



Top Ten Facts

CMS Fraud Prevention Initiative

1. Health care fraud perpetrators steal billions of dollars each year from the Federal and State governments, private insurance companies, providers, American taxpayers and some of our most vulnerable citizens. Fraud, waste and abuse drive up costs for everyone in the health care system. 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.
2. The Affordable Care Act includes provisions enabling CMS 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 law offers more protections to keep those who are intent on committing fraud out of the Federal health care programs, and new tools for deterring wasteful and fiscally abusive practices, identifying and addressing fraudulent payment issues promptly, and ensuring the integrity of Medicare, Medicaid and CHIP.
3. CMS is collaborating on anti-fraud initiatives with law enforcement partners, including the U.S. Department of Health and Human Services Office of Inspector General (OIG), the Department of Justice (DOJ), and State Medicaid Fraud Control Units (MFCUs), which take a lead role in investigating and prosecuting alleged fraud. The agency 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. This 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.
4. 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. The agency 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.
5. CMS is working 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.

6. The Affordable Care Act contains numerous provisions that support CMS 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 barred or terminated from all other Medicaid programs and CHIPs.
 - **Temporarily stopping 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.
 - **Temporarily stopping 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.
 - **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.
 - **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.
7. Beneficiaries are the first line of defense against Medicare fraud. Medicare encourages beneficiaries to check their Medicare Summary Notices (MSNs) thoroughly and be on the lookout for potential fraud, unrecognized claims and overpayments on claims submitted for their care. Beneficiaries should report suspected instances of fraud by calling 1-800-MEDICARE. The sooner a beneficiary sees and reports errors, the sooner Medicare can investigate and stop the fraud. Beneficiaries can learn more about protecting themselves and spotting fraud at www.StopMedicareFraud.gov or by contacting their local Senior Medicare Patrol (SMP) project. To find the SMP in their state, go to the SMP Locator at www.smpresource.org.
8. Health care providers can play an important role in stopping fraud by identifying and reporting cases of potential fraud. Providers should check Medicare's Provider Enrollment, Chain and Ownership System (PECOS) regularly (at least annually) to make sure their enrollment information is up to date and reflects their current practice. Providers should call 1-800-HHS-TIPS or their Medicare Administrative Contractor (MAC) to report suspected fraud.

9. 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 others. This is the highest amount ever recovered from those who attempted to defraud seniors and taxpayers.
10. 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/. 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_Overview.asp.

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

