THE NATIONAL CONSUMER PROTECTION TECHNICAL RESOURCE CENTER

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Quick Stat

985:

Calls received after an article about SMP work ran in the *AARP Bulletin*

AoA Update

A Busy Spring for SMPs

Barbara Dieker

By Barbara Dieker

Director, Office of Elder Rights, U.S. Administration on Aging

Greetings, SMPs! So, finally, spring is upon us here in Washington, D.C. I have never quite appreciated cherry blossoms and warm days as much as this year, after surviving weeks of being buried in 3 feet of snow. And with spring have come many exciting events and initiatives.

At the end of January, HHS and DOJ hosted the first-ever National Summit on Health Care Fraud. The SMP program was well represented, with New Jersey SMP Coordinator Charles Clarkson and his volunteer Ruth Candeub Avins serving on one strategic breakout session and Delaware SMP Program Administrator Cynthia Allen and her volunteer Mary Covell in another. Bill Benson of Center subcontractor Health Benefits ABCs co-chaired one of the breakout sessions and did a fine job of presenting the work from his session later to the full conference. It was an exciting day – read the full account from Bill, Charles and Cynthia starting on page 8.

We were also thrilled in early March when the planners of a presidential visit to St. Louis asked AoA's help in recommending audience participants. Of course, Missouri SMP Program Manager Rona McNally and her staff and volunteers were top on our list! Rona shares her special experience that day on page 7.

And, unless anyone has just awakened from winter hibernation, you know that the recent passage of health care reform is another exciting development with many implications for our seniors. The Affordable Care Act contains a number of provisions designed to strengthen Medicare, including fraud-fighting measures. In addition, the Elder Justice Act was incorporated into the law, strengthening the protection of vulnerable elders from abuse, neglect and exploitation through new support for the Adult Protective Services program, the Long-Term Care Ombudsman program and

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AoA Update *(continued from page 1)*

much more. Nancy Aldrich provides further details on this historic legislation on page 20.

Finally, AoA has been doing a lot of listening lately. In preparation for the reauthorization of the Older Americans Act in 2011, AoA held listening sessions in February and March in Dallas, Texas, Alexandria, Va., and San Francisco, Calif. In addition, many organizations have held forums and listening sessions around the country, and much input has been received in writing. A variety of issues has been raised through this process, with the enhancement of elder rights prominent among them. Right now, AoA is working to review, compile and consider the many inputs received. In future editions of *The Sentinel,* I will update you on the reauthorization process including any implications for the SMP program.

Thanks to each of you for keeping up the great work and for cranking up the heat on SMP program publicity and media attention. It's definitely been a good spring for SMPs!

Looking forward to seeing you at the regional conferences in August and September!

Volunteers Honored for Contributions

On May 7, the National Association of Area Agencies on Aging (n4a) and MetLife Foundation honored recipients of the 2010 MetLife Foundation Older Volunteers Enrich America Awards at a ceremony in Washington, D.C. The program, now in its eighth year, honors older volunteers making exemplary contributions to their communities and promotes volunteering among older adults nationwide.

Ruth Candeub Avins

By Charles Clarkson, Esq.

Coordinator, SMP of New Jersey

Ruth Candeub Avins

When Jewish Family & Vocational Service of Middlesex County obtained a grant from the U.S. Administration on Aging (AoA) to inform and educate seniors about fraud, waste and abuse in Medicare and Medicaid, Ruth Candeub Avins was one of the first volunteers (and the only woman at that time) to join the many who would reach out to senior groups in New Jersey to give presentations.

For 8 years she has been reaching out to seniors and for the last 3 years she has been assistant coordinator of the New Jersey SMP, where she is also a member of the advisory committee. She has trained volunteers

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Volunteers *(continued from page 2)*

and has written and edited the newsletter *The Advocate,* which is dedicated to the SMP program.

Ruth has also helped individual seniors through one-on-one counseling sessions. She spends much of her time marketing the SMP program to senior facilities and senior groups throughout the state. Through her efforts, many thousands of seniors across the state of New Jersey have been informed and educated of the important message that the SMP provides.

Ruth considers herself "gainfully employed." That term usually implies a monetary remuneration; however, in this case, as a volunteer, she is rewarded by more than a feeling of satisfaction – a lifting of the spirit for a senior citizen who is doing something that really counts.

Ruth merits this special attention as she is the model of a senior citizen who would rather give than receive. The SMP of New Jersey would not be the success it is today but for the work of Ruth.

Larry Rivers

By Stephanie Minor

SMP Coordinator, Minnesota Board of Aging

Larry Rivers

With a background in health care, a knack for problem-solving and a keen interest in serving seniors, Larry Rivers contacted the Metropolitan Area Agency on Aging (MAAA) in 2005 wishing to volunteer with the Senior LinkAge Line®, Minnesota's SMP and SHIP. From the start, Larry has demonstrated not only a clear knowledge of the Medicare program and health care fraud but also an extraordinary ability to explain it in a manner that seniors can understand. As he began working with seniors at both the Burnsville Senior Center and the Lakeville Senior Center, word of his skill spread. "[Larry] is so calm, quiet and knowledgeable," remarked one senior center staff member. "He'll come in whenever you need him."

His genuine kindness and ability to connect with people carries over into his relationships with peer volunteers. With a tried and true expertise, Larry helps train new volunteers to the Senior LinkAge Line.

In addition to teaching training modules for new volunteers, Larry serves as a mentor, welcoming new volunteers to shadow him as he provides counseling to older adults.

Through his volunteer service, Larry generously gives of himself to help seniors gain access to the health information they need to make well-informed decisions and protect themselves from fraud. The Minnesota Board on Aging and MAAA are delighted to recognize Larry's remarkable impact on the volunteer program and the older adults in his community.

Building Connections: One Meeting at a Time


Tamra Simpson

By Tamra Simpson

SMP Project Manager

Indiana Association of Area Agencies on Aging

Sometimes it's all about timing. For the past few months I had been seeing commercials and hearing radio ads from the Indiana secretary of state and attorney general speaking about fraud. It was clear that consumer protection and protecting seniors in Indiana was high on their list but not once had I heard mention of Medicare fraud.

In March I received an invitation in the mail to attend an Aging Well Conference being given by one of our Area Agencies on Aging (AAA): LifeStream Services. The invitation listed Michelle Mayer, who is outreach services supervisor for the consumer protection division of the Indiana attorney general's office. I thought this would be a wonderful opportunity to network with her but I didn't want to wait until May. I visited my contact at that AAA and asked for an introduction. She sent her an e-mail and it took 2 weeks to have a meeting set up. During the scheduling of this meeting the letter to the state attorneys general and insurance commissioners came out from HHS Secretary Sebelius. Talk about perfect timing. I attached the letter to an e-mail and sent it to Michelle Mayer.

During the meeting I shared with her the message of the SMP program and what we were doing here in the state of Indiana. We discussed things that they were doing and ways that we could potentially partner. Medicaid fraud falls under the attorney general and she was unaware we helped Medicaid victims as well. She is going to make sure that the Medicaid fraud unit knows of our existence and our efforts. As part of her presentations throughout the state on consumer protection and fraud prevention she is going to speak about SMP. She took some pamphlets to hand out as well.

From this meeting I was able to network with her about different individuals that I should also share the SMP message with. I mentioned my interest of connecting with someone at the secretary of state's office, the Office of Faith Based and Community Initiatives and the Indiana Triads program (Triad is key in helping to prevent fraud and other crimes against seniors). She gave me names and numbers of individuals that I could contact. The day after our meeting the national SMP website became a link under the Senior portion of the Indiana attorney general's office (see http://www.in.gov/attorneygeneral/2389.htm).

I have also since then met with Melanie Woods, the investor education coordinator with the secretary of state office. She shared outreach opportunities with me and gave me names of different organizations that shared our common goal. She has also had our website added to the secretary of state website (see http://www.in.gov/sos/securities/2539.htm). We are now recognized by these two offices as a service in the community that helps seniors prevent fraud.

2010 Medicare Fraud Forum


Anne Fredrickson

By Anne Fredrickson, MHA, MGS

SMP Project Manager, Pro Seniors Inc. (OH)

In September 2009, the Ohio SMP Advisory Council members met at our regularly scheduled semiannual meeting. As we discussed ways of getting the word out about Medicare fraud, member George Zahn, director of WMKV public radio station in Cincinnati, suggested hosting a fraud forum with some of our experts on the council. He agreed to host the program at Maple Knoll Village, a continuing care retirement center in a northwestern suburb of Cincinnati, and to record it, free of charge, for both his station and others across Ohio.

We began the process of coordinating the event. I worked closely with George and his staff to not only line up the panel, but also to find sponsors. We offered sponsors a table and visibility on all advertising. George took care of all the radio "operations" concerns. I was a guest one afternoon on one of his weekly shows and discussed the upcoming forum.

The fraud forum took place on Wednesday, Feb. 24, from 10:00 a.m. to 11:30 a.m. Panel members included: Tomi Dorris, Ohio Department of Insurance, Office of Legal Services, fraud prevention coordinator; Baya Maitland, AdvanceMed Corp., Medicare operations manager; Mani James, office of Ohio Attorney General Richard Cordray, consumer educator; Dottie Howe, Ohio Department of Insurance, Communications, Fraud Protection Program coordinator; Gretchen Lopez, Ohio Department of Insurance, Ohio Senior Health Insurance Information Program (OSHIIP) director; Greg Haines, office of Ohio Attorney General Richard Cordray, Health Care Fraud Section special agent supervisor; Lamont Pugh III, DHHS/OIG/OI Chicago regional office, special agent-in-charge; George Zahn, WMKV 89.3 FM radio station director; Anne Fredrickson, Pro Seniors, Ohio Senior Medicare Patrol project manager.

I developed the panel questions, which included identifying fraud, who is affected by fraud and how seniors are the "best line of defense" in

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Fraud forum panelists were so enthusiastic that they offered to do it again next year.

Medicare Fraud Forum *(continued from page 5)*

fighting fraud. We also discussed questions on identity theft with the panel experts describing the impact of this crime in relationship to Medicare fraud and financial exploitation. Additionally, we discussed questions on reporting Medicare fraud and identity theft to the appropriate authorities. Finally, we had some questions regarding senior scams, how seniors can report the scams and how to protect themselves from these scams.

We had a good turnout for the forum and good audience interaction. Media coverage included a local NBC affiliate reporter, who interviewed Lamont Pugh, the special agent-in-charge, DHHS/OIG/OI Chicago regional office, and provided a short segment about the forum on the nightly news.

Tips from the panel included reading the quarterly Medicare Summary Notice, NOT giving unauthorized folks access to Medicare cards and numbers and reporting the fraud to the Ohio SMP when in question. Lamont Pugh stressed the urgency of reporting problems even if they are minor. He brought with him new pamphlets from the OIG titled "Who to Contact Fight Back": http://www.oig.hhs.gov/fraud/IDTheft/OIG_Medical_Identity_Theft_Brochure.pdf

The good news about the forum was that the panelists were so enthusiastic about the outcome of the event that they proposed we do it again next year! Hopefully, with our SMP Advisory Council members' support, the Medicare Fraud Forum will become an annual event.

Participants and audience members interact at the 2010 Medicare Fraud Forum held in Cincinnati in February.

President Obama Came to Missouri

By Rona McNally

SMP Project Manager

Care Connection for Aging Services (MO)

It began as a quiet Monday morning, March 8. As I was driving to an appointment, I received a call from Diana Hoemann, the Missouri SMP project director. She informed me that we had received a request to identify a senior Medicare fraud victim and/or an SMP specialist who had fought and won. As President Obama had scheduled an appearance in St. Charles for Wednesday, March 10, the administration would like this person be on the podium with, and introduce, the president. Since the elimination of Medicare/Medicaid fraud, waste and abuse is a cornerstone of the health care reform legislation, it was to be one of the focal topics of his campaign for health care reform. By the end of the day, we had provided the names of three individuals to be "vetted" by the White House.

By noon the next day, the White House had changed its plans for the introduction of the president. However, Diana and I were offered the opportunity to attend the event and hear what President Obama had to say firsthand. What an opportunity!

About 400 individuals were in attendance in the high school gymnasium, standing shoulder-to-shoulder for hours to hear President Obama. When the president finally arrived, he was warmly welcomed.

"The health care system has billions of dollars that should go to patient care and they're lost each and every year to fraud, to abuse, to massive subsidies that line the pockets of the insurance industry," President Obama explained as the primary reason health care reform is necessary.

"... By saving billions of dollars of the sort we just talked about – waste and abuse – in Medicare, reining in waste and inefficiencies, we're going to be able to help ensure Medicare's solvency for an additional decade."

President Obama spoke of the improvements the health care reform legislation will make for Americans, such as the removal of pre-existing condition clauses, the ability to remain on Employer Group Health Plans, the ability to insure a child under your plan until the age of 26 and preventive care. However, as an SMP project manager, the statement that I believe holds opportunity for SMPs was, "There's no cutting of Medicare benefits. There's just cutting out fraud and waste in Medicare to make it stronger."

Diana Hoemann and Rona McNally at the Obama rally in St. Charles, Mo., in March.

National Summit on Health Care Fraud

Recognizing the Importance of the SMP Role in States

By Bill Benson

Health Benefits ABCs

Thanks to Barbara Dieker, director of the Office of Elder Rights at the U.S. Administration on Aging (AoA), I had the privilege of attending the unprecedented U.S. Departments of Justice (DOJ) and Health & Human Services (HHS)-sponsored National Summit on Health Care Fraud held in late January at the National Institutes of Health in Bethesda, Md. Joining me at the conference were others from the national SMP community, including: Cynthia Allen, director of Delaware's SMP, and Mary Covell, a seasoned volunteer in the Delaware program, along with Charles Clarkson, coordinator of New Jersey's SMP program. Their thoughtful observations about the summit follow.

Based upon Barbara's recommendation, AoA nominated me to serve as a co-chair for one of the five "strategic working sessions" at the summit. With Doug Porter, director of Washington state's Medicaid program, we co-chaired the session "The Role of States in Preventing Health Care Fraud."

The morning consisted of plenary addresses and a truly riveting panel about the combined efforts of the DoJ, Federal Bureau of Investigation (FBI), the Centers for Medicare & Medicaid Services (CMS) and the Office of Inspector General (OIG) to investigate and prosecute health care fraud in South Florida. The highlight of the morning for us, however, Mr. Clarkson notes, was HHS Secretary Sebelius' glowing remarks about the SMP program, including her comment that the 20 million beneficiaries reached over the years by the SMP program are like having "20 million undercover cops" combating health care fraud, adding that we are "trying to beef up that effort."

The afternoon was devoted to the strategic working sessions and plenary reports from each of the five groups. Ms. Allen and Ms. Covell participated in the session I co-chaired on the role of states. Other participants included CMS, prosecutors, state Medicaid Fraud Control Units (MFCUs), state insurance commissions, Medicaid and private health plan program integrity personnel.

Our session examined effective strategies to fight Medicare and Medicaid fraud on the state level and considered where improvements could be made. Considerable emphasis was on the vital role of information sharing and collaboration among numerous stakeholders. There was much discussion about the value of key stakeholders within states convening regularly to share information,

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Bill Benson facilitates a discussion at the 2009 SMP National Conference last August. He also co-chaired a breakout session at the National Summit on Health Care Fraud in January.

National Summit on Health Care Fraud *(continued from page 8)*

especially because fraud isn't isolated to just Medicare, Medicaid or private insurers; a provider defrauding Medicare may well be also defrauding the property and casualty industries. A CMS representative noted the need for multipayer solutions as a way to attack the fraud and waste issue and combining resources and investigative activities. In addition to including prosecutors, law enforcement, regulators and payers' program integrity units, others at the table should include the SMP program as well as the state long-term care ombudsman. North Carolina and New York were recognized for their inclusive efforts. The North Carolina MFCU participant emphasized that this not only improves information sharing but also builds relationships and trust and leads to stronger prosecutions and more money recovered.

As with Secretary Sebelius' opening remarks, the SMP program received considerable attention in the working session on states' roles, as did the role of beneficiaries in identifying and fighting health care fraud. Ms. Allen gave a compelling description of SMP work. The draft minutes (not yet published) from the session note, "Session participants praised the Senior Medicare Patrol's efforts to educate and engage patients and families in helping to identify and report Medicare fraud and abuse." There was also agreement that a Medicare Summary Notice (MSN)-like document for Medicaid would be valuable in identifying potential fraud and errors. A DOJ senior trial attorney cited Medicare's MSN as a "very useful enforcement tool" and noted that beneficiaries are educated as a result of reviewing their MSNs. As noted in the draft minutes, "Session participants recommended that the Senior Medicare Patrol model and summary notices be used to help Medicaid patients and families spot and report fraud and abuse."

Other strategies to assist states in their efforts to combat health care fraud were discussed, such as allowing MFCUs to engage in data mining and the role of states' medical boards and licensure entities in sanctioning providers convicted of fraudulent practices. Doug Porter stressed the need to better track convicted providers. The group emphasized the importance of coordinated educational efforts to help stop fraudulent providers from moving across state lines and committing fraud in different areas of the country.

The first-ever National Summit on Health Care Fraud was inspiring in its scope and commitment to significantly ramping up the heat on health care fraud. It also represented the most significant acknowledgement among a broad spectrum of stakeholders, including prosecutors, program integrity personnel and public and private payers, of the importance of the SMP program in the battle against health care fraud.

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Want to Learn More?

For videos, transcripts and other National Summit on Health Care Fraud materials, go to: http://www.stopmedicarefraud.gov/videos.html

National Summit on Health Care Fraud

Reforming the Effort to Fight Fraud

By Charles Clarkson, Esq.

Coordinator, SMP of New Jersey

When Barbara Dieker asked me, in my capacity as coordinator of the SMP of New Jersey, and one of my volunteers to attend the National Summit on Health Care Fraud held at the National Institutes of Health in Bethesda, Md., on January 28, I was unsure what to expect. The summit was a joint undertaking by the U.S. Department of Health & Human Services (HHS) and the U.S. Department of Justice (DOJ). I knew it would be a chance to represent the SMP program but other than that, it was difficult to get a feel for exactly what would be discussed.

Charles Clarkson

I am glad to report that the SMP program is now well-positioned to take a leading role in helping the current administration fight health care fraud. I was glad to see the government finally taking this subject seriously. This was, in fact, the first national summit to deal exclusively with health care fraud.

To emphasize the new priority to fight fraud, waste and abuse, the heavyweights from the main agencies overseeing Medicare and fighting fraud were on the agenda. Participants also included private-sector leaders, law enforcement personnel and health care experts. During the morning plenary session, some of the important speakers included William Corr, Assistant Secretary of HHS; Gary Grindler, Acting Deputy Attorney General; Dan Levinson, Inspector General, Office of the Inspector General (OIG); William Holder, Attorney General; and Kathleen Sebelius, Secretary of HHS.

They spoke of the renewed effort to fight fraud as part of the overall health care reform being spearheaded by the Obama administration. It was obvious that fighting fraud in Medicare and Medicaid was something all could agree upon and efforts to combat this problem would go forward.

Dan Levinson noted that one out of every three Americans depend on Medicare, Medicaid and children's programs and that for every dollar invested in fighting health care fraud, OIG sees an $8 return. He also stated that fighting fraud is what OIG does but that they cannot do it alone.

Secretary Sebelius put criminals on notice. The Obama administration has zero tolerance for health care fraud. HHS wants every good idea to combat this growing problem. Medicare has been an easy target. Fraud has grown faster than the solutions. It violates two sacred trusts: to spend money wisely and to do everything we can to protect Medicare for future generations. She further noted that we need a single searchable database so that we can be smarter about analyzing data in real time to spot suspicious trends.

Secretary Sebelius went on to say that one of the most effective ways to stop fraud is prevention: Stop fraud before it happens. To my surprise and delight, she highlighted the SMP program, which reaches out to 20 million seniors, meaning that HHS has 20 million undercover agents to help uncover health care fraud.

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National Summit on Health Care Fraud *(continued from page 10)*

Attorney General Holder highlighted efforts to fight health care fraud: to redouble HEAT (Health Care Fraud Prevention and Enforcement Action Team) initiatives; to push for additional investment to fight fraud; to work with Congress to impose greater sanctions for health care fraud; and to work with the private sector to assist in this effort.

Following the morning session, participants broke up into smaller strategic planning sessions that focused on specific topics. These included: (1) "Use of Technology to Prevent and Detect Fraud and Improper Payments"; (2) "The Role of States in Preventing Health Care Fraud"; (3) "Effective Law Enforcement Strategies"; and (4) "Measuring Health Care Fraud, Assessing Recoveries and Determining Resource Needs."

I attended a session titled "The Development of Effective Prevention Policies and Methods for Insurers, Providers and Beneficiaries." A sampling of the group of approximately 20 individuals represented organizations such as Blue Cross Blue Shield, AARP, the American Medical Association, OIG, DOJ, the Centers for Medicare & Medicaid Services, and departments of insurance and similar institutions. After introductions for everyone around the table, I realized that SMP was the only organization present dealing directly with outreach and receipt of fraud complaints from beneficiaries.

Our breakout session concentrated on two major areas: sharing of information between public and private institutions and being more proactive to stop fraud.

For the first area, it was apparent that data on health care fraud was fragmented across the country and institutions are doing a poor job sharing this valuable information. This inability or unwillingness to share data gives criminals a decided advantage when committing fraud. In addition, HIPAA privacy rules would have to be overcome to allow more information sharing.

As for the second area, the use of new technologies to analyze data more efficiently and to cease the current method of recovering money fraudulently paid, known as "pay and chase," needs to be reversed. Presently, Medicare is required to make timely payments to providers, even if there is suspicion of fraud. Giving Medicare the flexibility to cease or suspend payment if it suspects fraud would go a long way in the fight to prevent fraud.

Finally, the audience in our breakout session was permitted to ask questions. A woman asked if a national education campaign in the form of a public service announcement would be something that made sense. I was finally able to advise the participants in the room that the SMP program already has years of experience reaching out to beneficiaries. The program has vast amounts of materials ready to use to help in this fight and we do not have to reinvent the wheel. Also, Barbara Dieker, Director of the Office of Elder Rights at the U.S. Administration on Aging (AoA), noted that AoA is seeking funding to put together such a national campaign.

Overall, this first national summit to fight fraud was an impressive first step. But the task is daunting and will need more direction and leadership from the Obama administration. For the SMP program, we might be seeing some light at the end of a long tunnel.

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National Summit on Health Care Fraud

Coordinating a National Response

By Cynthia M. Allen and Mary Covell

SMP Delaware, State of Delaware State Unit on Aging

The first National Summit on Health Care Fraud gathered together leaders in government and the private sector to address the increasingly urgent topic of health care fraud. Secretary Kathleen Sebelius of the U.S. Department of Health & Human Services (HHS) gave the opening address. She emphasized the Obama administration's zero tolerance for health care and abuse.

She added that the recently created Health Care Fraud Prevention and Enforcement Action Team (HEAT) has made fighting Medicare Fraud a Cabinet-level priority for both the Department of Justice (DOJ) and HHS.

Secretary Sebelius' remarks were followed by Attorney General Eric Holder, who emphasized the magnitude of the challenge, reiterating the president's commitment to the importance of the fight against health care fraud and abuse. While recognizing the progress that has been made, he expressed the need for a continuing, collaborative, coordinated national response. He applauded this newly forged alliance of government, law enforcement and the private sector. He assured the audience that the president will support programs that have demonstrated a proven record of preventing fraud, reducing payment errors and returning funds to the government.

Next came presentations from: U.S. Rep. Ron Klein (Fla.) and DOJ, Federal Bureau of Investigation (FBI) and Office of Inspector General (OIG) representatives from South Florida.

Each presentation was extremely informational about specifics in its discipline. South Florida is frequently referred to as "Ground Zero" because of the propensity of abuse of the health care system, particularly Medicare fraud.

The investigators and prosecutors gave real-life examples of cases they had followed and successfully prosecuted. The energy and dedication to the mission of ending the cycle of health care fraud and abuse was clearly evident. Their efforts in South Florida will certainly benefit those in other jurisdictions similarly committed.

James Roosevelt Jr., CEO of Tufts Health Plan, Boston, Mass., presented "The Role of the Private Sector." Dr. Roosevelt is in a unique position, as an attorney and a physician, to offer cogent remarks as an executive with one of the country's largest health systems.

The afternoon consisted of strategic working and planning sessions. Topics included:

- "The Use of Technology to Prevent and Detect Fraud and Improper Payments"
- "The Role of States in Preventing Health Care Fraud"
- "The Development of Effective Prevention Policies and Methods for Insurers, Providers and Beneficiaries"

continued

National Summit on Health Care Fraud *(continued from page 13)*

- "Effective Law Enforcement Strategies"
- "Measuring Health Care Fraud, Assessing Recoveries and Determining Resource Needs"

Participants and moderators reported a high degree of participation from all panelists, with an exchange of information and experiences that will have a positive effect on strengthening the collaboration of the various public and private entities represented.

Secretary Sebelius' closing remarks summarized that "… Health care fraud isn't just a government problem. Criminals do not discriminate. They are stealing from Medicare, Medicaid and private companies at an unacceptable rate. We have a shared interest in stopping these crimes and this summit brought us together to discuss how we can all work together to fight fraud."

These comments seemed to concur with the thoughts of most of the summit attendees with regard to all of our efforts working toward the elimination of health care fraud and abuse.

Information Sources: National Summit on Health Care Fraud session materials

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Cynthia Allen and Mary Covell, back center, take part in a breakout session at the National Summit on Health Care Fraud in January. A story about the session appears on the next page.

Role of States Breakout Session

Focus Statement: Health Care fraud is an industry-wide challenge, though faced by diversity with each state currently combating fraud, waste and abuse. Please note that private industry follows Medicare/Medicaid policies. How can this industry create/continue partnerships given that there are multiple relationships both in the private and public sectors?

Representatives at the roundtable included: United States Department of Justice; Centers for Medicare & Medicaid Services Deputy Director for State Operations; State insurance commissioners; Medicare Fraud Control Unit (MFCU) State Director, Deputy Attorney General and investigators; Congressional representatives; State Attorney General Bureau of Medi-Cal Fraud & Elder Abuse; State Department of Medical Assistance Services; HHS Office of Inspector General; Coalition Against Insurance Fraud; National Association of Insurance Commissioners; Federation of State Medical Boards; National governors associations; National Association of MFCU; National Health Care Anti-Fraud Association; National Association of Insurance Commissioners (NAIC) Department of Insurance, Securities and Banking; State Unit on Aging/Senior Medicare Patrol.

Main Issues Discussed

1. Reduce investigation time with "criminal" intent of potential fraud, abuse and waste of funds.

2. More informed consumer who can read Medicare Summary Notice (MSN) and Explanation of Benefits (EOB) to report red flags. Sound familiar? Here are suggestions: Having a statement printed with a hotline to call to report fraud; Medicaid clients not getting MSNs – CMS has a pilot program running.

3. Change reimbursement procedure to a multipayer concept (public/private); check and balance system in place.

4. Data/information sharing with partnership both in private/public sectors on all levels (federal, state and local); data mining is not on a local level.

Results from Discussion

1. Form a task force involving law enforcement partners within each state, sponsored by the U.S. Attorney's office. Gain trust with private/government. The North Carolina MFCU has an existing partnership. The following resource was researched: http://www.justice.gov/usao/nce/psn/index.html.

2. Create a uniform database through a "Medicare Integrity Program" with medical association, health care and law enforcement partnership. Kansas U.S. Attorney has a central database for state and local cases. I've researched the following resource at: http://www.justice.gov/usao/ks/lecc.html. ⬢

— Cynthia M. Allen and Mary Covell

Now Enrolled, Now Not

Beneficiary loses Advantage coverage and is stuck with the bills.

By Maureen Patterson

Media Manager, SMP Resource Center

A beneficiary from Missoula, Mont., has worked hard his whole life. He's taken care of the people around him. When the now-retired cement contractor started his own business in 1975, he could have offered low wages and benefits.

But that's not his way. "When I worked years ago for other people I was always union. Then when I went into business I decided I always enjoyed a decent wage and I figured I'd like to keep my guys at a decent wage and of course the insurance thing. I chose to go union," says the beneficiary, whom we'll call Bob.

As the years progressed, his personal health insurance became an increasing burden. By the time he was 64 years old, he was paying $600 a month for health insurance. When an insurance agent approached him near this 65th birthday in 2008, promises of a drastically reduced rate with a different company looked attractive. He was not planning to retire or collect Social Security until he turned 66, but the agent didn't ask. Explains Renee LaBrie-Shanks, SMP/I&A program manager, Missoula Aging Services, Missoula, Mont., "The agent said normally all he does is add an 'A' onto the end of the Social Security number because he assumed [Bob], being 65 or older, was on Medicare. He just assumed it instead of asking to see his Medicare card."

Bob had not signed up for Medicare, and, according to Labrie-Shanks, Medicare sent the insurance company a letter saying so. The company processed the application anyway and sent Bob insurance cards twice. He canceled his former coverage and thought he was covered. The new insurance company paid his claims but never sent him a bill. He expected to pay but figured that Medicare was taking care of it.

continued

"... Every consumer really needs to be educated. We do need to all be buyers beware and not assume somebody else is out for our interest."

— Renee LaBrie-Shanks, Montana SMP

Beneficiary Loses Advantage *(continued from page 15)*

Until one day it didn't. In January 2009, after more than 6 months with the new company, he broke his collar bone. "Shortly after that I got a call on the thing from somebody from [the company] asking if that was my claim or if that was for somebody else, which I thought was awful strange. I said, "No, that's for me,'" he says.

When he went to the pharmacy shortly after, the pharmacist told him that his insurance card no longer worked. His health care providers started calling him with news that either the insurance company was not paying or, if it had already paid, wanted its money back.

"I never got nothing from [them] saying, 'You're dropped' or anything like that. They quit paying, made the card inactive, with no explanation, nothing," Bob explains.

He called his insurance agent, who went with him to his local Social Security office, where he signed up for Medicare Part A. It was too late to sign up for Part B, so he has had to go without. He can't get it until he turns 67 in July, and then he'll have to pay a 10 percent penalty per month. He also was stuck with $6,000 in medical bills.

Bob contacted LaBrie-Shanks' office and she contacted the insurance company. At first she was told that everything was fine but she was later told that Bob was not eligible for coverage. She contacted Social Security, the insurance commissioner's office, MEDICs (Medicare Drug Integrity Contractors) and the Centers for Medicare & Medicaid Services (CMS). "Medicare has on file that they did not approve his enrollment," she says. "We're kind of on a standby. Everybody says it's somebody else's fault."

Part of the problem was that Bob did not understand that when you turn 65 you need to sign up for Medicare if you're not taking Social Security. It's not automatic, as it once was. The rest of the problem, she says, came from the insurance company, which should not have signed him up and, after receiving notification from CMS that he was ineligible, should have notified Bob and canceled the policy.

Bob holds no ill will toward the agent. His main concern is having little health coverage. This is, after all, a man who paid a lot of money for health insurance over the years, always working to protect himself and those around him.

Concludes LaBrie-Shanks, "This is a message that every consumer really needs to be educated. We do need to all be buyers beware and not assume somebody else is out for our interest. We need to be that first-line defense and know, be educated about our benefits, what they are, what they're not, when we need to enroll, when we don't. It's a sad story when somebody has to learn this way." ⬢

Montana SMP
Empowering Seniors To Prevent Healthcare Fraud

National Hispanic SMP Strategies Successful in Preventing Medicare Fraud Among Hispanic Older Adults

By Maria Eugenia Hernandez-Lane, MSM/MBA

Vice President, National Hispanic Council on Aging

In South Texas, Mr. Sanchez reviewed his Medicare statement. He found that his account had been billed more than $7,000 for 100 boxes of diabetes test strips and another 100 boxes of lancets when, in fact, he had only received one box of each.

Ms. Contreras was double billed for medical equipment and actually paid the full amount. Mr. Torres was billed by a hospital for more than $106,000. When he tried to resolve the matter with the hospital, they refused to resubmit the claim for review.

Sanchez, Contreras and Torres are all Hispanic older adults living in the Rio Grande Valley of Texas. Each of them were able to successfully resolve their situations with help from the National Hispanic Council on Aging's (NHCOA's) National Hispanic Senior Medicare Patrol (NHSMP) program and its flagship local community-based partner Senior Community Outreach Services of Alamo, Texas.

Medicare fraud costs $60 billion per year to U.S. taxpayers at a time when they can ill afford it, due to the economic downturn. Hispanic older adults are especially vulnerable to Medicare fraud due to several factors: low English proficiency, cultural isolation coupled with a cultural tendency to not "fight the system" and low levels of formal education.

The Medicare system contains a level of complexity that makes it challenging to master even for persons with native English proficiency and a high level of formal education. For Hispanic older adults, it often seems impossibly complicated. Moreover, the culture and experience of their home countries often make Hispanic older adults afraid to question the system. "Companies and doctors can retaliate if I don't agree with them" or "The doctor won't see me next time if I question the charges" are typical sentiments expressed by Hispanic older adults when discussing Medicare fraud.

So, how did it happen that Sanchez, Contreras and Torres, among many others, challenged the system and approached the NHSMP program to get informed? The

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Catalina Hernández talks about Medicare fraud prevention to seniors from different parts of the country during the NHCOA Annual Conference in Washington, D.C.

National Hispanic SMP *(continued from page 17)*

answer is NHSMP's ability to successfully reach Hispanic older adults through cultural-, linguistic- and age-sensitive practices.

Hispanic older adults are typically hard-working people seeking to enjoy their golden years with their families. They usually have little disposable income and fraudulent medical charges take away from monies budgeted for food, clothing, housing and legitimate medical expenses. Despite fear and linguistic and cultural barriers, Hispanic older adults will stand up for their rights when faced with Medicare fraud if they know how to recognize it and where to go for help in reporting it and resolving issues surrounding fraudulent billing. NHCOA has identified best practices that it implements through the NHSMP program that are proving successful.

SMP volunteers provide one-on-one information and materials to seniors during a community event.

The first of these best practices is conducting outreach and education to Hispanic older adults in a linguistically, culturally and age-appropriate manner. Reaching and serving Hispanic older adults appropriately goes beyond just translating outreach materials into Spanish. The Spanish information must be presented in a simple and easy-to-read manner. It must also be expressed in Spanish familiar to people of Latin American roots, and written Spanish-language materials must be in a font large enough for them to see. In addition, there should be consistent messages across all materials, and they should be repeated constantly through print and audio materials. Messages may be relayed through flyers posted in places where Hispanic older adults routinely gather. They should also be communicated one-on-one through community educators or through radio and television public service announcements.

Working on the basis of these best practices, NHCOA has developed and distributed linguistically, culturally and age-appropriate materials in both written and audio format, including flyers, posters and public service announcements with consistent messages. The messages for these materials are based on the most common types of Medicare fraud experienced by Hispanic older adults as gleaned through a series of community forums implemented by NHSMP in Texas last year.

The second successful best practice is reaching Hispanic older adults one-on-one through people Hispanic older adults trust. Because of Hispanic older adults' social isolation and linguistic and cultural gaps with the mainstream community, social workers and service providers often find it difficult to reach Hispanic older adults. *Promotores,* or volunteer community educators from the same local community, however, are able to reach Hispanic older adults because they understand the

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National Hispanic SMP *(continued from page 18)*

needs of the local community and know many of the people as neighbors and friends. *Promotores* are volunteers trained by the NHSMP who are trusted and can communicate the concepts of Medicare fraud in a way that is linguistically and culturally appropriate. In addition, they often act as informal social workers, helping clients review Medicare statements or medical bills to identify Medicare fraud and guide them through the process of reporting the fraud and seeking help in resolving fraudulent bills.

The third successful best practice is reaching not only Hispanic older adults but also their families and caregivers. Hispanic families generally act as a single unit in decision-making. Moreover, most Hispanic older adults live with extended family – children, nieces or nephews and their families – with the larger extended family operating with the closeness of immediate family. NHCOA makes it a policy to involve family members whenever possible in outreach and education efforts, ensuring that entire family units understand how to recognize and report Medicare fraud.

At least 3 percent of the $2 trillion U.S. taxpayers spend on health care a year is lost to fraud, according to the National Health Care Anti-Fraud Association. There's enormous potential for savings in successfully reaching Hispanic older adults, who are common targets of Medicare fraud. Through the NHSMP, NHCOA is doing just that.

Currently, the NHSMP is conducting a needs assessment in Florida and the District of Columbia, as it did in Texas. This assessment will provide data and form the basis for education efforts that will increase rates of detection, prevention and reporting of Medicare fraud among the diverse Hispanic populations in these areas. In addition, NHCOA has developed a portal on its website (http://www.nhcoa.org/elearning-center.php) that provides resources on empowering Hispanics to combat Medicare fraud. NHCOA also has a toll-free line (1-866-488-7379) to answer questions from community-based organizations and SMPs wanting to educate Hispanic seniors on how to prevent Medicare fraud.

NHSMP volunteers from NHCOA's affiliate organization in the Rio Grande Valley: Senior Community Outreach Services. Volunteers are, left to right: Manuel Garcia, Carlos Tamez, Jesús Hernandez, Cesar Pedraza, Rigo Martinez, Ricardo Ortiz, Marisela Lopez, Cindy Rios and Cristela Munguía. Staff of NHCOA's affiliate organization are José Pérez, standing, second row, left, and Rachanna Rodriguez, kneeling, right.

Anti-Fraud Provisions in New Health Reform Law

By Nancy Aldrich

Health Benefits ABCs

On March 23, President Obama signed the Affordable Care Act (H.R. 3590), the much-debated health care reform legislation that contains a number of anti-fraud provisions, including:

- Allowing provider screening, including licensure check and, for certain providers as deemed appropriate by HHS (U.S. Department of Health & Human Services), a criminal background check, fingerprinting, site visits, database checks, etc.
- Strengthening Medicare review prior to paying providers to prevent fraud, waste and abuse
- Extending the review period to 90 days for Durable Medical Equipment claims when there is a significant risk of fraud
- Enhancing penalties for providers and suppliers who commit fraud, waste and abuse
- Limiting maximum time for submission of Medicare claims to 12 months
- Limiting the time period for providers and suppliers to return overpayments
- Increasing authority to suspend payment for services or items pending fraud investigations
- Expanding the role of government contractors who monitor fraud and abuse in Medicare Advantage and Part D, including ensuring timely inspections and enforcing marketing restrictions
- Requiring providers and suppliers to have a compliance program
- Improving data sharing among federal and state programs
- Increasing funding for anti-fraud activities

Other key Medicare reforms of interest to SMPs:

- Payments to Medicare Advantage (MA) plans will be lowered to equal those paid through traditional Medicare. As a result, some MA plans may cut optional benefits such as vision and dental, but they are prohibited from cutting mandated benefits.
- Part D (prescription drug program) reforms include:

1) A $250 rebate check for Part D enrollees who enter the coverage gap (donut hole) in 2010. This check will be sent automatically; Medicare will not call or visit anyone to provide this benefit. Eligible Medicare beneficiaries will receive a notice in the mail from CMS (the Centers for Medicare & Medicaid Services), but they do not need to take any action to receive the check.

2) A 50 percent discount on brand-name drugs and biologics for low- and moderate-income (below $85,000 per individual and $170,000 per couple) enrollees who are in the donut hole. (The donut hole is the $3,600 gap in the drug benefit when consumers pay full price.)

3) No copayments for dual-eligible beneficiaries receiving home- and community-based services.

- Prevention/wellness improvements will remove the copay and deductible for an annual wellness visit and personalized prevention assessment. Prevention services include referrals to education and preventive counseling or community-based interventions to address risk factors.

Medicare Fraud Estimates: A Moving Target?

By Nancy Aldrich

Health Benefits ABCs

$850 billion? $100 billion? $60 billion? Just how much does health care fraud cost the nation each year?

While there are no exact figures on the cost of health care fraud in the United States, estimated annual losses are definitely in the billions of dollars. "The units of measure for losses due to health care fraud and abuse in this country are hundreds of billions of dollars per year. ... These are staggering sums of money to waste, and the task of controlling and reducing these losses warrants a great deal of serious attention," says health care fraud expert and Harvard University Professor Malcolm K. Sparrow.

All health care programs are subject to fraud; however, the Medicare and Medicaid programs are the most visible, the most frequently cited and, unlike the private sector, are required to release certain data, according to the Federal Bureau of Investigation (FBI).[1]

"There is no requirement for private insurers to report their fraud rates," Bill Corr, Deputy Secretary, Department of Health & Human Services (HHS), told the Senate Judiciary Committee at an Oct. 28, 2009, hearing on preventing health care fraud.

A 2009 study by the George Washington University School of Public Health and Health Services concluded, "National reporting systems on health care fraud fail to capture private sector fraud."[2]

Estimates of fraud, both public and private, run between 3 and 10 percent of total health care expenditures. The United States expects to spend $2.6 trillion on health care in 2010.[3]

Why is there no firm data on the cost of Medicare fraud? There are several reasons:

1. **Broad Definitions.** Estimates for misspent dollars may not distinguish fraudulent payments from those that involve waste or error. Or they may focus on the entire health care system, not just on Medicare fraud.

Fraud is defined as knowingly and willfully executing, or attempting to execute, a scheme or ploy to defraud the Medicare program.[4]

Abuse is defined as incidents or practices of providers that are inconsistent with accepted sound medical, business or fiscal practices.[5]

Waste, depending on whose definition you use, can include inefficient claims processing and health care administration, defensive medicine (redundant, inappropriate or unnecessary tests and procedures), preventable hospital readmissions, medical errors, unnecessary emergency room visits, hospital-acquired infections and money spent on preventable conditions (such as obesity or smoking).[6]

2. **Higher Stakes.** The dollar amount that occurs in a single incidence of fraud is rising, according to the U.S. Department of Justice (DOJ), making it harder to estimate fraud based on prior statistics. An individual case of fraud now may involve perhaps $30 to $50 million, instead of a $1 million figure that would have been eye-popping a decade ago, DOJ says.

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Medicare Fraud Estimates *(continued from page 21)*

3. **Unknowns.** Most fraud is undetected, and therefore difficult to count. "It is not possible to measure precisely the extent of fraud in Medicare and Medicaid," HHS Inspector General Daniel Levinson told the Senate Special Committee on Aging in May 2009.

Estimates for dollar losses, including waste, in all health care arenas include:

- $1.2 trillion a year, based on a 2008 report by PricewaterhouseCoopers' Health Research Institute.[7]
- $600 to $850 billion a year, according to a Thomson Reuters report[8] that uses a broad definition of "waste" (defined as "healthcare spending that can be eliminated without reducing the quality of care").
- $98 billion in improper health care payments ($54 billion from Medicare and Medicaid) in fiscal 2009, Peter Orszag, director of the White House Office of Management and Budget (OMB), said at a Nov. 17, 2009, media briefing. This was a 37.5 percent increase above $72 billion in 2008, partly due to a change in the way CMS calculates improper payments.[9] The two areas with significant increases in errors were inpatient services and Durable Medical Equipment. "Improper payments" are those made in the wrong amounts, to the wrong person or for the wrong reason.[10]
- $24.1 billion in improper payments was made to Medicare fee-for-service (FFS) providers in 2009, according to the Centers for Medicare & Medicaid Services (CMS).[11] This is based on a national paid-claims error rate in the FFS program of 7.8 percent (due to items such as missing or insufficient documentation, medically unnecessary services or incorrect coding). Each year the Medicare FFS error rate is reported in both CMS' and HHS' audited financial reports. The FFS error rate is not a measure of fraud but does provide an assessment of errors that need to be fixed.
- $1.2 billion in Medicare and Medicaid audit disallowances (findings of unallowable costs), according to the HHS Office of Inspector General (OIG).[12] In its FY 2008 report on the Health Care Fraud and Abuse Control Program, HHS reported it collected approximately $662.5 million in disallowances of improperly paid health care funds.[13]
- $209 million in improper payments for Medicare home health claims alone for the 12-month period ending September 30, 2007, according to the federal Comprehensive Error Rate Testing (CERT) program, which monitors payment accuracy in the Medicare FFS program. (Fraudulent claims may not be reflected in the CERT error rate estimate, according to the Government Accountability Office (GAO).[14])

Estimates for health care fraud and abuse that do not include "waste":

- $125 to $175 billion, according to the Thomson Reuters report.[15]
- $75 to $250 billion a year, according to the FBI, based on the assumption that fraudulent billings to public and private health care programs are 3 to 10 percent of total health care expenditures.[16]
- $60 billion a year, according to the National Health Care Anti-Fraud Association, an organization of about 100 private insurers and public agencies.[17]
- $32.7 billion or 10 percent (including a federal share of $18.6 billion) of state Medicaid claims paid in 2007 were improper, according to the GAO.[18]

Estimates for Medicare/Medicaid fraud:

- $100 billion annually in Medicare and Medicaid fraud, according to the Center for Health Transformation, a public-private collaborative formed by former Speaker of the House Newt Gingrich.[19]

continued

Medicare Fraud Estimates *(continued from page 22)*

President Barack Obama and Office of Management and Budget Director Peter R. Orszag, Jan. 26, 2009. (Official White House Photo by Pete Souza)

- $80 billion annually in Medicare fraud, according to the Coalition Against Insurance Fraud, an anti-fraud watchdog group for consumers, insurers, legislators, regulators and others.[20]
- $1 billion in costs for fraud involving the Medicare home health care sector alone, according to the American Association for Homecare.[21]
- Millions of dollars every year are lost due to Medicare fraud, CMS says.

Clearly these varying estimates can be confusing, but any way you measure it, the reality is that the health care system loses enough money each year to pay for insurance for the uninsured, keep premiums from rising and improve the health of Americans. And taxpayers bear the burden of Medicare fraud, waste and abuse. In addition, the fraud numbers for private health insurance plans, secondary payers and Medigap plans are likely to be high as well; those data are just not available.

The critical message for SMPs is that your work is more important than ever and there is no reason to assume it will diminish in the near future.

Footnotes

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Medicare Fraud Estimates *(continued from page 23)*

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Network Speeds Flow of Critical News

By Maureen Patterson

Media Manager, SMP Resource Center

On March 10, the Centers for Medicare & Medicaid Services (CMS) terminated the contract of Fox Insurance Co. of New York from providing Medicare Part D drug plans in 21 states. It found that the plan's deficiencies were too serious to correct during their period of suspension and jeopardized the health and safety of enrollees.

JoAnne Embry

"This is the first time that they've terminated a contract with a prescription drug plan," says SMP Project Director JoAnne Embry, who works with the Office of the Nevada Attorney General.

When CMS suspended enrollment and marketing of new members into Fox on Feb. 26, Embry wrote a press release and disseminated it among the attorney general's network of 450 media outlets and other groups, in addition to the SMP listserv. She also requested from CMS Region IX a spreadsheet listing the number of beneficiaries per county, per state who were enrolled in the drug plan for SMPs in the affected states and disseminated the information through the SMP Resource Center.

CMS findings include:

- Failing to provide access to Medicare prescription drugs benefits by imposing unapproved prior authorization and step therapy criteria that made it more difficult for beneficiaries to get drugs that are protected by law
- Not meeting the plan's appeals deadlines
- Not complying with Medicare regulations requiring enrollees to be transitioned to new drugs at the beginning of the new plan year
- Failing to notify enrollees about prior authorization and step therapy determinations as required by Medicare
- And, most serious, requiring medical procedures before approving some medications that had the potential effect of serious medical risks to the patient/enrollee

Swift communication in the aging network helped this serious problem to reach the public quickly. Says Embry, "It's absolutely imperative for us to have a communication system between CMS, the Administration on Aging, the SMPs and the SHIPs. We all need to be on the same page. When we're all doing something separate and everybody protects their information we're not serving the public. We are making serious headway in improving this communication gap, since we all have the same goal - protecting our consumers."