Medicare Provider Enrollment Compliance Conference

February 27-29, 2024

Presented by

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Centers for Medicare & Medicaid Services

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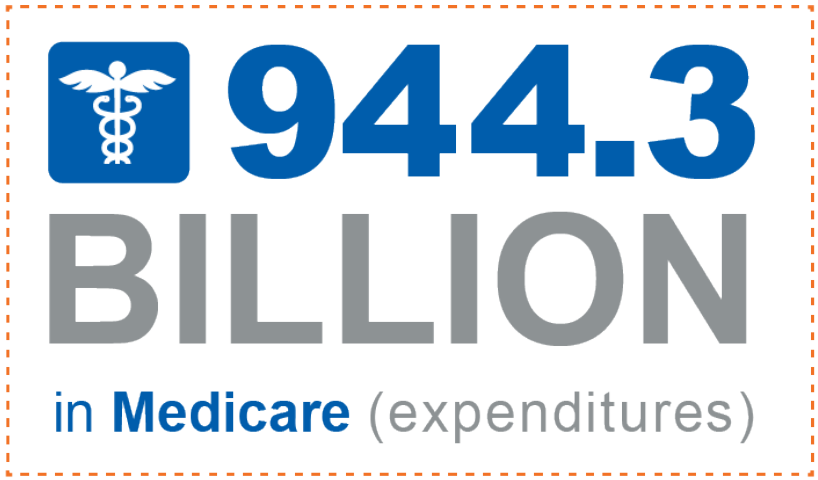
Deputy Director
Provider Enrollment & Oversight Group
Centers for Medicare & Medicaid Services

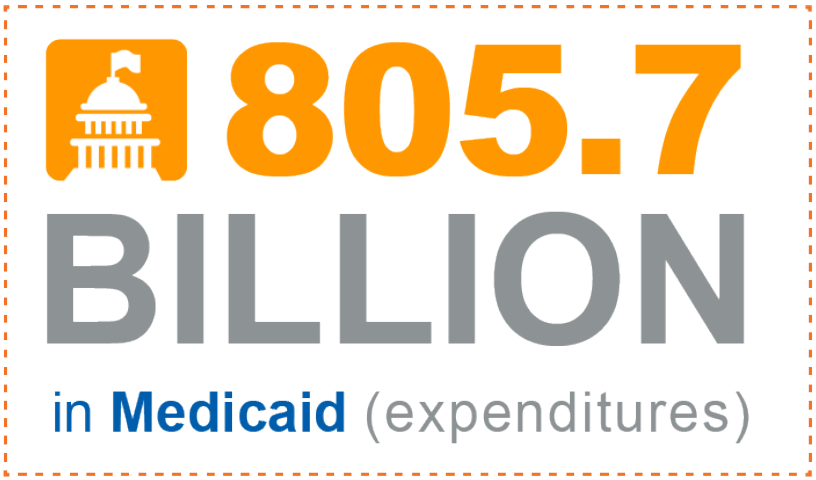
Session Overview

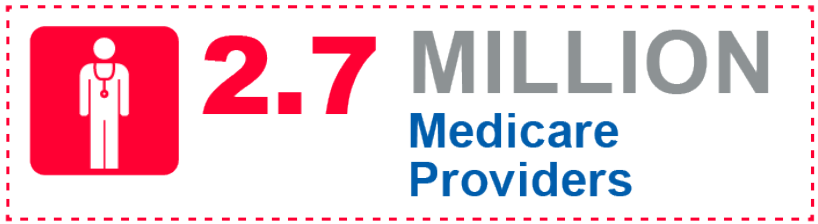
- Putting Patients First
- How Enrollment Works
- Medicare Policy Updates
- Survey and Certification
- Revalidation
- Our Enrollment Systems
- Medicaid Enrollment
- Protecting the Program
- Enforcement Actions

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

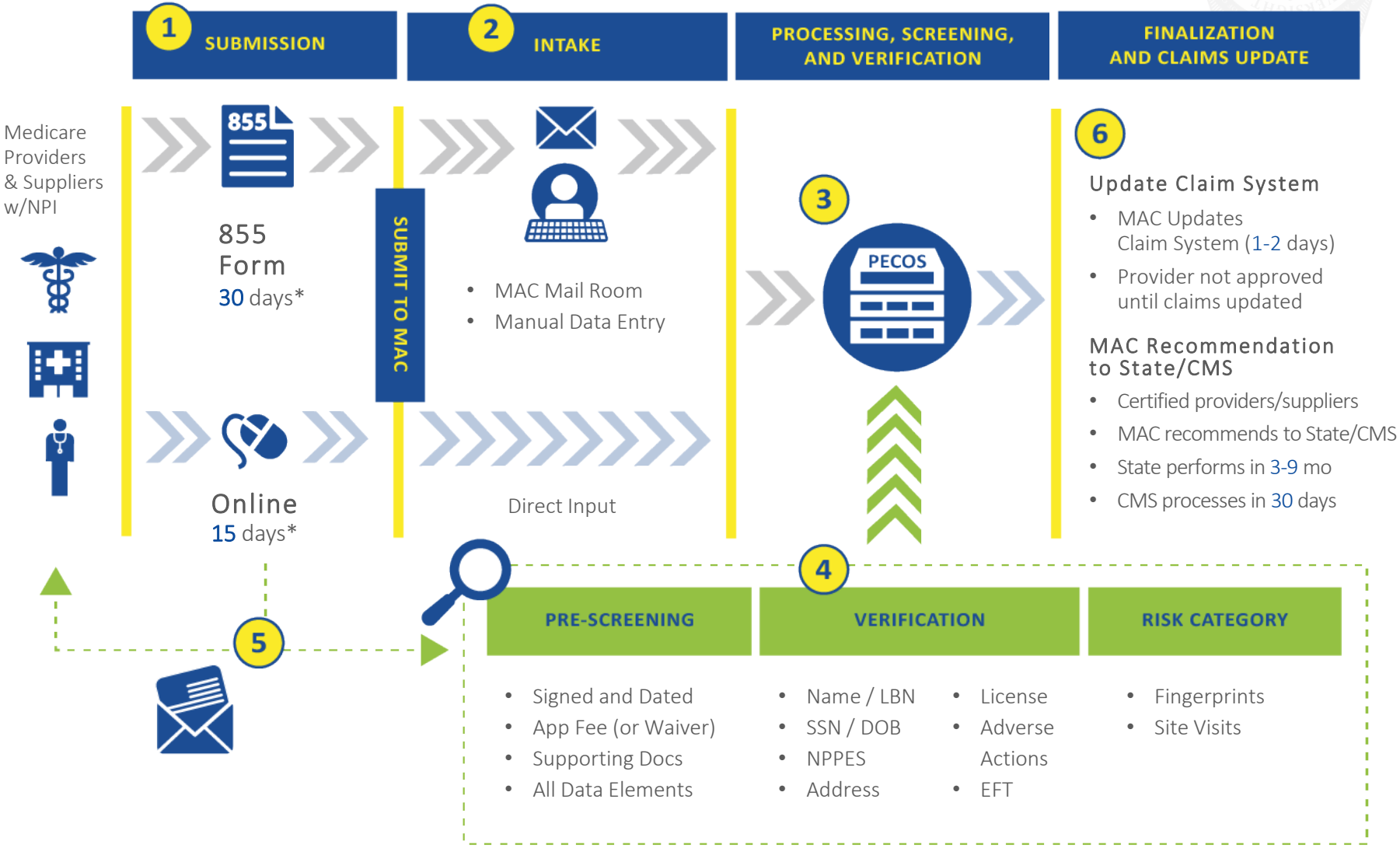
We believe enrollment should be **easy** for most providers, and **hard** for bad actors

ALWAYS IMPROVING

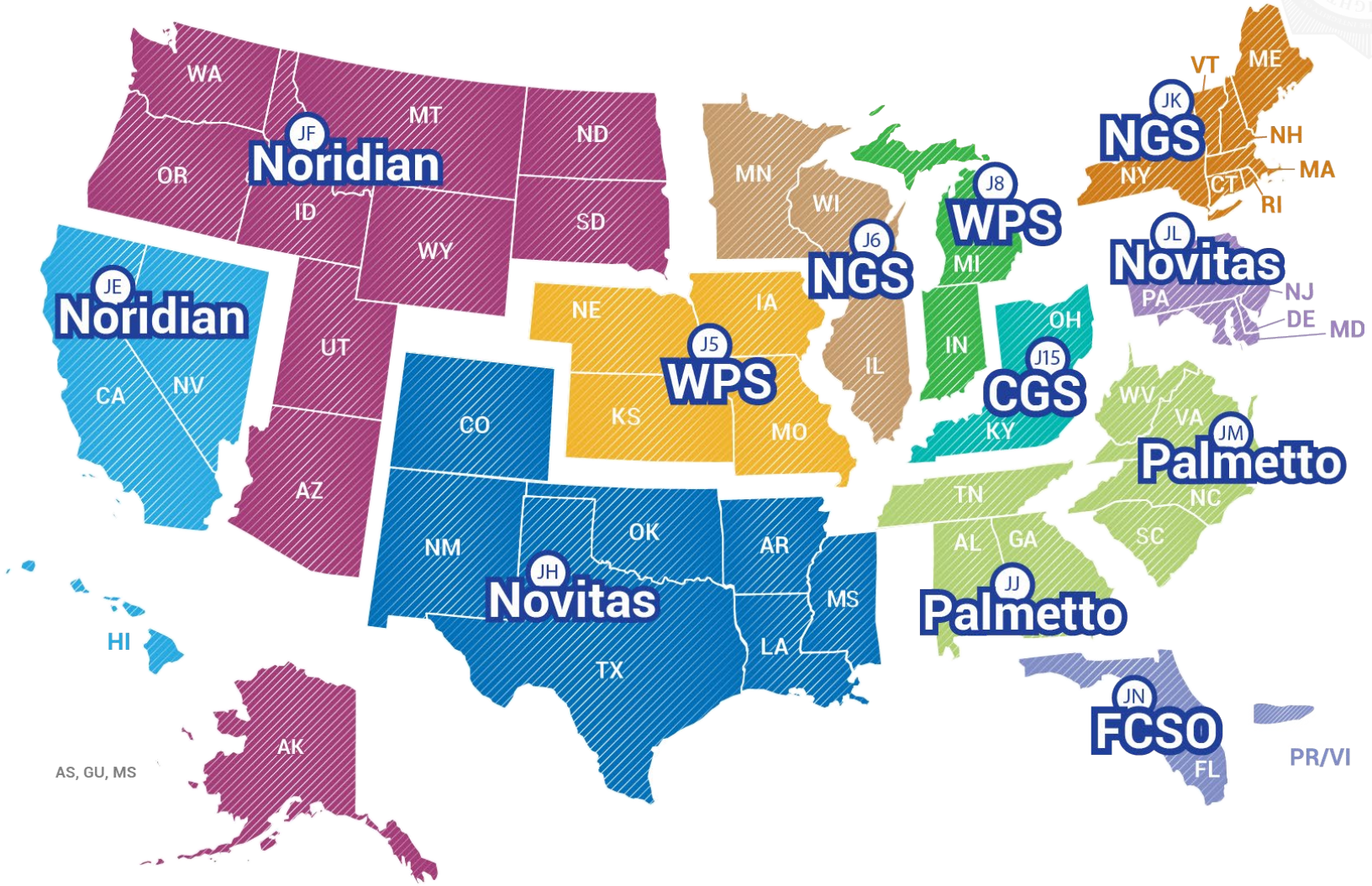
We will keep refining our systems, policies, transparency, and our vision

How Enrollment Works

How Enrolling Works

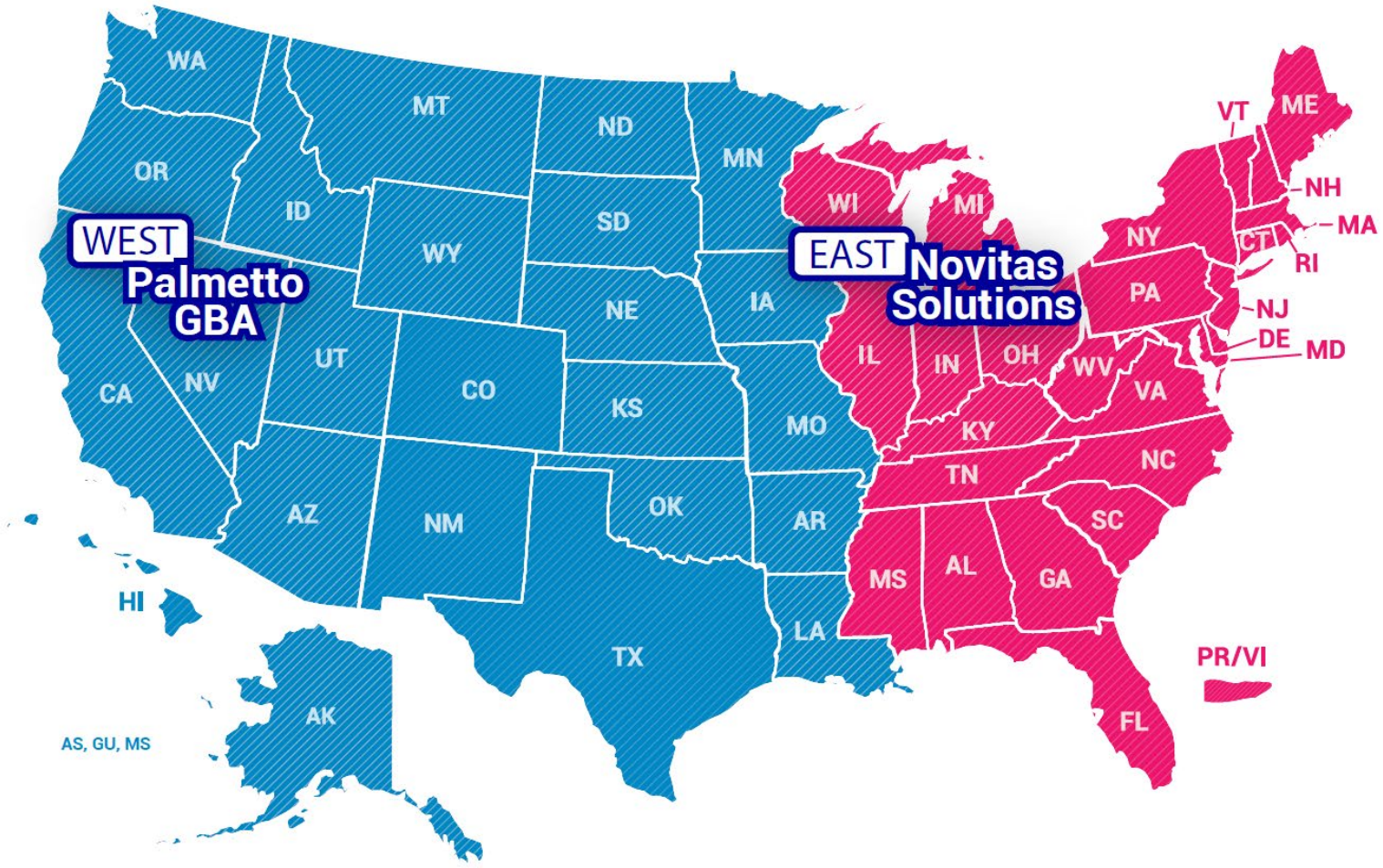


MAC Jurisdictions



National Provider Enrollment (NPE) East/West

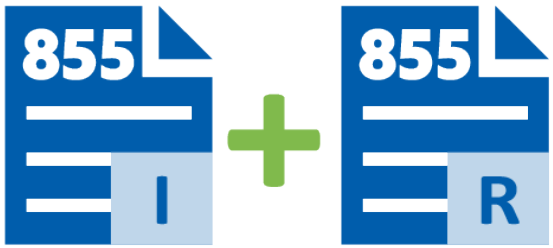
National Provider Enrollment Contractor for DMEPOS suppliers in Medicare



Map As of November 2022

Medicare Policy Updates

CMS-855I/855R Consolidation

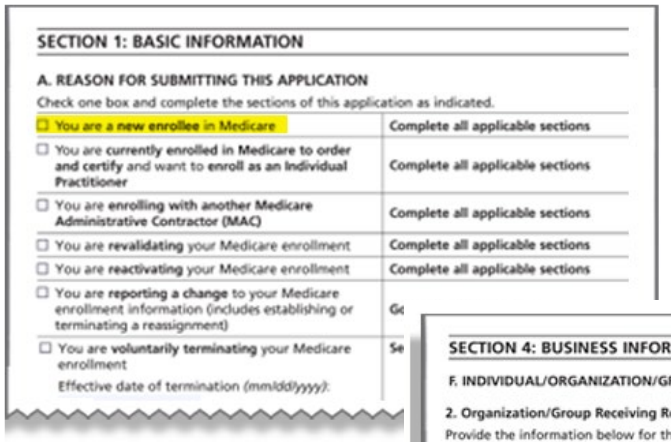


- Released on September 1, 2023
- Practitioners and groups can establish, terminate or change reassignments using only the 855I
- 855R data elements moved to the 855I
  - Reassignment connections
  - Primary/secondary practice location
  - Signatures
- Instructional guide at Consolidated CMS-855I/CMS-855R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



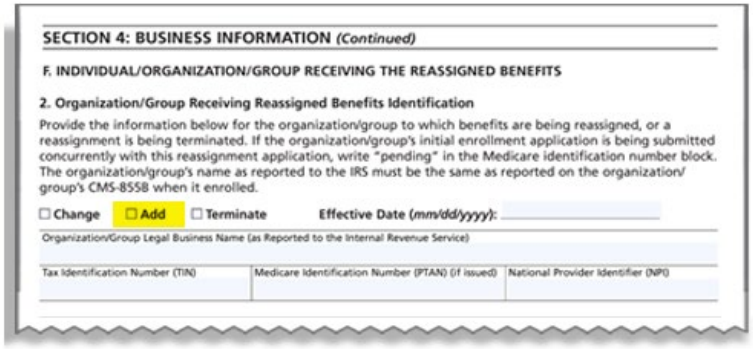
SECTION 1: BASIC INFORMATION

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 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

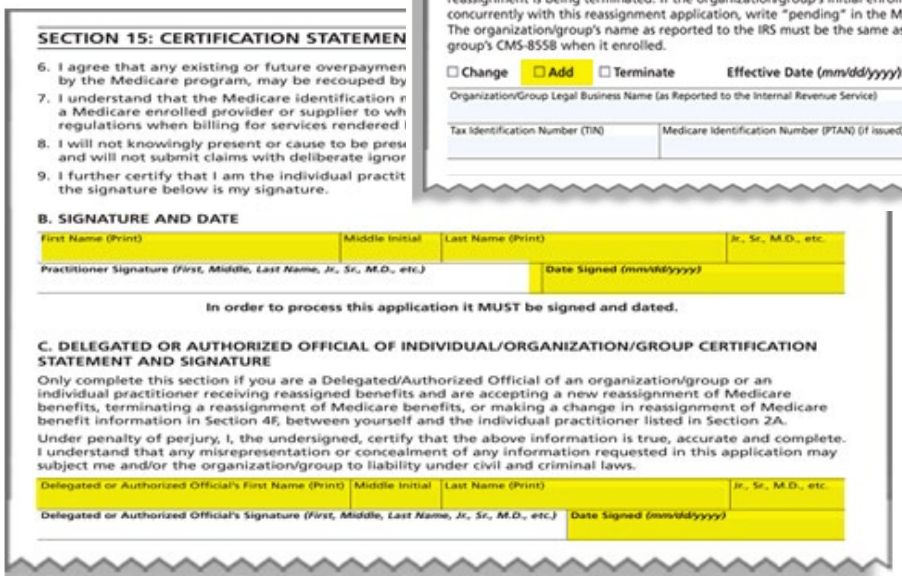
Provide the information below for the organization/group to which benefits are being reassigned, or a reassignment is being terminated. If the organization/group's initial enrollment application is being submitted concurrently with this reassignment application, write "pending" in the Medicare identification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

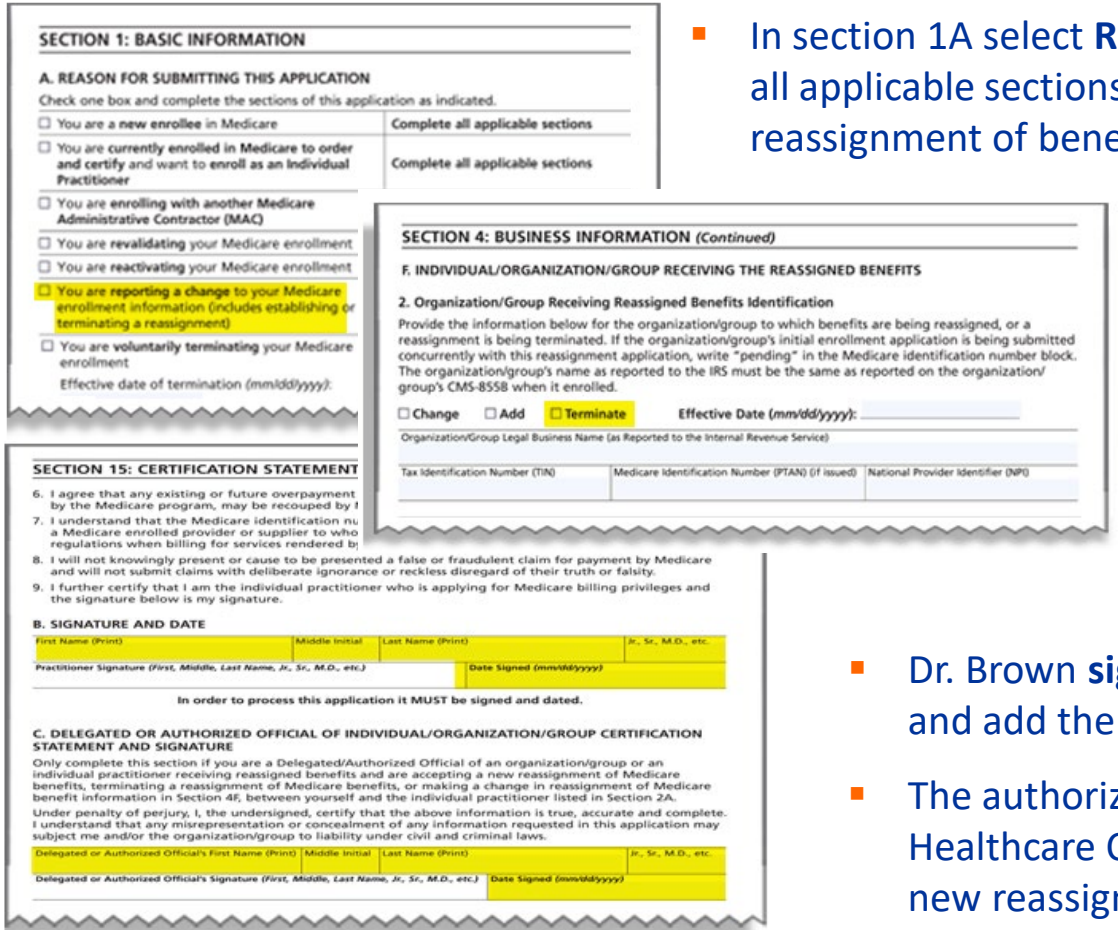
Delegated or Authorized Official's First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.

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 (continued)

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

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)**	
☐ 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

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)

SECTION 15: CERTIFICATION STATEMENT

6. I agree that any existing or future overpayment by the Medicare program, may be recouped by
7. I understand that the Medicare identification nu a Medicare enrolled provider or supplier to who regulations when billing for services rendered b
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-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?*
- Requires hospice and SNF medical directors and administrators to be reported as managing employees
- 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
  - Tentative release of the revised CMS-855A in late summer/early fall 2024

Nursing Home Ownership & Additional Disclosable Party Reporting (continued)

- 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-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 who are still receiving paper checks will be sent a letter requesting an EFT agreement
  - Letters will be sent in spring 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

New Dental Specialties

- Dentists can currently enroll and bill for limited dental services (e.g., must be an integral part of a covered primary procedure)
- Dentists must:
  - Be a doctor of dental surgery or dental medicine
  - Be legally authorized to practice by the state and act within the scope of their license
  - Submit an enrollment application via PECOS or the paper CMS-855I

New Dental Specialties (continued)

Medicare recognizes the following dental specialties for enrollment

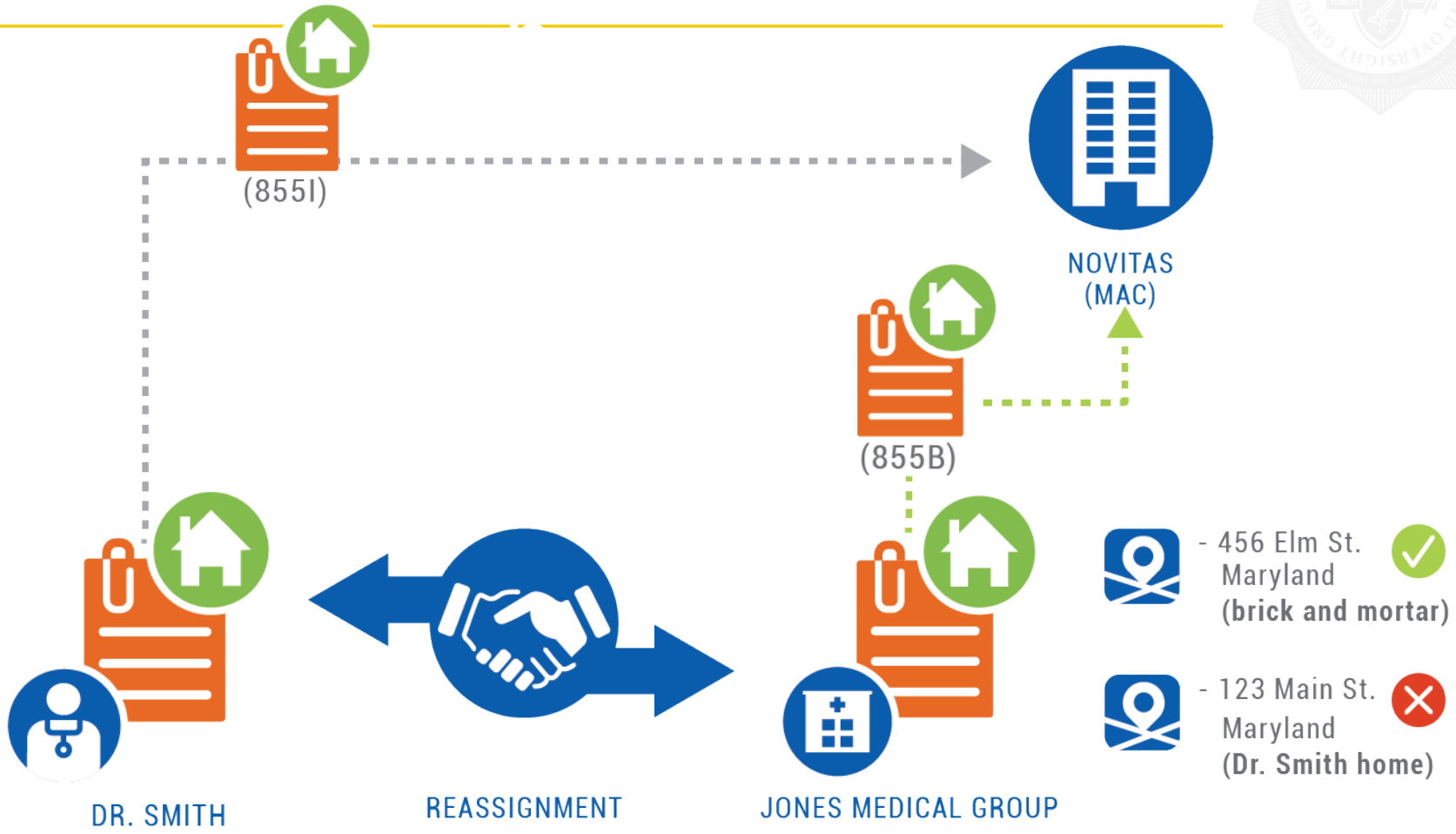
- Dental Anesthesiology
- Dental Public Health
- Endodontics
- Oral and Maxillofacial Surgery
- Oral and Maxillofacial Pathology
- Oral and Maxillofacial Radiology
- Oral Medicine
- Orofacial Pain
- Orthodontics and Dentofacial Orthopedics
- Pediatric Dentistry
- Periodontics
- Prosthodontics

See https://www.cms.gov/medicare/coverage/dental

Indian Health Services - Rural Emergency Hospitals (IHS-REH)

- New Medicare provider type established January 1, 2024
- Allows tribal or IHS operated hospitals to convert to an IHS-REH for hospital outpatient services provided to patients
- Submit a change of information via PECOS or a paper CMS-855A to convert to an REH, rather than an initial application
  - All IHS enrollment applications are handled by Novitas Solutions, Inc.
- See cms.gov/medicare/provider-enrollment-and-certification and https://www.cms.gov/files/document/mln2259384-rural-emergency-hospitals.pdf

Telehealth Policy



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 (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

Authorized and Delegated Officials - PECOS & I&A

AO Authorized Official

Enroll, make changes and ensure compliance with enrollment requirements

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

DO Delegated Official

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

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

AO Authorized Official

Assign surrogacy and controls access to PECOS and NPPES records

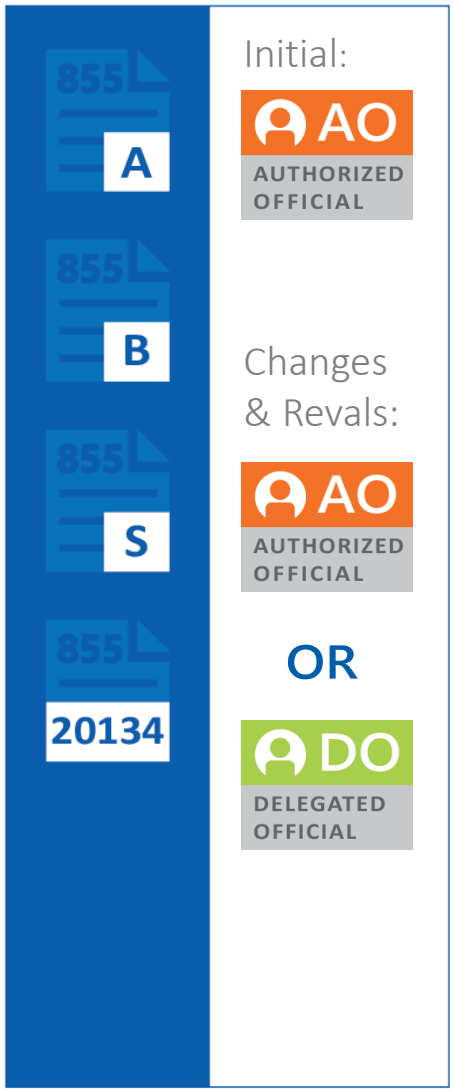
- CEO, CFO, partner, chairman, owner, or equivalent appointed by the org. AO requirements are same as PECOS
- Automatically approved if listed as AO in PECOS; if not, CP575 must be provided to approve access
- Manage staff and connections for the employer
- Approve Access Managers(AM) for the employer

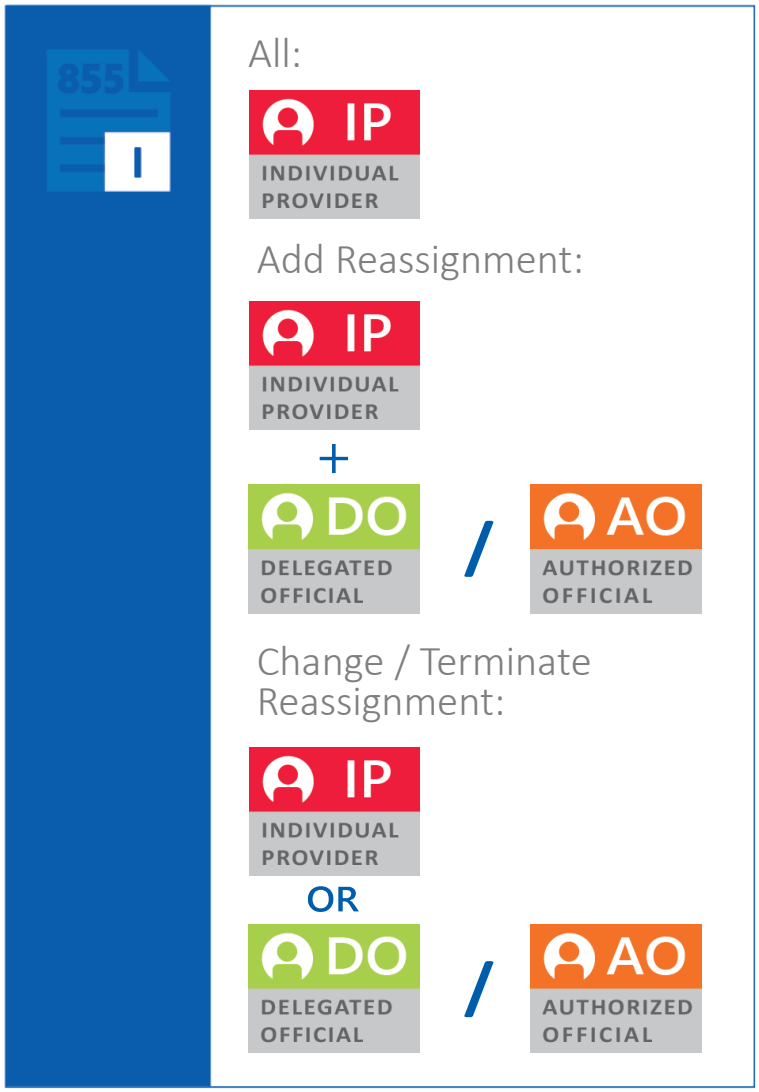
AM Access Manager

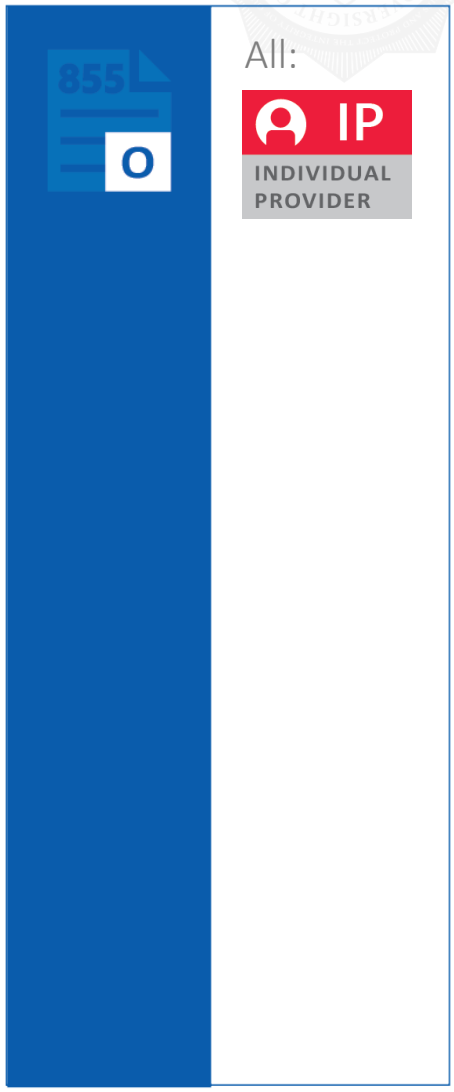
Authority to assign surrogacy and controls access to PECOS and NPPES records

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

Who Can Sign the Enrollment Application?







Opt-Out of Medicare

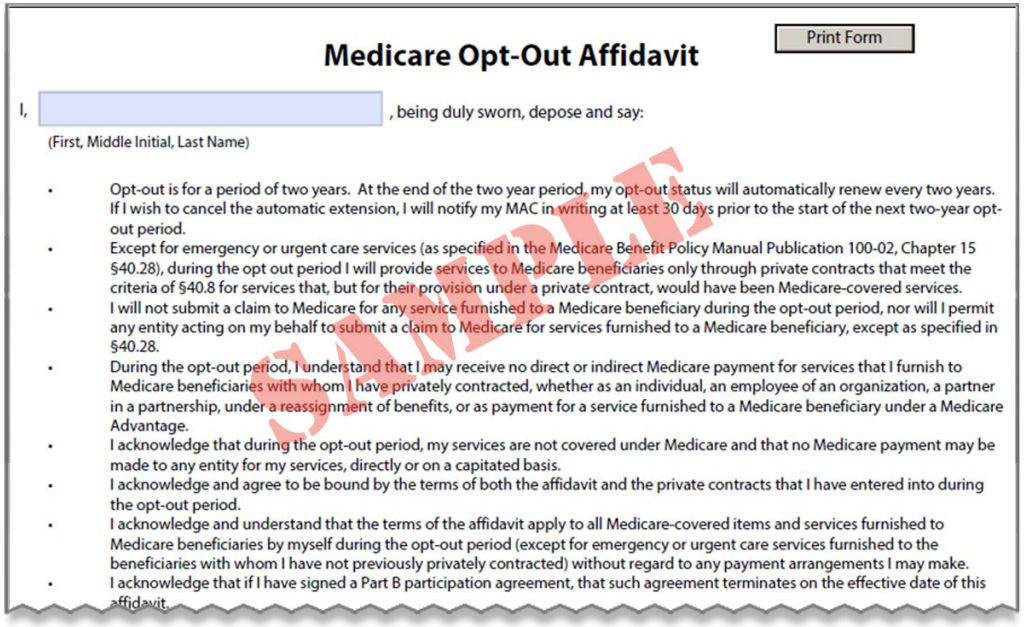
Physicians/practitioners who do not wish to enroll in the Medicare program may "opt-out"

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)

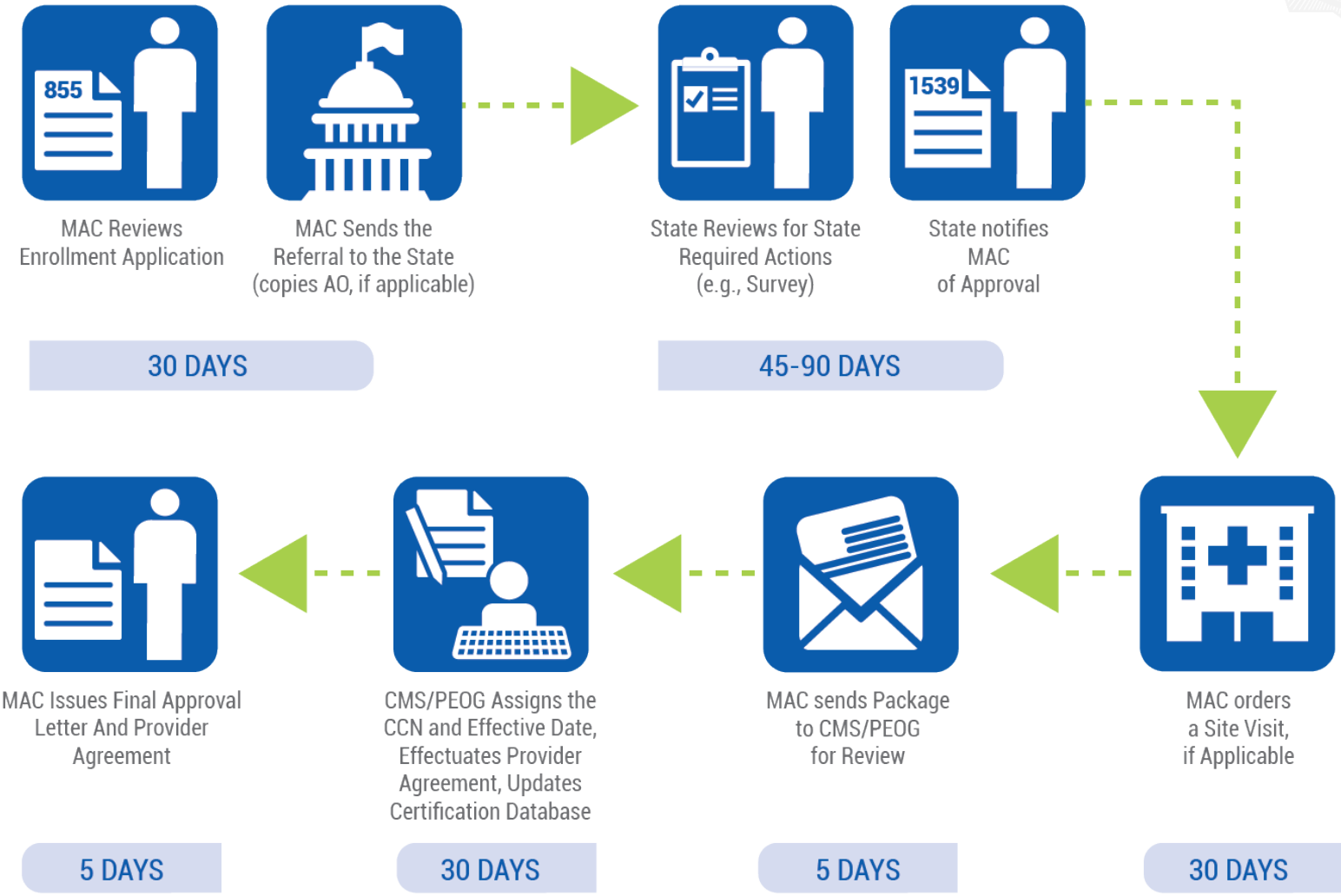
Survey and Certification

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

Process improvements and efficiencies

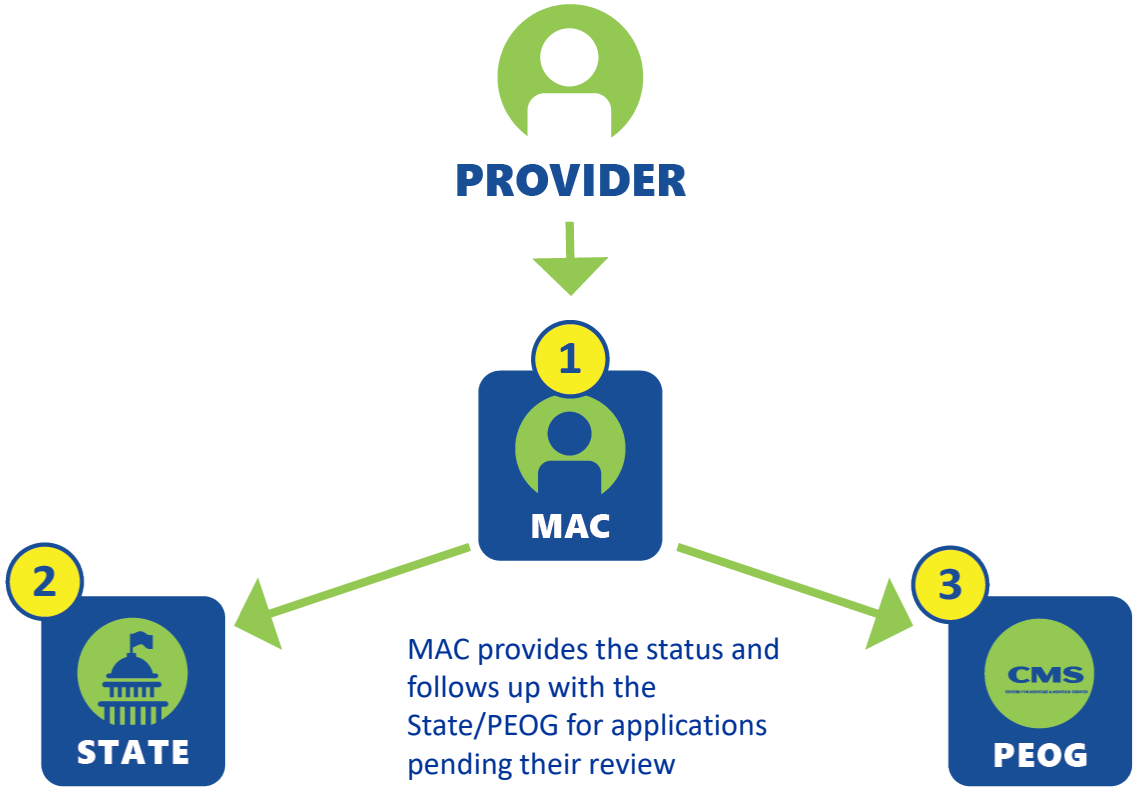
- Designate MACs as the first POC for application statuses
- Coordinate with MAC customer service staff to improve responses to provider inquiries
- Secure platform for sending MAC recommendation packages electronically to states to avoid lost packages
- Implement approval letter updates (December 2023)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



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

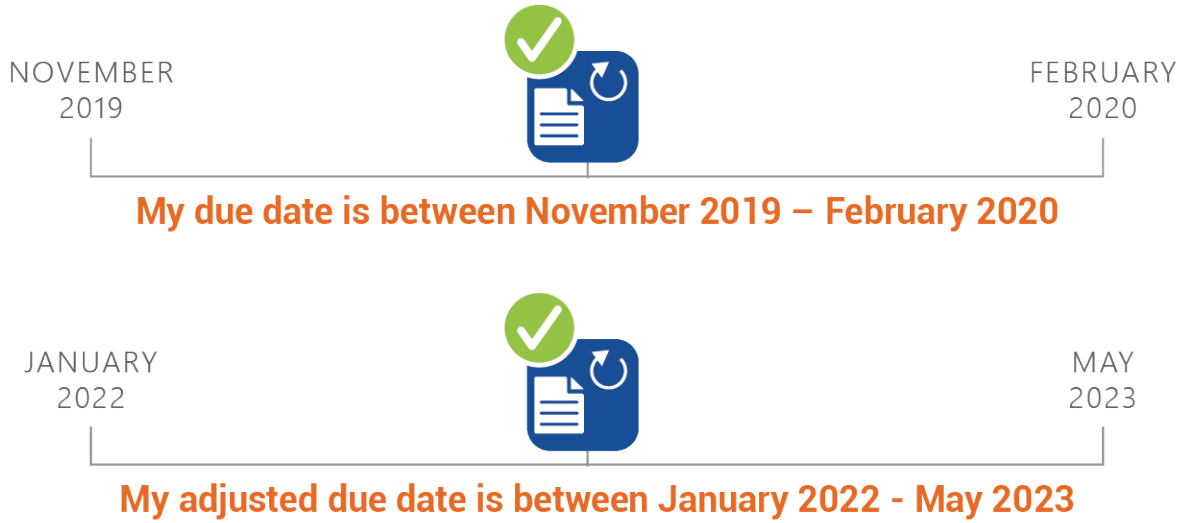
Revalidation – Current Status

- Providers/suppliers were notified of the changes to the revalidation process in an MLN newsletter issued on January 4, 2024
  - Revalidating organizations, no individual due dates
  - Resumed payment holds and deactivations for non-response
  - Resumed 6-7 months advance notice of revalidation due dates on revalidation look up tool
  - https://www.cms.gov/training-education/medicare-learning-network/newsletter/2024-01-04-mlnc#_Toc155185956

Revalidation – Current Status (continued)

- 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 (cont.)



- 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 receive an additional chance to comply before deactivation (includes non-response to revalidation development)
  - Letters will be sent spring 2024

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: MAY 31, 2024	MAC APPLIES THE STAY AND SENDS NOTICE	10 DAYS AFTER	JUNE 10 2024
SCENARIO (1) STAY APPLIED & PROVIDER RESPONDS	PROVIDER SENDS REVALIDATION	WITHIN 30 DAYS	JUNE 25 2024
	MAC REMOVES THE STAY CLAIMS WITH DOS DURING THE STAY ARE ELIGIBLE FOR PAYMENT	WITHIN 10 DAYS	JULY 5 2024

Stay of Enrollment – Non-Response to Revalidation (continued)

	MAC/PROVIDER ACTION	TIMEFRAME	SAMPLE TIMELINE
REVALIDATION DUE DATE: MAY 31, 2024	MAC APPLIES THE STAY AND SENDS NOTICE	10 DAYS AFTER	JUNE 10 2024
SCENARIO (2) STAY APPLIED & PROVIDER DOESN'T RESPOND	PROVIDER DOES NOT RESPOND	WITHIN 30 DAYS	JULY 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	JULY 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:

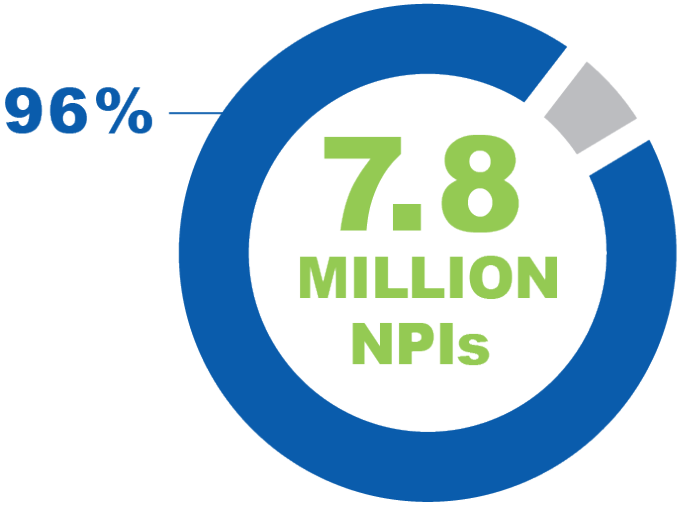
- ✓ Search for NPI records of Health Care providers in the NPPES system

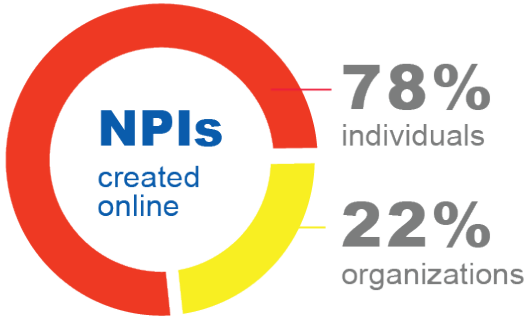
NPPES (NPI) Today

Every Month…

39,000
New NPIs

57,000
Updates



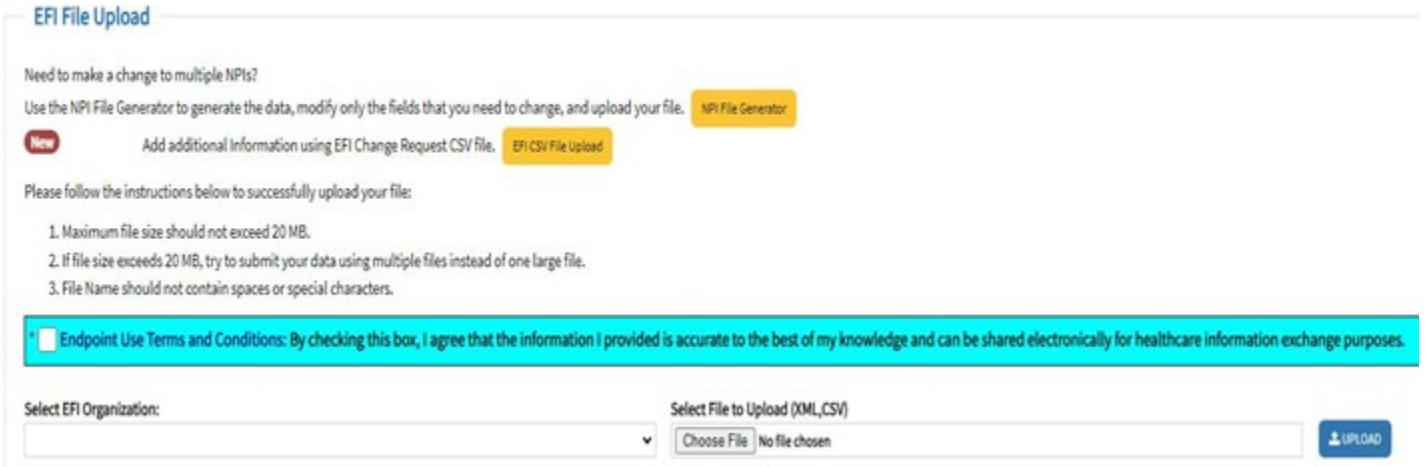


Maintain NPI Records

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

NPPES | Updates

- **NPPES Electronic File Interchange(EFI) enhancements for Bulk Updates**
  - Allow Sole Proprietors to apply for new/modify existing NPI Applications through EFI
    - On 6/27/2023, CMS made a system change to allow Sole Proprietors to apply for new/modify existing NPI Applications through the EFI process.

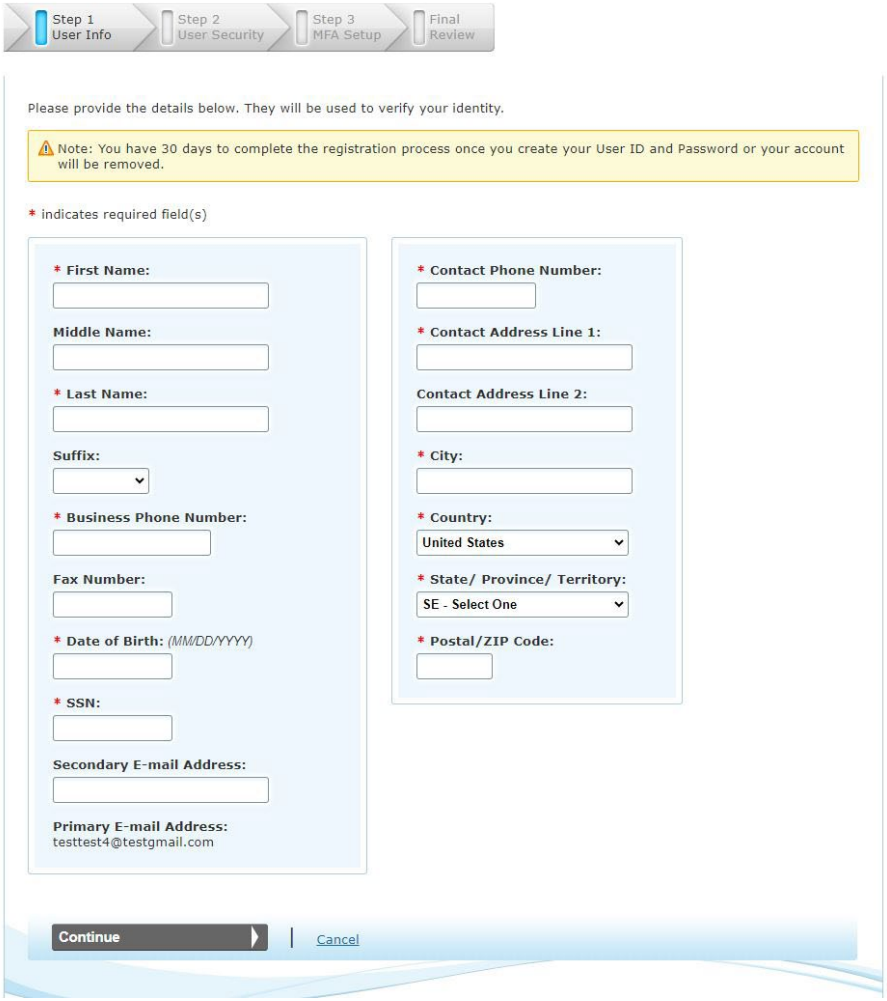


NPPES | I&A **Updates**

- **Optional Secondary Email in I&A**
  - On 12/26/2023, CMS made a system change to give users the option to include a secondary email in their profile. Users can now enter a secondary email to access and update I&A in the case they lose access to their primary email. Any emails directed to the primary email address will also be sent to the secondary email.

NPPES | I&A Updates (continued)

- On 12/12/2023, CMS made a system change by which the SSN is now requested earlier in the registration process to verify that it is not already in the system. This ensures that the system does not create incomplete accounts and makes the registration process more efficient and user-friendly.



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

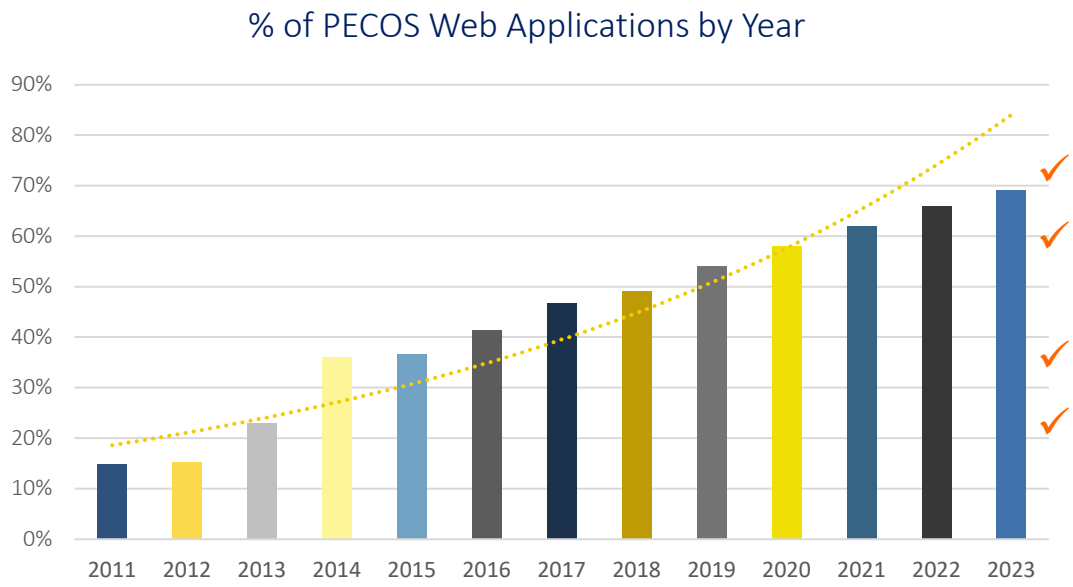
PECOS Today

Over 2.7 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

Poll Question

How frequently do you use PECOS: daily, weekly, monthly, in-frequently?

PECOS 2.0

Rethinking Provider Enrollment.

A few years ago, we started to look closer into how we could improve PECOS.

So, we talked to our stakeholders… and heard a lot.

“CMS knows it’s not the providers doing most of this work, right?”

Challenges

We needed to improve the overall experience for Providers

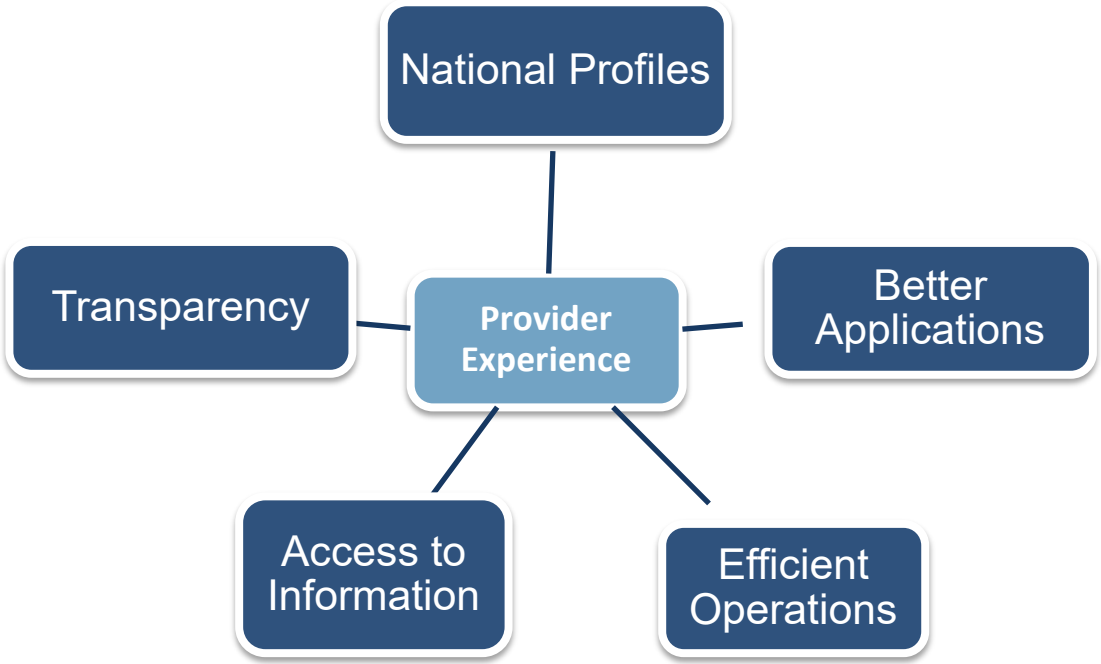
- Simplify overall policy complexity into clear simple steps and explain things in plain language
- Reduce the level of effort required for Providers to submit applications – excessive data entry and duplicate application submissions
- Provide tools for the individuals and groups managing large numbers of Providers
- Improve MAC application processing timelines and provide more transparency into the status of those applications
- Have a system that can more rapidly adjust to the changing landscape, CMS priorities, and community needs

…clearly, we need PECOS 2.0

We didn’t just need a new system. PECOS 2.0 needed to think about the Provider Experience.

Provider Experience for PECOS 2.0

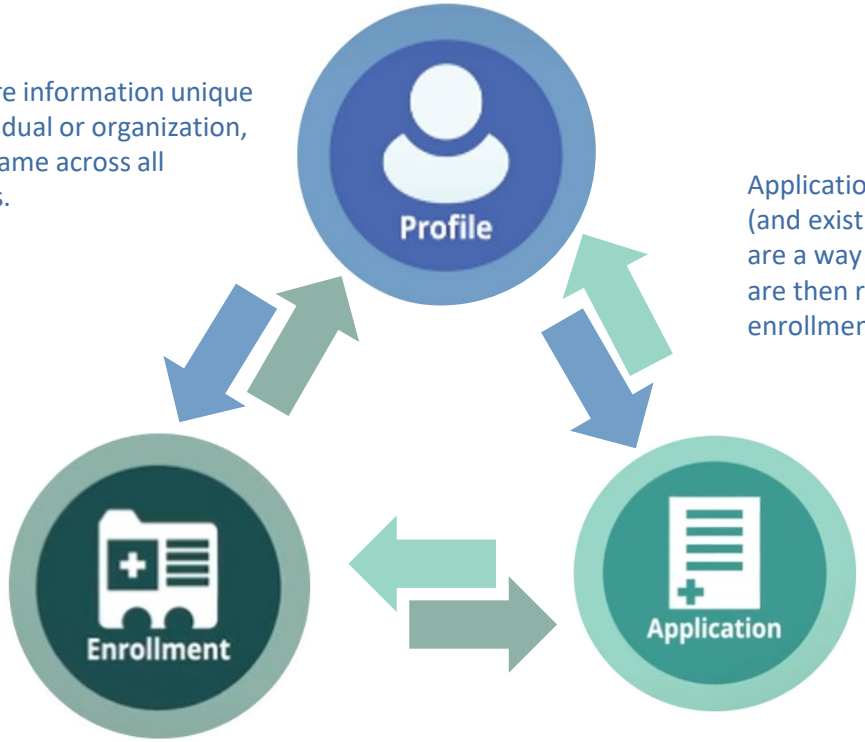
The vision for PECOS 2.0 is a ground up redesign focused on reducing provider burden, improving operational efficiency, and strengthening Program Integrity… and Provider Experience is at the heart of the process.



Foundational Difference in PECOS 2.0

PECOS 2.0 looks at enrollment information differently to more closely align policy and general operations. We start with a profile of the individual or organization, then the applications that report information, and then the enrollment, which feeds back into your profile.

Profiles store information unique to the individual or organization, that is the same across all enrollments.



Applications start with profile data (and existing enrollment info) and are a way to submit changes that are then reflected in your enrollments and profiles.

Enrollments store information unique to that, business operation, location(s), and relationships to ensure compliance.

PECOS 2.0 Preview (Video)

Poll Question

Which features are you most excited about?

PECOS 2.0 FAQ

Q: When will the PECOS 2.0 improvements begin rolling out?
A: Updates to the PECOS system will be introduced in 2024.

Q: Will this impact claims submission or payment?
A: **No.** These improvements will not impact billing or claims information.

Q: Will I need to do anything when these changes begin?
A: **No.** There is no need for Providers or their support staff to take any action.

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

PECOS 2.0 FAQ (continued)

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

A: **No.** CMS has been working with the community via focus groups to ensure the changes will be simple easy-to-use processes that should not require extensive re-training. We will also have informational articles and videos available to help answer questions.

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

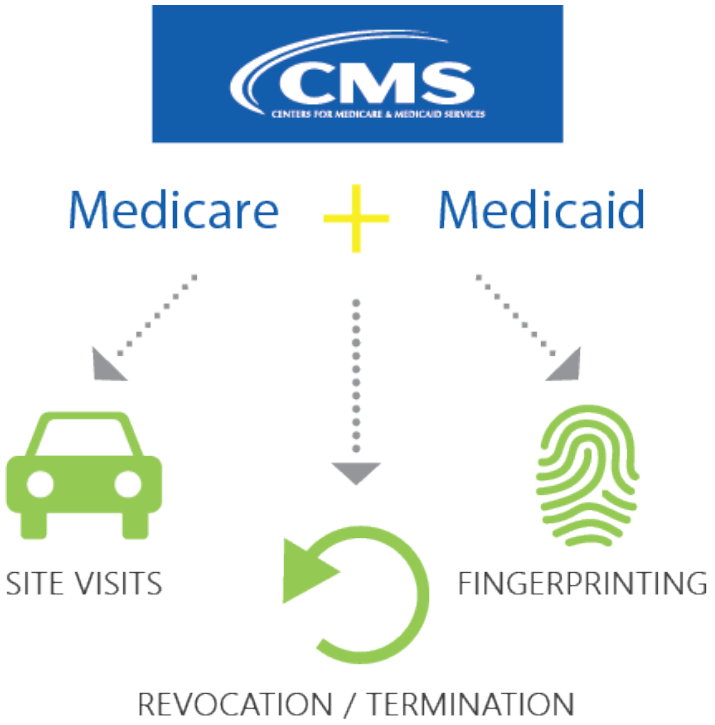
A: **We hope to encourage as many users as possible to transition to the online system when they see the simplicity and speed.** However, we will continue to allow submission of completed paper applications as we improve the system.

Question & Answer Session

Medicaid Enrollment

Medicaid Provider Enrollment

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



Advantages

Less burden for states and providers

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

More consistency among states

Clearer sub-regulatory guidance

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

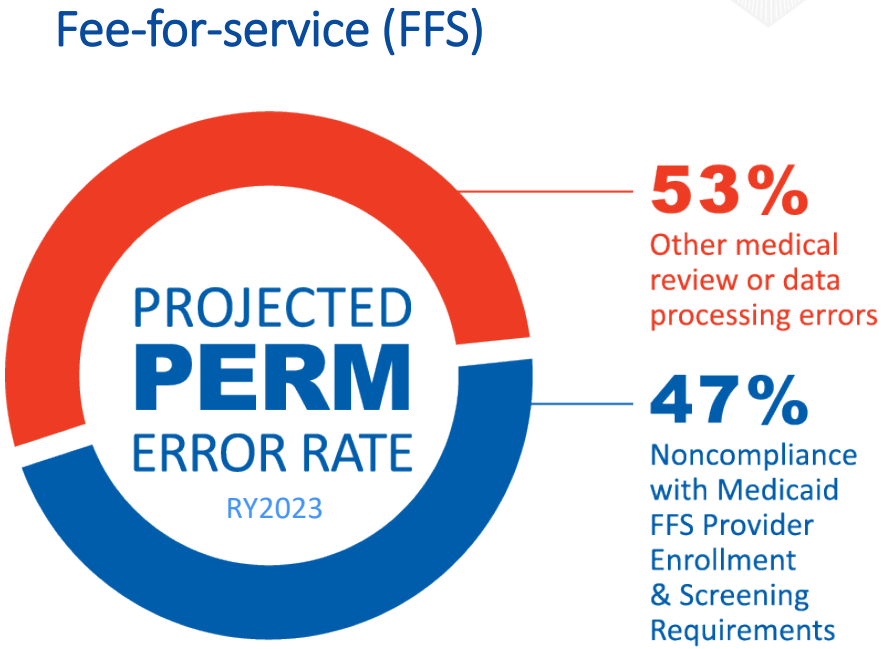
- Provide sub-regulatory guidance
- Support states in their statutory compliance efforts
- Provide Medicare data and screening activities to leverage for Medicaid enrollment
- Share best practices and make recommendations

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

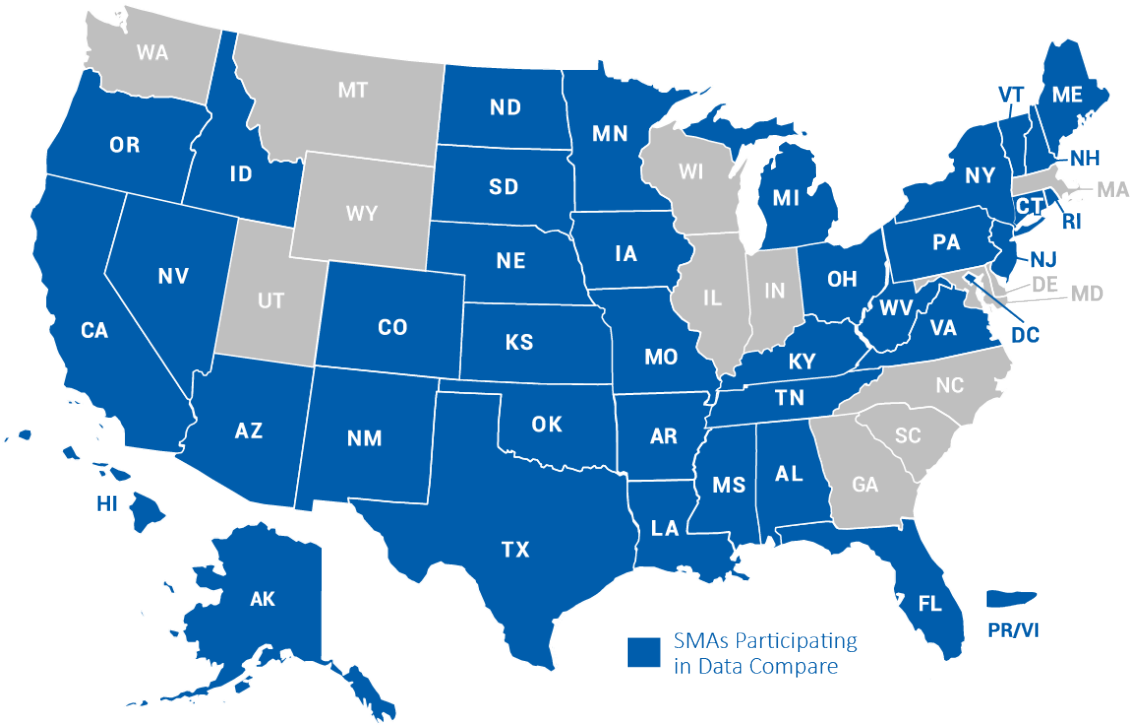
Screening Risk Levels (Section 1.3(D))

- 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

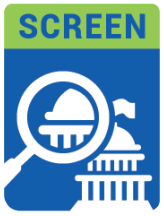
- For high Medicare reimbursements
- In high risk geographic areas

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

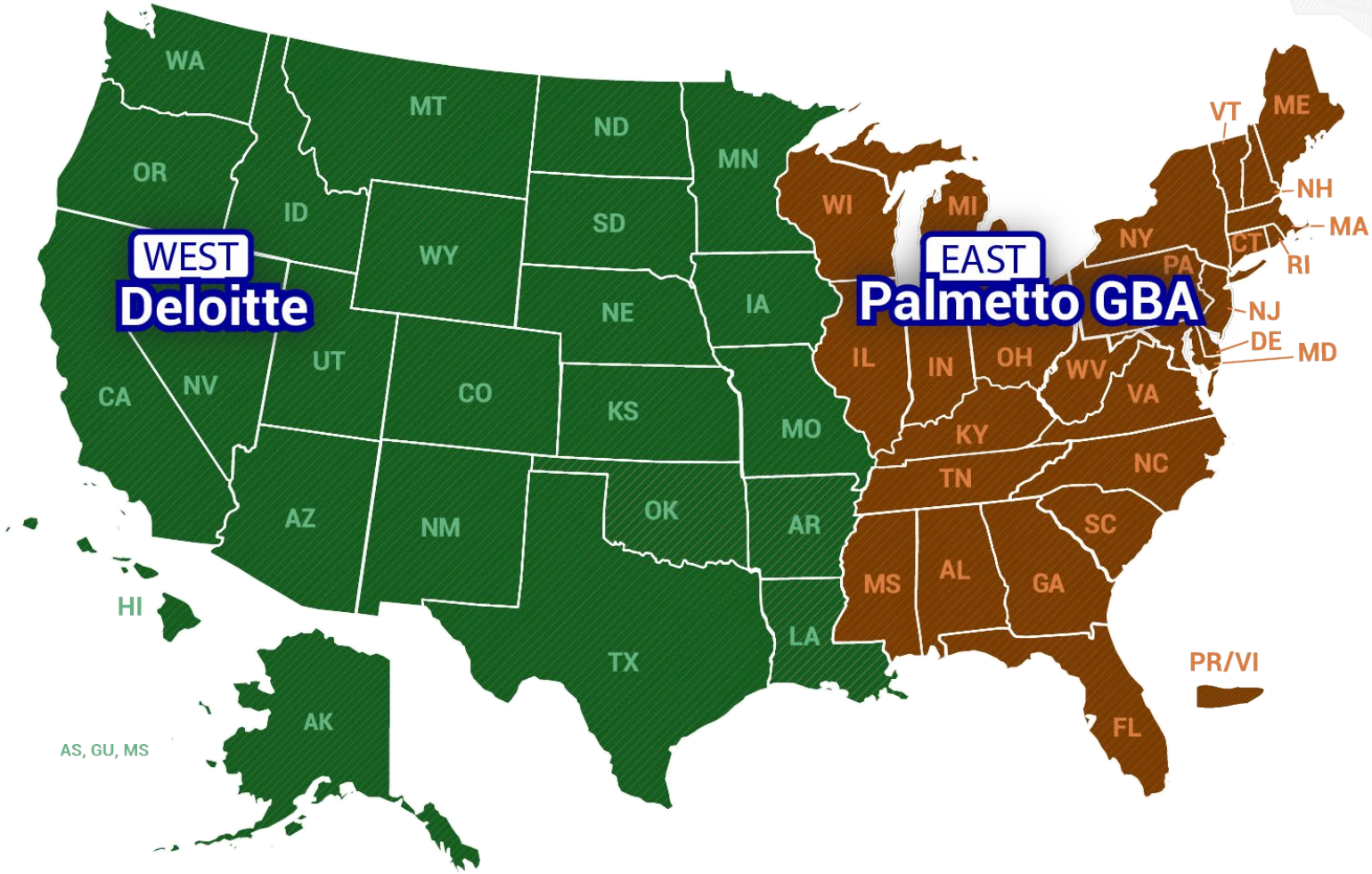
- Non-billing. EXEMPTIONS: order/refer/prescribe; certain specialties e.g., pediatricians, dentists and mass immunizers (roster billers)
- Inactive NPIs
- Deceased associates
- No active practice locations or reassignments for more than 90 days



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

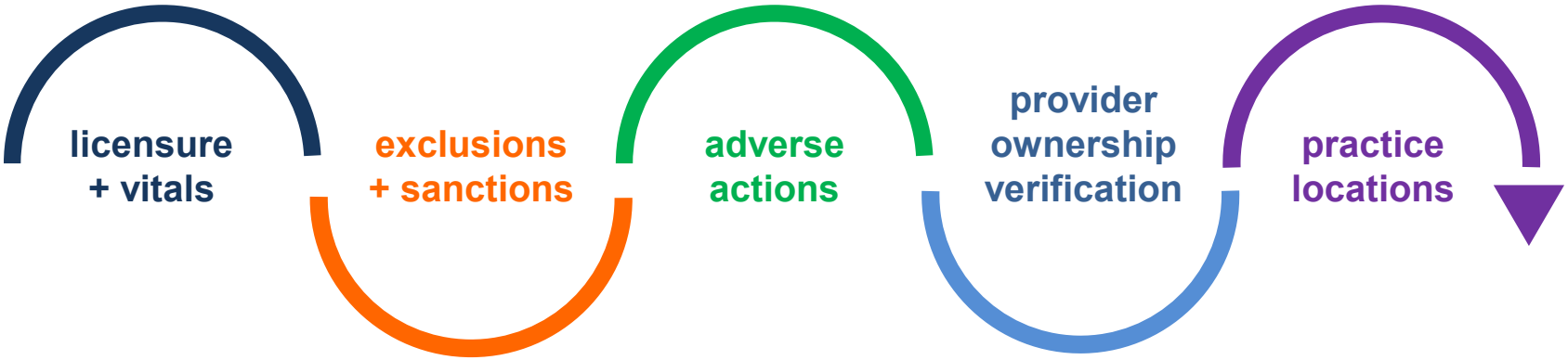
If the provider/supplier:

- 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 (continued)

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

Enforcement Actions

Adverse Legal Actions

Required during:

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

Applies to……

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

Failure to report…

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

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

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

x **Sanction or exclusion** (ever)

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

x Accreditation revocation or suspension (ever)

x Medicaid exclusion, revocation or terminations (ever)

Deactivations

CMS can deactivate Medicare billing privileges for:

8 Reasons for Enrollment Deactivation

42 C.F.R. §424.540(a)

Deactivations & Reactivations

Most Common Deactivation Reasons:

- x No claims submitted
- x Voluntary withdrawals

Newest Deactivation Reasons:

Effective January 1, 2022

- x Not compliant with enrollment requirements
- x Practice location is non-operational
- x Provider or supplier is deceased
- x Provider or supplier has voluntarily withdrawn from Medicare
- x The provider is the seller in an HHA change of ownership under § 424.550(b)(1)

Updated Deactivation Reason:

Effective January 1, 2024

- x Provider does not submit any Medicare claims for 6 consecutive calendar months.

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

To reactivate Medicare billing privileges:

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

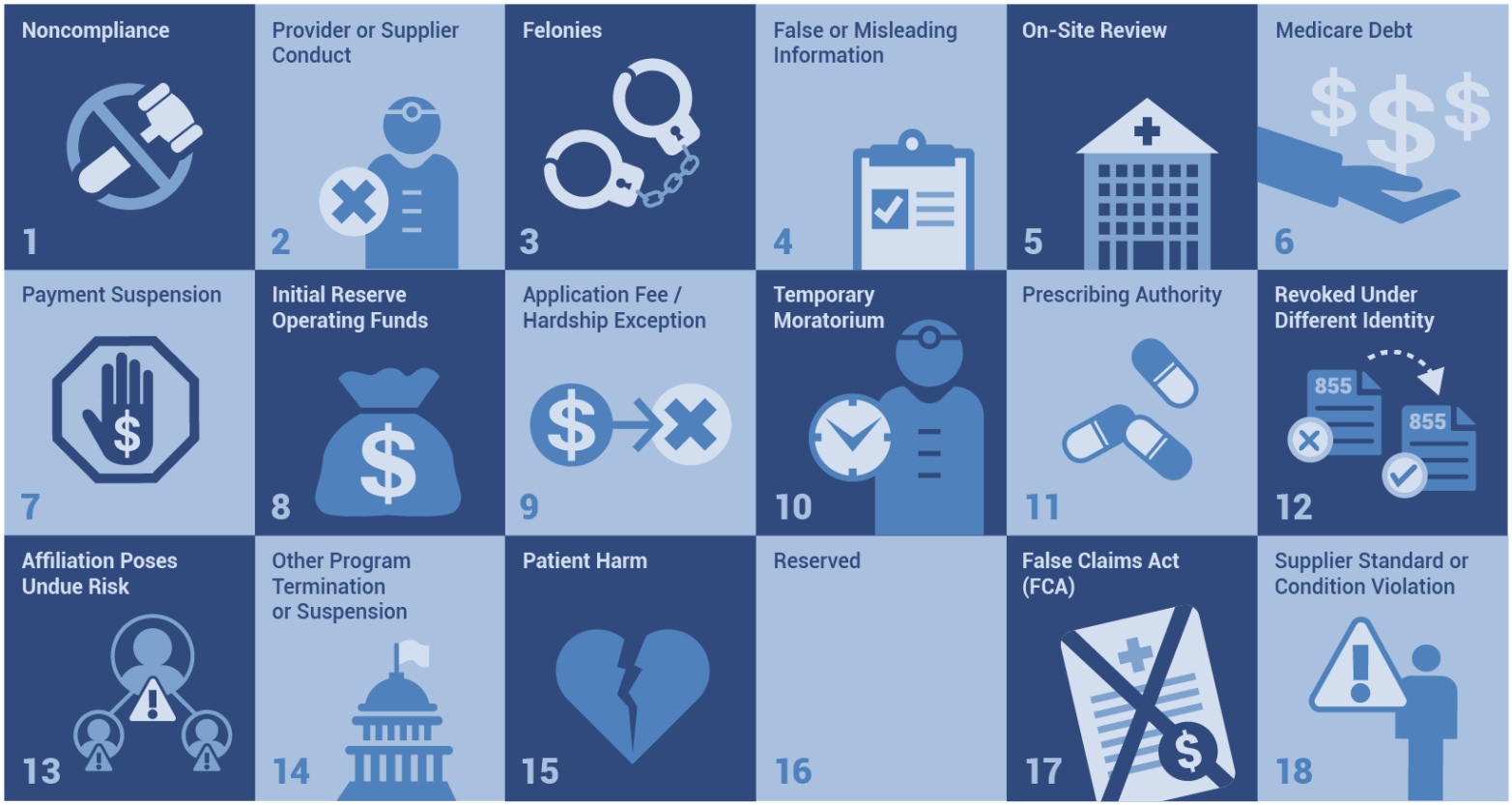
Deactivations

Reasons to Deny

CMS can deny Medicare enrollment for:

17 Reasons for Enrollment Denial

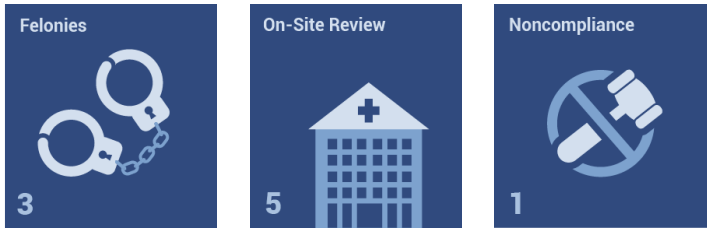
42 C.F.R. §424.530(a)



Reasons to Deny **(continued)**

Most Common Reasons:

- x Felony conviction within last ten years
- x On-site review, showing noncompliance
- x Noncompliance: program requirements



Newest Denial Reasons:

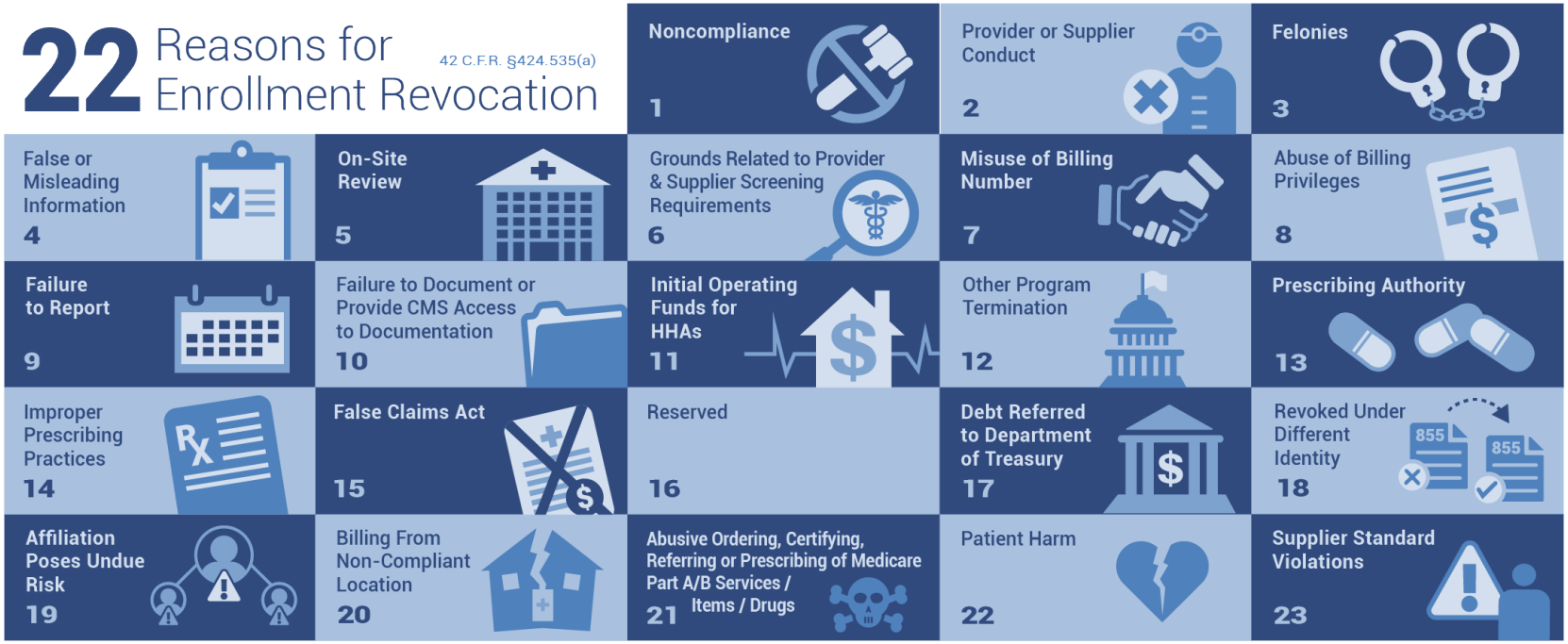
Effective January 1, 2024

- x False Claims Act Judgement
- x Supplier Standard Violation

Denials

Reasons to Revoke

CMS can revoke Medicare billing privileges for:



Reasons to Revoke **(continued)**

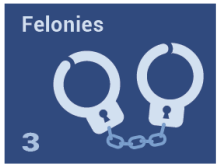
Most Common Reasons

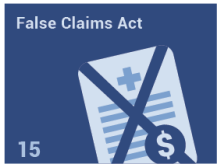
- x 424.535(A)(1) Noncompliance
- x 424.535(A)(9) Failure To Report
- x 424.535(A)(3) Felonies

Newest Revocation Reasons

Effective January 1, 2024

- x False Claims Act Judgments
- x Supplier Standard Violations





Re-enrollment Bar

Revoked providers or suppliers are barred from participating in the Medicare program from the date of the revocation until the end of the re-enrollment bar.

Re-enrollment bar lasts 1 – 10 years*

- *However,* CMS may add up to 3 more years to the provider or supplier's reenrollment bar if the provider or supplier is attempting to circumvent its existing reenrollment bar by enrolling in Medicare under a different name, numerical identifier or business identity.

Re-enrollment bar

1–10 Years*

**CMS may impose a reenrollment bar of up to 20 years if the provider or supplier is being revoked from Medicare for the second time.*

Revocations

Protecting Medicare Part C & D

CMS-4182F
started JAN 2019

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

Preclusion List

- Applies to individuals/entities
- Currently revoked and under an active re-enrollment bar,
- Could have revoked if enrolled in Medicare; or
- Convicted of a felony within last ten years under federal/state law; and
- Conduct that led to the revocation or felony is considered detrimental to the Medicare program

Part C & D Preclusion List

What happens if I'm on the Preclusion List?

You will receive a letter from CMS in advance of your inclusion on the Preclusion List

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

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

Part C & D Preclusion List **(continued)**

Medicare Advantage (Part C)

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

Prescriber (Part D)

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

Part C & D Preclusion List (cont.)

Preclusion List resources at https://www.cms.gov/medicare/provider-enrollment-and-certification/preclusion-list

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

CMS Preclusion list

PRECLUDED ENTITIES

5,981

January 1, 2019 — September 30, 2023

Hospice Provisional Period of Enhanced Oversight

- CMS implemented a Provisional Period of Enhanced Oversight (PPEO) on newly enrolling hospices located in Arizona, California, Nevada, and Texas.
- Over the last 12 months, we've received numerous reports of hospice fraud, waste, and abuse. The number of enrolled hospices has also increased significantly in these states, raising serious concerns about market oversaturation.
- The PPEO, which can last from 30 days to 1 year, may include medical review, such as prepayment review.
- For more information, see the MLN:
  - https://www.cms.gov/files/document/mln7867599-period-enhanced-oversight-new-hospices-arizona-california-nevada-texas.pdf

Authority: Section 1833(e) of the Social Security Act and 42 C.F.R. § 424.527

Provider Ownership Verification (POV)

- The POV contractor reviews and verifies the accuracy of provider/supplier reported ownership information through available sources, such as Secretary of State filings.
- If any ownership discrepancies are identified, the contact person reported on the enrollment record may receive a call from CMS or POV requesting that the ownership information be updated.
    - It is important that your enrollment information be current and up-to-date to ensure timely communication with CMS and its contractors.
- If the enrollment is not brought into compliance, administrative action may be taken.

Medicaid Terminations

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

SCENARIO #1

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

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

SCENARIO #2

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

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

SCENARIO #3

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

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

Medicaid Terminations (continued)

more than

2,500

Total Medicaid **TERMINATION** SUBMISSIONS

122

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

more than

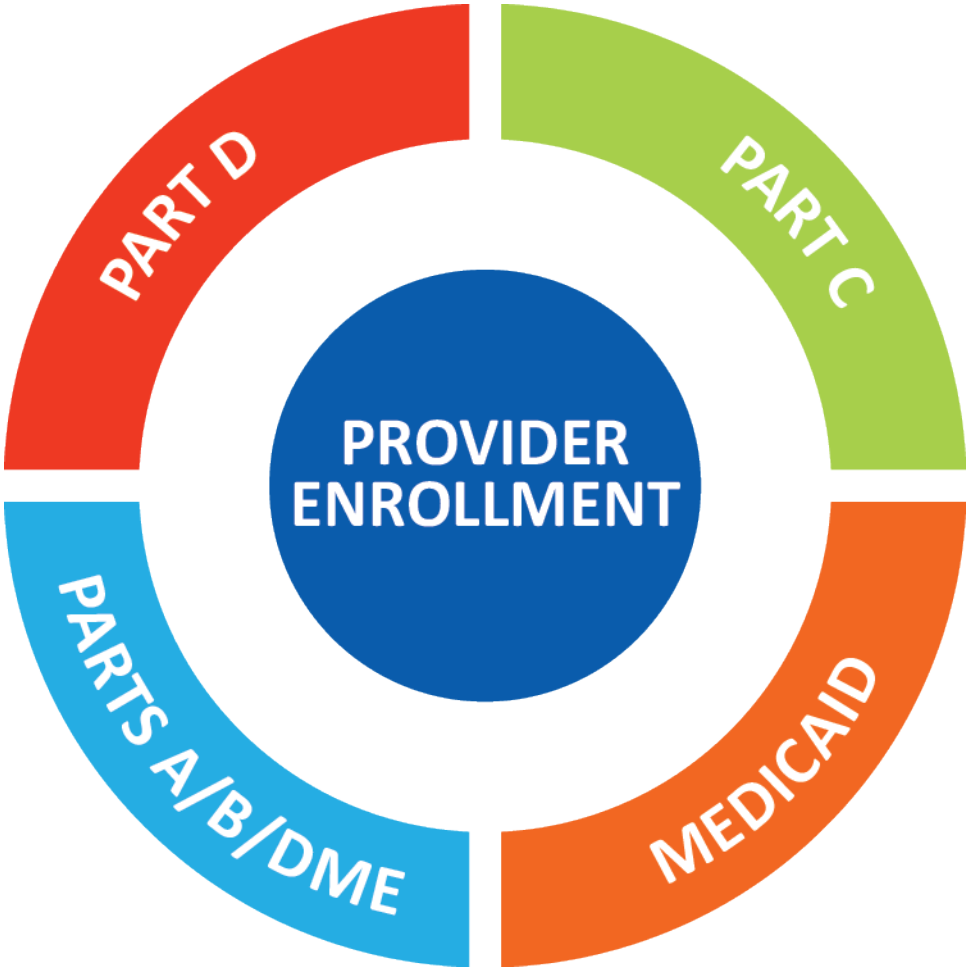
1,000

Total Medicare **REVOCATION** FILE ENTRIES

*FY 2023

Connections Between All Programs

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



Question & Answer Session

NPEC

NATIONAL PROVIDER ENROLLMENT CONFERENCE

65 Million Patients, **2.7 Million** Providers, **ONE** Mission

SAVE THE DATE

August 28-29, 2024

San Diego Convention Center

Resources

cms.gov

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

cms.gov/Revalidation

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

PECOS.cms.hhs.gov

account creation, videos, providers resources , FAQs

888-734-6433

PECOS Help Desk

ProviderEnrollment@cms.hhs.gov

Provider Enrollment contact

FFSProviderRelations@cms.hhs.gov

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

cms.gov/EHRIncentivePrograms

Electronic Health Record website

cms.gov MLN Matters® Articles

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

Thank You

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Centers for Medicare & Medicaid Services