Fighting Health Care Fraud: Research and Practice

Jetson Leder Luis, PhD
White House Task Force to Eliminate Fraud
Boston University & NBER (on leave)

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Introduction

- Hi everyone, I'm Jetson
- Assistant Professor at BU Questrom School of Business, as well as the Department of Economics and BU School of Law
- MIT Economics PhD 2020; research agenda on public program fraud
- Deputy Executive Director, White House Task Force to Eliminate Fraud

- Many thanks to ASPE Ge Bai; Secretary Kennedy and DepSec Klompe; CMS Administrator Dr Oz and COO Kim Brandt; as well as the fantastic CMS Program Integrity team I've had the pleasure of working with this past year

- Caveat: today is about research findings and publicly announced actions, not representative of Task Force/White House positions

Healthcare Fraud

- The US government spends $2 Trillion per year on federal health programs: Medicare, Medicaid, Affordable Care Act marketplaces, FEHB, etc.
- And loses probably at least $100 Billion per year to fraud

- Annual healthcare fraud is the size of a whole country's GDP (e.g. Kenya)
- About the size of total spending on SNAP; double the budget of TANF

- Fraud is a major administrative priority, worthy of serious public policy scholarship

Research and Policy

- What is **effective** at combating healthcare fraud?

- In today's talk, I will synthesize from some of my studies, and from examples of CMS and HHS actions, to discuss effective anti-fraud policy

Different Frauds

- **Healthcare fraud is not one (economic) behavior**
- Medical supplier bills for a brace for a patient they never met, no product delivered
- Physician bills for a 60 minute visit when they spent 40 minutes
- Patient actually receives a genetic cancer test, but it was not indicated/necessary
- Nursing home bills for around-the-clock care and abandons a patient, who is hurt

- These are all different behaviors with different economic/welfare consequences (Leder-Luis and Malani, 2025)
- Fraud occurs in all sectors of health care: hospitals, nursing homes, hospices, labs, surgical intervention, wound care, cardiac devices

Different Tools

- The US government has many tools for fighting fraud

- Criminal litigation
- Whistleblowing, civil enforcement
- Auditing
- Claim denials, prior authorization
- Suspensions, revocations, exclusions, preclusion

- Evidence helps us understand when different tools are relatively more effective

Today's Big Takeaway

- When fraud is diffuse – **many small firms** or individuals – focus on administrative intervention, prevention of future funds, **regulatory approach**
  - E.g. ambulance companies, hospices, durable medical equipment firms

- When fraud is conducted by **large firms** – then **civil litigation** can recover funds and produce big deterrence effects
  - E.g. Hospitals, pharmaceutical companies, insurance companies

Roadmap

- Synthesize two papers: Leder-Luis (2025, Review of Economics and Statistics) and Eliason, League, Leder-Luis, McDevitt, Roberts (2025, Journal of Political Economy)
- Examples of real-world cases from the past year that show this in practice
- Topics for today: ambulances, hospices, DME companies, MA plans, hospitals

Ambulance Taxis

- **Ambulance Taxis: The Impact of Litigation and Regulation on Health Care Fraud**
  → Eliason et al., Journal of Political Economy 2025

- Setting: the Medicare dialysis program
- Dialysis treats patients with non-functioning kidneys
- **1% of the US federal budget is spent on dialysis patients** (filtration + other care)

- Non-emergency dialysis ambulance transportation: only available for patients who cannot otherwise safely travel

Ambulance Taxis

- Starting in early 2000s, organized crime groups in Philadelphia noticed lax checks on medical necessity for dialysis ambulances
- Began offering patients free ambulance rides; then coffee, cash kickbacks for riding
- "The perfect healthcare fraud" – low overhead; repeat customers; $500 per round-trip ambulance ride, to and from home/dialysis; for the rest of the patient's life
- Rapid growth and diffusion: $7.7B on 37.5M rides, 2003 - 2017; over 3,000 firms

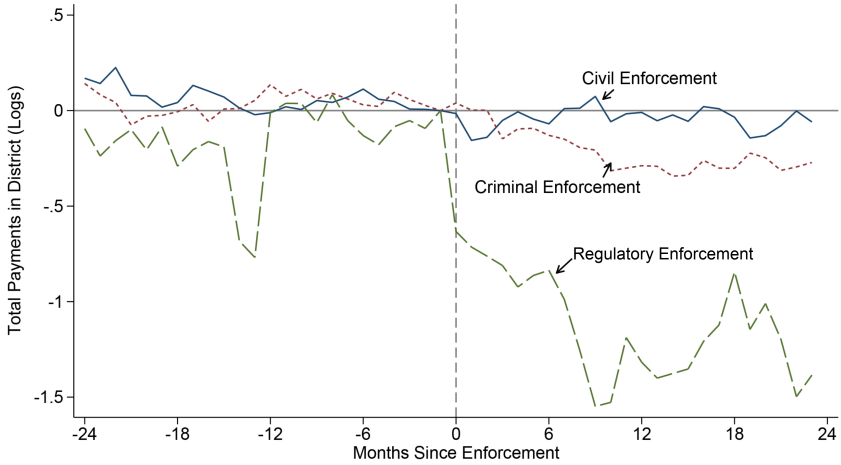
Regulation vs Litigation

- Ambulance Taxis provides the ideal opportunity to compare different enforcement regimes

- **Criminal Enforcement**: 43 criminal cases across 16 DOJ districts
- **Civil Enforcement**: 26 civil cases across 18 districts
- **Regulation**: physician sign-off on medical necessity before reimbursement (RSNAT), rolled out by state

- Data: 100% coverage, 2003 - 2017, all dialysis patient claims, from USRDS
- Identification: difference-in-differences on timing across DOJ districts/states

Comparing Litigation to Regulation



Main result

- Civil enforcement: no effects
- Criminal enforcement: modest deterrence effects – about 20% reduction
- Regulation caused a **persistent 68% drop** in payments

- Was this harmful to patients?
- Speaks to overall efficiency, and also whether the rides were necessary/legitimate

No Patient Harm from Regulation

	Dialysis Sessions (1)	Mortality (2)	All-Cause Hospitalizations (3)	Fluid Hospitalizations (4)
Prior authorization	−.0256	.000372	−.00132	−.000854
	(.0191)	(.000580)	(.00136)	(.000777)
Year-month fixed effects	1	1	1	1
District fixed effects	1	1	1	1
Patient/facility controls	1	1	1	1
Facility fixed effects	1	1	1	1
R^2	.0108	.00493	.0159	.00610
Dependent variable mean	12.12	.00988	.122	.0116
Observations	15,077,158	15,077,158	15,077,158	15,077,158

Why Litigation Failed: Low Probability of Detection

- Main takeaway: regulation massively outperformed litigation. Why?

Why Litigation Failed: Low Probability of Detection

- Main takeaway: regulation massively outperformed litigation. Why?

- #1: **Low probability of detection**
- Only about 100 of 3,000 firms prosecuted
- Litigation is hard to scale
  - Lawsuits are expensive for US government
  - High burden of proof
  - Non-specialization of prosecutors
- Closed firms reopen — sometimes under family members of the prosecuted

Why Litigation Failed: Limited Liability

- #2: **Limited liability** of firms
- Fly-by-night firms close in response to civil penalties
- No assets – in many cases just the ambulance
- In some cases, ties to organized crime, financial sophistication to hide/move cash
- Also explains why criminal outperforms civil: non-monetary penalties can still be assessed

Regulation works against small firms

- Regulation solves limited liability and low detection at once
- Denial of payment $\rightarrow$ no need to claw back assets
- Affects all firms uniformly — no longer probabilistic enforcement
- **Regulatory enforcement is a scalable solution for diffuse frauds**

In Practice: Hospice Fraud

- Over the past few years, acceleration of fraudulent hospices
- Hospices are supposed to provide care to terminal patients at the end of life
  - Eligibility: prognosis of terminal within 6 months
  - Care is mostly provided at the home or place of residence
- Fraudulent firms have enrolled patients without their knowledge, with no services delivered, and ties to organized crime
- **Thousands** of hospices, particularly in and around Los Angeles

Eliminating Hospice Fraud

- We undertook extensive regulatory enforcement over the past year
- **Payment suspensions** permit Medicare to withhold funds when there is a credible allegation of fraud
- Like the ambulance taxis example, we don't pay the fraudulent claims
- Over the past 6 months, we have suspended over 1,000 hospice firms
- Relies on data analysis like: 100% of a firm's patients didn't die after 6 months
- **Estimated savings: more than $1.5 Billion per year**

In Practice: DME Fraud

- DME, or durable medical equipment, provides equipment to patients, like orthotic devices, wheelchairs, CPAP machines, etc.
- Same firm profile: low capital, thousands of firms
- Regulatory crackdown:
  - Claim denials for obvious outliers
  - Data-driven suspensions of payments
  - Permanent revocation of certain firms' billing privileges
  - Temporary moratorium on new firms
  - Tightening of new firm enrollment rules
- Estimated savings: $1.9 Billion per year

In Practice: Exclusion and the Medicaid Fraud War Room

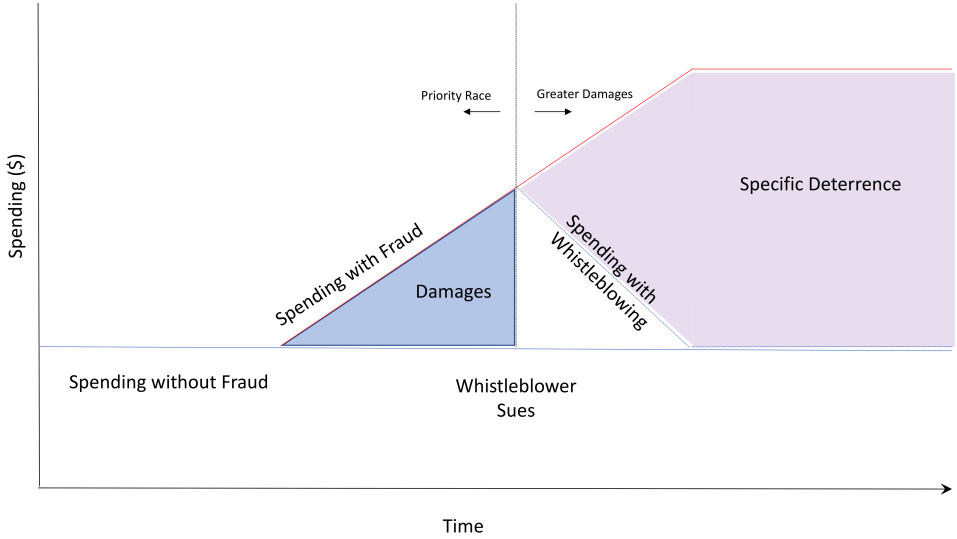
- Unlike in Medicare, CMS cannot see Medicaid claims before they are paid
- Medicaid is run through 50+ state programs, and CMS sees the claims after
- However, we can still focus on prevention/regulation, elimination of future fraud
- HHS (via OIG) has exclusion authority against Medicaid providers
- The new Medicaid fraud war room – a collaboration between CMS, HHS OIG, and the Task Force – uses data analysis to identify and exclude providers with egregious/impossible billing patterns
- $200M+ in estimated Medicaid savings in the first 90 days

When is Civil Litigation Effective?

- The past paper showed that civil enforcement was not effective at deterring ambulance taxis style behavior: diffuse frauds by many small firms
- When is civil litigation effective? **Large firms**

- Leder-Luis (2025 *REStat*)
- False Claims Act: federal law, combines whistleblowing with private enforcement
- Whistleblower hires an attorney, sues on behalf of the government
- Whistleblower earns a share of recovery
- **Private market** for anti-fraud

Value of Enforcement



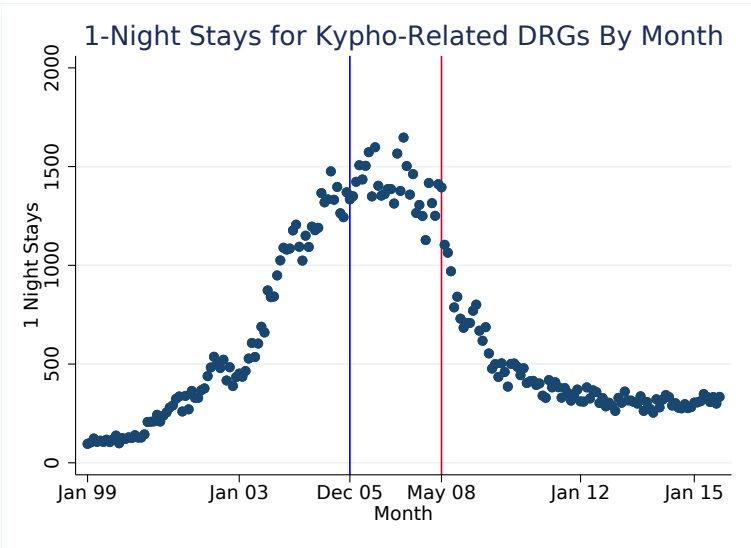
Empirical Design

- Pair enforcement data (FOIA of DOJ) with Medicare claims data
- Four case studies, largest categories of fraud, $1.9B in recovered settlements
  - Outlier payments
  - Botox off-label promotion
  - Unnecessary inpatient Kyphoplasty
  - Unnecessary hospital admissions
- In every case, measure deterrence effects as ratio of settlement
- Synthetic controls with other fast-growing spending categories

Case Example – Kyphoplasty

- Kyphoplasty is a spine surgery for patients with compression fractures
- Kyphoplasty can safely be performed outpatient
- Hospitals intentionally billed inpatient kyphoplasty instead of outpatient
  - Allegations that manufacturer of surgical kit encouraged inpatient stays to justify higher prices
- FCA lawsuits against dozens of hospitals for this conduct
- First lawsuit filed 2005, first settlement 2008

1-Night Kyphoplasty Stays



Deterrence results

- Using synthetic controls, estimate deterrence for each of 4 case studies

Type of Care	Type of Fraud	Settlement Total	Specific Deterrence	Ratio
Inpatient	Manipulation of Outlier Payments	\$923 Million	\$17.5 Billion	18.92
Botox	Off-Label Promotion	\$600 Million	−\$41.7 Million	−0.07
Kyphoplasty	Inpatient Procedure Should be Outpatient	\$214.2 Million	\$281.1 Million	1.31
Inpatient	Unnecessary Hospital Admissions	\$172.3 Million	\$1.2 Billion	7.09
Total		\$1.91 Billion	\$18.9 Billion	
			Average Ratio	6.81

- **\$1.9B** in case-study settlements → almost **\$19B** in specific deterrence over five years
- Heterogeneity in the deterrence-to-settlement ratio across case types
- A lower bound — general deterrence unmeasured

When Civil Litigation Works

- Large firms are not judgment proof, do not close easily
- Hospitals have physical assets, legitimate business to conduct, will not close after a $10M settlement
- Firms know this, and therefore civil litigation changes their behavior
- Produces deterrence effects on both the defendants and on other similar firms

In Practice: large-firm enforcement

- Recent large civil settlements
- Example: Ongoing issues with upcoding MA patients to receive higher risk adjustments
- March 2026: $118M settlement against insurer
- August 2026: $541M settlement against provider engaged in risk-sharing with insurer
- August 2026: $14M settlement against management org that operated providers with risk sharing
- These cases – against large providers and insurers – are likely to produce changes to future behavior, even greater savings

What About Patient Health?

- Howard & Leder-Luis (NBER Working Paper 2026)
- FCA lawsuits against hospitals for over-admitting Medicare ED patients
- Corporate management pushed inpatient care for higher revenue
- 8 hospital systems, 205 hospitals, settled 2005 - 2017; DOJ recovered $476M

- Difference-in-differences: hospital systems with lawsuits vs similar trends but no enforcement
- Analysis at the visit level – 238M ER visits 2005 - 2019

Savings + Health Benefits

- Litigation reduced unnecessary admissions
- 90-day Medicare episode spending fell $380/patient (-3.9%)

- Admission rates fell **3.58 pp** (-9.7%) at investigated hospitals
- **30-day mortality fell 0.13 pp** (-2.3%) — patients did not get sicker; if anything, outcomes improved
- 30-day ED revisits rose slightly (+3.4%) — mechanical "incapacitation effect" of fewer admissions, not a sign of worse care
- 5-year discounted savings: $1.3B

Bottom Line

- These research papers show that anti-fraud enforcement is extremely valuable
- Tens of billions of savings, plus improvements in care quality
- However, the tool must be appropriate for the fraud
- Civil litigation/whistleblowing is a great tool for large firms, but doesn't work for small firms
- **CMS** must – and now does – use its regulatory regime to rein in widespread frauds

The Next Set of Questions

- Enforcement — litigation or regulation — reacts to existing problems of fraud
- What can be done even further upstream? **Program design**
- Examples opening up in this space:
  - New working paper (Diwan et al., 2026) discusses the role of competition/market structure on fraud
  - In practice: skin substitutes were subject to payment rate decreases, coverage changes that massively reduced fraud
- How can CMS (and other federal benefits programs) be designed to reduce fraudulent incentives while ensuring access to care?

Conclusion/Q&A

Thank you

jetson.l.luis@who.eop.gov
jetson@bu.edu

http://jetson.org