



AN AMERICAN SOLUTION QUALITY AFFORDABLE HEALTH CARE

HEALTH REFORM AT A GLANCE:

PROTECTING PROGRAM INTEGRITY BY PREVENTING WASTE, FRAUD AND ABUSE

Reducing waste, fraud, and abuse saves taxpayer dollars and protects the health care investments made by individuals, businesses, and government. Under the draft proposal, existing compliance and enforcement tools are strengthened for Medicare and Medicaid. In addition, the new public health insurance option and Health Insurance Exchange contain protections against waste and abuse that build upon the safeguards and best practices gleaned from experience in other areas.

PROGRAM INTEGRITY PROVISIONS IN THE DISCUSSION DRAFT:

IMPROVE MEDICARE AND MEDICAID PROGRAM REQUIREMENTS FOR PROVIDERS, SUPPLIERS, AND CONTRACTORS

- Require providers and suppliers to adopt compliance programs as a condition for participating in Medicare and Medicaid.
- Require Medicare and Medicaid integrity contractors that carry out audits and payment review, to provide annual reports and conduct regular evaluations of effectiveness.

ADEQUATELY FUND EFFORTS TO FIGHT FRAUD AND AGGRESSIVELY MONITOR MEDICARE AND MEDICAID FOR EVIDENCE OF FRAUD, WASTE, AND ABUSE

- Increase funding for the Health Care Fraud and Abuse Control Fund to fight Medicare and Medicaid fraud. CBO has estimated that every \$1 invested to fight fraud results in approximately \$1.75 in savings.
- Create a comprehensive “Medicare and Medicaid Provider/Supplier” Data Bank, to enable oversight of suspect utilization and prescribing patterns and complex business arrangements that may conceal fraudulent activity.
- Narrow the window for submitting Medicare claims for payment in order to decrease the opportunities for “gaming” the system.

IMPROVE SCREENING OF PROVIDERS AND SUPPLIERS

- Create a national pre-enrollment screening program to determine whether potential providers or suppliers have been excluded from other federal or state programs or have a revoked license in any state.
- Allow enhanced oversight periods, or enrollment moratoria in program areas determined to pose a significant risk of fraudulent activity.
- Require that only Medicare-participating physicians can order durable medical equipment (DME) or home health services paid for by Medicare, and allow the Administrator of the Centers for Medicare and Medicaid Services to adopt similar requirements for other “at-risk” programs.

NEW PENALTIES TO DETER FRAUD AND ABUSE

- Create new penalties for submitting false data or for obstructing audits or investigations related to Medicare or Medicaid.
- Establish new penalties for Medicare Advantage and Part D plans that violate marketing requirements or submit false bids, rebate reports, or other submissions to CMS.