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April 25, 2016

The Honorable Sylvia Mathews Burwell, HHS Secretary
The Honorable Andrew M. Slavitt, CMS Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244

RE: File Code CMS-6058-P

Dear Secretary Burwell and Administrator Slavitt:

On behalf of the National Health Care Anti-Fraud Association (NHCAA), I am writing in response to the proposed rule published in the March 1, 2016, issue of the *Federal Register* with file code CMS-6058-P, relating to program integrity enhancements to the provider enrollment process under Medicare, Medicaid and the Children's Health Insurance Program (CHIP).

Established in 1985, NHCAA is the leading national organization focused exclusively on combating health care fraud and abuse. We are unique among associations in that we are a private-public partnership—our members comprise the nation's most prominent health insurance plans as well as those federal, state and local government law enforcement and regulatory agencies having jurisdiction over health care fraud.

For more than three decades, NHCAA's mission has been to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution and prevention of health care fraud and abuse. Our commitment to this mission remains the same regardless of whether a patient has private health coverage, or is a beneficiary of Medicare, Medicaid, or any other public program.

On a national level, fraud infects and undermines our nation's health care system and is a drain on finite resources. The extent of financial losses due to health care fraud in the United States, while not entirely known, is estimated to range in the tens of billions of dollars or more annually. It is a serious and costly

problem that affects every patient and every taxpayer. To be sure, the financial losses are considerable, but those losses are compounded by numerous instances of patient harm — unfortunate and insidious side effects of health care fraud that impact patient safety and diminish the quality of our medical care. Health care fraud is not just a financial crime, and it is certainly not victimless. It is from this perspective that NHCAA offers our comments. NHCAA supports CMS's stated purpose for implementing these rules: To address existing program integrity issues and vulnerabilities.

In our reading of the proposed rule, it will, in summary:

- Implement sections of the Affordable Care Act (ACA) requiring Medicare, Medicaid and CHIP providers and suppliers to disclose current and previous affiliations that they have/had with other providers and suppliers. The proposed rule defines affiliations to include those where the provider or supplier:
    - Has uncollected debt;
    - Has been or is subject to payment suspension under a federal health care program;
    - Has been excluded from participation in Medicare, Medicaid or CHIP; or
    - Has had its billing privileges denied or revoked.
- Provide CMS with additional authority to deny or revoke a provider's or supplier's Medicare enrollment:
    - CMS may deny or revoke enrollment if currently revoked under a different name, numerical identifier or business identity;
    - CMS may revoke enrollment if the provider or supplier billed for services performed at or items furnished from a location that it knew or should have known did not comply with Medicare enrollment requirements;
    - CMS may revoke enrollment if the physician has a pattern or practice of ordering, certifying, referring or prescribing Part A or B services, items or drugs that is abusive, represents a threat to the health and safety of beneficiaries or otherwise fails to meet requirements;
    - Proposes to increase the maximum reenrollment bar from 3 to 10 years (with exceptions);
    - Proposes to prohibit a provider or supplier from enrolling in Medicare for up to 3 years if its enrollment application is denied for submitting false or misleading information;
    - CMS may revoke enrollment for an existing debt referred to the US Treasury.
    - CMS may deny a provider's or supplier's Medicare enrollment application if (1) they are currently terminated, suspended or barred from participation in a state Medicaid

program or any other federal health care program, or (2) their license is revoked or suspended in a state other than that in which the provider or supplier is enrolling.

- Require that to order, certify, refer or prescribe any Part A or B service, item or drug a physician (or other eligible professional) must be enrolled in Medicare in an approved status or have validly opted out of the Medicare program.

The rule would permit the Secretary to deny or revoke provider and supplier enrollment based on affiliations that the Secretary determines pose an "undue risk of fraud, waste or abuse," in order to help make certain that entities and individuals who pose risks to the Medicare program are removed and kept out of Medicare for extended periods of time. We are particularly supportive of the effort to address providers and suppliers who attempt to circumvent Medicare requirements through name and identity changes as well as through elaborate, inter-provider relationships.

When the ACA was enacted in 2010, NHCAA was vocal in our support of the many beneficial anti-fraud tools it encompassed—in particular, the provisions devoted to more rigorous provider screening and enrollment processes. From an anti-fraud perspective, one long-held criticism of the Medicare program has been the relative ease with which providers could gain access to the program and begin billing with little more required of them than completing and submitting the necessary paperwork. Of course, with a program that serves more than 55 million American seniors, it is important to ensure that there is acceptable access to health care to meet the needs of beneficiaries. The vast majority of health care providers are legitimate and honest, and follow the rules prescribed by the Medicare program. No one has an interest in burdening honest providers to the extent that they are dissuaded from participating in the program. These underlying considerations had for decades culminated in establishing Medicare as a program that has traditionally enabled "any willing provider" to participate.

However, to the extent that an individual or entity looks to enter a federal health care program with intent to commit fraud, inadequate provider screening and enrollment processes can represent the Achilles' heel of program integrity. For the past several years, the greatly enhanced provider screening requirements enabled by the ACA have contributed to many significant fraud-fighting successes for federal health care programs. The ACA gave the Secretary the authority to establish levels of screening for provider enrollment, to impose payment suspensions "pending an investigation of a credible allegation of fraud," and to impose temporary moratoria on new provider enrollments based on fraud risk. These screening and enrollment requirements have been particularly successful because they address fraud at the historically vulnerable, provider entry point.

We recognize the challenge of implementing provider screening and enrollment reforms that achieve the goal of eliminating fraud while not impacting beneficiary access to care or unnecessarily encumbering legitimate providers who wish to serve the Medicare population. But in order to protect our enormous, yet finite, investment in the program, it is important that Medicare enrolls only qualified providers and suppliers who meet and maintain compliance with the program's participation requirements. The screening and enrollment processes now in place because of the ACA do a good deal in the service of that goal, and the enhanced policies, authorities and requirements described in the proposed rule would do even more to enhance these processes. We strongly support the proposed rule.

With regard to providers and suppliers, NHCAA appreciates that CMS has taken steps to minimize the overall burden imposed by the rule provisions by, for instance, proposing to limit the affiliation look-back period to 5 years and adopting a standard of ''knew or should reasonably have known'' for affiliation disclosures.

Since its inception, NHCAA has been focused on the sharing of anti-fraud information among all payers of health care as an effective means of combating fraud. As CMS seeks to implement these program integrity and provider enrollment requirements, we recommend that the potential for sharing information with other payers, both private and public, concerning the actions taken under these requirements be considered. For example, if CMS revokes or denies enrollment based on risk for fraud, waste or abuse it should share that information -- either about the provider specifically, or any related fraud pattern generally -- with other payers, including Medicare Part C or D contractors, state Medicaid managed care programs, and private health insurers. This type of information sharing is critical to the effective and timely prevention of health care fraud and abuse throughout our nation's health care system.

On behalf of the National Health Care Anti-Fraud Association, thank you for this opportunity to comment on CMS's proposed rule aimed at enhancing program integrity and provider enrollment under federal health care programs. We are available for any questions that you may have.

Sincerely,

Louis Saccoccio
Chief Executive Officer