

Attacking Waste, Fraud, and Abuse in Health Reform

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Recent health care reform legislation will greatly increase the availability of health insurance and broadly impact the delivery of health care in America. This fact sheet looks specifically at how the legislation will help reduce waste, fraud, and abuse in the health care system.

Starting in 2010, health care legislation provides increased funding and requires enhanced enforcement and screening procedures for health care providers to reduce waste, fraud, and abuse in Medicare, Medicaid, and other sectors of the health care system.

Waste, fraud, and abuse cost the health care system billions of dollars annually. Although the actual amount is unknown, estimates of health care spending lost to fraud range from 3 percent to 10 percent.¹ Wasteful services have an even greater cost. Some experts have estimated that Medicare spending would fall by almost 30 percent if unnecessary health services could be avoided.²

Increased Funding for Oversight and Enforcement

To enhance the critical role played by federal oversight and enforcement authorities, health reform legislation increases funding for the Medicare and Medicaid Health Care Fraud and Abuse Control Fund by about \$350 million over 10 years, with automatic adjustments for inflation.

Increased Scrutiny of Providers in Federal Health Programs

Health reform legislation subjects Medicare and Medicaid providers and

suppliers to enhanced oversight and screening measures such as licensure checks, fingerprinting, criminal background checks, multistate inquiries, and random, unannounced site visits. The legislation also provides for the following:

- Registration of billing agents and clearinghouses that submit claims on behalf of Medicaid providers. Registration with state Medicaid agencies and the Department of Health and Human Services (HHS) allows greater oversight.
- A requirement that physicians who order Medicare durable medical equipment (DME) or home health services must verify the need by visiting face-to-face with the patient. Medicare will be allowed to withhold DME payments for 90 days to investigate suspected fraud. Competitive bidding for DME supplies will be expanded to encourage lower Medicare prices.
- Potential exclusion from federal health programs of providers and suppliers that are affiliated with delinquent providers.
- Increased Department of Labor (DOL) oversight of Multiple Employer Welfare Arrangements (MEWAs)³ and shutdown of plans that conduct fraudulent activities.

MEWAs will be required to register with DOL and will be subject to criminal penalties for false statements in marketing materials.

Increased Transparency, Reduced Conflicts of Interest

The legislation requires manufacturers of drugs, devices, and medical supplies to report all but *de minimis* payments (single payments under \$10 and aggregate amounts under \$100 a year) to physicians or teaching hospitals. The legislation also—

- Requires manufacturers and distributors to report to HHS on prescription drug samples given to physicians;
- Requires pharmacy benefit managers who contract with Medicare or a health insurance exchange to report to HHS on rebates, discounts, and other price concessions to health plans;
- Bars physician-owned hospitals from Medicare participation unless grandfathered;
- Requires Medicare and Medicaid nursing homes to (1) disclose ownership information; (2) adopt antifraud compliance and ethics programs; and (3) provide 60-day advance notice of closure;

- Requires owners and employees to report suspected crimes committed at a nursing home; and
- Requires HHS to conduct a national independent monitoring demonstration of large nursing home chains.

Stronger Oversight and Enforcement

The legislation directs the Office of Inspector General and the Department of Justice to analyze claims and payment data for federal programs held in the Integrated Data Repository to detect fraud and abuse. In addition, the legislation—

- Authorizes the Internal Revenue Service and HHS to share data to help identify fraudulent and tax-delinquent providers;
 - Requires providers to automatically return Medicare and Medicaid overpayments within 60 days;
 - Allows providers and suppliers who furnish false information to be fined up to \$50,000 and excluded from federal health programs;
- Strengthens fines and penalties for violations by Medicare Advantage and Part D plans; and
- Ensures that providers who are terminated under Medicare are also automatically terminated under Medicaid.

Endnotes

¹ FBI Federal Crimes Report for FY 2007. Available at http://www.fbi.gov/stats-services/publications/fcs_report2007.

² J. E. Wennberg et al., “Geography and the Debate Over Medicare Reform,” *Health Affairs*, W96–W114 (Feb. 13, 2002).

³ MEWAs allow small employers to pool their contributions to purchase group health and other insurance benefits for their employees.

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