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CMS Program Integrity Rules: Enhanced Enforcement Through Medicare and Medicaid Enrollment

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CMS Final Rule with Comment Period

- Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process
  - Published Sept. 10, 2019 at 84 Fed. Reg. 47794
  - Effective Nov. 4, 2019
  - Requested comments by Nov. 4, 2019
    - CMS requested comments on obtaining affiliation information for all newly enrolling and revalidating providers and suppliers

The Big Picture

- In general, the final rule grants CMS the authority to deny or revoke a provider's or supplier's Medicare/Medicaid/CHIP billing privileges for certain "bad acts" of the provider's or supplier's current and past affiliates and the current and past affiliates of the provider's/supplier's owners and managers

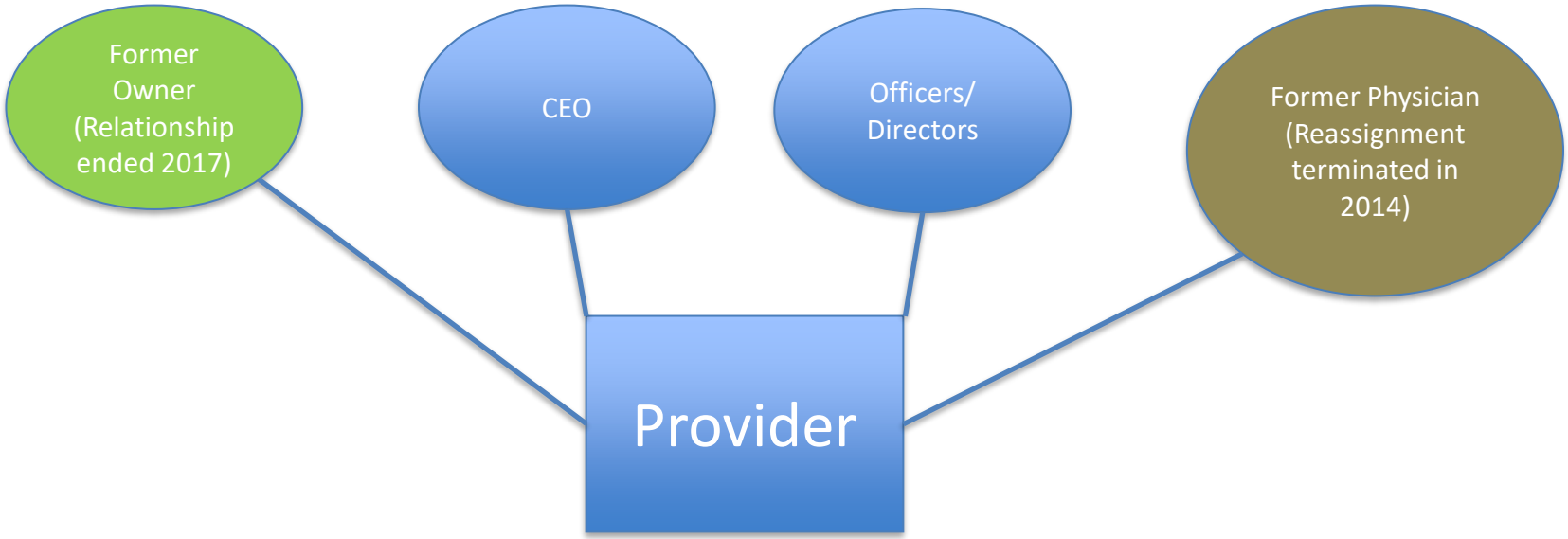
Affiliate Reporting Requirements

- Under the rule, a provider/supplier submitting an initial or revalidation enrollment application may have to disclose certain current and past affiliations with other providers/suppliers that have been subject to a “disclosable event”
- Initially, CMS will inform a provider/supplier when it must report such an affiliation
  - CMS plans further rulemaking to require all providers/suppliers to make such disclosures
- CMS has delayed enforcement of the affiliation rules until it has updated the Form 855 enrollment applications and the online PECOS system

Affiliations

- Under the rule, an “affiliate” means any:
  - 5% or greater direct/indirect ownership interest
  - General or limited partnership interest (regardless of the percentage)
  - Individual/entity with operational or managerial control
  - Officer or director of a corporation
  - Reassignment relationship
- The rule uses a 5 year look-back period to determine whether an affiliation exists

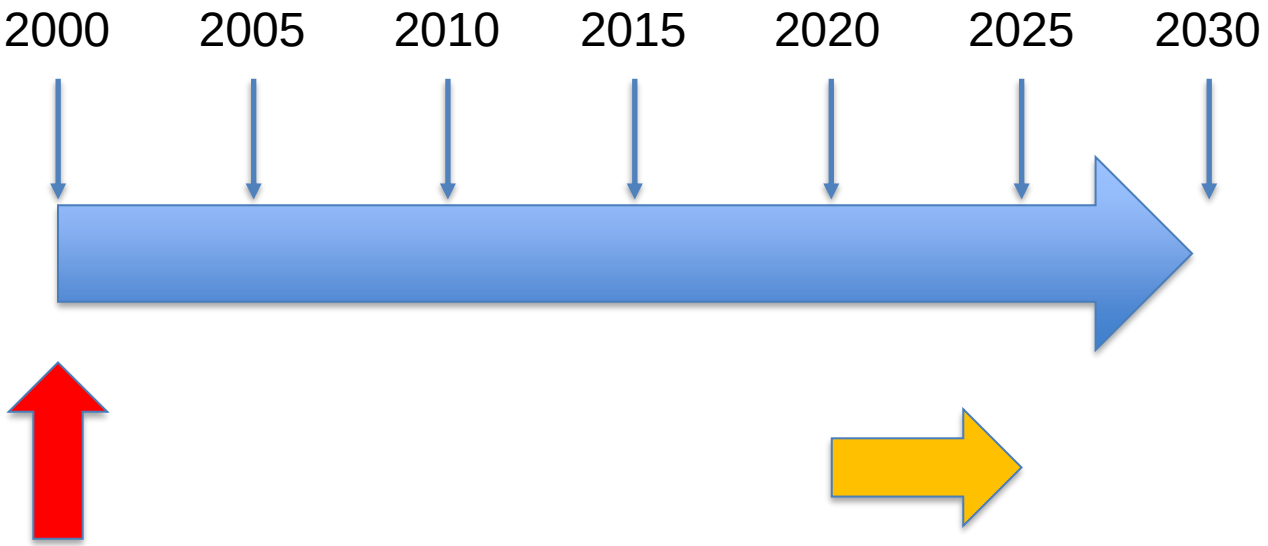
Affiliations – Cont'd



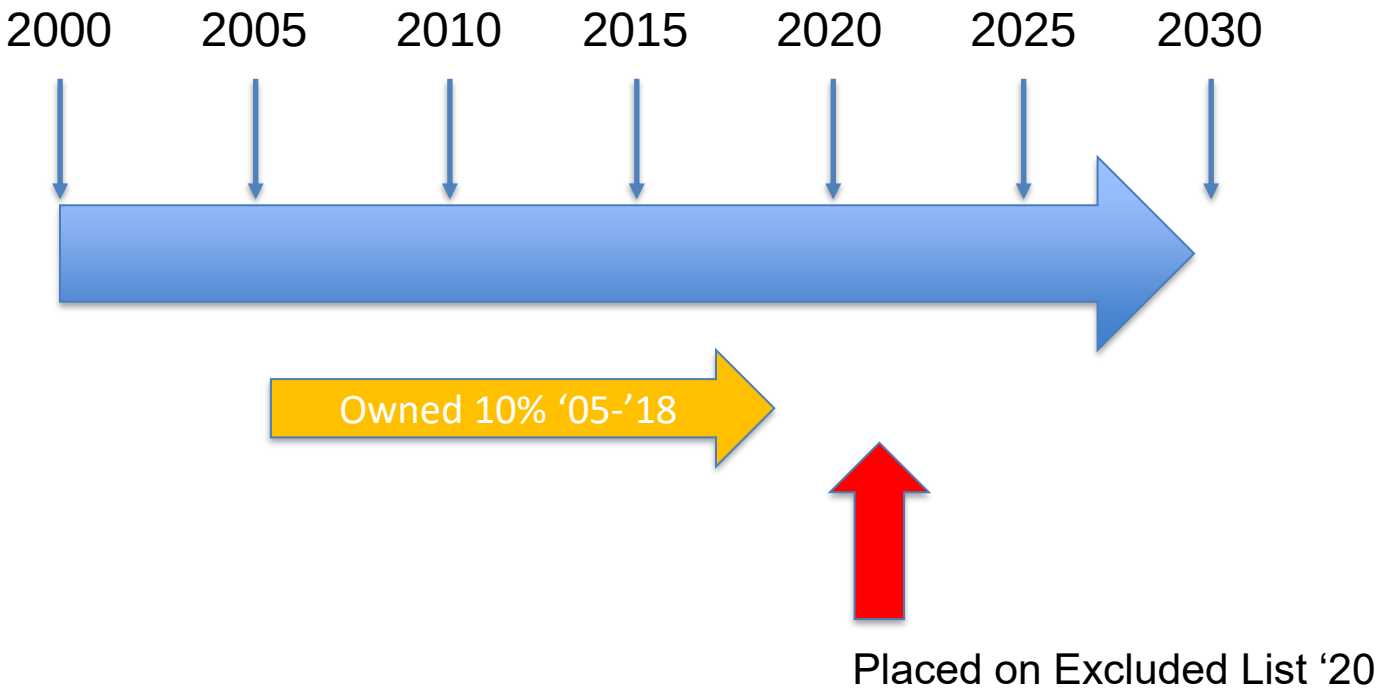
Disclosable Events

- A “disclosable event” includes:
  - Uncollected Medicare, Medicaid, or CHIP debt
  - The provider/supplier has been subject to a payment suspension
  - OIG Exclusion from the Medicare, Medicaid, or CHIP programs
  - Denial or revocation of billing privileges
- There is no limit or look-back period to a disclosable event

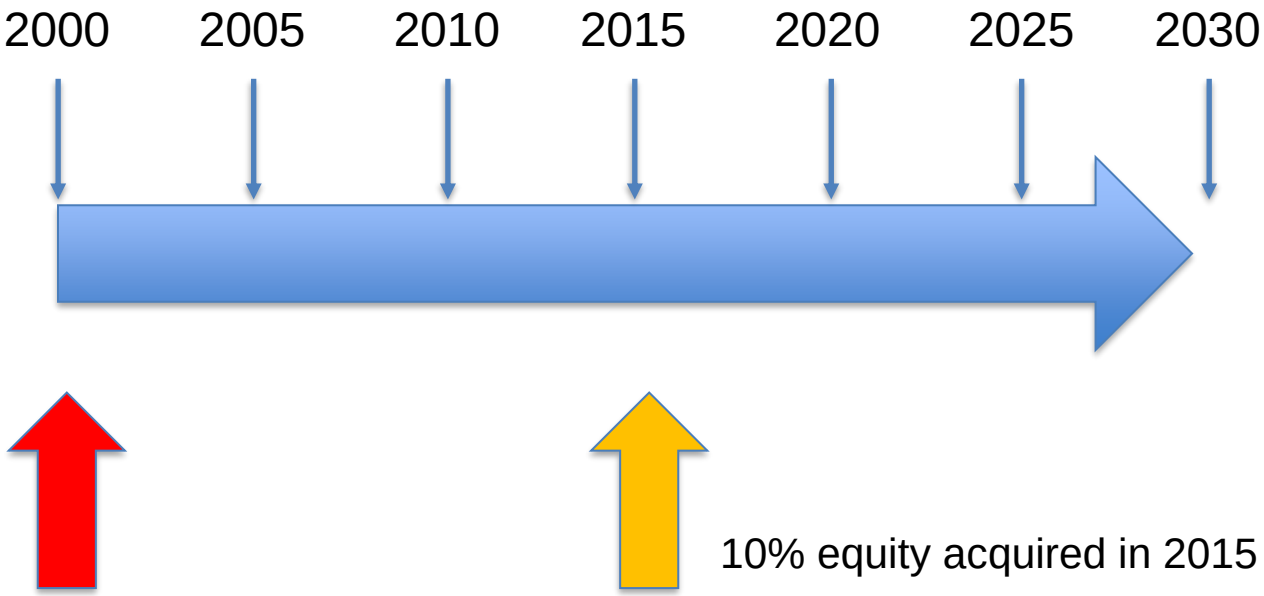
Disclosable Event – Cont'd



Disclosable Event – Cont'd



Disclosable Event – Cont'd



Placed on Excluded List '00, but enrollment bar expired in '03

Reporting Requirement

- In addition to reporting its own affiliates, a provider/supplier may have to report the affiliations of its owners and managing employees
- Upon CMS's request, the provider/supplier will need to report the specific affiliation identified by CMS, as well as any other affiliation with a disclosable event
- CMS may deny or revoke privileges for a provider's or supplier's failure to report an affiliation/disclosable event that it knows, or should have known would lead to a denial or revocation of enrollment

Undue Risk

- Once reported, CMS will determine whether the affiliation poses an “undue risk” to the Medicare, Medicaid, or CHIP programs and, if so, deny or revoke the provider or supplier’s enrollment

Undue Risk – Cont'd

- In determining whether an affiliation is an undue risk, it will consider:
  - Duration of the affiliation
  - Whether the affiliation still exists/when it terminated
  - Degree and extent of affiliation
  - Reason for termination of affiliation
  - As well as:
    - Type of disclosable event
    - When the disclosable event occurred
    - Whether the affiliation existed when the disclosable event occurred
    - The amount of debt, whether the debt is being repaid, and to whom the debt is owed
    - The reason for the denial, revocation, or payment suspension

Undue Risk – Cont'd

- In response to comments that its proposed rule was overly burdensome, CMS says Don't Worry!!
  - CMS plans to issue subregulatory guidance on various issues, including the level of effort providers and suppliers must expend trying to map out potential affiliates with reportable events
- Likewise, in response to various comments that disclosures could result in denials and revocations for relatively common and/or minor "disclosable events," CMS said that it would consider the "undue burden" factors "very carefully" before making a determination and will only deny or revoke a provider/supplier's privileges after "careful consideration"

Medicaid

- The final rule requires states to adopt the same affiliation disclosure requirements
- Medicaid rules will not become effective until states adopt such rules and revise enrollment forms
- States may implement the rules in one of two ways
  - Require all newly enrolling and revalidating Medicaid providers to report affiliations with disclosable events; or
  - Only require such reporting upon request of the State

Denial and Revocation of a Related Provider/Supplier

- Under the final rule, CMS may deny or revoke a provider's enrollment if it determines that the provider/supplier is currently revoked under a different name, numerical identifier, or business entity, and the reenrollment bar period has not expired
- When making this determination, CMS will consider:
  - Similar ownership or management
  - Geographic location
  - Provider/supplier type
  - Business structure
  - Evidence indicating that the two parties are similar or that the provider/supplier was created to circumvent the revocation and reenrollment bar

Noncompliant Location

- CMS may also revoke a provider's/supplier's enrollment, including all practice locations, if it billed for goods or services from a location that the provider/supplier knew or should have known did not comply with Medicare's enrollment requirements
- CMS will consider:
  - Reason for non-compliance
  - Number of additional locations involved
  - The provider's/supplier's history of final adverse actions or payment suspensions
  - Degree of risk posed to Medicare
  - Length of time of non-compliance
  - Amount billed
  - Other information deemed relevant by CMS

Noncompliant Location – Cont'd

- CMS seems focused on a provider or supplier's failure to notify CMS of a relocation in a timely manner as well as use of "false storefronts"
- CMS could result in an organization losing ALL of its enrollments

Failure to Timely Report Enrollment Information

- The final rule expands CMS's authority to specifically allow it to revoke a provider or supplier's enrollment for failure to timely report **any changes** to its Medicare enrollment information
  - This was previously limited to physicians/non-physicians that failed to report an adverse event or a change in practice location
  - Note, this is also in addition to CMS's previous authority to revoke a provider/supplier for non-compliance
- In using this authority, CMS will review:
  - Whether the data was reported
  - How belatedly the data was reported
  - Materiality of the data
  - Any other information CMS deems relevant

Other Updates

- Extends the re-enrollment bar to 10 years
- Allows an additional 3-year bar if a provider or supplier tries to circumvent a bar using a different name/entity
- Allows for a 20-year bar for repeat offenders

Key Takeaways

- Review existing Medicare and Medicaid enrollment information to verify that information is up to date and correct Common issues include:
  - Wrong or missing NH Administrator
  - Changes to the Board of Directors and Officers were never reported
- Prepare and implement a plan to track affiliations

Questions?

THANK YOU

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