes. Berger, Neuman, and Searles (1994) describe law enforcers as "impact filters" (p. 3) who have the power to modify the intent of legal reforms. Enforcement agents must be committed to the goals of the reform in order for success. To gain an understanding of this, it is important to look not only at laws and statistics but also at anecdotal literature surrounding the Affordable Care Act; what has been written about its impact already. What is the character of the law as administered?

The issue of history deals with coincidental historical occurrences that seem to explain the change in behavior just as the intervention of the legal reform can. One must acknowledge the influence that non-legal factors can have on legal impact and how social and economic dynamics must be taken into account when attempting to explain causal relationships.

When examining laws and policies impacting health care in the past and present, particular attention must be paid to goals and outcomes. Horney and Spohn (1990) describe how a piece of legislation can have multifaceted goals and must be scrutinized from every perspective. Manifest goals are what the law appears to set out to accomplish. Latent goals, however, are the hidden agenda. Symbolic goals are typically intended to placate constituents but

create little change in the legal sense. Ultimate goals lie far in the future and are more akin to hopes. Proximal goals are short term, and lead to ultimate goals.

Another key piece of information to consider when analyzing policy is whether the reform was effectively implemented (Horney & Spohn, 1990). First, one must consider who the reform was intended to target and were those intended reached? Second, were there unintended targets of the reform and what effect do they have on it achieving overall success? Did those impacted by the reform comply with its substantive and procedural components? In other words, did key stakeholders "buy in?" If participants disagree with the law in principle or feel its implementation will interfere with the smooth and efficient operation of their established system they may find ways to avoid compliance. When this happens, those negatively impacted will "engage in adaptive behavior designed to serve their own goals and institutional or personal needs" (Horney & Spohn, 1990, p. 184).

Summary of Methodology

The qualitative nature of this study will allow the Affordable Care Act to be examined within the context of Fraud Triangle Theory, as well as the social, economic, and political climate of the U.S. These factors will serve as the backdrop in telling the story of the effect the Act has had on human behavior in terms of pressure, opportunity, and rationalization. There is no hypothesis at the outset; rather, the coding process leads the findings to be comprised of the most relevant concepts, grounded in Cressey's (1953) theory. Issues such as bias, both in documents and on the part of the researcher, will be guarded against by presenting multiple viewpoints on a topic. Other areas of consideration include differences between how the law was written versus how the law is administered; whether the law is more than simply the prevalent will of the people; and are there spurious factors that can account for changes thought to be a result of the

law? The following chapter presents the findings of the document analysis; the provisions of the Act that influence fraud commission, the nature of their influence, and their significance within the context of the health care system as a whole.

Findings

Decreasing Pressure through Grants, Incentives, and Appropriations

Cressey (1953) describes pressure as a non-shareable financial problem which is necessary and precedes the act of fraud commission. There are several provisions in the Affordable Care Act that either add to or detract from the financial security of individuals, businesses, and systems. The purpose of Title I was to improve, ensure, and expand health coverage for all Americans. Sec. 1002 of Subtitle A amends Sec. 2793 of the Public Health Service Act by directing the Secretary of the DHHS, or the Secretary, to award grants to states to enable them (or exchanges operating within the states) to establish, expand, or provide support for offices of health insurance consumer assistance or health insurance ombudsman programs. To be eligible, states must designate an independent office of consumer assistance or ombudsman that collaborates with state health insurance regulators to address consumer questions and complaints regarding federal health insurance requirements and state laws. This office or ombudsman must also track inquiries reported by consumers and submit a report to the Secretary concerning this data. Similarly, Sec. 1003 of Subtitle A of Title I requires the Secretary to collaborate with the states in forming a process for the annual review of health insurance premium increases. The Secretary may award grants to states for a five year period in which the states will review and, if allowable under state law, increase insurance premiums while providing reasons and recommendations to the Secretary for future practice. Grants may also be allocated to states for the establishment of centers within academic and non-profit institutions to collect medical reimbursement information from health plans. This data will then be disseminated among insurance companies, providers, researchers, policy makers, and the public.

Sec. 1102 of Subtitle B requires the Secretary to establish a temporary reinsurance program to provide reimbursement to assist participating employer-based health plans with the cost of providing health benefits to eligible retirees. To be eligible, the employer-based plan must implement plans and procedures that will reduce expenses associated with caring for enrollees with chronic and high-cost conditions. Additionally, employer-based plans are restricted to use reimbursement funds for the purpose of lowering premiums and cost-sharing for beneficiaries. Sec. 1421 of Subtitle E provides tax credits to businesses with twenty-five or fewer full time employees with average annual wages of less than $50,000. The company must pay at least 50% of the premium costs for full time employees and the coverage must be obtained through the Small Business Health Options Program (SHOP). The amount of the credit is based on a sliding scale according to an employer's total premium contributions. The tax credit is highest for companies with fewer than ten employees who are paid $25,000 per year or less; thus, the system is designed so the smaller the business, the larger the credit.

Sec. 1322 of Subtitle D of Title I requires the Secretary to establish a Consumer Operated and Oriented Plan (CO-OP) program to assist in the creation of qualified non-profit health insurance issuers to offer Qualified Health Plans (QHPs) in the small group markets of states licensed to offer such plans. QHPs are plans that are certified by state exchanges, provide essential health benefits, follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements. A QHP will have a certification by each exchange in which it is sold. This provision instructs the Secretary to award grants to entities applying to become qualified issuers to help meet state solvency requirements and pay licensing fees, as well as loans to offset miscellaneous start-up costs. A fifteen member advisory board makes recommendations to the Secretary regarding which entities should receive

grants and loans. At the beginning of 2016, there were eleven CO-OPs offering QHPs in thirteen states (Norris, 2016).

Sec. 1331 deals with funding states in which qualified health plans (QHPs) are operating. In states that have at least one QHP, the Secretary must transfer the amount equal to 95% of the premium tax credits and cost-sharing reductions that would have been provided for the year to eligible individuals enrolled in standard health plans (minimum essential coverage) in the state if such individuals were allowed to enroll in QHPs through the state exchange. States are also required to establish trust funds for the deposit of these funds and must use the money to reduce premiums and cost-sharing or provide additional benefits for individuals enrolled in standard health plans within the state, with special attention paid to individuals whose income is below 200% of the federal poverty level (Health Policy Alternatives, 2010).

Title II relates to funding and expanding eligibility for public programs like Medicaid. Sec. 2001 requires states to expand Medicaid eligibility to include individuals with incomes not exceeding 133% of the poverty level who are under age sixty-five, not pregnant, not entitled to Medicare, and not otherwise eligible for Medicaid. Along with this expansion, the Act increased the FMAP to 100% for 2014 through 2016 and significantly increases the FMAP thereafter by approximately 30%. The purpose of this was to help alleviate the financial burden the states would otherwise have experienced with accommodating the large numbers of new Medicaid enrollees. To further ease pressure on states, the federal government provided 100% funding for newly eligible Medicaid enrollees in 2014 through 2016, and will provide 95% funding in 2017, 94% funding in 2018, 93% funding in 2019, and 90% funding in 2020 and beyond.

Title IV comprises several provisions that channel grant funding toward prevention and healthy lifestyle programs. Sec. 4108 of Subtitle B provides incentives for the preclusion of

chronic diseases among the Medicaid population. Programs must be evidence-based and facilitate participant accomplishment of healthy behavior goals such as tobacco and alcohol cessation, lowering cholesterol, lowering blood pressure, weight loss, and diabetes management (Health Policy Alternatives, 2010). Sec. 4201 of Subtitle C authorizes community transformation grants for state and local government agencies, as well as community-based organizations for the implementation, evaluation, and dissemination of evidence-based preventive health activities including healthier school environments and workplace wellness programs. Similarly, Sec. 4202 appropriates grant sums for state and local health departments to provide public health interventions and clinical referrals for individuals aged fifty-five to sixty-four. Interventions may involve improvements to nutrition, physical fitness, reducing tobacco and alcohol use, and mental health screenings. Grants can also be used for screenings for heart disease, cancer, stroke, and diabetes. Sec. 4206 authorizes an almost identical grant for at-risk populations utilizing community health centers to test the effectiveness of individualized wellness plans in the hindrance of preventable conditions.

Title V contains provisions that alleviate financial pressure on individual providers by decreasing or eliminating their medical student loan debt. Sec. 5204, for example, establishes a loan repayment program for public health students and workers. The Secretary will pay up to $35,000 per year of the eligible loan balance in exchange for the provider working at least three years at a federal, state, local, or tribal public health agency. There are similar incentives for allied health professionals, direct care workers, and providers specializing in pediatrics, particularly for those who are willing to serve in a Health Professional Shortage Area, Medically Underserved Area, or serve a Medically Underserved Population.

Title X contained many amendments to the Affordable Care Act. Perhaps most notable was the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA). MACRA permanently repealed the flawed Sustainable Growth Rate (SGR) formula for Medicare physician payment, which calculated a 21% cut to Medicare provider payments. Instead, the legislation replaced the cut with a 0.5% payment increase for 2015 through 2019. Sec. 3102 of Title III extends the work geographic index floor and revises the practice expense geographic adjustment aspect of the Medicare physician fee schedule, increasing physician fees in rural areas and providing relief to areas negatively impacted by past calculations of the formula.

Increasing Pressure through Financial Sanctions

There are some provisions of the Affordable Care Act that may place a financial hardship on health care entities. Sec. 3025 of Title III, the Hospital Readmission Reduction Program, imposes a financial penalty on hospitals with excess Medicare readmissions (a Medicare patient discharged and readmitted within thirty days). "Excess" readmissions are defined as those that exceed the expected readmission rate for a hospital, based on national readmission rates and adjusted for the demographic characteristics and severity of illness of the hospital's patients (James, 2013). This program went into effect in October of 2012 and 2,200 hospitals were fined approximately $280 million. The following year, CMS estimates that 2,225 hospitals were fined $227 million. James (2013) states that, despite accounting for demographic differences, "hospitals serving a large number of low income patients were about twice as likely to receive penalties as hospitals with the fewest poor patients" (p. 3). Critics of the program feel that certain hospitals are being treated unfairly, particularly hospitals that care for the sickest and most vulnerable patients. Hospitals penalized by this program are facing increased financial pressure

because effective readmission reduction strategies are unaffordable for many institutions. James (2013) writes,

> because Medicare does not provide any direct payment to hospitals for services that may help prevent readmissions, such as discharge planning and follow-up, the additional, unreimbursed costs of employing strategies to reduce readmissions, together with reduced revenues from fewer readmissions, raise doubts about how cost-effective it is for hospitals to try and avoid the penalties (p. 4).

Sec. 2551 of Title II calls for reductions in disproportionate share hospital (DSH) allotments to states from 2014 through 2020. Disproportionate share hospitals are hospitals that serve a large number of Medicaid and low income, uninsured patients. States provide additional support to such hospitals through supplemental payments. The Act requires the Secretary to develop a methodology to allocate reductions in these supplemental DSH payments. According to the Kaiser Family Foundation (2013a), the methodology takes into account how well states target DSH payments to hospitals that serve a high percentage of Medicaid patients or exhibit high rates of uncompensated care. In 2014 and 2015, the reductions were relatively small but get larger as time goes on. Due to the fact that many states participated in the Medicaid expansion, it was assumed that over time hospitals would experience fewer cases of uncompensated care and gain back revenue from patients newly enrolled in Medicaid. Hospitals in states that choose not to participate in the expansion, however, will experience the DSH payment reduction and still face the costs associated with uncompensated care. This aspect of the Act puts pressure on states to participate in the Medicaid expansion, or else feel the financial strain of continuing to opt out.

Sec. 1104 of Subtitle B of Title I deals with the concept of administrative simplification. The goals of administrative simplification are to reduce clerical burden, push electronic transaction adoption, standardize operating rules for eligibility, claims status, claims payment and remittance, and enrollment and referral authorization, and ensure adherence to new standards. According to the Agency for Healthcare Research and Quality (2011),

> the real-life cost of implementing electronic health records (EHR) in an average five-physician primary care practice, operating within a large physician network committed to network-wide implementation of electronic health records, is about $162,000 with an additional $85,500 in maintenance expenses during the first year (p. 1).

The Health Resources and Services Administration (HRSA) acknowledges that establishing a return on investment from an EHR implementation is often challenging, especially for smaller practices. In addition to the up-front costs of purchasing an EHR system, there are costs related to the "effect of EHR implementation upon productivity, especially the initial changes in the practice including chart management, transitions in workflow, and other time constraints associated with electronic versus paper records" (HRSA.gov, n.d., p. 1). Providers and staff may also need to spend time and money to adapt the EHR system to specific needs and preferences within the practice. The HRSA (n.d.) cited a study which sought to determine if EHR were feasible for small practices and found that practices were able to make back the cost of EHR in two to three years and then profited an average of approximately $23,000 per year per full-time employee in net benefits. The gains were primarily a result of increased efficiency as coding became more accurate and more patients were able to be seen due to time saved. Based on these figures, it appears that the transition to EHR comes with very steep up-front costs, which may

increase pressure on providers, particularly those with small practices; however, if they can survive the first few years the system will bring a return on investment.

Sec. 9010 of Subtitle A of Title IX imposes an annual fee on any entity that provides health insurance for U.S. health risk, including foreign companies. The annual fee on health insurance is "a unique tax levied on health insurance companies as a fixed amount each year that is roughly proportional to their insurance market share, as measured by total premiums" (Book, 2014, p. 1). While the language of the Act refers to an annual fee, it is commonly known as the "annual fee tax." According to Book (2014), this provision was created under the assumption that insurance companies will see large profits due to the increased numbers of insured Americans and therefore, should be able to pay more in taxes to the federal government.

To illustrate the magnitude of this provision, the annual fee tax for 2014 was $8 billion; $11.3 billion in 2015 and 2016; $13.9 billion for 2017; and $14.3 billion in 2018. Beyond 2018, the tax is indexed to the rate of health insurance premium growth with the amount apportioned among insurers based on their market share for the prior year. Market share is based on total health U.S. health insurance premiums from the prior year. "Taken into account for calculating market share are 50% of net premiums between $25 million and $50 million and 100% of net premiums over $50 million" (Health Policy Alternatives, 2010, p. 162). This annual fee is not tax deductible and insurance companies are required to file an annual report with the U.S. Department of Treasury. Further fees and monetary penalties apply for non-compliance or understatement of net premiums.

Book (2014) studied the impact of the annual fee tax and found that in order to meet and maintain actuarial and state solvency requirements, insurance companies pass the fiscal burden along to enrollees in the form of higher premiums; with those enrolled in an exchange who do

not qualify for premium tax credits the most severely affected. Book (2014) found that as premiums increase, the amount of premium tax credits increase, causing the government to effectively "pay the tax to itself in the case of subsidized exchange customers" (p. 3), while those whose employers only offer individual coverage or whose income exceeds four times the federal poverty level for their family size pay the highest premiums.

Lastly, Sec. 1513 of Title I became commonly referred to as the "Cadillac Tax" because its aim was to target lavish employer-sponsored health plans, which were thought to cause enrollees to overutilize health care. The provision mandates that applicable large employers (employers with fifty or more full time employees) offer affordable minimum essential coverage to their employees and their dependents. If the applicable large employer fails to provide such coverage, they must make a payment to the IRS in the form of a 40% non-deductible tax against their employer-sponsored health plan. The purpose of this mandate is to force employers to make their health plans more efficient, which is expected to reduce national health expenditures by more than $40 billion in 2024, with even greater savings in later years. By increasing employer incentive to negotiate for better prices and steer enrollees toward lower priced providers the tax will help check market power and drive prices down (Moody, 2016).

This provision of the Act has been delayed multiple times. Several sources state the shared responsibility payment, or excise tax, will now take effect in 2018 (Claxton & Levitt, 2015; Coulam, Meade, & Egge, 2015; Miller, 2014). The health coverage is considered affordable if "the employee's required contribution for the lowest cost self-only coverage does not exceed 9.5% of the employee's household income" (Borden, 2015, p. 1). Compliance is determined monthly and a full time employee is defined as any employee that averages thirty hours of work per week during a month. Furthermore, large employers are subject to an excise

tax for any month in which at least one employee receives a premium tax credit for coverage through a state exchange. An excise tax is also imposed on a large employer that offers coverage to full time employees and their dependents if one or more employees qualify for a premium tax credit through the exchange because the employer does not offer minimum essential coverage or the coverage is determined to be unaffordable. The Act also instructs the Secretary of Labor to conduct a study to determine whether employee wages are being reduced as a result of the shared responsibility taxes imposed on employers.

Troy and Wilson (2015) conducted a survey to assess the implications of the excise tax on large employers and their employees. The study found that 90% of large employers are taking steps to prevent their company from having a plan that triggers the excise tax by 2018; however, 30% of employers stated they will have at least one plan impacted by the excise tax in 2018. Most damaging is the finding that "among employers who are going to reduce the values of their plans as a result of the excise tax, 71% of employers said that they probably would not provide a corresponding wage increase" (Troy & Wilson, 2015, p. 1). This is supported by Claxton and Levitt (2015) who studied the ways companies are preparing to reduce costs in anticipation of the tax and found activities like increasing deductibles and cost-sharing, eliminating covered services, capping or eliminating tax-preferred savings accounts, and using narrower provider networks.

The shared responsibility tax seems to have both benefits and drawbacks. Some employers will reduce employee benefits to avoid the tax but will increase wages to make up for it, while others will simply reduce benefits with no wage increase. Employers are "right sizing" their benefits packages in anticipation of the tax, which is what the law intended. Lane (2015) cites this as one reason health care cost growth has remained moderate, despite the fact that

millions of Americans have recently enrolled in health insurance. Furthermore, financing expanded coverage in the long term is somewhat dependent upon revenue generated from the tax, which is estimated to bring in approximately $87 billion between 2018 and 2025, according to the Congressional Budget Office.

Impact of the Affordable Care Act on Opportunity

Cressey (1953) pointed to the fact that, within every organization, many individuals possess the knowledge and skills necessary to execute a trust violation, were they to perceive the trust violation as a secret solution to a non-shareable problem. The knowledge and skills are often learned on the job and therefore it is very important to minimize organizational weaknesses. The trust violator does not wish to be caught and only chooses to commit fraud under the assumption that their actions will go undetected, therefore it is important to increase the chances of detection to reduce opportunity. Effective deterrence (punishment) also plays a role in decreasing the propensity for trust violation. Generally, the Affordable Care Act decreases opportunity through (a) increased regulation and oversight; (b) linking provider payment with quality and outcomes; (c) reporting requirements that demand accountability and transparency; (d) alternative payment methods; and (e) innovation through demonstration projects testing new models of health care delivery.

Increased regulation and oversight. The vast majority of anti-fraud provisions in the Affordable Care Act can be found within Title VI, which focuses on transparency and program integrity. According to the White House (n.d.) Title VI:

> Reins in waste, fraud and abuse by imposing tough new disclosure requirements to identify high-risk providers who have defrauded the American taxpayer. It gives states new authority to crack down on providers who have been penalized in

> one state from setting up in another, and it gives states flexibility to propose tort reforms that address several criteria, including reducing health care errors, enhancing patient safety, encouraging efficient resolution of disputes, and improving access to liability insurance (p. 1).

Sec. 6401 mandates screening (including a criminal background check) of all providers and suppliers prior to the granting of Medicare, Medicaid, or CHIP billing privileges. Providers and suppliers wishing to enroll under Medicare, Medicaid, or CHIP must also disclose any current or previous affiliation with a provider or supplier who has uncollected debt with an entity that has been suspended or excluded from a program, subject to payment suspension, or has had its billing privileges revoked.

Sec. 6402 requires CMS to develop the aforementioned Integrated Data Repository, which expands data sources, sharing, and matching across federal programs for the purpose of identifying potential fraud, waste, and abuse. The provision mandates administrative penalties for knowing participation in a fraud scheme, imposes penalties for false statements on provider or supplier enrollment applications, and imposes financial penalties on providers excluded from federal programs who nevertheless order a covered service. This section also authorizes program exclusions and financial sanctions for any entity that makes false statements or misrepresents a material fact, including Medicare Part C and D plans and Medicaid managed care organizations. New authority is given to subpoena witnesses in program exclusion investigations and the intent requirement of the anti-kickback statute is revised so that a person need not have knowledge of the law or intent to break the law in order to be charged with fraud.

As Sparrow (1996a) discovered in his work with MFCUs, regulations can have limited impact without the necessary funding and personnel. Sec. 6402 increases Health Care Fraud and

Abuse Control (HCFAC) funding by $10 million each year for ten years, and appropriates an additional $250 million for 2011 through 2016. These funds are to be indexed by DHHS, the OIG, the FBI, and the Medicare and Medicaid Integrity Programs.

Sec. 6403 requires the Secretary to maintain a national health care fraud and abuse data collection program for reporting action taken against providers, suppliers, and other entities and submit this information in the National Practitioner Data Bank (NPDB). Sec. 6501 requires that if a provider is barred from participation in Medicaid in one state, all other states must bar that provider from Medicaid participation. Furthermore, Sec. 6502 dictates that states must exclude from Medicaid for a period any individual or entity that owns, controls, or manages an entity with unpaid overpayments determined to be delinquent, whose participation in Medicaid is suspended, excluded, or terminated, or that is affiliated with an entity that has been suspended, excluded, or terminated. In order to have a broader view of whom and where these entities are, Sec. 6503 requires that any agent or alternate party who submits a claim on behalf of a provider must register with the state and the Secretary of DHHS.

Sec. 6504 calls for the Secretary to compile an expanded set of data elements for use in electronic transmission of claims data consistent with the Medicaid Statistical Information System (MSIS) for the purpose of detecting fraud and abuse. This provision also requires that Medicaid managed care organizations maintain sufficient encounter data to identify the provider who delivered each service to each patient and that this data be provided periodically to the state.

Title VI also contains provisions such as the National Correct Coding Initiative, which promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B claims and Medicaid claims (Medicaid, n.d.)

and other provisions that decrease opportunity within fraud-prone sectors of health care such as skilled nursing facilities (SNFs), home health care, and durable medical equipment (DME). Sec. 6112 of Subtitle B of Title VI specifically addresses SNFs by directing the Secretary to develop, test, and implement a program that employs an independent agency to monitor the activities of large interstate and intrastate facilities.

Sec. 6405 and Sec. 6408 of Subtitle E of Title VI provide new regulation in areas of health care in which fraud has been generally endemic. Only providers enrolled in Medicare can order Medicare-covered home health services and DME. Financial penalties are imposed for the submission of false claims data under a federal health care program. Fines are also imposed for refusal to grant timely access to auditors and investigators and the existing law is extended in terms of investigation and audit obstruction. Sec. 6505 of Subtitle F prohibits states from making payments for Medicaid services to any entity or financial institution located outside the U.S.

Sec. 6506 extends the amount of time states have to recover program overpayments in cases of fraud. Whereas states used to have only sixty days, they now have one year to recover overpayments. The Secretary must also embark on a campaign to educate states about correcting identified overpayments within the new Medicaid Management Information System (MMIS).

Linking provider payment with quality and outcomes. The literature cited accreditation as a means for fraud reduction. In order to become accredited, rigorous standards of safety, quality, and patient satisfaction must be met. For these reasons, consumers look for accredited plans; therefore accreditation helps plans win business, satisfy regulatory requirements, and stand out from the competition. “The greatest improvements in cost and quality can be achieved by a market-driven system based on value-conscious consumer choice” (Baird, 2016, p. 1).

Sec. 1311 of Subtitle D of Title I states that a state exchange cannot make available any health plan that is not a Qualified Health Plan (QHP). QHPs are defined, in part, as plans that (a) do not employ marketing practices that discourage individuals with significant health needs from enrollment; (b) ensure sufficient choice of providers and supply information to enrollees regarding in-network as well as out-of-network providers; and (c) be accredited with respect to local performance on clinical quality measures using the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance plans or issuers. This provision also required the Secretary to develop a survey system that evaluates the level of enrollee satisfaction with QHPs offered through an exchange. Exchanges must present this survey information to the public so prospective enrollees can compare satisfaction between different plans. According to Healthinsurance.org (2015) the QHP label is an extra layer of consumer protection, one that makes shopping in the exchanges a good idea even for people who do not qualify for subsidies; therefore a great amount of business is guaranteed with participation in an exchange.

While the nature of accreditation reduces the propensity for fraud and improves a plan's market position, the Affordable Care Act contains measures that directly link performance with payment, effectively creating financial incentives to provide high quality care while reducing costs. Quite literally, Sec. 3007 of Subtitle A of Title III directs the Secretary to amend the physician fee schedule to vary payment to providers based on the quality of care provided relative to the cost.

The overarching intention of the Act was to direct the health care system away from a volume-based system toward a value-based system. This is evidenced by provisions such as Sec. 3002 of Subtitle A of Title III, which establishes a mandatory physician quality reporting program through the already-established Physician Quality Reporting Initiative (PQRI). Beginning in 2015, physicians who report quality data for a defined period will receive a bonus. Physicians who do not report data will have their Medicare payments reduced by 1.5% for 2015 and 2% for 2016 and beyond. As with accreditation, part of the power of imposing quality standards and linking them with payment lies in the ability of the consumer to access this information and decide where to spend their money. Quality and reporting, in the context of the Act, truly go hand in hand. For example, Sec. 10331 of Title X requires the Secretary to create a Physician Compare website, similar to Medicare's Hospital Compare website, which contains information on providers participating in the PQRI, including patient satisfaction data.

Correlating payment with performance is not relegated solely to physicians. Sec. 3004 of Subtitle A of Title III established quality reporting programs for long term care hospitals (LTCHs), inpatient rehab hospitals, hospice programs, and psychiatric hospitals. If these entities fail to report quality measures they face a financial penalty. Sec. 3006 of Subtitle A of Title III requires the Secretary to devise value-based purchasing plans for home health agencies, SNFs, and ambulatory surgical centers. Sec. 3201 of Subtitle C of Title III introduced quality incentive payments for health insurance plans based on a five-star quality rating system. As of 2012, plans with four or five stars receive a bonus based on a percentage of their quarterly earnings.

Baird (2016) cites several potential problems with payment models that marry compensation with quality including discrepancies in quality measurement, adverse effects on disadvantaged health care populations, and the relatively small impact of financial incentives.

"Many programs require the adoption of specific technology that is needed to collect and report data needed for evaluations. The financial incentives need to be large enough to cover these additional costs and also provide profit" (Baird, 2016, p. 4). RAND Corporation (2014) conducted a study on the effects of pay for performance arrangements and found they had little impact on health outcomes, however, the researchers did not report any negative or unintended consequences associated with such systems.

Reporting requirements. The literature indicates that providers are dissatisfied with the increased volume of paperwork brought on by the Affordable Care Act because it costs them both time and money. In order to commit fraud, however, one must feel fairly confident that their activities will go undetected and that is why one of the main strengths of the Act is its insistence on timely, comprehensive, and transparent financial reporting. At virtually every level, whether it is providers, exchanges, plans, or government entities, the Act requires studies and reports that dissect the inner workings of the health care system. In many cases, the findings are made available to the public.

Insurance plans. Sec. 1001 of Subtitle A of Title I amends Sec. 2717 of the Public Health Service Act by requiring the Secretary to develop reporting requirements for group health plans and health insurance issuers offering individual coverage. Plans are to report on benefits and reimbursement structures that (a) improve health outcomes through effective case management and care coordination; (b) prevent hospital readmissions; (c) improve patient safety and reduce medical errors; and (4) implement wellness promotion activities (Health Policy Alternatives, 2010). The Secretary is also directed to develop and impose penalties for non-compliance with the reporting requirements. Sec. 2718 further requires any health insurance issuer to submit an annual report to the Secretary stating the ratio of incurred loss plus the loss

adjustment expense to earned premiums. Other financial information must also be included such as total premium revenue, receipts for risk adjustment and risk corridors, payments of reinsurance, the amount plans have paid out for clinical services, activities that improve health care quality, and any other costs not related to claims. These reports are publicly available on the DHHS website. Sec. 1311 of Subtitle D of Title I mandates that any health plan seeking certification by a state exchange must first submit information regarding claims payment policies, financial disclosures, enrollment, denials, rating practices, out-of-network cost sharing, and enrollee rights to exchange, the Secretary, the state insurance commissioner, and the public. This information must be made available in both electronic and paper form.

Sec. 1104 of Subtitle B of Title I was about administrative simplification and, while it may increase pressure, contains some aspects that decrease opportunity. According to the Council for Affordable Quality Healthcare (2016) this provision requires that health plans:

> provide for timely acknowledgement, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals); and describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required or conditioned upon set values in other fields, and prohibit additional conditions (except where necessary to implement state or federal law, or to protect against fraud and abuse) (p. 1).

Health plans must file a statement with the Secretary certifying that data and information systems are in compliance with new standards and operating rules. The Secretary must also conduct periodic audits to ensure compliance and can impose financial sanctions of $1 per person covered by the plan for which data systems for medical policies are not in compliance. Sanctions

can go as high as $20 per covered individual if it is found the plan knowingly provided inaccurate or incomplete information. Uniformity decreases the opportunity for fraud, as strict guidelines must be followed when dealing with the electronic exchange and use of health information for the purposes of financial and administrative transactions. There are also benefits to electronic transactions in terms of fraud detection. For example, it is easier to identify when records are copied and used inappropriately, wrongly modified or altered by date or author (O'Donnell, 2014).

Exchanges. State health insurance exchanges are a unique aspect of the Affordable Care Act, as they were previously used mainly in the private sector. Exchanges are online price comparison websites where consumers can purchase health insurance that counts as minimum essential coverage, receive federal subsidies, and be granted exemptions. Exchanges play a huge role in the new health care landscape, as they serve as the nexus between plans, consumers, and state and federal government.

Several provisions in the Act regulate how exchanges operate and this impacts opportunity for fraud within the exchange. Sec. 1311 of Title I prohibits an exchange from utilizing any funds intended for operational or administrative expenses for purposes such as staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative modifications. Sec. 1311 also requires an exchange to publish the average costs of licensing, regulatory fees, and any other payments required by the exchange, as well as its administrative costs on a website to educate consumers about such expenditures. Exchanges must also publish the amount of money lost to waste, fraud, and abuse. Sec. 1313 of Subtitle D of Title I requires exchanges to keep an accurate account of all activities, receipts, and expenditures and to annually submit a report to the Secretary. The Secretary and the OIG are

permitted to investigate and examine all property and records belonging to the exchange and the exchange must fully cooperate. If it is determined that misconduct has occurred, the Secretary may rescind or reduce payments owed to the state until corrective action is taken.

Historically fraud-prone sectors. The literature shows some divisions of health care to comprise more opportunity for fraud commission than others. Sectors like DME, for example, hold greater opportunity because suppliers act merely as middle-men, purchasing equipment from manufacturers, shipping it to patients, and billing insurance. This arrangement has traditionally made regulation difficult. The Affordable Care Act makes a point to address these issues; increased reporting is just one way it accomplishes this.

DME and home health care. Sec. 6406 of Subtitle E of Title VI authorizes the Secretary to dis-enroll any provider or supplier who fails to maintain and provide access to documentation relating to written orders for DME or home health referrals from Medicare for up to one year for each failure. Similarly, Sec. 6407 requires physicians certifying or recertifying the need for Medicare or Medicaid home health care or DME to have a documented face-to-face encounter with the patient during the previous six months.

Skilled nursing facilities. Sec. 6103 of Subtitle B of Title VI requires skilled nursing facilities (SNFs) to increase the amount of information submitted to Medicare's Nursing Home Compare website and the Secretary must review the information regularly. Listed information now includes staffing data, a standardized complaint form, certification information, disclosure of enforcement actions, and financial information. Sec. 6104 mandates that SNFs generate reports pertaining to staff wages and benefits, as well as detailing expenditures associated to direct care, indirect care, capital assets, and administrative costs and these reports must be made available to the public upon request.

Hospice. Sec. 3132 of Subtitle B of Title III applies to hospice reform. The provision requires the Secretary to study data within hospice cost reports and claims and revise the methodology for determining hospice payment rates for home care and other services (Health Policy Alternatives, 2010). The provision also mandates that hospice providers visit a patient to determine continued Medicare eligibility every six months and provide documentation attesting that such visits took place. CMS must review all cases in which a patient remains in a hospice facility beyond the six month recertification period.

Alternative payment methods. In an attempt to reduce health care spending, the Affordable Care Act authorized changes to compensation programs and established the CMS Innovation Center to develop and test alternative payment and service delivery models, designed to steer the focus of provider payment systems from volume-based to value-based care. Every alternative payment method in use today began as demonstration project under the Act.

Accountable Care Organizations. Sec. 3022 of Subtitle A of Title III codified the Accountable Care Organization (ACO) model into law and created the Medicare Shared Savings Program to determine whether this new model would yield higher quality care at a lower cost. ACOs are networks of doctors, hospitals, and other providers who organize into a legal entity to coordinate care and determine cost metrics for a defined patient population. In traditional FFS, providers are paid for each test and procedure, driving up costs, by rewarding them for doing more, even when unnecessary. ACOs still pay on a FFS basis but create an incentive to keep costs low because Medicare shares a portion of any savings with the providers. In managed care there was a tendency for underutilization which proved detrimental to patient health. ACOs, however, must meet specific quality benchmarks and focus on prevention; they get paid more for keeping patients healthy and there are financial penalties for failing to meet performance and

savings benchmarks. There is evidence that shows ACOs are achieving their intended purposes of savings and patient health. According to Gold (2015), "in 2014, the third year of the Medicare ACO program, ninety-seven ACOs qualified for shared savings payments of more than $422 million" (p. 2). Numerof (2011) however, cites three main issues with ACOs. The first is the perception that ACOs do not empower consumers to be stakeholders in their own care. Medicare ACOs do not provide patients with incentives to reward healthy behavior or stay within the ACO network for their care. Second, Numerof (2011) argues that ACOs do not foster provider accountability because they continue to be paid for each service they perform, thus the tendency to overutilize remains. "Even with the possibility of a bonus from shared savings, maintaining the FFS system encourages providers to continue delivering an excess of services so that they can maximize their return. By creating incentives for each provider to increase his own productivity, FFS payment undermines the importance of provider collaboration across the continuum of care" (Numerof, 2011, p. 1). Third, ACOs create an unfair competitive advantage for large organizations. Groups of independent practitioners as well as other types of small and mid-sized practices may lack the infrastructure, technology, or other resources needed to qualify and succeed on their own. Conversely, large systems will have increased leverage with payers; or, without effective competition, they might have little incentive to reduce spending or improve quality of care (Numerof, 2011).

Bundled payments. A second alternative payment method is that of bundled payments. Under bundled payments, payers compensate providers with a single payment for an episode of care, defined as a set of services delivered to a patient over a specific period of time (Breakaway Policy Strategies, n.d.). For example, if a patient has cardiac bypass surgery, rather than making one payment to the hospital, a second payment to the surgeon, and a third payment to the

anesthesiologist, the payer would combine these payments for the entire episode of care (American Medical Association, 2016). If the costs of services are less than the bundled payment, participating providers retain the difference. If the costs exceed the bundled payment, providers are not paid the difference.

Several provisions in the Affordable Care Act call for the use of bundled payments in different demonstration projects. Sec. 2704 of Subtitle I of Title II establishes a bundled payment demonstration project under Medicaid in eight states in which the episode of care is a hospital stay. Sec. 3023 of Subtitle A of Title III requires the Secretary to develop, test, and evaluate alternative Medicare payment methodologies through the National Pilot Program on Payment Bundling. Here also, a hospital stay is observed.

According to Warrington and Brunkow (2011), proponents of payment bundling believe physicians, specialists, and hospitals will be encouraged to not only communicate with one another on patient progress, but also coordinate acute and post-acute care as a team of providers. Providers will work together in an efficient manner that will result in an overall reduction in treatment costs and these savings are to be shared by the team. Given this aspect of bundling, the incentive to provide unnecessary or costly care (overutilization) is eliminated. Lastly, because the level of care required is considered during negotiation of the bundle payment, bundled payments include all services provided throughout the episode of care and therefore does not penalize providers who care for severely ill patients.

While bundled payments encourage providers to improve care coordination, limit expensive and unnecessary services, and decrease variations in care not related to quality and outcomes, some disadvantages have been linked with payment bundling. Breakaway Policy Strategies (n.d.) state that bundling encourages providers to only treat the sick and not focus on

preventive care. There are also problems related to the nature of illness itself. Some types of diseases and conditions do not fall neatly into "episodes" and may require long periods of time to treat across multiple health systems. In these situations, effectively coordinating care, tracking quality, and controlling costs can become difficult. Providers may struggle to predict the total cost of care that will be necessary throughout an episode of care. The actual cost at the end of an episode of care could be much higher than the original predicted cost. In addition, because the bundled payment is partially based on historical costs, providers that already operate efficiently would have less room to improve and reduce costs below the target payment price (Warrington & Brunkow, 2011). The situation described is essentially one of underutilization. If less care or inadequate care is provided, fewer costs are accumulated and more of the episode payment is available for division among the team. From there, the physicians, specialists, and hospitals involved in an episode of care may find it difficult to agree on a fair method of distributing the lump payment.

Pay for performance. Pay for performance, or P4P, is another alternative payment model promoted by the Affordable Care Act, and is associated with the concept of value-based purchasing. The Act explicitly steers CMS in this direction by providing for demonstrations and incentives for value-based purchasing, physician quality reporting, and Medicare Advantage plan bonuses.

Sec. 3001 of Subtitle A of Title III advances the Medicare value-based purchasing program for hospitals, physicians, and other providers. As the name implies, value-based purchasing rewards healthcare entities based on the quality of care they provide as opposed to the quantity. In P4P, providers are reimbursed based on whether they achieve a pre-determined set of quality measures. If quality goals are met, the provider is paid a bonus. Under P4P, other

financial inducements include, “withholds, penalties, fee schedule adjustments, per-member payments, payments for the provision of a particular service, lack of payment for poor performance, shared savings, quality grants or loans, or payment for participation in certain activities or for reporting on certain activities” (Breakaway Policy Strategies, n.d., p. 4).

Overland (2015) writes that P4P models have been successful at lowering costs and increasing quality as well as offer incentives for providers to care for disadvantaged patients. Some P4P models, “strengthen quality-based incentive payments to providers who care for disadvantaged patients, while only slightly weakening incentives for other provider organizations and eliminating the redistribution of money to well-resourced providers” (Overland, 2015, p.1). The primary drawback with P4P models has to do with the de-selection of patients likely to have negative health outcomes and therefore cause the provider to fall below the pre-determined quality standard. Patients with low health literacy, inadequate financial resources to afford expensive medications or treatments, and ethnic groups traditionally subject to healthcare inequities may also be deselected by providers seeking improved performance measures (Cannon, 2007).

Patient-Centered Medical Homes. Lastly, the Patient-Centered Medical Home (PCMH) model facilitates care for a patient through their primary care provider. The Affordable Care Act supports the use of PCMHs, as evidenced in Sec. 3502 of Subtitle F of Title III which mandates a new grant or contract program to establish health teams to support the PCMH. Teams are sought to support primary care practices to help them coordinate and manage care, including coordination of the appropriate use of alternative services. Sec. 5405 of the Act defines primary care as “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained

partnership with patients, and practicing in the context of family and community" (American Association of Physician Assistants, n.d., p. 1).

The AHRQ (n.d.b) outlines five characteristics of the PCMH:

> (a) It is comprehensive in that it is responsible for meeting the large majority of each patient's physical and mental health care needs and involves a team of providers; (b) it is patient-centered, meaning relationship-based and tailored to the needs of the individual; (c) it involves coordinated care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports; (d) services are accessible, which can mean shorter waiting times for urgent needs, expanded in-person hours, and telephone or electronic access to a member of the care team; and (e) a commitment to quality and safety by ongoing engagement in evidence-based medicine, clinical decision-support tools to guide shared decision making with patients and families, performance measurement and improvement, and assessing and responding to patient satisfaction (p. 1).

There is no set payment arrangement for PCMHs. A number of PCMH initiatives use a payment model that includes traditional FFS payments, a fixed management fee and P4P payments. The design of a given PCMH can vary; therefore the costs for practice transformation can differ dramatically. Payers and PCMH developers want to create incentives for performance improvements in access, quality and efficiency. The NCQA conducted a 2015 study on the effectiveness and efficiency of PCMHs and uncovered promising findings. The NCQA (2015) found that study participants who belonged to a PCMH had fewer hospitalizations, lower Medicare payments, and lower Medicaid costs. The study also found increases in quality

outcomes such as lower antibiotic use among children, higher A1C and cholesterol screening among adults, increased cancer screenings, and more weight assessments. Perhaps most telling is what the patients themselves reported about the PCMH. Ninety percent of parents stated they had no trouble obtaining appointments for their children when needed. Seventy-three percent of Medicare beneficiaries stated they wanted PCMH-style care and 61% thought such a system would improve their overall health (NCQA, 2015).

> Breakaway Policy Strategies (n.d.) however, cites some concerns with PCMHs: For the model to work, providers must receive adequate compensation for the additional time and effort involved in coordinating care across the various care settings. Some primary care practices may not have the financial stability to invest in the transformation to a PCMH without assistance to cover initial costs, such as those involving health information technology (HIT) (p. 6).

Also of concern is the size of the health care workforce in a given location, particularly rural areas with shortages of primary care providers where there may not be enough health care infrastructure to create a PCMH.

Demonstration Projects

The Affordable Care Act calls for a plethora of demonstration projects in which new policies and procedures are introduced in a setting and the resulting effects are then compared with other settings in which the changes have not been introduced, usually with the intention of demonstrating the benefits of the changes being tested (Marshall, 1998). The Center for Medicare and Medicaid Innovation (CMI) within CMS tests new payment and delivery models with the goal of reducing program spending while enhancing quality of care. The Secretary of the DHHS must select models for testing when evidence suggests the model addresses a

medically needy population or an area of health care in which there are poor clinical outcomes or unnecessary costs. From a fraud control perspective, these demonstration projects serve an important function because, if proven successful, they have the power to alter the entire health care infrastructure in new and unforeseen ways. At the time CMI was created, the Secretary had provided approximately twenty models for testing and in the years since, many more have been added. What follows is an overview of the demonstration projects which are most relevant to this study.

Medicaid Global Payment System Demonstration Project. Found in Sec. 2705 of Subtitle I of Title II, the Medicaid Global Payment System Demonstration Project directs the Secretary, in conjunction with CMI, to pay large safety net hospitals in up to five states under a system of global capitated payments. Global capitation involves a single, pre-determined payment for health care services provided to an individual patient over the course of a defined period of time, typically one year (Kaiser Family Foundation, 2015). The payment amount is risk-adjusted based on the health, age, and gender of the patient. To safeguard against underutilization, global capitation models incorporate outcome and quality measures and physicians are rewarded based on performance. Robinow (2010) found global capitation to be successful in reducing unsustainable health care cost trends, as it optimizes care of the chronically ill. Furthermore, linking provider payment with quality outcomes and financial accountability changes the foundation of the overall delivery system. “Comparative clinical effectiveness information is a long-awaited tool to support better patient and physician decision making on care interventions” (Robinow, 2010, p. vi). Whereas Robinow (2010) believes global capitation will enhance shared decision making between providers and patients, Kane (2010)

believes the opposite to be true, stating that such systems cut the patient out of the decision making process.

> Patients need to become aware that doctors and hospitals are making decisions about their healthcare, based on the goal of saving money. By encouraging doctors and hospitals to keep costs down, healthcare professionals would be at odds with the patients. This is going to run counter to the American way of choice and autonomy. (Kane, 2010, p. 3).

The National Conference of State Legislatures (2010) cites several studies that point to the effectiveness of global capitation as a cost control strategy. Participants in the Patient Choice program were found to choose more cost effective providers and this has led providers to reduce their costs while improving quality in order to attract consumers. Similar findings reported by the research firms Mathematica, Inc. and the Lewin Group found "payment approaches involving risk-sharing with providers, including global capitation, are associated with lower service use and cost when compared with FFS arrangements" (National Conference of State Legislatures, 2010, p. 3).

Hospital Value-Based Purchasing Program. Sec. 3001 of Subtitle A of Title III directs the Secretary to establish a value-based purchasing program under the Medicare hospital inpatient prospective payment system. According to CMS (2015), this provision came about in an effort to link Medicare's payment system to a value-based system to improve the quality of inpatient care in hospital settings. "The program attaches value-based purchasing to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,500 hospitals across the country" (CMS, 2015, p. 1). Under the value-based purchasing program, participating hospitals are paid for services based on the quality of care they

provide as opposed to simply the quantity of care. The program bases its standards for hospital quality on the Hospital Inpatient Quality Reporting (IQR) Program, which was authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Medicare payments are adjusted based on how hospitals perform in four domains; the clinical process of care domain, the patient experience of care domain, the outcome domain, and the efficiency domain. The data are then publicly displayed on the Medicare Hospital Compare website for consumers to review, thus leading hospitals to compete based on quality and efficiency. DiChiara (2015) writes that the sum of value-based incentives for 2016 is approximately $1.5 billion. The DHHS has set a goal of transitioning 85% of traditional Medicare payments to value-based payments in 2016 and 90% in the three years following. CMS states that reaching this goal is important, not only from a quality-improvement perspective, but also because it seeks to promote a culture based on the needs of patients (DiChiara, 2015).

Large-scale quality improvement efforts. One of the main features of the Affordable Care Act is its focus on improving health care quality and basing payment for services on achieving quality benchmarks. The entirety of Part II of Subtitle A of Title III is dedicated to formulating a National Strategy to Improve Healthcare Quality. This provision requires the Secretary to "establish and update annually, a national strategy to improve the delivery of health care services, patient health outcomes, and population health through a transparent and collaborative process" (Health Policy Alternatives, 2010, p. 84). According to the AHRQ (2011), the Strategy pursues three goals; (a) improving the quality of care; (b) improving the overall health of the U.S. population; and (c) reducing the cost of health care. The Strategy is comprised of national priorities laid out through a strategic plan with the goals of identifying and addressing gaps in quality, efficiency, and effectiveness. Broadly, some of these topics include

modifications to federal payment policies, improved methods of using health care data, and addressing the high cost of chronic illnesses. Multi-stakeholder groups convene to develop quality measures for the Strategy and determine whether they are being met. The AHRQ (2011) states that over 300 groups, organizations, and individuals provided comments and feedback for the Strategy and quality measures.

Once priorities are set, information is disseminated among federal, state, regional, and local health agencies, as well as private sector organizations, and serves as a foundation for various initiatives. The Secretary must submit an annual report to Congress on the progress of the National Strategy and these reports are made available to the public. According to the 2015 report, the AHRQ monitors over 250 health care process, outcome, and access measures across a range of settings. The DHHS (2015) report cites:

> a significant reduction in rates of hospital-acquired conditions; steady improvements in person-centered care, especially among children; care coordination improved as providers enhanced discharge processes and adopted health information technologies; effective treatment in hospitals improved, as indicated by measures publicly reported by the CMS on the Hospital Compare website; and healthy living improved in about half of the measures followed, led by increased administration of selected adolescent vaccines from 2008 to 2012 (p. 1).

Among the findings was the fact that the number of uninsured adults between the ages of eighteen and sixty-four had decreased substantially during 2014. As of June, 2015, approximately 9.9 million consumers had obtained health insurance through a state exchange and of these, 84% had received a premium tax credit to make the insurance more affordable. The

study also stated that care affordability in the years preceding the Affordable Care Act (2002 through 2010) worsened but turned around thereafter. This indicates that the Act is achieving its goals of increasing access to care, improving care quality, and providing avenues to make quality health care affordable.

The Agency for Healthcare Research and Quality (AHRQ) is essentially the hub for quality and safety data under the Affordable Care Act. The AHRQ (n.d. a) is tasked with "producing evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work within the DHHS and with other partners to make sure that the evidence is understood and used" (p. 1). Sec. 3501 of Subtitle F of Title III requires the AHRQ to form a Center for Quality Improvement and Patient Safety to conduct research on best practices for quality improvement. Research is focused on reinventing payment systems and modes of care delivery, identification of effective and efficient providers, and disseminating strategies for best practices across continuums of care. In addition to the Center for Quality Improvement and Patient Safety mandated by the Act, the AHRQ has since created numerous other centers and offices geared toward addressing specific issues such as communications and knowledge transfer, extramural research, education and priority populations, evidence and practice improvement, and financing, access, and cost trends.

The AHRQ also has discretion in terms of awarding grants to entities that "demonstrate experience in providing technical support and assistance to health care providers regarding quality improvement and for the provision of technical assistance on implementation of a best practice model for health care providers" (Health Policy Alternatives, 2010, p. 111). Sec. 3508 of Subtitle F of Title III allows the AHRQ to award grants to academic institutions to develop and implement curricula that integrate quality improvement and patient safety into the education of

health professionals. In addition to awarding grants, the AHRQ Patient Safety Network is a virtual warehouse of health care quality and patient safety information and training materials. The site offers weekly updates of patient safety literature, news, tools, and meetings, and a large set of links to research and other information.

Increasing Opportunity

Considering the Affordable Care Act's high prioritization of fraud control, there was very little, on its face, which was found that would increase the opportunity for fraud. Sec. 2202 of Title II, deals with hospitals and presumptive eligibility for Medicaid. When an individual goes to a hospital, they are asked to provide information about their income and household size. States also have the option to inquire about citizenship, immigration status, and residency. If the individual appears to be eligible for Medicaid based on this information, the hospital shall determine the individual presumptively eligible for Medicaid and bills Medicaid for services provided to that individual.

This provision seems to stand at odds with the goals of the Affordable Care Act as a whole because it gives authority to health care entities to access public funds. Whereas in so many other provisions there is increased oversight, this provision seems to "give the henhouse back to the fox." This opinion is supported by Tobias (2013) who describes this provision as a way to ensure that hospitals are paid but if it is later discovered that a patient does not qualify for public assistance, the state is responsible for those costs. Presumptive eligibility is not a new phenomenon, and has been used to provide care for pregnant women and children while their Medicaid or CHIP qualifications were determined. The problem with presumptive eligibility, according to Tobias (2013), "is presumptive eligibility doesn't require the same level of verification as an actual application, which likely could lead to more patients lying about their

personal information, such as income or family size, to receive care" (p. 1). Even if all patients are truthful about their personal information, hospitals may view presumptive eligibility as a way to abuse the Medicaid program.

Finally, one goal of the Affordable Care Act was that every American would obtain health insurance and contains provisions that push people toward this goal. That is also why many find presumptive eligibility unnecessary; "presumptive eligibility goes away if everyone has become insured in the first place" (Tobias, 2013, p. 1). It is naïve to assume everyone will become insured, and literally impossible to enforce; however, perhaps that was the intention behind Sec. 2202. If people fail to obtain insurance, health care institutions will sign them up. It seems safer nonetheless, from an opportunity perspective, to leave that determination in the hands of the organization paying the claims as opposed to the entity standing to profit.

Impact of the Affordable Care Act on Rationalization

Cressey (1953) stated that rationalizations allow the trust violator to mentally frame the relationship between their non-shareable problem and the illegal solution in a way that is either "non-criminal, justified, or part of a general irresponsibility for which he is not accountable" (p. 93). Rationalization can be defined as a pattern of thoughts that run through a trust violator's mind preceding the decision to commit the criminal act. It is a reconciliation between the fact that their behavior (or intended behavior) is against the law versus commonly accepted notions of decency. How can a piece of legislation address this inner dialogue? The law cannot control for personal problems individuals get themselves into, however; the law can enable a discussion about the broader issues people in the field of healthcare face on a daily basis and take steps to address those issues. If a person feels no outside help is available, is dissatisfied with their job, or does not understand the consequences of their actions, an inclusive culture of self-efficacy would

mitigate those feelings. It is in this manner that certain aspects of the Affordable Care Act diminish the number of rationalizations, or perhaps diminish the power of rationalizations that would otherwise propel one to commit fraud.

Sec. 1104 of Title I amends the section of the HIPAA administrative simplification provisions to necessitate that standards be uniform and administrative simplification reduce clerical burden on patients, providers, and health plans. The Secretary must consider recommendations for operating rules established by a qualified non-profit entity that represents a multi-stakeholder consensus.

Title III contains several provisions that allow for the opinions of those in the health care industry to be heard and utilized to make policy recommendations. Sec. 3003 made enhancements to the Physician Feedback Program, which provides comparative performance information to physicians and medical practice groups as part of Medicare's efforts to improve the quality and efficiency of health care for beneficiaries. The program delivers constructive information to physicians so they can supply the highest quality care and be good stewards of health care dollars.

Sec. 3013 requires the Secretary to identify gaps in existing Medicare quality measures and consult with various entities, including the AHRQ, CMS, and other stakeholders to develop a set of consensus-based quality measures as part of the National Strategy to improve the delivery of health care services, patient health outcomes, and population health through a transparent and collaborative process. Sec. 3014 goes on to require a consensus-based entity to convene multi-stakeholder groups for input on selection of quality and efficiency measures for Medicare and heath care in general. The provision requires CMS to publish a report listing the measures being considered for use in Medicare reporting and payment so other entities can

provide feedback. Sec. 3015 requires the Secretary to develop and implement a strategic framework for publicly reporting performance information and encourages the Secretary to contract with multi-stakeholder groups and other entities that enable data to be integrated and compared across multiple sources. The Secretary must also create standardized websites to make public performance information tailored to meet the needs of different stakeholders, and to consult with diverse entities about the content and layout of the websites. Sec. 3023 directs the Secretary to develop, test, and evaluate alternative Medicare payment models through a national pilot program. The program will examine an episode of care provided during a hospitalization and seek ways to improve the coordination, quality, and efficiency of such services. The Secretary must collaborate with the AHRQ and other consensus-based entities to develop and disseminate new quality standards for hospitalizations.

Summary of Findings

The Affordable Care Act impacts pressure by imposing regulation that influences the flow of dollars to and from institutions and individuals, thereby affecting their market position, and in some cases, very livelihood. Grants and other financial incentives are provided to help health care entities conform to the new rules ushered in by the Act so the mission of the legislation can be promulgated. Monetary sanctions, ultimately, serve a similar purpose; although sometimes with unintended negative consequences that increase pressure.

The Act effects opportunity most of all; the most basic means of which is by strengthening existing laws and creating new ones. Never before has the eye of government been so sharply focused on the activities of the health care industry while concentrating funding, manpower, and technology toward this scrutiny. Transparency and accountability have been demanded, but great room has also been made for innovation and experimentation. The concept

of value-based payment has changed the nature of care delivery, which opens up possibilities for quality and efficiency but also presents new challenges.

While it may appear that the Act has little effect on rationalization, a byproduct of the legislation may, in fact, be very psychologically powerful. Cressey (1953) found that trust violators assimilate definitions of situations in which trust violation is sanctioned. The Act directly impacts the culture of the healthcare industry in a way that disallows favorable definitions of trust violation. The Act has created an environment in which it is wrong to profit from trust violation and no longer is it profitable. Quality standards are in place and must be met in order to receive optimum pay. Reporting to the government is required and oversight serves as reinforcement. Reducing opportunity in this manner diminishes one's ability to rationalize, and in so doing creates a twofold deterrent against fraud. The next chapter will provide further conceptual interpretation of the findings and their implications.

Discussion

Implications

This study sought to determine the impact of the Affordable Care Act on pressure, opportunity, and rationalization; the three aspects of Cressey's (1953) Fraud Triangle that dictate trust violation. The stated goals of the Act are to (a) decrease health care costs; (b) improve health care quality; and (c) make health care more accessible, particularly for the uninsured. In an attempt to accomplish these goals, the Act includes provisions that make extensive changes to the way health care is delivered and providers are compensated, which impacts the dynamics of fraud. In addition, the Act sets forth an array of new provisions specifically aimed at reducing fraud, waste, and abuse. Despite some provisions that appear to stand contrary to fraud control, as well as particular negative unintended consequences of the Act, the way the legislation was written and intended decreases pressure, opportunity, and rationalization. Perhaps the most impartial way of interpreting the impact of the Act is that it "is so big and sweeping that it has had effects both positive and negative" (Rovner, 2016, p. 1). From a purely fraud-control perspective, however, there is evidence that the new rules are having an effect (see Figures 1-4).

Figures 1-4 were created using data from Health Care Fraud and Abuse Control (HCFAC) Program reports from 2000 through 2015. These reports are produced annually by the DHHS and the DOJ for the purpose of reporting the impact of fraud, waste, and abuse within federal programs. Each yearly report states the number of investigations, convictions, provider exclusions, and recoveries as well as other information. These data were imported into Excel and sorted so that bar graphs could be created showing how the numbers vary by year, thus making the real-world impact of the anti-fraud provisions in the Affordable Care Act clear.

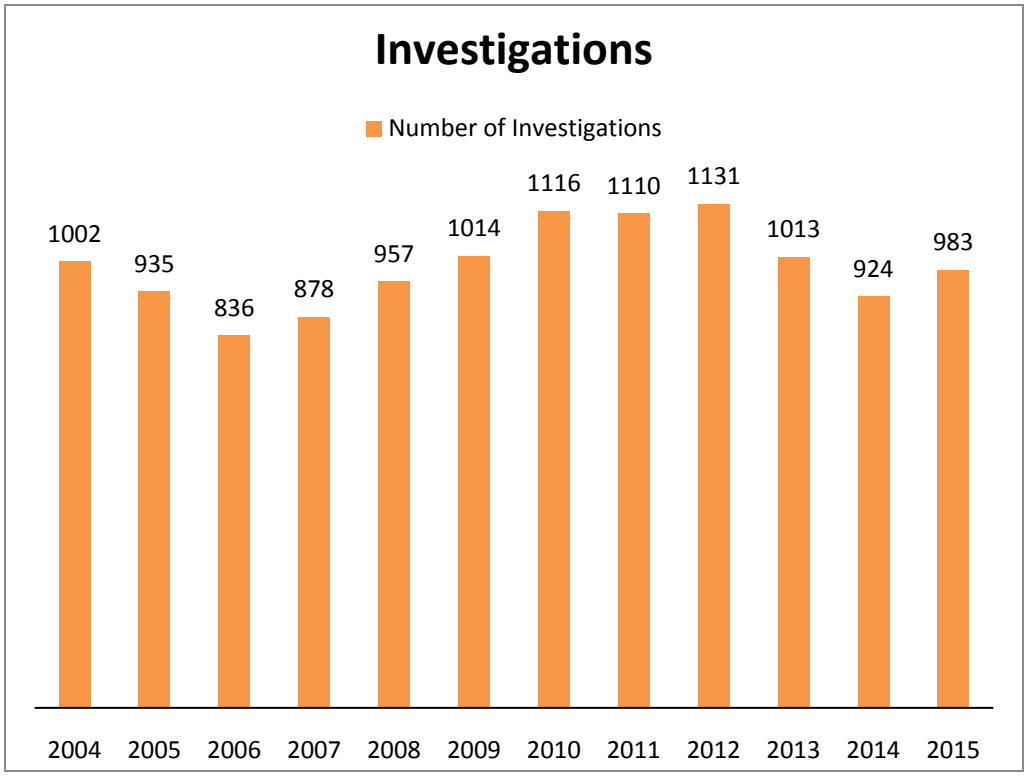


Figure 1

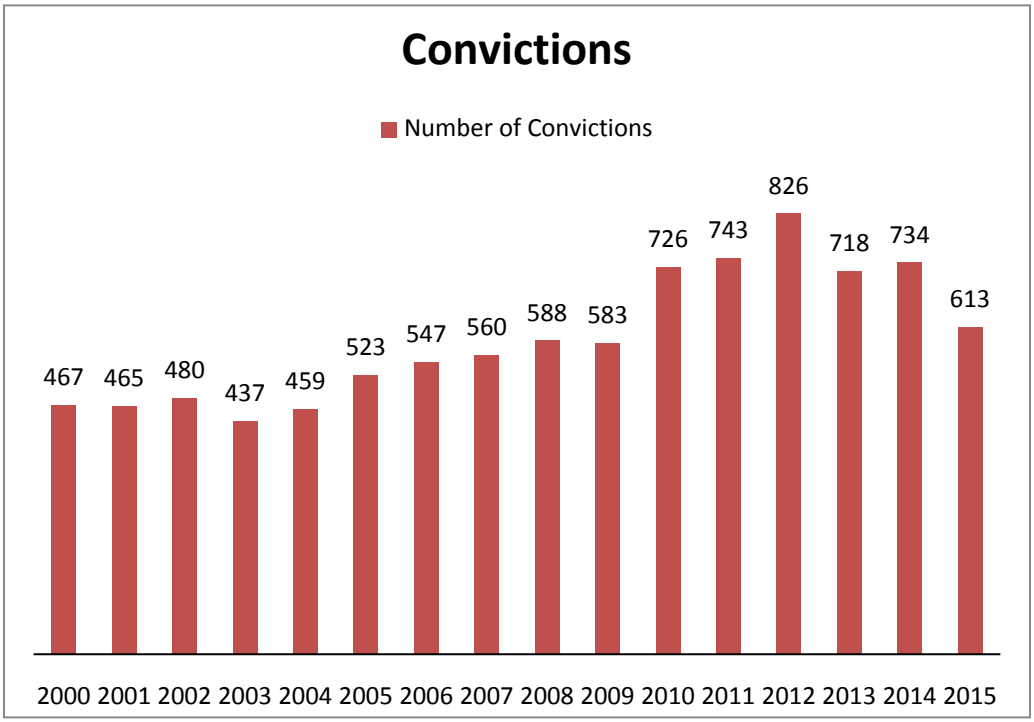


Figure 2

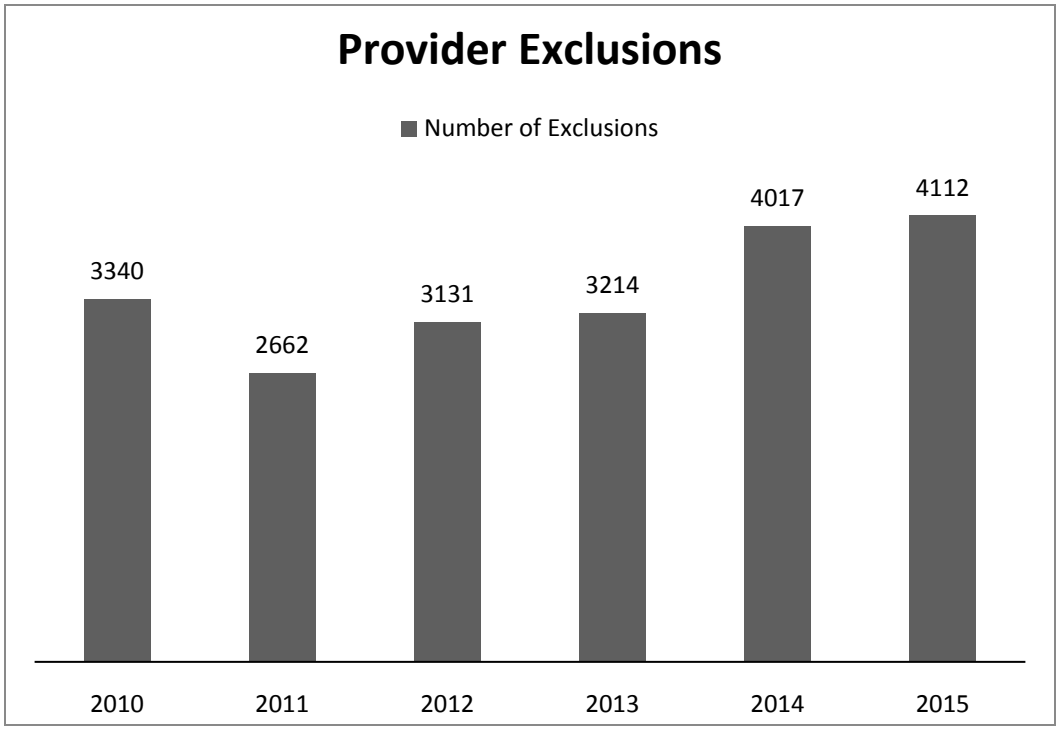


Figure 3

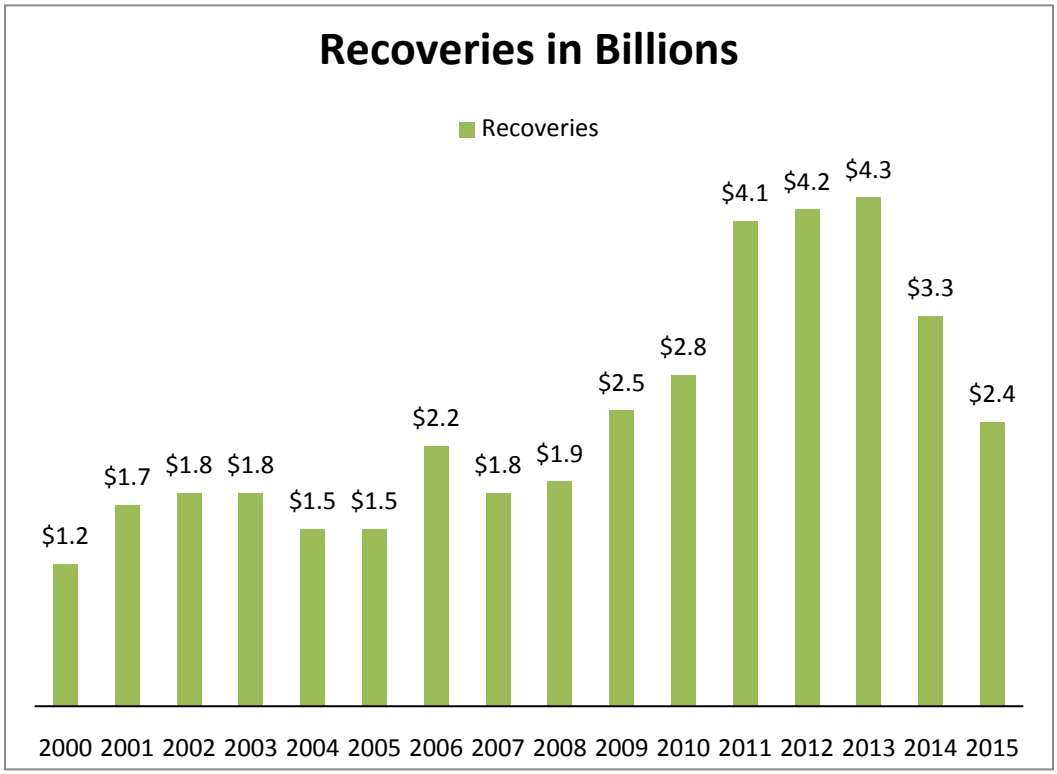


Figure 4

The amount of fraud recoveries spiked dramatically in the years immediately following the passage of the Affordable Care Act, reaching record high numbers and return on investment (Easley, 2014). In recent years, however, the amount of recoveries has tapered off to levels that were typical of times prior to the Act. This could be due to a real decrease in fraud. Schencker (2015b) supports this opinion, claiming the decline in recoveries is largely due to the absence of major drug industry settlements but does not reflect a decrease in government oversight. The trend is the same for the number of fraud investigations and convictions; both sharply rose in the years following the passage of the Act and have since fallen. The practice of excluding providers, suppliers, and other entities from federal program participation was part of the Affordable Care Act. Since implementation of this provision, the number of exclusions has steadily increased; a trend that illustrates a shift toward more proactive regulatory behavior. Evidence also exists that indicates promising changes in provider behavior.

The "sentinel effect" is defined as "the tendency for human performance to improve when participants become aware that their behavior is being evaluated and believe that meaningful consequences could follow" (Piso, 2013, p. 1). Since the passage of the Affordable Care Act, CMS (2014c) has observed a significant reduction in provider billing after the implementation of regulatory actions such as program exclusions for fraudulent providers. Similarly, CMS (2014c) has reported a decline in unnecessary orders and referrals for service. Providers have reduced their billing in areas where program activities are especially focused. For example, DME and home health care billing reductions have been noted in south Florida where fraud prevention system (FPS) models, HEAT Strike Force, and other regulatory activities are concentrated.

Under the Affordable Care Act, providers have been faced with costly new regulations, payment reforms that tie reimbursement with quality and reporting, and the required use of electronic health records. Providers have also witnessed a shift away from privately insured patients to patients enrolled in federal programs like Medicaid, which pays less than private insurance (Gottlieb, 2015). Page (2013) writes that the increased numbers of Medicaid patients may actually provide a financial benefit to primary care providers, who previously treated approximately eight patients each week on a discounted or free basis. Another advantage to the Act deals with the way it has allowed providers to restructure their payer mix. Statistically, people covered through state exchanges tend to be younger and therefore require less medical care (Page, 2013). A provider with a large proportion of elderly Medicare patients can choose to accept exchange patients, thereby diversifying their payer mix. Over time, the provider can determine which plans reimburse optimally and drop lower paying plans.

While overutilization has largely contributed to the increase of health care costs, underutilization has proven to be dangerous to patient health. The key to striking a balance between to two seems to be rooted in imposing quality standards to a system of payment that forces providers to be mindful of the costs of the products and services they administer. The Act accomplishes this by replacing FFS payments with new payment methodologies based on quality and outcomes. Page (2013) states "the new payment methodologies also require sophisticated IT systems, a great deal of data reporting, and shared networks" (p. 3). These alternative payment methodologies require those in the health care field to undergo a cultural transformation, which will force them to work in teams and form clinical judgments in conjunction with other providers for the advancement of patient health. As the Act clearly demonstrates, this is not a choice for providers because those who do not comply with the new standards of quality, reporting, data

sharing, and use of technology are penalized. While all health care entities do not agree with the laws, they must follow them. Some may argue that implementation of certain policies harms their bottom line, but from the perspectives of patient health, cost control, and fraud control, the new approaches are promising.

Theoretical implications. The Affordable Care Act exemplifies how opportunity and rationalization can be related and by reducing one it creates a psychological block against the other. To illustrate, the Act contains several provisions that call for the implementation of new payment models that link payment with performance. In order to achieve the quality benchmarks necessary to receive a bonus, a provider is dissuaded from committing acts of fraud. To further ensure that the provider is in compliance, the Act mandates and appropriates funding for government oversight. Fraud, as a means of secretly solving a non-shareable financial problem, is no longer profitable and not worth the risk. The fraud controls built into the Act do more than simply take the profitability out of trust violation. Cressey (1953) stated that a great deal of fraud is committed due to status gaining or status maintaining behavior. The provisions contained in Subtitle F of Title VI, for example, give the government and states great power to identify fraudulent providers, suppliers and other entities and effectively bar them from operating in any state. This would cause a trust violator to lose their high status position in the community as a doctor. The fact that the provider committed a criminal act goes against the commonly held view of physicians as upstanding members of society. The Act increases the likelihood of being detected and consequently exposed to shame after it comes to light that one has violated these ascribed obligations.

In order to rationalize, a trust violator must frame their behavior in ways that make it appear non-criminal, justified, or part of something for which they are not responsible. The Affordable Care Act dictates that health care entities report performance and financial

information and sanctions are imposed for non-compliance. Various entities, including CMS, the AHRQ, and others compile and disseminate materials intended to educate the health care workforce about the new laws and policies. In other words, the Act speaks to the notion of rationalization in that it makes it very difficult for anyone to "claim ignorance." As previously discussed, Sec. 6402 of Subtitle E of Title VI makes it literally impossible for trust violators to claim ignorance by stating that "a person need not have actual knowledge of the law or specific intent to violate the law" (Health Policy Alternatives, 2010, p. 145) in order to be held liable.

Similarly, endeavors such as the National Strategy to Improve Healthcare Quality that involve a large number of diverse stakeholders throughout the health care industry erode the perception that fraud is an accepted, commonplace behavior. In reference to rationalization, Cressey (1953) wrote that "before being internalized by the individual they exist as group definitions in which crime is appropriate" (p. 96) and that trust violators have an excess of contacts to whom definitions of trust violation are favorable. Many authors (DiChiara, 2015; Page, 2013) mention this idea of a shift in organizational culture away from volume-based care and toward a quality-based, patient-centered approach. This culture change is important because it creates a challenge for would-be trust violators to take on the role of the "generalized other." When an organization adopts policies and procedures that are intended to improve outcomes for patients and these improved outcomes bring in greater financial rewards, the outlook of the people within the organization will change. It will no longer be enticing to sidestep honesty and integrity because doing the right thing feels good and is lucrative.

Limitations

One limitation of this study has to do with the fact that most of the appropriations of the Act were temporary. For example, Sec. 3027 of Subtitle A of Title III involved the funding of

two projects through CMS that allow hospitals to provide gainsharing payments to physicians that represent a portion of savings acquired as a result of joint efforts to improve quality and efficiency. The Act appropriated $1.6 million in 2010 for this demonstration and a final report was submitted to Congress in 2014. While the findings of this particular demonstration project found the gainsharing arrangements successful, it is questionable whether enough time, subjects, and resources are channeled into demonstrations to make the results generalizable. While it must be accepted that funding is limited (especially since sequestration occurred during the rollout of the Act), some findings that seem to point in one direction or another may do so on a summary or tentative basis. Part of this has to do with the fact that the Act is not fully implemented and several demonstrations are still in the data collection phase. There is still much to be learned from this legislation but any findings must also be carefully evaluated for reliability and validity.

Some provisions in the Act were initially passed but were later repealed due to opposition backlash. Such was the case with Sec. 3403 of Subtitle E of Title III; a provision that became derisively known as the "death panel" legislation. This section established a fifteen member Independent Payment Advisory Board tasked with presenting Congress with proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries. Pro-life opponents of the provision feared that it would have forced providers to deny life-saving medical treatment to those on Medicare, infringing on the rights of patients, families, and physicians to make health care choices. The U.S. House of Representatives voted to repeal this portion of the law in June of 2015. Provisions that never came to pass or were repealed were not included among the findings because of their limited applicability and relevance. Therefore it is outside the scope of this study what effect, if any, these failed provisions have had on the health care landscape, however; when a provision is repealed it can impact the federal budget and spending.

Recommendations

Cressey's (1953) study and ensuing theory was groundbreaking and continues to have relevance today when used to explain the causal factors behind trust violation. It also provides cogent psychological profiles of different types of trust violators based on socio-economic status. Workforce demographics and the economy have changed a great deal since the time of Cressey's (1953) study. New inquiry could be carried out to assemble an updated profile of the contemporary trust violator. The Association of Certified Fraud Examiners (n.d.) suggests there is a different breed of occupational offender prevalent in modern society; "one who simply lacks a conscience sufficient to overcome temptation" (p. 11). The Association of Certified Fraud Examiners also point out that Cressey's (1953) theory does not take into account the predatory employee who takes a job with the intent to steal, but these types of individuals seem to be the exception rather than the rule. Cressey's (1953) theory applies to the majority of employees and therefore can be useful for identifying characteristics of at-risk individuals.

A DOJ representative made statements about the future of government anti-fraud priorities at an April, 2016 conference in Chicago. The DOJ will be concentrating their efforts on anti-kickback violations, pharmacy fraud, home health fraud, and particularly on corporate health care fraud. According to Cotter (2016), enforcement entities like the Medicare Strike Force are "expanding with significant numbers of new personnel, a sure harbinger of more investigations and prosecutions" (p. 1). With the high number of Americans enrolled in managed care organizations coupled with the current trend of large hospitals purchasing physician groups, the government intends to hold both corporate entities and the individuals within them criminally liable for fraud. "The past practice of generally responding to larger health care providers' health

care violations in terms of civil sanctions may no longer be the DOJ's approach" (Cotter, 2016, p. 1).

To build on these directions for the future, forthcoming legal impact studies should examine the influence of the Affordable Care Act in 2020 and beyond to obtain a sense of the health care industry after full implementation. "This is a young program that will shore up its processes over time" (Sullivan, 2015, p. 1). Once all aspects of the legislation have been realized, individuals and entities in health care will have assimilated to the new system. Fraud dynamics will evolve with time as well. As people become familiar with the new rules, they will inevitably invent ways to circumvent the law. Will health care fraud control continue to be a priority for future administrations? As President Obama prepares to leave office, both republican and democratic candidates are talking about making changes to the Affordable Care Act. Americans themselves are equally divided; the law is still opposed by more than 50% of the country (Cook, 2016). "Whatever the law's successes, Americans still seem to mostly hate it. At least, they say they hate it, even though they like what it does" (Rampell, 2016, p. 1). Despite the disapproval the Act faces from many, some authors (Rampell, 2016; Surowiecki, 2015) point to reasons why it may endure. Americans believe it is important to have health insurance and that people should not be denied coverage due to pre-existing conditions. They believe that people should pay equal premiums regardless of gender or health history and that poorer individuals and families should receive subsidies to help them afford health insurance. The Affordable Care Act contains elements that decrease pressure, opportunity, and rationalization but fraud will never totally disappear under any system. As this study illustrates, the Act helps reduce fraud but proponents and critics of the Act are able to cite numerous flaws with its construction and public opinion is

deeply divided on the law based on partisanship. The Act is a point on the continuum of health care fraud control, but decidedly not the end.

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