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Eli's Hospice Insider

Enrollment: Don't Overlook This Coming Enrollment Burden

Watch for final rule on sweeping changes to enrollment process.

With so many reimbursement and regulatory changes on hospices' plates this year, an onerous proposed rule may have slipped under your radar. You'd better place it back on before it's too late.

The **Centers for Medicare & Medicaid Services** wants providers to drastically increase items they report when they enroll or reenroll in Medicare, according to a proposed rule published in the March 1 Federal Register. And CMS wants greater authority to revoke provider enrollment in a number of new circumstances.

"If these regulations are finalized as proposed, get ready for a fire storm," warns Washington, D.C.-based healthcare attorney **Elizabeth Hogue**.

At the top of the list of items to report are "any current or previous direct or indirect affiliation" with a provider or supplier that has had these "disclosable events":

(1) uncollected debt;
(2) a payment suspension under a federal health care program;
(3) exclusion from Medicare, Medicaid or CHIP; or
(4) denial or revocation of its Medicare, Medicaid or CHIP billing privileges.

Why? "This provision permits the Secretary to deny enrollment based on affiliations that the Secretary determines pose an undue risk of fraud, waste or abuse," CMS says in the rule.

CMS also wants to set a very broad definition of "affiliation." That definition will be "substantially more than related parties," warns consulting firm **The Health Group** in Morgantown, W. Va.

Under the proposed reg, affiliations requiring reporting of disclosable events would be:

- 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 sole proprietorships), either under contract or through some other arrangement, regardless of whether 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.
- Reassignment.

These requirements will give CMS "significant sanction authority on the provider and so-called Affiliations," warns The Health Group. The rule "takes the enrollment process, revalidation of enrollment, and reporting changes to an increased level of priority."

Reporting affiliates and their disclosable events are the provisions most likely to give providers "heartburn," Hogue predicts. The changes may mean "that some owners are effectively excluded and some managing employees may be unemployable in the home care industry," she tells **Eli**.

CMS has been making enrollment/revalidation more important for a while, Hogue observes.

But "many providers ... don't seem to understand the enhanced significance," she reports. "We encounter providers who don't file Forms 855 as required, don't pay attention to the accuracy of the information they put on the forms, don't understand the forms or concepts involved, and assign staff who lack appropriate knowledge and experience to complete the forms."

Take action: "Now is clearly the time to get it right on all counts when it comes to provider enrollment," Hogue stresses. "Getting it right is likely to include review of forms by legal counsel prior to submission," she advises.

"All providers need to take notice" of the new regs, The Health Group emphasizes.

Outstanding Debt Will Get You Revoked

Other provisions in the rule include:

- Increasing the maximum reenrollment bar from 3 to 10 years, adding three years to the ban if the provider tries to reenroll early, and permitting a 20-year ban if the provider is revoked a second time;
- Revoking enrollment if the provider has an existing debt that CMS refers to the **U.S. Department of Treasury**;
- Revoking a physician's 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";
- Requiring that "to order, certify, refer or prescribe any Part Aor B service, item or drug, a physician ... must be enrolled in Medicare ... or have validly opted-out of the Medicare program";
- Denying enrollment if the provider is barred from Medicaid or in another state;
- Denying or revoking 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";
- Revoking 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 ... a location that it knew or should have known did not comply with Medicare enrollment requirements"; and
- Revoking enrollment if a provider fails to report changes such as practice location, change of ownership, or a license revocation within 30 days.

Stay tuned: Providers should keep an eye out for the forthcoming final rule to see whether CMS changes provisions in response to commenters' feedback (see stories, pp. 92 and 94).

Note: See the proposed rule at www.gpo.gov/fdsys/pkg/FR-2016-03-01/pdf/2016-04312.pdf.