

HEALTH CARE EXECUTIVES' PERCEPTIONS ON FRAUD LEGISLATION: A
REPLICATED QUANTITATIVE STUDY

by

Barbara Hess

A Dissertation Presented in Partial Fulfillment
of the Requirements for the Degree
Doctor of Health Administration

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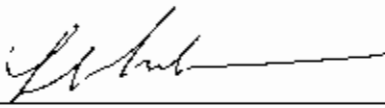
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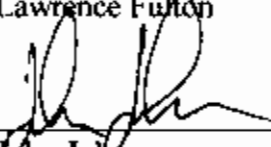
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ABSTRACT

According to the National Coalition on Health Care (NCHC) (2009) inappropriate care, waste, and fraud is evident in the United States' (U.S.) health care system. Conservative estimates of 3%, or \$68 billion, of health care spending is lost because of fraud (National Health Care Anti-Fraud Association [NHCAA], 2009). The purpose of this quantitative descriptive study was to compare the Arizona AHCCCS program contractor executives' perception of the level of adequacy of legislation and corporate compliance programs in deterring unethical behaviors to the perceptions of hospital executives. Using a validated survey from Van Crombrughe's (2002) study of health care executives in the hospital setting, this replicated study of health care executives in health plans was completed. Results indicated that there is a significant difference in the perceptions of between both executive types on fraud in hospitals and fraud legislation. One outcome of this study was the even though there were differences in perception on fraud, both types of executives perceived that compliance programs had significant impacts on deterring fraud. Eighty-six percent of the hospital executives and 99% of the payers indicated that corporate compliance programs were established to deter fraud. Recommendations include replicating this study with other health care executives to gain a broader perspective on perceptions.

DEDICATION

I dedicate this current doctoral dissertation to my parents. To dad, you were right; it is hard to improve on perfection and always get back on the horse that bucked you off. Mom, thanks for putting me on the bus the first day of kindergarten.

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I am grateful to the many people who helped me in the completion of this project. I will remain grateful to my mentor Dr. Larry Fulton, Dr. John Johnson, Dr. Richard Schuttler, and to the staff and educators at University of Phoenix. Michelle Williams, my academic counselor, thanks for arranging, rearranging, and encouragement. No, I still do not know my IRN number.

To life. You have given me all the vicissitudes in a short period. Being married, getting a divorce, selling a house, buying a house, getting a new job, being laid off, and trying to find gainful employment while proceeding through the doctoral process has been a growth opportunity in itself for the last two years. Thank you to the employers who have let me leave early, come in late, or not come in so that I may finish this.

Many thanks to my family for their support through this process. Thank you mom for reading my proposal. To my brothers, in your own individual ways you have inspired me and don't forget to put on chap stick! Phillip, continue to celebrate your naughtiness! Thanks to my ex-husband, Jason, who saw me through most of this process.

Thank you to my friends, especially my collaborator in crime, Susan Murphy, for all the support and encouragement that kept me inspired. To Gary Smyth who motivated me and always dusted me off when I fell. To all my doctoral colleagues and the teams, especially LM, SS, LS, WV, KP, WM, MK, RG, and JR. May the faucet of education be ever flowing.

Special gratitude to Dr. Phyllis Von Crombrughe. May your research progress health care fraud deterrence!

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Chapter 1: Health Care Executives' Perceptions on Fraud Legislation

According to the National Coalition on Health Care (NCHC) (2009) inappropriate care, waste, and fraud is evident in the United States' (U.S.) health care system. Conservative estimates of 3%, or \$68 billion, of health care spending is lost because of fraud (National Health Care Anti-Fraud Association [NHCAA], 2009). Although historical literature exists on theories to deter fraud (Cressey, 1953; Sutherland, 1940) and the development of ethical behavior (Gilligan, 1982; Kohlberg, 1958), there is minimal modern literature on transforming fraud research into business practice. Although surveys and literature exist on the perspectives of many health care stakeholders, a gap in literature exists between apparent consensus of perspectives between health care executives on the adequacy of legislation and corporate compliance programs in deterring fraud.

The focus of this replicated quantitative study was to examine the perceptions of Medicaid health care insurance payer executives in Arizona on the ability of current legislation to deter health care fraud and compare these perceptions to those of hospital executives. This comparison might close the gap in literature that exists between examining the consensus of perspectives. Chapter 1 includes a background to the study, the general and specific problem of health care fraud, and the assumptions, limitations, and delimitations of this study. An introduction of the research questions and hypotheses follow the background of the problem. Because of the social interest in fraud, the results of this study may enable health care professionals and other industry leaders in leading the changes needed to deter fraud.

Background of the Problem

Fraud has social interest because of the amount of financial loss sustained by stakeholders and theoretical interest of criminologists, researchers, and theorists. The increasing

number of fraud cases reported and the amount of financial resources recovered determines social interest in fraud. Theoretical interest in fraud has evolved through historical research (Cressey, 1953; Kohlberg, 1958; Sutherland, 1940) and researching different social elements like gender (Gilligan, 1982), occupation (Wells, 1997), culture (Bierstaker, 2009), and economic status (Fakinlede, 2008).

Theoretical Interest

Developed in the 1940s and 1950s, the majority of historical theories on fraud focused on deterrence and the development of ethical behavior. Occupational fraud theories (Cressey, 1953; Sutherland, 1940) and moral development research (Kohlberg, 1958) were developed to further the understanding of who committed fraud, ways to deter fraud, and why fraud was committed. The professional landscape of business practices has changed substantially since the 1950s and so has the complexity of fraud schemes. However, a gap existed not only between the length of time that has elapsed since the development of fraud theories but between theory, research, and business practice.

Furthering the historic theories on fraud, modern advancements in fraud research have sought to improve the understanding of fraud (Gilligan, 1982; Wells, 1997). Studies in fraud include a combination of quantitative, qualitative, and mixed-method research. Research has explored different variables like the impact of occupation (Wells, 1997), culture (Bierstaker, 2009), poverty (Fakinlede, 2008), and punishment (Taylor, 2002) and how these elements influence fraud deterrence.

Social Interest

Health care fraud has an extensive social interest as well. The health care industry had five of the largest federal False Claims Act (FCA) settlements in 2005. The five organizations

included Gambro, HealthSouth, GlaxoSmithKline, CareMark, and Staten Island University Hospital (Olson, 2006). Gambro violated anti-kickback regulation and allegations that included unnecessary testing and services. Gambro was operating a deceptive durable medical equipment company (Taxpayers Against Fraud [TAF], 2007). Allegations against HealthSouth included systematically defrauding Medicare and other federal health programs (TAF).

The social interest in fraud does not only affect large, privately held corporations. Fraud exists in public and rural organizations as well. Allegations of fraud and settlements continue into the 21st century. Family Health Care of Alabama, a not-for profit primary care organization operating 17 community health centers, lost a \$6 million contract in 2001 because of non-compliance and allegations of mismanagement and fraud (Savage, Dunkin, & Ford, 2004). In July 2009, New York State and the city of New York agreed to repay the federal government \$500 million to settle the largest government Medicaid False Claims case to date (TAF, 2009a).

Considering the social and financial interest in fraud, minimal modern research existed on the subject (Wells, 2005). Key stakeholders in health care are the provider, the member or patient, and the payer (Kroncke & White, 2009). Minimal research on health care fraud as it pertains to each key stakeholder exists. No prior studies have addressed the perceptions of the health care insurance payer on the ability in which legislation deters fraud. Although studies from the provider perspective exist, the payer who is one of health care's prominent stakeholder groups does not.

Statement of the Problem

The general problem of health care fraud is that although there are an increasing number of legislations enacted and amended to deter fraud, there are an increasing number of reported fraud cases. According to TAF (2007) statistics, 382 newly reported fraud cases with judgments

and settlements reaching over \$3 billion were reported in 2006. Of the 382 newly reported cases, 110 of these cases involved health care related issues. The specific problem is a lack of understanding of health care executive perceptions of the adequacy of laws in place to deter health care fraud. Gaining the perceptions of health care payer executives on fraud was a starting point to developing an understanding of the clear gaps in the inadequacies of laws enacted to deter fraud.

The general population group for this replicated descriptive quantitative study was program contractor executives employed by organizations that contract with the Arizona Health Care Cost Containment System (AHCCCS) to provide claims payment and other health services like quality improvement and case management. Results from the 200 program contractor executives surveyed in this replicated descriptive quantitative study would increase knowledge of the perceptions of health care insurance payer perceptions of the adequacy of laws in deterring fraud. The results compared to those results gained of hospital executive perceptions (Van Crombrughe, 2002) would be a starting point toward an extensive understanding of the adequacy in deterring fraud in the health care industry.

Purpose of the Study

The purpose of this quantitative descriptive study was to compare the Arizona AHCCCS program contractor executives' perception of the level of adequacy of legislation and corporate compliance programs in deterring unethical behaviors to the perceptions of hospital executives. Van Crombrughe (2002) conducted a similar study to gain hospital executives' perceptions on health care fraud and abuse in California. Study results indicated that health care executives have not had the opportunity to express views on this topic (Van Crombrughe, 2002).

This research study contained discrete variables identifying the executive role and

continuous variables. Continuous variables included the indication of years in the position. Independent variables identified the perception of health care executives on the legislation enacted to detect, deter, and decrease fraud. To formalize the understanding of the perceptions of health care executives, results from these two studies would provide a comparative outcome.

The specific population of this study was the executives working for organizations contracted with AHCCCS. Program contractors provide claims payment for medical services, casework, and quality improvement efforts to the Medicaid eligible underprivileged and elderly population of Arizona. This mix of perceptions, both from the medical and business professional viewpoint, will promote a better understanding of the perceptions of each prominent position within the program contractor organization.

Significance of the Problem

The research study was important because the study may have an impact on increasing the knowledge of fraud deterrence. An earlier study conducted by Van Crombrughe (2002) sought to further the understanding of hospital executives' perception on the adequacy of legislation and corporate compliance programs to deter fraud because no other literature or studies existed. The study was important because it could increase the knowledge and add to the minimal research that exists on fraud deterrence. According to Van Crombrughe, minimal research exists to examine health care executives' opinions on enforcement of laws to deter fraud.

Health care costs are growing at six times the rate of inflation (Cucciare & O'Donohue, 2006). The National Coalition on Health Care (NCHC) (2009) estimated that national health spending in 2009 will reach \$2.5 trillion and by 2018, health care expenditures will reach \$4.4 trillion. If the estimated financial loss to health care fraud were 3% of these values, \$75 billion

would be lost to fraud in 2009 and \$132 billion would be lost in 2018. With such significant statistics and estimated costs to society, a need could exist to understand fraud and unethical behavior to deter it. The use of a different population to provide evidence of executive perception on health care fraud and replication of a study could increase the validity of modern research on health care fraud.

Significance of Study to the Field of Leadership

The information obtained by this research could help other industry leaders in developing and implementing effective internal controls such as corporate compliance programs that deter fraud. According to the Association of Certified Fraud Examiners (ACFE) (2008), organizations that implemented internal controls significantly lower losses because of fraud. The goal of this study was to provide the health care industry and other industry leaders with knowledge of executive perceptions on the adequacy of laws as it pertains to deterring fraudulent behavior.

Executives believe that executive roles should have a larger leadership role in efforts to address sociopolitical efforts in health care (Abbas, 2008; McKinsey Quarterly, 2007). Of the 400 executives surveyed in the McKinsey study, 37% stated that the U.S. health care system had the greatest effect on shareholder value. Results from the McKinsey study indicated that 41% of the executives believed that U.S. health care issues were personally most important.

Learning from other industries is pertinent to strategic development, corporate compliance, and culture. Leaders in other industries are concerned with regulation and legislation that affect industry business practices. Results from a McKinsey Quarterly study (2007) indicated that 42% of the executives surveyed cited federal regulations had the greatest effect on shareholder value of the company. Whether governmental entities or privately held companies, executive perceptions play a key role in defining legislation.

Nature of the Study

The purpose of this quantitative descriptive study was to compare the Arizona AHCCCS program contractor executives' perception of the level of adequacy of legislation and corporate compliance programs in deterring unethical behaviors to the perceptions of hospital executives. Two hundred Arizona program contractor executives could provide quantitative data for the research. Participants are located throughout Arizona and employed by organizations that contract with AHCCCS to provide claims payment services.

The research study was based on the characteristics of quantitative research that was the strongest aspect of the original study. This research bases data collection from a validated survey instrument collecting numerical values for statistical analysis, including the nonparametric chi-square hypotheses testing method, and graphical representation of data. Although qualitative data was discussed and presented in the original study, the qualitative approach was not fully developed and would be the weakest part of this study. Detailed explanations of this exclusion of the qualitative aspect of the original study are in chapter 3.

Overview of Research Method

Quantitative research tests hypotheses (Creswell, 2005; Neuman, 2006). This study started with hypotheses identified from the research questions posed by Van Crombrughe in 2002 and revised for this study. According to Neuman (2006), quantitative research has standard procedures and these studies are frequently replicated (p. 157). This study replicated the quantitative aspect from research conducted by Van Crombrughe (2002) that studied hospital executives' perceptions of the adequacy of legislation to deter fraud.

As opposed to open-ended questions posed in qualitative research, the validated survey instrument used in this study collected quantitative data. Instead of collecting qualitative

responses in text format, data was collected with a 10-question survey with a 5-point Likert-type scale to describe the area of fraud. Although collecting text in qualitative format is important in research, the survey instrument contained no qualitative questions. The replicated study focused on the quantitative aspects of the original study. Permission to use this existing survey is in Appendix A.

Neuman (2006) stated that statistics, charts, graphs, and discussion follow analysis on how the hypotheses relate to the research (p. 157). This study used charts and a chi-square statistical test that will be presented in chapter 4 along with discussion of the results. With scientists and theorists as a skeptical group (Neuman, 2006), this research took the original study and progressed knowledge and acceptance in replication. This replicated study, with the addition of hypotheses, could further interest in fraud research with changing and developing alternative hypotheses by other researchers.

Overview of Design Appropriateness

The purpose of the descriptive design of the quantitative research method is to provide a highly accurate picture of the phenomenon, locate new data that may contradict past data, and clarifies a sequence of steps (Neuman, 2006, p. 34). This quantitative study sought to establish a statistically accurate picture of health care executives' perceptions of fraud. Gathered will be a new set of data and results compared to past research results with other health care executives' perceptions. The appropriateness of the research design indicates that replication clarifies a sequence of steps and is descriptive in nature. A descriptive study presents a picture of types of people (Neuman, 2006). The goal of this study sought to identify the perceptions of program contractors and compare these perspectives to the perspectives of health care executives.

Other designs, like exploratory research or experiential research, were not appropriate for this study. Because the qualitative research approach was not appropriate, the research designs associated with qualitative methodology were not suitable. Qualitative research designs and mixed-method designs were not used for this current study and the reasons are discussed chapter 3.

Research Question

The purpose of this quantitative descriptive study was to compare the Arizona AHCCCS program contractor executives' perception of the level of adequacy of legislation and corporate compliance programs in deterring unethical behaviors to the perceptions of hospital executives. Formulation of the research questions drives this study by four distinguishing factors. The dramatic increase of the number of health care fraud cases (TAF, 2007), the sheer volume of claims paid by payers (NHCAA, 2009), the estimated financial losses to organizations from fraud (NHCAA, 2009; ACFE, 2008), and the gap in literature that exists in better understanding health care executives' perceptions of fraud legislation was the dynamic forces of this study. The literature review conducted by Van Crombrughe (2002) supported the fact that as of 2002 no research to date exists concerning health care executives' "candid and confidential opinions on the perceptions about health care fraud" (p. 23). A literature review of current information proved that no research exists on the health care payer executives' perception of the adequacy of legislation in deterring fraudulent activities.

According to Van Crombrughe (2002), the review of the literature in 2002 reflected that there was no research on health care executives' opinions regarding the enforcement of legislation on health care fraud. These research questions posed in this study are specific to the dilemma of health care fraud and the study of these highly educated, skilled leaders provided

insight into the problem of fraud (Van Crombrughe, 2002). Using research questions posed by Van Crombrughe as a basis, the research questions pertaining to this replicated quantitative descriptive study are:

R1: What are the differences between program contractor executive and hospital executive perceptions on the presence of health care fraud and abuse (as defined by federal lawmakers and regulatory agencies) in hospitals?

R2: What are the differences between program contractor executive and hospital executive perceptions of health care fraud and abuse laws and regulations as applied to the hospital setting?

R3: What are the differences between program contractor executive and hospital executive perceptions on health care fraud and abuse laws and regulations to assist health care executives in conducting ethical business practices?

R4: What are the differences between program contractor executive and hospital executive perceptions on the governmental focus on enforcement of fraud and abuse laws and regulations to assist honest health care executives in identifying risky business practices?

Hypotheses

According to Creswell and Plano-Clark (2007), researchers write a hypothesis to make a prediction about the results gained from the study (p. 104). The quantitative hypotheses of this study were to examine and compare health plan executives' perceptions. The hypotheses for this study to test the differences of perceptions of fraud between program contractor and hospital executives were:

H₁₀: There is no significant difference between program contractor executives and hospital executives' perceptions of the presence of health care fraud and abuse in hospitals.

H1: There is a significant difference between program contractor executives and hospital executives' perceptions of the presence of health care fraud and abuse in hospitals.

H2₀: There is no significant difference between program contractor executives and hospital executives' perceptions of health care fraud and abuse laws and regulations as applied to the hospital setting.

H2: There is a significant difference between program contractor executives and hospital executives' perceptions of health care fraud and abuse laws and regulations as applied to the hospital setting

H3₀: There is no significant difference between program contractor executives and hospital executives' perceptions on health care fraud and abuse laws and regulations to assist health care executives in conducting ethical business practices.

H3: There is a significant difference between program contractor executives and hospital executives' perceptions on health care fraud and abuse laws and regulations to assist health care executives in conducting ethical business practices.

H4₀: There is no significant difference between program contractor executives and hospital executives' perception on the governmental focus on enforcement of fraud and abuse laws and regulations to assist honest health care executives in identifying risky business practice.

H4: There is a significant difference between program contractor executives and hospital executives' perception on the governmental focus on enforcement of fraud and abuse laws and regulations to assist honest health care executives in identifying risky business practice.

A literature review in quantitative research plays a major role, justifying the research problem and the need for the study (Creswell, 2005). The identified specific research problem in this study indicated that there was a lack of understanding of health care executives' perceptions

of the adequacy of laws in place to deter health care fraud. A literature review of current information proved that no studies existed in comparing hospital executive perceptions to program contractor perceptions. Minimal studies existed on the perception of hospital executive perceptions (Van Crombrughe, 2002) but no information was available on the perceptions of health plan executives. No studies of health care program contractor executives and hospital executives existed that compared the perceptions of two distinct groups of fraud.

Theoretical Framework

The research on fraud and perceptions fell within the broad theoretical areas of ethical conduct, moral development, and criminal justice. Understanding the deterrence of fraud was an essential part of modifying behavior through the perception of negative consequences (Wells, 2005, p. 399). Wren (2005) wrote that ethics was one of moral conduct, good or bad, and had occupied the thoughts of philosophers and theologians for an indefinite time (p. 474). According to Wren, early reactions to business misconduct were legislation (p. 476) or that of a negative consequence as Wells defined understanding fraud deterrence. As reactions to business misconduct, such as fraud, increases, the study could inform health care leaders and other industry leaders in the perceptions of the adequacy of legislation to deter fraud.

Summary of Historical Theories

Researchers in the 1940s and 1950s concentrated on two areas of fraud related topics. Sutherland (1940) introduced the theoretical concept of criminal, white-collar crime, and Cressey (1953) introduced the idea of trust violators with non-sharable financial problems. Much of the historical occupational theories were being developed and coinciding with the models of moral development. While occupational fraud research was intensifying, moral development theories and the idea of an individual's ethical progression of ethical decision making was growing. Top

theorist of fraud have been students or research associates of one another that has progressed fraud research and created a web of understanding, related topics, and much discussion. These historical models still guide modern research and the basis for many studies.

Differential association. The dominant criminologist of the 21st Century was Edwin Sutherland (Laub & Sampson, 1991). Wells (1997, 2005) stated that Sutherland was to the world of white-collar criminality as Freud was to psychology. The most widely accepted theory of criminal behavior was Sutherland's theory of differential association (Wells, 1997, 2005). The differential association theory described the environmental considerations of criminology (Wells, 1997, 2005). Before Sutherland's published work, criminologists and sociologists believed that criminals begot criminals, or that genetics had a role in criminality. Most of the research on white-collar crime was based on non-white-collar criminals such as rapists and murders (Sutherland, 1940). Sutherland (1940) hypothesized that criminality was a learned behavior and occurred with the assistance of others and could not happen individually (Wells, 1997).

Sutherland argued that criminal behaviors were not because of poverty for three reasons (Sutherland, 1940). Sutherland stated that contemporary studies of the time based generalizations on a biased sample that omitted the behavior of white-collar criminals. Second, white-collar criminals were not in poverty, brought up in slums or in deteriorated families, and were not the problem child (Sutherland, 1940). According to Sutherland, the third reason that was inconsistent with white-collar criminality related to poverty was that "lower class criminals commit robbery and burglary and not false pretenses" (p. 10).

Criminal violations of Trust. Donald Cressey was a criminologist and expert on sociology of crime. Cressey was a one-time student of Sutherland. Cressey studied embezzlers whom he called "trust violators" because of the difficulties in legal and scientific exploration in

legal definition (Cressey, 1953, p. 20). Cressey defined the central phenomenon under study was that of “criminal violation of financial trust ” (Cressey, 1953, p. 20). The central problem that Cressey defined was 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, p. 12). Cressey revised his hypothesis three times before the final hypothesis proved superior to the last two (Cressey, 1953).

Cressey (1953) summarized and concluded: (a) rationalization is necessary to criminal violation, (b) a culture must be present that sanctions trust violations, and (c) the social and economic position of the “trust violator” must be linked (Cressey, 1953, p. 136). Modern professional criminologists and researchers have credited Cressey with the development of the “fraud triangle” (Wells, 1997, p. 11). In this model, three factors existed for fraud to be committed. For fraud to be committed there must be a rationalization to commit fraud, the opportunity to commit fraud, and a perception of financial pressure (American Institute of Certified Public Accountants [AICPA], 2003).

Moral development. In 1958, Lawrence Kohlberg wrote a dissertation on moral development basing his work on prior theories and research from James Mark Baldwin’s research on moral development and Jean Piaget’s stages of cognitive development (Kohlberg, 1958). Known as the six distinct stages of moral reasoning, Kohlberg (1958) based his model on three moral development levels of Pre-conventional, Conventional, and Post Conventional. These three levels contained six stages. Kohlberg’s models was similar to that developed by Piaget’s except Kohlberg’s model ignored the amoral phase, occurring up to two years in a developing child, and expanded on the levels of development (Edge & Groves, 2006).

Summary of Modern Theories

Modern researchers or those who have conducted research past the 1980s on fraud still use historical models as a basis for much of research. Gillian (1982) based research on Kohlberg's moral development model. Researchers have expanded on the theories of fraud deterrence hypothesizing that culture influences ethical behaviors and choices (Bierstaker, 2009; Lopez, Rechner, & Olson-Buchanan, 2005). Fakinlede's (2008), although basing his research on Kohlberg, had a difference of opinion with Sutherland (1940) in that poverty did play a role in moral development and therefore ethical behavior. Gurley, Wood, and Nijhawan (2007) studied the effects of perceived influence of punishment on ethical behavior.

Gender and moral development. Kohlberg's most notable critic is Carol Gilligan, who was once Kohlberg's student and who illuminated the study of morality for her (Gilligan, 1982). Gillian (1982) posited that Kohlberg's work excluded gender differentiation when moral decisions existed (Gilligan, 1982; Reinstein, Moehrle, & Reynolds-Moehrle, 2006.). Gilligan stated that when the study of moral development of women ensues that moral conception differs from that of Freud, Piaget, and Kohlberg (p. 19). Gilligan posited that Kohlberg's work failed to consider gender in the development of morality (Gilligan, 1982). Gilligan stated that gender is a fundamental role in ethical thinking. According to Donleavy (2008), the Kohlberg-Gilligan controversy has received intermittent but inconclusive attention for many years.

Culture and corruption. Bierstaker (2009) studied the attitudes of managers and employees regarding fraud across cultures. The purpose of the literature review was to provide theories on why differences in attitudes occur and to provide recent examples of cultural differences in ethical perception. Bierstaker posited that multinational corporations must be careful in considering how to manage business affairs because so many managerial principles

influence organizational culture. According to Bierstaker, what one culture finds as acceptable, another culture may view as corrupt. The conclusion of Bierstaker's study was that corporate culture could be equally as important as an employee's culture when guiding ethical behavior (Bierstaker).

Poverty and criminality. Fakinlede (2008) had a differing opinion from Sutherland regarding poverty and criminality. Fakinlede's quantitative study was based on Kohlberg's theory of whether morality comes from teaching or from natural feeling or instinct. Fakinlede based the study of the significance of poverty on individual development of Kohlberg's moral development theory. Conclusions of Fakinlede's study indicated that when there was increased poverty, family dependence on those family members who worked was increased. Fakinlede concluded that there was a strong correlation between moral judgment and poverty.

Punishment and decision-making. Gurley, et al. (2007) studied the effects of perceived punishment and crime. This quantitative research study investigated four variables and the impact on ethical decision-making. These four variables of the quantitative research study included moral values, the probability of being caught, valence of outcome, and severity of punishment. The survey respondents rated six ethical scenarios. Conclusions of Gurley, et al.'s study included the major roles of moral values played on ethical decision-making. According to Gurley, et al., people do not operate solely on an economic perspective. A second finding was the importance of severity of punishment. Study results, consistent with past research, indicated that severity of punishment encourages ethical decision-making.

Definitions

According to Marczyk, DeMotto, and Festinger (2005), clarifying operational definitions reduce confusion in a specific study (p. 36). Terms have different meanings in different studies

(Marczyk, et al., 2005). The following section includes operational definitions for this replicated quantitative study.

Abuse. Abuse is actions that cost an organization to lose resources or dollars and not constituting fraud by counterproductive behavior (Wells, 2005).

Arizona Health Care Cost Containment System (AHCCCS). AHCCCS (pronounced as ‘access’) is Arizona’s Medicaid program. AHCCCS directs contracted health plans in the provision of health services to individuals and families who are entitled to Medicaid and other services (AHCCCS, 2009).

Executive. An executive is a person who has managerial or administrative duties within an organization (Oxford Reference Online, 2009a).

Fraud. Fraud is any crime for gain that uses deception as its principle concept (Wells, 2005).

Health plan. A term used to describe a medical health insurance plan for medical services or health care that is either provided by the government or offered to employers (Oxford Reference Online, 2009b)

Non-response. The participants in a research study who do not return surveys or questionnaires to the researcher (Champion, 2006).

Occupational fraud and abuse. Employing one’s profession for individual enrichment through purposeful misappropriation of an employer’s resources or assets (Wells, 2005).

Payer. An organization that furnishes money to pay for provisions of health care. A payer can be a non-profit entity, government entity such as Medicaid, or commercial insurance or some other entity (Slee, 1987).

Program Contractor. A program contractor is a health plan contracted with AHCCCS to provide health services (AHCCCS, 2009). Program contractors are paid a monthly capitation rate for each enrolled member (Arizona Medical Information Exchange [AMIE], 2009). The program contractor carries the risk associated with providing the necessary health services (AMIE, 2009).

Replication. A replication study is a study that is based on the general concepts of a previous study with the attempt to obtain the same results from a different population (Champion, 2006).

Stakeholder. A stakeholder is an individual, group, or organization that is affected by an organization's decisions, who seeks to influence the organization's decisions, and who's interests and demands may conflict with each other's and the organizations (Longest, Rakich, & Darr, 2000).

White-Collar Crime. Sutherland coined the term white-collar crime in 1939 meaning any criminal act of corporations or individuals acting in a corporate capacity (Wells, 2005). The modern term means any criminal financial or economic activity committed by an employee of an organization (Wells, 2005).

Relevance of Study to Conceptual Framework

Van Crombrughe (2002) recommended that further research and replicating the research project in other states to compare and contrast responses be conducted to determine the significance of other health care executives' perception outside of California. This study would not only solidify findings from the Van Crombrughe study but also will add additional knowledge of fraud and perception to an industry with many stakeholders with different views and perspectives as discussed in chapter 2. The four evident health care stakeholders in the U.S. health care system include patients, providers, payers, and employers (Kroncke & White, 2009).

As do other industry executives, health care executives face an ever-changing regulatory environment. With changing regulatory and legislative environments come modifications in educating future health care executives. According to Hartman and Crow (2002), health care's dynamic nature requires "advanced executive expertise to survive" (p. 359). Hartman and Crow stated that the current system of "educating and developing health care managers may be flawed" (p. 360). This study would add to the knowledge base on perceptions of health care executives to train the next generation.

According to Champion (2006), social scientists believe that each action relates to an attitude (p. 386). Ethics, as an attitude, is an issue in the detection, deterring, and decreasing of health care fraud. Not only does executive decisions on ethical issues relate to quality of care (Nelson, 2006), ethical decisions and actions make an impact on the organization's culture and corporate compliance. According to Wren (2005), business transactions go beyond that of legal boundaries to that of moral conduct because these transactions are deeply embedded in the trust and confidence of society (p. 474).

Assumptions

The current replicated quantitative descriptive study was based on two assumptions. The first assumption is that participants in the study will respond honestly to the survey. Participants are executives employed by contracted organizations and may contend that responding honestly to a survey regarding fraud could put contractual agreements in jeopardy. This is also a limitation of the study. The second assumption is that payers have an opinion on fraud legislation and corporate compliance programs. Because no literature exists on perceptions of payers, the assumption is that this population has not been studied or has not had an opportunity to provide input.

Limitations

The most concerning bias in this study is physical presence. Physical presence bias occurs when the interviewer can influence the subject in unperceived ways (Cooper & Schindler, 2002). Although this study used the Internet to gain information, the perceived influence of AHCCCS may provide a certain bias because of the contractual agreement between these organizations and decrease the potential of program contractor to respond candidly. Using Internet surveying tools to minimize physical bias provides indirect observation, and the focus on confidentiality, therefore decreasing physical biasness and increasing the potential for program contractors' candid responses. According to Cooper and Schindler (2002), indirect observation lessens biasing and is less erratic in accuracy (p. 407).

One limitation that Van Crombrughe (2002) addressed in the initial research was that of brevity of the survey instrument. Brevity of the survey instrument could be considered as a limitation by readers and researchers (Van Crombrughe, 2002, p. 33). Although considered a limitation in the initial study, the survey response rate was over 46% (Van Crombrughe, 2002). The limitation addressed in this study builds from the excellent response rate that Van Crombrughe is that payors and other individuals in general may not respond to the survey. Survey response rates are declining in general (Curtis & Redmond, 2009).

Scope and Delimitations

The scope of this study was to survey executives employed by program contractors within the AHCCCS system. The focus of this study was on the perceptions of the program contractor executives' perception on the ability of legislation to deter fraud. The research examined perceptions using quantitative research questions in a 5-point Likert-type scale and a

comment section to gain open-ended responses to determine the perception of the sufficiency of fraud laws deterring current health care fraudulent and abusive behaviors.

Delimitations to this quantitative study were the use of a pre-existing survey instrument. Creswell (2005) stated that a researcher should first consider if a survey instrument exists to measure the research variables (p. 362). Because designing a survey is challenging and complex (Creswell, 2005), this study included the use of a pre-existing, validated questionnaire.

Delimitations of replicating and using another survey instrument includes that the data is only as good as the survey instrument and the cost and resources to design, pilot, validate, and perform the survey is significantly reduced. Not selected was the alternative qualitative or a mixed-method longitudinal or two-phased method designs because of cost (Cooper & Schindler, 2002, p. 150; Neuman, 2006), time (Cooper & Schindler, 2002, p. 150; Creswell & Plano-Clark, 2007, p. 74; Neuman, 2006), and other resources such as access to resources (Neuman).

Summary

Chapter 1 introduced statistics that indicate the significance of the cost of health care fraud. Organizations lose up to 7% of revenue because of fraudulent behavior (ACFE, 2008) and estimated costs to health care are \$68 billion (NHCAA, 2009). Chapter 1 provided a summary of four historical theories (Cressey, 1953; Gilligan, 1982; Kohlberg, 1958; Sutherland, 1940) that literature mentions when researchers examined fraud. Cressey's hypothesis, better known as the fraud triangle, develops the concept of three contextual elements that need to be present for fraud to exist (Cressey, 1953). Another theory discussed in research literature on fraud is Kohlberg's theory of the six stages of moral development (Kohlberg, 1958).

Chapter 1 presented research questions, hypotheses, and the scope, limitations, and delimitations of this study. The initial Van Crombrughe 2002 study was introduced as the

results indicated that there is a need to understand and further research on health care executives' perceptions of fraud. Chapter 2 contains an extensive literature review that contains detailed literature on Cressey's theories and Kohlberg's models. The literature review contains research on the key stakeholders' perception of health care fraud.

Chapter 2: Literature Review

Conservative estimates of 3%, or \$68 billion, of health care spending is lost because of fraud (NHCAA, 2009). Chapter 1 introduced the topic of health care fraud and the significant impact of cost and the financial impact these behaviors have on organizations and the health care industry. Introduced in Chapter 1 was a background literature review of fraud deterrent theories (Cressey, 1953; Gilligan, 1982; Kohlberg, 1958; Sutherland, 1940). Quantifying the problem of health care fraud was statistical proof that provided a rationale for this study, the conceptual framework of health care spending, and the cost of fraud. Chapter 1 introduced the purpose of this quantitative descriptive study and the significance to the health care industry as well as to other industries (ACFE, 2008; McKinsey Quarterly, 2007). Identified were the study methodology appropriateness and the survey population.

Chapter 2 contains the literature review for the replicated research study. The scope of this study's literature review encompasses critical evaluations and comparisons of (a) perspectives from key health care stakeholders, (b) methods to deter fraud, (c) theories and models on how to deter fraud, and (d) justification that the gap in research provides the opportunity for this research study. The replicated study captured perceptions of a "real life" phenomenon, compare and contrast executives' perceptions, and adds to research and knowledge.

Research Study Review

The replicated quantitative study addressed the general problem of excess financial losses in health care because of fraud that increases the cost of health care services. The specific problem is a lack of understanding of all health care executives' perception of the adequacy of

laws to deter fraud. The purpose of this quantitative descriptive study was to compare Arizona AHCCCS program contractor executives' perception to those of hospital executives of the level of adequacy of legislation and corporate compliance programs in deterring unethical behaviors to the perceptions of hospital executives. The research questions in this study were:

R1: What are the differences between program contractor executive and hospital executive perceptions on the presence of health care fraud and abuse (as defined by federal lawmakers and regulatory agencies) in hospitals?

R2: What are the differences between program contractor executive and hospital executive perceptions of health care fraud and abuse laws and regulations as applied to the hospital setting?

R3: What are the differences between program contractor executive and hospital executive perceptions on health care fraud and abuse laws and regulations to assist health care executives in conducting ethical business practices?

R4: What are the differences between program contractor executive and hospital executive perceptions on the governmental focus on enforcement of fraud and abuse laws and regulations to assist honest health care executives in identifying risky business practices?

Title Searchers, Terms, and Literature Resources

Useful search terms included in the study varied and were not restricted to identifying fraud literature in the health care industry. Because fraud is prevalent not only in health care but also in many industries, and this study referenced the interest that the research will have in the field of leadership, broad searches were used. Prominent online, electronic database, EBSCOHost, ProQuest, Emerald, and ProQuest Dissertations archive, and Internet search terms included words or phrases: (a) fraud, (b) fraud and abuse, (c) health care fraud, (d) corporate

compliance, (e) ethics, (f) perceptions and fraud, and (g) quantitative study. Listed in the left column of Table 1 are the initial title searches that led to the identification of literature review topics.

Table 1

Summary of Literature Reviewed by Search Topic of Current Study

Literature Review Topic	Organizations, Websites, and Surveys	Peer-Reviewed Journals	Dissertations and Thesis'	Books	Total
Facts and Statistics	6			1	7
Perspectives	7	16		1	24
Methods	5	15	1		21
Theories and Models	2	9	2	7	20

Note. Current study literature by source type. Table format was adapted from “*Precipitating Events Leading to Voluntary Employee Turnover Among Information Technology Professionals: A Qualitative Phenomenological Study*” by W. Von Hagel, Jr., 2009, p. 20. Copyright 2009 by William Von Hagel, Jr. Adapted with permission at Appendix B.

The Internet was used for searches to find original and up-to-date statistics and studies on fraud from industry professionals and expert organizations. These organizations include the Association of Certified Fraud Examiners (ACFE), Centers for Medicare and Medicaid (CMS), Department of Justice, Civil Division, Taxpayers Against Fraud (TAF), and the Arizona Health Care Cost Containment System (AHCCCS). Other resources used in this study included textbooks defining research methodology and design (Creswell, 2005; Creswell & Plano-Clark, 2007; Neuman, 2006).

Extensive searches for the primary sources were inspired if the peer-reviewed, secondary source referenced the literature. As Creswell (2005) cautioned, use of primary sources is best practice. To show relevance of the research topic in fraud, statistics and literature cited is from surveys and research from the past five to seven years. Indicated in Table 2 is the existing gap in literature. The use of literature past seven years in this study existed to demonstrate germinal perceptions and techniques in deterring fraud. Historical research regarding theories and models in deterring unethical behavior in this study came from sources more than 10 years old (Cressey, 1953, 1971; Gilligan, 1982; Kohlberg, 1958; Sutherland, 1940). Modern research investigating fraud and ethical development are included in the literature review (Gilligan, 1982; Wells, 2000, 2001, 2005).

Table 2

Summary of Literature Reviewed by Year of Publication for Current Study

Literature Review Topic	Year of Publication				Total
	<1989	1980-1989	1990-1999	2000-2009	
Facts and Statistics				6	6
Perspectives			2	23	25
Methods			1	20	21
Theories and Models	6			14	20

The remainder of this chapter is a review of literature on the perceptions of health care stakeholders continuing with the methods used by organizations to deter fraud. Although methods are in place to deter fraud, there are gaps in the literature on the perceptions of health care executives. According to an ACFE (2008) study, the three most victimized industries of

fraud were banking and financial services, government, and health care. A study conducted by Van Crombrughe (2002) concluded that useful and reliable results can be gained from researching health care executives' perceptions and that the executives are willing to provide input. The following chapter contains the dissertation population, sample, and design method. The review concludes with an examination and critique of gaps in the literature and an introduction to chapter 3.

Stakeholder Perspectives Overview

Research and studies exists on the individual perspectives of health care stakeholders on fraud. According to Champion (2006) although there is uncertainty with the attitude-action relation, criminologists and other believe that there should be studies on attitudes (p. 386). Health care stakeholders include member/patients, employee/employers, taxpayers, the public, and health care providers (Kroncke & White, 2009). According to the State Health Facts website, the U.S. had 4,897 hospitals (2009a), 577 Health Maintenance Organizations (2009b), more than 991,000 nonfederal physicians (2009c), and 2.5 million registered nurses (2009d). In tax year 2007, 142 million individual filed tax returns (Internal Revenue Service [IRS], 2009). In 2009, the U.S. population estimates exceeded 307.5 million people (United States Census Bureau, 2009).

Health care stakeholders are an immense and diverse population. The three most evident stakeholders in health care are the patient, the provider, and the payer (Kroncke & White, 2009). Other, evident stakeholders include scientists, researchers, lawyers, legislators, and employees (Kroncke & White, 2009). Each individual stakeholder could have multiple roles in the current, complex health care system (Kroncke & White, 2009). Some stakeholders are more tolerant of

health care fraud then others and have contrasting perspectives. The study's literature review will define these diverse perspectives.

Executive Perspectives

The executives who have committed fraud have known that punishment for these crimes were public embarrassment and termination of employment however these executives still remained wealthy (Olson, 2006). According to the ACFE (2008) study, executives committed 18% of fraudulent activities. The median loss from executive fraud was \$852,000 (ACFE, 2008). The ACFE reported that the top occupational fraud category was asset misappropriation that included false invoicing or billing. Median loss because of asset misappropriation was \$150,000 (ACFE, 2008). Submitted every year for reimbursement are four billion health care insurance claims ranging from outpatient procedures to large hospital bills (Medical News Today, 2009; NHCAA, 2009). Small portions of these were fraudulent but added up in dollar amounts ranging from 3% to 10% of health care outlays, and between \$56 and \$170 billion annually.

According to Olson (2006), few executives are prosecuted for unethical behavior. The lack of prosecution in these cases was because of the complexity of the health care system and the billing and payment practices. Officials found it easier to accept a large settlement from a company instead of reviewing the thousands of pages concerning the case to determine who was responsible (Olson, 2006). Although executives did not face prosecution for unethical behavior, Persons (2006) stated that allegations of fraud meant termination of the executive by the organization. Persons used Columbia/HCA Health Care Corporation's Chief Executive Officer firing in 1997 following a federal investigation of the organizations billing practices. Persons found that firms under investigation for fraud more likely to changed top executives when the chief executive officer was not the board chair or had been the board chair for a short period.

Taylor (2002) indicated a recent shift in punishment of executives with an attack on health care fraud and white-collar crime. According to Taylor, health care executives have become the unlucky target of investigations and held criminally accountable for shady business practices. Historically, these shady business practices would have ended as an informal dismissal. Many of those in Taylor's case study were provider executives living an extensive life-style before sent to prison.

Legislator Perspectives

Klein and Campbell (2006) stated that the scope and number of health care fraud legislation and the accompanying regulations had expanded significantly in the last 20 years. According to Estrada (2008), Congress again reviewed the FCA to add more amendments. Changes in the FCA was in aspiration to keep the FCA up-to-date by providing legislation that closed the loopholes and remained current in prosecuting newer fraudulent activities and schemes. The amendments included expanding the class of whistle-blowers. The existing law only protected employees and former employees against retaliation from organizations (Estrada). Estrada stated that other types of employees, such as contractors, subcontractors, and other agents, fell outside the boundaries of the existing FCA.

In May 2009, U.S. President Obama signed into law the Fraud Enforcement and Recovery Act (FERA) (White, 2009). This act strengthened the ability of the government to pursue fraudulent contractors with additional legislation support from the FCA. According to White, the legislation reassured the taxpayers that there was zero tolerance to fraud. This statement came shortly before the July 2009 news that New York State and City agreed repay the federal government \$500 million to settle the largest government Medicaid False Claims case to date (TAF, 2009a).

Member, Patient, and Policyholder Perspectives

Modern studies exist on the use of legislation like the FCA to change the approach of the health care fraud enforcement system. The modern approach that the government was the victim has seen changes to a patient-centered approach focusing on the patient. Krause (2006b) stated that health care fraud injured patients. Not compensated for injuries under the current enforcement system are patients and beneficiaries. Krause investigated the potential use of the FCA to gain compensation for the patients because of fraud that is financially, physically, or intangibly harmful to the patient. Krause argued that fraud is harmful to the patient and considered a “bloodless” form of wrongdoing.

A study conducted by Werner, Alexander, Fagerlin, and Ubel (2004) had a decidedly different patient perspective of fraud. According to Werner, et al., research has concluded that over one-third of physicians reported misrepresentation of health issues for reimbursement on behalf of patients to obtain desired health care services. Werner, et al. studied survey responses of patients who received health service denials by insurance companies. Results from the study showed that patients were twice as likely as physicians to misrepresent facts in gaining health care services.

Miyazaki (2009) reported that from a policyholder perspective (e.g. a member of a health plan) insurance fraud was committed in a mixture of venues, including health care. Miyazaki studied the impact of insurance deductibles and the effects on consumer behaviors with the moderating factor of ethical beliefs. Miyazaki hypothesized those consumers with less ethical beliefs viewed insurance claim padding as less unethical, fairer to the insurance company, and would result in higher monetary claims when the deductible was higher. According to Miyazaki

results from the study indicated that the deductible influenced the perceptions of ethicality of padding insurance claims.

Employee and Employer Perspectives

Meiners (2005) summed up employers' optimistic and hopeful opinions of employees. According to Meiners, employers hoped and believed that all employees were hardworking, honest, and had the employers' best interest at heart. Although every employer wishes to believe this, losses from employee fraud still occur. Employers lose 6% of annual revenues to employee fraud (ACFE, 2008; Meiners; Wells, 1997).

A 2008 ACFE study concluded that the median loss of occupational fraud was \$175,000 and that many of these schemes frequently continued over years before detection. According to the ACFE survey, the average duration of fraudulent activity was 24 months. The ACFE reported that 27% of these fraudulent schemes were corruption. Fraudulent billing was 24% of corrupt activities. These fraudulent activities were found to be committed by the accounting department or upper management and the number one factor cited for internal fraud in these organizations was the lack of internal controls (ACFE, 2008).

Ernst & Young, an employer who had been in the headlines for suspected ethical misconduct, conducted research on why fraud exists and how to deter unethical behavior. Ernst & Young (2009) provided a different perspective of fraud from the employees and management in the 21st century economy. In Ernst & Young's 2009 study, participants responded with suggestions that management was, in fact, part of the problem and overwhelmingly questioned the integrity of the organization's leaders. Ernst & Young (2009) also provided a change in the perception of internal fraud by stating that there was an alarming tolerance growing of unethical behavior.

According to the Ernst & Young (2009) survey, 13% of senior managers stated that in today's economy, misstating financial performance was justifiable. Another alarming outcome of the survey was that 47% of the respondents thought that one or more types of unethical behavior were acceptable to help the business to be viable through the economic downturns. Of the respondents, 54% stated that a less stringent approach by regulators would not be appropriate.

Taxpayers and the Public Perspectives

Payer, legislator, or providers are all stakeholders and are taxpayers in the U.S. system. According to Stanton's (2001) research, taxpayers and experts in health care both perceived that health care fraud is widespread and the effects were serious contributors to the increase in health care costs. The perceptions of the public on white-collar crimes such as fraud have changed over the years. Historically, the public did not pay much attention to white-collar crimes (Holtfreter, Piquero, & Piquero, 2008). These public perceptions have changed and attitudes toward white-collar criminals have become more punitive (Holtfreter, et al., 2008). In a study conducted by the Coalition Against Insurance Fraud (2009), one in five U.S. adults say that insurance fraud is acceptable.

A Quantitative study conducted in 1997 by the Coalition Against Insurance Fraud, measured the public attitudes toward insurance carriers. Focus group findings included three possible reasons for committing fraud: (a) save money and reduce costs, (b) to obtain expensive work done that could not otherwise be afforded, and (c) to "get back" at insurance companies (Coalition Against Insurance Fraud [CAIF], 1997). Of the 602 study participants, one significant finding was that most of the respondents found that padding insurance claims, or considered soft fraud, was acceptable and common. Two-thirds of the respondents agreed that insurance premiums increased regardless of fraud.

Health Care Provider Perspectives

Health care provider perspectives were different from those of other health care professionals, legislators, and taxpayers. According to Stanton's (2001) research, providers were angered over the enforcement of congressional compromise to limit excesses. According to Stanton, fraud had created a substantial backlash among providers. The government had tried to assure providers that there was a difference between negligent errors and outright fraudulent behavior (Stanton, 2001). Stanton addressed this issue in that providers are under financial stress and squeezed by the pressures of lower reimbursement from the Medicare and Medicaid program contracting. These areas fall within what Krause (2006a) indicates as gray areas of regulation that require an exercise in judgment.

Up until recently, providers believed that there was no obligation to repay overpayments on health insurance claims. Providers had a myriad of defenses if the government sought to gain civil or criminal penalties (Romano, 2009). According to Romano, historically there had been considerable uncertainty of the obligation to self-report and refund overpayments. With the recent changes in legislation, such as the FCA and the Stark Statute, the defenses had decreased and had provided a change in providers' beliefs (Romano, 2009).

As do other industry executives, health care executives face an ever-changing regulatory environment. With changing regulatory and legislative environments come modifications in educating future health care executives. According to Hartman and Crow (2002), health care's dynamic nature requires "advanced executive expertise to survive" (p. 359). Hartman and Crow stated that the system of "educating and developing health care managers may be flawed" (p. 360). This dissertation would add a knowledge base on perceptions of health care executives of fraud and deterring fraud to train the next generation. Not only does executive decisions on

ethical issues relate to quality of care (Nelson, 2006), ethical decisions make an impact on the organization's culture and corporate compliance.

Methods to Deter Fraud

Organizations must have appropriate safe guards and place and a strong sense of social responsibility to operate in the U.S. Knouse, Hill, and Hamilton (2007) analyzed the American business code of ethics. The study reviewed the establishment of codes of ethics over the last 150 years. According to Knouse, et al., public opinion of the 1970s and 1980s business excess forced corporations to re-evaluate the organization's morals and values. According to Knouse, et al.'s historical analysis of corporate social responsibility, established in 1864 was the first formal American business code of ethics at the first meeting of the American Medical Association. Developed were code of ethics to enhance the declining status of the medical profession.

In reviewing articles and journals from pre-2000 the need to for employers to develop strategies to combat fraud in health care was beginning to change in the 1990s. Pflaum and Rivers (1991) stated that historically employers have taken a tolerant view of fraud. The change in employer philosophies on detecting and deterring health care fraud started to change (Pflaum & Rivers). Pflaum and Rivers recommended that employers should create policy statement, administrative guidelines, and procedures that discourage employee fraud. Provider fraud was also becoming prevalent in the 1990s. Pflaum and Rivers suggested that employers should enlist the assistance from employees and set corporate guidelines to deter fraud. Identifying health plans' claims administration process as the first line of defense, Pflaum and Rivers cautioned that payers should determine that a portion of claims payments were processed and fall into the category of provider employee omissions and not constitute intentional acts of unethical behaviors by the provider.

Reporting to Deter Fraud

Doost and Fishman (2004) continued the historical analysis of unethical behavior in business practices. The 1980s brought scandals reminiscent of the McCarthy era. Terminated were those individuals who brought these unethical actions to light (Doost & Fishman, 2004). Statistics back this statement. A report from TAF (2006) showed that in 1987 there were 361 non-Qui Tam new cases and no new Qui Tam Cases (TAF, 2006). Of those 361 cases, 14 were from fraud cases that covered matters in the Department of Health and Human Services as the primary agency (TAF, 2006).

Tips or complaints from employees, customers, vendors, or other sources currently identify fraud (ACFE, 2008). According to the ACFE, 46% of initial detection of fraud was through tipsters. The National Business Ethics Survey, conducted by the Ethics Resource Center (ERC) in 2007, indicated that compliance programs had a greater impact on reporting fraud than the organization's culture (p. 12). According to the ERC (2007), reporting rates of organizations with a well-implemented compliance program were higher than organizations that did not have well-implemented compliance programs. An analysis done by the ERC indicated that employee reporting of unethical behavior had improved in 2005 but were lower than 2003. The indication that employees are not reporting suspected fraud poses significant risk for organizations when under-reporting or no reporting is occurring.

Legislation to Deter Fraud

Initial research presented in chapter 1 of this study and the reports from the public media have demonstrated that fraud exists in every industry. Even as training, education, and technology increases, so does the complexity of fraudulent and abusive schemes. Different schemes provide for an array of corporate and white-collar crimes. According to TAF (2006),

there were 900-plus active qui tam investigations as of September 2006. The number of investigations clearly substantiates and identifies that there is a need for research in the area of fraud. Olson (2006) stated that no industry was immune to fraudulent activity. In 2006, several industry leaders, which include Booz Allen, Bearing Point, and Ernst & Young, paid fines for not disclosing travel costs and rebates (Olson, 2006).

The False Claims Act (FCA) is one legislative tool used in prosecuting fraud and has had many changes over the last 140 years. Enacted in 1863, with a proponent of President Abraham Lincoln, the FCA, also known as the Lincoln Law, was legislators' response to rampant, fraudulent activity of defense contractors during the Civil War. FCA amendments took place in 1986.

In 2005, attention to the FCA brought state focus to the federal legislation. The Deficit Reduction Act (DRA) of 2005 provided for state incentives to become more active in detecting provider fraud by adopting state level false claims acts similar to that of the federal act (Robbins & McGregor, 2006). As of 2009, 24 states had enacted state level False Claims Acts that enabled them to recover losses at the state and municipal levels (TAF, 2009b). The DRA not only added incentives for states establishing false claims acts, it required certain entities to adopt written policies regarding federal and state false claims laws (Robbins & McGregor).

One legislative tool to make a mark on fraud was the Sarbanes-Oxley Act of 2002 (SOX). The SOX legislation was to restore public trust in corporate America (Daily & Brookmire, 2005). Daily and Brookmire stated that the purpose of the SOX legislation was to make the creation of an ethical and transparent culture essential for corporations. According to Barlas, et al. (2005), financial executives stated that because of the necessity to comply with the SOX legislation, companies had stronger internal controls. Nelson (2006) wrote a brief article on

incorporating the provisions of the SOX legislation into an organization's health care compliance program. According to Nelson, although the Sarbanes-Oxley standards are not required by nonprofit organizations, the practices have become "best practices" in deterring fraud.

Romero (2007) posited the importance of the Deficit Reduction Act of 2005 (DRA) in regulating health care fraud. According to Romero, a consequence of the DRA was that health care providers should expect greater scrutiny of submitted Medicaid claims. The DRA specifically directs CMS to establish a national strategy for detecting and preventing Medicaid fraud (Romero, 2007). Romero stated that the DRA attempted to close the loophole that existed in the federal False Claims Act (FCA) by providing states the opportunity to pass false claims legislation.

Medicare published a report in 2002 regarding its program to control health care fraud. Medicare, with an outlay of \$219 billion dollars in health care expenses and 40 million beneficiaries, reported that the joint Health Care Fraud and Abuse Control (HCFAC) committee was brought about by Congress as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Reports of deposits reaching \$210 million for fiscal year 2000 and \$464 million for 2001 were pursuant to HIPAA as recovered fines from fraudulent and abusive convicted cases (Medicare, 2002). These fines were mainly penalties and multiple damages, with criminal fines and civil monetary penalties reported separately (Medicare, 2002). Meyer (2006) estimated that Medicare would spend \$327 billion in health care outlays for 42 million beneficiaries by 2006.

Technology to Deter Fraud

Because not all individuals report fraud, increased surveillance adds to business operations to detect fraud. Studies exist over many years on using information technology to

detect fraudulent claims submissions by payers. Before the development of advanced electronic tools to detect fraud, payers manually audited claims. The purpose of an upcoding study by Rosenberg, Fryback, and Katz (2000) was to develop a statistical model to detect DRG upcoding. The aim of this developed system was to reduce inappropriate expenditures. Rosenberg, et al. reported that Blue Cross Blue Shield of Michigan (BCBSM) spent \$20 per claim and audited 10,000 out of 150,000 paid claims per year. Rosenberg, et al. concluded that a statistical system would greatly enhance a payer's capability to detect upcoding.

Bierstaker, Brody, and Pacini (2006) studied the extent in which accountants used fraud detection methods and accountant's perceptions of the different methods to combat internal fraudulent and abusive behaviors. Health care organizations can implement electronic claims payments systems to combat employee fraud as well as external provider false claims submissions and member schemes. According to Bierstaker, et al., organizations use firewalls, virus and password detection, and internal controls to combat intentional behaviors. These technological advancements in claims payment systems implemented in many health care organizations provide faster communications of information. In using technology, information becomes readily available, in which manual systems may have hindered the flow of information.

Used to detect potential fraudulent claims, payers implement information technology (IT) software edits and rules to decrease the instances of paying fraudulent claims. Systems rules such as pending an identified and suspected fraudster's claims, flagging a claim when it has been submitted after the date of death or termination date of the member, and running reports for duplicate dates of service can be implemented in the system to detect potential fraudulent activity. According to Jason (2007), "advanced technologies should be used to detect and deter fraud, abuse, and error" (p. 21). Jason argued that detection in mere luck over judgment and that

potential fraudulent activity detected through whistleblowers and tip-offs rather than routine monitoring and auditing are more productive.

Differentiating opinions exist about the use of IT in detecting and deterring health care fraud. Sparrow (2008) argued that the structures of the American health care system helped account for the prevalence of fraud. The author listed three features: (a) Fee-for-service payment structure, (b) private sector involvement, (c) highly automated claims processing systems, and (d) accuracy of claims processing over verification. Health care insurance payers process many claims without any human interaction or scrutiny. Sparrow related that well-designed fraud schemes are transparent in perpetuity therefore the underlying scope of health care fraud problems remain unknown.

Corporate Compliance Programs to Deter Fraud

Key findings of the Ethics Resource Center (ERC) (2007) survey indicated that organizations had relatively few ethics and compliance programs in place. According to the ERC survey, of companies with comprehensive compliance programs in place 29% of the employees failed to report misconduct. Survey results indicated that only one of four companies had a well-implemented corporate compliance program. Results of the survey revealed that 40% of companies did not have a comprehensive compliance program in place. A comprehensive compliance program involved the inclusion of all key elements of fraud deterrence. The ERC points out that there were six elements for an organization 's comprehensive compliance program: (a) Written ethical standards, (b) training on company ethical standards and workplace conduct, (c) a method for seeking ethical advice, (d) a reporting mechanism, (e) disciplinary actions, and (f) assessments of ethical conduct.

The Code of Federal Regulations specifies seven elements that must be included in an organization's corporate compliance plan (42 CFR 438.608, 2005). Element number one contains the general requirement that an MCO develop a mandatory compliance plan that guarded against fraud. Specific requirement of the CFR rule included written policies and procedures that outline conduct and the organization's commitment to comply with federal and state laws. The CFR outlines designation of a compliance officer and compliance committee, incorporation of effective training programs, effective lines of communication, enforcement of standards, the provision of internal auditing and monitoring, and finally the provision of a prompt response to detected offenses including corrective actions plans as elements of a successful corporate compliance plan.

Three of the fundamental elements outlined by the ERC (2007) were required for compliance with the Sarbanes-Oxley Act of 2002 (SOX). Elements included written standards of ethical conduct, a reporting mechanism for anonymous tipsters, and disciplinary actions for those employees who violated the organization's standards (ERC). Nelson (2006) wrote that health care organizations were feeling the increasing pressures of today's regulations. Although corporate compliance programs have three of the elements of SOX requirements, there was an increasing pressure to implement auditing standards as set forth by the regulation (Nelson, 2006).

HealthSouth Corp., a provider of medical rehabilitation services, paid \$325 million for systematically defrauding Medicare and other federally funded programs (Largest Health care Fraud Settlements, 2007). Jason (2007) maintained that research of fraud focused on provider opportunity, however, citizens and employees have also taken advantage of the Medicaid system. Providers are not the only focus of Corporate Compliance Programs that detect fraud. According

to Carroll (2004), compliance programs detect and resolve conduct that does not conform to legislation or regulations.

Although Jason (2007) argued that detecting fraudulent and abusive activity without computerized software was mere luck, many organizations do not have the capital or the finances available to develop and implement a fraud detection plan. Many corporate compliance tools exist for an organization to incorporate into business practices. These include continuous auditing and training of staff to be the eyes and ears the corporate compliance program.

These perceptions can be significant in leading internal corporate ethical spirit as well as nation wide regulation and legislation development. Health care costs are raising and becoming a growing concern. By reducing fraud and fraudulent claims, health care costs will decrease or at least increase at a less substantial rate. Executives can increase fraud detection and prevention by keeping the health plan current on compliance and developing effective corporate compliance programs. To accomplish effective compliance programs, defining health care executives' stance on health care legislation on fraud provides baseline ideas of corporate compliance programs and legislation.

Executives need to take a leadership role in defining and developing a Corporate Compliance Program. According to Frank (2004) both executives and audit committees needed to take an active role in efforts to develop effective antifraud programs, controls, and risk assessment processes. An article by Judge (2005) described several key compliance areas that health care financial executives needed to review. These included an antitrust checklist, a corporate responsibility checklist, and a fraud checklist that organizations should focus compliance around legal issues that pose potential high-risk areas and potentially serious

consequences. These are key areas of legal compliance that will help executives realize a positive bottom line (Judge, 2005).

Theorists of Ethical Development and Models on Fraud Deterrence

When researchers, politicians, lawmakers, and students discuss fraud, there are four well-known researchers in the field of ethical development and fraud deterrence. These researchers are Sutherland, Cressey, Kohlberg, Gilligan, and Wells. According to Wells (2005) considering the social impact that fraud has, relatively minimal research exists on occupational fraud (p. 12). Theories and models related to fraud research include those developed from criminologists, sociologists, accountants, and researchers. Although some of the research dates from the 1920s and 1930s, the research has provided germinal perspectives, thoughts, and ideas into modern day theory of why fraud exists and how to deter it.

Research in Occupational Fraud

Edwin Sutherland. Sutherland (1940) wrote about concerns for crime in relationship to business. Sutherland's paper combined the views of economics and criminality in business, stating that economists were not used to viewing the point of crime, and criminologists were not used to viewing crime in the relationship to business. According to Sutherland, the concept of criminal research and crime statistics had focused mainly on those handled by police for murder, burglary, and assault. Researchers had derived the general theory that principle data indicated that because crime is associated with the lower class, poverty caused crime. Sutherland rejected those theories stating that the theories were misleading and that crime and criminal behavior take different paths.

Perceived as less criminalistic, Sutherland (1940) focused some of his research on the medical profession. His findings concluded that in the medical profession, sales of alcohol and

narcotics, illegal services, fraudulent reports, extreme cases of unnecessary treatments, and fee splitting was prevalent. Sutherland's final statements in the paper concluded that white-collar crime was a valid crime because it violated criminal law, white-collar crime differs from lower class crime, and contemporary theories concluded that crime was because of poverty were misleading. Sutherland (1940) wrote:

The hypothesis which is here suggested as a substitute for the conventional theories is that white-collar criminality, just as other systematic criminality, is learned; that it is learned in direct or indirect association with those who already practice the behavior; and that those who learn criminal behavior are segregated from frequent and intimate contacts law abiding behavior. (p. 10)

Donald Cressey. Donald Cressey worked alongside Edwin Sutherland and co-authored several books. Cressey's work evolved during his association with Sutherland (Akers & Matsueda, 1989). According to Wells (2005), Cressey was one of Sutherland's brightest students during the 1940s (p. 13). Cressey's (1953) final revised hypothesis was:

Trusted persons become trust violators when they conceive of themselves as having a financial problem which is non-sharable, are aware this problem can be secretly resolved by violation of the position of financial trust, and are able to apply their own conduct in that situation verbalizations which enable them to adjust their conceptions of themselves as trusted persons with their conceptions of themselves as users of the entrusted funds or property. (p. 30)

Cressey (1953) viewed social characteristics of trust violators as an element in fraud. Cressey stated that trust violation was both a cultural phenomenon as well as a psychological phenomenon. According to Cressey, social characteristics of a trusted individual, such as age,

race, religion, or socio-economic status are significant in trust violators because of the requirements to obtain positions of trust (p. 145).

Research from Cressey involved a 1940s project interviewing 200 imprisoned embezzlers and executives (Wells, 2001). Cressey (1953, 1971) changed his hypothesis four times before the final form of “trusted persons become trust violators when they conceive of themselves that having a financial problem which is non-sharable” (p. 30). Avoiding the concept of embezzlement, Cressey established two criteria in its place (Cressey, 1953, 1971). According to Cressey, the first criteria were that a person had an accepted position of trust (p. 20). The second criterion was that the person had violated the trust by committing a crime (Cressey, 1953, p. 20). Cressey observed financial obligations were the reason these individuals committed fraud (Wells, 2001).

Other observations of Cressey during this landmark study included that there were two other reasons these individuals committed fraud (Wells, 2002). These individuals must have perceived that there was opportunity to commit fraud and that there must be a rationalization for offensive behavior (Cressey, 1953, 1971; Wells, 2002). Cressey’s interest was in those individuals who gave into temptation and excluded those individuals who took trusted positions for stealing (Wells, 1997). Wells (1997) stated that Cressey’s fraud triangle helped to explain most, but not all, occupational fraud.

Joseph T. Wells. Joseph T. Wells, the founder and chair of the Association of Certified Fraud Examiners (ACFE) and a former FBI investigator, continued research in occupational fraud and elaboration on Cressey’s fraud triangle (see Figure 2) as adopted by Wells. According to Wells (1997) Cressey, who he had known personally, had considerable influence on his

antifraud theories. Wells had published several books on fraud including *Occupational Fraud and Abuse* (1997) and *Principles of Fraud Examination* (2005).

In 1997, Wells conducted research on organizational fraud. Wells had provided a plethora of current articles and literature on fraud and white-collar crimes. In 2000, Wells contributed articles to the role of the accountant in detecting fraud. According to Wells (2000), the role of auditor-fraud detector dates back to historical times. The role of auditor is changing as business practices and transactions become more complex (Wells).

Figure: The Fraud Triangle as interpreted by Joseph T. Wells



Figure: Interpreted by Wells of Donald Cressey’s work on occupational fraud. Adapted from “*Occupational Fraud and Abuse*,” by Joseph T. Wells, 1997, p. 11. Reprinted with permission (Appendix C).

Wells continues his research into the 21st century in progressing models and finding gaps in literature. Wells (2005) explained Cressey’s hypothesis that trusted people become trust violators. Occupational fraud has developed since Cressey’s original study concluded and there has been considerable social change (Wells, 2005). According to Wells, researchers have tested the “fraud triangle” but gaps still exist in fully executing fraud prevention programs (p. 20). Even Cressey’s model does not fit all situations (Wells, 2005).

Wells (1997) provided recent studies on occupational fraud. Wells wrote about current fraudulent schemes as these schemes applied to the late 1990s and into the 21st century. He divided occupational fraud into three parts: corruption, asset misappropriation, and fraudulent statements. Wells stated that although the current workforce was obviously different from Cressey's time, those who committed trust violations and were in non-sharable financial need had not changed.

Research in Moral Development

Lawrence Kohlberg. According to Edge and Groves (2006), Lawrence Kohlberg was one of the foremost theorists in value development. Kohlberg based his stages of development from Piaget's thinking on moral development (Edge & Groves, 2006; Gump, Baker, & Roll, 2000; Kohlberg, 1958; Fakinlede, 2008). Piaget's theory centered on a child's moral development stages. Moral development consists of three stages. The first phase Piaget described as amoral witch occurs up to age two (Edge & Groves, 2006). The second stage of child development was that of self-centeredness occurs between the ages of two to seven (Edge & Groves, 2006). Stage three, or the heteronomous stage, occurred around seven to 12, which revolved around the morality of constraint Kohlberg's (1958) identified gaps in research as:

In spite of the obviousness and philosophical currency of such formal criteria of morality as have been listed, a search through twenty-one published tests of moral judgment and fifty-nine empirical studies of individual morality published since 1890 in English and French failed to locate any systematic general observations of moral behavior, attitudes, or concepts in terms of some such set of formal criteria of morality although there have been several valuable studies of justice. (p. 16)

Kohlberg's moral development theory included six sub-stages in which an individual matures in value orientation based on punishment and obedience through the sixth stage of guidance by a moral compass (Donleavy, 2008; Edge & Groves, 2006; Reinstein, et al., 2006). The pre-conventional morality level, ages two through seven, include stages of rewards and punishments and individualism and exchange (Donleavy, 2008; Edge & Groves, 2006). Level two, or the conventional morality level, consists of good behavior, law, and order (Donleavy, 2008; Edge & Groves, 2006). The post conventional level has the last two stages of social contract and individual rights and universal principles, which is the highest level of moral development in which an individual commits to the social principles of equal rights, social justice, and dignity (Donleavy, 2008; Edge & Groves, 2006).

Kohlberg's theory was not without challengers. Gilligan (1982) stated that Kohlberg based his research from active, decision-making males. When used to research moral development in females, results indicated that females did not progress to the sixth and final stage of value orientation (Edge & Groves, 2006; Gump, et al., 2000). Gilligan rejected Kohlberg's theory on the basis that gender plays a fundamental role in decision-making and that based his research exclusivity on male-oriented taxonomies (Donleavy, 2008; Gump, et al., 2000).

Carol Gilligan. Gillian, a past research assistant of Kohlberg from the 1970s, had become one of his work's critics (Donleavy, 2007; Edge & Groves, 2006; Gump, et al., 2000). Gilligan (1982) criticized Kohlberg's theory as that males base development on justice while female values were based on caring (Donleavy, 2007) and that genders do not see values in the same light (Edge & Groves, 2006). According to Edge and Groves, Kohlberg took Gilligan's

criticism well and revised his scoring methodology to include gender (p. 20). Gilligan (1982) wrote:

This different construction of the moral problem by women may be seen as the critical reason for their failure to develop within the constraints of Kohlberg's system. Regarding all constructions of responsibility as evidence of a conventional moral understanding, Kohlberg defines the highest state of moral development as deriving from a reflective understanding of human rights. That the morality of rights differs from the morality of responsibility in its emphasis on separation rather than connection. (p. 19)

Cultural, Ethnicity, and Gender Influences and Fraud Studies

Researches into other factors that influence ethical behavior exist. The purpose of Lopez, Rechner, and Olson-Buchanan (2005) study was to increase the understanding of the influences that certain forces have in shaping ethical perceptions. Lopez, et al. stated that with recent and high profile events that bring focus to fraud, those business managers are still experiencing ethical lapses in judgment. One important note that Lopez, et al.'s literature brought forward was that the tolerance of unethical behavior decreased with formal education. Lopez, et al. hypothesized that there was a difference in ethical perceptions. These differences included factors such as education, culture, specialization within the business arena, and gender.

The results of Lopez, et al.'s (2005) study supported the relevance in explaining ethical perception of intra-national culture and the differences dealing with fraud, self-interest, and coercion. On the other hand, the results of the study indicated partial support of the hypothesized gender differences in tolerance of unethical behavior. Lopez, et al., indicated that females were slightly less tolerant of unethical behavior when compared to male counterparts. Although this study is pertinent to perceptions, the population was 353 business school students.

Perceived Punishment Influences and Fraud Studies

Factors such as culture, gender, business education, and professional specialization influence perceptions of fraud. Results of perceived punishment in deterring unethical behaviors influence perceptions of fraud as well. Gurley, et al. (2007) studied the effects of punishment on ethical behavior involving personal gain. Gurley, et al. studied the effects of four variables on determining if punishment deterred corporate crime. The four variables introduced in Gurley, et al.'s study on ethical decision making were (a) outcome valence, (b) probability of being caught, (c) severity of penalty, and (d) moral values.

One hypothesis from Gurley, et al.'s (2007) study was that values, probability of being caught, and punishment severity were directly related to ethical behavior. Results from this study indicated that for this hypothesis, there was a significant correlation with ethical score. According to Gurley, et al. the significance of this literature was to demonstrate the importance of punishment in an individual decision when presented with a choice of ethical options. Although this study is pertinent to perceptions of unethical behavior, the population was 115 students.

Gaps in Research Literature

Many executives have been criminally charged with fraud. Many more executives need to understand the condition of current organization corporate compliance programs. These executives need either to understand perceptions of the legislation revolving around fraud and what steps are needed to take to turn corporate compliance program around in detecting fraud. As Wells (2002) concluded of Cressey's model, the gap in research is taking the research and implementing it into practice in terms of developing a corporate compliance plan to deter fraud.

Using Milton's 1988 hypothesis, Micewski and Troy (2007) agreed that executives and profit-driven organizations had to meet social responsibilities by accepting the constraints imposed "by the basic rules of society, both those embodied in law and those embodied in ethical custom". Micewski and Troy concurred that when businesses went beyond governmental rules and requirements mandated by regulatory agencies, self-imposing measures that went beyond these authorities, was when ethical reinvigoration of the business world could be accomplished (p. 18). To go beyond the governmental rules and mandates, executives must impose strict standards that supersede regulations and legislation, making the organization's standards higher.

According to Olson (2006), fraud control started and ended with the governing board. An effective governing board had control of the executive staff (Olson, 2006). Bringing the accountability factor back to the health care executive would bring about reduction in fraud. Spevak (2006) contested that the most dramatic way a health care executive learns about a fraud investigation through the presentation of a warrant. Executives should be more aware of compliance programs and more accountable for the actions of the organization.

Van Crombrughe (2002) suggested additional research into areas that can contribute to the understanding of health care executive perceptions of fraud legislation. Further suggestions of Van Crombrughe included research of states other than California so that there are comparisons and contrasts. Initial research involved executives in the hospital setting (Van Crombrughe, 2002). Health care is a vast and diverse industry with different aspects in the cycle of care. Adding to the initial research of Van Crombrughe, comparing and contrasting executive views from the hospital to those of a health plan setting, would provide beneficial information and results.

Conclusion

Research and literature from this review suggests that understanding perceptions of fraud are an important concept in deterring unethical behavior. Significant elements in deterring fraud are robust information systems, reporting systems, and corporate compliance programs. Understanding the theories of ethical development and other elements that contribute to unethical behavior are important to understanding why an individual commits unethical behavior and how to deter it.

Historical theories used to examine and research fraud are those like Sutherland's differential association and Cressey's fraud triangle. Current theorists such as Gilligan and Joseph T. Wells built and progressed understandings of fraud. Although these theories have provided groundwork for deterring fraud, there are remaining gaps in the literature in providing modern models and theories.

Van Crombrugge (2002) recommended that usable and reliable research results can help the government revise legislation and structure new regulations into applicable, comprehensive, and consistently applied laws without becoming too intrusive. Although legislation for prosecution of fraud crimes exists, an organization's single most important protection is an effective corporate compliance program (Van Crombrugge, 2002).

Summary

Chapter 2 provided a review of the literature that explored the perspectives on fraud of executives, member and patient, employees, and health care providers. Established in chapter 2 were several methods to deter fraud like legislation, technology, and effective corporate compliance. Presented in chapter 2 was a detailed review of historical and current theories on ethical development and models to deter fraud. Other studies presented in the literature review

explored and expanded on historical and current theories and models. The examination of perspectives showed a clear gap in the literature as far as the payer, a key stakeholder in health care, perceptions were missing.

Chapter 3 will detail the methodology of this research study. An elaboration of the introduction in chapter 1, which introduced the appropriateness of the design to match the study, is in chapter 3. Chapter 3 contains the description of population, geographic location, and data collection methods and data analysis for this study.

Chapter 3: Method

Statistics illustrated that fraud has an impact on organizations and society. Conservative estimates of 3%, or \$68 billion, of health care spending is lost because of fraud (NHCAA, 2009). The estimated amount of financial resources that is lost to fraud could potentially cover health insurance for the uninsured. Interested in this study would be health care professionals in executive perceptions to help in developing adequate laws to deter fraud. Interested in this study would be other industry professionals and leaders because no industry is immune to fraud (Olson, 2006). Several of the laws used to deter fraud are not specific to health care and apply to all industries.

The purpose of this quantitative descriptive study was to compare the Arizona AHCCCS program contractor executives' perception of the level of adequacy of legislation and corporate compliance programs in deterring unethical behaviors to the perceptions of hospital executives. Research questions in this study expanded initial 2002 research that studied hospital executives' perceptions on the ability of legislation to deter fraud. A comparison between the quantitative results obtained from this study and the quantitative results from the initial Van Crombrughe study on health care executives will be analyzed to determine the differences in perceptions of hospital executives and program contractors. The value of comparison of this study of hospital executives' perceptions to the aspects of payer executives' perceptions advanced the knowledge of the health care industry, other industries, and fraud deterrence.

As defined, health care has three easily identified evident stakeholders with many other non-visible stakeholders (Kroncke & White, 2009). Literature supports that different stakeholders in the health care system have different views of fraud even going as far as to state that some stakeholders were more tolerant than others of fraud. The literature review provided

information on the impartiality of taxpayers and the public to fraud. Literature supported the member, patient and policyholder perspectives stating that many instances were supported with misrepresentation to gain health services (Werner, et al., 2004). Research in health care fraud indicated that providers, the second evident stakeholder in the complex health care system, that there has been a change in perspectives from a no obligation to repay overpayments to that of more co-operation by providers in returning money. These, and all other stakeholders, have been surveyed and questioned on perspectives of fraud but one of the key stakeholders are lacking information that could provide for further information.

Chapter 3 details the replicated quantitative research method and the design appropriateness for the purpose of this study. Chapter 3 will review the data collection methods for the survey and the data analysis techniques engaged to compare executives' perceptions of laws to deter fraud and corporate compliance programs are effective. This chapter contains a detailed review on the consent and privacy that falls within the scope of this study. Finally, chapter 3 will expand on the limitations of the study as related to the specifics of research method and design.

Research Method and Design Appropriateness

This study was quantitative research. Quantitative data is used to statistically analyze results and use hypothesis, variables, and hard data, in the form of numbers (Neuman, 2006, p. 139). Quantitative research approaches ask specific questions and not open-ended questions to collect data (Creswell, 2005). Supported by the use of hypothesis driven research, a quantitative validated survey instrument with a 5-point Likert-type scale responses, the ability to replicate research, and the capability to statistically analyze data through the nonparametric chi-square test

to compare data, indicate that the quantitative research method is the most appropriate research method.

The first trend of quantitative methods emphasizes the collection and analysis of information and data gathered in the form of numbers. The quantitative research method was most appropriate because this research collected information in the form of numbers and involves the use of statistics and measurements to quantify results. Qualitative research involves studies that do not tend to quantify results through statistics or formal measurement (Marczyke, et al., 2005, p. 17).

Unlike qualitative research, in which questions are open-ended, this study collected data in the form of 10 Likert-scale questions in which distributions and frequencies are collected. Approaches to qualitative research include in-depth interviewing and participant observation (Cooper & Schindler, 2002, p. 152). Recognized as historical qualitative research trends are the needs to listen to the participants in the study, therefore the participant providing answers to questions in the form of words or text (Creswell, 2005) without constriction to a list of responses.

The second emphasis of quantitative research includes collecting data that measures attributes of individuals (Creswell, 2005). Perception may be one of the hardest indicators to measure as in determining quality in health care, perception of key roles in health care, and determining justification for unethical behaviors. Dating from the early 19th century quantitative research design was traditionally used in the early research of physics and chemistry and presented three historical trends: statistical procedure, test, and measurement practices (Creswell, 2005, p. 39).

The third trend of quantitative methods emphasizes procedures of comparing group (Creswell, 2005). This study sought to obtain quantitative data from program contractor

executives and compare these results to the perceptions of hospital executives on fraud. After initial analysis of frequencies and distributions, the data collected from this study provides comparative results to those results gained from a previous study on hospital executives. Comparisons of results by a chi-square testing method, a nonparametric test to determine the differences between samples, will be in chapter 4 (Cooper & Schindler, 2002).

This research was not considered qualitative research or mixed-method in design. Although qualitative data was discussed and presented in the original study, the qualitative approach was not fully developed and would be the weakest part of this study. Van Crombrughe (2002) received much feedback in the initial study in the form of comments, which were coded and reported in the appendix section of the initial study but were beyond the scope of the initial study (Van Crombrughe, 2002). Although Van Crombrughe discussed that the original study might be categorized as mixed-method, the qualitative aspect of the study was not used in the study. The lack of formal open-ended questions in the survey instrument, made a weak case for categorizing Van Crombrughe's study as a mixed-method study. The lack of qualitative questions would make this the weakest part of the replicated study so focus was on the quantitative aspect of the study.

The goal of this study is to provide the health care industry and other industries with knowledge of health plan executives' perception of the adequacy of laws as it pertains to deterring fraudulent behavior. Knowing the perception of health plan executives may be an impetus to review and revise laws not sufficient to deter fraud. This study's objective is to compare and contrast results gained from program contractors to those of hospital executives. This will compound the knowledge and increase awareness of executive perceptions in the health care industry.

Geographical Location

AHCCCS is Arizona's single state agency that coordinates payment and services through program contractors for Medicaid eligible residents. Since 1992, Arizona has been operating under an 1115 Research and Demonstration Waiver that allows contractors for the state to act as managed care programs. Acting as a managed care program involves private-public collaboration to bring health services to AHCCCS eligible residents. Private collaboration comes from providers and managed care organizations, whereas public involves federal, state, county, and local government. Arizona has 15 counties in which eligible program contractors operate. With a combined membership of 1.1 million member lives, AHCCCS funds health care services for approximately 17% of Arizonans (AHCCCS, 2008).

Geographical Service Areas (GSA) divides the membership for program contractors. AHCCCS has seven GSAs that provide managed care services to acute care and long-term care eligible members. AHCCCS program contractors are both governmental (county) health plan entities and private health plans operating in Arizona. Program contractors vary in the number of member lives covered, the types of services (acute or long-term care) provided, and geographical area. According to Cooper and Schindler (2002), area sampling is defined as research that involves some geographical area (p. 196).

Population and Sampling

This study focused on AHCCCS program contractor executives. AHCCCS, Arizona's Medicaid, has 19 program contractor organizations that provide managed care services to Arizona's poor population through the acute plan, and mostly elderly or disabled population through its long term care program. Program contractor executives surveyed in this study will include those positions and responsibilities in the health plan. Not all program contractor

organizations had the same organizational structure but invitations to participate in this study were sent to the appropriate title.

In 2009, AHCCCS contracted with nine Acute Care Health plan program contractor organizations, nine Long-Term Care Health Plan program organizations, and one Behavioral Health Plan program contractor organization (AHCCCS, 2009). The AHCCCS website lists 19 program contractor organizations with five to seven executives employed by each program contractor organization. A sampling error formula was used because of the association with surveys whereas a power analysis is used to calculate sample sizes for experiments (Creswell, 2005, p. 150). With a confidence level of 95% and a selected 4% confidence interval, the sample size for this study is 150 executives (Survey Systems, 2009). According to Creswell over sampling reduces sampling error and decreases non-response rates. As the percentage of participants who meet the criteria for this study is 100%, the percentage of people contacted will be 100% of the eligibility rate or 150 participants.

Recruitment

In May 2009, initial contact with the director of AHCCCSs Office of Program Integrity (OPI) was made introducing the study and informal authorization to survey the program contractor executives. A presentation to the compliance committee was given that included topics on fraud theories, why people commit fraud, and initial comments on this study was given to the corporate compliance committee. Although contact with the compliance committee may potentially be a bias to the candor of participants' responses, the recruitment letter and all information state that this research was in no way affiliated to the fraud prevention office or AHCCCS. Formal recruitment of participants includes an initial letter stating the purpose of the study.

Recruitment Process

A recruitment letter will be sent to the program contractor executives after formal approval of this study. The recruitment letter (Appendix D) for this study was based on Creswell's (2005) sample cover letter. The recruitment letter will include the importance of participating in the research and the purpose of the research study. Included in the recruitment letter are the assurance that participation is voluntary and confidential, the completion time, and contact information of the principle investigator (Creswell, 2005, p. 370).

Response Rate

The initial (2002) study of California hospital executives noted a response rate from 1,030 hospital executive survey totaled 46.5%. According to Champion (2006) no one knows what a normal response rate is (p. 224). Champion stated that a "normal" response rate range from 30% to 70%. In social science research, a response rate is about a third (Champion, 2006). Although a response rate is usually one-third of the participants, Champion cautions that criminological researchers see up to a 70% non-response rate (p. 97). In this replication quantitative study, a response rate calculation based on Champion's assumptions would be 66 responses on the lower end to 140 on the higher response end.

Non-Response Rate

Non-responses to surveys can be a major issue because if the majority of the participants fail to respond the researcher may not be able to generalize (Champion, 2006; Neuman, 2006). As cooperation in survey research has declined over the last 20 years (Neuman, 2006), factors in recruitment may influence the participant. Contained in the cover letter of this study was the amount of time that the survey should take. Galesic and Bosnjak (2009) hypothesized that the expected length of a web-based questionnaire negatively affects the initial willingness of

participants to participate in the study. Results of this study indicated that the shorter the stated length of the questionnaire is the more respondents started and completed the questions (Galesic & Bosnjak, 2009). The recruitment letter for this study indicated that there are 10 Likert-type questions and a comment section and the entire survey should take about 10 minutes (Appendix D).

Informed Consent and Confidentiality

Informed consent for this study was gained before the Internet survey started. A radio button provided on the electric questionnaire will be used to opt-in for consent that notifies the participant of the research purposes of this study (Appendix E). Human research subjects must have details about the study, describing voluntary participation in the study, the length of participation in the study, and provided with the risk and benefits of the study (CITI, 2009; Cooper & Schindler 2002; Creswell, 2005; Neuman, 2006).

According to Creswell (2005), it is important to maintain the confidentiality of participants in the study (p. 151). The primary ethical issue related to online information is confidentiality (Cooper & Schindler, 2002; Nancarrow, Pallister, & Brace, 2001). Information from this survey was held in confidence and no name of participants or AHCCCS program contractors were released. Nancarrow, et al. defined seven mistakes that researchers can make while using the Internet for research purposes. According to Nancarrow, et al. the seven mistakes are (a) excess, (b) omission, (c) exposure, (d) privacy intrusion, (e) negligence, (f) off-loading, and (g) complacency.

Information generated from this research, such as e-mail addresses, detailed names, or GSAs, was held in the strictest of confidence. The electronic questionnaire did not include the name of the participant, the program contractor name, and if the organization was private or

governmental. All recruitment e-mails were sent to the primary researcher's e-mail address at University of Phoenix, and blind copied (bc) to the participants. Sending a blind copied request to participate in the survey minimized the attempts for unsolicited e-mails or the executives added to an unwanted e-mailing list.

Data Collection

This study used a computer-assisted, self-interviewing survey technique for collecting data (see Appendix F). Respondents who agree to participate in the survey will use the online survey tool [surveymonkey.com](http://www.surveymonkey.com). The electronic survey was open for respondents to use for a period of two weeks. Creswell (2005, p. 361) stated that the electronic survey technique is an easy, quick form of collecting data. Although Creswell (2005) stated that use of the electronic survey might be limited due to access to the Internet, the represented population in this survey had access to the Internet.

On-Line Data Collection

The rationale for online data collection had two advantages. Other techniques, such as mailed questionnaires, one-on-one interviews, focus group interviews, and telephone interviews were deemed inappropriate because of the disadvantages that consisted of time constraints, cost, or protection of anonymity (Creswell, 2005). With consideration to the executives' time, program contractors are extremely busy with little time to complete mailed surveys or attend one-on-one or focus group interviews. Wyner (2003) stated technology could increase sample size. Sampling could be easily expanded to sample more individuals with the use of technology such as the Internet (Wyner, 2003). All potential participants were surveyed due to the ease of use and advancements of technology.

Implementing an online survey could facilitate future follow-up studies or replication of the study in different U.S. states or even internationally. Strickland, et al. (2003) stated to take advantage of the Internet, data collection takes planning, creativity, and expertise. One attractive online design element is that when replying to the questions, respondents are initially entering the data themselves (Andreasen, 2002) and confidentiality is maintained at the highest level. Online surveying can be cost-effective as well as minimizing resource intensiveness.

On-Line Data Collection Limitations

The limitation of data collection for this study was the question of if the health care executives will be candid regarding perceptions of fraud. Because of the program contractors' financial relationship with AHCCCS, the response rate may be low. According to Cooper and Schindler (2002), some topics are too sensitive to answer (p. 369). Sensitive topics include family and money matters (Cooper & Schindler, 2002). A potential significant limitation of this study is that although this study does not have direct association with AHCCCS, results of the study will become publicly available.

On-Line Data Collection Mitigation of Limitations

Tools provided by Internet capabilities may mitigate limitations. The use of computerized analysis of unanswered questions before the participant submits the survey could provide for a decrease in unanswered questions. Using the Internet capabilities may mitigate the limitations of unanswered questions by pointing out the unanswered question to the respondent before the final submission. Using computerized methods to force the respondents to answer the questions can reduce errors. Strickland, et al. (2003) stated that using the Internet has shown to have less missing questionnaire data. Researcher expertise plays a crucial role in web-based data collection (Strickland, et al., 2003). The successful use of the Internet to collect data depends on the

researcher's creativity in writing interview questions in the context of the Internet (Strickland, et al., 2003).

Instrument Design

Data collection of this study consisted of a 10 quantitative questions with a 5-point Likert-type scale (see Appendix F). The simple and succinct survey questions are used to collect program contractor perceptions on the amount of fraud in hospitals, the laws and regulations in making decisions, and the level of comfort with compliance programs in deterring fraud. The initial survey instrument (Van Crombrughe, 2002) *Opinions about Fraud and Abuse Survey* provided a tested, reliable, and valid survey instrument to collect perceptions of health care executive-level professionals on legislation to deter fraud questionnaire (see Appendix G). Using a quantitative design, the data collection occurs at one time at which point the study will examine attitudes, beliefs, and perceptions.

The survey questions consisted of a 5-point Likert-type scale response. According to Neuman (2006), Likert-type scales are widely used and common in research (p. 197). Respondents were asked the level of agreement or disagreement to questions using (*Strongly Agree (SA), Agree (A), Neither Agree or Disagree (N), Disagree (D), Strongly Disagree (SD)*). The most important consideration when building a Likert-type scale is to use at least five responses (Allen & Seaman, 2007) and not more than nine (Neuman, 2006). Neuman stated that the strength of the Likert-type scales is in its ease of use and simplicity. Other scales not selected in this study such as the Thurston scale or the Bogardus Social Scale was because of the complexity of the scales (Neuman, 2006).

The survey length, consisting of 10 questions and a comment section, was short and comprehensive as validated. Studies have indicated that there are negative effects of survey

length on response rates (Galesic & Bosnjak, 2009). As Van Crombrughe (2002) suggested because of the limited time of executives, the survey instrument was short and succinct taking less than 10 minutes to answer the 10 questions and provide extensive comments to the survey on fraud.

Validity and Reliability

Many strategies are available to ensure reliability and validity using online surveys. Strickland, et al. (2003) stated the investigator must determine if the Internet is the correct forum for data collection and what influence the Internet will have on the quality of the data. Gained through replication is validity and reliability (Champion, 2006). Replication of a study is the last step in the scientific method and considered one of the most important elements (Marczyk, et al., 2005).

Validity

In relying on a validated instrument, Creswell and Plano-Clark (2007) stated reviewing scores previously taken from the instrument assesses quantitative validity and reliability. Van Crombrughe conducted piloting and validation of the instrument in the 2002 study. Van Crombrughe (2002) established content validity of the instrument through a panel of five experts. The five highly experienced professionals agreed that the research questions matched with each of the survey questions (Van Crombrughe, 2002). Van Crombrughe piloted the 2002 study with 40 hospital directors and managers to establish validity and reliability of the survey instrument. The reason Van Crombrughe used directors and managers in the pilot study were that there was an organizational relationship between participants and researcher. Rationalization for the method was to retain all executive level participants and as a timesaving measure (Van Crombrughe, 2002).

Table 3

Summary of Survey Items that Significantly Address Research Questions

Survey Item	Item 1	Item 2	Item 3	Item 4	Item 5	Item 6	Item 7	Item 8	Item 9	Item 10
H1/R1	X									
H2/R2		X			X	X	X			
H3/R3		X	X		X	X		X		
H4/R4			X		X	X				

Note. The vertical axis represents the four research questions. The horizontal axis represents the survey instrument items 1-10.

Table 3 is a summation of Van Crombrughe's (2002) pilot testing of the survey instrument for content validity. According to Van Crombrughe, to be included in the survey each item must have three or more experts agree that the survey question answered the research question. Van Crombrughe noted that although survey item 4, 9, and 10 had less than three expert panelists agree that the survey question answered a research question, these items were included in the survey because of the added additional depth in ideas expressed. Presented in Appendix L are these items, the results from the original survey, and the results from the replicated research.

Reliability

One way to define the reliability of a study is to replicate it. According to Marczyk, et al. (2005), replication serves many integral research purposes, including establishing reliability (p. 16). Van Crombrughe (2002) employed Cronbach's Alpha to establish reliability of the 10 items associated with the four research questions (p. 96). Using the panel of experts, Van

Crombrugge analyzed the internal reliability on survey items associated to each research question (p. 109). Results from the Cronbach's Alpha Reliability analysis ranged from .77 to .83. These indicated a high level of consistency that measures the same construct (Van Crombrugge, 2002).

Data Analysis

According to Cooper and Schindler (2002) data analysis involves reducing the size of the data to be manageable, developing summaries, determining patterns, and applying statistical techniques (p. 87). Quantitative methods used in this study included that of analyzing frequency distributions and percentages. A distribution table analyzing response frequencies and percentages for the 10 Likert-type survey items replicating the initial research data analysis will follow (see Appendix H). After completing the quantitative data analysis from the program contractors, chapter 4 will contain an analytical comparison between program contractor responses and hospital executive responses (see Appendix I). Visual representation of results combining SA (Strongly Agree) and A (Agree) responses for each survey item related to each research question will be displayed in charts comparing initial results to the current study results (see Appendix L).

Because data from this study did not provide means or variances in this replicated quantitative study, chi-square testing was appropriate when analyzing differences between two samples are required (Cooper & Schindler, 2002, p. 541). Investigation of ordinal data and counts is through a nonparametric test using chi-square (Cooper & Schindler, 2002). The use of the chi-square tested each null hypothesis of difference between perceptions of hospital executives and program contractors. See appendix K for an example of the chi-square testing of each null hypothesis comparing hospital executive responses to program contractor responses.

Summary

Chapter 3 included a formal review on the study's research method and design appropriateness (Cooper & Schindler, 2002; Creswell, 2005; Creswell & Plano-Clark, 2007). The chapter included detailed strengths of using quantitative research and the ability to describe trends and perceptions. Design appropriateness included a literature of other study design limitations while expanding on the strengths of the quantitative design. Presented in chapter 3 were the population, sampling, and recruitment method for this study.

The ability to gain consent and maintain confidentiality is a highly valued trait of research. The electronic survey used a radio button to opt-in to taking the survey and offers consent. Confidentiality measures were established because of the nature of the executives being surveyed. Data collection methods using an established survey were refined and a review of data analysis was detailed. Chapter 3 introduced study limitations of data collection.

Presented in chapter 4 of this study are the results of the quantitative study and a descriptive analysis and chi-square testing of the null hypotheses of the comparison of program contractor executives and hospital executives' perceptions of fraud legislation. The results from the study that captured the perceptions of program contractors were compared to those results gained from the initial Van Crombrughe 2002 survey of hospital executives on fraud legislation and corporate compliance programs.

Chapter 4: Analysis and Presentation of Results

The purpose of this quantitative descriptive study was to determine the relationship between the perceptions of Arizona AHCCCS program contractor executives' and hospital executives of the level of adequacy of legislation and corporate compliance programs in deterring unethical behaviors to the perceptions of hospital executives. The data collection process included conducting an online survey with 150 professionals who work for program contractor organizations in Arizona. The goal of this quantitative study was to gain an understanding of the perceptions of leading health care executives and compare them with the results of a study conducted in 2002 of hospital executives. Chapter 4 includes the research questions, results of the current research project, the comparison of results to those of the original study, and the summary.

An important factor of this study is the analysis of non-response and non-response bias. Chapter 4 presents the chi-square data analysis of results based on the 10 survey items. Presented in Appendix L are the frequencies and percentages of results from the replicated quantitative study. The statistical analysis contains chi-square tests of the null hypotheses that compare the results from the original study to those of the replicated study.

Research Questions and Hypotheses

Following are the research questions that guided the current study:

R1: What are the differences between program contractor executive and hospital executive perceptions on the presence of health care fraud and abuse (as defined by federal lawmakers and regulatory agencies) in hospitals?

R2: What are the differences between program contractor executive and hospital executive perceptions of health care fraud and abuse laws and regulations as applied to the hospital setting?

R3: What are the differences between program contractor executive and hospital executive perceptions on health care fraud and abuse laws and regulations to assist health care executives in conducting ethical business practices?

R4: What are the differences between program contractor executive and hospital executive perceptions on the governmental focus on enforcement of fraud and abuse laws and regulations to assist honest health care executives in identifying risky business practices?

Hypotheses designed for this study are:

H1₀: There is no significant difference between program contractor executives and hospital executives' perceptions of the presence of health care fraud and abuse in hospitals.

H1: There is a significant difference between program contractor executives and hospital executives' perceptions of the presence of health care fraud and abuse in hospitals.

H2₀: There is no significant difference between program contractor executives and hospital executives' perceptions of health care fraud and abuse laws and regulations as applied to the hospital setting.

H2: There is a significant difference between program contractor executives and hospital executives' perceptions of health care fraud and abuse laws and regulations as applied to the hospital setting

H3₀: There is no significant difference between program contractor executives and hospital executives' perceptions on health care fraud and abuse laws and regulations to assist health care executives in conducting ethical business practices.

H3: There is a significant difference between program contractor executives and hospital executives' perceptions on health care fraud and abuse laws and regulations to assist health care executives in conducting ethical business practices.

H4₀: There is no significant difference between program contractor executives and hospital executives' perception on the governmental focus on enforcement of fraud and abuse laws and regulations to assist honest health care executives in identifying risky business practice.

H4: There is a significant difference between program contractor executives and hospital executives' perception on the governmental focus on enforcement of fraud and abuse laws and regulations to assist honest health care executives in identifying risky business practice.

The next section presents the data collection process, data gathering, and handling of missing data. The section concludes with an analysis of non-response bias with a representation of early and late respondent differences.

Data Collection Process

Data Gathering

In the first phase, 150 potential participants received introductory recruitment letters. The potential participants included chief executive officers, chief financial officers, and directors. There were no returned initial recruitment letters due to incorrect mailing address or title. The second phase consisted of an e-mail reminder sent to those participants who could be identified by name were located by extensive web searches. Thirty-six e-mails with an announcement to the link of the [surveymonkey.com](https://www.surveymonkey.com) with few returned due to non-verification of e-mail address. Like the initial, first phase recruitment letter, due to contractual merging, employees with multiple roles in one organization, and lack of e-mail addresses, decreased the number of

potential respondents. Phase two started nine days after the initial recruitment letter was sent and six days before the end of the study.

Missing Data and Web Survey Breakoffs

In total, 25 respondents entered the link to [surveymonkey.com](https://www.surveymonkey.com). Twenty-four respondents consented to take the survey and one respondent opted not to take the survey at the consent screen. Two participants consented but skipped all questions while one respondent created a single missing data point. Of the 10 questions and a comment section of this survey, no fields were required. By not requiring participants to enter data into each field created the opportunity for respondents to skip questions in the survey but did not create missing data. Missing data is information absent about a response for which other information is present (Cooper & Schindler, 2002, p. 473).

Removed from the data analysis were three respondents because one respondent did not consent to take the survey and two consented but did not provide any data. According to Marczyk, et al. (2005), often excluded is missing data due to the potential of the data skewing the results (p. 205). The analysis pack included the option to ignore cases when data was missing.

Breakoff, another form of response behavior largely seen in web-based surveys, results when the web survey participant starts the survey but fails to complete it (Peytchev, 2009). According to Peytchev, breakoffs occur at high rates in web surveys. Breakoff rates range from 16% to 34% causing errors of non-observation and is a threat to survey inference (Peytchev, 2009). This study had two respondent breakoffs, or 10% of the total respondents. For the purpose of this study, breakoffs were removed from reports and considered with non-response (Peytchev, 2009).

Demographics

The following section presents the demographic profile of the participants in this study. Results suggested that 23% of the respondents were program contractor Chief Executive Officers (CEO) of an organization. Sixty-five percent of the program contractor participants had been in current position for less than six years. No other demographic information was collected due to the limitations expressed in chapter 3 regarding de-identified information and the contract implications that were assumed.

Presented in Table 4 is the distribution between program contractors and hospital executives' current titles. In comparison, the program contractor analysis showed that more respondents (50%) chose the "other" category when representing job titles compared to those of the hospital executives (9%). When reviewing organizational charts to determine a participant list, noted that many executives had multiple roles or contracts. The significance in indicating that some executives had multiple roles is discussed in the limitation section in chapter 5.

Table 4

Distribution of Respondents by Current Title

Current Title	Program Contractors		Hospital Executive	
	(n=22)		(n=442)	
CEO	5	23%	192	43%
CFO	2	9%	113	26%
COO	2	9%	94	22%
Medical Director	2	9%	0	0%
Other	11	50%	43	9%
Total	22	100%	442	100%

Data Analysis Procedure

According to Cooper and Schindler (2002), data analysis involves reducing the size of the data to be manageable, developing summaries, determining patterns, and applying statistical techniques (p. 87). Quantitative analysis methods used in this study included that of analyzing frequency distributions and percentages. Frequencies establish the number of responses to a given survey item. Percentages simplify the data and reduce the data into all numbers ranging from zero to 100, translating these numbers for relative comparisons (Cooper & Schindler, 506).

Hypothesis Testing

This study tested the null hypotheses established in chapter 1 for the current study and those hypothesis of the non-response bias analysis. According to Cooper and Schindler (2002), the null hypothesis is a statement that holds there is no difference between the existing prior measurement and the measures from a more recently drawn sample (p. 523). Consistent evidence shows that a hypothesis stated in the positive manner can almost never be accepted on conclusive grounds (Cooper & Schindler, 2002). Using the null hypothesis to test, analysts determine whether there has been no change or whether a significant difference exists (Cooper & Schindler, 2002). In this study, a “failed to reject the null hypothesis” and a “Rejected the null hypothesis” was used for explaining outcomes of the chi-square test.

Type of Test

The selected test for this study for both the current study and non-response bias analysis was the chi-square non-parametric test. The chi-square test is a non-parametric test used widely and involves cases in which events, persons, or objects are classified into two or more groups (Cooper & Schindler, 2002). Categorized in this study were survey responses into “yes” and

“no” groups. Not used in this study were parametric tests involving ratio and interval data (Cooper & Schindler, 2002).

The statistical analysis of the null hypotheses for this study consisted of using chi-square non-parametric testing. According to Cooper and Schindler (2002), the chi-square test is appropriate to test for differences between samples (p. 540). Used were manually calculated tests that based statistical testing on data from the previous study being in hard copy form. Andreasen (2002) stated that chi-square testing of the null hypotheses are exceedingly simple to understand and almost as simple to calculate (p. 214). To test the null hypotheses of this study, the significance level as $\alpha = .05$ and the degrees of freedom $df = 1$ was used. As defined in Cooper and Schindler's table of Critical Values of the Chi-Square Distribution, the critical test value was determined at 3.84 (p. 821).

Non-Response Bias Analysis

Since there was a minimal amount of participation in this study, a non-response bias analysis was conducted. Out of the 150, 25 respondents started the online survey for the current study. The response rate to was 16%. The response rate for the Van Crombrughe (2002) study was over 46%. Twenty-two of the 25 participants totally completed the electronic survey, meaning there was consent to take the survey, no breakoffs, or other disruption in the electronic survey. In the first phase, there were nine participants. After the e-mail reminder, or second phase of recruitment, 13 participants had responded. Due to the considered low response rate of this study, a non-response bias testing and analysis was conducted to potentially explain how non-respondents would have answered the survey items.

Determining Non-Response Bias

According to Champion (2006), non-respondents are the participants in a study who do not return surveys or questionnaires to the researcher. Several methods exist to estimate non-responses and non-response bias. The extrapolation method presumes that the “late” or last respondents in the sample theoretically indicate a sample of the non-respondents. According to Armstrong and Overton (1977), the extrapolation method of estimating non-response assumes that the participants in a study who respond less readily are more like non-respondents (p. 397).

Demographics of Non-Responses Analysis Participants

To examine if there is non-response bias, according to Armstrong and Overton (1977), other data must be located about the non-respondents. The collection of other data about the participants identifies if there is non-response bias. In a review of U.S. Census statistics on state, county, and city data, the respondents had the same or like socioeconomic statuses, race, and gender demographics. Table 5 demonstrated some of the statistics gained to determine non-response bias. Through the review of socioeconomic data, it was determined that the non-respondents had similar titles to the respondents. Determining that the participants had the same socioeconomic status presented an opportunity to use a chi-square test on the early and late respondents.

Table 5

Distribution of Socioeconomic Statistics by Arizona County

Indicator	Arizona County					
	Cochise	Maricopa	Pima	Pinal	Arizona	U.S.
Bachelors Degree or Higher	18%	25%	26%	11%	23%	24%

Median Household Income	\$44,000	\$56,511	\$46,653	\$50,208	\$51,009	\$52,029
Median value of owner-occupied housing	\$88,200	\$129,200	\$114,600	\$93,900	\$121,300	\$119,600

Note: Arizona counties were chosen to evaluate rural versus urban housing statistics and the main locations of program contractors to identify non-respondent bias (Quickfacts, 2010).

Armstrong and Overton (1977) indicated that the most common extrapolation is over successive waves in the survey, meaning that some sort of stimulus generates the responses. In this study, there were two phases of recruitment. The initial mailing that recruited respondents occurred from day zero to day 10. The participants that responded between day zero and day 10 denoted the early responders. Generated on day 10 was the second stimulus wave consisting of the follow-up e-mail with the link to the web survey tool and considered late respondents. Table 6 defines the distribution in title of the early and late responders.

Table 6

Distribution of Early and Late Respondents by Title

Response	Title					Total	Percent
	CEO	CFO	COO	Medical Director	Other		
Early	3	1	1	0	4	9	40%
Late	2	1	1	2	7	13	60%
Total	5	2	2	2	11	22	100%

Non-Response and Testing Hypotheses

The differences between early and late respondents might indicate the presence of differences between respondents and non-respondents (Armstrong & Overton, 1977). Therefore, if there are no significant difference between early and late respondents, then the null hypotheses fails to be rejected. If there is little to no significant differences determined, then the presence of potential non-response bias does not seem to exist in the study population.

Restated null hypotheses (H1A₀ H2A₀ H3A₀ H4A₀) were used for the purpose of chi-square testing to determine the relationship of early participants to late participants. The null hypotheses stated that there were no differences between early and late respondents. By failing to reject the null, the results in Table 6 establish that there were no significant differences between groups determining that non-response bias does not exist and the results indicated that the non-respondents would respond as did the late ones.

Table 7

Hypothesis Findings of Current Study between Early and Late Respondents

Null Hypotheses	Critical Value	Calculated Value	Results
H1A ₀ : There is no significant difference between early respondents and late respondents perceptions of the presence of health care fraud and abuse in hospitals.	3.84	1.35 (<i>p</i> = .2453)	Failed to reject the null
H2A ₀ : There is no significant difference between early respondents and late respondents perceptions of health care fraud and abuse laws and regulations as applied to the	3.84	1.66 (<i>p</i> = .1976)	Failed to reject the null

hospital setting.

H3A ₀ : There is no significant difference between early respondents and late respondents perceptions on health care fraud and abuse laws and regulations to assist health care executives in conducting ethical business practices.	3.84	1.20 (<i>p</i> = .2733)	Failed to reject the null
H4A ₀ : There is no significant difference between early respondents and late respondents perception on the governmental focus on enforcement of fraud and abuse laws and regulations to assist honest health care executives in identifying risky business practice	3.84	1.61 (<i>p</i> =.2045)	Failed to reject the null

Note. Table displays the results of current study findings to determine non-biasness. Table format adapted from “*The Relationship Between Information Technology Project Manager Personality Type and Project Success*” by Desiree C. LeBlanc., 2008, p. 122. Copyright 2008 by Desiree C. LeBlanc. Modification permission in Appendix M.

Results for the Study Hypotheses

Tables in Appendix L display the amount of agreement or disagreement to the survey items as related to the null hypotheses. For the purpose of chi-square (χ^2) analysis, the responses from the Van Crombrughe (2002) survey and the current survey that represented don't know (DK) and neither agree or disagree (NAD) were distributed among the other answers based on a percentage to the agreements (SA, A) and the disagreements (D, SD). Cooper and Schindler (2002) suggested distributing the DK and NAD in the same ratio that the other answers occurred thus taking into account all answers.

The chi-square (χ^2) non-parametric test is appropriate when testing for differences between samples (Cooper & Schindler, 2002, p. 540). A chi-square (χ^2) statistical method determined the association and tested the null hypothesis for differences between hospital executives and program contractor perceptions of fraud. The probability of .05 was to reject the null hypotheses or fail to reject the null hypotheses.

Table 8 summarizes the results with two different critical test values. Although the degrees of freedom of a 2 x 2 table cannot be changed, the critical test value and probability can be re-examined therefore increasing or decreasing the probability. According to Cooper and Schindler (2002) changing the critical value of a Type 1 error moves the critical value either closer or further away from the parameter (p. 527). For this study, the degree of freedom (df) = 1 and the significance level (α) at .05. With these parameters, the critical test value was 3.84 (Cooper & Schindler, 2002, p. 821).

Table 8

Testing the Null Hypotheses between Hospital Executives and Program Contractors

Hypothesis	df	Critical Value ($\alpha=.05$)	Critical Value ($\alpha=.01$)	Calculated Value (χ^2)	Results ($\alpha=.05$)
H1 ₀ (Survey Item 1)	1	3.84	9.21	40.66	Rejected the null
H2 ₀ (Survey Items 2, 5, 6, 7)	1	3.84	9.21	1.23	Failed to reject the null
H3 ₀ (Survey Items 2, 3, 5, 6, 8)	1	3.84	9.21	12.25	Rejected the null
H4 ₀ (Survey Items 3, 5, 6)	1	3.84	9.21	5.57	Rejected the null

Note. From “The Relationship Between Information Technology Project Manager Personality Type and Project Success” by Desiree C. LeBlanc, 2008, p. 122. Copyright 2008 by Desiree C. LeBlanc. Modification permission in Appendix M

Hypothesis Testing Results

Hypothesis H1. The null hypothesis (H_{10}) was tested to determine if there was a real difference in perceptions between program contractors and hospital executives of the presence of health care fraud and abuse in hospitals. Used was a chi-square non-parametric statistical test with a probability of .05, meaning that the probability of a correct analysis is true at 95%, with a critical test value of 3.84. The results from the chi-square statistical test indicated a significant difference between program contractors and hospital executive’s perceptions ($\chi^2 (1, N = 462) = 40.66, p < .0001$). The null hypothesis was rejected.

Hypothesis H2. The null hypothesis (H_{20}) was tested to determine if there was a real difference in perceptions between program contractors and hospital executive, perceptions of health care fraud and abuse laws and regulations as applied to the hospital setting. A chi-square non-parametric statistical test was used with a probability of .05 with a critical test value of 3.84. The results from the chi-square indicated that there was no significant difference between program contractors and hospital executive’s perceptions ($\chi^2 (1, N = 1,849) = 1.23, p = .2674$). The null hypothesis failed to be rejected.

Hypothesis H3. The null hypothesis (H_{30}) was tested to determine if there was a real difference between program contractors and hospital executives of the perceptions on health care fraud and abuse laws and regulations to assist health care executives in conducting ethical business practices. A chi-square non-parametric statistical test was used with a probability of .05 with a critical test value of 3.84. The results from the chi-square indicated a significant

difference between program contractors and hospital executive's perceptions ($\chi^2 (1, N = 2,310) = 12.25, p = .0005$). The null hypothesis was rejected.

Hypothesis H4. The null hypothesis (H_{4_0}) was tested to determine if there was a real difference between program contractors and hospital executives' perception on the governmental focus on enforcement of fraud and abuse laws and regulations to assist honest health care executives in identifying risky business practice. A chi-square non-parametric statistical test was used with a probability of .05 with a critical test value of 3.84. The results from the chi-square indicated a significant difference between program contractors and hospital executive's perceptions ($\chi^2 (1, N = 1,318) = 5.57, p = .0183$). The null hypothesis was rejected.

Additional Survey Items

As stated in chapter 3, Van Crombrughe noted that although survey items 4, 9, and 10 had less than three expert panelists agree that the survey question answered a research question, these items were included in the survey because of the additional depth in ideas expressed. The Van Crombrughe (2002) study indicated that 12.90% of hospital executives perceived that there was a substantial amount of health care fraud and abuse in hospitals. The current research indicated that 59.09% of program contractor respondents perceived that there was substantial fraud and abuse in hospitals.

Corporate Compliance Question 10. Van Crombrughe noted that although the hospital executives perceived fraud as minimal in the hospital setting, 86% of the executives believed the organizations protected with a compliance program in place that is noted in Item 10 in Appendix L. Although the program contractors thought there was more fraud in the hospital setting, both hospital executives (85.29%) and program contractors (90.91%) agreed that having a corporate compliance program in place protected organizations from potential fraud.

As noted by Van Crombrughe (2002), the expert panelists who validated the survey stated that Item 10 on the survey would not be helpful with answering any of the research questions or hypotheses. According to Van Crombrughe, the information acquired from Item 10 remains useful and that many of the hospitals and payer organizations have invested in a corporate compliance program in an effort to reduce or minimize potential risk. It was noted that most hospital executives and program contractor respondents perceived that there was a peace of mind knowing that organizations had a corporate compliance program to protect them

Open-Ended Survey Question . The current survey consisted of an open-ended question. Van Crombrughe's (2002) open-ended question collected text-rich information and comments in the open-ended question. Unlike Van Crombrughe's study, many of the participants in the current study did not respond to the open-ended question. The comments collected through the current study are displayed in Appendix N.

Summary

The purpose of this quantitative descriptive study was to compare the Arizona AHCCCS program contractor executives' perception of the level of adequacy of legislation and corporate compliance programs in deterring unethical behaviors to the perceptions of hospital executives. The return rate for this study was 16% compared to the return rate of 45% from the previous Van Crombrughe (2002) study. Due to the low response rate a modeling for non-response bias was tested. Chi-square (χ^2) testing of the null hypotheses determined if there was a significant difference between early and late respondents. Determined was that non-response bias was not experienced. The late respondents were determined to respond like the non-responders and that the early and late responders were accepted as the same. The research continued with the non-response biasness noted.

Results indicated that there were differences in perceptions between program contractors and hospital executives. Results indicated that the null hypotheses were rejected on hypothesis H1, H3, and H4. Calculations for H2 failed to reject the null hypothesis. One notable factor of this research was that although there was a significant difference in perceptions of hospital executives and program contractors on laws and regulations, all agreed that corporate compliance programs helped protect organizations from fraud and abuse.

Chapter 4 presented the data collection procedures and results for the research study. The chapter presented an analysis of non-response biasness to determine if the low response rate would be acceptable. Chi-square (χ^2) test results from the null hypothesis testing on the comparison of hospital executives to those of program contractors were presented in chapter 4. Frequencies and percentages of the study results are included Appendix L.

Chapter 5 presents further conclusions and recommendations of the study. Chapter 5 includes limitations found during this study. Chapter 5 also includes recommendations for further exploration for future studies.

Chapter 5: Conclusion and Recommendations

Fraud and abuse is conservatively estimated to be 3%, or \$68 billion dollars (NHCAA, 2009), of health care spending, creating an expensive problem for leaders in health care organizations. Health care fraud and abuse encompasses occupational fraud and moral development. The purpose of this quantitative descriptive study was to compare the Arizona AHCCCS program contractor executives' perception of the level of adequacy of legislation and corporate compliance programs in deterring unethical behaviors to the perceptions of hospital executives.

Chapter 4 presented a detailed non-response bias analysis and descriptive statistics including frequencies and percentages of hospital executives and program contractors to each survey item. Chi-square statistical test results were presented. Chapter 5 includes major findings of the study and interpretations of the conclusions as to how these findings tie back to the problem statement.

Conclusions

The quantitative descriptive study was designed to determine if there was a significant difference between hospital executives and program contractors on perceptions of fraud legislation and the ability to deter fraud through legislation as measured through Van Crombrughe's (2002) Opinions about Fraud and Abuse survey. The general problem of health care fraud is that although there are an increasing number of legislations enacted and amended to deter fraud, there are an increasing number of reported fraud cases. The specific problem is a lack of understanding of health care executive perceptions of the adequacy of laws in place to deter health care fraud.

Previous studies (Krause, 2006a; Werner, et al, 2004; Miyazaki, 2009) indicated that there was a wide variety in perceptions of health care fraud. Perspectives have been studied from the member/patient aspect. Studies of employer and employee perspectives of fraud have been conducted (Meiners, 2005; ACFE, 2008; Wells, 1997; Ernst & Young, 2009). Other studies have been conducted on the taxpayer perspectives (Stanton, 2001; Holtfreter; CAIF, 2009) as well as the practitioner or health care provider (Stanton, 2001; Krause, 2006a; Romano, 2009). Health care fraud studies have one theme; the lower the risk the individual perceives the higher the tolerance to health care fraud.

Major Findings

Rejection of the null hypothesis occurred in three of the four chi-square testing. This current research has increased the knowledge of perceptions of health care executives on the inadequacies of laws enacted to deter fraud. As summarized in Table 9, this study has concluded that there is a significant difference between hospital executives and program contractor perceptions of fraud legislation, the amount of fraud in hospitals, legislation assisting health care executives to conduct ethical business practices, and assist honest health care executives in identifying risky business practice.

Interpretations of Findings

Champion (2006) stated that criminologists and other believe that there should be studies on attitudes (p. 386). Results of the previous study differ from other studies conducted because other studies do not compare the significance of perceptions between groups. The other studies focused on individual perceptions of fraud in the health care industry in which the current study focused on determining the significance of the differences of perceptions between two of the most visible stakeholders in the industry. Following is a discussion on the discoveries of the

current study and how the discoveries relate to the general and specific problem of health care fraud.

Hypothesis 1 - Presence of fraud in hospitals. A significant difference occurred between hospital executives and program contractors on perceptions of the amount of fraud in hospitals. Where 68% of the program contractor agreed that fraud was prevalent and there was a substantial amount of fraud in hospitals, 87% of the hospital executives disagreed that fraud was substantial in hospitals. Stanton (2001) addressed fraud and providers as providers are under financial stress and squeezed by the pressures of lower reimbursement from the Medicare and Medicaid program contracting. The results of the chi-square statistical test indicated that there was a significant difference between the perceptions of hospital executives and program contractors in the amount of fraud in hospitals ($p < .0001$).

The specific problem was a lack of understanding of health care executive perceptions of the adequacy of laws in place to deter health care fraud. The results indicated that there was a significant difference between the perceptions of the executives in the amount of fraud in hospitals. The results related back to the problem statement in that if one group perceives there is significant amount of fraud in hospitals and the other group perceives that there is minimal fraud in hospitals, then fraud and abuse laws are not deterring fraud. However, this current research has added to the body of knowledge about the perceptions of fraud legislation.

Hypothesis 2 - Fraud legislation applied to hospitals. Gurley, et al. (2007) studied the effects of perceived punishment and crime. Gurley, et al. concluded that the presence of punishment could encourage ethical decision-making. Results of the current study chi-square statistical test indicated that there was not a significant difference between hospital executives and program contractors. Analysis of the results indicated that there was no significant

differences of (a) the necessity of laws and regulations to counteract fraud in hospitals, (b) legislation assisting health care executives to do the right thing, (c) that laws and regulations are more helpful than a hindrance, and (d) the necessity of the focus of the government in the current hospital environment ($p = .2674$). Klein and Campbell (2006) stated that the scope and number of health care fraud legislation and the accompanying regulations had expanded significantly in the last 20 years.

The specific problem was a lack of understanding of health care executive perceptions of the adequacy of laws in place to deter health care fraud. Concluded from this current research is that although executives have different perceptions of the amount of fraud in hospitals, there is a consistency that the laws are applied in the hospital setting. The results related back to the problem statement in that this current research has added to the body of knowledge of the perceptions of health care executives and fraud legislation.

Hypothesis 3 -Conducting ethical business practices. Employers lose 6% of annual revenues to employee fraud (ACFE, 2008; Meiners, 2005; Wells, 1997). A significant difference was found between hospital executives and program contractors in the perceptions of fraud and abuse laws and regulations supporting honest health care executives in carrying out day-to-day operations and the belief that the intention of fraud and abuse enforcement ensure quality, ethical care is being delivered to the public. Results of the chi-square statistical test indicated that there was a significant difference between perceptions of laws and regulations assisting health care executives in conducting ethical business practices ($p = .0005$). According to ACFE (2008), the median loss of occupational fraud was \$175,000 and that many of these schemes frequently continued over years before detection. According to the ACFE survey, the average duration of fraudulent activity was 24 months.

The specific problem was a lack of understanding of health care executive perceptions of the adequacy of laws in place to deter health care fraud. Concluded from this current research is that there is a significant difference between health care executives on fraud and abuse legislation in assisting health care executives in conducting ethical business practices. This current research related back to the problem statement is that the perceptions of health care executives have been explored and there is an understanding of the significant differences in perceptions.

Hypothesis 4 - Identifying risky business practices. According to the Ernst & Young (2009) survey, 13% of senior managers stated that in today's economy, misstating financial performance was justifiable. Results of the Ernst & Young survey indicated that 47% of the respondents thought that one or more types of unethical behavior were acceptable to help the business to be viable through the economic downturns. Results of the chi-square statistical test indicated that there was a significant difference between perceptions of laws and regulations assisting health care executives in assisting health care executives in identifying risky business practices ($p = .0183$).

The specific problem was a lack of understanding of health care executive perceptions of the adequacy of laws in place to deter health care fraud. Concluded from this current research was that there was a significant difference in perceptions of health care executives on the governmental focus on enforcement of fraud and abuse laws and regulations to assist honest health care executives in identifying risky business practice. This current research related back to the problem statement in that there is now known research on the perceptions and this has increased the understanding of health care executives' perceptions that one group has been identified that there is a difference in perceptions of the adequacy of legislation.

Other Results - Corporate compliance. Results of an Ethics Resource Center (ERC) (2007) survey indicated that organizations had relatively few ethics and compliance programs in place. As determined in this study, hospital executives and program contractors vary in perceptions. The first most significant agreement between the groups was in item 10 of the survey that corporate compliance programs deter fraud. Eighty-six percent ($n= 377$) of the hospital executives and 99% ($n= 20$) of the program contractors indicated that the corporate compliance programs deterred fraud. However, ERC survey results indicated that only one of four companies had a well-implemented corporate compliance program.

The specific problem was a lack of understanding of health care executive perceptions of the adequacy of laws in place to deter health care fraud. The results of this study directly address the problem statement in three ways. The major conclusion is that there is current research on the perceptions of health care executives on understanding of the adequacy of laws in place. The second is now there is an understanding that differences exist on perceptions observed in the ability of legislation to assist health care executives in conducting ethical business practices and identifying risky business practices. The third conclusion is that corporate compliance programs are determined to deter fraud even though fraud still exists.

Implications

The results of this study might be important to not only health care executive but also to other leaders in other industries. Chapter 1 outlined the limitations to this study with an extensive discussion in chapter 3. Implications are an important aspect of this current study and may provide future researchers with insight and information in fraud research and surveying. Researchers may use the differences between hospital executives and program contractors when

conducting further research as a differentiating aspect of the complexity of the health care industry.

Non-Response Rate Implications

Implications of non-response include item non-response and unit-non-response (MacDonald, et al., 2009). This study did not contain item non-response excluding those who experienced breakoffs. Although item non-response was not prevalent in the study, unit non-response was noted with a return rate of 1%. Unit non-response occurs when surveys are not returned and no information is collected.

For this study, strategies were used to decrease non-response implications. According to MacDonald, Newburn-Cook, Schopflocher, and Richter (2009), strategies for addressing non-response fall into two categories. The first category aimed to increase response rate and the second was to adjust for post survey non-response. To minimize the non-response rates, survey length was minimal with 10 items, survey length was announced before the start of the survey (Peytchev, 2009; Galesic & Bosnjak, 2009), and survey reminders were sent (Peytchev, 2009). Although these strategies to reduce non-response rate were present, non-response still occurred.

MacDonald, et al. (2009) cautioned that trying to increase response rate by using some strategies could lead to an increase in non-response bias. The use of financial or other response incentives was not included as a strategy in this study. According to MacDonald, et al., researchers should tailor a survey package of strategies that is guided by some knowledge of the groups' response (p. 90). Because the current survey revolved around perceptions of program contractors who contracted with the state governmental agency to provide services to the indigent, the use of financial incentives with groups of executives could have been observed as an indicator of fraud or engaging in illegal activities.

Limitations

This study employed a quantitative exploration into the perceptions of health care professionals. Combined with the study results of the Van Crombrugghe (2002) study, this study provides perspectives of two different roles in the complex health care system. Two limitations were identified after the proposal for this quantitative study. The first limitation was that executives in health plans tend to have multiple roles in the organization. The second limitation was that health plans administer more than one contract.

The first limitation discovered during the current research was that executives tend to have multiple roles within an organization. Organizations have reduced staff levels or combined roles and responsibilities. The indication that organizations have reduced staff levels or combined job responsibilities was prevalent in the organizational charts of many of the program contractors.

The second limitation was that many of the health plans were administering multiple contracts for AHCCCS. Noted was that one health plan administered health benefits for both the acute care population and the ALTCS populations. A couple of health plans administered contracts in different counties. This limitation decreased the sample population from the original sample as contracts changed through out the research.

Recommendations

According to Wells (2007), considering the social and financial interest of fraud, minimal modern research exists on the subject (Wells, 2005). Significance of health care fraud is in the statistics. With health care costs growing at six times the rate of inflation (Cucciare & O'Donohue, 2006) and national health spending in 2009 reaching \$2.5 trillion (NCHC, 2009),

health care fraud is estimated to be 3% or \$68 billion dollars (NHCAA, 2009). The findings of this study extended the foundation for future studies to examine the perceptions of health care executives. Recommendations for future studies are based on the finding from the data in chapter 4.

Recommendations for Leadership

The current research can help leaders improve organizational performance through identifying executive perceptions of fraud. Barnes and Webb (2008) studied the factors that affect an organization's susceptibility to fraud. According to Barnes and Webb, fraud increases with organizational size, supporting previous research. Significance of seniority of the perpetrator also determines the amount of loss (Barnes & Webb, 2008) which was also indicated in the literature review that the median loss from executive fraud was \$852,000 (ACFE, 2008). Barnes and Webb suggested that future research should focus on implementation of effective and efficient counter-theft and fraud policies and procedures.

The recommendation for leadership is to continue investigation of corporate compliance programs as anti-fraud controls. The data suggested that in survey item 10 (Appendix L), although hospital executives and program contractors differed significantly in perceptions in parts of the current research, the current research suggested that 85.29% of hospital executives and 90.91% of program contractor executives believed that corporate compliance programs protect an organization from fraud. Although the suggested data gained perspectives, there is no research of why or how corporate compliance programs protect and organization as fraud continues to increase in the health care industry.

Recommendations for Future Research

The first recommendation for future research is to replicate the study using a different population of health care executives. Replication of studies is the last step in the scientific method and considered one of the most important elements (Marczyk, et al., 2005). The results from this study indicated a significant difference in perceptions of hospital executives and program contractors in the presence of fraud in hospitals ($p < .0001$), regulations and laws assisting health care executives in conducting ethical business practices ($p = .0005$), and laws and regulations assisting health care executives in identifying risky business practices ($p = .0183$). Knowing there is a significant difference in perceptions exist an opportunity is presented for future research and exploration into other health care executive perceptions. With the complexity of the current health care system, perceptions can be compared between health care specialties, different facility types (e.g. rehabilitation facilities, skilled nursing facilities, or home health agencies), and different payer types (e.g. commercial, governmental, or managed care). The comparison would improve the understanding of the significance of different perceptions. Gained through replication is validity and reliability (Champion, 2006).

The second recommendation for future research is to replicate the study using a different research method, such as a mixed method adding a qualitative perspective. Mixed method research builds on the strength of both quantitative and qualitative data (Creswell, 2005). Using a mixed method would provide actual participants' words to describe fraud and perceptions of fraud. This study collected quantitative data that determined if there was a significant difference between perceptions but did not determine why there are differences, providing a complex picture of fraud (Creswell, 2005). Van Crombrughe (2002) reported many comments in the

study that was replicated. The results obtained from the Van Crombrughe study in the comment section may involve changing the data collection method.

Summary

The purpose of this quantitative descriptive study was to compare the Arizona AHCCCS program contractor executives' perception of the level of adequacy of legislation and corporate compliance programs in deterring unethical behaviors to the perceptions of hospital executives. To determine if there was a significant difference between these populations, an online replicated survey instrument was presented to the potential participants. Following is a summary of results of the study, how this study added to the body of knowledge of fraud research, and how this study added to the improvement of organizational performance.

Summary of Results

Results in chapter 4 identified a significant difference in three of the four hypotheses. All four chi-square tests were calculated with a $\alpha=0.5$ and $d.f.=1$. Chi-square results indicated that there was a significant difference in perceptions on the amount of fraud in hospitals ($p < .0001$). Minimal differences in perceptions on the application of health care fraud and abuse laws as applied in the hospital setting existed ($p = .2674$) and failed to reject the null hypothesis. Results of the current study rejected the third and fourth null hypothesis indicating that there was a significant difference between perceptions on regulations helping health care professionals use ethical business practices ($p = .0005$) and assisting executives in identifying risky business practices ($p = .0183$).

Summary of the Addition to the Body of Knowledge

The general problem of health care fraud is that although there are an increasing number of legislations enacted and amended to deter fraud, there are an increasing number of reported fraud cases. According to TAF (2007) statistics, 382 newly reported fraud cases with judgments and settlements reaching over \$3 billion were reported in 2006. Of the 382 newly reported cases, 110 of these cases involved health care related issues. The specific problem for this study was a lack of understanding of the differences between health care executive perceptions of the adequacy of laws in place to deter health care fraud. Gained from this study is an indication that there is a significant difference between the perceptions of hospital executives and program contractors.

The current study was one of the first studies conducted in the investigation into program contractor perceptions of fraud and joins the extensive research in hospital executive perceptions and patient perceptions, opening the investigation of perceptions into the triad of most visible health care stakeholders. Results from the Van Crombrughe (2002) study set the foundation on hospital executive perceptions of fraud and abuse legislation.

Summary of the Improvement to Organizational Performance

Fraud affects organizational performance. Even though reported fraud cases are increasing, both hospital executives and program contractors agreed that there was a sense of comfort knowing that organizations had a corporate compliance program in place. The sense of comfort may prove to be a false sense of security indicating that there may not be an effective corporate compliance program in place (Van Crombrughe, 2002). As indicated by the results of this study, hospital executives and program contractors have a significant difference of perception on the amount of fraud in hospitals. Significant differences occurred in the amount of

fraud in hospitals, using regulations to assist in conducting ethical business practices, and assist in identifying risky business practices.

According to Pelletier and Bligh (2008), employees attribute poor organizational performance to three elements in leadership; (1) lack of moral reasoning, (2) trust breaches, (3) hypocrisy, and (4) poor ethical role modeling. Poor employee attitudes toward leadership roles and executives who maintain those roles result in poor performance of an organization. Understanding how the perception of executives and those who employees perceive in a leadership role may be an indication of how the organizational would perform. Results of this study contributed to improving organizational performance by adding to the understanding of executive perceptions of health care fraud

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10.1080/15265160490518566

APPENDIX A: PERMISSION TO USE EXISTING SURVEY

UNIVERSITY OF PHOENIX
PERMISSION TO USE AN EXISTING SURVEY

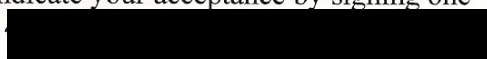
Date 09/17/2009


Ms. Barbara Hess


Dear Ms Hess:

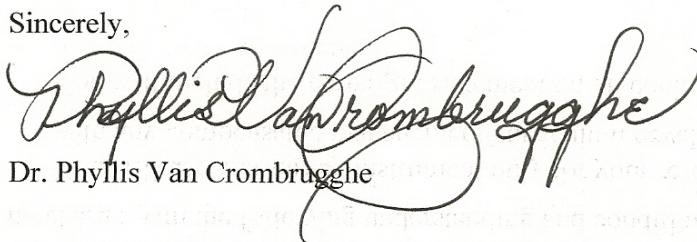
Thank you for your request for permission to use in your research study the survey instrument I developed for my 2002 Pepperdine University research study concerning *California Hospital Health Care Executives and Government Enforcement of Fraud and Abuse and Regulations, A Study to Obtain Opinions of California Hospital Health Care Executives about Governmental Enforcement of Fraud and Abuse Laws and Regulations*. I am willing to allow you to reproduce the instrument as outlined in our discussion and your research proposal submittal at no charge with the following understanding and conditions:

- You will use this survey instrument only for your research study and will not sell or use it with any compensated management/curriculum development activities.
- You will include the copyright statement on all copies of the instrument and in your final research study documents.
- You will validate by acceptable scientific research methods any alterations, edits or changes made to the survey instrument employing comparable validation methods used originally to develop the survey instrument.
- You will send your research study and one copy of reports, articles, and the like that make use of this survey instrument and data promptly to my attention.

If these are acceptable terms and conditions, please indicate your acceptance by signing one copy of this letter on page 2 and returning it to me at 

 Please accept my encouragement and best wishes with your study.

Sincerely,



Dr. Phyllis Van Crombrughe

APPENDIX B: PERMISSION TO USE EXISTING TABLE/FIGURE

UNIVERSITY OF PHOENIX
 PERMISSION TO USE AN EXISTING TABLE/FIGURE

Date: 12/10/2009

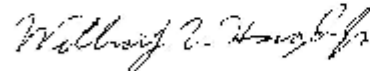
Ms. Barbara Hess
 [REDACTED]

Dear Ms. Hess:

Thank you for your request for permission to reprint/adapt the table I developed for my 2009 University of Phoenix research study, Precipitating Events Leading to Voluntary Employee Turnover Among Information Technology Professionals: A Qualitative Phenomenological Study. I am willing to allow you to reproduce the table as outlined in our discussion and your research proposal submittal at no charge with the following understanding and conditions:

- You will use this table for your research study and will not sell or use it with any compensated management/curriculum development activities.
- You will include the copyright statement on all copies of the table and in your final research study documents.

Sincerely,



William J. Von Hagel, Jr., D.M.

APPENDIX C: PERMISSION TO USE REPRINTED MATERIALS



Barbara Hess [REDACTED]

Fraud Triangle

4 messages

Barbara Hess [REDACTED]

Tue, Oct 6, 2009 at 2:19 PM

To: [REDACTED]

Hi. I am a doctoral student with the University of Phoenix. I am working on my dissertation topic of fraud and abuse. More specifically the Perception of Health Care Payor Executives on the efficiency of laws enacted to deter fraud. I was reading Joseph Wells' article on Why Employees Commit Fraud from Feb 2001. I have also purchased his book. I would like permission to reproduce the fraud triangle as viewed from the magazine article.

Thank you for your time and I look forward to your earliest response!

-B

Barbara Hess [REDACTED]

Tue, Oct 6, 2009 at 6:32 PM

To: [REDACTED]

Hi Mr. Wells. Please see below. I would like to use the triangle diagram published in your article Why Employees Commit Fraud from the Feb 2001 issue for my dissertation on health care fraud and abuse.

Thanks for your response in advance!

-B

[Quoted text hidden]

Joseph T. Wells [REDACTED]

Wed, Oct 7, 2009 at 3:34 AM

To: Barbara Hess [REDACTED]
Cc: Jeanette LeVie [REDACTED]

Ms. Hess,

You have my permission. If you need assistance with a higher-quality visual of the triangle, please contact my assistant, Jeanette LeVie, CFE.

Sincerely,

Joseph T. Wells, CFE, CPA
Chairman of the Board of Directors



<https://mail.google.com/a/email.phoenix.edu/?ui=2&ik=3c298ce6ad&view=pt&search=inbox&th=1242bb...> 10/7/2009

APPENDIX D: RECRUITMENT LETTER

Barbara Hess, ABD
 XXX XXXXXXXX
 XXXX, XXX XXXXXX
XXXXXXXXXX@yahoo.com
 XXX.XXX.XXXX

__, 2010

Dear Colleague:

My name is Barbara Hess and I am completing my doctoral studies at the University of Phoenix. As executive level health care professionals, you know how much fraud is costing the health care industry and the impact that fraud has on the increase of health care costs. Your response to this survey can greatly enhance the understanding of health care fraud and ways to deter it. The questionnaire was designed specifically for its brevity and contains 10 Likert-type questions and a comment section. This survey should take 10 minutes and both responses and comments are appreciated.

The purpose of this quantitative study is to compare the Arizona AHCCCS program contractor executives' perception of the level of adequacy of legislation and corporate compliance programs in deterring unethical behaviors to the perceptions of hospital executives. Results from this study will be compared to those of a previous study conducted with hospital executives in 2002.

Please be assured that your participation in this study is voluntary. All information and data that is provided will be de-identified so as to maintain the highest level of confidentiality. The use of all data is limited to this research study. If you have questions or concerns please do not hesitate to contact me at the above e-mail address or phone number.

Please take 10 minutes to respond by typing the below hyperlink into the browser and answering the questions. All names and individual survey responses will be de-identified at the website questionnaire level and information will be held in the strictest of confidence.

_____@_____

There is no need to print and return the survey. All information will be sent via the electronic survey process to the principle investigator.

Please contact me with any questions, concerns, or issues. Please complete the electronic survey by ____, 2009.

Thanks you again for your participation.

Sincerely,

Barbara Hess
 Doctoral Candidate

APPENDIX E: ELECTRONIC CONSENT

Electronic Consent form with Radio Buttons found on Surveymonkey.com

HEALTH CARE EXECUTIVES' PERCEPTIONS ON FRAUD LEGISLATION

CONSENT TO PARTICIPATE IN STUDY

*** Esteemed Colleague: I am a student at the University of Phoenix working on a doctoral degree in Health Care Administration. I am conducting a research study entitled Health Care Executives' Perceptions on fraud Legislation: A replication mixed-method triangulation Study. Twenty-one program contractors with the Arizona Health Care Cost Containment System will be asked to complete the following survey. The data from this survey may provide health care professionals further research in the perceptions of industry leaders on fraud and abuse legislation.**

Your participation in this study will involve a 10-minute survey with 10 questions on your perception of legislation to deter fraud and your perception of corporate compliance programs to deter fraud. All personal information, such as your name, location, etc. will be de-identified and not disclosed. This research project is not funded or directly involved with AHCCCS. At no time will your detailed information be distributed. Only combined/aggregate totals will be published in this proposed research.

Your participation in this study is voluntary. If you choose not to participate at any time, you can withdrawal from the electronic survey without penalty or loss of benefit to yourself.

This research study has no foreseeable risk to you or your status as a program contractor. There is no foreseeable benefits to you, only that this research will further understanding and research into the real life phenomenon of fraud, why it occurs, and possible ways to deter fraud from happening.

By checking the radio button below, you are acknowledging that you understand the nature of this research and your participation. Your identity will be kept confidential at all times. By checking the radio button below you are indicating that you are 18 years of age or older and giving voluntary permission to participate in this research.

Questions or responses regarding this survey, directed to Barbara Hess at [REDACTED]

Yes
 No

APPENDIX F: EXAMPLE ELECTRONIC SURVEY AND QUESTIONS

Example Electronic Survey

1. Default Section						
1. 1	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Don't Know
I believe that, in general, there is still a substantial amount of fraud and abuse in many hospitals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. 2	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Don't Know
The laws and regulations presently promulgated by the federal government are often necessary to counteract fraud and abuse in hospitals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. 3	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know
Fraud and abuse laws and regulations often support honest health care executives in carrying out day-to-day operations and transactions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. 4	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Don't Know
The application of fraud and abuse laws and regulations is often too broad or aggressive in current enforcement actions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Fraud and abuse laws and regulations often assist health care executives in doing the right thing.						
	Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree	Don't Know
5	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Quantitative Survey Questions

Participants in this replicated quantitative study included 200 program contractor executives supporting the Arizona's AHCCCS program in Arizona.

The 5-point Likert-type scale questions are:

1. I believe that, in general, there is still a substantial amount of fraud and abuse in many hospitals.
2. The laws and regulations presently promulgated by the federal government are often necessary to counteract fraud and abuse in hospitals.
3. Fraud and abuse laws and regulations often support honest health care executives in carrying out day-to-day operations and transactions.
4. The application of fraud and abuse laws and regulations is often too broad or aggressive in current enforcement actions.
5. Fraud and abuse laws and regulations often assist health care executives in doing the right thing.
6. Because of the presence of fraud and abuse in some hospitals, the laws and regulations promulgated by the federal government are more likely to be helpful than a hindrance.
7. The government focus on health care fraud and abuse regulation is unnecessary in the current hospital environment.
8. I believe the government's intention in fraud and abuse enforcement in hospitals is to ensure quality, ethical care is delivered to the public.

9. I believe the government's intention in health care fraud and abuse enforcement in hospitals is motivated more by recovery of money than by concern for quality, ethical care delivered to the public.
10. I feel comfortable knowing my organization has a compliance program to protect my organization from potential fraud and abuse.

APPENDIX G: VAN CROMBRUGGHE'S 2002 SURVEY

Opinions about Fraud and Abuse

We would like your opinions about fraud and abuse in hospitals.

Please indicate your opinion (there are no right or wrong answers) on the items below by using this response scale:
Please circle your response.

SA: Strongly Agree A: Agree NAD: Neither Agree nor Disagree
D: Disagree SD: Strongly Disagree DK: Don't know

1. I believe that, in general, there is still a substantial amount of fraud and abuse in many hospitals.	SA	A	NAD	D	SD	DK
2. The laws and regulations presently promulgated by the federal government are often necessary to counteract fraud and abuse in hospitals.	SA	A	NAD	D	SD	DK
3. Fraud and abuse laws and regulations often support honest health care executives in carrying out day-to-day operations and transactions.	SA	A	NAD	D	SD	DK
4. The application of fraud and abuse laws and regulations is often too broad or aggressive in current enforcement actions.	SA	A	NAD	D	SD	DK
5. Fraud and abuse laws and regulations often assist health care executives in doing the right thing.	SA	A	NAD	D	SD	DK
6. Because of the presence of fraud and abuse in some hospitals, the laws and regulations promulgated by the federal government are more likely to be helpful than a hindrance.	SA	A	NAD	D	SD	DK
7. The governmental focus on health care fraud and abuse regulation is unnecessary in the current hospital environment.	SA	A	NAD	D	SD	DK
8. I believe the government's intention in fraud and abuse enforcement in hospitals is to ensure quality, ethical care is delivered to the public.	SA	A	NAD	D	SD	DK
9. I believe the government's intention in health care fraud and abuse enforcement in hospitals is motivated more by recovery of money than by concern for quality, ethical care delivered to the public.	SA	A	NAD	D	SD	DK
10. I feel comfortable knowing my organization has a compliance program to protect my organization from potential fraud and abuse.	SA	A	NAD	D	SD	DK

Thank you very much for your assistance. Any comments you might have on fraud and abuse or the above items would be appreciated.

Now that you have given me your opinion, please tell me a little about yourself. Please place a check mark on the appropriate line for each question or fill in the blank. Note: All information will be kept **CONFIDENTIAL**. Thank You!

- CURRENT POSITION (Please Check One)
CEO _____ COO _____ CFO _____ CBO _____ Other _____
- YEARS IN CURRENT POSITION: _____
- SIZE OF INSTITUTION: _____ Beds

P. Van Crombrughe, Copyrighted Document (2002)

APPENDIX H: SAMPLE DISTRIBUTION AND FREQUENCY TABLE

Frequency and Percentage Distribution Table Example

This is an example of the combined frequencies and percentages that compares from hospital executives to program contractor perceptions of fraud. Results will be displayed in appendix L.

Table 1: Example Program Contractor Distribution of Responses to Item 10

Response	Frequency	Percent	Valid Percent	Cumulative Percent
	Program Contractor	Program Contractor	Program Contractor	Program Contractor
SA				
A				
Neither				
D				
SD				
DK				
Subtotal				
Missing				
Total				

Note. This table represents an example of the distribution of responses from program contractors. The first column represents the 5-point Likert-type scale for Item 10: I feel comfortable knowing my organization has a compliance program to protect my organization from potential fraud and abuse. As a replication study of Van Crombrughe's 2002 research column two displays the actual total count for each response. Column three represents the percentage of each response including the missing responses divided by the total number of responses. The fourth column represents omission of the missing responses by dividing the response by the subtotal. Column five represents a running percentage starting with the Strongly Agree (SA) through the subtotal.

APPENDIX I: SAMPLE COMBINED DISTRIBUTION TABLE USED IN APPENDIX L

Combined Frequency and Percentage Distribution Table Example

This is an example of the combined frequencies and percentages which compares from hospital executives to program contractors. Results will be displayed in chapter 4.

Table 2: Example of Comparison Distribution of Responses to Item 10

Response	Frequency		Percent		Valid Percent		Cumulative Percent	
	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor
SA								
A								
Neither								
D								
SD								
DK								
Sub-Total								
Missing								
Total								

Note. This table represents an example of the distribution of responses from program contractors compared to the hospital executive responses. The first column represents the 5point Likert-type scale for Item 10: I feel comfortable knowing my organization has a compliance program to protect my organization from potential fraud and abuse. As a replicated study of Van Crombrughe's 2002 research, column 2 displays the actual total count for each response. Column 3 represents the percentage of each response including the missing responses divided by the total number of responses. The fourth column represents omission of the missing responses by dividing the response by the subtotal. Column 5 represents a running percentage starting with the Strongly Agree (SA) through the subtotal.

Where Responses are: SA = Strongly Agree A = Agree, Neither = neither agree or disagree, D = Disagree, SD = Strongly Disagree, and DK = Do not Know

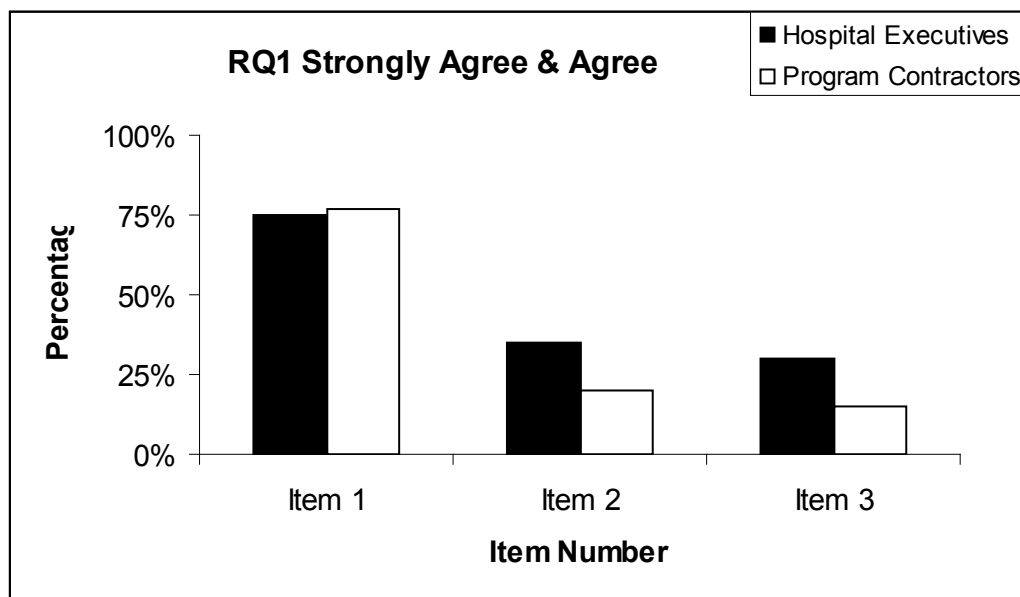
APPENDIX J: SAMPLE PARETO CHART FIGURE

Pareto Chart Figure

This Pareto Chart will be used to compare the results of each research question between hospital executives and program contractors.

Figure 2: Comparison between Hospital Executives and Program Contractors on Research

Question one (RQ1)



Note. This table represents an example of the distribution of responses from program contractors compared to hospital executive responses for Hypothesis one which is directly related to research question one (RQ1). Through the Cronbach's alpha test, the expert panel found that

APPENDIX K: EXAMPLE CHI-SQUARE TABLE

Chi-square figure

The Chi-square test will be used to determine the differences in responses between hospital executives and program contractor executives.

Figure 3: Example of Chi-square testing Procedure for Comparing Hypothesis One (H1)

Hospital Executives to Program Contractor responses.

Count	Yes	No
	(# SA, %NAD, & A)	(# D, %NAD, & SD)
Hospital Executives		
Program Contractors		

H₀: There is no significant difference between program contractor executives and hospital executives in perceptions of health care fraud and abuse in hospitals.

H₁: There is a significant difference between program contractor executives and hospital executives in their perception of health care fraud and in hospitals.

APPENDIX L: RESULTS FROM SURVEY ITEMS BY RESEARCH QUESTION:

Combined Frequency and Percentage Distribution Tables

The first column represents the 5-point Likert-type scale survey item. As a replicated study of Van Crombrughe's 2002 research, column 2 displays the count for each response. Column 3 represents the percentage of each response including the missing responses divided by the number of responses. The fourth column represents omission of the missing responses by dividing the response by the subtotal. Column 5 represents a running percentage starting with the Strongly Agree (SA) through the subtotal.

Table L1

Comparison Distribution of Responses to RQ1/H1 (Survey Item 1)(N=462)

Response	Frequency		Percent		Valid Percent		Cumulative Percent	
	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor
SA/A	57	13	12.90%	59.09%	12.95%	59.09%	12.95%	59.09%
Neither	32	2	7.24%	9.09%	7.27%	9.09%	20.23%	68.18%
D/SD	325	7	73.53%	31.82%	73.86%	31.82%	94.09%	100.00%
DK	26		5.88%		5.91%		100.00%	
Sub-Total	440	22						
Missing	2		0.45%					
Total	442	22	100.00%	100.00%	100.00%	100.00%		

Note: H1₀: There is no significant difference between program contractor executives and hospital executives' perceptions of the presence of health care fraud and abuse in hospitals.

Table L2

Comparison Distribution of Responses to RQ2/H2 (Survey Items 2,5,6,7)(N=1849)

Response	Frequency		Percent		Valid Percent		Cumulative Percent	
	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor
SA/A	648	38	36.80%	43.18%	36.80%	43.18%	36.80%	43.18%
Neither	334	12	18.97%	13.64%	18.97%	13.64%	55.76%	56.82%
D/SD	754	38	42.82%	43.18%	42.82%	43.18%	98.58%	100.00%
DK	25		1.42%		1.42%		100.00%	
Sub-Total	1761	88						
Missing								
Total	1761	88	100.00%	100.00%	100.00%	100.00%		

Note: H2₀: There is no significant difference between program contractor executives and hospital executives' perceptions of health care fraud and abuse laws and regulations as applied to the hospital setting.

Table L3

Comparison Distribution of Responses to RQ3/H3 (Survey Items 2,3,5,6,8)(N=2,310)

Response	Frequency		Percent		Valid Percent		Cumulative Percent	
	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor
SA/A	910	64	41.36%	58.18%	41.36%	58.18%	41.36%	58.18%
Neither	385		17.50%	0.00%	17.50%	0.00%	58.86%	58.18%
D/SD	869	46	39.50%	41.82%	39.50%	41.82%	98.36%	100.00%
DK	36		1.64%		1.64%		100.00%	
Sub-Total	2200	110			100.00%			
Missing								
Total			100.00%	100.00%	100.00%			

Note: H3₀: There is no significant difference between program contractor executives and hospital executives' perceptions on health care fraud and abuse laws and regulations to assist health care executives in conducting ethical business practices.

Table L4

Comparison Distribution of Responses to RQ4/H4 (Survey Items 3,5,6)(N=1,384)

Response	Frequency		Percent		Valid Percent		Cumulative Percent	
	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor
SA/A	574	37	43.55%	56.06%	43.55%		43.55%	56.06%
Neither	250	12	18.97%	18.18%	18.97%		62.52%	74.24%
D/SD	472	17	35.81%	25.76%	35.81%		98.33%	100.00%
DK	22		1.67%		1.67%		100.00%	
Sub-Total	1318	66			100.00%			
Missing			0.00%					
Total			100.00%	100.00%				

Note: H₄₀: There is no significant difference between program contractor executives and hospital

executives' perception on the governmental focus on enforcement of fraud and abuse laws and regulations to assist honest health care executives in identifying risky business practice.

Table L5

Comparison Distribution of Responses to Item 4

Response	Frequency		Percent		Valid Percent		Cumulative Percent	
	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor
SA/A	306	12	69.23%	54.55%	69.23%	54.55%	69.23%	54.55%
Neither	62	6	14.03%	27.27%	14.03%	27.27%	83.26%	81.82%
D/SD	58	4	13.12%	18.18%	13.12%	18.18%	96.38%	100.00%
DK	16		3.62%		3.62%		100.00%	
Sub-Total	442	22			100.00%			
Missing								
Total	442	22	100.00%	100.00%		100.00%		

Note: Item 4 was stated as the application of fraud and abuse laws and regulations is often too

broad or aggressive in current enforcement actions.

Table L6

Comparison Distribution of Responses to Item 9

Response	Frequency		Percent		Valid Percent		Cumulative Percent	
	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor
SA/A	307	12	69.46%	54.55%	69.46%		69.46%	54.55%
Neither	42	1	9.50%	4.55%	9.50%		78.96%	59.09%
D/SD	83	9	18.78%	40.91%	18.78%		97.74%	100.00%
DK	10		2.26%		2.26%		100.00%	
Sub-Total	442	22			100.00%			
Missing			0.00%	0.00%				
Total	442	22	100.00%	100.00%				

Note: Item 9 was stated as I believe the government's intention in health care fraud and abuse enforcement in hospitals is motivated more by recovery of money than by concern for quality, ethical care delivered to the public.

Table L7

Comparison Distribution of Responses to Item 10

Response	Frequency		Percent		Valid Percent		Cumulative Percent	
	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor	Hospital	Program Contractor
SA/A	377	20	85.29%	90.91%	85.88%		85.88%	90.91%
Neither	40		9.05%	0.00%	9.11%		94.99%	90.91%
D/SD	22	1	4.98%	4.55%	5.01%		100.00%	95.67%
DK			0.00%		0.00%		100.00%	
Sub-Total	439				100.00%			
Missing	3	1	0.68%	4.55%				
Total	442		100.00%	100.00%				

Note: Item 10 was stated as I feel comfortable knowing my organization has a compliance program to protect my organization from potential fraud and abuse.

APPENDIX M: PERMISSION TO USE EXISTING TABLE/FIGURE

UNIVERSITY OF PHOENIX
PERMISSION TO USE AN EXISTING TABLE

Date 06/14/2010

Ms. Barbara Hess


Thank you for your request for permission to alter Table 21 Hypotheses Findings in your research study. We are willing to allow you to reproduce the instrument as outlined in your letter at no charge with the following understanding:

- You will use this Table only for your research study and will not sell or use it with any compensated management/curriculum development activities.
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If these are acceptable terms and conditions, please indicate so by signing one copy of this letter and returning it to us.

Best wishes with your study.


Sincerely,

Desiree LeBlanc, DM, PMP, PHR
Desiree LeBlanc, DM, PMP, PHR

Signature

I understand these conditions and agree to abide by these terms and conditions.

Signed _____ Date 

Expected date of completion 

APPENDIX N: OPEN-ENDED QUESTION

Open-Ended Question Responses

#	Open-Ended Response
1	Most discussions regarding fraud and abuse both at the federal and state level are not directed at the hospitals but at the member or provider. I feel that hospital fraud is a very small part of the big picture
2	Fraud and Abuse is a perpetuating issue. Laws are put into place to stop abuse however, staffing, time, and bureaucracy does not allow insurance companies to do the right thing. An act of congress will not help this issue. When Fraud and Abuse is reported, it is often swept under the rug. Hospitals are too concerned with their political presence and perception to take swift action.
3	It is amazing to see the types of health care providers, from DME companies, Home Health Agencies to hospitals that knowingly submit fraudulent claims for services that were either not rendered or were partially completed.
4	I think the governmental agencies are far too aggressive in prosecuting supposed fraud and abuse in the case of providers, while lackadaisical about prosecution of fraud and abuse in patients. And I think there is a lot of fraud and abuse perpetrated by patients. There are certainly doctors and home health agencies and hospitals who overcharge or pad bills, but I think that is relatively minimal.
5	I agree that Fraud and Abuse regulation is needed, I am not completely sure that the way it is regulated is helpful in all matters related to Fraud and Abuse. I believe some of the Fraud and Abuse that happens does not get dealt with because it does not fall under specific criteria. I feel that the current system needs to be looked at and revamped.