DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICARE

DATE: June 21, 2023

TO: Medicare Advantage Organizations, Prescription Drug Plan Sponsors, Section 1876 Cost Plans and Programs of All-Inclusive Care for the Elderly Organizations

FROM: Zabeen Chong, Director Provider Enrollment & Oversight Group, Center for Program Integrity

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SUBJECT: Preclusion List Requirements

The Centers for Medicare & Medicaid Services (CMS) is issuing this memo as a reminder of the requirements outlined in previously issued guidance, and regulatory obligations found under 42 CFR §§ 422.222, 422.224, 423.120(c)(6), 417.478(e), and 460.86.

On November 2, 2018, CMS issued a memo titled "Preclusion List Requirements" providing guidance, including Preclusion List requirements and a sample beneficiary notice, with respect to the final rule CMS-4182-F published on April 16, 2018. On December 14, 2018, CMS published a subsequent memo titled "Preclusion List Requirements Frequently Asked Questions (FAQ)" that supplemented the November 2, 2018, memo with FAQs and a revised sample beneficiary notice. Finally, CMS published updated preclusion list FAQs on December 16, 2020, which can be found at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Preclusion_List_FAQs.pdf

On October 25, 2023, The Office of Inspector General (OIG) published Report No. A-02-20-01027 titled "CMS Generally Ensured That Medicare Part C and Part D Sponsors Did Not Pay Ineligible Providers for Services to Medicare Beneficiaries." As a part of the audit findings, the OIG noted that some plans submitted to CMS encounter and PDE data indicating that ineligible providers rendered services and wrote prescriptions for Medicare beneficiaries.

Under CMS regulations, 42 CFR §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi), plans must adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct noncompliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse, including payments made to ineligible providers. Plans should have processes in place to routinely review their lists of contracted providers and take necessary actions to ensure that only eligible providers receive payments for Medicare services in accordance with Medicare payment rules. Moreover, in instances where

plans have identified payments for Medicare services made to excluded or precluded providers, attempts should be made to recoup any recoverable payments.

For questions related to exclusion and preclusion list requirements, please email providerenrollment@cms.hhs.gov.