South Carolina Department of Health and Services

Medicaid Provider Fraud

Report for Proviso 21.37

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. Not only is this mandated by federal regulations found in 42 CFR 455, it is even more critical because of the need to better manage scarce public resources in a time of rising demand and decreasing tax dollars. The department is committed to increasing the numbers of cases referred to the SC Attorney General's Office for fraud and 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 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 as opposed to criminal cases.

The following table reports Medicaid provider fraud cases that were opened during calendar year 2010 and 2011, updated for the most current data available through January 2012; 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 (approximately 68%) 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.

FRAUD CASES

	CY 2010	CY 2011
Provider Fraud Cases		
New Provider Fraud Cases Opened	**50**	**69**
# / % Referred by SCDHHS	**15 / 30%**	**30 / 46%**
Current Status:		
Active	**12**	**40**
Closed	**38**	**29**
Results		
Recovered from Provider Fraud Cases (1)	**$167,668.25**	**$3,301,128.86**
Recoveries from all other Program Integrity cases (2)	**$7,632,185.73**	**$10,500,628.32**
Convictions	**6**	**8**
Pharmaceutical Manufacturer Cases		
# Of Cases with Recoveries	**18**	**19**
Amounts Recovered	**$16,776,135.42**	**$16,265,889.39**

(1) All dollars shown are Federal and State. Some of the recoveries in one year 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.