Summary of Anti-Fraud Provisions in the Affordable Care Act

The Patient Protection and Affordable Care Act, more commonly known as the Affordable Care Act, enacted in 2010, provides tools to prevent, detect and take strong enforcement action against fraud in Medicare, Medicaid and private insurance.

The Affordable Care Act (ACA) seeks to improve anti-fraud and abuse measures by focusing on prevention rather than the traditional "pay-and-chase" model of catching crooks after they have committed fraud. There are four principle ways the ACA seeks to make changes:

1. More money to prevent and fight fraud
2. Better screening and compliance
3. New penalties
4. Better data sharing

1. More money to prevent and fight fraud:

The ACA provides $350 million over 10 years (FY 2011 through FY 2020) through the Health Care Fraud and Abuse Control Account (HCFAC). The ACA also allows these funds to support the hiring of new officials and agents that can help prevent and identify fraud.

2. Better screening and compliance:

The ACA allows the Centers for Medicare & Medicaid Services (CMS) to conduct background checks, site visits, and other enhanced oversight to weed out fraudulent providers before they start billing the program. The ACA makes changes in the following areas:

a) **Screening and Disclosure.** Creates a national pre-enrollment screening program for all providers, and requires disclosure of prior association with delinquent providers or suppliers. States will have to screen providers to determine if they have a history of defrauding government. Those types of providers and suppliers that have been identified in the past as posing a higher risk of fraud (such as durable medical equipment suppliers) will be subject to a more thorough screening process.

b) **Licensing, Background Checks.** Increases oversight of providers and suppliers participating or enrolling in Medicare and Medicaid through mandatory licensure checks, fingerprinting of high-risk providers, site visits and criminal background checks before a provider can begin billing Medicare or Medicaid.

c) **Temporary Moratorium.** Allows the Health and Human Services (HHS) Secretary to prohibit new providers from joining the program where necessary to prevent or combat fraud, waste or abuse in certain geographic areas or for certain categories of services.

d) **Withholding Payments.** Allows the HHS Secretary to temporarily withhold payment to any Medicare or Medicaid provider if a credible allegation of fraud has been made and an investigation is pending.

e) **High-Risk Controls.** Places new controls on high-risk programs, like home health services or durable medical equipment, to ensure that only Medicare and Medicaid providers in good standing can provide these services. Providers and suppliers who order or refer DME or home health for Medicare beneficiaries must enroll in Medicare and maintain documentation on orders and referrals.

f) **Recovery Audit Contractors.** Expands the Recovery Audit Contractors (RACs) program to Medicaid, Medicare Advantage (Part C) and Medicare drug benefit (Part D) programs. Recovery Audit Contractors are CMS contractors that are used to detect and correct improper payments *after* Medicare has paid a bill. RACs will help identify and recover over and underpayments to providers under Medicare and Medicaid. Part C and Part D providers and suppliers must report and return Medicare and Medicaid overpayments within 60 days of identification.

g) **National Provider Identifier.** Requires providers to include their National Provider Identifier on all applications and claims.

h) **Surety Bonds.** Strengthens the government's authority to require surety bonds as a condition of doing business with Medicare.

i) **Compliance Plans.** Requires providers and suppliers to establish compliance plans ensuring that they are aware of anti-fraud requirements and utilize good governance practices.

j) **Claims Filing Limit.** Requires providers and suppliers to file fee-for-service claims within 12 months of providing the item or service.

3. New penalties to deter fraud and abuse:

The ACA better prevents unscrupulous providers from participating in Medicare or Medicaid in the first place and includes strict new fines and penalties. The ACA makes changes in the following areas:

a) **OIG Authority.** Provides the Office of Inspector General (OIG) with the authority to impose stronger civil and monetary penalties on providers who have committed fraud, including $50,000 for each false statement or misrepresentation of a material fact and $50,000 or triple the amount of the claim involved for providers who know of an overpayment but do not return it.

b) **Federal Sentencing Guidelines.** An ACA provision 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.

c) **Overpayments.** Allows new fines and penalties against providers who identify an overpayment from Medicare or Medicaid but do not return it within 60 days.

d) **Recapture.** Makes it easier for the government to recapture any funds acquired through fraudulent practices.

e) **New Penalties.** Creates new penalties for submitting false data on applications, false claims for payment, or for obstructing audits or investigations related to Medicare or Medicaid.

f) **Marketing Penalties.** Establishes new penalties for Medicare Advantage and Part D plans that violate marketing regulations or submit false bids, rebate reports, or other submissions to CMS.

g) **Nursing Homes.** The ACA makes it easier for the Department of Justice (DOJ) to investigate potential fraud or wrongdoing at facilities such as nursing homes.

4. Data sharing to identify fraud:

The ACA expands the CMS "integrated data repository" to incorporate data from all federally supported health care programs. The ACA makes changes in the following areas:

a) **Claims Data.** Requires certain claims data from Medicare, Medicaid and CHIP, the Veterans Administration, the Department of Defense, the Social Security Disability Insurance program, and the Indian Health Service to be centralized, thereby making it easier for agency and law enforcement officials to identify criminals and prevent fraud on a system-wide basis.

b) **Data Bank.** Creates a comprehensive Medicare and Medicaid Provider/Supplier Data Bank to conduct oversight of suspected utilization, prescribing patterns, and complex business arrangements that may conceal fraudulent activity.

c) **False Front Providers:** Allows use of the centralized database of compromised or stolen beneficiary and provider numbers to identify "false front" providers to prevent or recover overpayments, trigger administrative actions and support seizures by law enforcement.

d) **Data Access.** Gives the DOJ and OIG clearer rights to access CMS claims and payment databases.

e) **Medicaid Data.** Allows the HHS Secretary to require states to report additional Medicaid data elements with respect to program integrity, program oversight and administration.

f) **Termination Data.** Requires sharing information about providers who have been terminated from the Medicare program with state Medicaid agencies within 30 days of provider termination.