Reducing Waste, Fraud and Abuse

Reducing waste, fraud and abuse in Medicare, Medicaid, and CHIP will save taxpayer dollars. In private insurance markets, fraudulent operators prey on small businesses and individuals, using the promise of low premiums to lure unsuspecting purchasers to buy bogus coverage. The National Health Care Anti-Fraud Association estimates that fraud amounts to at last three percent of total health care spending, or more than $60 billion per year. The *Affordable Care Act* includes many policies that will significantly reduce fraud and abuse in Medicare, Medicaid, CHIP and private insurance.

Increases Funding for Program Integrity

- ✓ Increases funding for the Health Care Fraud and Abuse Control fund to fight fraud in public programs. The Office of Management and Budget estimates that every $1 invested to fight fraud results in approximately $17 in savings.

Improves Screening of Providers and Suppliers

- ✓ Requires the Secretary of Health and Human Services to institute a new screening process for all providers and suppliers before granting Medicare billing privileges.
- ✓ Provides states new authority to impose screening procedures on Medicaid providers. States that do not create effective screening programs could lose federal financial assistance.
- ✓ Provides the Secretary of Health and Human Services the ability to subject claims from new durable medical equipment suppliers to additional scrutiny.
- ✓ Establishes tougher standards for entities to qualify and bill as community mental health centers.

Requires Providers and Suppliers to Implement Compliance Programs

- ✓ Requires providers and suppliers to implement compliance programs as a condition of participating in Medicare and Medicaid.

Establishes New and Enhanced Penalties and Procedures to Deter Fraud and Abuse

- ✓ Establishes new penalties for submitting false data on applications, false claims for payment, or for obstructing audit investigations related to Medicare, Medicaid, and CHIP.
- ✓ Establishes new penalties for Medicare Advantage and Part D plans that violate marketing regulations or submit false information to the Centers for Medicare & Medicaid Services.
- ✓ Establishes broader use of prepayment medical review of Medicare claims.

New Tools to Deter Fraud and Abuse in Private Insurance Markets

- ✓ Creates new penalties and enforcement tools to deter fraudulent health insurances scams, especially through bogus Multiple Employer Welfare Arrangements (MEWAs).
- ✓ Provides the Department of Labor authority to shut down fraudulent plans before operators can inflict financial harm on innocent parties.
- ✓ Encourages uniform reporting by private health plans to state insurance departments.