



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS  
STRONG MEDICINE FOR AMERICA

June 18, 2013

Marilyn Tavenner, Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Room 445–G, Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

Re: Requirements for the Medicare Incentive Reward Program and Provider Enrollment

Dear Administrator Tavenner:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 110,600 family physicians and medical students nationwide, I write in response to the [proposed rule](#) titled, “Requirements for the Medicare Incentive Reward Program and Provider Enrollment,” as published by the Centers for Medicare & Medicaid Services (CMS) in the April 29, 2013, *Federal Register*.

*Medicare Incentive Reward Program*

This regulation proposes to increase potential reward amounts associated with the [Medicare Incentive Reward Program](#) (IRP), which is designed to seek information about individuals and entities that are or have engaged in acts or omissions which resulted in the imposition of a sanction. Created under authority of the *Health Insurance Portability and Accountability Act*, the IRP currently incentivizes individuals to report these acts by offering a potential reward amount of 10 percent of the overpayments recovered in the case or \$1,000, whichever is less. So far, the IRP has resulted in CMS only collecting an annual average of \$193,069.

The Internal Revenue Service (IRS) conducts a similar program that authorizes reward payments to individuals providing information on violations of the IRS code. In 2003, the IRS collected approximately \$61 million, but then in 2004, the IRS significantly increased the potential reward amount (rewards range from 15 percent to 30 percent), resulting in the IRS collecting over \$592 million in 2012.

In general, the AAFP finds the CMS proposal to increase the potential IRP reward as reasonable. The proposed increase (15% of amounts collected up to \$66 million) is similar to changes the IRS made to their program, which made it more successful. Since

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CMS has issued only 18 IRP rewards in the past 15 years, it seems clear that the current incentives are not effective. The AAFP agrees with the CMS assumption that a larger reward may encourage more individuals to report the specific information needed to begin the review or investigation of a provider or supplier for a sanctionable conduct that may lead to the recoupment of an overpayment. The AAFP is hopeful that these changes will result in higher amounts of fraudulently dispersed funds being properly returned to the Medicare Trust Funds and that the increased IRP reward amounts will surpass CMS estimations that this change could recoup approximately \$29 million per year in future recoveries.

Though CMS openly seeks to increase the number of incoming IRP-related tips, the AAFP nevertheless is compelled to urge CMS and its contractors to prepare thoroughly for this increase. Tips, though perhaps made with good intentions, could ultimately include erroneous information, and the AAFP is concerned that increasing the incentive will likely yield many more frivolous submissions. CMS attempts to address this contingency by a proposed attestation requirement, which the agency estimates will take 5 hours to complete. The 5 hours needed for this arduous process may discourage some frivolous tips. An additional way would be to consider holding individuals liable for the provider's costs in responding to the resulting inquiry from CMS when an attestation or related tip is found to be false.

#### *Provider Enrollment*

Separate from the IRP proposed changes, this regulation also proposes to expand the instances in which CMS is able to deny Medicare enrollment. In general, the AAFP supports these changes, since they improve the agency's ability to detect new fraud schemes. We continue to support efforts that help ensure that deceitful entities do not enroll in or maintain their enrollment in the Medicare program.

However, we are concerned that well-intended fraud detection efforts could inadvertently snare law-abiding physicians that unintentionally make a mistake during the enrollment process. The AAFP recognizes and appreciates that the agency revised its program integrity manual and recently published a related educational [document](#) concerning clarifications and improvements to the Medicare Provider Enrollment, Chain and Ownership System (PECOS). Since these proposed efforts and other existing CMS fraud detection and prevention efforts increasingly complicate the enrollment process for family physicians and their practice's administrators, the AAFP encourages CMS to continually evaluate PECOS and make further improvements by the identification and removal of unnecessary and outdated requirements.

In general, the AAFP supports the CMS proposal to use the term "Medicare debt" instead of "overpayment" for reasons the agency specifies, and we believe this term should be interpreted liberally. However, the AAFP does not support CMS expanding this revision to include the enrolling entity's current managing employees, corporate officers, directors, or board members. We find that particular proposed expansion to be excessively broad and unnecessarily complicated.

CMS also proposes to deny Medicare enrollment if the provider, supplier, or current owner was the owner of another provider or supplier that had a Medicare debt that existed when the latter's enrollment was voluntarily or involuntarily terminated or revoked. In general, we support the proposed changes for reasons outlined in the rule. However we strongly encourage CMS to exercise discretion in the application of this authority, as CMS indicates it intends to do in the proposed rule. For example, the AAFP does not believe a 5-percent owner for six months should be penalized to the same extent as someone who has been a 50-percent owner for five years. We think CMS has identified the appropriate factors to consider in this regard, and the only one we might add is whether or not the person was an owner at the time the debt was incurred. That is, if the debt was incurred either before the individual became an owner or after the individual gave up ownership, then we do not think it is appropriate to penalize them for the debt in question. We do not have any minimum or maximums to suggest for any of the factors. As with the proposed debt provision referenced above, the AAFP does not support expanding this change to include managing employees or corporate officers, directors, or board members; we would find such an expansion to be too extensive.

Under current rules, CMS may revoke a provider's or supplier's Medicare billing privileges if the provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service for several specific reasons. CMS proposes to expand dramatically this revocation reason by permitting revocation if the agency determines that the provider or supplier has a pattern or practice of billing for services that do not meet Medicare requirements.

The AAFP flatly opposes this approach. Despite CMS's assertion that it would not use this provision to revoke providers and suppliers for isolated and sporadic claim denials or innocent errors in billing, there are no mechanisms or safeguards to prohibit CMS or its multiple contractors from doing so. In addition, CMS did not include in the proposed regulation a thorough discussion of the factors that would supposedly be used in making this determination. Our opposition to this proposal is that we find the statements made by CMS in this section to be unrealistic. For example the proposed regulation asserts that, "We believe that our proposed revocation reason is important because it would place providers and suppliers on notice that they are under a legal obligation to always submit correct and accurate claims," and later in this same section, it states that, "We believe that a provider or supplier should be responsible for submitting valid claims at all times and that the provider or supplier's repeated failure to do so poses a risk to the Medicare Trust Fund" (emphasis added).

Given the complexity of Medicare's billing and coding rules and the frequency with which they change, Medicare providers will inevitably submit claims that fail to meet Medicare requirements. With no definition of what constitutes a "pattern or practice" of submitting such improper claims, CMS could use this provision to revoke billing privileges for anyone at any time, with the onus put on the provider to prove otherwise on appeal. While CMS's intent may be noble, this proposal is not, and as such, the AAFP opposes it.

Finally, in the 2009 final Medicare physician fee schedule, CMS began to require that revoked physician organizations, physicians, nonphysician practitioners, or independent diagnostic testing facilities must submit all claims for items and services furnished within 60 calendar days of the effective date of the revocation. In this proposed rule, CMS expands the reach of this provision to include all revoked Medicare providers and suppliers, regardless of type. The AAFP supports that expansion, since it would put physicians on a level playing field with other Medicare providers and suppliers in this regard.

We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have or clarifications you might need. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or [rbennett@aafp.org](mailto:rbennett@aafp.org).

Sincerely,

A handwritten signature in black ink that reads "Glen Stream MD". The signature is written in a cursive, flowing style.

Glen Stream, MD, MBI, FAAFP  
Board Chair