

The Tricare Fraud: A Case Study in Data Analytics for Healthcare Fraud Detection

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Healthcare fraud is a huge problem in the United States and around the world. In fiscal year 2016, the U.S. Department of Justice recovered \$2.5 billion in settlements and judgments from civil cases involving fraud and false claims related to the healthcare industry (DOJ, 2016a). Government agencies as well as insurers can use data analytics to detect health care fraud. The Tricare case is a recent example of healthcare fraud, and involved a dozen doctors, pharmacy owners and marketing professionals who were indicted over a complex scheme involving a fake medical study. Over \$100 million was stolen from Tricare (the federal health program for veterans and their families). This case allows students to learn about health care fraud and its prevention, the role of the auditor, and the increasing use of data analytics in fraud prevention and detection.

INTRODUCTION

Healthcare fraud is a huge problem in the United States and around the world. In fiscal year 2016, the U.S. Department of Justice recovered \$2.5 billion in settlements and judgments from civil cases involving fraud and false claims related to the healthcare industry (DOJ, 2016a). Government agencies as well as insurers can use data analytics to detect health care fraud. Looking at each claim one by one is inefficient and impractical. Predictive models and data analytics are needed to zoom in on cases that require more scrutiny. According to the Association of Certified Fraud Examiners, data analytics, also known as data monitoring and analysis, is one of the most effective anti-fraud controls (ACFE, 2016). Data analytics can be used to spot claim duplicates, spot providers with unusually high claim rates, unusually high billing rates, determine per patient average billing amounts, per patient average prescription ratios, per patient average medical tests, spot other unusual patterns, etc.

This case examines a recent case of healthcare fraud, involving a dozen doctors, pharmacy owners and marketing professionals who were indicted over a complex scheme involving a sham medical study used to steal over \$100 million from Tricare (the federal health program for veterans and their families). The case is ongoing, one defendant recently pleaded guilty, while the other eleven are awaiting trial (DOJ, 2017). It is important to note that the case information is obtained from the indictment, and that the remaining defendants are presumed innocent until proven guilty in a court of law.

COMPOUNDED DRUGS

Compounded drugs are customized medications created by pharmacists by combining, mixing or altering drug ingredients. These medications are tailored to the needs of individual patients. For example, a patient with an allergy to an ingredient in a commercially available drug may require a special formulation of the drug to be made without that ingredient (FDA, 2017). Compounded drugs are not FDA-approved and are typically overseen by state boards of pharmacy.

In recent years, new concerns have materialized about spending for compounded drugs and the potential for fraud abuse. A 2016 report from the Office Inspector General found that spending for compounded topical drugs rose more than 3,400 percent since 2006 for Medicare Part D (OIG, 2016). In its Fiscal Year 2016 Report to Congress, Tricare reported a similar spending pattern, with a 1,156 percent increase in the average cost for a compounded prescription (from \$170 in 2012 to \$2,135 in 2015). In April 2015, Tricare was spending \$483 million per month on compounded prescriptions alone. Additionally, several cases of fraud and abuse in Florida, New Jersey and Minnesota have heightened the concerns about compounded drug billing practices (DOJ 2015a, DOJ 2015b, FBI, 2015).

TRICARE PROGRAM

Tricare is the publicly funded federal health program of the United States Department of Defense Military Health System, providing coverage for 9.5 million active duty and retired military members and their families. Because it is publicly funded, Tricare is required to file an annual report to Congress each year, which includes measures on the program's access, quality and cost) to Congress each year.

Tricare is managed by the Defense Health Agency (DHA), who is responsible for overseeing and administering its services. These services include providing comprehensive health support to its members, including most prescription drugs (Tricare, 2017). Beneficiaries are able to fill their prescriptions through military pharmacies, a home delivery program, network pharmacies, and non-network pharmacies. As part of becoming an accepted network pharmacy, the pharmacy must agree to be bound by and comply with all applicable State and Federal laws (including those laws relating to fraud, waste and prescription drug abuse).

THE FRAUD SCHEME

In 2014, CCMGRX, LLC was formed in Dallas, Texas to market compounded pain and scar creams to current and former U.S. military members and their families, on behalf of compounding pharmacies. According to the indictment, the defendants orchestrated a complicated scheme through this marketing company to generate prescriptions by paying kickbacks to Tricare beneficiaries and prescribing physicians and receiving payments from four compounding pharmacies.

CCMGRX's primary marketing mechanism was a medical study that offered monetary compensation to beneficiaries in exchange for obtaining compounded drugs through CCMGRX's partner pharmacies with their Tricare prescription benefits. These prescriptions were typically for compounded pain creams, scar creams, migraine creams and vitamins. Beneficiaries were paid \$250 per month for each prescription. These payments were disguised as "grants" for participating in a medical study, referred to as the "Patient Safety Initiative", which was supposed to evaluate the safety and efficacy of compounded drugs. This study was actually a sham and was not affiliated with or approved by Tricare. Additionally, the fake medical study was not overseen or run by a medical professional, had no control group and was not designed to gather any useful scientific data.

To disguise the source of the "grants" paid to beneficiaries, the defendants created a fake charity (the Freedom from Pain Foundation), registered it as a tax-exempt charitable organization, and use it to make the payments. The defendants also falsely represented that this charity was independent from CCMGRX, when it was in fact run by the same individuals.

In addition to the payments made to Tricare beneficiaries, CCMGRX paid kickbacks to physicians for writing prescriptions for compounded drugs. The defendants paid \$60 for each compounded pain or scar cream, and \$30 for each compounded vitamin prescription. To mask the payments, CCMGRX disguised the checks as payment for consulting services from the physicians.

In order to maximize the dollar value of claims being submitted to Tricare, CCMGRX employees would determine the highest-paying formulation for these compounded prescriptions by submitting and re-submitting claims to the insurance company. This was done without regard for medical necessity. Once the highest paying formulation was discovered, CCMGRX would send pre-filled prescriptions forms to the physicians for approval. According to the indictment, the physicians spent less than two minutes on the phone with patients they had never met, and wrote prescriptions for patients living in states where the physicians were not licensed. In many cases CMGRX used a doctor's signature stamp to complete prescriptions. From October 2014 through June 2015, Tricare paid more than \$102 million for these compounded drug prescriptions.

As part of the fraud scheme, CCMGRX entered into marketing service agreements with compounding pharmacies, where the pharmacies agreed to pay back a percentage of the gross revenue for the claims submitted to Tricare for prescriptions generated by CCMGRX. The pharmacies attempted to disguise these kickbacks by classifying the payments as "employee wages". The owners of four of these pharmacies are included in the indictment.

AFTERMATH

The individuals named in the indictment face several charges, including conspiracy to commit health care fraud and payment or receipt of illegal remuneration. If convicted, they face prison time and large fines. The FBI and DOD special agents were able to identify and seize millions of dollars in assets from the defendants (including homes, bank accounts and vehicles) but the financial impact of the fraud for Tricare was over \$100 million.

In response to the huge increases in the costs of compounded drugs (from an average of \$6 million per month to a high of \$483 million in April 2015) Tricare began actively screening compound prescriptions and instituted policy changes regarding the ingredients in compound medications. CCMGRX ceased its operations in mid-2015 after these Tricare policy changes in were announced. By June 2015, monthly spending on compounded prescriptions had returned to normal levels.

QUESTIONS

1. Briefly describe the alleged fraud committed against Tricare. What happened?
2. Describe how the fraud triangle may have come into play here. What were some of opportunities, incentives/pressures and attitudes/rationalizations that led to the alleged fraud scheme?
3. How could Tricare have utilized its own historical program data to identify or prevent some of these fraudulent claims? What about data from other federal healthcare providers, such as Medicare or Veterans Affairs?
4. What other types of data might Tricare have analyzed to help prevent or detect this fraud? Consider compounded drugs, Tricare beneficiaries, and network pharmacies.
5. What are some of the "policy changes" that Tricare instituted as they relate to compounded medication? Are they sufficient to prevent this type of abuse from recurring?
6. What are some other examples of risks that make Tricare susceptible to improper payments?
7. Are there any additional data analysis techniques Tricare could utilize as fraud deterrents in the future?
8. Provide some examples of data-related challenges Tricare may face in implementing data analytics to fight healthcare fraud.

TEACHING NOTES

Overview and Learning Objectives

The primary objective of the case is to expose students to the concept of using data analytics to prevent and detect health care fraud. A secondary objective of the case is to reinforce the topic of the fraud triangle. This case is appropriate for use in an auditing course or fraud/forensics course.

The case allows students to learn about health care fraud and its prevention, the role of the auditor, and the increasing use of data analytics in fraud prevention and detection. Today's accounting graduates will be expected to be familiar with data analytics.

Implementation Guidance

This case has been used in an upper-level undergraduate Auditing course. It is also appropriate for a Fraud/Forensics course and could also be used at the graduate level. The case goes beyond what can be found in a traditional textbook. In the Auditing class, it was assigned as an individual project. It could also be assigned as a group project. The case details a real world case of health care fraud at a massive level. If used in an Auditing class, the case can be assigned after a discussion of the use of data analytics. We typically allow approximately 15 minutes of class time to present an overview of the case. We allow students a week of time outside of class to complete the case questions. On the due date, we spend the entire class period (one hour) to discuss the case solutions. The cases take approximately 15-20 minutes each to grade. Instructors can emphasize the demand for fraud control professionals, which should be good news for accounting professionals.

Evidence regarding case efficacy

We have had positive student feedback on the case. Students find it surprising that there is such a problem with health care fraud in this country and even more shocking to learn that it is impossible to know exactly how big the problem is, since it is impossible to know how much fraud has gone undetected.

To help determine efficacy of the case, we administered a survey to an upper level auditing class. An Appendix to this section (Appendix: Evidence of Case Effectiveness) includes the survey questions and results. The survey was completed anonymously to ensure unbiased feedback. A majority of the students have indicated that they "agree" or "strongly agree" with the following statements:

- My understanding of data analytics increased as a result of this case.
- My understanding of the fraud triangle increased as a result of this case.
- My understanding of the role data analytics in healthcare fraud deterrence and detection increased as a result of this case.
- Through this case, my understanding of evaluating risks in the healthcare industry increased.
- I understand the role of data analytics better after completing this case.
- I found this case interesting.

Suggested Solutions to Case Questions

1. Briefly describe the alleged fraud committed against Tricare. What happened?
A marketing company illegally paid Tricare beneficiaries to have prescriptions filled for expensive compounded medications, under the guise of a medical study. The defendants also paid kickbacks to doctors for writing new prescriptions and/or calling in refills for existing patients. The company also received payments from pharmacies for providing these pharmacies the additional business. Tricare paid out over \$100 million for these claims.
2. Describe how the fraud triangle may have come into play here. What were some of opportunities, incentives/pressures and attitudes/rationalizations that led to the alleged fraud scheme?
Opportunities: Weak controls at Tricare; inconsistent policies in relation to the reimbursement for compounded medications (ingredients did not have to be FDA-approved)

Incentives/Pressures: Live/maintain extravagant lifestyle – FBI identified bank accounts, investment accounts, numerous vehicles, boats, recreational vehicles, firearms, jewelry, and artwork that were traceable to the alleged fraud.

Attitudes/Rationalization: The parties involved may have felt that it was ok to cheat the government, that the government has a lot of money so it is ok. They may have felt that it was a victimless crime.

3. How could Tricare have utilized its own historical program data to identify or prevent some of these fraudulent claims? What about data from other federal healthcare providers?

For Tricare program data, analyze the following on a monthly, quarterly or annual basis:

- Total dollar amount paid for compounded drug prescriptions
- Compounded drug prescriptions as a percentage of total claims paid
- Compounded drug prescriptions by pharmacy setting (mail order, military treatment facility, retail)
- Compare compounded prescription drug costs to other Federal Healthcare Programs (for ex. Medicare or Veterans Affairs)

From other Federal healthcare providers:

- Compare the above data metrics for Tricare to Medicare or Veterans Affairs
- Compare payment practices with these other healthcare providers

4. What other types of data might Tricare have analyzed to help prevent or detect this fraud? Consider compounded drugs, Tricare beneficiaries, and network pharmacies.

For compounded drug data, analyze the following on a weekly, monthly, or annual basis:

- Average cost per compounded prescription
- Total number of claims for compounded prescriptions

For individual beneficiaries, analyze the following on a monthly or annual basis:

- Average number of different types of drug per beneficiary
- Duplicates claims analysis
- Average number of compounded prescriptions per beneficiary
- Percentage of prescriptions received that were for compounded drugs
- Incidence of multiple claims or rejections for prescriptions
- Percentage with an excess supply of prescriptions for compounded drugs – defined as 500+ days of medication received in a 365 day period.
- Average number of prescribers for compounded drugs
- Track prescriptions per beneficiary category – retirees and dependents, active duty personnel and dependents, non-active duty and dependents.

For pharmacies, analyze the following on a monthly or annual basis:

- Average number of compounded prescriptions filled per pharmacy
- Percentage of total prescriptions filled that were for compounded drugs
- Number of physicians prescribing compounded drugs
- Number of prescriptions filled per physician

5. What are some of the “policy changes” that Tricare instituted as they relate to compounded medication? Are they sufficient to prevent this type of abuse from recurring?

On May 1, 2015, Tricare began a new screening process of all the ingredients included in compounded drugs. DHA is allowed to determine whether prescriptions meet coverage criteria by requiring all ingredients in compounded medications to be approved by the FDA. This policy ensures that Tricare is paying only for compounds proven to be safe and effective, and is in agreement with existing Tricare policies prohibiting payment for procedures and medications not approved by the FDA. This policy is consistent with the policies of private insurers, as well as the policies of Medicare and the VA.

6. What are some other high-risk areas that could potentially make Tricare susceptible to improper payments in the future?
 - Patient eligibility
 - Duplicate claims
 - Prior Authorization
 - Other health insurance/third party liability
 - Timely filing
 - Sanctioned provider/beneficiary list
 - Pricing discrepancies
7. What are some additional data analysis techniques for fraud detection that Tricare may utilize?
 - Benford's law
 - Data mining to classify, cluster and segment data
 - Duplicates detection
 - Pattern recognition
 - Other analytics techniques:
 - Look at high/low values
 - Identify anomalies and outliers
 - Classify data and transactions based on specific factors (geography, age, date, etc.)
8. Provide some examples of data-related challenges Tricare may face in implementing data analytics to fight healthcare fraud.
 - Data acquisition, organization and storage processes
 - Data security and integrity
 - Privacy and confidentiality of beneficiary data
 - Increased costs - procuring and maintaining up-to-date data analytics software
 - Additional employee training; steep learning curve
 - Evolution of fraud schemes

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APPENDIX: EVIDENCE OF CASE EFFECTIVENESS

	Survey Question	Response*	1	2	3	4	5
1.	My understanding of data analytics increased as a result of this case.	Response Frequency % Frequency	-	-	2 17%	7 58%	3 25%
2.	My understanding of the fraud triangle increased as a result of this case.	Response Frequency % Frequency	-	-	3 25%	6 50%	3 25%
3.	My understanding of the role data analytics in healthcare fraud deterrence and detection increased as a result of this case.	Response Frequency % Frequency	-	-	3 25%	6 50%	3 25%
4.	Through this case, my understanding of evaluating risks in the healthcare industry increased	Response Frequency % Frequency	-	-	4 33%	4 33%	4 33%
5.	I understand the role of data analytics better after completing this case.	Response Frequency % Frequency	-	-	3 25%	5 42%	4 33%
6.	I found this case interesting.	Response Frequency % Frequency	-	-	3 25%	3 25%	6 50%

*Students were required to respond to a questionnaire designed using the following scale:
 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly Agree