Fraud, Waste, and Abuse Toolkit

Health Care Fraud and Program Integrity: An Overview for Providers

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Content Summary

This booklet addresses common types of Medicaid fraud, waste, and abuse so that providers may recognize, report, and prevent them. The booklet also addresses some of the program integrity measures against such activities. The focus of the discussion is primarily on fee-for-service providers rather than cost-based services such as nursing homes. Examples illustrate different types of fraud, waste, and abuse and the consequences for engaging in these activities. The booklet concludes with how to report fraud, waste, and abuse and measures that may be taken to prevent them.

Fraud, waste, and abuse divert significant resources away from necessary Medicaid services. Recent figures on the Medicaid program illustrate the scale of the problem. In 2015 Medicaid covered medical expenses for more than 70 million beneficiaries enrolled in 56 State- and territory-administered programs. According to the Centers for Medicare & Medicaid Services (CMS), the cost of this coverage in fiscal year (FY) 2015 was $547.7 billion. The Federal government paid $341.6 billion of that amount.[1] The Government Accountability Office (GAO) designated Medicaid as a program at high risk for improper payments because of the vulnerability to fraud, waste, and abuse. Improper payments "include those made for treatments or services that were not covered by program rules, that were not medically necessary, or that were billed for but never provided."[2]

The U.S. Office of Management and Budget estimates that improper payments made under the Medicaid program totaled $29.12 billion in FY 2015. This figure represents

a 9.78 percent improper payment rate.[3] Becoming aware of the extent and nature of the problem may put health care professionals in a better position to help prevent and detect Medicaid fraud, while also protecting their practices and the Medicaid program.

Definitions and Comparison

Before considering common types of health care fraud, waste, and abuse, reviewing term definitions may be helpful. Waste is not defined in the rules, but "is generally understood to encompass the overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act."[4] Examples of waste by a beneficiary could include making excessive office visits or accumulating more prescription medications than necessary for the treatment of specific conditions. Waste by a provider could include ordering excessive laboratory tests such as a comprehensive metabolic panel; ordering a group of blood tests, when only one test is needed; or ordering magnetic resonance imaging (MRI) instead of a mammogram for preventive care.

Abuse is defined in the Medicaid rules as:

> Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.[5]

A provider can abuse the Medicaid program even if there is no intent to deceive. Fraud is different and involves intent.

Providers, beneficiaries, corporate officials, and others can commit health care fraud. The rules governing Medicaid define "fraud" as:

> An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.[6]

For purposes of enforcement, there is a difference between unintentional mistakes and fraudulent or abusive behavior. For example, submitting an erroneous claim for payment is different from submitting the same claim "with actual knowledge of the falsity of the claim, reckless disregard, or deliberate ignorance of the falsity of the claim."[7] An honest mistake should lead to the return of funds to Medicaid. Providers who improperly bill for services and beneficiaries who cause unnecessary costs risk losing continued eligibility to participate in the Medicaid program and may face criminal and civil monetary penalties.[8]

Types of Fraud, Waste, and Abuse

Fraud, waste, and abuse in the Medicaid program may occur in many different ways, including:

- Medical identity theft;
- Billing for unnecessary services or items;
- Billing for services or items not rendered;
- Upcoding;
- Unbundling;
- Billing for noncovered services or items;
- Kickbacks; and
- Beneficiary fraud.

Medical Identity Theft

Medical identity theft involves the misuse of a person's medical identity to wrongfully obtain health care goods, services, or funds. Specifically, medical identity theft is defined as "the appropriation or misuse of a patient's or [provider's] unique medical identifying information to obtain or bill public or private payers for fraudulent medical goods or services."[9] A new Federal law describes identity theft in more detail for Federal health programs: the act of an individual who "without lawful authority knowingly and willfully purchases, sells or distributes, or arranges for the purchase, sale, or distribution of a beneficiary identification number or unique health identifier for a health care provider" in Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).[10]

Unique medical identifying information for physicians includes the National Provider Identifier, Tax Identification Number, U.S. Drug Enforcement Administration number, and State medical license number. Physician medical identifiers are used, for example, to identify the physician of record on claims or for tracking purposes. Fraudsters may use stolen physician identifiers to fill fraudulent prescriptions, refer patients for unnecessary additional services or supplies, or bill for services never provided.

Beneficiary medical identifiers include Medicaid cards and numbers. Fraudsters may use these identifiers to support fraudulent billings for services or items not provided, or to enable an ineligible person to receive services by impersonating the beneficiary. A beneficiary guilty of card sharing (that is, a person who shares his or her card to help another) may not mean to cause harm to the Medicaid program. No matter the intent, card sharing is considered fraud, hurts the Medicaid program, and can also hurt the person who shares their card.

The following examples illustrate the issues associated with identity theft:

- A Nebraska pharmacist was sentenced to 110 months in prison followed by 3 years of supervised release after pleading guilty to 12 counts of health care fraud and 6 counts of identity theft. The pharmacist forged provider names and credentials and used the names of children of his customers, all of whom were unaware of the scheme, to bill prescriptions for an expensive cystic fibrosis drug, TOBI, he never dispensed and for patients who did not have the disease. Nebraska Medicaid paid him over $14.4 million on those claims, much of which supported a gambling addiction. He was ordered to repay the entire $14.4 million and also had property seized. The Nebraska Medicaid Fraud Control Unit (MFCU) noticed the higher-than-normal utilization of TOBI from this provider, and a subsequent investigation helped put a stop to this fraudulent scheme.[11]
- The owner of a Texas durable medical equipment (DME) company, his wife, and other employees admitted to participating in a fraud scheme that involved recruiting beneficiaries to give up their Medicare or Medicaid numbers, misappropriating physicians' medical identifiers, submitting fraudulent billings, and submitting up to $11 million in false claims, representing about 85 percent of their income. In many instances the physicians did not see the patients, and beneficiaries never received the items ordered in their names. In 2013, the owner was sentenced to 12 years in prison and ordered to pay $6.1 million in restitution.[12]
- A Louisiana provider was convicted on 18 counts of health care fraud, conspiracy, and kickbacks. She used recruiters to obtain Medicare numbers and subsequently billed Medicare for DME and orthotics that patients did not need or want, and in some cases were not provided. A large portion of the $3.2 million in claims she billed to Medicare were fraudulent. Additionally she upcoded back and knee braces to more expensive versions while providing cheaper versions to the patients. The press release does not indicate if any other medical providers were implicated or compromised in the scheme.[13]

Health care professionals may help prevent identity theft by managing enrollment information with payers, updating their practice location and reimbursement accounts, monitoring billing and compliance processes, controlling unique medical identifiers and prescription pads, educating and training staff, and making patients aware of the risks of medical identity theft. An example of how monitoring billing processes could have revealed identity theft comes from one of the cases mentioned above. One of the providers whose identity was compromised by the Nebraska pharmacist had 185 Medicaid claims with his information, and he denied in an affidavit that he had written any of the prescriptions in the fraud scheme.[14]

Providers may obtain more information by reviewing the booklet titled "Medicaid Program Integrity: Understanding and Preventing Provider Medical Identity Theft"

available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Med-ID-Theft-Booklet-ICN908264.pdf on the CMS website. Additionally, a web-based training course titled "Safeguarding Your Medical Identity," approved for continuing medical education (CME) credit, is posted to the CMS website. To register for this course, visit https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html on the CMS website.

Billing for Unnecessary Services or Items

The Federal Medicaid statute authorizes payment for items and services included in each State's approved plan.[15] The included items and services vary from State to State. Only those items and services included in the relevant State's plan are authorized. Even if an item or service is authorized, it is not billable under Medicaid unless it is also medically necessary.

Under Section 1902(a)(30)(A) of the Social Security Act, States are required to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan … as may be necessary to safeguard against unnecessary utilization of such care and services."[16] Under the regulations implementing this requirement, CMS says, States may "place appropriate limits on a service based on such criteria as medical necessity."[17] For Medicaid, each State defines medical necessity. Health care professionals are responsible for ensuring services meet the definition of medical necessity, or are otherwise authorized, in the States where they practice. When a physician signs billing documents, he or she certifies the truth, accuracy, and completeness of the claims.[18]

Billing for unnecessary services may involve misrepresenting symptoms in the patient's medical record and performing procedures putting their health at risk. For example, a hematologist-oncologist in Michigan was convicted of 13 counts of health care fraud in addition to other related charges in connection with a scheme to defraud Medicare by providing unnecessary cancer treatments and other unnecessary treatments and services to patients, some of whom did not have cancer. The physician "callously violated his patients' trust as he used false cancer diagnoses and unwarranted and dangerous treatments as tools to steal millions of dollars from Medicare, even stooping to profit from the last days of some patients' lives." He provided and administered "unnecessary aggressive chemotherapy, cancer treatments, intravenous iron and other infusion therapies to patients [and] … unnecessary and expensive positron emission tomography (PET) scans." On July 10, 2015, he was sentenced to 45 years in prison and ordered to forfeit $17.6 million in restitution.[19]

This example shows how unnecessary services may jeopardize the health of beneficiaries by subjecting them to the risks of treatment without the benefits. Specifically, each patient was needlessly subjected to the risks of aggressive and invasive cancer therapy and other treatments.[20]

Additional examples of billing for unnecessary services or items include:

- A Maine nursing home agreed to pay a $300,000 settlement to resolve allegations their therapy contractor provided unreasonable, unnecessary, or unskilled rehabilitation therapy;[21]
- A Massachusetts doctor was "sentenced to 360 days in the House of Correction, with 11 months to serve, and the balance suspended for 10 years," and he and his clinic were ordered to pay $9.3 million for giving kickbacks to rehabilitation homes for referring residents of the homes for drug urine tests to his laboratory, even though he never saw the patients in his clinics and failed to determine if such tests were medically necessary;[22] and
- The city of Dallas, Texas, was ordered to pay a $2.47 million settlement for allegedly ordering its billing company to always bill 911-dispatched medical transportation as ambulance transports (advance life support) even when patients only needed basic life support transport.[23]

Billing for Services or Items Not Provided

A billed service or supply must be provided to be covered by Medicaid. Providing different services or supplies is no justification for submitting a bill for a service or supply not provided. Some health care professionals bill Medicaid for a covered service or item but do not provide the service or item. For example, in support of claims submitted to Illinois Medicaid, a personal care attendant filled out time sheets and forged a beneficiary's signature stating he provided care to the beneficiary even though the attendant moved from the area and never provided the service. He billed a Medicaid waiver program for the services. He pleaded guilty to stealing from a health care program, was sentenced to 2 years of probation with 4 months' home confinement, and was ordered to pay $6,660.75 in restitution to the Medicaid program.[24] Providers may only bill for the medically necessary or otherwise authorized services or items provided to beneficiaries.

Upcoding

Upcoding is an undefined term in Federal Medicaid regulations, but it is generally understood as billing for services at a level of complexity higher than the service actually provided or documented.[25] For example, after a peer review audit found a

St. Louis psychiatrist billed Medicaid for 20-minute sessions after spending 5 minutes or less with patients, the psychiatrist and his employers agreed to pay $441,870 to Medicaid to settle upcoding allegations. The psychiatrist pleaded guilty to making a false statement during the course of an investigation to the Federal Bureau of Investigation (FBI).[26] He was sentenced to 5 months' imprisonment, forfeiture of $100,000, and payment of a $30,000 fine.[27]

Another example of upcoding involves a Florida physician who ordered discounted drugs unapproved by the U.S. Food and Drug Administration (FDA). She administered them to unsuspecting patients, but billed for more expensive FDA-approved drugs. Additionally, she submitted false diagnosis codes and billed for medically unnecessary tests. As a result of those instances and several other false claims, she was convicted in May 2016 of 162 counts of health care fraud. She can receive up to 10 years in prison for each count at her sentencing.[28]

A final example of upcoding is billing for complex office visits when only simple office visits occurred. The CEO of an Illinois health care company and one of his physician employees were found guilty of upcoding basic home visits to more complex evaluations, usually reserved for moderate to high severity cases. The physician employee also certified some patients as homebound when they were not. They defrauded Medicare and the Railroad Retirement Board of over $1.8 million.[29, 30] As this case illustrates, providers may only bill at the level of the services or items actually furnished to beneficiaries.

Unbundling

According to the FBI, unbundling "is the practice of submitting bills in a fragmented fashion in order to maximize the reimbursement for various tests or procedures that are required to be billed together at a reduced cost."[31] For example, a medical billing company convinced three medical groups they could make more money offering nuclear stress test services in their offices, but then billed such services twice, manipulating the codes. They also billed a separate code for interpreting the images, even though that service is covered in the stress test code.[32]

Cases of unbundling have arisen in the context of laboratory providers. In this type of scenario, a physician orders a panel of tests for a patient and the laboratory is supposed to seek reimbursement for the entire panel at one price. Instead, the laboratory unbundles the tests and bills for each test individually to increase total reimbursement.[33] Unbundling inflates the cost of Medicaid services and items. Providers should be familiar with their State's Medicaid rules regarding which services and items are bundled together when billed, bearing in mind that specific Medicaid requirements may vary from State to State.

Noncovered Services or Items

Fraud, waste, and abuse may involve services that are provided but not covered by Medicaid or Medicare. For example, under Medicare, an eligible woman may receive one screening mammogram once every 12 months and a diagnostic mammogram when medically necessary.[34] However, an oncologist at a Maryland hospital allegedly falsified diagnoses for women so that he and the hospital could bill for the more expensive diagnostic mammogram, and upcoded screening mammograms that otherwise would not have been covered because of frequency. In April 2016, the hospital and the oncologist were ordered to pay $400,000 to settle the fraud allegations.[35]

Another example of billing for services not covered, involves a Vermont physician billing for non-FDA-approved chemotherapy medications he purchased from Canada and allegedly used in patient treatments. To resolve the allegations, he and his company agreed to repay Medicare and Medicaid $500,000.[36] Health care professionals may face consequences if they bill for services, supplies, and items not covered, particularly if the bills are disguised in this manner.

Kickbacks

Rewarding sources of new business may be acceptable in some industries, but not when Federal health care programs are involved.[37, 38] Kickbacks in health care can lead to overutilization, increased program costs, corruption of medical decision-making, patient steering, and unfair competition. For example, the prior owners of a company providing pharmacy services through home delivery gave gift cards and routinely waived beneficiary copayments to generate referrals or enrollment of Medicare and Medicaid patients as customers. The current owners agreed to a civil settlement of $5 million for damages and penalties that occurred prior to their ownership.[39] Claims resolved under civil settlement are considered allegations and therefore no determination of liability was made.

Visit the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) online at https://oig.hhs.gov/fraud/enforcement/index.asp to learn about the full range of provider fraud prosecutions and settlements.

Beneficiary Fraud

Medicaid beneficiaries also participate in fraud, waste, and abuse. Common forms of beneficiary fraud include eligibility fraud, card sharing, doctor shopping, and drug diversion. Eligibility fraud involves misrepresenting one's circumstances to obtain program coverage for which one does not qualify.[40, 41] Card sharing occurs when a beneficiary shares his or her Medicaid identity card with a person who is not covered so the noncovered person may receive services in the beneficiary's name. This practice may expose the beneficiary to the danger of identity theft and compromise the integrity

of the beneficiary's medical record. Health care professionals should require an additional form of identification to discourage card sharing.

Doctor shopping involves beneficiaries visiting different providers to obtain multiple prescriptions for the same or a similar type of drug. This practice may endanger the beneficiary's health and subject the Medicaid program to unnecessary expense. Useful tools to prevent this practice are prescription drug monitoring programs (PDMPs), which are statewide electronic databases that collect information on controlled substance prescriptions. Prescribers in most States have access to such databases.[42] Through access to these databases, a prescriber can see whether another prescriber already wrote a prescription that is the same as or similar to the one the patient is requesting. Health care professionals with questions about access to such a database in their State may contact their State professional licensing body or visit the website of the National Alliance for Model State Drug Laws at http://www.namsdl.org/prescription-monitoring-programs.cfm for more information. Florida is an example of a State with an effective PDMP. The State of Florida reported a 65 percent reduction in doctor shopping in their 2015 PDMP annual report.[43]

Drug diversion is the deflection of prescription drugs from medical sources into the illegal market[44] or the use of prescription drugs for illegal or nonmedical purposes. Drug diversion may be accomplished by forging or altering prescriptions, by obtaining prescriptions under false pretenses, or by colluding with a willing prescriber. For example, a Pennsylvania physician and one of his patients pleaded guilty to drug diversion. The physician wrote prescriptions for the patient, Medicare paid for them, but they were delivered to two different persons on separate occasions.[45]

By being aware of beneficiary fraud and provider schemes, health care professionals are better equipped to recognize them. Providers who suspect beneficiary fraud should report it to their State Medicaid agency (SMA).

Health Care Fraud Laws

As illustrated by the cases discussed, there are a variety of Federal and State laws, both civil and criminal, to deter and punish fraud in Medicaid. Major Federal laws include, but are not limited to:

- The Health Care Fraud Statute;
- The False Claims Act;
- The Anti-Kickback Statute;
- The Patient Access and Medicare Protection Act

- Exclusion provisions; and
- The Civil Monetary Penalties Law.

Many States have similar laws. For example, a number of States, including California,[46] New York,[47] and Texas,[48] have State false claims acts that punish false claims made to State Medicaid programs.[49] These three States also have anti-kickback statutes.[50, 51, 52]

All of the Federal laws listed, except for the Health Care Fraud Statute and the new Patient Access and Medicare Protection Act, are discussed in a web-based training course offered by HHS-OIG titled "Avoiding Medicare Fraud and Abuse: A Roadmap for Physicians." The course is approved for continuing education credit. Course information is posted to https://oig.hhs.gov/compliance/101/cme.asp on the HHS-OIG website.

Exclusion Provisions

Under Section 1128 of the Social Security Act, HHS-OIG has authority to exclude individuals from participating in Federal health care programs, including Medicaid, for various reasons. Exclusions can be mandatory, meaning the HHS-OIG has no choice about whether to exclude, or discretionary, which means the HHS-OIG does have a choice. Exclusion is mandatory for convictions of program-related crimes, convictions relating to patient abuse, felony convictions relating to health care fraud, and felony convictions relating to controlled substances. Exclusion is discretionary for loss of license due to professional competence or financial integrity concerns, convictions relating to fraud, convictions relating to obstruction of an investigation or audit, misdemeanor convictions relating to controlled substances, and participation in prohibited conduct such as kickbacks and false statements.[53]

As a Federal health care program, Medicaid will not pay for items or services ordered, prescribed, or supplied by an excluded individual or entity.[54] If someone on a provider's staff is excluded from participation in a Federal health care program, the provider should not bill any Federal health care programs for any items or services furnished, ordered, or prescribed by the excluded individual. "Furnished" is a key word that refers to items or services provided or supplied, directly or indirectly, by an excluded individual or entity.[55]

While a health care professional who provides services through Medicaid may employ an excluded individual who does not provide any items or services paid for, directly or indirectly, by Federal health care programs,[56] health care professionals should exercise caution here. A professional who contracts with or employs "a person that the provider knows or should know is excluded by HHS-OIG … may be subject to CMP [Civil Monetary Penalty] liability if the excluded person provides services payable, directly or indirectly, by a Federal health care program."[57] The prohibition

is not limited to items or services involving direct patient care, but extends to filling prescriptions, providing transportation services, and performing administrative and management services not separately billable.[58] If, for example, a biller is excluded from a government health care program, payments on claims submitted by the practice through the biller may be considered overpayments subject to recoupment.

It is in the best interest of providers to screen potential employees and contractors prior to employment or contracting to ensure they are not excluded from participating in Federal health care programs. Additionally, providers should regularly check the List of Excluded Individuals/Entities (LEIE) database to ensure that none of the practice's employees or contractors have been excluded. CMS has issued guidance to SMAs that they should require providers to screen their employees and contractors for exclusions by checking the database on a monthly basis. The guidance further advises States to require all providers to immediately report any exclusion information discovered.[59]

The LEIE database is available at https://exclusions.oig.hhs.gov/ on the HHS-OIG website. Both licensed and unlicensed individuals may be excluded, so it is best to check for both. Providers should also check the Exclusions Extract available at https://www.sam.gov/portal/SAM/#1 on the System for Award Management website.

Fraud Detection, Prosecution, and Recovery

U.S. Department of Justice and Office of Inspector General

Through enforcement of the health care fraud laws and other actions, the government has taken significant steps against fraud in health care. In fiscal year (FY) 2015, the combined health care fraud enforcement efforts of the U.S. Department of Justice and the U.S. Department of Health and Human Services recovered $1.6 billion in taxpayer dollars for the Medicare Trust Fund and another $800 million to the Treasury and private individuals affected by fraud. A total of 613 defendants were convicted of health care fraud related crimes, and Federal prosecutors charged 888 defendants in 463 separate cases with health care fraud related crimes, which was also a record. In addition, of the over 4,100 individuals and entities HHS-OIG excluded in FY 2015, more than 1,300 were excluded because of Medicare- or Medicaid-related criminal convictions.[60]

Medicaid Fraud Control Units

States actively enforce health care fraud laws in Medicaid cases through their respective MFCUs. The HHS-OIG MFCU Statistical Data sheet for FY 2015 showed 1,553 criminal convictions and 795 civil settlements and judgments against providers. The SMAs recovered more than $744 million for the Medicaid program in FY 2015.[61]

Monitoring and Auditing

Investigations that lead to criminal charges often start with the identification of improper payments. There are a number of ways the government may identify improper Medicaid payments, including:

- CMS' Payment Error Rate Measurement (PERM) program, which measures and reports improper payments in Medicaid and identifies common errors;[62]
- Audit Medicaid Integrity Contractors (Audit MICs), which contract with CMS to perform audits and identify overpayments;[63] and
- Medicaid Recovery Audit Contractors (RACs), which contract with States to audit providers and identify overpayments.[64]

CMS, through its Center for Program Integrity, undertakes or oversees other significant anti-fraud efforts. These include tracking medical identity theft; providing a remediation process for the victims of medical identity theft; using predictive modeling to identify suspect claims before payment; screening providers at enrollment; suspending payments during the investigation of a credible allegation of fraud; and imposing more rigorous requirements on State Medicaid programs for terminating providers for cause across Medicaid programs as discussed in the Reciprocal Termination section later in this booklet.[65]

Anti-Fraud Efforts

Screening of Providers

Medicaid rules require that SMAs screen providers before enrollment. This screening searches for certain information depending on an assigned categorical risk of fraud.[66] All providers are screened to ensure current licensure and to determine whether they have been excluded from Federal health care programs or have been terminated from such programs for cause. Providers may fall into a high-risk category because of provider type or adverse actions such as previous exclusions, terminations, or payment suspensions. These providers may be subject to additional screening, including a fingerprint-based criminal background check.[67] In its FY 2015 annual report, HHS identified State difficulties with implementing risk-based screening on new providers as a main cause of the increase in the improper payment rate.[68, 69, 70] The objective is to prevent fraud on the front end rather than paying claims and then chasing providers to recover lost funds.[71]

Suspension of Payments

Federal regulations require States to suspend Medicaid payments to providers whenever they determine that a credible allegation of fraud exists and there is a pending investigation became effective in February 2011.[72] A "credible allegation"

is one "which has been verified by the State," has indicia of reliability, and has been reviewed carefully in light of all the evidence on a case-by-case basis.[73] When the SMA verifies and reviews an allegation and finds that indicia of reliability, they refer the case to the MFCU, where it is investigated as a "credible allegation."

Reciprocal Termination

Before the Affordable Care Act, State actions to terminate providers from Medicaid for cause only applied to the State that took the action. The Affordable Care Act requires an SMA to terminate any provider (individual or entity) that has been terminated by Medicare or another State Medicaid program.[74] Through rulemaking, CMS defined termination to only apply to those providers who are terminated for cause—for reasons of fraud, integrity, or quality—and expanded the requirements to include the Children's Health Insurance Program (CHIP).[75, 76] Therefore, if a provider is terminated for cause by Medicare, or a State's Medicaid program or CHIP, the provider is required to be terminated by Medicaid and CHIP programs in other States.

To learn about other new means of fighting fraud, refer to https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/BackgrounderFraudPreventionInitiative.pdf posted to the CMS website.

How to Report Fraud, Waste, and Abuse

Prevention and fraud, waste, and abuse detection is not solely the government's responsibility. Providers play an important role. Legitimate providers and the government share the same goal: provision of quality medical care appropriately documented and billed. If a provider learns something that indicates another provider may be engaging in suspect practices, several options are available for reporting. Suspect provider practices may be reported to:

- The SMA;
- The MFCU;
  - Contact information for SMAs and MFCUs is posted to https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/fraudabuseforconsumers/report_fraud_and_suspected_fraud.html on the CMS website; and
- HHS-OIG
  - 1-800-HHS-TIPS
  - https://forms.oig.hhs.gov/hotlineoperations

You can report fraud anonymously, but it is helpful if you provide your telephone number or email address, allowing investigators to contact you for more information, if needed. If you do give your contact information, your identity will be protected to the maximum extent provided by the law. When reporting suspected fraud, waste, and abuse, you should include:

- The contact information for the source of the information, suspects, and witnesses;
- The details of the alleged fraud, waste, and abuse;
- Identification of the specific Medicare or Medicaid rules allegedly violated; and
- The suspect's history of compliance, education, training, and communication with your organization or other entities.

A provider who suspects a beneficiary issue, such as card sharing or eligibility fraud, should report the issue to their SMA.

Compliance Programs: Prevention by Providers

In addition to reporting suspect practices, providers may take steps to prevent fraud, waste, and abuse, including:

- Knowing the regulations and laws governing the services offered by the practice;
- Screening potential and existing employees and contractors for current exclusion, or grounds for exclusion, by HHS-OIG; and
- Implementing a compliance program.

Under Section 1128J(d) of the Social Security Act, any provider who has received funds he or she is not entitled to under the Medicaid program is required to return the funds to the State within 60 days of the date the overpayment was identified.[77]

Providers may benefit from adopting a compliance program. HHS-OIG and CMS have recommended seven basic elements of a compliance program:

- Conducting internal monitoring and auditing;
- Implementing written standards and procedures;
- Designating a compliance officer or contact(s) to monitor compliance;
- Conducting training and education on standards and procedures;

- Developing corrective action plans to respond to detected violations;
- Developing open lines of communication; and
- Enforcing disciplinary standards through well-publicized guidelines.[78, 79]

Implementing a compliance program is voluntary for certain providers and suppliers,[80] but the Affordable Care Act[81, 82] requires the Secretary of HHS to establish, as a condition of enrollment in Medicare and Medicaid, a compliance "program" containing core elements for providers or suppliers within a particular industry or category.[83] A recent final rule for Medicaid managed care has identified elements of a compliance program that expanded on the HHS-OIG recommendations. Changes include mandatory reporting to the State of potential fraud, waste, abuse, and changes in provider circumstances that may affect participation.[84]

Providers who create an internal compliance program to prevent fraud, waste, and abuse may consult guidance from HHS-OIG by visiting https://oig.hhs.gov/fraud/complianceguidance.asp on the HHS-OIG website. Guidance is available for different provider types, ranging from hospitals to small or solo physician practices. Additional compliance materials have been posted to https://oig.hhs.gov/newsroom/video/2011/heat_modules.asp on the HHS-OIG website.

Conclusion

Providers play an important role in preserving the solvency of the Medicaid program, protecting beneficiaries from harm, and preventing fraud, waste, and abuse. By understanding common forms of fraud, waste, and abuse, providers will be better able to recognize, report, and prevent them. By following the applicable rules, reporting suspected violations, and taking preventive measures in their own practices, providers may help protect their practices and at the same time make a valuable contribution in the fight against fraud, waste, and abuse.

To see the electronic version of this booklet and the other products included in the "Fraud, Waste, and Abuse" Toolkit posted to the Medicaid Program Integrity Education page, visit https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html on the CMS website.

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