Fraud, Waste and Abuse Provisions

Patient Protection and Affordable Care Act, PL 111-148
Health Care and Education Reconciliation Act, PL 111-152

Program for Criminal Background Checks of Long-Term Care Employees
(P.L. 111-148, Title VI, Subtitle C, Sec. 6201)

- HHS will establish a program for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis.
- Utilize a search of State-based abuse and neglect registries and databases, including
    - Abuse and neglect registries of another State in the case where a prospective employee previously resided in that State,
    - State criminal history records,
    - Records of any proceedings in the State that may contain disqualifying information about prospective employees (such as proceedings conducted by State professional licensing and disciplinary boards and State Medicaid Fraud Control Units).
- Federal criminal history records, including:
    - Fingerprint check using the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation.
- Under similar terms and conditions as the pilot program created by Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 2257),
    - Prohibition on hiring abusive workers
    - Authorization of the imposition of penalties by a participating State.

Enhanced Provider Screening and Enrollment Provisions: Medicare, Medicaid and CHIP
(P.L. 111-148, Title VI, Subtitle E, Sec. 6401)

- Requires HHS to establish new procedures for screening providers and suppliers within 180 days of enactment (September, 2010). The level of screening will be determined by level of potential risk:
    - Will include licensure check,
    - May include criminal background check, fingerprinting, unscheduled and unannounced site visits, database checks, and other appropriate screening as HHS determines.
- Application Fee
    - Individual providers will pay $200, institutional providers will pay $500.
    - Will increase based on consumer price index each year.
    - May be waived for some Medicaid providers for hardship.
- Requires provider and supplier applicants or those revalidating enrollment to disclose affiliations with a provider of medical or other items or services or supplier who:
    - Has uncollected debt, been or is subject to a payment suspension under a Federal health care program, been excluded from participation, or had its billing privileges denied or revoked.
- HHS may deny enrollment if previous affiliation is determined to cause undue risk of fraud, abuse or waste.

- Requires providers to establish compliance programs in order to participate in federal healthcare programs.
    - HHS, OIG will establish core elements of the programs for providers and suppliers within a particular industry or category.
    - Implementation date to be determined by HHS.
- Establishes a program for enhanced oversight for new Medicare, Medicaid, or CHIP providers such as prepayment review or payment caps.
- Authorizes HHS to adjust payments for providers of services and supplies with the same tax ID number for past-due obligations.
    - Even if provider is assigned a new billing number or national provider identification number.
- HHS is authorized to impose temporary moratoria on the enrollment of new providers in Medicare, Medicaid and CHIP if necessary to combat fraud, abuse and waste.
    - State not required to comply with HHS moratorium if it would adversely impact beneficiaries' access to medical assistance.
- All ordering or referring physicians or other professionals must be enrolled under the State Medicaid, CHIP or waiver plan.
- States will use the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to HHS.
- CMS will establish a process for making available the identity of any terminated provider or supplier under Medicare or CHIP to each state Medicaid or CHIP agency
- All Medicare, Medicaid, and CHIP providers will include their National Provider Identifier on enrollment applications and claims for payment by January 1, 2011. (P.L. 111-148, Title VI, Subtitle E, Sec. 6402)
    - Provider identifier of physician or other professional must be specified on any claim for payment that is based on an order or referral.

Medicare Integrity Program and Medicaid Integrity Program
(P.L. 111-148, Title VI, Subtitle E, Sec. 6402)

- Requires the Medicare Integrity Program and Medicaid Integrity Program contractors to provide the HHS and OIG as requested with performance statistics, including:
    - Number and amount of overpayments recovered,
    - Number of fraud referrals,
    - Return on investment for such activities.
- HHS will conduct evaluations of contractors not less frequently than every three years.
- HHS must annually report to Congress how the program funds were used and effectiveness of the program.
- CMS will include in the Integrated Data Repository (IDR) claims and payment data from:
    - Medicare (Parts A, B, C, and D), Medicaid, CHIP, and health-related programs administered by the Departments of Veterans Affairs (VA) and Defense (DOD), the Social Security Administration, and the Indian Health Service (IHS).
    - CMS, DOD, VA and IHS will enter data sharing agreements to help identify waste, fraud and abuse.

Medicaid Integrity Program
(P.L. 111-148)

- States must terminate individuals or providers from their Medicaid programs if they were terminated from Medicare or another state's Medicaid program. (Title VI, Subtitle F, Sec. 6501)
- Medicaid agencies must exclude individuals or entities from participating in Medicaid for a specified period of time if the entity or individual owns, controls, or manages an entity (Title VI, Subtitle F, Sec. 6502) that has:
    - Failed to repay overpayments during a specified period;
    - Been suspended, excluded, or terminated from participation in any Medicaid program; or
    - Been affiliated with an individual or entity that has been suspended, excluded, or terminated from Medicaid participation.
- State Medicaid plans must require any billing agents, clearinghouses, or other alternate payees that submit claims on behalf of health care providers to register with the state and the Secretary. (Title VI, Subtitle F, Sec. 6503)
- States must submit data from state mechanized claims processing and information retrieval system (under the Medicaid Statistical Information System) (Title VI, Subtitle F, Sec. 6504)
    - HHS will determine data necessary for program integrity, program oversight, and administration.
- Federal matching funds may be withheld from states that do not report enrollee encounter data to MSIS in a timely manner, as determined by HHS. (Title VI, Subtitle E, Sec. 6402)
- State mechanized Medicaid claims processing and information retrieval systems must incorporate methodologies compatible with Medicare's National Correct Coding Initiative. (Title VI, Subtitle F, Sec. 6507)
- Medicaid managed care entity contract must provide patient encounter data to identify the physician who delivers the services. (Title VI, Subtitle F, Sec. 6504)
    - Frequency and level of detail to be specified by HHS.
- State Medicaid plans are prohibited from making payments for items or services to any financial institution or entity located outside of the US. (Title VI, Subtitle F, Sec. 6505)
- Extends the period for states to recover overpayments from 60 days to one year after discovery of the overpayment. (Title VI, Subtitle F, Sec. 6506)
    - When overpayments due to fraud are pending, state repayments of the federal portion of such overpayments shall not be due until 30 days after the date of the final administrative or judicial judgment on the matter.

Enhanced Oversight of DME and Home Health Providers
(P.L. 111-148)

- Requires DME or home health services to be ordered by an enrolled Medicare eligible professional or physician. (Title VI, Subtitle E, Sec. 6405)
- Medicare enrolled physicians or suppliers must maintain and provide access to written orders or requests for payment for DME, certification for home health services, or referrals for other items and services. (Title VI, Subtitle E, Sec. 6406)

- Requires a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife, or physician assistant to have a face-to-face encounter with an individual before issuing a certification for home health services or DME. (Title VI, Subtitle E, Sec. 6407)

(P.L. 111-152)

- Allows a 90-day period of enhanced oversight and withholding of payment in cases where the HHS Secretary identifies a significant risk of fraud among DME suppliers. (Title I, Subtitle D, Sec. 1304)
- Allows IRS to provide tax return information to CMS for Medicare providers to determine tax debts (Title I, Subtitle D, Sec. 1303)
    - CMS will use information to deny enrollment or provide enhanced oversight.

Funding for Programs Fighting Fraud, Waste and Abuse

(P.L. 111-148, Title VI, Subtitle E, Sec. 6402)

- Increases funding for the Medicare Integrity Program (MIP), HHS OIG, and FBI by the percentage increase in the consumer price index over the previous year.
    - Mandatory Appropriation for MIP in FY10 was $720 million.
    - Mandatory Appropriation for HHS OIG in FY10 was $160 million.
    - Mandatory Appropriation for FBI in FY10 was $114 million.

(P.L. 111-152,Title I, Subtitle D, Sec. 1303)

- Increases Health Care Fraud and Abuse Control Fund by $250 million over the five years.
- Increases funding for the Medicaid Integrity Program by the percentage increase in the consumer price index over the previous year.
    - Mandatory appropriation in FY10 was $75 million

Enhanced Penalties

(P.L. 111-148, Title VI, Subtitle E, Sec. 6402)

- Enhanced penalties for false statements on provider or supplier enrollment applications
    - $50,000 for each false statement
    - Applies to acts committed on or after January 1, 2010
- Enhanced penalties for submission of false statements material to a false claim
    - $50,000 or triple amount of claim for each false record or statement
    - Applies to acts committed on or after January 1, 2010
    - Enhanced penalties if supplier or provider fails to grant timely access to HHS OIG for audit, investigation, and evaluations.
        - Applies to timely inspections relating to contracts with MA organizations.
        - $15,000 a day.
- HHS may also impose an administrative penalty on any individual who knowingly participated in healthcare fraud.

National Practitioner Data Bank (NPDB)

(P.L. 111-148, Title VI, Subtitle E, Sec. 6403)

- HHS will submit all information reported to the national health care fraud and abuse data collection program on certain final adverse actions taken against health care providers, suppliers, and practitioners to the National Practitioner Data Bank (NPDB).

- HHS will terminate the Healthcare Integrity and Protection Databank (HIPDB) and ensure that the information formerly collected in it is transferred to the NPDB.

Guidelines for Reporting and Returning Overpayments
(P.L. 111-148, Title VI, Subtitle E, Sec. 6402)

- Providers must return and report overpayment in writing to HHS, State, Carrier, or contractor to whom overpayment is due.
    - 60 days after overpayment was identified or before the corresponding cost report is due.
    - Must explain the reason for overpayment.
- Clarifies that an overpayment retained after the deadline for reporting and returning is an "obligation" for purposes of the False Claims Act (FCA).

Other Provisions
(P.L. 111-148)

- Requires HHS to establish within six months a self-disclosure protocol for Stark violations. (Title VI, Subtitle E, Sec. 6409)
- Expands the Recovery Audit Contractor program to Medicaid, Medicare+Choice and Prescription Drug Program. (Title VI, Subtitle E, Sec. 6411)
- Reduces from three years to one year after the date of service the maximum period for submission of Medicare claims. (Title VI, Subtitle E, Sec. 6404)
- Allows CMS to suspend Medicare, Medicaid, or CHIP payments to providers pending an investigation of a credible allegation of fraud against the provider. (Title VI, Subtitle E, Sec. 6402)
- Clarifies that services performed and billed as a result of kickbacks are false claims under the FCA. (Title VI, Subtitle E, Sec. 6402)
    - a person or entity need not have actual knowledge of the statute or specific intent to commit a violation of the statute

(P.L. 111-152)

- Medicare prepayment medical review process is streamlined to facilitate additional reviews. (Title I, Subtitle D, Sec. 1302)
- Repeals Section 1847A of the Social Security Act which permits HHS to enter into contracts with any eligible entity to serve as a Medicare Administrative Contractor (MAC) and process Medicare Part A and B Fee for Service (FSS) claims.