Health Cost Containment and Efficiencies

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# Combating Health Care Fraud and Abuse

## Cost Containment Strategy and Logic

Health care fraud and abuse control programs are designed to prevent, identify and prosecute unlawful billings by health care providers, patients and insurers. A fraudulent health care claim involves an intentional false representation that causes the government to pay more than is allowable. Abuse involves substandard, negligent or medically unnecessary practices that increase the cost of health care. Abusive practices often indicate fraud. Among 28 federal programs examined by the U.S. General Accountability Office in 2007, Medicaid had the highest number of improper payments.

State Medicaid fraud control offices have seen a rapid increase in recent years in both the number of fraudulent schemes targeting Medicaid dollars and the degree of sophistication with which they are perpetrated. According to one report, "Increasing enrollment, expanded services and growing numbers of providers have created a system that is ripe for fraud and abuse."[1]

Through prevention, detection and prosecution, the goal of Medicaid fraud control programs is to reduce opportunities to defraud Medicaid, recoup payments that were based on false representations, and encourage strict compliance with fraud and abuse laws to hold down health care expenditures.

## Target of Cost Containment

Medicaid expenditures for fraudulent claims cost states billions of dollars each year. In Florida, for example, Medicaid fraud accounts for between 5 percent and 20 percent of the Medicaid budget.[2] Fraud and abuse account for between 3 percent and 10 percent of Medicaid payments nationwide, yet the average state recovery rate is only 0.09 percent; the range among states is from less than 0.01 percent to a little more than 1 percent.[3]

**Evidence shows concerted state anti-fraud and abuse efforts save states millions—and in some cases billions—of dollars each year, and states potentially could double or even triple current collections.**

Health care fraud and abuse take many forms, ranging from billing for services not performed (medical service providers) to medical identity theft (patients and providers) to systematic denial and underpayment of claims (insurance companies). Table 1 lists some major types of fraud.

Approximately 72 percent of health care fraud is committed by medical providers (i.e., health professionals; facilities; and service, equipment and prescription drug suppliers), 10 percent by consumers and the balance by others, including insurers and their employees.

## Federal Health Reform

The Patient Protection and Affordable Care Act, signed March 2010, includes several anti-fraud and -abuse provisions that apply to Medicaid and Medicare (sections 6001-6003, 6401, 6409 and 1304 (enhanced fraud and abuse program funding)). The act strengthens the federal False Claims Act (e.g., by allowing broader sources of information to bring a whistleblower suit) and the Anti-Kickback Statute (e.g., by making it easier to establish that a provider violated the statute). It includes new requirements regarding return of overpayments, additional federal funding and enforcement powers to fight fraud and abuse, and increased criminal and civil penalties.

**Table 1. Major Types of Fraud**

| Provider Fraud | Patient Fraud | Insurer Fraud |
|---|---|---|
| • Billing for services not performed | • Filing a claim for services or products not received | • Undervaluing the amount owed by the insurer to a health care provider under the terms of its contract |
| • Billing duplicate times for one service | • Forging or altering receipts | • Denying valid claims |
| • Falsifying a diagnosis | • Obtaining medications or products that are not needed and selling them on the black market | • Overstating the insurer's cost in paying claims |
| • Billing for a more costly service than performed | • Providing false information to apply for services | • Misleading enrollees about health plan benefits |
| • Accepting kickbacks for patient referrals | • Doctor shopping to get multiple prescriptions | |
| • Billing for a covered service when a non-covered service was provided | • Using someone else's insurance coverage for services | |
| • Ordering excessive or inappropriate tests | | |
| • Prescribing medicines that are not medically indicated or for use by people other than the patient | | |

## State Examples

### *Laws and Actions Targeting Public Program Fraud and Abuse*

- **State False Claims Acts.** State false claims acts enable states to recover money by giving them jurisdiction over fraudulent activities that affect publicly funded state programs, in most cases including but not limited to Medicaid. The acts usually mirror the federal False Claims Act, which applies only to federally funded programs. Federal law provides states a financial incentive to enact false claims acts that include specific provisions.[4] States can retain up to 10 percent of amounts that otherwise would be repaid to the federal government in the event of a fraud recovery from a false or fraudulent health care claim. As of June 2010, 35 states and the District of Columbia had false claims acts; of these, 14 qualified for the federal incentive (Table 2). California, Illinois and Florida give insurers the same right as the state to bring a false claims action against those that defrauded the private insurer.

- **Electronic Fraud and Abuse Detection Systems**. Data mining software exists to prevent and investigate fraudulent claims before payment. The federal government and some states contract with "cybersleuths" who use sophisticated computer programs to scan Medicaid billing records for patterns of bogus claims. South Carolina, for example, uses advanced anti-fraud software to identify beneficiaries who show a pattern of doctor-shopping to obtain narcotic prescriptions and other controlled substances. An audit of the Utah Department of Health's Program Integrity program issued in 2009 estimated an improved recovery system, including better detection systems, could help the state recoup $5.8 million annually.

- **Medicaid Inspector General Offices**. Inspector general offices consolidate responsibilities and staff from state agencies that are involved in anti-fraud activities to more effectively combat fraud and establish clear accountability for fraud control efforts. At the end of 2009, Florida, Georgia, Illinois, Kansas, Kentucky, New Jersey, New Mexico, New York and Texas had some type of independent Medicaid inspector general.

- **Prosecutorial Authority**. Every state has a Medicaid Fraud Control Unit, but the units' ability to prosecute cases differ. In some states (e.g., New York), fraud control units are authorized not only to develop but also to prosecute fraud cases.[5] In other states (e.g., Florida, Texas and Virginia), fraud cases developed by the units must be turned over to district attorneys or statewide prosecutors.

### *Laws and Actions Targeting Both Public and Private Fraud and Abuse*

- **State Whistleblower Laws**. Whistleblower laws encourage people to report fraudulent activities, including, but not limited to, health insurance fraud. These laws generally protect an employee from employer retaliation for disclosing information to a government or law enforcement agency if the employee reasonably believes the information violates state or federal law. A state's law may apply to public employees only or to all employers and their employees.[6] As of June 2010, 27 states and the District of Columbia had state false claims acts (described above) that, with regard to publicly funded health care, allow citizens with evidence of fraud to sue on behalf of the government to recover fraudulently obtained health care payments and receive a portion of the recovered funds. Several states also reward people who report cases of fraud against private insurers.

- **State Anti-Kickback Laws.** Anti-kickback laws make it a criminal offense to knowingly and willingly offer, pay, solicit or receive a kickback, bribe or rebate or to induce or reward referrals or items or services reimbursable to a government health care program. As of July 2009, the federal government, 36 states and the District of Columbia had anti-kickback laws (Table 2). State anti-kickback laws usually apply to all payers; the federal law applies only to federal health care program payments. Some state laws are broader than the federal law (e.g., cover more types of self-referrals).[7] It should be noted that, in at least one state—Florida—the courts have ruled federal anti-kickback law preempts state Medicaid anti-kickback laws.

- **State Self-Referral Laws.** As of July 2009, the federal government and 34 states had laws regarding referrals by health care providers to entities in which they have a financial interest (e.g., a physician referring a patient to a surgical center in which he or she is an investor; see Table 2). Some state laws mirror federal law, which prohibits most self-referrals. Others prohibit all self-referrals and ban physicians from any ownership interest in hospitals or other facilities to which they refer patients. Several simply require disclosure of financial interests to patients.

- **Prescription Drug Monitoring Programs**. Prescription drug monitoring programs are statewide electronic databases that collect data on substances dispensed. They are an important tool to combat abuse and illegal acquisition and resale of prescription drugs on the black market, known as drug diversion. According to the Coalition Against Insurance Fraud, insurance fraud drains public and private health insurers of up to $72.5 billion a year. Prescription drug monitoring data can reveal patterns of illegal use and distribution and help prosecute false and fraudulent prescription drug insurance claims. As of January 2010, 34 states had prescription drug monitoring programs, and five states and Guam had enacted laws to establish, but did not yet have, fully operational programs.[8]

- **Larger Anti-Fraud Units.** Most state anti-fraud units have a backlog of cases due mainly to limited staff. To increase recovery rates, some states have provided additional funding for Medicaid fraud units, attorney general offices and departments of insurance. New York's SFY 2007-08 budget, for example, increased by 30 percent the number of positions in the Medicaid Inspector General Office. This included 100 new auditors to identify, prevent and combat Medicaid fraud.

**Table 2. State False Claims, Anti-Kickback and Self-Referral Laws, 2009**

| State/ Jurisdiction | False Claims Acts (FCA)[1] | Anti-Kickback Laws | Self-Referral Laws |
|---|---|---|---|
| Alabama | - | ☒ | - |
| Alaska | - | - | - |
| Arizona | - | ☒ | ☒ |
| Arkansas | • + | ☒ | ☒ |
| California | ⧖ * | ☒ | ☒ |
| Colorado | ⧖ + | ☒ | - |
| Connecticut | ⧖ + | ☒ | ☒ |
| Delaware | ⧖ | ☒ | - |
| District of Columbia | ⧖ | ☒ | - |
| Florida | ⧖ | ☒ | ☒ |
| Georgia | ⧖ + * | - | ☒ |
| Hawaii | ⧖ * | - | ☒ |
| Idaho | - | - | - |
| Illinois | ⧖ * | ☒ | ☒ |
| Indiana | ⧖ * | ☒ | - |
| Iowa | ⧖ | - | - |
| Kansas | • | ☒ | ☒ |
| Kentucky | - | ☒ | ☒ |
| Louisiana | ⧖ + | ☒ | ☒ |
| Maine | - | - | ☒ |
| Maryland | ⧖ + | - | ☒ |
| Massachusetts | ⧖ * | ☒ | ☒ |
| Michigan | ⧖ + * | ☒ | ☒ |
| Minnesota | ⧖ | - | ☒ |
| Mississippi | - | ☒ | - |
| Missouri | • | ☒ | ☒ |
| Montana | ⧖ | ☒ | ☒ |
| Nebraska | • | - | - |
| Nevada | ⧖ * | ☒ | ☒ |
| New Hampshire | ⧖ | ☒ | ☒ |
| New Jersey | ⧖ | ☒ | ☒ |
| New Mexico | ⧖ | ☒ | - |
| New York | ⧖ * | ☒ | ☒ |
| North Carolina | • | ☒ | ☒ |
| North Dakota | - | - | - |
| Ohio | - | ☒ | ☒ |
| Oklahoma | ⧖ | ☒ | ☒ |
| Oregon | • | - | - |
| Pennsylvania | - | ☒ | ☒ |
| Rhode Island | ⧖ * | ☒ | - |
| South Carolina | - | ☒ | ☒ |
| South Dakota | - | ☒ | ☒ |
| Tennessee | ⧖ * | - | ☒ |
| Texas | ⧖ + * | ☒ | - |
| Utah | • | ☒ | ☒ |
| Vermont | - | - | - |
| Virginia | ⧖ * | ☒ | ☒ |
| Washington | • | ☒ | ☒ |
| West Virginia | - | ☒ | ☒ |
| Wisconsin | ⧖ + * | ☒ | ☒ |
| Wyoming | - | - | - |
| Total | | 37 | 34 |

| | |
|---|---|
| ☒ State has law | ? |
| - No state law | ? |
| ⧖ FCA with whistleblower provisions | 28 |
| • FCA without whistleblower provisions | 8 |
| + Act applies to Medicaid only, not all state programs | 8 |
| * Meets DRA requirements | 14 |

1. Includes laws enacted in the first half of 2010.

**Sources:** 1) Sara Rosenbaum, Nancy Lopez and Scott Stifler, *Health Care Fraud* (Washington, D.C.: George Washington University, Oct. 27, 2009); http://www.rwjf.org/files/research/50654.pdf, and 2) Phillips & Cohen LLP, State False Claims Act Web page, http://www.phillipsandcohen.com/CM/StateFalseClaimsLaws/StateFalseClaimsLaws152.asp.

***Laws and Actions Targeting Private Insurance Fraud and Abuse***

■ **Mandatory Insurer Fraud Detection Programs.** As of July 2010, 19 states and the District of Columbia required health and other insurance companies to meet certain fraud detection, investigation and referral standards to maintain their licenses.[9]

■ **Comprehensive Legislation.** Pennsylvania is considering a comprehensive package of laws that include anti-fraud and abuse provisions. Bills introduced in Pennsylvania's 2010 session and pending as of July 1, 2010, would expand the definition of insurance fraud, fraud plans and fraud warnings (H.1750); require health facilities to have posters offering a reward for reporting fraud (H.1737); allow asset forfeiture by those convicted of insurance fraud (H.1740); expand the state immunity law to allow greater exchange of information among enforcement agencies about an insurance fraud (H.2154 and S.1181); and create a state false claims act (H.1679).

## Evidence of Effectiveness

Evidence shows concerted state anti-fraud and abuse efforts save states millions—and in some cases billions—of dollars each year, and states potentially could double or even triple their collections. It appears the more anti-fraud tools a state has at its disposal, the greater likelihood of fewer unwarranted payments and larger recoveries. Experts generally agree the following weapons are among the most effective for combating fraud: state false claims acts that include whistleblower protections, electronic data mining systems, and enhanced staffing of state anti-fraud agencies.

Several caveats regarding assessments of the effectiveness of anti-fraud laws should be noted. Because the number and magnitude of fraudulent activities continue to grow, it is sometimes difficult to determine whether larger recoveries are the result of new anti-fraud laws and additional funding or simply reflect growth in the average size of fraud cases. In most cases, information about the effectiveness of state anti-fraud efforts comes not from an independent source but from the anti-fraud units themselves. Research for this brief did not uncover any comparative assessments of fraud control tools.

■ The addition in 2009 of 10 staff to Ohio's Medicaid Fraud Control Unit helped the state increase its recoveries from $65 million in 2008 to $91 million in 2009.[10]

■ Between state fiscal year 2004 and 2009, the Texas Legislature increased funding for Medicaid fraud enforcement by 550 percent, from $2.2 million to $14.5 million a year. Recoveries grew from $162 million in SFY 2007 to $338.5 million in FY 2009.[11]

■ New York saved $132 million in 2007 from a health department anti-fraud data mining initiative.[12]

■ Medicare cybersleuth pilot programs in California, New York and Texas recaptured $900 million in fraudulent Medicare claims between 2005 and 2008.[13]

■ Officials at the federal Centers for Medicare and Medicaid Services estimate the return on each $1 invested in health care fraud prosecutions is between $2 and $7.[14]

■ Using their false claims act authority, states and the federal government recovered more than $20 billion between 1986 and 2010.

## Challenges

- Enhanced staffing to identify and prosecute fraud is critical to successful anti-fraud efforts. This usually requires an upfront investment, however, that may be difficult for states that are facing large deficits. Some states are dealing with this challenge by contracting with private firms to analyze Medicaid data for fraud and paying them a percentage of actual or projected recoveries rather than making an upfront investment.

- Up-to-date, advanced electronic fraud detection systems can reap significant benefits but also require an upfront investment.

- Broader definitions of fraud and tougher Medicaid fraud penalties have been opposed by some medical groups that argue physicians will stop seeing Medicaid patients if they fear a minor mistake could lead to a felony prosecution. Fraud control laws and actions should distinguish between payment errors and intentional fraud to avoid penalizing honest mistakes.

- Increasingly sophisticated fraud schemes mean states must continually update and enhance their fraud control laws and tools.

## For More Information

Coalition Against Insurance Fraud Web site, http://www.insurancefraud.org.

Health Management Associates. "Compliance: Myths and Facts About Medicaid Fraud and Abuse," *Issues in Missouri Health Care 2008*. St. Louis: Missouri Foundation for Health, October 2008; www.healthcare4kc.org/.../Compliance%20Myths%20and%20Facts%20About%20Medicaid%2.

National Association of Medicaid Fraud Control Units Web site, http://www.namfcu.net/about-us/what-is-medicaid-fraud.

Rosenbaum, Sara, et al. *Health Care Fraud*. Washington, D.C.: George Washington University, Oct. 27, 2009; http://www.rwjf.org/files/research/50654.pdf.

The latest information on this topic is available in an NCSL online supplement at www.ncsl.org/?tabid=19935.

## Acknowledgment

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## Notes

1. Senate Republican Task Force on Medicaid Fraud, *Combating Medicaid Fraud in New York State*, Preliminary Report (Albany: New York Senate, March 2010); http://www.nysenate.gov/files/pdfs/0317.Combating%20Medicaid%20Fraud%20in%20NYS.pdf.

2. Doug Trapp, "Medicaid Fraud in Florida Highest for Home Health Services," *amednews.com*, Jan. 27, 2010; http://www.ama-assn.org/amednews/2010/01/25/gvse0127.htm.

3. For a state-by-state list of Medicaid recovery rates, see: Jim Sheehan, New York Medicaid Inspector General, PowerPoint testimony presentation to the New York Senate Committee on Investigations and Government Operations, (Jan. 7, 2010); http://www.omig.state.ny.us/data/images/stories//testimony_presentation_1_7_10_lb.pdf.

4. For a list of the provisions a state false claims act must include for a state to qualify for the incentive, go to the U.S. Department of Health Human Services, State False Claims Act Reviews Web page, http://oig.hhs.gov/fraud/falseclaimsact.asp.

5. John Buntin, "A Medicaid Fraud-Stopping Mold," *Governing* (June 2010); http://www.governing.com/topics/health-human-services/A-Medicaid-Fraud-Stopping-Mold.html.

6. For a list of state laws that protect whistleblowers from employer retaliation and statutory citations, see National Conference of State Legislatures, State Whistleblower Laws Web page, http://www.ncsl.org/default.aspx?tabid=13390.

7. Kaiser Family Foundation, State Health Care Fraud Laws Web page, http://www.statehealthfacts.org/comparemaptable.jsp?ind=790&cat=4.

8. States with operational prescription drug monitoring programs as of January 2010 were Alabama, Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Nevada, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Vermont, West Virginia and Wyoming. Alaska, Florida, Kansas, Oregon, New Jersey and Guam had enacted legislation to establish programs, but they were not fully operational. Source: U.S. Department of Justice, Drug Enforcement Administration, "State Prescription Drug Monitoring Programs: Questions and Answers," Web site, http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm#4.

9. The states are Arkansas, California, Colorado, Florida, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, New Hampshire, New Mexico, New York, New Jersey, Ohio, Pennsylvania, Tennessee, Vermont and Washington.

10. John Buntin, "A Medicaid Fraud-Stopping Mold."

11. *Office of Inspector General Annual Report, State Fiscal Year 2009* (Austin: Texas Health and Human Services Commission, 2009); https://oig.hhsc.state.tx.us/Reports/OIG_Annual_Report_SFY_2009.pdf.

12. Valerie Bauman, Associated Press, "Medicaid Fraud Collections Rise," *LegislativeGazette.com* (Dec. 31, 2007); http://www.legislativegazette.com/Articles-c-2007-12-31-62146.113122_Medicaid_fraud_collections_rise.html.

13. Neil Verse, "CMS to fight Medicare, Medicaid fraud with high-tech 'bounty hunters'," *FierceHealthIT* e-newsletter (March 29, 2010); http://www.fiercehealthit.com/story/cms-fight-medicare-medicaid-fraud-high-tech-bounty-hunters/2010-03-29.

14. John Buntin, "A Medicaid Fraud-Stopping Mold."

15. Charles Doyle, *Qui Tam: The False Claims Act and Related Federal Statutes* (Washington, D.C.: Congressional Research Service, Aug. 6, 2009); http://www.fas.org/sgp/crs/misc/R40785.pdf.

**About this Project**

NCSL's Health Cost Containment and Efficiency Series describes multiple alternative state policy approaches, with an emphasis on documented and fiscally calculated results. The project is housed at the NCSL Health Program in Denver, Colorado. It is led by Richard Cauchi, program director, and Martha King, group director, with Barbara Yondorf as lead researcher.

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