Fraud, Waste & Abuse

Challenges and Opportunities

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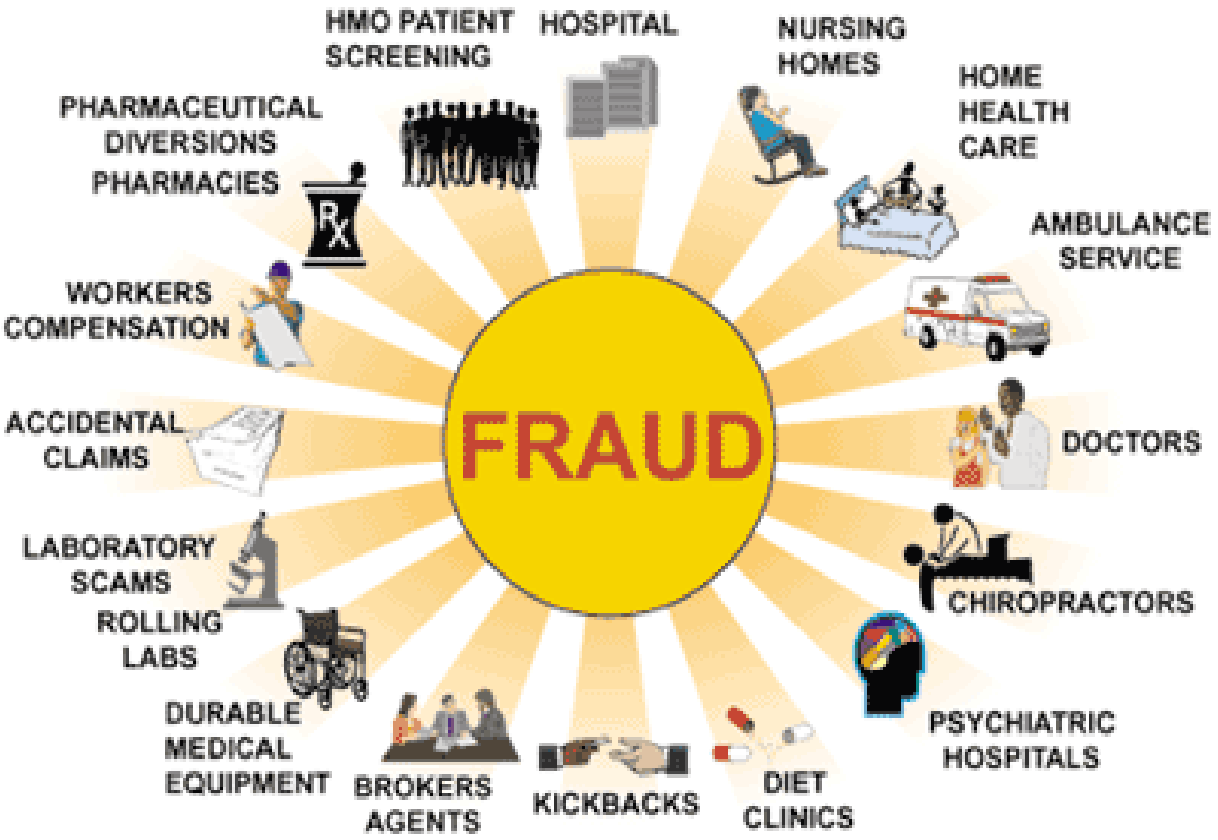
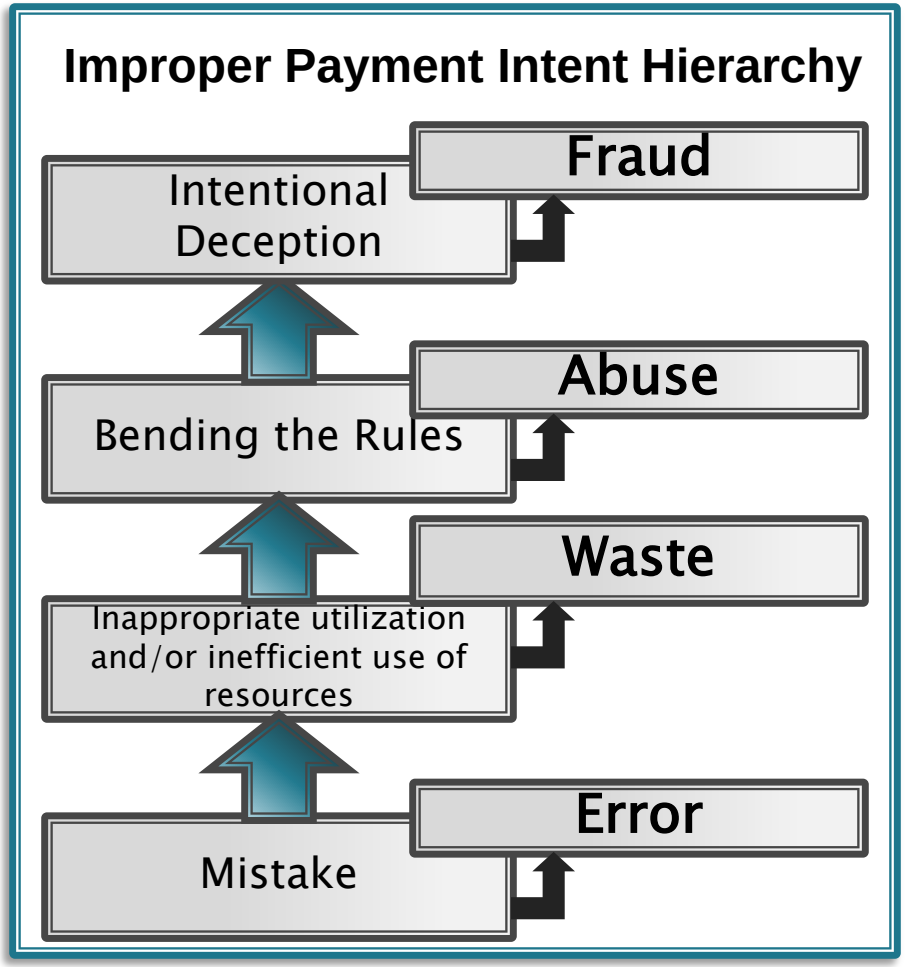
Introduction:
The Face of Fraud and Abuse



Development of PI Strategic Plan–Background



Challenges In Preventing Fraud

- Staying a step ahead of the fraudsters
- Distinguishing between bona fide and fraudulent business deals
- Preventing fraud through effective program safeguards

We Need A Careful Balance

- The majority of providers and suppliers are honest and want to do the right thing.

- Tension exists between:
  - paying claims on time vs. conducting medical review; and
  - preventing and detecting fraud and brokering good partnerships

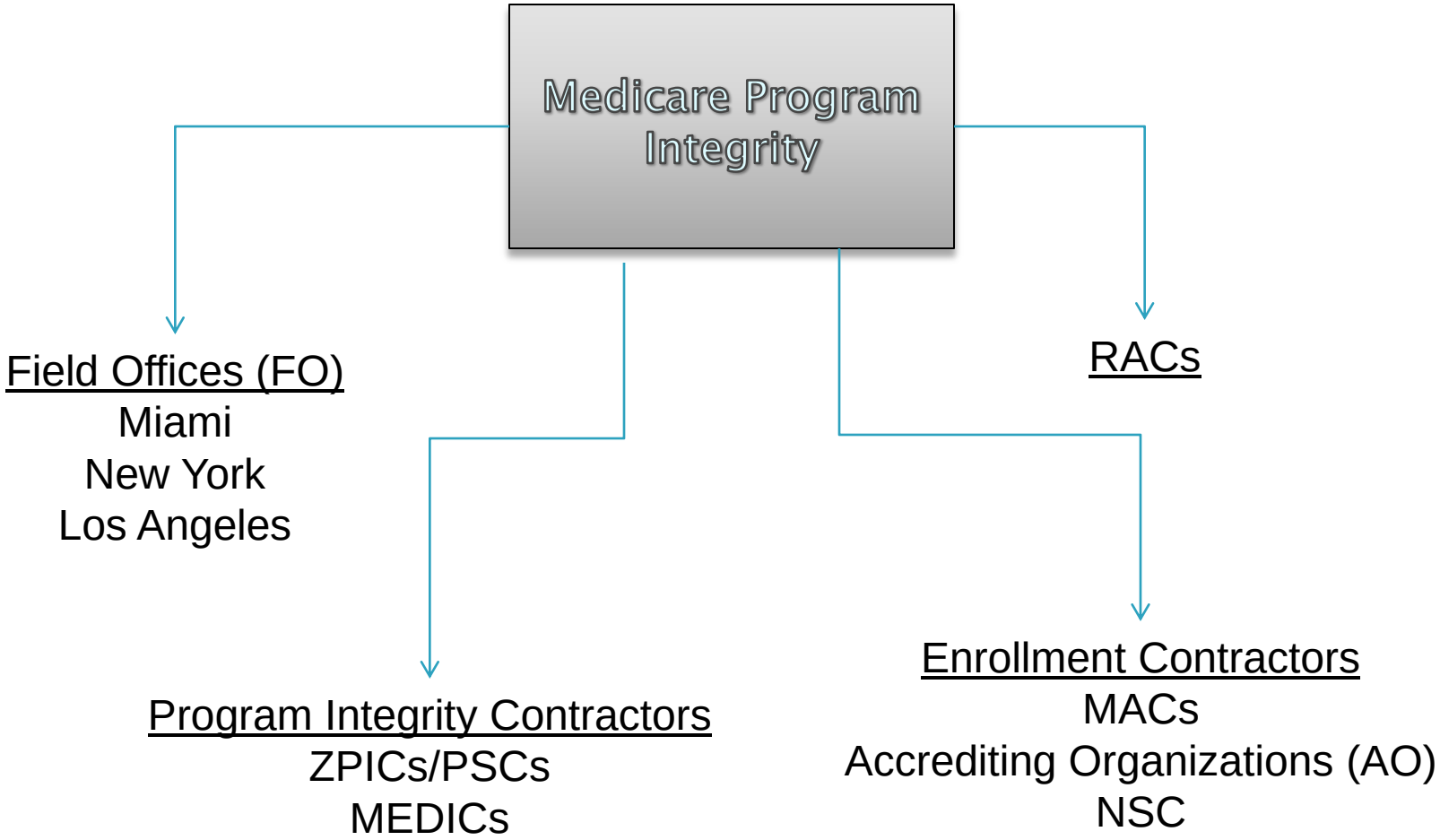
Scope of Medicare Program

- Medicare pays over 4.4 million claims per day to more than 1.5 million distinct providers and suppliers totaling $431.2 billion in annual Medicare payments.
- CMS must pay submitted claims within 30 days of receipt.
- Due to time and resource limitations, Medicare reviews fewer than 3% of all submitted claims before they are paid.
- Each month CMS receives 18,000 Part A & B provider enrollment applications and 900 DME supplier applications.

Scope of Medicare Fraud

- There is no reliable or accurate measure of the percentage of outright fraud in Medicare.
- In 2009, CMS estimated billions of dollars in improper payments in the Medicare program.

Medicare Program Integrity and its Contractors



CMS Payment Oversight: Waste

- CMS utilizes a number of payment edits to stop improper payments from being made
  - Medically unlikely services
  - Clinically unlikely services
- During 2009, CMS prevented over $450 million in improper payments through the use of edits

Examples of Fraud & Abuse

- Simple Scams
  - Cash payments to patients to use their Medicare numbers.
  - Paying physicians to sign fake certificates of medical necessity.
  - Billing for higher level of service than provided.

- Complex Business Schemes
  - Causing the submission of false claims by improper "off-label" marketing for indications Medicare/Medicaid does not cover.
  - Accounting practices to inflate cost reports.

Civil & Administrative Enforcement

- Not all fraud is criminal
- Civil False Claims Act ("whistleblowers")
  - Focus Areas:
    - Pharmaceuticals
    - Hospitals
    - Quality of Care
    - Labs
- OIG administrative sanctions
  - Civil Monetary Penalties (CMPs)
  - Exclusions

Health Care Fraud Prevention & Enforcement Action Team (HEAT)

- Chaired by:
  - HHS Deputy Secretary
  - Deputy Attorney General

- Subcommittees: Operations, Budget, Legislative, Data Sharing, Pharmaceuticals, and Public Outreach
  - Chaired by Marc Smolonsky (HHS) and Ed Siskel (DOJ)

- Purposes: sharing information, developing strategies, identifying needs

CMS Recommendations for Future Actions

- Focus on Provider Enrollment
  - Ensuring accurate information
  - Site visits to verify presence
- Focus on High Fraud Areas
  - High vulnerability projects
  - Data analysis to identify emerging trends
- New data infrastructure
  - Creating integrated database to contain all Medicare payment data

In Conclusion

- Making strides
- Inter-agency, multi-disciplinary approach
- Use of cutting edge technology
- Renewed commitment at all levels
- Public-Private Partnerships