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CMS Rolls Out Its New Affiliation Disclosure Requirement for Enrollment

On September 5, 2019, CMS released its final rule on **Program Integrity Enhancements to the Provider Enrollment Process.** Effective November 4, 2019, the new regulations introduce additional disclosure requirements that could exclude certain providers from enrolling and participating in Medicare and Medicaid.

With the basic intent of broadening its efforts to protect federal health care programs from potential fraud, waste and abuse, CMS expanded its enrollment process to require providers to disclose any current or previous direct or indirect "affiliation" with a provider or supplier that:

- Has been excluded from Medicare, Medicaid, or Children's Health Insurance Program (CHIP) by the Office of the Inspector General (OIG)
- Has had its Medicare, Medicaid or CHIP billing privileges denied, voluntarily or involuntarily
- Has uncollected debt of any amount to Medicare, Medicaid or CHIP – regardless if the debt is currently being repaid or being appealed
- Has been, or is subject to, a payment suspension under a federal health care program

It's important to understand what CMS considers an affiliation:

- 5% or more 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 operation of another organization
- An officer or director position of a corporation
- Any reassignment relationship

The rule enforces a 5-year look back on affiliations, meaning providers will have to identify and maintain the disclosable events from those affiliations for review by CMS. Based on the details of the disclosure CMS can then approve or deny an initial application for enrollment, or revoke enrollment if it determines the provider creates an undue risk of fraud, waste and abuse through that relationship.

CMS advises that "these provisions will help make certain that entities and individuals who pose risks to the Medicare and Medicaid programs and CHIP are removed from and kept out of these programs"… and further comments that they "will also assist in preventing providers and suppliers from circumventing Medicare requirements through name and identity changes, as well as through elaborate inter-provider relationships." To that end, the agency has proposed that the new rule will lead to approximately 2,600 new revocations per year.

The final rule calls for the expanded disclosure reporting requirements to follow a phased-in approach. To start, CMS will only require providers to report disclosable affiliations upon request. Medicare tentatively projects an average of 2,500 requests per year for the first 3 years. Per the final rule, no predication on request volume is available for Medicaid, citing 1) the states have two options for

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requesting the information and it isn't known which states will use which option; and 2) it isn't known when each state will update its data collection mechanism to incorporate the new requirement.

This "upon request" approach will ultimately segue into a revision of enrollment form-855 to include additional fields for the required disclosure information. Updating of the form will follow the typical notice and comment process. CMS has committed to issuing guidance for completing the affiliation disclosure process and its expectations regarding the level of effort required of providers in obtaining the relevant affiliation information. APS will continue to provide updates as additional information is released.

Full details of the final rule can be read at the following link:
https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-19208.pdf