State Options for Responding to Federal Health Policy Changes
How Big is the Problem?
MEDICARE FRAUD
$60 Billion
MEDICAID FRAUD
$60 Billion

$36 Billion
$96 Billion Yearly

Medical FRAUD
What is the...
Fraud Outpaces Major Federal Spending
Fraud Outpaces Abuse/Neglect Cases

Chart 3: Number of Criminal Convictions by Type of Case, FYs 2011-2015

Legend
- Dark Blue: Fraud Convictions
- Light Blue: Abuse or Neglect Convictions

FOLLOW THE
DOCTOR PLEADS GUILTY TO HEALTH CARE FRAUD

A physician pleaded guilty today to conspiracy to commit Medicare fraud scheme involving three Detroit-area physicians.

Acting Assistant Attorney General Kenneth A. Blanco of the Eastern District of Michigan, Special Agent in Charge LaChante Peach of the U.S. Drug Enforcement Administration (DEA), Chicago Regional Office and Special Agent in Charge John B. Lyon of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), made the announcement. Amedee Fray, 72, of Westland, Michigan, pleaded guilty in front of Judge Denise Page Hood of the Eastern District of Michigan before Judge Hood.

DENTAL MANAGEMENT COMPANY AGREES TO PAY $23.5 MILLION TO SETTLE FALSE CLAIMS ACT ALLEGATIONS

The Justice Department announced today that its Hatch-Waxman False Claims Act alleging a company (Defendant LLC, also known as Redsun LLC) and more than 100 of its a which Defendant provides business management and administrative services. Under Sleepy, Sleepy will the United States and participating states a total of $23.5 million that they knowingly submitted false claims on payment for their Medicaid program services on children assisted by Medicaid.

"Billing Medicaid for dental procedures that are not necessary could put vulnerable patients at risk by performing medically unnecessary procedures and increasing the cost of care for all Americans," Assistant Attorney General Jose E. Rodriguez of the Justice Department’s Civil Division said. "This settlement will hold the defendant accountable for its actions and help ensure that critical care is not compromised for our most vulnerable people."
His fraud cost victims $10 million. Now, it's costing him time, land and a $22,000 Rolex

BY DAVID J. NEAL
dNeal@miamiherald.com
April 29, 2018 12:50 PM
Updated April 30, 2018 07:20 AM

Vladimir Prado Sr. worked well with others, as evidenced by his teamwork with three people in a $10 million healthcare fraud.

Alas, Prado, 52, will be going solo in serving his eight-year federal prison sentence. And, there’s just over $4 million in restitution that will cost him the cash from three bank accounts, 11 real estate properties and a woman’s $22,500 diamond Rolex watch.

The Miami-Dade man pleaded guilty to one count of conspiracy to commit healthcare fraud and wire fraud from an October indictment and one count of the same from a November indictment. Unlike most South Florida healthcare fraud cases, Prado didn’t just rip off the government via Medicare and Medicaid. He also skinned Blue Cross Blue Shield.
Provider Health Insurance Fraud Schemes, Settlements Top $310M

Law enforcement agencies have charged providers and organizations in health insurance fraud schemes more than $310 million in the opening weeks of 2018.
DoJ Settles $27.68M in Medicare Fraud, False Claims Act Violations

The Department of Justice has recovered $27.68 million in Medicare fraud settlements related to False Claims Act violations.

By Thomas Beaton

April 17, 2018 - The Department of Justice continues its crackdown on Medicare fraud by settling various criminal cases related to $27.68 million of False Claims Act violations.

Provider settlements remain the primary medium for healthcare fraud recoveries, according to recent data released by the Office of the Inspector General (OIG). Settlements helped law enforcement officials recover $1.1 billion in fraudulently billed services and criminal activities aimed to exploit Medicare reimbursement policies.

Law enforcement officials still incorporate needed criminal convictions when certain schemes to defraud Medicaid or Medicare are too egregious to pursue civil recoveries.
FRAUD OCCURS AT EACH PHASE

<table>
<thead>
<tr>
<th>Provider Fraud</th>
<th>Patient Fraud</th>
<th>Insurer Fraud</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Billing for services not performed</td>
<td>• Filing a claim for services or products not received</td>
<td>• Overstating the insurer's cost in paying claims</td>
</tr>
<tr>
<td>• Billing duplicate times for one service</td>
<td>• Forging or altering receipts</td>
<td>• Misleading enrollees about health plan benefits</td>
</tr>
<tr>
<td>• Falsifying a diagnosis</td>
<td>• Obtaining medications or products that are not needed and selling them on</td>
<td>• Undervaluing the amount owed by the insurer to a health care provider under</td>
</tr>
<tr>
<td>• Billing for a more costly service than performed</td>
<td>the black market</td>
<td>the terms of its contract</td>
</tr>
<tr>
<td>• Accepting kickbacks for patient referrals</td>
<td>• Providing false information to apply for services</td>
<td>• Denying valid claims</td>
</tr>
<tr>
<td>• Billing for a covered service when a noncovered service was provided</td>
<td>• Doctor shopping to get multiple prescriptions</td>
<td></td>
</tr>
<tr>
<td>• Ordering excessive or inappropriate tests</td>
<td>• Using someone else's insurance coverage for services</td>
<td></td>
</tr>
<tr>
<td>• Prescribing medicines that are not medically necessary or for use by people</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
STRONGER ANTI-FRAUD LAWS

- False Claims Acts
- Anti-Kickback/Brokering
- Dedicated Prosecutors
- Encourage Civil Recovery Actions
Chart 5: Civil Settlements and Judgments, FYs 2011-2015

STRONGER ANTI-FRAUD LAWS

❖ Encourage Civil Recovery Actions

☐ “Whistleblower” Acts
☐ Insurer Recovery
☐ State RICO Actions
STATE & FEDERAL JOINT EFFORTS

❖ Joint Task Forces
❖ Information Sharing
❖ Proper Targeted Enforcement
❖ Laws Can be a “Bridge” or “Wall”.
Auditor flags Florida's oversight of Medicaid fraud

Among the findings of an audit released last week: the state's Office of Medicaid Program Integrity did not refer leads or referrals about possible wrongdoing to managed-care organizations for investigation. Also, the state spent $5.5 million with a well-connected vendor despite its inability to include data on the majority of people enrolled in the Medicaid program.

By News Service of Florida   April 2
Health Care Fraud Prevention Partnership

- Includes the federal government, state officials, private health insurance organizations, and health care anti-fraud groups
  - Shares information and best practices
  - Improves detection
  - Prevents payment of fraudulent health care billings across public and private payers
  - Enables the exchange of data and information among the partners
FORMED IN 2012
HEALTHCARE FRAUD PREVENTION PARTNERSHIP

WHAT IS THE HEALTHCARE FRAUD PREVENTION PARTNERSHIP (HFPP)?

The HFPP is a voluntary, public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations to identify and reduce fraud, waste, and abuse across the healthcare sector. HFPP partners regularly collaborate, share information and data, and conduct cross-payer studies to achieve these objectives. Given the HFPP's broad membership encompassing a variety of players interested and involved in detection of fraud, waste, and abuse in the healthcare system, it is uniquely positioned to examine emerging trends and develop key recommendations and strategies to address them.

THE HFPP CURRENTLY HAS 98 PARTNERS, INCLUDING:

- 27 State & Local Partners
- 50 Private Payers
- 9 Federal Agencies
- 12 Associations

MORE THAN $300 MILLION IN SAVINGS

WHY DOES THE HEALTHCARE FRAUD PREVENTION PARTNERSHIP EXIST?

- To deliver unique cross-payer analyses of healthcare data across the Centers for Medicare and Medicaid Services (CMS), state Medicaid offices, and private payers
- To identify potential savings that Partners cannot identify in their data alone
- To increase detection of fraud, waste, and abuse across the private and public healthcare spectrum

WHAT MAKES THE HFPP UNIQUE?

- IMPACT: HFPP's studies enable Partners to take substantive actions to stop fraud and waste
- INSIGHT: HFPP provides Partners with greater visibility into the universe of healthcare fraud and abuse
- INNOVATION: Partners work with experts to identify emerging threats and trends in healthcare fraud and abuse
COMMIT
NEEDED
RESOURCES
What happens when states go hunting for Medicaid fraud

Nation  May 24, 2017  3:59 PM EDT

By the time Illinois decided to crack down on Medicaid fraud in 2012, state officials knew that many people enrolled in the program probably weren’t eligible. For years, case workers hadn’t had the time or resources to check.

To catch up, the state hired a private contractor to identify people who might not be eligible for the low-income health program and to make recommendations for whose benefits should be canceled. Within about a year, Illinois had canceled benefits for nearly 150,000 people whose eligibility could not be verified — and saved an estimated $70 million.
❖ Unilateral “across the board” cuts.
What Does Work...

❖ Return/Benefit based funding.
❖ Protection of public investment.
❖ Action:
  ☐ Criminal penalties/fines
  ☐ Licensure revocations/suspensions.
TALK ABOUT FRAUD
THEY CARE!
How concerned are you about insurance fraud?

80%
New Medicare Card Telephone Scam

The Centers for Medicare and Medicaid are not calling senior citizens and asking for personal information ahead of the launch of a new Medicare card.

Seniors, watch out. A move to prevent your identity from getting stolen actually is breeding those schemes.

Nearly 60 million seniors will receive new Medicare cards without Social Security numbers over the next year. Seniors are getting red, white and blue paper cards with a mix of 11 numbers and digits instead.
PROTECTING YOUR MEDICARE
CROOKS ARE STEALING YOUR HEALTH CARE DOLLARS. FEDERAL AGENTS ARE FIGHTING BACK—AND YOU CAN HELP!

IN 2017
MEDICARE COST
$591 BILLION

$60 BILLION*
WAS LOST TO FRAUD

AARP Bulletin
April 2018
You Have the Voice & the Ability to Lead the Discussion
1. State Laws and Policies
2. State Budgets
3. Communication
4. Outreach
5. Awareness

Coalition Against Insurance Fraud
THANK YOU!