2013 Program Report Card: Health Care Fraud, Office of the Attorney General

Quality of Life Result: Taxpayer funds are wisely and effectively spent on health care services to those in need.

Contribution to the Result: The health care fraud program will reduce or eliminate taxpayer funds that are wasted on fraud, abuse or misuse.

Program Expenditures	State Funding	Federal Funding	Other Funding	Total Funding
Actual FY 12	$864,949 ($166,806 is located in DSS budget)*			$864,949*
Estimated FY 13	$757,015			$757,015

*— The state may receive federal revenue associated with health care fraud expenses. The Office of the Attorney General ("AGO") submits these expenses as part of the Statewide Cost Allocation Plan to the Comptroller but is not informed as to the amount of federal dollars that the state has received into the General Fund that is associated with these expenses.

Partners: Department of Social Services ("DSS"), Division of Criminal Justice, Department of Public Health, federal agencies including the Department of Justice, the Department of Health and Human Services Office of the Inspector General, other law enforcement agencies and health oversight agencies, as well as private relators and their attorneys who bring *qui tam* actions

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How Much Did We Do?

Performance Measure 1:

The amount of revenue generated from health care fraud settlements and judgments

Connecticut Civil Recoveries for Health Care Fraud

Fiscal year	*Totat CT Medicaid*	*CT state share*
FY12-13***	$21.4 million	$11.8 million
FY11-12	$8.0 million	$3.6 million
FY10-11:	$50.1 million*	$29.1 million*
FY 09-10:	$47.5 million**	$34.3 million**
FY 08-09:	$16.8 million	$11.4 million
FY 07-08:	$10.2 million	$5.4 million
FY 06-07:	$8.6 million	$6.0 million
FY 05-06:	$7.0 million	$4.0 million
FY 04-05:	$6.7 million	$3.4 million

*- McKesson case $24 million/ CT state share $15 million
**-EliLilly case $30.8 million/ CT state share $25.1 million
***-current fiscal year as of 12/2012

Story behind the baseline:

In October 2009, the General Assembly approved the state's False Claims Act. Authorization for 2 new AAG positions was granted in June, 2010. Revisions to the state's False Claims Act necessary for federal authorization of an additional enhancement of 10% in the federal/state allocation for Medicaid recoveries were passed in June 2011. Federal approval of the state False Claims Act for such purposes was received on November 15, 2011.

Most prior health care fraud recoveries were based on federal and multi-state litigation and settlements. We expect this trend to continue with a steady stream of open global investigations.

While the FY09-10 and FY10-11 fiscal years were very good years, they each benefited from single large recovery cases. Further the recovery cycle does not always match up to fiscal years. Thus, the dip for FY11-12 was more than offset by the recoveries to date for FY12-13. If those outlier recoveries are excluded, and if the recovery trend is evaluated over time, the current trend is revenue remaining stable in the range of $10 million annually.

It is difficult to accurately predict the future frequency and magnitude of health care fraud, and by extension, health care fraud-related revenue recoveries. The state False Claims Act provides potential for significantly increased revenue generation through expanded tools for combating and remedying fraud.

We anticipate measurable and meaningful revenue enhancements from the Act over the next three to five years, a time frame reflecting the recent effective date of the law, the complexity of financial fraud investigations, initiatives to enhance coordination with both criminal investigators and state partners, and the time necessary to pursue fraud investigations to completion. Enhancements to the AGO's fraud reporting website and a dedicated fraud reporting "hotline" are intended to improve the State's ability to realize revenue. In addition and as the caseload increases, the funding and hiring of additional forensic fraud examiners within the AGO may also significantly improve the State's ability to realize revenue enhancements.

Proposed Actions to turn the curve:

As noted above, we expect measurable and meaningful revenue enhancements over the next three to five years. Enhancements to the AGO's fraud reporting website and a dedicated fraud

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reporting "hotline" may significantly improve the State's ability to realize revenue enhancements. In addition and as the caseload increases, the funding and hiring of additional forensic fraud examiners within the AGO may also significantly improve revenue enhancements.
Trend: ◄►

Performance Measure 2:

The number of civil health care fraud cases initiated by the Office of the Attorney General

Story behind the baseline:

Prior to this year, civil health care fraud cases were primarily federal, multi-state actions. The few civil cases initiated by the state relied upon CUTPA. The passage of the state False Claims Act provides an important new tool which is well tailored to combating fraud. The state may bring its own civil health care fraud cases. We now expect to be moving towards using the state False Claims Act more and CUTPA less, although there may still be future cases where CUTPA continues to serve as an appropriate vehicle for obtaining relief for the state.

National Cases: We continue to be involved in a steady stream of multi-state global investigations, including those arising out of many dozens of *qui tam* cases filed by private relators still under seal. Most, but not all, of these open matters involve claims against large pharmaceutical companies. Some of these cases will ultimately result in multi-state settlements generating substantial revenue for the state. Others will be closed, following investigation, as lacking merit. One of these cases, now unsealed, is being actively litigated in federal court in Boston.

Local Cases: During FY11-12 there were 3 cases resolved involving local healthcare providers which generated revenue for the state (totaling $367,138 attributable to Connecticut Medicaid, of which the state share was $193,695.49). Also, during FY11-12 we commenced the first case initiated by the State under the new state False Claims Act.

Local cases typically result from referrals from DSS, referrals from other governmental agencies, and complaints from members of the public. Further, state health care fraud cases may be brought to the state's attention through *qui tam* cases initiated by private relators. For example, one *qui tam* case filed in Connecticut against a local provider developed into a joint federal/state false claims settlement during FY11-12 and resulted in a financial recovery ($212,000 attributable to Connecticut Medicaid, of which the state share was $106,000).

Proposed Actions to turn the curve:

New civil health care fraud cases will increase revenue and provide additional deterrence to future fraud. We anticipate measurable and meaningful increase in the number of cases initiated under the state False Claims Act over the next three to five years, a time frame reflecting the recent effective date of the law, the complexity of financial fraud investigations, initiatives to enhance coordination with both criminal investigators and state partners, and the time necessary to pursue fraud investigations to completion. Enhancements to the AGO's fraud reporting website and a dedicated fraud reporting "hotline" should improve the State's ability to realize revenue enhancements. As the caseload increases, the funding and hiring of additional forensic fraud examiners within the AGO may also significantly improve revenue enhancements.

Trend: ◄►

Performance Measure 3:

Health care fraud cases that result in exclusions

Store behind the baseline:

Exclusion, also known as debarment, is a strong deterrent because participation in state health care programs is often a critical source of revenue for health care providers and medical equipment companies. Exclusions occur automatically after a program-related criminal conviction. In addition, the DSS has discretionary authority to exclude people who commit health care fraud and abuse, even in the absence of a criminal conviction.

During FY10-11 there were two cases in which we were successful in working with the DSS to exclude wrongdoers. There was another such case during FY12-13. This is an increase from exclusions in three cases in the several fiscal years from FY03-04 — FY 09-10.

Proposed actions to turn the curve:

As civil investigations under the False Claims Act develop strong evidence of wrongdoing, one of the civil remedies considered should be exclusion from state health care programs. This will further deter health care fraud.

The AGO, with the cooperation of the DSS, will endeavor in all appropriate cases to gather the necessary evidence to support a request for exclusion, as well as for restitution and civil penalties under the state False Claims Act.

Trend: ▲

Data Development Agenda: