Fraud-Fighting Provisions in the Affordable Care Act Remain Intact

While most of the publicity surrounding the Patient Protection and Affordable Care Act (PPACA) has been focused on the individual mandate and various health insurance reforms, the PPACA also contained many significant provisions aimed at curbing health care fraud and abuse. In light of the Supreme Court's decision upholding the PPACA (with the exception of certain Medicaid expansion provisions), these fraud-fighting provisions remain intact, and most already have been or are currently being implemented. Some of the key anti-fraud provisions are:

- Providers are now required to report and return any overpayment within 60 days of the date on which the overpayment is identified. Any overpayment which is not returned within this 60-day deadline is considered an "obligation" for purposes of triggering liability under the False Claims Act.
- The anti-kickback statute (AKS) has been amended to change the intent requirement so that the government no longer needs to show that a person intended to violate the AKS to establish liability. This reverses case law established by the 9th circuit court of appeals. PPACA also makes a violation of the AKS constitute a "false claim" for purposes of the False Claims Act.
- Potential penalties for violations of fraud and abuse laws have been significantly expanded. In particular, the PPACA mandates that federal sentencing guidelines be expanded by 20 to 50% for violations of criminal health care laws involving more than $1 million in losses. Additionally, the PPACA authorizes the Department of Health and Human Services (HHS) to suspend payments to a provider where there is a credible allegation of fraud, and expands civil monetary penalties for violators of federal health care laws.
- Certain health care goods and services, including home health services and DME, will require a face-to-face encounter between the patient and a health care professional before a certification can be issued for the goods or services.
- Whistleblowers may pursue qui tam lawsuits based on publicly-disclosed information under the False Claims Act if they have knowledge which materially adds to allegations against a provider. Previously, a whistleblower could only pursue such a lawsuit if he or she was a direct and independent source of the information forming the basis of the allegations. Further, information which is disclosed outside of a federal court setting is no longer considered to be "publicly disclosed" for purposes of a qui tam lawsuit.
- All providers and suppliers will, as a condition of enrollment in Medicare, Medicaid, or CHIP, be required to establish a formal compliance program containing certain "core elements", which are yet to be developed by HHS. The date on which such compliance programs will be required for enrollment is yet to be determined.

In addition, the PPACA substantially increases funding for investigation and enforcement of anti-fraud laws and gives authorities new powers to investigate potential violations of law:

- Funding of the Health Care Fraud and Abuse Control Account has been significantly increased — the PPACA added $350 million through 2020 to aid in the government's fraud-fighting efforts.
- Medicare contractors now have expanded authority to conduct random pre-payment reviews of

providers' claims. Previously, such reviews could only be conducted under very limited circumstances.

- The PPACA requires HHS to increase scrutiny of providers enrolling in federal health care programs.
- The Recovery Audit Contractor program has been expanded to include Medicare Parts C and D, as well as Medicaid.
- HHS' subpoena power has been significantly expanded; HHS may delegate its subpoena power to OIG and CMS.

With these changes to the law and a substantial increase in fraud-fighting resources, it is safe to say that federal authorities will be pursuing fraud and abuse investigations and enforcement actions more vigorously than ever before. Our experienced health care attorneys are available to help you identify and mitigate risks in this area to maintain compliance.