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MCR-Proactive Rule Seeks to Curb Fraud and Abuse Against Vitally Important Federal Healthcare Programs

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The Centers for Medicare & Medicaid Services (CMS) issued a final rule earlier this month that strengthens their ability to stop fraud before it happens by keeping unscrupulous providers out of our federal health insurance programs. This first-of-its-kind action changes the agency's approach to fraud prevention – moving from "pay and chase" to a methodology that aims to stop fraudsters before they receive payment. Here's an overview of how CMS plans to address various program integrity issues.

"The final rule, Program Integrity Enhancements to the Provider Enrollment Process (CMS-6058-FC), creates several new revocation and denial authorities to bolster CMS' efforts to stop waste, fraud, and abuse. Importantly, a new 'affiliations' authority in the rule allows CMS to identify individuals and organizations that pose an undue risk of fraud, waste or abuse based on their relationships with other previously sanctioned entities," according to CMS.

Under the new rule, going into effect Nov. 4, CMS can deny or revoke Medicaid, Medicare, and CHIP program enrollment from providers and suppliers if an owner or manager has a direct or indirect affiliation, now or in the past, with an organization that previously had its enrollment revoked. Medicare, Medicaid, and CHIP providers will have to disclose any current or previous affiliation with an organization that has been excluded, terminated, or suspended from those programs, has uncollected debt, has had a payment suspension under a federal healthcare program, or has had billing privileges denied or rescinded.

The rule also includes other authorities that will enhance CMS' fraud-fighting capabilities by providing a basis for administrative action to revoke or deny Medicare enrollment if a provider or supplier:

- ⇒ Circumvents program rules by coming back into the program, or attempting to come back in, under a different name (e.g., provider attempts to "reinvent" itself)
- ⇒ Bills for services/items from non-compliant locations
- ⇒ Exhibits a pattern or practice of abusive ordering or certifying of Medicare Part A or Part B items, services, or drugs

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⇒ Has an outstanding debt to CMS from an overpayment referred to the Treasury Department

Upping the Stakes for Fraud

Applicants who submit false or misleading information in their initial application will be prohibited from reapplying for up to three years, and any provider or supplier whose enrollment has been revoked will not be permitted to re-enroll for up to 10 years. An applicant whose enrollment has been revoked twice will not be permitted to re-enroll for up to 20 years.

CMS Shifts the Burden of Proof

CMS has implemented several new initiatives in addition to today's rule to increase provider and supplier transparency and accountability while mitigating the burden on Medicare and Medicaid programs. This new rule continues the trend of shifting the burden of proof off CMS and onto providers. Expanding CMS' authority to identify and take action against unqualified and potentially fraudulent entities and individual suppliers who hire, employ, or engage with individuals found to have fraudulent dealings with federal health insurance programs will hopefully deter other parties from engaging in unscrupulous deceptive and criminal behavior.