

Medicare Continues its Updates to Provider Enrollment Policies as Part of Efforts to Enhance Program Integrity and Transparency

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The Centers for Medicare & Medicaid Services (“CMS”) continued its efforts to increase oversight of the Medicare program by updating Medicare provider enrollment regulations and policies through recent regulatory and sub-regulatory actions. These efforts, which are described in detail below, include updates to Medicare’s provider and supplier enrollment regulations at 42 C.F.R. §424, Subpart P and changes to the Form CMS-855A for the first time in twelve years. These changes are another indicator of Medicare’s trend towards enhanced oversight and enforcement of program integrity standards as health care providers and suppliers have exited the COVID 19 Public Health Emergency. Notably, CMS has consistently trended towards enhanced disclosure and publication of ownership and control interests for certain providers, including a recent policy to finalize public disclosure of the ownership interests of skilled nursing facilities (which are subject to a separate e-Alert). This e-Alert provides a high-level overview of the recent Medicare provider enrollment updates. Please reach out to the authors or your Polsinelli attorney with any questions.

1. CMS Finalized Several Proposals Amending the Medicare Provider Enrollment Regulations for All Medicare Providers and Suppliers in the [2024 Medicare Physician Fee Schedule Final Rule](#).

- *CMS established a “Stay of Enrollment” Status to Provide an Opportunity for Providers or Suppliers to Correct Their Enrollment Information Rather than Face Deactivation.* CMS finalized its policy to create a “stay of enrollment” provider enrollment status, which it describes as a “middle ground between a deactivation and non-action on our part,” where there is non-compliance with Medicare enrollment requirements. A “stay of enrollment” will be a “pause” in an existing supplier or provider’s enrollment and would not last for more than 60 days. CMS will impose a stay of enrollment only when: (i) a provider or supplier is not compliant with at least one Title 42 enrollment requirement; and (ii) when it ascertains the non-compliance may be remedied through the provider or supplier’s submission of the appropriate enrollment report (Form CMS-855, Form CMS 20134, or Form CMS-588). A provider or supplier placed on a stay of enrollment will be permitted to retroactively bill for services performed during the stay period if CMS or a MAC determines they have returned to compliance prior to the expiration of the 60 day stay period and the stay ends prior to the end of the 60-day period.

- *CMS Expands its Denial and Revocation Authorities to Include Civil False Claims Act Judgments.* CMS finalized new regulations creating a discretionary denial or revocation authority if a provider or supplier, or any owner, managing employee or organization, officer, or director has had a False Claims Act (“FCA”) civil judgment entered against them within the previous 10 years. “Civil judgment” would not include False Claims Act settlement agreements. In exercising its discretionary authority, CMS will consider the conduct leading to the FCA judgment in making an enrollment determination. This authority will only apply to FCA judgments entered after January 1, 2024.
- *CMS Declined to Expand its Revocation Authority to Certain Misdemeanors.* Although CMS proposed expanding revocation authority to instances where a provider or supplier, or any owner, managing employee or organization, officer, or director had been convicted of a misdemeanor under certain circumstances, it declined to finalize the authority in the final rule. After receiving several comments opposing the proposal, CMS noted they will continue to monitor cases of misdemeanor convictions involving significant misconduct and may pursue future rulemaking to address them.
- *CMS Amended or Created Several New Regulatory Definitions.* CMS responded to several requests by providers and suppliers to amend key definitions and implemented changes or additions to the following:
 - Added a definition of “indirect ownership interest,” as follows: “(1)(i) Any ownership interest in an entity that has an ownership interest in the enrolling or enrolled provider or supplier. (ii) Any ownership interest in an indirect owner of the enrolling or enrolled provider or supplier. (2) The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the provider or supplier, A’s interest equates to an 8 percent indirect ownership interest in the provider or supplier and must be reported on the enrollment application. Conversely, if B owns 80 percent of the stock of a corporation that owns 5 percent of the stock of the provider or supplier, B’s interest equates to a 4 percent indirect ownership interest in the provider or supplier and need not be reported.” 42 C.F.R. 424.502(1). This provides clarity in regulatory text of how providers and suppliers should calculate the ownership percentages for indirect owners.
 - Amended the definition of “supplier” at 42 C.F.R. 424.502 to include physical therapists in private practice, occupational therapists in private practice and speech-language pathologists.
 - Amended the definition of “authorized official” to clarify that the “organization” referenced in the definition is meant to refer to the enrolling entity, as defined by its legal name and tax identification (rather than the provider or supplier type the entity is enrolling as).
- *CMS Clarified the Timelines for Reporting a Change in Location.* The Final Rule requires all providers and suppliers to report a change in practice location within 30 days of the change (currently, some must report within 90 days). CMS also clarified that a change in practice location includes adding a new location or deleting an existing location.
- *New Enrollment Categories: Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs).* Marriage and Family Therapists (“MFTs”) and Mental Health Counselors (“MHCs”) are now able to enroll as Medicare suppliers as of November 2, 2023. MFTs and MHCs may begin billing Medicare for their services on January 1, 2024 – services rendered before this date will not be payable.
- *Remote Practitioner Enrollment.* CMS is extending the flexibility for telehealth practitioners to use their currently enrolled practice location instead of using their home address when providing services from their home through CY 2024. CMS requests that interested parties provide examples of how the enrollment process shows material risks

to practitioners when considering including a practitioner's home address as the distant site.

2. CMS Implemented the 36 Month Rule for Medicare Enrolled Hospices and Categorized Hospices as “High-Risk” in the [2024 Home Health Prospective Payment System Final Rule](#).

- *CMS Applies 36-Month Rule to Enrolled Hospices.* Effective January 1, 2024, Medicare enrolled hospice providers will be subject to the “36-Month Rule” which will forbid any change in majority ownership of a hospice provider during the 36 months after initial Medicare enrollment or its most recent change in majority ownership. If a change in majority ownership occurs within 36 months of an initial enrollment or previous change in majority ownership, the enrolled hospice's Medicare provider agreement will not be assigned to the purchaser. Additionally, the purchaser will be required to go through the initial enrollment process, which can take up to a year or more to complete.

The 36-Month Rule was originally created for Medicare enrolled home health agencies. When proposed, CMS explained the impetus behind the expansion of the 36 Month Rule to hospice providers was influenced by growing concerns about improper behavior and compliance violations within the hospice community. Therefore, CMS' decision to expand the 36 Month Rule to hospice providers is generally consistent with the rationale that led to the rule's original application in the home health industry. Namely, CMS is attempting to discourage investors and operators from “flipping” an enrolled facility quickly after its enrollment or purchase for the purpose of circumventing a CMS survey.

- *CMS Categorized Hospices as “High-Risk.”* Hospices initially enrolling in Medicare will now be deemed “high risk” providers. This means all individuals with a 5% or greater indirect or direct ownership interest in a newly enrolling hospice will be required to submit fingerprints for a criminal background check. Further, any new individual owners with 5% or greater indirect or direct ownership in a currently enrolled hospice will be required to undergo fingerprinting.

3. CMS Releases Revisions to CMS Form 855A – The First Amendments in Twelve Years

Be aware that for the first time in 12 years CMS has released a new [CMS Form 855A](#). The form was primarily designed to capture new requirements on identifying private equity and Real Estate Investment Trust (“REIT”) owners (See Sect. 5.B.), but also makes other changes. Most notably, those include the following:

- Updating the form to accommodate enrollment of Rural Emergency Hospitals (“REH”) and Opioid Treatment Programs (Sect. 10).
- Requires submission of an Action Plan pursuant to Section 125 of the Consolidated Appropriations Act of 2021.
- Updating Sect. 4.A. that now requires hospital providers to identify whether a new hospital outpatient department is located on- or off-campus.
- Updating the definition of the term “managing control” in the instructions to Sect. 5.
- Updating Sect. 5.A. to inquire whether the reported entity is owned by any other person or entity.
- Updating Sect. 6 to require reporting of medical directors.
- Updates the False Claims Act language included in the Penalties contained in Sect. 14 and the Certification Statement in Sect. 15.

- Updates to the Supporting Documentation requested in Sect. 16 (e.g., removal of the submission of a notarized copy of a Certificate of Good Standing from our licensing agency, and requirement for sales agreements for ‘all ownership changes’ required to be reported regardless of the percentage involved, inclusion of REH Action Plan, etc).

The new form also includes some administrative updates. Original signatures are no longer required, the form may be submitted with e-signatures. Additionally, forms are now required to be typed, and handwriting is prohibited.

CMS indicated the MACs started accepting the newly revised 09/23 version of the form on November 17, 2023, and will continue to accept the prior 07/11 version of the form through December 17, 2023. After that date if you file using the prior 07/11 version of the form the MAC will return it with a letter to informing you that the form is no longer valid, and you must submit the 09/23 version.

For more information on how the final rules may impact providers and suppliers, contact Polsinelli’s team of [Licensure, Enrollment & Certification](#) attorneys.