



Frequently Asked Questions & Answers

CMS Fraud Prevention Initiative

Health care fraud perpetrators steal billions of dollars each year from Federal and State governments, providers, private insurance companies, 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.

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 U.S. 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).

Consumers, health care providers and others can also play an important role in helping to reduce and prevent health care fraud, by identifying and reporting suspected cases of potential fraud and abuse. The following fact sheet outlines the *CMS Fraud Prevention Initiative* and ways the public can help in the fight against fraud. If questions are not answered here, consumers should call 1-800-MEDICARE (1-800-633-4227) or visit www.StopMedicareFraud.gov to learn about protecting themselves and spotting fraud.

How is CMS coordinating efforts to reduce and prevent health care fraud and abuse?

CMS formed the Center for Program Integrity (CPI) in 2010 to coordinate program integrity and anti-fraud activities across Federal health care programs, including Medicare, Medicaid and the Children's Health Insurance Program (CHIP). This centralized approach enables 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 (MFCUs).

The Affordable Care Act allows 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.

How is CMS ensuring that fraud prevention activities do not interfere with health care delivery?

As CMS seeks to reduce fraud, waste, and abuse in Medicare, Medicaid, and CHIP, the agency 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 CMS beneficiaries every day. CMS is committed to continuing to provide health care services to beneficiaries and reducing the burden on legitimate providers, while targeting fraud perpetrators and saving taxpayer dollars.

CMS aims to:

- **Prevent** fraud and abuse in the first place;
- **Detect** fraud and abuse that is taking place;
- **Report** suspected fraud and abuse; and
- **Recover** funds that have been lost to fraud and abuse.

In what ways is CMS working to *prevent* fraud and abuse in the first place?

The Affordable Care Act contains numerous provisions that support Medicare's efforts to prevent fraud and abuse, including:

- **Creating a rigorous screening process** for providers and suppliers enrolling in Medicare, Medicaid or CHIP to keep fraudulent providers out of those programs.
- **Incorporating sophisticated new technologies** and innovative data sources to identify patterns associated with fraud and avoid paying fraudulent claims.
- **Requiring cross-termination among Federal and State health programs** where providers and suppliers who had their Medicare billing privileges revoked for cause or whose participation has been terminated by a State Medicaid program or CHIP for cause will be 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 new 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.
- **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.

In what ways is CMS working to *detect* fraud and abuse that is taking place?

The Affordable Care Act promotes the sharing of data to fight fraud, by requiring that 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 be integrated, making it easier for agency and law enforcement officials to detect criminals and prevent fraud on a system-wide basis.

CMS is also requiring that providers and suppliers file fee-for-service (FFS) claims within 12 months of providing the item or service, so that improper and suspicious billing patterns may be detected. Suppliers, including physicians, must maintain and provide access to documentation of written orders for durable medical equipment (DME), home health or other items and services, so that they may be referenced if suspicious activity is detected.

How is CMS working to enhance *reporting* of suspected fraud and abuse?

CMS has improved the processes for reporting, analyzing, and investigating complaints of potential fraud. For example, Medicare has made modifications to the 1-800-MEDICARE call center procedures, so that if a beneficiary reports that they do not recognize a provider or did not receive the service documented on their Medicare Summary Notice (MSN) form, 1-800-MEDICARE will review the beneficiary's claims records with them and file a complaint immediately if the discrepancy is not resolved. Medicare is now also generating regular "fraud complaint frequency analysis reports" that compile provider-specific complaints and flag providers who have been the subject of multiple fraud complaints for a closer review.

Medicare continues its education and communication with beneficiaries, providers and other stakeholders about the importance of, and process for, reporting suspected fraud and abuse.

In what ways is CMS working to *recover* funds that have been lost to fraud and abuse?

CMS is working collaboratively with other Federal law enforcement partners to increase the recovery of improper payments and fraud. The Affordable Care Act expands the Recovery Audit Contractors (RACs) program to Medicaid, Medicare Advantage (Part C) and Medicare Drug Benefit (Part D) programs. Under these expansions, RACs will help identify and recover improper payments in these programs for the first time. 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. This builds on already existing similar efforts in the Medicare FFS parts A and B programs.

In addition, States now have one year from the date of discovering a Medicaid overpayment to recover, or attempt to recover, such overpayment before the State is required to refund the Federal share of the overpayment. Prior to passage of the Affordable Care Act, States were allowed only 60 days to recover such overpayment.

How can Medicare beneficiaries and their caregivers help identify and prevent fraud?

Every Medicare beneficiary holds the keys to help stop health care fraud by identifying and reporting cases of suspected fraud. Below are some ways that beneficiaries can play an important role in the fight against fraud:

- Beneficiaries and caregivers should check their Medicare claims summaries thoroughly to make sure they are accurate. Medicare is working with beneficiaries to redesign MSNs so that beneficiaries can more easily spot potential fraud or overpayments on claims submitted for their care.
- If a beneficiary suspects Medicare fraud, he or she should call 1-800-MEDICARE. (Medicaid beneficiaries should call 1-800-HHS-TIPS or their state Medicaid Agency.) The sooner he or she sees and reports errors, the sooner Medicare can investigate and stop the fraud.
- Beneficiaries should guard their Medicare and Social Security numbers, and tell their friends and neighbors to do the same. They should never let anyone borrow or pay to use their Medicare ID.
- Beneficiaries can learn more about protecting themselves and spotting fraud at *StopMedicareFraud.gov* or by contacting their local Senior Medicare Patrol (SMP) program through the SMP Locator at *www.smpresource.org*.

How can health care providers help detect and eliminate fraud?

Health care providers can play an important role in stopping fraud by identifying and reporting cases of potential fraud:

- Providers should check PECOS regularly (at least annually) to make sure the information is up to date and that it reflects their current practice.
- Providers should call 1-800-HHS-TIPS or their Medicare Administrative Contractor to report suspected fraud.
- Providers can learn more about protecting themselves and spotting fraud at www.cms.gov/MLNProducts/downloads/Fraud_and_Abuse.pdf.

How is CMS working with other partners and stakeholders to eradicate fraud?

CMS is committed to working with partners in the public and private sector to develop and implement long-term solutions and a collaborative approach to eliminating health care fraud and abuse.

CMS is partnering with the Administration on Aging (AoA) to expand the SMP program, which 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.

CMS is 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.

CMS is also working with HHS, including the OIG, and the Department of Justice (DOJ) to co-host a series of regional summits on health care fraud prevention. These summits bring 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.

How does the CMS Fraud Prevention Initiative complement existing efforts to crack down on health care fraud?

The CMS *Fraud Prevention Initiative* enhances existing efforts to crack down on health care fraud. It complements the joint HHS and DOJ Health Care Fraud Prevention & Enforcement Action Team (HEAT), which aims to eliminate fraud and investigate fraudulent operators who are cheating the system. During FY 2010, HEAT and the Medicare Fraud Strike Force expanded their partnership by mounting a substantial outreach campaign to educate seniors and other Medicare beneficiaries about how they can help prevent scams and fraud. Since its inception in March 2007, Medicare Fraud Strike Force operations in nine locations have charged over 1,000 defendants who collectively billed Medicare for more than \$2.3 billion.

The Health Care Fraud and Abuse Control Program (HCFAC) has steadily grown since it began in 1997. The annual HCFAC report, released January 24, 2011, shows that the government's health care fraud prevention and enforcement efforts recovered more than \$4 billion in taxpayer dollars in Fiscal Year 2010, which was returned to the Medicare Health Insurance Trust Fund, the Treasury and other entities. This is the highest amount ever recovered from those who attempted to defraud seniors and taxpayers.

In addition, 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. Medicare is working to promote this list to beneficiaries, providers and other stakeholders, and engage proactive participation in efforts to track down these fugitives, thus reducing, and potentially preventing, fraud.

Where can the public find more information about the CMS *Fraud Prevention Initiative*?

To learn more about the CMS *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.

This information is provided by the United States Department of Health and Human Services.

