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Did You Know Medicare Implemented New Provider and Supplier Enrollment Requirements?

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The Centers for Medicare & Medicaid Services (CMS) has revised certain payment policies under the Medicare physician fee schedule, and updated provider and supplier enrollment regulations. CMS recently published a final rule (the Final Rule) effective January 1, 2024. Technical and typographical errors in the Final Rule were later corrected by a subsequent final rule (the Subsequent Rule), effective February 12, 2024. Of the changes addressed herein, only the new "stay of enrollment" was impacted by the Subsequent Rule.

Summary of Major Updates

The below outlined changes are described in more detail in this article.

- **Stay of Enrollment:** CMS now has a new option for disciplining providers and suppliers that is less punitive than deactivation or revocation from Medicare.
- **Timing Changes:** All Medicare providers and suppliers are now required to report additions, deletions, or changes in their practice locations within 30 days.
- **New and Revised Revocation Policies:**

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- ***False Claims Act Civil Judgments:*** CMS now has the authority to revoke a provider or supplier's Medicare enrollment if they have had a civil judgment under the False Claims Act (FCA) imposed against them within the previous 10 years.

- ***Effective Dates of Revocation:*** The Final Rule clarifies the timing of revocation from Medicare, which includes certain timing exceptions based on the reason for the revocation.

- ***Reversal of Revocation:*** Providers and suppliers now have less time to terminate relationships with certain business partners whose adverse activity caused the revocation.

Stay of Enrollment

The new "stay of enrollment" status permits CMS to discipline providers and suppliers for minor violations *of provider enrollment requirements* that do not justify the more punitive implications of a deactivation or revocation. For example, "stay of enrollment" may be used when a provider fails to report a change of practice location. Per CMS, "[t]his 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 remain enrolled in Medicare; in this vein, CMS would neither formally nor informally treat the stay as a sanction or adverse action for purposes of Medicare enrollment."

CMS may *stay* an enrolled provider's or supplier's enrollment if the provider or supplier:

- Is non-compliant with at least one enrollment requirement in Title 42; and
- Can remedy the non-compliance via the submission of, as applicable to the situation, a Form CMS–855, Form CMS–20134, or Form CMS–

588 change of information or revalidation application.

Claims submitted by the provider or supplier during a "stay of enrollment" will be rejected. However, the claims will become eligible for payment once CMS or its contractor determines that the provider or supplier has resumed compliance with all Medicare enrollment requirements in Title 42. The stay ends on or before the 60th day of the stay period. "A deactivation, on the other hand, has no finite timeframe, meaning that services and items may not be payable for a long period of time if the provider or supplier does not submit the required reactivation application."

Importantly, CMS has the discretion to impose a stay, based on the facts and circumstances of each case. CMS may impose a deactivation or revocation (if grounds exist for either) without first applying a stay in enrollment beforehand. Or, it may decide to impose a stay of enrollment and, if the non-compliance persists, proceed with imposing a deactivation or revocation.

Timing Changes

Pursuant to the Final Rule, all Medicare providers and suppliers are now required to report additions, deletions, or changes in their practice locations ***within 30 days***.

Previously, Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, Independent Diagnostic Testing Facilities (IDTFs), physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations were required to report changes in practice location within 30 days of the change, while all other Medicare providers and suppliers were required to report practice location changes within 90 days of the change. This change tightens the notification timeline and puts all providers and suppliers on the same notification timeline.

New and Revised Revocation Policies

CMS also used the Final Rule as an opportunity to clarify and add policies related to the revocation process. These changes include the ability to revoke enrollment for civil judgments under the FCA, and revisions related to effective dates of revocation and the reversal of revocations.

False Claims Act Civil Judgments

CMS now has the authority to revoke a currently enrolled provider or supplier's Medicare enrollment and any corresponding provider agreement or supplier agreement if the provider or supplier (or any owner, managing employee or organization, officer, or director of the provider or supplier) has had a civil judgment under the FCA imposed within the previous 10 years. Previously an FCA civil judgment against a provider or supplier, in and of itself, did not impact the provider or supplier's Medicare enrollment.

In determining whether a revocation is appropriate, CMS will consider the following factors, as outlined in the new 42 C.F.R. § 424.535(a)(15):

- The number of provider or supplier actions that the judgment incorporates (e.g., 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, which includes one or more of the following actions:
- A Medicare-imposed revocation of any Medicare billing privileges;
- Suspension or revocation of a license to provide healthcare by any state licensing authority;
- Revocation or suspension by an accreditation organization;

- A conviction of a federal or state felony offense within the last 10 years preceding enrollment, revalidation, or re-enrollment; or
- An exclusion or debarment from participation in a federal or state healthcare program
- Any other information that CMS deems relevant to its determination

Effective Dates of Revocation

CMS clarified that, unless an exception applies, a revocation becomes effective *30 days after* CMS or the CMS contractor mails notice of its determination to the provider or supplier.

The Final Rule also provided further clarification regarding some of the situations where retroactive revocation effective dates have been applied, including, but not limited to, those revocations based on a:

- *Federal exclusion or debarment* – exclusion effective date that is the date of the exclusion or debarment.

- *Felony conviction* – exclusion effective date that is the date of the felony conviction.

The Final Rule also adds the following additional situations where a retroactive effective date is warranted, including, but not limited to, those revocations that are based on a:

- *State license surrender in lieu of further disciplinary action* – exclusion effective date that is the date of the license surrender.

- *Termination from a federal healthcare program other than Medicare* (for example, Medicaid) – exclusion effective date that is the date of the termination.

- *Termination of a provider agreement* – exclusion effective date that is, as applicable to the type of provider involved, the later of the following: (A) the date of the provider agreement termination; or (B) the date that CMS establishes under 42 CFR § 489.55. (That regulation permits payments beyond the provider agreement termination date in certain instances and for a certain period.)

Reversal of Revocation

The Final Rule shortens the period of time to 15 days (from 30) for a provider or supplier whose enrollment has been revoked due to an adverse activity (e.g., sanction, exclusion, or felony) of a business partner (e.g., an officer, director, medical director) to terminate the relationship with that business partner. The provider or supplier must also submit proof of termination of the business relationship with that business partner within that same time period.

Next Steps

It is important that Medicare providers and suppliers review, understand, and comply with the new Medicare enrollment policies. We stand ready to assist providers or suppliers seeking guidance regarding how these new requirements may impact them and how to proceed moving forward.
