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Leadership Strategies for Combating Medicare Fraud

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Walden University

College of Management and Technology

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Taniesha Grant

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Walden University
2017

Abstract

Leadership Strategies for Combating Medicare Fraud

by

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MBA, Strayer University, 2005

BS, Southern University A&M College, 2003

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Business Administration

Walden University

October 2017

Abstract

Healthcare fraud is threatening the economic stability of the U.S. healthcare system and negatively affecting organizational costs. Financial losses from healthcare fraud account for approximately \$80 billion per year of the \$2.4 trillion healthcare budget. Leadership strategies that may aid in combating Medicare fraud were explored in this qualitative single case study. The criminal violation of trust theory guided the study as it provides healthcare leaders with an understanding of the portion of the fraud triangle over which they have the most control to combat fraud: the opportunity to commit fraud. Data were gathered from review of publically available documents and information received from 10 semistructured interviews with health care leaders in the Mid-Atlantic area of the United States who have the responsibility of overseeing, developing, monitoring, or implementing control mechanisms for Medicare services. Yin's 5-step data analysis process and thematic analysis were used to analyze the data. Three key themes emerged from the study: an effective control environment, an adequate accounting system, and adequate control procedures. Health care leaders in the study recognized that the control environment plays a crucial role on the integrity and ethical values of its employees. The health care leaders acknowledged that an effective accounting system ensures Medicare funds are properly tracked and accounted for. Health care leaders also shared that adequate control procedures aid in deterring fraud and provide reasonable assurance that leaders meet the fiscal and programmatic objectives of the Medicare program. Social implications include reducing healthcare costs for U.S. citizens and creating control strategies that may contribute to a healthcare system to lead to a healthier citizenry.

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Dedication

I dedicate this doctoral study to my father, the late Detective Michael Grant, who always pushed me to challenge myself no matter the task. My father instilled in me the importance of hard work, dedication, and perseverance and I am forever grateful. I miss my father deeply and wish he were here to witness this chapter in my life. I can only hope that my accomplishments, both professionally and academically, are a testament to the high standards that my dad demanded from me on an everyday basis.

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Section 1: Foundation of the Study

The cost of providing healthcare to an aging population is a pressing issue in the United States. In 2011, the Medicare program provided medical benefits to over 49 million elderly and disabled U.S. citizens with expenditures totaling \$549 billion (Centers for Medicare & Medicaid Services [CMS], 2013). Medicare also provides a lucrative business opportunity for criminals who strive to defraud the program (Hill, Hunter, Johnson, & Coustasse, 2014). Medicare fraud occurs when individuals knowingly and intentionally make false statements to collect Medicare reimbursement illegitimately (DiSantostefano, 2013; Hill et al., 2014). An organization receiving Medicare funds must ensure that it has an effective internal control system to decrease the probability of waste, fraud, or misuse of agency resources (Mayhew & Murphy, 2012; Murphy & Free, 2016; Schuchter & Levi, 2016). Widely interpreted, internal controls consist of policies and procedures that are developed and maintained to provide reasonable assurance that leaders achieve the fiscal and programmatic goals of the agency (Johnson, Hartong, & Kidd, 2014). Ongoing efforts to develop and implement effective strategies and systems to address the problem of healthcare fraud require a holistic understanding of the factors that influence the design of such systems (U.S. Department of Health and Human Services [HHS], 2013; Schuchter & Levi, 2016). The purpose of this qualitative, descriptive case study was to explore control strategies that healthcare leaders use to combat Medicare fraud.

Background of the Problem

CMS contracts with Medicare Administrative Contractors to operate as intermediaries between the federal government and healthcare providers (Showalter, 2014). Although most healthcare providers are honest, a minority of providers who are intent on abusing the healthcare system have created the need for robust laws and control strategies that combat healthcare fraud (Federal Bureau of Investigation [FBI], 2013; Miller, 2013a). Fraudulent activity has plagued the healthcare environment causing a substantial financial burden on healthcare spending and businesses. The cost of Medicare fraud can have negative consequences both financially and to the reputation of organizations. Consequently, healthcare leaders require robust fraud preventive measures to address the phenomenon.

Problem Statement

Healthcare fraud is threatening the economic stability of the U.S. healthcare system and negatively impacting business costs (FBI, 2013; Krouse, 2015). Financial losses due to healthcare fraud account for approximately \$80 billion per year of the \$2.4 trillion U.S. healthcare budget (Miller, 2013a). The general business problem is Medicare fraud costs healthcare businesses time, money, and reputation. The specific business problem is some healthcare leaders may lack knowledge regarding adequate control strategies that aid in combating Medicare fraud.

Purpose Statement

The purpose of this descriptive qualitative single case study was to explore control strategies that healthcare leaders use to combat Medicare fraud. I interviewed 10

leaders from a single organization who have the responsibility of overseeing, developing, monitoring, or implementing successful control mechanisms for Medicare services in the Mid-Atlantic area of the United States. The findings from this study may support business leaders' efforts to identify and implement effective control strategies to reduce Medicare fraud. Effective control strategies might contribute to social change by reducing healthcare bills for U.S. citizens. Control strategies may contribute to a healthcare system that leads to a healthier citizenry.

Nature of the Study

Qualitative research is designed to understand human behavior, opinions, and experience in the natural world (Maxwell, 2012). In quantitative studies, researchers gather numerical data and test hypotheses (Bishop & Lexchin, 2013; Frels & Onwuegbuzie, 2013). Mixed method research utilizes both quantitative and qualitative methods to study a phenomenon (Spillman, 2014). The exploratory nature of this study did not align with quantitative or mixed method research. The intent of this study was to understand the strategies healthcare leaders use to combat Medicare fraud. The objective was not to establish relationships between or among the variables that influence Medicare fraud, nor was the objective to analyze trends and ratios. Thus, the qualitative approach to address in-depth exploration and description of leadership behaviors relative to Medicare fraud reduction was more appropriate for this study.

Prior to selecting a single case study approach, I reviewed several other qualitative research designs: phenomenology, narrative research, grounded theory, and ethnography. The goal of the phenomenology design is to understand participants' lived

experiences; the data collection efforts focus solely on interviews (Hou, Ko, & Shu, 2013). Narrative research combines opinions and stories from the lives of participants with the viewpoint of the researcher (Petty, Thomson, & Stew, 2012). In grounded theory designs, researchers formulate hypotheses from theories (Petty et al., 2012). Ethnography researchers explore a cultural group over an extensive period by collecting data on group members (Manuj & Pohlen, 2012). Case study research can consist of a single case or multiple cases to develop detailed descriptions of phenomena (Yin, 2014). Case study researchers can use multiple sources of information (Yin, 2014). Given the alternative research designs are not as comprehensive or offer in-depth exploration of the phenomena, a case study was the preferred design.

Research Question

The following central research question guided this study:

RQ: What control strategies do healthcare leaders use to combat Medicare fraud?

The goal was to delve deeply into the complex set of issues surrounding control efforts aimed at reducing Medicare fraud. I designed the interview questions to provide data in addressing the research question.

Interview Questions

In a qualitative study, interviews are a crucial part of data collection (Braun & Clarke, 2013). Case study questions should center on the unique feature of interest (Bernard, 2013). I asked study participants the following interview questions in order to delve deeply into the problem surrounding control efforts that may aid in combating Medicare fraud:

1. What are some examples of actions that may constitute Medicare fraud?
2. What control strategies have your organization implemented to combat Medicare fraud?
3. Which control strategies do you perceive as having been most effective in combating Medicare fraud?
4. What internal or external factors may influence the design of control systems aimed to combat Medicare fraud?
5. What additional control strategies would you recommend that organizations use to aid in combating Medicare fraud?

Conceptual Framework

Cressey (1953), in studying fraudsters, defined the central phenomenon as the criminal violation of financial trust. Cressey discovered that while some people who were in a position of financial trust violated that trust, others, who were in the same or like position, did not violate that trust (Cressey, 1953). Cressey concluded that (a) rationalization is necessary for criminal violation to occur, (b) culture must be present that sanctions trust violations, and (c) linkage must occur between the social and economic position of the trust violator. Modern professional criminologists and researchers have credited Cressey with the development of the fraud triangle, Figure 1 (Association of Certified Fraud Examiners [ACFE], 2014). In this model, three factors must occur for fraud to be committed: a perception of financial pressure, a rationalization to commit fraud, and the opportunity to commit fraud (ACFE, 2014).

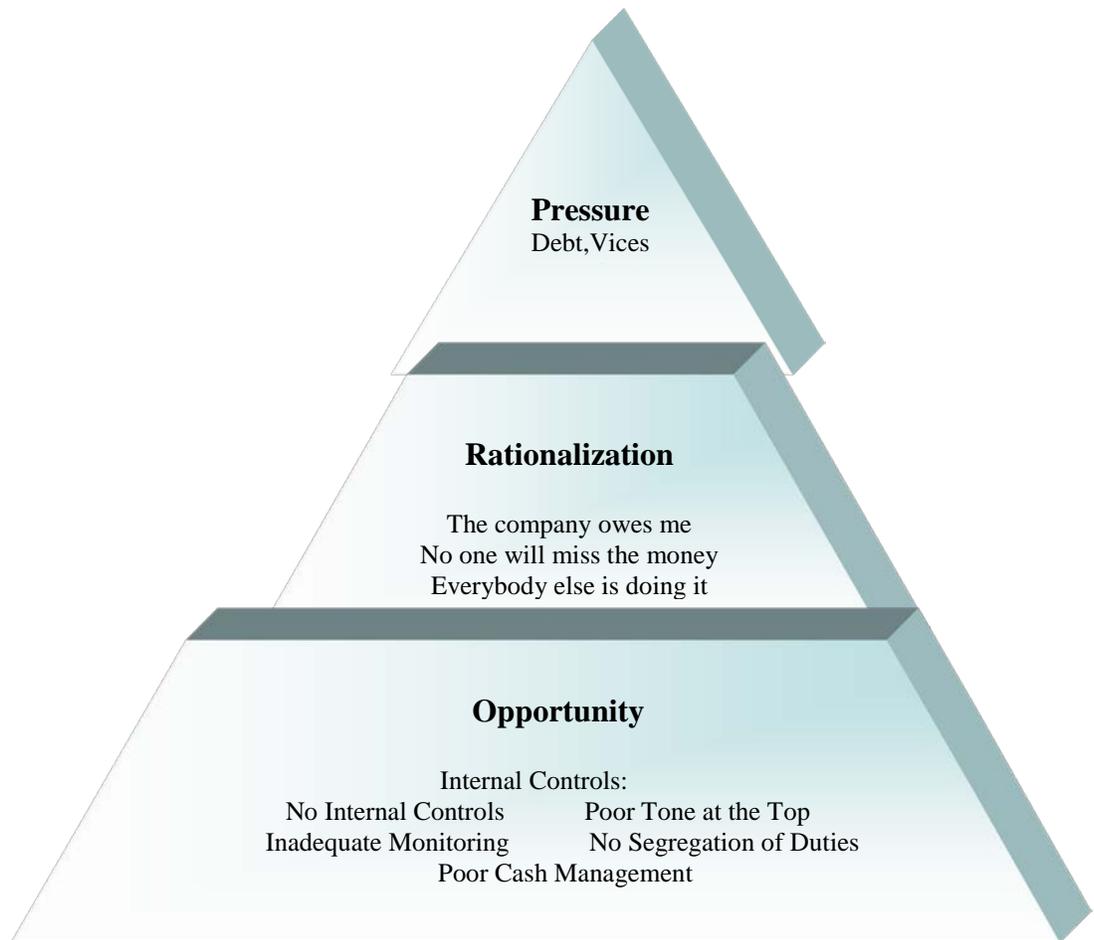


Figure 1. The Fraud Triangle. This figure illustrates the three elements of the fraud triangle.

In the Fraud Triangle, pressure is the need felt by the individual who commits fraud (Murphy & Free, 2016). The need might encompass a real financial need or a nonmonetary need (Murphy & Free, 2016). The financial need might include high medical bills or debts. The nonmonetary necessity may be high pressure for an individual to perform well on the job. Rationalizing is the behavior by which an individual determines that it is acceptable to commit fraud (Murphy & Free, 2016).

Regarding rationalizing fraud, rationalizations can include (a) moral justification, by interpreting an act as being morally worthy; (b) advantageous comparison, by comparing the act to something worse; (c) euphemistic labeling, or using convoluted language to make the act look better; (d) minimizing, ignoring, or misconstruing the consequences of the act; (e) denial of or blaming the victim; (f) displacing responsibility by blaming someone else; and (g) diffusing responsibility by blaming everyone else (Mayhew & Murphy, 2012; Murphy & Free, 2016; Schuchter & Levi, 2016). The opportunity to commit fraud is possible when employees have access to company assets and information that allows them to both commit and conceal fraud (Verschoor, 2015). When an organization has weak internal controls, fraudsters may have an opportunity to commit fraud (Verschoor, 2015).

The healthcare fraud phenomenon is the result of multiple contributing factors including self-interest or financial gain on the part of perpetrators and a lack of organizational education, training, and effective internal controls (Mayhew & Murphy, 2012; Murphy & Free, 2016; Schuchter & Levi, 2016). Cressey's criminal violation of financial trust theory serves as an appropriate choice as the conceptual framework for this study. Healthcare leaders can exert more control over fraud by working on the portion of Cressey's fraud triangle over which they have the most control: the opportunity to commit fraud. Company leaders can reduce Medicare fraud when they limit opportunities for fraud. Management may be unable to control an employee's needs or rationalizations (Verschoor, 2015), but management can take specific action to reduce the risk of

opportunity when they implement and enforce stronger internal controls (Verschoor, 2015).

Operational Definitions

Fake storefront scheme: A fake storefront scheme is a method in which a fraudulent health care entity creates a fictitious storefront location for the purposes of submitting fraudulent billings to health care providers in an attempt to collect funds (Miller, 2013a).

Improper payment: Improper payment is a healthcare payment made due to fraud, abusive practices, or for billing errors (Thornton, Brinkhuis, Amrit, & Aly, 2015).

Kickback: Kickback is a scheme in which providers or others offer, solicit, or accept money or gifts in exchange for referral of services that may be paid by Medicare or Medicaid (FBI, 2013).

Pay and chase model: The pay and chase model is a traditional model where the government pays providers for submitted claims, then enforcement officials chase down fraud and abuse after the fact (Iglehart, 2010).

Phantom billing: Phantom billing is a scheme in which the medical provider bills for unnecessary or undelivered healthcare products or services (Thornton et al., 2015).

Remuneration: Remuneration consists of anything of value such as kickbacks, bribes, rebates, and gifts, as well as leases, equipment, employment contracts, and other arrangements that depart from fair market value (Bucci, 2014).

Self-referral: Self-referral is a controversial practice in which a physician refers patients to other facilities such as clinical laboratories and ambulatory surgery centers in which the physician has a financial interest (Krause, 2013).

Unbundling: Unbundling is a fraudulent billing practice of submitting multiple bills for a procedure or visit instead of submitting one bill in an effort to receive a higher reimbursement (Thornton et al., 2015).

Upcoding: Upcoding is a billing practice of using codes that result in higher reimbursement rates than the level of service justifies (Thornton et al., 2015).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions are elements in the study that are out of the researcher's control but are necessary to ensure relevance in the study (Simon, 2011). I assumed that the interview process and supporting documentation would truthfully represent the problem of Medicare fraud. I also assumed that the interview was free from bias and research participants provided responses independent of their peers' thoughts and opinions. In addition, I assumed that participants had a general knowledge of the laws and regulations pertaining to Medicare fraud. The last assumption was that supporting documentation provided an accurate and current portrayal on structural and individual perceptions of Medicare fraud controls.

Limitations

Limitations consist of potential weaknesses in the study that are out of the researcher's control (Simon, 2011). Although qualitative research is a popular method of

study, researchers recognize it has limitations (Bailey, 2014; Maxwell, 2012). One limitation in this study was the findings represented only a particular group of healthcare leaders in the entity. A second limitation was that findings from this case study might not be transferable across other groups or populations such as the Medicaid program and privately funded healthcare programs.

Delimitations

Delimitations are within the researcher's control and are the scope limitations of the study (Simon, 2011). The scope of this study was limited to healthcare entities. Delimitations include the sample population, sample size, and research problem. For example, this study centered on fraud in the Medicare program versus other healthcare programs. Because of the desired geographic location, the research population had a delimitation to leadership perspectives regarding controls methods and systems to the prevention of Medicare fraud in the Mid-Atlantic area only. This study centered on fraud control strategies and methods for individuals and organizations that provide health or administrative services to Medicare beneficiaries. Another delimitation was the participant sample excluded Medicare beneficiaries.

Significance of the Study

Contribution to Business Practice

This qualitative, descriptive case study may facilitate the identification and description of managerial practices and organizational structures that influence control systems in response to the problem of Medicare fraud and abuse. Control systems aid in motivating and controlling the behaviors of all levels of employees in an organization

(Murphy & Free, 2016; Rodgers, 2012; Schuchter & Levi, 2016). Findings from this study might contribute to the development of control models needed for the introduction of effective and integrative fraud prevention strategies. The identification of effective control models could enhance the capability and efficiency of health care leaders and organizations to provide medical services. Effective strategies may allow health care providers and service organizations generate health care cost savings from decreases in fraudulent activity.

Implications for Social Change

From 1960 to 2008, U.S. healthcare spending grew exponentially from approximately \$150 billion to \$2.2 trillion, which represented an estimated 6% annual growth rate (Chernew, 2011). In 2012, the United States healthcare spending grew 3.7%, reaching approximately \$2.8 trillion (CMS, 2014). The rising healthcare costs, as illustrated by the statistic from 1960 to 2008 and in 2012 (CMS, 2014; Chernew, 2011), are constraining economic growth, consuming increasing portions of the nation's gross domestic product, and placing added burdens on families, businesses, and government (DiSantostefano, 2013; Wisk et al., 2014). Healthcare leaders may benefit from an increased understanding of effective internal control strategies and techniques and might apply this knowledge to efforts to stop the escalating growth of Medicare costs to ensure Medicare trust funds remain available to meet the specific healthcare needs of the most vulnerable U.S. citizens.

A Review of the Professional and Academic Literature

The goal of this literature review was to provide a conceptual framework and confirmation of the basis of inquiry for the principal RQ: What control strategies do healthcare leaders use to combat Medicare fraud? The purpose of this descriptive qualitative single case study was to explore internal control strategies that healthcare leaders use to combat Medicare fraud. The organization of the literature review begins with an overview of the Medicare program, focusing on the practicality, key attributes, and financial stability of the program. The literature review consists of an overview of Medicare fraud and conceptual framework used in this study. In this review, I explore common Medicare fraud schemes and major laws governing Medicare fraud. Next, the review includes a discussion on the importance of internal control procedures as a tool in reducing and possibly preventing Medicare fraud. The literature review concludes with an explanation of the general problem of Medicare fraud increasing healthcare and business costs, consequently increasing the need for healthcare entities to develop and implement robust control methods to reduce Medicare fraud.

The strategy for the literature review was a thematic review, organized around the major themes of this study. In this strategic approach, my sources included the most relevant theoretical and empirical studies to answer the research question. The strategy included researching sources of peer-reviewed and other scholarly journal articles, books, and government documents. Relevant articles were collected from online databases available through the Laureate University Library, with detailed catalogues used including Business Source Complete/Premiere, ProQuest Central, ScienceDirect,

ABI/INFORM Complete, Sage Journals, and Academic Search Complete. Relevant books were obtained through local public and college libraries. Government sources relevant to the study topic were obtained via Internet research tools such as Google Scholar. Government websites served as the source for identified government sources. Words and phrases searched included *criminal violations trust theory, compliance programs, fraud triangle, healthcare fraud, internal controls, Medicare, Medicare fraud schemes, and Medicare laws*. The literature review included 83 references. The year of publication for 71 (86%) of these references was within 5 years of 2017. Seventy five of the 83 references (90%) were peer-reviewed journal articles.

The Medicare Program

Congress enacted the Medicare program in 1965 (Oberlander, 2015). The initial purpose of the Medicare program was a health insurance program for elderly Americans (Fried, 2015). Since its inception, Medicare has provided millions of older North Americans with financial security and access to medical care (Altman, 2015). Since 1972, Medicare has provided coverage to persons under age 65 with permanent disabilities and end-stage renal disease (Oberlander, 2015; Tarraf, Jensen, & González, 2016).

Medicare is a government health insurance program that assists with care in hospitals, skilled nursing facilities, hospice care facilities, and some home health care (Novelli & Banerjee 2015; Oberlander, 2015). Coverage can also include physician services and prescription drugs (Roberts, Gellad, & Skinner, 2016). The government expanded Medicare benefits for preventative care and drug coverage (Wilensky, 2015).

Medicare is financed through a combination of taxes and general revenues, with additional financing coming from Medicare beneficiary premiums (Moon, 2015). In 2011, the Medicare program accounted for approximately 15% of the federal budget (Soriano, 2013). As a result of increasing enrollment and the Affordable Care Act, Medicare spending growth is expected to average 6.3% annually from 2013 through 2020, with coverage expanding to an additional 26 million people by 2024 (Adepoju, Preston, & Gonzales, 2015; Emanuel, 2014). Medicare spending is projected to increase to 24% of all federal spending and to equal 6% of the gross domestic product by 2037, which is prompting policy makers to once again consider ways to control spending growth of the program (Eibner, Goldman, Sullivan, & Garber, 2013).

Medicare is a large and multifaceted program, which makes it susceptible to fraud, waste, and abuse (Hill et al., 2014). In 2010, Medicare had approximately \$48 billion in improper payments, not including improper payments in its prescription drug benefit program (U.S. Government Accountability Office, 2013). CMS administers the Medicare program and is responsible for the integrity of the program (DiSantostefano, 2013). Since February 2011, congressional committees held over 20 hearings on the integrity of the Medicare program (U.S. Government Accountability Office, 2013). A primary focus of the CMS administration has been reducing improper payments. In 2012, CMS estimated that it would reduce improper payments in all parts of Medicare by more than \$44 billion (U.S. Government Accountability Office, 2013). CMS faces challenges in the future as the number of Medicare beneficiaries is anticipated to rapidly increase (DiSantostefano, 2013). The projected increase in spending and the large

number of participating providers presents an increased opportunity for individuals who seek to commit Medicare fraud (DiSantostefano, 2013; Eibner et al., 2013). The combination of these factors may pose a risk to the solvency of the Medicare trust fund.

Medicare Fraud

Studies addressing the problem of healthcare fraud have focused on analysis of the major regulations governing the investigation of healthcare fraud (DiSantostefano, 2013; Taormina, 2013). Certain studies focused on methodologies that may prove effective to identify billing errors and claims (Dietz, Gamble, Marchlowska, & Wheeler, 2013; Hsu, Lee, & Su, 2013). Fraud is an intentional deception resulting in a financial or personal gain (Hill et al., 2014). Fraud is defined as making dishonest statements or representations of material facts for financial gain for which no privilege would otherwise exist (DiSantostefano, 2013). Millions of dollars are lost yearly because of Medicare fraud (DiSantostefano, 2013; Hill et al., 2014). Despite the vast amount of financial resources committed to fraud monitoring and control efforts, concerns regarding the effectiveness of fraud mitigation efforts persist (U.S. Government Accountability Office, 2013). Researchers suggest that individuals who are not trustworthy and subconsciously challenged by their actions are the main perpetrators of fraud (Busch, 2012). The perpetrators of Medicare fraud include, but are not limited to, providers, insured patients, and insurance agents (Busch, 2012).

Healthcare fraud is a form of white collar crime that creates financial losses affecting many, such as patients, insurance companies, government, providers, suppliers, taxpayers, and businesses that offer employee health coverage (DiSantostefano, 2013;

Miller, 2013a). White-collar crime is a crime that violates trust and is not dependent on the application of violence or physical force (Miller, 2013a). Individuals or organizations commit such crimes for the sole purpose of obtaining personal or competitive business advantage (DiSantostefano, 2013). Numerous incidences of inappropriate billings, which have resulted in patient harm, have compounded financial losses. Fraud has infiltrated into all areas of healthcare including hospital activities, medical and dental practice activities, and other human health activities such as occupational and behavioral health (DiSantostefano, 2013). Countless fraudulent schemes are threatening the funding source that provides care for the elderly and disabled, who are the nation's most vulnerable citizens (FBI, 2013). Consequently, the fraud schemes are hurting honest patients, physicians, and legitimate businesses. Schemes may go undetected as perpetrators of fraud transfer their operations from one location to another (FBI, 2013; Hill et al., 2014).

In fiscal year 2010, the federal government recovered nearly \$4 billion in judgments, settlements, and administrative impositions in healthcare fraud cases and proceedings (DiSantostefano, 2013). Although Medicare fraud totals approximately \$80 billion, partnerships within governmental agencies recovered over \$4.2 billion of taxpayer dollars in 2012 (Hill et al., 2014; Miller, 2013a). Hill et al. (2014) explained that Medicare fraud is a sizeable, but decreasing, issue in the United States because of new investments in governmental partnerships and innovative detection systems. Dietz et al. (2013), on the other hand, stated that Medicare fraud remains a sizeable issue in the United States.

The U.S. Government Accountability Office (GAO) has continuously labeled Medicare as a high-risk program because its size, complexity, and susceptibility to payment errors from various causes have made it highly vulnerable to fraud (GAO, 2013). From 2008 to 2011, the federal government Healthcare Fraud Prevention and Enforcement Action Team charged over 1,400 defendants who defrauded the Medicare program for more than \$5 billion (Miller, 2013a). In 2011, the U.S. Department of Justice (DOJ) convicted 323 defendants who collectively billed the Medicare program more than \$1 billion in fraudulent claims (DOJ, 2012a). While there have been numerous convictions for multimillion-dollar schemes that defrauded the Medicare program, the extent of the problem is unknown (Ogrosky, 2015; DOJ, 2012a). Although defrauding federal government programs is a felony, the Medicare program has become a lucrative business for criminals in America (DOJe, 2012b).

Some research documented that preventing Medicare fraud is a challenging process because of inadequate safeguards in the system (Hill et al., 2014). Government agencies such as CMS, DOJ, FBI, and the Department of Health and Human Services (HHS) have vigorously joined to combat Medicare fraud. Although there has been some improvement, fraud continues to plague the Medicare program (FBI, 2013; GAO, 2013).

Efforts to reduce and prevent Medicare fraud within healthcare entities require a general understanding and knowledge of the fraud schemes and activity that may occur. Health care leaders should understand the internal controls that aid in preventing fraud. As government and businesses becomes more proficient to understand controls that aid in

combating Medicare fraud, identification, and eradication of schemes are more likely to occur (FBI, 2013; Hill et al., 2014; GAO, 2013).

Conceptual Frameworks

Scholars studying the problem of Medicare fraud have applied frameworks aimed to explore the internal and external business factors designed to control fraud, waste, and abuse (Evbayiro, 2011; Musul & Ekin, 2017). Evbayiro (2011) applied agency theory to examine the roles of providers and entities' ability to ensure the integrity of government-run healthcare programs. A tenet of agency theory is that the most efficient and effective way to establish relationships is where one party (i.e., agent) delegates work, while another party (i.e., principal) performs the work (Evbayiro, 2011). For example, in businesses, the shareholders delegate to company management functions to perform on their behalf. A conjecture of agency theory is that both parties are driven by self-interest, which creates unavoidable conflicts. If both parties are motivated by self-interest, then they are likely to pursue self-interested objectives. Yet, in businesses, shareholders are supposed to act in the sole interest of their management team. Within agency theory is agency loss, which is a term used to identify when an agent's objectives may or may not align with the principal's interest. For instance, when a shareholder acts consistently with management's interests, agency loss is zero. Self-interest is a major culprit that leads to high agency loss. Agency loss is reduced when the (a) principal and agent share common interest, and (b) principal is aware of the consequences of the agent's activities (Evbayiro, 2011). The main assumption to agency theory is that self-interested agents who seek to maximize personal financial wealth must be present. The challenge for

business leaders is to get agents to either set aside their self-interest or work towards maximizing their personal wealth while still maximizing the wealth of the principal. A standard of agency duty is necessary because the likelihood for differences between the two parties' interests exists. Evcbayiro's application of agency theory to the relationship between health care providers and the government reveals that the government is at a disadvantage over providers because of the information providers share with patients. Evcbayiro (2011) explained that providers who are intent on abusing the healthcare system use information to promote self-interest to the harm of public programs such as Medicare and Medicaid. The federal government has designated HHS-OIG and CMS to function as overseers over providers' activities in an attempt to detect and prevent health care fraud and abuse (Evcbayiro, 2011).

Evcbayiro (2011) also applied accountability theory to examine the roles of providers and entities' ability to ensure the integrity of government-run healthcare programs. Accountability theory explains how the perceived need to rationalize behaviors causes one to feel accountable for the manner in which an individual reaches decisions. Because of the perceived need to account for decisions and outcomes, one might feel more compelled to ponder deeply about his or her behaviors. Accountability theory is often applied in organizational research. The two most prevalent uses to understand accountability are as a virtue and mechanism (Evcbayiro, 2011). As a virtue, an individual shows a willingness to accept responsibility for his or her actions. As a mechanism, an individual has a duty to explain his or her actions to another person who can pass judgement and has the authority to punish or reward the individual for his or her

actions. Accountability theory focuses on the process of responsibility. The main objective of public management is efficient use of public resources. While the government creates programs to alleviate social problems, public officials and those responsible for the implementation of public programs must account for their actions since oversight is a requirement of public policy. Evbayiro (2011) applied the accountability theory to show that accountability is a prerequisite for effective implementation of healthcare programs such as Medicare and aids in ensuring that providers are good stewards of taxpayer dollars.

Musul and Ekin (2017) applied the Bayesian framework to provide an analysis of an efficient alternative tool to recoup medical overpayments. The scholars proposed a Bayesian inflated mixture-based model that connects the known medical payment population and the information gathered from a sample of audited investigations in an effort to provide valid estimates that comply with the governmental guidelines. The goal was to reach at least 90% confidence level in overpayment methods. Musul and Ekin (2017) investigated the efficiency of the model with respect to the recovery amount focusing on partial overpayments. The model may aid in revealing the overpayment pattern and quantify learning of medical overpayments (Musul & Ekin, 2017). The model allows leaders to conduct tests to determine the medical overpayment estimation, which can potentially have a positive impact on the cost savings efforts in healthcare.

The aforementioned scholars' application of agency, accountability, and Bayesian frameworks have framed the study of healthcare fraud around the roles of organizational and individual interactions contributing to healthcare fraud and the mechanisms designed

to recover medical overpayments. Healthcare fraud is a multifaceted phenomenon that requires insight of the business opportunity factors that cause organizations and individuals to commit fraud and possible ways to mitigate those factors. To explore the business opportunity factors that contribute to fraudulent behaviors, the conceptual framework applied to this study was the criminal violation of financial trust theory.

Healthcare leaders are at the forefront of creating organizational solutions designed to combat fraud. Cressy's criminal violation of trust theory provides business owners and executives with an understanding of the portion of the fraud triangle over which they have the most control to mitigate or reduce fraud: the opportunity to commit fraud. Cressy (1953) hypothesized that trusted persons become trust violators when they become aware of a financial deficiency in their lives and are aware that they can resolve their deficiency in a secretive manner by violation of the position of financial trust. Cressy also hypothesized that individuals are able to rationalize their actions to adjust their thoughts of themselves as trusted persons with their thoughts of themselves as entitled users of the entrusted funds or property. Cressy's hypothesis formed the fraud triangle, which suggests that three factors lead to fraudulent behavior: a perception of financial pressure, a rationalization to commit fraud, and the opportunity to commit fraud (ACFE, 2014). Scholars agree that one or more of the fraud triangle factors typically motivate perpetrators to commit fraud (Omidi, Qingfei, & Omidi, 2017).

Audit professionals understand the pressure or motive factor of the fraud triangle as an individual's desire to obtain some type of financial benefit, typically resulting from the enticement of greed (Roden, Cox, & Joung Yeon, 2016). Mackevicius and Giriunas

(2013), on the other hand, stated that the pressure or motives factor usually stems from several factors such as financial pressures, unexpected expenses, gambling, or drug addiction. This distinction in philosophy is noteworthy because business professionals such as auditors have concluded that someone steals because of a need of financial gain (Reinstein & Taylor, 2017). Business professionals may need to account for this distinction and adjust their brainstorming sessions when planning risk assessment worksheets that influence the likelihood of someone committing fraud. The rationalization factor of the fraud triangle occurs when an individual defends their inappropriate behavior or make excuses for their behavior (Verschoor, 2015). For example, the individual may genuinely believe that they will lose possessions such as a home or car if they do not commit the fraud. Opportunity is the ability to commit the fraud and can exist when organizations have inadequate controls (Rodgers, Soderbom, & Guiral, 2015; Verschoor, 2015). Examples of inadequate controls include insufficient supervision and no separation of key work duties (Schuchter & Levi, 2016). Opportunity is the element of the fraud triangle in which organizations have the most control (Lenz & Graycar, 2016). Organizations can attempt to take control the opportunity factor of the fraud triangle by creating systems of adequate controls and monitoring those controls periodically (Azrina & Ling Lai, 2014).

Application of the criminal violation of financial trust theory encourages researchers to view fraud through the lens of the perpetrator. The framework may assist healthcare leaders with understanding the opportunity factors that contribute to Medicare fraud. Conduct of the qualitative case study through the criminal violation trust theory

may support efforts to identify ways to implement control systems that may reduce Medicare fraud.

Common Medicare Fraud and Abuse Schemes

Fraudulent healthcare schemes are unduly burdening honest providers, taxpayers, and beneficiaries. Fraud schemes are affecting healthcare programs, such as Medicare, at an alarming rate (Federal Bureau of Investigation, 2013; Pande, & Maas, 2013).

Although experts are unable to precisely measure the full extent of healthcare fraud, the FBI estimates that fraudulent billings are approximately \$80 billion of the \$2 trillion in health spending (Miller, 2013a). Information regarding transparent methods and preventative strategies of healthcare fraud, waste, and abuse might support current and future legislation efforts to safeguard the health and welfare of beneficiaries and reduce future spending (HHS, 2013).

A general understanding of the healthcare services payment and reimbursement process is the key to understand how individuals and organizations commit the most common types of fraud schemes (Davis, Davis, & Schmelzle, 2013). Third party payers make most payments to healthcare entities and medical professionals (Rahmathulla et al., 2014). Third party payers and healthcare providers developed a comprehensive, standardized system known as coding (Houser, Morgan, Clements, & Hart-Hester 2013). CMS regulates the coding system, which consists of a series of numbers and descriptors used for the purpose of reimbursement, planning, and research (Rahmathulla et al., 2014). Coding is a complex system, and accurate coding is essential for claims submitted by third party payers (Hoffman & Podgurski, 2013; Rahmathulla et al., 2014). The intimate

link between coding and reimbursement can encourage many dishonest providers to commit fraud schemes (Hoffman & Podgurski, 2013). Common schemes include phantom billing, patient billing, upcoding, unbundling, and double billing. Medical identity theft is another growing fraud trend (Miller, 2013a). Organized medical fraud is also a serious concern for investigators and other law enforcement officials (Miller, 2013a).

Phantom billing. Phantom billing occurs when medical providers bill for non-performed procedures and services (Thornton et al., 2015). For example, a physician may document or code that a patient received a procedure but does not provide the service. In most cases, the beneficiary is unaware of the billed services, which makes this scheme easy to accomplish. Another type of phantom billing occurs when a physician codes a procedure or service and submits claims for a non-existent or deceased patient (Jackson, 2013). This scheme widely occurs in entities that mainly cater to an older population such as a nursing home or hospice facility. Organized crime rackets who commit medical identity theft and owners of bogus companies engage in phantom billing (Thornton et al., 2015).

Patient billing or beneficiary schemes. FBI investigations nationwide are focusing on practitioners who conduct unnecessary surgeries and prescribe unsafe drugs in the absence of medical necessity (FBI Financial Crimes Report, 2013). The *Healthcare Fraud* section of the FBI report provides several significant cases of behavior that risk patient harm in fraudulent schemes (FBI Financial Crimes Report, 2013). To understand the various patient-billing schemes, individuals should first obtain a general

understanding of the relationship between the patient and provider. Most patients have a unique parent-child relationship with their provider. At one point, the relationship resembled an inferiority parent-child relationship because the patient was dependent on the provider to make most of the decisions regarding his or her healthcare needs (Busch, 2012). Programs such as consumer directed healthcare plans are changing the face of the relationship between the patient and provider. These programs place the patient, labeled as the consumer, in a more superior position to that of the provider (Busch, 2012). The consumer, which implies a financial relationship, is the dominant decision maker of the healthcare needs (Busch, 2012).

President Clinton created the Advisory Commission on Consumer Protection and Quality in the Healthcare Industry in 1997 and charged it with developing provisions aimed to protect consumers in the healthcare industry (Busch, 2012; Cassel, 2015). The provisions provide consumers with several rights regarding information disclosure, choice of providers and plans, access to emergency services, participation in treatment decisions, respect and non-discrimination, confidentiality of health information, and complaints and appeals (Busch, 2012). The consumer is also encouraged to assume reasonable responsibilities for his or her health. With the consumer in the dominant role in directing their healthcare needs, patients have more opportunity to commit Medicare fraud (Busch, 2012).

In the beneficiary scheme, numerous forms of fraud may occur which includes knowingly submitting false claims for non-performed services and colluding with providers in exchange for kickbacks (Federal Bureau of Investigation, 2013). For

example, the provider bills Medicare for any reason and the patient willingly admits that he or she indeed received the medical treatment. The patient and provider split the proceeds. Another complex fraud scheme, known as rent-a-patient, encourages patients to allow dishonest providers to perform unnecessary tests on them and submit claims for reimbursement (Busch, 2012).

Upcoding, unbundling, and double billing scheme. Upcoding is a most implemented Medicare fraud schemes because it allows providers to inflate bills (Cascardo, 2015). Upcoding occurs when the provider inflates bills by using a billing code that indicates the patient needs expensive procedures (Fleishman, 2014; Thornton et al., 2015). The incentive for upcoding is more favorable in for-profit entities versus private providers of care. Theoretically, any classification system that manages reimbursement or a payment process may be vulnerable to providers employing the upcoding scheme. Medicare Part B pays outpatient physicians according to the billed Current Procedural Terminology codes, which differ in procedure and intensity. Some physicians may feel incentivized to use upcoding to increase profitability of a visit because many performed services merely differ by intensity. Medicare may benefit financially by clarifying its classification rules. Medicare program officials should redefine distinctions between types of Medicare visits in a way that eliminates ambiguity to deter upcoding schemes (Herbst, 2014).

Unbundling is a fraudulent practice that occurs when providers submit bills separately for a higher reimbursement instead of billing a visit or service under a single bill (Ferenc, 2013; Thornton et al., 2015). For example, practitioners may break down

blood or chemical panels to their individual components, resulting in higher Medicare payment. Double billing is another fraudulent practice that involves a practitioner or healthcare entity charging for the same procedure or service more than once (Thornton et al., 2015).

Medical identity theft. Typically associated with financial transactions, medical identity theft also occurs in the healthcare environment (Taitzman, Grimm, & Agrawal, 2013). Medical identity theft happens when someone uses the identity of another person in an effort to receive healthcare needs such as medical treatment, prescription drugs, or surgery (Luizzo & Scaglione, 2012). It also occurs when dishonest medical professionals use the information of another person to submit fraudulent bills to insurance companies (Taitzman et al., 2013). Medical identity theft adversely affects consumers and physicians, resulting in financial losses and the creation of inaccurate medical records (Luizzo & Scaglione, 2012; Miller 2013a). Members of organized medical fraud groups work as a team to steal, share, and sell sensitive beneficiary information (Miller, 2013a). Fraudsters can set up a fake store front scheme, bill Medicare for services, and receive payments from Medicare when they deploy the medical identity theft scheme (Miller, 2013a). The Federal Bureau of Investigation (FBI), Financial Crimes Report, *Healthcare Fraud* section (2013) showed that a significant trend observed in healthcare fraud cases includes the development of organized crime groups that risk patient harm in their schemes.

Medicare Fraud and Abuse Laws

Medicare fraud laws have been in effect since the start of the Medicare program (Hill et al., 2014). The False Claims Act (FCA) of 1863, Anti-Kickback Statute, Physician Self-Referral Law (Stark Law), and Patient Protection and Affordable Care Act, (ACA) of 2010 are some of the federal laws governing Medicare fraud prevention and enforcement efforts (Evbayiro, 2011; Hill et al., 2014; Hyer, 2013; Krause, 2013; Orfield, 2015). These laws include the criminal or civil remedies the government can impose upon individuals or entities that commit Medicare fraud (DiSantostefano, 2013). Violations of these laws may result in fines and penalties such as exclusion from participation in the Medicare program and all other federal health care programs, nonpayment of claims, and criminal and civil liability (DiSantostefano, 2013).

False Claims Act. The FCA, which makes individuals liable for knowingly submitting fraudulent claims, has been at the cornerstone of anti-fraud efforts (Hill et al., 2014; Krause, 2013). Enacted in 1863, Congress designed the law in an effort to prevent suppliers from defrauding the Union Army during the Civil War (Krause, 2013). The FCA includes several amendments and penalties (Hill et al., 2014). FCA requires that individuals who knowingly commit fraud pay government damages plus a civil penalty of between \$5,500 and \$11,000 for each false claim (Krause, 2013). In less than ten years following the passage of the FCA, enforcement agencies have recovered over \$200 billion (Evbayiro, 2011). Evbayiro (2011) conducted an historical analysis of federal regulations governing healthcare and concluded that the qui-tam provision of the FCA, in

which the whistleblower typically benefits from the recovered funds, have dramatically increased the success of anti-fraud efforts (Krause, 2013).

Qui-tam provisions of the FCA have been successful in deterring healthcare fraud (Hyer, 2013). Hyer (2013) advised that rural providers commonly face liability risks under the FCA. Hyer (2013) also emphasized that the qui-tam whistle-blower provisions creates strong financial incentives for individuals to bring and pursue FCA cases against healthcare providers.

Anti-Kickback Statute. The Anti-Kickback Statute is a criminal statute that protects patients and federal health care programs from fraud and abuse by preventing bribes from affecting health care decisions (Bucci, 2014). The Anti-Kickback Statute is comprehensive and establishes penalties for individuals and entities on both sides of the prohibited transaction (Chaiyachati, Asch, & Grande, 2017). The law states that anyone who knowingly and willfully accepts or offers remunerations of any sort and in any manner intended to influence the referral of Medicare and Medicaid services can face felony charges (Bucci, 2014). Convictions may result in a prison sentence up to 5 years and a fine of up to \$25,000 (Krause, 2013). The federal government can exclude entities or individuals found guilty of violating the law from participation in federal health care programs (Bucci, 2014; Climo, 2015). The government may also assess civil money penalties, which could result in \$50,000 plus damages for each violation of the Anti-Kickback Statute (Bucci, 2014; Lambert, 2014).

In an effort to protect legitimate business arrangements and relationships, the federal government has enacted *safe harbor* provisions (Lambert, 2014; Nelson &

Staggers, 2013). Safe harbor provisions detail common business arrangements in which there is no danger of patient or program abuse (Lambert, 2014). Examples of safe harbor practices include provisions pertaining to investment interest, personal service and management contracts, and space rental (Santo, 2014). Under the statute, these provisions do not constitute a criminal offense as long as individuals and entities meet certain conditions.

Physician self-referral law or Stark Law. Congress enacted the Stark Law in 1989 to prevent physicians from making referrals of certain designated services with organizations in which the physician has a financial relationship unless an exception applies within the law (Able, 2013; Tharp, 2014). The Stark Law aims to prevent self-referral practices (Able, 2013). For example, Medicare prohibits physician referral for patients requiring clinical laboratory services to entities in which physicians or family members of physicians have financial interests (Tharp, 2014).

Violations of the Stark law carry severe penalties (Tharp, 2014). Physicians are required to repay the government for submitting Medicare claims that violate the law (Able, 2013). Physicians are at risk of exclusion from participation in all federal health care programs if they violate the Stark law (Tharp, 2014). Researchers have expressed some concern regarding the effectiveness of the law as a tool to discourage physician self-referral (Tharp, 2014; Able, 2013). Able (2013) explained that current enforcement efforts of the law discourage providers from self-disclosing even minor violations of the Stark Law.

Patient Protection and Affordable Care Act. President Obama signed the Affordable Care Act (ACA) into law in March 2010, which provides an additional \$350 million over ten years to combat fraud, waste, and abuse (Gibson & Singh, 2012). The law provides federal enforcement agents new authorities to deter and prosecute perpetrators of fraud (Gibson & Singh, 2012). The ACA, more commonly referred to as health reform, contains several provisions aimed at promoting new healthcare payment and delivery methods and strengthening laws aimed at combating fraud (Gibson & Singh, 2012; Tharp, 2014). Provisions of the ACA have received extensive attention from scholars, legislators, and members of the public media (Orfield, 2015). A broad consensus has formed on the need to intensify fraud enforcement efforts. Key provisions within the law aims to promote control in healthcare costs (Tanner, 2013). Specifically, the cost containment provisions encourage administrative streamlining, enhanced coordination of care, and the reduction of waste, fraud, and abuse within Medicare and Medicaid (Orfield, 2015; Persad, 2015).

Strategies for combating fraud and abuse include increased scrutiny of billing patterns and data analytics techniques. The ACA provides for stricter penalties such as requiring physicians to report and return Medicare and/or Medicaid overpayments within 60 days (Persad, 2015; Tharp, 2014). In addition to increasing anti-fraud efforts, the ACA supports efforts of moving the government from after-the-fact *pay and chase* methods to a more effective prevention model (Gibson & Singh, 2012; Krause, 2013).

Regulatory requirements have tightened and law enforcement increased efforts to combat Medicare fraud. Effective regulations and increased law enforcement may prove

effective in eliminating fraud, resulting in healthcare costs savings for families, businesses, and the federal government. To achieve substantial cost savings and prevent fraud within the Medicare program, leaders within healthcare entities must also develop and implement robust internal control procedures that identify and limit risk within its organization.

Fraud and Internal Control

Internal controls consist of organizational elements such as resources, processes, culture, and tasks that collectively assist in achieving organizational goals and objectives (Johnson et al., 2014). Internal controls are a consolidation of business models, processes, procedures, employee initiatives, and data processing or information technology (Rodgers, 2012; Verschoor, 2015). The objectives of such processes are safeguarding assets of the business, providing relevant and reliable information, promoting efficient operations, and complying with managerial policies and procedures (Rodgers, 2012; Verschoor, 2015). Because internal controls provide reasonable but not absolute assurance, the assumption of competent and trustworthy employees is crucial for effective controls (Rodgers, 2012). Thus, healthcare providers, practitioners, and suppliers should develop control mechanisms that assist employees with understanding the healthcare fraud and abuse laws and the consequences of violating them.

Research efforts to describe the root causes of healthcare fraud and internal control methods to prevent healthcare fraud have lagged. Johnson et al. (2014) cited a lack of fraud control education and training as contributing to the inattention paid by healthcare programs such as Medicare to fraud and abuse mitigation. Some individuals

working within the healthcare system are resistant to the implementation of fraud reduction efforts because of a desire to protect income gained from fraudulent activity (Miller, 2013b). In 2011, GAO conducted a review of Medicare program management by the CMS and cited pervasive internal control problems that could lead to the loss of billions of taxpayer dollars to improper payments (U.S. Government Accountability Office, 2013). Management has little assurance it can achieve the goals and objectives of the organization if the internal controls are inadequate (Rodgers, 2012). Although strong systems of internal control provide reasonable and not absolute safeguards against fraud, healthcare entities can diligently perform control responsibilities and limit access to property, systems, and information in an attempt to mitigate risks and deter fraud (Rodgers, 2012). Effective controls might decrease the chance that major errors or fraud will occur and remain undetected.

Individuals responsible for internal controls. Management, including an institution's governing board, is responsible for ensuring that adequate controls are in place and properly performed to safeguard assets – not external auditors (Johnson et al., 2014). A governing board is primarily responsible for overseeing all aspects of the control environment (Mohd-sanusi, Rameli, Firdaus, Omar, & Ozawa, 2015). A board does not design the control systems or prepare written policies. Board members should carefully review and obtain a general understanding of the policies and procedures prior to their approval (D'Aquila, 2013).

A governing board relies upon management, especially the chief executive officer (CEO) to design effective control systems and polices (D'Aquila, 2013). The

CEO, in turn, depends on managers and overseers in departments to recommend and implement policies and procedures that identify organizational risks factors (D'Aquila, 2013). The CEO sets the tone for the culture of the organization (D'Aquila, 2013; Krambia Kapardis, & Papastergiou, 2016). The CEO creates a positive tone when he or she conducts the affairs of the organization in an honest and ethical manner. If the CEO fails to exhibit strong support for internal controls, then the entire organization will most likely practice poor internal controls (D'Aquila, 2013).

Surveying the environment. Prior to developing or amending internal controls, organizations must identify its greatest risk factors (Rodgers, 2012). These risk factors may represent issues within the external or internal level of the organization. Some external risk factors may include a new financial reporting standard or regulations that can affect customer service and production processes (Johnson et al., 2014). Examples of internal risk factors include a change in management style or the types of training programs that helps set the tone for control consciousness within the organization (Johnson et al., 2014). Internal transaction cycles such as accounting, compliance, cash management, and inventory control are also risk factors (Rodgers, 2012). Developing and implementing internal controls is an on-going process that requires constant revision. Organizations should monitor and test controls regularly and consider alternative methods as the business evolve.

Fraud defenses. Controls are people-centered and not systems of policy manuals and forms (Rodgers, 2012). For that reason, organizations should consider implementing a written code of ethics and require all employees and board members to sign (Rodgers,

2012). Policies and procedures provide reasonable assurance that leaders achieve the fiscal and programmatic goals of the agency (Johnson et al., 2014). Additionally, fraud awareness training and access to an employee assistance program may help eliminate some of the financial pressures caused by debt, addictions, marital issues and other personal matters, which can lead employees to commit fraud (Rodgers, 2012; Verschoor, 2015). Hotlines and anonymous whistle blower programs have also proven to be a tool in detecting fraud (Andrews & Leblanc, 2013; Gupta, 2016). One of the best defenses to fraud is hiring trustworthy and honest people (Bonny, Goode, & Lacey, 2015). Thorough background checks, including employment history and criminal background, are a way to narrow the hiring pool to eliminate some of the applicants (Sarode & Deore, 2017). This tool has limits to preventing fraud. Just as businesses evolve over time, so do its employees. Personal and work situations of an employee may change over time. Therefore, organizational leaders should consider conducting periodic employee background checks as a part of their control system.

Biometric applications may prove to be a tool in fraud defenses (Kovács & David, 2016). Biometric measurements collected for patients may include individual features such fingerprints or palm prints (Kovács & David, 2016). Healthcare providers merge biometric measurements with other patient information in an effort to verify patient identity and minimize medical identity theft (Newman, 2013). Electronic health records (EHRs) might also assist with combating Medicare fraud (Herbst, 2014). Healthcare leaders must properly safeguard patient information within their electronic system.

Exception modeling (i.e., data modeling and data mining) is a fraud defense that organizations should utilize (Luizzo & Scaglione, 2012; Siregar & Tenoyo, 2015). Auditors utilize exceptional modeling to identify aberrant patterns of behavior in an effort to obtain a glimpse of potential suspicious activity (Luizzo & Scaglione, 2012). The concept of exception modeling is not new and is the basis for many forms of statistical analyses (Luizzo & Scaglione, 2012).

Through a comprehensive study on occupational fraud, the ACFE found that confidential reporting mechanisms could dramatically reduce fraud losses (Johnson et al., 2014). Common control methods such as audits and management reviews are less effective as detection tools (Johnson et al., 2014). The ACFE also found that organizational leaders and investigators more likely detect occupational frauds via an employee tip versus a routine audit (Johnson et al., 2014). Auditors and in-house security should work together in order to uncover fraud before it wreaks havoc on the organization's assets and bottom line (Luizzo & Scaglione, 2012).

Costs Impact of Medicare Fraud

An intrinsic component of most fraud schemes is concealment, which is the main reason why much of fraud costs remain uncovered. Although the exact measure of health care fraud is hard to determine, perpetrators intent on abusing the system can cost taxpayers billions of dollars (DiSantostefano, 2013; Hill et al., 2014). Medicare fraud and abuse increases the risk of the solvency of the Medicare Trust Fund (DiSantostefano, 2013). The effect of these losses and risks increase as the number of Medicare beneficiaries continue to grow. Fraudulent activity contributes to the rising health care

costs (Hill et al., 2014). Most frauds negatively influence an organization's productivity, causes reputational damage, as well as the costs associated with investigating and remediation of the fraud (DiSantostefano, 2013; Miller, 2013a; Wisk et al., 2014).

Healthcare costs. Healthcare spending in the United States grew from approximately \$150 billion in 1960 to \$2.2 trillion in 2008, which represents a 5.7% annual growth rate (Chernew, 2011). In 2012, the United States healthcare spending grew 3.7%, reaching an estimated \$2.8 trillion (CMS, 2014). Medicare fraud has been partly responsible for the rising costs (Hill et al., 2014). The rising healthcare costs affect families, businesses, and government (DiSantostefano, 2013; Wisk et al., 2014). For families, the increasing medical care cost decreases household income and forces difficult choices between balancing food, living expenses, necessary medical care, and other priorities (Wisk et al., 2014). For businesses, the rising healthcare costs present challenges in adding new employees, maintaining retiree coverage, and competing globally (Shin-Horng, Pei-Chang, & Chih-Kai, 2014). For federal, state, and local governments, the rising healthcare costs aids in higher Medicare and Medicaid costs (Hill et al., 2014).

Business costs. Medicare fraud puts companies in jeopardy for more than fines and penalties. The organization itself is often one of the many victims of the fraud. Recent organizations cited for healthcare fraud include Victory Pharma, Inc., Pfizer Coventry Health Care, Optim Healthcare (U.S. Department of Justice, 2012c; U.S. Department of Justice, 2012d; U.S. Department of Justice, 2012e; & U.S. Department of Justice, 2012f).

Victory Pharma Inc., a pharmaceutical company California, paid over \$11 million in a deferred prosecution agreement with the DOJ in late 2012 to resolve civil and criminal liability (U.S. Department of Justice, 2012c). The accusations included kickbacks to induce doctors to write prescriptions for its Medicare covered products (U.S. Department of Justice, 2012c). The kickbacks included tickets to professional and collegiate sporting events, tickets to concerts and plays, spa outings, golf and ski outings, dinners at expensive restaurants; and numerous other out-of-office events (U.S. Department of Justice, 2012c). A whistleblower brought the alleged scheme to the attention of enforcement officials and received \$1.7 million as part of the resolution (U.S. Department of Justice, 2012c).

Pfizer H.C.P. Corporation, an indirect wholly owned subsidiary of Pfizer Inc., entered into a deferred prosecution agreement with the DOJ in 2012 (U.S. Department of Justice, 2012d). Pfizer H.C.P. Corporation entered into the agreement over violations of the anti-bribery, and books and records provisions of the Foreign Corrupt Practices Act connected with improper payments to foreign government officials, including publicly employed regulators and health care professionals (U.S. Department of Justice, 2012d). The company paid \$60 million in penalties: \$15 million to resolve a foreign bribery investigation and \$45 million to the Securities and Exchange Commission in civil disgorgement of profits in connection with the same charges (U.S. Department of Justice, 2012d).

Coventry Health Care, a health insurance provider in Maryland, agreed to pay \$3 million as part of a non-prosecution agreement (U.S. Department of Justice, 2012e).

Some of its employees inappropriately accessed the Medicare database to obtain Medicare eligibility information for the sale of Medicare set-aside products (U.S. Department of Justice, 2012e). In addition to the monetary settlement, Coventry has agreed to take corrective actions of maintaining training for all employees who have access to government databases, which include mandatory testing on fraud abuse, privacy and security (U.S. Department of Justice, 2012e).

Optim Healthcare, a healthcare entity based in Georgia, agreed to pay \$4 million to settle allegations that they submitted fraudulent claims (U.S. Department of Justice, 2012f). The settlement resolves allegations that Optim Healthcare submitted Medicare claims for surgical and other medical procedures that were improper, intentionally miscoded, and violated the federal prohibition against the Stark Law (U.S. Department of Justice, 2012f). Additionally, the settlement resolves allegations that were originally part of a federal lawsuit filed under the whistleblower provisions of the False Claims Act (U.S. Department of Justice, 2012f).

As evident in the above high-profile cases, investigations and responses to fraud are costly and can distract the organization from its core mission. Additionally, organizations risk reputation damage (Miller, 2013a). White-collar crime such as fraud results in serious harm to corporate reputations (Miller, 2013a). The typical outcome of an investigation, with either convictions through prosecution or an agreement, is a press release from the DOJ and media coverage. Thus, decision makers of healthcare entities require an understanding of control strategies that may aid in reducing Medicare fraud.

Transition

Section 1 began with the foundation and background to provide an understanding of how leadership strategies aimed to combat Medicare fraud emerged as an important topic for research. The problem and purpose statements expanded the scope and indicated the direction of this study. The nature of the study included a brief objective for selecting a qualitative method and descriptive design. The research question and conceptual framework provided a foundation and assisted with organizing the study. Operational definitions defined technical terms. Assumptions, limitations, and delimitations assisted in identifying and setting aside biases. The significance of the study included detailed descriptions and value to businesses and contributions for improved business practices and positive social change. Section 1 concluded with an academic literature review. The literature review reveals that Medicare fraud is detrimental to healthcare and business costs. Business costs (time, money, and reputation) due to Medicare fraud are costly and can distract healthcare leaders from its core mission. Although government officials have made a concerted effort to introduce new tools and techniques to combat Medicare fraud, the phenomenon has continued to plague healthcare organizations (Gibson & Singh, 2012; Krause, 2013). Scholars suggest that leaders may benefit from control strategies such as biometrics and data mining to assist them in combating fraud, which may assist healthcare leaders with carrying out their business mission (Kovács & David, 2016; Luizzo & Scaglione, 2012; Siregar & Tenoyo, 2015). Section 2 includes a description of structure and methodology for the study. Section 3 includes a presentation of the findings, application to professional

practice, implications for social change, recommendations for action and further research, reflections, and conclusions.

Section 2: The Project

Section 2 contains a discussion of the design for this study, with content focusing on the role of the researcher, participant selection process, and research method and design. This section also includes discussion of the study population and sampling protocol used and the data collection, organization, and analysis methods used for the study. Finally, I provide descriptions of the strategies and techniques employed to ensure study credibility, transferability, dependability, and confirmability. This section sets the foundation for and transition into Section 3, which includes data results from the interviews, study conclusions, application to professional practice, implications for social change, and personal recommendations.

Purpose Statement

The purpose of this descriptive qualitative single case study was to explore control strategies that healthcare leaders use to combat Medicare fraud. The study consisted of 10 leaders who have the responsibility of overseeing, developing, monitoring, or implementing control mechanisms for Medicare services in the Mid-Atlantic area of the United States. The findings from this study might support business managers' efforts to identify and implement effective control strategies to improve business operations relative to reducing Medicare fraud. Effective strategies might contribute to social change because effective fraud control strategies and techniques are necessary to keep healthcare costs from increasing and to ensure funds are available to meet the healthcare needs of the most vulnerable U.S. citizens. These control strategies might contribute to a robust healthcare system that leads to a healthier citizenry.

Role of the Researcher

Researchers are the primary individuals who obtain data from study participants (Whiteley, 2012). My role as the researcher in this study included screening, selecting, and interviewing research participants. My role included arranging appointments, conducting participant interviews, sorting and coding responses, and reporting the findings. Additionally, I gathered organizational data to support the study purpose and central research question. As an auditor, one of my roles consists of evaluating internal controls as part of the audit planning process. I am not responsible for the design and implementation of controls in an organization. I have identified potential areas of weaknesses within control systems, and my experience has allowed me to develop some insights and understanding of control efforts to reduce Medicare fraud. A researcher's expertise in a subject area adds credibility with participants (Vaccaro, 2012).

In 1979, a U.S. government commission produced the Belmont Report, which includes guidelines for including vulnerable study participants including minority populations (Rogers & Lange, 2013). The Belmont Report includes protections against the use in research of study participants without their consent (Rogers & Lange, 2013). The Belmont Report also includes protection of mentally challenged individuals from unjust research (Rodgers & Lange, 2013). During the interview process, researchers must adhere to ethical standards in order to ensure they protect research participants (Gibson, Benson, & Brand, 2013). My goal was to abide by the ethical standards included in the Belmont Report protocol, which supports respect for persons, beneficence, and justice. I completed the Protecting Human Research Participants

training offered by the National Institutes of Health Office of Extramural Research (Certification Number: 1144247). The National Institutes of Health participant protection training aids researchers in the informed consent process, in the protection of participants, and in dealing with ethical challenges in research (Resnik, Miller, Kwok, Engel, & Sandler, 2015).

The role of the researcher is to remove or minimize any bias that may influence the data collection and analysis process (Onwuegbuzie & Hwang, 2014). When conducting a study, researchers should report information as accurately as possible and separate personal opinions or bias (Tufford & Newman, 2012). The researcher should remain as neutral as possible in dress, tone, and body language when conducting interviews (Braun & Clarke, 2013). To ensure the interview questions are impartial, the researcher should refrain from asking leading questions (Braun & Clarke, 2013). While conducting interviews, I refrained from asking leading questions, dressed in neutral tones, maintained a calm and even tone, and avoided betraying any personal opinions through my speech, facial expressions, or body language.

Researchers have found that interview protocols are important in gaining as much information as possible while using open-ended questions that are likely to give control of the information-sharing process to study participants (Brown et al., 2013). Foley and O'Conner (2013) suggested that an interview protocol ensures reliability in qualitative studies. An interview protocol provides a consistent structure for study participants (Bölte, 2014). My interview protocol (see Appendix A) served as the basis for

qualitative, semistructured interviews to obtain as much information as possible about my research topic.

Participants

Researchers should specify the principles and criteria for selecting study participants to assist other researchers with assessing the transferability of the research findings (Elo et al., 2014). Damianakis and Woodford (2012) claimed that following the criteria for selecting study participants is critical in protecting participants. The eligibility criterion was for participants to occupy a leadership position such as a director, acting director, policy group, or internal auditor. The participants also have the responsibility of overseeing, developing, monitoring, or implementing control mechanisms for Medicare services in the Mid-Atlantic area of the United States. For qualitative case studies, participants having experience of the study phenomenon is necessary (Yin, 2013).

Once I received approval from the Walden University Institutional Review Board (IRB; approval number 01-18-17-0183521), I researched publically available documents and websites in an effort to identify and select healthcare leaders located within my primary geographic area of interest. The participants received letters via e-mail detailing the intent and purpose of the study outlined in the cover letter (see Appendix B). Based on the content included in the letter, the participants had the opportunity to decide whether they would accept or decline my invitation.

I built working relationships with participants by reiterating the purpose and goals of this research and how the goals of the study might have an impact on healthcare cost

savings strategies. Participants are more likely to share their knowledge when they are reminded of a significant research purpose (Bailey, 2014). The study purpose is a factor that affects participant's willingness to share expert knowledge (Bartkowiak, 2012). My use of open-ended questions in addition with effective listening techniques also aided in establishing working relationships with participants. Prowse and Camfield (2013) stated that open-ended interviews improve the quality of data generated in qualitative studies. The relationship between researcher and participants is based on mutual respect and is integral to quality of study output (Holloway & Wheeler, 2013). Building trust between researcher and participants is critical to establish credibility (McDermid, Peters, Jackson, & Daly, 2014). I built trust with participants by allowing them to openly express their thoughts and opinions on the study topic.

Research Method and Design

Research Method

Three methodologies are available for researchers to utilize when studying a phenomenon: quantitative, mixed method, and qualitative (Spillman, 2014). Qualitative research is an exploratory method for understanding individual perspectives (Yin, 2014). Research that aims to understand the perspectives of Medicare fraud and methods of reducing the phenomenon must follow the human viewpoint. Therefore, I chose a qualitative research methodology to satisfy this inquiry.

Quantitative researchers emphasize the measurement and analysis of casual relationships between variables and test hypotheses (Denzin, 2017). Successful quantitative research depends on the analysis of statistical data and the extent to which

the results are generalizable (Allwood, 2012). Probability and statistics are the fundamental components of quantitative research (Goertz & Mahoney, 2013). Because I did not focus my research on testing hypotheses nor seeking statistical data, a quantitative method was not appropriate for this study.

Mixed method research combines both qualitative and quantitative methods within a single study (Spillman, 2014). A researcher aims to combine, gather, develop, and illustrate study results using both qualitative and quantitative methods in mixed method studies (Denzin, 2017; Yin, 2014). The mixed method approach consigns qualitative analysis to an exploratory tool and does not maximize quantitative analysis as a tool to understand the cause of the problem and identify potential solutions (Sparkes, 2014). The focus of this study was not to support numerical results based on hypotheses, but rather to explore and obtain information regarding the control strategies that managers utilize to prevent Medicare fraud. A mixed method approach may have provided a lens into the research topic; however, the mixed-method approach would not satisfy the research goal for this study given the complexity of the mixed method approach. A mixed method approach would not have fully aligned with the goal of the study, which was to explore the research phenomenon comprehensively using a qualitative, exploratory approach.

Qualitative research involves constant interaction among the various design components such as the purpose of the study, conceptual framework, and research questions (Maxwell, 2012). Qualitative research is an exploratory method for understanding human behavior, phenomena, groups, or individuals (Yin, 2014).

Qualitative research design, unlike quantitative research, does not begin with a predetermined starting point or proceed through a fixed sequence of steps (Maxwell, 2012). Each component of qualitative research interacts with each other rather than being linked in a linear sequence (Maxwell, 2012). Qualitative research methods encompass descriptive and interpretive characteristics (Bailey, 2014). Using a qualitative research approach, the descriptions of the participants enabled me to explore the effect of control methods on Medicare fraud and their impact on business operations over several periods instead of a fixed period. The qualitative research approach enabled an exploration of healthcare leaders' understanding of internal control used to combat Medicare fraud. Qualitative research has earned respect within the scope of academics, and commercial qualitative market research success is substantial (Bailey, 2014). This method is consistent with other qualitative studies in the field of business and management that sought to understand the human viewpoint. For example, Hahn and Lülfs (2014) used a qualitative approach to analyze the communicative legitimation methods organizations use when reporting negative aspects caused by business activity. Smith (2014) employed a qualitative research design to obtain a better understanding of how senior leaders increasingly place paradoxes into their organization's strategy, yet have difficulties in managing them effectively. My selection of qualitative research is consistent with Hahn and Luff (2014) and Smith (2014) in researching the human viewpoint regarding Medicaid fraud.

Research Design

Phenomenology, narrative, grounded theory, ethnography, and case study are designs that qualitative researchers can use under the qualitative paradigm (Petty et al., 2012). A meticulous research design is critical in guiding a researcher throughout a study (Yin, 2013). For this study, I chose a case study design. Case study researchers explore a setting, an individual, or a situation (Wynn & Williams, 2012). Case study researchers also illustrate the perspectives of participants using multiple data sources to determine how participants make decisions and obtain knowledge about a phenomenon (Yin, 2013). A case study design is appropriate for this study since I utilized multiple sources of data to explore the best control strategies for combating Medicare fraud.

The focus of a phenomenological design is to explore the meaning participants associate with a phenomenon (Hou, et al., 2013). Phenomenological designs allow researchers to probe deep into the meaning of a phenomenon (Kordeš & Klauser, 2016). The goal of phenomenological studies is to describe participants lived experiences (Roberts, 2013). A phenomenological design was not appropriate for the study because I explored participants' strategies for reducing Medicare fraud as opposed to lived experiences with the phenomenon.

Narrative research combines thoughts and stories from the lives of participants with the perspective of the researcher (Petty et al., 2012). Wattanasuwan (2012) noted that narrative research is an exploration of how participants view their experience in an event. Narrative research is based on a collection of stories told by research participants (Maiello, 2014). The narrative design was not appropriate for this study because

participants' understanding of specific control strategies is the focus, rather than a reminiscence of an event.

Grounded theory formulates hypotheses from theories (Manuj & Pohlen, 2012). Researchers utilizing a grounded theory design recognize that the study typically starts with a collection of qualitative data (Berge, Loth, Hanson, Croll, & Neumark-Sztainer, 2012). Grounded theory researchers develop new theories based on conceptual ideas (Johnson, 2015). I did not develop a theory; therefore, a grounded theory design was not appropriate for this study.

Ethnography researchers investigate a cultural group over an extensive period by collecting data (Petty et al., 2012). Researchers using an ethnographic design observe a cultural group over a period of time (Cruz & Higginbottom, 2013). A researcher uses ethnography to explore participants' behavior in a natural setting to explore a cultural phenomenon (Marshall & Rossman, 2016). An ethnographic design was not appropriate because the design would not provide comprehensive coverage and rich exploration in this study of control strategies aimed to combat Medicare fraud.

A case study design delves deeply into a contemporary phenomenon in its real life context (Yin, 2013). Researchers conducting case studies rely on multiple sources of evidence such as documents, observations, and interviews (Yin, 2013). For example, Yap and Webber (2015) used a qualitative case study design and relied on multiple sources of evidence to explore the perceptions of staff within an organization's training department. Karen, Ellie, and Moll (2012) used a qualitative case study design to investigate significant challenges in conducting controversial research in a workplace

setting. Given the foregoing studies, applying a case study approach is a preferred method because multiple sources of evidence were used in the studies to explore the individual and organizational perspective of the phenomenon. Because I used multiple sources of evidence (i.e., interviews and publically available documents), a case study design supported the exploration of the problem of Medicare fraud and control methods necessary to support preventative efforts.

Data saturation occurs when no new data add to current findings or themes (Higginbottom, Rivers, & Story, 2014). Data saturation occurs when no new data emerge, no new coding is necessary, and other researchers can replicate the study and achieve the same results (Bristowe et al., 2015). Qualitative researchers should continue interviewing more participants until achieving data saturation (Kwong et al., 2014). In this study, data saturation was achieved by interviewing purposefully selected research participants until no new themes emerged in the study.

Population and Sampling

I explored leadership strategies for combating Medicare fraud using the case study of a large healthcare agency in the Mid-Atlantic area of the United States. The population for this study was healthcare leaders who have the responsibility of overseeing, developing, monitoring, or implementing control mechanisms for Medicare services. I employed purposeful sampling in an effort to recruit research participants with relevant knowledge and expertise. Purposeful sampling is an ideal method to use when conducting qualitative case studies (Barratt, Ferris, & Lenton, 2015). Francis-Smythe, Robinson, and Ross (2013) used purposeful sampling in their qualitative study

of how current academic theory on evidence-based management is consistent with the decision-making process of general managers. Researchers using purposeful sampling to seek research participants could use a small sample size (Bernard, 2013).

In qualitative research, a researcher uses the sample size to assure the richness of the information; and, the number of participants depends on the topic and availability of resources (O'Reilly & Parker, 2012). Marshall, Cardon, Poodar, and Fontenont, (2013) claimed that rules do not apply to selecting the sample size in qualitative inquiries. Maxwell (2012) argued that defining participant size prior to research counters the exploratory nature of qualitative inquiry. Sample size depends on the overall purpose of the study and the gathered information that will have credibility and usefulness (Marshall et al., 2013). I sampled 10 healthcare leaders knowledgeable in the area of control mechanisms that may aid in reducing Medicare fraud.

Data saturation is the point in which no new data is revealed from the collected data (O'Reilly & Parker, 2012). I achieved data saturation through interviewing 10 healthcare leaders with the most expert knowledge, which lead to data repetition. No new themes emerged from the collected interview data; therefore I did not need to interview more healthcare leaders.

Researchers should ensure that interviews are convenient for the participants (Chaney, Barry, Chaney, Stellefson, & Webb, 2013). The participants in this study chose the setting, time, and location for the interviews. The duration of the interviews was between 30 – 60 minutes and the interviews were conducted in a neutral location. A

neutral location can eliminate distractions and maintain anonymity (James, Pilnick, Hall & Collins, 2016).

Ethical Research

Nishimura et al. (2013) noted that participants should understand their role before taking part in a study. The informed consent is a crucial part of a research study (Nishimura et al. 2013). Participants received an informed consent form via e-mail to review and sign regarding the study purpose and intent. Prior to the interviews, the participants signed and returned the consent forms. Participants did not receive incentives in exchange for their participation. Participants had the opportunity to withdraw from the research process via phone or e-mail without consequence up until I completed the analysis. The participants remained in the study throughout the data analysis process.

A research ethics board is necessary to ensure the researcher conforms to ethical standards (Aluwihare-Samaranayake, 2012). The IRB process guided the structuring and conduct of the data collection phase to assure that ethical practices for protection of participants were adequate. An essential component of research ethics is to ensure the confidentiality of participants (Damianakis & Woodford, 2012). This study is not sensitive in nature and study participants only required limited protection to protect confidentiality. In an effort to ensure privacy of the participants and their organization, each participant received an assigned alphanumeric code that began with *P* and included sequential numbers from *1* to *10* for de-identification purposes during the data analysis

process. Yin (2013) noted that the use of unique identifiers in research ensures confidentiality and protects the safety of study participants.

Cronin-Gilmore (2012) emphasized the importance of storing all data in a safe cabinet prior to destroying the data. The electronic data will remain on a password-protected computer, and the hard copies will remain locked in a safe container. Additionally, the data will remain in a safe and secure location for a period of 5 years to protect the rights of participants. After the 5-year retention period, I will destroy the data. The Walden University approval number for this study is 01-18-17-0183521 and the approval expires on January 17, 2018.

Data Collection Instruments

I served as the primary data collection instrument. Researchers typically serve as the primary data collection instrument when obtaining data from study participants (Pezalla, Pettigrew & Miller-Day, 2012; Yin, 2014). As the primary data collection instrument, a researcher must establish credibility with research participants (McDermid, et al., 2014). I established credibility by following an interview protocol (see Appendix A).

This study included collected data from the conduct of semistructured interviews and a review of publically available documents. The semistructured interviews consisted of open-ended and follow-up questions. Researchers commonly use semistructured interviews in qualitative researcher during the data collection process (Pezalla et al., 2012). Semistructured interviews improve the quality of data generated in qualitative studies (Prowse & Camfield, 2013). Semistructured interviews can be time-consuming

(Edmunds & Brown, 2012), however the data obtained from interviews is easy to analyze (Yin, 2014). The publically available documents (see Appendix C) served as the secondary data collection source. Documents provide supplemental research data that can be valuable additions to a study (Aydin, 2012). Although the interpretation of documents may provide different results (Langen et al., 2014), the use of documents assist researchers in conducting a highly robust research study (Snyder, 2012).

I applied member checking during the interview process as a method of assuring research validity. Houghton et al., (2013) described member checking as a tool that optimizes the validity of research. Researchers provide study participants with the opportunity to review the interpretation of responses in an effort to support data completeness and accuracy (Houghton et al., 2013). After data collection and analysis, researchers may choose to incorporate member checking to offer research participants the opportunity to include additional perspectives on the research topic (Awad, 2014). Awad (2014) explained that member checking provides researchers an opportunity to obtain participants' corroboration of the interview response. I provided participants a synopsis via e-mail of my interpretation of their interview responses to ensure that I accurately captured the participants' responses.

Interview protocols aid in providing control of the information-sharing process to study participants (Brown et al., 2013). Foley and O'Conner (2013) claimed that an interview protocol ensures constancy in qualitative studies. An interview protocol provides a reliable structure for study participants (Bölte, 2014). My interview protocol

(see Appendix A) served as a consistent guide and aided in ensuring reliability in this study.

Data Collection Technique

The data collection component of research is a standard process for acquiring information that assists researchers with an inquiry (Marshall & Rossman, 2016). Qualitative researchers can collect data using techniques such as interviews, review of organizational documents, and observations (Yin, 2014). The data collection techniques for this study included the semistructured interviews, a review of publically available documents related to organizational controls, and a data log to assist with tracking data.

I used an interview protocol (see Appendix A) to ensure interviews were conducted in a consistent manner. The data collection process for the interviews began with introductions to inform study participants of the study process. Once the introductions were completed, I asked permission to record the interview, and when approved, turned on the recording device. During the interviews, I summarized and clarified responses with the participants to ensure accuracy in this study. At the conclusion of the interview, I thanked the participant and ended the session. Qualitative researchers commonly utilize semistructured interviews during the data collection process (Pezalla et al., 2012). The interview is one of the most significant sources of case study research (Yin, 2014). Semistructured interviews based on an interview protocol (see Appendix A) with open-ended questions regarding leadership strategies on controls aimed to reduce Medicare fraud was appropriate for this study. Data from semistructured

interviews is fairly reliable and easy to analyze (Yin, 2014). On the other hand, semistructured interviews can be time-consuming (Edmunds & Brown, 2012).

Qualitative researchers frequently collect documents during a case study to triangulate the data to increase credibility and validity (Yin, 2013). An advantage of collecting documents is that documents provide supplemental research data that can be valuable additions to a knowledge base (Aydin, 2012). A disadvantage to document reviews includes the interpretation of documents providing different results (Langen et al., 2014; Yin, 2013). Multiple sources such as participant interviews and documents assist researchers in obtaining a highly robust research study (Snyder, 2012). My review of publically available documents related to organizational controls supported the exploration of how healthcare leaders attempt to combat Medicare fraud. The document review assisted me with identifying the internal or external factors that may influence the design of control systems aimed to combat Medicare fraud and the business opportunity factors that contribute to fraudulent behaviors. I reviewed the following documents: (a) Medicare Financial Manual, (b) the Green Book, (c) Chief Financial Officer Act of 1990, (d) Federal Information Security Management Act (FISMA), and (d) the Center for Program Integrity Key Anti-Fraud Activities.

I recorded the interviews using a handheld voice digital recorder. Interview recordings can assist researchers in the data analysis process (Al-Yateem, 2012). Recording interviews allows the researcher to listen to the interview at their leisure (Yin, 2013). Researchers use audio recordings to validate responses (Yin, 2014). After the interviews, I transcribed the recordings using EureScribe 2.0. While listening to the audio,

I reviewed the transcribed text to summarize my understanding of the individual interview responses for member checking. Member checking is utilized to reduce bias in the data (Houghton et al., 2013). Member checking helps establish thoroughness of a study (Koelsch, 2013). During the member checking process, the collected data assists researchers with achieving a relatively higher level of accuracy and consensus of the data (Koelsch, 2013). The use of member checking allows study participants to verify a researcher's interpretation of information for accuracy (Awad, 2014). For this study, member checking consisted of sharing interview interpretations via e-mail with study participants to allow them to provide comments as necessary. None of the participants had changes or additions.

Data Organization Technique

Data organization is important to manage a large amount of information (Yin, 2014). Data organization also enables the development of an audit trail of cross-references to other sources of data (Wahyuni, 2012; Yin 2014). The researcher can easily assemble useful information for the final report when data is properly organized. For this study, I maintained data on a data log in Microsoft Excel on a password-protected computer. The data log contained (a) the contact information and identification number for each participant, (b) a list of the case study documents, (c) the date of collection of the participant's contact information, (d) the date of collection and source information for the case study documents, and (e) the time; place; and setting of interviews. Wagstaff, Hanton, and Fletcher (2013) suggested use of a log, which can assist with providing a transparent research trail necessary for improving the organization of the data. I also

took notes while reviewing the documents and during the conduct of the interviews. I placed brackets around information in the documents that coincided with information obtained in the literature review. The notes in the margin of the documents provided a brief description of how the bracketed information related to the literature review and conceptual framework. I took notes during the conduct of the interview that documented my understanding of the participant's responses. Yin (2014) stated that note taking is a good practice for adequate capturing of information included in reviewed documents and interviews prior to and immediately following fieldwork. Data were stored on a password-protected laptop computer. A password-protected removable disk served as the backup method for secondary copies of this study. Yin (2013) recommends storing large amounts of data electronically when possible. I will retain data and analytical results for 5 years and subsequent destruction of data will occur after 5 years.

Data Analysis

I used methodological triangulation in order to enhance confidence in this study's findings. Methodological triangulation is the use of multiple data sources to understand a phenomenon in a research study (Denzin, 2017). Bekhet and Zauszniewski (2012) noted that the use of two data collection methods increases the comprehensive validity of data and enriched understanding of a case. Wierenga, Engbers, van Empelen, Hildebrandt, and van Mechelen (2012) noted that methodological triangulation enables a researcher to probe for patterns in the data to develop an overall interpretation using multiple perspectives. Multiple sources of data (e.g., interviews and archival documents) may support study construct reliability through triangulation. The ability to perform a

comprehensive review of sources pertaining to controls used to reduce Medicare fraud can allow for the assessment of data from the interviews and documentation, which may lead to the creation of additional knowledge.

Data analysis involves the exploration of recurring themes, patterns, or concepts and then transferring the data into useful information (Nassaji, 2015). Qualitative researchers should analyze data in a logical and sequential manner (Brakewood & Poldrack, 2013). I followed Yin's 5-step data analysis process to compile, disassemble, reassemble, interpret, and conclude the data (Yin, 2014).

In compiling the data, I created a Microsoft One Note database that consisted of 10 healthcare leaders' interview reports. Each report covered the data collected in response to five interview questions (the questions were previously shown in the "Interview Questions" section of this study). The reports were then organized according to the health leaders' responses to the five interview questions. The database also included five documents (see Appendix C). The documents covered internal controls that organizational leaders use to reduce or prevent fraud.

Disassembling the data was the next step, which consisted of identifying common words and phrases in the documents and transcribed interviews. During the disassembling phase, researchers may become aware of broader patterns in the data (Yin, 2014). My review of the publically available documents consisted of establishing patterns in controls strategies used to combat Medicare fraud and matching control strategies from the interviews to Medicare fraud trends in the document data.

The next step involved reassembling the data to identify emergent themes. Scholars use computer software to assist with analyzing data (Wilkerson, Iantaffi, Grey, Bockting, & Simon Rosser, 2014). Qualitative researchers use QRS NVivo software for coding thematic categories and extracting themes that may assist in answering a research question (Trotter, 2012). QRS NVivo codes and manipulates the data, and then displays the codes. I used QRS NVivo 11 to assist with coding the data. Once I reviewed and entered the data into the QRS NVivo 11 software, I identified themes related to control strategies for combating Medicare fraud. The themes identified were directly associated to the portion of the criminal violation of trust theory over which healthcare leaders have the most control to combat fraud: the opportunity to commit fraud. The use of thematic analysis in this study aided in identifying patterns within the data that emphasize the key themes within the literature to develop a deeper appreciation of the control strategies aimed to reduce Medicare fraud.

The interpreting phase brings a researcher's entire analysis together (Yin, 2014). In the interpreting phase, I focused on the overarching research question for this study which was what control strategies do healthcare leaders use to combat Medicare fraud? When research is centered on finding a central explanation to a phenomenon, the explanation drives the structure of the entire study (Yin, 2014). Three key themes emerged and are detailed in Section 3 of this study. Completed qualitative research may result in one or more conclusions. A conclusion consists of an overarching statement or series of statements that elevates the findings of a study to a higher conceptual level or wide-ranging set of ideas (Yin, 2014). In the conclusion phase, I captured the broader

significance of the study by annotating the applications to professional practice, implications for social change, recommendations for action, and recommendations for further research. The conclusions of the study are detailed in Section 3.

Reliability and Validity

Reliability

Reliability means quality or accuracy in measurement (Rennie, 2012). The objective of reliability and validity is to remove bias and reduce errors in qualitative research (Podsakoff, MacKenzie, & Podsakoff, 2012). The terms reliability and validity are terms more appropriate for quantitative research. Yin (2013) suggested that dependability, credibility, transferability, and confirmability are critical elements needed to gauge the validity of qualitative research. Researchers should have thorough awareness of self-imposed bias (Yin, 2013). Participants verified my interpretation of their interviews to aid in ensuring reliability in this study.

Researchers agree that dependability and reliability share similar qualities in qualitative research (Foley & O'Conner, 2013). Dependability ensures that the researcher has an awareness of all changes affecting the research process and properly documents these changes (Houghton et al., 2013). Reflective journals are personal records that the researcher uses to record information throughout the study (Menzies, 2012). I used a reflective journal throughout the research process to document the progress of my learning, which assisted with ensuring dependability. As my main sources of data, I utilized perceptions obtained during semistructured interviews from management involved in overseeing, developing, implementing, and monitoring control

systems, and publically available documents related to control mechanisms for Medicare services. The emergent themes from the interview questions assisted in assessing how the varied perspectives aligned with determining how healthcare leaders attempt to combat Medicare fraud. Member checking helps establish thoroughness in the research and allows study participants to review the interviews for accuracy (Yin, 2013). I conducted member checking to minimize bias in the data in this study.

Validity

Rennie (2012) argued that validity is a complicated term to define because it lacks a universally accepted definition. Podsakoff et al. (2012) stated that validity is critical in qualitative research. Credibility, transferability, and confirmability assists with establishing validity and the overall quality of the study (Yin, 2013).

Credibility consists of ensuring the study results are trustworthy from the assessment of the participant (Cope, 2014). Member checking process aids in establishing credibility (Houghton et al., 2013). Awad (2014) claimed researchers may choose to incorporate member checking to offer research participants the opportunity to include additional perspectives on the research topic. I used member checking to assist with establishing credibility, which allowed me to share the data with research participants prior to finalizing the study results.

Transferability refers to the degree in which study results can be transferred to other populations or settings (Cope, 2014). Representative study samples and rich descriptions of study contexts enable qualitative researchers to enhance the transferability of their social science research (Bernard, 2013). Additionally, semistructured interviews

enhance transferability (Yin, 2013). In this study, semistructured interviews with open-ended questions assisted in producing research findings that allows transferability across other populations or settings.

Confirmability refers to the degree to which others could corroborate the study findings (Houghton et al., 2013). Qualitative researchers may use a number of strategies for enhancing confirmability. The researcher can document the procedures for checking and rechecking the data throughout the study. Confirmability also refers to the degree in which study results are free from bias (Yin, 2014). After the study, researchers can perform an audit that explores the data collection and analysis methods and makes judgments about the potential for bias to ensure confirmability (Houghton et al., 2013). A detailed audit trail that demonstrates how each decision was made aided in ensuring confirmability.

Data saturation is the point in which no new data is revealed during the coding process (O'Reilly & Parker, 2012). Data saturation is a key component in ensuring credibility in qualitative research (White, Oelke, & Friesen, 2012). Palinkas et al. (2013) noted an appropriate sample provides an effective analysis of a research topic to achieve data saturation. I achieved data saturation through interviewing individuals with the most expert knowledge, which lead to data repetition. I achieved data saturation by ensuring no new themes emerged.

Transition and Summary

Section 2 included an outline of the intent, research design, population sample, and data collection and analytical methods used for this study of Medicare fraud and

abuse. The conduct of a qualitative case study enabled exploration of how healthcare leaders in the Mid-Atlantic area of the United States describe necessary control strategies for combating Medicare fraud and abuse. I gathered data from semistructured interviews and publically available documents in order to obtain an understanding and knowledge of control strategies that might support on-going preventative efforts of Medicare fraud and abuse. Section 3 includes an overview of this study and a presentation of findings from the analysis of collected data. Section 3 also includes discussion of applications of the research to professional practice and the presentation of recommendations, reflections, and conclusions resulting from the conduct of this study.

Section 3: Application to Professional Practice and Implications for Change

In Section 3, I provide a detailed review of the data collected, the conceptual framework, and the findings related to the research question. Included in this section are an overview of the study, presentation of the findings, application to professional practice, implications for social change, and recommendations for action. This section ends with recommendations for further studies, reflections on my experience in the DBA doctoral study process, and a synopsis of the study conclusions.

Introduction

The purpose of this descriptive qualitative case study was to explore internal control strategies that healthcare leaders use to combat Medicare fraud. I conducted semistructured interviews with 10 healthcare leaders who have the responsibility of overseeing, developing, monitoring, or implementing control mechanisms for Medicare services in the Mid-Atlantic area of the United States. I performed data triangulation from my analysis of document reviews. I performed member checking and methodological triangulation to ensure data saturation, credibility, and confirmability of the study results. Study findings revealed three core themes that may assist organizations in effectively administering the Medicare program: (a) establish an effective control environment, (b) develop an effective accounting system, and (c) establish adequate control procedures. The findings from this study may support business leaders' efforts to identify and implement effective control strategies to reduce Medicare fraud. The control strategies identified during the study might contribute to social change by reducing

healthcare costs for U.S. citizens. The control strategies may contribute to a healthcare system that leads to a healthier citizenry.

Presentation of the Findings

The overarching RQ for this study was: What control strategies do healthcare leaders use to combat Medicare fraud? Effective internal controls minimize the risk that major errors or fraud will occur and remain undetected in an organization (Johnson et al., 2014). Internal control also serves as the entity's defense in safeguarding assets and combating fraud (Document 1). Based on the criminal violation of financial trust theory, literature reviews, and data collections, I identified three key themes that provide insights about internal control strategies healthcare leaders can use to combat Medicare fraud.

Figure 2 shows the three themes identified from research findings.

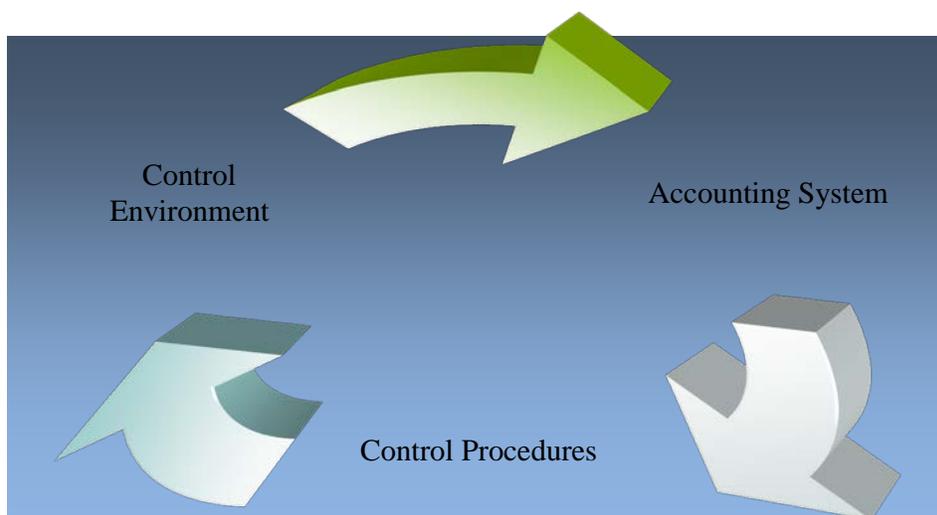


Figure 2. Themes from research findings.

Theme 1: Establish an Effective Control Environment

All of the participants (Participants 1 – 10) acknowledged the need for an effective control environment. The governing body and senior managers of an entity

receiving Medicare funds must institute a sound control environment (D'Aquila, 2013; Document 1). Participants 3, 7, 9, and 10 recognized that the control environment plays a key role in the overall attitude of individuals in an entity. As noted by one participant, "The control environment can be the bridge between an individual choosing to do right or commit any wrong doings" (Participant 7). Several key internal and external elements make up an effective internal control environment, which includes the (a) management philosophy and operating style, (b) organizational structure of the agency, (c) control methods for monitoring performance, (d) personnel policies and practices, and (e) sensitivity to external influences (Document 1).

Management philosophy and operating style. Most of the participants acknowledged that management should establish and maintain an environment that encourages positive attitudes toward internal control. Participants 4 and 7 explained that senior leadership sets the tone for the culture of an entity. If senior leadership advocates ethics and integrity, then its employees most likely will follow the examples of those leaders. If upper management appears indifferent to ethics and focuses solely on making a profit, then employees will surmise that the organization does not expect ethical conduct and be more prone to commit fraud. In the high profile case involving Victory Pharma Inc., allegations suggested that leaders in the organization engaged in a scheme to pay kickbacks to doctors to encourage them to write prescriptions for Victory's products, including prescriptions for Medicare patients (DOJ, 2012c). Although Victory resolved allegations through settlement, the resolution underscores the need for managers

to operate under the realm of internal controls that encourages conscientious management.

Organizational structure. The organizational structure is vital in the development of a sound control environment for entities receiving Medicare funds (Document 1). Leaders should develop an organizational structure that provides the overall framework for directing, planning, and controlling activities aimed at achieving the mission of the organization. Participants 4, 6, 7, 9, and 10 expressed that the organizational structure needs to clearly define authority and responsibility in an entity and establish appropriate lines of reporting. One participant noted, “Organizational structure encourages teamwork, where all individuals work toward one common goal” (Participant 6).

Control methods for monitoring performance. The internal control system should assess the quality of performance regularly and ensure that management promptly resolves observations and findings of audits and other reviews. Participants 5, 9, and 10 stated that healthcare leaders should include robust peer review programs in its policies and procedures to aid in monitoring performance of individuals. Participant 9 noted, “There are horrid accounts of fraud that demands the question on whether Medicare products and services are actually medically necessary.” Optim Healthcare allegedly submitted Medicare claims for surgical and other medical procedures that were improper, intentionally miscoded, and violated the federal Stark Law (DOJ, 2012f). Periodic peer reviews and careful review of providers might have prevented allegations of such wrongdoings by ensuring colleagues held doctors accountable for their actions. Periodic

peer review may assist organizations in identifying individuals who warrant special monitoring and review.

Personnel policies and procedures. Participants 3, 4, 7, and 9 stated that organizations should incorporate the performance of background investigations in its personnel policies and procedures in an attempt to hire honest workers. Background investigations should be proportional to the business requirements, the types of information being accessed, and the perceived risks that have been formally identified. At a minimum, organizations should consider conducting background investigations to address criminal, education, and reference checks, as well as licensing and employment verification. There are health care organizations that still conduct criminal background investigations for only their surrounding counties or statewide as a cost-saving measure. Although an organization may incur additional costs, the agency should consider conducting nationwide checks. Also, an organization should consider conducting periodic background reinvestigations for workers with higher levels of insider access in areas such as system administration or finance and accounting. Participant 1 stated, “An external factor that may influence controls aimed to combat Medicare fraud is federal government funding as more resources provide the ability to conduct more investigations.” Participants 7 and 9 stated that the reinvestigations have both a deterrent and preventive effect against healthcare fraud. Policies and procedures that ensure staff is adequately trained and knowledgeable regarding Medicare laws and regulations are crucial in combating Medicare fraud (Document 2). Participants 3, 5, and 7 have confidence that organizations can develop security awareness and training programs to

include health care fraud examples of indicted or prosecuted fraudsters. The programs should coincide with training that ensures workers have the proper level of knowledge to identify when harm might occur, whether it is with accounting procedures or the improper use of information assets.

Sensitivity to external influences. Participants 1, 5, 8, and 10 stated that organizations should be aware of external influences that may influence controls aimed to combat Medicare fraud such as federal government funding and oversight. All of the participants (Participants 1 – 10) acknowledged that organizations should be fully aware of internal and external influences, such as internal and external audits performed on the entity. The organizations should plan for and be responsive to the influences through accurate reporting on agency operations and establishment of specific internal control structure policies or procedures. Organizations can periodically check the U.S. Department of Health and Human Services website for published reports that identify internal controls the agency might need to consider strengthening to aid in ensuring that it effectively manages Medicare funds.

Theme 2: Develop an Effective Accounting System

An effective accounting system is one of the key elements of an agency's internal control system (Document 1). Entities that receive Medicare funds must have accounting systems that can adequately track and account for all Medicare financial data (Document 1). Healthcare leaders should ensure its accounting system consists of the methodologies and documentation established to account for and report on transactions and maintain accountability for the entity's net worth (Document 1, Document 3).

Theme 3: Establish Adequate Control Procedures

Control procedures are the policies and procedures in addition to the control environment and accounting system (Johnson et al., 2014). The procedures are developed and maintained to provide reasonable assurance that management achieves the fiscal and programmatic objectives of the agency (Document 1). Although strong systems of internal control provide reasonable and not absolute safeguards against fraud, organizations can diligently perform control responsibilities and limit access to property, systems, and information in an attempt to mitigate risks and deter fraud (Rodgers, 2012). Several control procedures may aid in creating an environment of ethical fiscal management such as (a) segregation of duties, (b) information security, (c) audits, and (d) documentation (Document 1).

Segregation of duties. Participants 5, 6, and 8 expressed the need for segregation of duties. Segregation of duties assists in combating fraud, waste, and abuse (Document 2). A control objective of an entity receiving Medicare funds should ensure adequate segregation of duties exists between various functions within Medicare operations and is supported by appropriately authorized and documented policies (Document 1). Participant 8 stated, “Leaders should not have dual functions in duties such as cash handling.” For example, durable medical equipment suppliers should not allow the person who orders equipment also sign off on checks to suppliers (Participant 8). Leaders should ensure that it disseminates cash reporting responsibilities appropriately to prevent theft by collusion (Participant 8).

Information security. FISMA describes a comprehensive structure to protect government information such as Medicare data, operations, and assets against natural or human threats (Document 4). All participants (Participants 1-10) acknowledged that organizations should implement physical and electronic security measures to ensure the safety of Medicare data. Participants 3, 4, and 6 expressed that organizations should store sensitive data in secure areas or on password protected devices and only allow access to select employees. Leaders should also require employees to periodically change passwords to ensure security of their computer accounts (Participant 4). Employees of Coventry Health Care, a health insurance company in Maryland, inappropriately accessed the Medicare database to obtain Medicare eligibility information for the sale of Medicare set-aside products (DOJ, 2012e). The organization paid \$3 million as part of a non-prosecution agreement (DOJ, 2012e). A network administration team or a security company could conceivably have assisted the organization with developing security systems that ensured management processes and procedures included reporting of intrusion attempts and intrusions in accordance with FISMA (Document 4).

Audits. Participant 1 expressed that on-site audits are most effective at combating Medicare fraud. Participant 2 stated, “Audits highlight elements of fraud.” All of the participants (Participants 1 – 10) believed that healthcare leaders should have processes in place to ensure third-party accounting audits periodically review the agency’s financial control systems. Participant 4 added, “Audits are typically an examination of company documentation and not necessarily a check to determine whether beneficiaries actually received products or services.” Nonetheless, entities should work with auditors who have

no conflicts of interest with the company or its employees (Participant 8). Johnson et al. (2014) explained that audits and management reviews are less effective as detection tools. The periodic use of a third-party auditor to discover financial mismanagement might have prevented recent organizations (i.e., Victory Pharma, Inc., Pfizer Coventry Health Care, Optim Healthcare) cited for healthcare fraud from undergoing costly litigation and financial mayhem.

Documentation. Maintaining adequate accounting records is required to meet basic, widely accepted standards of accountability (Document 2). Participants 4, 7, and 9 stated that an entity should maintain accurate accounting records and source documentation to ensure the organization could adequately track and account for Medicare funds. Participants 3, 4, 6, 7, and 10 expressed that an organization's inability to maintain adequate records increases its risk of being subject to fraud. The entity's independent auditor examines accounting records and source documentation as a part of the audit in order to substantiate the information that appears in the financial statements (Document 2). An audit involving Medicare expenditures that the entity is unable to adequately support with source documentation may result in questioned or disallowed costs, in which the organization may have to pay back to the grantor agency.

Relation to Conceptual Framework

The findings from this study support the idea that the criminal violation of financial trust theory, as it relates to the opportunity to commit fraud, might serve as an important theory for guiding the development of control strategies for leaders in the healthcare industry. Cressy (1953) described opportunities as those perceived by a

potential fraudster (Trompeter, Carpenter, Desai, Jones, & Riley, 2013). Healthcare leaders attempt to anticipate what fraudsters might perceive as opportunities and design an environment to minimize the potential for fraud (Trompeter et al., 2013). The opportunity to commit fraud is possible when employees have access to company assets and information that allows them to both commit and conceal fraud (Verschoor, 2015). Because the sheer size and complexity of the Medicare program makes it vulnerable to fraud, leadership development and implementation of a strong internal control system within organizations might minimize the opportunity to commit fraud (Verschoor, 2015; U.S. Government Accountability Office, 2013). Findings reveal that an effective control environment, adequate accounting system, and effective control procedures might aid in providing reasonable assurance that entities are good stewards of Medicare funds.

Applications to Professional Practice

Study findings highlight the need for health care leaders to develop and implement robust internal control systems to combat Medicare fraud and abuse. Healthcare leaders should view its internal controls as essential parts of each system that management uses to achieve the overall objectives of the Medicare program (Document 1). The federal government used a traditional model known as the pay and chase model where the providers received payment for submitted claims, then enforcement officials pursued fraud and abuse after the claims were paid (Gibson & Singh, 2012). Study participants noted that the pay and chase model was not a deterrent to Medicare fraud. The government now uses predictive analytics to identify providers and other individuals in the health care industry who might have participated in payment fraud (Document 5).

This research makes significant contributions to the literature. Specifically, this study shows that healthcare industry leaders can promote the detection and deterrence of Medicare fraud through developing and implementing proactive strategies that focus on the organization's internal control system such as policies and procedures centered on the control environment, accounting system, and control procedures.

The control environment sets the tone for the organization, influencing the attitudes and behaviors of employees (Schmidt, 2014). An effective control environment can positively influence anti-fraud efforts of combating Medicare fraud (COSO, 2013). For example, the existence of fair and robust grievance and disciplinary procedures might reduce the possibility of a case against the company for wrongful termination of unscrupulous employees. Additionally, the existence of human resources policies and practices that focus on matters such as sufficient ongoing training as well as recruiting and maintaining honest workers demonstrates the CEO or directors' favorable attitude toward their company's workforce. Most likely, the CEOs' favorable attitude may build good working relationships with employees, leading to an increased chance that individuals would perform their tasks with integrity in the best interests of the organization – which may result in a reduced risk of Medicare fraud.

Schaum (2017) noted that one of the difficult challenges healthcare leaders face is dealing with the fast-changing statutory requirements in the healthcare industry. Regulatory changes within Medicare have caused some healthcare leaders to outsource their billing with the accompanied loss of revenue (Stryker, 2015). Other healthcare leaders have managed to keep their billing in-house (Stryker, 2015). Nonetheless, an

effective accounting system is necessary to ensure Medicare billings are timely, accurate, informative, and reliable (Document 1). Additionally, an effective accounting system might prevent and detect fraud, waste, and theft (Document 2).

Control procedures are the methods and rules leaders should enforce in order to fulfill a particular control activity (Dascalu, 2016). Control activities occur at all levels within an organization and include a wide-range of activities including segregation of duties, security of assets, audits, and documentation (Document 1). These activities help ensure that healthcare leaders are good stewards of Medicare funds (Document 1). In business practice, normative acts such as state and federal laws, instructions, or circular forms diversify and regulate the control procedures. Healthcare leaders are encouraged to implement policies and procedures thoughtfully and update as necessary.

Based on this study's findings, healthcare leaders may identify effective control strategies that aid in combating Medicare fraud. Leaders should note that internal controls cannot provide absolute assurance that the organization will meet financial objectives. Internal controls may not always prevent or detect fraud. Thus, even if an organization's internal control system is determined to be effective, it can provide only reasonable assurance with respect to the preparation and presentation of financial data and detection of fraud. External factors such as political changes and demographic or economic conditions are beyond healthcare leaders' control. Therefore, healthcare leaders should always be prepared to revise procedures as necessary to ensure its internal control system is adequate to manage the Medicare program.

Implications for Social Change

From 1960 to 2008, U.S. healthcare spending grew exponentially from approximately \$150 billion to \$2.2 trillion, which represented an estimated 6% annual growth rate (Chernew, 2011). In 2012, the United States healthcare spending grew 3.7%, reaching approximately \$2.8 trillion (CMS, 2014). The growing healthcare costs are constraining economic growth, consuming increasing portions of the nation's gross domestic product, and placing added burdens on families, businesses, and government (DiSantostefano, 2013; Wisk et al., 2014). Healthcare leaders may benefit from an increased understanding of effective control strategies and techniques, and might apply this knowledge to efforts to stop the escalating growth of Medicare costs.

Study findings point to strategies that might enable health care leaders to strengthen their internal control procedures in an effort to effectively combat Medicare fraud and ensure effective stewardship of government resources. The provision of a sound control environment might provide the discipline and structure necessary to mitigate unethical behaviors that ultimately foster nefarious acts within the Medicare program. An effective accounting system might increase the awareness of the checks and balances that are necessary to accurately account for and report on Medicare costs incurred within an agency. Additionally, effective control procedures might provide the reasonable assurance that leaders will achieve the objectives of the organization. The implementation of strategies identified from this study might strengthen the efficiency of health care leaders and support their efforts in limiting the opportunities necessary in the commitment of Medicare fraud.

Recommendations for Action

The healthcare fraud phenomenon is the result of many contributing factors including inadequate training, financial gain on the part of perpetrators, and a lack of effective internal controls (Mayhew & Murphy, 2012; Murphy & Free, 2016; Schuchter & Levi 2016). Current and future healthcare leaders can take specific actions to reduce the risk of opportunity when they develop and implement effective internal controls that aids in ensuring organizations have an adequate and comprehensive financial management system to administer the Medicare program (Document 1; Document 2; Verschoor, 2015). Healthcare leaders, including CMS contractors, should:

- develop or strengthen personnel policies and procedures to aid in assisting the organization to hire honest workers;
- develop or strengthen fiscal controls, accounting procedures, and trainings to ensure that staff are knowledgeable of Medicare requirements and can comply with guidelines set forth by CMS;
- develop or strengthen fiscal controls and accounting procedures to ensure adequate documentation is maintained for the claims submitted to CMS;
- develop or strengthen written procedures identifying the entity's methodologies for accounting for and reporting on Medicare claims. Claims submitted to CMS should be traceable to information maintained in the organization's financial management system. Healthcare leaders should clearly document the methodologies used to calculate reported claim amounts submitted to Medicare; and

- develop or strengthen policies and procedures to ensure funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation.

Scholarly journals and business publications are ways to disseminate the information included in this study to healthcare leaders. Healthcare leaders may also receive this study information through seminars, training courses, and conferences. This study will also be available through the ProQuest/UMI dissertation database for future scholars and healthcare organizations.

Recommendations for Further Research

One recommendation for further study includes the exploration of leadership strategies for combating Medicaid fraud in various states or at the federal government level. Researchers could employ a qualitative approach similar to that used for this study of leadership strategies used to combat Medicaid fraud. Another recommendation is researchers could use findings from this study to develop a survey that serves as the basis for a quantitative assessment of how health care leaders across the nation characterize necessary internal controls to combat Medicare or Medicaid fraud. The study excludes perceptions of Medicare beneficiaries. Therefore, researchers may want to obtain Medicare beneficiary perceptions of Medicare fraud, which might also aid in obtaining control strategies to combat the problem.

Reflections

The DBA Doctoral Study process was one of the most challenging yet rewarding experiences in my life. Although the dissertation process is overwhelming, the

continuous support of my committee members and Walden resources has made the process conquerable. I embarked on the DBA doctoral study process after a lengthy hiatus from academia. Therefore, the faculty's elevated expectation of my writing caused some minor discomfort. There were several iterations of my doctoral study proposal. The invaluable expertise of my committee members made all the revisions worthwhile. The findings from this study affected me on a profound professional level. Prior to the study, I was not fully aware of how the intricate elements of an effective internal control system might minimize the likelihood of fraud, waste, or abuse of Medicare funds. Through the analysis of interviews and documents, I gained knowledge of control strategies leaders could develop or strengthen within their organizations that might aid in combating Medicare fraud. The overall study findings were consistent with the literature review and reinforced the need for businesses to develop and implement proactive strategies to combat Medicare fraud.

Conclusion

Medicare fraud exposes organizations to potential criminal or civil liability that could lead to imprisonment, fines, and penalties. Criminal and civil fines and penalties for Medicare fraud emphasizes the serious concerns associated with health care fraud and the need for robust anti-fraud strategies. Health care leaders should ensure entities have an effective internal control system to minimize or reduce the likelihood of Medicare fraud. The cost savings resulting from efforts to combat Medicare fraud might enable leaders to improve the quality of care for Medicare beneficiaries. As the Medicare program continues to expand, leaders may have challenges developing and implementing

effective fraud initiatives. Recommendations from this study might enable health care leaders to develop strategies that might halt the escalating growth of Medicare program costs and ensure that health care services continue to be available to the most vulnerable American citizens.

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Appendix A: Interview Protocol

Interview Title: Leadership strategies for combating Medicare fraud.

1. I will begin the interview with introductions.
2. I will provide each research participant a hard copy print out of the informed consent form, which he or she signed, for his or her records. I will thank the participant for agreeing to participate in the study.
3. Because member checking is crucial for reliability and validity of the research data, I will elaborate on the member checking procedures introduced in the consent letter. I will also schedule time with the interview participants for member checking procedures following transcription of the data.
4. I will inform the participant when I am turning on the audio recorder.
5. I will state the date, time, location, and coded sequential representation of the participant's name e.g., 'participant R01' on the audio recording, and will begin the interview.
6. Each participant will have sufficient time to answer each interview question as well as any follow-up questions.
7. At the close of the interview, I will thank each research participant for his or her time and participation in the study.

Appendix B: Cover Letter

Date

Dear _____:

My name is Taniesha Grant and I am a Doctor of Business Administration (DBA) candidate at Walden University. I am conducting a doctoral study project to examine the control strategies that healthcare leaders in the Mid-Atlantic area of the United States use to combat Medicare fraud. My study is intended to explore the following question: What control strategies do healthcare leaders use to combat Medicare fraud?

Based on your experiences with overseeing, developing, monitoring, or implementing control mechanisms for Medicare services, I would like to interview you in order to gather information about your perceptions and beliefs about control systems necessary for combating Medicare fraud and abuse. The interview will require 30-60 minutes of your time and will be scheduled at a time and place convenient for you. I will conduct this semistructured interview at a location of your choice. I also invite you to share with me any e-mail messages, administrative documents, reports, and/or memoranda that you feel may provide additional information about control mechanisms for Medicare services. I note that the provision of any documents on your part is voluntary. If you do not wish to provide documents, I am still asking that you participate in the study as an interviewee.

Your participation will be instrumental in ensuring that I gather data from healthcare leaders in the Mid-Atlantic area of the United States with direct knowledge of the control systems and the problem of Medicare fraud and abuse. If you decide to participate in my study, I will send you an informed consent form via e-mail for your review and signature. This informed consent form provides background information on the study and outlines your rights during the interview process. Please contact me if you have any questions or require additional information.

I kindly request a response to this letter indicating your agreement to participate or your declination by [RESPONSE DATE TO BE INSERTED AFTER INTERVIEW TIME PERIOD IS FINALIZED FOLLOWING IRB APPROVAL]. Thank you in advance for your consideration and your support of my study of a topic of national significance.

Sincerely,
Taniesha Grant

Appendix C: Case Study Documents

Document identification	Description
Document 1	Medicare Financial Manual
Document 2	The Green Book
Document 3	Chief Financial Officer Act of 1990
Document 4	Federal Information Security Management Act (FISMA)
Document 5	Center for Program Integrity Key Anti-Fraud Activities
