Senior Medicare Patrol Program: National & Local Perspectives

Barbara Dieker, Administration on Aging

Jean Stone, Centers for Medicare and Medicaid Services

John Morris, SMP Volunteer

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What We'll Discuss Today

- **SMP program background**
- **SMP Projects: making an impact on fraud**
- **Recent scams and fraud reported by SMP projects**
- **Recent SMP news and initiatives**
- **CMS overview of Medicare hot scams**
- **Medical identity theft**
- **CMS partnerships with law enforcement and SMP**
- **CMS' new fraud fighting tools**
- **Role of SMP Volunteers in local fraud fighting: Who, Why, What, When and Where**

AN ounce of prevention….

SMP
Empowering Seniors To Prevent Healthcare Fraud

SMP Program: Empowering Seniors To Prevent Healthcare Fraud

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Senior Citizens a Target for Scammers

Because :

1) Perceived as wealthy
2) Handshake was their bond
3) Trusting
4) Shopped in person
5) May be lonely, isolated
6) Medicare complicated, confusing
7) May have diminished capacity

An Ounce of Prevention…

- Prevention really is the best medicine
- Consumers can make a big difference
- Get smart about their health care
- Understand Medicare basics
- Stand up for themselves
- Guard Medicare card and personal information
- Create a good relationship with their providers
- Record health care services received in Personal Health Care Journal
- Review Medicare Summary Notices and check for services not received
- Report unusual activities

Seniors Educating Seniors….

SMP volunteers across the country play an important role in educating our older Americans and their caregivers on how to **prevent, detect and report** suspected health care fraud.

SMP Program Background

- **1995 – Congressional demonstration program, "Operation Restore Trust": targeted federal, state & local resources to areas most plagued by abuse (5 states).**
- **1997—Omnibus Consolidated Appropriations Act (P.L. 104-209): directed AoA to establish demonstration projects. Senator Harkin's language:**
  - **"utilize the skills and expertise of retired professionals in identifying and reporting error, fraud and abuse."**
- **1997—HIPPA (P.L. 104-191) provided HCFAC funding to AoA**
  - **"*Provider and consumer education*" 1 of 5 primary purposes of HCFAC funding**
- **SMP funding sources (FY 2010):**
  - **$9.3M in Older Americans Act funds—SMP project grants**
  - **$3.3 M in HCFAC funds—SMP capacity-building, support**
  - **$9M –CMS capacity building funds**

SMP Program: Then and Now

- **12 local demonstration projects started in 1997**
- **<u>Today:</u> national program of statewide SMP projects in all 50 states, DC, Guam, Puerto Rico and the Virgin Islands**
- **<u>Message</u>: empowering seniors to prevent, detect and report health care fraud, error and abuse**
- **<u>Mission unchanged</u>:**
  1) **Recruit and train senior volunteers to conduct outreach and education of seniors and caregivers about their Medicare**
  2) **Receive, investigate and refer, as appropriate, beneficiary complaints of potential health care fraud, error and abuse building funds**

SMP Program Achievements

SMP Program since 1997:

- Achieved national program coverage
- 70,000 volunteers trained
- Over 111,000 complaints handled
- 4.2 million people educated
- 83,000 group education sessions
- Over 1.1 million one-on-one counseling sessions
- Over 1.3 million media outreach activities
- Almost $106M in savings

SMP Program Fights Fraud

- Next--a few examples of how SMPs fraud education and outreach, as well as assistance with beneficiary fraud complaints, have made a difference
- All came from outreach work at senior housing developments, which are prime targets for scam artists

Case 1: SMPs Fighting Fraud Efforts Yield Results

Miami, Florida

ISSUE:

- June 2009—resident of senior housing complex contacts SMP
- Reports employee of complex recruited her to go to therapy or mental health clinic 3 or 4 times/week for $400-700/month
- Employee receives $100-200 for each beneficiary recruited
- Resident's neighbor tried to recruit her, divulging names of other participants in the scheme and touting the benefits of re-selling fraudulently obtained wheelchairs for profit
- Another resident reported unneeded DME & oxygen tanks

SMP RESPONSE:

- SMP made referral of the issues to CMS and OIG, which helped further develop an open case

RESULT:

- July 2011—OIG confirmed judgment of $3.8 million and recovery of $1.6 million
- One defendant sentenced to 3 years in prison + 3 years probation

Case 2: SMPs Fighting Fraud Efforts Yield Results

- **California**

ISSUE:

- 2004 SMP presentation in Vietnamese to residents of large senior living facility on Medicare fraud awareness
- Residents came up after presentation to report receiving medical equipment they did not request or need
- The agent had told her "Medicare wanted her to have the equipment in case she needed it in the future."

- **SMP RESPONSE:**
- SMP alerted CMS and OIG investigators

- **RESULT:**
- Interviews were conducted with 30 residents
- Case led to dismissal of 11 providers from Medicare and prosecuted, jail time for one physician
- Monies recouped to Medicare and SMP credited with $1.3M in Medicare costs avoided from claims not paid

Recent Scams Reported by SMPs

- **FL—Beneficiary approached in doctor's waiting area; taken to pharmacy to select diabetic shoes**
- **UT—Caller offered new types of health care plans**
- **KS & AR—Caller claimed Medicare is going broke BUT offered alternatives**
- **DE—Beneficiary received mailing with CMS logo--requested personal information**

Recent Scams Reported by SMPs

- **PA , MT—"Free diabetic supplies"; require beneficiary provide Medicare number**
- **HI—Clinics receive FAXes asking physicians to prescribe diabetic supplies for beneficiaries**
- **AK, TX, MO—Free equipment from "Christian" organizations in return for Medicare number**
- **CA—Doctor reportedly provided "breathing treatments" to long term care facility residents**

Recent Scams Reported by SMPs

- **TX—Caller claimed new Part D benefit: medications delivered by UPS**
- **IL—DME company convinced Japanese, Chinese and Korean immigrants to accept unneeded DME**
- **CA—Hospital chain using malnourishment code-- for a rare African syndrome that occurs in children-- to admit seniors to hospitals**

Recent Program Developments

- **New program visibility**
  - **Secretary Sebelius a vocal supporter of SMP program**
  - **AoA full partner with CMS, OIG, DoJ at Departmental fraud summits, press conferences**
  - **Value of consumer education in fraud prevention recognized**
  - **Press coverage: AP, Wall Street Journal, AARP Bulletin, USA Today recent article; state and local press/media**
- **CMS support for expanded SMP funding**
  - **SMP funding doubled in 2010 and 2011: $9M in new grants to SMP projects each year**
  - **Two-pronged focus: new collaborative strategies in high fraud areas and expansion of program capacity—"more feet on the ground"**
  - **AoA administers grants in partnership with CMS**

2011—New Initiatives (cont.)

- **National Hispanic SMP--Developing strategies for reaching Hispanic elders with fraud control messages**
- **National Volunteer Risk and Program Management Initiative—new policies, resources and tools to ensure consistent approaches among SMP projects.**
- **SMP Program evaluation to assess program effectiveness & performance.**
- **SMP Media campaign: PSAs, media toolkit launched in March 2011 (access via www.stopmedicarefraud.gov)**

Senior Medicare Patrol Program: National & Local Perspectives

Where to Report Medicare Fraud

- **Your local SMP**
  Find out how to contact your state SMP by:

  Phone: 1-877-808-2468
  or
  www.smpresource.org

- **Medicare: 1-800-MEDICARE (1-800-633-4227)**

- **HHS Office of Inspector General: 1-800-447-8477**

Thank you!

Barbara.Dieker@aoa.hhs.gov

Senior Medicare Fraud Patrol Panel
CMS' Perspective

NHCAA ATC Atlanta, GA
11/16 & 17/2011

Jean Stone, Director
Northeastern Program Integrity Field Office
Center for Program Integrity, *CMS*
212-616-2541
Jean.Stone@cms.hhs.gov

Medicare Expenditures

Per 2007 Medicare Trustees Report:
FY 2006 = $408 billion
43.2 million beneficiaries
FY 2008 = $456.3 billion
44.6 million beneficiaries

Per CMS OFM June 2010:
FY 2009 = $497.4 billion
46.1 million beneficiaries
FY 2010 = $521.7 billion
***47.0* million beneficiaries**

Every *8 seconds*, someone becomes Medicare eligible (>675 people will become eligible before we finish this panel)

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Medicare Expenditures

Congressional Budget Office (CBO) projects expenditures to *double* over the next 10 years.

Majority (approx 75%) of Medicare spending is for Part A & B benefits (fee-for-service portion of program)

Medicare spending = one of fastest growing sectors of federal budget - -
***Challenge i*s to maintain & ensure integrity of nation's largest health insurance program.**

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Medicare Fraud Examples

- Kickbacks, kickbacks, kickbacks
- Home Health Care Fraud
- Scooter Scams
- Arthritis Kit Scams
- Ambulance Rides
- Free Tests and Screenings
- Diabetic Supplies

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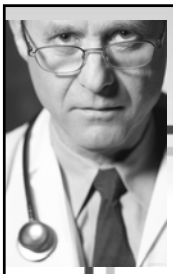

MDs - Physician Fraud

Vast **majority** are **straight-shooters.**

Bad behavior:

- **Bill for services not rendered**
- **Up-code, fragment, unbundle care**
- **Bill for medically unnecessary services**
- **Receive/solicit/pay kickbacks**
- **Sign orders for unnecessary lab & diagnostic tests [from Independent Diagnostic and Testing Facilities (IDTFs),] physical therapy, DME, HHA &/or Hospice care, prescription drugs**

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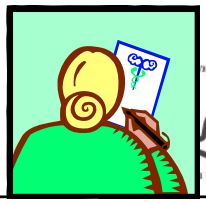
Durable Medical Equipment (DME) Fraud

- Pay kickbacks for referrals
- Bill for equipment not provided
- Falsify physician orders & proof of delivery
- Forge/alter medical records
- Misrepresent patient diagnosis or medical condition
- "Phantom" providers – bill with no inventory, bill after closing location
- Up-code or Swap – bill high end/substitute lesser equipment
- Hire nominee owners



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Hospice Care Fraud

- Forge/alter medical records to obtain coverage
- Misrepresent patient diagnosis or condition (patient *not* "terminally ill" as defined in § 1879(g)(2) of SSA)
- Transfer in & out of hospice for non-palliative care
- Underutilize (Quality of Care)

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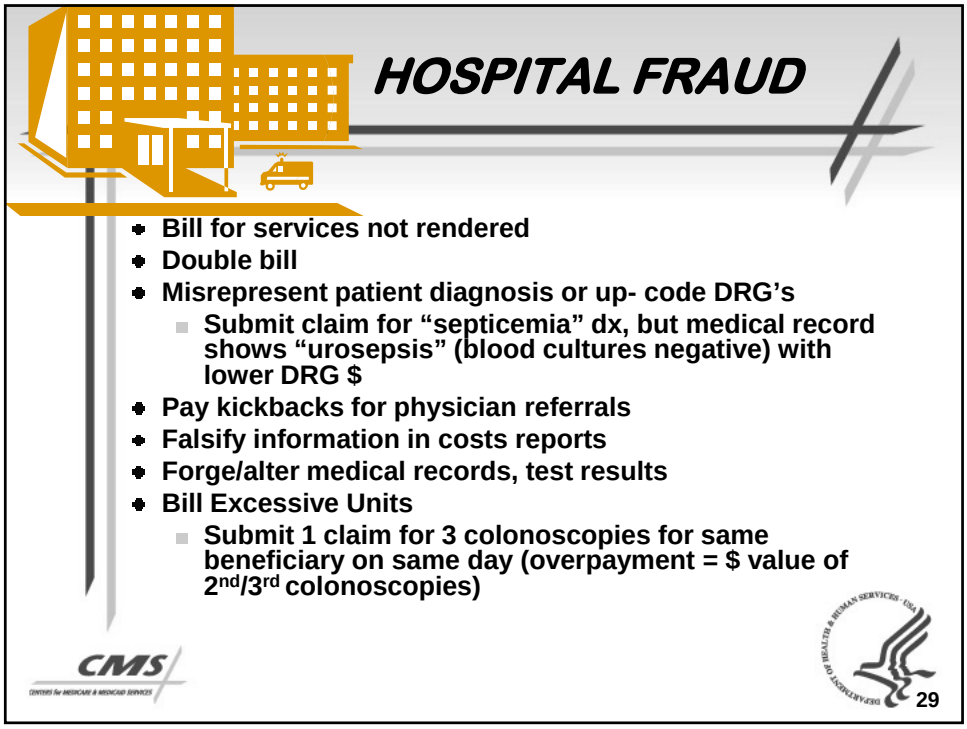
HOSPITAL FRAUD
Bill for services not rendered
Double bill
Misrepresent patient diagnosis or up- code DRG's
Submit claim for "septicemia" dx, but medical record shows "urosepsis" (blood cultures negative) with lower DRG $
Pay kickbacks for physician referrals
Falsify information in costs reports
Forge/alter medical records, test results
Bill Excessive Units
Submit 1 claim for 3 colonoscopies for same beneficiary on same day (overpayment = $ value of 2nd/3rd colonoscopies)
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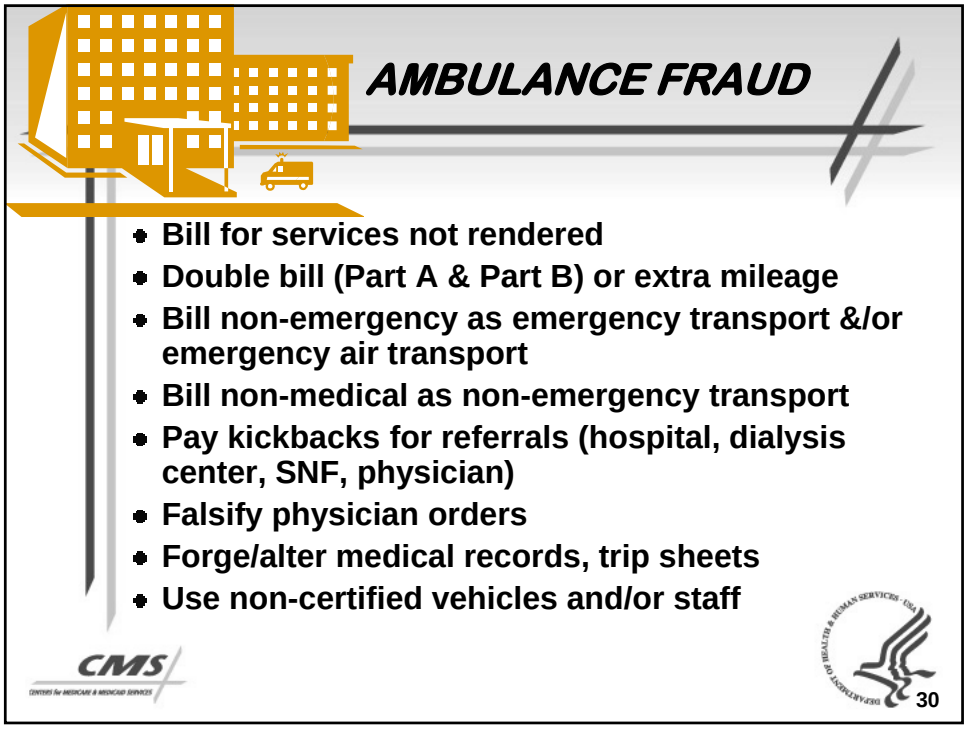
AMBULANCE FRAUD
Bill for services not rendered
Double bill (Part A & Part B) or extra mileage
Bill non-emergency as emergency transport &/or emergency air transport
Bill non-medical as non-emergency transport
Pay kickbacks for referrals (hospital, dialysis center, SNF, physician)
Falsify physician orders
Forge/alter medical records, trip sheets
Use non-certified vehicles and/or staff
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Home Health Fraud

- Admit *non-homebound* patients
- Coach diabetic patients to not self-inject &/or stop oral medication to qualify for daily/twice daily nursing visits to inject insulin for patients able to self-inject &/or with willing caregivers
- FL SHIFT *from* diabetes care *to* PT
- Bill unnecessary therapy visits; bill care without therapy order
- Up-code HIPPS codes
- Provide daily/twice daily aide visits (not reasonable & necessary)
- Bill for services not rendered
- Recruit patients (pay kickbacks - incentives of cash and aides)
- Use non-licensed staff

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Home Health ACA Sec. 6307

As amended by Sec. 10605

- Face-to-Face Encounter with patient is required before physicians may certify eligibility for HHA services or DME under Medicare
- The provision also allows Secretary to apply the face-to-face encounter requirement *to other items or services* for which payment is provided under Medicare, based upon a finding that such a decision would *reduce the risk of fraud, waste, or abuse.*

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Pharmacy (Part D) Fraud

- Pay kickbacks to physicians to prescribe unnecessary medications
- Up-code (bill name brand/give generic)
- Dispense, buy back drug & re-sell
- Bill for services not rendered (short count or fail to dispense)
- Buy prescriptions
- Recruit patients/pay *kickbacks*
- Divert drugs/buy *black* market, re-label/re-package, &/or sell expired stock

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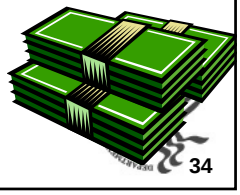
Beneficiary Fraud

- "Professional" patients
- Solicit kickbacks to participate in fraud
  - receive unnecessary service (surgery/tests)
  - accept free transport, sign logs for services not received
- Obtain physician orders for unnecessary diagnostic tests, drugs, treatments
- "Rent" use of Medicare ID # ("no show" patient)
- Re-sell drugs back to pharmacy after dispensing
- Recruit friends for "finder's fee"



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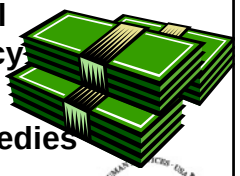
Beneficiary Fraud – ACA Sec 6402(a)

Administrative Remedy for Knowing Participation by Beneficiary in Health Care Fraud Scheme

- **Effective upon enactment, this provision requires Secretary to impose an administrative penalty on a Medicare, Medicaid, or CHIP-eligible individual, commensurate with the offense or conspiracy, for *knowing participation* by individual in a Federal health care fraud offense or conspiracy to commit such an offense.**
- **This is in addition to any existing remedies available to Secretary.**



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CMS Efforts to Reduce Medicare Improper Payments

- **Predictive Modeling & Data analysis to target highest risk providers/services**
- **New/clarified national/local coverage determinations & Provider Education**
- **Prepayment claim review**
  - **New edits (automated review)**
  - **Medical record review (complex review)**
- **Postpayment claim & medical record review**
- **Overpayment recoupment**
- ***Enhanced* Provider Enrollment & more frequent, *unannounced* site visits**
- **Revocation or Deactivation of Medicare billing privileges**
- **Suspension of Medicare payments**

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CMS Efforts to Reduce Medicare Fraud – Stop Pay & Chase

New CMS approach: **Stop the "pay & chase"**

- **Take administrative actions as early as possible**
- **"*Stop the bleeding*" - No longer "business as usual"**

- **New approach requires closer coordination /more frequent *substantive* communication between CMS & PSC/ZPIC and OIG and law enforcement regarding implementation of :**
  - **Payment Suspension**
  - **Prepay Edits**
  - **Postpay Review (request & review medical records, compute overpayment and issue demand letter)**

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CMS Efforts to Reduce Medicare Fraud – Stop Pay & Chase

- **New CMS predictive modeling contractor: Northrop Grumman is developing rapid predictive modeling methods to analyze "live" claims for payment before the bills are adjudicated**

- **CMS implemented final regs March 2011 based on ACA to suspend Medicare payments based on "credible allegations" of fraud**

- **On 6/16/11, CMS Administrator Dr. Donald Berwick said predictive modeling will be one factor that can lead regulators to withhold payments.**
  - **(Modern Healthcare 6/17/11)**

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Medical Identity Theft

- Medical identity theft is the **misuse of another individual's personal information to obtain or bill for medical goods or services.**
- Such theft creates both patient safety risks and financial burdens for those affected. **Use of compromised numbers can lead to erroneous entries in beneficiaries' medical histories and even the wrong medical treatment.**
- Medical identity theft not only **harms beneficiaries and providers,** it causes significant **financial losses for the Medicare Trust Funds and taxpayers**.

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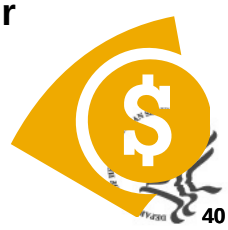
How Numbers Become Compromised

- Sometimes, Medicare numbers are stolen or used without the provider's or beneficiary's knowledge. This can happen through outright theft (e.g., "dumpster diving", purse snatching, etc.) - or theft by staff within a health care setting or insurance company with access to the numbers.
- **Other times, the provider and/or beneficiary is complicit in the scheme, receiving payment for use of their Medicare number.**



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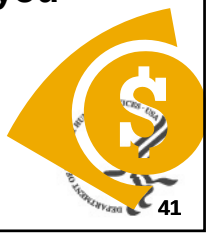
"Guard Your Card"*

- **40% of callers to our Medicare fraud hotlines (1-800-Medicare) have *already given out their number <u>before</u>* they call!**
- **If it sounds too good to be true, *it is!***
- **Just hang up on telemarketers pressuring you to get something you don't want or need**
- **There is no Medicare deadline: if you don't get it TODAY, you can still get it later when you need it**
- ***OIG NY experience is exact opposite: fraud victims don't want to give THEM their Medicare #s!***



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How Numbers Become Compromised

At the current time (Sept 2011), CMS is aware of about

5,126 compromised Medicare provider numbers,

169 compromised Medicare Part D provider numbers and

283,095 compromised Medicare beneficiary numbers.

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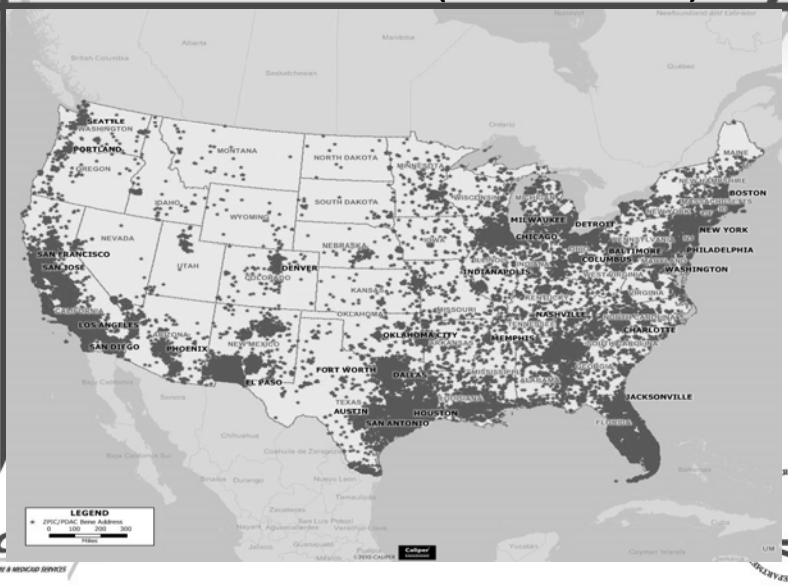
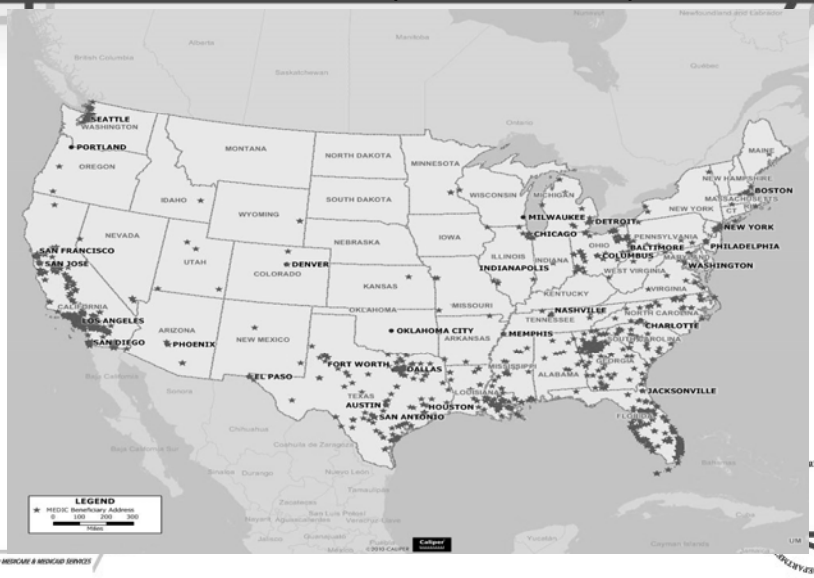
Map of Compromised Beneficiary Numbers
PSC / ZPIC / PDAC (Part B and DME)



Map of Compromised Beneficiary Numbers
MEDIC (Part C and D)



Distribution of PSC/ZPIC/PDAC/MEDIC (Part B, Part C and DME) Provider Addresses in the CNC Database - Sept 2011

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Distribution of MEDIC (Prescriber and Pharmacy) Addresses in the CNC Database - Sept 2011

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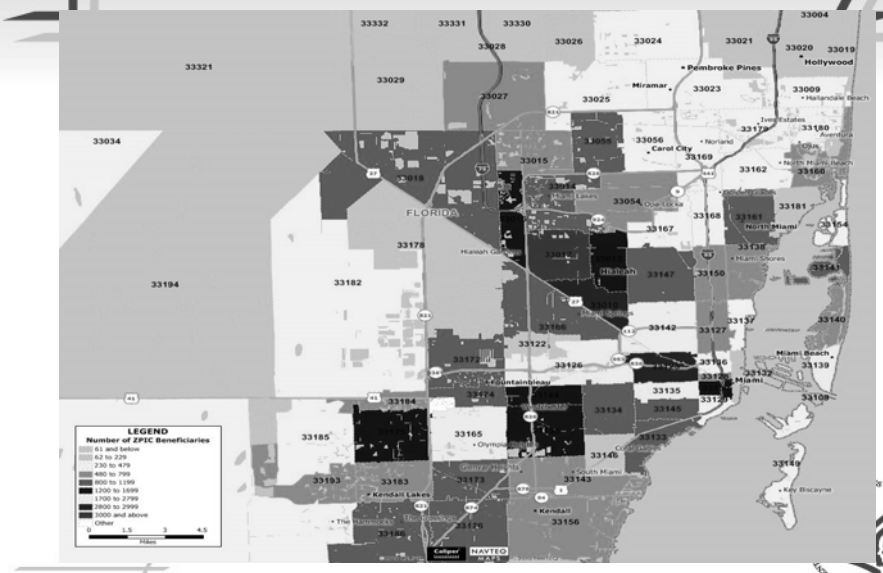
Florida (Hialeah/Miami area) by Zip Code PSC/ZPIC/PDAC (Part B and DME) Beneficiaries



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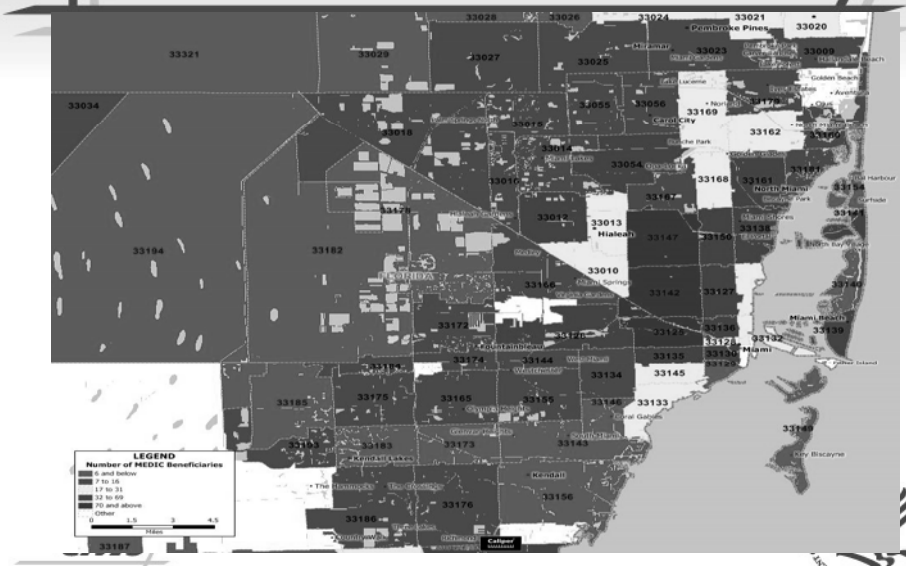
Florida (Hialeah/Miami area) by Zip Code MEDIC (Part C and D) Beneficiaries



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Zip Code Distribution of PSC/ZPIC/PDAC (Part B and DME) Beneficiaries from Puerto Rico

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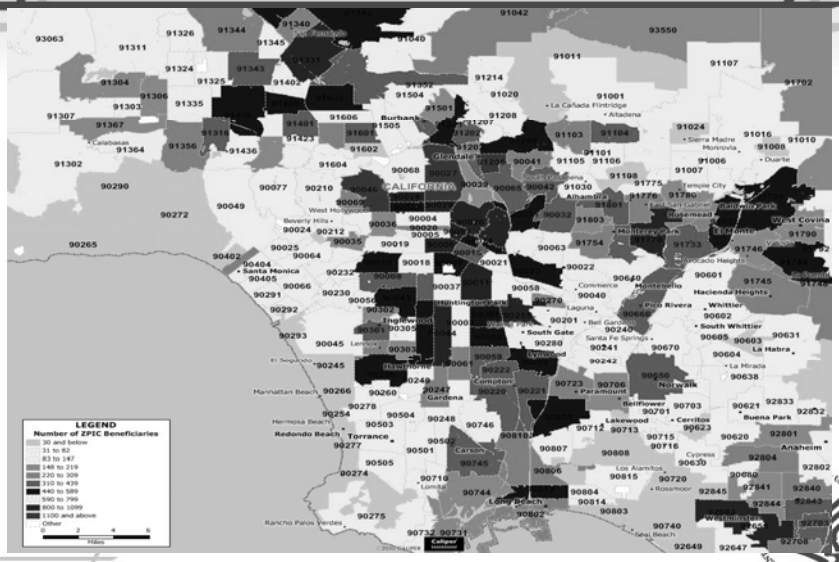
California (Los Angeles Area) (Part B and DME) by Zip Code



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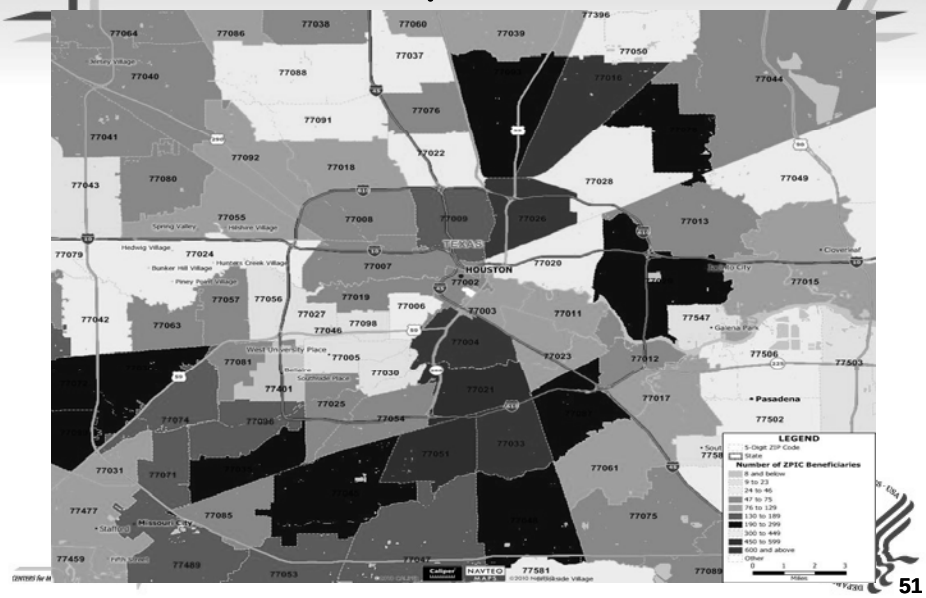
Texas (Houston Area) (Part B and DME) by Zip Code



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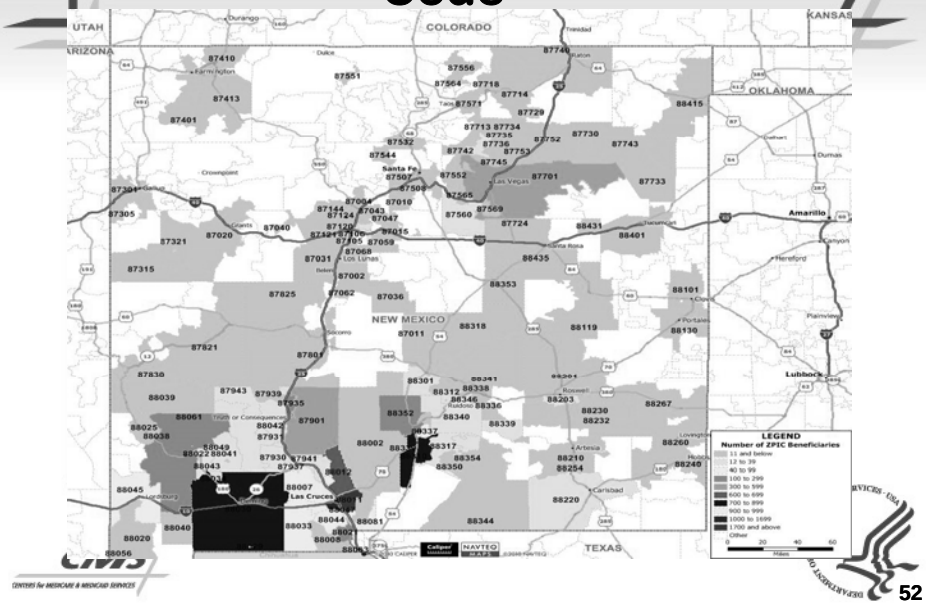
New Mexico (Part B and DME) by Zip Code



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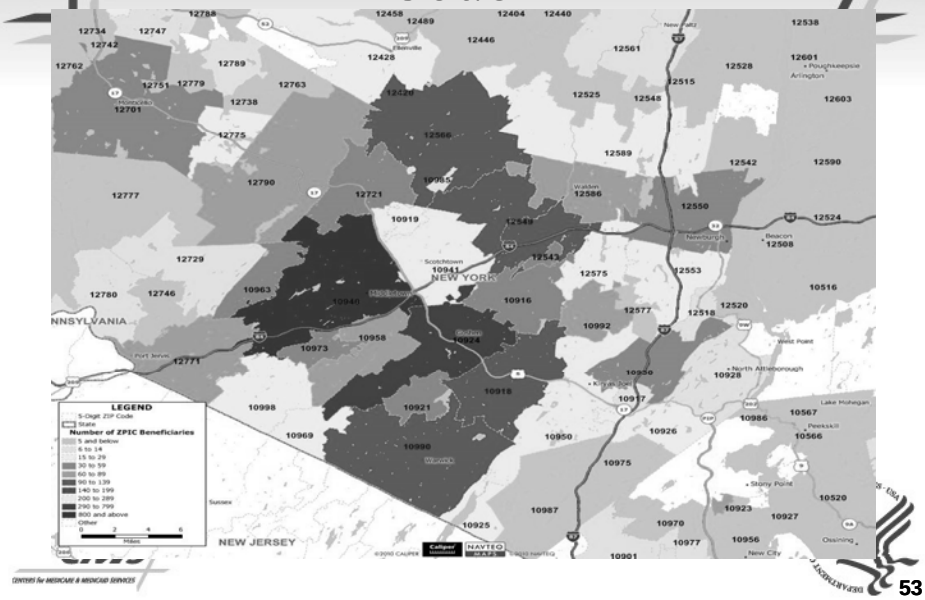
New York (Part B and DME) by Zip Code



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National Medicare *ID Theft* Case Arrests

- **October 13, 2010: OIG & FBI arrested 73 individuals in 5 states directly linked to 2,500 stolen NY Medicare HICNs**
- **DOJ indicted 73 in *NY (44), CA (10), OH (6), GA (6) & NM (7)* in the largest Medicare fraud scheme ever perpetrated by single criminal enterprise**

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National Medicare *ID Theft* Case Arrests

- CMS and its Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs) partnered with law enforcement: data analysis; payment suspension; enrollment revocation; requests for information to support investigation, indictment & prosecution;
- Organized crime enterprise throughout US & Armenia perpetrated large-scale, nationwide Medicare scam
- $163 M in fraudulent Medicare billing for unnecessary medical treatment in 118 false front clinics in 25 states
- May 20, 2011: Rafik Terdjanian pled guilty to 1 count conspiracy to commit bank fraud in SDNY
- Rafik assisted son Robert with managing bank accounts for $35 M Medicare fraud scheme (2006-2010)

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Demographic Characteristics of the CNC Database (Quarterly) 65% are Dual-Eligible

Gender/Race	Number of Beneficiaries
1 Male	**97,106**
1 White	51,374
2 Black	18,895
5 Hispanic	17,756
4 Asian	6,565
3 Other	2,199
6 North American Native	163
0 Unknown	154
2 Female	**124,531**
1 White	66,223
5 Hispanic	28,044
2 Black	17,554
4 Asian	9,640
3 Other	2,681
0 Unknown	220
6 North American Native	169
No Gender/Race	**32,846**
Grand Total	254,483

Medicare Status	Number of Beneficiaries
10 Aged without ESRD	179,072
20 Disabled without ESRD	38,143
No Status	32,846
21 Disabled with ESRD	2,078
11 Aged with ESRD	2,071
31 ESRD only	273
Grand Total	**254,483**

Coverage	Number of Beneficiaries
Part A	211,666
Part B	220,678
Part C	34,203

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CMS Efforts to Reduce Medicare Fraud

- **Field Offices (FOs): CMS established FOs in High Risk Areas (Miami, Los Angeles & New York)**
- **Medicare Program Safeguard Contractors (PSCs), Zone Program Integrity Contractors (ZPICs) & Medicare Part D Integrity Contractors (MEDICs)**
  - **perform proactive data analysis to ID vulnerabilities, investigate & refer potential fraud to OIG**
  - **perform audits & evaluations**
  - **assist law enforcement (respond to Requests for Information, perform data analysis)**
  - **lead Medi-Medi initiative - combined Medicare-Medicaid data analysis to identify/investigate potential fraud and abuse**
  - **Partner with federal & state law enforcement**
    - **HEAT Strike Forces**
    - **National & local health care fraud Task Forces**

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9 Medicare Strike Forces

- Since its inception in March **2007**, Medicare ***Fraud Strike Force*** operations in **9** locations have charged **>1,140 defendants** who collectively billed Medicare program **>$2.9 billion**.
- In addition, HHS' ***CMS***, working in conjunction with the HHS-OIG, is taking steps to increase accountability and decrease the presence of fraudulent providers.
- To learn more about the ***H*ealth Care Fraud Prevention and *E*nforcement *A*ction *T*eam (*HEAT*)**, go to: www.stopmedicarefraud.gov .

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Contact Information

Email: Jean.Stone@cms.hhs.gov

Telephone: (212) 616-2541

USEFUL WEBSITES:

www.cms.hhs.gov/medlearn
Notices, alerts, bulletins, on-line education
www.stopmedicarefraud.gov
Strike Force & HEAT & prosecution info, press releases, indictments by state

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SMP Volunteers

Who

What

Why

Where

When

Who - do we try and reach

- Medicare Beneficiaries
- Medicaid Beneficiaries
- Caregivers
- Pre-Medicare Individuals
- Disabled Individuals
- More vulnerable Individuals
- Medical Providers

What – do we tell these individuals

- PROTECT – your identity
- DETECT – errors, fraud and abuse
- REPORT – suspicious activity
- Current Activities and Scams

Why - we do this?

- Increase the understanding of the Medicare Program
- Increase the awareness of potential Fraud
- Identify potential fraud for further investigation

Where - do we do this

- •Senior Centers
- •Civic groups
- •Churches – senior groups
- •Veterans groups
- •55+ communities
- •Medical Provider organizations

When - do we do this

Every chance we get

Contact information

Barbara Dieker, AoA
Barbara.Dieker@aoa.hhs.gov
202-357-0139

Jean Stone, CMS
Jean.Stone@cms.hhs.gov
212-616-2541

John Morris
morrisjg@bellsouth.net
904-476-0063

QUESTIONS