<u>Game-Changing Reforms to Combat Waste and Fraud in the U.S. Health Care System</u>

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Health care fraud[1] is often seen as a victimless paper crime, but in actuality, the financial burden falls on all of us. Employers pay for it through increased overhead costs[2] while individuals pay for fraud through increased premiums.[3] Even individuals who cannot afford or choose not to have health insurance pay for fraud through higher taxes or reduced social services.[4] The amount of money lost due to fraud and waste in the health care system is staggering. An estimated seventy-five to two hundred and fifty billion dollars, or three to ten percent of our national healthcare spending, is lost each year to fraud and abuse.[5]

Combating actual fraud is an important step in making federal health care programs more efficient and effective. Generally speaking, fraud is defined as, "a

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[1] Health care fraud can be perpetrated in a variety of different ways, including billing for services not rendered, upcoding of services or items, duplicate claims, unbundling, excessive or unnecessary services or items, and kickbacks defrauding programs such as Medicare, Medicaid, the Department of Veterans Affairs, or other insurers or providers. *See* INSURANCE FRAUDS BUREAU, N.Y. STATE INSURANCE DEPARTMENT, THE ANNUAL REPORT OF THE SUPERINTENDENT OF INSURANCE ON THE ACTIVITIES OF THE INSURANCE DEPARTMENT TO INVESTIGATE AND COMBAT HEALTH INSURANCE FRAUD IN ACCORDANCE WITH SECTION 410 OF THE N.Y.S. INSURANCE LAW (2010), www.ins.state.ny.us/frauds/fd09hlthrp.pdf.

[2] Noam N. Levey, *U.S. Employers Push Increase In Cost Of Healthcare Onto Workers*, LOS ANGELES TIMES, Sept. 02, 2010, http://articles.latimes.com/2010/sep/02/business/la-fi-healthcare-costs-20100903.

[3] *Id.*

[4] *What is Health Care Fraud?*, THE UNITED STATES ATTORNEY'S OFFICE, (July 7, 2009), http://www.justice.gov/usao/miw/programs/health.html.

[5] *See* Department of Health and Human Services, Centers for Medicare & Medicaid Services, National Health Expenditures WebTables, at Table 1, *available at* http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf (estimating that $2.25 trillion was spent national health care expenditures); 2009 Financial Crimes Report Fiscal Year 2009, Federal Bureau of Investigations, http://www.fbi.gov/stats-services/publications/financial-crimes-report-2009.

knowing misrepresentation of the truth or concealment of a material fact to induce another to act to his or her detriment."[6] At its heart, fraud requires an intent to conceal or deceive another to in order to unjustly gain. A fraudulent representation need not be the sole inducement to act; the essential dimension is that, without the representation, the injured party would not have acted.[7]

With the passage of the Patient Protection and Affordable Care Act[8] and the Health Care and Education Reconciliation Act[9] (collectively known as the Affordable Care Act "ACA"), the federal government has a new set of tools to both prevent and punish intentional fraud and abuse. With the passage of these laws, regulators and prosecutors have additional funds,[10] new enforcement mechanisms,[11] and have signaled their intention to aggressively pursue fraudulent activity.[12] Once the ACA's multi-phased

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[6] Black's Law Dictionary 731 (9th ed. 2009).

[7] Restatement 2d of Torts, § 525 (1977).

[8] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 [hereinafter PPACA]; a concise break down of the PPACA with all of its Titles, subtitles, as well as specific sections relevant to fraud, waste, and abuse is provided as an appendix *infra*.

[9] Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 [hereinafter HCERA].

[10] The 2011 fiscal year budget includes $1.7 billion to fight waste, fraud, and other improper payments, including $561 million in discretionary funding. HHS projects these expenditures, together with new program authorities and administrative actions, will save nearly $25 billion in Medicare and Medicaid cosyts over 10 years. *Efforts to Combat Health Care Fraud and Abuse: Hearing on Before the Subcomm. On Labor, Health and Human Services, Education, and Related Agencies of the H. Comm. on Appropriations, 111th* Cong. (2010) (statement of William Corr, Deputy Sec'y U.S. Dep't of Health and Human Serv.), *available at* http://www.hhs.gov/asl/testify/2010/03/t20100304a.html.

[11] *See infra* Part I.

[12] Gary G. Grindler, Acting Deputy Att'y Gen., Address at the National Ass'n of Attorneys Gen. Summer Meeting (June 14, 2010) (stating that the Department of Justice ("DoJ") and the Department of Health and Human Services ("HHS") have created the Health Care Fraud Prevention and Enforcement Action Team ("HEAT") whose purpose is to prevent and aggressively combat fraud, waste and abuse); in fiscal year 2010, HHS and DOJ report that $1.2+ billion was recovered in criminal fines, $21+ million in civil monetary fines, $3.2+ billion in

implementation process[13] is complete, health care providers will have to contend with a new set of anti-fraud and waste provisions in both the statutory legislation, as well as in new regulations proposed or promulgated by HHS and other administrative agencies. These changes will require health care providers and suppliers to understand the risks and obligations imposed by the ACA and conform their practices to comply with the new requirements.

This comment will examine the PPACA's waste and fraud provisions as it relates to providers of medical services and suppliers of medical goods ("providers and suppliers") participating in federal healthcare programs.[14] Part I of this comment will catalog specific PPACA provisions dealing with waste and fraud and incorporate relevant rules/regulations proposed and promulgated by various administrative agencies.[15] Part II of this comment will offer analysis and make policy recommendations addressing enforcement. This comment will recommend that although a heightened level of scrutiny may help make the heath care system more cost-effective, overly aggressive enforcement of technical violations may in fact make the system less efficient by requiring industry to allocate limited resources to legal and administrative tasks instead of providing actual health care.

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restitution and compensatory damage. See *Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010*, U.S. DEP'T OF HEALTH AND HUMAN SER'V. at 5, http://oig.hhs.gov/publications/hcfac.asp; for access to some civil and criminal recoveries, *see Criminal and Civil Enforcement Archive*, U.S. DEP'T OF HEALTH AND HUMAN SER'V, http://oig.hhs.gov/fraud/enforcement/criminal/.

[13] *See Implementation Timeline*, *Health Care Reform Source*, KAISER FAMILY FOUNDATION, http://healthreform.kff.org/timeline.aspx.

[14] Medicare, Medicaid, and Children's Health Insurance Program ("CHIP").

[15] Although individuals can perpetrate fraud and waste, this comment will be focused on institutional and organizational fraud and waste.

I. Fraud and Waste Provisions within the PPACA[16]

A. Enrollment Screening

The PPACA authorizes HHS to establish procedures and criteria for screening providers and suppliers participating in a federal health care programs based on the level of risk due to fraud and abuse each applicant presents.[17] At a minimum, screening will include licensure checks, however, HHS is permitted to perform criminal background checks, fingerprinting, random or unannounced site visits, multi-state database checks or other types of screening deemed appropriate to the agency.[18]

The PPACA's enrollment screening provisions are designed identify the level of risk a particular applicant poses with regards to fraud and waste and implement various restrictions and requirements on the applicant based on that risk.[19] Applicants are identified as limited risk, moderate risk, or high risk.[20] Applicants that are identified as limited risk[21] must: (1) meets all applicable states and federal requirements for the

[16] The PPACA is comprised of Titles I—Title X with Title IV containing most of the fraud and waste provisions. See appendix for a graphical road map of the PPACA.

[17] PPACA § 6401, 124 Stat. 747 (codified at 42 U.S.C. 1395cc(j)).

[18] PPACA § 6401(a)(3), 124 Stat. 748; *see also* Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers, 75 Fed. Reg. 58204 (proposed Sept. 23, 2010) *revised* 76 Fed. Reg. 5862 (proposed Feb. 2, 2011).

[19] Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers, 75 Fed. Reg. 58204 (proposed Sept. 23, 2010) *revised* 76 Fed. Reg. 5862 (proposed Feb. 2, 2011).

[20] 76 Fed. Reg. 5868 (proposed Feb. 2, 2011).

[21] 76 Fed. Reg. 5868 (proposed Feb. 2, 2011). Providers identified by HHS as limited risk are:

> Physician or non- physician practitioners and medical groups or clinics; providers or suppliers that are publicly traded on the NYSE or NASDAQ; ambulatory surgical centers (ASCs); end-stage renal disease (ERSD) facilities; Federally qualified health centers (FQHCs); histocompatibility laboratories; hospitals,

provider or supplier type; (2) be duly licensed; and (3) be subject to database checks to ensure that applicant continues to meet the enrollment criteria for their provider/supplier type.[22] Applicants that are identified as moderate risk[23] are subject to unannounced pre and or post site visits from OIG inspectors in addition to the requirements applicable to the limited risk applicant.[24] Lastly, applicants identified as high risk[25] are subject to the requirements of the limited and moderate risk applicant but must also submit to background checks and finger printing.[26]

Implementation of the enrollment screening requirements takes place in stages. Providers and suppliers that were not enrolled in a federal health care program at the time of the PPACA's enactment must be screened by March of 2011 as a condition to

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including critical access hospitals (CAHs); Indian Health Service (IHS) facilities; mammography screening centers; organ procurement organizations (OPOs); mass immunization roster billers, portable x- ray suppliers; religious nonmedical health care institutions (RNHCIs); rural health clinics (RHCs); radiation therapy centers; skilled nursing facilities (SNFs), and public or government-owned ambulance services suppliers.

[22] *Id.*

[23] 76 Fed. Reg. 5870 (proposed Feb. 2, 2011). Providers identified by HHS as moderate risk are: Community mental health centers; comprehensive outpatient rehabilitation facilities; hospice organizations; independent di- agnostic testing facilities; independent clinical laboratories; and non-public, non-government owned or affiliated ambulance services suppliers. (Except that any such provider or supplier that is publicly traded on the NYSE or NASDAQ is considered ''limited'' risk); currently enrolled (revalidating) home health agencies. (Except that any such provider that is publicly traded on the NYSE or NASDAQ is considered ''limited'' risk); Currently enrolled (re-validating) suppliers of DMEPOS (Except that any such supplier that is publicly traded on the NYSE or NASDAQ is considered ''limited'' risk).

[24] 76 Fed. Reg. 5869 (proposed Feb. 2, 2011).

[25] 76 Fed. Reg. 5870 (proposed Feb. 2, 2011). High risk applicants are ant newly enrolling home health agencies and suppliers of durable medical equipment, prosthetics, orthotics, and supplies. (Except ones which are publicly traded on the NYSE or NASDAQ).

[26] *Id.*

enrollment.[27] Providers that were already participants at the time of the PPACA's enactment need not be screened until March 2012, unless such provider is required to revalidate its enrollment in the program.[28] In such cases, a screening under section 6401 is required as of June 23, 2010.[29]

PPACA also requires that HHS establish procedures for enhanced oversight, such as prepayment review and payment caps, of newly enrolled providers and suppliers for a provisional period of up to one year.[30] HHS is given the express authority to impose a temporary moratorium on the enrollment of new providers or suppliers if necessary to prevent or combat fraud, waste, or abuse.[31] The decision to impose a moratorium is not subject to judicial review.[32]

As of March of 2011, providers and suppliers enrolling or relicensing will have to disclosure it's current or past affiliations with any other provider that has uncollected debt, has been suspended or excluded from participation from a federal health care

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[27] PPACA § 6401(a)(3), 124 Stat. 749.

[28] PPACA § 6401(a)(3), 124 Stat. 749 *stating* "…a provider of medical or other items or services or supplier who is enrolled in the program under this title, title XIX, or title XXI as of such date of enactment, on or after the date that is 2 years after such date of enactment."

[29] PPACA § 6401 (a)(1)(d)(iii), 124 Stat. 749 *stating* "[e]ffective beginning on the date that is 180 days after such date of enactment, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program."; For proposed HHS regulations regarding Enrollment Screening, *see* Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers, 75 Fed. Reg. 58204 (proposed Sept. 23, 2010) *revised* 76 Fed. Reg. 5862 (proposed Feb. 2, 2011).

[30] PPACA § 6401(a)(3), 124 Stat. 749.

[31] PPACA § 6401(a)(3), 124 Stat. 750.

[32] PPACA § 6401(a)(3), 124 Stat. 751.

program, or has had its billing privileges denied or revoked.[33] Enrollment can be denied if HHS determines that these affiliations pose an undue risk of fraud, waste, or abuse.[34] In conjunction with these disclosure requirements, the PPACA also authorizes HHS to satisfy the past-due obligations of the affiliated delinquent provider if the applicant for enrollment or revalidation shares the same taxpayer identification number (TIN). [35]

Section 1902(ii)(1) of the SSA, as amended by the PPACA, requires Medicaid providers be screened to confirm they are program eligible.[36] The ACA allows HHS to identify and deactivate providers and suppliers that are enrolled in a federal program but have not submitted a claim within 12 consecutive months.[37] A deactivated provider wishing to reinstate must then undergo the screening process outlined in section 6401.[38]

B. Program Integrity Provisions

The program integrity provisions in section 6402 shift the government's strategy of combating fraud waste and abuse. These new provisions place an emphasis on proactive prevention of abuse rather than retroactive recovery of funds improperly distributed.[39]

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[33] PPACA § 6401(a)(3), 124 Stat. 750; the statute leaves it up to regulation to define the scope of "uncollected debt."

[34] PPACA § 6401(a)(3), 124 Stat. 750.

[35] PPACA § 6401(a)(3), 124 Stat. 750.

[36] *See supra* note 18.

[37] Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers, 75 Fed. Reg. 58216 (Sept. 23, 2010) (to be codified at 42 C.F.R. 455.418).

[38] Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers, 75 Fed. Reg. 58216 (Sept. 23, 2010) (to be codified at 42 C.F.R. 455.426).

[39] News Release, U.S. DEP'T OF HEALTH & HUMAN SERVS., May 13, 2010, *available at* http://www.hhs.gov/news/press/2010pres/05/20100513a.html.

Section 6402 authorizes HHS to obtain "any records necessary for evaluation of the economy, efficiency, and effectiveness of the programs" including "any supporting documentation necessary to validate claims for payment or payments" from any provider, supplier or individual, including a beneficiary, for purposes of protecting the integrity of the health care programs.[40]

Section 6406 expressly requires physicians and suppliers to maintain and, upon request, provide HHS documentation regarding payments for durable medical equipment ("DME"), certifications for home health services, or referrals for other items or services as required by regulation.[41] Physicians recommending home health services[42] or DME[43] are also required to have a "face to face encounter" with the patient before the physician can receive payment. Face to face encounters are not limited to home services or DME---HHS may require these encounter "upon a finding that such an decision would reduce the risk of waste, fraud, or abuse."[44]

HHS seeks to implement and expand upon the new statutory requirement of Section 6407 requiring the certifying physician or a designated non-physician practitioner to document the face-to-face encounter with the patient within 30 days prior to the home health start of care.[45] While the law allows a nurse practitioner, a clinical nurse specialist, or a physician's assistant to make the actual patient encounter, the physician

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[40] PPACA § 6402(a), 124 Stat. 754—55.

[41] PPACA § 6406(a), 124 Stat. 769 (codified at 42 U.S.C. 1395u(h)).

[42]PPACA § 6407(a), 124 Stat. 769 (codified at 42 U.S.C. 1395(f)).

[43] PPACA § 6407(b), 124 Stat. 770 (codified at 42 U.S.C. 1395m(a)(11)(B).

[44]PPACA § 6407(c), 124 Stat. 770 (codified at 42 U.S.C. 1395f).

[45] Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices, 75 Fed. Reg. 43266—67 (proposed July 14, 2010) (to be codified at 42 C.F.R. pt. 424).

must still sign the certification stating the requirement was fulfilled.[46] Additionally, if the patient's clinical condition changes after the encounter, there must be another face-to-face encounter within two weeks of the start of care for the new condition.[47] Prescribing home health care or DME without this face-to-face physician encounter would not qualify for payment under the federal programs.

C. Overpayments

In the event of an overpayment, section 6402 imposes a duty on providers and suppliers to report and return any funds they receive to which they are not actually entitled.[48] The provider must not only return the funds within sixty days after which it was identified, but also provide an explanation for the overpayment.[49] If a provider or supplier retains an overpayment past the sixty-day statutory period, that provider or supplier becomes liable under the False Claims Act ("FCA") even though the payment was not induced by fraud.[50]

Additionally, the period of time the federal government has to collect overpayments has been extended. Regulators now have one year to identify and collect overpayments as opposed to sixty days prior to the PPACA's enactment.[51] At the same time, the maximum time a provider or supplier has to submit a claim for payment has been

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[46] *Id.*

[47] *Id.*

[48] PPACA § 6402, 124 Stat. 755 (codified at 42 U.S.C. 1320a-7k).

[49] PPACA § 6402, 124 Stat. 755 (codified at 42 U.S.C. 1320a-7k).

[50] False Claims Act, 31 U.S.C. § 3729; *see also infra* note 81.

[51] PPACA § 6506, 124 Stat. 777 *amending* 42 U.S.C. 1396b(d)(2).

shortened from three years to one year.[52] Section 6402 also amends the Social Security Act[53] to allow providers and suppliers who have made false statements to be excluded from future participation in a health care program.[54] Beneficiaries of a federal health care program who knowingly participate in a fraud scheme face administrative penalties in addition to any other criminal and civil sanctions.[55]

D. Expansion of the RAC Program

Congress created the Recovery Audit Contractor (RAC) program as part of the Medicare Modernization Act of 2003[56] in order to recover any federal funds improperly made to the 1.2 billion claims filed by providers and suppliers.[57] The RAC contractors are private entities that are retained by the government to identify and recover overpayments and to identify and return underpayments to physicians and other healthcare providers.[58] The OIG reported that the Medicare RACs identified over $1 billion in improper payments, but referred only two cases of potential fraud.[59] Because the RACs receive contingency fees based only on overpayments collected, they had no

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[52] PPACA § 6404, 124 Stat. 767 *amending* 42 U.S.C. 1395f(a)(1).

[53] Social Security Act, 42 U.S.C. § 301 et. seq. [hereinafter "SSA"].

[54] PPACA § 6402, 124 Stat. 757 (codified at 42 U.S.C. 1320a-7(b)).

[55] PPACA § 6402(a), 124 Stat. 755.

[56] Medicare Modernization Act of 2003, Pub. L. 108-173, 117 Stat. 2066.

[57] CMS RAC Demonstration Evaluation Report, U.S. DEP'T OF HEALTH AND HUMAN SER'V 9, *available at* https://www.cms.gov/RAC/02_ExpansionStrategy.asp#TopOfPage.

[58] For a thorough treatment on RACs, *see* Mark E. Reagan, *Taming the Medicaid Beast: The Federal Government's Ambitious Attempt to Combat Medicaid Fraud, Waste, and Abuse*, 3 J. HEALTH & LIFE SCI. L. 1 (July 2010); Recovery Audit Contractor Program, AMERICAN HOSPITAL ASSOCIATION, http://www.aha.org/aha/issues/RAC/index.html (last updated Jan. 26, 2011); *see also* Recovery Audit Contractors, U.S. DEP'T OF HEALTH AND HUMAN SER'V, https://www.cms.gov/RAC/ (last updated Jan. 29, 2011).

[59] U.S. DEP'T OF HEALTH & HUMAN SERVS., RECOVERY AUDIT CONTRACTORS' FRAUD REFERRALS, (Feb. 2010) *available at* oig.hhs.gov/oei/reports/oei-03-09-00130.pdf.

incentive to report fraud.

Section 6411 of PPACA expands the use of RACs to Medicaid and provides HHS with general authority to enter into contracts with RACs allowing them to work on a contingency basis.[60] However, section 6411 also establishes special rules that require RACs to ensure that each provider has anti-fraud plans in place and to review the efficacy of those plans.[61] New HHS regulations ensure that the RACs report instances of fraud and/or criminal activity in addition to the pursing overpayments.[62] This rule requires RACs to report instances criminal activity that defrauds a federal program to the appropriate law enforcement officials.[63]

HHS requires states to contract with a RAC to review claims submitted by providers and suppliers in order to determine whether correct payment was made and to recover any overpayments identified.[64] However, it will be up to the states to decide how to recover Medicaid overpayments.[65] Finally, RACs will also examine claims for reinsurance payments and determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under the statute.[66]

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[60] PPACA § 6411(a), 124 Stat. 773—74 (codified at 42 U.S.C. 1396a(a)(42)).

[61] PPACA § 6411(b), 124 Stat. 775 (codified at 42 U.S.C. 1395ddd(h)).

[62] Medicaid Program; Recovery Audit Contractors, 75 Fed. Reg. 69040—41 (proposed Oct. 29, 2010) (to be codified at 42 C.F.R. pt. 455.).

[63] *Id.*

[64] Medicaid Program; Recovery Audit Contractors, 75 Fed R. 69042 (proposed Nov. 10, 2010) (to be codified at 42 C.F.R. pt. 455.506).

[65] Medicaid Program; Recovery Audit Contractors, 75 Fed R. 69042 (proposed Nov. 10, 2010) (to be codified at 42 C.F.R. pt. 455.506).

[66] PPACA § 6411(b), 124 Stat. 775 (codified at 42 U.S.C. 1395ddd(h)).

E. Civil Monetary Penalties and Other Remedies

The Office of the Inspector General (OIG) at the HHS is authorized to impose civil penalties and assessments on providers and suppliers who engage in various types of misconduct, including presenting false or fraudulent claims with respect to federal health care programs.[67] PPACA amends the Civil Monetary Penalties Law and provides regulators and prosecutors with enhanced tools to combat fraud.[68] These amendments authorize penalties for knowingly making false statements in an application or filing a fraudulent claim for payment.[69] Providers and suppliers can face a $50,000 fine for each and every false statement or false claim.[70]

With regards to investigating these fraudulent acts, the PPACA authorizes HHS to levy a $15,000 fine per day against a provider or supplier that fails to grant HHS access to records and documents for audits and investigations.[71] Providers and suppliers can also face fines up to three times the amount the provider unlawfully gained or attempted to gain.[72] Additionally, payments to a provider or supplier may be suspended while the provider is under investigation for fraud[73] or HHS may also determine that a minimum

[67] 42 U.S.C. § 1320a-7a.

[68] Social Security Act § 1128A(a) (codified at 42 U.S.C. § 1320a-7a (a)).

[69] PPACA § 6408, 124 Stat. 770—71.

[70] *Id.*

[71] PPACA § 6408, 124 Stat. 770—71.

[72] 42 U.S.C. § 1320a-7a (stating in part "[i]n addition, such a person shall be subject to an assessment of not more than 3 times the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim. . .").

[73] PPACA § 6402(h), 124 Stat. 760 (codified at 42 U.S.C. 1395y) *see also* 42 C.F.R. 455.23 (withholding of payments in cases of fraud or willful misrepresentation); 43 C.F.R. 405.371 (suspension, offset, and recoupment of Medicare payments to providers and suppliers of services); Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers, 76 Fed. Reg. 5928 (proposed Feb. 2, 2011) (allowing CMS to suspend payments to a provider upon reliable information that an overpayment

$50,000 surety bond be posted by the provider or supplier.[74] As with any conduct prohibited by law or regulation for which a civil monetary penalty may be imposed, the OIG may also exclude providers and suppliers who engage in such activities from participating in federal health care programs either temporarily or permanently.[75]

False statements for marketing purposes are also prohibited. The PPACA amends ERISA[76] by authorizing criminal sanctions against false statements made in connection with the marketing or sale of a multiple employer welfare arrangement concerning: (1) the financial solvency of the plan; (2) plan benefits; (3) the regulatory status regarding the plan's labor organization; or (4) statements regarding exemption from state regulatory authority.[77] Violators can be fined or imprisoned for up to ten years.[78]

The federal False Claims Act (FCA) imposes civil liability on any individual who knowingly engages in misconduct involving federal government money or property including submitting a false or fraudulent claim or other health fraud related conduct.[79] Under the FCA, actions may be brought by the Attorney General or by a *qui tam* action ("whistleblower") allowing the private litigant with knowledge of the FCA violation to

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exists or a "credible allegation" of suspected fraud. CMS liberally construes "credible allegation of fraud" as having an "indicia of reliability," a term not further defined).

[74] PPACA § 6402(g), 124 Stat. 759 (codified at 42 U.S.C. 1395y).

[75] 42 U.S.C. § 1320a-7(a) (stating "[i]n addition the Secretary may make a determination in the same proceeding to exclude the person from participation in the Federal health care programs (as defined in section 1128B(f)(1) [42 USCS § 1320a-7b(f)(1)]) and to direct the appropriate State agency to exclude the person from participation in any State health care program.").

[76] Employee Retirement Income Security Act of 1974 (codified at 29 U.S.C. 1131 et seq.) [hereinafter ERISA].

[77] PPACA § 6601, 124 Stat. 779 (codified at 29 U.S.C. 1149); *see generally* Joel D. Hesch, *Restating the "Original Source Exception" to the False Claims Act's "Public Disclosure Bar,"* 1 Liberty U. L. Rev. 111 (2006) (discussing the FCA whistleblowing provision awarding a private citizen who reports the fraud a percentage of the recovered amount).

[78] PPACA § 6601, 124 Stat. 779 (codified at 29 U.S.C. 1131).

[79] *See supra* note 2.

collect a percentage of the judgment or settlement.[80] Liability for a violation under the FCA can include five thousand to ten thousand dollars per false statement *and* three times the amount of damages sustained by the government.[81] PPACA has made it easier for prosecutors to use the FCA to recover unreturned overpayments because of the statutory link created in section 6402.[82]

Furthermore, if a sanction has been imposed on a provider or supplier, that information is maintained and published. HHS is required to maintain a national health care fraud and abuse data collection program, pursuant to section 6403, publishing final adverse actions against health care providers, suppliers, or practitioners and furnishing the information to the National Practitioner Data Bank.[83] HHS has also established a process by which providers and suppliers can report the misconduct of other entities relating to self-referrals as set forth in the SSA.[84]

F. Amendments to the SSA's Anti-Kickback Statutes

The PPACA amended the Medicare-Medicaid anti-kickback laws making it easier

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[80] 31 U.S.C. § 3730.

[81] 31 U.S.C. § 3729(a) (stating a person " is liable to the United States Government for a civil penalty of not less than $ 5,000 and not more than $ 10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410), plus 3 times the amount of damages which the Government sustains because of the act of that person).

[82] PPACS § 6402(a), 124 Stat. 755 (stating in part that "[a]ny overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.); for a full treatment of PPACA's effect on the FCA, *see* James J. Belanger & Scott M. Bennett, *The Continued Expansion of the False Claims Act*, 4 J. HEALTH & LIFE SCI. L. no. 4 26, 33 (Oct. 2010).

[83] PPACA § 6403(a), 124 Stat. 763 (codified at 42 U.S.C. 1320a-7e); National Practitioner Data Bank established as part of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).

[84] PPACA § 6409(a), 124 Stat. 772; Social Security Act, 42 U.S.C. 1395nn.

to prosecute unlawful referrals and kickbacks.[85] The anti-kick back laws make it a felony for a person to knowingly and willfully give or receive anything of value in return for a referral.[86] Criminal sanctions for violating the anti-kickback statute include a fine of up to $25,000, imprisonment of up to five years, and exclusion from participation in federal health care programs for up to one year.[87] As a way to make enforcement less burdensome on the prosecutor, the PPACA legislatively overturned a Ninth Circuit decision which established a requirement showing the defendant have actual knowledge of the statute and specific intent to violate the anti-kickback law.[88] Section 6402 also modifies the SSA by making claims for items or services arising out of a violation of the anti-kickback statute to constitute a false claim under the False Claims Act[89], subjecting violators to the hefty civil penalties and treble damages.[90] Anyone found guilty of violating these anti-kickback laws may be fined, imprisoned, and barred from participating in federal health care programs.[91]

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[85] Social Security Act § 1128B, 42 U.S.C. § 1320a-7b. These statutes makes it a crime to offer or receive any form of remuneration to induce referrals for providing goods or services covered by federal healthcare programs.

[86] 42 U.S.C. § 1320a-7b(b).

[87] 42 U.S.C. § 1320a-7b(d).

[88] *See Hanlester Network v. Shalala*, 51 F.3d 1390, 1400 (9th Cir. 1995) (construing "'knowingly and willfully' in § 1128B(b)(2) of the anti-kickback statute as requiring appellants to (1) know that § 1128B prohibits offering or paying remuneration to induce referrals, and (2) engage in prohibited conduct with the specific intent to disobey the law"; *but see* PPACA § 6402(f)(2) stating: "With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section."

[89] PPACA § 6402(d), 124 Stat. 757, *amending* 42 U.S.C. § 1320a-7b (stating "[i]n addition to the penalties provided for in this section or section 1320a-7a of this title, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of Title 31").

[90] False Claims Act, 31 USC § 3729

[91] *See* 42 U.S.C. §§ 1320a-7a—1320a-7b (authorizing imprisonment for up to five years and fines up to $25,000).

G. Enhanced Criminal Sanctions

Criminal sanctions for federal health care offenses[92] have been increased. Section 10606 changes the Federal Sentencing Guidelines and increases the offense levels for defendants convicted of defrauding the health care system more than one million dollars.[93] Defendants convicted of defrauding any amount between one million to seven million dollars will face a two-step increase in penalty.[94] Defendants convicted of a seven to twenty million dollar loss will face a three step increase in penalty, while any amount over twenty million dollars will result in a four step increase.[95]

10606 makes the aggregate amount of money fraudulently billed prima facie evidence as the amount the defendant intended to defraud[96] and simultaneously increases the penalties for such violations.[97] For example, if a doctor fraudulently bills one thousand dollars to a federal health program but receives only five hundred dollars, once discovered, that doctor will be charged for defrauding the government of one-thousand dollars.

The Fourth Circuit directly addressed the issue of using the billed amount as

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[92] As defined by 18 U.S.C. § 24.

[93] PPACA § 10606(a)(2)(B), 124 Stat. 1007.

[94] PPACA § 10606(a)(2)(C), 124 Stat. 1007.

[95] *Id.*

[96] PPACA § 10606(a)(2)(b), 124 Stat. 1007.

[97] PPACA § 10606(a)(2)(C), 124 Stat. 1007 (amending the Federal Sentencing Guidelines to provide "(i) a 2-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $1,000,000 and less than $7,000,000; (ii) a 3-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $7,000,000 and less than $20,000,000; (iii) a 4-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $20,000,000…"

evidence of intended loss.[98] In *U.S. v. Miller*, a doctor was convicted of defrauding Medicaid, Medicare, and the West Virginia Workers' Compensation program.[99] Miller's sentence was based on the amount he billed to Medicare and not the amount he actually received or was entitled to receive if the services were actually rendered.[100] Miller appealed his sentence and argued that "the court erred in using the amount he billed to Medicare and Medicaid, rather than the payments those programs allow, in estimating the amount of loss he intended because he could not have any reasonable expectation to be paid beyond what the program allows."[101] Miller argued that the "intended loss" should be limited to the reimbursement fee schedules and not the amount he actually billed. The *Miller* court rejected that argument, holding that "the Guidelines permit courts to use intended loss in calculating a defendant's sentence, even if this exceeds the amount of loss actually possible, or likely to occur, as a result of the defendant's conduct."[102].

The Fourth Circuit's reasoning was based on assessment that "[a]s anyone who has received a bill well knows, the presumptive purpose of a bill is to notify the recipient of the amount to be paid."[103] The court concluded that the billed amount served as *prima facie* evidence of the amount the defendant intended to defraud, placing the burden on Miller to rebut the presumption.[104]

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[98] *United States v. Miller*, 316 F.3d 496 (4th Cir. 2003).

[99] *Id.* at 496.

[100] *Id.* at 497.

[101] *Id.* at 501 (internal quotation marks omitted).

[102] *Id.* at 502.

[103] *Id.* at 504.

[104] *Miller*, 316 F.3d at 504; other courts have also applied the *Miller* reasoning, *see, e.g., United States v. Mikos*, 539 F.3d 706, 714 (7th Cir. 2008) ("[The defendant] billed the Medicare program for $1.8 million; that's the intended loss whether Medicare paid or not . . . ."); *United States v.*

Section 10606 not only affirms the proposition that the amount billed by a defendant is evidence of the amount that defendant intended to defraud the government, but also modified the culpability requirements of the federal health care fraud statute.[105] Section 10606 no longer requires the defendant to have "actual knowledge of [section 1347] or specific intent to commit a violation of [section 1347]" but rather a showing of general intent will satisfy the mens rea element of the law.[106]

G. Enhanced Funding

The ACA increases funding to HHS and the FBI for fraud and abuse enforcement activities. Prior to the enactment of the ACA, the HHS was appropriated $160,000,000[107] for fraud prevention activities[108] while the FBI was appropriated $114,000,000[109] for the same. The PPACA and the HCERA each increased these appropriations. Section 6402

Cruz-Natal, 150 Fed. Appx. 961, 964 (11th Cir. 2005) (approving use of billed amount to calculate intended loss in Medicare fraud case "because the intended loss is easily calculated and greater than the actual loss").

[105] 18 U.S.C. 1347.

[106] PPACA § 10606(b), 124 Stat. 1007.

[107] 42 USCS § 1395i(k)(3)(A)(i)(VIII)—(IX) (stating in pertinent part, "(VIII) for fiscal year 2007, not less than $ 160,000,000, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year; and (IX) for each fiscal year after fiscal year 2007, not less than the amount required under this clause for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year."

[108] 42 USCS § 1395i(k)(3)(C) (defining the purpose of the funds to include "the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a) [42 USCS § 1320a-7c(a)], including the costs of--(i) prosecuting health care matters (through criminal, civil, and administrative proceedings); (ii) investigations; (iii) financial and performance audits of health care programs and operations; (iv) inspections and other evaluations; and (v) provider and consumer education regarding compliance with the provisions of title XI [42 USCS §§ 1301 et seq.]".

[109] 42 USCS § 1395i(k)(3)(B)(vi)—(vii) (stating in pertinent part "(vii) for each of fiscal years 2003, 2004, 2005, and 2006, $ 114,000,000; and (viii) for each fiscal year after fiscal year 2006, the amount to be appropriated under this subparagraph for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.

of the PPACA added an additional $100,000,000 over the course of ten years to combat fraud.[110] HCERA section 1303 appropriated another $250,000,000 through 2016.[111] These appropriations are in addition to any other funds already allocated to the agencies or the funds recovered as part of criminal and civil settlements and restitutions.[112]

H. HEAT Medicare Fraud Strike Force

In 2009, HHS and DOJ created the Health Care Fraud Prevention and Enforcement Action Team (HEAT), to combat Medicare fraud.[113] The Strike Force teams use data-mining techniques to identify high or unusual billing levels so that inter-agency teams can target emerging or migrating schemes.[114] The Strike Force combines data analysis capabilities of the Center for Medicare and Medicaid Services, and the investigative resources of the FBI and HHS with the prosecutorial resources of the DOJ Criminal Division, Fraud Section and the United States Attorney's Offices.[115] Based on the success of these efforts and increased appropriated funding for the program, DOJ and HHS expanded the Strike Force.[116]

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[110] PPACA § 6402, 124 Stat. 761 (codified at 42 USCS § 1395i(k)(7)).

[111] HCERA § 1303, 124 Stat. 1057 (codified at 42 USCS § 1395i(k)(8)).

[112] 42 USCS § 1395i(k).

[113] *Attorney General Holder and HHS Secretary Sebelius Announce New Interagency Health Care Fraud Prevention and Enforcement Action Team*, (May 20, 2009), U.S. DEP'T OF HEALTH AND HUMAN SER'V, http://www.hhs.gov/news/press/2009pres/05/20090520a.html.

[114] *Id.*

[115] *Reducing Fraud, Waste and Abuse in Medicare: Hearing on Before the Subcomm. On Health Oversight of the H. Comm. on Ways and Means, 111th* Cong. (2010) (statement of Kimberly Brandt, Director, U.S. Dep't of Health and Human Serv.), *available at* http://www.hhs.gov/asl/testify/2010/06/t20100615a.html.

[116] *Supra* note 114.

II. Policy recommendations

Preventing and prosecuting actual fraud is a necessary step in making federal health care programs efficient and effective but a liberal interpretation of fraud combined with overly aggressive enforcement of hyper-technical rules can be counterproductive in achieving the policy goals. With respect to actual fraud, dishonest providers and suppliers intentionally manipulate the claims payment process for financial gain through bribes, kickbacks, and racketeering.[117] Health care fraud is perpetrated by deceiving a public or private health insurer into paying claims that the provider or supplier is not otherwise entitled to.[118] However, there may be instances where a provider or supplier receives a payment that it is not entitled but which does not involve fraud. An improper payment can arise from simple errors in documentation, coding, reporting, verification, and other technical matters related to the administration of public programs.[119] In these cases, an erroneous payment may simply have been made or claimed in error, but with the newly modified health care fraud intent requirements,[120] these unintentional errors may be punished as severely as actual fraud.

With over 1.2 billion claims for payment being submitted each year,[121] providers, suppliers, or their third party billing contractors are inevitably bound to make mistakes. Improper payments and errors must be distinguished from actual fraud and treated accordingly. If clear regulations and guidelines narrowly defining fraudulent conduct

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[117] See ANNUAL REPORT, *supra* note 2.

[118] *Id.*

[119] Joan H. Krauset, Following the Money in Health Care Fraud: Reflections on a Modern-Day Yellow Brick Road, 36 AM. J. L. AND MED. 343, 346—47 (2010).

[120] 18 U.S.C. § 1347; *see also* discussion *supra* notes 89, 107; Joan H. Krauset, Following the Money in Health Care Fraud: Reflections on a Modern-Day Yellow Brick Road, 36 AM. J. L. AND MED. 343, 346—47 (2010).

[121] See *supra* note 58.

existed, then consistently imposing severe sanctions on such conduct would be an effective general and specific deterrant to fraudulent conduct. However, due to the ever increasing complexities of health care law,[122] billing errors that are treated the same as actual fraud inevitably increases the cost of providing health care because of the legal and administrative costs associated with keeping up with the requirements.[123] With the potential for unlimited liability,[124] providers often have little choice but to settle, even if they would have a good chance going to trial. A provider cannot risk putting the issue of its culpability to a trier of fact regardless of whether the violation was due to innocent misinterpretation of a complex and unclear rule.[125] The only way a provider or supplier can protect itself from liability is to divert more of its limited resources from providing actual health care to its administrative and legal departments in order to mitigate such risks. This imbalance of power between the provider and the governmental body prosecuting the provider further compounds the problem of an overly restrictive business

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[122] Joan H. Krauset, Following the Money in Health Care Fraud: Reflections on a Modern-Day Yellow Brick Road, 36 AM. J. L. AND MED. 343, 347—48 (2010) (*citing Mayo Chronicles Medicare Regs: It's 132,720 Pages of Red Tape*, MODERN HEALTHCARE, Mar. 15, 1999, at 64 (estimating that the rules governing Medicare alone exceeded 130,000 pages and continues to grow).

[123] Joan H. Krause, *Regulating, Guiding, And Enforcing Health Care Fraud*, 60 N.Y.U. ANN. SURV. AM. L. 241, 247—48 (2004) (discussing that health care providers must contend with rules arising out of the 3 distinct sources—the traditional rulemaking process of the various administrative agencies, informal guidance from the same agencies, and the rules established through litigation—forcing providers to deal with more, but not necessarily clearer, rules).

[124] In addition to the monetary fines that can be imposed by the FCA as discussed *supra* note 82, HHS can permanently exclude a provider or supplier from participating in a federal health care program. *See supra* note 76. This exclusion arises to the level unlimited liability in that it is often the "financial death" of that provider. HEALTH CARE FRAUD AND ABUSE: PRACTICAL PERSPECTIVES 32 (Linda Baumann ed., 2002).

[125] Timothy S. Jost & Sharon L. Davies, *The Empire Strikes Back: A Critique of the Backlash Against Fraud and Abuse Enforcement*, 51 ALA. L. REV. 239, 265 (1999).

environment because often times, regulators and prosecutors can impose a new set of conditions and requirements on the provider as part of a settlement agreement.[126]

The data sets and methodologies relied upon by regulators to identify the prevalence of fraud within the federal health care programs is also questionable. Federal programs heavily rely on documentation by the provider to determine the proper payment for any given set of services performed.[127] In a 2007 audit, CMS determined that 3.9 percent of the audited claims were improperly paid either because the claim did not have any documentation, proper documentation or sufficient documentation to support the claim.[128] The 3.9 percent of the claims deemed "improper" were in fact claims with documentation errors.

The same 2007 data set was reevaluated in 2009 using a stricter auditing methodology designed to detect more nuanced deviations from the Medicare documentation requirements.[129] The same data set under the tightened review indicated that in 2007, 7.8 percent (rather than the original 3.9 percent) of the claims were paid improperly.[130] What this comparison shows is that because the methodologies used to calculate "improper payments" is merely a calculation for documentation error and not

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[126] Lars Noah, *Administrative Arm-Twisting in the Shadow of Congressional Delegations of Authority*, 1997 WIS. L. REV. 873, 922 (1997); *see also* Corporate Integrity Agreements, U.S. DEP'T OF HEALTH AND HUMAN SER'V, http://oig.hhs.gov/fraud/cias.asp (providing access to various agreements between the OIG and providers made as part of settlements of civil and criminal investigations).

[127] Joan H. Krauset, *Following the Money in Health Care Fraud: Reflections on a Modern-Day Yellow Brick Road*, 36 AM. J. L. AND MED. 343, 345 (2010) (*citing Mayo Chronicles Medicare Regs: It's 132,720 Pages of Red Tape*, MODERN HEALTHCARE, Mar. 15, 1999, at 64 (estimating that the rules governing Medicare alone exceeded 130,000 pages and continues to grow).

[128] *Id. at 345*.

[129] Joan H. Krauset, *Following the Money in Health Care Fraud: Reflections on a Modern-Day Yellow Brick Road*, 36 AM. J. L. AND MED. 343, 345 (2010)

[130] *Id.*

necessarily fraud, and the error rate is substantially dependent on the criteria used in the methodology, that statistical analysis determining health care fraud is " . . . [a]t best, ambiguous; at worst, perverse and misleading."[131]

Using these documentation audits as the basis for determining fraudulent conduct brings to question whether a claim without the proper documentation is intentional fraud deserving of the severe punishments under the FCA, or something less nefarious like an honest mistake or misinterpretation of the rules and regulations. For example, a claim by an honest doctor with the proper documentation for the services she performed but with an incorrect billing code entered mistakenly would be identified as a potential fraud under the above audit, while a fraudulent doctor that bills for services he never performed but supplies the correct, albeit false, documentation in support of the claim would not be detected and eventually paid.[132]

This critique of the methods used to identify fraud in no way means we should ignore actual misconduct, but rather look to alternatives to achieve the policy goal of providing "Quality, Affordable Health Care For All Americans."[133] Some alternatives to consider have already been incorporated into the PPACA.[134] These include the stringent screening of providers before granting enrollment to a federal health care program, as well as the enhanced oversight and closer review of claims before payment is made outlined in Section 6401. These provisions act proactively to prevent resource dollars

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[131] *Id. quoting* MALCOLM K. SPARROW, LICENSE TO STEAL: HOW FRAUD BLEEDS AMERICA'S HEALTH CARE SYSTEM 121 (2000).

[132] *Id.* at 347.

[133] PPACA Title I.

[134] *See supra* Part I.

from being spent unnecessarily and allow the funds to be focused where it is needed—on the patients.

Another alternative that can be implemented through agency regulations is standardizing and simplifying claim documentation requirements for the 1.2 billion claims processed each year.[135] This measure would not only allow the provider to focus more of its resources on patient care rather than the legal and administrative duties necessary to property submit the claim, but would also allow the health care program to reallocate funds back into patient care rather than processing claims. Furthermore, a less cumbersome claims process that is nationally standardized will act as a better tool to ferret out actual fraudulent misconduct because the likelihood that a documentation error is due to mistake is reduced. Although the prosecutorial "stick" will still be necessary to deter would-be bad actors, a "carrot" in the form of an incentive program that rewards providers and suppliers for continued good behavior would help achieve policy goals. After all, it is not unreasonable to believe that some, if not many, claims that are up-coded are done so not because the provider means ill will towards the program, but rather has an honest belief that his or her services are worth more than what the program pays and that up-coding is the only means in which to get properly compensated. An incentive program that rewards providers for error free claims with increased compensation based on the length of time that provider has been error-free would address the underlying problem as to why up-coding occurs in the first place.

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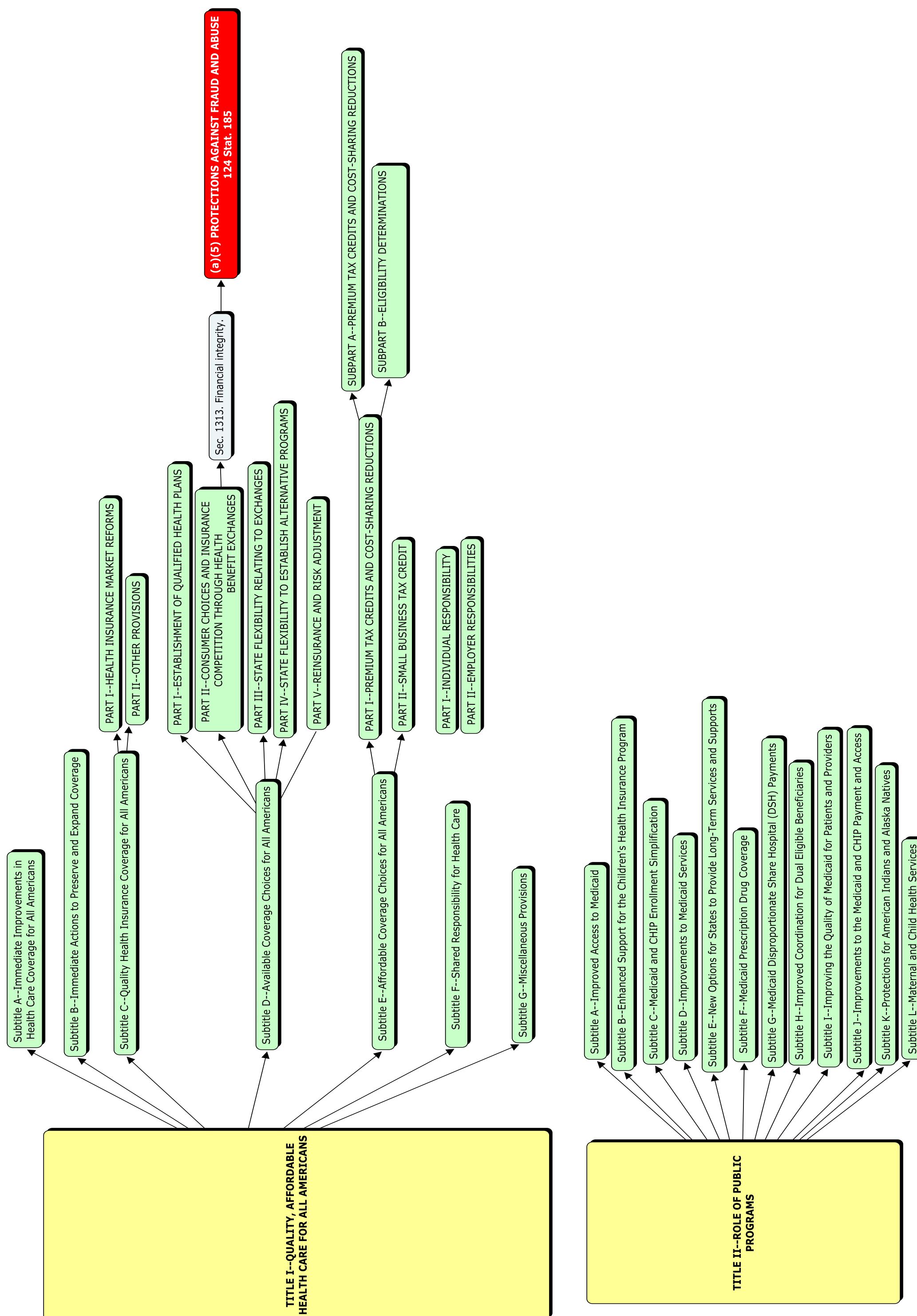
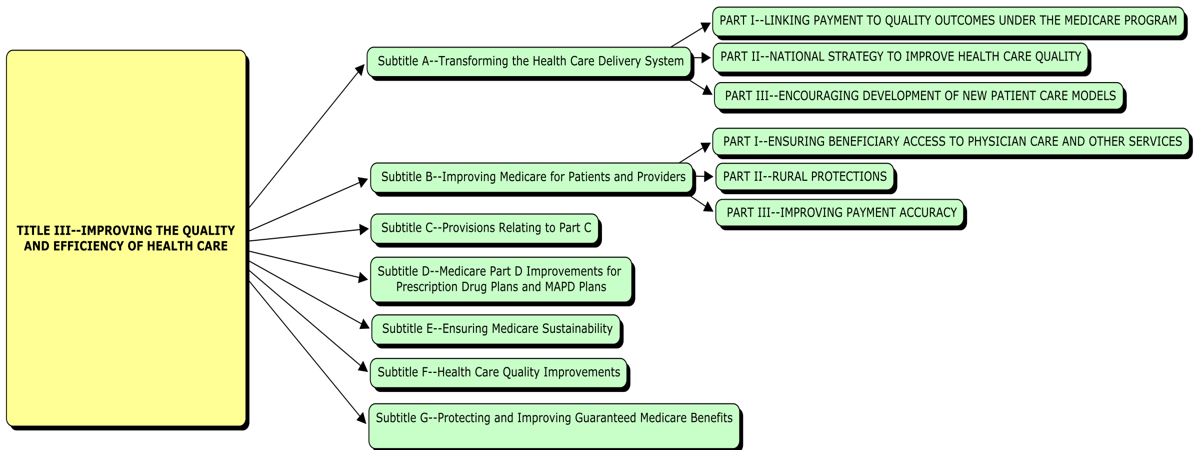
[135] *See supra* note 58; the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 ["HIPAA"] requires some providers and suppliers to use standardized forms when submitting claims, however not all.

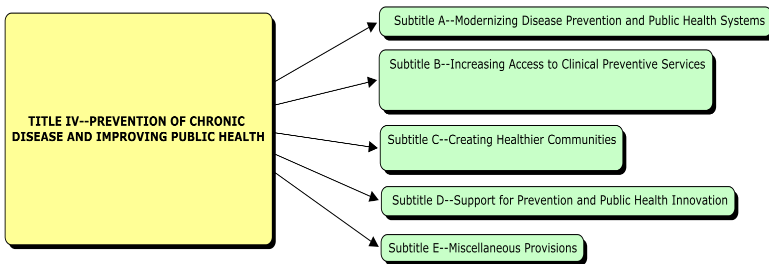
The intent behind the ACA was to make available the best possible health care, to the most number of people, given the finite resources available. To meet these policy objectives, federal health care program must be efficient and effective. In an ideal world, a dollar invested in federal health care would be a dollar spent on providing necessary care to a patient. However, due to fraud, waste and abuse, federal programs must spend billions of dollars to make sure funds are not lining the pockets of individuals not entitled to the money but rather actually treating or preventing sickness and dieses. Figuring out how to reduce this unwanted but necessary expenditure will be dependent whether we can implement creative solutions that actually *prevent* fraud, waste and abuse rather than try to recover what has already been lost.

Appendix

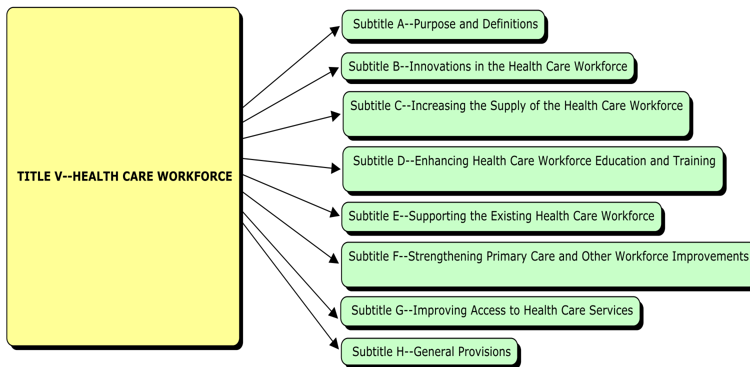




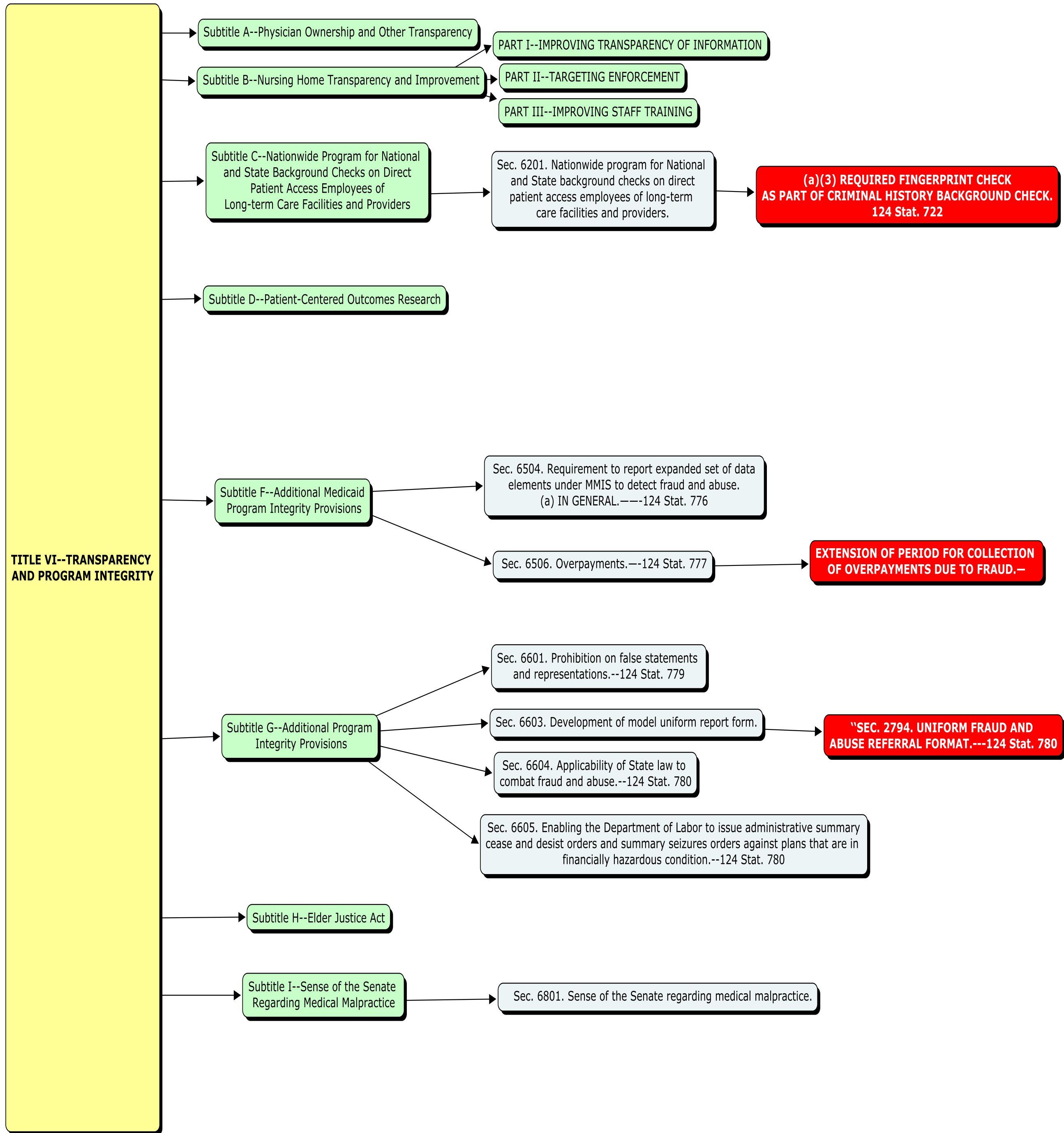
TITLE III--IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE
Subtitle A--Transforming the Health Care Delivery System
PART I--LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM
PART II--NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY
PART III--ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS
Subtitle B--Improving Medicare for Patients and Providers
PART I--ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES
PART II--RURAL PROTECTIONS
PART III--IMPROVING PAYMENT ACCURACY
Subtitle C--Provisions Relating to Part C
Subtitle D--Medicare Part D Improvements for Prescription Drug Plans and MAPD Plans
Subtitle E--Ensuring Medicare Sustainability
Subtitle F--Health Care Quality Improvements
Subtitle G--Protecting and Improving Guaranteed Medicare Benefits



TITLE IV--PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH
Subtitle A--Modernizing Disease Prevention and Public Health Systems
Subtitle B--Increasing Access to Clinical Preventive Services
Subtitle C--Creating Healthier Communities
Subtitle D--Support for Prevention and Public Health Innovation
Subtitle E--Miscellaneous Provisions



TITLE V--HEALTH CARE WORKFORCE
Subtitle A--Purpose and Definitions
Subtitle B--Innovations in the Health Care Workforce
Subtitle C--Increasing the Supply of the Health Care Workforce
Subtitle D--Enhancing Health Care Workforce Education and Training
Subtitle E--Supporting the Existing Health Care Workforce
Subtitle F--Strengthening Primary Care and Other Workforce Improvements
Subtitle G--Improving Access to Health Care Services
Subtitle H--General Provisions


TITLE VI--TRANSPARENCY AND PROGRAM INTEGRITY
Subtitle A--Physician Ownership and Other Transparency
Subtitle B--Nursing Home Transparency and Improvement
PART I--IMPROVING TRANSPARENCY OF INFORMATION
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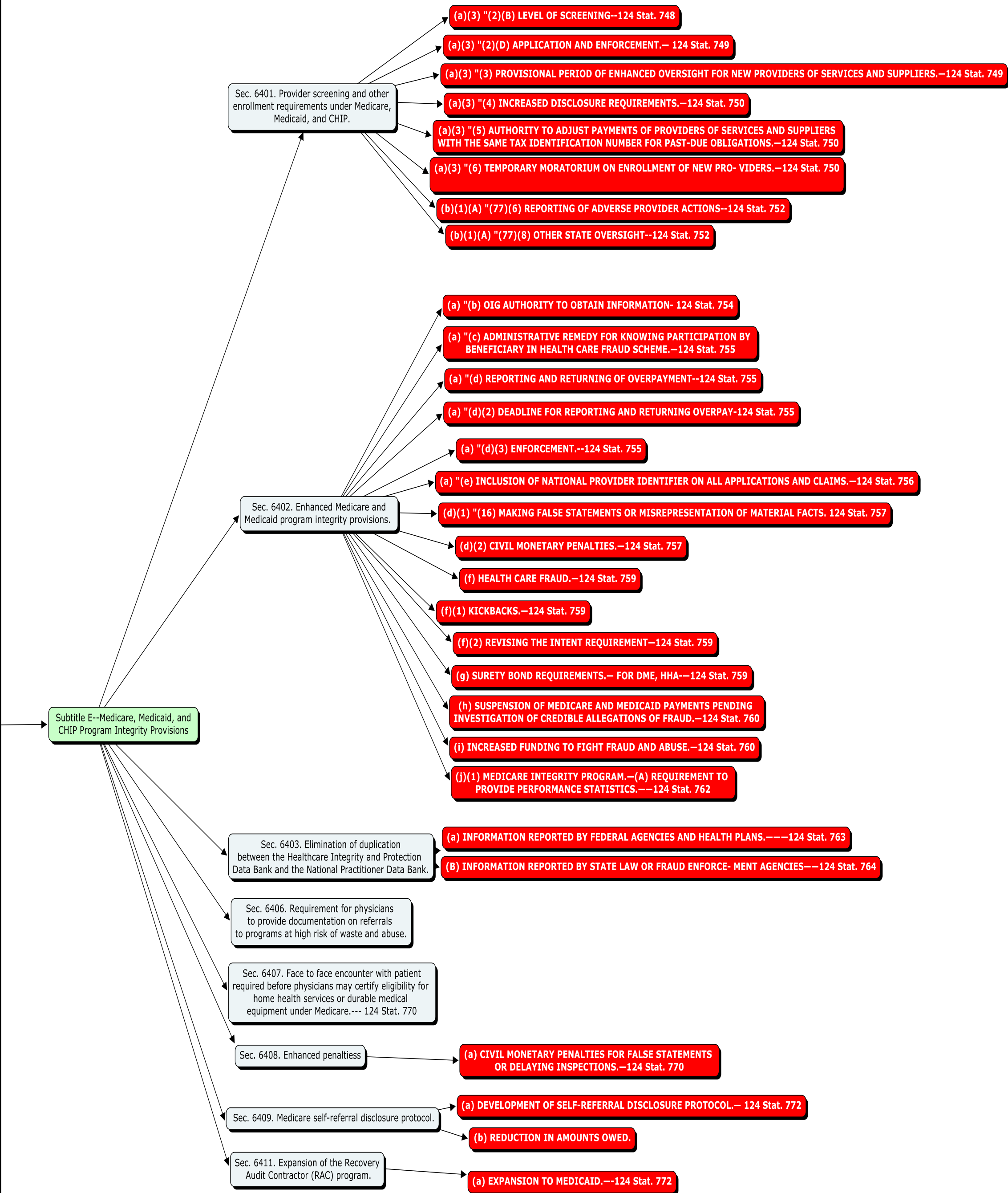
PART III--IMPROVING STAFF TRAINING
Subtitle C--Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers
Sec. 6201. Nationwide program for National and State background checks on direct patient access employees of long-term care facilities and providers.
(a)(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK. 124 Stat. 722
Subtitle D--Patient-Centered Outcomes Research
Subtitle F--Additional Medicaid Program Integrity Provisions
Sec. 6504. Requirement to report expanded set of data elements under MMIS to detect fraud and abuse. (a) IN GENERAL.——-124 Stat. 776
Sec. 6506. Overpayments.—-124 Stat. 777
EXTENSION OF PERIOD FOR COLLECTION OF OVERPAYMENTS DUE TO FRAUD.—
Subtitle G--Additional Program Integrity Provisions
Sec. 6601. Prohibition on false statements and representations.--124 Stat. 779
Sec. 6603. Development of model uniform report form.
''SEC. 2794. UNIFORM FRAUD AND ABUSE REFERRAL FORMAT.---124 Stat. 780
Sec. 6604. Applicability of State law to combat fraud and abuse.--124 Stat. 780
Sec. 6605. Enabling the Department of Labor to issue administrative summary cease and desist orders and summary seizures orders against plans that are in financially hazardous condition.--124 Stat. 780
Subtitle H--Elder Justice Act
Subtitle I--Sense of the Senate Regarding Medical Malpractice
Sec. 6801. Sense of the Senate regarding medical malpractice.


TITLE VI--TRANSPARENCY AND PROGRAM INTEGRITY
Subtitle E--Medicare, Medicaid, and CHIP Program Integrity Provisions
Sec. 6401. Provider screening and other enrollment requirements under Medicare, Medicaid, and CHIP.
(a)(3) "(2)(B) LEVEL OF SCREENING--124 Stat. 748
(a)(3) "(2)(D) APPLICATION AND ENFORCEMENT.— 124 Stat. 749
(a)(3) "(3) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS OF SERVICES AND SUPPLIERS.—124 Stat. 749
(a)(3) "(4) INCREASED DISCLOSURE REQUIREMENTS.—124 Stat. 750
(a)(3) "(5) AUTHORITY TO ADJUST PAYMENTS OF PROVIDERS OF SERVICES AND SUPPLIERS WITH THE SAME TAX IDENTIFICATION NUMBER FOR PAST-DUE OBLIGATIONS.—124 Stat. 750
(a)(3) "(6) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PRO- VIDERS.—124 Stat. 750
(b)(1)(A) "(77)(6) REPORTING OF ADVERSE PROVIDER ACTIONS--124 Stat. 752
(b)(1)(A) "(77)(8) OTHER STATE OVERSIGHT--124 Stat. 752
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(a) "(b) OIG AUTHORITY TO OBTAIN INFORMATION- 124 Stat. 754
(a) "(c) ADMINISTRATIVE REMEDY FOR KNOWING PARTICIPATION BY BENEFICIARY IN HEALTH CARE FRAUD SCHEME.—124 Stat. 755
(a) "(d) REPORTING AND RETURNING OF OVERPAYMENT--124 Stat. 755
(a) "(d)(2) DEADLINE FOR REPORTING AND RETURNING OVERPAY-124 Stat. 755
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(a) "(e) INCLUSION OF NATIONAL PROVIDER IDENTIFIER ON ALL APPLICATIONS AND CLAIMS.—124 Stat. 756
(d)(1) "(16) MAKING FALSE STATEMENTS OR MISREPRESENTATION OF MATERIAL FACTS. 124 Stat. 757
(d)(2) CIVIL MONETARY PENALTIES.—124 Stat. 757
(f) HEALTH CARE FRAUD.—124 Stat. 759
(f)(1) KICKBACKS.—124 Stat. 759
(f)(2) REVISING THE INTENT REQUIREMENT—124 Stat. 759
(g) SURETY BOND REQUIREMENTS.— FOR DME, HHA-—124 Stat. 759
(h) SUSPENSION OF MEDICARE AND MEDICAID PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—124 Stat. 760
(i) INCREASED FUNDING TO FIGHT FRAUD AND ABUSE.—124 Stat. 760
(j)(1) MEDICARE INTEGRITY PROGRAM.—(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.——124 Stat. 762
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(a) INFORMATION REPORTED BY FEDERAL AGENCIES AND HEALTH PLANS.———124 Stat. 763
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Sec. 6406. Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse.
Sec. 6407. Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare.--- 124 Stat. 770
Sec. 6408. Enhanced penaltiess
(a) CIVIL MONETARY PENALTIES FOR FALSE STATEMENTS OR DELAYING INSPECTIONS.—124 Stat. 770
Sec. 6409. Medicare self-referral disclosure protocol.
(a) DEVELOPMENT OF SELF-REFERRAL DISCLOSURE PROTOCOL.— 124 Stat. 772
(b) REDUCTION IN AMOUNTS OWED.
Sec. 6411. Expansion of the Recovery Audit Contractor (RAC) program.
(a) EXPANSION TO MEDICAID.—-124 Stat. 772

TITLE VII--IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

- Subtitle A--Biologics Price Competition and Innovation
- Subtitle B—More Affordable Medicines for Children and Underserved Communities

TITLE VIII--CLASS ACT

TITLE IX--REVENUE PROVISIONS

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TITLE X--STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR

- Subtitle A--Provisions Relating to Title I
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  - PART III--INDIAN HEALTH CARE IMPROVEMENT
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  - SEC. 10606. HEALTH CARE FRAUD ENFORCEMENT.
    - (a) FRAUD SENTENCING GUIDELINES.—
- Subtitle G--Provisions Relating to Title VIII
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