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Health care fraud prevention and enforcement efforts recover record \$4 billion; new Affordable Care Act tools will help fight fraud

Joint DOJ and HHS joint efforts result in largest sum ever recovered in single year; New rules under the Affordable Care Act will keep fraudulent providers and suppliers out of Medicare, Medicaid, CHIP and avoid payments of fraudulent claims

U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius and U.S. Associate Attorney General Thomas J. Perrelli today announced a new report showing that the government's health care fraud prevention and enforcement efforts recovered more than \$4 billion in taxpayer dollars in Fiscal Year (FY) 2010. This is the highest annual amount ever recovered from people who attempted to defraud seniors and taxpayers. In addition, HHS today announced new rules authorized by the Affordable Care Act that will help the department work proactively to prevent and fight fraud, waste and abuse in Medicare, Medicaid and the Children's Health Insurance Program (CHIP).

These findings, released today, in the annual Health Care Fraud and Abuse Control Program (HCFAC) report, are a result of President Obama making the elimination of fraud, waste, and abuse a top priority in his administration. The success of this joint Department of Justice (DOJ) and HHS effort would not have been possible without the Health Care Fraud Prevention & Enforcement Action Team (HEAT), created in 2009 to prevent waste, fraud and abuse in the Medicare and Medicaid programs and to crack down on the fraud perpetrators who are abusing the system and costing American taxpayers billions of dollars. These efforts to reduce fraud will continue to improve with the new tools and resources provided by the Affordable Care Act, including the new rules announced today.

"President Obama has made it very clear that fraud and abuse of taxpayers' dollars are unacceptable. And for too long, our fraud prevention efforts have focused on chasing after taxpayer dollars after they have already been paid out," said Sebelius. "Thanks to the President's leadership and the new tools provided by the Affordable Care Act, we can focus on stopping fraud before it happens."

"Our aggressive pursuit of health care fraud has resulted in the largest recovery of taxpayer dollars in the history of the Justice Department," said Perrelli. "These actions are in large part because of the great work being led by the Health Care Fraud Prevention and Enforcement Action Team. Through this initiative, we are working in partnership with government, law enforcement and industry leaders, and the public to protect taxpayer dollars, control health care costs, and ensure the strength and integrity of our most essential health care programs."

Health Care Fraud and Abuse Control Program Report

More than \$4 billion stolen from federal health care programs was recovered and returned to the Medicare Health Insurance Trust Fund, the Treasury, and others in FY 2010. This is an unprecedented achievement for the Health Care Fraud and Abuse Control Program (HCFAC), a joint effort of the two departments to coordinate Federal, State, and local law enforcement activities to fight health care fraud and abuse.

The Affordable Care Act provides additional tools and resources to help fight fraud that will help boost these efforts, including an additional \$350 million for HCFAC activities. The Administration is already using tools authorized by the Affordable Care Act, including enhanced screenings and enrollment requirements, increased data sharing across government, expanded overpayment recovery efforts, and greater oversight of private insurance abuses.

HHS and DOJ have enhanced their coordination through HEAT and have expanded Medicare Fraud Strike Force teams since 2009. HHS and DOJ hosted a series of regional fraud prevention summits around the country, and sent letters to state attorneys general urging them to work with HHS and Federal, state and local law enforcement officials to mount a substantial outreach campaign to educate seniors and other Medicare beneficiaries about how to prevent scams and fraud. During FY 2010, HEAT and the Medicare Fraud Strike Force expanded local partnerships and helped educate Medicare beneficiaries about how to protect themselves against fraud.

In FY 2010, the total number of cities with Strike Force prosecution teams was increased to seven, all of which have teams of investigators and prosecutors dedicated to fighting fraud. The Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. Strike Force enforcement accomplishments in all seven cities during FY 2010 include:

140 indictments involving charges filed against 284 defendants who collectively billed the Medicare program more than \$590 million;

217 guilty pleas negotiated and 19 jury trials litigated, winning guilty verdicts against 23 defendants; and

Imprisonment for 146 defendants sentenced during the fiscal year, averaging more than 40 months of incarceration.

Including Strike Force matters, federal prosecutors opened 1,116 criminal health care fraud investigations as of the end of FY 2010, and filed criminal charges in 488 cases involving 931 defendants. A total of 726 defendants were convicted for health care fraud-related crimes during the year.

In addition to these criminal enforcement successes, 2010 was a record year for recoveries obtained in civil health care matters brought under the False Claims Act—more than \$2.5 billion, which is the largest in the history of the Department of Justice.

The HCFAC annual report can be found here, oig.hhs.gov/publications/hcfac.asp. For more information on the joint DOJ-HHS Strike Force activities, visit: <http://www.StopMedicareFraud.gov/>.

New Affordable Care Act Rules to Fight Fraud

Today, HHS also announced new rules authorized by the Affordable Care Act which will help stop health care fraud. The provisions of the Affordable Care Act implemented through this final rule include new provider screening and enforcement measures to help keep bad actors out of Medicare, Medicaid and CHIP. The final rule also contains important authority to suspend payments when a credible allegation of fraud is being investigated.

“Thanks to the new law, CMS now has additional resources to help detect fraud and stop criminals from getting into the system in the first place,” CMS Administrator Donald Berwick, M.D. said. “The Affordable Care Act’s new authorities allow us to develop sophisticated, new systems of monitoring and oversight to not only help us crack down on fraudulent activity scamming these programs, but also help us to prevent the loss of taxpayer dollars across the board for millions of American health care consumers.”

Specifically, the final rule:

- Creates a rigorous screening process for providers and suppliers enrolling Medicare, Medicaid and CHIP to keep fraudulent providers out of those programs. Types of providers and suppliers that have been identified in the past as posing a higher risk of fraud, for example durable medical equipment suppliers, will be subject to a more thorough screening process.
- Requires new enrollment process for Medicaid and CHIP providers. Under the Affordable Care Act, States will have to screen providers who order and refer to Medicaid beneficiaries to determine if they have a history of defrauding government. Providers that have been kicked out of Medicare or another State’s Medicaid or CHIP will be barred from all Medicaid and CHIP programs.
- Temporarily stops enrollment of new providers and suppliers. Medicare and State agencies will be on the look out for trends that may indicate health care fraud – including using advanced predictive modeling software, such as that used to detect credit card fraud. If a trend is identified in a category of providers or geographic area, the program can temporarily stop enrollment as long as that will not impact access to care for patients.
- Temporarily stops 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.

A copy of the regulation is on display today at the Federal Register and may be downloaded from the following link: www.ofr.gov/inspection.aspx. Several days after the regulation is published, the preceding link will be deactivated and the published version of the regulation will be available on the National Archives website at www.archives.gov/federal-register/news.html. CMS will continue to take public comments on limited areas of this final rule for 60 days.

More information can be found at www.HealthCare.gov, a web portal made available by the U.S. Department of Health and Human Services. A fact sheet on the new rules is available at www.HealthCare.gov/news/factsheets.

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