

**2020 SMP/SHIP
National Conference**

July 21-23, 2020



FRAUD TRENDS PANEL

July 22, 2020

3:15 – 4:15 pm ET

Medicare Fraud: A Multiagency Perspective

Louis Saccoccio, CEO
National Health Care Anti-Fraud Association (NHCAA)

2020 Senior Medicare Patrol/State Health Assistance Programs National Conference
Virtual Meeting
July 22, 2020

Annual Health Care Expenditures*

U.S. National Health Expenditures were
\$3.6 trillion in 2018.

Equates to \$11,172 per person,
and accounted for 17.7% of the
Gross Domestic Product.

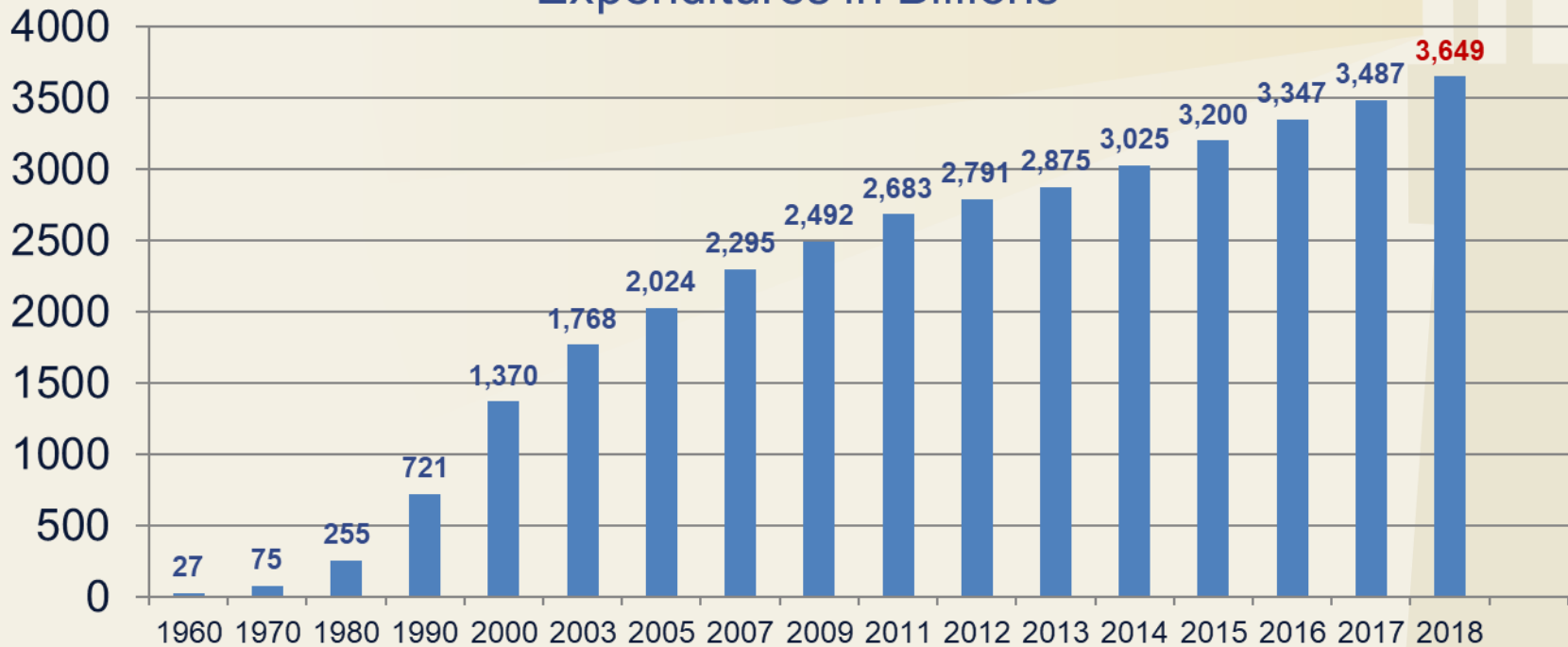
U.S. Population: 329.9 million>

*unless otherwise noted, data in presentation is from the Office of the Actuary at CMS

>United States Census Bureau, population estimate as of 6/29/2020

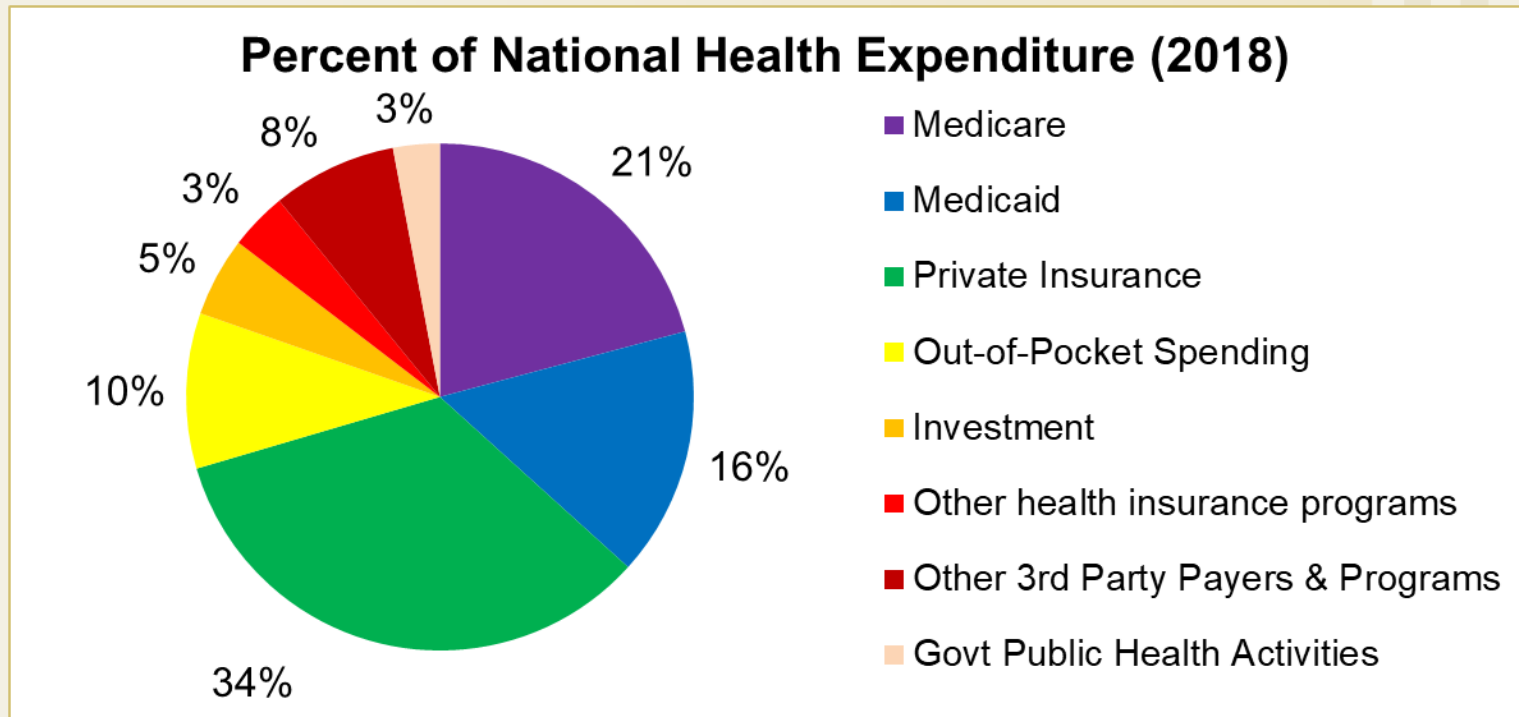
National Health Expenditures, 1960-2018

Expenditures in Billions



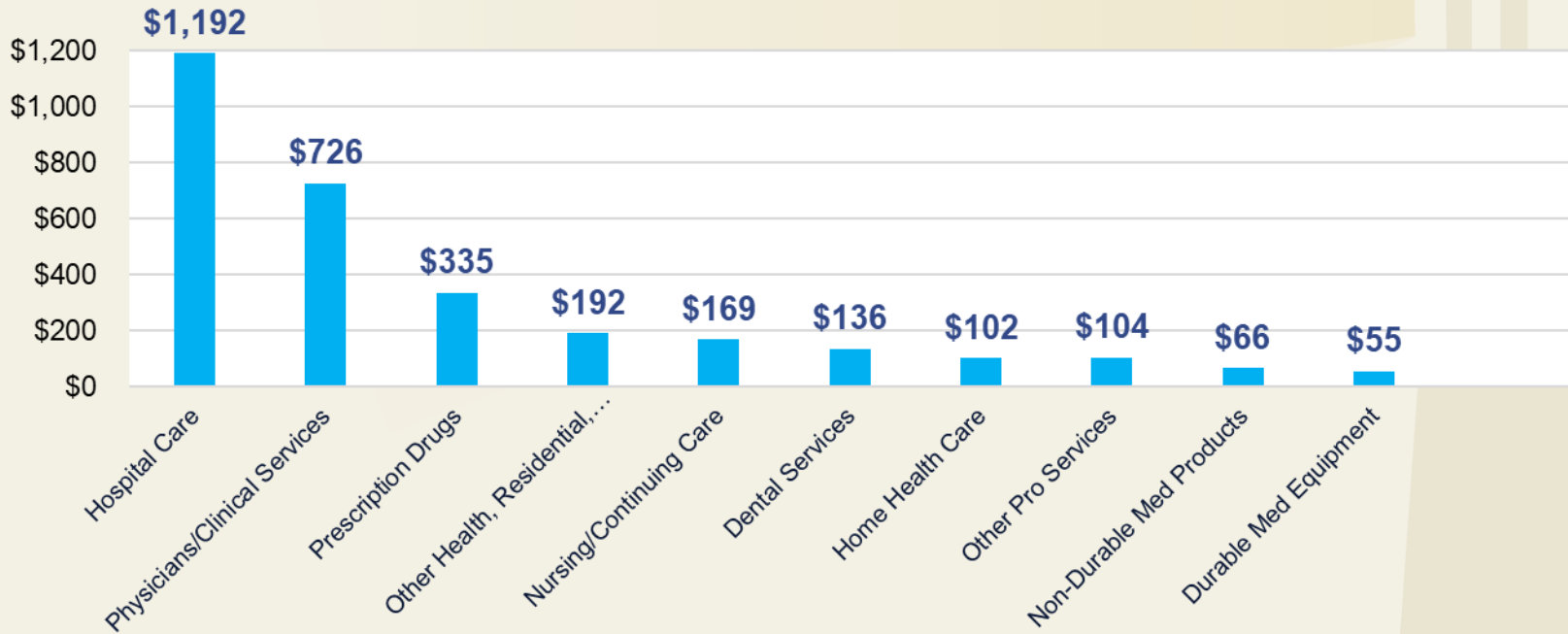
* National Health Expenditure Accounts (NHEA), Historical, Office of the Actuary, CMS

Annual Health Care Expenditures



Where is the Money Spent?

2018 National Health Care Expenditures in Billions of Dollars



Fraud in the System

- NHCAA estimates that the financial losses due to health care fraud are in the tens of billions of dollars each year. The most conservative estimate is 3% of total health care expenditures.

Fraud in the System

Other health care fraud estimates for the U.S.:

- An October 2019 JAMA study titled “Waste in the US Health Care System: Estimated Costs and Potential for Savings” finds that the annual cost of waste from fraud and abuse in Medicare alone is estimated between \$58.5B and \$83.9B.
- In a 2013 report titled “Best Care at Lower Cost: The Path to Continuously Learning Health Care in America,” the Institute of Medicine of the National Academies estimates health care fraud at \$75 billion a year.
- A study co-authored by a RAND Corporation analyst, Andrew D. Hackbarth and a former CMS administrator, Donald M. Berwick estimated that “fraud and abuse” represented between \$82 billion and \$272 billion in 2011 across the U.S. health care system and cost Medicare and Medicaid as much as \$98 billion in 2011.
- In May 2014, The Economist repeated Hackbarth and Berwick’s estimates in an article titled, “The \$272 billion swindle.”

Fraud in the System

Beyond the financial losses, health care fraud poses the real risk of patient harm.

- In October 2019, Johns Hopkins, Bloomberg School of Public Health published a study titled: “Association between treatment by Fraud and Abuse Perpetrators and Health Outcomes Among Medicare Beneficiaries”
- In summary, the study finds that providers that perpetrate fraud and abuse deliver measurably worse care that can harm patients.
- The study found that patients treated by providers that were later excluded from the Medicare program for fraud, patient harm or a revoked license were between 14% to 17% more likely to die than those who were treated by providers not committing fraud.
- The study shows that fraud and abuse contributed to 6,700 premature deaths in 2013.
- Study: <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2753426>

NHCAA MISSION

To protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud and abuse.



NHCAA

National Health Care Anti-Fraud Association®

- The National Health Care Anti-Fraud Association (NHCAA) was founded in 1985 as a private-public partnership against health care fraud and that theme remains central to what we do today, 35 years later.
- NHCAA is a national association with dues-paying, private-sector insurer members. We primarily serve health care fraud investigators and other employees of health insurance plans' Special Investigative Units (SIUs).
- We are also proud to have the active participation of representatives of many public-sector law enforcement and regulatory agencies, both state and federal, responsible for fighting health care fraud.



NHCAA

National Health Care Anti-Fraud Association®

NHCAA Members

- 98 Member Organizations (primarily health insurers)
- 190+ Law Enforcement Liaisons (law enforcement and regulatory agencies)
- 16 Supporting Members (industry solutions partners, vendors)
- 350+ Individual Members (primarily health care fraud investigators)



NHCAA

National Health Care Anti-Fraud Association®

- NHCAA is dedicated to providing trusted venues for facilitating information sharing, cooperation and partnership.
- NHCAA offers unparalleled education and training for health care fraud-fighting professionals.
- NHCAA recognizes and advances professional specialization in the detection, investigation and/or prosecution of health care fraud and abuse through accreditation of health care anti-fraud professionals.

NHCAA Fraud Briefs

An expanding library of summaries authored by experienced anti-fraud professionals that describe fraud schemes, often related to specific health care services. NHCAA Fraud Briefs offer fraud investigators and executive management a quick summary to gain a general understanding of a fraud issue. They are intended to be used as a reference or guideline for investigators seeking to conduct their own investigations.

NHCAA Fraud Briefs

As of June 2020, NHCAA has published 18 Fraud Briefs

ACA Enrollment Fraud	Home Health Services
Acupuncture	Intensive Outpatient Therapy
Applied Behavior Analysis	Intraoperative Neuromonitoring
Community-Based Behavioral Health Services	Pain Creams – Telemarketing
Dental Extractions	Personal Care Services
Durable Medical Equipment	Sober Homes
Elevated MME Prescribing	Telemarketing
Foot Baths	Telemedicine
Genetic Testing	Urine Drug Screens



HHS OIG HOTLINE OPERATIONS

July 2020

Nenette Day

Assistant Special Agent in Charge

Director of Hotline Operations

800-HHS-TIPS/TIPS.HHS.GOV





OIG Regions

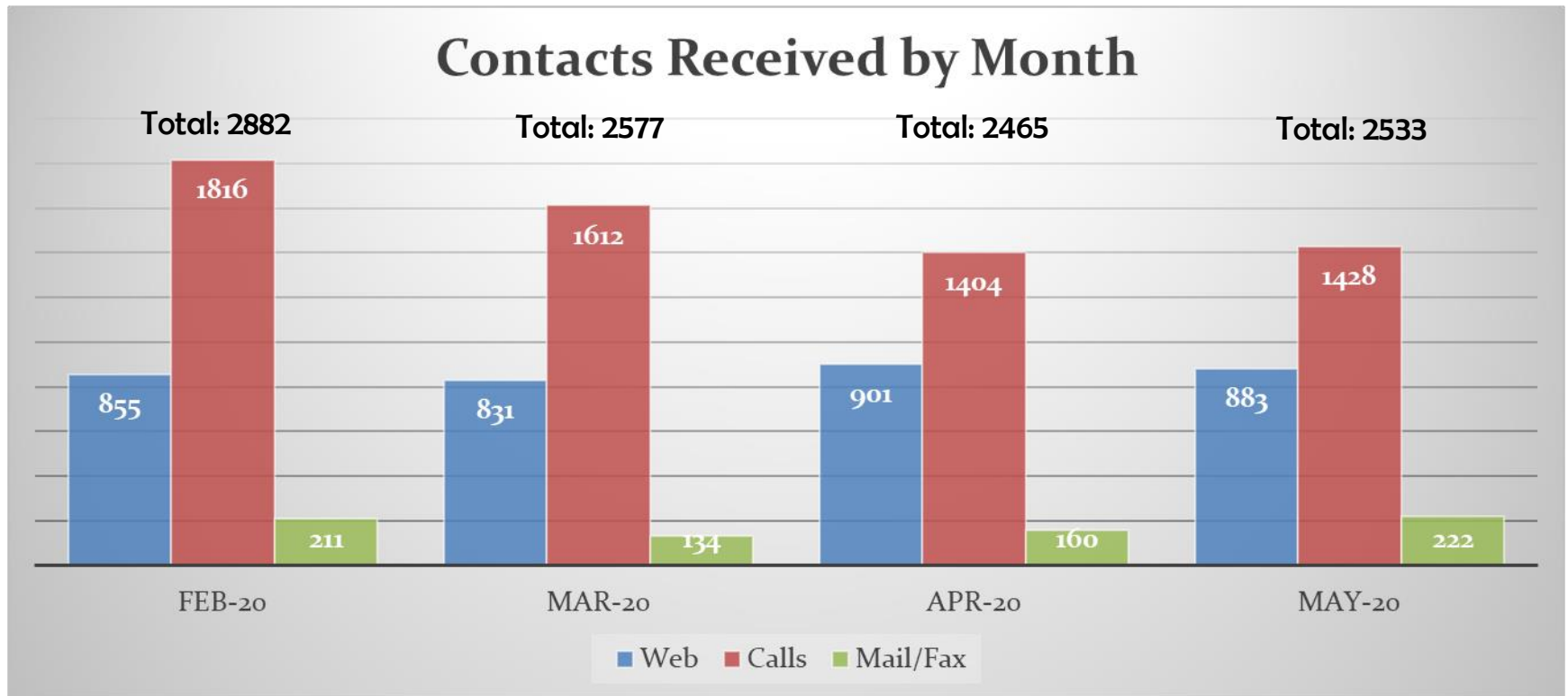


- OIG has approximately 500 Special Agents.
- Hotline Operations has approximately 30 Call Center employees and 5 Investigative Analysts.
- The Hotline accepts complaints via call center, website, fax and mail.
- OIG has 10 investigative Regions





Hotline Complaint Volume



➤ Every single tip is reviewed by an OIG employee.





Complaint Routing

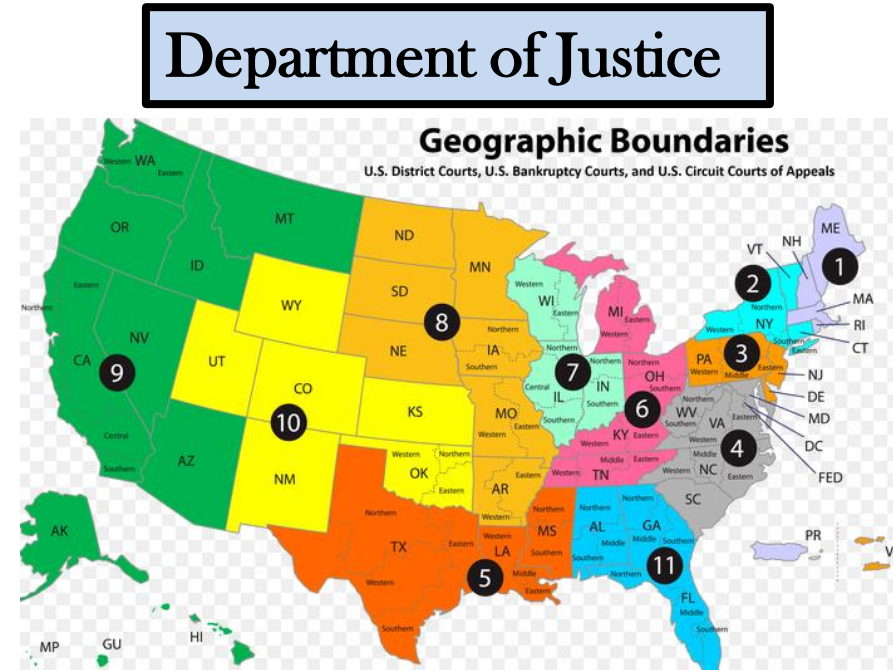
- Tier 1 receives a complaint and inputs it into our Case Management System
- Complaint is categorized
 - No Basis for Action
 - HHS OIG Interest
 - Other HHS Op/Div Interest
 - Other Federal/State Agency Interest
- Actionable complaints are then forwarded to an OIG Regional Office, HHS Operating Division or other Government agency
- If the Region declines, they can request the complaint be forwarded to an OpDiv or another government agency





Investigations

- Each Region makes the decision on which cases they will investigate. Some of the determining factors:
 - Availability of resources to investigate
 - Regional priorities/Significance of the damage/threat/potential public harm, etc
 - The likelihood of a successful DOJ prosecution
 - Are civil or administrative options available





Can you give us the status of an Investigation?

- With the volume of complaints we receive, it is simply not possible.
- And even if we could, we cannot confirm the existence of an investigation.
- The capacity to conduct covert investigations is critical.
- If necessary for the investigation, you will be contacted.





Hotline Innovations

- Branding HHS TIPS
- Improved referral process for Operating Divisions and SMP through our WebPortal
- New computer system being developed to manage complaints
- Intelligence products



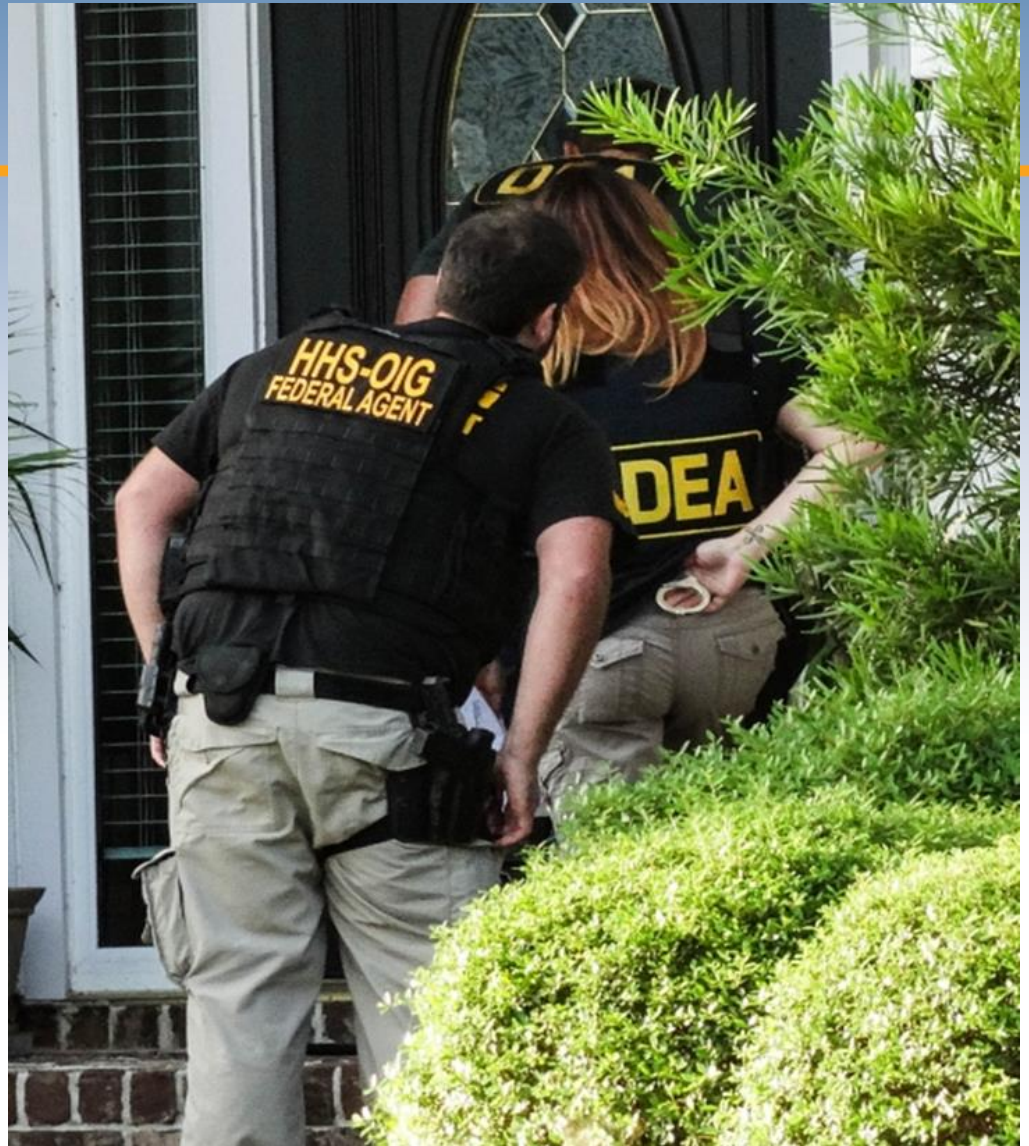


What Makes a Good Complaint

- Details, Details, Details
- Complete and accurate information
- If applicable, an impact statement
- Supporting documentation or witnesses
- Anonymous complaints are very problematic (ex. poison pen)
- Timely reporting



SMP HEALTH CARE FRAUD TRENDS



CASE CATEGORIZATION

Case Allegation



Medically Unnecessary Services



Upcoding and Overcharging



Misrepresentation



Billing For Services Not Rendered



Cyber Fraud (including Medical Identity Theft)

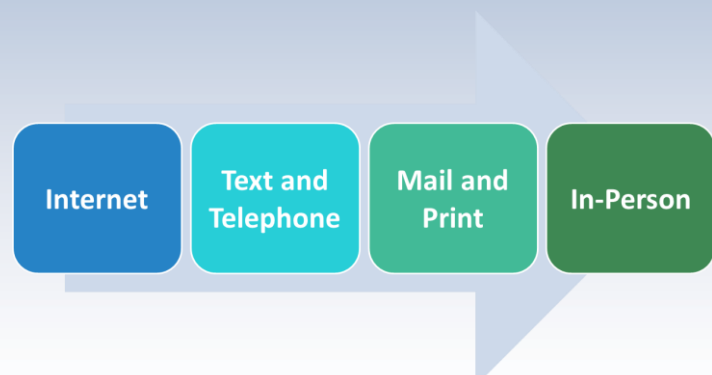


Kickbacks and Conspiracies



Patient Harm

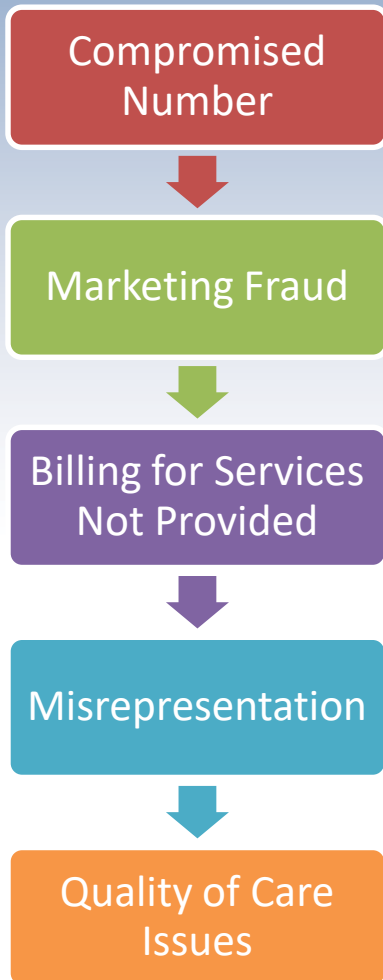
Method of Contact



Case Type



SMP ISSUES



SMP COMMON CASE TYPES

Medicare Part A and B

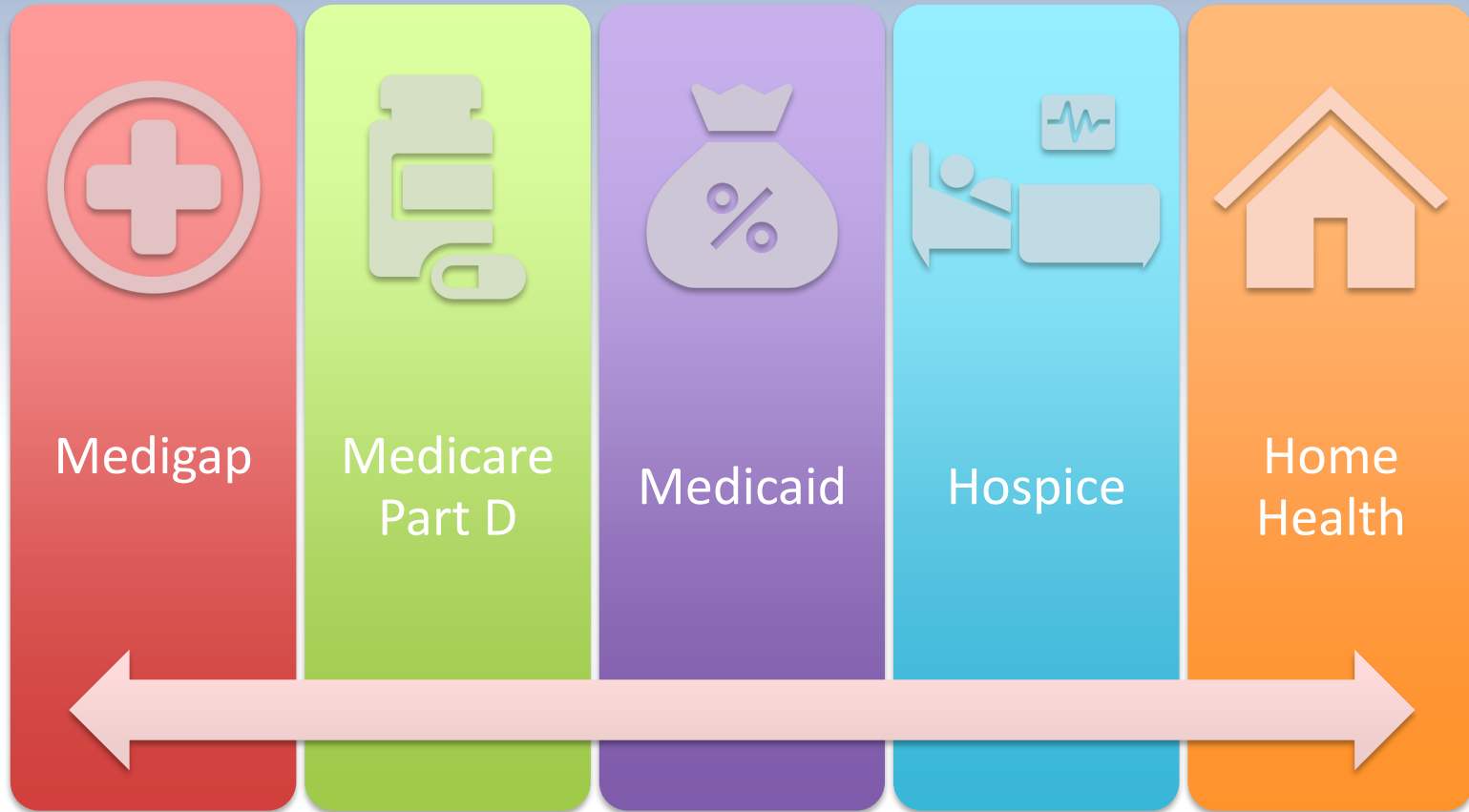
Medical Identity Theft

Genetic Testing

Durable Medical Equipment (DME)

Medicare Advantage

SMP CASE TYPES (cont'd)



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What are we seeing?

COVID-19

Health Care Fraud Challenges Posed by COVID-19

- This national emergency is demanding unprecedented amounts of health care resources. It has prompted enormous government spending along with relaxed regulations and oversight, expanded use of telehealth and the waiver of some copayments and patient obligations. COVID-19 has also created an atmosphere of fear and anxiety across the nation.
- In this unique environment, health care fraud (along with other types of fraud, such as cyber fraud) has become sadly prevalent as criminals seek to exploit weaknesses created as a result of this extraordinary event and our responses to it.

Health Care Fraud Challenges Posed by COVID-19

Some examples of COVID-19 health care fraud:

- Individuals and businesses selling fake cures, vaccines, tests and advice on unproven treatments for COVID-19.
- Labs marketing unapproved tests (COVID-19, antibody, etc.)
- Coding COVID-19 for other respiratory ailments.
- Medical providers obtaining patient information for COVID-19 testing and then using that information to fraudulently bill for other tests, procedures and equipment.
- Hoarding and price gouging schemes involving resources and equipment designated by HHS as “scarce” (respirator masks, ventilators, other PPE, etc.).
- Fake providers contacting people by phone and email to offer telehealth services or to demand payment for treatment provided to a friend or relative.



COVID19 Trends

- Telemarketing fraud calls are rampant
- Snake oil salesmen
- Contact Tracing fraud
- Fake testing sites
- HHS COVID19 Grant fraud
- Telehealth billing fraud
- Test bundling fraud



COVID-19: SMP Resource Center Perspective

- Telehealth (including add-on DME)
- Cyber Scams (including fake charities and investment opportunities)
- Criminal Enterprises/Medical Identity Theft
- Mental Health Services

A graphic with a dark background featuring a pattern of purple and blue virus-like particles. At the top, the text "SMP SCAM WATCH" is written in a bold, white, sans-serif font, with a small starburst icon to the left of "SMP". Below this, the word "CORONAVIRUS" is written in a larger, white, sans-serif font. In the lower-left corner, a white rectangular label with the word "Coronavirus:" is shown, held by a hand. To the right, a dark grey box contains white text and a bulleted list.

SMP SCAM WATCH
CORONAVIRUS

Be on the lookout for scams that could arise from the coronavirus (COVID-19) pandemic.

As a reminder:

- Protect your Medicare number and only provide it to your doctor and Medicare providers.
- Be cautious of anyone going door to door to offer free coronavirus testing, supplies, or treatments.
- Don't fall for scare tactics or time-sensitive offers.

Contact the SMP for questions or to report Medicare fraud, errors, or abuse at 877.808.2468 or at smpresource.org.

QUESTIONS?

