COSMOS
Navigate the Compliance Universe

Report on Medicare Compliance Volume 32, Number 27. July 31, 2023
CMS Proposes New Grounds for Medicare Revocation but Also a 'Stay'

By Nina Youngstrom

CMS again is proposing to raise the bar for Medicare enrollment and make it easier to revoke billing privileges, according to the proposed 2024 Medicare Physician Fee Schedule (MPFS) regulation announced July 12.[1]

This time around, there's a False Claims Act (FCA) angle and new middle ground—a "stay of enrollment"—for providers that flubbed paperwork. With a stay, the provider's enrollment status is protected while it fixes its noncompliance. The additions also heighten the risk around "affiliates," echoing a 2019 regulation.

With these proposals, CMS continues to build the fortress around Medicare to protect it from providers it considers a threat to the program. "Every year, they have been expanding their authorities under the enrollment regulations," said attorney Judy Waltz, with Foley & Lardner LLP in San Francisco. Keeping providers and suppliers out of Medicare if they're deemed a risk to the program and taking away their billing privileges are core program-integrity strategies. "This is the way they're going to avoid fraud and abuse as opposed to pay and chase," Waltz said. As CMS puts it in the proposed rule, "The overarching purpose of the enrollment process is to help confirm that providers and suppliers seeking to bill Medicare for services and items furnished to Medicare beneficiaries meet all applicable Federal and State requirements to do so. The process is, to an extent, a 'gatekeeper' that prevents unqualified and potentially fraudulent individuals and entities from entering and inappropriately billing Medicare."

An Additional Risk of a FCA Trial

CMS already is empowered to yank a provider's enrollment for various reasons, including failure to abide by enrollment requirements and a felony conviction. Now CMS is proposing to add to the grounds for revocation.

For one thing, CMS for the first time could revoke billing privileges for an FCA judgment. CMS would base its revocation decision on these factors:

- 'The number of provider or supplier actions that the judgment incorporates (for example, the number of false claims submitted).
- "The types of provider or supplier actions involved.
- "The monetary amount of the judgment.
- "When the judgment occurred.
- "Whether the provider or supplier has any history of final adverse actions (as that term is defined in § 424.502).
- "Any other information that CMS deems relevant to its determination."

The revocation authority would not apply if providers entered into an FCA settlement, Waltz noted.

Vulnerable to Managing Employees, Officers

In another addition, CMS would be able to revoke a provider's billing privileges for a misdemeanor within the past decade. According to the proposed rule, "CMS may revoke a provider's or supplier's enrollment if they, or any owner, managing employee or organization, officer, or director thereof, have been convicted (as that term is defined in 42 CFR 1001.2) of a misdemeanor under Federal or State law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program and its beneficiaries."

While providers are familiar with the risk of Medicare exclusion if they settle FCA cases, the misdemeanor and FCA additions add another dimension in the event of an FCA judgment, Waltz said. If the proposals become final, attorneys should think twice about recommending providers go to trial or plead to misdemeanors because "it may have consequences down the line," she said.

This raises the stakes for ensuring the key people in your organization don't have baggage. "The message is pretty clear," Waltz said. "CMS is looking more and more at the people in the background—managers and directors—who are probably pulling the strings." Organizations "have to do background checks on everyone in the position of management or control and make it very clear that people need to have a clean background in terms of what Medicare expects." Some black marks—such as criminal convictions or exclusions from federal health care programs—should be easy to identify. But there's no database to check for CMS revocation, the way that organizations can check the List of Excluded Individuals and Entities (LEIE), she notes. Organizations have little recourse other than asking the person whether their Medicare provider number is in good standing or billing and getting a denial.

The proposal goes hand in hand with a 2019 program-integrity regulation on affiliates that's designed to keep, or kick, providers out of Medicare if they pose an "undue risk" of fraud, waste or abuse (42 C.F.R. § 424.519). The regulation, which implements provisions of the Affordable Care Act, requires providers, at CMS's request, to disclose "affiliations" with other providers who have experienced a "disclosable event," defined in 42 C.F.R. § 424.502, which includes having been suspended or excluded from Medicare, Medicaid or the Children's Health Insurance Program (CHIP); owe the programs money; or had their billing privileges denied or revoked. "You may be judged by the company you keep," Waltz noted. According to the rule, providers will have to report affiliations when they enroll and revalidate via the 855 enrollment form.

Middle Ground: The 'Stay of Enrollment'

The 2024 proposed MPFS rule also floats a new enrollment status—the stay of enrollment—with the idea of holding off deactivation of Medicare provider numbers while less-serious problems are solved. Deactivation is not the same as revocation, CMS noted. Deactivations put billing privileges on ice until the provider follows enrollment procedures, and CMS said it sometimes imposes them "instead of a revocation when we believe a more modest sanction is warranted."

Because deactivations may be "too punitive," CMS is proposing the stay of enrollment, which would be "a preliminary, interim status—prior to any subsequent deactivation or revocation—that would represent, in a sense, a 'pause' in enrollment, during which the provider or supplier would still remain enrolled in Medicare," the proposed rule explains. CMS wouldn't treat it as a sanction or adverse action. But two circumstances must apply: providers are noncompliant with an enrollment requirement and are able to repair the noncompliance with a change of information form (CMS-588) or revalidation.

'A Fair Enough Trade'

"It's probably a good workaround," Waltz said. It gives CMS flexibility to mete out consequences for providers that have screwed up without the draconian act of kicking them out of Medicare because, for example, they didn't revalidate in time.

"It's a good thing for them to have a less severe option for a less severe offense," Waltz said. "If someone is a decent provider, you don't want to get rid of them. The provider won't get paid, but that's a fair enough trade compared to the alternative."

The proposed rule would also convert some noncompliance with provider and supplier standards into grounds for Medicare revocation with respect to independent diagnostic testing facilities and durable medical equipment prosthetics, orthotics suppliers, opioid treatment programs, home infusion therapy suppliers and Medicare diabetes prevention programs. That may be an attempt by CMS to turn provider and supplier standards into conditions of payment rather than conditions for coverage or conditions of participation, Waltz said. If providers or suppliers lose their billing privileges over a failure on the supplier standards front, they'd have to appeal. "It won't be easy to get out of that hole."

Contact Waltz at jwaltz@foley.com.

1 Centers for Medicare & Medicaid Services, Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, proposed rule, July 12, 2023, https://bit.ly/43phEkj.