South Carolina Department of Health & Human Services

Proviso Report

21.26 – DHHS: Medicaid Provider Fraud

Submitted on April 8, 2013

The following is submitted as required by Proviso 21.26 of the SFY 2013 Appropriations Act

21.26. (DHHS: Medicaid Provider Fraud) The department shall expand and increase its effort to identify, report, and combat Medicaid provider fraud. The department shall report to the General Assembly before April 1, 2013 on the results of these efforts, funds recuperated or saved, and information pertaining to prosecutions of such actions, including pleas agreements entered into.

South Carolina Department of Health and Services

Medicaid Provider Fraud

Report for Proviso 21.26

The South Carolina Department of Health and Human Services (SCDHHS) engages in an on-going effort to prevent and identify fraud in the Medicaid program, and to recover the funds lost because of fraudulent and excessive practices on the part of healthcare providers. These activities are mandated by federal regulations found in 42 CFR 455. The department is committed to increasing the numbers of cases referred to the SC Attorney General's Office for fraud and to the recovery of funds lost to those providers.

The National Health Care Anti-Fraud Association estimates that fraud accounts for 3 percent of the nation's annual health care spending. Other estimates by government and law enforcement agencies such as the FBI place the loss due to health care fraud as high as 10 percent of annual health care expenditures. Federal regulations define fraud as "intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to himself or some other person." (42CFR 455.2) Medicaid fraud is a criminal matter. Waste, improper claims, billing errors, and abuse also cause losses of Medicaid funds but are not criminal actions.

SCDHHS receives fraud "tips" from its fraud hotline and also conducts extensive data mining to identify potential fraud cases. Federal regulations require SCDHHS to conduct a preliminary investigation upon suspicion of fraud and then refer the cases to the Medicaid Fraud Control Unit (MFCU) in the SC Attorney General's Office. Cases are also referred to the MFCU from other sources, such as the FBI, the federal Office of Inspector General, other SC state agencies, and the MFCU's own fraud hotline. SCDHHS' Division of Program Integrity conducts these preliminary investigations and collaborates with the MFCU on all fraud cases. Fraud cases can take several years before final adjudication and the collection of any penalties or claim refunds by SCDHHS.

In general, healthcare fraud involves filing a false claim for Medicaid payments, which can include services that were never provided, or were provided but were not medically necessary. The MFCU also participates in national cases against pharmaceutical companies that manipulate wholesale prices on drugs to get more money from Medicaid. While these are also considered fraud cases, they are prosecuted as civil cases instead of criminal cases.

The following table reports Medicaid provider fraud cases that were opened during calendar year 2012, updated for the most current data available through February 2013; the amounts recovered by the Attorney General's Office and Program Integrity and the number of convictions for the same time frame; and the number of recoveries from civil settlements in the national pharmaceutical cases. The federal share of the Medicaid funds recovered must be returned; SCDHHS can retain the state share of these recoveries and use it to again match federal monies for the on-going operation of the Medicaid program.

The total number of on-going cases for Medicaid provider fraud at the Attorney General's totaled 85 as of February 2013; 63 of these cases were referred by SCDHHS. This includes cases that were opened in previous years (and therefore not counted in the table below) but are still on-going.

FRAUD CASES 2012

Provider Fraud Cases	
New Provider Fraud Cases Opened	**67**
Active	**50**
Closed	**17**
Number / % Referred by SCDHHS	**41 / 61%**
Results	
Recovered as a result of Provider Fraud Convictions/Referrals (1)	**$261,949**
Recoveries from all other PI cases (2)	**$7,860,927**
Convictions	**12**
Pharmaceutical Manufacturer Cases	
# Of Cases Settled	**20**
Amounts Recovered (3)	**$23,095,507**

(1) All dollars shown are federal and state; the state share is approximately 32%. Some of the recoveries in 2012 are from cases opened in prior year(s).

(2) Program Integrity recoveries due to cases for waste, overpayments, improper payments, and abuse that were not referred for potential fraud.

(3) 58% of the recoveries from global pharmaceutical manufacturer cases are state funds.