Medicare & Medicaid Provider Enrollment

Presented by

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Centers for Medicare & Medicaid Services

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Provider Enrollment & Oversight Group
Centers for Medicare & Medicaid Services
Session Overview

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

Question 1
Poll
Question 2
By the Numbers

- **632.9 BILLION** in Medicare (expenditures)
- **552.3 BILLION** in Medicaid (expenditures)
- **2 MILLION** Providers
- **59 MILLION** Patients
Why We’re Here

LISTENING TO YOU

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

FINDING A BALANCE

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

ALWAYS IMPROVING

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

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How Enrollment Works
How Enrollment Works

1. **Submission**
   - Medicare Providers & Suppliers (w/NPI)
   - Online
     - 45 days*
   - Direct Input
     - 855 Form
     - 60 days*
   - Submit to MAC

2. **Intake**
   - MAC mail room
   - Manual data entry
   - 2
   - PECOS

3. **Processing, Screening & Verification**
   - Pre Screening
     - signed + dated
     - app fee (or waiver)
     - supporting docs
     - all data elements
   - Verification
     - Name / LBN
     - SSN / DOB
     - NPPES
     - Address
     - License
     - Adverse Actions
   - Risk Based
     - Fingerprints
     - Site Visits

4. **Finalization & Claims Update**
   - Update claim system
     - MAC updates claim system (1-2 days)
   - Provider not approved until claims updated
   - MAC Recommendation to State / RO
     - Certified providers/suppliers
     - MAC recommends to RO
     - RO performs in 3-9 mo

*If the app is complete, and no site visit

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CMS | National Provider Enrollment Conference | April 2018

04/19/2018 | 9
MAC Jurisdictions
Policy Updates
Recent Policy Changes

- Providers who are reassigned to a deactivated/revoked organization will have 90 days to submit a new practice location or reassignment before being deactivated (*April 2018*) ★

- Require fillable CMS-855 paper applications (*September 2018*) ★
  - All paper applications shall be typed using the fillable CMS-855 form option
  - MACs will return all hand-written applications
Recent Policy Changes

- MACs should not call to speak directly to providers reporting a change in specialty
- MACs should not request a diploma or degree unless education requirements cannot be verified online
- MACs should not request a SSN card or driver’s license for identification
- MACs should not request a phone, utility, power bill or lease to validate LBN or DBA
  - Lease only required to validate exclusive use of facility for PT/OT or ambulance suppliers leasing aircraft
Recent Policy Changes

- Approval letters will list all changed/updated information for change of information submissions
- MACs shall only request the dated signature of at least one authorized/delegated official for applications requiring development
- MACs may accept a CP-575, federal tax department ticket, or any other pre-printed document from the IRS to validate TIN and/or LBN
## Authorized and Delegated Officials - PECOS & I&A

### Authorized Official (AO)
- **Enroll, make changes and ensure compliance with enrollment requirements**
  - CEO, CFO, partner, chairman, owner, or equivalent appointed by the org
  - May sign all applications *(must sign initial application)*
  - Approves DOs

### Delegated Official (DO)
- **Authority to assign surrogacy and controls access to PECOS and NPPES records**
  - CEO, CFO, partner, chairman, owner, or equivalent appointed by the org. AO requirements are same as PECOS
  - Automatically approved if listed as AO in PECOS; if not, CP575 must be provided to approve access
  - Manage staff and connections for the employer
  - Approve DOs for the employer

### Authorized and Delegated Officials

<table>
<thead>
<tr>
<th>AO</th>
<th>DO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authorized Official</strong></td>
<td><strong>Delegated Official</strong></td>
</tr>
<tr>
<td>Enroll, make changes and ensure compliance with enrollment requirements</td>
<td>Appointed by the AO with authority to report changes to enrollment information</td>
</tr>
<tr>
<td>- CEO, CFO, partner, chairman, owner, or equivalent appointed by the org</td>
<td>- Ownership, control, or W-2 managing employee</td>
</tr>
<tr>
<td>- May sign all applications <em>(must sign initial application)</em></td>
<td>- Multiple DOs permitted</td>
</tr>
<tr>
<td>- Approves DOs</td>
<td>- May sign changes, updates &amp; revalidations <em>(cannot sign initial application)</em></td>
</tr>
</tbody>
</table>

### Authorized Officials (AO)
- **Assign surrogacy and controls access to PECOS and NPPES records**
  - CEO, CFO, partner, chairman, owner, or equivalent appointed by the org. AO requirements are same as PECOS
  - Automatically approved if listed as AO in PECOS; if not, CP575 must be provided to approve access
  - Manage staff and connections for the employer
  - Approve DOs for the employer

### Delegated Officials (DO)
- **Authority to assign surrogacy and controls access to PECOS and NPPES records**
  - Delegated by the AO of org provider or 3rd party org
  - Less restrictive DO requirements than PECOS
  - May add the employer to his profile, manage staff and connections for the employer
  - Multiple DOs permitted
Who Can Sign the Enrollment Application?

Initial:
- Authorized Official (AO)
- Individual Provider (IP)

Changes & Revals:
- Authorized Official (AO)

Adding:
- Individual Provider (IP)
- Authorized Official (AO)

Changing / Terminating:
- Individual Provider (IP)
- Authorized Official (AO)

OR
- Delegated Official (DO)

OR
- Delegated Official (DO)
## Release of Enrollment Information

<table>
<thead>
<tr>
<th></th>
<th>Individual Provider</th>
<th>AO / DO</th>
<th>Contact Person</th>
<th>Outside Person / Entity</th>
</tr>
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<tbody>
<tr>
<td>PTANs</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Effective Dates</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Group Affiliations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Practice Locations</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Revalidation Status Information</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Approval Letters</td>
<td>X</td>
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<td>X</td>
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</table>
# Provider Enrollment Moratoria

<table>
<thead>
<tr>
<th>Year</th>
<th>Initial Implementation</th>
<th>Expanded</th>
<th>No Changes</th>
<th>Lifted</th>
<th>Lifted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td><strong>Initial Implementation</strong></td>
<td><strong>Expanded</strong></td>
<td><strong>No Changes</strong></td>
<td><strong>Lifted</strong></td>
<td><strong>Lifted</strong></td>
</tr>
<tr>
<td></td>
<td>July 2013</td>
<td>January 2014</td>
<td>January 2015</td>
<td>July 2016</td>
<td>September 2017</td>
</tr>
<tr>
<td></td>
<td>- HHA and HHA sub-units</td>
<td>- HHA and HHA sub-units</td>
<td>- HHA and HHA sub-units</td>
<td>- Emergency ambulance services</td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Miami &amp; Chicago</em></td>
<td><em>Miami, Ft. Lauderdale, Detroit, Dallas, Chicago</em></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Ambulance and ambulance suppliers</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><em>Houston</em></td>
<td><em>Houston, Philadelphia, surrounding New Jersey</em></td>
<td><em>Houston, Philadelphia, surrounding New Jersey</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td><strong>Initial Implementation</strong></td>
<td><strong>Expanded</strong></td>
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<td><strong>Lifted</strong></td>
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</tbody>
</table>

For more information refer to the Federal Register notice at [https://www.federalregister.gov](https://www.federalregister.gov)
Part C & D Preclusion List

CMS-4182F starts JAN 2019

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

Preclusion List

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

Medicare Advantage (Part C)
- 120,000 unenrolled MA providers
- Opted out providers cannot receive Medicare payment for services furnished to Medicare beneficiaries under FFS or a MA plan
- MA plans will deny payment for a health care item or service if the individual/entity is on the Preclusion List

Prescriber (Part D)
- 340,000 unenrolled prescribers
- Pharmacy will deny prescriptions at point of sale if the provider is on the Preclusion List
Poll

Question 3
Question & Answer Session
Revalidation
Poll
Question 4
Revalidation Basics

5-year cycles
3-year for DME suppliers

When is your revalidation due?
go.cms.gov/MedicareRevalidation

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

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

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

No Response?
- deactivate (not revoke)

Late Revalidation?
- break in billing
- new effective date

RESPONSE RATE
90%

60 DAYS TO RESPOND
Revalidation Web Submissions

CYCLE 1

PART A 43%
PART B 45%

CYCLE 2

PART A 65%
PART B 61%
Revalidation Details

Unsolicited Revalidations

- If your record’s due date is “TBD”, do not send an application
- CMS will accept applications submitted within 6 months before due date, any application submitted beyond this timeframe will be returned
- If you want to *update or change* your enrollment record, send the relevant 855 form

Deactivations

- If you don’t provide a complete revalidation your Medicare billing privileges will be deactivated
- Respond to all development requests by your MAC within 30 days
- If we deactivate you, you need to resend a complete enrollment application for reactivation
- If CMS reactsivates you, you keep your old PTAN, and you are reactivated to the receipt date of the new application
- Approval letters will include gap in billing language (*January 2018*) ★
Revalidation Details

Changes received prior to revalidation

- Changes received within 6 months of revalidation due date may be processed as a revalidation, or

- Provider can choose to continue with the change in lieu of revalidation
  - MAC will process the change and proceed with revalidation process
  - Changes reported within 6 months of revalidation due date are not required to be reported on the revalidation application
  - MAC will not override the previous changes
# Revalidation Timeline

<table>
<thead>
<tr>
<th>CMS (MAC) ACTION</th>
<th>TIMEFRAME</th>
<th>SAMPLE TIMELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>POST TO THE REVAL LIST</td>
<td></td>
<td>MAR 30 2018</td>
</tr>
<tr>
<td>NOTIFY LARGE GROUPS</td>
<td>6 MONTHS BEFORE</td>
<td>PROVIDER SENDS REVALIDATION</td>
</tr>
<tr>
<td>SEND NOTICE (E-MAIL OR LETTER)</td>
<td>2-3 MONTHS BEFORE</td>
<td>JUN 30 2018</td>
</tr>
</tbody>
</table>

### REVALIDATION
- DEACTIVATE BILLING PRIVILEGES FOR NON-RESPONSE
- DUE DATE
- SEPT 30 2018
Poll

Question 5
Missing Reassignments - No Break in Billing

SCENARIO #1

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

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Received</td>
<td>09/01/2018</td>
</tr>
<tr>
<td>Development Letter Sent</td>
<td>10/15/2018</td>
</tr>
<tr>
<td>Development Due</td>
<td>11/15/2018</td>
</tr>
<tr>
<td>Development Received</td>
<td>11/10/2018</td>
</tr>
<tr>
<td>Revalidation Due</td>
<td>10/31/2018</td>
</tr>
<tr>
<td>Revalidation Complete</td>
<td>11/30/2018</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Event</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Receipt</td>
<td>10/01/2018</td>
</tr>
<tr>
<td>Development Letter Sent</td>
<td>10/15/2018</td>
</tr>
<tr>
<td>Development Due</td>
<td>11/15/2018</td>
</tr>
<tr>
<td>Revalidation Due</td>
<td>10/31/2018</td>
</tr>
<tr>
<td>Reassignment End</td>
<td>11/15/2018</td>
</tr>
<tr>
<td>Revalidation Receipt</td>
<td>12/01/2018</td>
</tr>
<tr>
<td>Reactivation Effective</td>
<td>12/01/2018</td>
</tr>
</tbody>
</table>

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

Question 6
Revalidation Look-up Tool

Medicare providers must revalidate their enrollment record information every three or five years. CMS sets every provider's revalidation due-date at the end of a month, and posts the upcoming six months online. A due date of "TBD" means that CMS has not set the date yet.

Find a Provider

Provider Name or National Provider Identifier (NPI):
- Organization Name
- First Name
- Last Name
- NPI

Location
- Any State

Access Data
- All records
- Only records with due dates
- Records with due dates in the specified range

FIND PROVIDER

About the tool
- All Due Dates will not be removed and will continue to be displayed on the website even after a Provider has revalidated successfully.
- This data was last refreshed on December 22nd, 2017
- Revalidation due dates included on this list range between March 31st, 2016 and July 31st, 2018
- The next data refresh is tentatively scheduled for March 1st, 2018
- Affiliations now include Reassignments as well as PA Employment Relationships
- Data now includes DME Due Dates between November 1st, 2016 and July 31st, 2018
- DME Suppliers are identified on the downloadable file in a new column called "Enrollment Type" and are identified as "1"
Revalidation Look-up Tool

data.cms.gov/revalidation

3 Sets of Data Files

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

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**Online tables**

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

1. **Group practice members only**
   - A-D | E-L | M-R | S-Z
   
   Search list of all group records and their reassigned members.

2. **Entire list of providers and suppliers**
   
   Search list of all provider and supplier enrollment records.

3. **Reassignments and PA Employment relationships**
   
   Search list of all reassignments and employment relationships.

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

   **How to use the online tables:**
   
   1. Sort on a column by clicking its grey header
   2. Search with the [Find in this Dataset] search bar
   3. Filter the data by clicking the blue [Filter] button
   4. Download the file by clicking the light blue [Export] button
Revalidation Look-up Tool

Looking for reassigned providers?

Use “Group practice members only”

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

Sort and filter by:

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

Search by: Individual Last Name, First Name or NPI

Records include details and links to all affiliated records
(e.g. Individual records show details on affiliated organizations or providers, plus a link to the group’s record)
Revalidation Look-up Tool

Records will include details and links to all affiliated records
(e.g. group records show details on affiliated individuals, plus a link to the individual record)

Search by: Organization Name or NPI
search results show # of reassignments & physician assistants
Because of Your Feedback

Changes we’ve made

- Advanced notice of your revalidation due date
- Search and download all reassignments
- Reassignment information on revalidation notices

How you can help

- Talk to your provider
- Use the revalidation look up tool
- Respond timely
- Set up your access to PECOS now
- Use PECOS to submit your revalidation
Question & Answer Session
Provider Enrollment Systems
Provider Enrollment 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.
NPPES (NPI) Today

Every Month...

26,000 New NPIs

58,000 Updates

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

94% created online

5.2 MILLION NPIs

Since May 2017...
- New design with easier screens
- Surrogacy (like PECOS)
- More data fields
- Improved customer service

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

NPIs created online
- 76% individuals
- 24% organizations
Poll Question 7
NPPES | Data Collection Updates

- Organization Name can be included for address standardization
- Exclude Medicare other identifiers from User Interface & Data Dissemination files
- Updates to provider Endpoint information data fields
- NPI Registry updated with additional practice locations
NPPES | User Privilege Updates

- Authorized Official and Delegated Official can deactivate NPIs
- Create Organizational NPIs when all other NPIs are deactivated
- I&A Users can cancel role requests and disassociate from organizations
NPPES | Communication Updates

- Enhanced NPPES ‘ANNOUNCEMENTS’ Section
- E-mail confirmation check during NPI application
- Warning alerts throughout application
- System generated email notifications for application status updates

YouTube video introducing the new NPPES:
https://youtu.be/BOJCAj1P2u8

“Getting Ready for the new NPPES” FAQ:
https://nppes.cms.hhs.gov/NPPES/powerpoint/GettingReadyForTheNewNPPES.pptx
NPPES | Future Updates

- Optimization of the Electronic File Interchange which allows for upload of large files (up to 200 MB)
- Update NPI Registry to show other names and Endpoint information
- Additional Supplemental Data Dissemination files
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 the CMS-855 enrollment form.

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

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

Question 8
Over 2 Million Enrollments

Encouraging Online Applications

Every month...
18,000 new enrollments

% of PECOS Web Applications by Year

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

- Categories for final adverse actions
- No longer required to report Medicare Payment Suspensions or Medicare Revocations
- Displays all reported final adverse actions
- Final adverse actions reported prior to April 1, 2018 that CMS could not categorize, will be placed under the “other” category
PECOS Upcoming Changes | July 2018

- Emails will identify the individual that needs to e-sign the application when multiple signatories exist.
- Emails will identify signers who have requested a PIN.

PECOS will display two fields: Signatory Name and Signatory Role in the following e-mails:
- Pending E-Signature E-mail
- E-signature Reminder E-mail
- PIN Regeneration E-Mail
Digital Submission

PROVIDER \[\rightarrow\] PECOS

- E-SIGN
- UPLOAD SIGNED CERTIFICATE
- U.S. MAIL
- PAPER
Physician Compare

**medicare.gov/physiciancompare**

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

Learn more: Search “physician compare” at cms.gov

Get support: PhysicianCompare@Westat.com
PECOS Redesign

PECOS 2.0

✓ Simplified interface focused on automated functions
✓ Increase speed of application processing
✓ Track the status of an application from submission through approval
✓ Update multiple records at one time
✓ Live support to help users
✓ Support increased alignment between Medicare and Medicaid
✓ Reduce redundant data collection
You May Be Wondering

Q: When will the PECOS 2.0 improvements begin rolling out?
A: We’re expecting updates to the PECOS system will be introduced in late 2019.

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

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

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

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

Q: Will I or my staff need to undergo training to learn the updates?
A: We will be working with the community via focus groups to insure the changes will be simple easy-to-use processes that should not require extensive re-training. We will also have information available to help answer questions.

Q: Does this mean I can’t submit paper applications?
A: We hope to encourage as many users as possible to transition to the online system when they see the simplicity and speed. However, we will continue to allow submission of completed paper applications as we improve the system.
Question & Answer Session
Medicaid Enrollment
CMS Center for Program Integrity manages Medicare and Medicaid enrollment.

**Advantages**

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

- More consistency among states
  Clearer sub-regulatory guidance
  Each state has a CMS point-of-contact

**Medicaid Provider Enrollment Compendium (MPEC)**
Similar to the Medicare Program Integrity Manual
Improper Payment Rate

- Measures improper payments in Medicaid and CHIP and produces error rates for each program.

**PROJECTED PERM ERROR RATE**

Fee-for-service (FFS)

- 20% Other medical review or data processing errors
- 80% Noncompliance with Medicaid FFS Provider Enrollment & Screening Requirements

2017
CMS’ Role in Medicaid Provider Enrollment

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

Can’t
- Require states alter their enrollment process
- Align the enrollment process across all states
- Require timeframes for processing applications
- Define the manner by which the states implement Federal regulations
Poll

Question 9
MPEC Updated June 2017

- For State Medicaid Agencies (SMA) and providers
- Guidance on federal Medicaid enrollment standards (42 CFR 455 Subparts B, E)
- States may be stricter than Federal regulations

Sample Guidance

**Revalidation** (Section 1.5.2, 1.5.3)
- Required every 5 years (includes ordering and referring physicians)
- Discretion to require revalidation on a more frequent basis

**Approval letters** (Section 1.7)
- SMAs should not request MAC “welcome letter” as a condition of provider enrollment

**Out of State Providers** (Section 1.5.1C)
- SMAs may pay claims for out-of-state providers who are unenrolled

**Retroactive Dates of Service** (Section 1.6B)
- SMA makes determination to grant a retroactive billing date based on compliance
Relying on Medicare Screening

- SMA determines to what extent it may reduce its own screening through reliance on Medicare’s screening activities.
- SMAs MAY rely upon Medicare screening, however are not required to.
- For SMAs to rely on Medicare's screening:
  - Must have occurred in the last 5 years
  - Must be the same provider in Medicare
  - Must be an “approved” Medicare provider

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Comparison</th>
<th>Risk Category</th>
<th>SMA Action</th>
</tr>
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<tr>
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<td>Medicare Risk Category</td>
<td>None</td>
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<td>&gt;</td>
<td>Medicare Risk Category</td>
<td>Gap Screening</td>
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<tr>
<td>Medicaid Risk Category</td>
<td>&lt;</td>
<td>Medicare Risk Category</td>
<td>None</td>
</tr>
</tbody>
</table>

* Exception for DME and HHA risk levels
### PROVIDER INFORMATION

<table>
<thead>
<tr>
<th>Name: Richard McRoberts</th>
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<tbody>
<tr>
<td>Legal Business Name:</td>
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<tr>
<td>NPI: 1023054806</td>
</tr>
<tr>
<td>Medicare Risk Category</td>
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<tr>
<td>Risk Level: Low</td>
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</tbody>
</table>

**Medicare Risk Category:**
- **Risk Level:** Low

**Address:**
- Address Line 1: 123 East Way, Springfield, MA 01109
- Address Line 2: Suite #2300

**Contact:** Dave Wilson

**Provider/Supplier Type:** Physician - ADDICTION MEDICINE

**NPI Verified in NPPES:** YES

**Doing Business As Name:**
- **TIN:** XXX-XX-3109 (SSN)
- IRS Information: LLC

**Effective Date:** 06/15/2016

**Change of Ownership Information:**
- Type: Merger/Acquisition
- Provider Agreement Accepted?: Yes
- Effective Date: 05/30/2013
- Buyer/Seller Entity Name: AMS, Inc.
- Transaction Type: Seller
- Buyer/Seller Entity TIN: XXX-XX-4637
- Buyer/Seller NPI: 1023064536

**Reassigning Practitioner:** Mary Williams

**Reassigning Practitioner NPI:** 1037463526

**Reassigning End Date:** 01/15/2017

**Reassignment Effective Date:** 04/13/2016

**Reassigning End Date:** 01/15/2017
PECOS State’s Page

Medicare Details

Medicare Provider Info:

- **Current Status:** Approved
- **First Approved On:** 04/30/2003
- **Status Effective Date:** 04/30/2003

Practice Location Info:

- **Address Line 1:** 87465 West Avenue
- **Address Line 2:** Room 966
- **City:** Worcester
- **State:** MA
- **ZIP:** 37465
- **Site Visit Date:** 02/15/2016
- **Site Visit Result:** PASS
### Disclosure Information:

#### 5% or More Owners

<table>
<thead>
<tr>
<th>Name: John Smith</th>
<th>Role Effective Date: 03/15/2015</th>
<th>Date of Birth: 04/01/1977</th>
<th>SSN (Last 4): XXXX-XX-3297</th>
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<tbody>
<tr>
<td>FCBC Order Date: 04/10/2015</td>
<td>FCBC Result: PASS</td>
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</table>

#### Managing Entity

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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Disclosures:**
- FCBC Order Date: 04/10/2015
- FCBC Result: PASS
### Screening History:

**MEDICARE SCREENING HISTORY (RICHARD MCROBERTS)**

<table>
<thead>
<tr>
<th>Provider Screening Information</th>
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<tbody>
<tr>
<td>Date Ordered: 04/12/2016</td>
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<tr>
<td>APS Profile Link:</td>
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</table>

<table>
<thead>
<tr>
<th>Revalidation Information</th>
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<tr>
<td>Revalidation Due Date: 03/20/2017</td>
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<tr>
<td>Revalidation Completed Date:</td>
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<tr>
<td>Revalidation Status: COMPLETED</td>
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</table>

<table>
<thead>
<tr>
<th>SSA Death Master File Information</th>
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</thead>
<tbody>
<tr>
<td>Date Reported on Death Master File:</td>
</tr>
<tr>
<td>Date of Death:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OIG LEIE Medicare Exclusionary Database (MED) Information</th>
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</thead>
<tbody>
<tr>
<td>Date Reported on MED File:</td>
</tr>
<tr>
<td>MED Sanction:</td>
</tr>
<tr>
<td>Date Reported on Waiver File:</td>
</tr>
</tbody>
</table>

**Revalidation Status: COMPLETED**
Data Compare Service

SMAs that have participated in Data Compare

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

**California** Reported

167,375 Providers

- Data Compare Report Had a Match of 121,403 Providers
- Reliable Data Compare 86,844 Individual Providers
- 52% Reliable for revalidation

**Ohio** Reported

69,725 Providers

- Data Compare Report Had a Match of 51,837 Providers
- Reliable Data Compare 50,924 Individual Providers
- 73% Reliable for revalidation
CMS State Assessment Visits

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

OR

**BEST PRACTICES**

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

CT

**BEST PRACTICES**

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

VA

**BEST PRACTICES**

Virginia established a 100% online enrollment process.

WI

**BEST PRACTICES**

Wisconsin established a 24 hour auto-enrollment process.
Medicaid Managed Care

CMS-2390 began JAN 2018

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

- enroll in Medicaid

Reduces Fraud

1. Ensures compliance with enrollment requirements across all programs
2. Ensures services are provided by qualified providers
3. Ensures consistency across CMS programs
Question & Answer Session
Protecting the Program
**Stronger Screening**

**Increase Site Visits**
- All geographical areas
- All provider types

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

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

*Authority: 42 CFR 424.517*
Site Visit Data

**COMPLETED**
Total Site Visits
- 55,434
- 23,134
- 17,745

**OPERATIONAL**
Site Visit Results
- HIGH / MODERATE Non-DME
  - 46,072
- Limited Risk
  - 16,418
- Durable Medical Equipment (DME)
  - 17,638

**NON-OPERATIONAL**
Site Visit Results
- HIGH / MODERATE Non-DME
  - 9,362
- Limited Risk
  - 6,716
- Durable Medical Equipment (DME)
  - 107

*FY 2017*
Poll

Question 10
Fingerprinting

CMSfingerprinting.com

**Applies to:**
- New HHAs
- New DME suppliers
- New MDPP suppliers
- High risk providers/suppliers

**Excludes:**
- Managing Employees
- Officers
- Directors

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

**5% (+) Ownership/Partners in a high risk provider/supplier**

- Letter will be sent giving 30 days to get fingerprinted
- Medicare phased rollout
- SMAs may rely on Medicare’s fingerprint results
- SMAs may request fingerprints in advance of Medicare to comply with July 2018 deadline

**If the provider/supplier:**
- Has a felony conviction
- Refuses fingerprinting

Then CMS or SMA may deny the application, or revoke/terminate their billing privileges
Fingerprint Data

**FINGERPRINTS REQUESTED**

6,545

**COMPLETED**

4,650

**NON-RESPONSE**

1,790

*FY 2017*
Continuous Monitoring

- **licensure**
  - License via Automated screening
  - SSA Death Master File
  - NPI and LBN Integrated via NPPES

- **exclusions + sanctions**
  - OIG and GSA websites Integrated in PECOS Monthly checks

- **adverse actions**
  - Criminal alerts via Automated screening

- **practice locations**
  - Ad hoc site visits
Data Sharing

Public data files from PECOS

- **Public Provider Enrollment File**
  - Currently approved individuals and orgs
  - Reassignments
  - Practice location data (limited)
  - Primary and secondary specialty
  - Updated quarterly

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

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

- **Opt Out File**
  - Currently opted-out of Medicare
  - Updated quarterly

All files contain Names and NPIs
Available at data.cms.gov
Connections Between All Programs

Failure to maintain accurate enrollment data could impact your participation in other Medicare & Medicaid programs.
Poll
Question 11
Question & Answer Session
Enforcement Actions
Adverse Legal Actions

**Required during:**
- Initial enrollment
- 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)*

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

- **Misdemeanor conviction in last 10 years**
  - Patient abuse or neglect
  - Theft, fraud, embezzlement

- **Sanction or exclusion (ever)**

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

- **Accreditation revocation or suspension (ever)**

- **No longer required to report Medicare Payment Suspensions or CMS-Imposed Medicare Revocations (April 2018)**
Deactivations and Reactivations

CMS can deactivate Medicare billing privileges for:

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

To reactivate Medicare billing privileges:

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

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

DEACTIVATIONS

933,421

OCT 1, 2011

SEPT 30, 2017

380,554

41%

Percent deactivated for failure to respond to revalidation
Reasons to Deny

**CMS can deny Medicare applications for:**

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

**Unless:**
- approved repayment plan
- offset or appeal
- bankruptcy
Denials

**DENIALS**

12,904

OCT 1, 2011 to SEPT 30, 2017

**TOP REASONS FOR DENIAL**

- Non-Operational: 21%
- Non-Compliance: Provider/Supplier Type Requirements Not Met: 42%
Reasons to Revoke

CMS can revoke Medicare billing privileges for:

- Felony conviction
- DEA suspended or revoked
- Medicaid billing privileges terminated
- Excluded from federal program
- Abusive prescribing
- Non-operational (onsite visit)
- Insufficient capital (HHA)
- Abuse of billing privileges
- Misuse of billing number
- False or misleading information
- Fee not paid (including if hardship exception denied)
- Noncompliance: document requirements
- Noncompliance: program requirements
- Failure to report to MAC...

1–3 Year Re-enrollment bar

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

...in 90 days: all other information
- Must report to the MAC
- Notifying a state, Regional Office, or another agency is not enough
Revocations

REVOCATIONS

49,699

OCT 1, 2011

SEPT 30, 2017
How to Appeal

1 Corrective Action (CAP)
For all denial reasons, but only noncompliance revocation reason
Simply correct the issue:
- Send CAP within 30 days
- MAC/CMS has 60 days to process

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

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

3 Administrative Law Judge

4 HHS Departmental Appeals Board

5 Federal District Court

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

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

Question 12
Poll

Question 13
Poll

Question 14
Medicaid Terminations

**Medicare Revocation Impact on Medicaid**

*If Medicare revokes “for cause”...

**Medicaid Termination Impact on Medicaid**

*If one state terminates “for cause”...

**Medicaid Termination Impact on Medicare**

*If terminated from any state “for cause”...

Then the states must terminate a provider from their program.

Then all states must terminate a provider from their program.

CMS has the discretion to revoke from Medicare.
Medicaid Terminations

- More than 1,900 Total Medicaid TERMINATION SUBMISSIONS
- More than 600 Total Medicaid TERMINATION SUBMISSIONS Resulting in Medicare REVOCATION
- More than 3,000 Total Medicare REVOCATION FILE ENTRIES
Poll
Question 15
Question & Answer Session
Resources

cms.gov
- ordering and referring, DMEPOS accreditation, supplier standards
- MAC contacts: (search for Medicare enrollment contact”)

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

ProviderEnrollment@cms.hhs.gov
Provider Enrollment contact

888-734-6433
PECOS Help Desk

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

 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

PECOS.HHS.GOV

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Thank You

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Centers for Medicare & Medicaid Services