HAWAII HEALTH SYSTEMS
C O R P O R A T I O N

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COMPLIANCE ALERT 10-29

Affordable Care Act: New Tools to Fight Fraud and Strengthen Medicare

On May 13, 2010, HHS Secretary Kathleen Sibelius announced that the Patient Protection and Affordable Care Act ("The Affordable Care Act"), includes several new tools to fight fraud and abuse in the Medicare system. *Highlights of the new efforts announced include:*

Tough New Rules and Sentences for Criminals:

- Increased penalties for crimes that involve more than $1,000,000 in losses.
- Obstructing a fraud investigation defined as a crime.
- Easier to recapture any funds acquired through fraudulent practices.
- DOJ can investigate potential fraud or wrongdoing at facilities like nursing homes.

Enhanced Screening and Other Enrollment Requirements:

- New authorities for stepped-up oversight of providers and suppliers participating or enrolling in Medicare, Medicaid, and CHIP including mandatory licensure checks.
- Secretary can 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:

- An additional $350 million over the next ten years to help fight fraud

Sharing Data to Fight Fraud:

- CMS integrated data repository must include information from most Federal payers and agencies so that government can identify criminals and prevent fraud.
- DOJ and OIG both receive clearer rights to access CMS claims and payment databases.
- States can be required to report additional Medicaid data elements with respect to program integrity, program oversight and administration.

New Tools to Prevent Fraud:

- Providers and suppliers must 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
- Strengthens the government's authority to require surety bonds as a condition of doing business with Medicare.
- Required enrollment in Medicare to crack down on fraud in orders and referrals, providers and suppliers who order or refer certain items or services for Medicare beneficiaries.

Expanded Overpayment Recovery Efforts:

- 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:

- OIG has authority to impose stronger civil and monetary penalties on those found to have committed fraud.
- New authority to prevent providers from participating in Medicare or Medicaid.
- Strict new fines and penalties for false statements on applications or contracts to participate in a Federal health care program and for providers who identify a Medicare overpayment and do not return it.
- 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:

- Enhanced tools and authorities to address abuses of multiple employer welfare arrangements and protect employers and employees from insurance scams.
- New powers to HHS Secretary and OIG to investigate and audit the health insurance Exchanges.

A full summary is included at:
http://www.healthreform.gov/affordablecareact_summary.html