HHS Pursues Mandate to Clamp Down on Fraud

BY ALICIA AULT

Physicians may find themselves under increased scrutiny as a result of provisions in the Affordable Care Act—one of the health reform laws—giving government agencies new funding and enforcement powers to go after fraud and abuse.

The Affordable Care Act will require providers and suppliers to meet new compliance criteria, said Daniel Levinson, inspector general for the Department of Health and Human Services. After the criteria are issued, his office will provide training to health care providers, he added at a May 13 briefing.

HHS Secretary Kathleen Sebelius said that the Affordable Care Act provides $600 million over the next 10 years to combat fraud and abuse. In 2009, the federal government recovered $2.5 billion in fraudulent Medicare payments, officials said at the briefing.

Potential Medicare or Medicaid providers will be categorized as at high, medium, or low risk of fraud at the time of enrollment. More face-to-face checks will be used to verify a provider's legitimacy, Ms. Sebelius said. The law increases penalties for fraud, and puts more emphasis on real-time detection of fraud and abuse, she noted, as opposed to the current "pay and chase" model.

The HHS and the Department of Justice also will be adopting strategies used by credit card companies to flag aberrant charges and stop fraud in its tracks. "As we try to bring down skyrocketing costs across our health care system, we can't afford to ignore the billions of dollars we lose to fraud and theft," she said.

In 2009, the federal government received about $1.6 billion in settlements and judgments from hospitals, health care providers, drug and device makers, and non–health providers found to have illegally billed federal health care programs. With penalties and settlements, $2.5 billion was returned to the Medicare Trust Fund and $441 million to Medicaid, according to the Health Care Fraud and Abuse Control Program Report.

A total of 583 individuals were convicted of health care fraud in 2009. On the civil side, the Department of Justice opened 886 new investigations and had 1,155 civil fraud matters pending.

Ms. Sebelius and Attorney General Eric Holder highlighted efforts by the Health Care Fraud Prevention and Enforcement Action Team (HEAT) Medicare Fraud Strike Force, which was formed in 2007 to address durable medical equipment fraud and abuse in south Florida. The strike force has been expanded to focus on potential hot spots of potential fraud, identified by claims patterns. Los Angeles, Detroit, and Houston were added in 2009. The strike force now also operates in Brooklyn, N.Y.; Baton Rouge, La.; and Tampa, Fla.

New types of scams are emerging as criminals try to take advantage of seniors who may not understand the health reform laws. Scam artists have gone door-to-door in some states selling bogus "ObamaCare" policies, or asking Medicare beneficiaries for identifying information to issue "new Medicare cards," Ms. Sebelius said.

Other scams are tied to the issuance of rebate checks to Medicare beneficiaries whose Medicare Part D drug expenditures push them into the so-called doughnut hole that limits coverage, she said.

The HHS is working with advocacy organizations to educate laypeople who can train their peers how to recognize illegal and inappropriate schemes, Ms. Sebelius added. ■

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