Long-Term Care Fraud
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Executive Summary

Health care fraud is large already and growing rapidly. Long-term care (LTC), vital because of America's aging population, is especially susceptible to fraud. Government or corporate third parties finance most LTC which creates a moral hazard by facilitating fraud and reducing its risk. Individuals, naturally averse to fraud, fund much less LTC out of their own pockets. Most LTC is delivered in private homes without supervision inviting fraudulent billings. We know the incidence and cost of fraud in private LTC insurance. But there is no published measure of LTC fraud in the public sector. Medicaid and Medicare present special problems that make LTC fraud identification, processing and prosecution exceptionally difficult. The Trump administration has undertaken a major push to reduce public sector health care fraud. Private sector advances to control LTC fraud could help reduce obstacles on the public side. A key is prioritization, focusing on cases most likely to produce results. This paper examines LTC fraud in both sectors and recommends measures to curtail its growth and impact.

Fraud Defined

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. In 2023, private LTC insurance fraud touched between five and ten percent of $14.1 billion in paid benefits. Public sector LTC fraud involving Medicaid and Medicare is harder to pin down because it is reported as part of "improper payment rates" (IPR). After backing out 77 percent of IPR as merely "insufficient documentation," the residual rate of actual public sector health care fraud, is three to ten percent or as much as $300 billion annually.

There is, however, no published measure for the proportion of public sector health care fraud attributable specifically to LTC. That rate is likely higher than the average overall public health care fraud incidence, because of LTC's larger fraud vulnerability attributable to its being delivered increasingly (87.1 percent as of 2025) in unsupervised home and community-based settings often with care self-directed by recipients and their families. Disentangling LTC from health care in general is critical, because the six percent of Medicaid recipients who receive it account disproportionately for 37 percent of total expenditures. Bottom line: LTC fraud is large and growing but we know more about its specific magnitude on the private than on the public side.

Increasing Incidence

Public and private insurers, representing other people's money as they do, were insensitive to fraud historically, treating it as an unavoidable cost of doing business. A 1998 U.S. Justice Department study opined that most insurers, public and private, failed to measure fraud systematically. That is changing rapidly as health care and LTC fraud explode across the United

States. A growing incidence of fraud in public and private LTC insurance has alarmed officials leading to major efforts by government and private carriers to identify, mitigate, and prosecute fraud. The current administration placed a new emphasis on potential fraud in Medicaid with its Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) initiative. Centers for Medicare and Medicaid Services (CMS) Administrator Dr. Oz exposed rampant fraud in Medicaid and Medicare adding up to $100 billion in a single year. The White House established a Task Force to Eliminate Fraud, targeting state-administered programs that receive federal funding. States have received Congressional inquiries about potential fraud in Medicaid. Dr. Oz asked all 50 governors to revalidate Medicaid providers of services with high fraud risk. The Paragon Health Institute (PHI) publishes a Health Care Fraud Dashboard that tracks "criminal and civil enforcement actions and federal oversight and accountability measures" as well as highlighting media coverage exposing fraud. PHI published several papers identifying fraud risk and incidence and sponsored events covering the topic.

LTC's Third-Party Fraud Vulnerability

LTC is especially vulnerable to fraud because most of it is funded by third parties who stand in between the providers and receivers of care. Third-party payers, including private insurance companies and government agencies, have less incentive to control fraud than individuals do because they face high detection costs, depersonalized relationships with claimants, and the ability to pass costs on to policyholders or taxpayers. State Medicaid agencies have an added disincentive to pursue fraud because the more they spend, especially when enhanced by provider taxes or intergovernmental transfers, the more revenue they receive from federal matching funds. The presence of insurance itself induces fraud through "third-party moral hazard," because the payer is a "deep pocket" that can afford to cover losses, unlike individuals paying out of their own pockets.

Individuals have an obvious incentive to be wary of fraud, but they only account for a small portion of LTC spending. Most LTC funding comes through third parties, primarily government programs that have less incentive to worry about fraud. The following table (configured with the help of my Paragon Health Institute colleague Niklas Kleinworth) shows that third parties finance most LTC. In 2024, Medicaid paid $316.9 billion (B) or 44.6 percent of total $709.8B LTC spending. Medicare covered another 15.2 percent or $107.6B. Other third-party payers include private insurance at 10.9 percent, $77.7B (mostly health insurance, not private LTC insurance which is much smaller, $14.1B as of 2023 and is reported as part of "out-of-pocket" spending, not private insurance) and "other payers" at 16.5 percent and $117.2B., which include more government third parties, such as Tricare, Veterans Affairs (VA), the Indian Health Service, and state/local general assistance programs.

Notably, only 12.7 percent of LTC spending or $90.3B comes out of consumers' pockets. Of this small out-of-pocket share, half comes from income, mostly their Social Security benefits, not assets, leaving only 6.4 percent that could come from savings, making it less vulnerable to fraud due to personal self-interest and diligence. The half of out-of-pocket LTC spending that comes from income actually goes to offset the cost of the recipients' care funded by Medicaid, meaning even more of the fraud vulnerability falls on the public program. If individual consumers bore a

larger share of LTC cost, fraud indicidence would decline substantially because they would have a larger stake in the transaction.

2024 Total Long-Term Care Spending
By Type and Source, Billions of Dollars, with Percent Increase Since 2023

Category Billions of $ (Growth Since 2023) Share of Total Spend	Medicaid	Medicare	Private Insurance	Out of Pocket	Other Payers	Total
Nursing Home and Continuing Care Retirement Communities	78.9 (+9.6%)	47.3 (+7.5%)	19.3 (+6.6%)	48.7 (+6.3%)	25.7 (+1.6%)	219.9 (+7.3%)
	35.9%	21.5%	8.8%	22.1%	11.7%	100.0%
Home Health Care	38.2 (+12.4)	55.7 (+7.5%)	37.3 (+12.3%)	30.4 (+10.9%)	7.8 (+9.9%)	169.4 (+10.3%)
	22.6%	32.9%	22.0%	17.9%	4.6%	100.0%
Other Health, Residential, and Personal Care	199.8 (+8.9%)	4.6 (+2.2%)	21.1 (+11.1%)	11.2 (+10.9%)	83.7 (+9.1%)	320.5 (+9.1%)
	62.3%	1.4%	6.6%	3.5%	26.1%	100.0%
Total	316.9 (+9.5%)	107.6 (+7.3%)	77.7 (+10.5%)	90.3 (+8.4%)	117.2 (+7.6%)	709.8 (+8.8%)
	44.6%	15.2%	10.9%	12.7%	16.5%	100.0%

Source: 2024 National Health Expenditures, Tables 13, 14, and 15.

Changing Attitudes Condone Fraud

Already serious, health and LTC fraud are likely to become much worse straight away because of changing attitudes about fraud and "victimless" crime. Evidence grows that segments of the public, especially younger people, are becoming more tolerant of non-violent law breaking. Insurance fraud, seen as a victimless crime against large, wealthy corporations or government agencies, rather than individuals, is a prime example. A 2023 study found that while 84 percent of Americans still consider insurance fraud a crime, only 64 percent aged 18-25 agreed, compared to over 95 percent of those 55 and older. In fact, over a quarter of those 18-34 are "motivated" to commit insurance fraud compared to less than seven percent of those over 45. The same study revealed that nearly 53 million Americans could justify taking money from insurance companies when it is not owed to them. Over 36 percent of Americans surveyed believed it was acceptable to submit an inflated auto damage claim, and 30 percent of 25-34-year-olds said they "definitely would" submit a fraudulent property damage claim.

Insurance fraud is a slippery slope to even more disturbing attitude changes about crime. A growing minority of Americans accepts or justifies the use of violence to achieve political or economic goals. This trend, now 30 percent, up from 19 percent 18 months ago, is particularly evident among the young and political fringes.

Types of LTC Fraud

Older people, managing for themselves, especially those living alone, are vulnerable to financial exploitation. Unethical caregivers, dishonest providers, and financially stressed LTC facilities can take advantage of elders' vulnerabilities. Fraud against them, or making use of them, has many forms, such as billing for services and hours not provided (phantom care and billing); charging for a level of care higher than actually delivered (upcoding); modifying medical records and care logs, or providing unnecessary treatments or equipment. Unscrupulous personal representatives may insist on handling all billing and communications, pressure patients to grant

Power of Attorney (POA), demand kickbacks or steal their medical identities. When both public and private insurance are involved, double billing scams can take advantage of the communication gap between private carriers and government programs. Fraudsters can use a single service delivery to trigger several payment streams.

Fraud Vulnerability

Certain locations, patient types, and care services are more vulnerable to fraud than others. Paid care provided in a private home, for example, is especially susceptible due to its privacy and lack of objective outside review. Cognitively impaired people, often recipients of Medicaid- or private-LTC-insurance-funded services, are less able than others to protect themselves from financial abuse. Personal Care Services (PCS) are often delivered in private residences without oversight, leading to "ghost billing" for care never provided and other fraudulent interventions. Home and community-based services funded through Medicaid waivers often pay family members to provide the care. Several states, including New Mexico, Indiana and California, offered sign-on bonuses to recruit paid family caregivers. The USDHHS Office of Inspector General published an advisory opinion on January 5, 2026 holding that such bonuses are likely illegal under the federal Anti-Kickback Statute.

Red Flags

Private LTC insurers have learned that certain circumstances indicate a higher probability that fraudulent activity may be present. These "red flags" include billing unreasonable hours such as full time, 24-hour care; apparent upcoding to a higher level for basic care documentation that appears copy-and-pasted, unusual provider behavior such as offering free care; sudden spikes in claim activity such as billing higher hours, more caregivers, or more complex services; third party marketers that may be fraud rings; and weak documentation. More red flags include early duration claims, claims filed just outside of the contestable period, inconsistent medical documentation, exaggerated symptoms, unusual billing patterns, frequent caregiver changes, familial caregiver relationships, lack of cooperation, multiple policies with different insurers, and inconsistent lifestyle activities.

Investigative Methods

Nowadays private long-term care (LTC) insurance companies pursue fraud detection aggressively. 84 percent of life insurance carriers have designated individuals or investigative teams, up from only one in 2016. Special Investigative Units (SIUs) analyze suspicious LTC claims. They spot red flags. Companies use a wide range of investigative methods. They employ field surveillance that may involve hidden "unmanned" motion-activated cameras or drones. They analyze social media, online maps, and other public records seeking to contradict disability claims. Lately, more companies are shifting toward artificial intelligence (AI) and machine learning to analyze claims, detecting anomalies such as outlier billing patterns or excessive service intensity.

Special Fraud Challenges Faced by Public Third Party Payers

Public sector health programs such as Medicaid and Medicare face special challenges combating fraud compared to private sector insurance. Their mandated service coverage, large-scale payment processing, and complex state-federal bureaucratic structures complicate fraud detection and processing. Specific ways the public sector falls short include fraud prevention, identification, and prosecution.

Medicaid's patchwork administration across 50 different state programs makes it difficult to identify providers committing fraud across state lines or across both Medicare and Medicaid. Private insurers tend to have more centralized data systems. While Medicaid managed care plans (MCOs) are required to report fraud, reports indicate some MCOs make few or no referrals of potential provider fraud to state authorities, leaving significant amounts of fraud unidentified. In the public sector, identifying fraud is not the only bottleneck; a major hurdle is the limited staff capacity to investigate the huge volume of flagged cases.

Government LTC programs tend to "pay-and-chase," paying claims first and auditing later. Private insurers, by contrast, use more advanced predictive analytics to deny suspicious claims in real-time before paying. Public programs are often required to enroll providers who meet basic qualifications, whereas private insurers can be more selective, keeping out providers with shaky histories. Until recently, adoption of proactive, technology-driven prevention tools such as Electronic Visit Verification (EVV) was slower in state-run Medicaid programs than in the private sector.

Public programs take years to identify, audit, and investigate fraudulent actors, often leading to smaller recovery rates compared to private payers' faster legal actions. State Medicaid Fraud Control Units (MFCUs) responsible for prosecuting Medicaid fraud often have limited staff and funding that prevent them from pursuing all leads compared to the more ample resources major private insurers can devote to legal actions.

Private insurers use AI to flag and block suspicious claims in milliseconds. Public programs often still rely on post-payment audits, which is why experts recommend a shift toward earlier verification tools. Although CMS focused historically on auditing and reclaiming funds rather than immediately suspending payments to suspicious providers, this approach is beginning to change as of early 2026. CMS announced recently that it will rely more heavily on ways to prevent spending federal funds in cases of potential fraud, which could create major complications for states and Medicaid recipients.

Summary of key differences:

Public (Medicare/Medicaid): High volume of transactions, regulatory constraints on provider exclusion, and slower technology adoption.

Private Sector: Faster adoption of AI/predictive analytics, tighter network controls, and quicker termination of providers suspected of fraud.

Recommendations

Government tends to ignore the 80/20 Pareto Principle that says we get 80 percent of results from 20 percent of effort, so focus on the most promising opportunities. I know this from personal experience in three state/federal programs. Working in child support enforcement, I found that state programs pursued all absent parents the same, wasting time on trying to find long gone shirkers while making no special effort to locate and collect from prosperous local deadbeats. Working in Medicaid third party liability, I found that state programs frittered away time and effort treating every case the same instead of identifying and pursuing easy cases of private insurance coverage held by recipients and absent parents employed by local companies. Working in Medicaid estate recovery (MER), I found that state programs went through the motions on all cases whether likely to generate recoveries or not thereby losing the opportunity to target and collect on cases with larger, more accessible estates. Likewise in estate recovery, I found that state programs starved their MER units for staff and resources content with low marginal returns of one or two dollars per dollar invested instead of reaching for achievable returns of 13 or 14 to one. Oregon accomplished such high recovery rates before the Beaver State cut its MER effort way back sacrificing much of that added revenue. From these experiences, I conclude it is highly likely that government fraud control operates in a similar way and could be improved by thoughtful prioritization of effort.

Lessons from the private sector to improve public sector fraud control:

1. Identify & Prevent: Private payers use AI and predictive modeling to "score" providers and claims before payment, focusing resources on the riskiest cases.

- Instead of reviewing all claims, employ AI to assign a risk score to providers based on billing anomalies, such as extreme upcoding, impossible service volumes, or serving patients with inconsistent lifestyle activities.
- Adopt the private sector "prepayment edits" model to suspend payments for claims that fail algorithmic checks, rather than paying first and trying to recover funds later.
- Focus resources on high-loss areas like durable medical equipment (DME), genetic testing, and long-term care fraud, which often show signs of recycled, identical documentation.
- Use AI to identify "straw owners" and phantom providers before they are enrolled in the system, rather than auditing them afterward.

2. Detection: Leveraging Data Fusion

Private insurers connect disparate data sources to see the whole picture of a fraud scheme.

- Create a centralized "Data Fusion Center" that merges Medicare/Medicaid data with private insurer data, prescription drug monitoring programs, and state licensing boards to identify coordinated schemes across systems.
- Use graph analytics to map relationships between providers, recruiters, and beneficiaries to identify organized crime rings, as fraud is often a network activity rather than an isolated incident.
- Actively monitor for "impossibilities," such as one doctor seeing over 100 patients a day or performing procedures in rural areas they do not work in, as these are high-probability signals of fraud.

3. Processing & Investigation: Prioritizing High-Value Leads

Instead of treating all complaints equally, focus investigation capacity on cases with the highest potential return on investment (ROI).

- Establish a strict triage protocol that prioritizes cases based on the projected dollar value, complexity of the scheme, and clear evidence of intent, rather than a "first-come, first-served" approach.
- Build profiles of known fraud networks (e.g., specific billing behavior patterns) to automatically flag new, similar perpetrators, as used in the Department of Justice's "Operation Gold Rush."
- Shift from random audits to targeted audits based on predictive analytics alerts, ensuring 80% of auditor time is spent on the 20% of providers with the highest risk scores.

4. Prosecution: Proactive & Collaborative Action

- Actively participate in programs like the Healthcare Fraud Prevention Partnership (HFPP), which shares data between public and private sectors to bolster cases.
- Create dedicated channels for whistleblowers, as internal informants often identify the actors causing the most damage.
- In long-term care, focus on identifying fabricated documentation—such as identical handwriting on daily logs or "ghost" visits (caregiver billed for visits while they were out of town)—which are strong evidence for prosecution.

5. Invest: Fund and Staff Fraud Units

- Keep adding funds and staff until the marginal return on investment (ROI) is achieved.
- Even more important than the amount recovered is the deterrent effect of aggressive fraud control.
- Reward fraud unit staff with bonuses or promotions based on successful prosecutions and financial recoveries.

Summary

Area	Traditional Government Approach	Private Sector Approach
Focus	Treats all providers/claims equally.	Focuses on high-risk 20%.
Timing	Pay-and-chase (Reactive).	Prepayment edits (Preventive).
Data	Siloed, internal data.	Data fusion (Public + Private).
Audit	Random audits.	Predictive risk scoring.
Goal	Compliance/Documentation check.	Stopping fraudulent actors.

Conclusion

LTC fraud is inevitable in a health care system that relies heavily on third-party payment, limited supervision, and complicated public administration. As demand for LTC grows with population aging, the chances for phantom billing, upcoding, identity abuse, and organized fraud expand unless payers respond more aggressively. Private LTC insurers have identified and reduced fraud by using targeted investigation, risk scoring, and early intervention instead of waiting to recover losses after the fact. Public programs, especially Medicaid and Medicare, face greater barriers, but they could employ the most effective private-sector practices more aggressively. Focus on high-risk claims; use data analytics to stop suspicious payments earlier; and prioritize cases with the greatest return on investigative effort. In a system where most LTC spending comes from third parties, fraud control will always depend on incentives. Replacing Medicaid's wide open federal funds matching system with capped block grants would encourage states to focus more vigorously on fraud control. Absent the temptation of unlimited federal revenue, state Medicaid

programs would more effectively protect vulnerable recipients, preserve public funds, and maintain trust in long-term care.