



Health Care Reform Anti-Fraud Provisions

Tip Sheet

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 principal 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

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.

More Money. 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.

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:

- 1) **Screening and Disclosure.** Creates a national pre-enrollment screening program for all providers, and requires disclosure of affiliation with providers and suppliers that have been the subject of certain adverse actions. States will be subject to similar requirements. 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.
- 2) **Licensing, Background Checks.** Increases oversight of providers and suppliers participating or enrolling in Medicare and Medicaid through mandatory licensure checks, fingerprinting and criminal background checks of certain high-risk providers, and site visits before a provider can begin billing the Medicare or Medicaid programs or Children's Health Insurance Program (CHIP).
- 3) **Temporary Moratorium.** Allows the Secretary of the Department of Health and Human Services (HHS) to prohibit new providers from enrolling in the federal programs where necessary to prevent or combat fraud, waste or abuse in certain geographic areas or for certain categories of services.
- 4) **Withholding Payments.** Allows the HHS Secretary to temporarily withhold payment to any Medicare or Medicaid provider based on a credible allegation of fraud and pending resolution of an investigation.

Protect, Detect, Report

- 5) **Required Medicare Enrollment.** Ensures that those who order and refer certain items and services on behalf of Medicare beneficiaries are enrolled in the Medicare program. Providers and suppliers must also maintain documentation on certain orders and referrals.
- 6) **Recovery Audit Contractors.** Expands the Recovery Audit Contractors (RACs) program to Medicaid, Medicare Advantage (Part C) and Medicare drug benefit (Part D) programs. Medicare RACs are CMS contractors that are used to detect and correct improper payments *after* Medicare has paid a bill. RACs will continue to help identify overpayments and underpayments in Medicare and recoup overpayments from providers participating in Medicare.
- 7) **National Provider Identifier.** Requires providers to include their National Provider Identifier on all applications and claims.
- 8) **Surety Bonds.** Strengthens the government's authority to require surety bonds as a condition of doing business with Medicare.
- 9) **Compliance Programs.** Requires providers and suppliers to establish compliance programs.
- 10) **Claims Filing Limit.** Requires Medicare providers and suppliers to file fee-for-service claims within 12 months of providing the item or service.

New Penalties. The ACA 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:

- 1) **OIG Authority.** Provides the Office of Inspector General (OIG) with the authority to impose stronger civil 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.
- 2) **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.
- 3) **Overpayments.** Requires providers and suppliers that identify an overpayment from Medicare or Medicaid to report and return the overpayment within 60 days.
- 4) **Recapture.** The law makes obstructing a fraud investigation a crime and makes it easier for the government to recapture any funds acquired through fraudulent practices.
- 5) **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.
- 6) **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.

Protect, Detect, Report

Better Data Sharing. 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:

- 1) **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.
- 2) **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.
- 3) **Data Access.** Gives DOJ and OIG better access to CMS claims and payment databases.
- 4) **Medicaid Data.** Allows the HHS Secretary to require states to report additional Medicaid data elements with respect to program integrity, program oversight and administration.
- 5) **Termination Data.** Requires that CMS establish a process for sharing information about providers and suppliers who have been terminated from the Medicare program or CHIP with state Medicaid agencies within 30 days of provider termination.

How Your Senior Medicare Patrol (SMP) Can Help

The local SMPs are ready to provide Medicare beneficiaries with the information they need to **PROTECT** seniors from Medicare errors, fraud and abuse; **DETECT** potential errors, fraud and abuse; and **REPORT** their concerns. SMPs use trained senior volunteers to help educate and empower older adults in the fight against health care fraud. The local SMP can help beneficiaries with questions, concerns or complaints about potential fraud and abuse issues. It also provides information and speakers for your facility.

For assistance, call your local SMP program: 1-800-247-4422



For more information or to locate your state SMP, visit www.smpresource.org
Supported by grant number 90NP0001/01 from the U.S. Administration on Aging (AoA),
Department of Health and Human Services

Protect, Detect, Report