

The Affordable Care Act: New Tools to Fight Fraud, Strengthen Medicare and Protect Taxpayer Dollars

The Affordable Care Act will improve and expand consumer protections, strengthen Medicare, and reduce health care costs. One important way it achieves these goals is by improving government-wide efforts to fight fraud and waste. The new law contains some critical new tools to improve and enhance the Administration's efforts to prevent, detect and take strong enforcement action against fraud in Medicare, Medicaid and the Children's Health Insurance Program as well as private insurance. The new law contains:

Tough New Rules and Sentences for Criminals: The Affordable Care Act directs the Sentencing Commission to increase the Federal sentencing guidelines for health care fraud offenses by 20-50% for crimes that involve more than \$1,000,000 in losses. The law makes obstructing a fraud investigation a crime and makes it easier for the government to recapture any funds acquired through fraudulent practices. And the law makes it easier for the Department of Justice (DOJ) to investigate potential fraud or wrongdoing at facilities like nursing homes.

Enhanced Screening and Other Enrollment Requirements: The Affordable Care Act provides critical tools for fraud prevention, including new authorities for stepped-up oversight of providers and suppliers participating or enrolling in Medicare, Medicaid, and CHIP such as mandatory licensure checks. Based on the level of risk of fraud, waste and abuse, providers could be subject to fingerprinting, site visits and criminal background checks before they begin billing Medicare, Medicaid, or CHIP. The Act also allows the Secretary to prohibit new providers from joining the program where necessary to prevent or combat fraud, waste or abuse. The law also allows the Secretary to withhold payment to any Medicare or Medicaid providers if a credible allegation of fraud has been made and an investigation is pending.

New Resources to Fight Fraud: The Affordable Care Act provides an additional \$350 million over the next ten years to help fight fraud through the Health Care Fraud and Abuse Control Account (HCFAC) from FY 2011 through 2020. The Act also allows these funds to support the hiring of new officials and agents that can help prevent and identify fraud.

Sharing Data to Fight Fraud: Building on the Obama Administration initiatives, the law requires the Secretary to expand the Centers for Medicare and Medicaid Services integrated data repository to include information from Medicaid, Veterans Administration, Department of Defense, Social Security Disability Insurance, and Indian Health Service, and enhances data matching agreements among Federal agencies. These agreements will make it easier for the Federal government to share data, identify criminals and prevent fraud. The DOJ and Office of the Inspector General (OIG) both receive clearer rights to access CMS claims and payment databases. The Secretary also now has authority to require States to report additional Medicaid data elements with respect to program integrity, program oversight and administration.

New Tools to Prevent Fraud: The Affordable Care Act requires providers and suppliers to establish plans detailing how they will follow the rules and prevent fraud as a condition of enrollment in Medicare, Medicaid, or CHIP. Other prevention provisions focus on high fraud-risk providers and suppliers including Durable Medical Equipment (DME) suppliers, home health agencies, and

Community Mental Health Centers (CMHCs). For example, CMHCs will now be required to serve at least 40 percent non-Medicare beneficiaries to crack down on centers that only bill Medicare and are not legitimate CMHCs.

The bill also strengthens the government's authority to require surety bonds as a condition of doing business with Medicare. To crack down on fraud in orders and referrals, providers and suppliers who order or refer certain items or services for Medicare beneficiaries will be required to enroll in Medicare and maintain documentation on orders and referrals.

Expanded Overpayment Recovery Efforts: The Secretary is provided new authorities to identify and recover overpayments through the expansion of Recovery Audit Contractors (RACs) to Medicaid, Medicare Advantage and Part D (the Medicare drug benefit). Providers, suppliers, Medicare Advantage plans, and Part D plans must self-report and return Medicare and Medicaid overpayments within 60 days of identification.

Enhanced Penalties to Deter Fraud and Abuse: The Affordable Care Act provides the OIG with the authority to impose stronger civil and monetary penalties on those found to have committed fraud. The Secretary also is provided new authority to prevent providers from participating in Medicare or Medicaid. For example, the Secretary may exclude providers and suppliers for providing false information on an application to enroll or participate in a Federal health care program. Individuals who order or prescribe an item or service while being excluded from a Federal health care program, make false statements on applications or contracts to participate in a Federal health care program and providers who identify a Medicare overpayment and do not return it are also subject to strict new fines and penalties under the new law. Finally, the law ensures that States may terminate a provider under Medicaid if a provider is terminated under Medicare or another State Medicaid program.

Greater Oversight of Private Insurance Abuses: The new law also provides enhanced tools and authorities to address abuses of multiple employer welfare arrangements and protect employers and employees from insurance scams. It also gives new powers to the Secretary and Inspector General to investigate and audit the health insurance Exchanges. This, plus the new rules to ensure accountability in the insurance industry, will protect consumers and increase the affordability of health care.

Implementation Progress to Date

The Administration is already at work implementing provisions in the Act to help fight fraud. On April 30, 2010, HHS issued an Interim Final Rule with Comment that:

- Requires inclusion of the National Provider Identifier on all applications and claims;
- Requires physicians and eligible professionals who order or refer supplies, items, or services to be Medicare enrolled; and,
- Requires physicians and suppliers to provide documentation of written orders for DME, home health or other items and services.
- CMS also issued guidance notifying providers and suppliers of the new 12 month claims submission deadline under the new law.