From Analytics to Action and Results

A Law Enforcement Perspective

Gary Cantrell

Deputy Inspector General for Investigations
U.S. Department of Health and Human Services - OIG
Program Scope

• CMS is the largest purchaser of health care in the world – approximately $802 billion
• Medicare, Medicaid, and Children’s Health Insurance Program provide care for approximately 1 in 4 Americans (roughly 107 million beneficiaries)
• CMS processes more than 1 billion Medicare claims annually
The Institute of Medicine estimates about $\textbf{765 billion} is lost to waste and inefficiency which is roughly one-third of the $2.6 trillion in annual U.S. health care spending

- $210 billion – unnecessary services
- $190 billion – administrative costs
- $130 billion – inefficiently delivered services
- $105 billion – excessive prices
- $75 billion - fraud
## Five Year Overview

<table>
<thead>
<tr>
<th>OIG Action</th>
<th>FY09</th>
<th>FY10</th>
<th>FY11</th>
<th>FY12</th>
<th>FY13</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criminal Actions</td>
<td>671</td>
<td>647</td>
<td>723</td>
<td>778</td>
<td>960</td>
<td>3,779</td>
</tr>
<tr>
<td>Civil Actions</td>
<td>394</td>
<td>378</td>
<td>382</td>
<td>367</td>
<td>472</td>
<td>1,993</td>
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<tr>
<td>Exclusions</td>
<td>2,556</td>
<td>3,340</td>
<td>2,662</td>
<td>3,131</td>
<td>3,214</td>
<td>14,903</td>
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<tr>
<td>HHS Investigative Receivables</td>
<td>$3.0 Billion</td>
<td>$3.2 Billion</td>
<td>$3.6 Billion</td>
<td>$4.3 Billion</td>
<td>$4.0 Billion</td>
<td>$18.2 Billion</td>
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<tr>
<td>Non-HHS Investigative Receivables</td>
<td>$1.0 Billion</td>
<td>$576.9 Million</td>
<td>$952.8 Million</td>
<td>$1.7 Billion</td>
<td>$1.03 Billion</td>
<td>$5.2 Billion</td>
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<tr>
<td>Total Investigative Receivables</td>
<td>$4.0 Billion</td>
<td>$3.8 Billion</td>
<td>$4.6 Billion</td>
<td>$6.0 Billion</td>
<td>$5.0 Billion</td>
<td>$23.5 Billion</td>
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</tbody>
</table>
How do you conduct oversight and enforcement in a program so large?
Data Analytics

• Data analytics plays a significant role in OIG’s oversight and enforcement strategy
  – Allocate Resources
  – Triage Allegations
  – Investigations are more efficient
  – Measure Impact
Specific Schemes
Transportation Fraud

- In connection with dialysis services, mental health services, and assisted living facilities
  - Kickbacks to recruiters, beneficiaries and medical directors
- BLS to ALS upcoding
- “Nearest facility”
- Specialty transports
Ambulance Model

- Percent of all providers
- Percent of top 100
Outcomes: Ambulance Trends

Sustained declines in Medicare payments have followed Federal enforcement and oversight action.

- Total Medicare payments for ambulance services (mostly for BLS non-emergency transports and mileage) in Houston are **down approximately 50%** from $30 million to $15 million per quarter since 2010.
- The **Houston Chronicle** published article about high numbers of “private” ambulance companies and Medicare payments in October 2011.
- Numerous **Medicare Fraud Strike Force** cases involving fraudulent ambulance claims filed in May 2012.
- CMS announced six-month “moratorium” to halt enrollment of Houston-area ambulance providers in July 2013 (extended another six-months in January 2014).
- **American Taxpayer Relief Act of 2012** reduced by 10% fee schedule payments for non-emergency BLS transports of individuals with End-Stage Renal Disease (ESRD) to and from renal dialysis treatment effective October 2013.
Durable Medical Equipment (DME)

- Wheelchairs
- Custom Orthotics & Ortho Kits
- Adult Diapers
- Oxygen
- Mattresses
- Nutrition Supplies
- Prosthetics
DME

- Increasing use of patient recruiters
  - Use of kickbacks such as cash, drugs, food, or other goods
- Increasing use of telemarketing
  - Diabetic test strips
Outcomes: DME Payment Trends

Sustained declines in Medicare payments have followed Federal enforcement and oversight action.

- Medicare payments for DME in Miami peaked at more than $60 million per quarter in 2006.
- In 2007, numerous federal oversight and administrative initiatives were launched by CMS, OIG and others, including the Medicare Fraud Strike Force in May 2007.
- Miami-area DME payments decreased from over $40 million per quarter in 2007 - before the Strike Force’s first takedown - to $15 million per quarter in 2011 (e.g., approximately $100 million in annual savings thereafter).

Analysis Run Date: April 4, 2014
Note: The results of this analysis are subject to change as claims are adjusted or deleted. Medicare timely filing requires providers to submit their claims within 12 months of the date of service. Medicare Claims Processing Manual, Chapter 1, Section 70.1.
Home Health

- Billing for services not rendered
- Criminal Enterprises
- High dollar for stolen HH identities
- Patient co-conspirators
- Abuse, neglect, and embezzlement
- Bust-out schemes
HHA model

Metro area distribution of the 200 HHAs with the highest risk scores

- Dallas
- Detroit
- Los Angeles
- Chicago
- Houston
- Miami

Number of HHAs
Sustained declines in Medicare payments have followed Federal enforcement and oversight action.

- Medicare payments for Home Health care increased from 2006 until 2010
- In 2009, federal enforcement actions (initiated by the HEAT Strike Force case *U.S. v. Zambrana* in Miami), followed by the OEI HHA Outlier Payments report, influenced CMS to change Medicare’s HHA outlier coverage policy
- Since 2010, Medicare payments for home health care nationally decreased by more than $300 million per quarter (e.g., more than $1 billion annually)
  - In Miami, payments for HHAs decreased by $100 million per quarter since peak in 2009
  - In Dallas and McAllen, TX, payments for HHAs are down by $30 million per quarter
  - In Detroit, payments for HHAs decreased by $25 million per quarter since peak in 2009
Behavioral Health

- Community Mental Health Centers (CMHCs)
  - Adult day care
  - Criminal enterprises and spa vacations
  - Unqualified providers allowed by some states

- Partial Hospitalization Programs (PHPs)
  - Intensive Outpatient Programs (IOPs)
  - Switching between CMHC and PHP
  - Therapy by Skype
Outcomes: CMHC Payment Trends

Sustained declines in Medicare payments have followed Federal enforcement and oversight action.

- In Baton Rouge: Medicare payments fell nearly $5 million per quarter
- In Houston: Medicare payments fell nearly $10 million per quarter
- In Miami: Medicare payments declined about $40 million per quarter
- Nationally, payments for CMHCs decreased from $70 million to under $5 million per quarter ($250 million annually)
Prescription Drug Diversion

• Gradual shift from controlled substances to highly reimbursable non-controlled
• Increase in anti-psychotics, compounds, HIV/AIDS anti-virals and other expensive meds
  – Still see cocktails of pain killer/anti-psych/sleep aid
• Increasing number of pharmacy cases, to include pharmacy/wholesaler schemes
• Phantom pharmacy and bust-out schemes
Prescription Drug Diversion

- Although deaths due to oxycodone decreased in some areas, still a problem with prescription drugs to include hydrocodone and hydromorphone
- Increase in heroin addiction
- Pill Mills and Pain Clinics
Pharmacy model

Metro area distribution of the 1,000 pharmacies with the highest risk scores

- Miami
- New York
- Los Angeles
- Detroit
- Houston
- McAllen
- Tampa
- Dallas

Number of pharmacies

0 50 100 150 200 250 300 350 400 450
Prescriber model

Metro area distribution of the 1,000 prescribers with the highest risk scores

- Houston
- Phoenix
- Tampa
- Atlanta
- Los Angeles
- Detroit
- New York
- Miami

Number of prescribers
Metro area distribution of the 1,000 prescribers with the highest risk scores

- Seattle
- Detroit
- Phoenix
- New York
- Philadelphia
- Atlanta
- DC/Baltimore
- Nashville

Number of prescribers
We’ve come a long way. The future of analytics in enforcement continues to evolve.
Questions?

Gary.Cantrell@oig.hhs.gov