Medicare enrollment information and access to links are available on the Centers for Medicare and Medicaid Services (CMS) webpage.

https://www.cms.gov/medicare/provider-enrollment-and-certification/enroll-as-an-institutional-provider

ENROLLMENT UPDATES EFFECTIVE JANUARY 1, 2024

Over the years CMS has issued various final rules about provider enrollment. These rules were intended not only to clarify or strengthen certain components of the enrollment process but also to enable action against providers and suppliers who are:

engaging (or potentially engaging) in fraudulent or abusive behavior

presenting a risk of harm to Medicare beneficiaries or the Medicare Trust Funds; or

otherwise, unqualified to furnish Medicare services or items

CMS has growing concerns about improper behavior within the hospice community and is equally concerned about the quality-of-care provision by providers who may be engaging in the above practices.

PROVISIONAL PERIOD OF ENHANCED OVERSIGHT (PPEO)

CMS will establish a provisional period between **30 days and 1 year** during which new providers and suppliers will be subject to **enhanced oversight.** Oversight can include but is not limited to prepayment review and payment caps.

DEFINITION OF A "NEW" PROVIDER OR SUPPLIER:

- A newly enrolled Medicare provider or supplier. (This includes providers that must enroll as a new provider per the change in majority ownership provisions in § 424.550(b).
- A certified provider or certified supplier changing ownership consistent with the principles of 42 CFR 489.18. (This includes providers that qualify under § 424.550(b)(2) for an exception from the change in majority ownership requirements in § 424.550(b)(1) but which are changing ownership under 42 CFR 489.18).
- A provider or supplier **(including an HHA or hospice)** undergoing a 100 percent change of ownership via a change of information request under § 424.516.

PPEO EFFECTIVE DATE

The effective date of the PPEO is the date on which the new provider or supplier submits its first claim to their Medicare Administrative Contractor (MAC).

RETROACTIVE PROVIDER AGREEMENT TERMINATIONS

CMS finalized and updated the regulations at § 489.52(b) that a provider may request a retroactive termination date, but only if no Medicare beneficiary received services from the facility on or after the requested termination date. This would financially protect beneficiaries by helping to ensure that Medicare may still cover the services furnished to them near the end of the provider's operations.

HOSPICE SCREENING CATEGORY

CMS in recent years has become increasingly concerned about program integrity issues within the hospice community, particularly (though not exclusively) potential and actual criminal behavior, fraud schemes, and improper billing.

SCREENING UPDATES

- CMS revised § 424.518 to move initially enrolling hospices and those submitting applications to report any new owner into the "high" level of categorical screening; revalidating hospices would be subject to moderate risk-level screening.
- CMS requires all hospice owners with 5 percent or greater direct or indirect ownership to submit fingerprints for a criminal background check. This would help CMS detect parties potentially posing a risk of fraud, waste, or abuse before it begins.

36-MONTH RULE FOR CHANGES IN MAJORITY OWNERSHIP – HOSPICES

CMS expanded the scope of § 424.550(b)(1) to include hospice change in majority ownership (CIMO).

- A "change in majority ownership" occurs when an individual or organization acquires **more than** a 50 percent direct ownership interest in a hospice during the 36 months following the hospice's initial enrollment or most recent CIMO.
  - This includes an acquisition of majority ownership through the cumulative effect of asset sales, stock transfers, consolidations, or mergers.
  - Under § 424.550(b)(1), a 42 CFR 489.18-level change of ownership and/or 100 percent ownership transfer is not necessary to trigger this "36-month rule." Only crossing the 50 percent ownership threshold is required.
- If a hospice changes in majority ownership by sale within 36 months after the effective date of initial enrollment in Medicare or within 36 months after the most recent "change in majority ownership, the provider agreement and Medicare billing privileges do not convey to the HHA's new owner.

The prospective provider/owner of the HHA must instead:

- enroll in Medicare as a new (initial) HHA, and
- obtain a state survey or accreditation from an approved accreditation organization.

**Part 424 – Conditions for Medicare Payment/§ 424.550 Prohibitions on the sale or transfer of billing privileges.*

DEACTIVATION OF PROVIDER NUMBER

One of the reasons for deactivating a provider or supplier (§ 424.540(a)(1)) is that they did not submit any Medicare claims to their MAC for 12 consecutive months.

DEACTIVATION UPDATE

CMS reduced the 12-month timeframe currently in § 424.540(a)(1) to 6 months as a measure to:

- help detect fraud schemes involving extended periods of non-billing
- help protect the Medicare program by deactivating a provider number while verifying whether the provider or supplier remains in existence

DEFINITION OF "MANAGING EMPLOYEE"

Providers and suppliers are required to report their managing employees via the applicable Medicare enrollment application to enroll in Medicare.

CMS defines a "managing employee" in § 424.502 as a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of the provider or supplier, either under contract or through some other arrangement, whether or not the individual is a W–2 employee of the provider or supplier.

CMS revised the definition of a managing employee at § 424.502 to add the following:

- A managing employee also includes a general manager, business manager, administrator, director, or consultant, who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.
- For purposes of this definition, this includes but is not limited to, a hospice or skilled nursing facility administrator and a hospice or skilled nursing facility medical director.

Any individual who meets the definition of managing employee in § 424.502 must be reported irrespective of the precise amount of the person's managing control.

PREVIOUSLY WAIVED FINGERPRINTING OF HIGH-RISK PROVIDERS AND SUPPLIERS

CMS waived the fingerprinting requirement for the COVID-19 public health emergency for 5 percent or greater owners of newly enrolling providers and suppliers falling within the high-risk screening category in § 424.518(c). They intended to reinstate fingerprint-based criminal background checks (FBCBCs) for

high-risk providers and suppliers that initially enrolled during the PHE upon their revalidation once the PHE ends. However, this was not possible under existing regulations because the revalidation applications will only be screened at the moderate-risk level.

FINGERPRINT UPDATE

- CMS will subject hospices to the highest level of provider enrollment application screening, which includes fingerprinting all 5 percent or greater owners of hospices
- Any new 5% or greater individual owners in an already enrolled hospice will also need to undergo fingerprinting

EXPANSION OF REAPPLICATION BAR

CMS prohibits a prospective provider or supplier from enrolling in Medicare 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 enroll.

REAPPLICATION UPDATE

CMS prohibits prospective providers or suppliers from enrolling in Medicare for 10 years to account for provider or supplier conduct of particular severity. This expansion will prevent problematic parties from repeatedly submitting applications over many years to somehow get into the program.

ORDERING, REFERRING, CERTIFYING, AND PRESCRIBING RESTRICTIONS

CMS believes providers and suppliers who engage (or potentially engage) in fraudulent or abusive behavior should have restrictions regarding the ordering, referring, certifying, or prescribing of Medicare services, items, and drugs, too. Such ordering, referring, certifying, or prescribing can involve improper conduct that is as harmful to Medicare beneficiaries as the actual furnishing of services.

ORDERING, REFERRING, CERTIFYING, AND PRESCRIBING UPDATE

In tandem with the changes to the reapplication bar, any provider or supplier currently subject to a reapplication bar may not order, refer, certify, or prescribe Medicare-covered services, items, or drugs.

- CMS is updating the regulatory text to state that a physician or other eligible professional who has had a felony conviction within the previous 10 years that CMS determines is detrimental to the best interests of the Medicare program and its beneficiaries may not order, refer, certify, or prescribe Medicare-covered services, items, or drugs (§ 424.530(f))
- CMS will prohibit Medicare payment for any otherwise covered service, item, or drug that is ordered, referred, certified, or prescribed by a physician or other eligible professional who has had a felony conviction within the previous 10 years that CMS determines is detrimental to the best interests of the Medicare program and its beneficiaries (§ 424.542)

RESOURCES

CMS Medicare provider enrollment webpage
https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers

Medicare Provider Enrollment MLN tool
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/EnrollmentResources/provider-resources/provider-enrolment/Med-Prov-Enroll-MLN9658742.html

Provider Enrollment, Chain, and Ownership System (PECOS)
https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

REFERENCES

Calendar Year 2024 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Program Requirements; etc. (CMS-1780-F) https://public-inspection.federalregister.gov/2023-24455.pdf