Health Care Alert: CMS Proposed Rule Would Establish Powerful New Measures for Uncovering and Combating Medicare Fraud

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On April 24, 2013, the Centers for Medicare and Medicaid Services (CMS) issued a Proposed Rule revamping the Medicare Incentive Reward Program (IRP) and providing CMS with greater discretion to deny or revoke enrollment privileges to certain providers and suppliers posing a higher risk of fraud to the Medicare program. In addition to reducing high-risk enrollments, these changes greatly enhance incentives to whistleblowers and could sharply increase the number of tips that CMS receives regarding potential fraud. Taken together, these changes could significantly boost CMS's ability to detect and recover fraudulent payments.

Maximum Rewards for Reporting Medicare Fraud Increase from $1,000 to $9.9 Million

Under the current IRP, CMS limits rewards for Medicare fraud tips to 10 percent of the first $10,000 of the final amount collected, or a total of $1,000. This rule has had limited efficacy. Since its inception in 1998, the IRP has resulted in collections of less than $3.5 million and payment of only eighteen awards at an aggregate total of less than $16,000. In contrast, under the Proposed Rule, CMS would permit rewards amounting to 15 percent of the final amount collected up to the first $66 million. This new $9.9 million payment cap would undoubtedly create substantial incentives for beneficiaries, providers, and others to report sanctionable conduct despite the three- to five-year timeframe for collection of any reward.

CMS modeled the proposed new IRP off of a highly successful Internal Revenue Service program that has resulted in collections of almost $1.6 billion with approximately $193 million paid out as rewards. CMS projects that its version of the reward program could increase fraud recoveries to an estimated $24.5 million per year at an estimated cost of only $70,000 in reward payouts. To facilitate the IRP and encourage beneficiary involvement, CMS has already begun providing beneficiaries simplified quarterly explanations of benefits containing instructions on how to spot fraud. Types of activities that could lead to eligible tips include billing for services never rendered or supplies not

ordered and offering money, goods, or free services in exchange for a beneficiary's Medicare identification number.

Though in some ways similar to the *qui tam* provisions of the False Claims Act (FCA), the IRP is an entirely separate incentive program. Individuals who have filed a state or federal FCA claim are not eligible to receive the incentive awards. Further, only the first individual to provide specific information leading to an investigation and sanctions would be eligible to receive a payout from the IRP. Thus, tips providing information already included in an FCA claim or subject to other investigation would be ineligible to receive a reward.

Proposed Enrollment Restrictions Target Medicare Fraud

In addition to establishing incentive rewards for viable fraud tips, the Proposed Rule revises enrollment requirements for providers and suppliers perceived to engender a heightened risk of fraud. To that end, CMS proposes four major changes.

First, the Proposed Rule expands the instances in which CMS may deny enrollment based on an unpaid Medicare debt. Anecdotal reports from the Office of Inspector General and assistant U.S. Attorneys General indicate that individuals and entities presently can skirt enrollment restrictions on physicians or nonphysician practitioners who owe a debt to Medicare because of CMS's narrow focus on whether the enrolling provider, supplier, or owner itself has received an "overpayment." Signaling a broader approach to both the relevant type of debt and the scope of the enrollment restrictions, the Proposed Rule examines the total debt owed to Medicare—not solely overpayments—and expands the inquiry whether the individual owner, provider, or supplier owed a debt to whether the individual had a prior relationship with an entity that owed a debt. Thus, if an enrolling provider, supplier or owner was affiliated with an entity that had outstanding Medicare debt or previously owned a provider or supplier that had its enrollment voluntarily or involuntarily terminated, CMS could use those prior relationships to restrict enrollment under a new entity. To overcome these enrollment restrictions, providers and suppliers with these types of prior relationships would have to submit to a repayment plan for the outstanding debt.

Second, the Proposed Rule would expand the instances in which a felony conviction can serve as the basis for denying or revoking enrollment. The current rule permits denial or revocation only if an owner, provider, or supplier has been convicted of a serious felony such as murder, rape or assault; a financial crime; or a felony that exposes Medicare or its beneficiaries to immediate risk. The Proposed Rule eliminates this enumerated list and instead gives CMS broad discretion to deny or revoke enrollment privileges based on *any* felony conviction it deems detrimental to the best interests of Medicare or its beneficiaries. CMS further proposes that this provision would apply to convictions against a provider or supplier's managing employees rather than limiting its application to convictions against an owner or the provider or supplier itself. By expanding the felony requirements to encompass the actions of general or business managers, administrators, directors and others who exercise direct or indirect control over an entity's day-to-day operations, this change would dramatically expand the scope of employees whose conviction could lead to the denial or revocation of an entity's Medicare enrollment.

Third, the Proposed Rule permits CMS to revoke privileges from providers and suppliers that engage in a pattern or practice of submitting improper claims. 42 C.F.R. § 424.535(a)(8), which permits revocation for abusive billing practices, currently permits CMS to revoke billing privileges if a provider or supplier submits

a claim that clearly could not have been furnished to a particular beneficiary on the specified date of service. The Proposed Rule expands this provision to also include an evaluation of whether the billings meet Medicare's requirement that a service be reasonable and necessary. This change shifts CMS's focus from the propriety of individual claims to an examination of overall billing patterns. Although the change gives CMS much broader discretion to revoke enrollment status based on a pattern of inaccurate or erroneous submissions, CMS emphasizes that it intends to apply the provision only in cases where there is an unusually high volume of claims denied for failure to meet Medicare requirements.

Fourth, the Proposed Rule would limit backbilling by ambulance suppliers. CMS previously limited backbilling for physicians and nonphysician practitioners (and their organizations) to claims occurring after the later of (1) the filing date of a subsequently approved enrollment application or (2) the date an enrolled physician or nonphysician practitioner first began furnishing services. But CMS has not previously applied these restrictions globally to all other providers and suppliers. At present, the proposed rule change would apply only to ambulance suppliers; other entities — including rehabilitation centers and home health agencies — would remain exempt from the backbilling restrictions because of the more intensive enrollment process applicable to such certified providers and suppliers. As justification for this approach, CMS cites its belief that ambulance suppliers present a particularly acute risk of overutilization and fraudulent billing. Despite limiting the scope of the backbilling restrictions to ambulance suppliers, however, CMS estimates that the proposal could result in Medicare savings of over $327 million each year.

In addition to these more significant provisions, the Proposed Rule also contains the following minor changes, which may also impact Medicare enrollment:

- rephrasing the definition of enrollment to clarify distinction between provider enrollment in the Medicare program to obtain billing privileges and enrollment that does not receive billing privileges and is solely for the purpose of ordering or certifying items or services for Medicare beneficiaries;
- narrowing the time period in which any provider or supplier other than a home health agency may submit post-revocation claims from 27 months to 60 days after the effective date of the revocation;
- fixing the effective date of the one-to-three-year enrollment bar as beginning 30 days after CMS or a CMS contractor mails notice of revocation rather than permitting the bar to become operative on the effective date of the revocation; and
- limiting the circumstances in which a provider or supplier may submit a corrective action plan (CAP) to cases in which the provider or supplier is determined not to be in compliance with enrollment requirements and providing entities only one opportunity to submit a CAP to correct any deficiencies serving as the basis for a revocation.

The Proposed Rule will be published in the Federal Register on April 29, 2013, and will be open for public comment for 60 days thereafter. Among other things, CMS seeks comment on (1) whether to adopt a more flexible reward structure for the IRP that permits a range of rewards from 15 to 30 percent of total recovery; (2) whether to institute an appeals process for individuals initially granted an award under the IRP but later deemed ineligible; (3) whether the enrollment restrictions on owners, suppliers, or providers with prior Medicare debt should be expanded to include an enrolling entity's managing employees, such as board members, officers and directors; (4) the types of billing patterns that should qualify as a "pattern or practice"; (5) whether the "pattern or practice" rule should incorporate a knowledge standard, such as actual knowledge or reckless disregard; and (6) whether the expanded backbilling restrictions should

encompass more entities than just ambulance suppliers.

If you have questions regarding the implications or scope of this Proposed Rule, please contact your Vorys attorney.