NPEC

NATIONAL PROVIDER ENROLLMENT CONFERENCE

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

August 28 - 29, 2024

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Presented by

Zabeen Chong, Director

Provider Enrollment & Oversight Group
Centers for Medicare & Medicaid Services

Session Overview

- Putting Patients First

- How Enrollment Works

- Medicare Policy Updates

- Survey and Certification

- Revalidation

- Our Enrollment Systems

- Medicaid Enrollment

- Protecting the Program

Putting Patients First

By the Numbers

944.3 BILLION in **Medicare** (expenditures)

805.7 BILLION in **Medicaid** (expenditures)

2.8 MILLION Medicare Providers

61.5 MILLION Patients

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
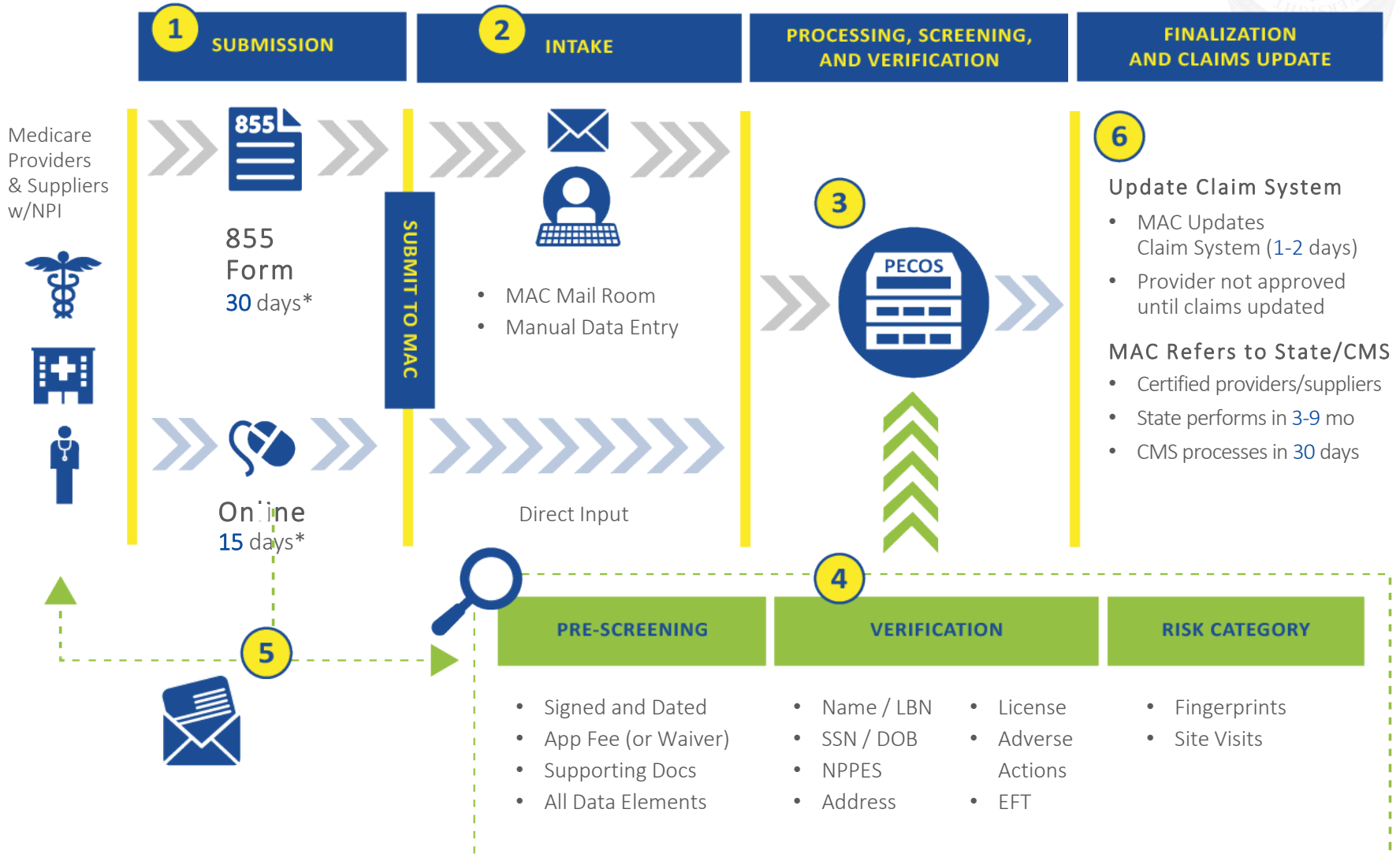
ALWAYS IMPROVING

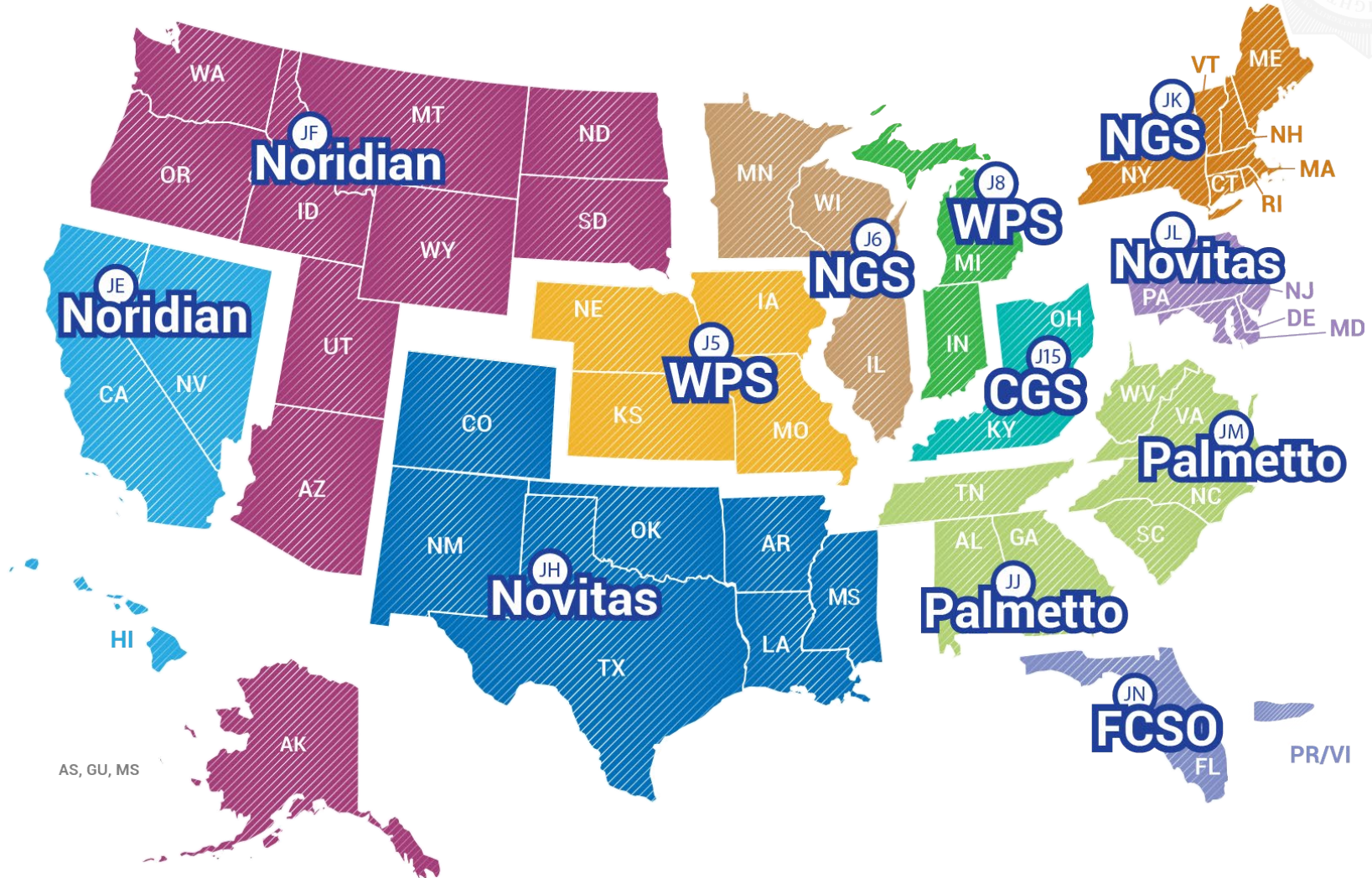We will keep refining our systems, policies, transparency, and our vision

How Enrollment Works

How Enrollment Works

Medicare Providers & Suppliers w/NPI

1 SUBMISSION

855 Form
30 days*

Online
15 days*

SUBMIT TO MAC

2 INTAKE

- MAC Mail Room
- Manual Data Entry

Direct Input

PROCESSING, SCREENING, AND VERIFICATION

3 PECOS

6

Update Claim System

- MAC Updates Claim System (1-2 days)
- Provider not approved until claims updated

MAC Refers to State/CMS

- Certified providers/suppliers
- State performs in 3-9 mo
- CMS processes in 30 days

FINALIZATION AND CLAIMS UPDATE

5

4

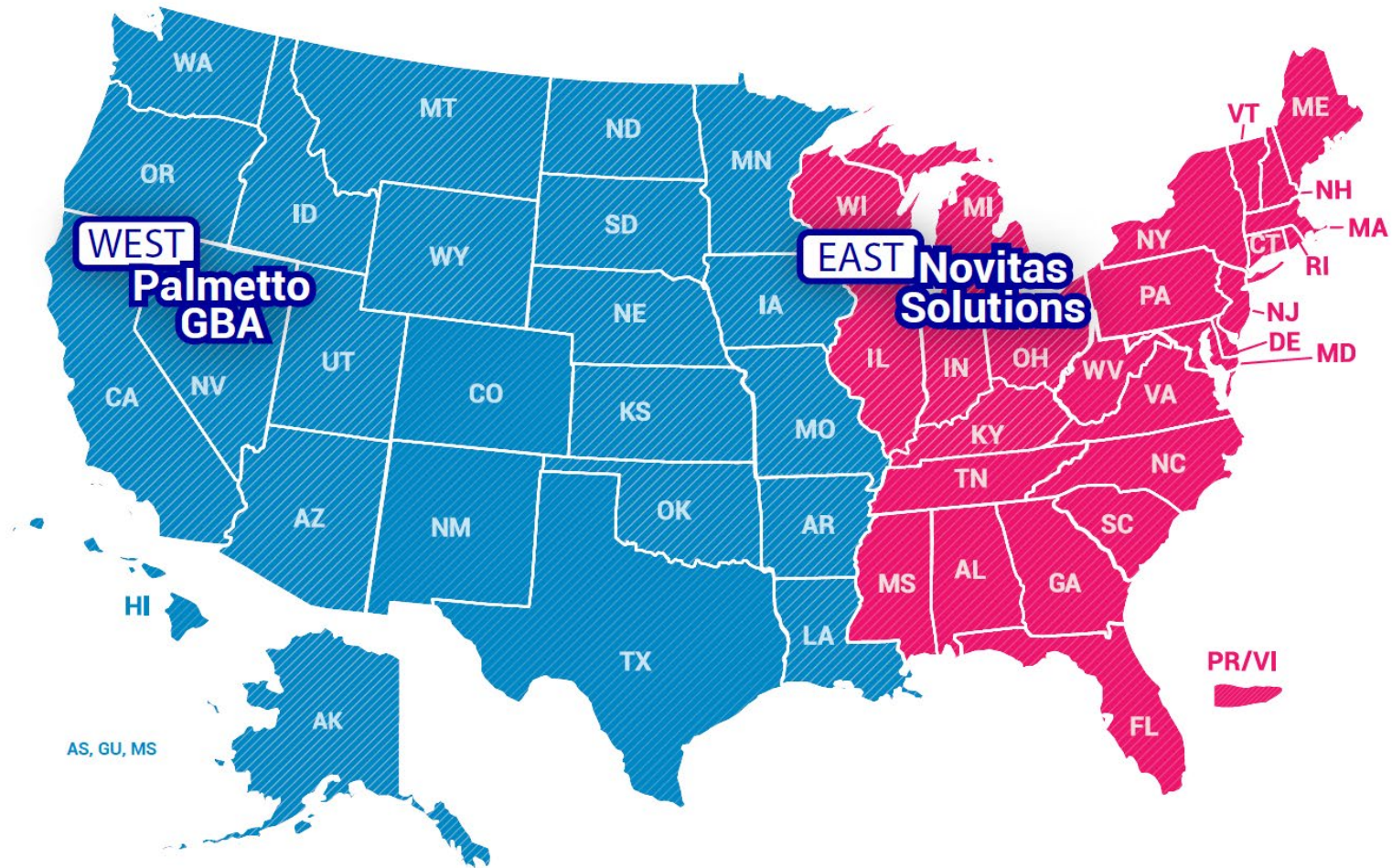| PRE-SCREENING	VERIFICATION		RISK CATEGORY
• Signed and Dated	• Name / LBN	• License	• Fingerprints
• App Fee (or Waiver)	• SSN / DOB	• Adverse Actions	• Site Visits
• Supporting Docs	• NPPES		
• All Data Elements	• Address	• EFT	

MAC Jurisdictions

National Provider Enrollment (NPE) East/West

National Provider Enrollment Contractor for DMEPOS suppliers in Medicare


Map As of November 2022

Medicare Policy Updates

Screening and Verification

- MACs will no longer call the contact person to verify telephone numbers, practice locations, or IDTF supervising physicians *(March 2024)*

- Quality and Certification Oversight Reports (QCOR) used by MACs to verify the CLIA numbers instead of requesting the CLIA certificate *(April 2024)*

- Hospice and SNF medical directors and administrators are required to be reported as managing employees

  - Letters mailed in March 2024 reminding providers of the managing employee requirement and to report any changes via PECOS or the paper CMS-855A

Non-Billing Deactivations
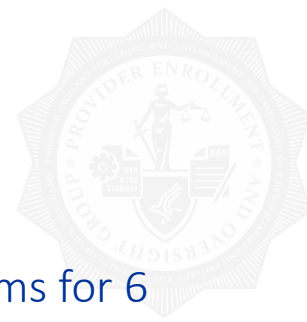
- CMS may deactivate a provider who has not submitted any Medicare claims for 6 consecutive calendar months

- MACs issue a deactivation letter with rebuttal rights

- Must submit a complete CMS-855 to reactivate

- Effective date is based on the receipt date of the application

- You will be issued a new Provider Transaction Access Number (PTAN)

  - Except for certified providers (e.g., hospice)

DEACTIVATION » REACTIVATION » PECOS » EFFECTIVE DATE = DATE APP RECEIVED » NEW PROVIDER PTAN ISSUED

Non-Billing Criteria – Hospice

- In March 2024, CMS began deactivating hospices after 6-months of non-billing if:

  - Enrolled in Medicare for at least 6 months

  - No Medicare or Medicaid billing in the last 6 months

  - No revalidation completed in the last 6 months, no due date in the next month or no revalidation in progress in the last 3 months

- Medicare certification and provider agreement are not impacted by the deactivation

- A new survey is not required to reactivate

Non-Billing Criteria – Other Part A Providers

- Other Part A providers (e.g., HHA, SNF) are deactivated after 13 months of non-billing if:

  - Enrolled in Medicare for at least 13 months

  - No Medicare or Medicaid billing activity in the last 13 months

  - No Part C billing activity

  - No revalidation completed in the last 13 months, no due date in the next month, or no revalidation in progress in the last 3 months

  - No history of deactivation for non-billing in last 2 years

- Certain part A providers are excluded:

  - Children's Hospital, Histocompatibility Laboratory, and Organ Procurement Organization (OPO)

  - Part A Providers that submitted a cost report in the latest fiscal year

Non-Billing Criteria – DME Suppliers

- DME suppliers are deactivated after 13 months of non-billing if:

  - Enrolled in Medicare for at least 13 months

  - No Medicare or Medicaid billing activity in the last 13 months

  - No revalidation completed in the last 13 months, no due date in the next month, or no revalidation in progress in the last 3 months

- Certain DME suppliers are excluded: Pharmacy, Optician, Optometrist, and Hospital

Non-Billing Criteria – Individuals

- Individual Providers (855I only) are deactivated after 13-months of non-billing if:

  - Enrolled in Medicare for at least 13 months

  - No Medicare or Medicaid billing activity in the last 13 months

  - No Medicare FFS claim during an Inpatient Stay or Outpatient Visit at a Children's Hospital in the Last 2 Years

  - No Part C billing activity

  - No revalidation completed in the last 13 months, no due date in the next month, or no revalidation in progress in the last 3 months

  - No history of deactivation for non-billing in the last 2 years

- Certain individual providers are excluded:

  - Dentists, Pediatricians, Pediatric related sub-specialties, IDTF Interpreting Physician, Supervising Physician, Technicians, Mass Immunization billers

  - Sole owners of organizations that are billing

Non-Billing Criteria – Part B Providers

- Part B providers are deactivated after 13-months of non-billing if:

  - Enrolled in Medicare for at least 13 months

  - No Medicare or Medicaid billing activity in the last 13 months

  - No Part C billing activity

  - No Part A hospital billing in the last 13 months under the TIN of the Part B supplier

  - No revalidation completed in the last 13 months, no due date in the next month, or no revalidation in progress in the last 3 months

  - No history of deactivation for non-billing in the last 2 years

- Certain Part B organization providers are excluded:

  - Mass Immunization Roster Billers, Centralized Flu Billers, Pharmacy, CLIA

Hospice Certifying Requirements

CMS-1787

since JUN 2024

Physician who certifies the hospice services:

Must enroll in Medicare

or opt-out through an affidavit

Reduces Fraud

Who can certify hospice:

See article MM13531 and Q&As

- Hospice medical director
- Physician member of the hospice interdisciplinary group
- Attending physician

Hospice claims submitted without an enrolled or opted-out physician will deny.

Verify the physician's enrollment or opt-out status using the ordering and referring file.

CMS-855B Revisions

- Revisions published in Federal Register on July 9, 2024, for 60-day comment period

- Groups can establish, terminate or change reassignments using the 855B

- Removes physician assistant employer relationship

- Adds submittal reason: *You are solely enrolling in Medicare to participate in Medicaid or another health care program*

- Adds practice location types: Business Office for Administrative/Telehealth Use Only <u>and</u> Home Office for Administrative/Telehealth Use Only

CMS-855A Revisions

- Released on November 17, 2023
- Private Equity Company and Real Estate Investment Trust checkboxes
- Addition of Ultimate Owner Question: *Is this organization itself owned by any other organization or by any individual?*
- Adds hospice and SNF medical director and administrator checkboxes for managing employee reporting
- New Rural Emergency Hospital provider type
- Expands location types to include provider-based locations
- Collects Opioid Treatment Program Personnel

Nursing Home Ownership & Additional Disclosable Party Reporting
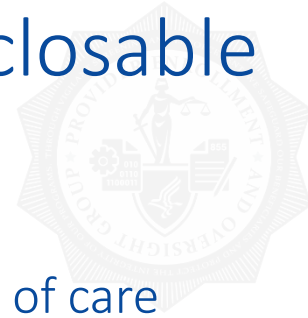
- CMS-6084-F published on November 17, 2023, addresses quality of care concerns in nursing homes through increased transparency

  - Requires nursing homes to disclose certain information about their owners, operators and related parties (management, administrative, consulting, financial services)

  - Defines private equity company and real estate investment trusts

- Information will be collected via the CMS-855A as a separate attachment

  - CMS-855A revisions published in federal register on February 16, 2024, for 60-day comment period and July 3, 2024, for 30-day comment period

  - Tentative release of the revised CMS-855A in fall 2024

Nursing Home Ownership & Additional Disclosable Party Reporting

- Nursing homes must report the disclosures during:

  - Initial enrollment

  - Revalidation

  - Change of information (with respect to the information that is changing)

  - Change of ownership (CHOW)

- Off-cycle revalidation conducted for all nursing homes after the revised CMS-855A is released

- Public release of the nursing home data on data.cms.gov

CMS-855I/855R Consolidation

- Released on September 1, 2023
- Practitioners and groups can establish, terminate or change reassignments using only the 855I
- 855R data elements moved to the 855I
    - Reassignment connections
    - Primary/secondary practice location
    - Signatures
- Instructional guide at Consolidated CMS-855I/CMS-855R Enrollment Applications Bulletin (PDF)

- 855R was discontinued effective October 31, 2023
- Effective November 1, 2023, all reassignment information must be reported on the 855I

CMS-855I/855R Consolidation

SCENARIO #1: Dr. Smith is a new enrollee and reassigns all benefits to Jones Medical Group

SECTION 1: BASIC INFORMATION

A. REASON FOR SUBMITTING THIS APPLICATION

Check one box and complete the sections of this application as indicated.

☐ You are a new enrollee in Medicare	Complete all applicable sections
☐ You are currently enrolled in Medicare to order and certify and want to enroll as an Individual Practitioner	Complete all applicable sections
☐ You are enrolling with another Medicare Administrative Contractor (MAC)	Complete all applicable sections
☐ You are revalidating your Medicare enrollment	Complete all applicable sections
☐ You are reactivating your Medicare enrollment	Complete all applicable sections
☐ You are reporting a change to your Medicare enrollment information (includes establishing or terminating a reassignment)	Co...
☐ You are voluntarily terminating your Medicare enrollment	Se...

Effective date of termination (mm/dd/yyyy):

- In section 1A select **New Enrollee** and complete all applicable sections (identifying information, adverse legal action)

SECTION 4: BUSINESS INFORMATION *(Continued)*

F. INDIVIDUAL/ORGANIZATION/GROUP RECEIVING THE REASSIGNED BENEFITS

2. Organization/Group Receiving Reassigned Benefits Identification

Provide the information below for the organization/group to which benefits are being reassigned, or a reassignment is being terminated. If the organization/group's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification number block. The organization/group's name as reported to the IRS must be the same as reported on the organization/group's CMS-855B when it enrolled.

☐ Change   ☐ Add   ☐ Terminate   Effective Date (mm/dd/yyyy):

Organization/Group Legal Business Name (as Reported to the Internal Revenue Service)

Tax Identification Number (TIN)	Medicare Identification Number (PTAN) (if issued)	National Provider Identifier (NPI)

- In section 4F2 select **Add** and provide information for Jones Medical Group

SECTION 15: CERTIFICATION STATEMEN...

6. I agree that any existing or future overpaymen... by the Medicare program, may be recouped by...

7. I understand that the Medicare identification ... a Medicare enrolled provider or supplier to wh... regulations when billing for services rendered ...

8. I will not knowingly present or cause to be pres... and will not submit claims with deliberate ignor...

9. I further certify that I am the individual practit... the signature below is my signature.

B. SIGNATURE AND DATE

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Practitioner Signature (First, Middle, Last Name, Jr., Sr., M.D., etc.)	Date Signed (mm/dd/yyyy)

In order to process this application it MUST be signed and dated.

C. DELEGATED OR AUTHORIZED OFFICIAL OF INDIVIDUAL/ORGANIZATION/GROUP CERTIFICATION STATEMENT AND SIGNATURE

Only complete this section if you are a Delegated/Authorized Official of an organization/group or an individual practitioner receiving reassigned benefits and are accepting a new reassignment of Medicare benefits, terminating a reassignment of Medicare benefits, or making a change in reassignment of Medicare benefit information in Section 4F, between yourself and the individual practitioner listed in Section 2A.

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me and/or the organization/group to liability under civil and criminal laws.

Delegated or Authorized Official's First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

Delegated or Authorized Official's Signature (First, Middle, Last Name, Jr., Sr., M.D., etc.)	Date Signed (mm/dd/yyyy)

- Dr. Smith **signs** section 15B

- The authorized/delegated official for Jones Medical Group signs 15C

CMS-855I/855R Consolidation

SCENARIO #2: Dr. Brown is terminating his existing reassignment to Family Clinic and adding a new reassignment to Healthcare Center Inc.

- In section 1A select **Reporting a Change** and complete all applicable sections (identifying information, reassignment of benefits)

  - In section 4F2 select **Terminate** and provide information for Family Clinic

  - Copy section 4F2, select **Add** and provide information for Healthcare Center Inc.

- Dr. Brown **signs** section 15B to terminate and add the new reassignment

- The authorized/delegated official for Healthcare Centers Inc. **signs** 15C to add the new reassignment

CMS-588
Electronic Funds Transfer (EFT) Agreement

- All providers/suppliers must receive Medicare payments via the EFT

- Must include a copy of a voided check or bank letter verifying account information

- Providers who reassign all of their benefits to a group are *not* required to submit an EFT agreement

- DME suppliers still receiving paper checks were sent a letter requesting an EFT agreement in April 2024

  - 90 days to comply before deactivation

Marriage and Family Therapists & Mental Health Counselors

- Effective January 1, 2024, Medicare covers services for Marriage and Family Therapists and Mental Health Counselors

- Requirements: (1) master's or doctor's degree; (2) licensed/certified by State; (3) 2 years or 3,000 hours of clinical supervision post degree; and (4) other requirements determined by the Secretary

- Individuals who meet the MHC requirements but are licensed/certified under a different title may enroll as an MHC

  - clinical professional counselor, professional counselor, addiction counselor, alcohol and drug counselor

  - The list is not exhaustive and varies by state

  - Must select MHC on the enrollment application

Marriage and Family Therapists & Mental Health Counselors

- 2 years or 3,000-hours clinical supervision verification requirements

  - A statement on letterhead from the provider/supplier where the services were performed (hospital, clinic) and signed by a supervisor, department head or current AO/DO

  - A statement on letterhead from a licensing/credentialing body or national credentialing organization and signed by any official

- If the state requires the clinical supervised experience as a condition of licensure or certification, a statement is not required

See FAQs at https://www.cms.gov/files/document/marriage-and-family-therapists-and-mental-health-counselors-faq-09052023.pdf

Telehealth Policy - Reassignment

(855I)

NOVITAS (MAC)

(855B)

DR. SMITH

REASSIGNMENT

JONES MEDICAL GROUP

- 456 Elm St. Maryland **(brick and mortar)** ✅
- 123 Main St. Maryland **(Dr. Smith home)** ❌
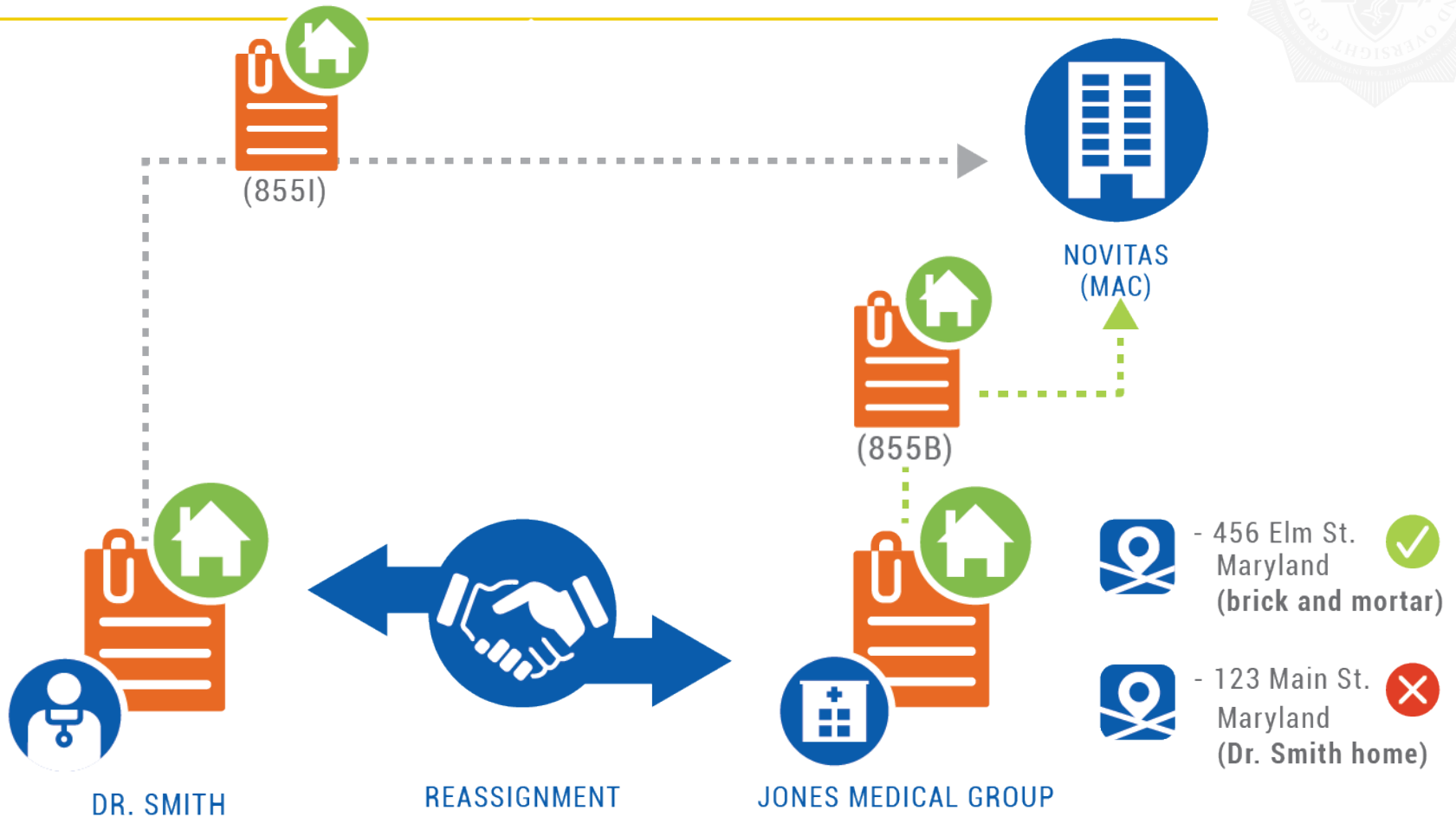
Telehealth Policy – Private Practice

DR. SMITH

- 123 Main St.
Maryland
(Dr. Smith home) ✓

(855I)

NOVITAS
(MAC)
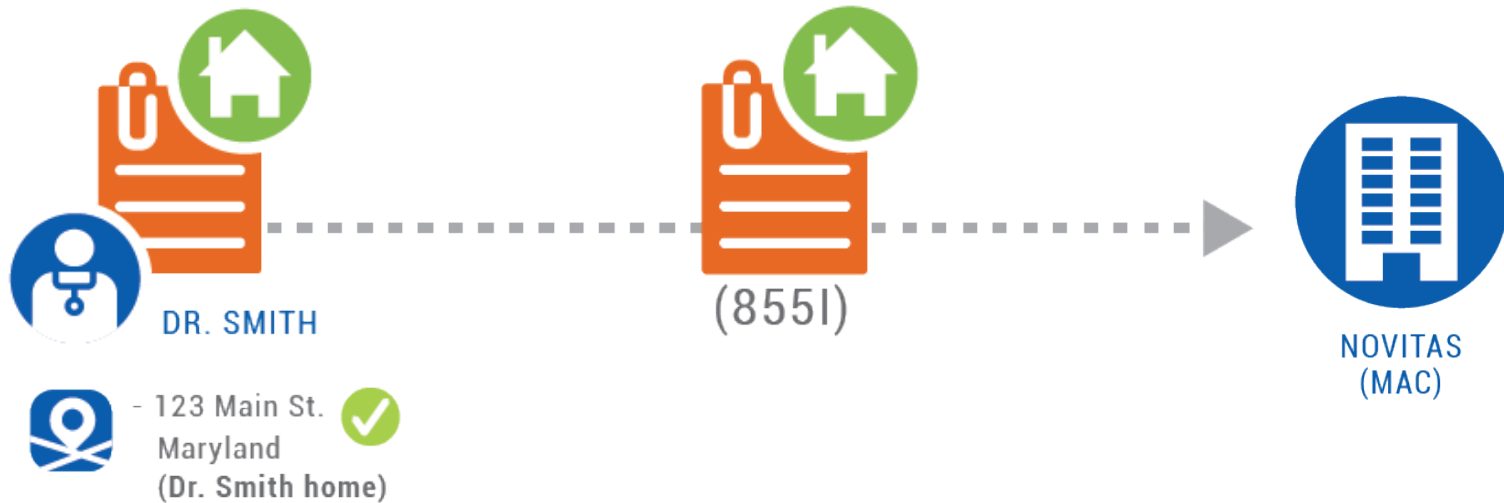
Home Addresses on Care Compare

- Home addresses previously reported on enrollment applications may be publicly displayed on Care Compare

- Practice locations appropriately identified as home addresses are now suppressed on Care Compare

- Update your practice location type via PECOS or the CMS-855 application

- Contact QPP@cms.hhs.gov to have your home address suppressed, while your enrollment application is being processed

Reporting Changes of Information

- **Within 30 days**

  - Change of ownership or control, including changes in authorized or delegated official(s)

  - Adverse Legal Action (e.g., suspension or revocation of any state or Federal license)

  - Change in practice location (includes any new reassignments)

- **Within 90 days**

  - All other changes to enrollment

42 CFR 424.516

Authorized Official

- An appointed official with the legal authority to enroll, make changes and ensure compliance with enrollment requirements (CEO, CFO, partner, chairman, owner, Administrator, President)

  - Individuals with approved titles will be accepted as AOs

  - Individuals without approved titles and lack signature authority will require a different AO be submitted (e.g. charge nurse, purchasing agent, claims processor)

  - If MACs are unsure of an individual's authority, they will develop for more information (1) the individual's role within the organization; and (2) why the provider believes the individual has signature authority

Delegated Official

- Appointed by the authorized official with authority to report changes to enrollment information

  - Owner, control interest, or W-2 managing employee

  - Multiple delegated officials are permitted

  - May sign changes, updates, and revalidations but not initial applications

Who Can Sign the Enrollment Application?

855 A
855 B
855 S
855 20134

Initial:

AO AUTHORIZED OFFICIAL

Changes & Revals:

AO AUTHORIZED OFFICIAL

OR

DO DELEGATED OFFICIAL

---

855 I

All:

IP INDIVIDUAL PROVIDER

Add Reassignment:

IP INDIVIDUAL PROVIDER

+

DO DELEGATED OFFICIAL / **AO** AUTHORIZED OFFICIAL

Change / Terminate Reassignment:

IP INDIVIDUAL PROVIDER

OR

DO DELEGATED OFFICIAL / **AO** AUTHORIZED OFFICIAL

---

855 O

All:

IP INDIVIDUAL PROVIDER

Opt-Out of Medicare

Physicians/practitioners who do not wish to enroll in the Medicare program may "opt-out"

What this means:

- The physician/practitioner nor the beneficiary submits a bill and is reimbursed by Medicare for services rendered (beneficiary pays out-of-pocket)

- A private contract is signed between the physician/practitioner and the beneficiary

- The physician/practitioner submits an affidavit to Medicare to opt-out of the program

Filing an Opt-Out Affidavit

- A standard CMS form is not available

- Some MACs have a form available on their website

- Must be filed with all MACs who have jurisdiction over the claims the physician/ practitioner would have otherwise filed with Medicare

Impacts of Opting-Out

- May not receive direct or indirect Medicare payment for services furnished to Medicare beneficiaries
  - Traditional Medicare fee-for- service
  - Under a Medicare Advantage plan
- Cannot terminate early unless opting out for the first time and within 90 days after the effective date of the opt-out period
  - Locked in for 2 years if you miss the 90-day window
- May order or certify items and services or prescribe Part D drugs for Medicare beneficiaries. Must provide following:
  - NPI
  - Date of Birth
  - Social Security Number

Survey and Certification

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

- Providers are given inaccurate status information

- MAC referral packages sent to States/PEOG are delayed or packages are incomplete

- Approval letters omit critical information (modalities/services, # of dialysis stations, CHOW effective dates)

Survey and Certification

CMS transferred **95%** of survey and certification functions for certified providers to the **Provider Enrollment & Oversight Group** and the **MACs**

Process improvements and efficiencies

- Designate MACs as the first POC for application statuses
- Coordinate with MAC customer service staff to improve responses to provider inquiries
- Secure platform for sending MAC recommendation packages electronically to states to avoid lost packages
- Implement approval letter updates (December 2023)
- Implement MAC checklists to ensure complete packages are sent to PEOG (March 2024)
- Publish roadmap to outline each step of the enrollment and certification process with timeframes and POCs for each step (May 2024)
- Continue to implement efficiencies by reducing post survey processing times
- Collaborate with provider associations and groups to solicit feedback on the efficiencies

Survey and Certification

MAC Reviews Enrollment Application

MAC Sends the Referral to the State (copies AO, if applicable)

30 DAYS

State Reviews for State Required Actions (e.g., Survey)

State notifies MAC of Approval

45-90 DAYS

MAC Issues Final Approval Letter And Provider Agreement

5 DAYS

CMS/PEOG Assigns the CCN and Effective Date, Effectuates Provider Agreement, Updates Certification Database

30 DAYS

MAC sends Package to CMS/PEOG for Review

5 DAYS

MAC orders a Site Visit, if Applicable

30 DAYS

Who Should I Call?

First Point of Contact is Always your MAC

PROVIDER

1 MAC

2 STATE

3 PEOG

MAC provides the status and follows up with the State/PEOG for applications pending their review

Providers can contact the State using contact information in Referral Letter

Providers can contact CMS/PEOG at Medicareproviderenrollment@cms.hhs.gov
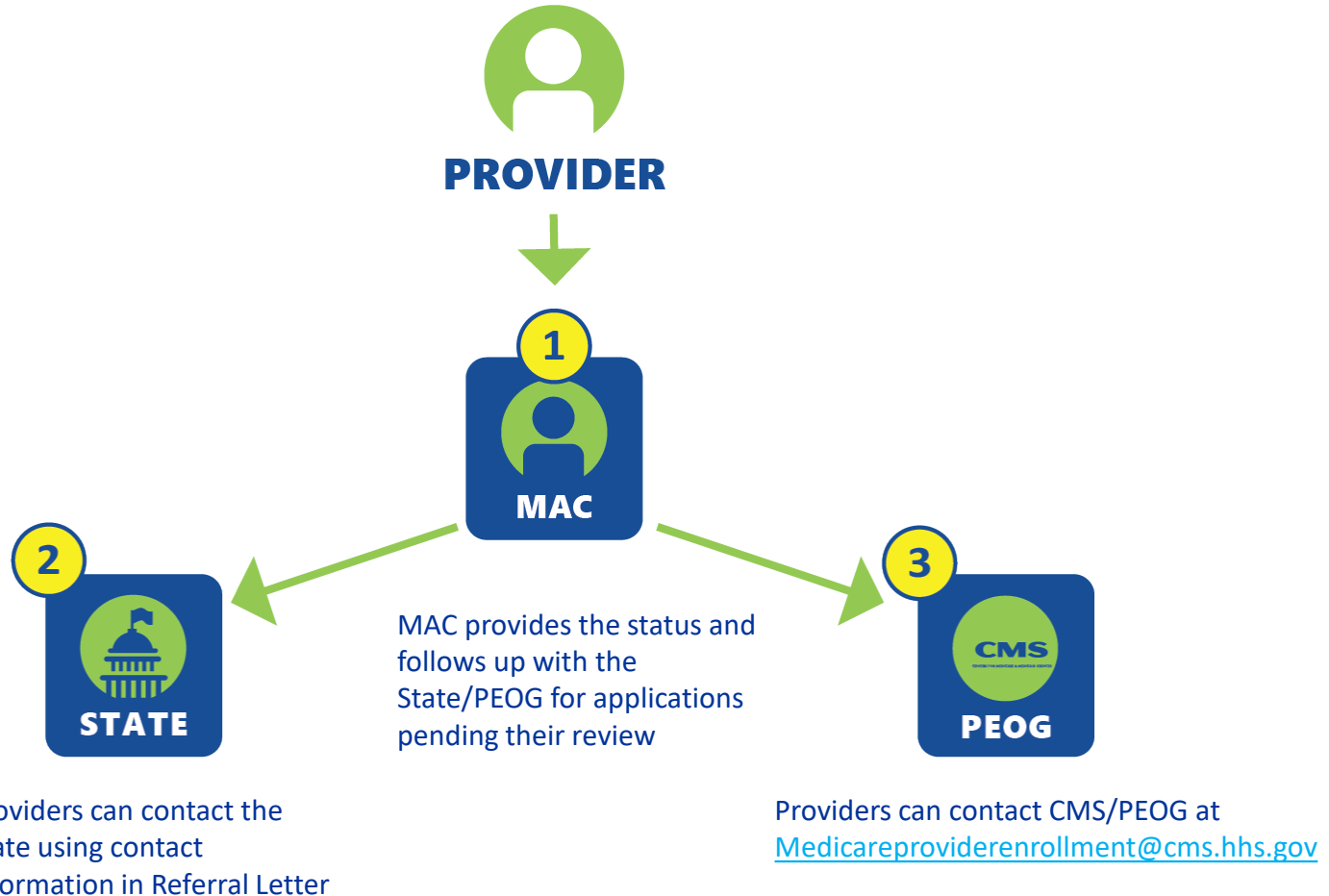
Question & Answer Session

Revalidation

Revalidation – Current Status

- Providers/suppliers were notified of the changes to the revalidation process in an MLN newsletter issued on January 4, 2024, and on the revalidation look up tool

  - Revalidating organizations, no individual due dates

  - Implemented stay of enrollments and deactivations for non-response

  - Resumed 6-7 months advance notice of revalidation due dates on revalidation look up tool

  - No revalidation due dates for November 2024 – January 2025

  - https://www.cms.gov/training-education/medicare-learning-network/newsletter/2024-01-04-mlnc#_Toc155185956

Revalidation – Current Status

- Providers may be asked to revalidate off-cycle (in advance of or beyond their 3 or 5 year due date)

  - Off-cycle revalidation notifications may not happen 6 months in advance but at least 90 days will be given

- No action needed until you see a revalidation due date on the revalidation look up tool and/or receive a letter from your MAC

- Revalidation due dates on or after July 2023, will show under 'Due Dates' and not 'Adjusted Due date'

- Continue to communicate changes to the revalidation process through MLN newsletters, Open Door Forums, provider enrollment website

Revalidation – Current Status

NOVEMBER 2019   FEBRUARY 2020

My due date is between November 2019 – February 2020

JANUARY 2022   MAY 2023

My adjusted due date is between January 2022 - May 2023

- No deactivations for failure to respond to revalidation
- If you submitted and received approval, no further action needed
- If you did not respond, you will be assigned a new due date

Stay of Enrollment

Stay of Enrollment

- Interim action taken against non-compliant providers prior to imposing a deactivation or revocation

    - Must be non-compliant with at least one enrollment requirement that can be remedied with the submission of a CMS-855 (non-response to revalidation, ownership discrepancies)

    - Pauses enrollment temporarily while the provider comes into compliance

    - Provider remains enrolled in Medicare during the stay (enrollment status will continue to be approved)

    - Claims submitted with dates of service during the stay period are rejected

    - Stay lasts no longer than 60 days

    - Not considered a sanction or adverse action

Stay of Enrollment – Non-Response to Revalidation

Begins May 2024

REVALIDATION DUE DATE: AUGUST 31, 2024

SCENARIO (1)
STAY APPLIED & PROVIDER RESPONDS
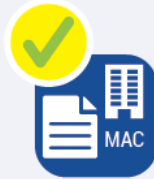
MAC/PROVIDER ACTION	TIMEFRAME	SAMPLE TIMELINE
MAC APPLIES THE STAY AND SENDS NOTICE	10 DAYS AFTER	SEPTEMBER 10 2024
PROVIDER SENDS REVALIDATION	WITHIN 30 DAYS	SEPTEMBER 25 2024
MAC REMOVES THE STAY. CLAIMS WITH DOS DURING THE STAY ARE ELIGIBLE FOR PAYMENT	WITHIN 10 DAYS	OCTOBER 5 2024

Stay of Enrollment – Non-Response to Revalidation

REVALIDATION
DUE DATE: AUGUST 31, 2024

SCENARIO (2)
STAY APPLIED &
PROVIDER DOESN'T RESPOND

MAC/PROVIDER ACTION	TIMEFRAME	SAMPLE TIMELINE
MAC APPLIES THE STAY AND SENDS NOTICE	10 DAYS AFTER	SEPTEMBER 10 2024
PROVIDER DOES NOT RESPOND	WITHIN 30 DAYS	OCTOBER 10 2024
MAC DEACTIVATES BACK TO THE REVALIDATION DUE DATE CLAIMS WITH DOS DURING THE STAY AND AFTER DEACTIVATION ARE INELIGIBLE FOR PAYMENT	WITHIN 10 DAYS	OCTOBER 20 2024

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.

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…

39,000
New NPIs

57,000
Updates

96% created online

8.1 MILLION NPIs

NPIs created online
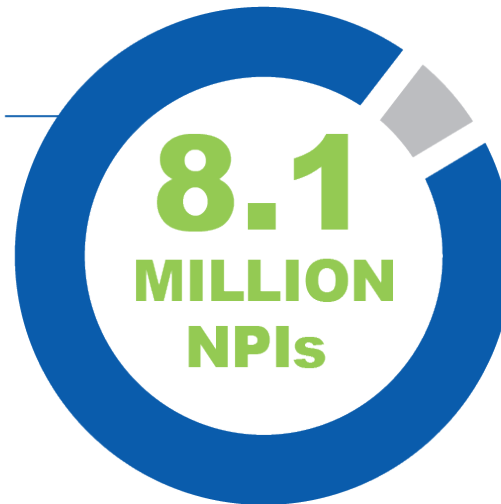
78% individuals

22% organizations

Maintain NPI Records

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

NPPES | Federal Register Notice

- A Federal Register Notice was published on March 4, 2024, that allows the National Plan and Provider Enumeration System (NPPES) to make the following data changes:

  - **Acceptance of PO Boxes -** a post office box or personal mailbox can be used as a practice location when a physical location other than a home address is unavailable (e.g., provider exclusively furnishes telehealth services from their home)

  - **Expands Gender Code Options -** Two additional options are available, Unspecified (X) and Undisclosed (U).

- The NPPES changes were effective April 3, 2024

- These changes are available to the public in the downloadable files and NPI registry

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
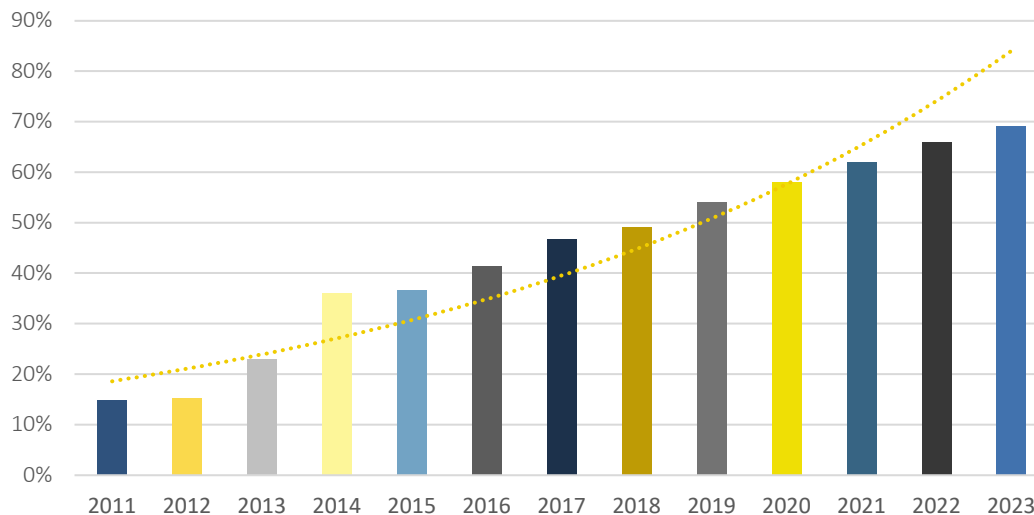
PECOS Today

Over 2.8 Million Enrollments

Every month…
19,000 new enrollments

Encouraging Online Applications

% of PECOS Web Applications by Year

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

PECOS 2.0

Rethinking Provider Enrollment.

PECOS 2.0 Status Update

CMS is focused on improving the enrollment experience and PECOS 2.0 is still in-progress; however, it will not be introduced in 2024 as expected.

When will the PECOS 2.0 improvements begin rolling out? We have not determined a revised timeline, yet. As we continue development, we will release more information via CMS.gov.

I thought it was close to launching, why is it delayed? We are considering different strategies to reduce potential downtime at launch, improve the process of migrating all the existing data, and to address important feedback from testing. It will take time to consider these changes, make system adjustments, and go through more testing.

Will it still have all the features we have seen? The features and capabilities you have seen will continue to be part of the PECOS 2.0 strategy and CMS will continue to collaborate with the Provider community to make sure PECOS 2.0 meets your needs and exceeds expectations.

Does this delay impact current PECOS? No. We will continue to improve the current system, and the changes to PECOS 2.0 timelines and launch strategy will not impact any current enrollment information or impact billing/claims information.

Question & Answer Session

Medicaid Enrollment

Medicaid Provider Enrollment

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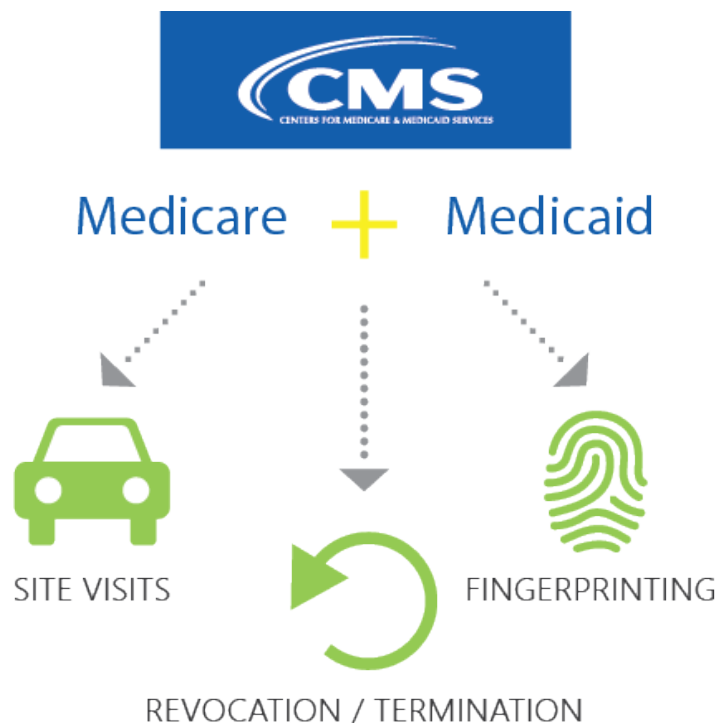
Advantages

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

Centralized CMS point-of-contact for all states

Medicaid Provider Enrollment Compendium (MPEC)

Similar to the Medicare Program Integrity Manual

How Can CMS Help?

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

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

- Processing error examples include:

  - Provider not appropriately screened using risk-based criteria

  - Ordering, Referring, Prescribing NPI required, but not listed on claim

  - Attending or rendering provider NPI required, but not listed on claim

  - Billing provider NPI required, but not listed on claim

Fee-for-service (FFS)

PROJECTED
PERM
ERROR RATE

RY2023

53%
Other medical review or data processing errors

47%
Noncompliance with Medicaid FFS Provider Enrollment & Screening Requirements
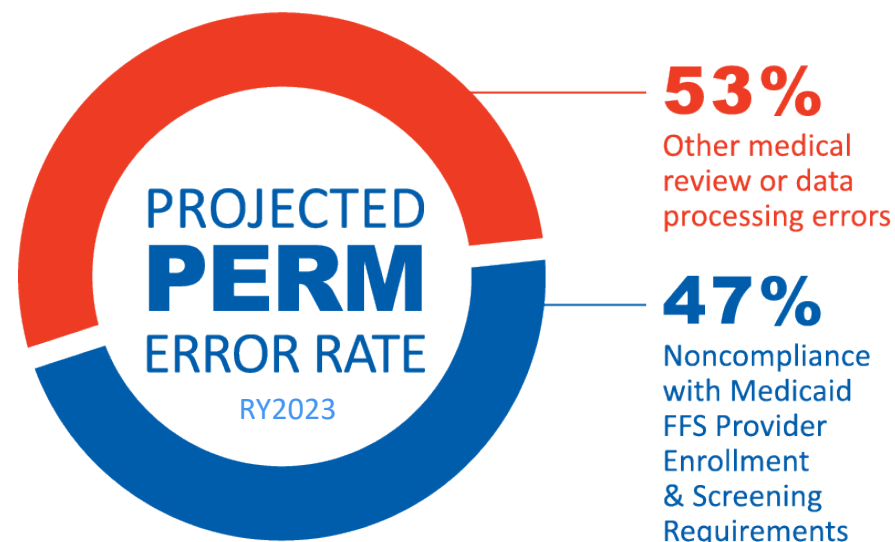
Medicaid Provider Enrollment Compendium

MPEC

- **Sub-Regulatory guidance on federal Medicaid enrollment and screening requirements** (42 C.F.R. § 455 Subparts B, E)

- **States may impose stricter requirements than Federal regulations**

Sample Guidance

Screening Risk Levels (Section 1.3(D))

- Conduct full screening appropriate to provider's risk level

- May rely on Medicare or another state's screening

- Newly enrolling and changes in ownership for Skilled Nursing Facilities (SNF) and hospices are now at the high-risk level

  - Revalidating SNFs and hospices are screened at the moderate screening level

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

SMAs Participating in Data Compare
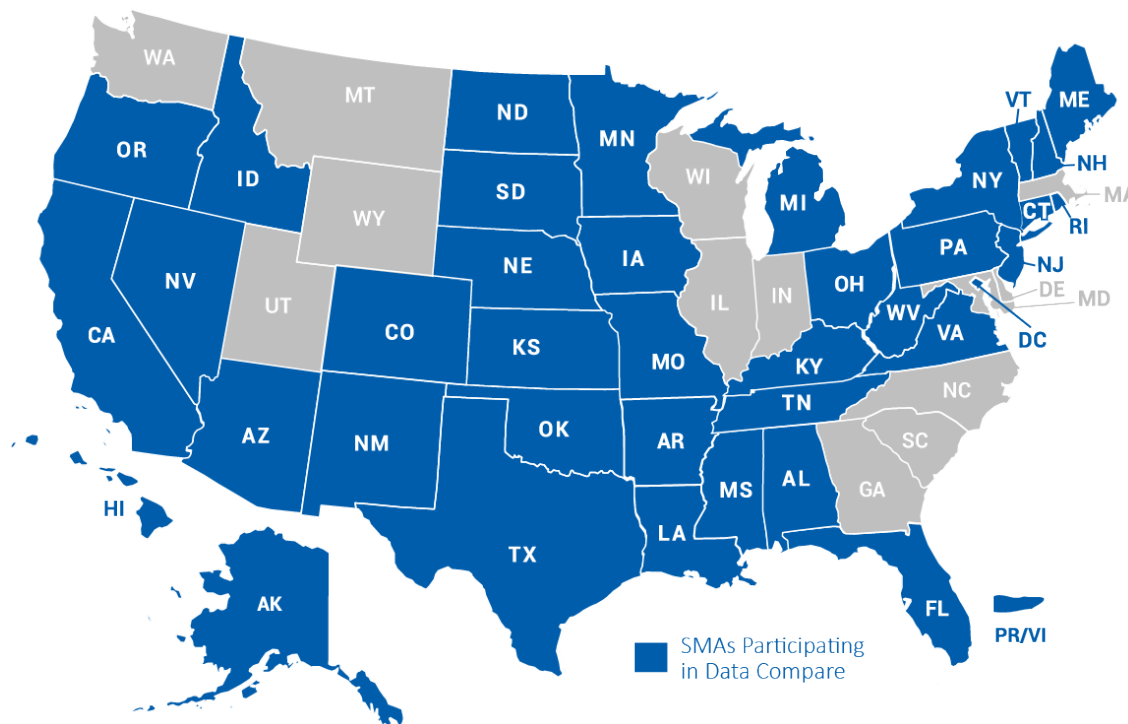
Data Compare Results

Mississippi Reported
92,098
Providers

Data Compare
Report Had a Match of
81,680
Providers

88.7% Match Rate

Reliable Data Compare
67,969
Limited Risk Providers

Nevada Reported
43,882
Providers

Data Compare
Report Had a Match of
31,814
Providers

72.5% Match Rate

Reliable Data Compare
18,498
Limited Risk Providers

New Hampshire Reported
26,015
Providers

Data Compare
Report Had a Match of
26,015
Providers

97.8% Match Rate

Reliable Data Compare
14,027
Limited Risk Providers

State Best Practices

MT
BEST PRACTICES
Montana created an abbreviated enrollment application for Referring, Ordering, Prescribing and Attending providers by removing sections that don't apply, to reduce provider burden and expedite the enrollment process.

CA
BEST PRACTICES
California performs automated searches of the Death Master File and generates alerts on deceased providers, which allows billing numbers to be deactivated in a timely manner and prevents potential identity theft.

VA
BEST PRACTICES
Virginia established a 100% online enrollment process.

OH
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.

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

Deactivations

- Non-billing
- Inactive NPIs
- Deceased associates
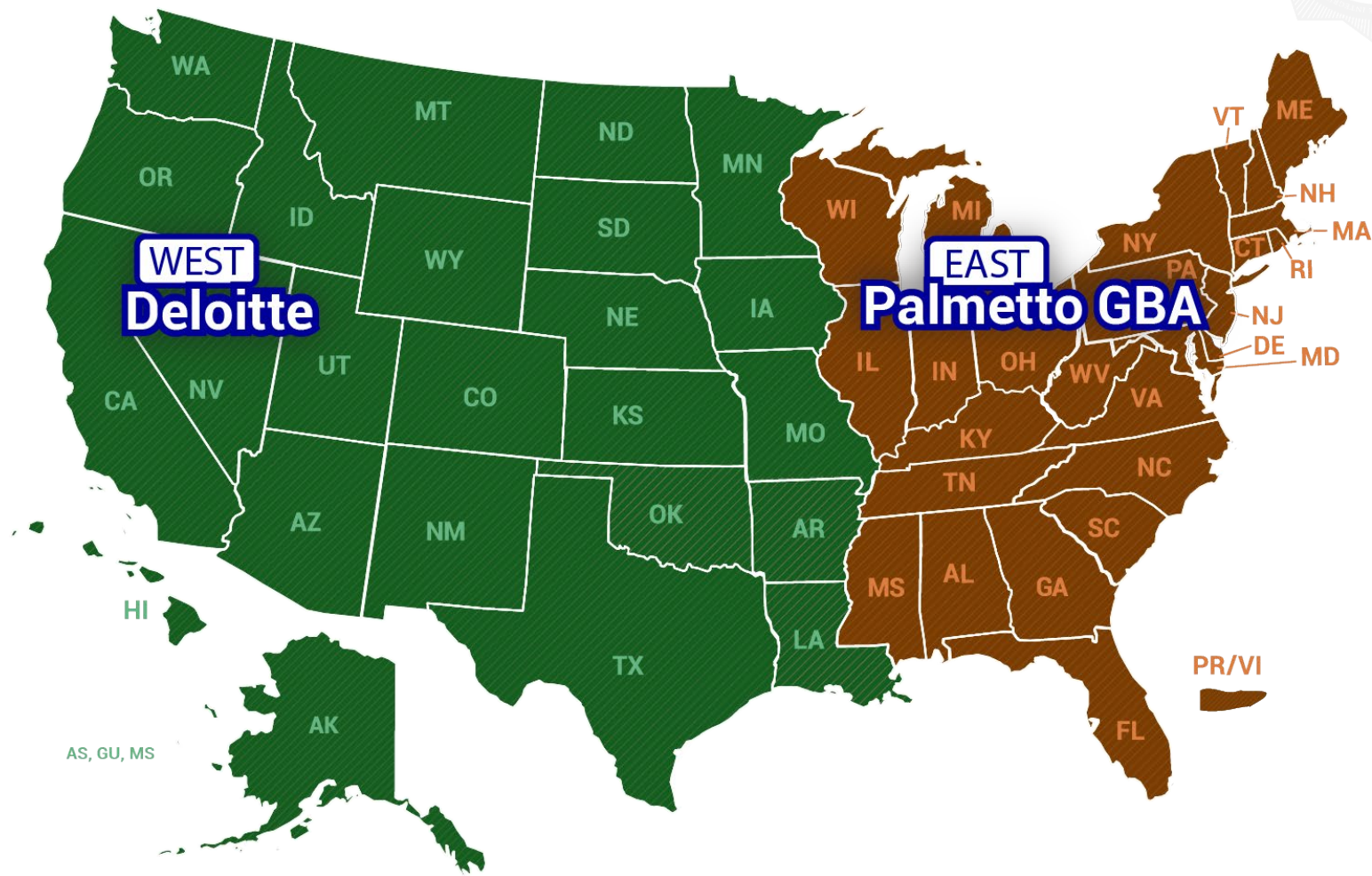- No active practice locations or reassignments for more than 90 days

Screen Medicaid-only Providers

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

National Site Visit Contractor (NSVC)

Site Visits | National Site Visit Contractors (NSVCs)

- All enrollment site visits conducted by the NSVC
- Required for moderate/high risk providers
  - initial enrollment, revalidation, adding a new location
- CMS has the authority to perform site visits on all providers
- Verifies practice location information to determine compliance with enrollment requirements
- Separate from State/AO surveys for certified providers

What to expect during a site visit?

1. Unannounced site visit conducted during normal business hours 9am – 5pm
2. An external or internal review, by an inspector, with limited disruption to your business
3. Photographs of the business
4. Inspector will possess a photo ID and a letter of authorization issued and signed by CMS
   - To verify an inspector is associated with a CMS ordered site visit contact your MAC

Fingerprinting

CMSfingerprinting.com

Applies to:

- New HHA, DME, MDPP, OTP, Hospice, SNF

- Existing HHA, DME, MDPP, OTP, Hospice, SNF reporting a change of ownership or new owner

- Revalidating HHA, DME, MDPP, OTP, Hospice, SNF who had fingerprints waived during a PHE

- High risk providers/suppliers

Excludes: Managing Employees, Officers, Directors

5%(+) Ownership/Partners

in a high risk provider/supplier

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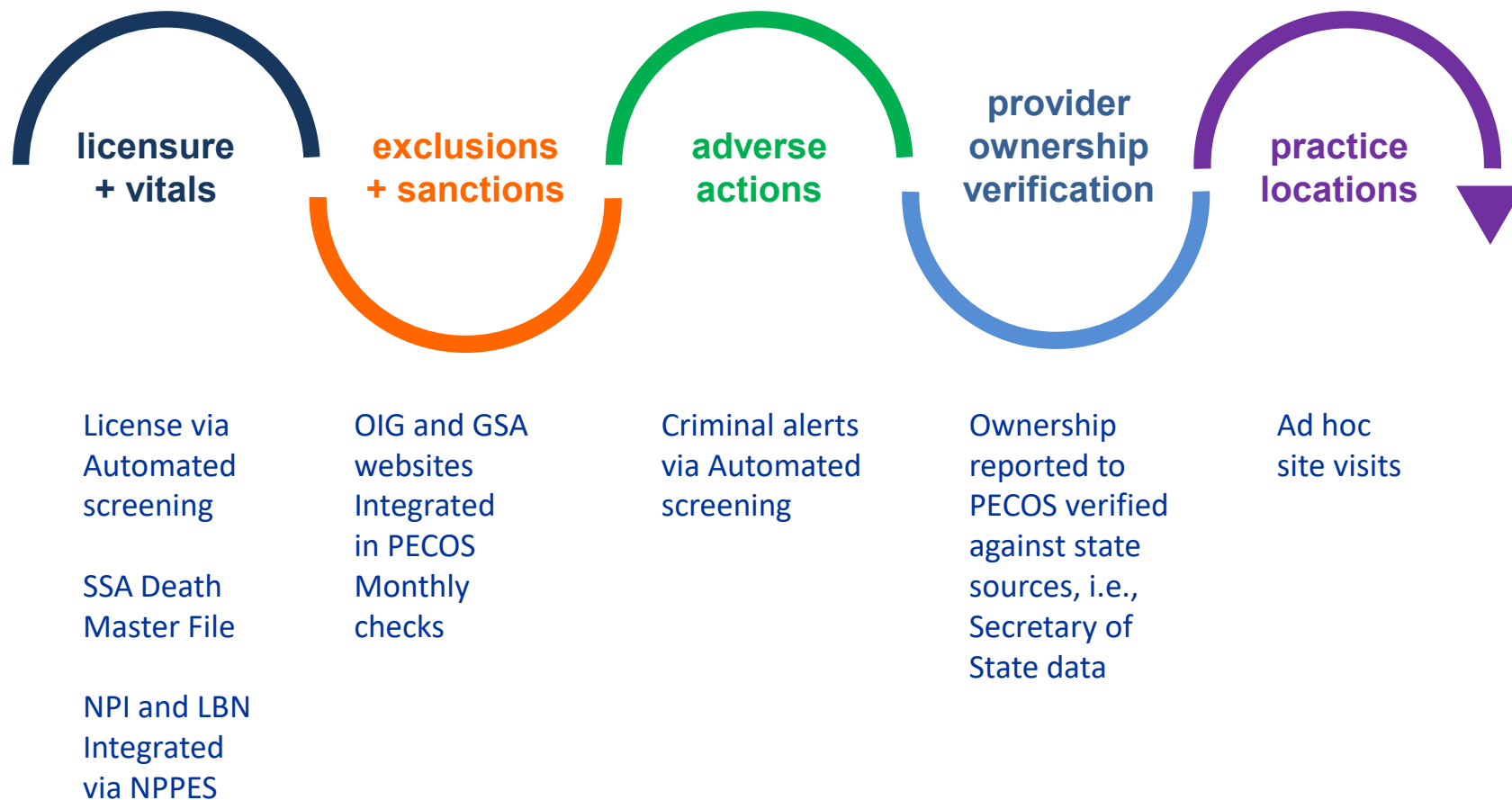
- Medicare phased rollout

If the provider/supplier:

- Has a felony conviction

- Refuses fingerprinting

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

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

Continuous Monitoring

licensure + vitals

exclusions + sanctions

adverse actions

provider ownership verification

practice locations

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

Ownership reported to PECOS verified against state sources, i.e., Secretary of State data

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 30 days

Ordering Referring File

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

Data Sharing

Public data files from PECOS

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

Opt Out File

- Currently opted-out of Medicare
- Updated quarterly

**Hospital , SNF
All Ownership File
Change of Ownership File**

- All ownership for currently enrolled Hospitals (including CAH and REH) and SNFs – updated monthly
- CHOW transactions since 2016 for currently enrolled Hospitals ,SNFs , updated quarterly

HHA, Hospice, FQHC, RHC

- All ownership for currently enrolled HHA ,Hospices , FQHC, RHC– updated quarterly
- CHOW transactions since 2016 for currently enrolled HHA ,Hospice , FQHC and RHC– updated quarterly

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 MLN Matters® Articles

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

Thank You

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Centers for Medicare & Medicaid Services