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Are we having fun yet? CMS posts new 855 enrollment applications

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On July 5, 2011, the Centers for Medicare & Medicaid Services (CMS) posted new versions of the Medicare enrollment applications, or 855s, on its website. Although CMS has been slow to publicize these new applications, some of the changes may significantly impact Medicare providers and suppliers. The revised 855s, coupled with the recent announcement that CMS will require most current Medicare providers and suppliers to revalidate their enrollment information between now and March 2013, will make the already challenging Medicare enrollment process even more daunting. This article discusses key revisions to the 855s, anticipated impacts on the provider and supplier community, and tips for providers and suppliers navigating the enrollment and revalidation process.

The new enrollment applications

In the months leading up to the publication of the new 855s, CMS quietly submitted drafts of the revised applications to the Office of Management and Budget (OMB) for review, but did not widely broadcast its intention to revise the applications. In fact, provider enrollment representatives at certain Medicare contractors have, during informal conversations, indicated that they did not learn of the new 855s until after CMS had published them on its website. Further, some provider enrollment representatives have indicated that the Medicare contractors first learned of the new applications when providers and suppliers called with inquiries—not from announcements or guidance from CMS. On August 23, 2011, approximately seven weeks after posting the forms on its website, CMS finally made a public announcement, via its e-mail listserv to fee-for-service providers, that the new 855s are available on the website. In its listserv announcement, CMS encouraged providers and suppliers to use the revised 855s, but indicated that the old forms may be used through October 2011.

All 855 enrollment applications now bear an effective date of July 2011. Of the revised 855 forms, the most substantial changes have been made to the Form 855A (for institutional providers), but CMS also revised the Form 855B (for clinics/group practices and certain other suppliers), the Form 855I (for physicians and non-physician practitioners), the 855R (for reassignment of Medicare benefits), and the 855S (for durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] suppliers). In addition, CMS introduced a new Form 855O, which will be used by physicians and non-physician practitioners (NPPs) who enroll for the sole purpose of ordering or referring items for Medicare beneficiaries. Note that many of the changes made to the 855s are formatting changes, but certain of the substantive changes, mainly with respect to the 855A, may significantly increase the burden associated with obtaining

and maintaining enrollment in the Medicare program.

Changes applicable to all institutional providers

Form 855A is the Medicare enrollment form used by institutional providers, including hospitals, skilled nursing facilities, home health agencies, hospices, rural health clinics, end-stage renal disease facilities, comprehensive outpatient rehabilitation facilities, and certain other providers. Among the more significant changes to the disclosures required by all institutional providers on the new 855A are:

- Providers must indicate in Section 2.A.4 whether they are physician-owned hospitals.
- Providers must report whether they are proprietary or non-profit and their year-end cost report date in Section 2.B.1.
- For providers organized as limited partnerships, limited partnership interests need to be reported only if the interest is at least 10% (a welcome liberalization of the former commonly accepted interpretation that all limited partnership interests, irrespective of percentage, must be reported).
- Organizations and individuals with an ownership interest or managing control must report their "exact" percentage of ownership in the provider in Section 5 and Section 6, respectively.
- Organizations with an ownership interest or managing control must indicate whether they were "solely created to acquire/buy the provider and/or the provider's assets."
- Organizations with an ownership interest or managing control must indicate their type of organization in Section 5 (e.g., holding company, medical staffing company, investment firm, etc.).
- Organizations and individuals with an ownership interest or managing control must indicate in Section 5 and Section 6 what type of contractual services (if any) they provide to the enrolling provider.
- Providers must submit an organizational diagram identifying all of the entities listed in Section 5 (organizations with an ownership interest and/or managing control) and their relationships with the provider and with each other. If the provider is a skilled nursing facility, the provider must submit a diagram identifying the organizational structures of all of its owners, including owners that were not required to be listed in Section 5 (organizations) or Section 6 (individuals); and
- Section 17 makes it clear that the Medicare contractor "may request, at any time during the enrollment process, documentation to support or validate" information reported in the 855, including documents not specifically requested on the application form.

Given the specificity of the information that must now be reported in the 855A, the new 855A has the potential to significantly increase the burden on providers to obtain and maintain their Medicare enrollment. For example, given the precision with which ownership interests must be reported, it is unclear whether CMS will expect providers to submit an 855A change of information to the contractor each time an ownership percentage fluctuates. If so, this would prove particularly burdensome—if not unrealistic—for providers owned by publicly-traded companies, where ownership levels change continually. Furthermore, it is unclear whether CMS will expect providers to submit a change of information each time the nature of contractual services provided by an organization or individual with an ownership interest or managing control changes. Given the ambiguously broad reach of these disclosures, CMS will hopefully provide additional guidance to the provider community as well as to CMS' contractors.

Changes specific to physician-owned hospitals

One of the main factors presumably driving the development of the

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new 855A is Section 6001 of the Patient Protection and Afford able Care Act (PPACA), which amends the whole hospital exception to the Stark Laws. The amended whole hospital exception effectively prohibits the formation of new physician-owned hospitals and prevents any increase in the level of physician ownership of existing physician-owned hospitals. To this end, it requires all Medicare-enrolled hospitals to disclose to CMS whether they have physician owners and, if so, information regarding those physician owners. Accordingly, Section 2 of the 855A now requires the applicant to indicate whether it is a physician-owned hospital. The 855A defines a physician-owned hospital as

> any participating hospital in which a physician, or an immediate family member of a physician has an ownership or investment interest in the hospital….through equity, debt, or other means, and includes an interest in an entity that holds an ownership or investment interest in an entity that holds an ownership or investment interest in the hospital.[1]

A physician-owned hospital must complete the new Attachment 1 to the 855A, which consists of two sections. Providers who do not have physician ownership are not required to complete Attachment 1.

Section 1 of Attachment 1 must be completed for every *organization* that has *any* percentage of ownership or investment interest in the physician-owned hospital. Similarly, Section 2 of Attachment 1 must be completed for every *individual* who has *any* percentage of ownership or investment interest in the physician-owned hospital. This standard is different than Section 5 of the 855A, which generally requires the reporting of owners (with the exception of general and limited partners as described above) only if they have a direct or indirect ownership interest *of at least 5%.* Section 1 and Section 2 of Attachment 1 require the submission of information regarding these owners, including the owner's:

- Full legal name
- Address
- Medicare identification number and National Provider Identifier (NPI), if applicable
- Effective date of ownership interest
- Percentage of ownership interest (reported to two decimal places), and
- History of certain reportable final adverse legal actions

Section 1 of Attachment 1 does not expressly state that *organizations* with an *indirect* ownership interest in a physician-owned hospital must be reported, so presumably only direct ownership interests must be reported for organizations. Please note that this comment applies only to Attachment 1. Providers must still report both direct and indirect ownership by organizations that equals or exceeds 5% in Section 5 of the 855A.

In contrast to Section 1 of Attachment 1, Section 2 of Attachment 1 states that all *individuals* with any direct or *indirect* ownership in a physician-owned hospital must be reported in Section 2. Specifically, along with all physicians and immediate family members of physicians who have a direct or indirect interest in a physician-owned hospital, CMS requires "[a] ll individuals who are not physicians or immediate family members of a physician, but who have a direct or indirect ownership interest or investment interest in a physician-owned hospital" to be reported in Section 2 of Attachment 1.[2] CMS then gives the following example: "Nancy Jones, a teacher, has a 2% direct ownership interest in a physician-owned hospital. Ms. Jones's ownership interest must be reported in Attachment 1, Section 2." Based on CMS' broad language requiring disclosure of all individuals' direct and indirect ownership interests, Ms. Jones's ownership arguably would need to be reported even if her ownership or investment interest in

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the physician-owned hospital is indirect (i.e., if Ms. Jones owns stock in a company that operates physician-owned hospitals). If this is really CMS' intention, then the Attachment 1 disclosures may present a formidable challenge to many physician-owned hospitals. Hopefully, CMS will provide additional guidance to clarify (and narrow the scope) of this disclosure requirement.

Forms CMS-855B and CMS-855S

Although most of the revisions to the remaining 855 forms were cosmetic changes, CMS did make some substantive changes. For example, the 855B now requires the supplier to report whether it is proprietary or non-profit. In addition, both the 855B and 855S require the supplier to disclose the state and country of birth for individuals reported in Section 6 as having an ownership interest or managing control in the supplier.

Form CMS-855O

The 855O is a relatively short enrollment application, consisting of only six sections and 13 pages. The application, which is to be completed only by providers or non-physician practitioners (NPPs) who will order or refer Medicare items or services but not submit claims to Medicare, asks for only basic information about the provider or NPP. For example, the provider or NPP must provide basic identifying information, contact information, professional licensure and credentialing information, and a description of any adverse legal history.

Request for revalidations

Revalidation is a process by which a Medicare provider or supplier recertifies the accuracy of its enrollment information by submitting a complete 855 application. Although Medicare revalidations are generally not required more frequently than every five years, CMS has authority under 42 CFR 424.515(d) to request "off-cycle" revalidations in certain situations.

On August 8, 2011,[3] CMS announced that it will require all providers and suppliers who enrolled in Medicare prior to March 25, 2011 to revalidate their enrollment under the new enrollment screening criteria imposed by Section 6401(a) of PPACA. CMS' contractors will request these revalidations by March 23, 2013. Newly enrolled providers and suppliers who submitted their enrollment applications to a CMS contractor on or after March 25, 2011 will not be required to submit these off-cycle revalidations.

CMS has instructed providers and suppliers that they should wait and submit the revalidations only after being asked to do so by their respective Medicare contractors. Once a provider or supplier receives a revalidation request from its Medicare contractor, it will generally have 60 days from the date of the request letter to submit complete enrollment forms. Failure to submit the enrollment forms as required may result in the deactivation or revocation of the provider's or supplier's Medicare billing privileges. As a result, providers and suppliers may wish to ensure that all of their practice locations (and not just their "official" correspondence address on the 855) can receive and forward mail for proper handling. There have been informal reports of revalidation requests being sent not to the official correspondence address, but to practice locations.

Unless a provider or supplier qualifies for a hardship exception, a revalidation submitted by a provider or supplier (excluding physicians, NPPs, and physician and NPP organizations) must be accompanied by an application fee, as required by PPACA. For calendar year 2011, the application fee is $505.

What providers and suppliers can do now

Providers and suppliers should become familiar with the new 855s as soon as possible, because the new forms may require significant additional disclosures,

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although providers and suppliers will not be required to use the new 855s until November 2011. We also recommend that providers and suppliers immediately begin to gather the information that will be required to complete the applicable 855. For some providers and suppliers, this will involve preparing organizational diagrams to submit to a Medicare contractor and/or gathering detailed information about all organizations and individuals who have an ownership interest or managing control in the provider or supplier. Providers and suppliers should also understand what documents, such as state operating licenses, may need to be included with the 855 as part of a revalidation. By preparing this information now, providers and suppliers will find themselves in a much better position when (not if) they receive a mandatory revalidation request from a Medicare contractor and the 60-day clock begins to run.

Because of the limited time afforded a provider or supplier to respond to a revalidation request and because of the potential of deactivation or revocation of Medicare billing privileges for noncompliance, we recommend that providers and suppliers incorporate Medicare enrollment into their compliance plans. For example, a compliance plan may include the process for logging, handling, and responding to a request for revalidation to ensure that the provider or supplier responds to the Medicare contractor in a timely manner. A compliance plan might also outline how information regarding owners is maintained and how changes are reported to CMS contractors in a timely manner. ■

1. See Section 2, "Special Enrollment Notes," p. 9 of CMS-855A (07/11).
2. See Attachment 1, Section 2 instructions, p. 56 of CMS-855A (07/11).
3. See MLN Matters Number SE1126 (August 8, 2011). A revised MLN Matters Number SE1126 was published on August 10, 2011, and corrected the PPACA citation from Section 6401(d) to 6401(a).