Presentation to
The Utah Health Care
Anti-Fraud Alliance

Louis Saccoccio, Executive Director
April 28, 2011

A General Look at
Health Care Fraud
The Reality

- In 2009, $2.5 trillion was spent on health care in the U.S.
- This translates to $8,086 per person or 17.6% of the nation’s Gross Domestic Product (GDP).

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

2009 Health Care Expenditures

*in Billions of Dollars*

<table>
<thead>
<tr>
<th>Category</th>
<th>Expenditure (in Billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Care</td>
<td>$759</td>
</tr>
<tr>
<td>Physicians/Clinical Care</td>
<td>$506</td>
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<tr>
<td>Prescription Drugs</td>
<td>$250</td>
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<td>Nursing/Continuing Care</td>
<td>$137</td>
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<tr>
<td>Dental Services</td>
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<tr>
<td>Home Health Care</td>
<td>$68</td>
</tr>
<tr>
<td>Other Professional Care</td>
<td>$67</td>
</tr>
<tr>
<td>Non-Durable Medical Care</td>
<td>$43</td>
</tr>
<tr>
<td>Durable Medical Care</td>
<td>$35</td>
</tr>
</tbody>
</table>
The Reality

- Consensus among NHCAA members estimates that 3% of health care expenditures are fraudulent.
- That means that in 2009, $75 billion was lost to fraud.
- This is a conservative estimate. Some government and law enforcement agencies place the loss as high as 10% of our annual health outlay.

Fraud Hurts Everyone

**Federal & state governments and private insurance companies**
$205 million lost per day, every day of the year (3% of $2.5 trillion annual health-care expenditures).

**Consumers**
Fraud contributes to rising health care premiums and higher taxes.

**Patients**
Subjected to bodily injury, violations of privacy, falsification of medical records. Fraud can erode aggregate benefits and limit future access to healthcare.

**Medical Professionals**
Medical professional dignity, credibility undermined for the vast majority of honest, ethical providers.
The Nature of Health Care Fraud

*Unique aspects of health care fraud:*

1. The vast majority of “claims” are submitted, not by the insured, but by medical care providers – hospitals, physicians, dentists, pharmacies, etc.

2. Detection of health care fraud often requires the application and knowledge of medical and clinical best practices and terminology and arcane coding systems – ICD-9 codes, CPT and CDT codes, DRGs, etc.

3. Government, both Federal and state, are major payors – Medicare, Medicaid, TRICARE – and therefore are very much involved in the fight against health care fraud.

4. Health care fraud isn’t just a financial crime. Patients can be put at risk for, or be a victim of, physical harm through unnecessary or dangerous procedures.

5. The sheer volume of health care and dental claims makes fraud detection a challenge. Those committing fraud have the full range of medical conditions, treatments and patients on which to base false claims.

6. The ability to spread false claims among many insurers (including Federal and state governments) simultaneously, increasing proceeds from fraud while lessening the chances of detection.
The Nature of Health Care Fraud

Unique aspects of health care fraud:
7. The challenges of HIPAA Privacy regulations.
8. The importance of health plan provider networks.
9. ERISA health benefit claims regulations.
10. State prompt pay laws.
11. Pending MLR definitions.

Trends Seen by NHCAA

- The geographic migration of schemes from one area of the country to another.
- Organized criminal groups committing large scale identity theft and utilizing empty store fronts/offices, P.O. Boxes, or UPS stores as addresses for claims.
- Provider Identity Theft
- Beneficiaries paid a fee for participating in fraud schemes.
- Claims submitted using CPT codes for procedures done in an office setting that if actually performed must be done in a hospital or outpatient clinic.
Trends Seen by NHCAA

- Fraud by specialists – e.g. an anesthesiologist selling prescriptions
- Billing services submitting fraudulent claims on behalf of foreign-based providers
- Recent areas of concern:
  - Durable Medical Equipment (DME)
  - Infusion Therapy
  - Home Health Care
  - Proliferation of Pain Management Clinics

Health Care Fraud & Abuse

*Most common general types of provider fraud:*

- Billing for services not rendered – either by using genuine patient information, sometimes obtained through identity theft, to fabricate entire claims or by padding claims with charges for procedures or services that did not take place.

- Billing for more expensive services or procedures than were actually provided or performed, commonly known as “upcoding” – i.e., falsely billing for a higher-priced treatment than was actually provided (which often requires the accompanying “inflation” of the patient’s diagnosis code to a more serious condition consistent with the false procedure code).
Health Care Fraud & Abuse

Most common general types of provider fraud, continued:

- Unbundling – billing each step of a procedure as if it were a separate procedure.
- Billing a patient more than the co-pay amount for services that were prepaid or paid in full by the benefit plan under the terms of a managed care contract.
- Accepting kickbacks for patient referrals.
- Waiving patient co-pays or deductibles and over-billing the insurance carrier or benefit plan.

Health Care Fraud & Abuse

Most common general types of provider fraud, continued:

- Performing unnecessary services solely for the purpose of generating insurance payments – seen very often in diagnostic-testing schemes.
- Billing for covered services, but actually performing cosmetic services.
- Falsifying a patient’s diagnosis to justify tests, surgeries or other procedures that aren’t medically necessary.
- Altering claim forms and medical or dental records.
- Routine waiver of a patient’s co-payment or deductible.
Current National Health Care Anti-Fraud Efforts

- National Health Care Fraud & Abuse Control Program (HCFAC)
- Health Care Fraud Prevention & Enforcement Action Team (HEAT)
- National Health Care Fraud Prevention Summits
- Health Care Reform – Affordable Care Act (ACA) and other Federal Activity
- 2011 Congressional Activity

National Health Care Fraud & Abuse Control Program (HCFAC)

- The HIPAA Act of 1996 established a national Health Care Fraud & Abuse Control Program under the joint direction of the Attorney General and the Secretary of the Department of Health & Human Services to be “a far-reaching program to combat fraud and abuse in health care, including both public and private health plans.”

- Acting through the HHS-OIG, HCFAC is designed to coordinate Federal, state and local law enforcement activities with respect to health care fraud and abuse.

- In its 14th year, the success of HCFAC confirms the benefits of a collaborative approach to identify and prosecute health care fraud, to prevent future fraud or abuse, and to protect program beneficiaries.

- The HCFAC account has returned over $18 billion to the Medicare Trust Fund since the inception of the Program in 1997.
Health Care Fraud & Abuse Control Program – FY2010 Allocations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Mandatory Allocation</th>
<th>Discretionary Allocation</th>
<th>Total Allocation</th>
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<tr>
<td>Dept of HHS</td>
<td>$211,097,043</td>
<td>$281,210,000</td>
<td>$492,307,043</td>
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<tr>
<td>Dept of Justice</td>
<td>$55,328,139</td>
<td>$29,790,000</td>
<td>$85,118,139</td>
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<tr>
<td>Grand Total</td>
<td>$266,425,182</td>
<td>$311,000,000</td>
<td>$577,425,182</td>
</tr>
</tbody>
</table>

HCFAC – Fiscal Year 2010 Report

- HCFAC Report for Fiscal Year 2010 released January 24, 2011
- 2010 Report along with FY reports since 1998 are available at oig.hhs.gov/publications/hcfac.asp
- HHS Secretary Kathleen Sebelius stated that FY 2010 was the “most successful year ever” for federal fraud fighting efforts.
- In FY 2010, more than $4 billion stolen from federal health care programs was recovered and returned to the Medicare Health Insurance Trust Fund, the Treasury, and others.
HCFAC – Fiscal Year 2010 Report

- The federal government won or negotiated approximately $2.5 billion in health care fraud judgments and settlements.
- The Medicare Trust Fund received transfers of approximately $2.86 billion.
- The Department of Justice (DOJ) opened 1,116 new criminal health care fraud investigations involving 2,095 potential defendants.
- Federal prosecutors had 1,787 health care fraud criminal investigations pending, involving 2,977 potential defendants, and filed criminal charges in 488 cases involving 931 defendants.

HCFAC – Fiscal Year 2010 Report

- A total of 726 defendants were convicted for health care fraud–related crimes during the year.
- DOJ opened 942 new civil health care fraud investigations and had 1,290 civil health care fraud matters pending at the end of the fiscal year.
- HHS–OIG excluded 3,340 individuals and entities from Medicare, Medicaid, and other Federal health care programs:
  - 894 for criminal convictions for crimes related to Medicare and Medicaid
  - 263 excluded based on other health care programs
  - 247 for patient abuse or neglect
  - 1,582 as a result of licensure revocations
Established in May 2009

Inter-agency effort between the Department of Justice (DOJ) and Department of Health & Human Services (HHS)

HEAT is a cabinet-level commitment to prevent and prosecute Medicare fraud.
Health Care Fraud Prevention & Enforcement Action Team (HEAT)

“With this announcement, we raise the stakes on health care fraud by launching a new effort with increased tools, resources and a sustained focus by senior-level leadership.”

“...we are turning up the heat on perpetrators who steal from the taxpayers and threaten the future of Medicare and Medicaid.”

The HEAT program adopted and has expanded the Medicare Fraud Strike Force model launched in 2007.

Medicare Fraud Strike Forces are inter-agency teams of federal, state and local investigators designed to combat Medicare fraud through the use of Medicare data analysis techniques and an increased focus on community policing.
Health Care Fraud Prevention & Enforcement Action Team (HEAT)

- Strike Force teams are established based on geographical location.
- Each Strike Force team is led by a federal prosecutor from the respective U.S. Attorney’s Office or the Criminal Division’s Fraud Section.

HEAT – Current Strike Force Areas

1. Miami Dade County
2. Los Angeles
3. Detroit Metro
4. Houston Metro
5. Brooklyn, NY
6. Baton Rouge, Louisiana
7. Tampa, Florida
8. Dallas, Texas
9. Chicago
National Health Care Anti-Fraud Efforts

National Summit on Health Care Fraud

Held January 28, 2010 in Washington, D.C.

Hosted by:

- U.S. Department of Health & Human Services (HHS) – Secretary Kathleen Sebelius
- U.S. Attorney General Eric Holder
National Summit on Health Care Fraud

Summit purpose:

- To bring together leaders from the public and private sectors to identify and discuss innovative ways to eliminate fraud, waste and abuse in the U.S. health care system.

- The Summit is part of the Obama Administration’s coordinated effort to fight health care fraud under the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative.

National Summit on Health Care Fraud

Breakout Session Themes

*Three major themes were common to the discussion in each of the workgroups:*

- Technology must play a key role in fighting fraud:
  - consolidation of data where possible
  - consolidation of all public and private claims data is probably impractical, but the government can do a better job consolidating and analyzing its own data
  - better sharing of data between Medicare and Medicaid
National Summit on Health Care Fraud

Breakout Session Themes, continued

- Information sharing, such as that sponsored by NHCAA, is critical to the success of the fight against fraud
  - Better information sharing by the public and private sectors
  - Better information sharing at the federal and state levels
  - Re-examine and remove where possible the legal obstacles to effective information sharing by the public sector with the private sector and to effective data analysis

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National Summit on Health Care Fraud

Breakout Session Themes, continued

- The public needs to be made more aware of the problem of fraud
  - Better and clearer benefit explanation notices
  - A national education campaign
Regional Health Care Fraud Prevention Summits

Focus on provider and beneficiary education regarding Medicare fraud

Regional Summits:
- Miami (July 16, 2010)
- Los Angeles (August 26, 2010)
- New York (November 5, 2010)
- Boston (December 16, 2010)
- Detroit (March 15, 2011)
- Philadelphia (TBD)
- Las Vegas (TBD)

February 3, 2011: Office of Inspector General of the Department of Health & Human Services launched its Most Wanted Fugitives List

The ten individuals on the “Most Wanted Health Care Fugitives List” have allegedly cost taxpayers more than $124 million in fraud.

http://oig.hhs.gov/fugitives

Most Wanted List Hotline: 1–888–476–4453
HHS–OIG is offering free half-day Compliance Training Sessions for local health care providers, compliance professionals and their legal counsel in:

- Houston (Feb 16)
- Tampa (March 2)
- Kansas City (March 23)
- Baton Rouge (April 12)
- Denver (May 3)
- Washington, D.C. (May 18)

The May 18 training in Washington, D.C. will be offered as a Webcast to accommodate interest.

http://compliance.oig.hhs.gov

Focus: The realities of health care fraud and the importance of implementing an effective compliance program.

This compliance training dovetails with a requirement in the ACA that providers and suppliers adopt compliance plans.

Registration for all six programs was closed as of Feb 8, due to extremely high interest.
National Health Care Anti-Fraud Efforts

Health Care Reform and the 112th Congress

Health Care Reform

March 23, 2010, signed into law
H.R. 3590 – The Patient Protection & Affordable Care Act

March 30, 2010, signed into law
H.R. 4872 – Health Care and Education Reconciliation Act of 2010

Collectively known as the: Affordable Care Act (ACA)
Health Care Reform

H.R. 3590 – The Patient Protection & Affordable Care Act

- Section 6401 – Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP.
  - Opportunity for additional and enhanced screening of providers who participate in Medicare and Medicaid.
  - Directs the HHS Secretary to determine by regulation the “level of Screening” for provider enrollment “according to the risk of fraud, waste, and abuse,...with respect to the category of provider of medical or other items or services or supplier.”
  - Authorizes the Secretary to impose additional burdens where there are more significant fraud concerns.
  - Creates additional requirements related to ongoing licensing and oversight of newly enrolled providers, for both Medicare and Medicaid.

- Authorizes the Secretary to impose a temporary moratorium on the enrollment of new providers of services and suppliers under Medicare, Medicaid and CHIP when necessary to prevent or combat fraud, waste or abuse.

- Mandates providers and suppliers to establish compliance programs as a condition for enrollment in the Medicare, Medicaid and CHIP programs and directs the HHS Secretary to develop the “core elements” for such a compliance program.
Health Care Reform

H.R. 3590 – The Patient Protection & Affordable Care Act
- Section 6402(h) – Suspension of Medicare and Medicaid Payments Pending Investigation of Credible Allegations of Fraud.
  - Authorizes the Secretary to suspend payments to a provider of services or supplier pending investigation of a credible allegation of fraud (unless the Secretary determines there is good cause not to suspend payments).
  - Directs the Secretary to work with the HHS Inspector General in determining whether a “credible allegation” exists.
  - Directs the Secretary to promulgate regulations.

Rulemaking process for Sections 6401 and 6402
- September 23, 2010 – Proposed Rule Published
- November 16, 2010 – Comments Due – NHCAA commented
- February 2, 2011 – Final Rule Published
- Title:
  “Medicare, Medicaid, and Children’s Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers”
Provider Screening Rules

- Establishes the procedures under which screening is conducted for providers of medical or other services and suppliers in the Medicare program, providers in the Medicaid program, and providers in CHIP.
- Effective Date: March 25, 2011

- Designated categories of providers or suppliers that are subject to screening procedures based on assessment of the level of screening based on the risk presented by the category of provider.
- Three levels of screening and associated risk:
  - Limited
  - Moderate
  - High
- Each provider/supplier category is assigned to one of these three screening levels
**Health Care Reform**

### Final Level of Required Screening for Medicare Physicians, Non-Physician Practitioners, Providers, and Suppliers

<table>
<thead>
<tr>
<th>Type of screening required</th>
<th>Limited</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verification of any provider/supplier-specific requirements</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Conduct license verifications (may include licensure checks across States)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Database Checks (SSN, NPI, NPDB licensure, an OIG exclusion; Tax ID, tax delinquency; death)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Unscheduled or Unannounced Site Visits</td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Fingerprint-Based Criminal History Record Check of law enforcement repositories*</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

*This category merges “fingerprinting” and “criminal background checks,” which were listed as separate categories under the proposed rules.

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**Health Care Reform**

### Final Medicare Providers & Suppliers Categories: “Limited” Risk

- Physician or non-physician practitioners and medical groups or clinics, with the exception of physical therapists and physical therapist groups.
- Ambulatory surgical centers, competitive acquisition program/Part B vendors, end-stage renal disease facilities, Federally qualified health centers, histocompatibility laboratories, hospitals, including critical access hospitals, Indian Health Service facilities, mammography screening centers, mass immunization roster billers, organ procurement organizations, pharmacies newly enrolling or revalidating via the CMS-855B, radiation therapy centers, religious non-medical health care institutions, rural health clinics, and skilled nursing facilities.
Health Care Reform

Final Medicare Providers & Suppliers Categories: “Moderate” Risk

- Ambulance suppliers; community mental health centers; comprehensive outpatient rehabilitation facilities; hospice organizations; independent diagnostic testing facilities; independent clinical laboratories; physical therapy including physical therapy groups and portable x-ray suppliers.
- Currently enrolled (revalidating) home health agencies.
- Currently enrolled (revalidating) DMEPOS suppliers.

Health Care Reform

Final Medicare Providers & Suppliers Categories: “High” Risk

- Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of DMEPOS.
Health Care Reform

Suspension of Medicare and Medicaid Payments Pending Investigation of Credible Allegations of Fraud – Rules

“Credible Allegation of Fraud” defined for Medicare & Medicaid

Credible Allegation of Fraud

Medicare:

A credible allegation of fraud is an allegation from any source, including but not limited to the following:

(1) Fraud hotline complaints.
(2) Claims data mining.
(3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have indicia of reliability.
Credible Allegation of Fraud

Medicaid:

A credible allegation of fraud may be an allegation, which has been verified by the State, from any source, including but not limited to the following:
(1) Fraud hotline complaints.
(2) Claims data mining.
(3) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

Suspension of Payments – Rules

Medicare:

- In cases of suspected fraud, payments may be suspended “in whole or in part” by CMS or a Medicare contractor if they have consulted with HHS–OIG (and the DOJ as appropriate) and determined that a “credible allegation of fraud” exists.
- Explains what a “good cause exception” would be, whereby the Secretary would not suspend payments.
- Every 180 days after the initiation of a suspension of payments, CMS will evaluate whether there is good cause to continue the suspension and request certification from the investigating agency that a continued suspension is warranted.
Medicare:

A payment suspension that has been in place for 18 months with no resolution of the investigation constitutes good cause not to continue to suspend payments, except

CMS may extend the suspension beyond 18 months:

1) If the case has been referred to HHS-OIG for administrative action, or

2) The DOJ submits a request to CMS that the suspension continues based on an ongoing investigation and anticipated court filings.

Medicaid:

- Requires the State Medicaid agency to suspend all Medicaid payments to a provider after it determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.

- The Medicaid agency is not required to notify the provider before suspending payments (but is required to notify).

- A provider may request and must be granted administrative review of the suspension.
**Suspension of Payments – Rules**

**Medicaid:**

Medicaid payment suspensions based on a “credible allegation of fraud” will be “temporary” and will cease:

- When the agency determines there is insufficient evidence of fraud,
- Legal proceedings related to the alleged fraud are completed.

When a State Medicaid Agency suspends payment to a provider the agency is required to make a fraud referral to other state Medicaid Fraud Control Units (or appropriate law enforcement agency).

**Health Care Reform**

**Temporary Moratorium on Provider Enrollment, Rule**

- HHS may impose a temporary moratorium (6 months) on provider enrollment in situations where:
  - CMS identifies a trend that appears to be associated with a high risk of fraud, waste or abuse;
  - A state has imposed a moratorium on enrollment in a particular geographic area or on a particular provider of supplier type or both; or
  - CMS identifies a particular provider or supplier type and/or a particular geographic area as having a significant potential for fraud, waste or abuse.
Health Care Reform

Compliance Program Requirements, Rule

- Comments were accepted regarding the requirement in Section 6401 of the ACA that providers and suppliers establish compliance programs as a condition for enrollment in Medicare, Medicaid and CHIP.

- Rule excerpt: "We do not intend to finalize compliance plan requirements in this final rule with comment period; rather, we intend to do further rulemaking on compliance plan requirements and will advance specific proposals at some point in the future."

- ACA directs the HHS Secretary to develop the “core elements” of the compliance program. The Rule indicates that the Secretary will consider “the use of the seven elements of an effective compliance and ethics program as described in Chapter 8 of the U.S. Federal Sentencing Guidelines Manual as the basis for the core elements of the required compliance programs for Medicare, Medicaid and CHIP enrollment."

Health Care Reform

H.R. 3590 – The Patient Protection & Affordable Care Act

- Section 6402(a) – Expanded Data Matching

  Mandates an expanded “Integrated Data Repository” at CMS that will incorporate data from all federal health care programs:

  - Medicare (Parts A, B, C & D)
  - Medicaid
  - CHIP
  - Health–related programs administered by the Secretary of Veterans Affairs.
  - Health–related programs administered by the Secretary of Defense.
  - Federal old-age, survivors, and disability insurance benefits established under Title II.
  - The Indian Health Service and the Contract Health Service program
Health Care Reform

H.R. 3590 – The Patient Protection & Affordable Care Act

- Section 6402(a) – Expanded Data Matching

  - Inclusion of Medicare data into the Integrated Data Repository “shall be a priority.”
  - Data from the other Federal programs shall be included “as appropriate.”
  - Appears to be an “all claims” database that is limited to government programs.
  - Purpose: conducting law enforcement and oversight activities to the extent consistent with applicable information, privacy, security, and disclosure laws.

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Health Care Reform

H.R. 3590 – The Patient Protection & Affordable Care Act

- Section 6402(a) – Return of Overpayments

  - Providers and insurers participating in Federal health care programs have a legal obligation to return overpayments from Medicare and Medicaid.
  - This is consistent with the new False Claims Act amendments, where a failure to return an overpayment in light of a legal obligation constitutes a “false claim.”
Health Care Reform

H.R. 3590 – The Patient Protection & Affordable Care Act

- Section 6402(a) – Beneficiary Involvement in Fraud Schemes
  - Dictates that the HHS Secretary impose an “appropriate” administrative penalty where “an individual has knowingly participated in a Federal health care fraud offense or conspiracy.”

- Section 6404 – Maximum Period of Submission of Medicare Claims
  - Reduces the available submission period for Medicare claims to 12 months from the previous standard of 36 months.
  - This new requirement applies to services furnished on or after January 1, 2010.
Health Care Reform

H.R. 3590 – The Patient Protection & Affordable Care Act

- Section 6501 et seq – Medicaid Integrity Program
  - Makes several changes to the Medicaid Integrity Program
    - New provisions regarding exclusions from Medicaid
    - Terminate participation under Medicaid if terminated under Medicare or other state plan.
    - Exclude from participation if the individual or entity owns, controls or manages an entity that has unpaid overpayments, is suspended or terminated from participation or is affiliated with an individual or entity that is suspended or terminated from participation.

- Other examples of changes to the Medicaid Integrity Program
  - New provisions regarding data reporting
  - Prohibition on payments to certain entities outside of the U.S.
  - An extended period for the collection of fraud-related overpayments
Health Care Reform

H.R. 3590 – The Patient Protection & Affordable Care Act

- Section 10606 – Additional Criminal Sentencing Provisions
  - Instructs the U.S. Sentencing Commission to review the sentencing guidelines for criminal convictions related to health care fraud offenses and review the relevant policy statements and ensure that the Federal Sentencing Guidelines and policy statements:
    1. reflect the serious harms associated with health care fraud and the need for aggressive and appropriate law enforcement action to prevent such fraud; and
    2. provide increased penalties for persons convicted of health care fraud offenses in appropriate circumstances.
  - We await proposed amendments to sentencing guidelines from the Commission.

- Section 6402(i) – Increased Funding to Fight F&A
  - Provides for significant additional funding for the overall anti-fraud effort.
  - Adds $10 million to the Health Care Fraud & Abuse Control Account for each year from 2011–2020.
  - Significant additional funding is provided for in the reconciliation bill (see next slide).
  - “Indexing” increases in appropriations to individual agencies for their anti-fraud efforts.
Health Care Reform

H.R. 4872 – Reconciliation Bill
Additional Funding for Anti-Fraud Efforts

- In addition to the increase in anti-fraud funding under HR 3590, the reconciliation bill provides for the following additional amounts:
  - $95 million for 2011
  - $55 million for 2012
  - $30 million for each of fiscal years 2013–2014
  - $20 million for each of fiscal years 2015–2016

Medical Loss Ratio (MLR) Requirement Rule

- Based on Section 2718 of the Patient Protection & Affordable Care Act: "Bringing Down the Cost of Health Care Coverage" which requires large group market insurers to expend at least 85% of annual premium revenue on a combination of reimbursement for medical services and for activities that improve health care quality (for the individual and small group market the percentage is 80%).

- On December 1, 2010, HHS issued an “Interim Final Rule.”

- NHCAA submitted several comment letters throughout the rule-making process arguing that health care anti-fraud activities are activities that improve health care quality.
Health Care Reform

Medical Loss Ratio (MLR) Requirement Rule

- The MLR interim final rule excludes anti-fraud efforts in the definition developed for “Improving Health Care Quality Expenses.”
- It only allows a very limited recognition that the lesser of recoveries or recovery expenses could be counted against fraud claims expenses.
- The rule is careful not to categorize this recognition as a quality-improving activity (any perceived link between fraud recoveries and quality improvement was stripped by a Dec. 30 “corrections” document).
- Otherwise, all other anti-fraud expenses are reported as cost containment.

H.R. 5297: Small Business Jobs and Credit Act of 2010

- Signed into law, September 27, 2010
- Establishes predictive analytics technologies requirements for the Medicare fee-for-service program
- Directs the HHS Secretary to use “predictive modeling and other analytics technologies” to identify improper claims for reimbursement and to prevent the payment of such claims under the Medicare fee-for-service program.
H.R. 5297: Small Business Jobs and Credit Act of 2010

- Details a four year implementation process.
- Addresses contractor selection, qualifications and data access requirements.
- Describes the “request for proposal” process (note: CMS posted a notice under the CPI Industry Day of its intent to solicit proposals)
- Appropriates $100 million (not more than 5% shall be reserved for the purpose of conducting a required independent evaluation)
- At a March 30 Senate committee budget hearing, Secretary Sebelius indicated that implementation was moving more slowly than hoped.

112th Congress Shows Interest in Health Care Fraud

Several Congressional hearings have been held in 2011 on HCF:

- February 15: Senate Appropriations Committee, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, “Fighting Fraud and Waste in Medicare and Medicaid”
- March 2: Senate Finance Committee, “Preventing Health Care Fraud: New Tools and Approaches to Combat Old Challenges”
Congressional Hearings on Health Care Fraud, continued

March 2: House Ways & Means Committee, Subcommittee on Oversight, “Improving Efforts to Combat Health Care Fraud”


NHCAA Testifies at Congressional Hearing

March 2 House Ways & Means Committee, Subcommittee on Oversight hearing

- Louis Saccoccio testified
- Other witnesses:
  - Karen Ignagni, President & CEO, America’s Health Insurance Plans (AHIP)
  - Peter Budetti, MD, Deputy Administrator & Director, Center for Program Integrity, CMS
  - Lewis Morris, Chief Counsel, HHS Office of Inspector General
  - Convicted DME fraudster Aghaegbuna "Ike" Odelugo
Current Issue: Medicare Claims & Payment Database


- **March 2** – Senate Finance Committee Hearing. Senators Chuck Grassley (R–IA) and Ron Wyden (D–OR) stated their intention to introduce legislation to open up the database.

Current Issue: Medicare Claims & Payment Database

- **March 2** – Senator Grassley introduced Senate Bill 454, “Strengthening Program Integrity and Accountability in Health Care Act of 2011.”

- **April 7** – Senator Grassley and Senator Wyden introduced the co-sponsored Senate Bill 756, “Medicare Data Access for Transparency and Accountability Act.”

- **April 14** – Senator Dick Durbin (D–IL) introduced Senate Bill 856, “Medicare Spending Transparency Act of 2011.”
NHCAA - Our Role

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.

Partnering

*Bringing to the table public agencies and private payors:*

- Health Insurance Community
- Law Enforcement and Regulatory Community
**NHCAA Member Organizations**

1199 SEIU Nat'l Benefit & Pension Fund • AdvanceMed • Aetna • American Family Insurance Company • American Medical Security • American Republic Insurance • American Specialty Health • AMERIGROUP Corporation • APWU Health Plan • Arkansas Blue Cross Blue Shield • Blue Cross Blue Shield Association • Blue Cross Blue Shield of Alabama • Blue Cross Blue Shield of Florida • Blue Cross Blue Shield of Kansas • Blue Cross Blue Shield of Louisiana • Blue Cross Blue Shield of Massachusetts • Blue Cross Blue Shield of Minnesota • Blue Cross Blue Shield of Mississippi • Blue Cross Blue Shield of Montana • Blue Cross Blue Shield of Nebraska • Blue Cross Blue Shield of North Carolina • Blue Cross Blue Shield of Rhode Island • Blue Cross Blue Shield • Blue Cross Blue Shield of Tennessee • Blue Cross Blue Shield of Texas • Blue Shield of California • Bravo Health • Capital Blue Cross • Capital District Physicians’ Health Plan • CareFirst Blue Cross Blue Shield • Centene Corporation • CIGNA • Community Health Network of Connecticut • Crossroads Healthcare Management LLC • Coventry Health Plan • EmblemHealth Services • Excellus Blue Cross Blue Shield • Farmers Insurance • Government Employees Hospital Association • Guardian • Hawaii Medical Service Association • Health Care Service Corporation • Health Insurance Plan of Greater New York • Health Net Federal Services • Health Net • HealthFirst • Health Integrity • HealthMarkets • HealthNow New York • Health Plan of Michigan • Highmark • Horizon Blue Cross Blue Shield of NJ • Humana • Independent Health • Insurers Administrative Corporation • Kaiser Foundation Health Plan • Keystone Mercy Health Plan • Magellan Behavioral Health • Medical Excess LLC • Medical Mutual of Ohio • Mutual of Omaha • MVP Health Plan • National Elevator Industry Health Benefit Plans • Nationwide Health Plans • Premara Blue Cross • Prime Therapeutics • Principal Financial Group • SCAN Health Plan • State Farm Mutual Automobile Insurance Company • Sterling Life Insurance • The Health Care Group • St. Paul’s Travelers Companies • Thomson Reuters • TMG Health • TriWest Healthcare Alliance • Trustmark • Tufts Health Plan • United Health Group • Universal American • Universal Healthcare • UPMC Health Plan • ValueOptions • Virginia Premier Health Plan • Vision Service Plan • WEA Insurance Corp. • Wellcare • Wellmark • WellPoint • Western Southern Life Ins. Co. • Wisconsin Physicians Service • XL Health

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**Law-Enforcement Liaisons**

- Public-sector law enforcement, prosecutorial or regulatory agencies
- Dues–free membership
NHCAA
Law Enforcement Liaisons

FBI • U.S. Department of HHS-OIG • Centers for Medicare & Medicaid Services • IRS-Criminal Investigation • U.S. Dept. of Justice • U.S. Dept. of Defense • TRICARE • U.S. Dept. of Defense • OIG • U.S. Postal Service, Postal Inspection Service • U.S. Dept. of Veterans Affairs, Office of Inspector General • U.S. Gov’t Accountability Office, Office of Special Investigations • U.S. Dept. of VA, Health Administration Center, P&C Division • U.S. Railroad Retirement Board • U.S. Office of Personnel Management • OIG • U.S. General Accounting Office • National Association of Attorneys General • National Association of Insurance Commissioners • National Association of Medicaid Fraud Control Units • Ontario Provincial Police • Amtrak, Office of Inspector General • San Diego County District Attorney’s Office • South Carolina Dept. of HHS • Massachusetts Office of Inspector General • Kansas Insurance Department • Montana Department of Justice, Division of Criminal Investigation • Medicaid Fraud Control Unit of Vermont, Office of the Attorney General • Medicaid Fraud Control Unit of South Dakota, Office of the Attorney General • Medicaid Fraud Control Unit of Massachusetts, Office of the Attorney General • Medicaid Fraud Control Unit of Kentucky, Office of the Attorney General • Medicaid Fraud Control Unit of Pennsylvania, Office of Attorney General • Los Angeles Police Department, Worker’s Compensation Fraud Coordination Unit, Cape May County Prosecutor’s Office • Maryland Insurance Administration, Insurance Fraud Division • Nebraska Department of Insurance, Insurance Fraud Prevention Division • Miami-Dade Police Department • California Department of Insurance • Texas Health and Human Services Commission, Office of Inspector General • Texas Dept. of Insurance, Fraud Unit • Nevada Attorney General’s Office, Insurance Fraud Unit • District of Columbia Dept. of Insurance, Securities and Banking • Texas Department of Insurance, Fraud Unit • Minnesota Department of Commerce, Insurance Fraud Division • Connecticut Department of Insurance • Georgia Bureau of Investigation, State Health Care Fraud Control Unit • State of California • Office of the Inspector General • New York State Office of the Comptroller • Kansas Department of Social Services • Washington State Dept. of Social & Health Services • Idaho Dept. of Health & Welfare • Pennsylvania Insurance Fraud & Auto Theft Prevention Authorities • Arkansas Dept. of Insurance, Criminal Investigation Division • Florida Dept. of Financial Services, Division of Insurance Fraud • New York City Human Resources Administration – Investigation, Revenue & Enforcement Administration • Ohio Bureau of Worker’s Compensation • New Jersey Office of the Insurance Fraud Prosecutor • Orange County District Attorney’s Office • Massachusetts OAG, Insurance and Unemployment Fraud Division • Inspectorate of Public Health, Netherlands Antilles • Bureau of Fraud Deterrence for State of New Jersey - Dept of Banking/Insurance

Law Enforcement Liaisons Growth

As of April 20, 2011 – 85 Law Enforcement Liaisons
Affiliate Members

Other insurers that reimburse medical claims:
- P&C
- Workers’ Comp
- Long-term care
- Disability

Information Sharing

NHCAA’s Information Sharing toolkit:
- SIRIS
- In–person information sharing meetings
- RIAs for law enforcement
- PERC
- Fraud Alerts
- Work Groups
Special Investigation Resource and Intelligence System

SIRIS: the latest tool in fighting health care fraud

www.nhcaa.lexisnexis.com

- NHCAA has offered electronic case information sharing since 1992
- SIRIS was launched in November 2005
- SIRIS is hosted and supported technically by LexisNexis
- SIRIS benefits from LexisNexis system security, administration and data security
SIRIS: the latest tool in fighting health care fraud

www.nhcaa.lexisnexis.com

- Data is owned by NHCAA
- The data is secure with access by NHCAA members only
- An Information Sharing Agreement governs use of SIRIS
- SIRIS integrates with the LexisNexis Accurint for Health Care platform (for LexisNexis subscribers); Users can search and attach data from LexisNexis databases, particularly provider licensing and sanction data.

- NHCAA SIRIS Sub-Committee works with LexisNexis to determine enhancement priorities and release schedule
- SIRIS is now integrated to the NAIC OFRS
Information Sharing - Request for Investigation Assistance (RIA)

- Three in-person sessions are held each year
- NHCAA Member Organizations, Law Enforcement Liaisons, and Affiliate Members meet to share specific case information and fraud related schemes
- CPE credits are available for attending each session
NHCAA Work Groups

- Medical Directors Advisory Group
- Behavioral Health Work Group
- Attorney Work Group
- Dental Fraud Work Group
- Foreign Claims Work Group
- South Florida Work Group

Contact NHCAA

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