Issue Brief

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CMS Issues Final Rule Regarding Program Integrity Enhancements to the Provider Enrollment Process

The Centers for Medicare & Medicaid Services issued a final rule regarding Program Integrity Enhancements to the Provider Enrollment Process (CMS-6058-FC). CMS says the rule will create several new revocation and denial authorities to bolster CMS' efforts to stop waste, fraud and abuse. The rule will require providers and suppliers to disclose certain current and previous affiliations with other providers and suppliers.

This final rule is effective on Monday, Nov. 4. A copy of the 269-page document is currently available at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-19208.pdf. Publication in the ***Federal Register*** is scheduled for Tuesday, Sept. 10. This rule was proposed on March 1, 2016.

The major provisions of this final rule will do the following.

- Implement a provision of the act that requires Medicare, Medicaid and CHIP providers and suppliers to disclose any current or previous direct or indirect affiliation with a provider or supplier that has uncollected debt; has been or is subject to a payment suspension under a federal health care program; has been excluded from Medicare, Medicaid or CHIP; or has had its Medicare, Medicaid or CHIP billing privileges denied or revoked (all of which are hereafter occasionally referred to as "disclosable events"); and that permits the secretary to deny enrollment based on such an affiliation when the secretary determines that it poses an undue risk of fraud, waste or abuse.

++ Define the terms "affiliation," "disclosable event," "uncollected debt" and "undue risk" as they pertain to this provision of the act.

- Provide CMS with the authority to do the following.

++ Deny or revoke a provider's or supplier's Medicare enrollment if CMS determines that the provider or supplier currently is revoked under a different name, numerical identifier or business identity, and the applicable reenrollment bar period has not expired.

++ Revoke a provider's or supplier's Medicare enrollment – including all of the provider's or supplier's practice locations, regardless of

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whether they are part of the same enrollment – if the provider or supplier billed for services performed at, or items furnished from, a location that it knew or should reasonably have known did not comply with Medicare enrollment requirements.

++ Revoke a physician's or eligible professional's Medicare enrollment if he or she has a pattern or practice of ordering, certifying, referring or prescribing Medicare Part A or B services, items or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements.

++ Increase the maximum reenrollment bar from three to 10 years, with exceptions.

++ Prohibit a provider or supplier from enrolling in the Medicare program for as much as three years if its enrollment application is denied because the provider or supplier submitted false or misleading information on or with (or omitted information from) its application to gain enrollment in the Medicare program.

++ Revoke a provider's or supplier's Medicare enrollment if the provider or supplier has an existing debt that CMS refers to the U.S. Department of Treasury.

++ Deny a provider's or supplier's Medicare enrollment application if (1) the provider or supplier currently is terminated or suspended (or otherwise barred) from participation in a state Medicaid program or any other federal health care program; or (2) the provider's or supplier's license currently is revoked or suspended in a state other than that in which the provider or supplier is enrolling.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

COMMENTS

CMS says, "Now, for the first time, we have tools to stop criminals before they can steal from taxpayers. This is CMS hardening the target for criminals and locking the door to the vault. If you're a bad actor, you can never get into the program, and you can't steal from it."

Then, one must ask why it has taken more than three years for CMS to finalize the proposal.

CMS says the following.

- "Our new revocation authorities will lead to approximately 2,600 new revocations per year, resulting in a 10-year savings of $4.16 billion (based on a projected per-revoked provider amount of $160,000)."
- "Our new reenrollment and reapplication bar provisions will apply to approximately 400 of CMS' revocations per year, resulting in an estimated 10-year actual savings of $1.79 billion (based on a projected per-revoked provider amount of $160,000) and a caused savings of $4.48 billion. 'Caused savings' refers to the full amount of money that will be saved based on the new reenrollment and reapplication bars applied over 10 years; a large portion of the savings will be made after the first 10-year period of interest and will not be fully actualized until year 20."
- "Given the foregoing savings estimates for revocations based on new authorities other than the affiliations authority, reenrollment and reapplication bars, and revocations stemming from the affiliations authority (using our median 40 percent figure), we project a total savings over a 10-year period of $47.35 billion."
- "Finally, we do not anticipate any significant impact on beneficiary access to care from the provisions in this final rule. Only a minute fraction of providers and suppliers, when compared to the entire population of providers and suppliers enrolled in Medicare, will be revoked or denied as a result of these new and revised revocation and denial authorities."