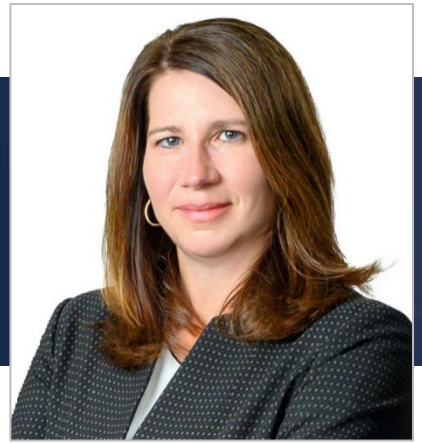
CPAs & BUSINESS ADVISORS

MEDICARE PROVIDER ENROLLMENT CONSEQUENCES POST PHE

Iowa HFMA | January 11, 2023

PRESENTER



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OBJECTIVES

Understand which COVID-19 relief measures will expire at the conclusion of the PHE and how they may impact your Medicare enrollments, licensure considerations and the like.

Review the reinstatement of Medicare's enrollment effective date policy and consequences for missed revalidations.

Learn about the new Provider Ownership Verification (POV) contractor and the importance of complete and accurate enrollment records or risk deactivation or revocation.

Review requirements for timely reporting of updates by provider/supplier type.

IMPORTANCE OF MEDICARE PROVIDER ENROLLMENT

- The Medicare enrollment process is where everything begins. It is the foundation to ensure proper Medicare billing and compliance with all of Medicare's statutory, regulatory and manualized rules for the enrolled provider or supplier type:
  - Must be part of an organization's planning process and not an after thought.
  - Must be completed in concert between compliance, credentialing and billing teams to ensure the accuracy and completeness of initial enrollments, updates to enrollments and revalidations of existing Medicare enrollments:
    - Consequences of not doing so can be no cashflow, longer cashflow delays, lost of expected reimbursement, compliance issues and the possible tainting of other Medicare and Medicaid enrollments.

COVID-19 PUBLIC HEALTH EMERGENCY

- Where are we today?
  - COVID-19 PHE was put into place effective January 27, 2020:
    - Renewals every 90 days starting April 21, 2020.
    - Latest renewal on October 13, 2022:
      - Current expiration January 11, 2023.
  - Letter to Governor's January 2021 from The Secretary of HHS:
    - HHS will provide States with 60 days' notice prior to termination of the PHE.
    - Notification was not received by November 12th so PHE likely will renew January 11, 2023 for another 90 days.
  - CMS issued fact sheet on August 18, 2022 "Creating a Roadmap for the End of the COVID-19 PHE":
    - https://www.cms.gov/blog/creating-roadmap-end-covid-19-public-health-emergency
  - CMS virtual listening calls scheduled to discuss impact of waivers and emergency preparedness post PHE.
  - CMS released new FAQs on October 17, 2022 to help States prepare for the end of the COVID-19 PHE.

CMS 1135 BLANKET WAIVERS

- CMS created a number of 1135 blanket waivers to provide hospitals/CAHs and other provider and supplier types flexibilities to provide care to patients.
  - Some waivers have expired prior to termination of the PHE
  - Current listing of waivers can be found here: COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers (cms.gov)
- Interim Final Rules passed
  - CMS-1744-IFC, issued March 30, 2020
  - CMS-5531-IFC, issued May 1, 2020
- Weekly CMS Stakeholder calls

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HOSPITAL/CAH 1135 BLANKET WAIVERS

- CMS created multiple 1135 blanket waivers for hospitals and CAHs. We will address those which typically impact Medicare Provider Enrollment:
  - Physical Environment
  - Telemedicine
  - CAH Status and Location
  - Temporary Expansion Locations
  - Practitioner Locations / License / Opt-Out
  - 60-Day Limit for Substitute Billing Arrangements
- Which waivers has your facility implemented which may need addressed at the end of the PHE?
- Do any of these impact your Medicare enrollments? Licensure?

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CMS PROVIDER ENROLLMENT WAIVERS

- CMS issued a Fact Sheet for the COVID-19 PHE specific to Provider Enrollment:
  - 2019-Novel Coronavirus (COVID-19) Medicare Provider Enrollment Relief Frequently Asked Questions (FAQs) (cms.gov)
- Notable items:
  - Expedited enrollment review
  - Practitioner temporary Medicare billing privileges
  - ~~Application fees~~ Reimplemented
  - ~~Revalidations~~ Reimplemented (Phased-in approach without deactivations)
  - ~~Finger-print Criminal Background Checks~~ Reimplemented
  - ~~Site visits~~ Reimplemented
- Additionally, any PHE creates a 90-day look back for effective date provisions:
  - MPIM, Chapter 10, Section 10.6.2.B.3.
- Which above items will impact your Medicare enrollments at the end of the PHE?

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IOWA MEDICAID PROVIDER ENROLLMENT COVID-19 FLEXIBILITIES

- IME issued Information Letter No: 2387-MC-FFS-CVD on October 17, 2022
  - Addresses unwinding of flexibilities afforded by the PHE related to provider enrollment.
    - Suspension of site visits for newly enrolled providers.
      - IME will begin working through a backlog of site visits.
      - All moderate or high-risk providers subject to pre- and post-enrollment site visits.
      - Not required to conduct site visits for providers already screened by Medicare or another state's Medicaid or CHIP program with in the past 12 months.
    - Suspension of enrollment revalidation requirements.
      - Revalidate enrollments in phases by provider type.
      - First phase will focus on home and community-based services and behavioral health providers.
      - IME will issue information letters by provider type when revalidation is open
      - Providers who shoe to complete revalidation during the PHE will not be required to complete again.

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THINGS TO START WATCHING

- CMS-6058-FC – Affiliation Rule – Effective November 9, 2019:
  - Calendar Year 2022 - PECOS enhancements to track affiliations on contractor side.
  - Transmittal 11536 – Provider/Supplier Enrollment Adverse Legal Action (ALA) – Effective Sept 6, 2022:
    - "Contractor shall search PECOS to determine whether the individual/entity with ALA has any other associations listed in PECOS as an owner or managing employee. This review requires searching the tax-identification number of the individual/entity and clicking "Associates w/Connections" in PECOS. If the contractor finds such an association and there are grounds to revoke the associated enrollments(s) of other provider(s)/suppliers(s), the contractor shall submit the revocation referrals(s) to CMS."
    - "Contractor shall review each submission…for (1) any exclusion(s) by HHS OIG of the provider/supplier and (2) exclusion(s) of any associated individuals/entities listed in "Ownership Interest and/or Managing Control Information"…"
- *Think twice if considering whether or not to disclose all owners, directors, officers, managing employees, etc.:*
  - *Penalties for Falsification / Authorized/Delegated Official Certification Statement.*

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THINGS TO START WATCHING

- New Provider Ownership Verification (POV) Contractor, implementation Fall 2021:
  - POV reviews Medicare ownership/control disclosures against third party databases (i.e. Secretary of State, IRS, websites, etc.) to identify omitted and/or inconsistencies in ownership/control information required to be reported.
  - In our most recent experience, it appears CMS does not afford the provider/supplier an opportunity to explain or resolve ownership discrepancies between what is reported on a Medicare enrollment application and what is discovered through external database verifications by the POV prior to CMS initiating action against the provider/supplier.

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CLINIC/GROUP PRACTICE 10 YEAR REVOCATION

- FACTS:
  - A clinic/group practice contacted us as their billing agent completed and submitted the clinic/group practice's Medicare revalidation at the end of May, 2022. As required by CMS, the submitted revalidation was signed by the authorized or delegated official of the clinic/group practice.
  - The billing agent omitted updated ownership information provided by the clinic/group practice on the revalidation, but the clinic/group practice also failed to provide other updated ownership information to the billing agent. The result was the submitted revalidation did not accurately disclose the clinic/group practice ownership and was not reflective of the POV's external database reviews.
  - After the submission of the revalidation, the next and only communication the clinic/group practice received was notification of REVOCATION for 10 years.
  - REVOCATION means the clinic/group practice is no longer part of the Medicare program, in this case, for 10 years. Second revocation offenses result in a 20 year enrollment bar.
    Authority: CMS-6058-FC

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ADDITIONAL CONSIDERATIONS

- CMS-6058-FC more closely aligned Medicare and Medicaid:
  - For example, revocation under Medicare = revocation under Medicaid (after appeals are exhausted).
  - What if Medicaid disclosures are out of date?
  - OIG reports, both dated May 20, 2016:
    - Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure.
    - Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure:
      - OIG requested current ownership/control information from providers/suppliers.
      - Compared data provided to disclosures on Medicare and Medicaid enrollments:
        - 7% – Disclosures of ownership/control matched between Medicare, Medicaid and data provided to OIG.
        - 77% Error Rate - Disclosure of ownership/control between Medicare and data provided to OIG.
        - 90% Error Rate – Disclosure of ownership/control between Medicare and Medicaid.
        - 86% Error Rate – Disclosure of ownership/control between Medicaid and data provided to OIG.

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ADDITIONAL CONSIDERATIONS CONTINUED

- OIG Recommendations to CMS as a result of May 20, 2016 reports:
  - Review providers that submitted nonmatching owner names and take appropriate action.
  - Educate providers on requirement to report changes of ownership.
  - Increase coordination with State Medicaid program on collection and verification of provider ownership information in Medicare and Medicaid.
  - Ensure that contractors check exclusion databases as required.
- CMS agreed with all recommendations.

MEDICARE REPORTING REQUIREMENT REMINDERS

- Generally, information changes must be reported on the applicable CMS form within 90 calendar days of the changes:
  - Exception for IDTFs - must report changes in ownership, locations, general supervision and adverse legal actions within 30 calendar days. All other changes must be reported within 90 days.
  - Exception for DMEPOS suppliers - must report all changes within 30 days.
  - Exception for physician and NPP organizations and individual physicians and NPPs - must report changes of ownership, changes in adverse legal action, or changes in practice locations within 30 days. All other changes must be reported within 90 days.
  - Exception for MDPP suppliers – must report changes of ownership, changes to the coach roster and final adverse legal history within 30 days of the reportable event. All other changes, including changes in the MDPP supplier's administrative location(s), are required to be reported to CMS within 90 days of the reportable event.

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MEDICARE REPORTING REQUIREMENT REMINDERS

- All providers and suppliers (other than IDTFs, DMEPOS suppliers, physician and NPP organizations, individual physicians and NPPs and MDPP suppliers) must report to CMS the following information within the specified timeframes:
  - Within 30 days for a change of ownership, including changes in authorized official(s) or delegated official(s).
  - All other changes to enrollment must be reported within 90 days.
- Failure to update information may result in deactivation or revocation so it is important to update information as changes occur and not wait until the revalidation process.
- Remember AO/DOs are signing to the accuracy of the ENTIRE enrollment each time a submission is made and not just for the changes made.

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POST PHE – ENROLLMENT ITEMS TO WATCH

- Reinstatement of Medicare's enrollment effective date policy for:
  - Clinic/group practice enrollments – no more 90-day retrospective effective dates from the MAC's receipt date of the enrollment once the PHE ends (back to no more than 30 days retrospective effective dates from the MAC's receipt date of the enrollment) (same for individual practitioner enrollments and all reassignments)
  - DMEPOS suppliers – no more 90-day retrospective effective dates from the MAC's receipt date of the enrollment (back to the effective date based on the MAC's enrollment submission receipt date provided all DMEPOS supplier standards are met)
  - These are the most common examples, others will be impacted as well.
- Revalidations with consequences for not timely completing once the PHE ends:
  - Not completed by revalidation due date - pay hold placed on enrollment within the first 25 days after the due date, pay hold will be lifted if the revalidation is submitted within 60 to 75 days of the due date, but if revalidation is not submitted within 60 to 75 days of the due date then the enrollment is deactivated and a gap in billing exists (permanent loss of reimbursement between the deactivation date and the reactivation date).

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OTHER MEDICARE PROVIDER ENROLLMENT CHANGES

- EFT/Special Payment changes require verification by long-standing AO/DO/Contact Person.
- Changes to processing of voluntary terminations and CHOWs for some provider/certified supplier types.
- PECOS 2.0 Platform Change:
  - Effective date TBD.
  - Enhancements are many – e.g. greater ease of ownership/control reporting across an entity's like enrollments.
  - Keep copies of all enrollment submissions.
  - Migration issues?

OTHER MEDICARE PROVIDER ENROLLMENT CHANGES

- Rural Emergency Hospital (REH) new provider type effective January 1, 2023:
  - New 42 CFR §424.575, but subject to all other applicable enrollment regulations.
  - 855A, change of information, to convert to REH with no application fee, subject to the limited level of screening category and effective date would be based on meeting all Medicare enrollment requirements and applicable CMS survey/certification requirements:
    - The CAH or hospital does not need to submit a Form CMS-855A voluntary termination application.
    - A REH cannot file a change of information application to convert back to a CAH or hospital. Instead, a termination as an REH and initial enrollment as a CAH or hospital would be required.
  - Eligible CAHs/Hospitals that closed after December 27, 2020 are not prohibited from seeking REH designation.

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UPCOMING MEDICARE PROVIDER ENROLLMENT EDUCATION

- Two-Part Webinar Series:
  - January 19th - PECOS Surrogacy Access: What You Need to Know to Get Your Organization and Practitioners Established.
  - January 24th - Enrolling Practitioners in PECOS and Reassigning to Your Clinic/Group Practice.
- Medicare Provider Enrollment Compliance Conference:
  - CMS Keynote Speakers and Representation from all MACs.
  - April 25-28, 2023 at the Phoenix Convention Center:
    - https://medicareproviderenrollment.com

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QUESTIONS?

THANK YOU!

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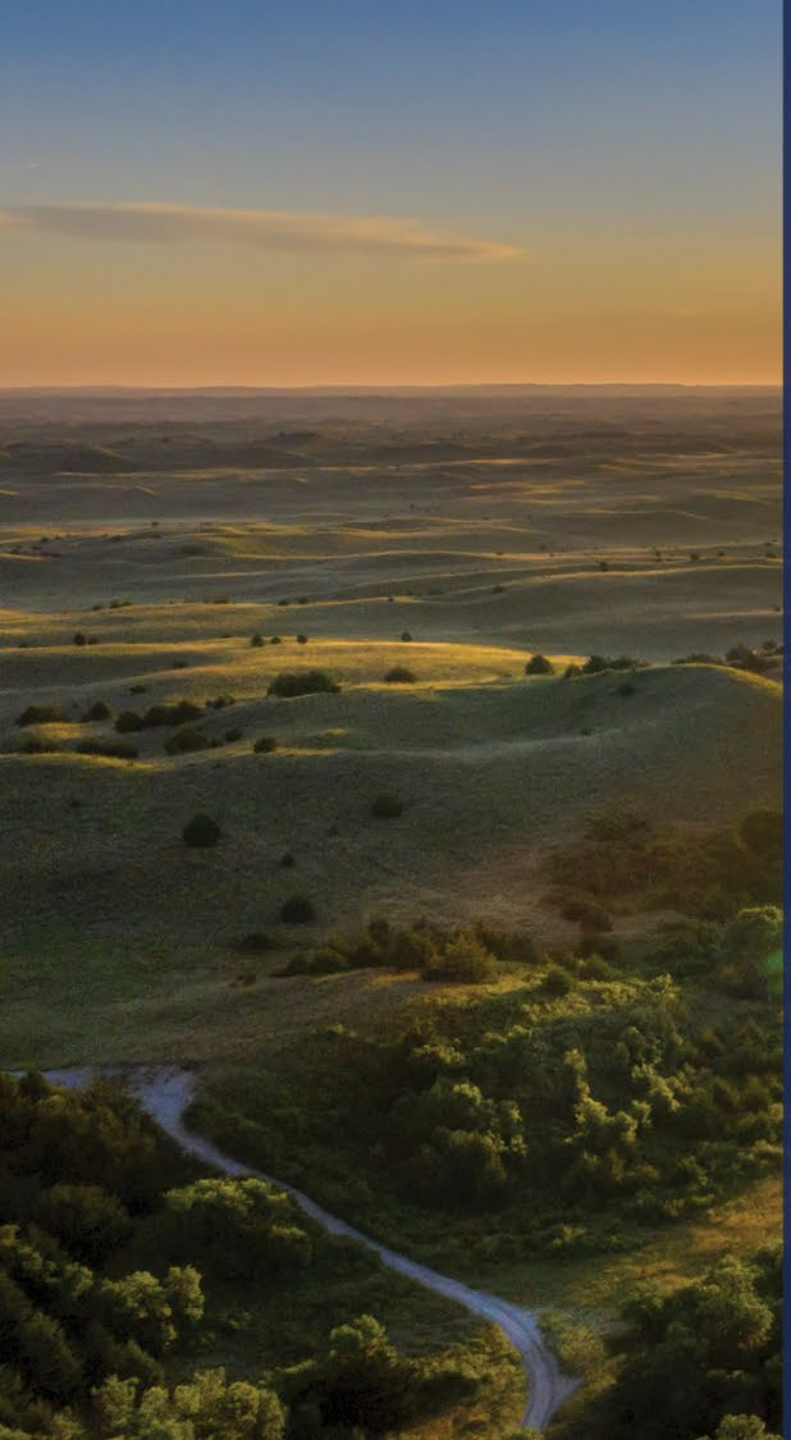

SAVE THE DATE

CRITICAL ACCESS HOSPITAL CONFERENCE 2023

OMAHA, NEBRASKA

COTTONWOOD KIMPTON HOTEL

APRIL 19-21, 2023

MORE DETAILS COMING SOON!

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