Issue Brief

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KEY POINTS

- CMS proposes additional provider enrollment provisions of the ACA to reduce fraud, waste and abuse.
- The provision would require certain Medicare, Medicaid and CHIP providers and suppliers to disclose direct or indirect affiliations that pose an undue risk of fraud, waste or abuse.
- The provision would provide CMS with the authority to deny or revoke provider or supplier Medicare enrollment based upon these affiliations.

CMS Issues Proposed Rule Regarding Program Integrity Enhancements to the Provider Enrollment Process

The Centers for Medicare & Medicaid Services has issued a proposed rule that would implement additional provider enrollment provisions of the Affordable Care Act to help make certain that entities and individuals who pose risks to the Medicare program and beneficiaries are kept out of or removed from Medicare for extended periods.

A copy of the 152-page document is available at https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-04312.pdf. The rule is scheduled for publication March 1. A 60-day comment period is provided. After March 1, the above link will change to http://federalregister.gov/a/2016-04312.

COMMENT

CMS has not determined costs that providers will incur in reporting required requirements. Rather, CMS indicates that removing or maintaining exclusion of certain providers and suppliers would by itself save Medicare monies.

The major provisions in this proposed rule would do the following:

- Implement a provision of the ACA that requires certain Medicare, Medicaid and CHIP providers and suppliers to disclose if a provider or supplier has any current or previous direct or indirect affiliation with a provider or supplier that has uncollected debt; has been or is subject to a payment suspension under a federal health care program; has been excluded from Medicare, Medicaid or CHIP; or has had its Medicare, Medicaid or CHIP billing privileges denied or revoked, and that permits the Secretary to deny enrollment based on an affiliation that the Secretary determines poses an undue risk of fraud, waste or abuse.

- Provide CMS with the authority to do the following.
  - Deny or revoke a provider 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.

4712 Country Club Drive
Jefferson City, MO 65109

P.O. Box 60
Jefferson City, MO 65102

573/893-3700
www.mhanet.com

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- 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 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 are 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.
- CMS may impose a reenrollment bar of up to 20 years if the provider or supplier is being revoked from Medicare for the second time.
- 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 to gain enrollment in the Medicare program.
- Revoke a provider or supplier's Medicare enrollment if the provider or supplier has an existing debt that CMS refers to the United States Department of Treasury.
- Require that to order, certify, refer or prescribe any Part A or B service, item or drug, a physician or, when permitted under state law, an eligible professional, must be enrolled in Medicare in an approved status or have validly opted-out of the Medicare program. Also, the provider or supplier furnishing the Part A or B service, item or drug, as well as the physician or eligible professional who ordered, certified, referred or prescribed the service, item or drug, would have to maintain documentation for 7 years from the date of the service and furnish access to that documentation upon a CMS or Medicare contractor request.
- 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 particular 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.

DEFINITION OF "AFFILIATION"

CMS proposes to define "affiliation" as meaning, for purposes of applying § 424.519, any of the following.

- 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.

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- 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 § 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 § 424.80.

The first four types of interests are consistent with the definitions of — (1) "owner" and "managing employee" in § 424.502; and (2) "ownership or control interest" in Section 1124(a)(3) of the Act. CMS also notes that consistent with Sections 1124 and 1124A of the Act, entities and individuals that have one or more of these four interests in an enrolling or enrolled Medicare provider or supplier must be reported on the provider's or supplier's Form CMS-855 enrollment application. Likewise, reassignment relationships must be reported to Medicare via the Form CMS-855R (OMB Control No. 0938-1179); this form facilitates the reassignment of benefits from a physician or nonphysician practitioner to another Medicare provider or supplier. To make certain that there is uniformity with these other reporting requirements and that CMS is aware of prior and current relationships that could present risks of fraud, waste or abuse, CMS believes that the "affiliation" definition should include these five interests.

Disclosable Events (§ 424.519)

In new § 424.519, CMS proposes that 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 (consistent with the terms "owner" and "managing employee" as defined in § 424.502) has or, within the previous 5 years, has 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.
- Has been or is subject to a payment suspension under a federal health care program (as that term is defined in Section 1128B(f) of the Act), regardless of when the payment suspension occurred or was imposed;
- Has been or is excluded from participation in Medicare, Medicaid or CHIP, regardless of whether the exclusion is currently being appealed or when the exclusion occurred or was imposed (although Section 1866(j)(5) of the Act states "has been excluded," we believe it is appropriate to clarify that a current exclusion is also a disclosable event); 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. For purposes of § 424.519 only, and as stated in proposed paragraph (a), the terms "revoked," "revocation," "terminated,"

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and "termination" would include situations where the affiliated provider or supplier voluntarily terminated its Medicare, Medicaid or CHIP enrollment to avoid a potential revocation or termination.

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

CMS provides the following summarization process for disclosing information under § 424.519 as follows.

First, the provider or supplier must determine whether it or any of its owning or managing individuals or organizations has or has had an affiliation (as defined in § 424.502).

Second, if an affiliation exists or existed within the applicable 5-year timeframe, the provider or supplier must determine whether a disclosable event in § 424.519(b) has occurred. If it has, it must be disclosed.

Third, CMS would determine whether the affiliation poses an undue risk of fraud, waste or abuse. If it does, the provider's or supplier's application would be denied or, if applicable, the provider's or supplier's enrollment would be revoked. The provider or supplier may appeal the denial or revocation under § 405.874 or part 498, respectively.

FINAL THOUGHTS

It is hard to argue against rules that are intended to ferret out fraud and abuse. The overriding theme of this proposal is reporting and disclosure.

CMS has provided a number of examples that help clarify its position relative to such reporting and disclosure. Nonetheless, these examples cannot cover all possible situations.

While one can understand the requirements and changes being proposed, there is also a definite legal prescription present. Therefore, this proposal should be reviewed by provider legal counsel to avoid any potential problems.