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Insights

President's Proposed Budget Makes Deep Cuts, But Seeks Increases To Medicare Fraud Fight

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President Trump's March 16 "America First: A Budget Blueprint to Make America Great Again," proposes to cut $15.1 billion in Department of Health and Human Services ("HHS") spending, representing a nearly 18% reduction in annual spending.[1] The cuts target many entrenched programs and grants, including the National Institutes of Health and federally-backed nursing training programs. On the other hand, the proposed budget calls for increased spending in the federal government's fight against health care fraud, affirming HHS Secretary Tom Price's commitment to preventing waste, fraud, and abuse across the department, particularly within the Medicare and Medicaid programs.

What does proposed spending increases for HHS' fraud and abuse monitoring look like? The Health Care Fraud and Abuse Control (HCFAC) account represents the biggest beneficiary of the spending increases. The HCFAC program coordinates federal, state, and local law enforcement activities related to health-care fraud and abuse. HCFAC initiatives won or negotiated over $2.5 billion in judgments and settlements in 2016 alone, and has increased return on investment to $5 returned for every $1 invested. To summarize, an increased HCFAC budget likely equates to increased fraud and abuse judgments and settlements against providers.[2]

Increased HCFAC funding will likely stream to HHS' Health Care Fraud Prevention and Enforcement Action Team ("HEAT"), meaning Medicare Fraud Strike Force Teams will receive additional support to reduce Medicare fraud and recover taxpayer dollars. While Medicare fraud and abuse enforcement is emboldened by the proposed increases, questions remain regarding Medicaid fraud enforcement. Subsequent budget proposals or legislation may provide clearer guidance regarding this issue.

While the President's proposed budget is only an outline, an agreeable Congress may work to integrate President Trump's proposed measures in an actionable budget. In that instance, the onus is on Medicare-certified providers to ensure that their operations are in compliance with all applicable fraud and abuse rules. In the face of increased scrutiny, intensive program review and continued compliance are a provider's best practice against negative fraud and abuse findings. Despite the budget's limited mention of Medicaid fraud enforcement, Medicaid providers should nevertheless remain vigilant in compliance of the current fraud and abuse criteria.

The healthcare practice group at Krieg DeVault LLP provides its clients with the legal expertise required by today's sophisticated healthcare. If you would like to further discuss your fraud and abuse questions or strategies for program compliance, please contact Thomas N. Hutchinson.

[1] https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/budget/fy2018/2018_blueprint.pdf

[2] https://oig.hhs.gov/publications/docs/hcfac/FY2016-hcfac.pdf