# NATIONAL PROVIDER ENROLLMENT CONFERENCE

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

## August 28 - 29, 2024

CENTERS FOR MEDICARE & MEDICAID SERVICES


Presented by

Zabeen Chong,
Director

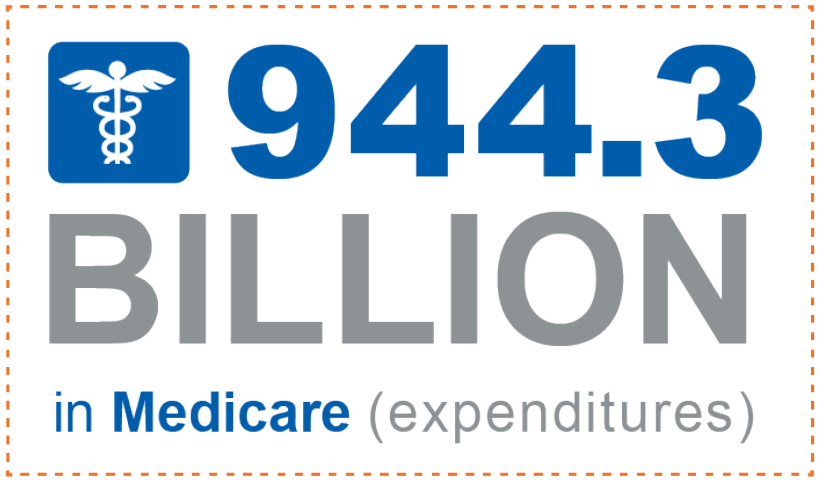
Provider Enrollment & Oversight Group
Centers for Medicare & Medicaid Services

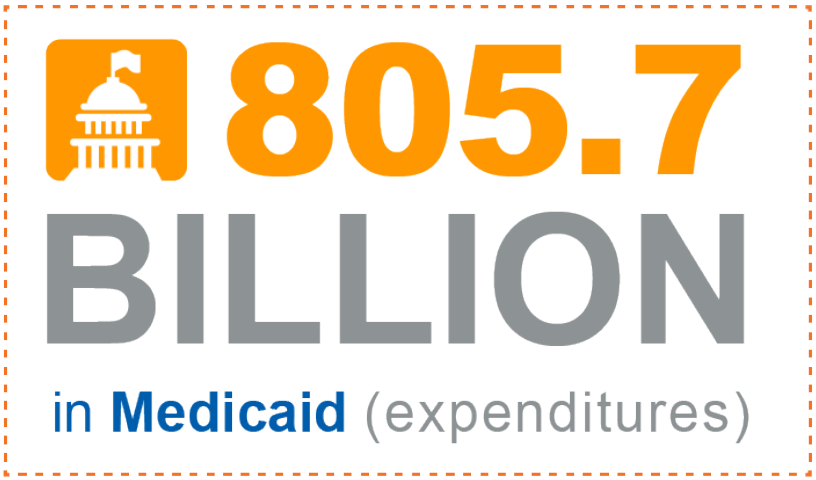
# Session Overview

- 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





# Why We're Here

## LISTENING TO YOU

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

## FINDING A BALANCE

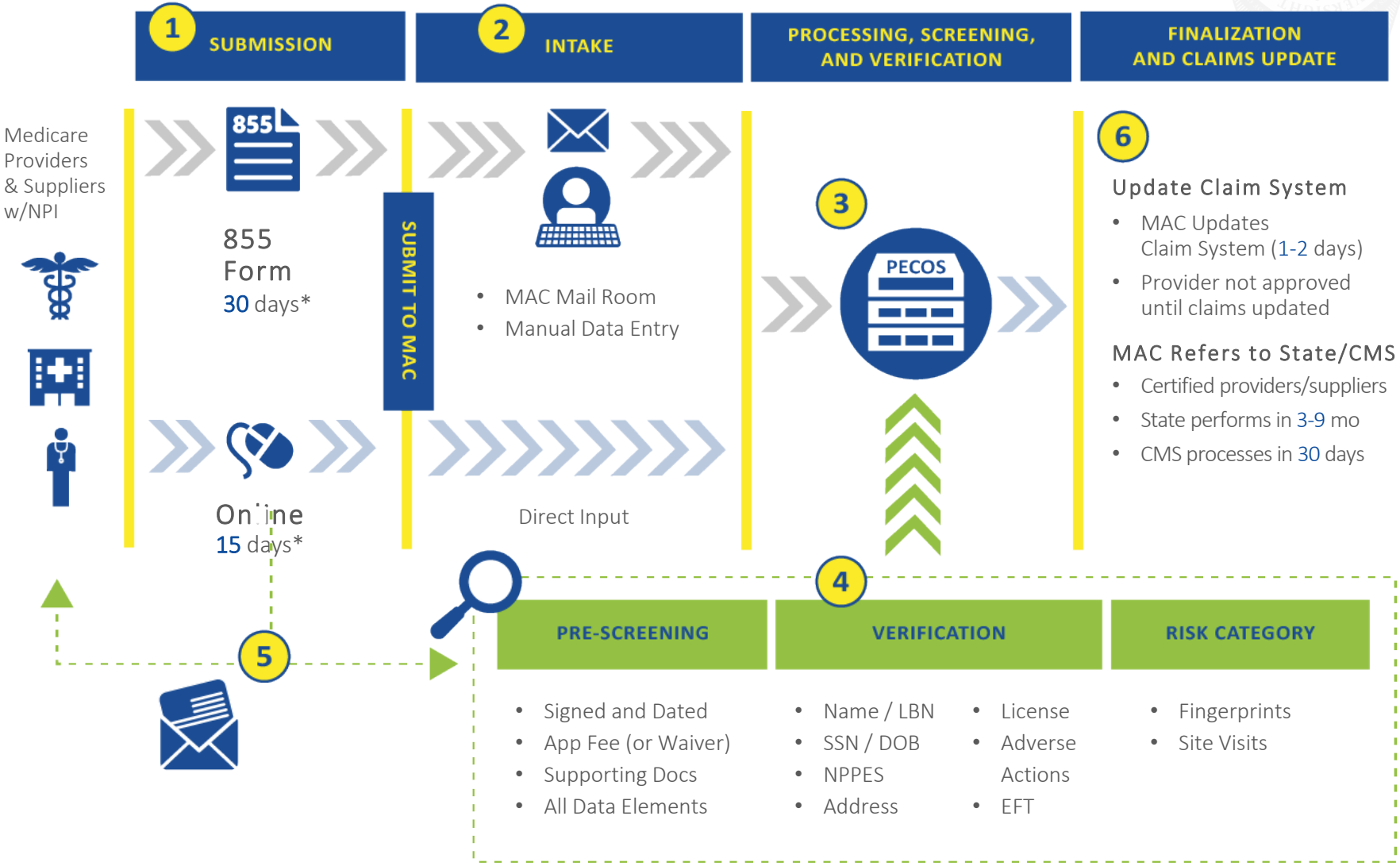

We believe enrollment should be **easy** for most providers, and **hard** for bad actors

## ALWAYS IMPROVING

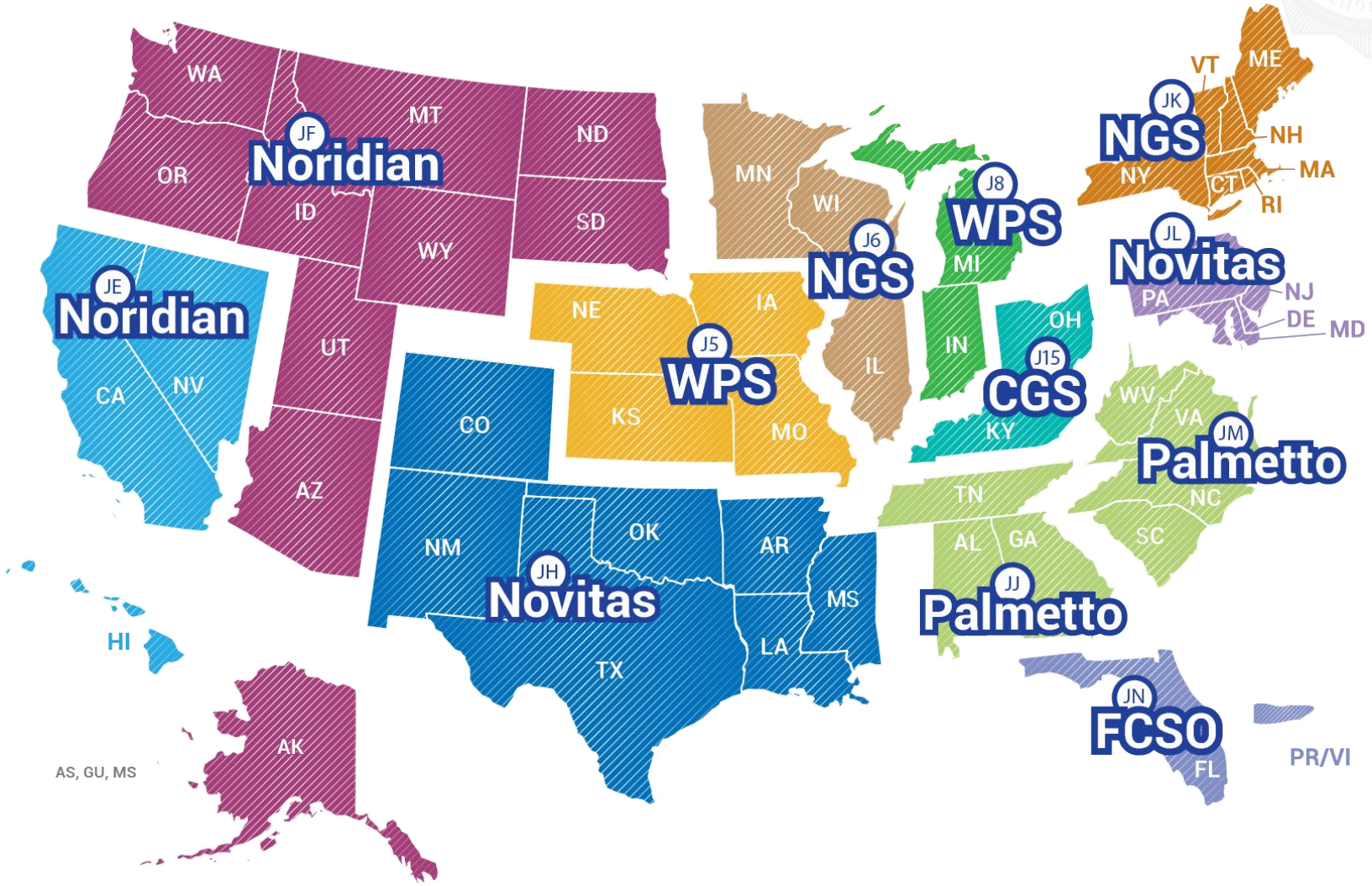

We will keep refining our systems, policies, transparency, and our vision

# How Enrollment Works

# How Enrollment Works

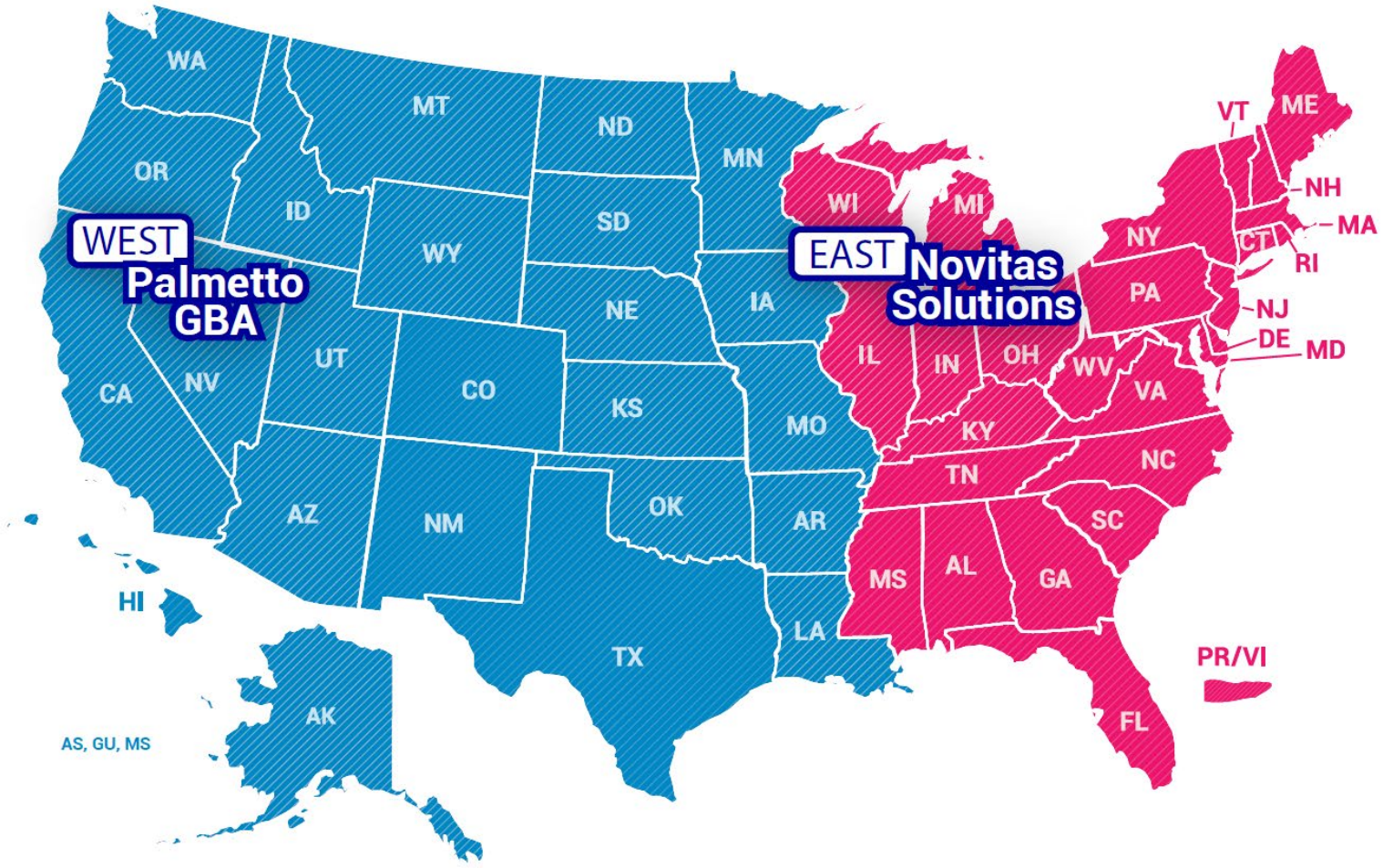


# MAC Jurisdictions



# 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)

# 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 and 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

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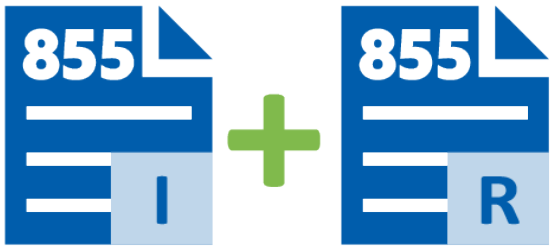
  - Requires nursing homes to disclose certain information about their owners, operators and related parties (management, administrative, consulting, financial services)
  - Defines private equity company and real estate investment trusts

- 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

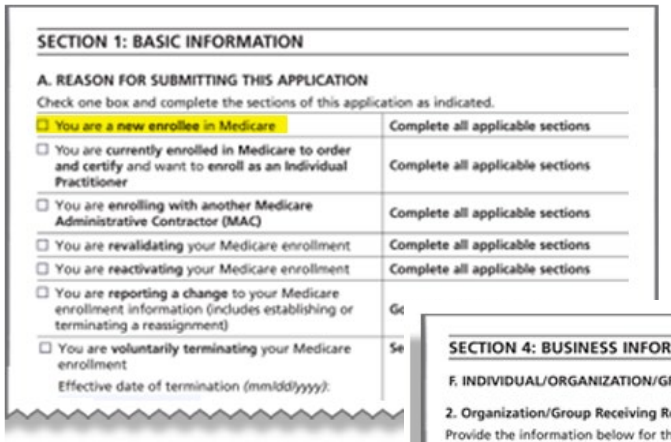



- Released on September 1, 2023
- Practitioners and groups can establish, terminate or change reassignments using only the 855I
- 855R data elements moved to the 855I
  - Reassignment connections
  - Primary/secondary practice location
  - Signatures
- Instructional guide at Consolidated CMS-855I/CMS-855R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



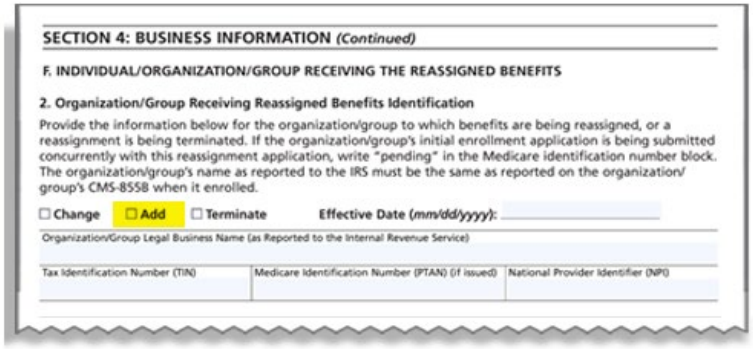
**SECTION 1: BASIC INFORMATION**

**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) | Go |
| ☐ You are **voluntarily terminating** your Medicare enrollment<br>Effective date of termination (*mm/dd/yyyy*): | Se |

- 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**

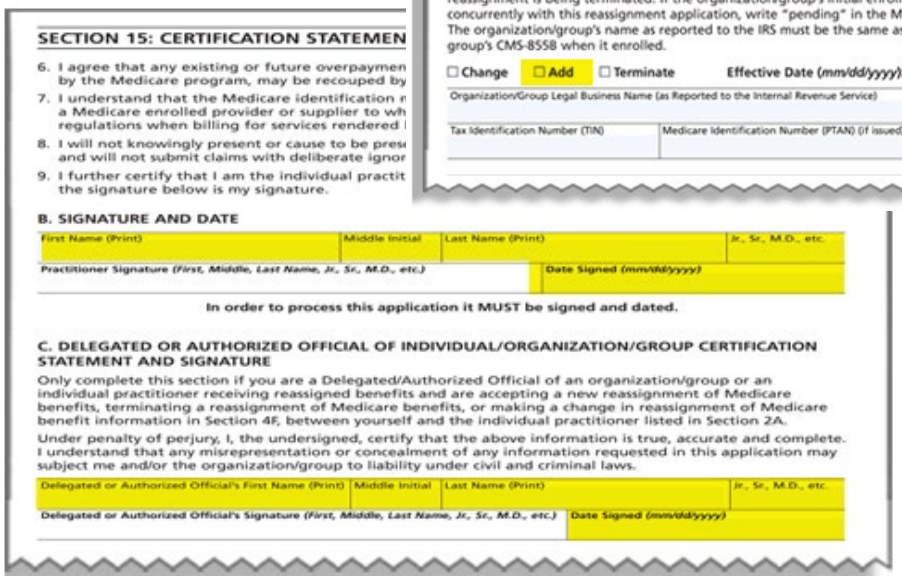
Provide the information below for the organization/group to which benefits are being reassigned, or a reassignment is being terminated. If the organization/group's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification 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 n 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.

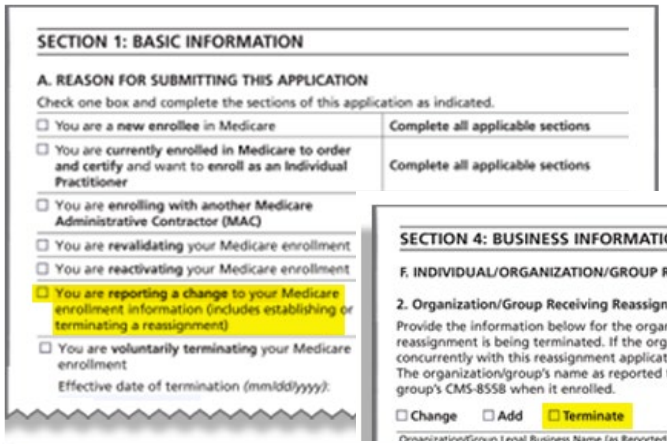
| Delegated or Authorized Official's First Name (Print) | Middle Initial | Last Name (Print) | Jr., Sr., M.D., etc. |
|---|---|---|---|
| | | | |

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.



**SECTION 1: BASIC INFORMATION**

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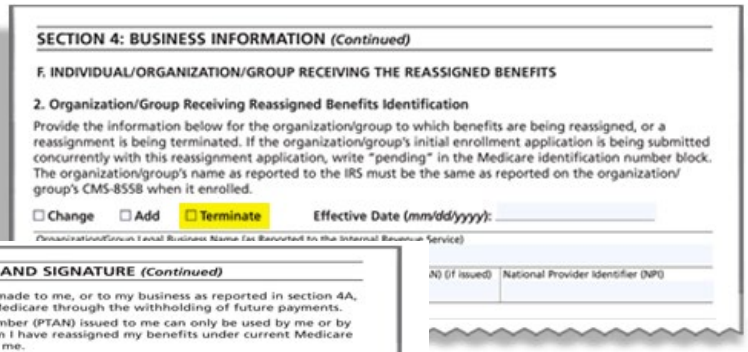
Check one box and complete the sections of this application as indicated.

| | |
|---|---|
| ☐ 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)** | |
| ☐ You are **revalidating** your Medicare enrollment | |
| ☐ You are **reactivating** your Medicare enrollment | |
| ☐ You are **reporting a change** to your Medicare enrollment information (includes establishing or terminating a reassignment) | |
| ☐ You are **voluntarily terminating** your Medicare enrollment | |

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



**SECTION 4: BUSINESS INFORMATION** *(Continued)*

**F. INDIVIDUAL/ORGANIZATION/GROUP RECEIVING THE REASSIGNED BENEFITS**

**2. Organization/Group Receiving Reassigned Benefits Identification**

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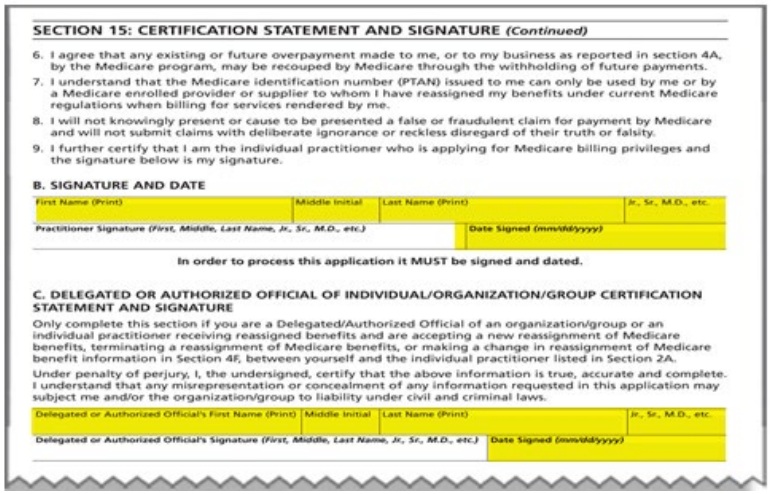
☐ Change ☐ Add ☐ Terminate **Effective Date** *(mm/dd/yyyy)*:

Service)

(N) (if issued) | National Provider Identifier (NPI)



**SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE** *(Continued)*

6. I agree that any existing or future overpayment made to me, or to my business as reported in section 4A, by the Medicare program, may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number (PTAN) issued to me can only be used by me or by a Medicare enrolled provider or supplier to whom I have reassigned my benefits under current Medicare regulations when billing for services rendered by me.
8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges and 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)* | |

- 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

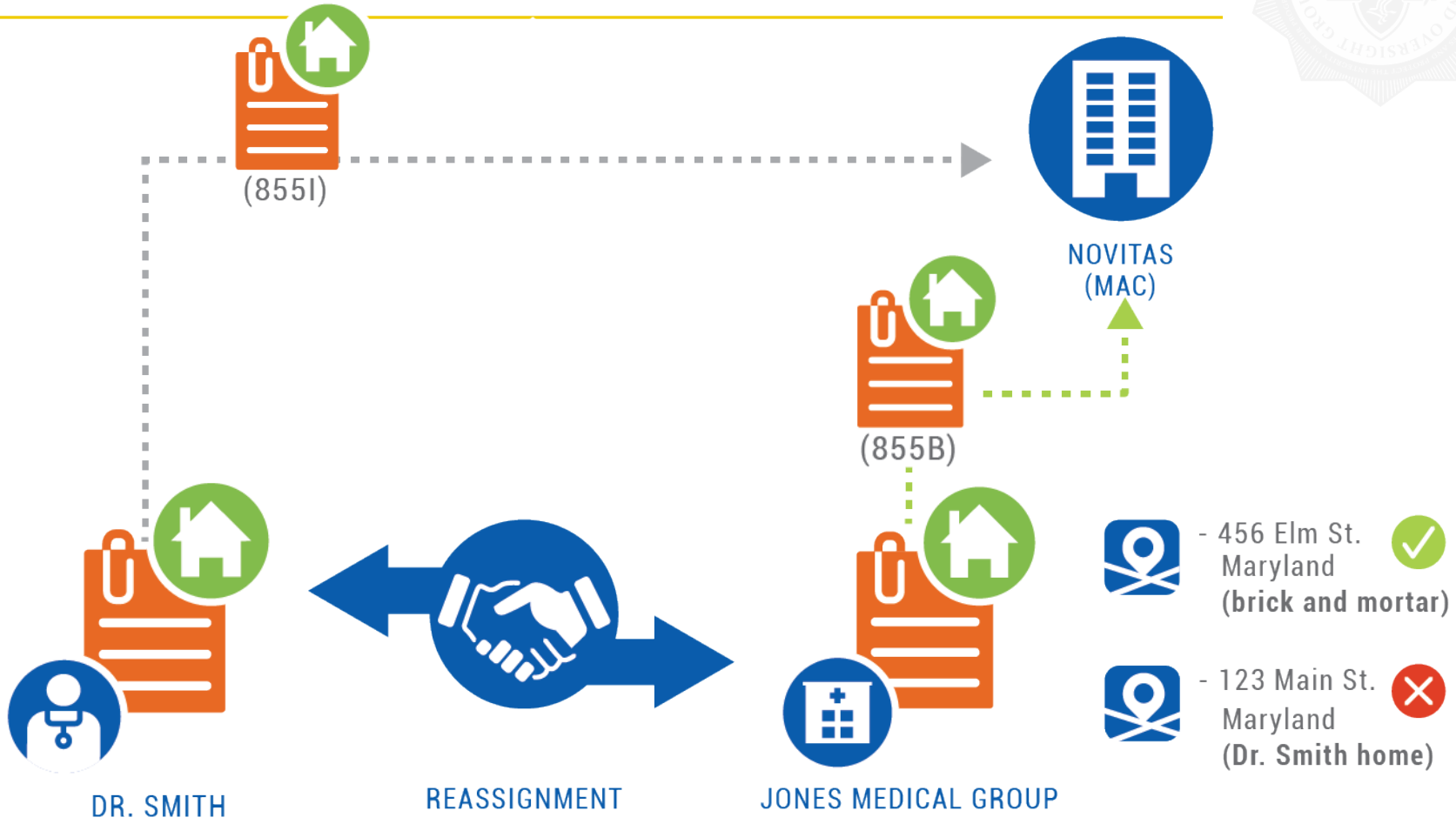
- Effective January 1, 2024, Medicare covers services for Marriage and Family Therapists and Mental Health Counselors
- Requirements: (1) master's or doctor's degree; (2) licensed/certified by State; (3) 2 years or 3,000 hours of clinical supervision post degree; and (4) other requirements determined 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



# Telehealth Policy – Private Practice

# 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*

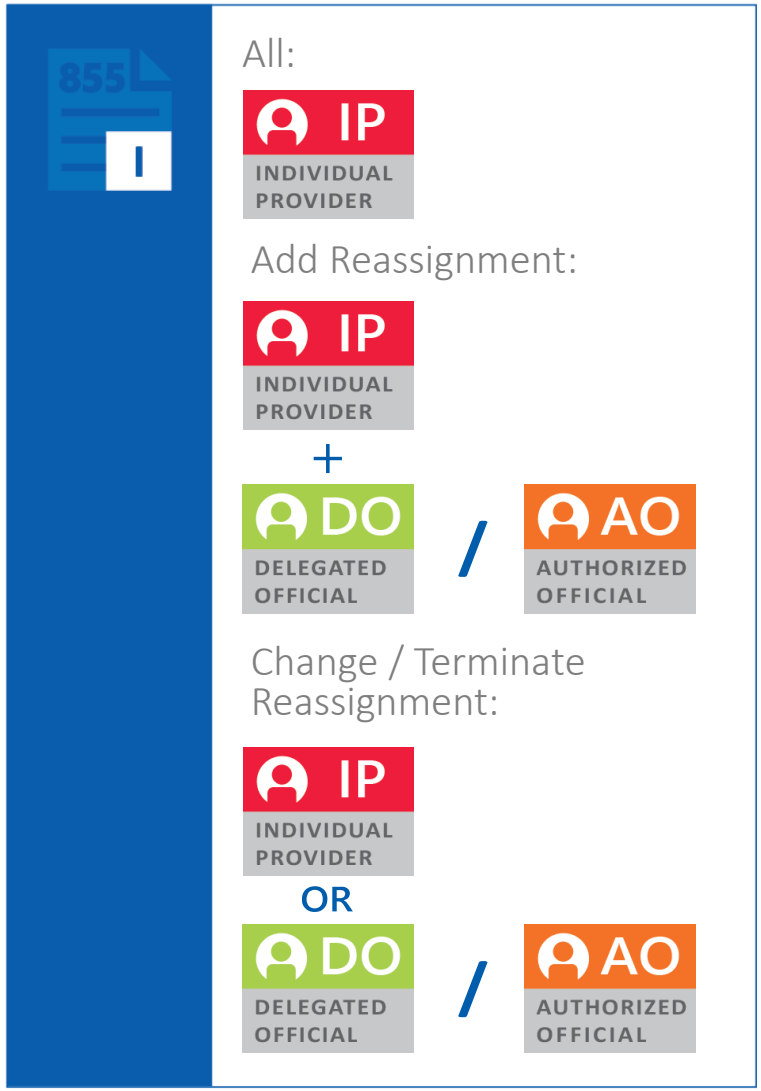
# Authorized Official

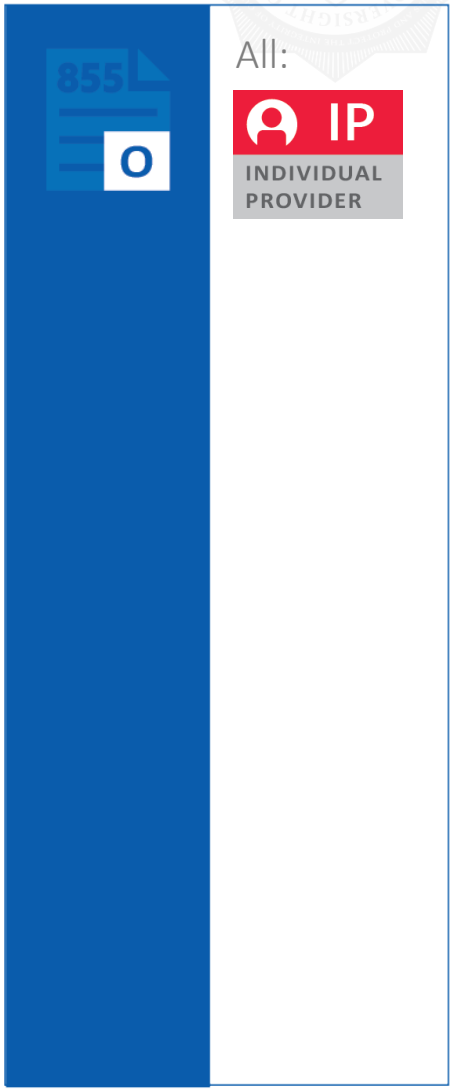
- An appointed official with the legal authority to enroll, make changes and ensure compliance with enrollment requirements (CEO, CFO, partner, chairman, owner, Administrator, President)
  - Individuals with approved titles will be accepted as AOs
  - Individuals without approved titles and lack signature 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?

# Opt-Out of Medicare

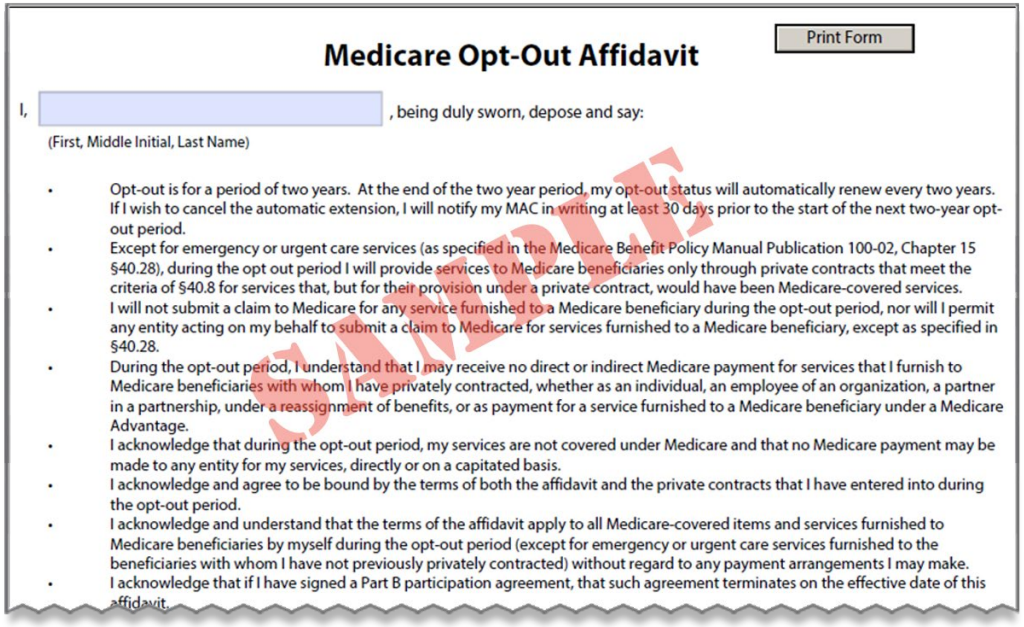
**Physicians/practitioners who do not wish to enroll in the Medicare program may "opt-out"**

**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



Print Form

**Medicare Opt-Out Affidavit**

I, _____, being duly sworn, depose and say:

(First, Middle Initial, Last Name)

- Opt-out is for a period of two years. At the end of the two year period, my opt-out status will automatically renew every two years. If I wish to cancel the automatic extension, I will notify my MAC in writing at least 30 days prior to the start of the next two-year opt-out period.
- Except for emergency or urgent care services (as specified in the Medicare Benefit Policy Manual Publication 100-02, Chapter 15 §40.28), during the opt out period I will provide services to Medicare beneficiaries only through private contracts that meet the criteria of §40.8 for services that, but for their provision under a private contract, would have been Medicare-covered services.
- I will not submit a claim to Medicare for any service furnished to a Medicare beneficiary during the opt-out period, nor will I permit any entity acting on my behalf to submit a claim to Medicare for services furnished to a Medicare beneficiary, except as specified in §40.28.
- During the opt-out period, I understand that I may receive no direct or indirect Medicare payment for services that I furnish to Medicare beneficiaries with whom I have privately contracted, whether as an individual, an employee of an organization, a partner in a partnership, under a reassignment of benefits, or as payment for a service furnished to a Medicare beneficiary under a Medicare Advantage.
- I acknowledge that during the opt-out period, my services are not covered under Medicare and that no Medicare payment may be made to any entity for my services, directly or on a capitated basis.
- I acknowledge and agree to be bound by the terms of both the affidavit and the private contracts that I have entered into during the opt-out period.
- I acknowledge and understand that the terms of the affidavit apply to all Medicare-covered items and services furnished to Medicare beneficiaries by myself during the opt-out period (except for emergency or urgent care services furnished to the beneficiaries with whom I have not previously privately contracted) without regard to any payment arrangements I may make.
- I acknowledge that if I have signed a Part B participation agreement, that such agreement terminates on the effective date of this affidavit.

SAMPLE

# 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)

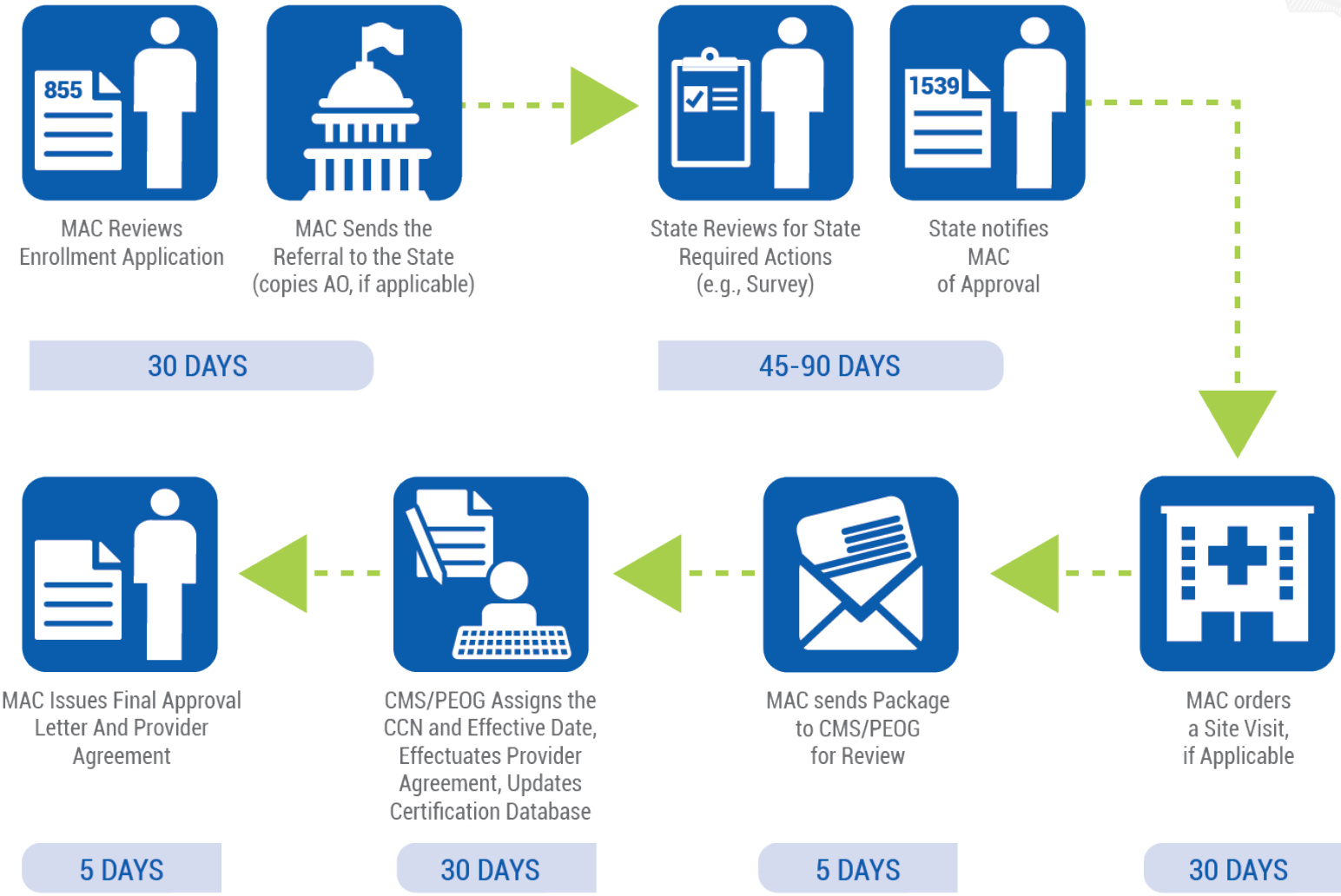
# Survey and Certification

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


**Process improvements and efficiencies**

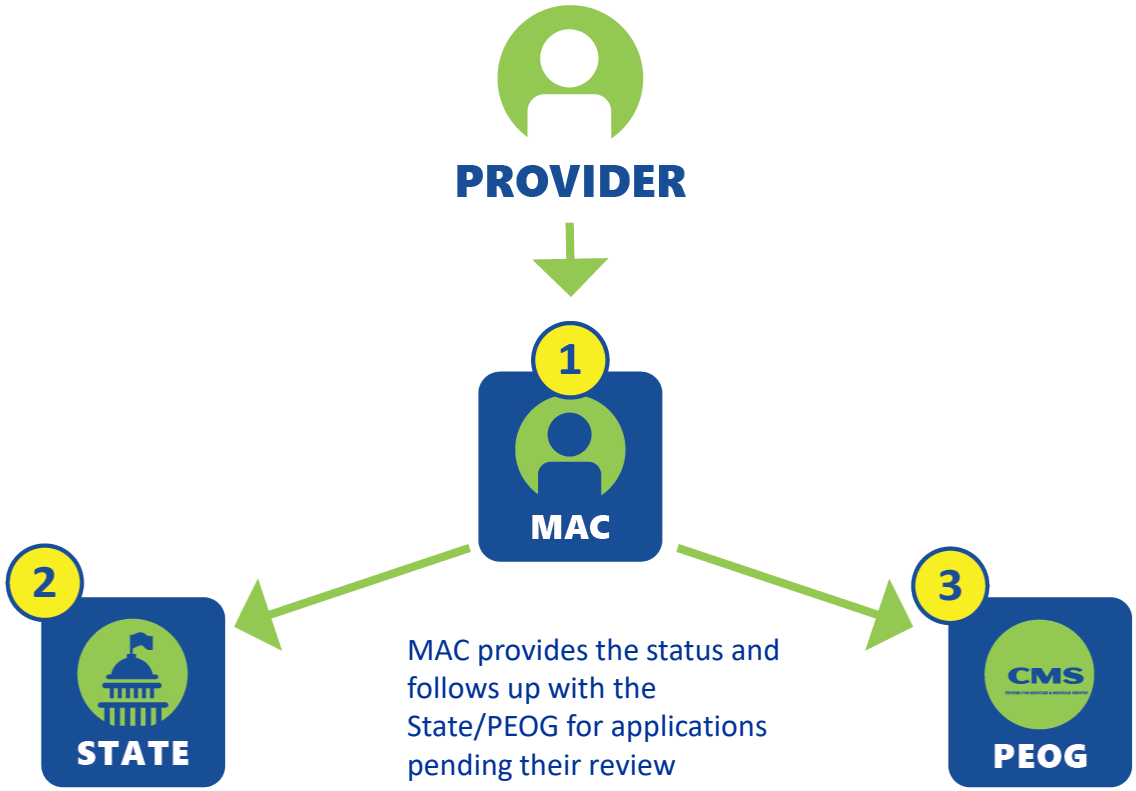
- Designate MACs as the first POC for application statuses
- Coordinate with MAC customer service staff to improve responses to provider inquiries
- Secure platform for sending MAC recommendation packages electronically to states to avoid lost packages
- Implement approval letter updates (December 2023)
- 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



# Who Should I Call?

## First Point of Contact is Always your MAC




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


**My due date is between November 2019 – February 2020**


**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 | MAC/PROVIDER ACTION | TIMEFRAME | SAMPLE TIMELINE |
|---|---|---|---|
| REVALIDATION DUE DATE: AUGUST 31, 2024 | MAC APPLIES THE STAY AND SENDS NOTICE | 10 DAYS AFTER | SEPTEMBER 10 2024 |
| **SCENARIO (1) STAY APPLIED & PROVIDER RESPONDS** | PROVIDER SENDS REVALIDATION | WITHIN 30 DAYS | SEPTEMBER 25 2024 |
| | MAC REMOVES THE STAY<br>CLAIMS WITH DOS DURING THE STAY ARE ELIGIBLE FOR PAYMENT | WITHIN 10 DAYS | OCTOBER 5 2024 |

# Stay of Enrollment – Non-Response to Revalidation

| | MAC/PROVIDER ACTION | TIMEFRAME | SAMPLE TIMELINE |
|---|---|---|---|
| REVALIDATION DUE DATE: AUGUST 31, 2024 | MAC APPLIES THE STAY AND SENDS NOTICE | 10 DAYS AFTER | SEPTEMBER 10 2024 |
| **SCENARIO (2)** STAY APPLIED & PROVIDER DOESN'T RESPOND | PROVIDER DOES NOT RESPOND | WITHIN 30 DAYS | OCTOBER 10 2024 |
| | MAC DEACTIVATES BACK TO THE REVALIDATION DUE DATE<br>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.

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:

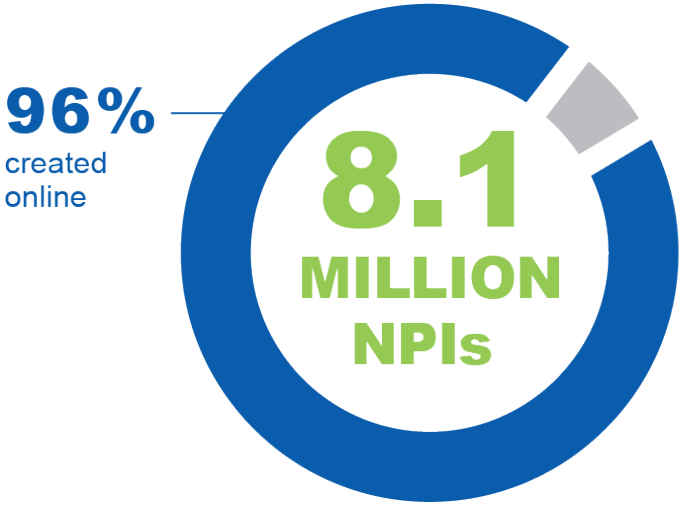
- ✓ Search for NPI records of Health Care providers in the NPPES system

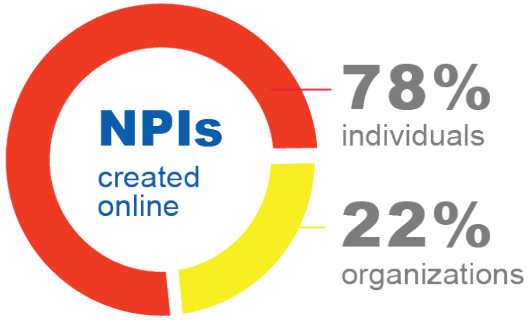
# NPPES (NPI) Today

## Every Month…

**39,000**
New NPIs

**57,000**
Updates




## 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

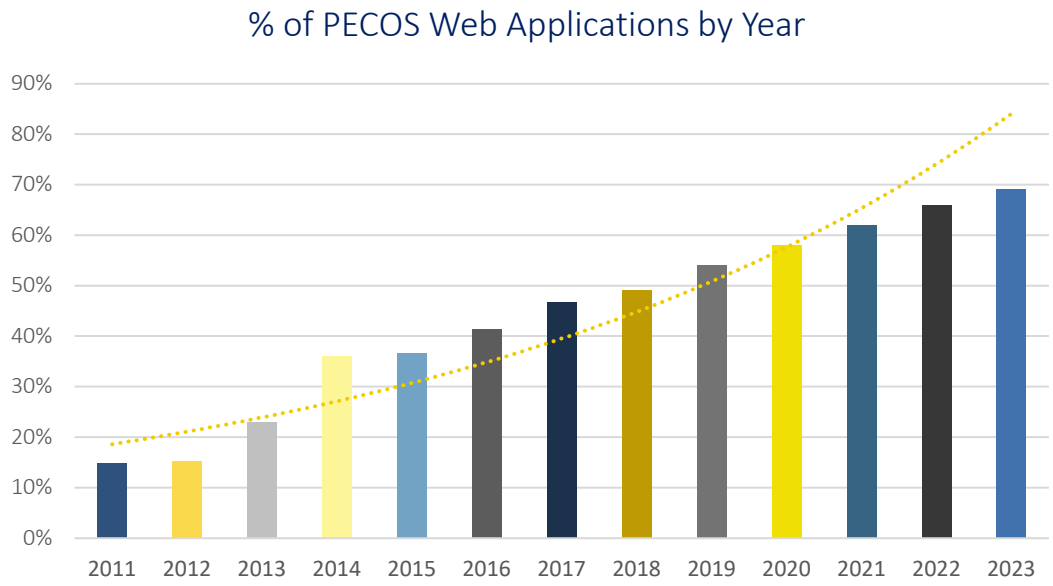
# PECOS Today

**Over 2.8 Million Enrollments**

**Every month…**

**19,000** new enrollments

## Encouraging Online Applications




- ✓ 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.

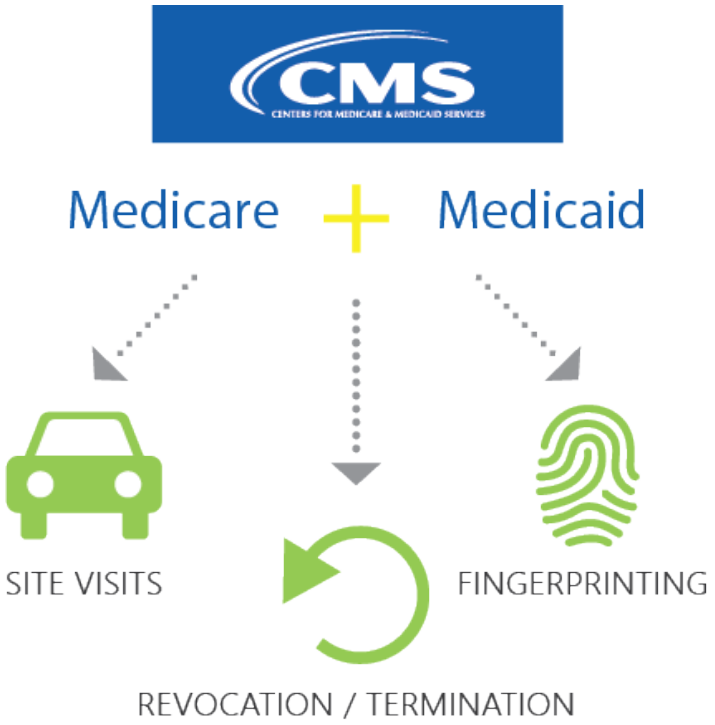
**Does this delay impact current PECOS?** No. We will continue to improve the current system, and the changes to PECOS 2.0 timelines and launch strategy will not impact any current enrollment information or impact billing/claims information.

# 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

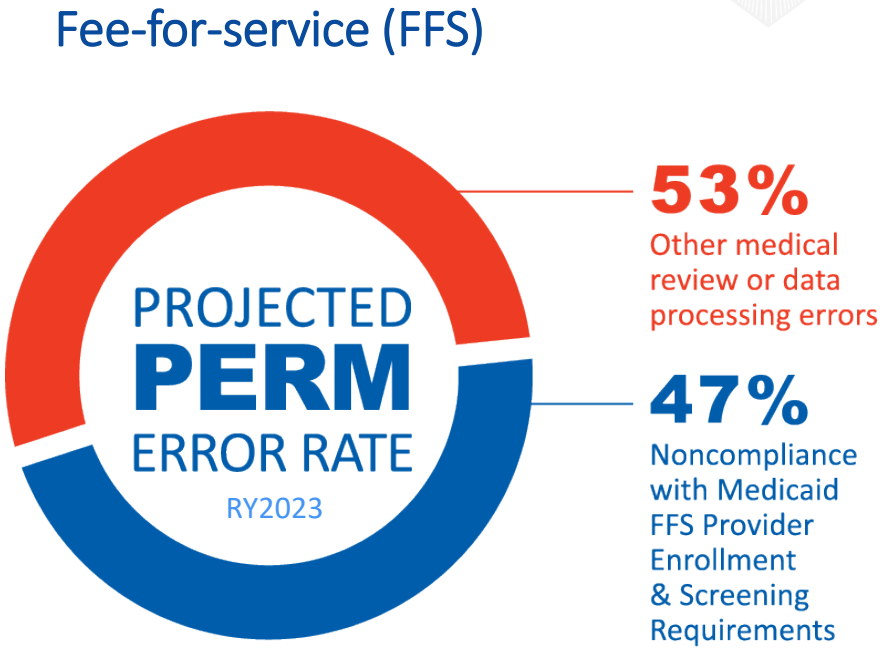
- Provide sub-regulatory guidance
- Support states in their statutory compliance efforts
- Provide Medicare data and screening activities to leverage for Medicaid enrollment
- Share best practices and make recommendations

## 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



# 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

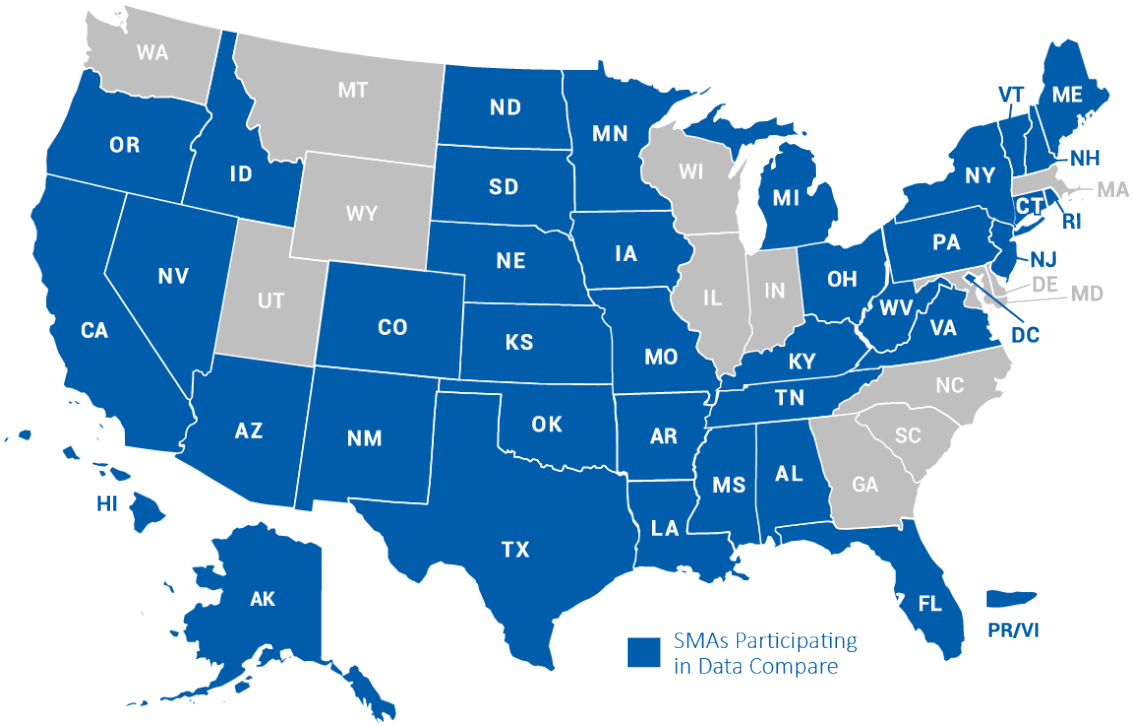
### Screening Risk Levels (Section 1.3(D))

- 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



# 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


## 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.


## 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.


## 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.

# Question & Answer Session

# Protecting the Program

# Stronger Screening


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

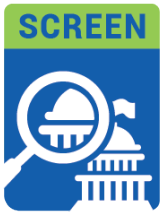
- For high Medicare reimbursements
- In high-risk geographic areas


## 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

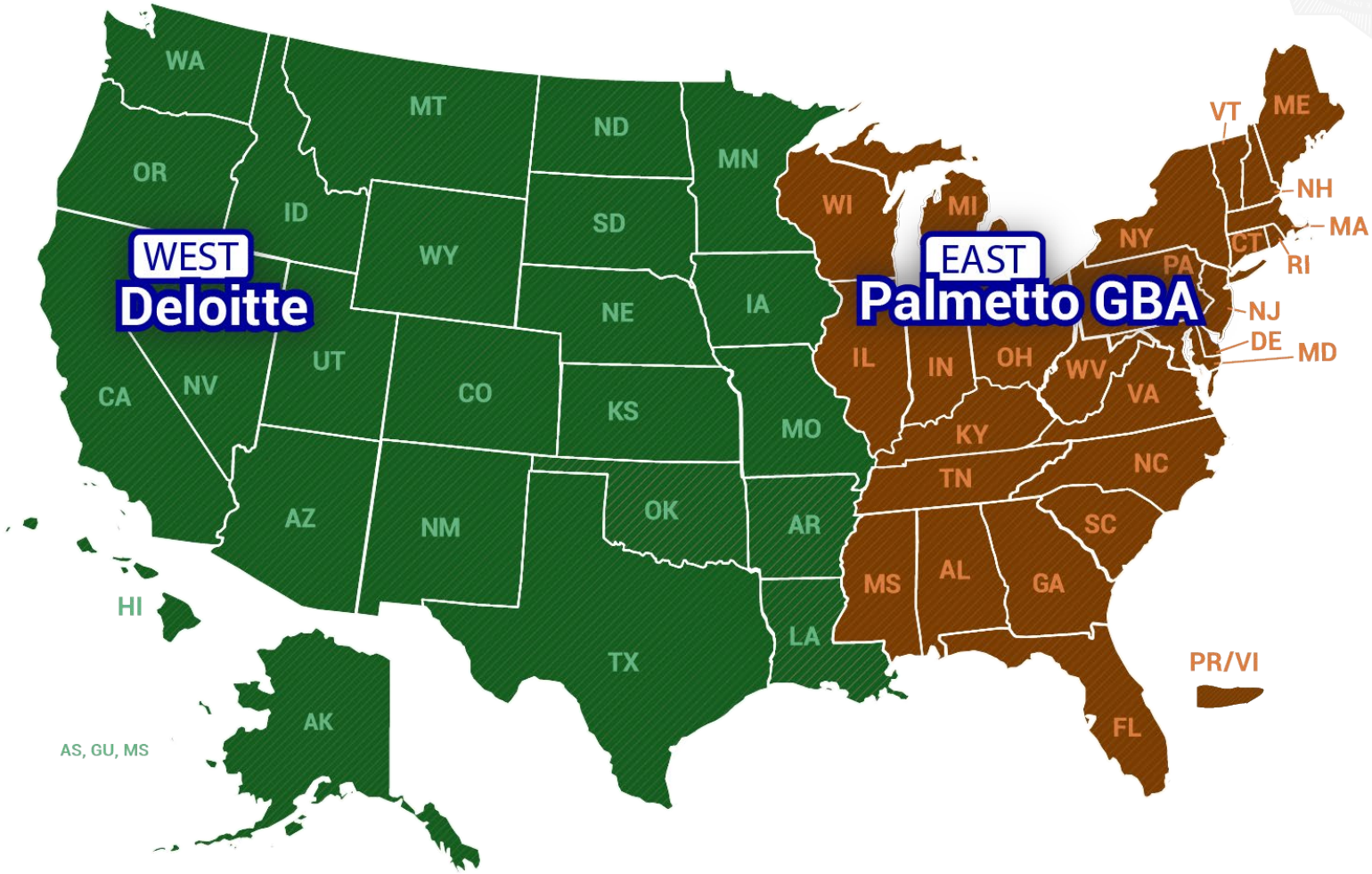
- Non-billing
- Inactive NPIs
- Deceased associates
- No active practice locations or reassignments for more than 90 days




## 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

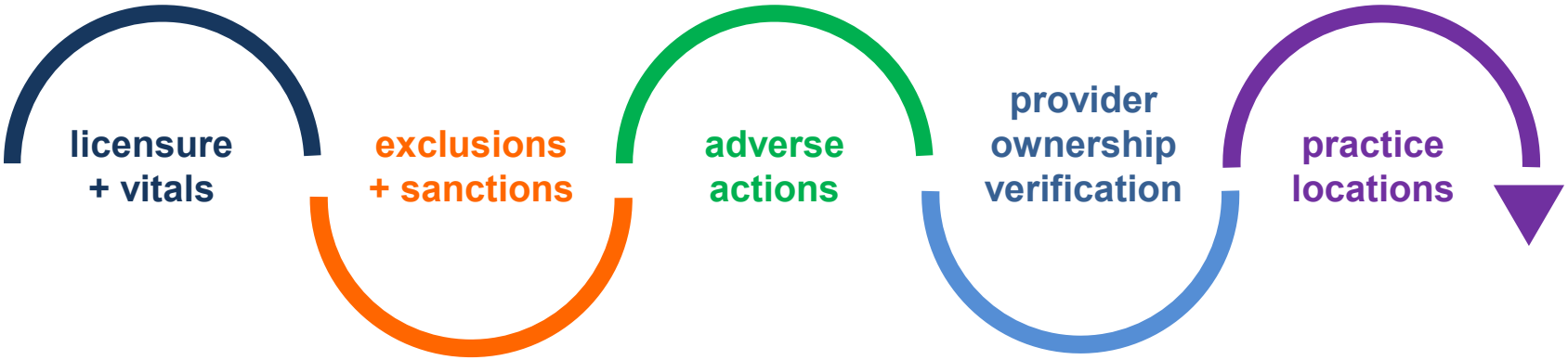
**If the provider/supplier:**

- 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<br><br>SSA Death Master File<br><br>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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If you need more accessibility options for the material, contact providerenrollment@cms.hhs.gov

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