Medicare & Medicaid Provider Enrollment
March 2019

Zabeen Chong, Director
Provider Enrollment & Oversight Group
Center for Medicare & Medicaid Services

Charles Schalm, Deputy Director
Provider Enrollment & Oversight Group
Center for Medicare & Medicaid Services

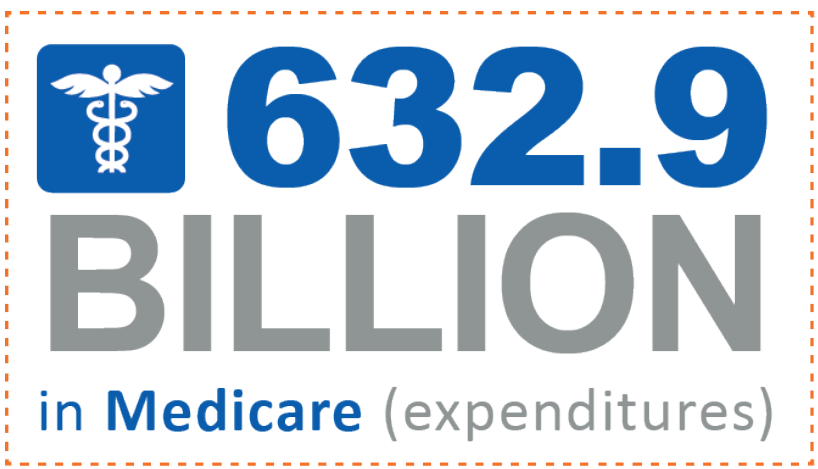
Session Overview

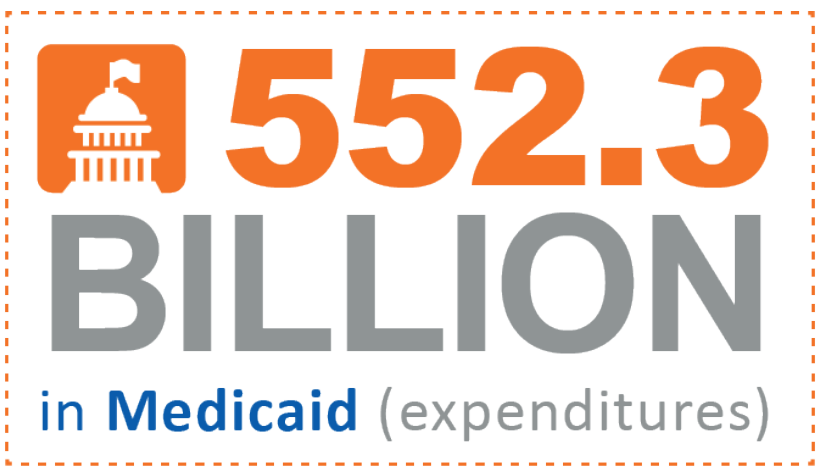
- Putting Patients First
- How Enrollment Works
- Medicare Policy Updates
- Revalidation
- Medicaid Enrollment
- Our Enrollment Systems
- Protecting the Program
- Enforcement Actions

Putting Patients First

Poll Question 1

By the Numbers





Poll Question 2

Why We're Here

LISTENING TO YOU

We hear you, and we've learned a lot from you

FINDING A BALANCE

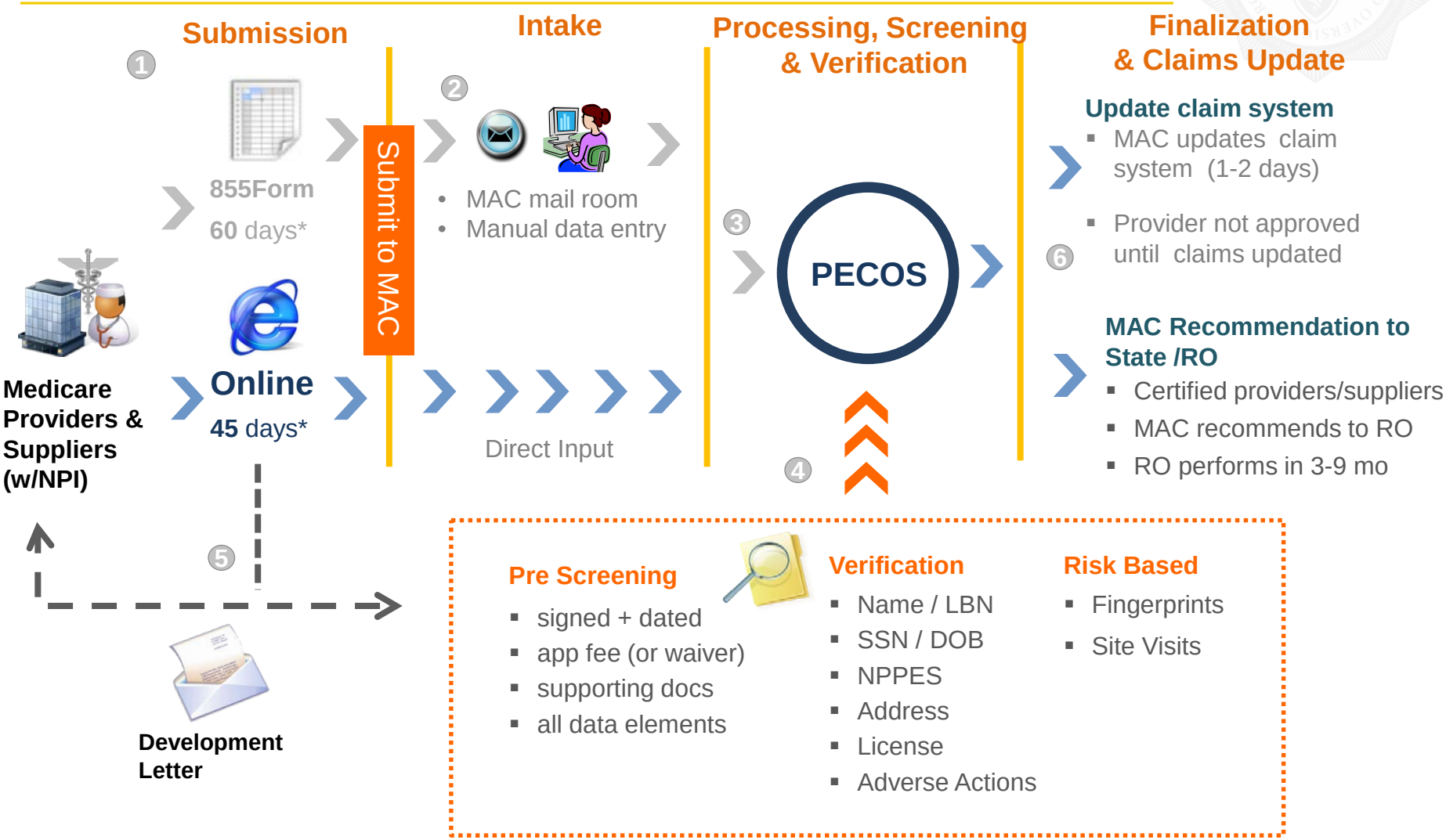
We believe enrollment should be **easy** for most providers, and **hard** for bad actors

ALWAYS IMPROVING

We will keep refining our systems, policies, transparency, and our vision

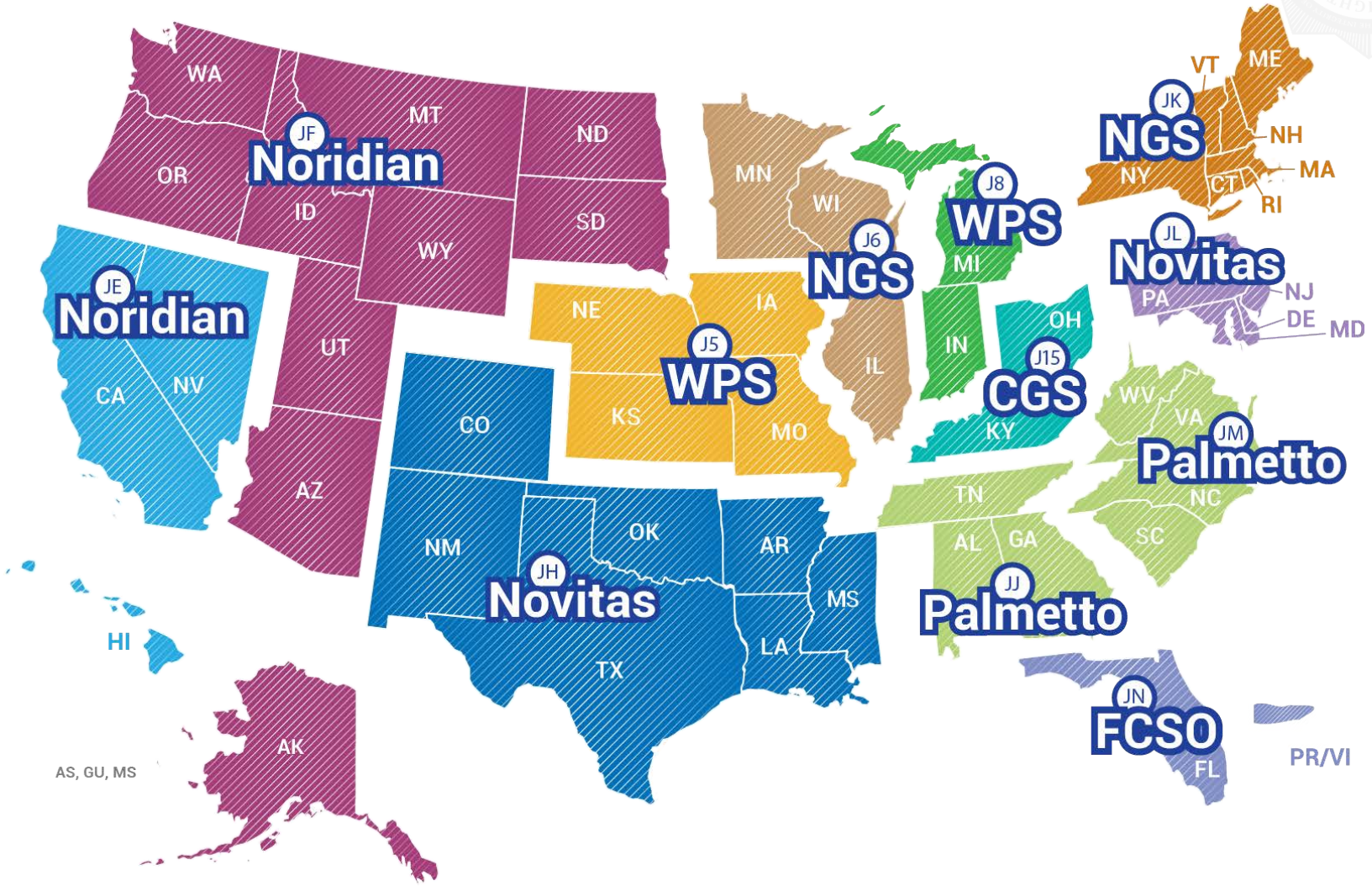
How Enrollment Works

How Enrollment Works



** If the app is complete, and no site visit*

MAC Jurisdictions



Policy Updates

Recent Policy Changes

- Online applications must be e-signed or signature uploaded (*October 2018)*
  - Difficult for MACs to match paper signature to web submission
  - Includes CMS-588 EFT and CMS-460 PAR Agreements
- No longer accept handwritten CMS-855 paper applications *(late 2019)*
  - All paper applications shall be typed using the fillable CMS-855 form option
  - MACs will return application if entire fields or sections are hand-written
    - No appeal rights
  - Could impact your effective date

Recent Policy Changes | April 2019

- IDTFs are not required to report equipment that is being leased for less than 90 days
- Private practices providing IDTF services to ANY outside patients must enroll as an IDTF
- MACs will request a change of information application if they are notified that a Interpreting or Supervising Physician no longer provides services at an IDTF
  - IDTF must remove the Interpreting or Supervising Physician from the IDTF enrollment and/or replace if that was the only physician on file
  - Failure to appropriately update the IDTF enrollment may result in revocation
- The effective date for IDTFs undergoing a CHOW that results in a new enrollment is date the business was transferred to the new owner

Recent Policy Changes

- Providers who are reassigned to a deactivated/revoked organization will have 90 days to submit a new practice location or reassignment before being deactivated
- MACs should not call to speak directly to providers reporting a change in specialty
- MACs should not request a diploma or degree unless education requirements cannot be verified online
  - Mostly impacts non-physician practitioners
- MACs should not request a SSN card or driver's license for identification

Recent Policy Changes

- MACs should not request a phone, utility, power bill or lease to validate LBN or DBA
  - Lease only required to validate exclusive use of facility for PT/OT or ambulance suppliers leasing aircraft
- MACs shall only request the dated signature of at least one authorized/delegated official for applications requiring development
- MACs may accept a CP-575, federal tax department ticket, or any other pre-printed document from the IRS to validate TIN and/or LBN

Survey and Certification Transition

What we've heard…

- The survey and certification process can take several months without any provider transparency
- Providers are unsure who to contact to request a status of their enrollment application
- Processes amongst the ROs are not consistent
- Changes in enrollment information is often reported to the RO outside of the CMS-855 process

Survey and Certification Transition

Phased Implementation

Phase I (Summer 2019)

All certified provider enrollment applications that do not require a state survey

- Voluntary terminations
- CHOWs
- Address changes
- FQHC (initials and location changes)

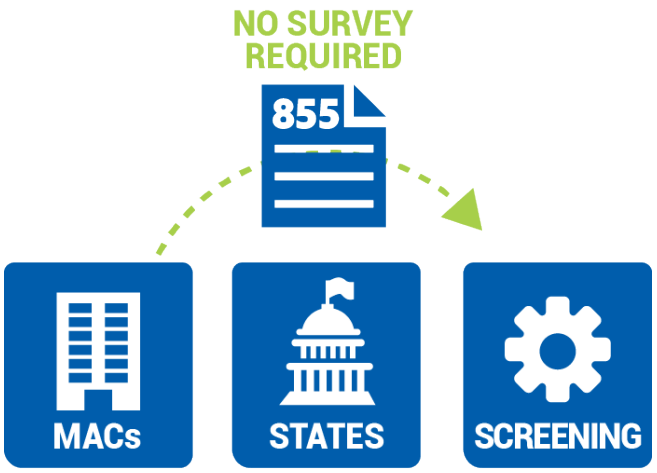
Phase II (Late 2019)

All certified provider enrollment applications that do require a state survey

- Initials
- Involuntary terminations
- Relocations

Survey and Certification Transition | Summer 2019

CMS will transfer **some** survey and certification functions for certified providers to the **Center for Program Integrity** and the **MACs**



Advantages

Reduce application processing times

- In some cases, MACs are able to process enrollment applications without making a recommendation to the CMS RO/State, if no survey is required.
- Direct coordination between the MACs and States for survey related actions.
- This process **will not** eliminate the need for a survey, if required.

Streamline the application process

- MACs will collect required information with the CMS-855 to avoid additional development requests from the CMS RO/state (OCR attestation, provider agreements, certification forms).

Authorized and Delegated Officials - PECOS & I&A

AO Authorized Official

Enroll, make changes and ensure compliance with enrollment requirements

- CEO, CFO, partner, chairman, owner, or equivalent appointed by the org
- May sign all applications *(must sign initial application)*
- Approves DOs

DO Delegated Official

Appointed by the AO with authority to report changes to enrollment information

- Ownership, control, or W-2 managing employee
- Multiple DOs permitted
- May sign changes, updates & revalidations *(cannot sign initial application)*

AO Authorized Official

Assign surrogacy and controls access to PECOS and NPPES records

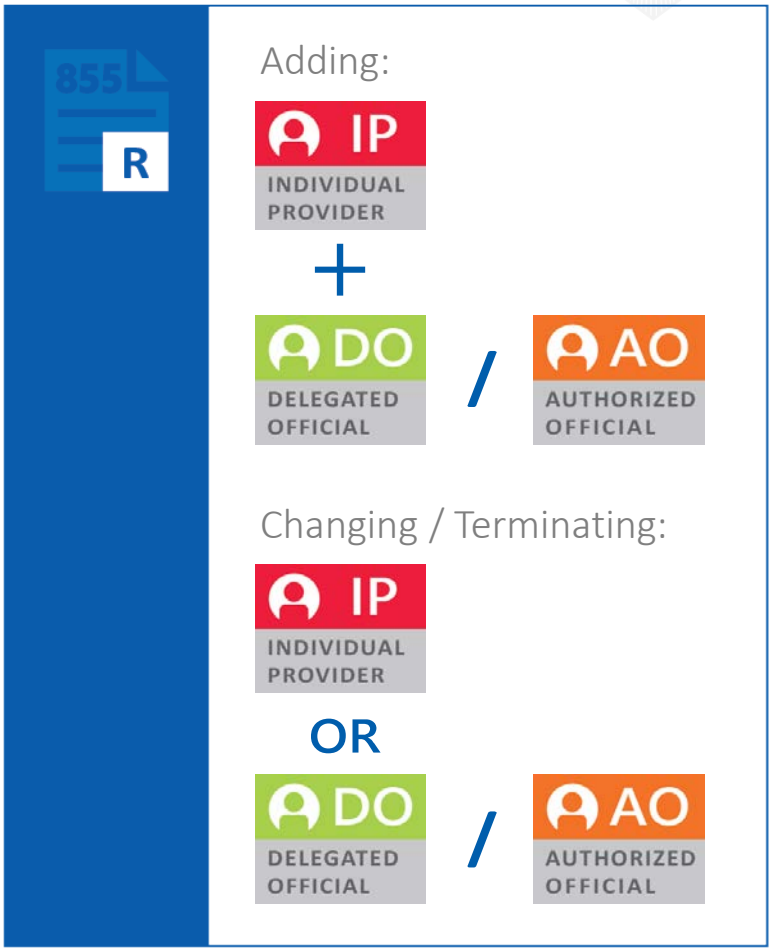
- CEO, CFO, partner, chairman, owner, or equivalent appointed by the org. AO requirements are same as PECOS
- Automatically approved if listed as AO in PECOS; if not, CP575 must be provided to approve access
- Manage staff and connections for the employer
- Approve DOs for the employer

DO Delegated Official

Authority to assign surrogacy and controls access to PECOS and NPPES records

- Delegated by the AO of org provider or 3rd party org
- Less restrictive DO requirements than PECOS
- May add the employer to his profile, manage staff and connections for the employer
- Multiple DOs permitted

Who Can Sign the Enrollment Application?



Release of Enrollment Information

	Individual Provider	AO / DO	Contact Person	Outside Person / Entity
PTANs	X	X	X	
Effective Dates	X	X	X	
Group Affiliations	X	X	X	
Practice Locations	X	X	X	
Revalidation Status Information	X	X	X	X
Approval Letters	X	X	X	

Part C & D Preclusion List

CMS-4182F
starts JAN 2019

Replaces the Medicare Advantage (MA) and Prescriber enrollment requirements and creates a Preclusion list

Preclusion List

- Applies to individuals/entities
- Currently revoked and under an active re-enrollment bar, or
- Could have revoked if enrolled in Medicare; and
- Conduct that led to the revocation is considered detrimental to the Medicare program

50%
of revoked felons continue to prescribe opioids to Medicare beneficiaries

Part C & D Preclusion List

What happens if I'm on the Preclusion List?

You will receive an email and letter from CMS in advance of your inclusion on the Preclusion List

The email and letter will be sent to your PECOS (enrolled) or NPPES (unenrolled) email/mailing address

The letter will contain the effective date of your preclusion, and your applicable appeal rights

Part C & D Preclusion List

Beginning APR 2019

Medicare Advantage (Part C)

- MA plans will deny payment for a health care item or service if the individual/ entity is on the Preclusion List

Prescriber (Part D)

- Pharmacy will deny prescriptions at point of sale if the provider is on the Preclusion List

Part C & D Preclusion List

For more information on the Preclusion List refer to:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html

- Frequently Asked Questions (FAQs)
- Preclusion List Reference Guide
- Guidance to the Healthcare Plans
- Resource mailbox for additional questions – providerenrollment@cms.hhs.gov

Poll Question 3

Question & Answer Session

Revalidation

Poll Question 4

Revalidation Basics

5-year cycles

3-year for DME suppliers

When is your revalidation due?

go.cms.gov/MedicareRevalidation

- Lists all affected, 6 - 7 months out
- MACs will send notices 2-3 months prior
- Always due on **last day of the month**
- List includes all reassignments

RESPONSE RATE

90%

We e-mail the PECOS contact

- If multiple contacts exist email most recent on file
- No phone calls
- If no email address, we mail to: correspondence and special payment addresses and/or practice location address

Large Group Coordination

- We mail an "FYI" to **large groups** every 6 months, with a spreadsheet of every relevant provider (Name, NPI, and Specialty)
- MACs can now ask one contact to verify multiple practice locations

60
DAYS TO RESPOND

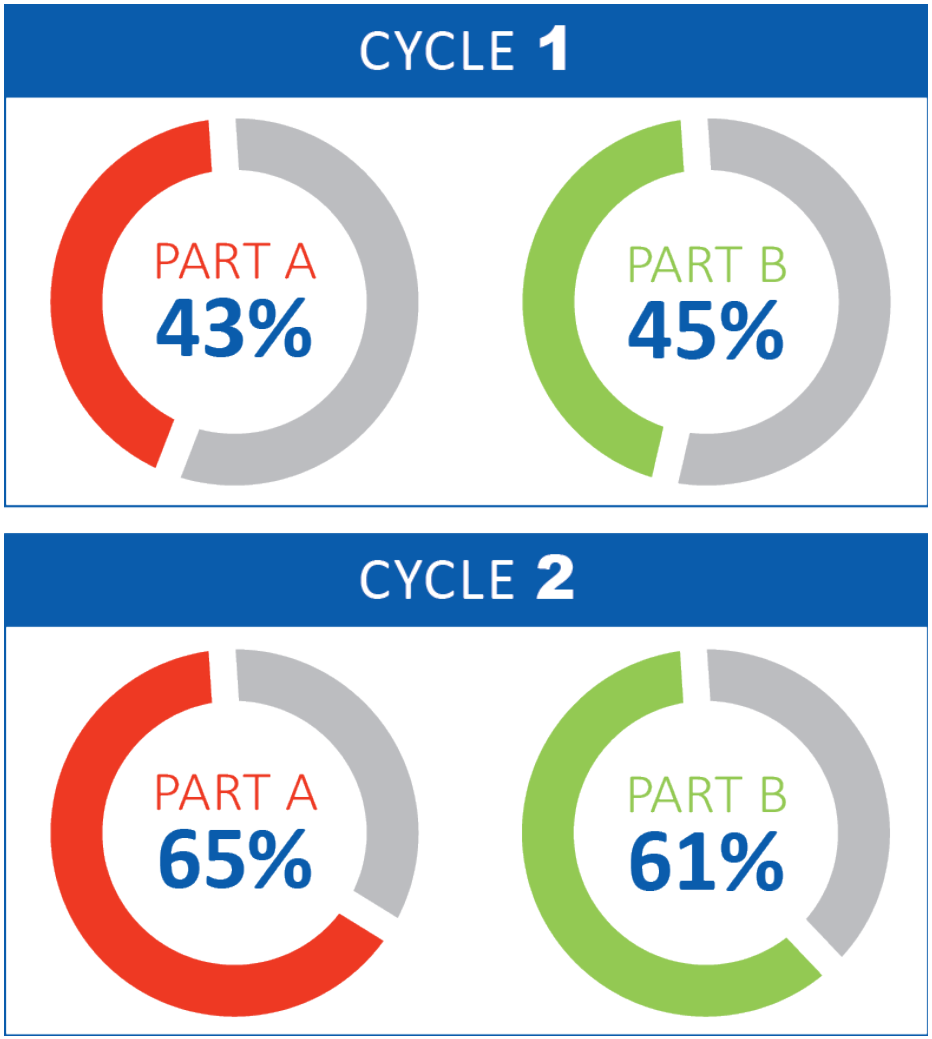
No Response?

- deactivate (not revoke)

Late Revalidation?

- break in billing

Revalidation Web Submissions



Revalidation Details

Unsolicited Revalidations

- If your record's due date is "TBD", do not send an application
- CMS will accept applications submitted within 7 months before due date, any application submitted beyond this timeframe will be returned
- If you want to *update or change* your enrollment record, send the relevant 855 form

Deactivations

- If you don't provide a complete revalidation your Medicare billing privileges will be deactivated
- Respond to all development requests by your MAC within 30 days
- If we deactivate you, you need to resend a complete enrollment application for reactivation
- If CMS reactivates you, you keep your old PTAN, and you are reactivated to the receipt date of the new application + 30 days for retrospective billing
- Approval letters include gap in billing language

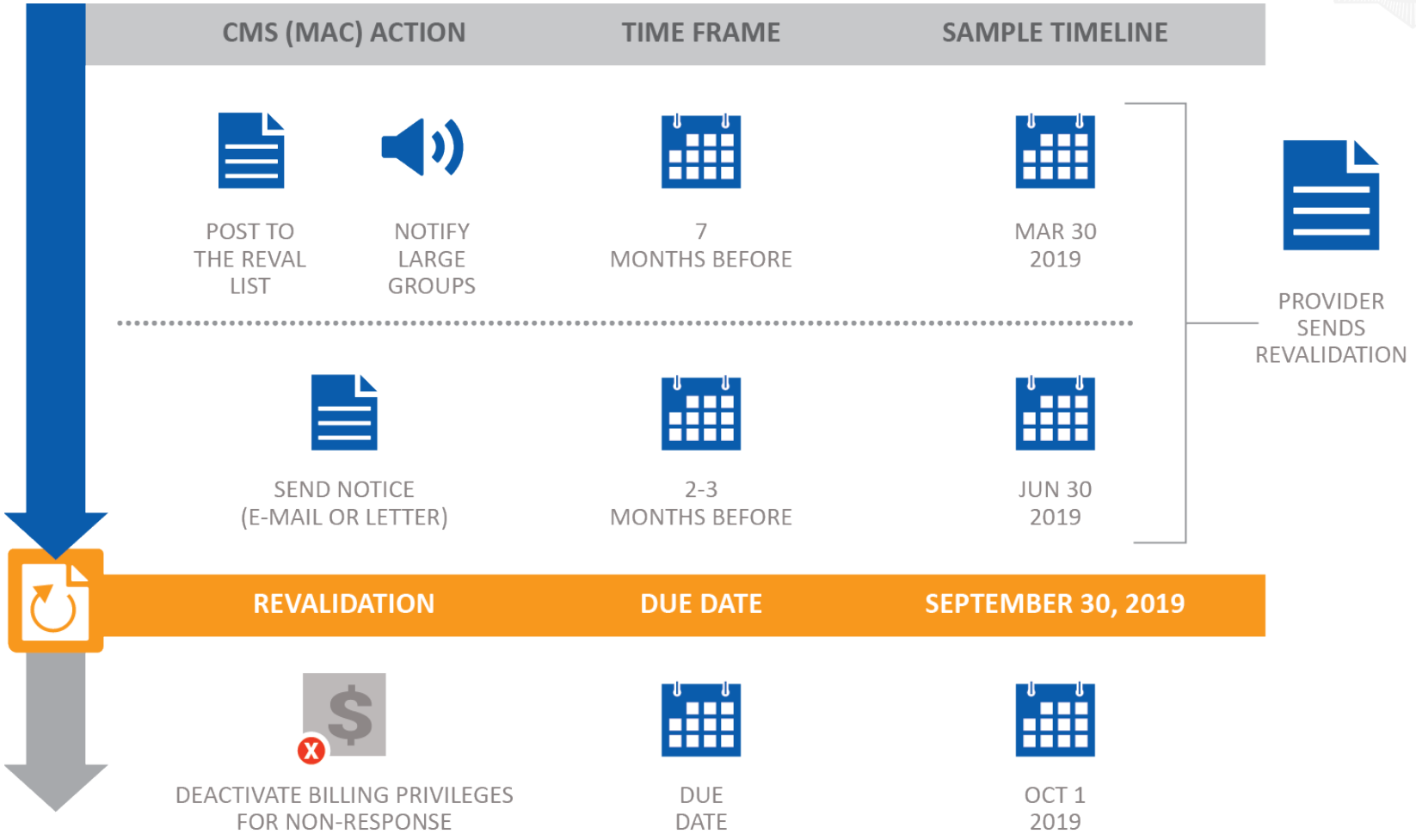
Revalidation Details

Changes received prior to revalidation

- Changes received within 7 months of revalidation due date may be processed as a revalidation, or

- Provider can choose to continue with the change in lieu of revalidation
  - MAC will process the change and proceed with revalidation process
  - Changes reported within 7 months of revalidation due date are not required to be reported on the revalidation application
  - MAC will not override the previous changes

Revalidation Timeline



Poll Question 5

Missing Reassignments - No Break in Billing

SCENARIO #1

- Revalidation application sent with missing reassignments
- Response received **before** due date

Application Received	**09/01/2019**
Development Letter Sent	**10/15/2019**
Development Due	**11/15/2019**
Development Received	**11/10/2019**
Revalidation Due	**10/31/2019**
Revalidation Complete	**11/30/2019**

- Revalidation notice includes reassignments for Groups A, B & C
- Revalidation application is received but only addresses reassignment for Group A
- MAC develops to Contact Person for missing reassignments for Groups B & C
- Provider responds with information for Groups B & C prior to the revalidation due date or the development due date (Section 1, 2, 4 & 15 of the 855I or a full 855I)
- **No break in billing**

Missing Reassignments - Break in Billing

SCENARIO #2

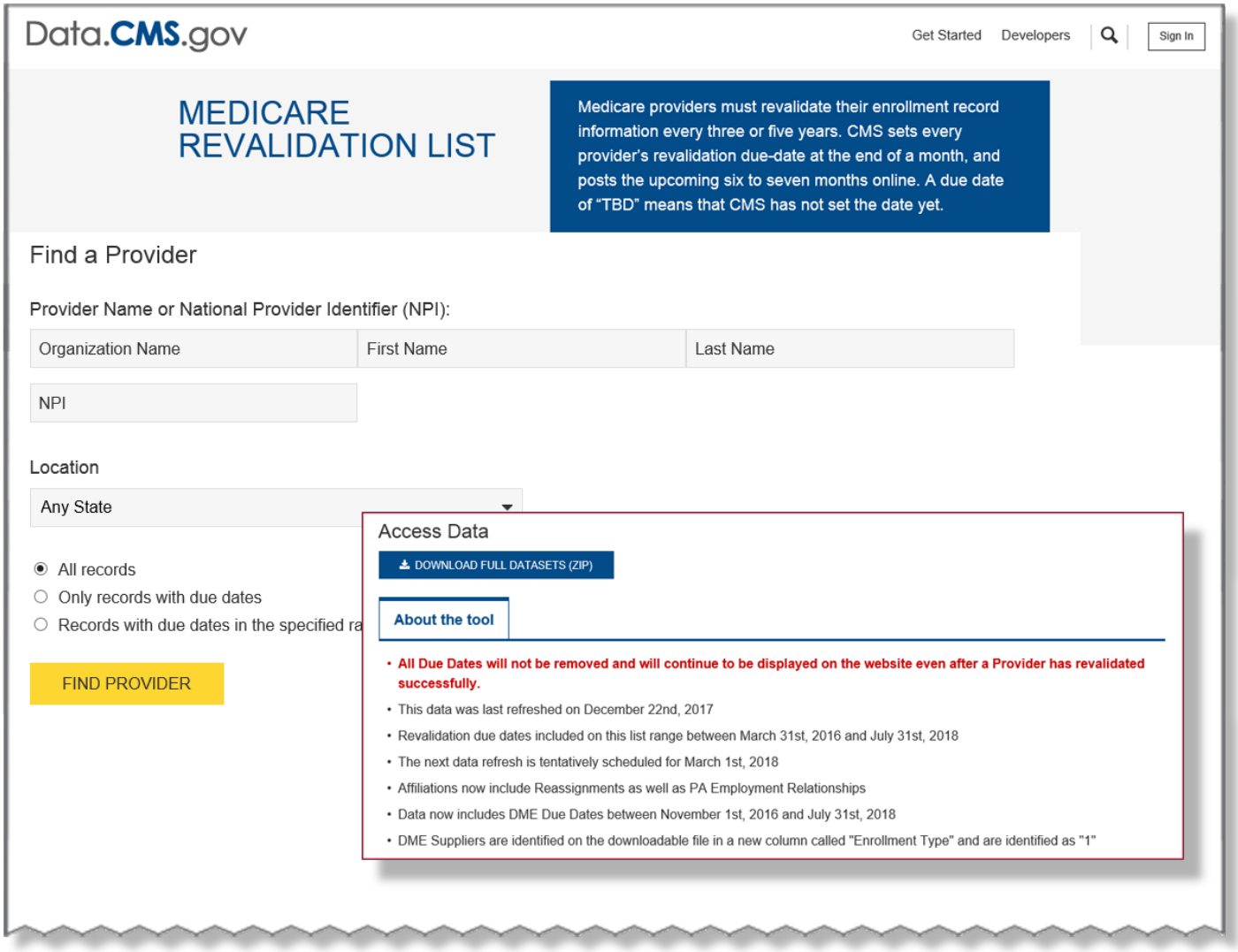
- Revalidation sent with missing reassignments.
- Response received **after** due date

Application Receipt	**10/01/2019**
Development Letter Sent	**10/15/2019**
Development Due	**11/15/2019**
Revalidation Due	**10/31/2019**
Reassignment End	**11/15/2019**
Revalidation Receipt	**12/01/2019**
Reactivation Effective	**12/01/2019**

- Revalidation notice includes reassignments for Groups A, B & C
- Revalidation application is received but only addresses reassignment for Group A
- MAC develops for missing reassignments for Groups B & C
- No response received from provider
- Group A's reassignment is revalidated. Groups B & C's reassignments are deactivated effective with the latter of the revalidation due date or the development due date
- Provider submits a reactivation application after the due date (full 855R required)
- Effective date for Groups B & C is based on receipt date of reactivation application
- **Break in billing**

Poll Question 6

Revalidation Look-up Tool

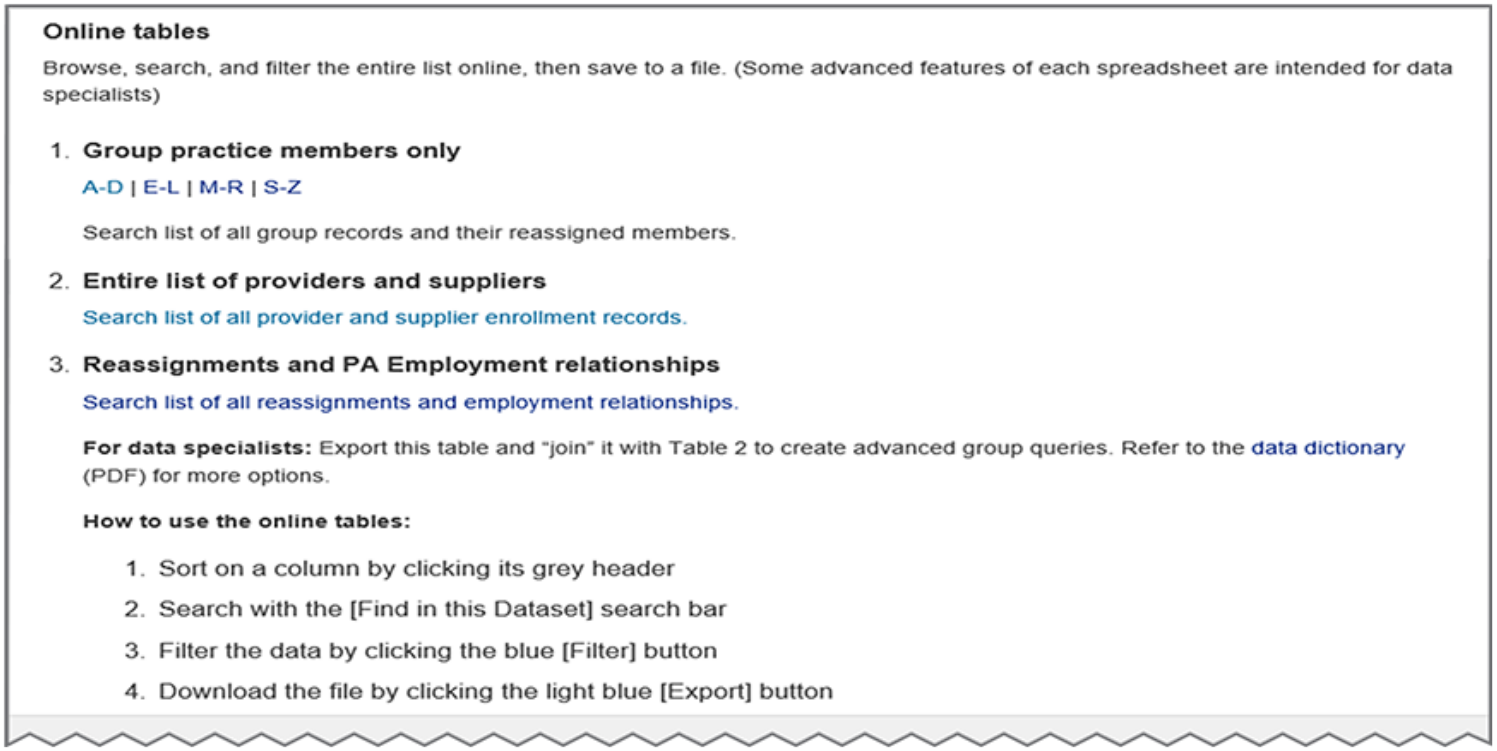


Revalidation Look-up Tool

data.cms.gov/revalidation

3 Sets of Data Files

for online filtering and download as Microsoft Excel, comma-delimited text files, xml…



Online tables

Browse, search, and filter the entire list online, then save to a file. (Some advanced features of each spreadsheet are intended for data specialists)

1. **Group practice members only**

   A-D | E-L | M-R | S-Z

   Search list of all group records and their reassigned members.

2. **Entire list of providers and suppliers**

   Search list of all provider and supplier enrollment records.

3. **Reassignments and PA Employment relationships**

   Search list of all reassignments and employment relationships.

   For data specialists: Export this table and "join" it with Table 2 to create advanced group queries. Refer to the data dictionary (PDF) for more options.

   How to use the online tables:

   1. Sort on a column by clicking its grey header
   2. Search with the [Find in this Dataset] search bar
   3. Filter the data by clicking the blue [Filter] button
   4. Download the file by clicking the light blue [Export] button

Revalidation Look-up Tool

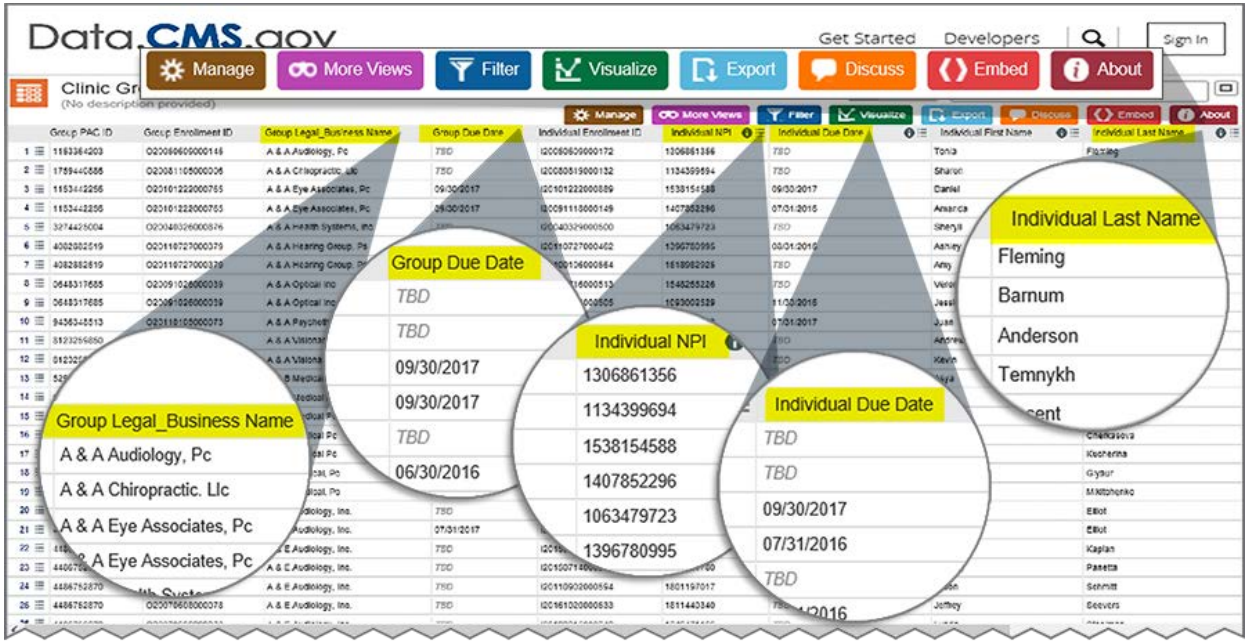
Looking for reassigned providers?

Use "Group practice members only"

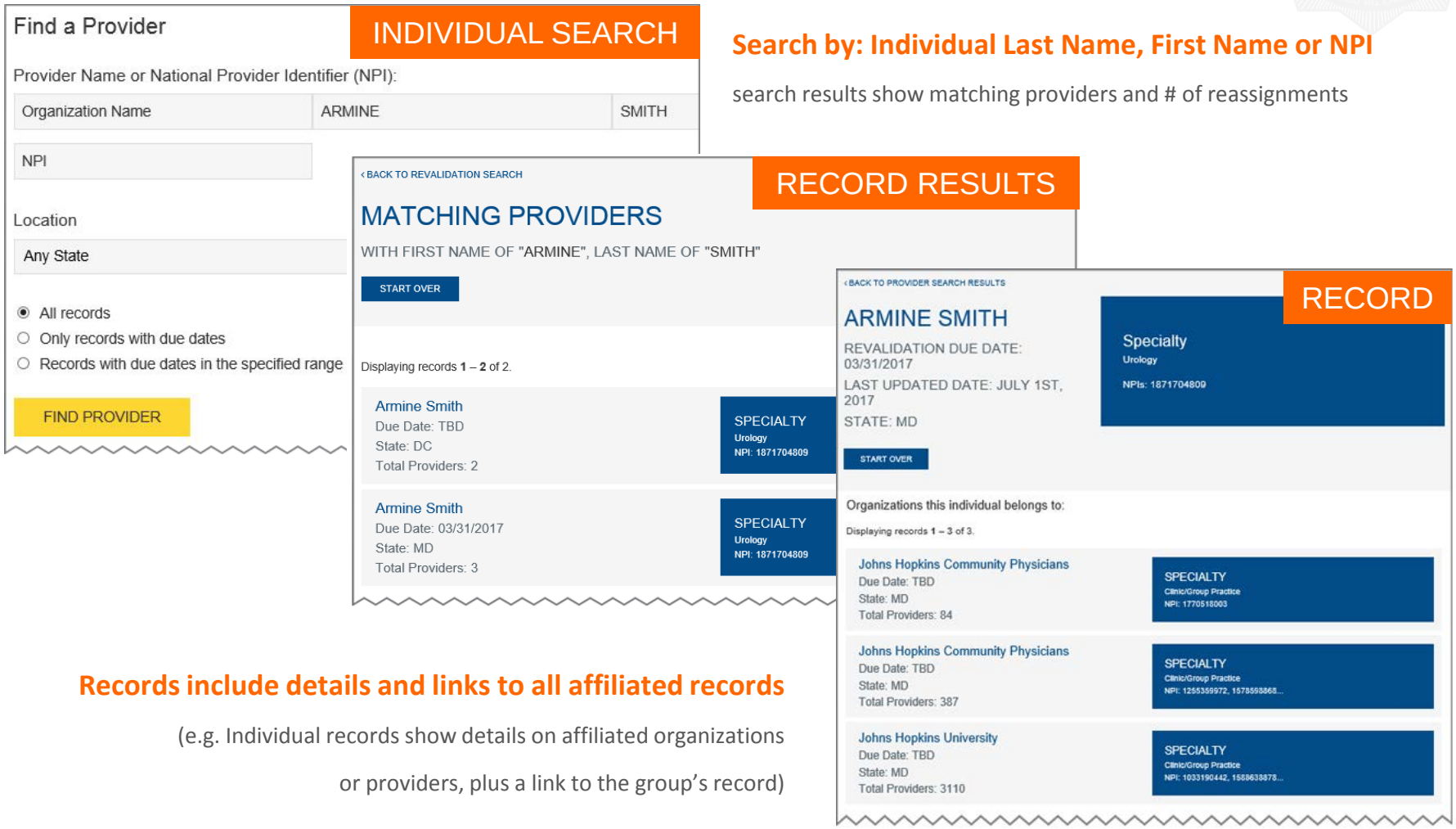
- Sort, download and save by large groups
- Includes all individuals that reassign to the group
- Shows the individual's total number of reassignments

Sort and filter by:

- Group Enrollment ID, State, and LBN
- Individual Enrollment ID
- Individual NPI
- Individual State
- Individual First and Last Name
- Individual Specialty Code
- Individual Revalidation Due Date
- Total Reassignments



Revalidation Look-up Tool



Search by: Individual Last Name, First Name or NPI

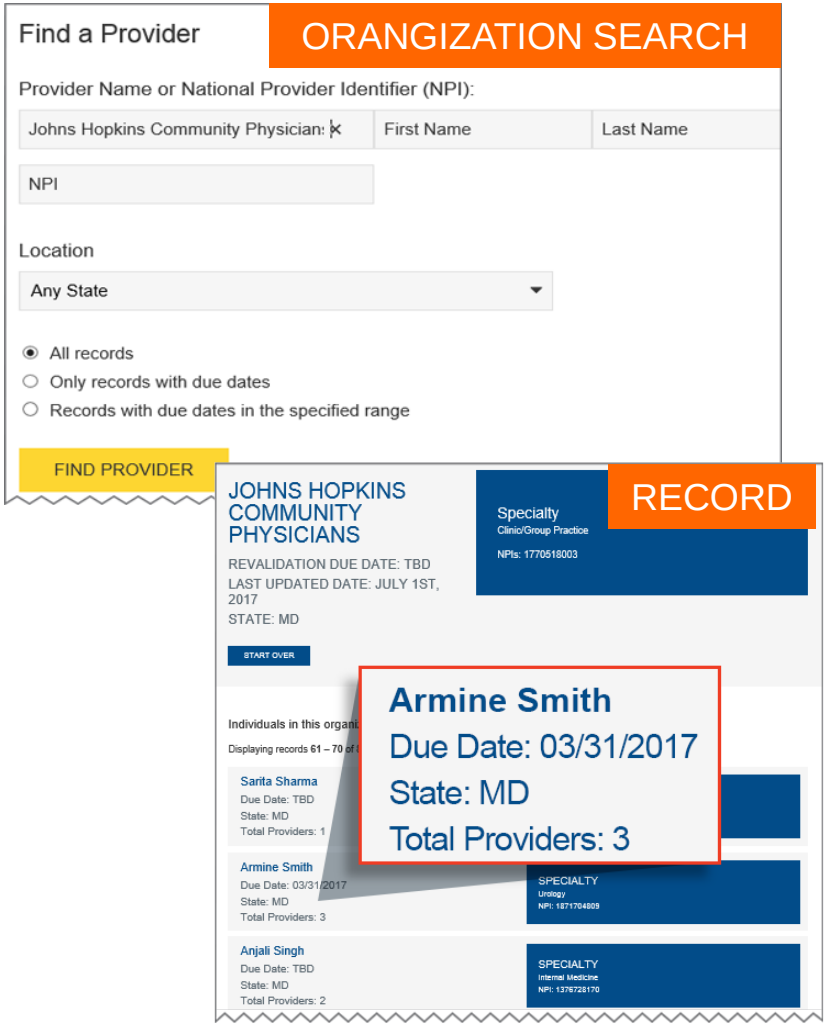
search results show matching providers and # of reassignments

Records include details and links to all affiliated records

(e.g. Individual records show details on affiliated organizations

or providers, plus a link to the group's record)

Revalidation Look-up Tool



Records will include details and links to all affiliated records

(e.g. group records show details on affiliated individuals, plus a link to the individual record)

Search by: Organization Name or NPI

search results show # of reassignments

& physician assistants

Because of Your Feedback

Changes we've made

- Advanced notice of your revalidation due date
- Reassignment information on revalidation notices
- Revalidation look up tool
- Improved letters to include gap in billing language
- Extend revalidation submission to 7 months

How you can help

- Talk to your provider
- Use the revalidation look up tool
- Respond timely
- Set up your access to PECOS now
- Use PECOS to submit your revalidation

Question & Answer Session

Provider Enrollment Systems

Provider Enrollment Systems

Provider Enrollment is the gateway to the Medicare Program. NPPES and PECOS serve as the systems of record for NPI and Provider Enrollment Information.

Provider Enrollment also supports claims payment, fraud prevention programs, and law enforcement through the sharing of data.

What is NPPES?

The National Plan and Provider Enumeration System electronically enumerates and assigns National Provider Identifier numbers for all providers nationwide.

NPPES
National Plan & Provider Enumeration System

The NPI number is a 10 digit unique identifier that is assigned to Healthcare Providers and Organizations across the United States.

NPPES Provider Interface - https://nppes.cms.hhs.gov/ can be used to:

- ✓ Submit initial NPI application
- ✓ View or submit changes to your existing NPI record
- ✓ Deactivate your NPI record

NPPES NPI Registry - https://npiregistry.cms.hhs.gov/ can be used to:

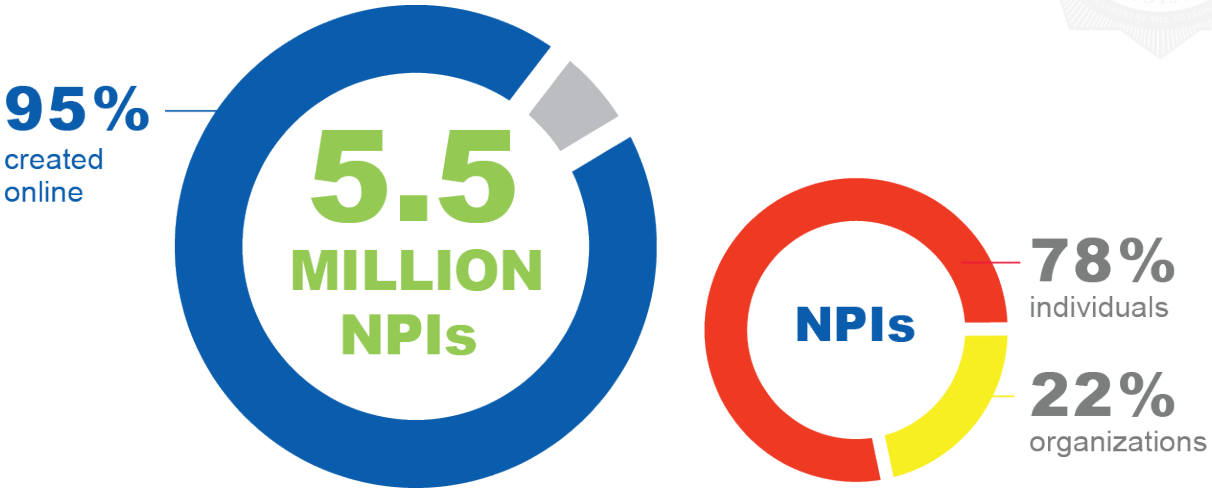
- ✓ Search for NPI records of Health Care providers in the NPPES system

NPPES (NPI) Today

Every Month…

30,000
New NPIs

57,000
Updates



Challenges

- Low usability / readability
- Targeted to providers, not admins
- Old technology, narrow design
- Strict customer service policies
- All lead to… outdated records

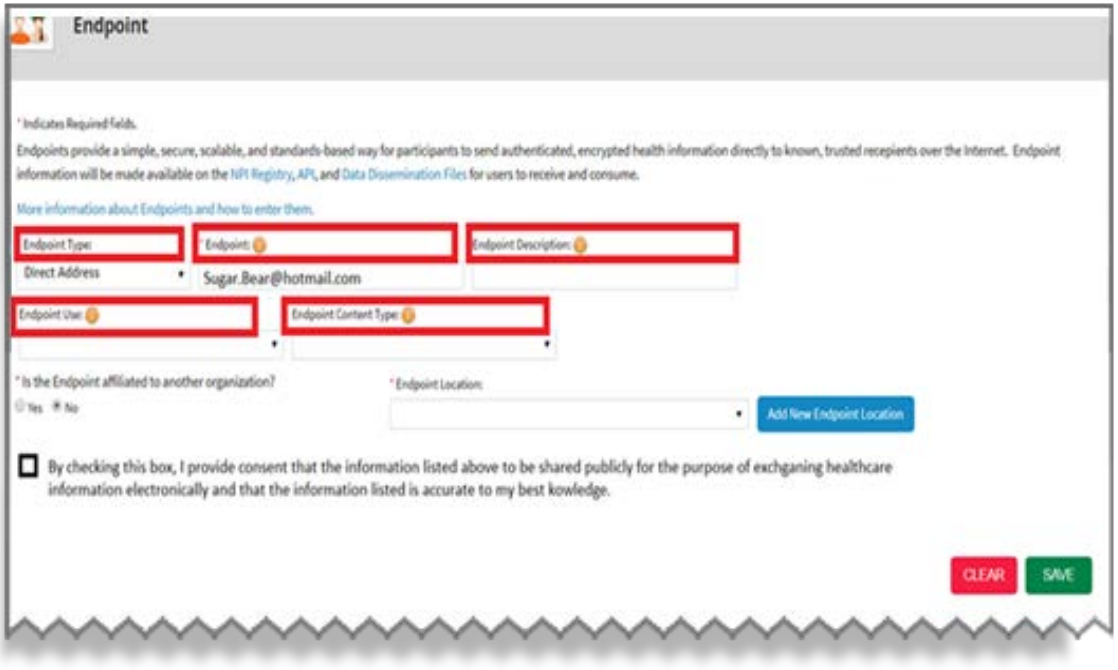
Recent Changes…

- New design with easier screens
- Surrogacy (like PECOS)
- More data fields
- Improved customer service

Maintain NPI Records

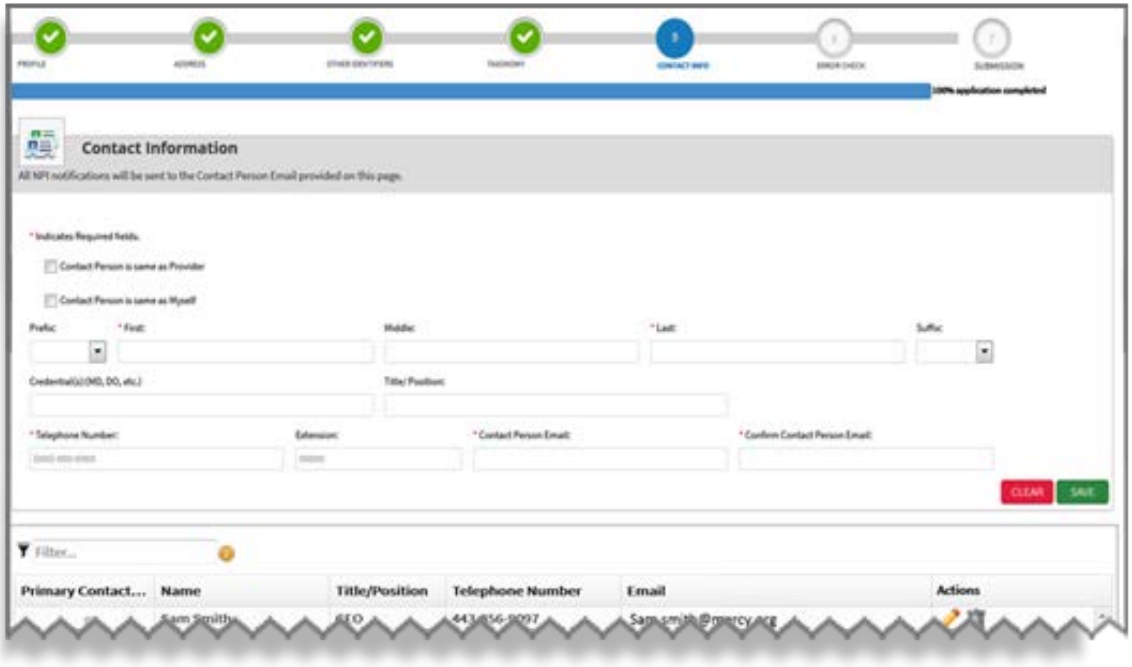
- National reach
- Used by Federal/State government and private plans to validate information

NPPES | Data Related Updates



- Endpoint (Electronic adresses) Information Collection
- EFI File Upload To Allow Large Files
- Data Dissemination supplemental Files

NPPES | User Privilege Updates



- Allow users to add multiple contacts on the contact persons section
- Allow Delegated Officials to deactivate NPIs

What is PECOS?

The Provider Enrollment Chain and Ownership System (PECOS) is a national database of Medicare provider, physician, and supplier enrollment information. PECOS is used to collect and maintain the data submitted on CMS 855 enrollment form.

PECOS Provider Interface (PECOS PI) - https://pecos.cms.hhs.gov can be used to:

- ✓ Submit an initial Medicare enrollment application
- ✓ View or submit changes to your existing Medicare enrollment information
- ✓ Submit a Change of Ownership (CHOW) of the Medicare-enrolled provider
- ✓ Add or change reassignment of benefits
- ✓ Reactivate an existing enrollment record
- ✓ Withdraw from the Medicare Program

Poll Question 7

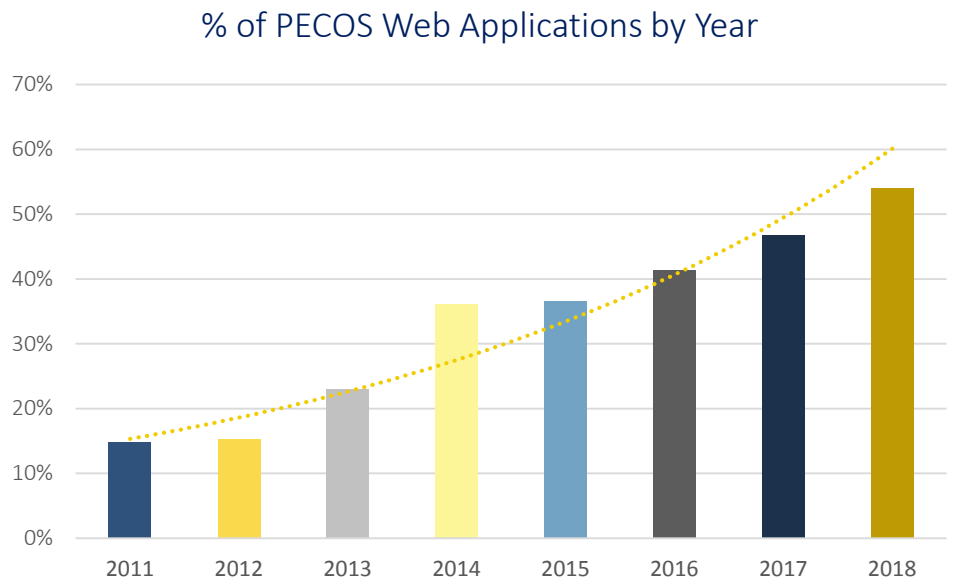
PECOS Today

Over 2.2 Million Enrollments

Every month…

17,000 new enrollments

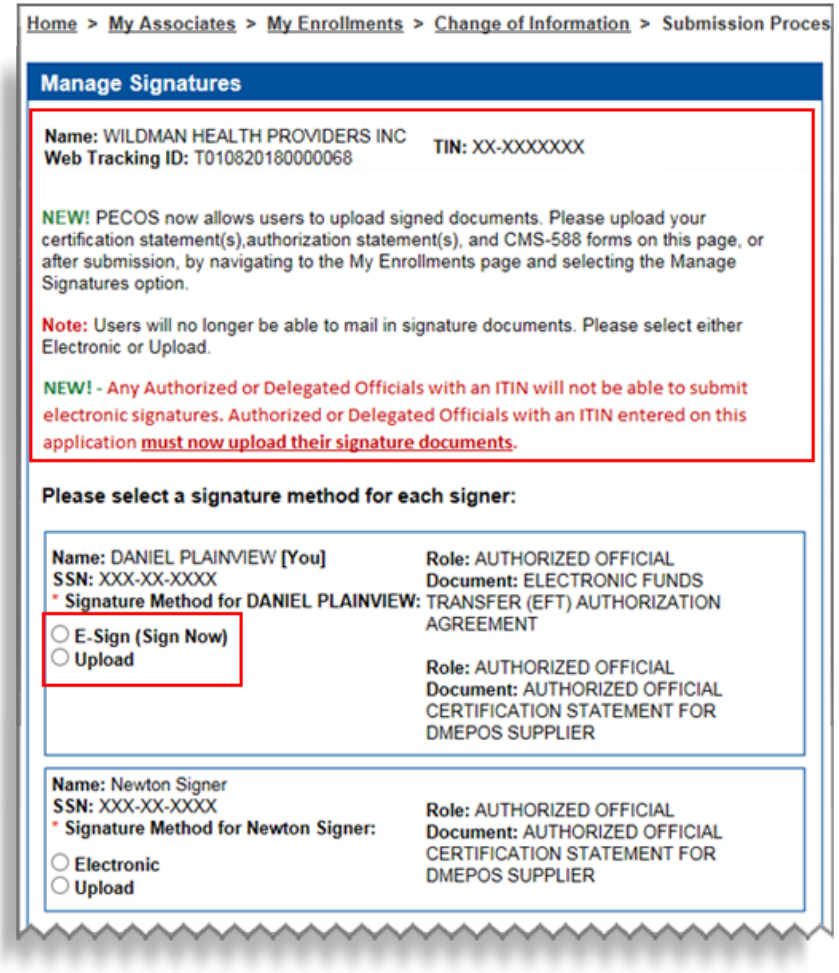
Encouraging Online Applications



- ✓ Completely paperless process
- ✓ Faster than paper-based enrollment
- ✓ Tailored application process
- ✓ Easy to check and update your information for accuracy

PECOS | 2018 Enhancements

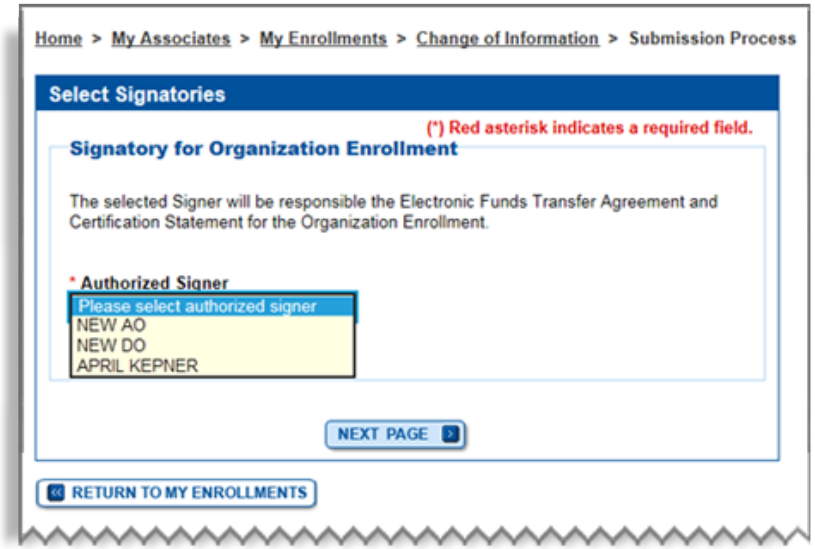
Upload Signature Documents



- Upload signature feature is now available and Paper is not an option as a signature method
- Once the user selects Upload, they will be prompted to upload each signature document
- Users can upload a signature document either during the submission process or after submitting the application

PECOS | 2018 Enhancements

Required Signer for Submission of Organization Enrollments



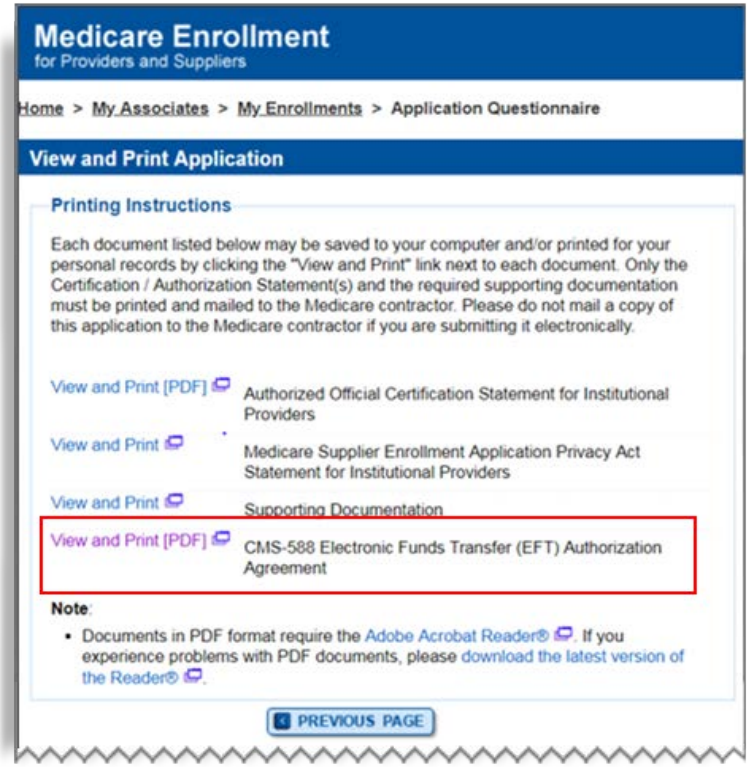
- DOs are listed and available for selection as Authorized Signers

- DOs are included as required signers in Manage Signatures

PECOS | 2018 Enhancements

CMS-588

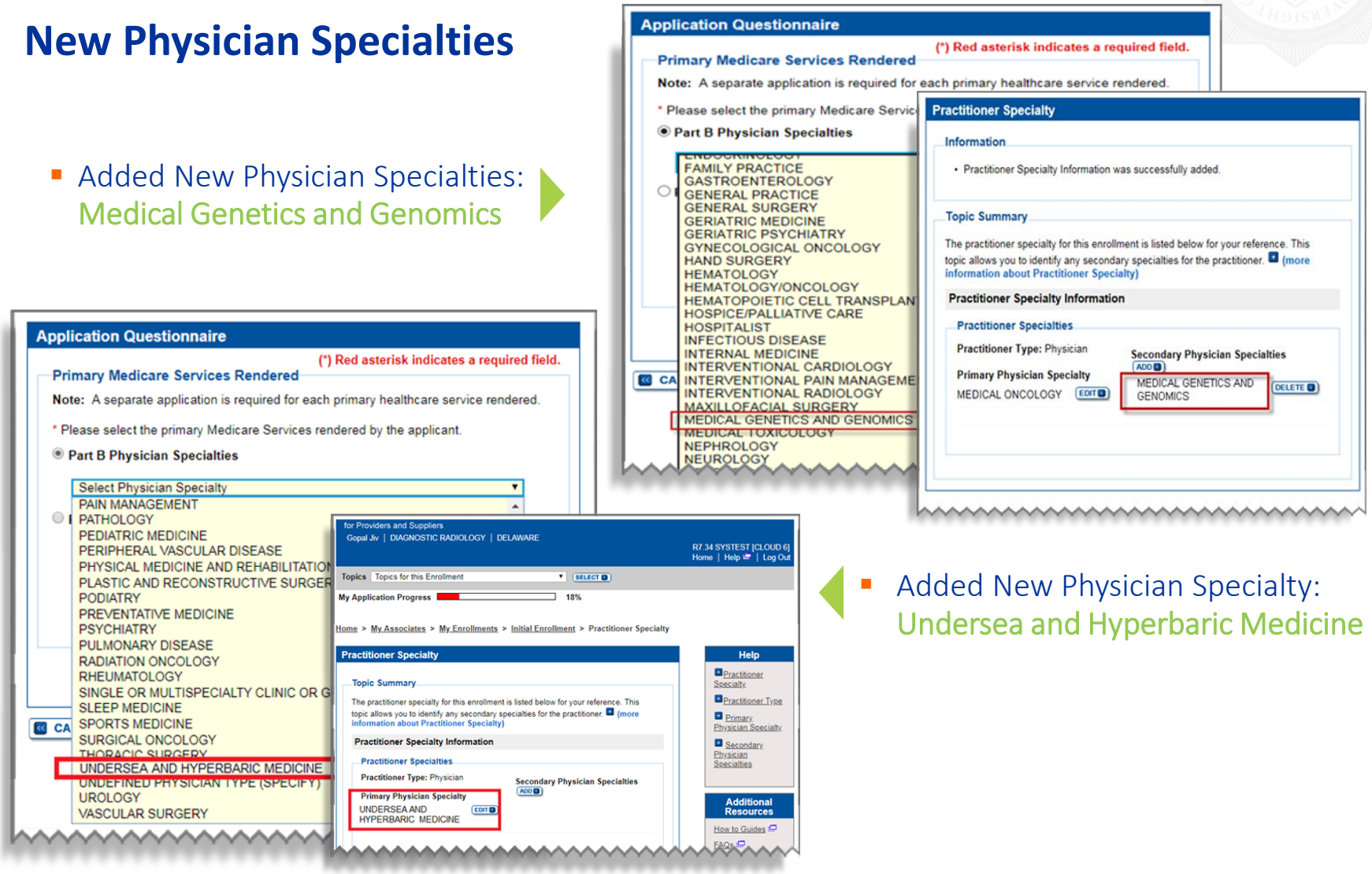
Electronic Funds Transfer (EFT) Authorization Agreement PDF in PECOS PI was updated to the newer version



Recent Enhancements | January 2019

New Physician Specialties

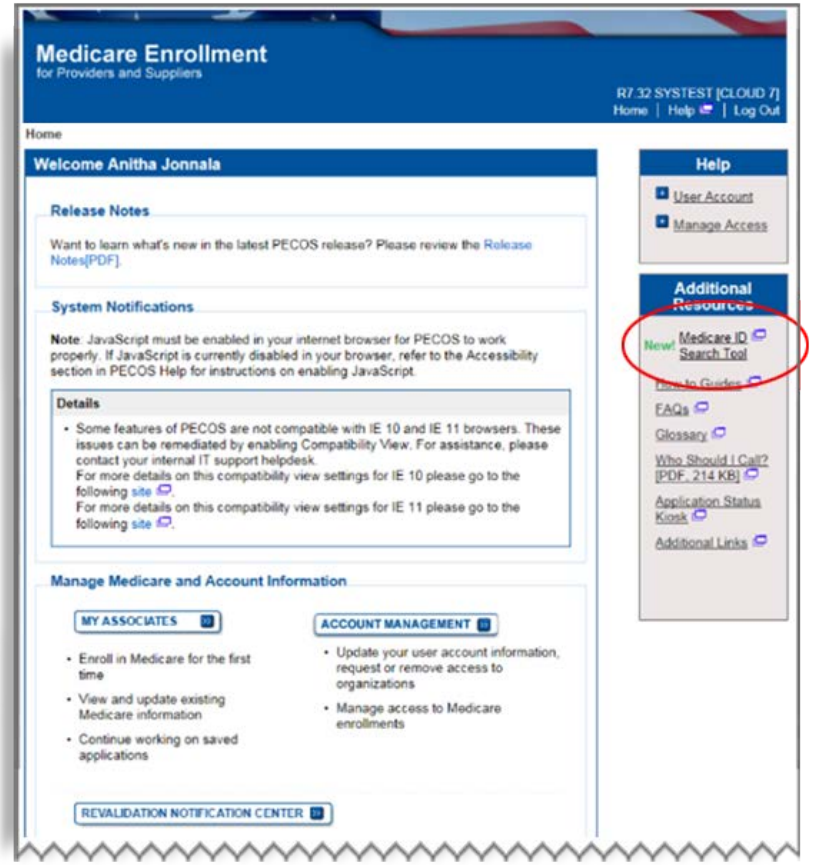
- Added New Physician Specialties: Medical Genetics and Genomics



- Added New Physician Specialty: Undersea and Hyperbaric Medicine

Recent Enhancements | January 2019

Medicare ID Look Up Tool

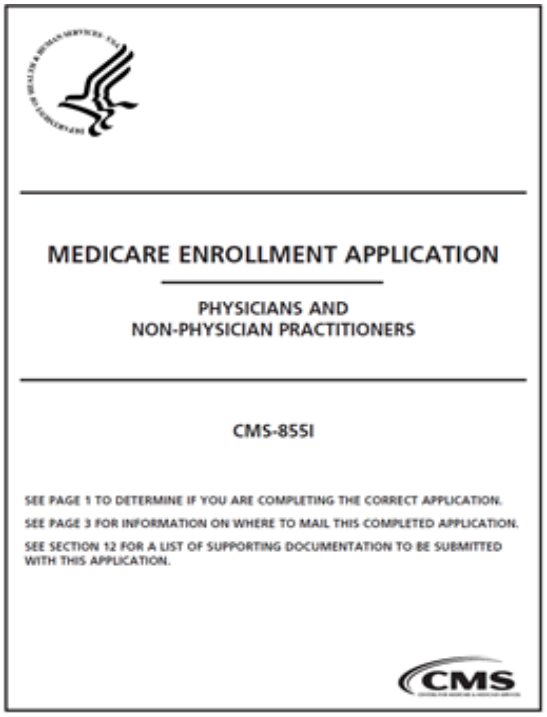


- From the Home Page, access the new Link for the Medicare ID Look Up tool under Additional Resources

- The User is navigated from the PECOS Welcome Page to a new window where they can use the Medicare ID Search Tool

Recent Enhancements | January 2019

CMS-855I Revisions



MEDICARE ENROLLMENT APPLICATION

PHYSICIANS AND
NON-PHYSICIAN PRACTITIONERS

CMS-855I

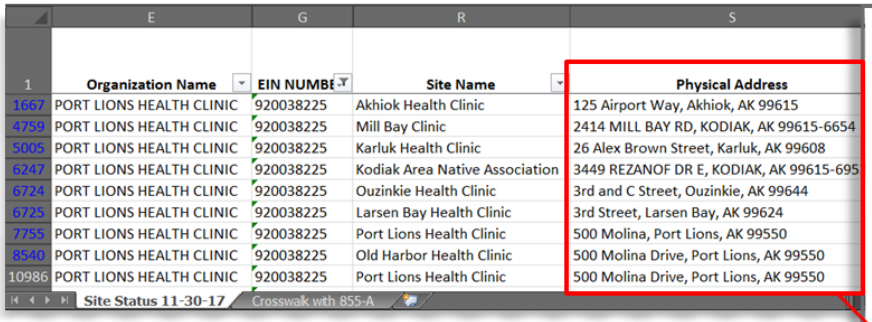
SEE PAGE 1 TO DETERMINE IF YOU ARE COMPLETING THE CORRECT APPLICATION.
SEE PAGE 3 FOR INFORMATION ON WHERE TO MAIL THIS COMPLETED APPLICATION.
SEE SECTION 12 FOR A LIST OF SUPPORTING DOCUMENTATION TO BE SUBMITTED WITH THIS APPLICATION.

CMS

- Removed Country and State of birth references for associates and managing employee
- Added Employer Medicare ID to Physician Assistant Employment Arrangement
- Removed Intern and Fellowship data collection in Section 2
- Added electronic record storage field to patient record storage address
- Added new Medical Record Correspondence Address
- Cleaned up supporting documentation list

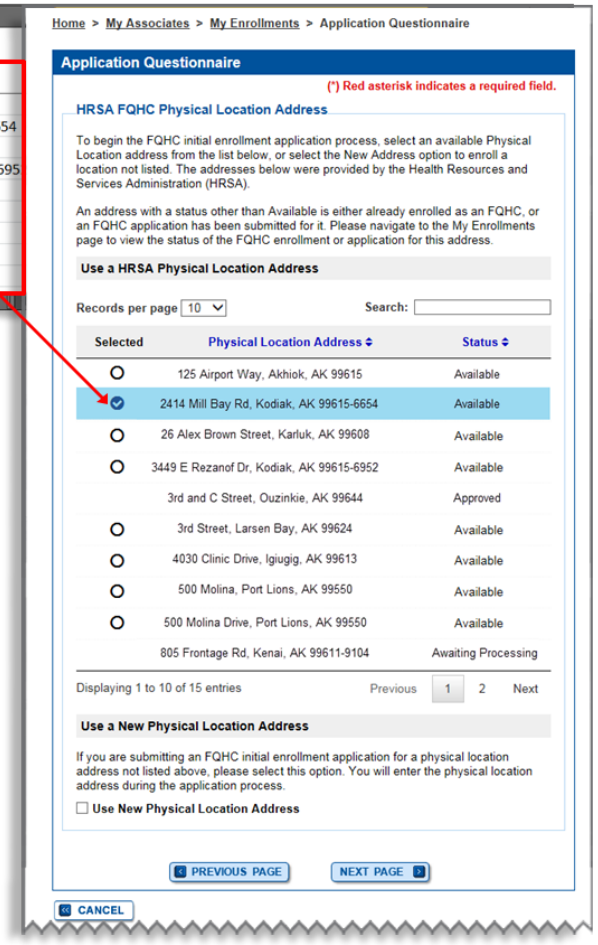
Coming Soon | April 2019 ★

Use HRSA Data to Prepopulate FQHC Initial Enrollment Applications



	Organization Name	EIN NUMBE	Site Name	Physical Address
1667	PORT LIONS HEALTH CLINIC	920038225	Akhiok Health Clinic	125 Airport Way, Akhiok, AK 99615
4759	PORT LIONS HEALTH CLINIC	920038225	Mill Bay Clinic	2414 MILL BAY RD, KODIAK, AK 99615-6654
5005	PORT LIONS HEALTH CLINIC	920038225	Karluk Health Clinic	26 Alex Brown Street, Karluk, AK 99608
6247	PORT LIONS HEALTH CLINIC	920038225	Kodiak Area Native Association	3449 REZANOF DR E, KODIAK, AK 99615-695
6724	PORT LIONS HEALTH CLINIC	920038225	Ouzinkie Health Clinic	3rd and C Street, Ouzinkie, AK 99644
6725	PORT LIONS HEALTH CLINIC	920038225	Larsen Bay Health Clinic	3rd Street, Larsen Bay, AK 99624
7755	PORT LIONS HEALTH CLINIC	920038225	Port Lions Health Clinic	500 Molina, Port Lions, AK 99550
8540	PORT LIONS HEALTH CLINIC	920038225	Old Harbor Health Clinic	500 Molina Drive, Port Lions, AK 99550
10986	PORT LIONS HEALTH CLINIC	920038225	Port Lions Health Clinic	500 Molina Drive, Port Lions, AK 99550

Site Status 11-30-17 | Crosswalk with 855-A

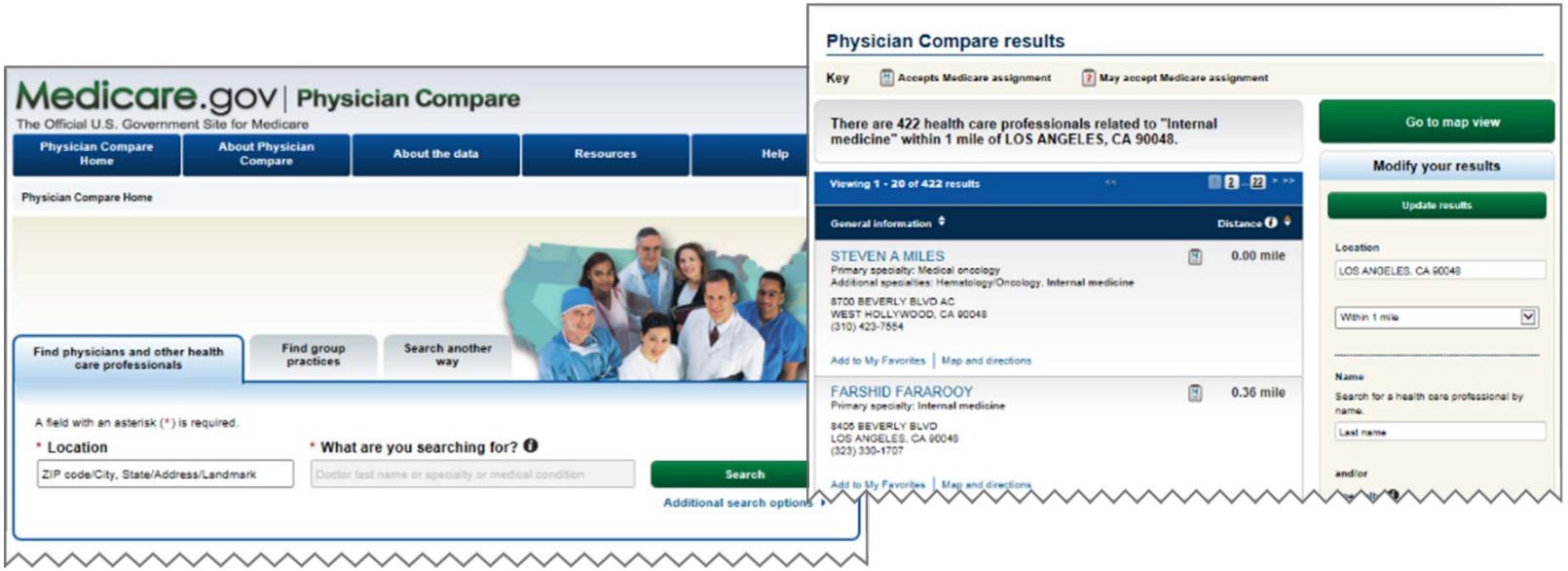


- ✓ HRSA will provide FQHC data (Physical and Mailing Addresses) to CMS
- ✓ CMS will upload data to PECOS for Selection
- ✓ PECOS will pre-populate initial enrollment applications with selected Physical and Mailing Addresses

Physician Compare

medicare.gov/physiciancompare

- Public directory of healthcare providers in Medicare.
- Based mostly on PECOS; updated twice a month



Learn more: Search "physician compare" at cms.gov

Get support: PhysicianCompare@Westat.com

PECOS Redesign

PECOS 2.0

- ✓ Simplified interface focused on automated functions
- ✓ Increase speed of application processing
- ✓ Track the status of an application from submission through approval
- ✓ Support increased alignment between Medicare and Medicaid
- ✓ Reduce redundant data collection
- ✓ Policy resources and help tutorials

National View of Enrollment

National Profile

Displays all information about an individual, provider, or supplier in a centralized location

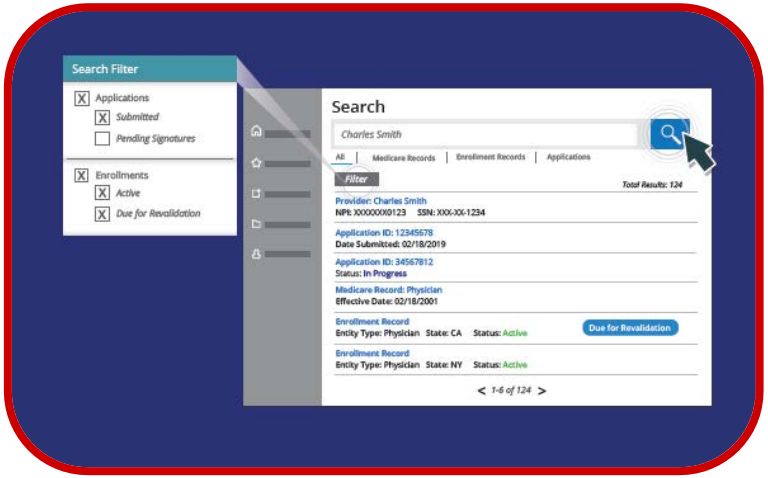
One Application for Multiple Enrollments

Allows providers operating in multiple states to submit one application

Enrollment Management Tools

Fast and Flexible Application Submission

Offers flexibility when starting, completing, and submitting an application



Enhanced Search Capability

Enables you to search for information from anywhere within the system and refine results

You May Be Wondering

Q: When will the PECOS 2.0 improvements begin rolling out?

A: We're expecting updates to the PECOS system will be introduced in late 2020.

Q: Will this impact claims submission or payment?

A: No. These improvements will not impact billing or claims information.

Q: Will I need to do anything when these changes begin?

A: No. There is no need for Providers or their support staff to take any action.

Q: Will I still have access to all my providers and their information?

A: Yes, absolutely. The improvements and updates will not impact the data that is already in the system. You will still have access to all of the same providers and application submission functions you do today, including your revalidation information.

You May Be Wondering

Q: What enhancements to PECOS can we expect?

A: Changes will include a new look and feel, new tools for managing provider information and applications, faster processing, submitting fewer duplicate applications, and greater access to information (eg. Approval letters, and requests for information).

Q: Will I or my staff need to undergo training to learn the updates?

A: We will be working with the community via focus groups to insure the changes will be simple easy-to-use processes that should not require extensive re-training. We will also have information available to help answer questions.

Q: Does this mean I can't submit paper applications?

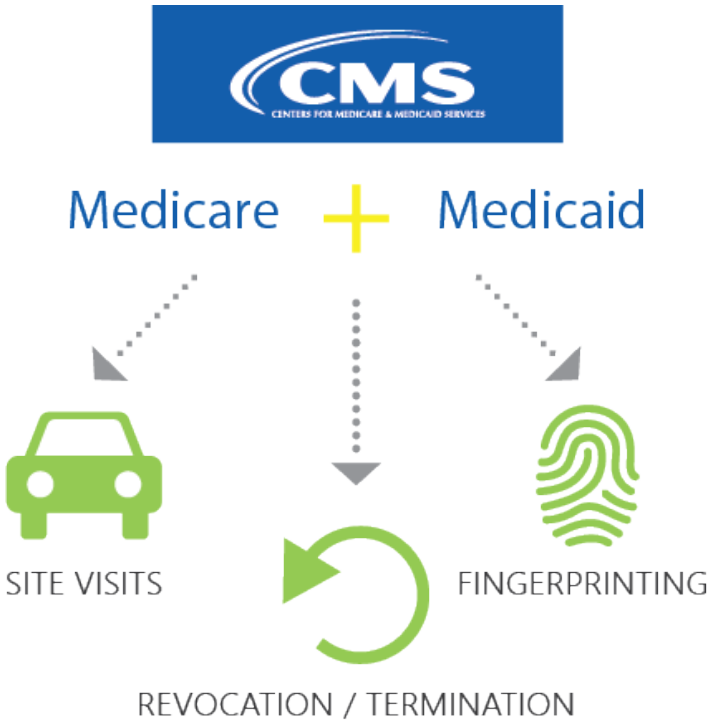
A: We hope to encourage as many users as possible to transition to the online system when they see the simplicity and speed. However, we will continue to allow submission of completed paper applications as we improve the system.

Question & Answer Session

Medicaid Enrollment

Medicaid Provider Enrollment

CMS **Center for Program Integrity** manages **Medicare** and **Medicaid** enrollment.



Advantages

Less burden for states and providers

In some cases, states can screen Medicaid providers using our Medicare enrollment data (site visits, revalidation, application fees, fingerprinting).

More consistency among states

Clearer sub-regulatory guidance

Each state has a CMS point-of-contact

Medicaid Provider Enrollment Compendium (MPEC)

Similar to the Medicare Program Integrity Manual

What CMS Provider Enrollment Can / Can't Do with States

Can

- Provide sub-regulatory guidance
- Support states in their statutory compliance efforts
- Provide Medicare data and screening activities to leverage for Medicaid enrollment
- Share best practices and make recommendations

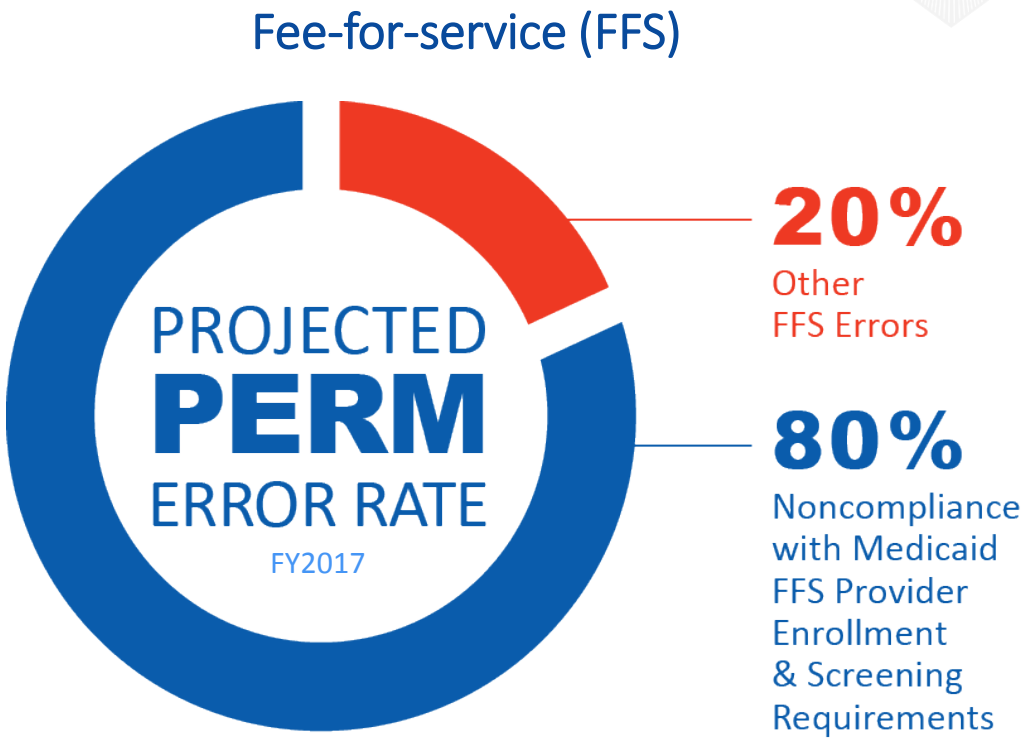
Can't

- Require states alter their enrollment process
- Align the enrollment process across all states
- Require timeframes for processing applications
- Define the manner by which the states implement Federal regulations

Poll Question 8

Improper Error Rates

- Measures improper payments in Medicaid and CHIP and produces error rates for each program
- Error rates are based on reviews of:
  - FFS,
  - Managed care, and
  - Eligibility



Medicaid Provider Enrollment Compendium

MPEC Updated July 2018

- For State Medicaid Agencies (SMA) and providers
- Guidance on federal Medicaid enrollment standards (42 CFR 455 Subparts B, E)
- States may be stricter than Federal regulations
- Find at https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf

Sample Guidance

Revalidation (Section 1.5.2, 1.5.3)

- Required every 5 years (includes ordering and referring physicians)
- Discretion to require revalidation on a more frequent basis
- Conduct full screening appropriate to provider's risk level
- May rely on Medicare or another state's screening

Approval letters (Section 1.7)

- SMAs should not request MAC "welcome letter" as a condition of provider enrollment

Out of State Providers (Section 1.5.1C)

- SMAs may pay claims for out-of-state providers who are unenrolled

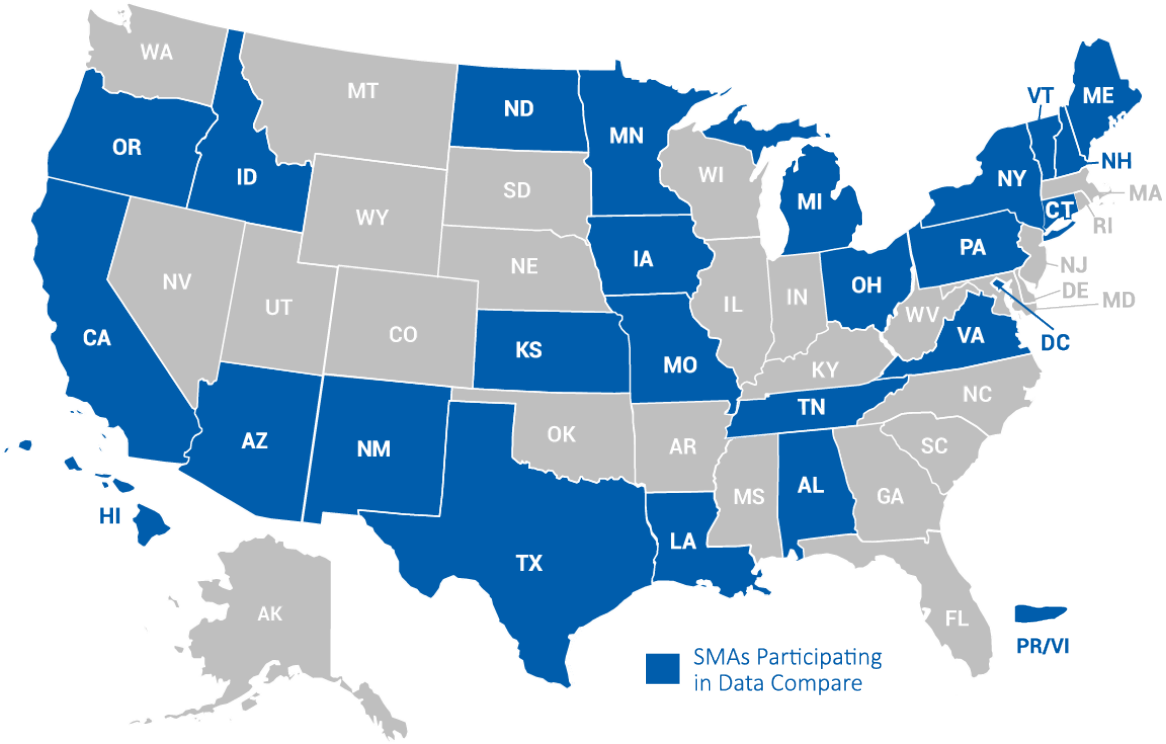
Retroactive Dates of Service (Section 1.6B)

- SMA makes determination to grant a retroactive billing date based on compliance

Data Compare Service

SMAs that have participated in Data Compare

- Ability for SMAs to rely upon Medicare screening data to comply with statutory requirements
- Identifies dually enrolled providers who have already been screened in Medicare



Data Compare Results

California Reported

167,375

Providers

Data Compare Report Had a Match of

133,902

Providers

80%

Match Rate

Reliable Data Compare

110,757

Individual Providers

Arizona Reported

119,331

Providers

Data Compare Report Had a Match of

110,060

Providers

92%

Match Rate

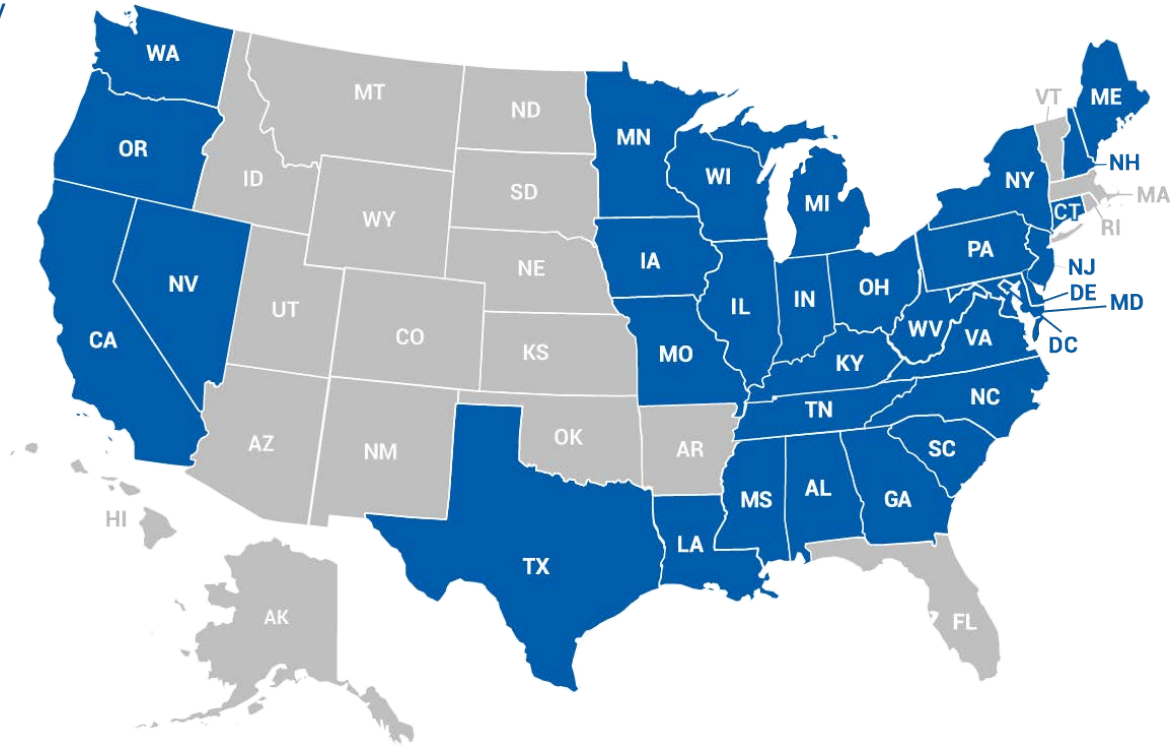
Reliable Data Compare

98,394

Individual Providers

CMS / State Assessment Contractor Visits

- CMS and State Assessment Contractor conduct assessments of the SMA's progress with screening and enrollment requirements
- Visits are 100% voluntary
- Work with the SMAs to identify best practices and opportunities for improvement
- Identify ways CMS can better support the SMAs, help reduce burden, and provide guidance



State Best Practices

BEST PRACTICES

Use of CMS Data Compare Service enabled Oregon to leverage Medicare screening and complete revalidation for 90% of their providers.

BEST PRACTICES

Automated checks of the Death Master File built into the online application identify inaccurate data in real time and prevent application submission.

BEST PRACTICES

Virginia established a 100% online enrollment process.

BEST PRACTICES

Ohio has worked closely with its Program Integrity Unit and Ohio's Medicaid Fraud Control Unit to develop robust site visit protocols, which are provider type specific.

Medicaid Managed Care

CMS-2390

starts JAN 2018

Medicaid Managed Care network providers that furnish, order, refer or prescribe must:

enroll in Medicaid

Reduces Fraud

1. Ensures compliance with enrollment requirements across all programs
2. Ensures services are provided by qualified providers
3. Ensures consistency across CMS programs

Question & Answer Session

Protecting the Program

Stronger Screening

Increase Site Visits **Authority:** 42 CFR 424.517

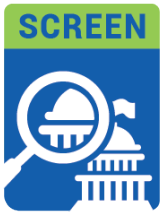
- For high Medicare reimbursements
- In high risk geographic areas

Find Vacant or Invalid Addresses

- Better automatic address verification in PECOS
- Includes US Postal Service feature that confirms the address is real (UPS store, mailboxes, unlikely to deliver mail)
- May trigger a site visit

Deactivate for Non-billing

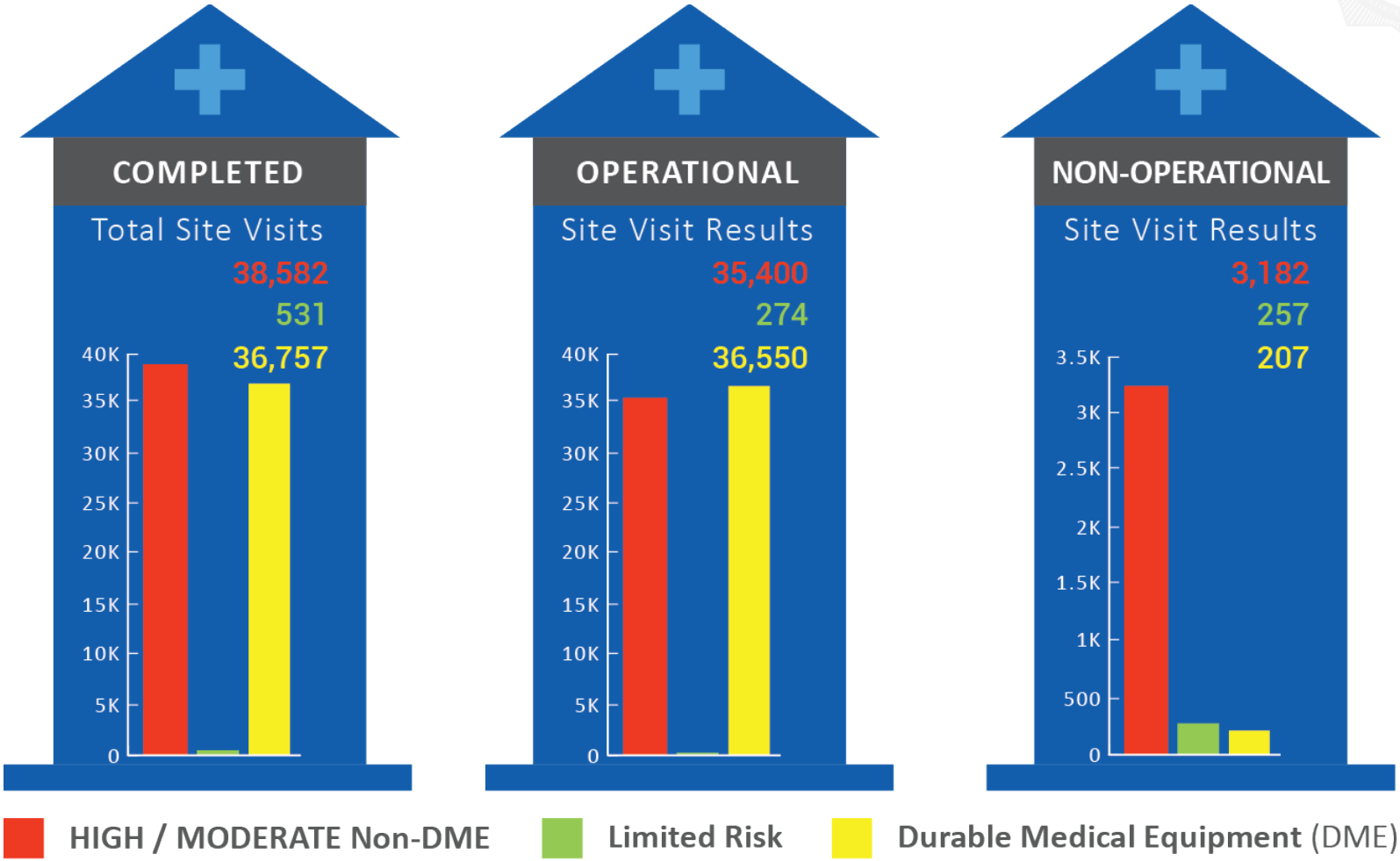
- EXEMPTIONS: order/refer/prescribe; certain specialties
  e.g., pediatricians, dentists and mass immunizers (roster billers)



Screen Medicaid-only Providers

- Improves efficiency and coordination across Medicare and Medicaid programs
- Reduces state and provider burden

Site Visit Data



*FY 2018

Poll Question 9

Fingerprinting

CMSfingerprinting.com

Applies to:

- New HHAs
- New DME suppliers
- New MDPP suppliers
- High risk providers/suppliers

Excludes:

- Managing Employees
- Officers
- Directors

If the initial fingerprints are unreadable a 2nd set of fingerprints will be requested

5%(+) Ownership/Partners

in a high risk provider/supplier

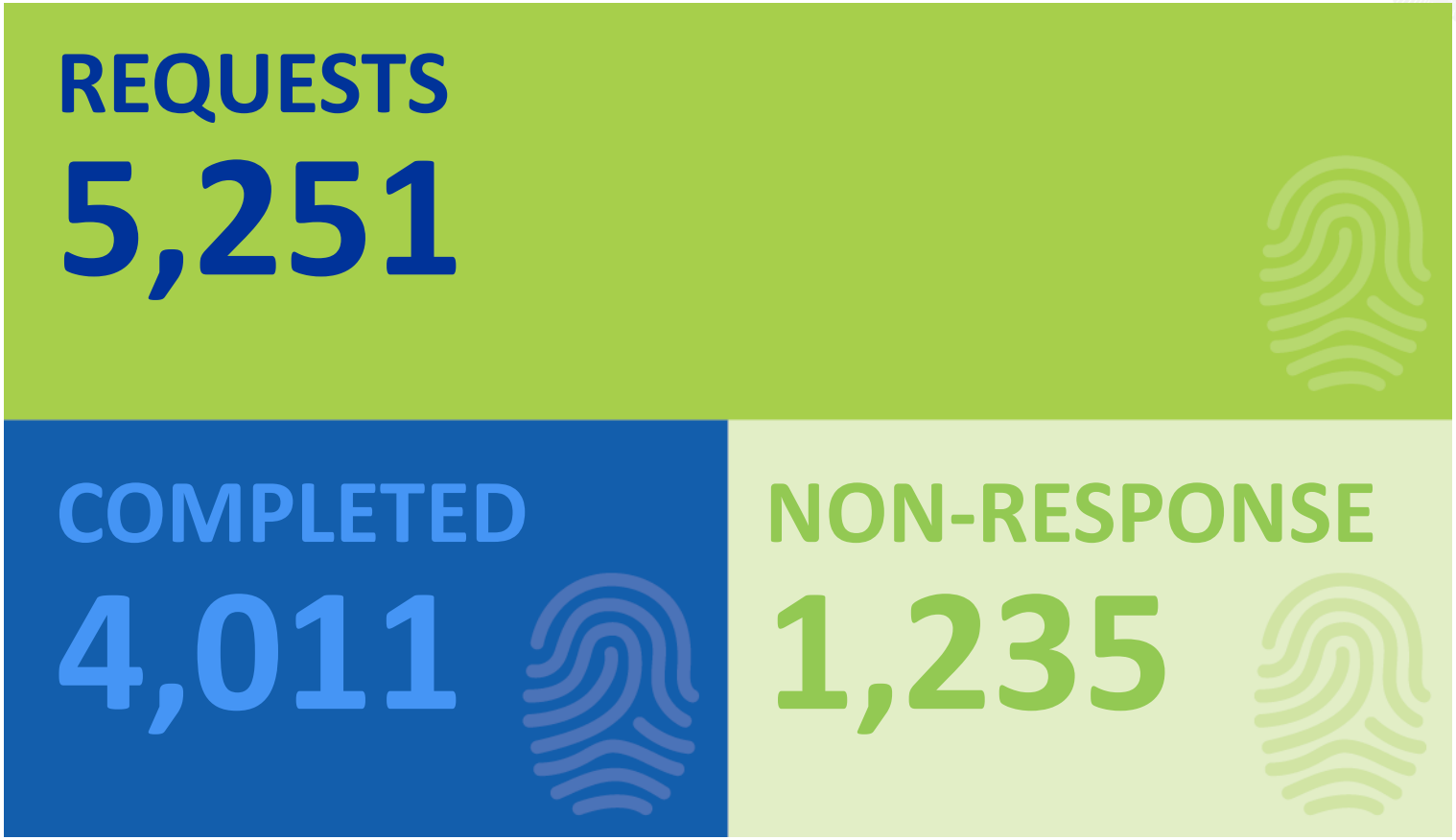
- Letter will be sent giving 30 days to get fingerprinted
- Medicare phased rollout

If the provider/supplier:

- Has a felony conviction
- Refuses fingerprinting

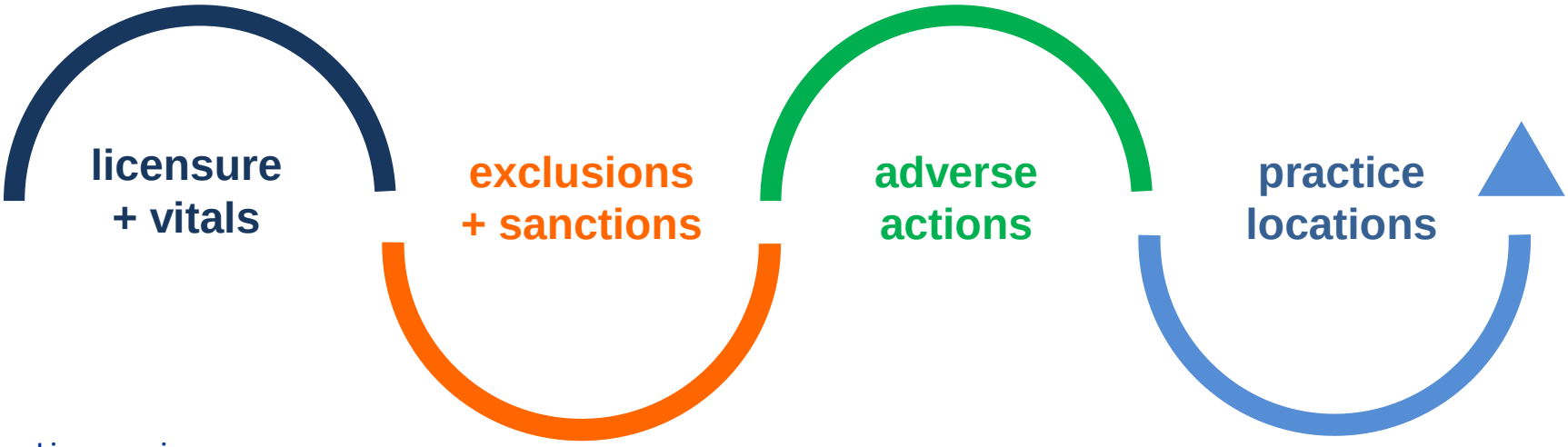
Then CMS may deny the application, or revoke their billing privileges

Fingerprint Data



*FY 2018

Continuous Monitoring



License via Automated screening

SSA Death Master File

NPI and LBN Integrated via NPPES

OIG and GSA websites Integrated in PECOS Monthly checks

Criminal alerts via Automated screening

Ad hoc site visits

Data Sharing

Public data files from PECOS

- All files contain Names and NPIs
- Available at data.cms.gov

Public Provider Enrollment File

- Currently approved individuals and orgs
- Reassignments
- Practice location data (limited)
- Primary and secondary specialty
- Updated quarterly

Revalidation File

- Currently approved, and due for revalidation
- Individuals and orgs
- Revalidation due date
- Reassignments
- Updated every 60 days

Ordering Referring File

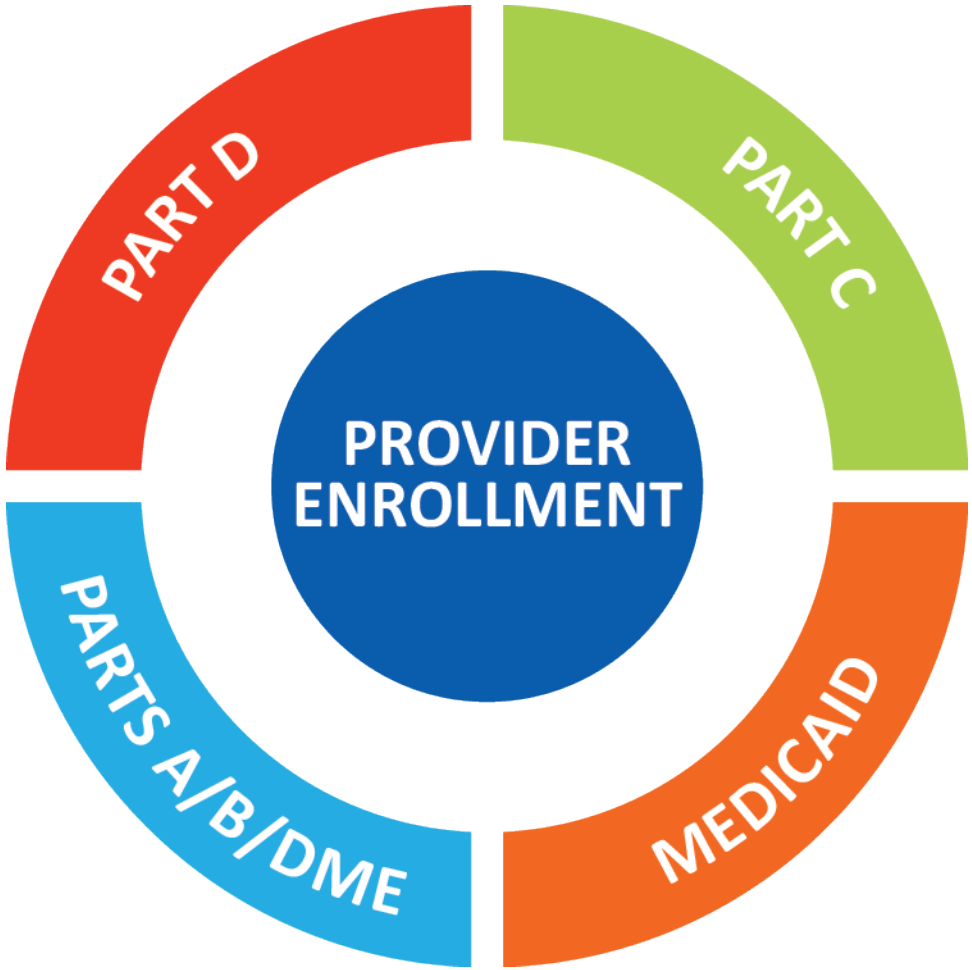
- Currently approved individuals
- Valid opt-out
- Eligible to order/refer
- Updated twice a week

Opt Out File

- Currently opted-out of Medicare
- Updated quarterly

Connections Between All Programs

Failure to maintain accurate enrollment data could impact your participation in other Medicare & Medicaid programs



Poll Question 10

Question & Answer Session

Enforcement Actions

Adverse Legal Actions

Required during:

- Initial enrollment
- Revalidation *(even if previously reported)*
- Within 30 days of the action

Applies to……

- Individual providers
- Individuals and organizations in section 5/6 (owners, managing employees, AO/DO)

Failure to report…

- **Deny application or revoke billing privileges**
  - Possible revocation back to the date of the action *(felony, sanction, exclusion)*
- No longer required to report **Medicare Payment Suspensions** or **CMS-Imposed Medicare Revocations** *(April 2018)*

x **Felony conviction in last 10 years**
  - Crimes against persons
  - Financial crimes

x Misdemeanor conviction
  - Patient abuse or neglect
  - Theft, fraud, embezzlement

x **Sanction or exclusion** (ever)

x **License revocation or suspension** (ever)

x Accreditation revocation or suspension (ever)

x Medicare payment suspension (current)

x Medicare revocation (ever)

Deactivations and Reactivations

CMS can deactivate Medicare billing privileges for:

- x Non-billing for 12 months
- x **Failure to respond to revalidation**
- x **Failure to report a change with 90 days (practice location, managing employee)***
- x Failure to report a change in ownership in 30 days

To reactivate Medicare billing privileges:

- ✓ **Must submit a complete CMS-855 application**
- ✓ **Effective date based on receipt date of the reactivation application**
- ✓ Does not require a new state survey for certified providers (exception for HHAs)

Billing privileges were paused, but can be restored upon the submission of a new enrollment application or updated information

** Reporting a change of information to the state, Regional Office, or another agency does not meet Medicare's reporting requirements and may lead to deactivation/revocation.*

Deactivations

DEACTIVATIONS

1,092,385

OCT 1, 2011 — SEPT 30, 2018

38%

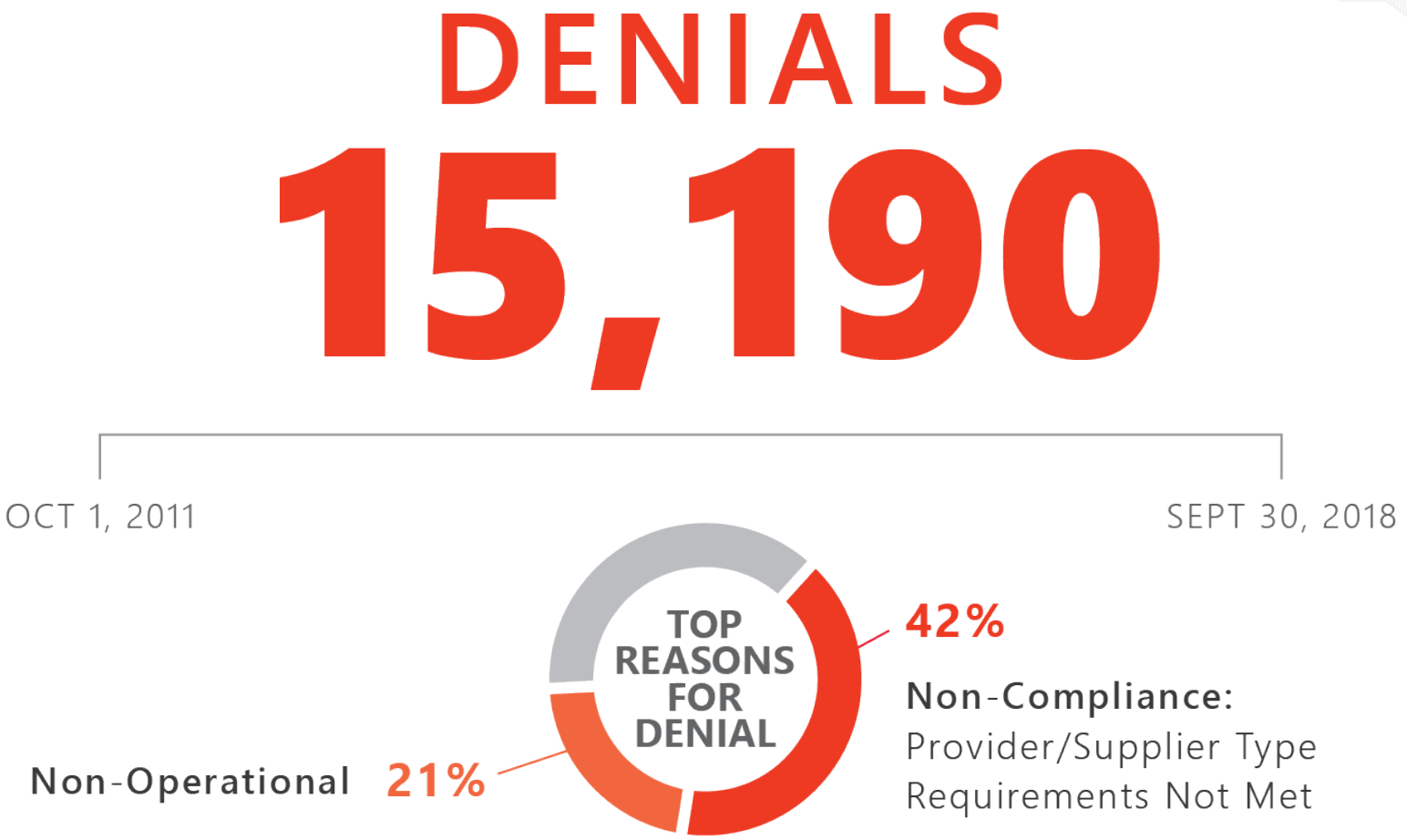
Percent deactivated for failure to respond to revalidation

Reasons to Deny

CMS can deny Medicare applications for:

- x **Felony conviction**
- x DEA suspended or revoked
- x Medicare payment suspension (active)
- x Excluded from federal program
- x Insufficient capital (HHA)
- x **False or misleading information**
- x Fee not paid (including if hardship exception denied)
- x **Noncompliance: program requirements**
- x **On-site review, showing noncompliance**
- x Temporary moratorium
- x **$1,500 overpayment** (current) ..... **Unless:**
  - **approved repayment plan**
  - **offset or appeal**
  - **bankruptcy**

Denials


DENIALS
15,190
OCT 1, 2011
SEPT 30, 2018
TOP REASONS FOR DENIAL
42%
Non-Compliance:
Provider/Supplier Type Requirements Not Met
Non-Operational
21%

Reasons to Revoke

CMS can revoke Medicare billing privileges for:

- x Felony conviction
- x DEA suspended or revoked
- x Medicaid billing privileges terminated
- x excluded from federal program
- x pattern or practice of prescribing
- x non-operational (onsite visit)
- x insufficient capital (HHA)

1–3 Year
Re-enrollment bar

- x Abuse of billing privileges
- x Misuse of billing number
- x **False or misleading information**
- x Fee not paid (including if hardship exception denied)
- x Noncompliance: document requirements
- x **Noncompliance: program requirements**
- x **Failure to report to MAC…**

…in 30 days: ownership change, practice location change, adverse legal action

…in 90 days: all other information

- Must report to the MAC
- Notifying a state, Regional Office, or another agency is not enough

Revocations

How to Appeal

1 Corrective Action (CAP)

For all denial reasons, but only noncompliance revocation reason

Simply correct the issue:

- Send CAP within 30 days
- MAC/CMS has 60 days to process

2 Reconsideration

- Provider must appeal within 60 days
- MAC/CMS has 90 days to process

Providers can send a Reconsideration and a CAP together, but if we accept the CAP, we void the Reconsideration

3 Administrative Law Judge

4 HHS Departmental Appeals Board

5 Federal District Court

- **If denial/revocation overturned…**
  Hearing officer sends letter to provider; directs MAC to reinstate them.

- **If denial/revocation upheld…**
  Hearing officer sends letter to provider; provider can accept or appeal further.

Medicaid Terminations

- **If Medicare revokes "for-cause" then the states must terminate a provider from their program**
- **If one state terminates "for-cause" then all states must terminate a provider from their program**
- **If terminated from any state "for-cause", CMS has the discretion to revoke from Medicare**

SCENARIO #1

- A provider is terminated for cause from California Medicaid
- The provider wants to enroll in Oregon Medicaid

➢ Provider cannot enroll in Oregon's Medicaid program because he is prohibited from enrolling in another state's Medicaid program while actively terminated in California.

SCENARIO #2

- A provider is revoked for cause from Medicare
- The provider would like to enroll in New Mexico Medicaid

➢ When a provider is revoked for cause from Medicare in any jurisdiction, the provider is unable to enroll in any state Medicaid program. Provider would not be permitted to enroll in New Mexico's Medicaid program

SCENARIO #3

- A provider is terminated for cause from Arizona Medicaid
- The provider is also enrolled in Texas

➢ When a provider is terminated for-cause from a state Medicaid program, ALL other State Medicaid programs MUST also terminate the provider. Here Texas must terminate this provider. If the provider is also enrolled in Medicare, CMS has the discretion to revoke.

Medicaid Terminations

more than

7,283

Total Medicaid **TERMINATION** SUBMISSIONS

more than

641

Total Medicaid **TERMINATION** SUBMISSIONS Resulting in Medicare **REVOCATION**

more than

5,482

Total Medicare **REVOCATION** FILE ENTRIES

*FY 2018

Question & Answer Session

Resources

cms.gov

- ordering and referring, DMEPOS accreditation, supplier standards
- MAC contacts: (search for Medicare enrollment contact")

cms.gov/Revalidation

- search all records online
- view and filter online spreadsheets
- export to Excel, or connect to with API

PECOS.cms.hhs.gov

account creation, videos, providers resources , FAQs

888-734-6433

PECOS Help Desk

ProviderEnrollment@cms.hhs.gov

Provider Enrollment contact

FFSProviderRelations@cms.hhs.gov

"ListServ" sign-up: Notice of program and policy details, press releases, events, educational material

cms.gov/EHRIncentivePrograms

Electronic Health Record website

cms.gov MLN Matters® Articles

articles on the latest changes to the Medicare Program and enrollment education products

Thank You

March 2019 | This summary material was part of an in-person presentation. It was current at the time we presented it. It does not grant rights or impose obligations. We encourage you to review statutes, regulations, and other directions for details.

If you need more accessibility options for the material, contact providerenrollment@cms.hhs.gov

Centers for Medicare & Medicaid Services