New Medicare Screening Requirements for Providers

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In conjunction with a step-up in other fraud and abuse enforcement activities, CMS recently announced new screening procedures, which will be applicable to newly enrolling providers and suppliers as well as to providers and suppliers who are currently enrolled in Medicare, Medicaid and CHIP who revalidate their enrollment information.

The new regulations are effective March 25, 2011. While the new regulations include many fraud and abuse-related provisions, this article focuses on new screening procedures for Medicare providers and suppliers in the long term care and related industries. The new screening procedures are applicable to *newly enrolling* providers and suppliers beginning on March 25, 2011. They will be applicable to *currently enrolled* Medicare, Medicaid, and CHIP providers and suppliers beginning March 23, 2012. The new screening procedures are applicable beginning on March 25, 2011 for providers and suppliers currently enrolled in Medicare, Medicaid, and CHIP who *revalidate* their enrollment information. Within Medicare, the March 25, 2011 implementation date will impact those current providers and suppliers whose 5-year revalidation cycle results in revalidation occurring on or after March 25, 2011 and before March 23, 2012.

How do these screening requirements affect those in the long-term care industry? Different levels of screening will be applicable to providers and suppliers according to the level of perceived risk they pose to potentially commit fraud, waste and abuse in federal health care programs. They are intended to keep fraudulent providers out of the programs.

The three levels of screening and associated risk are "limited," "moderate," and "high." The types of screening procedures to be used depending on the screening level include verification of provider/supplier specific requirements established by Medicare, license verifications, and database checks for limited risk providers; all of the above plus unscheduled or unannounced site visits for "moderate" risk providers; and all of the above plus fingerprint-based criminal history record checks for high risk providers and suppliers.

Of interest to those in the long-term care industry and entities they contract with, SNFs and hospitals are included in the "limited" screening level; CORFs, hospice organizations, and revalidating home health agencies are included in the "moderate" screening level; and prospective (newly enrolling) home health agencies are included in the "high" screening level.

Hospice organizations were perceived to present an elevated risk of fraud, waste and abuse in part due to an April, 2007 report titled "Medicare Hospices: Certification and Centers for Medicare and Medicaid Services Oversight" in which it was recommended that CMS seek legislation to establish additional enforcement remedies for poor hospice performance. CMS stated that "while the Medicare enrollment process is not designed to verify the conditions of participation, we do believe that more frequent onsite visits may help identify those hospice organizations that are no longer operational at the practice location identified on the Medicare enrollment application."

Hospices and home health agencies should be ready for additional site visits. In one comment to the regulations, several commenters argued that home health agencies and hospices are already subject to a state survey prior to enrollment, as well as on a periodic basis thereafter, which would make a site visit superfluous. These commenters argued that initially enrolling home health agencies and hospices should be included in the limited screening level rather than in the moderate screening level. Another commenter stated that including all revalidating home health agencies and hospices in the moderate screening level is unfair and inappropriate as they are already established providers. It was also argued that they should be exempt from the site visit requirement if they had been in existence for at least five years and there was no reason to suspect fraudulent activity.

CMS' response to these comments was that CMS does not believe a site visit is superfluous. CMS stated that:

> Due to the length of the enrollment, survey and certification processes, we believe it is important for us to institute verification activities at multiple points during this period, and not to restrict its validation efforts to the enrollment process and the state survey. Moreover, we do not believe that site visits should be limited to providers who have been enrolled for less than five years, as we do not have data to suggest that those who have been enrolled for five years or more present less of a fraud, waste, and abuse concern than newly enrolled providers and suppliers.

The new rule purports to be of importance in the transition of CMS' antifraud activities from "pay and chase" to fraud prevention. Compliance plans are key and should not be collecting dust on a shelf in the provider's offices. CMS noted the importance of compliance plans in this area. CMS stated that it does not intend to finalize compliance plan requirements in this final rule with comment period, but rather will do further rule making on compliance plan requirements "at some point in the future."

Please contact a member of the Foster Swift Health Care Practice Group if you have questions about how these new regulations will affect you as a provider.