



**CMS 2010 BI-REGIONAL MEDICARE HEALTH PLAN COMPLIANCE
CONFERENCE**

Boston & New York – Serving Our Beneficiaries Together

Verbatim Transcript
Medicare and Medicaid Fraud, Waste and Abuse
Jean Stone, Joel Truman

>> WE HAVE SELECTED THESE
PRIMARY TOPICS

FOR THIS AFTERNOON'S PLENARY
SESSION.

AND WE DID BECAUSE WE THOUGHT
THESE ARE THE PLACES THAT NEED

EMPHASIS HERE IN JUNE 2010.

SO I HOPE YOU ARE AGREEING THAT
THESE ARE THE THINGS

THAT WE NEED TO BE TALKING
ABOUT.

FROM OUR POINT OF VIEW, THEY ARE
VERY IMPORTANT TOPICS.

THE DIVISION FOR COMPLIANCE,
THAT JIM GAVE US

THIS PERSPECTIVE ON CASE WORK,
WHICH IS WHAT MY STAFF DOES,

AND THE NEXT SET OF SPEAKERS--
JEAN AND JOEL--

WILL FOCUS ON SOMETHING THAT
WE'RE PLACING MORE AND MORE

EMPHASIS ON, WHICH IS REDUCING
FRAUD, WASTE, AND ABUSE.

SO OUR NEXT SPEAKERS ARE JEAN
STONE AND JOEL TRUMAN.

AND I'LL INTRODUCE THEM
SEPARATELY.

JEAN STONE IS THE DIRECTOR OF
THE CMS NEW YORK FIELD OFFICE,

THE CENTER FOR PROGRAM
INTEGRITY.

AND THAT FIELD OFFICE IS HERE IN
NEW YORK CITY.

SHE HAS EXTENSIVE LAW
ENFORCEMENT TEACHING EXPERIENCE.

AND THAT INCLUDES--SHE WAS AN
INSTRUCTOR FOR MEDICARE

AND HEALTH CARE FRAUD COURSES IN
THE HEALTH AND HUMAN SERVICES

OFFICE OF THE INSPECTOR
GENERAL'S

SPECIAL AGENT BASIC TRAINING
PROGRAM.

AND SHE DID THAT FOR 3 YEARS--
'06 TO '09.

SHE ALSO TAUGHT IN THE FEDERAL
LAW ENFORCEMENT TRAINING CENTER

IN GEORGIA. SHE WAS AN
INSTRUCTOR FOR MEDICARE

AND HEALTH CARE FRAUD COURSES

AT THE FBI'S NEW AGENT TRAINING
PROGRAM IN QUANTICO.

SHE HAS NUMEROUS OTHER
EXPERIENCE

AND JOB RESPONSIBILITIES, AND
I'LL POINT OUT A FEW

SO YOU--HAVE THE IMPRESSION--
WELL, YOU CAN UNDERSTAND

WHERE SHE'S COMING FROM WHEN SHE
BEGINS TO TALK ABOUT

REDUCING MEDICARE FRAUD, WASTE,
AND ABUSE.

SHE HAS 39 YEARS OF EXPERIENCE

IN THE DEPARTMENT OF HEALTH AND
HUMAN SERVICES,

WORKING WITH MEDICARE AND
MEDICAID MONITORING

AND PROGRAM INTEGRITY.

SHE WAS DESIGNATED AS THE CMS
LIAISON

TO HEALTH CARE ANTIFRAUD
ENFORCEMENT ACTION.

IT WAS A TEAM, SO THE TEAM'S
NAME WAS HEAT--

HEALTH CARE ANTIFRAUD
ENFORCEMENT ACTION TEAM.

AND--SHE CONTINUES TO BE ON THAT
TEAM THAT BEGAN LAST YEAR

AS A PART OF THE NEW YORK STRIKE
FORCE.

SHE SERVED AS THE DIRECTOR OF
CMS IN THE FIELD OFFICE,

AS I MENTIONED, FROM '07 TO

PRESENT.

SHE DIRECTED THE CMS MIAMI FIELD OFFICE PRIOR TO THAT

AND LED THE SOUTH FLORIDA FRAUD INITIATIVES ON DME AND INFUSION

FRAUD AND ABUSE.

SHE LED MEDICARE'S 7-STATE DME STOP-GAP PLAN

IN NUMEROUS STATES,

WHERE SHE FOCUSED ON HIGH-RISK SUPPLIERS,

ORDERING PHYSICIANS, BENEFICIARIES, AND EQUIPMENT.

AND SHE BEGAN THAT IN '08 AND CONTINUES TO THE PRESENT.

JEAN ALSO SERVES AS THE CMS NATIONAL LEAD

ON MEDICARE INFUSION FRAUD. SHE BEGAN THAT WORK IN '05,

AND THAT CONTINUES TO THE PRESENT AS WELL.

JEAN HAS WON NUMEROUS AWARDS

FOR HER WORK IN PREVENTING FRAUD, WASTE, AND ABUSE.

AND SHE HAS A PUBLICATION, "FRAUD. WHAT IS THE EVIDENCE?"

THAT WAS PUBLISHED IN "CASE MANAGEMENT JOURNALS"

IN THE SPRING OF 2000.

AND LET ME TELL YOU A LITTLE BIT ABOUT JOEL

BEFORE THEY BOTH COME UP.

JOEL TRUMAN JOINED THE MEDICAID INTEGRITY GROUP IN MARCH 2007.

HE IS ONE OF TWO DEPUTY DIVISION DIRECTORS

IN THE DIVISION OF FIELD OPERATIONS.

JOEL SUPERVISES THE NEW YORK AND THE ATLANTA FIELD OFFICES

AND IS RESPONSIBLE FOR TECHNICAL ASSISTANCE TO ALL THE STATES

AND TERRITORIES IN CMS REGIONS 1-4.

PRIOR TO JOINING THIS GROUP, JOEL WAS A SPECIAL ASSISTANT

TO THE REGIONAL ADMINISTRATOR,

AND HE WAS A MEDICAID BRANCH CHIEF

IN THE NEW YORK REGIONAL OFFICE.

HE ALSO SERVED IN 2004 AS ACTING EXECUTIVE OFFICER

FOR THE REGIONAL DIRECTOR.

THAT'S THE HHS REGIONAL DIRECTOR,

AND THAT WAS IN NEW YORK.

AND THEN BEFORE COMING TO THE NEW YORK REGIONAL OFFICE

IN 1998, HE WAS A SPECIAL ASSISTANT TO THE MEDICAID

BUREAU DIRECTOR AND THE PROJECT OFFICER IN BALTIMORE.

SO WITH THAT AS A BEGINNING TO OUR DISCUSSION

ON FRAUD, WASTE, AND ABUSE,
PLEASE WELCOME JEAN AND JOEL.

[APPLAUSE]

>> THANKS, EVERYBODY. IT'S A
PLEASURE TO BE HERE.

AND I THINK THIS IS A VERY
IMPORTANT CONFERENCE.

AND I'M HOPING THAT MAYBE IN THE
COURSE OF THIS CONFERENCE,

WE CAN ESTABLISH SOME COMMON
GROUND ABOUT ISSUES

THAT FACE MEDICAID AND MEDICARE
ALIKE.

AND I HOPE TO TALK A LITTLE BIT
ABOUT OPPORTUNITIES

FOR COMMUNICATION ACROSS THE
PROGRAMS

AND DEALING WITH COMMON ISSUES.

FIRST LET ME BEGIN BY REMINDING
EVERYBODY

ABOUT SOME OF THE MAJOR
DIFFERENCES

BETWEEN THE MEDICAID PROGRAM AND
MEDICARE.

MEDICARE, AS EVERYONE KNOWS,
IS A CENTRALLY ADMINISTERED
PROGRAM.

THE BENEFITS, THE ELIGIBILITY
RULES, EVERYTHING IS ALIKE

ACROSS THE COUNTRY.

MEDICAID IN CONTRAST IS A

JOINTLY ADMINISTERED

AND FUNDED PROGRAM.

AND IT'S RUN BY THE STATES ON A
DAY-TO-DAY BASIS.

ALTHOUGH THERE'S BEEN A TENDENCY
OVER TIME

FOR SOME STANDARDIZATION OF
BENEFIT LEVELS AND THRESHOLDS,

CERTAIN MAINTENANCE-OF-EFFORT
REQUIREMENTS

THAT COME WITH ENHANCED FEDERAL
FINANCIAL PARTICIPATION,

AND THINGS LIKE THAT, STATES
STILL HAVE EXTENSIVE LEEWAY

IN SETTING ELIGIBILITY CRITERIA,
COVERAGE REQUIREMENTS,

PAYMENT METHODOLOGIES AND RATES,

AND ALSO THEY HAVE EXTENSIVE
LEEWAY

IN DETERMINING HOW THEY'RE GOING
TO ADMINISTER THE PROGRAM.

WHY THIS IS IMPORTANT FROM A
PROGRAM INTEGRITY

POINT OF VIEW, I'M SURE YOU CAN
ALL IMAGINE.

YOU KNOW, WHAT'S LEGAL IN ONE
STATE MAY BE ILLEGAL IN ANOTHER.

A PROVIDER CAN BILL FOR
SOMETHING IN GOOD FAITH

IN ONE STATE THAT'S COVERED,

AND IF THEY BILLED FOR THE SAME
THING IN ANOTHER STATE,

IT WOULD BE FRAUD BECAUSE IT
WOULDN'T BE COVERED.

THEY WOULD BE GETTING AWAY WITH
SOMETHING

THAT IS NOT ALLOWED.

THIS MAKES A BIG DIFFERENCE WHEN
IT COMES TO AN IMPORTANT

PART OF OUR MEDICAID INTEGRITY
PROGRAM, WHICH INVOLVES

THE FIRST EVER ESTABLISHMENT OF
A NATIONAL AUDIT PROGRAM.

BECAUSE OUR AUDITORS HAVE A MUCH
GREATER TASK IN TERMS

OF WHAT THEY HAVE TO DO TO SCOPE
OUT BENEFITS AND POLICY

IN EACH STATE AND MAKE A
DETERMINATION, REALLY,

ON WHAT ARE PROVIDERS DOING THAT
CONSTITUTES

FRAUD OR ABUSE ON A
STATE-BY-STATE BASIS.

IT BECOMES A MUCH MORE DIFFICULT
UNDERTAKING IN SOME WAYS

THAN THE TASK FACED BY MEDICARE
AUDITORS.

AND I'M NOT UNDERESTIMATING THE
DIFFICULTY OF THE TASK FACED

BY MEDICARE CONTRACTORS.

BUT AS I SAY, BOTH OF OUR
PROGRAMS FACE

A LOT OF COMMON CHALLENGES.

AND, YOU KNOW, THERE ARE A LOT

OF SYNERGIES THAT WE CAN DRAW
FROM EACH OTHER. AND I'M HOPING
TO EXPLORE SOME OF THOSE TODAY
AS WELL.

THIS IS KIND OF EMBARRASSING,
BUT I DON'T HAVE A CLICKER
THAT TELLS YOU WHEN TO ADVANCE
THE SLIDE.

COULD YOU GO TO THE NEXT SLIDE,
PLEASE?

JUST A LITTLE BIT OF BACKGROUND

IN TERMS OF OUR MEDICAID
INTEGRITY PROGRAM

AND HOW IT GOT ESTABLISHED.

YOU KNOW, THE MEDICAID PROGRAM
WAS ESTABLISHED

AT THE SAME TIME AS MEDICARE,
ALMOST AS AN AFTERTHOUGHT.

CONGRESS DECIDED AT THE TIME
THAT IT WOULD BE NICE

TO HAVE A HEALTH INSURANCE
COMPONENT ASSOCIATED WITH PEOPLE

ON WELFARE,

BASICALLY AID TO FAMILIES WITH
DEPENDENT CHILDREN.

OVER TIME, MEDICAID EXPANDED
GREATLY TO THE POINT NOW

WHERE IT COVERS MORE PEOPLE THAN
MEDICARE,

PROBABLY--IN THE NEIGHBORHOOD OF
60 MILLION PEOPLE,

WITH AN ADDITIONAL 15 MILLION

COMING ON BOARD

AS A RESULT OF HEALTH CARE
REFORM.

BUT FOR ALMOST 30 YEARS, PROGRAM
INTEGRITY ACTIVITIES

WERE ESSENTIALLY LEFT BY THE
FEDERAL GOVERNMENT

TO THE STATES TO HANDLE.

STATES HAD TO MAKE CERTAIN
COMMITMENTS

IN THEIR MEDICAID STATE PLANS--
THE CONTRACT THEY HAD

WITH THE FEDERAL GOVERNMENT
ABOUT HOW THEY WERE GOING

TO CONDUCT PROGRAM INTEGRITY
ACTIVITIES,

BUT IT WAS ALL COINED IN VERY
GENERAL LANGUAGE.

AND BASICALLY, BALTIMORE
HEADQUARTERS HAD NO IDEA

WHAT STATES WERE DOING.

THIS BEGAN TO CHANGE A LITTLE
BIT IN THE MID-NINETIES.

AT THAT TIME, THERE WAS A
REORGANIZATION IN CMS.

AND A FEW PEOPLE WERE ASSIGNED
PROGRAM INTEGRITY ACTIVITIES

IN THE BALTIMORE OFFICE.

THEY, IN TURN, LINED UP SORT OF
ON A CATCH AS CATCH CAN BASIS--

PEOPLE FROM OUR REGIONAL
OFFICES--TO HELP GO OUT AND DO

THE FIRST EVER PROGRAM INTEGRITY
REVIEWS OF STATES.

AND CONSIDERING THE LIMITED
NUMBER OF STAFF

THAT WERE AVAILABLE TO DO THESE
KINDS OF THINGS,

THEY ACTUALLY ACCOMPLISHED QUITE
A BIT.

IN A PERIOD OF ABOUT 6 YEARS
BEGINNING IN 2000,

WE UNDERTOOK SOMETHING LIKE 45
REVIEWS IN 44 STATES.

HOWEVER, BECAUSE OF LIMITED
STAFF AND LIMITED TRAVEL BUDGETS

AND SO ON, THERE WAS LITTLE
OPPORTUNITY TO DO

ANY FOLLOW-UP, TO ACTUALLY CHECK
WHETHER STATES

WERE TAKING CORRECTIVE ACTION ON
COMPLIANCE ISSUES

THAT WE IDENTIFIED DURING THESE
REVIEWS, AND SO ON.

SO IT WAS PRETTY MUCH, YOU KNOW,
A HAPHAZARD ENTERPRISE.

AND IT WAS REFLECTING THAT.

IT WAS BETTER THAN NOTHING. IT
WAS A START.

CONGRESS TOOK US BY SURPRISE IN
2005 BY PASSING

A MAJOR PROGRAM INTEGRITY
COMPONENT

WITHIN THE DEFICIT REDUCTION
ACT.

THEY GAVE US 100 FTEs, ACTUALLY,
TO BE DEDICATED TO THE LAUNCHING
OF A NATIONAL MEDICAID INTEGRITY
PROGRAM.

AND THEY ALSO PROVIDED A
SUBSTANTIAL FUNDING COMPONENT,

WHICH, AS YOU CAN SEE, COMES TO
SOMETHING LIKE 560 MILLION

IN THE FIRST 5 YEARS--

IT ACTUALLY BEGAN WITH SORT OF
SMALLER SEED MONEY AMOUNTS

AND THEN ROSE TO AROUND 75
MILLION PER YEAR.

AS A RESULT FOR THE FIRST TIME,
A MEDICAID INTEGRITY GROUP WAS

ESTABLISHED AT THE NATIONAL
LEVEL.

79 OF THE 100 FTEs BECAME

PART OF THAT MEDICAID INTEGRITY
GROUP.

WE WERE SET UP

AS PART OF THE CENTER FOR
MEDICAID AND STATE OPERATIONS,

WHICH UNDER CURRENT REALIGNMENT,
ITS NAME HAS CHANGED TO

CENTER FOR MEDICAID, CHIP, AND
SURVEY AND CERTIFICATION.

AND MOST RECENTLY AS A RESULT OF
THIS REALIGNMENT IN CMS,

WE'VE JOINED WITH OUR MEDICARE
PROGRAM INTEGRITY COUNTERPARTS

AND BECOME PART OF A NEW CENTER
WITHIN CMS CALLED

THE CENTER FOR PROGRAM
INTEGRITY.

AS PART OF THE LEGISLATIVE
CHANGES THAT CREATED

THE MEDICAID INTEGRITY GROUP,
THERE'S ALSO KIND OF

A CHANGING PROGRAM INTEGRITY
LANDSCAPE IN GENERAL AFFECTING

ALL FEDERAL HEALTH CARE
PROGRAMS.

YOU KNOW, THE AGENCIES THAT ARE
LISTED ON THIS SLIDE HERE--OIG,

DOJ, FBI, GAO--THEY'VE ALL BEEN
AROUND.

WELL, WE'RE FINDING NOW AS COSTS
RISE SO DRAMATICALLY

IN HEALTH CARE--AND THINK ABOUT
IT. IT'S NOT GOING TO BE

MANY YEARS BEFORE MEDICAID AND
MEDICARE COMBINE

TO COUNT FOR \$1 TRILLION.

YOU KNOW, MEDICARE IS WELL OVER
500 BILLION NOW PER YEAR,

AND MEDICAID IS CLOSE TO 400
BILLION.

AS COSTS RISE, THERE'S A
DETERMINATION TO TRY

AND GET MORE BANG FOR OUR BUCK
BY TRYING TO, YOU KNOW,

RUN THE PROGRAMS AS EFFICIENTLY
AS POSSIBLE

AND REDUCE FRAUD AND ABUSE.

AND SO THERE'S A TENDENCY NOW
FOR A LOT OF THESE AGENCIES

TO ENGAGE IN COLLABORATIVE
UNDERTAKINGS.

WHAT WAS MENTIONED JUST BEFORE
THE HEAT PROJECT HAS

A LOT OF THESE AGENCIES COMBINED
WORKING WITH CMS TO GO AFTER

FRAUD IN THE MEDICARE PROGRAM.

AND YOU'RE GOING TO SEE MORE AND
MORE OF THIS COMING ON.

WE ALSO FIND THAT, YOU KNOW,
THERE'S NEW INITIATIVES TO TRY

AND CUT DOWN ON PAYMENT ERRORS.

THERE'S A RECENT EXECUTIVE ORDER
DEMANDING THAT ALL DEPARTMENTS

IN THE FEDERAL GOVERNMENT MAKE
COOPERATIVE EFFORTS TO TRY

AND ELIMINATE ERRONEOUS
PAYMENTS.

AND IN MEDICARE, THEY'VE BEEN
DOING THIS SINCE MAYBE 2000

OR EVEN JUST BEFORE THAT, WHERE
THE PAYMENT ERROR RATE IS

MEASURED ANNUALLY.

AND WE'VE STARTED DOING THAT IN
MEDICAID AS PART OF

THE DEFICIT REDUCTION ACT SINCE
2006

IN THE SO-CALLED PERM PROGRAM,

WHICH STANDS FOR PAYMENT ERROR
RATE MEASUREMENT.

WE ALSO HAVE NEW AUDITING BODIES.

MEDICARE HAS COME UP WITH A VARIETY OF CONTRACTORS

THAT ARE SPECIALLY DESIGNATED TO IDENTIFY FRAUD.

AND THEY'VE ALSO COME UP WITH RECOVERY AUDIT CONTRACTORS,

WHICH HAVE NOW BEEN REQUIRED ON THE MEDICAID SIDE

UNDER HEALTH CARE REFORM.

AND WE ALSO HAVE, YOU KNOW, JOINT INITIATIVES, SUCH AS

THE SO-CALLED MEDI-MEDI PROGRAM, IN WHICH MEDICARE

AND MEDICAID, WE FIND A CONTRACTOR--

THIS IS EVENTUALLY GOING TO EXPAND NATIONWIDE,

BUT RIGHT NOW, IT APPLIES TO ABOUT 12 STATES.

WE HAVE A MEDICARE CONTRACTOR THAT HAS ACCESS TO

BOTH THE MEDICAID DATABASE AND THE MEDICARE DATABASE

FOR THAT STATE.

BY DOING DATA MINING

AND USING VARIOUS ALGORITHMS AND INVESTIGATIVE TECHNIQUES,

THEY'RE ABLE TO FIND PATTERNS OF FRAUD AND ABUSE

CUTTING ACROSS THE MEDICARE AND MEDICAID PROGRAM

THAT WOULDN'T BE APPARENT IF YOU
WERE JUST LOOKING AT

THE ONE PROGRAM.

SO THAT'S A VERY IMPORTANT AND
PROMISING INITIATIVE,

WORKING WELL IN MOST OF THE
STATES WHERE IT EXISTS NOW,

AND IT'S PROBABLY GOING TO BE
EXPANDED SOON.

HOW SOON IS MORE OF A LOGISTICAL
ISSUE

THAN THE QUESTION OF, YOU KNOW,
WHETHER IT WILL GO NATIONWIDE.

AND THEN LASTLY, WE ARE LOOKING
AT MORE AND DIFFERENT WAYS

OF TRYING TO ENFORCE FRAUD AND
ABUSE REGULATIONS

AND STATUTORY PROVISIONS.

YOU'RE SEEING MORE CREATIVE
WAYS--YOU KNOW, JUST LIKE

THE BAD GUYS ARE FOREVER WORKING
OUT NEW WAYS OF TRYING TO

PULL THE WOOL OVER OUR EYES,
WE'RE USING NEW TECHNIQUES

TO TRY AND NAIL THEM.

AND ONE USE IS FEDERAL AND STATE
FALSE CLAIM ACTS,

FOR EXAMPLE.

AND THIS IS VERY IMPORTANT IN
THE SENSE

THAT PROVIDERS WHO SOMETIMES
OFFER CHRONICALLY BAD

QUALITY OF CARE, THERE'S A FRAUD
LINK.

THEY'RE BILLING FOR SERVICES AS
IF THEY WERE PROVIDING

LEGITIMATE SERVICES.

AND WE CAN SOMETIMES GET THEM
AND PUT THEM OUT OF BUSINESS

BY USING FALSE CLAIMS ACT
LEGISLATION,

WHICH IS ON THE BOOKS AT THE
FEDERAL LEVEL,

AND INCREASINGLY, IN MORE AND
MORE STATES.

AND THERE ARE CERTAIN ADVANTAGES
AND INCENTIVES

WHICH THE LEGISLATION IN 2005
MAKES AVAILABLE TO STATES

IF THEY PASS FALSE CLAIMS ACT
THAT MEET FEDERAL STANDARDS.

NOW, AS THE LANDSCAPE CHANGES,
OF COURSE, THERE'S, YOU KNOW,

NEW DIRECTIONS THAT THE MEDICAID
INTEGRITY PROGRAM IS MOVING IN,

JUST AS MEDICARE IS.

FOR EXAMPLE, THIS NEW EXECUTIVE
ORDER ON IMPROPER PAYMENTS IS

REQUIRING GREATER COOPERATION
ACROSS AGENCIES.

WE'RE WORKING MORE CLOSELY WITH
STATES, ALSO,

ON AUDITING EFFORTS.

I'M GOING TO GET INTO THAT A

LITTLE BIT MORE AS WE MOVE ON.

IN OUR REGULATORY REVIEW
PROCESS,

WHICH I'M ALSO GOING TO TALK
ABOUT, WE'RE MOVING AWAY

FROM EVALUATING STATES IN TERMS
OF PAPER COMPLIANCE

WITH THE REGULATIONS, AND TRYING
TO GET AT MORE OF AN ASSESSMENT

OF WHETHER THEY'RE ACTUALLY
BEING EFFECTIVE IN PRACTICE.

WE'RE ALSO ATTEMPTING TO
INCREASE TECHNICAL ASSISTANCE

TO STATES, ISSUING FREQUENTLY
ASKED QUESTIONS DOCUMENTS,

BEST PRACTICE DOCUMENTS,
PERFORMANCE STANDARD DOCUMENTS,

AND THE LIKE.

AND THEN, YOU KNOW, LAST BUT NOT
LEAST, WE'VE REORGANIZED IN CMS.

WE'VE CREATED THIS NEW CENTER
FOR PROGRAM INTEGRITY.

AND, YOU KNOW, IT'S HOPED THAT

BY COMBINING MEDICARE AND
MEDICAID

PROGRAM INTEGRITY SPECIALISTS
UNDER COMMON LEADERSHIP,

WE'RE GOING TO BE ABLE TO
COMMUNICATE MORE EFFECTIVELY,

EXCHANGE IDEAS, AND ACTUALLY
DEVELOP NEW TECHNIQUES

MORE QUICKLY AND EFFECTIVELY
THAN WE HAVE IN THE PAST.

CHALLENGES IN THE NEW
LANDSCAPE--YOU KNOW,

WITH THESE NEW DIRECTIONS,
THERE'S A LOT OF CHALLENGES

THAT WE'RE FACING. WE HAVE TO
FIND WAYS OF COORDINATING--

WE'VE GOT SO MANY NEW AGENCIES
NOW DOING AUDITS

AND NEW ENTITIES BEING CREATED,
LIKE RECOVERY AUDIT CONTRACTORS.

WE'VE GOT TO FIND A WAY TO
COORDINATE THEIR EFFORTS,

YOU KNOW, MORE EFFECTIVELY.

WE ALSO HAVE TO RESOLVE CERTAIN
ONGOING GAPS

IN OUR AUDIT ACTIVITIES.

AND THIS IS SOMETHING THAT'S
VERY RELEVANT

TO ALL OF YOU IN THIS AUDIENCE
BECAUSE ONE OF THE THINGS

THAT STANDS OUT IN MY MIND IS
THAT THE AUDIT ACTIVITY RIGHT

NOW IS PRIMARILY COVERING THE
FEE-FOR-SERVICE SYSTEM.

MANAGED CARE--WE STILL DON'T
ACTUALLY HAVE A GOOD METHODOLOGY

WORKED OUT ABOUT HOW TO AUDIT
PROVIDERS

IN THE MANAGED CARE SYSTEM TO
SEE IF THEY'RE RIPPING OFF

MANAGED CARE ENTITIES.

BUT WE DO HAVE EVIDENCE THAT

SOME OF THE PROVIDERS

THAT ARE CAUSING PROBLEMS ON THE
FEE-FOR-SERVICE SIDE

ARE GRAVITATING TO MANAGED CARE
AND CREATING PROBLEMS THERE.

SO THAT IS A BIG GAP THAT WE
HAVE TO ADDRESS.

AND THAT'S ONE OF THE THINGS

THAT, I THINK, MEDICARE AND
MEDICAID

HAVE TO POOL THEIR RESOURCES ON.

YOU KNOW, THAT'S AN URGENT
PRIORITY.

HEALTH CARE REFORM ALSO POSES A
WHOLE UNIQUE SET OF CHALLENGES.

WE'RE GOING TO HAVE TO FIGURE
OUT A WAY TO PROVIDE GUIDANCE

ON ALL THE HEALTH CARE REFORM
REQUIREMENTS THAT ARE COMING OUT

AND WE'RE GOING TO HAVE TO
FIGURE OUT ALSO HOW TO TAKE

THOSE REQUIREMENTS AND INTEGRATE
THEM INTO THE TOOLS THAT WE USE

TO MONITOR STATES.

TWO AREAS IN WHICH I THINK THE
NEW CENTER FOR PROGRAM INTEGRITY

CAN HELP FOLKS ON THE MEDICAID
SIDE, LIKE ME, AND FOLKS

LIKE YOURSELF ON THE MEDICARE
SIDE IS TO BETTER COMMUNICATE

ACROSS THE PROGRAMS IN TERMS OF
IDEAS FOR HOW TO AUDIT

MANAGED CARE ENTITIES
EFFECTIVELY

AND HOW TO PERFORM PROVIDER
ELIGIBILITY

AND SCREENING MORE EFFECTIVELY.

HEALTH CARE REFORM IS GOING TO
BE GIVING US SOME NEW TOOLS

IN TERMS OF NEW REQUIREMENTS FOR
SCREENING PROVIDERS.

AND I THINK WE HAVE TO FIGURE
OUT A WAY FOR MEDICAID TO BE

ABLE TO COMMUNICATE TO YOU
PROBLEM PROVIDERS THAT WE FIND

AT THE STATE LEVEL WHO OFTEN
CREEP INTO THE MEDICARE PROGRAM,

AND YOU HAVE TO BE ABLE TO
COMMUNICATE TO US

PROBLEM PROVIDERS THAT MAY NOT
YET BE EXCLUDED BUT WHO YOU'RE

INVESTIGATING. YOU'VE GOT
ISSUES--

MAYBE ON THE MANAGED CARE SIDE--
WHO CAN SLIP

INTO THE FEE-FOR-SERVICE PROGRAM
UNDETECTED

IF WE'RE NOT ALERTED TO PROBLEMS
THAT THEY'VE BEEN CAUSING

FOR INDIVIDUAL HEALTH PLANS.

NOW, I'M GOING TO SAY A LITTLE
BIT ABOUT JUST

HOW WE'RE ORGANIZED.

ESSENTIALLY THE MEDICAID
INTEGRITY PROGRAM WAS SET UP

BY--THE LAW THAT CREATED US.

THE DEFICIT REDUCTION ACT IS

NOW A PART OF SECTION 1936 OF
THE SOCIAL SECURITY ACT.

AND IT PROVIDES FOR TWO MAIN
LINES OF BUSINESS.

WE HAVE A NATIONAL AUDIT PROGRAM
THAT'S SET UP

BASICALLY DOING POST-PAYMENT
AUDITS OF PROVIDERS.

AND WE ALSO ARE REQUIRED BY LAW
TO PROVIDE

SUPPORT AND ASSISTANCE TO THE
STATES

ON FRAUD AND ABUSE ISSUES.

I'M GOING TO TALK A LITTLE BIT
ABOUT OUR AUDIT ACTIVITY.

ESSENTIALLY WHEN WE DO PROVIDER
AUDITING, WE HAVE TWO KINDS

OF CONTRACTORS INVOLVED IN THAT
EFFORT.

THE FIRST CONTRACTOR IS CALLED A
REVIEW OF PROVIDER.

WE SAY MIC--MEDICAID INTEGRITY
CONTRACTOR.

THE REVIEW OF PROVIDER MIC
BASICALLY RUNS ALGORITHMS.

THEY DO DATA MINING UNDER THE
DIRECTION

UNDER ONE OF OUR DIVISIONS IN
THE MEDICAID INTEGRITY GROUP--

THE DIVISION OF FRAUD RESEARCH

AND DETECTION.

THEY'RE TOLD BASICALLY WHAT
KINDS OF THINGS TO LOOK FOR

IN CERTAIN STATES.

THEY HAVE COLLECTED ALL OF THE
MEDICAID DATA THAT'S REPORTED

BY STATES IN A SUPERCOMPUTER

AT THE UNIVERSITY OF
CALIFORNIA--SAN DIEGO.

AND THEY'VE POOLED IT ALL. AND
THEY RUN ALGORITHMS

TO IDENTIFY, FOR EXAMPLE,
PROVIDERS WHO ARE GETTING

PAYMENTS AFTER THE DATE OF DEATH
OF A PATIENT

OR CERTAIN OTHER THINGS, CERTAIN
KINDS OF DRUG ISSUES--

OVERPRESCRIBING, DUPLICATE
PAYMENTS.

THE ALGORITHMS RANGE FROM VERY
SIMPLE

TO FAIRLY COMPLICATED AND
SOPHISTICATED ANALYSES.

WE TRY TO USE A DATA-DRIVEN
APPROACH SO THAT WE'RE

NOT JUST RANDOMLY PICKING OUT
PEOPLE FOR AUDITING,

BUT WE'RE PICKING OUT PEOPLE WHO
THE DATA SHOWS ARE

LIKELY CANDIDATES TO HAVE
RECEIVED OVERPAYMENTS.

THEREFORE WE'RE GOING TO GET
MORE BANG FOR OUR BUCK

BECAUSE ONE OF THE THINGS THE
LAW REQUIRES US TO DO,

OF COURSE, IS TO SHOW A HIGH
RETURN ON INVESTMENT.

THE LIST OF PROVIDERS THAT COME
OUT WHEN YOU RUN AN ALGORITHM,

FOR EXAMPLE, OVERPAYMENTS FOR
PEOPLE AFTER THE DATE OF DEATH--

WE TRY TO CHECK WITH MEDICARE
CONTRACTORS,

WITH LAW ENFORCEMENT AUTHORITIES
AT THE FEDERAL AND STATE LEVEL

AND ALSO WITH THE STATE MEDICAID
PROGRAM INTEGRITY PEOPLE

WHETHER THESE PROVIDERS ARE
ALREADY UNDER INVESTIGATION.

IF THEY ARE UNDER INVESTIGATION,

WE BACK OFF. WE DON'T WANT TO
GET IN THE WAY

OF AN ONGOING INVESTIGATION THAT
IS COVERING THE SAME AREA.

WE RESERVE THE RIGHT TO REVIEW
THE SAME PROVIDERS IF WE'RE

TALKING ABOUT A WHOLE DIFFERENT
SET OF ISSUES

OR A DIFFERENT TIME PERIOD.

BUT GENERALLY IF YOU TELL US
YOU'RE INVESTIGATING

THIS PERSON FOR THE SAME ISSUES,
WE WILL STEP BACK

AND LET YOU HANDLE THAT BECAUSE
OUR MISSION IS BASICALLY

TO SUPPLEMENT EXISTING AUDIT
ACTIVITY, NOT TO SUPPLANT IT.

AFTER THE VETTING PROCESS, AFTER
WE GET A LIST OF PROVIDERS

WHO'VE BEEN CLEARED, AS NOT
BEING UNDER INVESTIGATION BY

ANYBODY ELSE, WE TURN OVER THE
LIST OF PROVIDERS,

THE CLEARED PROVIDERS, THE
VETTED PROVIDERS

TO AN AUDIT CONTRACTOR.

AND THE AUDIT CONTRACTOR
BASICALLY CONDUCTS

POST-PAYMENT AUDITS USING
SO-CALLED GAGA STANDARDS--

GENERALLY ACCEPTED GOVERNMENT
AUDITING,

OR SOMETIMES CALLED YELLOW BOOK
STANDARDS.

THE AUDITS IDENTIFY
OVERPAYMENTS, BUT THE PROCESS--

AND HERE'S AN AREA WHERE
MEDICAID IS VERY DIFFERENT

FROM MEDICARE.

OUR CONTRACTORS DON'T ACTUALLY
COLLECT THE PAYMENTS.

WE HAVE TO HAVE THE STATES
COLLECT THE OVERPAYMENTS

FROM THE PROVIDERS BECAUSE THE
FEDERAL GOVERNMENT HAS

NO DIRECT CONTRACTUAL
RELATIONSHIP WITH PROVIDERS.

PROVIDERS SIGN THEIR PROVIDER

AGREEMENT FOR MEDICAID

WITH THE STATES. AND SO THEY
HAVE TO ACTUALLY GIVE

THE STATES BACK THE MONEY.

AND THEIR APPEAL RIGHTS, WHICH
THEY HAVE, ARE THE SAME AS

THE APPEAL RIGHTS THEY ENJOY IN
THE STATE.

SO TWO KEY STATE
RESPONSIBILITIES IN THIS PROCESS

ARE ACTUALLY COLLECTING THE
MONEY

AND THEN SUPPORTING THE PROCESS
THROUGH THE APPEAL PROCESS,

THE ADMINISTRATIVE HEARING
PROCESS THAT EXISTS IN MEDICAID

AS A COUNTERPART TO, YOU KNOW,
MEDICARE APPEAL RIGHTS.

THE STATISTICS ON THE SCREEN
RIGHT NOW JUST SHOW BASICALLY

HOW THE AUDITS BREAK OUT.

YOU CAN SEE THAT HOSPITALS ARE
NUMBER ONE.

LONG-TERM CARE IS ALSO
SUBSTANTIAL. NO SURPRISE HERE.

THE HIGH-DOLLAR TARGETS ARE THE
ONES THAT TEND TO GET AUDITED.

SO, YOU KNOW, ROUGHLY HALF OR
51% ARE, YOU KNOW, FACILITIES

TO WHICH WE PAY THE HIGHEST
AMOUNTS.

PHARMACIES ARE ALSO FAIRLY
SIGNIFICANT

IN THE AUDITING SCHEME OF THINGS.

OBVIOUSLY WHEN AUDITS OCCUR, YOU HEAR A LOT OF STRANGE STORIES.

MY FAVORITE AUDIT STORY IS ABOUT A PROVIDER WHO WE SENT

A LETTER, WHAT WE WOULD CALL A DEMAND LETTER, ASKING FOR

AN OVERPAYMENT TO BE RETURNED.

OUR CONTRACTOR ACTUALLY MADE A MISTAKE AND SENT IT

TO THE WRONG PROVIDER.

THEY GOT PROVIDER NUMBERS MIXED UP.

AND YET EVEN THOUGH THEY SENT IT TO THE WRONG PROVIDER,

THAT PROVIDER IMMEDIATELY SENT US BACK A CHECK

FOR \$100,000.

THE WORD IN OUR AGENCY WAS, WE'D BETTER GO AUDIT THAT GUY,

YOU KNOW, AND SEE WHAT DO THEY HAVE TO HIDE.

ANYWAY, YOU CAN SEE THIS SLIDE SHOWS THE IMPORTANCE

OF THE STATE ROLE IN THE PROCESS.

WE SOLICIT A LOT OF INFORMATION FROM STATES ABOUT

LIKELY PROVIDERS TO TARGET, AREAS IN SPECIFIC STATES

THAT IT WOULD BE WORTH OUR WHILE

TO RUN ALGORITHMS ON.

WE HAVE, YOU KNOW, LIKE I SAY, A
VERY LARGE DATABASE.

WE HAVE TO DO THIS IN CONCERT
WITH THE STATES

BECAUSE THEY KNOW THE LANDSCAPE,
THEY KNOW THE ENVIRONMENT.

THEY KNOW WHERE THE PROBLEMS ARE
AND WHERE THE BODIES ARE BURIED.

SO WE CONSULT WITH STATES AT ALL
TIMES IN TRYING TO DEVELOP,

YOU KNOW, OUR DATA-DRIVEN
PROCESSES.

STATES ALSO PLAY A KEY ROLE IN
VETTING THE PROVIDERS

AND TELLING US WHICH ONES ARE

NOT SUITABLE TARGETS

BECAUSE THEY MIGHT BE UNDER
INVESTIGATION.

THEY REVIEW OUR DRAFT AUDIT
REPORTS.

THEY ALSO REVIEW OUR FINAL AUDIT
REPORTS.

AND AS I MENTIONED, THEY'RE
RESPONSIBLE FOR RECOVERING

OVERPAYMENTS AND RUNNING THE
APPEALS PROCESS

IN ACCORDANCE WITH THE EXISTING
MEDICAID APPEAL RIGHTS.

A THIRD TYPE OF CONTRACTOR

THAT WE HAVE IS

AN EDUCATION CONTRACTOR.

THE LAW SAYS BESIDES REVIEWING
AND IDENTIFYING PROVIDERS,

WHO'VE RECEIVED OVERPAYMENTS AND
AUDITING THEM, THAT WE'RE

ALSO SUPPOSED TO BE CONDUCTING
EDUCATION ON PAYMENT INTEGRITY

AND OTHER PROGRAM INTEGRITY
ISSUES FOR PROVIDERS,

MANAGED CARE ORGANIZATIONS,
RECIPIENTS, AND OTHERS.

THE LANGUAGE IS FAIRLY GENERAL,
BUT IT GIVES US

A BROAD EDUCATIONAL MANDATE.

AND WE HAVE ACTUALLY, YOU KNOW,
LET OUT BIDS TO GET

A COUPLE OF CONTRACTORS ON
STAND-BY TO PERFORM

EDUCATIONAL TASKS.

AND WE AWARDED A TASK ORDER--
ACTUALLY TWO TASK ORDERS

TO ONE OF THOSE TWO CONTRACTORS.

THEY'RE CALLED STRATEGIC HEALTH
SOLUTIONS.

WE HAVE THEM DOING ONE TASK
ORDER ON GENERAL EDUCATION

ON PROGRAM INTEGRITY BASED ON A
GAP ANALYSIS,

WHICH I'M GOING TO EXPLAIN.

AND WE ALSO HAVE THEM DOING

SOME MORE SPECIALIZED PROVIDER
EDUCATION BASED ON OUR FINDINGS

IN CERTAIN ALGORITHMS RELATING
TO PHARMACY ABUSE.

NOW, THE APPROACH THAT THE
EDUCATIONAL CONTRACTOR

IS USING IN THE MORE GENERAL
PROGRAM INTEGRITY EDUCATION IS

THEY BASICALLY HAVE DONE AN
ENORMOUS ENVIRONMENTAL SCAN

OF WHAT PROGRAM INTEGRITY
MATERIALS EXIST AS USED

BY STATES, BY MANAGED CARE
ORGANIZATIONS,

AND TO SOME EXTENT ALSO BY LAW
ENFORCEMENT ORGANIZATIONS,

ADVOCACY ORGANIZATIONS, AND SO
ON.

WHAT KIND OF STUFF IS OUT THERE

PROVIDING EDUCATION AND TRAINING
ON PROGRAM INTEGRITY ISSUES?

AFTER DOING THAT, THEY IDENTIFY
GAPS.

WHERE DO WE HAVE MATERIALS
LACKING EXPLAINING

THE CONSEQUENCES OF ENGAGING IN
FRAUD, FOR EXAMPLE,

OR WHAT IT MEANS IF YOU GET
CAUGHT ENGAGING

IN FRAUD AND ABUSE IN THE
PROGRAM?

THEY ISSUED A GAP ANALYSIS
REPORT TO US.

AND IN CONCERT WITH CMS,

WE CAME UP WITH SOMETHING LIKE

14 PRIORITY AREAS THAT THEY'RE
GOING TO BE DEVELOPING

TRAINING MATERIALS ON OVER THE
NEXT 4 YEARS.

THE AREAS ARE LISTED HERE.

AND YOU CAN SEE THAT IN ADDITION
TO CERTAIN PROVIDER TYPES

THAT, YOU KNOW, ARE

SPECIFIC AREAS WITHIN THE
MEDICAID PROGRAM KNOWN AS

HIGH-RISK PROVIDER TYPES, SOME
OF THESE WE HAVE IN COMMON:

DME, HOME HEALTH. YOU KNOW, NEED
I SAY MORE?

OTHERS ARE MORE SPECIFIC TO
MEDICAID,

LIKE DENTAL AND TRANSPORTATION
BECAUSE OF THE LIMITED NATURE

OF THE BENEFITS ON THE MEDICARE
SIDE.

BUT THEN WE ALSO HAVE A WHOLE
ISSUE ON RECIPIENT FRAUD

AND WE HAVE CROSS-CUTTING
ISSUES, SUCH AS, IN PARTICULAR,

TWO ISSUES THAT STAND OUT-- THE
IMPORTANCE OF CHECKING

FOR EXCLUDED INDIVIDUALS,

AND THE IMPORTANCE OF PROVIDING
ADEQUATE DOCUMENTATION,

YOU KNOW, TO SUPPORT CLAIMS THAT
YOU SUBMIT.

AND THAT, OF COURSE, IS

SOMETHING THAT CUTS ACROSS

ALL OF OUR PROGRAMS.

THE NEXT SLIDE, ACTUALLY SHOWS
WHO THE CONTRACTORS ARE

THAT ARE DOING THE VARIOUS WORK,
THEIR REVIEW PROVIDERS.

WE HAVE TWO OF THEM CURRENTLY
OPERATING.

YOU KNOW, EACH OF THEM HAS A
TASK ORDER THAT COVERS

TWO CMS REGIONS, WHICH ARE
LISTED.

WE HAVE 3 AUDIT CONTRACTORS THAT
HAVE BEEN AWARDED TASK ORDERS

IN THE SAME REGIONS.

AND THEN WE HAVE ONE EDUCATION
CONTRACTOR.

AND IN ALL CASES, WE DID A
PRELIMINARY BID PROCESS

TO SELECT UMBRELLA CONTRACTORS
WHO WOULD BE AVAILABLE

TO DO THE WORK.

AND THEN FOR EACH OF THESE TASK
ORDERS, WE LET

THOSE CONTRACTORS BID ON IT.

AND THESE ARE THE ONES THAT WERE
SELECTED.

THE OTHER LINE OF BUSINESS THAT
I WANT TO MENTION--

AND I MENTIONED EARLIER--WAS

SUPPORT AND ASSISTANCE TO THE
STATES.

THIS TAKES MANY FORMS.

YOU KNOW, PROGRAM INTEGRITY
REVIEWS.

I'M GOING TO GO OVER THESE
BRIEFLY.

TECHNICAL ASSISTANCE, FIELD
PROJECTS, AND SO ON.

I MYSELF AM DIRECTLY INVOLVED IN
THIS ACTIVITY--

PROGRAM INTEGRITY REVIEWS.

WE BASICALLY REVIEW ALL STATES
ON A TRIENNIAL SCHEDULE.

SO WE REVIEW 17 TO 18 STATES PER
YEAR, INCLUDING

WASHINGTON, D.C., AND PUERTO
RICO.

SINCE WE STARTED IN MARCH OF
2007,

WE'VE DONE 57 COMPREHENSIVE
PROGRAM INTEGRITY REVIEWS.

WE PERFORM THESE REVIEWS WITH
CERTAIN THINGS IN MIND.

WE WANT TO IDENTIFY
CIRCUMSTANCES WHERE STATES

ARE NOT IN REGULATORY
COMPLIANCE.

WE WANT TO IDENTIFY OTHER
PROGRAM WEAKNESSES THAT MAY NOT

RISE TO THE LEVEL OF A VIOLATION
OF FEDERAL REGS,

BUT THEY'RE A WEAKNESS
NONETHELESS.

BUT WE ALSO WANT TO LOOK FOR
OPPORTUNITIES

TO PROVIDE TECHNICAL ASSISTANCE.

AND WE WANT TO LOOK FOR
EFFECTIVE PRACTICES

THAT STATES ARE USING THAT WE
CAN SHARE WITH OTHER STATES

IN DIFFERENT AREAS BECAUSE A LOT
OF TIMES, STATES CAN LEARN

FROM ONE ANOTHER--THE ONES THAT
ARE DOING CERTAIN THINGS WELL.

AND I CAN HONESTLY SAY THAT WHEN
WE GO OUT IN THE FIELD,

ALTHOUGH WE'VE FOUND STATES THAT
HAVE HAD A LOT OF INSTANCES

OF NONCOMPLIANCE, THAT OFTEN

FALLS INTO CERTAIN TYPICAL
PATTERNS.

AND WE'VE NEVER HAD A REVIEW
WHERE WE HAVEN'T FOUND STATES

DOING SOME THINGS WELL THAT
OTHER STATES CAN LEARN FROM.

SOME OF THE MOST COMMON FINDINGS
ON OUR REVIEWS HAVE TO DO WITH

DISCLOSURES DURING PROVIDER
ENROLLMENT PERIOD.

FEDERAL REGULATIONS IN MEDICAID
REQUIRE THAT YOU DISCLOSE

OWNERSHIP AND CONTROL AND, YOU
KNOW, FAMILY RELATIONSHIPS,

RELATIONSHIPS WITH
SUBCONTRACTORS

AND THINGS LIKE THAT, AS PART OF

THE ENROLLMENT PROCESS.

YOU'RE ALSO REQUIRED IN YOUR
PROVIDER AGREEMENT TO DISCLOSE

CERTAIN BUSINESS TRANSACTION
INFORMATION IF IT'S REQUESTED

BY THE SECRETARY OR THE STATE
AGENCY, AND YOU'RE ALSO REQUIRED

TO DISCLOSE HEALTH CARE-RELATED
CRIMINAL CONVICTION INFORMATION.

THIS IS BASICALLY CRIMINAL
CONVICTION INFORMATION

RELATING TO MEDICAID, MEDICARE,

OR OTHER HEALTH PROGRAMS.

BUT NOT JUST FOR YOURSELF--
ACTUALLY, FOR OWNERS, AGENTS,

AND MANAGING EMPLOYEES OF A
GIVEN PROVIDER.

AND WE FOUND THAT A LOT OF
STATES ARE USING

ENROLLMENT FORMS AND OTHER
PRACTICES WHERE

THE PROVIDER AGREEMENT DOESN'T
PROVIDE FOR DISCLOSING

BUSINESS TRANSACTION
INFORMATION.

AND THE OTHER DISCLOSURES, YOU

KNOW, AREN'T PROVIDED FOR

IN THE FORMS.

SO WE DON'T ALWAYS KNOW, AS A
RESULT

WHETHER WE'RE HIRING SOMEONE
WHO'S GOT A MANAGING EMPLOYEE

WORKING IN A STRATEGIC POSITION

WHERE THEY'RE RESPONSIBLE FOR
BILLING,

AND THEY'VE ALREADY BEEN
EXCLUDED FROM 3 OTHER STATES--

MEDICAID PROGRAMS, FOR EXAMPLE,
OR OWNERS THAT HAVE CONVICTIONS.

YOU KNOW, WE'RE NOT GETTING THAT
KIND OF INFORMATION.

YOU KNOW, THE STATE HAD THEY
KNOWN THAT MIGHT HAVE DECIDED

NOT TO ALLOW THEM INTO THE
MEDICAID PROGRAM.

NOW, UNDER HEALTH CARE REFORM,
THERE IS GOING TO BE

MORE EXTENSIVE BACKGROUND CHECKS
REQUIRED.

THERE'S ALSO SOME REQUIREMENTS--
THE LANGUAGE IS KIND OF VAGUE,

AND WE'RE STILL DEVELOPING
REGULATIONS--

BUT WE'RE HOPING THAT BOTH
MEDICAID AND MEDICARE WILL SHARE

INFORMATION ABOUT WHAT THEY'RE
FINDING,

NOT JUST THAT THE STATES WILL
BE, YOU KNOW, COMPLIANT

WITHIN THEIR OWN WORLD, WHICH IS
LIMITED,

BUT THAT THEY'LL BE PROVIDING
INFORMATION ON WHAT THEY FIND

IN SOME KIND OF PLATFORM, WHERE
MEDICARE WILL BE ABLE TO

SEE IT AND DRAW CONCLUSIONS
ABOUT IT,

AND SIMILARLY, STATES WILL BE
ABLE TO FIND OUT MORE

ABOUT WHAT OTHER STATES ARE
SEEING,

AND SO WE CAN KEEP THE REAL
PROBLEM PROVIDERS OUT

MORE EFFECTIVELY.

AND AS YOU KNOW, WITH PROVIDERS,
A LOT OF THIS HAS TO DO

WITH THE 80/20 RULE.

YOU KNOW, IF WE CAN GET THE 20%
OF PROBLEM PROVIDERS OUT,

80% OF OUR PROBLEMS GO AWAY.

SO WE--PLACE GREAT STRESS ON
THAT.

AND ONE CHANGE THAT'S COMING--

AND I MADE A REFERENCE TO THIS
EARLIER--IS PREVIOUSLY,

YOU KNOW, WHEN WE DID OUR
REVIEWS COVERING ALL THE STATES

THE FIRST TIME AROUND, WE LOOKED
BASICALLY TO SEE

WHAT THEY WERE DOING. AND A LOT
OF TIMES, OUR EVALUATIONS TENDED

TO FOCUS ON PAPER COMPLIANCE,
YOU KNOW,

DOES THE PROVIDER AGREEMENT
CONTAIN THIS PARTICULAR CLAUSE?

DOES THE PROVIDER APPLICATION
CONTAIN LANGUAGE

THAT ECHOES THE FEDERAL
REGULATIONS?

NOW AS WE GO ON A SECOND CYCLE
OF REVIEWS, WE'RE GOING TO BE

LOOKING MORE--ASKING HARDER
QUESTIONS, AND LOOKING,

"WELL, YOU MAY BE COMPLIANT, BUT
IS WHAT YOU'RE DOING

ACTUALLY EFFECTIVE?"

WE'VE FOUND THAT, YOU KNOW,
STATES CAN BE 100% COMPLIANT

ON THE BOOKS. YOU KNOW,
OFFICIALLY THEY CAN LOOK GREAT,

AND YET LET'S SAY THEIR AUDIT
ACTIVITY, IF YOU LOOK AT

ALL THE DIFFERENT PROVIDER
TYPES,

THAT ARE IN A STATE MEDICAID
PROGRAM, IT'S A WIDE RANGE.

MAYBE EVEN GREATER THAN THE
DIFFERENT PROVIDER TYPES

UNDER MEDICARE. THEY MIGHT BE
AUDITING 20%

OF THOSE PROVIDER TYPES,

WHO ACCOUNT FOR 20% OF PROGRAM
REVENUE AS OPPOSED

TO THE LARGER PROVIDER TYPES,
THAT ACCOUNT FOR THE BIG BUCKS

IN THE PROGRAM.

SO WE'RE GOING TO BE ASKING
QUESTIONS LIKE THAT

AND TRYING TO ASSESS ACTUAL

EFFECTIVENESS AS WE GO FORWARD.

ANOTHER AREA THAT WE COVER IS
TECHNICAL ASSISTANCE.

I CAN SEE THAT TIME IS RUNNING
OUT ON ME.

BASICALLY WE'VE HANDLED OVER
1,000 REQUESTS OF ALL TYPES.

YOU CAN SEE THAT THERE'S, YOU
KNOW, MANY DIFFERENT SOURCES

OF OUR REQUESTS.

WE GET A LOT FROM LAW
ENFORCEMENT,

WE GET FROM STATES, OTHER
GOVERNMENT AGENCIES.

INTERESTINGLY, THE MOST COMMON
TYPE, THOUGH, IS ACTUALLY

STATISTICAL REQUESTS.

WE HAVE A STATISTICIAN ON BOARD.

ACTUALLY HIS NAME IS STEVE
[INDISTINCT].

SOME OF YOU IN MEDICARE MAY KNOW
HIM.

HE'S GOT A NATIONAL REPUTATION
HELPING ON MEDICARE CASES.

AND HE GIVES A LOT OF ASSISTANCE
TO STATES.

AND, BY THE WAY, ALL OF OUR
STAFF ARE ASSIGNED STATES

AS STATE LIAISONS. SO THEY EACH
HAVE, LIKE, TWO OR 3 STATES.

THE WORD IS OUT. THE STATES KNOW
THAT THIS IS THE GO-TO PERSON,

IF THEY HAVE QUESTIONS, IF THEY
HAVE REQUESTS FOR INFORMATION,

FOR TECHNICAL ASSISTANCE AND SO
ON.

SO THE NUMBER OF TECHNICAL
ASSISTANCE REQUESTS

KEEPS GROWING AS OUR STANDARD
OPERATING PROCEDURES

BECOME KNOWN AND STATES GET MORE
COMFORTABLE WORKING

WITH THE SPECIFIC PEOPLE
ASSIGNED TO THEM.

ANOTHER WAY IN WHICH WE HELP
STATES

IS SPECIAL FIELD PROJECTS.

WE'VE ALREADY DONE SOMETHING
LIKE 6 PROJECTS

SINCE OCTOBER 2007-- 5 IN
FLORIDA, ONE IN CALIFORNIA,

WHERE WE'VE PUT EXTRA PEOPLE ON
THE GROUND

HELPING DO MONITORING.

WE'VE DONE DME AND HOME HEALTH
PROJECTS IN FLORIDA,

HELPING THE STATE AGENCY,

AND WE'VE ALSO DONE A WEST
HOLLYWOOD PROJECT

IN CALIFORNIA WITH A SERIES OF
SORT OF ETHNICALLY-BASED

PROBLEM PROVIDERS THERE.

AND IN THE FIRST 3 OF THESE
PROJECTS THROUGH 2008,

THE STATES HAVE DOCUMENTED
SOMETHING LIKE \$10-PLUS-MILLION

IN COST AVOIDANCE.

WE'VE ALSO SET UP A SURVEY
CALLED

THE STATE PROGRAM INTEGRITY
ASSESSMENT QUESTIONNAIRE

IN WHICH WE CIRCULATE A
QUESTIONNAIRE

WITH ALL SORTS OF PROGRAM
INTEGRITY QUESTIONS TO STATES.

AND THIS IS SOMETHING--WE'VE
MADE A COMMITMENT

TO COLLECTING INFORMATION ABOUT
WHAT STATES ARE DOING

AT THE STATE LEVEL THAT WE NEVER
DID IN ALL THE YEARS

WHEN WE JUST LEFT PROGRAM
INTEGRITY TO THE STATES

WITH SORT OF BENIGN NEGLECT.

WE NEVER ACTUALLY KNEW HOW MUCH
MONEY STATES WERE SPENDING

ON PROGRAM INTEGRITY.

WE NEVER KNEW HOW MANY EMPLOYEES
THEY HAVE.

WELL, NOW WITH THESE PROGRAMS,
WE HAVE COLLECTED DATA.

WE HAVE THE RESULTS PUBLISHED
FROM OUR FIRST SURVEY.

THIS REQUIRED OMB APPROVAL, BY
THE WAY,

BECAUSE OF THE PAPERWORK
REDUCTION ACT.

YOU CAN SEE THE RESULTS SORT OF
IN GENERAL TERMS

FROM FEDERAL FISCAL YEAR 07, AND
WE ARE PROCESSING RIGHT NOW

THE FY 2008 RESULTS.

ONE OF OUR PROUDEST
ACCOMPLISHMENTS, ACTUALLY

IN THE MEDICAID INTEGRITY
PROGRAM IS THE CREATION OF

AN ACADEMY FOR TRAINING CALLED

THE MEDICAID INTEGRITY
INSTITUTE.

WE USED PART OF OUR
CONGRESSIONAL APPROPRIATION,

APPROXIMATELY 12.4 MILLION
COMMITTED OVER A 7-YEAR PERIOD,

TO ESTABLISH A TRAINING
INSTITUTE AT AN EXISTING

DEPARTMENT OF JUSTICE TRAINING
FACILITY

ON THE UNIVERSITY OF SOUTH
CAROLINA CAMPUS.

AND--THIS IS IN RESPONSE TO AN
ISSUE THAT STATES HAVE FACED

ALWAYS BECAUSE OF CHRONIC
FUNDING SHORTAGES.

THEY HIRE PEOPLE, THEY DON'T
HAVE THE MONEY TO TRAIN THEM

WITH THE PROPER EXPERTISE IN
PROGRAM INTEGRITY,

INVESTIGATIVE TECHNIQUES--
INTERVIEWING, CODING,

AND THINGS LIKE THAT.

SO WE'RE DOING THAT, ACTUALLY,
FREE OF CHARGE.

WE'VE TRAINED 1,250 STATE
EMPLOYEES THROUGH FY 09.

WE ESTIMATE ABOUT 1,900 WILL
BE TRAINED THROUGH THE END OF
THIS FISCAL YEAR.

WE'VE DONE 16 CLASSES.

WE HAVE 16 CLASSES CONDUCTED
THIS YEAR AND PROBABLY ABOUT

38 CLASSES IN ALL THAT WE'VE
OFFERED.

THE CLASSES VARY

FROM SORT OF BASIC KIND OF
INTRODUCTORY CONCEPTS

TO THINK TANK SYMPOSIUMS.

WE'VE HAD EMERGING TRENDS IN
MANAGED CARE,

PHARMACY, DME, AND HOME HEALTH,
AND THINGS LIKE THAT.

WE'VE ALSO HAD DATA ANALYSIS
SYMPOSIUMS.

AND IT'S BEEN VERY SUCCESSFUL.

THAT'S ONE THING.

YOU KNOW, STATES COMPLAIN ABOUT
THE AUDIT BURDEN.

WITH THE CHANGING LANDSCAPE,

THERE'S ALL SORT OF NEW
ORGANIZATIONS AUDITING THEM,

MORE INTEREST IN PROGRAM

INTEGRITY,

BUT ONE THING THEY ALWAYS PRAISE

IS THE MEDICAID INTEGRITY
INSTITUTE.

SOME OF THE MORE OBVIOUS KINDS
OF TECHNICAL ASSISTANCE,

WE HAVE WRITTEN A NUMBER OF
STATE MEDICAID DIRECTOR LETTERS

ON POLICY ISSUES.

WE HAVE ISSUED BEST PRACTICE
DOCUMENTS

AND PERFORMANCE STANDARD
DOCUMENTS

ON A VARIETY OF ISSUES, SUCH AS
FRAUD REFERRALS.

WE HAVE ISSUED STATE MEDICAID
DIRECTORS ON EXCLUSION POLICY,

TAMPER-RESISTANT DRUG PAD
POLICIES.

AND WE'VE GOT A LOT OF OTHER
THINGS COMING OUT.

AT THIS POINT, I'M JUST GOING TO
MENTION THAT, YOU KNOW, WE

HAVE DONE A GREAT DEAL TO GET A
NATIONAL MEDICAID PROGRAM

OFF THE GROUND, BUT I THINK
THERE'S A LOT MORE WE CAN DO

AT THIS POINT TO KIND OF FIRM UP
OUR TIES AND OUR RELATIONSHIPS

AND HAVE MORE EFFECTIVE
COMMUNICATION WITH MEDICARE.

AND, YOU KNOW, I WANT TO LEAVE
YOU WITH THAT THOUGHT--

THAT IT'S ESPECIALLY IMPORTANT
IN THE MANAGED CARE WORLD

BECAUSE ONE OF THE AREAS WHERE
WE'RE STILL FACING

SORT OF A BLACK HOLE IS WHAT'S
HAPPENING

IN THE MANAGED CARE WORLD.

WE DON'T KNOW THE EXTENT TO
WHICH PROVIDERS MAY BE

RIPPING OFF MANAGED CARE
ENTITIES.

WE DON'T HAVE DATA FROM MANAGED
CARE ENTITIES

THAT WE CAN AUDIT EFFECTIVELY.

WE WORK AROUND THE AGES.

WE CAN TELL

WHEN IMPROPER CAPITATION
PAYMENTS ARE BEING MADE,

BUT WE CAN'T ALWAYS TELL HOW
WISELY THE MONEY IS BEING SPENT

THAT WE HAVE, YOU KNOW, EXPENDED
IN THAT ARENA.

AND SO THIS IS AN AREA THAT I
THINK WE ALL HAVE TO POOL

OUR RESOURCES AND PUT MORE
EFFORT INTO AS TIME GOES ON.

AND THEN I'VE ALSO LEFT IN THE
REMAINING SLIDES,

YOU CAN SEE OUR CMS WEB SITE,
GENERAL CONTACT INFORMATION.

IF ANYBODY HAS ANY SUGGESTIONS
FOR OUR PROGRAM,

THERE'S A CORPORATE ADDRESS.

AND MY PERSONAL CONTACT
INFORMATION IS ALSO INCLUDED.

THANK YOU VERY MUCH.

[APPLAUSE]

>> I'M JEAN STONE.

I'M THE DIRECTOR OF THE NEW
YORK FIELD OFFICE, AND I OVERSEE

MEDICARE FRAUD DETECTION
AND PREVENTION IN NEW YORK,

PARTS OF NEW JERSEY,
AND PUERTO RICO

AND THE VIRGIN ISLANDS.

I'M HERE TODAY TO TALK TO YOU
ABOUT A PROBLEM THAT IS NOT

SPECIFIC TO MEDICARE FEE-FOR-
SERVICE, BUT I WANT TO TALK TO

YOU ABOUT WHAT WE'RE DOING
ON THE FEE-FOR-SERVICE SIDE

BECAUSE IT HAS DIRECT
IMPLICATIONS FOR YOU

ON THE MANAGED CARE
SIDE OF THE HOUSE.

IN THE INTRO ON MY BIO,
IT TALKED ABOUT MY STINT

AT THE MIAMI FIELD OFFICE,
AND AT THAT TIME, IT WAS

IN 2005 WHEN INFUSION FRAUD
WAS JUST GETTING OFF THE

GROUND ON FEE-FOR-SERVICE,
AND WE DID SUCH A GOOD JOB,

WE BASICALLY DROVE IT NORTH
INTO GEORGIA AND OTHER STATES,

AND WE DROVE IT
INTO MANAGED CARE.

A NUMBER OF THE INDIVIDUALS
WERE DUAL ELIGIBLES WHO WERE

THEN ENROLLING IN MANAGED
CARE PLANS, STAYING JUST LONG

ENOUGH TO GET THINGS
BILLED ON THEIR BEHALF.

BECAUSE MOST OF THEM WERE
DUAL ELIGIBLES, THEY WERE NOT

LOCKED IN AND THEY
COULD JUST CHANGE PLANS.

AND THEY WERE CHANGING PLANS
EN MASSE SO THAT THEY WERE,

YOU KNOW, A GROUP OF 90
BENEFICIARIES ALL MOVING FROM

ONE PLAN TO ANOTHER PLAN
ON A REGULAR BASIS.

THE PLAN THEY'VE JUST LEFT
GETS BILLED FOR, YOU KNOW,

\$10,000 WORTH OF INFUSION
TREATMENTS 3 TIMES A WEEK

FOR A MONTH, AND THAT ALONE--
AND A LOT OF PLANS DON'T HAVE

THE EDITS IN PLACE, AS WE DID
NOT, SO YOU ALL ARE JUST AS

VULNERABLE AS WE ARE
TO BEING RIPPED OFF.

SO A LOT OF WHAT'S GOING ON
ON THE FEE-FOR-SERVICE SIDE

OF THE HOUSE HAS
RESONANCE ON YOUR SIDE.

I WANT TO WELCOME YOU TO
BROOKLYN BECAUSE RIGHT NOW

IT'S THE SITE OF
OUR STRIKE FORCE.

WE'VE GOT DEPARTMENT OF
JUSTICE, OFFICE OF INSPECTOR

GENERAL, FBI AGENTS,
CMS STAFF, POSTAL, THE MFCU,

AND THE OFFICE OF MEDICAID
INSPECTOR GENERAL AGENTS.

THEY'RE HOUSED RIGHT AT
THE U.S. ATTORNEYS OFFICE

ABOUT A BLOCK AND
A HALF FROM HERE.

THEY'VE MADE 8 ARRESTS SO
FAR AND MORE TO COME.

IT'S ONE OF 7 CURRENT
STRIKE FORCE LOCATIONS.

WE STARTED, OF COURSE,
IN MIAMI AND THEN L.A.,

HOUSTON, DETROIT, BROOKLYN,
TAMPA, AND BATON ROUGE,

AND THERE ARE MORE
WAITING TO COME FORWARD.

THE DEPARTMENT OF JUSTICE HAS
A PLAN TO ROLL OUT TO MORE

SPECIFIC CITIES.

THESE ARE OUR HIGHEST RISK,
AND YOU ARE IN THE HEARTLAND

OF HIGH RISK RIGHT NOW.

THIS IS MY CONTACT
INFORMATION.

IF YOU HAVE ADDITIONAL
QUESTIONS, YOU CAN REACH ME

VIA EMAIL OR PHONE OR THROUGH

ANY OF THE REGIONAL PEOPLE

IN NEW YORK WHO KNOW ME WELL.

I ALSO WANT TO TELL YOU THAT
THERE'S A GREAT--FOR RESOURCES

FOR INFORMATION, THERE'S A
WEBSITE NOW THAT'S CALLED

WWW.STOPMEDICAREFRAUD.GOV.

YOU CAN GO IN AND CLICK ON
THE MAP BY STATE AND GET ALL

OF THE FRAUD INDICTMENTS AND
CONVICTIONS IN YOUR STATE.

IT'S A GREAT SOURCE OF
INFORMATION BECAUSE THE STATE

AGENCIES, THE MFCUs AS WELL
AS THE FEDS, ARE POSTING PRESS

RELEASES AS THEY ARREST
SOMEBODY, AS THEY CONVICT

SOMEBODY, AS THEY
SENTENCE SOMEONE.

AND IT'S A VERY INTERESTING
PLACE TO GO BECAUSE SOMETIMES

YOU SEE--YOU RECOGNIZE NAMES
THAT NO ONE HAS TOLD YOU WHO

WAS ALREADY INDICTED.

IT'S REALLY FUN.

LET'S START, SHALL WE?

MEDICARE IDENTITY THEFT--IT'S
WHERE I SPEND A LOT OF MY TIME

BECAUSE IT'S THE FASTEST-
GROWING PART OF FRAUD.

IT'S NOT JUST STEALING--AND
IT'S MEDICAL IDENTITY THEFT

THAT I'M HERE TO
TALK ABOUT TODAY.

IT'S THE MISUSE OF ANOTHER
INDIVIDUAL'S INFORMATION,

AND WHAT WE'VE DONE IS TRIED
TO DEVELOP CONSISTENCY IN HOW

WE TALK ABOUT THIS
PARTICULAR PROBLEM.

SO IT'S A THEFT OF A PERSON'S
IDENTITY, AND IT CAN BE AS

SIMPLE AS THE THEFT OF
A MEDICARE CARD.

SOMEONE LOSES THEIR WALLET.

IT CAN BE, YOU KNOW,
SOMEONE WHO'S IN COLLUSION

AT A PROVIDER'S OFFICE WHO
TAKES THE INFORMATION,

THEY XEROX YOUR DRIVER'S
LICENSE AND YOUR MEDICARE

CARD, AND THEY MAKE AN EXTRA
COPY AND SELL IT OUT

THE BACK DOOR.

AND THIS HAS SAFETY RISKS.

IT CAUSES FINANCIAL BURDENS
TO US, THE TRUST FUND,

AND THE BENEFICIARIES.

AND AS WE'RE MOVING TOWARD
ELECTRONIC HEALTH RECORDS,

AS THAT INFORMATION IS
BEING USED TO BILL MEDICARE

AND PRIVATE INSURERS
THROUGH THE SUPPLEMENTAL SIDE

OF THE HOUSE, THAT INFORMATION
IS GETTING INTO THE NATIONAL

CLAIMS HISTORY, AND IT'S
GETTING INTO THAT INDIVIDUAL

BENEFICIARY'S PROFILE.

SO THAT WHEN WE HAD THE
INFUSION FRAUD ISSUE

IN FLORIDA, THEY WERE BILLING
PATIENTS AS IF THEY HAD

HIV OR AIDS.

WHEN WE STARTED
CLAMPING DOWN ON THAT,

THEY STARTED BILLING THEM
AS IF THEY HAD CANCER.

WELL, IF ANYBODY IS USING
OUR MEDICARE DATA BASE, WHICH

A LOT OF RESEARCHERS DO,
THAT SCREWS UP THEIR DATA

FOR THEM BIG-TIME, ESPECIALLY
WHEN WE WERE PAYING 10 TIMES

MORE FOR IVIG IN FLORIDA THAN
THE WHOLE REST OF THE COUNTRY.

SO WHEN YOU'RE USING THAT,
YOU KNOW, OUR MEDICARE DATA

BASE TO DO SOME KIND OF
FORECASTING OR PUBLIC HEALTH

KINDS OF THINGS, ESPECIALLY
WITH HIV/AIDS POPULATION,

SCREWED-UP DATA HAS

RAMIFICATIONS AND RIPPLES WAY

BEYOND THE PAYMENTS OUT OF
THE MEDICARE TRUST FUND.

SO THIS TYPE OF THEFT NOT
ONLY HARMS BENEFICIARIES

AND PROVIDERS AND THE
TRUST FUND, BUT IT'S GOT

A RIPPLE EFFECT.

SOMETIMES THE
NUMBERS ARE STOLEN.

SOMETIMES SOMEBODY
JUST WANTS A LAPTOP.

THEY GET THE LAPTOP,
THEY LOOK IN IT,

AND "GEE. THERE'S PERSONAL
HEALTH INFORMATION IN HERE."

THIS IS EITHER A MARKETING
REP'S INFORMATION ABOUT WHERE

THE INDIVIDUALS LIVE, HOW OLD
THEY ARE, WHAT THEIR MEDICARE

NUMBERS AND MEDICAID NUMBERS
ARE, OR IT'S A VERY TARGETED

THEFT WHERE THEY ARE PICKING
EMPLOYEES OR CONTRACTORS OR

HEALTH PLANS.

AND SOMETIMES THE
BENEFICIARIES THEMSELVES ARE

IN THE MARKET TO
SELL THEIR NUMBERS.

THEY ARE PROFESSIONAL
PATIENTS, AND IT'S BECOMING

A GROWING PROBLEM.

WHAT WE'RE DOING NOW IS TRYING
TO GATHER ALL THE INFORMATION.

WE HAVE A NUMBER OF--PEOPLE
TALK ABOUT COMPROMISED

NUMBERS, AND THEY'RE OUT
THERE, SO WHAT I'VE TRIED TO

DO WITH A CONTRACTOR AND WITH
A WORK GROUP OF CMS PEOPLE IS

TO COME UP WITH
A CONSOLIDATED DATA BASE.

WHO ARE THESE PEOPLE, AND
CAN WE GET A NATIONAL BASE?

SO THAT IF I HAVE A NEW YORK
BENEFICIARY WHOSE NUMBER IS

COMPROMISED, THE CONTRACTOR
THAT OVERSEES HAWAII IS NOT

GOING TO KEEP
PAYING THOSE CLAIMS.

SO RIGHT NOW WE KNOW ABOUT
5,000 PROVIDERS AND ABOUT OVER

200,000 MEDICARE
BENEFICIARIES.

THESE ARE WHERE THE
BENEFICIARIES LIVE, AND YOU

CAN SEE FLORIDA IS BLACK
OR BLUE BECAUSE IT'S

HIGHLY BRUISED.

THE NORTHEAST, WHERE WE ARE
TODAY, IS ALSO THE SAME.

YOU GOT TO GET OUT IN THE
MIDDLE OF THE COUNTRY,

AND THAT'S WHERE THERE ARE
MORE CATTLE THAN THERE ARE

PEOPLE, THAT YOU HAVE
THE BLANK SPACES.

THIS IS FOR THE BENEFICIARIES.

WE'RE NOW MAPPING
THE PROVIDERS.

THAT'LL BE THE NEXT SLIDE,
NEXT TIME YOU SEE ME,

BECAUSE THE PROVIDER
MAY NOT BE ANYWHERE NEAR

THOSE BENEFICIARIES.

WHERE'S OUR BIGGEST PROBLEM?

AND I CAUTION YOU BECAUSE THIS

IS A DATA BASE--THESE ARE ONLY

THE ONES THAT SOMEONE'S
ALREADY FOUND OUT ABOUT

AND HAS REPORTED TO US THROUGH
OUR SYSTEM, SO THERE ARE

PROBABLY LOTS MORE OUT THERE.

BUT CALIFORNIA WAS IN THE
FOREFRONT OF REPORTING,

SO CALIFORNIA HAS THE HIGH--
YOU KNOW, MORE THAN

90,000 OF OUR COMPROMISED
NUMBERS.

THE NEXT STATE IS FLORIDA.

YOU WORK YOUR WAY DOWN
INTO TEXAS, AND NEW YORK IS

ABOUT NUMBER 6 ON THE LIST.

AND NEW MEXICO IS ACTUALLY
HIGHER THAN NEW YORK ON THIS

LISTING BECAUSE THE

BENEFICIARIES THERE, THEIR

NUMBERS HAVE ALSO
BEEN COMPROMISED.

A LOT OF OUR SITUATIONS,
YOU CAN TRACE IT BACK TO

A SPECIFIC BREACH OR A
SPECIFIC CASE OR A SPECIFIC

INDIVIDUAL OR A
SPECIFIC BILLING COMPANY

BECAUSE THE INFORMATION
IS VALUABLE.

WE'VE STARTED MAPPING WHERE
THE PATIENTS LIVE AND WHERE

THEIR NUMBERS ARE.

NORTH OF BURBANK IN THE
NORTHERN PART OF THE STATE

IN CALIFORNIA UP NEAR
GLENDALE, THERE IS AN ETHNIC

GROUP THAT'S EXTREMELY
INVOLVED IN IDENTITY THEFT,

AND THE INDIVIDUALS THEMSELVES
ARE ACTIVELY INVOLVED, EITHER

SELLING THEIR NUMBERS OR
THEY'RE THREATENED TO PROVIDE

THE INFORMATION OR SOMETHING
UNTOWARD WILL HAPPEN TO THEM

OR THEIR FAMILY.

THIS IS THE CALIFORNIA AREA,
FLORIDA, AND OBVIOUSLY

EVERYTHING HUGS THE COAST,
AND HIALEAH, WHICH IS

A SPECIFIC SUBURB IN MIAMI,
IS THE ONE THAT'S BRIGHT RED,

AND THE BRIGHT RED IS THE
AREA WHERE WE HAVE THE HIGHEST

CONCENTRATION OF STOLEN
NUMBERS OR COMPLICIT NUMBERS.

THERE ARE SOME ESTIMATES THAT
MEDICARE KICKBACKS ACCOUNT

FOR A HIGH PERCENTAGE OF
THE INCOME OF POOR MEDICARE

BENEFICIARIES IN
THE MIAMI AREA.

TEXAS, THE HOUSTON AREA--AS I
SAID, WE'VE GOT A STRIKE FORCE

ON THE GROUND IN HOUSTON.

SO YOU CAN SEE
THE BRIGHT PINK.

TO THE SOUTHWEST PART, IN THE
VALLEY, IF YOU'VE BEEN READING

THE KAISER HEALTH NETWORK
ABOUT McALLEN, TEXAS,

AND THE FACT THAT
STATISTICALLY THOSE

BENEFICIARIES ARE OFF THE
CHARTS IN THE UTILIZATION,

OR WHAT'S BILLED
ON THEIR BEHALF.

THEY'RE NOT A WHOLE LOT SICKER
THAN ANYBODY ELSE, AND EVEN AS

A RESULT OF ALL OF THIS
MEDICARE SERVICES PAID

ON THEIR BEHALF, THEY'RE NOT
A WHOLE LOT HEALTHIER THAN

ANYBODY ELSE, EITHER.

NEW MEXICO--UP PAST SANTA FE,
WE'VE GOT A BIG PROBLEM,

AND SOUTH OF ALBUQUERQUE,
DOWN BY LAS CRUCES, RIGHT OVER

THE BORDER FROM EL PASO,
WE'VE GOT A HOT SPOT.

AND SO THE MAPPING HELPS
US IDENTIFY WHERE THE

BENEFICIARIES LIVE, SO IT CAN
ALSO HELP US TRY AND FIGURE

OUT WHERE THE NUMBERS
WERE STOLEN OR WHERE OUR

PROBLEMS LIE.

ILLINOIS--ALSO A BIG
HOT--YOU KNOW, CHICAGO AREA.

DeKALB IS THE ONE THAT SHOWS
UP ON THE MAP AS THE WORST.

NEW YORK--BY ZIP CODE,
AND YOU'LL SEE THAT

MIDDLETOWN, NEW YORK,
IS A BLEEP ON THE BIG

RADAR SCREEN.

WE DO HAVE A
PARTICULAR PROBLEM THERE.

IF ANYBODY READ THE "NEW YORK
DAILY NEWS" ABOUT THE LADY WHO

HIT THE PAPERS COMPLAINING
THAT MEDICARE PAID \$5,000

FOR--SHE'S IN HER 70s.

WE PAID FOR A PREGNANCY TEST,

SEMEN ANALYSIS, AND PROSTATE

PROCEDURE ON HER.

SHE IS ONE OF THE
BENEFICIARIES ASSOCIATED

WITH THAT BLIP.

SO SHE AND I ARE BEST FRIENDS
NOW, AND WE'RE TRYING TO PLACE

SOME MORE EDITS IN THE SYSTEM.

AND THIS BECOMES AN ISSUE
FOR US BECAUSE THERE ARE SOME

EDITS THAT SHOULD HAVE BEEN
IN PLACE THAT WE ALL THOUGHT

WERE IN PLACE.

YOU KNOW, WE CALL
THEM "NEVER" EVENTS.

YOU'VE SEEN A LOT OF THE PRESS
ABOUT THEM, FOR THE IMPROVED

QUALITY OF CARE.

WE SHOULD NEVER PAY
FOR CERTAIN SERVICES.

WE SHOULDN'T PAY FOR A
HYSTERECTOMY ON A MALE.

WE SHOULDN'T PAY FOR
PROSTATECTOMIES ON FEMALES.

THERE ARE CERTAIN BASIC
SYSTEM EDITS THAT FROM A FRAUD

PERSPECTIVE SHOULD JUST
BE SYSTEM LOGIC EDITS.

SHOULDN'T TIE IT TO MRS.
JONES, MRS. SMITH

AND HER SITUATION.

IT SHOULD BE AN EDIT IN THE
SYSTEM, AND THERE APPEARS TO

BE A BREAKDOWN.

SO WE ARE IN THE PROCESS NOW
OF TRYING TO SEE WHAT EXACTLY

IS GOING ON, BECAUSE
IT APPEARS THAT WE HAVE

LOST CAPABILITY.

WE HAD THIS ABILITY IN THE
PAST, AND EITHER SOMETHING HAS

HAPPENED--EITHER THERE'S A
SWITCH THAT'S BEEN THROWN

INAPPROPRIATELY OR WE'VE
LOST A SYSTEM CAPABILITY.

SO ON THE FEE-FOR-SERVICE
SIDE, WE ARE RETRACING

OUR STEPS.

OHIO IS ONE OF THE AREAS
THAT'S ON OUR RADAR SCREEN,

AND I WANT TO JUST BRING
YOU A LITTLE CLOSER.

THE SANDUSKY AREA IS THE ONE,
RIGHT UP THERE ON LAKE ERIE,

THAT REALLY HAS
A HUGE PROBLEM.

A NUMBER OF BENEFICIARIES'
IDENTITIES HAVE BEEN STOLEN.

THE NUMBERS ARE BEING
BILLED ACROSS THE COUNTRY.

HOW DO WE IDENTIFY THEM?

PROACTIVE DATA ANALYSIS.

JOEL WAS TALKING ABOUT
ALGORITHMS, AND THAT'S ONE

OF THE THINGS THAT WE USE.

IF THE BENEFICIARY'S NUMBER IS
ON A STOLEN LIST AND WE KNOW

ABOUT 20 PROVIDERS THAT
ARE BILLING THEIR NUMBERS,

WELL, THEN WE SEE WHO ELSE IS
BILLING THAT LIST OF NUMBERS

BECAUSE WE MAY NOT KNOW ABOUT
THEM YET BECAUSE NOBODY

HAS COMPLAINED.

BUT THE DATA TELLS US WHERE
THOSE NUMBERS ARE TRAVELING.

BENEFICIARIES THEMSELVES
LOOK AT THEIR MEDICARE

SUMMARY NOTICES.

THEY CALL 1-800-MEDICARE.

THEY CALL THE IG.

THEY CALL THE STATE.

AS PART OF OUR FIELD OFFICES,
WE'RE DOING SPECIAL STUDIES.

WE'RE IDENTIFYING THE HIGHEST
RISK PROVIDERS, THE HIGHEST

RISK BENEFICIARIES,
THE HIGHEST RISK ORDERING

PHYSICIANS, AND WE'RE
CONDUCTION INTERVIEWS, AND AS

PART OF THAT INTERVIEW
PROCESS, BEFORE WE GO INTO

THE DOCTOR'S OFFICE, IF HE'S
ORDERED \$1 MILLION IN BREAST

PROSTHESES FOR MEDICARE
PATIENTS AND HE'S

A PSYCHIATRIST, WE'VE ALREADY
LOOKED AT THE PART "B" BILLING

TO SEE IF THERE'S EVER BEEN AN
OFFICE VISIT, ANYTHING ELSE.

SO WHEN WE GO SEE THE DOCTOR,
WHO TELLS YOU HE HAS NO IDEA

HOW HIS NUMBER HAS BEEN USED,
THEY ARE NOT HIS PATIENTS,

HE'S NOT PARTICIPATING IN
THE FRAUD, WE ASK HIM TO SIGN

AN OUT-OF-STATION, AND WE
COME BACK AND SLAP SOME EDITS

ON WHERE WE'RE NEVER GONNA PAY
BREAST PROSTHESES OR ANY DME

ORDERED BY THIS DOCTOR.

WE MAY NOT PAY ANYTHING
ORDERED BY THAT DOCTOR FOR DME

AND OTHER THINGS BECAUSE WHILE
WE'RE THERE, WE ASK ABOUT,

WHAT OTHER DIAGNOSTIC
TESTS MIGHT YOU ORDER?

SO THAT WE WON'T HAVE TO
PAY FOR NONINVASIVE VASCULAR

TESTING, DUPLEX DOPPLERS
OF THE BRAIN, MRIs UNLESS,

YOU KNOW, THERE'S A SPECIFIC
REASON THAT HE'S DOING THAT

KIND OF SERVICE.

ANOTHER WAY WE FIND OUT ABOUT
IT IS INVESTIGATIONS FROM

LAW ENFORCEMENT.

THEY'RE ON THE GROUND.

THEY'RE DOING--LIKE
THE STRIKE FORCE.

THEY'RE A GOOD SOURCE OF
INFORMATION FOR US ON WHOSE
NUMBERS ARE BEING STOLEN.

AND THEN THROUGH
OFFICIAL CHANNELS.

BENEFICIARIES CAN CALL 1-800-
MEDICARE, THE IG HOTLINE,

THE OMBUDSMAN.

IN FLORIDA WE'VE SET UP
OUR OWN FRAUD HOTLINE

BECAUSE THE PROBLEM WAS SO
SEVERE, IT WAS TAXING

THE 1-800 SYSTEM.

CMS--WE HAVE OUR OWN INSERT.

SOMETIMES WE PUT
IT ON THE MSN.

AND THE SENIOR MEDICARE PATROL
OR SMP--THEY ARE AN EXTREMELY

USEFUL NETWORK BECAUSE
THEY ARE COUNSELORS TO THE

BENEFICIARIES ON THE GROUND.

OUR MEDICARE

CONTRACTORS, THE MACs,

ARE ALSO THE ONES THAT

ARE PLACING THE CLAIMS

PROCESSING EDITS.

THEY RUN THE CUSTOMER SERVICE

UNITS FOR BENEFICIARIES,

AND THEY EDUCATE
THE PROVIDER COMMUNITY,
AND THEN OUR PROGRAM
SAFEGUARD CONTRACTORS,
THE PSCs AND OUR ZPICs,
THE ZONE PROGRAM
INTEGRITY CONTRACTORS,
ARE THE ONES THAT ARE
INVESTIGATING THE FRAUD.
THEY'RE DOING PROACTIVE
DATA ANALYSIS.
THEY'RE ASKING THE MACs TO PLACE
EDITS ON SPECIFIC BENEFICIARIES,
AND THEY WILL ALSO FOLLOW UP
ON CLAIMS OF IDENTITY THEFT.
AFTER WE'VE VERIFIED THAT
A NUMBER IS COMPROMISED,
WE CAN THEN PLACE IT
ON A PREPAY EDIT, AND THEN
IF WE GET A CLAIM SUBMITTED
USING THAT NUMBER, WE CAN EITHER
AUTOMATICALLY DENY IT
OR WE CAN DEVELOP
FOR ADDITIONAL INFORMATION.
IF WE FIND ENOUGH EVIDENCE

OF WILLFUL MISREPRESENTATION,
AN OVERPAYMENT, OR FRAUD,
WE CAN SUSPEND PAYMENT
TO THE MEDICARE PROVIDER.
THE OTHER THING THEY DO
IS DEVELOP CASES,
OPEN INVESTIGATIONS, AND MAKE
REFERRALS TO LAW ENFORCEMENT.
I TALKED A MINUTE AGO ABOUT
THE FLORIDA FRAUD HOTLINE.
BECAUSE WE HAD SO MUCH FRAUD
IN FLORIDA AND WE WERE
OVERWHELMING THE PHONE NUMBERS,
WE OPENED UP OUR OWN PHONE LINE
THROUGH SGS, OUR PROGRAM
SAFEGUARD CONTRACTOR.
IT'S NOW THE ZPIC.
WE'VE HAD ABOUT 1,100
FRAUD COMPLAINTS COME
INTO THE HOTLINE.
OF THAT, ABOUT ALMOST 2,000,
ABOUT 1,800, HAVE BEEN
REAL FRAUD,
HARDCORE-RELATED COMPLAINTS.
ABOUT 9,000 OF THEM
ARE NOT NECESSARILY FRAUD.

IT MIGHT BE OVERUTILIZATION.

IT MIGHT BE A MISUNDERSTANDING.

IT COULD BE ANOTHER THING,

AND SOME OF THEM, THEY CALLED

THE HOTLINE BECAUSE

IT WAS THE NUMBER.

THEY LIVE IN FLORIDA, AND SOME

OF THEM, WE ROOTED ELSEWHERE,

BUT ABOUT 6,000 OF THE 11,000

CAME FROM MSNs, BENEFICIARIES.

WE TRACK WHEN THEY MAKE A CALL,

"WHAT'S THE BASIS?

DID YOU LOOK ON YOUR MSN?"

AND OVER 6,000 OF THEM DID.

SO TELLING A BENEFICIARY WHAT

MEDICARE PAID ON THEIR BEHALF

REALLY DOES GET A RESULT.

WE HAVE TAKEN ACTION ON

ABOUT 1,800 OF THEM.

WE MADE A NUMBER OF REFERRALS.

WE'D OPEN FRAUD INVESTIGATIONS.

WE'VE SET UP EDITS, AND THEN

WE'VE REFERRED SOME OF THEM

OUT TO THE OTHER ENTITIES

THAT DEAL WITH THOSE

PARTICULAR BENEFICIARIES.

WE'RE INCREASING COMMUNICATION
AND EDUCATION.

THAT'S THE ONLY WAY WE CAN GET
THE WORD OUT,

AND WHAT IT IS WE'RE DOING,
WE'RE PARTNERING, AS I SAID,

WITH SENIOR MEDICARE PATROL,

ESPECIALLY IN
THE HIGH-RISK AREAS--

CALIFORNIA, TEXAS, AND FLORIDA.

WE'RE DOING PUBLIC-SERVICE
ANNOUNCEMENTS.

WE'RE PARTNERING
WITH THE OIG AND THE FBI.

WE'RE DOING A LOT OF TOWN HALL
MEETINGS WITH CONGRESSMEN,

GETTING THE WORD OUT
TO BENEFICIARIES

TO PROTECT THEIR NUMBERS
AND HOW TO REPORT IT.

OIG HAS A GREAT NEW
FRAUD IDENTITY THEFT BROCHURE.

YOU CAN DOWNLOAD IT FROM
THEIR WEB SITE, PRINT IT OUT.

IT'S ABOUT AN 8 1/2 x 11,
YOU KNOW, FOLDED.

IT'S RED, WHITE, AND BLACK.

IT'S VERY SIMPLE, REALLY USEFUL
HANDOUT FOR BENEFICIARIES

ON HOW TO REPORT FRAUD,

AND IT'S EXPLAINED TO THEM

IN LAYMAN'S TERMS
WHAT IDENTITY THEFT IS.

WHAT ELSE ARE WE DOING AT CMS?

YOU KNOW, WE'RE NOT AS DUMB
AS WE LOOK, REALLY.

YOU KNOW, I REALLY WOULDN'T HAVE
PAID THAT CLAIM

IF I'D LOOKED AT IT, BUT WE DO
HAVE A LABS AND PINs WORKGROUP

BECAUSE THAT'S ONE AREA OF THEFT
WHERE THE PROVIDERS

ARE OFTEN IN ANOTHER STATE, YOU
KNOW, BECAUSE OF REFERENCE LABS.

A DOC IN NEW YORK DRAWS
A BLOOD SAMPLE,

AND HE SENDS IT TO NEW JERSEY,
OR HE SENDS IT TO TEXAS.

SO THAT'S THE KIND OF CLAIM
THAT REGULARLY CROSSED

MEDICARE CONTRACTOR LINES,
AND THEN WE REALLY FOUND

A HUGE ISSUE, ESPECIALLY
IN CALIFORNIA LABS,

BILLING FOR LOTS
OF STOLEN IDENTITIES

FOR BENEFICIARIES
ACROSS THE COUNTRY,

AND SO WE STARTED TO WORK
WITH OIG AND FBI,

DEPARTMENT OF JUSTICE,

AND, YOU KNOW, WE WOULD SHARE
THE INFORMATION.

WE ACTUALLY IDENTIFY
INDIVIDUAL'S BILLING ADDRESSES,

UPS ADDRESSES, IP ADDRESSES,

THE COMPUTER FROM WHICH THEY'RE
ACTUALLY SUBMITTING THE CLAIMS,

WHAT THE SCAMS ARE,
WHO THE PROVIDERS ARE.

WE HAVE IT ON AN ENCRYPTED CD.

ONE OF THE CONTRACTORS CAPTURED
ALL OF THAT INFORMATION,

AND THE SLIDE TELLS YOU,
YOU KNOW, WHAT THEY IDENTIFIED

AS OF A FEW WEEKS AGO,
AND I HAVE, HOT OFF THE PRESS,

AS OF TODAY, THEY'VE IDENTIFIED
420 FALSE FRONT PROVIDERS,

AND APPROXIMATELY
A THIRD OF THEM,

PRIOR TO ANY PAYMENTS
BEING RELEASED,

THEY WERE IDENTIFIED
AND THEIR NUMBER SHUT DOWN.

WE HAVE ABOUT \$2.2 BILLION

SUBMITTED IN CLAIMS
FROM THESE PROVIDERS,

57.5 MILLION IN CLAIMS
APPROVED FOR PAYMENT,

BUT THE MONEY DIDN'T
GO OUT THE DOOR

BECAUSE WE TOOK AN
ADMINISTRATIVE ACTION IN TIME.

\$6.3 MILLION HAVE BEEN

IDENTIFIED AS OVERPAYMENTS

THAT HAVE GONE OUT THE DOOR, AND
WE'RE AFTER THOSE INDIVIDUALS,

AND WE HAD LAW ENFORCEMENT
SEIZE \$11.6 MILLION

IN ASSETS AT BANKS AND THINGS

BECAUSE WE'VE IDENTIFIED
THESE PROBLEM PROVIDERS.

THE OTHER PIECE THAT WE'RE DOING
IS THE CONTRACT

THAT I'M WORKING ON, THE
COMPROMISED NUMBER CONTRACTOR,

AND THIS IS WHERE WE'VE HIRED
A CONTRACTOR TO HELP US

DEVELOP A CENTRALIZED DATABASE
BECAUSE THIS PICTURE

IS BIGGER THAN
AN INDIVIDUAL CONTRACTOR.

EVEN THOUGH WE HAVE ZONE PROGRAM
INTEGRITY CONTRACTORS NOW

THAT RUN ACROSS MULTIPLE STATES,

THEY'RE RUNNING
ACROSS JURISDICTIONS,

SO WE'RE TRYING TO CENTRALIZE
THE INFORMATION.

CNC, OUR CONTRACTOR IS 2020 LLC.

THEY'RE AN 8(a) CONTRACTOR,
SMALL BUSINESS.

THEY'VE BEEN
EXTREMELY HELPFUL TO US.

ONE OF THE THINGS
I MENTIONED EARLIER

IS THAT WE WANT TO TALK
THE SAME LANGUAGE

BECAUSE WHAT I THINK
IS A COMPROMISED NUMBER

SOMEBODY ELSE MIGHT NOT.

YOU KNOW, PEOPLE THINK
IT HAS TO BE STOLEN,

AS OPPOSED TO SOLD,

SO WE'VE COME UP WITH

A COMMON WAY OF DEFINING

A VERIFIED COMPROMISED

BENEFICIARY NUMBER

AND A SUSPECT.

IF IT'S BEEN LOST OR STOLEN

OR PART OF A BREACH

AND IT'S ACTUALLY BEEN USED--

THERE'S BEEN A BILLING--

THEN THAT'S VERIFIED.

IF THE BENEFICIARY I.D.

IS SOLD--THE BENEFICIARY HAS

PARTICIPATED IN THE FRAUD,

IS PART OF A SCHEME--

AND LAW ENFORCEMENT HAS

CONFIRMED IT, THAT'S VERIFIED.

IF THE BENEFICIARY IS TIED

TO A P.I.N. WITH A VERIFIED

COMPROMISED PROVIDER--

YOU GOT A BAD PROVIDER
USING STOLEN NUMBERS--
EVEN IF IT WAS SUSPECT
WE CONSIDER THAT ONE VERIFIED
AT THAT POINT BECAUSE IT'S WITH
A VERIFIED BAD GUY,
AND IF IT'S ON ONE OF OUR
CMS-ISSUED FRAUD ALERTS,
SAME THING FOR THE SUSPECT.
THE I.D. HAS BEEN LOST
OR STOLEN.
YOU KNOW, I GOT A CALL FROM
AN INDIVIDUAL THE OTHER DAY,
AND HE LOST HIS WALLET.
SO I'VE GOT HIS NUMBER,
AND WE'VE GOT IT ON ALERT,
BUT SOMEBODY MAY JUST HAVE
WANTED THE MONEY IN THE WALLET,
OR HE MIGHT HAVE LOST IT AND
IT'S IN A LANDFILL SOMEWHERE,
AND NOBODY'LL EVER USE
HIS NUMBER, SO WE'RE TRACKING
THE SUSPECT, THOUGH.
IF WE'VE GOT A SINGLE
COMPROMISED SUSPECT PROVIDER,

BECAUSE THESE ARE REAL
BENEFICIARIES--SOMEBODY BILLS
THEIR NUMBER--THEY'RE SUSPECT.
THEY'RE ON OUR RADAR SCREEN,
BUT IT MAY BE A REAL SERVICE
BECAUSE THEY'RE A REAL DOCTOR
AND THE REAL PATIENT SHOWED UP
TO GET SOMETHING THEY NEEDED.
THE OUT-OF-STATE ISSUE
IS ONE WE'RE LOOKING AT,
ESPECIALLY BY SPECIALTY,
AND THEN A BENEFICIARY WHO SAYS,
"I DON'T KNOW WHO
THIS DOCTOR IS," BUT WE HAVEN'T
VERIFIED THAT THERE'S
ANY FRAUD INVOLVED BECAUSE
SOMETIMES THERE ARE LEGITIMATE
SITUATIONS WHERE BENEFICIARIES
ARE BILLED FOR SERVICE
AND IT'S A REFERENCE THING
OR AN INTERPRETATION BY A DOCTOR
WHO'S IN ANOTHER STATE
FOR THE LAB TEST
OR THE DIAGNOSTIC TEST
THEY HAD IN THE CITY.

DID I GET TO THE NEXT ONE? YEP.

PROVIDERS. SAME KIND OF THING.

IF THE PROVIDER
HAS GOT AN AFFIDAVIT

WHEN WE GO OUT AND
INTERVIEW THEM THAT SAYS,

"I HAVE NEVER SEEN THIS PATIENT.
IT'S NOT MY PATIENT.

IT'S NOT MY NUMBER," AND WE'VE
ALSO LOOK AT THE MEDICAL RECORD

OR THE BILLING RECORDS
TO SEE THAT

WE'VE NEVER GOTTEN A BILL
FOR THIS PATIENT FROM THIS GUY,

SO HE'S PROBABLY
TELLING THE TRUTH.

THEY'RE SUBMITTED AN EDIT,
THEY WEREN'T AWARE.

SOMEONE SUBMITS AN 855,
OPENS A NEW SOLO PRACTICE

FOR THEM, YOU KNOW, ACROSS TOWN.

THEY NEVER APPLIED FOR IT.

IT'S A FORGED SIGNATURE
ON THE APPLICATION,

OBVIOUSLY VERIFIED STOLEN.

IF THE DOCTOR IS RENTING OUT HIS
NUMBER AND RECEIVING KICKBACKS

OR IT'S A FALSE FRONT LAB
WHERE THEY SET UP LONG ENOUGH

TO GET A MEDICARE NUMBER,
BILL A MILLION BUCKS,

AND THEN SHUT DOWN,
THOSE ARE THE KINDS OF THINGS

WE CONSIDER, DUH, VERIFIED

IF THEY'RE ON A FRAUD ALERT
AND IF THERE'S BEEN CONFIRMED

BY A MEDICARE CONTRACTOR
THROUGH OUR INTERVIEWS

OR THROUGH LAW ENFORCEMENT
AS PART OF THEIR SCAMS...

AND THEN SUSPECT IS

THE SAME KIND OF THING.

SOMEBODY STEALS A LAPTOP,

THEY MIGHT JUST WANT A LAPTOP.

IN OTHER SITUATIONS, THEY

WANT IT FOR A SPECIFIC REASON.

EVERYBODY'S NAME ON THAT LAPTOP

HAS BEEN USED.

THOSE ARE CONSIDERED SUSPECT

UNTIL SOMEBODY IN THE CADRE

HAS BEEN BILLED.

I DON'T WAIT FOR MRS. JONES

TO GET A BILL, BUT IF SHE'S

IN A LIST WITH 200 AND SOME

OF THOSE 200 START TO GET

BILLED FISHY, WE MOVE THEM OUT

OF SUSPECT INTO COMPROMISED.

IF THEY'RE OUT OF STATE, WE NEED

TO LOOK BECAUSE THERE MAY BE
A LEGITIMATE REASON
WHY THEY'RE OUT OF STATE.
A LOT OF THE SNOWBIRDS,
THEY USED TO JUST GO TO FLORIDA.
NOW THEY GO TO ARIZONA.
TRYING TO MATCH UP WHAT'S
LEGITIMATE AND NOT GETS TO BE
KIND OF INTERESTING,
BUT WE DID FIGURE OUT
THEY DON'T TRAVEL IN PACKS.
IF THERE'S 75 OF THEM,
THEY DON'T ALL GET ON A BUS
AND DON'T ALL GO SOMEWHERE ON
THE SAME DAY TO THE SAME STATE,
SO SOME OF OUR ANALYSIS
IS PAYING OFF,
AND THEN WE HAVE PROVIDERS
WHO SAY, "MY NUMBER IS STOLEN,"
BUT THEY HAVEN'T FILLED OUT
AN AFFIDAVIT OR ANYTHING ELSE.
THEY KNOW WE'RE ONTO THEM,
AND THAT'S NOW THE FAVORITE
RESPONSE FROM SOME CROOKS.
"OH, MY NUMBER HAS BEEN STOLEN."

WE'RE PUTTING IN EDITS
NOW FINALLY

FOR PEOPLE LIKE THE LADY
IN TODAY'S NEWSPAPER.

IF THE BENEFICIARY--
WE NEED TO SEE IF IT'S VALID

FOR THE BENEFICIARY
IN THAT PARTICULAR STATE,

AND THEN THE PROVIDER EDIT--

AND THIS IS SPECIFIC
TO THAT PROVIDER.

IF I KNOW THIS IS A BAD DOC,

I'M NOT GONNA PAY ANYTHING
BILLED BY THIS DOC

FOR THIS PATIENT,

AND THAT'S A REALLY SPECIFIC
KIND OF EDIT

FOR THAT BENEFICIARY.

THESE ARE PROPOSED NOW
ON A NATIONAL BASIS.

THESE ARE THINGS THAT
WE'RE MULLING AROUND,

TRYING TO COME UP WITH
EFFICIENT WAYS OF DOING THIS.

YOU KNOW, VERIFIED PROVIDER,

DENY 'EM IF WE'VE GOT
A REALLY SPECIFIC NPI

VERIFIED AS COMPROMISED.

IF WE'VE GOT SOMEBODY
ON A SPECIALTY EDIT,

NOW I SHOULDN'T REALLY
NECESSARILY BE PAYING

A PSYCHIATRIST
FOR BREAST PROSTHESES,

ESPECIALLY FOR MALE PATIENTS
ON A LARGE SCALE.

THE BENEFICIARY
PROVIDER COMBO EDIT.

IF I'VE GOT
COMPROMISED PROVIDERS

BILLING
THESE COMPROMISED NUMBERS,

AUTO DENY.

AND THEN A VALID NPI
FOR THE PROVIDER EDIT,

AND JUST MAKING SURE
THAT THE NPI

THAT A PROVIDER IS USING
IS ACTUALLY HIS OR HERS.

AND THEN THE REFERRING
PROVIDER EDIT

BECAUSE DME COMPANIES, IDTFs ALL
NEED REFERRING PHYSICIAN I.D.s

TO GET THE CLAIM PAID.

BUT THE DOCTOR OUT THERE
DOESN'T OFTEN KNOW--

THEY DON'T KNOW WHAT'S
BEING BILLED ON THEIR BEHALF.

THERE'S NOT A CONNECTION
BACK TO THE ORDERING PHYSICIAN

TO SAY, "WERE YOU AWARE
THAT MEDICARE PAID \$2 MILLION

IN DME AND DIAGNOSTIC TESTS
LAST YEAR

FOR 15 PATIENTS OF YOURS?

THAT'S A CONNECTION I WOULD LOVE
TO BE ABLE TO MAKE

WHEN I GET TO BE QUEEN,
BUT UNTIL THEN...

GEOGRAPHIC EDIT.
THIS IS, YOU KNOW--

WE HAVE TO USE DIFFERENT
PARAMETERS IN NEW YORK

THAN WE DO IN WYOMING
AND SOUTH DAKOTA.

YOU KNOW, 15 MILES MIGHT BE
A LITTLE LONG IN NEW YORK CITY

TO TRAVEL TO SEE A PROVIDER,

BUT YOU KNOW,
YOU GET TO NORTH DAKOTA,

15 MILES IS NOTHING.

SO THESE ARE THE KINDS OF THINGS
THAT WE'RE TRYING TO BUILD INTO

OUR EDITING PROCESS--

USING ZIP CODES, USING
A NUMBER OF OTHER APPROACHES.

AND OF COURSE WE HAVE TO HAVE
EXCEPTIONS TO THE EDIT.

IF I'VE GOT SOMEBODY
ON AUTO DENIAL,

WE ALWAYS WANT TO PAY
THE EMERGENCY CLAIMS

BECAUSE WE DON'T WANT TO
INTERFERE WITH ACCESS TO CARE.

IF SOMEBODY NEEDS, YOU KNOW,
AN EMERGENCY AMBULANCE,

THEY NEED AN E.R. VISIT,
YOU KNOW,

WE ARE NOT INTERFERING
WITH THAT SORT OF THING.

AND THEN WE GOT TO FIGURE OUT
THE GEOGRAPHIC EDITS.

YOU KNOW, WE HAVE
A BUNCH OF SNOWBIRDS

WHO JUST CAME BACK TO NEW YORK,

AND THE EDITS WERE
SUPPOSED TO BE CHANGED,

AND I CAN TELL YOU HOW MANY
DIDN'T GET CHANGED

BECAUSE THEY CALL ME.

WHEN WE DO SET UP THE EDITS,
WE CAN DO DIFFERENT THINGS.

WE CAN ACTUALLY DENY THEM.

WE CAN ASK
FOR ADDITIONAL DOCUMENTATION,

OR WE CAN CLOCK THE INFORMATION

TO JUST SEE WHAT'S GOING ON,

AND IF WE INSTALL AND EDIT,

WHAT IMPACT IT'S GOING TO HAVE.

AND WE'VE GOT

AN EDIT STATUS FIELD

IN OUR DATA BASE,

SO YOU CAN TELL WHICH OF

OUR BENEFICIARIES ARE ON EDIT.

I TOLD YOU WE PULLED TOGETHER
THE INFORMATION

FROM OUR PSCs AND ZPIC,

AND WE HAD A LOT
OF DUPLICATION,

SOMETIMES WITHIN
THE SAME CONTRACTOR

BECAUSE THE PATIENT HAD
2 DIFFERENT NAMES

OR YOU KNOW, WAS REPORTED ONCE
AS "MRS. C. JONES,"

THE NEXT TIME WAS REPORTED
AS "CATHERINE JONES," NO "MRS."

SO WE'VE BEEN SIFTING DOWN TO
ELIMINATE ALL THE DUPLICATION

ACROSS PROVIDERS
AND BENEFICIARIES,

SO OUT OF ABOUT, YOU KNOW,
A MAXIMUM OF 373,

WE'VE GOT IT DOWN--
DISTILLED IT DOWN

TO ABOUT 200,000 BENEFICIARIES
AND 4,900 PROVIDERS,

AND I'M TELLING YOU
THERE'S LOTS MORE OUT THERE.

THESE ARE JUST THE ONES THAT
HAVE BEEN REPORTED TO US,

THAT HAVE BEEN IDENTIFIED SO FAR
BY THE CONTRACTORS.

AND JUST THIS GIVES YOU AN IDEA
OF THE DUPLICATION ACROSS--

THAT THEY'RE DIFFERENT.

AND IT'S MORE INTERESTING

DOWN AT THE BOTTOM

WHERE YOU'VE GOT
500 BENEFICIARIES

WHOSE NUMBERS HAVE SHOWN UP

ON 8 DIFFERENT PSC
AND ZPIC RADAR SCREENS,

WHICH MEANS THAT THOSE NUMBERS
HAVE LEGS,

AND THEY'RE ON A LIST,

AND THEY'RE BEING USED
ACROSS THE COUNTRY.

SAME THING FOR PROVIDERS.

WE'VE GOT, YOU KNOW,
18 PROVIDERS

THAT WERE ON 3 DIFFERENT
PSC AND ZPICs.

PROVIDERS DON'T MOVE
THE SAME WAY BENEFICIARIES DO.

THEY BILL
IN THEIR GEOGRAPHIC AREA,

SO WHEN YOU SEE MORE THAN 1 PSC,

A PROVIDER AT MORE THAN 1 PSC,
ESPECIALLY NATIONAL CHAINS

BECAUSE THEY KEEP
THEIR NUMBERS LOCAL.

YOU KNOW, YOU'RE NOT
GONNA HAVE A CHAIN

THAT'S GOT THE SAME NUMBER
ACROSS THE COUNTRY.

THEY'LL HAVE
15 DIFFERENT AFFILIATES,

AND THEY'LL HAVE

15 SEPARATE NUMBERS.

SO THOSE NUMBERS WILL SHOW UP
WHERE THEY LIVE.

JUST TO GIVE YOU AN IDEA,

YOU KNOW,
THE BIG PART OF THE PIE

IS THE THING
WE'RE CHIPPING AWAY AT,

THE HISTORICAL, BECAUSE
WHEN WE STARTED THE DATA BASE,

WE DON'T KNOW WHERE
THE NUMBERS CAME FROM

AT THE INDIVIDUAL CONTRACTORS,

SOME OF THE CONTRACTORS

HAD THEM ON EDIT

AND HAVE TRANSITIONED ON,

SO WE'RE CAPTURING THEM AND
WE'RE TRYING TO WORK IT DOWN,

SO ANYTHING THAT WAS SUSPECTED
AND VERIFIED,

THOSE HAVE COME IN
SINCE WE STARTED OUR CONTRACT

ABOUT, I GUESS, JANUARY,

SO WE'RE TRYING TO CHIP AWAY
AT THE HISTORICAL

BECAUSE AS WE GET INFORMATION

ON ANY BENEFICIARIES
ON ANY OF OUR LISTS,

WE'RE MOVING INTO THE SUSPECT,
INTO THE VERIFIED CATEGORY

BECAUSE I CAN'T PUT AN EDIT OUT

THERE UNLESS THEY'RE VERIFIED.

SAME THING,
SAME KIND OF AN EDIT ON--

HOW MANY ARE ON EDIT NOW?
AND THIS IS NOT CORRECT.

THIS IS TOTAL UNDERREPORTING
BY OUR PSCs AND ZPIC

BECAUSE I ALREADY KNOW THAT
90,000 OF THESE BENEFICIARIES

ARE ON EDIT IN CALIFORNIA
AND FLORIDA,

AND YET THEY'VE ONLY RECORDED
1,600 OF THEM TO US

ON OUR SPREAD SHEETS,

SO WE NEED TO GO
BACK TO THEM NOW

AND KIND OF HARASS THEM A LITTLE

TO GIVE US
THE UPDATED INFORMATION.

AND THEN DUAL ELIGIBLES BECAUSE
THE INFORMATION WE HAVE

IS FROM THE PSCs AND ZPICs
THAT HAVE FOUND OUT

THAT THESE BENEFICIARIES
ARE A COMPROMISE.

THEY DON'T ACTUALLY
HAVE INFORMATION

IN OUR NATIONAL CLAIMS
HISTORY ANYMORE

ABOUT THE BENEFICIARIES'
ELIGIBILITY STATUS,

SO FOR STATES LIKE--JOEL TALKED
THE STATE THAT HAVE MEDI-MEDI.

WE CAN GO BACK TO
THE MEDI-MEDI STATES

AND GET THE INFORMATION, SO
THEY'VE GOT THE JOINT DATA BASE.

IN THOSE OTHER AREAS,
WE'VE GOT TO FIGURE OUT A WAY

TO FIND OUT THE STATUS
OR THE BENEFICIARIES

TO SEE IF THEY'RE MEDI-MEDI.

PROVIDER SPECIALTIES
BECAUSE IF ZPICs HAVE THEM

IN RESPONSE TO EDITS
THAT WERE IN PLACE,

WE DON'T KNOW ABOUT 21% OF THEM.

WE KNOW WHO THE PROVIDER IS,
WE HAVE A NUMBER,

BUT WE DON'T HAVE HIS SPECIALTY.

SO WE'RE IN THE PROCESS NOW

OF GOING BACK INTO THE PROVIDER
ENROLLMENT SIDE OF THE HOUSE

TO GET THAT.

BUT FOR THE ONES THAT WE DO,

GENERAL PRACTICE
AND INTERNAL MEDICINE

ARE THE ONES
THAT ARE THE HIGHEST,

THAT ARE INVOLVED IN--

THAT THEY'RE HAVING
THEIR NUMBERS STOLEN.

IDTFs ARE INVOLVED.
THEY'RE UP ON OUR RADAR SCREEN.

PODIATRY, PHYSICAL THERAPY,
DIAGNOSTIC RADIOLOGY,

CLINICAL LABS, AND NEUROLOGY.

AND THE WORST ZIP CODES
BECAUSE THE VAST MAJORITY--

90,00 OF THE BENEFICIARIES
ON THE LIST--

COME FROM CALIFORNIA.

THE SUSPECT PROVIDERS
ASSOCIATED WITH THEM

ALSO HAPPEN TO BE IN CALIFORNIA.

SOME OF THESE PROVIDERS ARE
BILLING THE CALIFORNIA BENNIES,

BUT MOST OF THEM ARE BILLING
FOR NEW YORK BENEFICIARIES,

OHIO BENEFICIARIES, AND OTHERS.

SO CALIFORNIA REMAINS
ON OUR BIG RADAR SCREEN.

SO...WE DO HAVE A FEW MINUTES.

I JUST WANTED TO SEE IF ANYBODY
HAD AN Y QUESTIONS

EITHER FOR MYSELF OR FOR JOEL.

YES?

>> [WOMAN SPEAKING INDISTINCTLY]

>> OK, THE QUESTION WAS,
"HOW CAN MANAGED CARE

ORGANIZATIONS RECEIVE
THE CMS FRAUD ALERTS?"

OUR FRAUD ALERTS
WILL GO TO THE MEDIC.

HOW YOU INTERACT
WITH THE MEDIC IS...

THE MEDIC IS
OUR MEDICARE PART "C" AND "D"

PROGRAM INTEGRITY CONTRACTOR.

SO RATHER THAN ISSUE THEM
TO MANAGED CARE PLANS,

WE'RE ISSUING TO THE MEDICS,
AND YOU CAN INTERACT WITH THEM

TO FIND THAT INFORMATION.

THEY ARE ALSO NOW PART OF OUR
COMPROMISED NUMBER WORK GROUP,

AND THEY WILL BE
GETTING THE LIST

BECAUSE WE'RE ALSO
ASKING THEM TO TELL US

WHAT NUMBERS
THEY HAVE COMPROMISED

BECAUSE IF THE BAD GUYS
ARE RIPPING US OFF

ON REGULAR PART "A" AND "B,"
FEE FOR SERVICE,

THEY'RE PROBABLY DOING
THE SAME THING

WITH PRESCRIPTION DRUGS
AND MANAGED CARE.

>> FRAUD AND ABUSE MEDIC
IS ON AFTER THE BREAK.

>> TERRIFIC.
ANY OTHER QUESTIONS?

THANK YOU VERY MUCH.

[APPLAUSE]