HHS Announces Expanded Health Care Fraud and Abuse Prevention Measures

New tools the federal government can use to fight fraud and abuse in Medicare and other federal benefit programs were released by the US Department of Health and Human Services (HHS) during January. According to HHS Secretary Kathleen Sebelius, the expanded authority the new policies and procedures provide to HHS, its Office of Inspector General (OIG) and the US Department of Justice (DOJ) will enable the agencies to replace their previous "pay and chase" enforcement approach with a more proactive, preventive one.

Although the new policies and procedures, which were mandated in the health care reform legislation adopted in early 2010, should allow HHS to move more quickly to stop a fraud scheme, they could be problematic for providers. For example, new ASCs and those undergoing a change of ownership may confront a lock out on obtaining new national provider identifiers in areas where high rates of fraud and abuse have been uncovered in the past. Enhanced screening procedures could also trigger significant delays in obtaining those identifiers.

New Tools for Preventing Health Care Fraud, Waste and Abuse

- **Enhanced Screening and Enrollment Requirements**
  - As of March 25, 2011, providers in some categories of health care that have posed a higher risk of fraud or abuse in the past will be screened before they can enroll in Medicare, Medicaid or the Children's Health Insurance Program (CHIP). The Centers for Medicare & Medicaid Services and HHS's OIG can also delay enrolling providers for the first time if they operate in certain geographic areas that have experienced high rates of fraud and abuse in the past. In addition, HHS can require certain providers and suppliers to post a surety bond that is commensurate with their billing volumes.
- **Stopping Payments of Suspect Claims**
  - Under the new requirements, states are required to withhold all payments to providers or suppliers that are under or

Lower Threshold for Launching Investigations

One of the most far-reaching changes the new rules and procedures include is the government's ability to launch a fraud, waste and abuse investigation based on a "credible allegation of fraud."

Peter Budetti, CMS deputy administrator and director of the Center for Program Integrity said in January that HHS and its OIG will work in concert to determine what constitutes a "credible allegation," whether that allegation is delivered as a tip of some kind, as the result of a law-enforcement investigation, following a claims screening or by some other means. This new authority lowers the threshold for launching a fraud investigation and allows HHS to freeze payments and postpone issuing provider identification numbers to providers until the investigation is complete. These investigations can involve multiple organizations and cover large geographic areas.

Carrie Valient, a partner in the international health care and labor law firm Epstein Becker & Green, P.C., says she believes the new authority given to HHS has the potential to be abused. In an article in the

subject to investigation after an allegation of fraud that is considered credible has been made. Previously, payments were not withheld until after a fraud or abuse allegation had been investigated.

- **New Resources to Fight Fraud**
  - An additional $350 million has been allocated to increase anti-fraud measures, including the hiring of more law enforcement agents.
- **Sharing Data**
  - The law requires claims data to be centralized and shared among Medicare, Medicaid, CHIP, the Veterans Administration, the Department of Defense, the Social Security Disability Program and the Indian Health Service.
  - The law expands the Recovery Audit Contractor (RAC) program to include Medicaid, Medicare Advantage (Part C) and Medicare drug benefit (Part D) programs.
- **Tough New Rules and Enhanced Sentences**
  - Providers who lie on their applications or do not return identified overpayments within 60 days will be excluded from Medicare, Medicaid and any other federally funded health programs in all states.
  - Federal sentencing guidelines for crimes involving more than $1 million have been increased by 20 to 50 percent.
- **Greater Oversight of Private Insurance Abuses**
  - The government will be authorized to investigate and audit the new state-based health care exchanges that allow associations and other groups to collectively purchase health insurance as outlined in the Patient Protection and Affordable Care Act.
- **Lower Threshold to Initiate Investigations**
  - A new, lower threshold to initiate an investigation when an allegation of fraud that is considered credible has been established.

February 14, 2011, issue of *AIS Health Reform Week*, Valient says that the authority that rests with determinations of exactly what constitutes a credible allegation puts a lot of power into the hands of "whistleblowers" and that "credible is really in the eye of the beholder." She believes that provision of the new fraud and abuse tools compromises providers' ability to rely on due process to challenge allegations against them.

Rationale for Extra Investigative Authority

In explaining the rationale for broadening the scope of HHS's and DOJ's investigative procedures, Sebelius and several agents from the OIG testified before the House Energy and Commerce Committee and the Senate Finance Committee in March about the impact fraud and abuse can have on Medicare and other benefit programs. According to their testimony, in a recent one-year period, the OIG opened more than 1,700 health care fraud investigations resulting in 900 criminal and civil actions. Authorities expect to recover more than $300 billion as a result of that action.

In testimony he delivered to the Senate Finance Committee in March, HHS Inspector General Daniel Levinson described the ways various organizations obtained Medicare provider identifiers and then defrauded the Medicare system. In an investigation of one scheme involving an organized crime ring and up to 118 phony clinics across 25 states, the subjects allegedly stole the identities of thousands of Medicare beneficiaries and of doctors who were licensed to practice in multiple states. They are also accused of opening fraudulent clinics, billing Medicare for services that were never rendered and laundering the payments before sending them overseas.

Under the fraud and abuse prevention procedures in place previously, investigators needed months to establish patterns and analyze claims. Meanwhile, the criminal organizations would bill Medicare, withdraw all the monies received, shut down the fake provider organization they had created and start again with a new false provider identifier. The new tools now available to HHS and DOJ are designed to prevent these types of crimes from occurring.

What ASCs Can Do to Protect Themselves and Their Patients

The new investigative authority granted to HHS makes it imperative that ASCs keep accurate patient records and protect business

records from identity theft since failure to do so could make them targets of investigation. ASCs are also responsible for protecting their own and their patients' financial information. Administrators and physicians who plan to move or open a new center, which would require them to obtain a new provider identifier, may want to check with HHS to see if the area from which they plan to apply is under investigation and, if so, what they can do to expedite the application process. In addition, administrators should be alert to any complaints or questions patients pose about their bills involving

- receiving a bill for a person other than the patient who is being billed,
- a bill, product or service that the patient denies receiving, or
- a notice of insurance benefits (or explanation of benefits) for health care services never received.

Reports of those kinds of activities are considered red flags that may point to identity theft and should be examined carefully.

For more information on ways to prevent fraud, waste and abuse, HHS and DOJ have set up an informational web site at www.stopmedicarefraud.gov. The site includes contact numbers anyone can call if they suspect identity theft or fraud has been committed. ASC