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House Reform Bill Would Add Strong New Federal Enforcement Tools

The Affordable Health Care for America Act approved by the House of Representatives Nov. 7 provides more evidence that Congress is bent on improving Medicare and Medicaid compliance and reducing fraud and abuse through health reform or perhaps freestanding legislation.

Like other Senate and House reform measures, the House bill (HR 3962) promotes provider compliance while arming auditors and enforcers with more tools to identify and punish misconduct. For example, the bill would require compliance programs as a condition of enrollment and re-enrollment, and establish a provider self-disclosure process for Stark violations. But it also calls for adding $100 million to the Department of Justice/HHS war chest and penalizes an array of new offenses.

"You are seeing this with every bill," says John Kelly, former assistant chief for health care fraud at the DOJ's criminal division. "Rising health care costs are a big driver. Regardless of your political affiliation, one way to reduce health care costs is to reduce fraud, waste and abuse."

Kelly notes that the House bill is designed to help CMS and the HHS Office of Inspector General do a better job of keeping high-risk providers out of Medicare. For example, HR 3962 includes a new civil monetary penalty for knowing false statements or material misrepresentations on enrollment applications, says San Francisco attorney Judy Waltz, with Foley & Lardner. "It demonstrates that the government continues to view the enrollment process as the critical first line of defense in its efforts to protect itself against fraudulent providers," she tells *RMC*.

Here are some highlights of the House-passed bill, which will not become law until the Senate passes similar measures and the two chambers reconcile their differences:

◆ ***New civil monetary penalties:*** The bill adds several CMPs that would be levied by the HHS Office of Inspector General. For example, providers would face penalties of $15,000 a day for delaying or refusing to grant prompt access to OIG for audits, investigations or evaluations.

◆ ***Exclusion from Medicare and other federal health care programs:*** The bill allows the OIG to exercise its permissive exclusion authority against providers who obstruct an investigation or audit of fraud. Waltz is concerned about this provision, pointing out that "obstruction is a somewhat elastic concept, and the threat of exclusion has the potential to dramatically change the government's leverage in the audit process." She notes that "auditors and investigators have been known to ask for documents which providers are not required to provide; the potential threat of exclusion may convince providers to simply comply with every request, even those which are not justified as part of the audit."

◆ ***Mandatory overpayment return:*** Providers, suppliers, Medicare Advantage plans and Part D prescription drug plans must return Medicare overpayments within 60 days after learning they exist.

Contact Kelly at jkelly@fulbright.com and Waltz at jwaltz@foley.com. View a 10-page summary of the entire House bill at www.AISHealth.com, and a fraud and abuse/program integrity summary of the bill at http://tinyurl.com/yf8tnua. ✧