FACT SHEET: Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process

September 10, 2019

Background

The Centers for Medicare & Medicaid Services (CMS) released a final rule, effective November 4, 2019, implementing statutory provisions that require Medicare, Medicaid, and Children's Health Insurance Program (CHIP) providers and suppliers to disclose certain current and previous affiliations with other providers and suppliers. In addition, it provides the agency with more authority to deny or revoke a provider's or supplier's Medicare enrollment in certain specified circumstances.

The proposed rule was first published on March 1, 2016, and the final rule was published on September 10, 2019. The rule relies on statutory authority from the Affordable Care Act, which created additional requirements in Section 1866(j)(5) of the Social Security Act for disclosure of certain information upon provider enrollment and revalidation. The intention of the legislation and accompanying regulations is to identify relationships between currently enrolled or enrolling providers and suppliers and their affiliates who have run afoul of certain laws and regulations. The goal is to prevent providers and suppliers from being able to evade federal health care program integrity provisions by changing names or establishing complex entity relationships, and to identify those entities before enrolling and making payments that would not otherwise be eligible.

Rule

The rule, which goes into effect on November 4, 2019, will require providers and suppliers to disclose, at enrollment or revalidation, affiliations with entities that have had a disclosable event (see definitions section below). Providers and suppliers will be responsible for determining if any of their affiliates meet the reporting requirements. Failure to report may lead to denial or revocation of enrollment.

The rule gives CMS enforcement powers it may use on entities in certain situations. Under the new rule, CMS may:

- Deny or revoke a provider's or supplier's Medicare enrollment if CMS determines that the provider or supplier is currently revoked under a different name, numerical identifier, or business identity, and the applicable reenrollment bar period has not expired.
- Revoke a provider's or supplier's Medicare enrollment -- including all of the provider's or supplier's practice locations, regardless of whether they are part of the same enrollment -- if the provider or supplier billed for services performed at, or items furnished from, a location that it knew or should reasonably have known did not comply with Medicare enrollment requirements.
- Revoke a physician's or eligible professional's Medicare enrollment if he or she has a pattern or practice of ordering, certifying, referring, or prescribing Medicare Part A or B services, items, or drugs that is abusive, represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements.
- Increase the maximum reenrollment bar from 3 to 10 years, with exceptions as stated in this

rule.

- Prohibit a provider or supplier from enrolling in the Medicare program for up to 3 years if its enrollment application is denied because the provider or supplier submitted false or misleading information on or with (or omitted information from) its application in order to gain enrollment in the Medicare program.
- Revoke a provider's or supplier's Medicare enrollment if the provider or supplier has an existing debt that CMS refers to the United States Department of Treasury.
- Deny a provider's or supplier's Medicare enrollment application if (1) the provider or supplier is currently terminated or suspended (or otherwise barred) from participation in a state Medicaid program or any other federal health care program; or (2) the provider's or supplier's license is currently revoked or suspended in a state other than that in which the provider or supplier is enrolling.

Definitions

Affiliation:
For the purposes of the rule, affiliation is defined as:

- A 5 percent or greater direct or indirect ownership interest that an individual or entity has in another organization.
- A general or limited partnership interest (regardless of the percentage) that an individual or entity has in another organization.
- An interest in which an individual or entity exercises operational or managerial control over, or directly or indirectly conducts, the day-to-day operations of another organization (including, for purposes of 42 CFR § 424.519 only, sole proprietorships), either under contract or through some other arrangement, regardless of whether or not the managing individual or entity is a W–2 employee of the organization.
- An interest in which an individual is acting as an officer or director of a corporation.
- Any reassignment relationship under 42 CFR § 424.80, which allows entities to reassign the recipient of their Medicare claims payments under certain circumstances. Note this provision only applies to suppliers.

Disclosable Event:
A provider or supplier that is submitting an initial or revalidating Form CMS-855 application must disclose whether it or any of its owning or managing employees or organizations have or, within the previous 5 years, had an affiliation with a currently or formerly enrolled Medicare, Medicaid, or CHIP provider or supplier that:

- Currently has an uncollected debt to Medicare, Medicaid, or CHIP, regardless of (1) the amount of the debt; (2) whether the debt is currently being repaid (for example, as part of a repayment plan); or (3) whether the debt is currently being appealed;
    - “Uncollected debt" only applies to Medicare, Medicaid, or CHIP overpayments for which CMS or the state has sent notice of the debt to the affiliated provider or supplier; civil money penalties; and assessments.
- Has been or is subject to a payment suspension under a federal health care program regardless of when the payment suspension occurred or was imposed;
- Has been or is excluded by the Office of the Inspector General from participation in Medicare, Medicaid, or CHIP, regardless of whether the exclusion is currently being appealed or when the

exclusion occurred or was imposed; or

- Has had its Medicare, Medicaid, or CHIP enrollment denied, revoked or terminated, regardless of (1) the reason for the denial, revocation, or termination; (2) whether the denial, revocation, or termination is currently being appealed; or (3) when the denial, revocation, or termination occurred or was imposed.

How to Comply

Analyze your business affiliates to determine if they have had a disclosable event in the last 5 years. If they have, be prepared to report any such affiliation when enrolling or revalidating with Medicare, Medicaid, or CHIP. Furthermore, should you or your practice be subject to a disclosable event, use extreme caution in attempting to re-enroll in Medicare, Medicaid or CHIP. Ensure you are, in fact, eligible to reenter the program. CMS' enforcement powers have been greatly strengthened, andthere may be retributive consequences for attempting to re-enroll too soon.

Resources

Final Rule: Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process

CMS Press Release: Final Rule: Medicare, Medicaid, and Children's Health Insurance Programs; Program Integrity Enhancements to the Provider Enrollment Process

New Rule Allows CMS to Deny Enrollment to Providers Affiliated with Sanctioned Entities – PT in Motion 9/9/2019