CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS
NTP
NATIONAL
TRAINING PROGRAM
MODULE 10

Medicare and Medicaid Fraud, Waste, and Abuse Prevention

Contents

Session Objectives

This session should help you

- Define fraud, waste, and abuse
- Identify causes of improper payments
- Discuss how CMS fights fraud and abuse
- Explain how you can fight fraud and abuse
- Find sources of additional information

Lesson 1—Fraud, Waste, and Abuse Overview

- Defining health care fraud, waste, and abuse
- Protecting the Medicare Trust Funds and other public resources
- Examples of Medicare and Medicaid fraud
- Who commits fraud?
- Causes of improper payments
- Quality of care concerns

Definitions of Fraud, Waste, and Abuse

Fraud

When someone **intentionally** deceives or makes misrepresentations to obtain money or property of any health care benefit program.

Waste

The overutilization of services, or other practices that directly or indirectly, result in unnecessary costs to the Medicare Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

Abuse

When health care providers or suppliers perform actions that directly or indirectly result in unnecessary costs to any health care benefit program.

The primary difference between fraud, waste, and abuse is intention.

Protecting Taxpayer Dollars

The Centers for Medicare & Medicaid Services (CMS) must

- Protect Medicare Trust Funds
  - Medicare Hospital Insurance (Part A) Trust Fund
  - Supplementary Medical Insurance (Part B) Trust Fund
- Protect the public resources that fund Medicaid Programs
- Manage the careful balance between paying claims quickly and limiting burden on the provider community with conducting reviews that prevent and detect fraud

Examples of Fraud

- Medicare or Medicaid is billed for
  - Services you never got
  - Equipment you never got or that was returned
- A provider bills Medicare or Medicaid for services that would be considered impossible
- Documents are altered to gain a higher payment
- Dates, descriptions of furnished services, or your identity are misrepresented
- Someone uses your Medicare or Medicaid card with or without your permission
- A company uses false information to mislead you into joining a Medicare plan

Consequences of Sharing a Medicaid Card or Number

- Medicaid-specific lock-in program
  - Limits you to certain doctors/drug stores/hospitals
    - For activities like ER visits for non-emergency care and using multiple doctors that duplicate treatment/medication

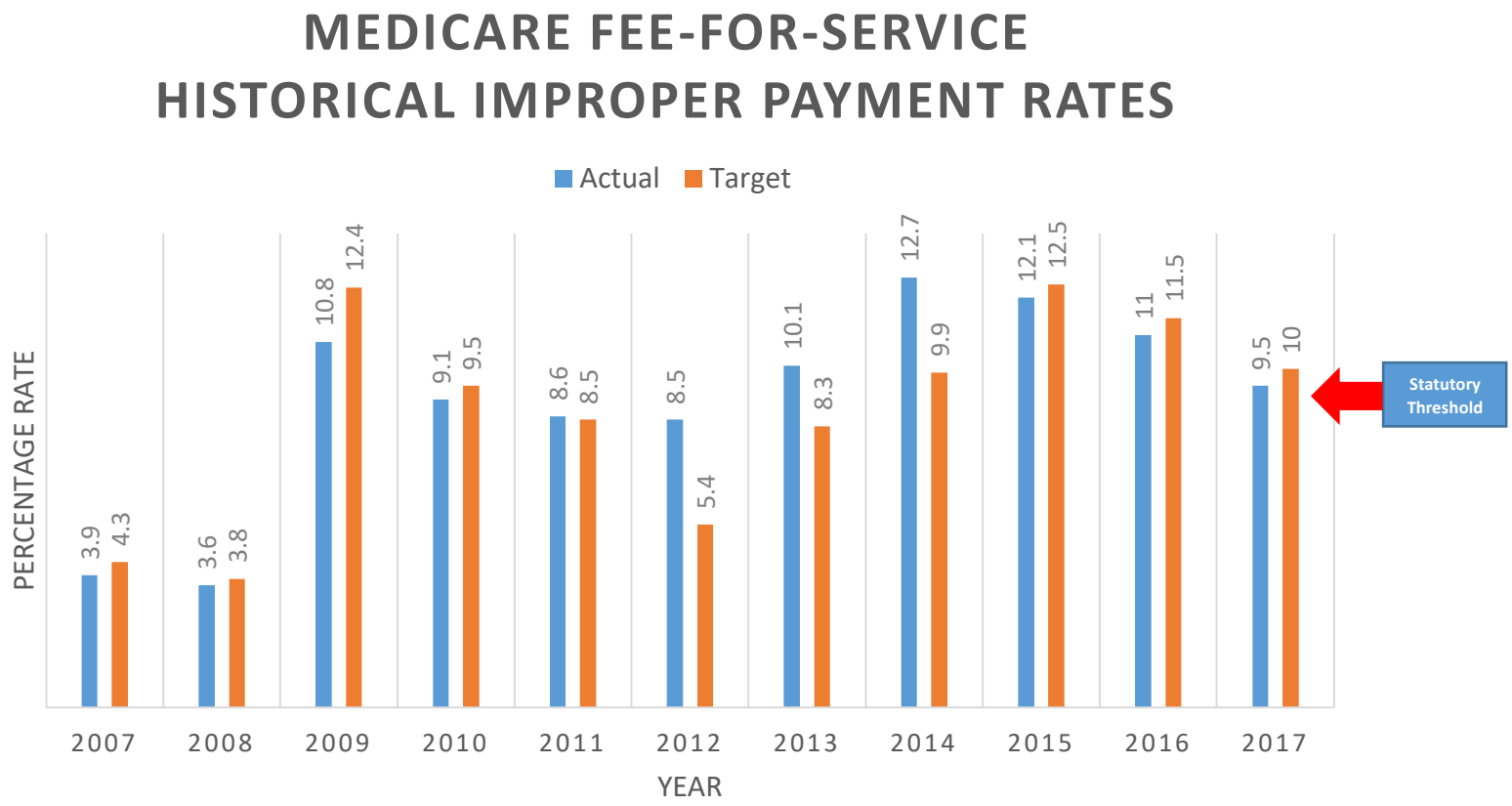
- Your medical records could be wrong
- You may have to pay money back or be fined
- You could be arrested
- You might lose your Medicaid benefits

Who Commits Fraud?

- Most individuals and organizations that work with Medicare and Medicaid are honest
- However, anyone can commit fraud including
  - Doctors and health care providers
  - DME suppliers
  - Employees of doctors or suppliers
  - Employees of companies that manage Medicare billing
  - People with Medicare and/or Medicaid

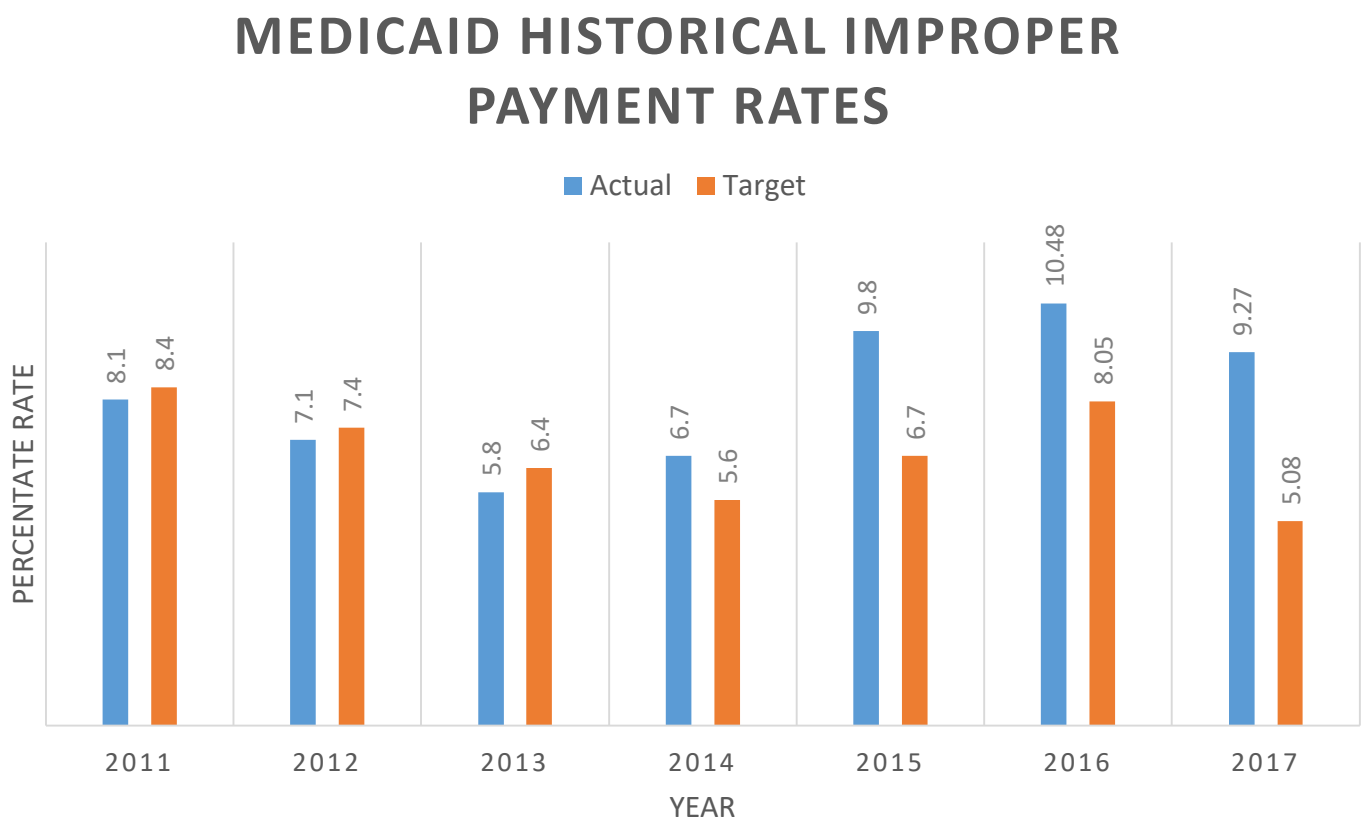
Improper Payment Transparency—Medicare

Medicare Fiscal Reporting Year 2017
Error Rate is 9.5% or $36.2 billion



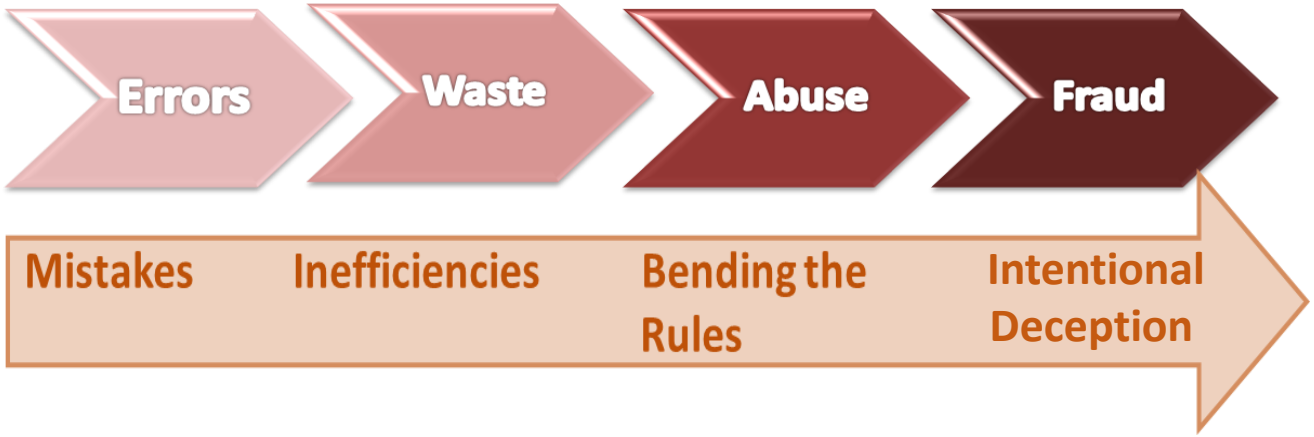
Improper Payment Transparency—Medicaid

Medicaid Fiscal Reporting Year 2017
Error Rate is 10.1% or $36.7 billion



Causes of Improper Payments

- Not all improper payments are fraud, but all payments made due to fraud schemes are improper



- CMS is targeting all causes of improper payments—from honest mistakes to intentional deception
- Most common error is insufficient documentation

Preventing Fraud in Medicare Part C and Part D

- Plan agents and brokers must follow CMS's Marketing Guidelines
- Examples of what plans can't do include
  - Send unwanted emails
  - Visit homes uninvited to encourage enrollment in their plan
  - Call non members
  - Offer cash to join their plan
  - Give free meals
  - Talk about their plan in areas where people get health care
- If you think an agent or broker broke Medicare plan rules, call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048

Telemarketing and Fraud—Durable Medical Equipment (DME)

- DME telemarketing rules
  - DME suppliers can't make unsolicited sales calls
- Potential DME scams
  - Calls or visits from people saying they represent Medicare
  - Phone or door-to-door selling techniques
  - Equipment or service is offered for free and then you're asked for your Medicare number for "record keeping purposes"
  - You're told that Medicare will pay for the item or service if you provide your Medicare number

Quality of Care Concerns

- Patient quality of care concerns aren't necessarily fraud
  - Medication errors
  - Change in condition not treated
  - Discharged from the hospital too soon
  - Incomplete discharge instructions and/or arrangements
- Contact your Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO)
  - Visit Medicare.gov/contacts
  - Call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048

Check-Your-Knowledge—Question 1

_____ occurs when someone intentionally deceives or makes misrepresentations to obtain money or property from any health care benefit program.

a. Abuse
b. Improper payment
c. Fraud
d. None of the above

Check Your Knowledge—Question 2

Billing errors always show a health care provider's or supplier's intent to commit fraud.

a. True

b. False

Lesson 2—CMS Fraud and Abuse Strategies

- The Center for Program Integrity (CPI)
- CMS Program Integrity Contractors
- CMS administrative actions
- Law enforcement actions
- The Health Care Fraud Prevention Partnership (HFPP)
- Health Care Fraud Prevention and Enforcement Action (HEAT) Team
- The Fraud Prevention Toolkit at CMS.gov/Outreach-and-Education/Outreach/Partnerships/FraudPreventionToolkit.html
- Provider and beneficiary education

The Center for Program Integrity (CPI)

- CPI coordinates anti-fraud waste, and abuse components
- Coordinates the work of anti-fraud contractors to investigate Medicare providers and conducts audits of Medicaid providers to identify potential overpayments
- Medicare, Medicaid, and the Children's Heath Insurance Program (CHIP) moved beyond the "pay and chase" approach to health care fraud
  - More rigorous screenings for health care providers
  - Revoke Medicare provider billing privileges if terminated from Medicaid and CHIP
  - May temporarily stop enrollment in high-risk areas
  - Temporarily stop Medicare payments in cases of credible allegations of fraud
  - Coordinate with private and public health payers and other stakeholders to detect and deter fraudulent behaviors within the health care system
  - Provides outreach and education to key stakeholders to reach key program objectives

Program Integrity Contractors

- A nationally coordinated Medicare/ Medicaid Program integrity strategy that cuts across regions
  - Unified Program Integrity Contractors (UPIC)
  - Recovery Audit Program
  - National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)
  - Outreach & Education Contractors

Unified Program Integrity Contractor (UPIC)

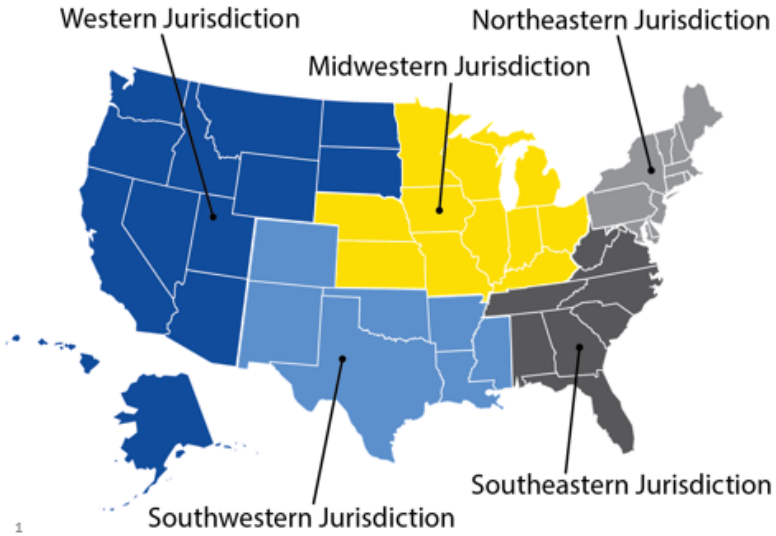
Unified Program Integrity Contractor (UPIC)

About UPIC:

Coordinates provider investigations across Medicare and Medicaid;

Improves collaboration with States by providing a mutually beneficial service; and

Increases contractor accountability through coordinated oversight



UPIC AWARDS:

- **MIDWESTERN JURISDICTION** AdvanceMed Corporation
- **NORTHEASTERN JURISDICTION** SafeGuard Services, LLC
- **WESTERN JURISDICTION** Qlarant
- **SOUTHEASTERN JURISDICTION** SafeGuard Services, LLC
- **SOUTHWESTERN JURISDICTION** Qlarant

Medi-Medi Data Matching Funds

- Offers opportunities for collaboration between State Medicaid agencies and CMS by targeting resources on data analyses and investigations that have the greatest potential for uncovering fraud, waste, and abuse
  - State participation is voluntary
  - Activities are separate tasks under the UPIC contracts
    - UPICs use the matched data to identify fraud, waste, and abuse to conduct investigations with State Medicaid agencies

Recovery Audit Program

- Recovery Audit Program's mission
  - Reduce improper Medicare payments by
    - Detecting and collecting overpayments
    - Identifying underpayments
    - Putting into place actions that will prevent future improper payments
- States establish Medicaid Recovery Audit Contractor (RAC) programs to
  - Identify overpayments and underpayments
  - Coordinate efforts with federal and state auditors

National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC)

- Monitors fraud, waste, and abuse in the Part C and Part D programs
- Works with law enforcement and other stakeholders
- Key responsibilities include
  - Investigating potential fraud, waste, and abuse
  - Investigating complaints alleging Medicare fraud
  - Performing proactive data analyses
  - Identifying program vulnerabilities
  - Referring potential fraud cases to law enforcement agencies

Outreach & Education Contractors

- Communicate CPI's efforts to detect and reduce fraud, waste, and abuse
- These contractors offer:
  - Outreach and education materials
  - Professional education
  - Information about regulations and guidance
  - Fraud-fighting resources
  - General news

CMS Administrative Actions

- When CMS suspects fraud, administrative actions include:
  - Automatic denials of payment
  - Payment suspensions
  - Prepayment edits
  - Revocation of billing privileges
  - Post-payment reviews for determinations
  - Referral to law enforcement

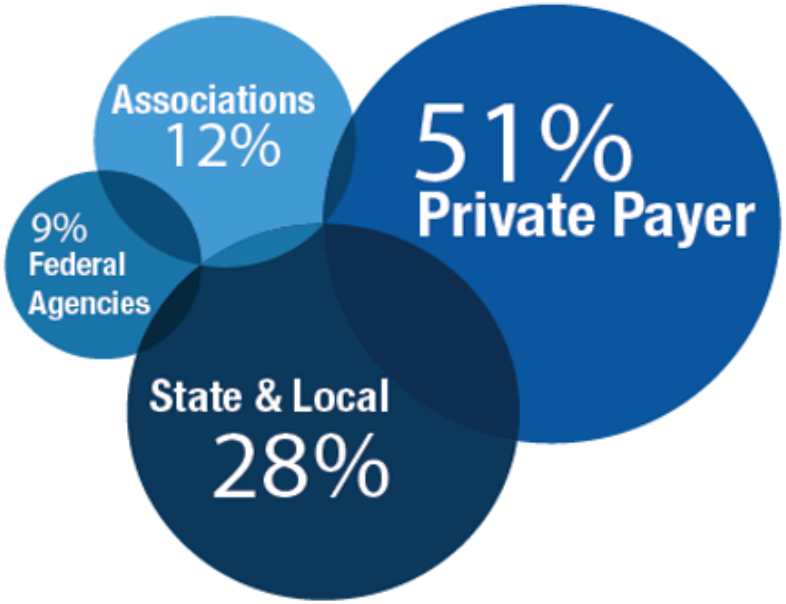
Law Enforcement Actions

- When law enforcement determines fraudulent activities, enforcement actions include:
  - Providers/companies are barred from the programs
  - Providers/companies can't bill Medicare, Medicaid, or CHIP
  - Providers/companies are fined
  - Arrests and convictions occur
  - Corporate Integrity Agreements may be negotiated

Health Care Fraud Prevention Partnership (HFPP)

Voluntary, public-private partnership between the federal government, state and local agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations to identify and reduce fraud, waste, and abuse across the healthcare sector

Make-up of the Partnership



100 Partners*

9 Federal Agencies

12 Associations

28 State and Local

51 Private Payers

* As of April 30, 2018

1

Health Care Fraud Prevention and Enforcement Action (HEAT) Team

- Joint initiative between HHS and U.S. Department of Justice
- The mission of the HEAT team is to:
  - Gather resources across the government to help prevent waste, fraud, and abuse in the Medicare and Medicaid Programs, and crack down on fraud perpetrators who abuse and cost the system billions of dollars
  - Reduce skyrocketing health care costs and improve the quality of care, by ridding the system of perpetrators who prey on people with Medicare and Medicaid
  - Highlight best practices of providers and public sector employees dedicated to ending waste, fraud, and abuse in Medicare
  - Build upon existing partnerships between HHS and DOJ to reduce fraud and recover taxpayer dollars

Medicare Fraud Strike Force Teams

- Multi-agency teams that
  - Are located in fraud "hot spot" areas
  - Use advanced data analysis to identify high-billing levels in health care fraud hot spots
  - Coordinate national takedowns
- CMS supports Strike Force takedowns
  - Performs data analysis
  - Suspends payment

Provider and Beneficiary Education

- Provider education helps correct vulnerabilities
  - Maintain proper documentation
  - Reduce inappropriate claims submission
  - Protect patient and provider identity information
  - Establish a broader culture of compliance
- Beneficiary education helps identify and report suspected fraud

Check Your Knowledge—Question 3

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) is a joint anti-fraud initiative between HHS and the U.S. Department of Justice (DOJ).

a. True

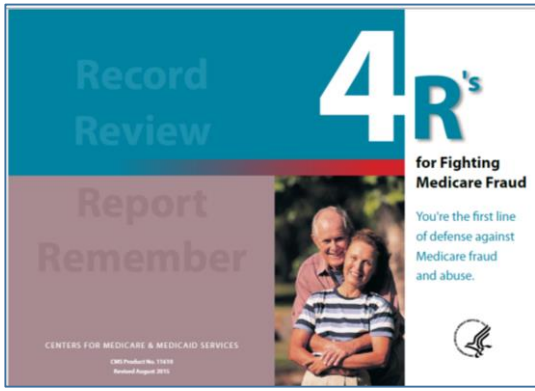
b. False

Lesson 3—How You Can Fight Fraud

- "4Rs" for fighting Medicare fraud
- Medicare.gov/fraud
- Medicare Summary Notices (MSNs)
- MyMedicare.gov
- 1-800-MEDICARE
- Senior Medicare Patrol (SMP)
- Protecting Personal Information and ID Theft
- Reporting Medicaid Fraud
- Helpful Resources
- Fraud Prevention Toolkit

"4Rs" for Fighting Medicare Fraud

- Publication about how you can protect yourself from fraud
  - Record appointments and services
  - Review services provided
    - Compare services actually obtained with services on your MSN
  - Report suspected fraud
  - Remember to protect personal information, such as your Medicare card and bank account numbers



CMS Product No. 11610 is available at Medicare.gov/Pubs/pdf/11610-4R-for-Fighting-Fraud.pdf

Medicare.gov/fraud

- Learn
  - Prevention tips
  - How to spot fraud
  - How to report fraud
- Plan marketing information

Medicare Summary Notice (MSN)

- CMS redesigned the MSN for Part A and Part B to make it easier to read and spot fraud
- Shows all your services or supplies
  - Billed to Medicare in a 3-month period
  - What Medicare paid
  - What you owe
- Read it carefully

Jennifer Washington THIS IS NOT A BILL | Page 2 of 4

Making the Most of Your Medicare

How to Check This Notice

Do you recognize the name of each facility? Check the dates.

Did you get the claims listed? Do they match those listed on your receipts and bills?

If you already paid the bill, did you pay the right amount? Check the maximum you may be billed. See if the claim was sent to your Medicare supplement insurance (Medigap) plan or other insurer. That plan may pay your share.

How to Report Fraud

If you think a facility or business is involved in fraud, call us at 1-800-MEDICARE (1-800-633-4227).

Some examples of fraud include offers for free medical services or billing you for Medicare services you didn't get. If we determine that your tip led to uncovering fraud, you may qualify for a reward.

You can make a difference! Last year, Medicare saved tax-payers **$4.2 billion**—the largest sum ever recovered in a single year—thanks to people who reported suspicious activity to Medicare.

How to Get Help with Your Questions

1-800-MEDICARE (1-800-633-4227)
Ask for "hospital services." Your customer-service code is 05535.

TTY 1-877-486-2048 (for hearing impaired)

Contact your State Health Insurance Program (SHIP) for free, local health insurance counseling. Call **1-555-555-5555.**

Your Benefit Periods

Your hospital and skilled nursing facility (SNF) stays are measured in **benefit days** and **benefit periods**. Every day that you spend in a hospital or SNF counts toward the benefit days in that benefit period. A benefit period begins the day you first receive inpatient hospital services or, in certain circumstances, SNF services, and ends when you haven't received any inpatient care in a hospital or inpatient skilled care in a SNF for 60 days in a row.

Inpatient Hospital: You have **56 out of 90 covered benefit days** remaining for the benefit period that began May 27, 2013.

Skilled Nursing Facility: You have **63 out of 100 covered benefit days** remaining for the benefit period that began May 27, 2013.

See your "Medicare & You" handbook for more information on benefit periods.

Your Messages from Medicare

Get a pneumococcal shot. You may only need it once in a lifetime. Contact your health care provider about getting this shot. You pay nothing if your health care provider accepts Medicare assignment.

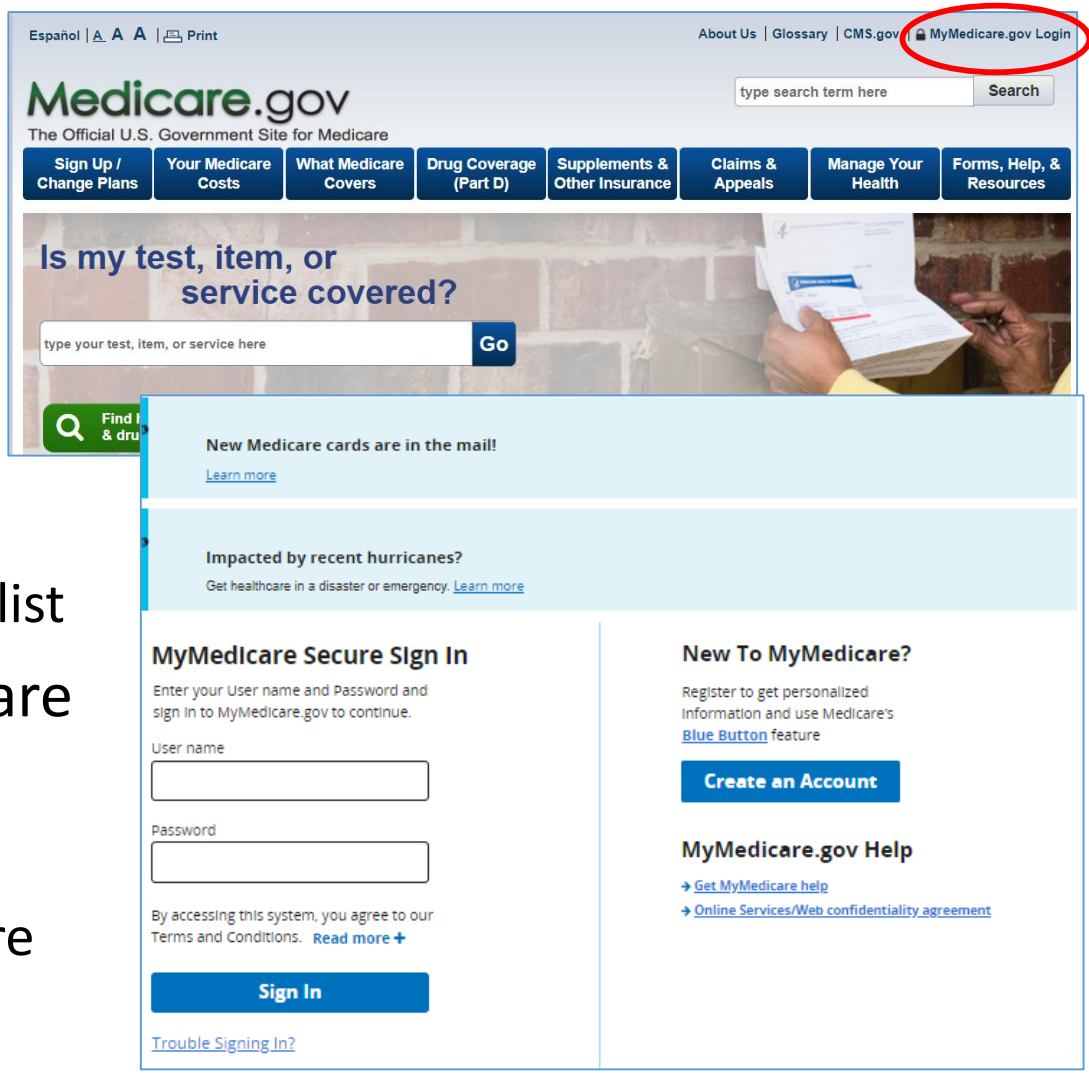
To report a change of address, call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Early detection is your best protection. Schedule your mammogram today, and remember that Medicare helps pay for screening mammograms.

Want to see your claims right away? Access your Original Medicare claims at www.MyMedicare.gov, usually within 24 hours after Medicare processes the claim. You can use the "Blue Button" feature to help keep track of your personal health records.

MyMedicare.gov

- Secure site to manage personal information
- You register to
  - Review eligibility, entitlement, and plan information
  - Track preventive services
  - Keep a prescription drug list
- Review claims for Medicare Part A and Part B
  - Available almost immediately after they are processed



1-800-MEDICARE (TTY: 1-877-486-2048)

- Incoming fraud complaints
  - Help target certain providers/suppliers for review
  - Show where fraud scams are heating up
- Using the Interactive Voice Response System
  - Access up to 15 months of claims
  - Check for proper dates, services, and supplies obtained
    - If not checking claims on MyMedicare.gov

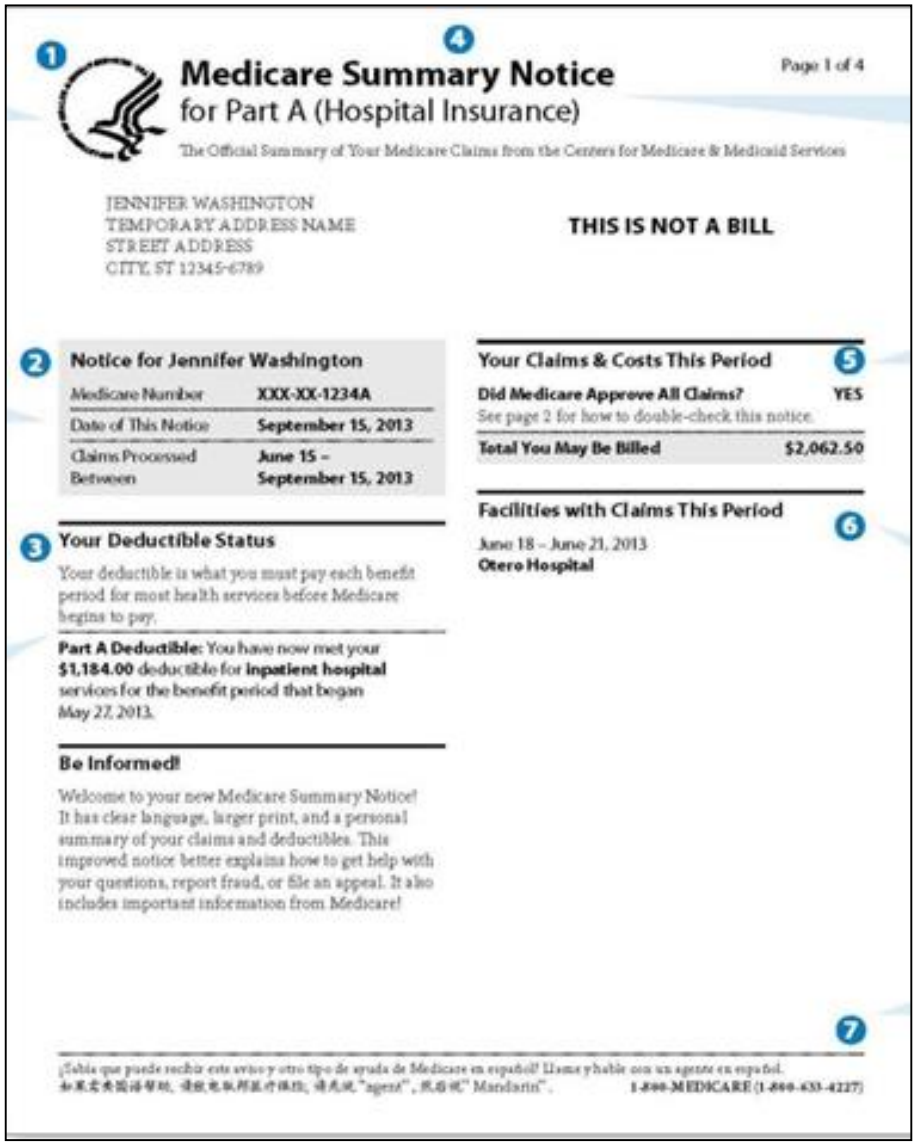
Fighting Fraud Can Pay

- You may get a reward if you meet all of these conditions:
  - You call either 1-800-HHS-TIPS (1-800-447-8477), or 1-800-MEDICARE (1-800-633-4227) to report suspected fraud; TTY: 1-877-486-2048
  - The suspected Medicare fraud you report must be investigated and validated by Medicare contractors
  - The reported fraud must be formally referred to the Office of Inspector General (OIG) for further investigation
  - You aren't an excluded individual
  - The person or organization you're reporting isn't already under investigation by law enforcement
  - Your report leads directly to the recovery of at least $100 of Medicare money

Learning Activity

Jennifer has concerns and wants to discuss her MSN with you.

What are some things that might indicate fraud?



Medicare Summary Notice
for Part A (Hospital Insurance)

Page 1 of 4

The Official Summary of Your Medicare Claims from the Centers for Medicare & Medicaid Services

JENNIFER WASHINGTON
TEMPORARY ADDRESS NAME
STREET ADDRESS
CITY, ST 12345-6789

THIS IS NOT A BILL

Notice for Jennifer Washington

Medicare Number	XXX-XX-1234A
Date of This Notice	September 15, 2013
Claims Processed Between	June 15 – September 15, 2013

Your Deductible Status

Your deductible is what you must pay each benefit period for most health services before Medicare begins to pay.

Part A Deductible: You have now met your **$1,184.00** deductible for **inpatient hospital** services for the benefit period that began May 27, 2013.

Be Informed!

Welcome to your new Medicare Summary Notice! It has clear language, larger print, and a personal summary of your claims and deductibles. This improved notice better explains how to get help with your questions, report fraud, or file an appeal. It also includes important information from Medicare!

Your Claims & Costs This Period

Did Medicare Approve All Claims? YES
See page 2 for how to double-check this notice.

Total You May Be Billed $2,062.50

Facilities with Claims This Period

June 18 – June 21, 2013
Otero Hospital

¿Sabía que puede recibir este aviso y otro tipo de ayuda de Medicare en español? Llame y hable con un agente en español.
"agent", Mandarin". 1-800-MEDICARE (1-800-633-4227)

Learning Activity: What Might Indicate Fraud?

- Was Jennifer charged for any medical services she didn't get?
- Are the dates of services correct?
- Was Jennifer billed for the same thing twice?
- Does her credit report show any unpaid bills for medical services or equipment she didn't get?
- Has Jennifer obtained any collection notices for medical services or equipment she didn't get?

The Senior Medicare Patrol (SMP)

- Education and prevention program aimed at educating people with Medicare on preventing, identifying, and reporting health care fraud
- Active programs in all states, the District of Columbia, Puerto Rico, and Guam
- Seeks volunteers to represent their communities

- Nationwide toll-free number: 1-877-808-2468
- For more information, visit smpresource.org

Protecting Personal Information

- Only share with people you trust
  - Doctors, other health care providers, and plans approved by Medicare
  - Insurers who pay benefits on your behalf
  - Trusted people in the community who work with Medicare, like your State Health Insurance Assistance Program (SHIP) or Social Security
- Call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048 if you aren't sure if a provider is approved by Medicare

Identity Theft

- Identity theft is a serious crime
  - Someone else uses your personal information, like your Social Security or Medicare number
- If you think someone is using your information
  - Call your local police department
  - Call the Federal Trade Commission's ID Theft Hotline at 1-877-438-4338; TTY: 1-866-653-4261
- If your Medicare card is lost or stolen, report it right away
  - Call Social Security at 1-800-772-1213; TTY: 1-800-325-0778

Reporting Suspected Medicaid Fraud

- Medicaid Fraud Control Unit (MFCU) investigates and prosecutes
  - Medicaid fraud
  - Patient abuse and neglect in health care facilities
- U.S. Department of Health & Human Services Office of the Inspector General (OIG) certifies and annually re-certifies each MFCU
  - Call to report fraud at 1-800-447-8477 (TTY: 1-800-377-4950)
- State Medical Assistance (Medicaid) office
  - See state listing for Medicaid
    - Located at CMS.gov/apps/contacts

Key Points to Remember

- ✓ The key difference between fraud, waste, and abuse is **intention**
- ✓ Improper payments are often mistakes
- ✓ CMS fights fraud, waste, and abuse with support from Program Integrity Contractors
- ✓ You can fight fraud, waste, and abuse with the 4Rs: Record, Review, Report, Remember

Medicare and Medicaid Fraud & Abuse Resource Guide

Centers for Medicare & Medicaid Services (CMS)	▪ Call 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048. ▪ CMS.gov ▪ Medicare.gov ▪ Medicare.gov/fraud
MyMedicare.gov	▪ MyMedicare.gov
Social Security	▪ Call 1-800-772-1213. TTY: 1-800-325-0778 ▪ socialsecurity.gov
Senior Medicare Patrol Program	▪ Call 1-877-808-2468 ▪ smpresource.org
National Health Care Anti-Fraud Association	▪ NHCAA.org
NBI Medic's Parts C&D Fraud Reporting Group	▪ Call 1-877-7SAFERX (1-877-772-3379). ▪ healthintegrity.org/contracts/nbi-medic/reporting-a-complaint

Medicare and Medicaid Fraud & Abuse Resource Guide (continued)

Health & Human Services Office of the Inspector General	▪ Call 1-800-HHS-TIPS; (1-800-447-8477); TTY: 1-800-377-4950 ▪ OIG.hhs.gov/fraud/report-fraud
Medicaid Beneficiary Education	▪ CMS.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html

Medicare and Medicaid Fraud & Abuse Resource Guide—Medicare Products

1. "Protecting Yourself & Medicare From Fraud"	CMS Product No. 10111
2. "Quick Facts About Medicare Plans and Protecting Your Personal Information"	CMS Product No. 11147
3. "4Rs for Fighting Fraud"	CMS Product No. 11610
4. "You Can Help Protect Yourself and Medicare From Fraud Committed by Dishonest Suppliers"	CMS Product No. 11442

To access these products:

- View and order single copies at Medicare.gov/publications.
- Order multiple copies (partners only) at Productordering.cms.hhs.gov.

You must register your organization.

Acronyms

BFCC-QIO Beneficiary and Family-Centered Care Quality Improvement Organization

CHIP Children's Health Insurance Program

CMS Centers for Medicare & Medicaid Services

CPI Center for Program Integrity

DME Durable Medical Equipment

DOJ Department of Justice

FFS Fee-for-Service

FPS Fraud Prevention System

FY Fiscal Year

HEAT Health Care Fraud Prevention and Enforcement Action Team

HHS Health and Human Services

IVR Interactive Voice Response

MAC Medicare Administrative Contractors

MEDIC Medicare Drug Integrity Contractor

MFCU Medicaid Fraud Control Unit

MICs Medicaid Integrity Contractors

MSN Medicare Summary Notice

Acronyms (continued)

NBI National Benefit Integrity

NTP National Training Program

O&E Outreach and Education

OIG Office of Inspector General

QIO Quality Improvement Organization

RAC Recovery Audit Contractor

SGS SafeGuard Services, LLC

SMP Senior Medicare Patrol

TTY Teletypewriter

ZPIC Zone Program Integrity Contractor

This Training is Provided by the

CMS National Training Program (NTP)

To view all available NTP training materials, or to subscribe to our email list, visit CMSnationaltrainingprogram.cms.gov.

Stay connected.

Contact us at training@cms.hhs.gov, or follow us  @CMSGov #CMSNTP