HHS: Affordable Care Act Helps Recover $4 Billion In Healthcare Fraud

U.S. Department of Health and Human Services (HHS) Secretary Kathleen Sebelius and U.S. Associate Attorney General Thomas J. Perrelli detailed a new report showing that the government's health care fraud prevention and enforcement efforts recovered more than $4 billion in taxpayer dollars in Fiscal Year 2010. This is the highest annual amount ever recovered. In addition, HHS announced new rules authorized by the Affordable Care Act that will help the department work proactively to prevent and fight fraud, waste and abuse in Medicare, Medicaid and the Children's Health Insurance Program (CHIP).

These findings, released in the annual Health Care Fraud and Abuse Control Program report, were cited as the result of President Obama making the elimination of fraud, waste, and abuse a top priority, and would not have been possible without the Health Care Fraud Prevention & Enforcement Action Team (HEAT), created in 2009 to prevent waste, fraud and abuse in the Medicare and Medicaid programs. Furthermore, a release from HHS states that "these efforts to reduce fraud will continue to improve with the new tools and resources provided by the Affordable Care Act."

More than $4 billion stolen from federal health care programs was recovered and returned to the Medicare Health Insurance Trust Fund, the Treasury, and others in FY 2010. The Affordable Care Act provides additional tools and resources to help fight fraud, including an additional $350 million for HCFAC activities. HHS and DOJ have enhanced their coordination through HEAT and have expanded Medicare Fraud Strike Force teams since 2009. HHS and DOJ hosted a series of regional fraud prevention summits around the country, and sent letters to state attorneys general urging them to work with HHS, as well as federal, state and local law enforcement officials to mount a substantial outreach campaign to educate seniors and other Medicare beneficiaries about how to prevent scams and fraud.

In FY 2010, the total number of cities with Strike Force prosecution teams was increased to seven, all of which have teams of investigators and prosecutors dedicated to fighting fraud. The Strike Force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that inter-agency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers.

Strike Force enforcement accomplishments in all seven cities during FY 2010 include:

- 140 indictments involving charges filed against 284 defendants who collectively billed the Medicare program more than $590 million.
- 217 guilty pleas negotiated and 19 jury trials litigated, winning guilty verdicts against 23 defendants.
- Imprisonment for 146 defendants sentenced during the fiscal year, averaging more than 40 months of incarceration.

Including Strike Force matters, federal prosecutors opened 1,116 criminal health care fraud investigations as of the end of FY 2010, and filed criminal charges in 488 cases involving 931 defendants. A total of 726 defendants were convicted for health care fraud-related crimes during the year. In addition to these criminal enforcement successes, 2010 was a record year for recoveries obtained in civil health care matters brought under the False Claims Act—more than $2.5 billion, which is the largest in the history of the Department of Justice.

The HCFAC annual report can be found here at www.oig.hhs.gov/publications/hcfac.asp. For more information on the joint DOJ-HHS Strike Force activities, visit: www.StopMedicareFraud.gov/.

HHS also announced new rules authorized by the Affordable Care Act which will help stop health care fraud. The provisions include:

- Creation of a rigorous screening process for providers and suppliers enrolling in Medicare, Medicaid and CHIP to keep fraudulent providers out of those programs. Types of providers and suppliers that have been identified in the past as posing a higher risk of fraud, for example durable medical equipment suppliers, will be subject to a more thorough screening process.
- Requirement of a new enrollment process for Medicaid and CHIP providers. States will have to screen providers who order and refer to Medicaid beneficiaries to determine if they have a history of defrauding government. Providers that have been kicked out of Medicare or another State’s Medicaid or CHIP will be barred from all Medicaid and CHIP programs.
- Temporary halting the enrollment of new providers and suppliers. Medicare and State agencies will be on the look out for trends that may indicate healthcare fraud – including using advanced predictive modeling software, such as that used to detect credit card fraud. If a trend is identified in a category of providers or geographic area, the program can temporarily stop enrollment as long as that will not impact access to care for patients.
- Temporary halting of 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.

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