NATIONAL PROVIDER ENROLLMENT CONFERENCE

61.5 Million Patients, **2.8 Million** Providers, **ONE** Mission

August 28 - 29, 2024

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Certified Providers

Presented by

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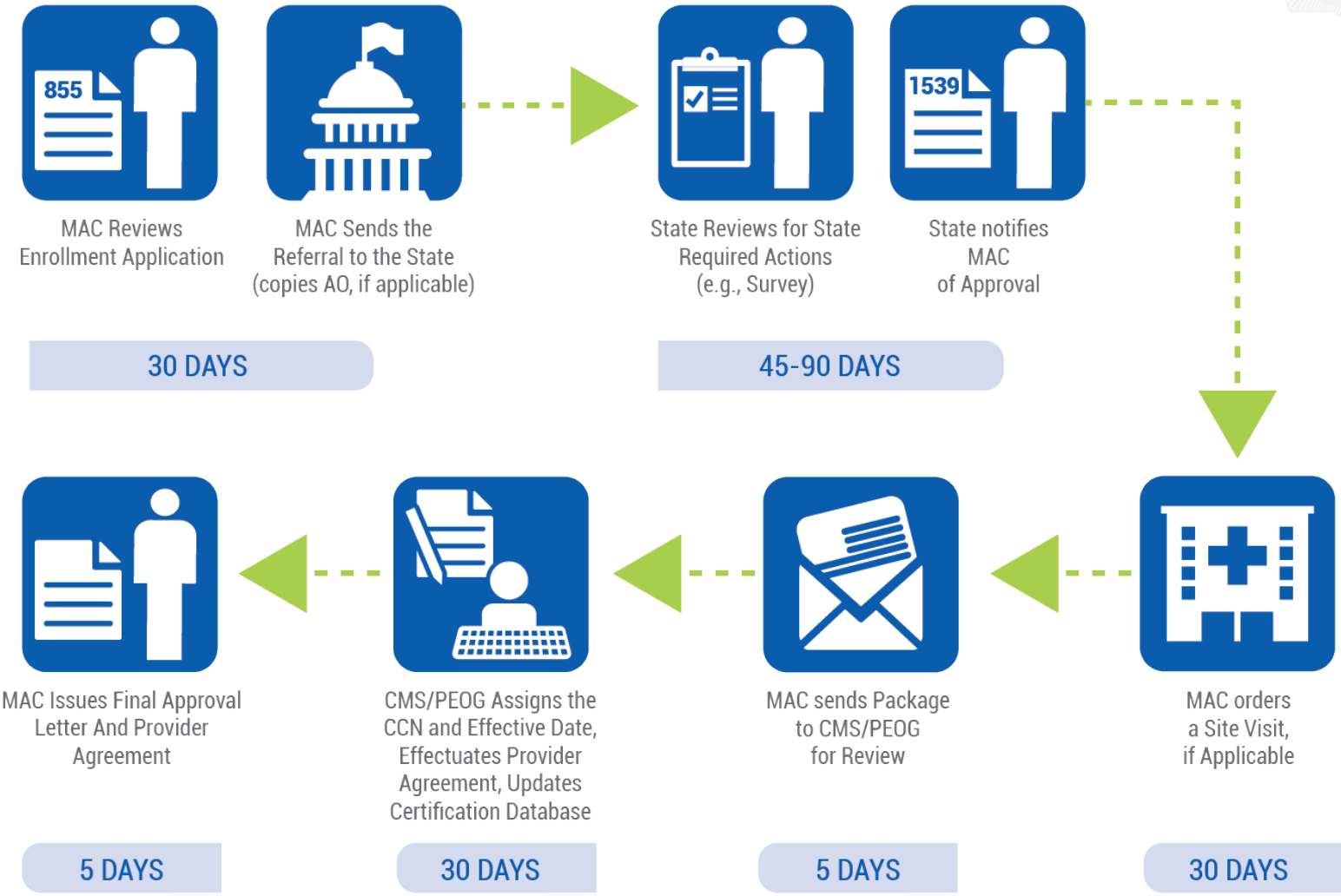
Session Overview

- Survey and Certification
- Application Review Process
- Certified Providers

Survey and Certification

Survey and Certification



Question & Answer Session

Application Process

Submission

- Submit your application:
  - PECOS
    - Scenario driven
    - User-friendly
    - Faster processing times
  - Paper CMS-855 applications
    - CMS-855A
    - CMS-855B
- To expedite processing, ensure all required supporting documents are included in packet submission
- An application may be submitted up to 180 days in advance of the effective date

Intake, Screening and Verification

- The MAC screens and verifies the information on the application
  - Signed and dated appropriately
  - Application fee, if applicable
  - License
  - Practice location
  - CMS-588 EFT and voided check/bank letter
  - Supporting documentation (org charts, IRS docs, cert docs, CHOW docs)
- The MAC will develop for missing information
  - Email sent to the contact person or authorized/delegated official
    - Ideally, whoever submits the application
    - Phone number should reach credentialing department
  - Providers have 30 days to respond before the application is rejected
  - Questions should be directed to your MAC
- Fingerprints are requested and site visit ordered, if applicable

Referral to the State

- Once the MAC completes screening and verification, they will refer the application to the State Agency
- The State will:
  - Review the referral package from the MAC
  - Perform any state-specific functions
  - Return application determination to the MAC

Referral to PEOG

- The MAC sends the enrollment package to PEOG within 5 days of receiving the approval from the State
  - If a site visit is required, it will be ordered prior to sending the package to PEOG
- CMS will: (1) assign the effective date, (2) assign a CCN (initial enrollments), (3) enter data into the national database, (4) execute the provider agreement and return to the MAC to finalize
  - CMS average processing time is *23 days*

MAC Finalization

- The MAC will finalize the application in PECOS and issue the approval letter
- Approval letter is sent to the contact person
- If no contact person is listed the letter is sent to the provider/supplier at their correspondence address
- Any questions on enrollment application status should be directed to MAC

Question & Answer Session

Certified Providers

Voluntary Terminations (VTs)

Voluntary termination occurs when the owner of Medicare provider agreement no longer wishes to participate in the Medicare program.

How do I report a voluntary termination?

- MACs assume primary responsibility for processing provider requested terminations
- Submit a CMS-855/PECOS application or letter on your business letterhead to report the termination

VT Reminders

VTs submitted via the CMS-855/PECOS must:

- Indicate you are voluntarily terminating in Section 1A, Reason for Submission of the paper application or online via PECOS
- Include the complete Legal Business Name (LBN) and Doing Business Name (DBA)
- Include the effective date of termination
- List the Medicare Identification Number
- Be signed by an authorized or delegated official

☐ You are voluntarily terminating your Medicare enrollment Effective date of termination *(mm/dd/yyyy)*: _____ Medicare Identification Number: _____	**Complete sections: 1, 2B1, 13,** either **15B** or **15C,** and **6** for the signer if that authorized or delegated official has not been established for this provider.

Ambulatory Surgical Centers (ASCs)

Required Documents

CMS-855B

HHS-690*

CMS-370*

Legal Documents**

Sales Agreement

Bill of Sale

Transfer Agreement

CMS-588

CMS-460

* Required for Initials and CHOWs

**Required for CHOWs

Community Mental Health Centers (CMHCs)

Required Documents

CMS-855A

HHS-690*

CMS-1561*

Legal Documents**

Sales Agreement

Bill of Sale

Transfer Agreement

CMS-588

* Required for Initials and CHOWs

**Required for CHOWs

Comprehensive Outpatient Rehabilitation Facilities (CORFs)

Required Documents:

CMS-855A

HHS-690*

CMS-1561*

Legal Documents**

Sales Agreement

Bill of Sale

Transfer Agreement

CMS-588

* Required for Initials and CHOWs

**Required for CHOWs

End-Stage Renal Disease Facilities (ESRDs)

Required Documents

CMS-855A

Certificate of Need, if required by State

CMS-3427 (Part I)*

Legal Documents**

Sales Agreement

Bill of Sale

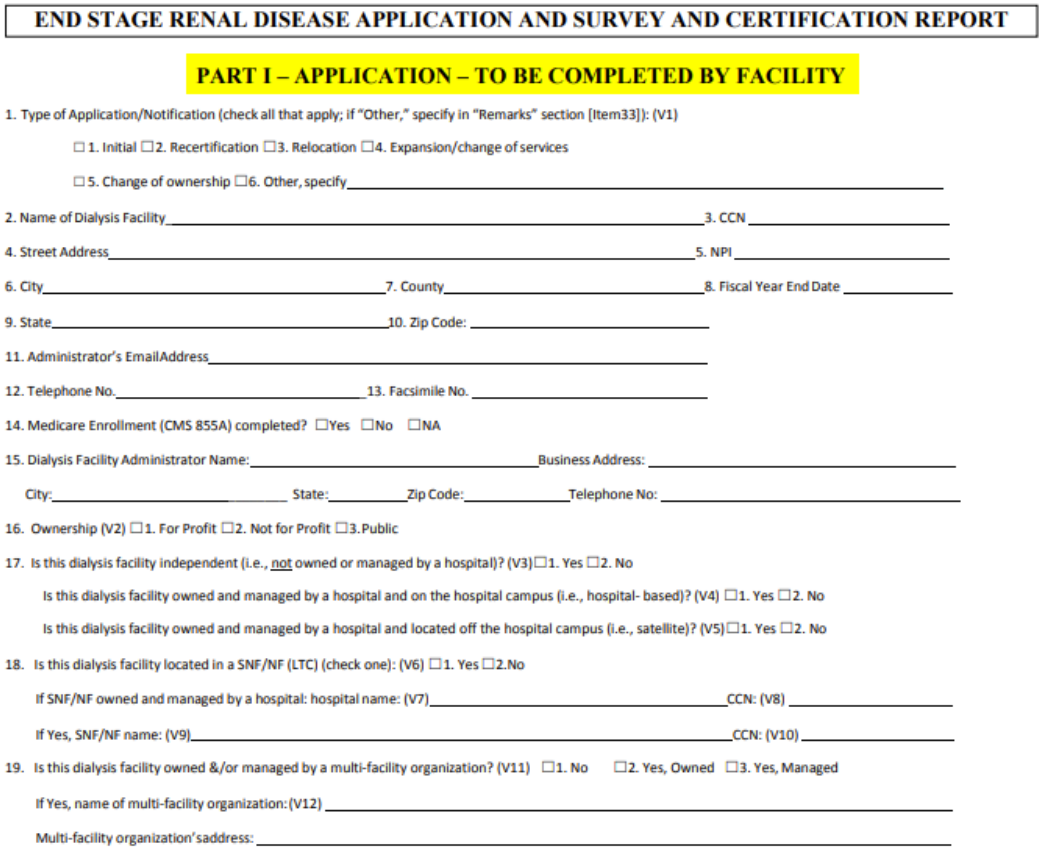
Transfer Agreement

CMS-588

* Required for Initials and CHOWs

**Required for CHOWs

End-Stage Renal Disease Facilities (ESRDs)



END STAGE RENAL DISEASE APPLICATION AND SURVEY AND CERTIFICATION REPORT

PART I – APPLICATION – TO BE COMPLETED BY FACILITY

1. Type of Application/Notification (check all that apply; if "Other," specify in "Remarks" section [Item33]): (V1)

☐1. Initial ☐2. Recertification ☐3. Relocation ☐4. Expansion/change of services

☐5. Change of ownership ☐6. Other, specify_____

2. Name of Dialysis Facility_____3. CCN _____

4. Street Address_____5. NPI_____

6. City_____7. County_____8. Fiscal Year End Date _____

9. State_____10. Zip Code: _____

11. Administrator's EmailAddress_____

12. Telephone No._____13. Facsimile No. _____

14. Medicare Enrollment (CMS 855A) completed? ☐Yes ☐No ☐NA

15. Dialysis Facility Administrator Name:_____Business Address: _____

City:_____ State:_____Zip Code:_____Telephone No: _____

16. Ownership (V2) ☐1. For Profit ☐2. Not for Profit ☐3.Public

17. Is this dialysis facility independent (i.e., not owned or managed by a hospital)? (V3)☐1. Yes ☐2. No

Is this dialysis facility owned and managed by a hospital and on the hospital campus (i.e., hospital- based)? (V4) ☐1. Yes ☐2. No

Is this dialysis facility owned and managed by a hospital and located off the hospital campus (i.e., satellite)? (V5)☐1. Yes ☐2. No

18. Is this dialysis facility located in a SNF/NF (LTC) (check one): (V6) ☐1. Yes ☐2.No

If SNF/NF owned and managed by a hospital: hospital name: (V7)_____CCN: (V8) _____

If Yes, SNF/NF name: (V9)_____CCN: (V10) _____

19. Is this dialysis facility owned &/or managed by a multi-facility organization? (V11) ☐1. No ☐2. Yes, Owned ☐3. Yes, Managed

If Yes, name of multi-facility organization: (V12) _____

Multi-facility organization'saddress: _____

- Ensure that Part I of Form CMS-3427 is completed by the facility

Federally Qualified Health Centers (FQHCs)

Required Documents:

CMS-855A

Exhibit 177*

HRSA Notice of Award (NoA) or Notice Look-Alike Designation (NLD)

Legal Documents **

Sales Agreement

Bill of Sale

Transfer Agreement

CMS-588

Clinical Laboratory Improvement Act (CLIA) Certificate

State License, if applicable

* Required for Initials and CHOWs

**Required for CHOWs

Federally Qualified Health Centers (FQHCs)

- Exhibit 177
  - Ensure the LBN, DBA and address match the CMS-855 application
  - Signed by Authorized Official
  - Dated on or after the effective date in Section 4 of the CMS-855 application

- HRSA
  - HRSA NoA should not have an expired budget and/or project period dates
  - HRSA NoA should match the practice location reported on the CMS855A

Summary Federal Award Financial Information

19. Budget Period Start Date 04/01/2020 - End Date 03/31/2021	
20. Total Amount of Federal Funds Obligated by this Action	$0.00
20a. Direct Cost Amount	
20b. Indirect Cost Amount	
21. Authorized Carryover	$0.00
22. Offset	$0.00
23. Total Amount of Federal Funds Obligated this budget period	$4,340,893.00
24. Total Approved Cost Sharing or Matching, where applicable	$12,277,421.00
25. Total Federal and Non-Federal Approved this Budget Period	$16,618,314.00
26. Project Period Start Date 04/01/2020 - End Date 03/31/2023	
27. Total Amount of the Federal Award including Approved Cost Sharing or Matching this Project Period	$16,618,314.00

Home Health Agencies (HHAs)

Required Documents:

CMS-855A

HHS-690*

CMS-1561*

Legal Documents**

Sales Agreement
Bill of Sale
Transfer Agreement

CMS-588

* Required for Initials and CHOWs
**Required for CHOWs

Hospices

Required Documents:

CMS-855A

HHS-690*

CMS-1561*

Legal Documents**

Sales Agreement

Bill of Sale

Transfer Agreement

CMS-588

* Required for Initials and CHOWs

**Required for CHOWs

Home Health Agencies

HHAs must have available sufficient funds at the time of the application submission and all times throughout the enrollment process and during the 3-month period following the conveyance of Medicare billing privileges.

- 4 Periods of Review

- Documents required for proof of operating funds
  - A copy of the statement(s) of the HHA's savings, checking or other account(s) containing the funds
  - Attestation from bank or other financial institution

Hospitals

Required Documents:

CMS-855A

HHS-690*

CMS-1561*

Legal Documents**

Sales Agreement

Bill of Sale

Transfer Agreement

CMS-588

* Required for Initials and CHOWs

**Required for CHOWs

Outpatient Physical Therapy/ Speech Pathology (OTP/SP)

Required Documents:

CMS-855A

HHS-690*

CMS-1561*

Legal Documents**

Sales Agreement

Bill of Sale

Transfer Agreement

CMS-588

CMS-381

* Required for Initials and CHOWs

**Required for CHOWs

Outpatient Physical Therapy/ Speech Pathology (OTP/SP) Form Updates

- In August 2024, CMS updated the Form CMS 381 (cert form for OPTs/SPs)
  - Combines the CMS-1856 and the previous CMS-381
  - Discontinues use of CMS-1856
- OPT's will be expected to complete the new CMS-381 form with initial enrollment and administrative change requests, consistent with the transition work outlined in Admin Info 22-02.

Portable X-Ray Suppliers (PXRs)

Required Documents:

CMS-855B

HHS-690*

CMS-1561*

Legal Documents**

Sales Agreement

Bill of Sale

Transfer Agreement

CMS-588

CMS-460

* Required for Initials and CHOWs

**Required for CHOWs

Skilled Nursing Facilities (SNFs)

Required Documents:

CMS-855A

HHS-690*

CMS-1561*

Legal Documents**

Sales Agreement

Bill of Sale

Transfer Agreement

CMS-588

* Required for Initials and CHOWs

**Required for CHOWs

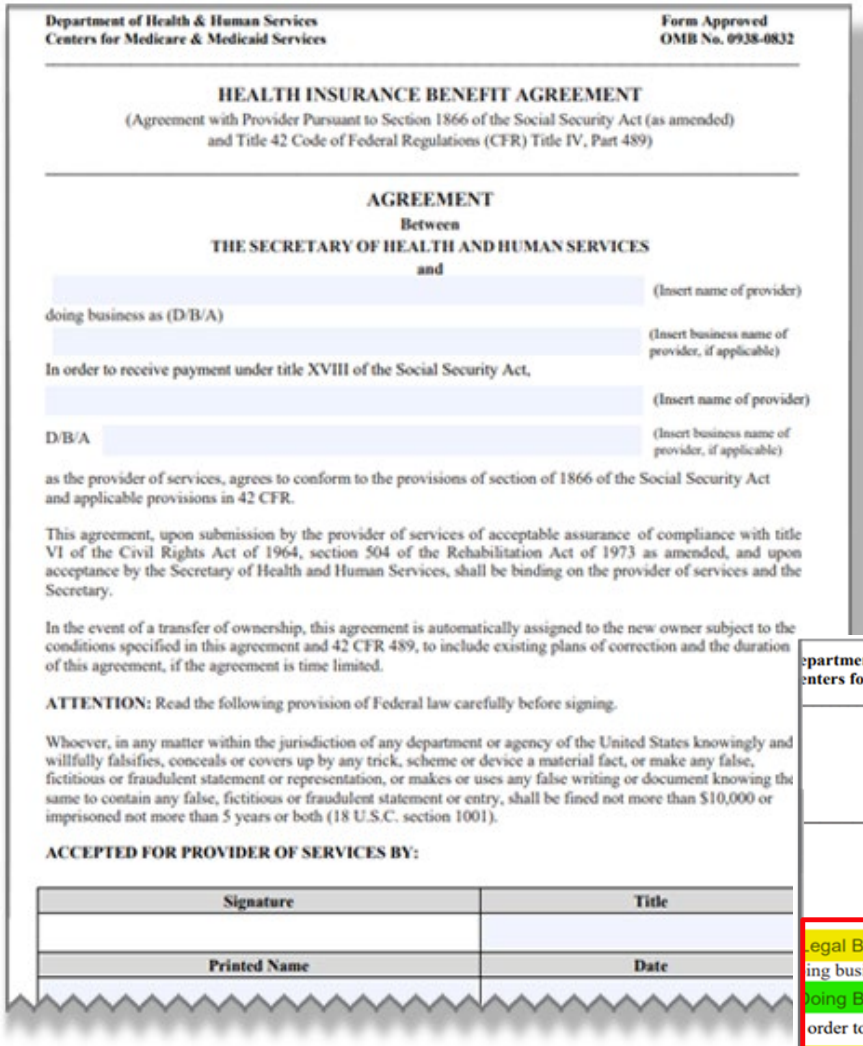
General Application Reminders

- Facility can submit their application **up to** 180 days in advance of their effective date
- Section 5 and 6 of the CMS-855A/CMS-855B must be complete
  - All direct and indirect owners must be reported
  - Individuals in section 6 must include the required roles, SSN, DOB, etc.)
  - All corporations must include officers and board members regardless of proprietary or non-proprietary status
- If applicable, submit:
  - Organizational Chart
  - License (address and DBA must match)
  - IRS 5013

General Application Reminders

- The CMS-588 EFT Authorization Agreement is submitted and includes a voided check or bank letter
- The application fee is paid
- The CMS-855 is signed by an Authorized Official (AO) as defined by 42 CFR § 424.502
- Change in Ownership (CHOW) applications include legal documentation (sales agreement, bill of sale, or transfer agreement) and must be signed by buyer and seller

CMS-1561



Department of Health & Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0832

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act (as amended) and Title 42 Code of Federal Regulations (CFR) Title IV, Part 489)

AGREEMENT
Between
THE SECRETARY OF HEALTH AND HUMAN SERVICES
and

(Insert name of provider)

doing business as (D/B/A)

(Insert business name of provider, if applicable)

In order to receive payment under title XVIII of the Social Security Act,

(Insert name of provider)

D/B/A

(Insert business name of provider, if applicable)

as the provider of services, agrees to conform to the provisions of section of 1866 of the Social Security Act and applicable provisions in 42 CFR.

This agreement, upon submission by the provider of services of acceptable assurance of compliance with title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973 as amended, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

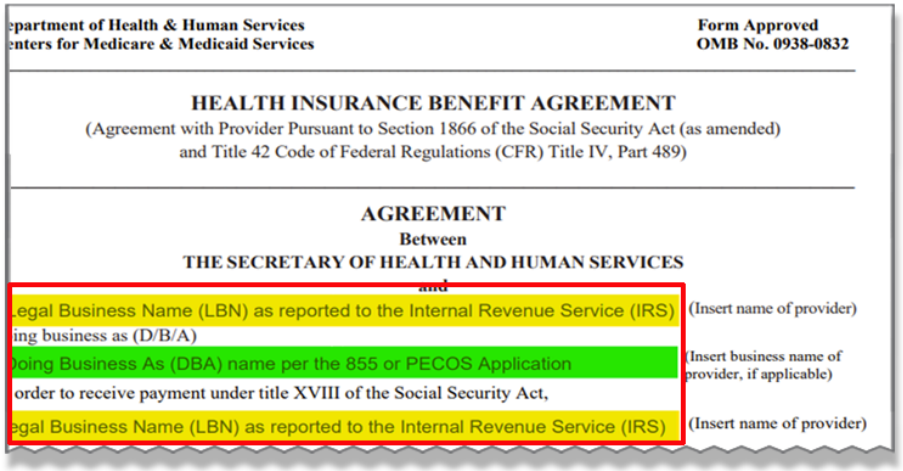
In the event of a transfer of ownership, this agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

ACCEPTED FOR PROVIDER OF SERVICES BY:

Signature	Title
Printed Name	**Date**



epartment of Health & Human Services
enters for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0832

HEALTH INSURANCE BENEFIT AGREEMENT

(Agreement with Provider Pursuant to Section 1866 of the Social Security Act (as amended) and Title 42 Code of Federal Regulations (CFR) Title IV, Part 489)

AGREEMENT
Between
THE SECRETARY OF HEALTH AND HUMAN SERVICES
and

egal Business Name (LBN) as reported to the Internal Revenue Service (IRS) (Insert name of provider)

ing business as (D/B/A)

oing Business As (DBA) name per the 855 or PECOS Application (Insert business name of provider, if applicable)

order to receive payment under title XVIII of the Social Security Act,

egal Business Name (LBN) as reported to the Internal Revenue Service (IRS) (Insert name of provider)

- Use the most current version of the CMS-1561
- Legal Business Name (LBN) matches IRS and the application, including punctuation
- Doing Business Name (DBA) must match the application, including punctuation

Form CMS-1561

Initial Enrollment

ACCEPTED FOR PROVIDER OF SERVICES BY:

Signature	Title
Signature of an Authorized Official for an Initial Enrollment	
Printed Name	**Date**

Change of Ownership (CHOW) application

ACCEPTED FOR THE SUCCESSOR PROVIDER OF SERVICES BY:

Signature	Title
Signature of an Authorized Official for a CHOW application	
Printed Name	**Date**

Summary of the Form CMS-1561

- Complete the most current version of the CMS-1561
- LBN matches to the IRS and the application, including punctuation
- DBA mirrors the application, including punctuation
- Signed by an Authorized Official
- Initial enrollments complete “Accepted for Provider of Services By:”
- CHOW applications complete “Accepted for the Successor Provider of Services By:”

Question & Answer Session

Thank You

August 2024 | 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