

agencies to an administrative sanction imposed by any Federal agency. Specifically, the law provides that: "No agency shall allow a party to participate in any procurement and non-procurement activity if any [other] agency has debarred, suspended, or otherwise excluded, that party from participation in a procurement or non-procurement activity." (FASA, section 2455). Therefore, consistent with FASA, its implementing regulation, and OIG regulations (42 CFR 1001.1901(b)), we would deny or revoke enrollment (revocation effective on the date of the exclusion) if the provider or supplier is subject to an OIG exclusion, or is debarred, suspended or otherwise excluded by any other Federal health care program or agency.

F. Rejection of a Provider or Supplier's CMS 855 for Medicare Enrollment

In new § 424.525, we propose that if a provider or supplier enrolling in the Medicare program for the first time fails to furnish complete information on the CMS 855, or fails to furnish missing information or any necessary supporting documentation as required by CMS under this or other statutory or regulatory authority within 60 calendar days of our request to furnish the information, we would reject the provider or supplier's CMS 855 application. Rejection will not occur if the provider or supplier is actively communicating with CMS to resolve any issues regardless of any timeframes.

Upon notification of a rejected CMS 855, the provider or supplier must again begin the enrollment process by completing and submitting a new CMS 855 and all applicable documentation. We are specifying in § 424.525(b) that the new form must also update any information that is different from that originally submitted. This will ensure that we have the most recent information about the provider or supplier. The enrollment process would culminate in the granting of billing privileges, or denial or rejection of the application.

G. Denial of Enrollment

We would deny enrollment in the Medicare program to providers or suppliers whom we determine to be ineligible. Providers and suppliers who are denied enrollment would not receive Medicare billing privileges. In § 424.530(a) we are proposing that a provider or supplier applying for enrollment in the Medicare program may be denied enrollment for the following reasons:

- Under § 424.530 (a)(1), enrollment may be denied if the provider or

supplier were found not to be in compliance (for example, failure to furnish required documentation, lack of qualified practice location) with the Medicare enrollment requirements applicable to the type of provider or supplier enrolling, unless the reason for non-compliance were corrected or the provider or supplier has submitted a plan of corrective action as outlined in Part 488 and under section 1812(h)(2)(c) of the Act.

- In § 424.530(a)(2) we propose that enrollment may also be denied if: (A) the provider or supplier, or any owner, managing employee, authorized or delegated official; or (B) any supervising physician, medical director, or other health care personnel furnishing Medicare reimbursable services who is required to be reported on the providers' or suppliers' CMS 855—for example, an ambulance crew member.)

- Is excluded from the Medicare, Medicaid and any other Federal health care programs, as defined in § 1001.2, in accordance with § 1001.1901(a);

- Is debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement activity in accordance with FASA section 2455; (See HHS Common Rule provisions that discuss the effect of a program exclusion under Title XI of the Act, as well as other Federal agency debarments, suspensions, and exclusions found at 45 CFR 76.100(c) and (d)).

We are required to ensure that no payments are made to any providers or suppliers who are excluded from participation in the Medicare program under authorities found in sections 1128, 1156, 1862, 1867, and 1892 of the Act, or who are debarred, suspended or otherwise excluded as authorized by FASA. This includes any individual, entity, or any provider or supplier that arranges or contracts with (by employment or otherwise) an individual or entity that the provider or supplier knows or should know is excluded from participation in a Federal health care program for the provision of items or services for which payment may be made under such a program (section 1128A(a)(6) of the Act), and any provider or supplier that has been debarred, suspended, or otherwise excluded from participation in any other Executive Branch procurement or non-procurement programs or activity (FASA, section 2455).

Therefore, when an individual or entity is excluded by the OIG under section 1128 of the Act, the exclusion is applicable to participation in all Federal health care programs (including Medicare and Medicaid as defined in

section 1128B(f) of the Act). In addition, section 1862(e) of the Act prohibits the Secretary from paying for items and services furnished by excluded individuals. We believe that our general authorities, in combination with the prohibition against paying for items or services furnished by excluded individuals, provides authority for us to deny enrollment unless a provider or supplier terminates its relationship with the relevant individual. The denial would remain effective until that provider, supplier, managing employee, or an authorized or delegated official; or a medical director, supervising physician, or other health care personnel furnishing Medicare reimbursable services, is no longer excluded or sanctioned. Section 424.530(b)(3) also provides that the denial may be within 30 days of the denial notification.

We also propose, in § 424.530(a)(3), that we may deny enrollment in the Medicare program if the provider or supplier, or any owner of the provider or supplier, has been convicted of a Federal or State felony offense that we determine to be detrimental to the best interests of the Medicare program or its beneficiaries. This authority is afforded to us in many of the HIPAA fraud and abuse provisions and section 4302 of the BBA. In making assessments, we are proposing to include any felony convictions from the last 10 years or more. In addition, we will consider the severity of the underlying offense.

Felonies that we determine to be detrimental to the best interests of the Medicare program or its beneficiaries include:

- Within the last 10 years or more preceding enrollment or revalidation of enrollment, crimes against persons, such as rape, murder, kidnapping, assault and battery, robbery, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions. We believe it is reasonable for the Medicare program to question the ability of the individual or entity with such a history to respect the life and property of program beneficiaries.

- Within the last 10 years or more preceding enrollment or revalidation of enrollment, financial crimes, such as extortion, embezzlement, income tax evasion, making false statements, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions. We believe it is reasonable for the Medicare program to question the honesty and integrity of the individual or entity with such a history in providing services and