Report on
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Trump Includes $70M More to Fight Fraud, Prevent Overpayments

President Trump's budget blueprint calls for spending more money to fight health care fraud and to ramp up the prevention of overpayments so auditors and enforcers spend less time chasing ill-gotten Medicare dollars after they've gone out the door. CMS has been moving away from "pay and chase" for years, and the Trump administration said it would push that approach. In addition, the budget blueprint calls for an additional $70 million in "discretionary funding" for the Health Care Fraud and Abuse Control program in fiscal year 2018.

"On its face, it looks like they're going in the right direction," says Peter Budetti, a physician-lawyer who is the former deputy CMS administrator for program integrity. But he'd like to see more emphasis on audits and investigations of fraud in Medicare Advantage (Part C) and the prescription-drug program (Part D) and an expansion of the Medicare rewards program for beneficiary whistleblowers.

"Everything we've talked about so far only speaks to fighting fee-for-service fraud. More attention needs to be paid to fraud in Medicare Advantage and Part D," Budetti tells *RMC*. "That has lagged way behind."

In a proposed 2013 enrollment rule, CMS included new requirements for the Medicare Incentive Reward Program. It markedly increased rewards for beneficiaries and others who have direct information, such as their own claims, about providers and suppliers who game Medicare. The reward would have risen from a maximum of $1,000 to 15% of the final amount collected applied to the first $66,000,000, which is almost $10 million, but CMS never finalized the changes to the 20-year-old rewards program. The CMS whistleblowers are different from whistleblowers through the *qui tam* provisions of the False Claims Act because it's an administrative program. Patients don't have to mount a lawsuit, survive legal challenges and then wait years for the disposition of the case. The reward program is for patients who suspect their providers are up to no good, and they don't need an attorney.

In terms of controlling fraud, Budetti says the "biggest breakthrough" in recent years has been the CMS Fraud Prevention System, which was implemented in 2011. The Fraud Prevention System screens all Medicare Part A and B claims before payment, running every claim against multiple models that address different types of vulnerabilities and schemes. It taps into the Integrated Data Repository, which includes claims, beneficiary data and Part D drug information, and uses other resources, including compromised beneficiary Medicare identification numbers. He says it has a return on investment of 11 to one, and the Fraud Prevention System 2.0 is about to be implemented.

A $70 million increase "would be very useful if spent the right way," says Budetti, now with Phillips & Cohen, a law firm representing whistleblowers.

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