CMS Fraud Prevention Initiative

New Tools to Fight Fraud and Protect Taxpayer Dollars

Health care fraud perpetrators steal billions of dollars each year from Federal and State governments, providers, American taxpayers and some of our most vulnerable citizens. Fraud, waste and abuse drive up costs for everyone in the health care system, in addition to hurting the long-term solvency of the Federal health care programs upon which millions of Americans depend. When families are working to make every dollar count, eliminating waste, fraud and abuse must be a top priority.

Through the Fraud Prevention Initiative, the Centers for Medicare & Medicaid Services (CMS) is working to ensure that correct payments are made to legitimate providers for covered appropriate and reasonable health care services. The Affordable Care Act contains numerous provisions that enable the Department of Health and Human Services (HHS), CMS and States to expand efforts to prevent and fight fraud, waste and abuse in all Federal health care programs including Medicare, Medicaid and the Children's Health Insurance Program (CHIP). The new authorities offer more protections and new tools to keep those who are intent on committing fraud out of the programs and address fraudulent payment issues promptly to ensure the integrity of Medicare, Medicaid, and CHIP.

As CMS and the States implement these provisions, the savings generated could help bring down health care costs for families, businesses and governments and protect the integrity of Federal health care programs.

STRIKING THE RIGHT BALANCE

The CMS is mindful of striking the right balance between preventing fraud and other improper payments and maintaining the timely delivery of critical health care services to beneficiaries.

At their core, Federal health care programs are designed to provide affordable health care to families in need, people with disabilities, and aging Americans. The vast majority of health care providers abide by their legal and professional duties and provide critical health care services to millions of beneficiaries every day. CMS is committed to continuing to provide health care services to beneficiaries and reducing the burden on legitimate providers, while targeting anyone who engages in fraudulent activities and saving taxpayer dollars.

The CMS aims to:

- Keep individuals and companies that intend to defraud Medicare, Medicaid, and CHIP out of these programs in the first place,
- Avoid payment of fraudulent claims when they are submitted, and
- Remove fraudulent individuals and companies from Federal health care programs if they do get in.

A CENTRALIZED APPROACH

In order to coordinate program integrity and anti-fraud activities across Federal health care programs, CMS formed the Center for Program Integrity (CPI) in 2010. This involved pulling together existing anti-fraud components from other areas of the agency, as well as forming new ones. This centralized approach has enabled CMS to pursue a more strategic and coordinated set of anti-fraud policies, as well as improve collaboration on anti-fraud initiatives with law enforcement partners including the HHS Office of Inspector General (OIG), the Department of Justice (DOJ), and State Medicaid Fraud Control Units.

The Affordable Care Act empowers CMS to jointly develop many Medicare, Medicaid and CHIP anti-fraud policies. For example, enhanced screening requirements for new providers and suppliers apply across the programs. The new integrated operation of program integrity activities ensures better consistency in CMS's approach to fraud prevention.

WAYS CMS IS FIGHTING FRAUD

On January 24, 2011, HHS announced new rules authorized under the Affordable Care Act that will help Medicare, Medicaid and CHIP reduce fraud while protecting both patients and legitimate physicians and other providers.

New rules will help all three health care programs do less "paying-and-chasing" of fraudulent health care claims and do more proactive and transparent fraud prevention. CMS is moving toward a "prevention and detection" model that will help identify potential fraud before it occurs. This model will stop criminals from getting into the system in the first place. CMS is planning to utilize analytical techniques to improve payment accuracy by identifying, in real-time, atypical trends that could be indicators of waste or fraud and intervening to keep the waste or fraud from taking place. The rules also give CMS new enforcement tools to fight fraud, such as the ability to suspend payments in cases of credible allegations of fraud. The new rules:

- **Create a rigorous screening process for providers and suppliers enrolling in Medicare, Medicaid or CHIP.** These enhanced screening processes will help to keep fraudulent providers out of these programs.
- **Require a cross-termination among Federal and State health programs.** This means that providers and suppliers who have had their Medicare billing privileges revoked or whose participation has been terminated by a State Medicaid program or CHIP will be barred or terminated from all other Medicaid programs and CHIPs.
- **Authorize CMS to temporarily stop enrollment of new providers and suppliers.** Medicare and State agencies will be watching for trends that may indicate a significant potential for health care fraud, and can temporarily stop enrollment of a category of providers or suppliers, or enrollment of new providers or suppliers in a geographic area that has been identified as high risk. In deciding whether to impose a temporary moratorium, CMS will consider the effect of a moratorium on beneficiary access to care.
- **Authorize CMS to temporarily stop payments to providers and suppliers in cases of suspected fraud.** Under the new rules, if there has been a credible fraud allegation, payments can be suspended while an action or investigation is underway.

Numerous other provisions of the Affordable Care Act support the Administration's ongoing work to prevent and fight fraud, waste and abuse in health care as well, by:

- **Incorporating sophisticated new technologies and innovative data sources.** These new technologies will help to identify patterns associated with fraud and avoid paying fraudulent claims.
- **Sharing data to fight fraud.** The law requires certain claims data from Medicare, Medicaid and CHIP, the Veterans Administration, the Department of Defense, the Social Security Disability Insurance program, and the Indian Health Service to be integrated, making it easier for agency and law enforcement officials to identify criminals and prevent fraud on a system-wide basis.
- **Expanding overpayment recovery efforts.** The law expands the Recovery Audit Contractors (RACs) program, requiring RACs to identify and recover improper payments across Medicare Parts C and D and in Medicaid. Providers must also report and return Medicare and Medicaid overpayments within 60 days of identification. This builds on already existing similar efforts in the Medicare fee-for-service (FFS) Parts A and B programs.
- **Enhancing penalties to deter fraud and abuse.** The Affordable Care Act provides the OIG with the authority to impose stronger civil and monetary penalties against those found to have committed fraud. The law also gives the HHS Secretary new authority to prevent problem providers from participating in Medicare or Medicaid.
- **Establishing tough new rules and sentences for criminals.** The Affordable Care Act increases the Federal sentencing guidelines related to health care fraud offenses involving $1M or more in losses to federal health care programs.
- **Launching the first phase of the new Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program.** This program aims to reduce Medicare's excessive payment amounts for certain DME items, which makes these items less attractive targets for fraud and abuse. Through supplier competition, the program sets new, lower payment rates for certain medical equipment and supplies, such as oxygen equipment, certain power wheelchairs and mail order diabetic supplies.

ENGAGING BENEFICIARIES AND PARTNERS

CMS continues to work with beneficiaries and collaborate with partners to reduce fraud, waste, and abuse in Medicare, Medicaid and CHIP.

- **The Senior Medicare Patrol (SMP) program,** led by the Administration on Aging (AoA), **empowers seniors to identify and fight fraud**. Since the program's inception, the program has educated more than 4.2 million beneficiaries and reached over 25 million people through community education outreach events. Medicare is partnering with AoA to expand the size of the SMP program and engage even more people in the community in the fight against fraud.
- Medicare encourages its beneficiaries to review their Medicare claims summaries thoroughly. Medicare is working with beneficiaries to **redesign Medicare Summary Notices (MSNs) so that beneficiaries can more easily spot potential fraud** or irregularities on claims submitted for their care.
- Some 10 million **beneficiaries** are enrolled into www.mymedicare.gov, a secure website, and **can now check their claims within 24 hours of the processing date**. This information is also available through the 1-800-MEDICARE automated system. A fact sheet and informational card have been developed to educate and encourage beneficiaries or caregivers to check their claims frequently and

to report any suspicious claims activity to Medicare. These materials are being used at regional fraud prevention summits and have been shared with both State Health Insurance Assistance Programs (SHIPs) and SMPs.

CMS is committed to working with law enforcement partners to investigate and prosecute alleged fraud.

- **Medicare provides support and resources to the Medicare Fraud Strike Forces**, which investigate and track down individuals and entities defrauding Medicare and other government health care programs. Strike Force prosecutions are data driven and target individuals and groups actively involved in ongoing fraud schemes. The Medicare Fraud Strike Force operations are part of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a joint initiative announced in May 2009 between DOJ and HHS to focus their efforts to prevent and deter fraud and enforce current anti-fraud laws around the country. Since its inception in March 2007 through February 2011, Strike Force operations in nine districts have charged over 1,000 individuals who collectively have falsely billed Medicare for more than $2.3 billion.
- HHS (including CMS and OIG) and the DOJ have co-hosted a series of **regional summits on health care fraud prevention**, bringing together Federal and State officials, law enforcement experts, private insurers, health care providers, and beneficiaries for a comprehensive discussion on the scope of fraud, weaknesses in the current health care system, and opportunities for collaborative solutions.
- The OIG launched its **Most Wanted Fugitives List** in February 2011 to focus public attention on the individuals most sought by authorities on charges of health care fraud and abuse. CMS is working to promote this list to beneficiaries, providers and other stakeholders, and engage proactive participation in efforts to track down these fugitives.
- CMS has launched the **"Blow the Whistle on Medicaid Fraud" initiative** to educate the public and to encourage reporting of suspected abuses to government entities. Additionally, CMS is hosting related education and outreach conferences to educate the States, contractors, and others about provider fraud and abuse.

MORE INFORMATION

To learn more about CMS's Fraud Prevention Initiative, visit *www.cms.gov/Partnerships/04_FraudPreventionToolkit.asp.* Medicare beneficiaries are encouraged to learn more about protecting themselves and spotting fraud at *www.StopMedicareFraud.gov/* . For direct help or for further information on the SMP program in their state, go to *www.smpresource.org*. If someone suspects Medicaid fraud, they should call 1-800-HHS-TIPS or their state Medicaid Agency. Providers seeking Medicaid fraud information should visit *www.cms.gov/FraudAbuseforProfs/01_Overiew.asp*.

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