The HEAT Is On

Medicare Fraud Fighters

by Dana Shilling, J.D.

There have been many ongoing efforts to reduce health-care costs by trimming waste and fraud in the Medicare and Medicaid programs, but the problem is a severe and persistent one, and many agencies are devoted to the task. This article looks at two ongoing fraud-fighting efforts: the Senior Medicare Patrol (SMP) and HHS' Health Care Fraud Prevention and Enforcement Action Team (HEAT).

Seniors Fight Fraud

The Medicare program benefits the elderly and the disabled, so they are the first-line victims of Medicare fraud. It's only poetic justice, then, that for 14 years seniors themselves have been fighting fraud under the Senior Medicare Patrol (SMP) program.

The SMP's homepage (*http://www.SMPResource.org//AM/Template.cfm?Section=Home*) is an entry point for senior health-care consumers to learn about the SMP and how to participate. Its homepage features a video about how to detect Medicare scams and avoid being victimized.

The SMP receives training and technical services from the National Consumer Protection Technical Resource Center, which was developed in 2003 with AoA funding. The Center maintains the online SMP Locator, which can be clicked on to find the nearest Senior Medicare Patrol outpost. SMP also receives funding under Title IV of the OAA.

The SMP's statutory authorization derives from Titles II and IV of the Older Americans Act (42 U.S.C. § 3032), as amended by P.L. 109-365 in 2006, and from the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). Starting in 1997, the AoA has been funding projects that recruit and train retired professionals as health-care fraud detectives.

The objective is to improve the well being of older adults by improving their decision-making and analytical skills.

The 54 SMP projects nationwide (in all 50 states, plus the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands) work within the aging network and join community, faith-based, health-care, and tribal organizations to prevent, detect, and report health-care fraud.

Training Provided. The SMP trains seniors to understand health-care regulations to protect themselves from Medicare/Medicaid fraud, error, and abuse. The SMP projects collaborate with fraud control and consumer protection entities (for example, the Office of the Inspector General, state Medicaid fraud control units, state Attorneys General, and Medicare contractors) to handle complaints from beneficiaries.

The National Consumer Protection Technical Resource Center offers training and technical assistance to SMP groups and funds programs via SMP Integration Grants.

HHS' Office of the Inspector General (OIG) monitors SMP's performance and collects data twice a year. The web-based SMART FACTS system tracks performance outcomes. According to the OIG's May 6, 2011 report, since 1997, SMP has achieved the following:

- Educated three million beneficiaries in group sessions;
- Counseled 1.1 million beneficiaries and their representatives in individual sessions;
- Reached more than 25 million people at community education events;
- Resolved or referred for investigation more than 267,000 complaints about Medicare/Medicaid fraud;
- Recovered for the Medicare/Medicaid programs and beneficiaries about $106 million. (Administration on Aging (AoA), "Senior Medicare Patrol," *http://www.AoA.gov/aoaroot/aoa_programs/elder_rights/smp/index.aspx* (updated Oct. 24, 2011).)

Factsheet. SMP has a FAQ on its site, "Stop Health-Care Fraud: Senior Medicare Patrol Frequently Asked Questions About Medicare Fraud." (*http://StopMedicareFraud.gov/preventfraud/smp/documents/consumer_factsheet.pdf.)* SMP's motto is "Protect, Detect, Report."

The site describes the SMP as "a group of highly trained volunteers who help Medicare and Medicaid beneficiaries avoid, detect, and prevent health-care fraud" by teaching beneficiaries how to guard their personal information from information theft, recognize scams (e.g., violations of marketing rules, billing for services not provided), and report fraud. The SMP teaches seniors by doing community outreach (counseling, answering telephone help lines, exhibits at events). When necessary, the SMP refers cases to organizations that can perform a full investigation.

The FAQ advises seniors who notice erroneous or suspicious entries on their Medicare Summary Notices or Part D Explanation of Benefits (EOB) to contact the health-care plan or provider—or to go directly to SMP if the senior is not comfortable contacting the health-care system.

Seniors are advised to record their health-care visits and the services and equipment they receive, and to keep copies of bills and notices from insurers and health-care providers. The site suggests that Medicare beneficiaries routinely review their Medicare Summary Notice and Part D EOB and check them against their personal records, to see if bills have been rendered for services that were not ordered by the beneficiary's health-care providers, for services and equipment that were not provided, or that have already been billed.

To reduce identity theft risk, the FAQ suggests refraining from giving out sensitive information such as Social Security and Medicare numbers, and not giving personal information on the phone or a non-secure Internet connection.

The SMP site also includes "badges" that can be added to any website ("Stop Medicare Fraud: Visit *www.StopMedicareFraud.gov*" and "Detener el Fraude Contra Medicare: Vaya *www.StopMedicareFraud.gov"*) to promote HHS' outreach to seniors. (The code for the "badge" is available at *http://www.StopMedicareFraud.gov/badges.html.* Code for a "widget" that website users can use to identify and report Medicare fraud is available at *http://www.StopMedicareFraud.gov/widget.html.*)

See MEDICARE FRAUD, next page

MEDICARE FRAUD, from page 73

Health Care Fraud Control Conference

The Administration on Aging held the tenth SMP National Health Care Fraud Control Conference August 9-11, 2011, at the Omni Shoreham Hotel. This year's theme was "Leading the Grassroots Fight Against Fraud." More than 200 people attended: directors, staff, and volunteers in SMP programs; AoA program officers; and representatives of CMS and the Office of the Inspector General.

HHS Secretary Kathleen Sebelius, the keynote speaker, cited a case in which Florida's SMP contributed significantly to stopping a fraud in which $1.6 million (out of a total of $3.8 million misappropriated) was recovered. One of the defendants was sentenced to three years' imprisonment plus three years of probation. Sebelius stated:

> One of the most effective and direct steps we can take to improve Medicare's long-term health is ridding the program of waste, fraud, and abuse. For the past 14 years, the Senior Medicare Patrol has been on the front lines on that fight.

The other speakers at the conference were:

- Dr. Peter Budetti (Centers for Medicare and Medicaid Services, Deputy Administrator for Program Integrity);
- The AoA's Cindy Padilla (Principal Deputy Assistant Secretary for Aging) and Barbara Dieker (director, Office of Elder Rights);
- Edwin Walker (Deputy Assistant Secretary for Aging); and
- Jennifer Trussell (director, HHS OIG, Investigations Unit).

A recognition ceremony was held to honor these 10 SMP volunteers:

- Larry Bauer (Illinois);
- Linda Burney (Michigan);
- Venancia R. Colet (Guam);
- Douglas Cooper (Maine);
- Tom Guamer (Ohio);
- Winnie Greenshields (Montana);
- Felice Hannah (New York City);
- Richard Hotinski (Texas);
- Dr. Harold Ishler (Louisiana); and
- Ray Jones (San Francisco).

(See AoA Aging News Update, "HHS Secretary Sebelius Keynotes the Tenth SMP National Health Care Fraud Control Conference" (Aug. 15, 2011); available at *www.AoA.gov/AoARoot/Press_Room/Enews/enewsletter/archive/2011/eNews_August_2.pdf*.)

Health Care Fraud Prevention Summit

Months earlier, on June 17, 2011, the sixth Health Care Fraud Prevention Summit was held in Philadelphia. It was hosted by Sebelius and Attorney General Eric Holder. Video of the keynotes, opening remarks, and the three panels (criminal and civil remedies to fight Medicare fraud, public-private collaboration, and technology and data sharing between public and private fraud fighters) are online at *http://www.StopMedicareFraud.gov/videos/fraudprevention_philadelphia.html*.

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Health Care Fraud Prevention and Enforcement Action Team

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) was launched in May 2009 as an initiative by the Department of Justice and HHS. (Medicare Strike Forces had already been in operation for several years, starting with pilot projects in South Florida in 2007 and Los Angeles in 2008, and then expanding to Houston, Detroit, Brooklyn, Baton Rouge, and Tampa.)

HEAT's mission is to cut health-care costs by reducing fraud, highlighting best practices for fighting waste and fraud, and strengthening the HHS/DOJ relationship (which already operate Medicare Fraud Strike Forces).

Civil Fraud Investigations. In fiscal 2009, the DOJ, CMS, and the HHS OIG worked together to open 886 new civil fraud investigations in the health-care arena. They got 583 criminal convictions and 337 civil administrative actions (covering both individuals and organizations). Joint agency fraud enforcement efforts recouped over $2.5 billion from criminal, civil, and administrative enforcement in fiscal 2009. The administration's budget request for fiscal 2011 included $60.2 million in additional funding so the Strike Forces could add to the number of cities in which they work.

In November 2009, the DOJ gathered prosecutors, law enforcement, and support staffers to learn about the Strike Force concept. CMS and the HHS OIG have an ongoing role in training HHS and DOJ staff in using technology to catch instances of fraud.

Another HHS department, the CMS Center for Program Integrity, was launched in April 2010 to use technology to improve the accuracy of Medicare payments to providers.

(Tracy Russo, "HEAT: A Year of Tackling Health Care Fraud" (Aug. 27, 2010); available at *http://Blogs.USDOJ.gov/blog/archives/934*.)

Funds Recouped. In a subsequent announcement, Sebelius and Associate Attorney General Tom Perelli reported that more than $4 billion in taxpayer dollars were recouped by health-care fraud enforcement in fiscal 2010—the highest ever. The data comes from the annual Health Care Fraud and Abuse Control Program report. The establishment of HEAT is one factor that the DOJ credits with this achievement.

As of fiscal 2010, when there were Strike Force teams in seven cities, 248 defendants were charged under 140 indictments involving over $590 million in Medicare billing; 217 guilty pleas were entered. There were 19 jury trials, resulting in guilty verdicts against 23 defendants, As a result of those trials and pleas, 146 prison sentences were imposed, averaging more than 40 months' imprisonment.

Notably, 2010 was also the year with the highest level of False Claims Act civil recoveries ever obtained: more than $2.5 billion. (DOJ Office of Public Affairs, "Health Care Fraud Prevention and Enforcement Efforts Recover Record $4 Billion; New Affordable Care Act Tools Will Help Fight Fraud" (Jan. 24, 2011), available at *http://www.Justice.gov/opa/pr/2011/January/11-asg-094.html*; HCFAC annual report, *http://www.OIG.HHS.gov/publications/hcfac.asp*.) ■