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Newsroom

New Tools to Fight Fraud, Strengthen Medicare and Protect Taxpayer Dollars

The Affordable Care Act takes landmark steps forward to fight health care fraud, waste, and abuse by providing critical new tools to improve and enhance the Administration's ongoing efforts to prevent and detect fraud, and crack down on individuals who attempt to defraud Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) as well as private insurance. For example, the President has committed to cutting the improper payment rate in the Medicare Fee for Service program in half by 2012. Below we highlight some of the accomplishments the new tools have produced in preventing and fighting fraud, waste, and abuse in these programs.

Summary of Fraud Prevention Accomplishments under the Affordable Care Act

Tough New Rules and Sentences for Criminals: The Affordable Care Act increases the federal sentencing guidelines for health care fraud offenses by 20-50% for crimes that involve more than $1 million in losses. The law establishes penalties for obstructing a fraud investigation and makes it easier for the government to recapture any funds acquired through fraudulent practices. And the law makes it easier for the Department of Justice (DOJ) to investigate potential fraud or wrongdoing at facilities like nursing homes.

Enhanced Screening and Other Enrollment Requirements: On January 24, 2011, the Centers for Medicare and Medicaid Services (CMS) announced some of the Affordable Care Act's most powerful new fraud prevention tools, which include new enrollment requirements for all Medicare, Medicaid, and CHIP providers and suppliers. These new rules, which take effect on March 25, 2011, require some categories of providers and suppliers who have historically posed a higher risk of fraud or abuse to be screened before enrolling in the Medicare or Medicaid programs or CHIP. The new rules also allow the Secretary to impose a temporary moratorium on newly enrolling providers or suppliers of a particular type in certain geographic areas if necessary to prevent or combat fraud, waste, and abuse. The new rules also authorize CMS, in consultation with the Office of Inspector General (OIG), to suspend Medicare payments to providers or suppliers when there is a credible allegation of fraud. This will move Medicare away from a "pay and chase" mode of having to track down fraudulent payments after the fact. The law also requires states to withhold payments to Medicaid providers where there is a credible allegation of fraud.

New Resources to Fight Fraud: The Affordable Care Act provides an additional $350 million over 10 years to ramp up anti-fraud efforts, including increasing scrutiny of claims before they've been paid, investments in sophisticated data analytics, and more "feet on the street" law enforcement agents and others to fight fraud in the health care system.

Increased Coordination of Fraud Prevention Efforts: Many of the Affordable Care Act provisions increase coordination between states, CMS, and its law enforcement partners at OIG and DOJ. The law ensures that fraudulent providers and suppliers cannot move from state to state or between Medicare and Medicaid by requiring all states to terminate anyone who has been terminated by Medicare or by another state. Under the Affordable Care Act, CMS must work hand-in-hand with OIG on suspending payments to suspect providers. CMS is also helping to provide OIG and DOJ improved real-time data access to enable

investigators and law enforcement agents to more quickly detect and prosecute fraud schemes.

Sharing Data to Fight Fraud: Building on the Obama Administration initiatives to improve coordination across the agencies charged with stopping 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 centralized, making it easier for agency and law enforcement officials to identify criminals and prevent fraud on a system-wide basis. The Obama Administration has already improved access to data for law enforcement, and DOJ and OIG continue to benefit from improved access to data to help identify criminals and fight fraud.

New Tools to Target High Risk Entities: The Affordable Care Act strengthens the government's authority to require certain high-risk providers and suppliers to undergo a higher level of scrutiny before enrolling in the program based on the risk of fraud, waste, or abuse they pose to the program. The Affordable Care Act modifies existing surety bond requirements to allow the Secretary to require certain provider and suppliers to post a surety bond that is commensurate with the volume of billing of a provider or supplier. In addition, under the Affordable Care Act, CMS issued new rules on May 5, 2010 to require providers and suppliers who order and refer certain items or services for Medicare beneficiaries to enroll in Medicare and maintain documentation on those orders and referrals.

New Focus on Compliance and Prevention: Under the new law, providers and suppliers must establish compliance programs ensuring they are aware of anti-fraud requirements and good governance practices and have incorporated these into their operations. Nursing homes are also subject to new compliance and ethics plan requirements. Other preventive measures focus on certain categories of providers and suppliers that historically have presented concerns, including Home Health agencies, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, and Community Mental Health Centers (CMHCs). For example, on November 17, 2010, CMS finalized a rule implementing the new Affordable Care Act requirement for patients to receive a "face-to-face" visit with an appropriate health care professional when receiving Medicare home health and hospice services. Additional face-to-face requirements for DME suppliers and Medicaid providers will be issued later this year. In addition, CMHCs will now be required to provide at least 40% of their items and services to non-Medicare beneficiaries in order to prevent the standing up of CMHCs solely for the purpose of fraudulently billing Medicare.

Expanded Overpayment Recovery Efforts: Drawing on lessons from the Medicare fee-for-service Recovery Audit Contractors (RAC) program, CMS is taking a multi-pronged approach to expanding the RAC program to all parts of Medicare and Medicaid. The law expands the RAC program to Medicaid, Medicare Advantage, and Medicare Part D programs. On December 27, 2010, CMS published in the *Federal Register* a national solicitation for comments on innovative approaches to RAC programs within Medicare Advantage and Part D. In January 2011, CMS entered into a RAC contract to identify overpayments in the Part D program and on February 17, 2011, CMS posted on its website a state-by-state map of the status of each state Medicaid RAC program. The Affordable Care Act also requires providers, suppliers, Medicare Advantage plans, and Part D plans to report and return Medicare and Medicaid overpayments within 60 days of identification.

New Durable Medical Equipment (DME) Requirements: CMS is implementing new requirements for DME suppliers, an area of particular concern when it comes to fraud. Under the Affordable Care Act, CMS is expanding the DME Competitive Bidding program to new areas of the country. Over 4 million Medicare beneficiaries living in these areas can save money through this new program, while continuing to have access to quality medical equipment from accredited suppliers they can trust. On November 3, 2010, CMS released the list of 356 suppliers that have contracts with Medicare to provide certain DME equipment and suppliers to beneficiaries under competitive bid rates in nine communities across the U.S. On August 27, 2010, CMS issued final rules enhancing Medicare enrollment standards for DME suppliers such as more stringent operations and facilities requirements to ensure only legitimate suppliers can participate in Medicare.

Enhanced Penalties to Deter Fraud and Abuse: The Affordable Care Act provides the OIG with the authority to impose stronger civil and monetary penalties on those found to have committed fraud. The Secretary also is provided new authority to prevent problematic providers from participating in Medicare or Medicaid. Under the new law:

- Providers and suppliers who lie on their application to enroll in Medicare or Medicaid may be excluded from the programs;
- Providers who identify an overpayment from Medicare or Medicaid but do not return it within 60 days may be subject to new fines and penalties; and
- Providers who are terminated from a state's Medicaid program will be terminated from Medicaid programs in other states.

Greater Oversight of Private Insurance Abuses: The new law also provides enhanced tools and authorities to address abuses of multiple employer welfare arrangements and protect employers and employees from insurance scams. It also gives new powers to the Secretary and Inspector General to investigate and audit the health insurance exchanges. This, plus the new rules to ensure accountability in the insurance industry, will protect consumers and increase the affordability of health care.

Posted: March 15, 2011