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Anti-Fraud Provisions of Affordable Care Act Should Not Be Overlooked

By Stuart J. Vogelsmeier

On June 28, 2012, the individual health insurance mandate in the Patient Protection and Affordable Care Act (more commonly known as the "Affordable Care Act") was upheld by the U.S. Supreme Court. Consultants, lawyers, lawmakers, lobbyists and bloggers have spent the weeks since that decision telling the American public just what this decision means. An overlooked portion of the Affordable Care Act is the Anti-Fraud provision. This article will summarize the Anti-Fraud provisions of the Affordable Care Act.

Health care fraud enforcement activity was on the rise even before the Affordable Care Act was passed. Recently, the Office of Inspector General ("OIG") of the U.S. Department of Health and Human Services published its review of the Missouri State Medicaid Fraud Control Unit. For fiscal years 2008 through 2010, the Missouri Unit reported recoveries of $135 million, 13 convictions, and 36 civil settlements. Those numbers are destined to rise given the Anti-Fraud priorities set forth in the Affordable Care Act.

The Affordable Care Act seeks to improve Anti-Fraud measures by increasing the resources devoted to fraud prevention, rather than merely chasing suspected fraud that has already occurred. The Affordable Care Act has four primary Anti-Fraud provisions:

1. Increased funding to prevent fraud. The Affordable care Act provides $350 million over 10 years to support the hiring and training of new officials and agents to help prevent and identify fraud.

2. Data Sharing. The CMS integrated data repository will be expanded to share data from all federally supported health care programs. Moreover, the Department of Justice and the OIG will have greater rights to access CMS claims and payment databases.

3. Improved Screening and Discipline. The Affordable Care Act gives CMS broader authority to conduct background checks and site visits of enrolling providers. If patterns of fraud are discovered, provider enrollment can be stopped until fraud is remedied. Moreover, if there is a "credible allegation of fraud", CMS can stop payment to a provider during the investigation process.

4. New Penalties. The Affordable Care Act also provides authority to the OIG to impose stronger civil and monetary penalties, provides greater authority for the government to recapture funds, allows new fines and penalties when overpayments are not timely returned, and directs changes to the Federal sentencing guidelines.

Additionally, the Affordable Care Act has also allocated resources to focus on the following "high-risk" areas:

- DME Fraud
- Home Health Fraud
- Hospice Fraud
- Medicare Advantage Fraud
- Nursing Home Fraud

Although the headlines regarding the Affordable Care Act focus on the individual mandates, providers should be aware of the increased resources that have been committed to Anti-Fraud measures.

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