NATIONAL PROVIDER ENROLLMENT CONFERENCE

59 Million Patients, **2 Million** Providers, **ONE** Mission

Medicare & Medicaid Provider Enrollment

Presented by

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Provider Enrollment & Oversight Group
Centers for Medicare & Medicaid Services

Session Overview

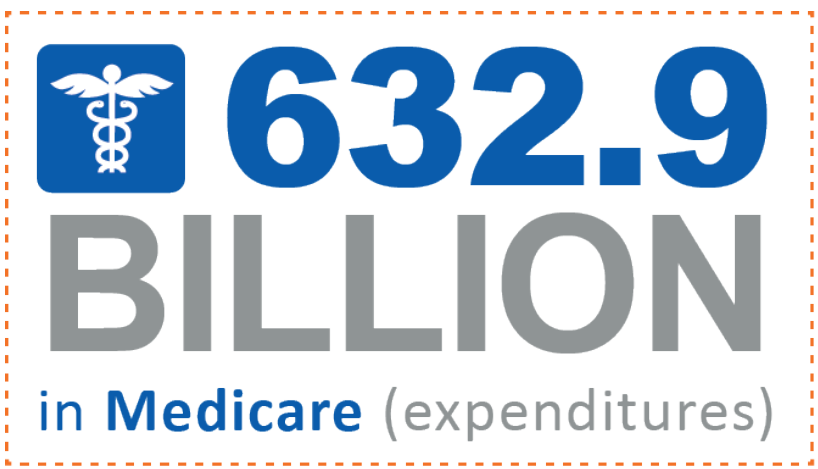
- Putting Patients First
- How Enrollment Works
- Medicare Policy Updates
- Revalidation
- Medicaid Enrollment
- Our Enrollment Systems
- Protecting the Program
- Enforcement Actions

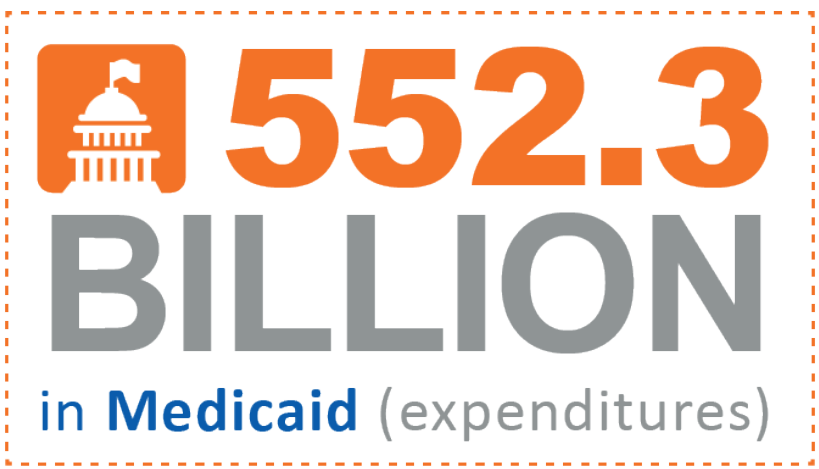
Putting Patients First

Poll Question 1

Poll Question 2

By the Numbers





Why We're Here

LISTENING TO YOU

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

FINDING A BALANCE

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

ALWAYS IMPROVING

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

How Enrollment Works

How Enrollment Works

Medicare Providers & Suppliers (w/NPI)

Submission

1

855Form

60 days*

Online

45 days*

5

Development Letter

Submit to MAC

Intake

2

- MAC mail room
- Manual data entry

Direct Input

Processing, Screening & Verification

3

PECOS

4

Finalization & Claims Update

Update claim system

- MAC updates claim system (1-2 days)

6

- Provider not approved until claims updated

MAC Recommendation to State /RO

- Certified providers/suppliers
- MAC recommends to RO
- RO performs in 3-9 mo

Pre Screening

- signed + dated
- app fee (or waiver)
- supporting docs
- all data elements

Verification

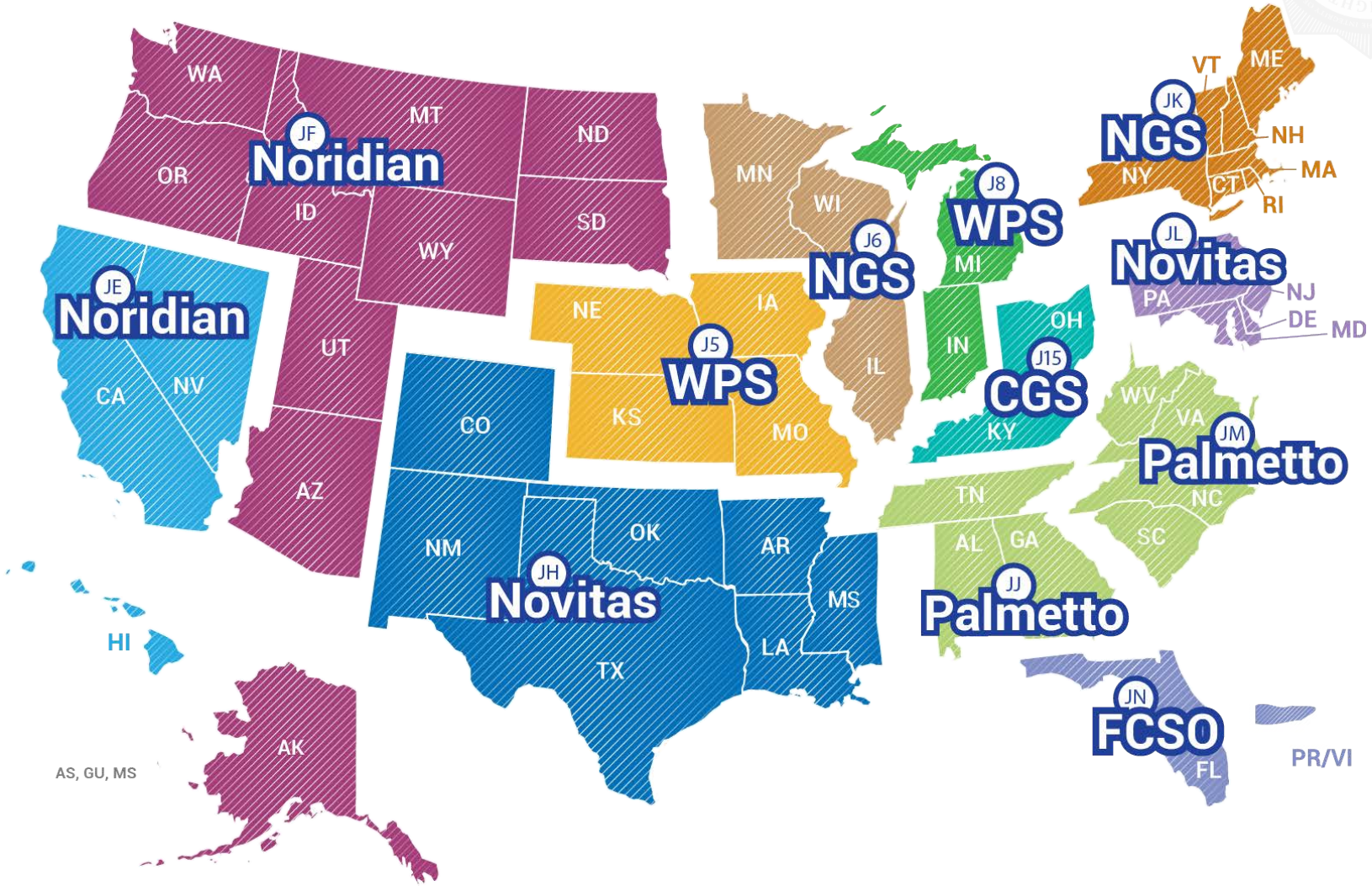
- Name / LBN
- SSN / DOB
- NPPES
- Address
- License
- Adverse Actions

Risk Based

- Fingerprints
- Site Visits

** If the app is complete, and no site visit*

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

AO Authorized Official

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

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

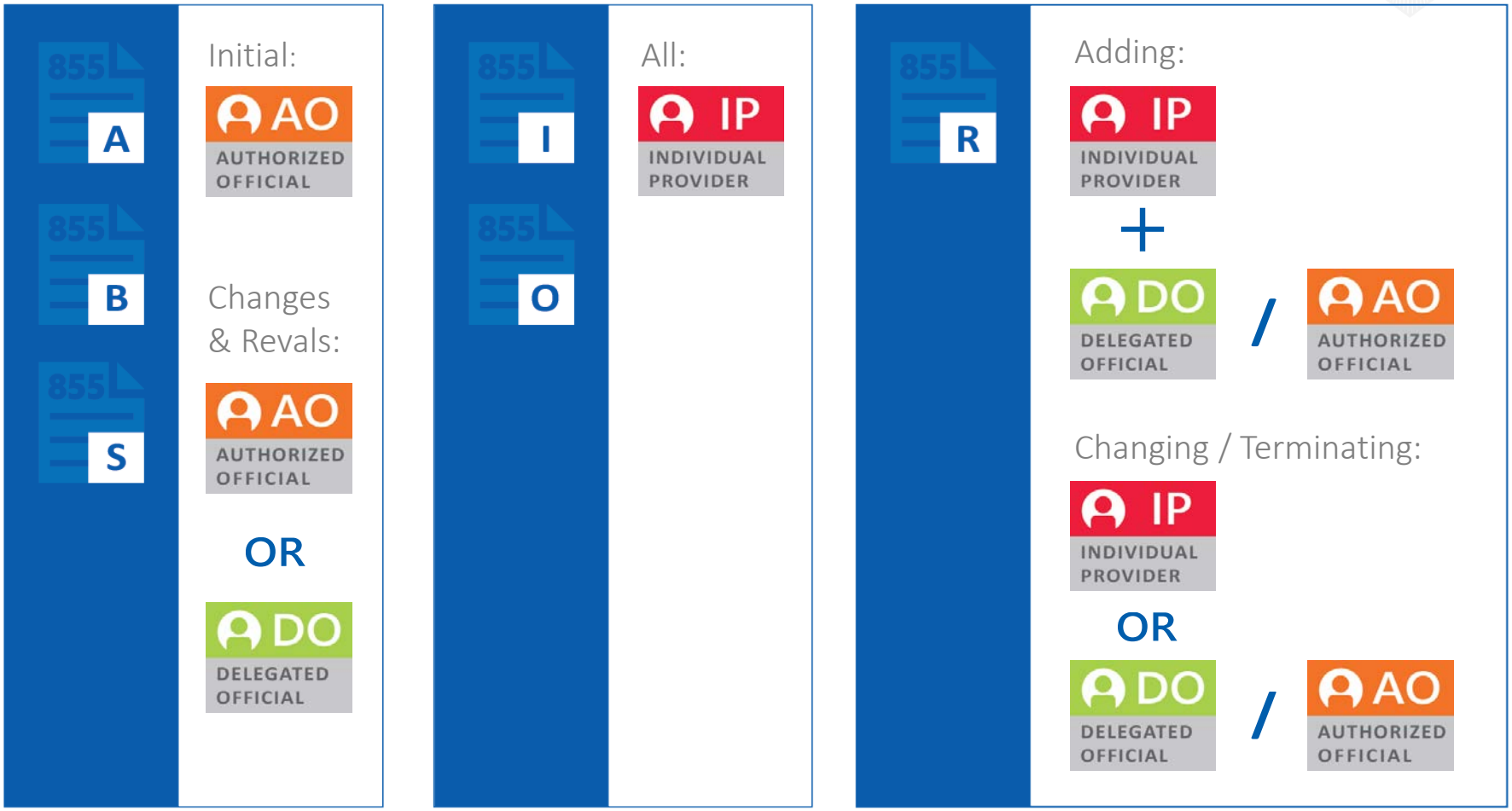
- CEO, CFO, partner, chairman, owner, or equivalent appointed by the org. AO requirements are same as PECOS
- Automatically approved if listed as AO in PECOS; if not, CP575 must be provided to approve access
- Manage staff and connections for the employer
- Approve DOs for the employer

DO Delegated Official

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?



Release of Enrollment Information

	Individual Provider	AO / DO	Contact Person	Outside Person / Entity
PTANs	X	X	X	
Effective Dates	X	X	X	
Group Affiliations	X	X	X	
Practice Locations	X	X	X	
Revalidation Status Information	X	X	X	X
Approval Letters	X	X	X	

Provider Enrollment Moratoria

2013

Initial Implementation

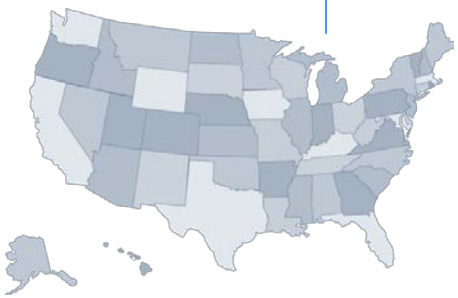
July 2013

- HHA and HHA sub-units

  Miami & Chicago

- Ambulance and ambulance suppliers

  Houston



2014

Expanded

January 2014

- HHA and HHA sub-units

  Miami, Ft. Lauderdale, Detroit, Dallas, Chicago

- Ambulance and ambulance suppliers

  Houston, Philadelphia, surrounding New Jersey

2015

No Changes

January 2015

- HHA and HHA sub-units

  Miami, Ft. Lauderdale, Detroit, Dallas, Chicago

- Ambulance and ambulance suppliers

  Houston, Philadelphia, surrounding New Jersey

2016

Lifted

July 2016

- Emergency ambulance services

Expanded

July 2016

- State wide
- HHA and HHA sub-units

  Florida, Illinois, Michigan, & Texas

- Non-emergency ambulances and ambulance suppliers

  New Jersey, Pennsylvania, & Texas

2017

Lifted

September 2017

- Non-emergency ambulance services in Texas

For more information refer to the Federal Register notice at 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

RESPONSE RATE

90%

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

60
DAYS TO RESPOND

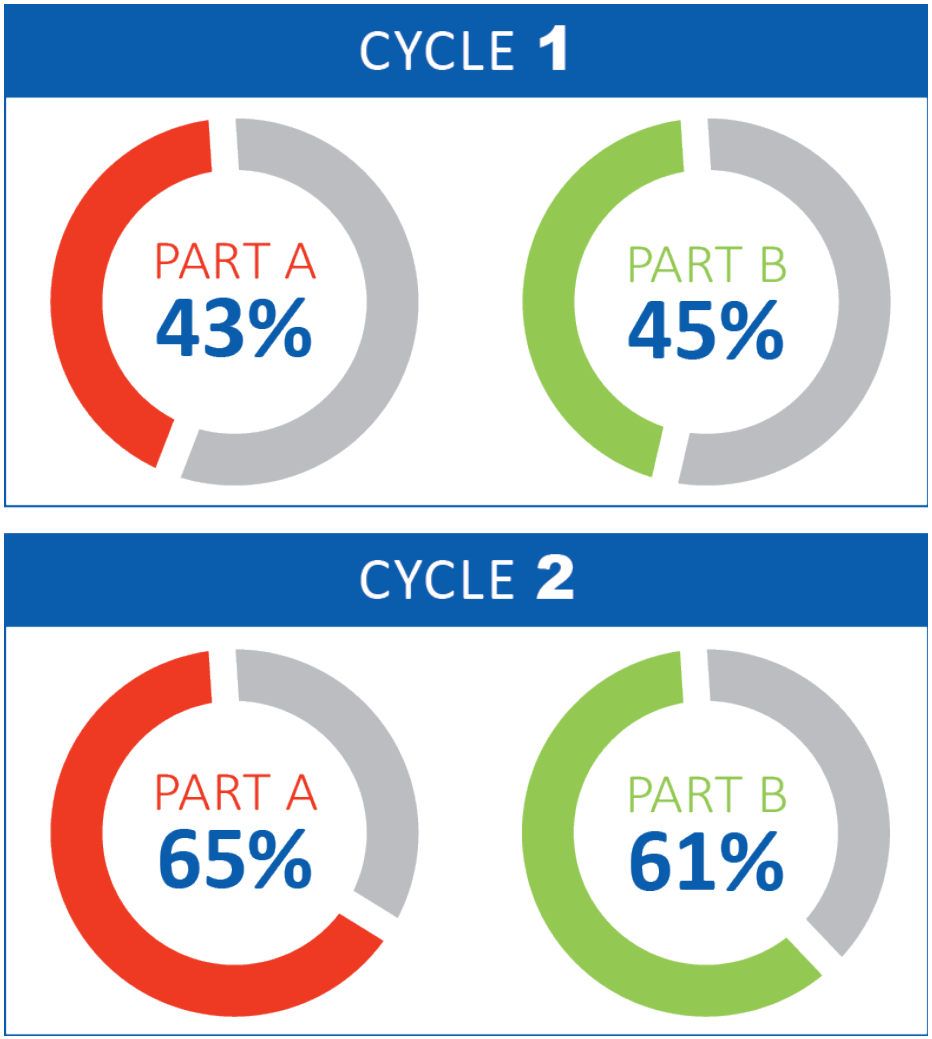
No Response?

- deactivate (not revoke)

Late Revalidation?

- break in billing
- new effective date

Revalidation Web Submissions



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 reactivates 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)* ★

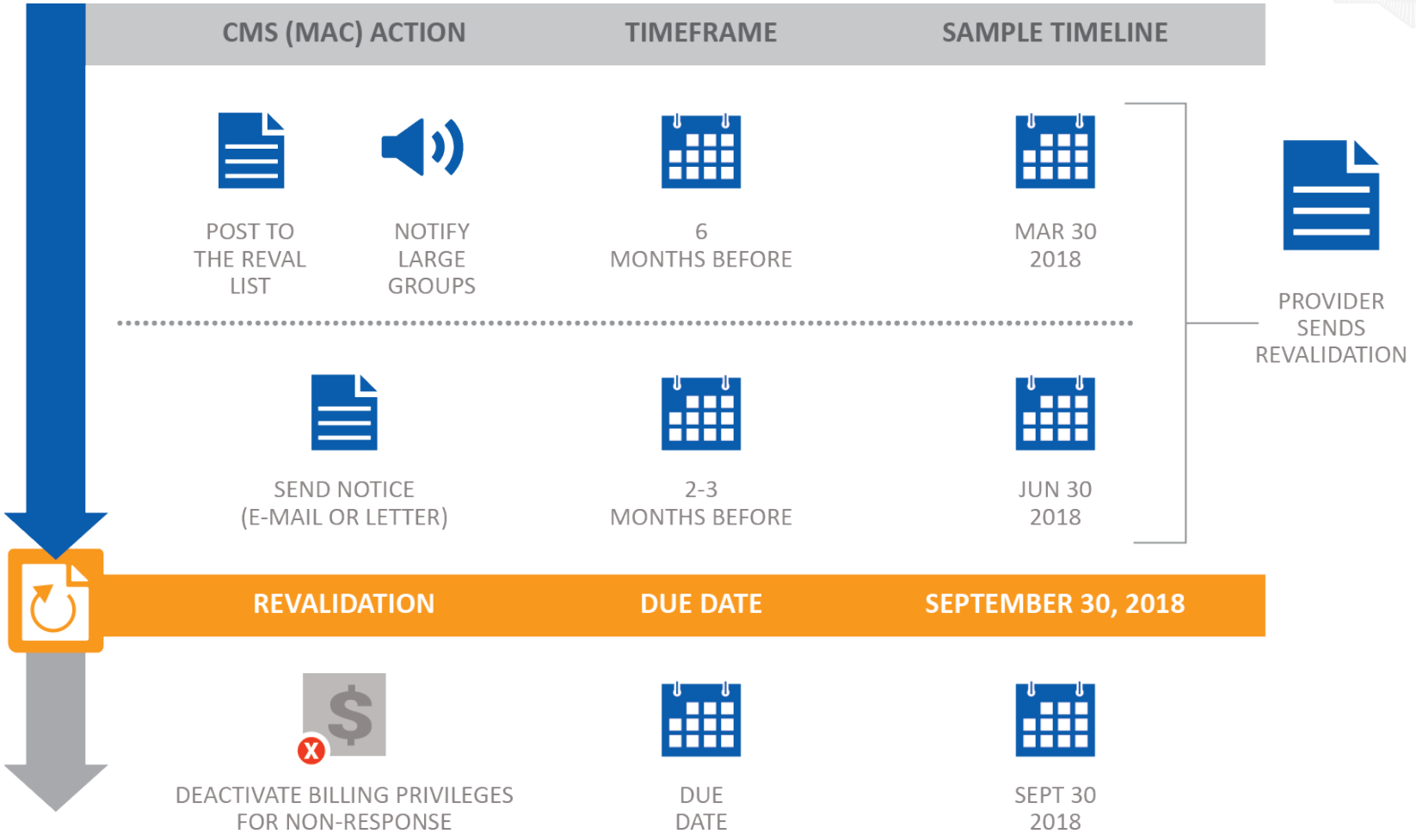
Revalidation Details

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



Poll Question 5

Missing Reassignments - No Break in Billing

SCENARIO #1

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

Application Received	**09/01/2018**
Development Letter Sent	**10/15/2018**
Development Due	**11/15/2018**
Development Received	**11/10/2018**
Revalidation Due	**10/31/2018**
Revalidation Complete	**11/30/2018**

- 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**

Missing Reassignments - Break in Billing

SCENARIO #2

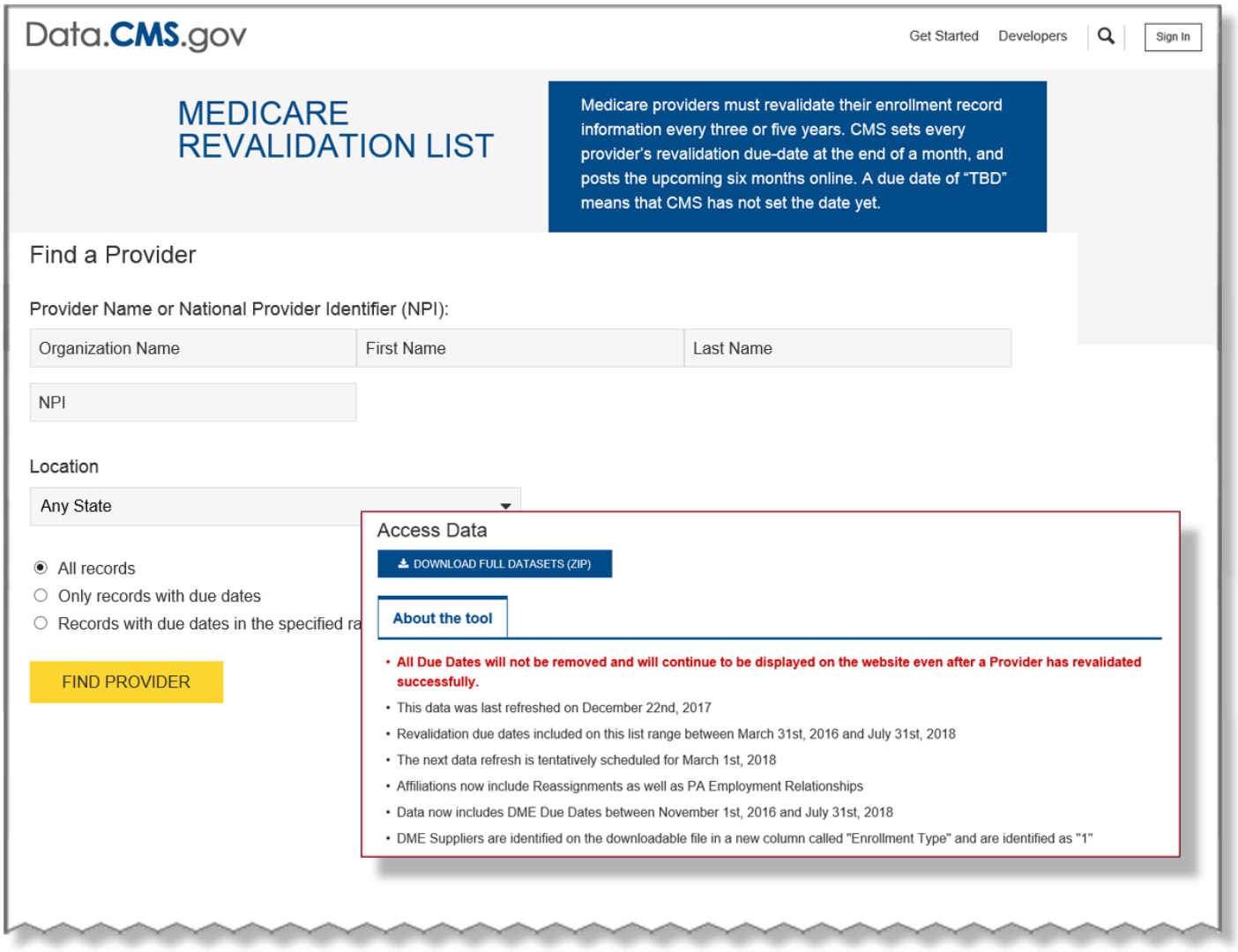
- Revalidation sent with missing reassignments.
- Response received **after** due date

Application Receipt	**10/01/2018**
Development Letter Sent	**10/15/2018**
Development Due	**11/15/2018**
Revalidation Due	**10/31/2018**
Reassignment End	**11/15/2018**
Revalidation Receipt	**12/01/2018**
Reactivation Effective	**12/01/2018**

- 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

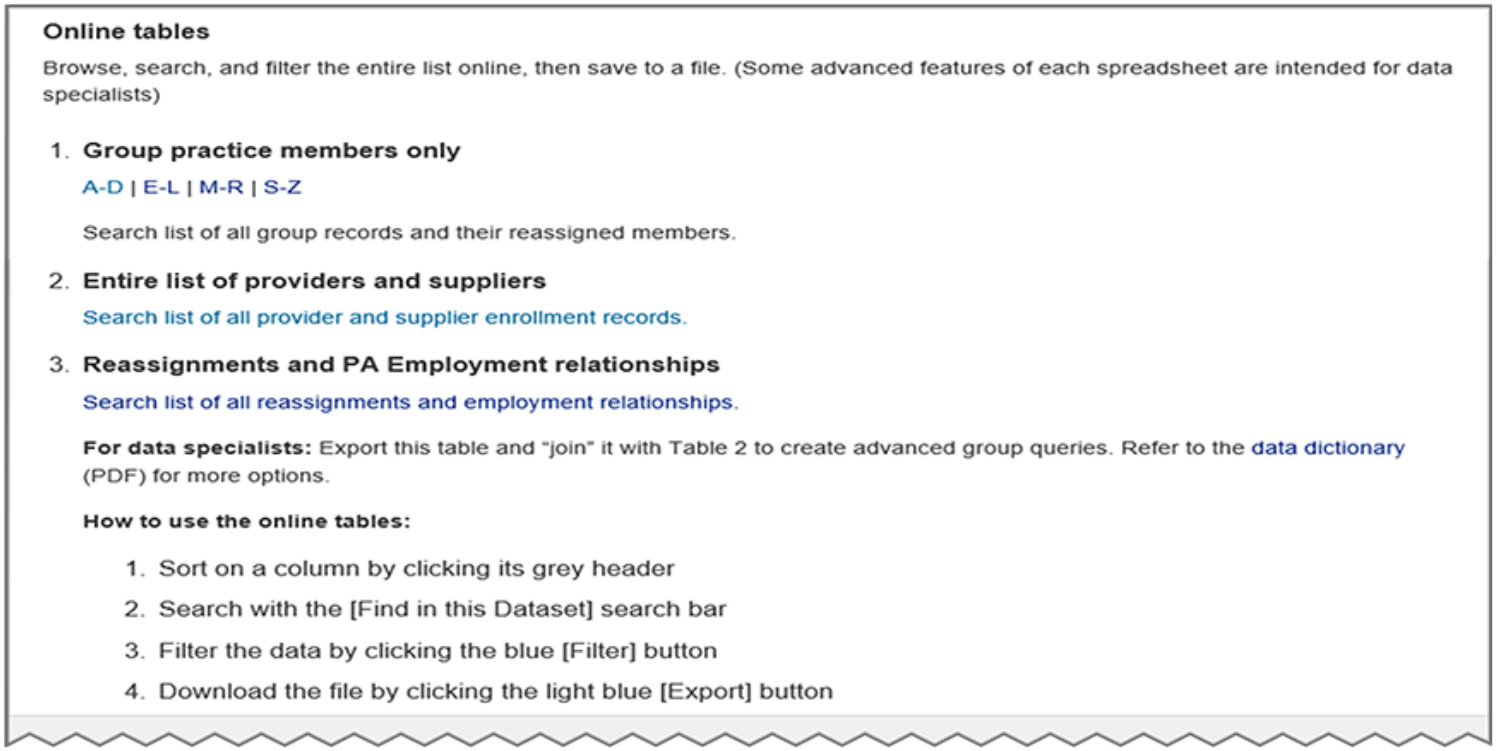


Revalidation Look-up Tool

data.cms.gov/revalidation

3 Sets of Data Files

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



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

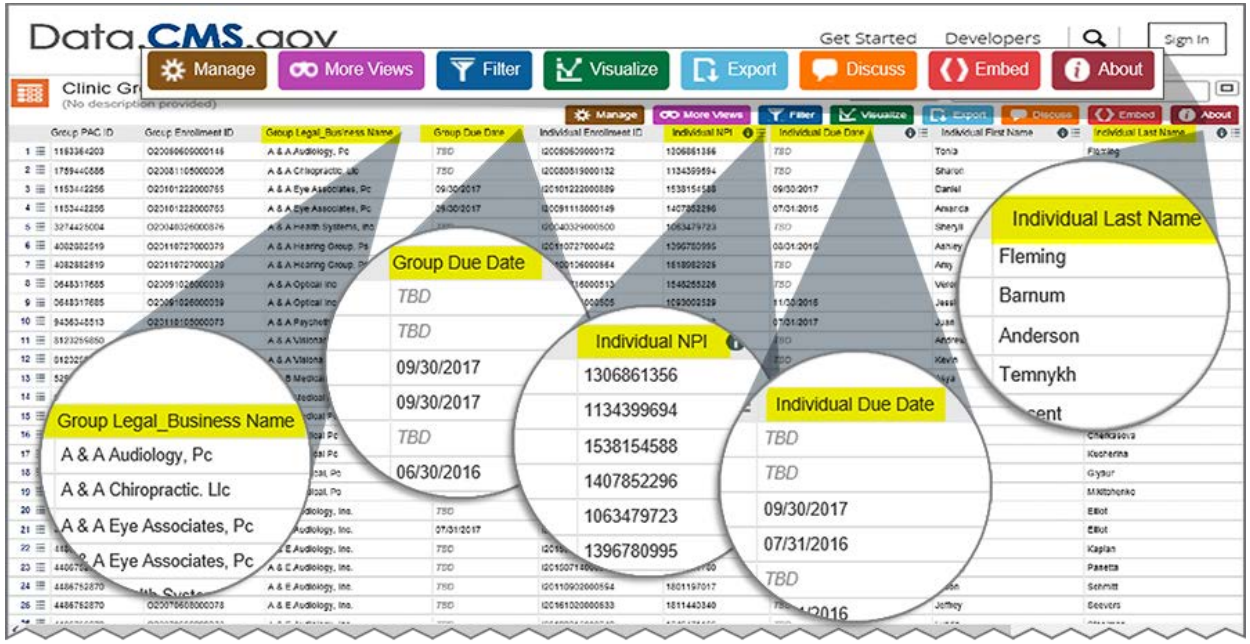
Looking for reassigned providers?

Use "Group practice members only"

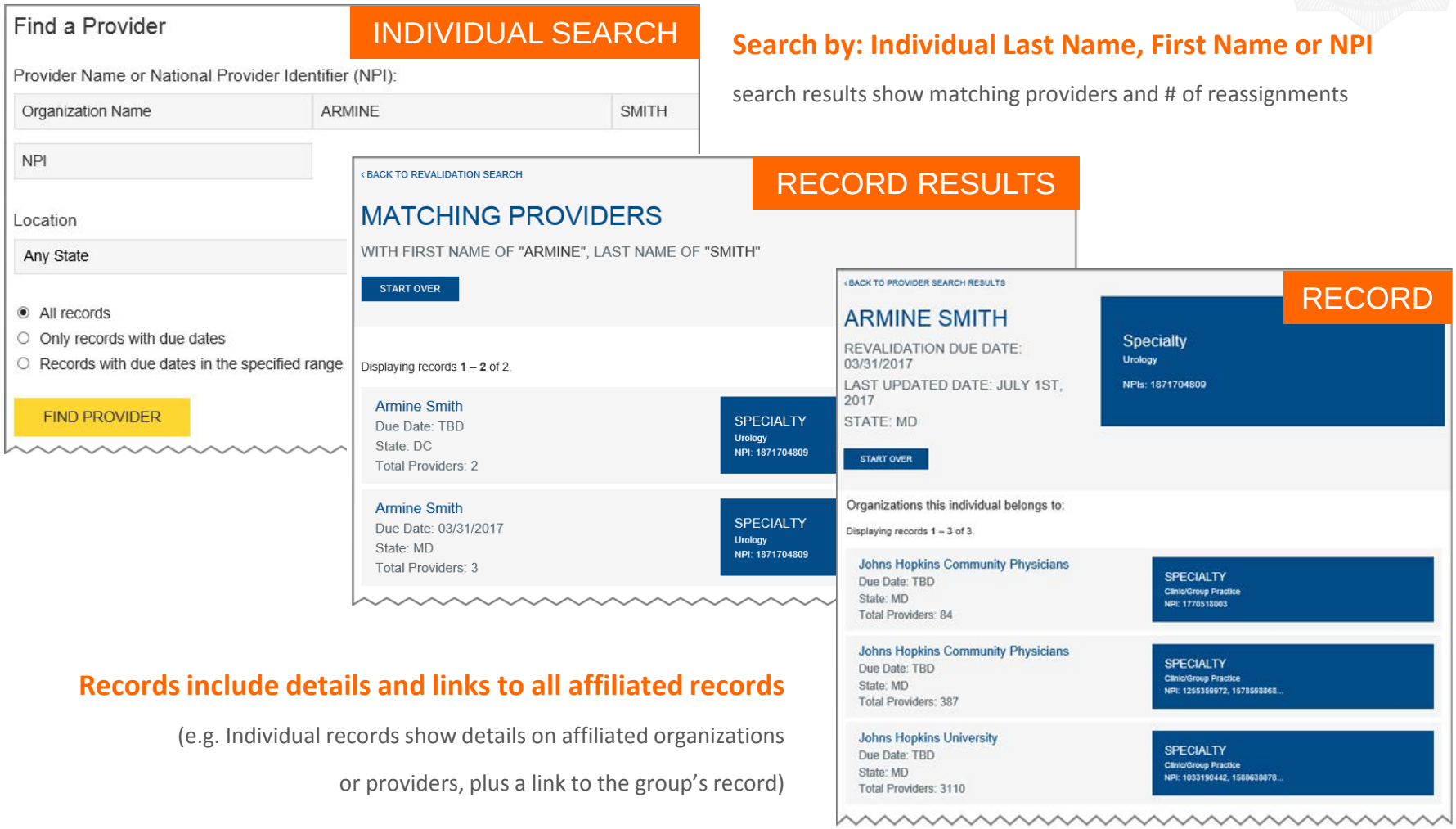
- Sort, download and save by large groups
- Includes all individuals that reassign to the group
- Shows the individual's total number of reassignments

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

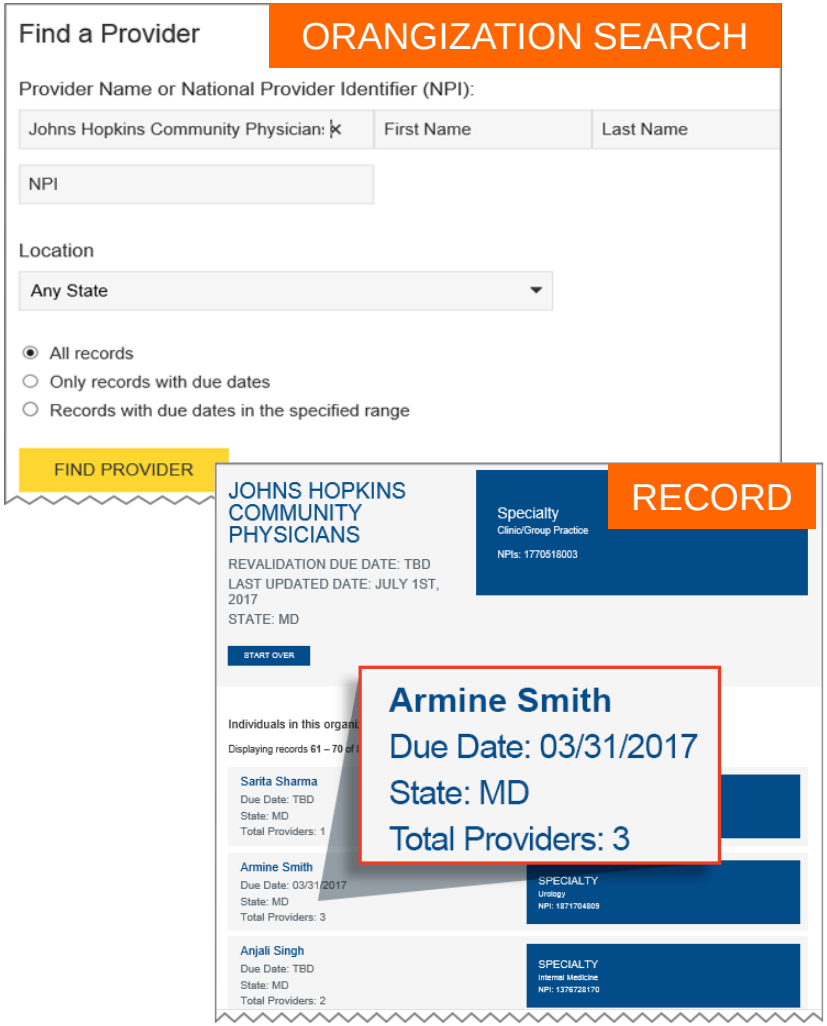
search results show matching providers and # of reassignments

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

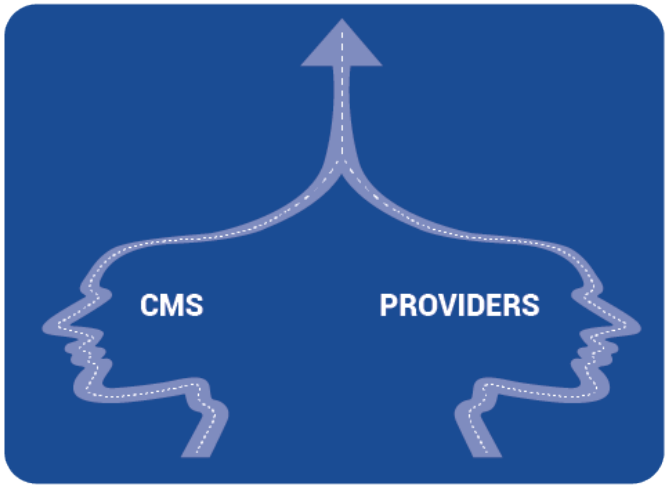
Because of Your Feedback

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



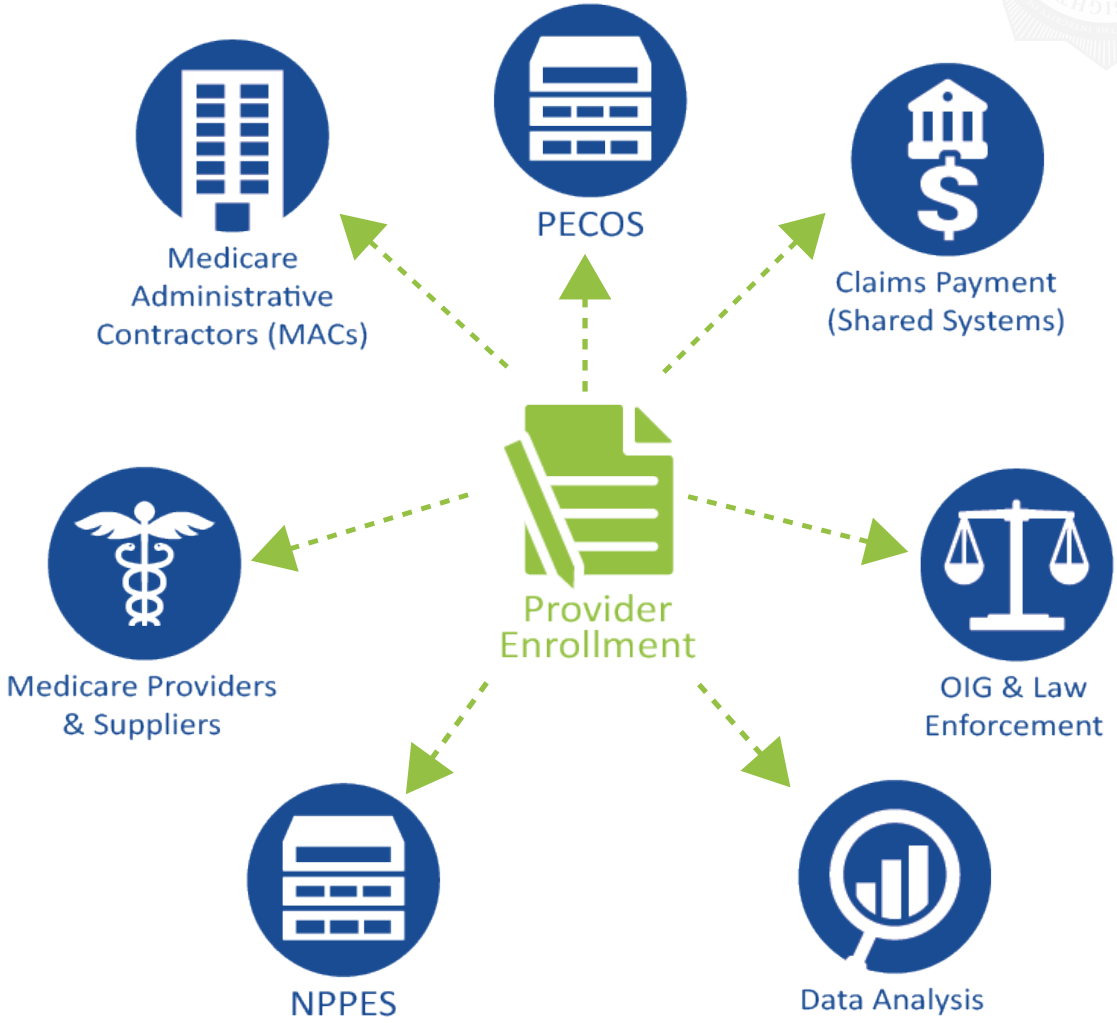
Question & Answer Session

Provider Enrollment Systems

Provider Enrollment 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.

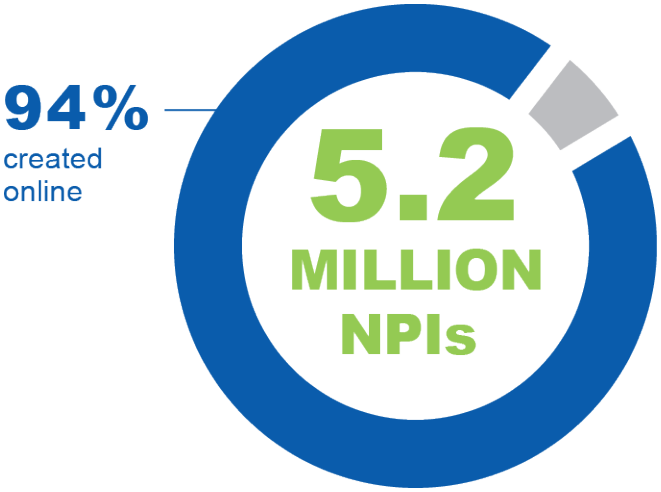


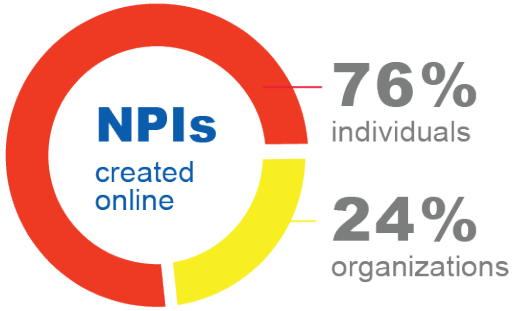
NPPES (NPI) Today

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

Since May 2017…

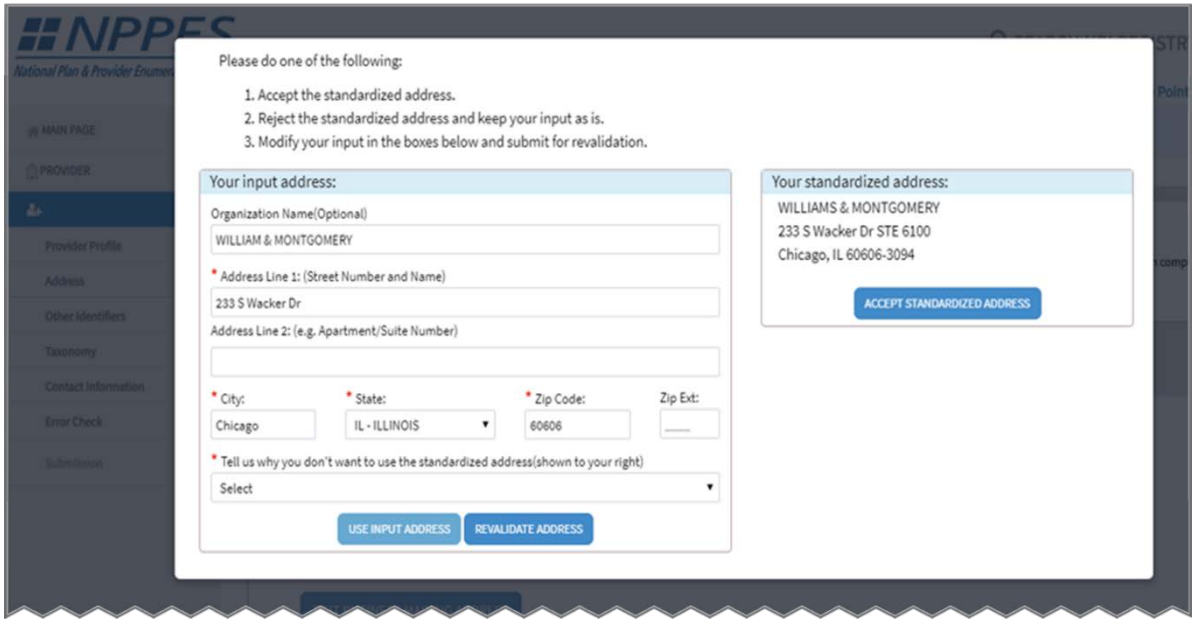
- New design with easier screens
- Surrogacy (like PECOS)
- More data fields
- Improved customer service

Maintain NPI Records

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

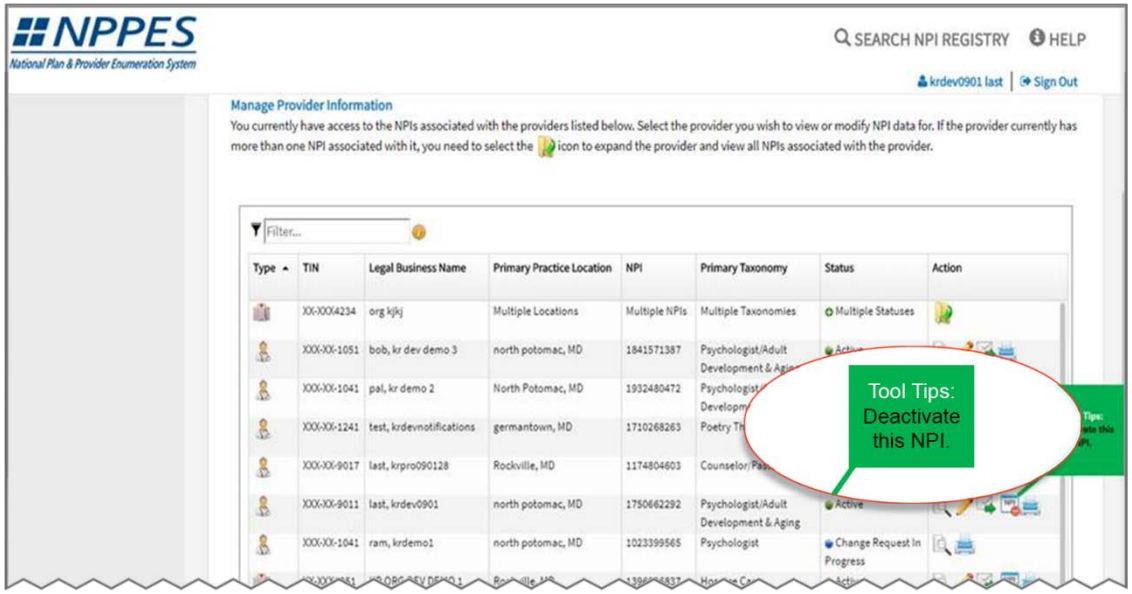
Poll Question 7

NPPES | Data Collection Updates



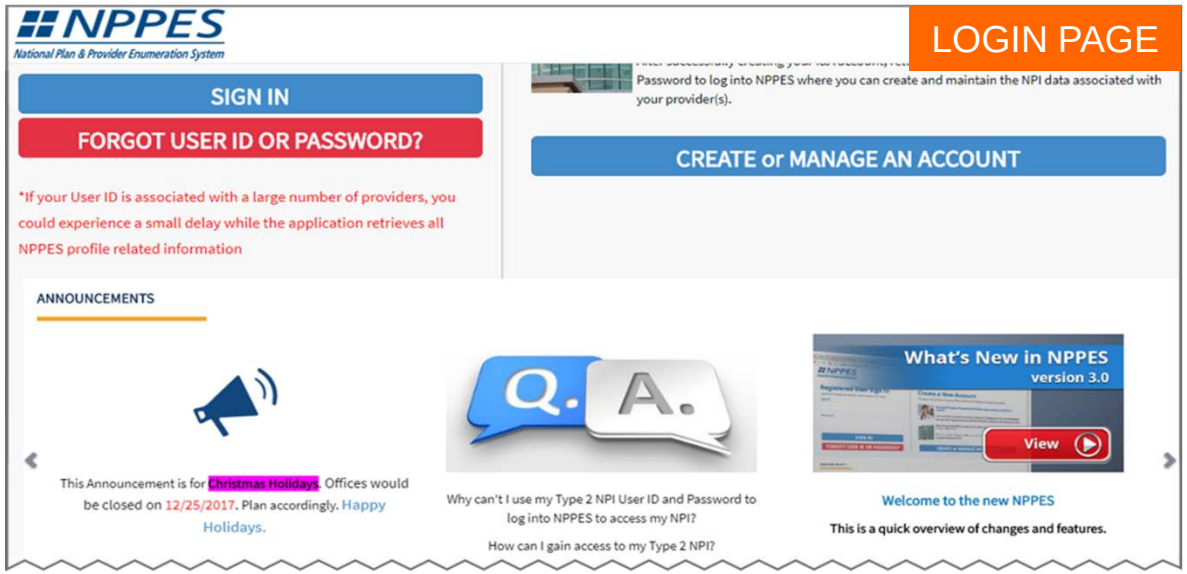
- ✓ Organization Name can be included for address standardization
- ✓ Exclude Medicare other identifiers from User Interface & Data Dissemination files
- ✓ Updates to provider Endpoint information data fields
- ✓ NPI Registry updated with additional practice locations

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

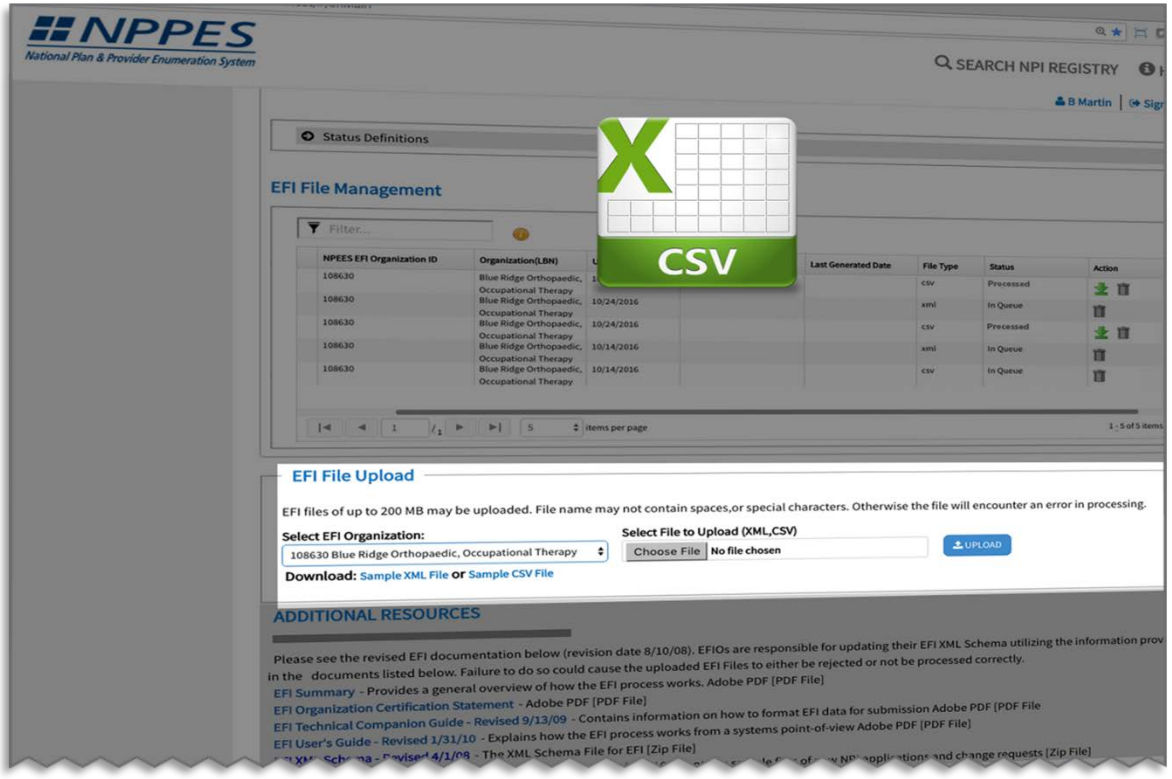


- ✓ Enhanced NPPES 'ANNOUNCEMENTS' Section
- ✓ E-mail confirmation check during NPI application
- ✓ Warning alerts throughout application
- ✓ System generated email notifications for application status updates

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 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

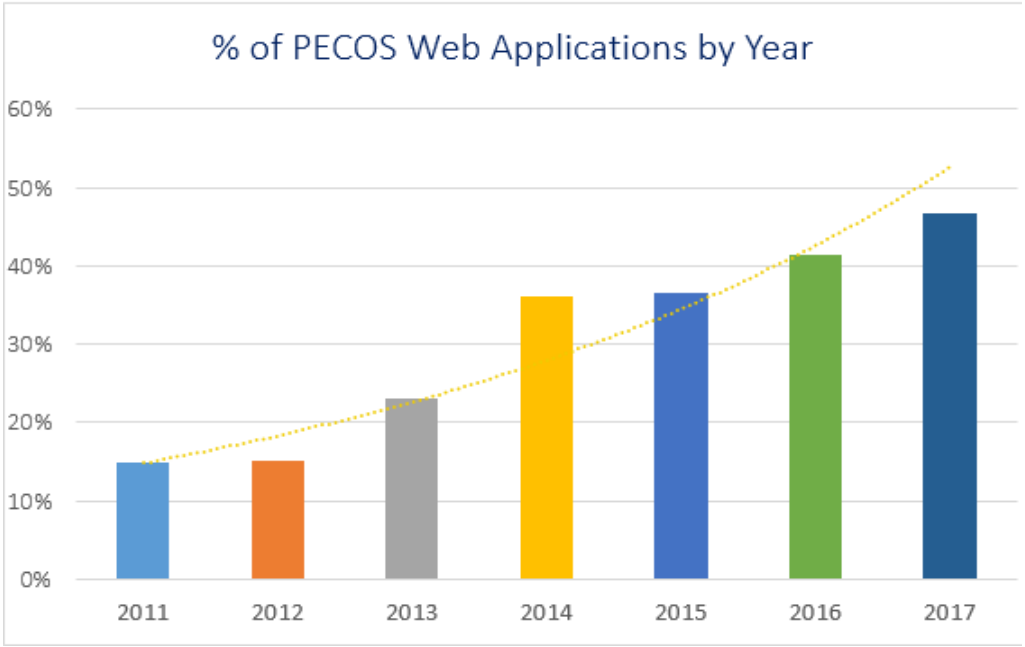
PECOS Today

Over 2 Million Enrollments

Every month…

18,000 new enrollments

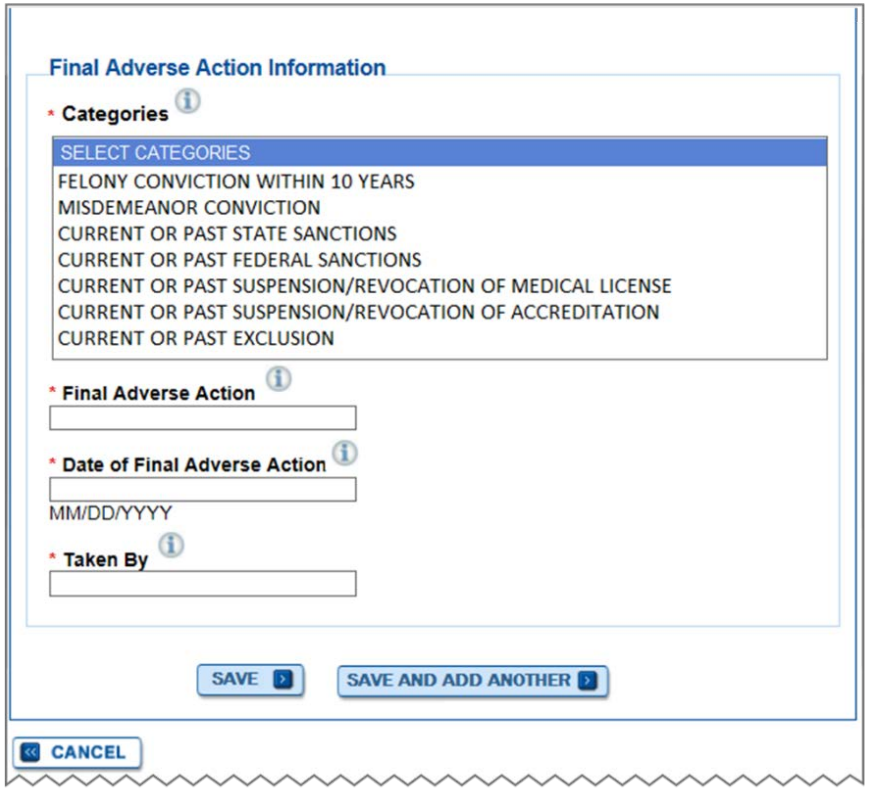
Encouraging Online Applications



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

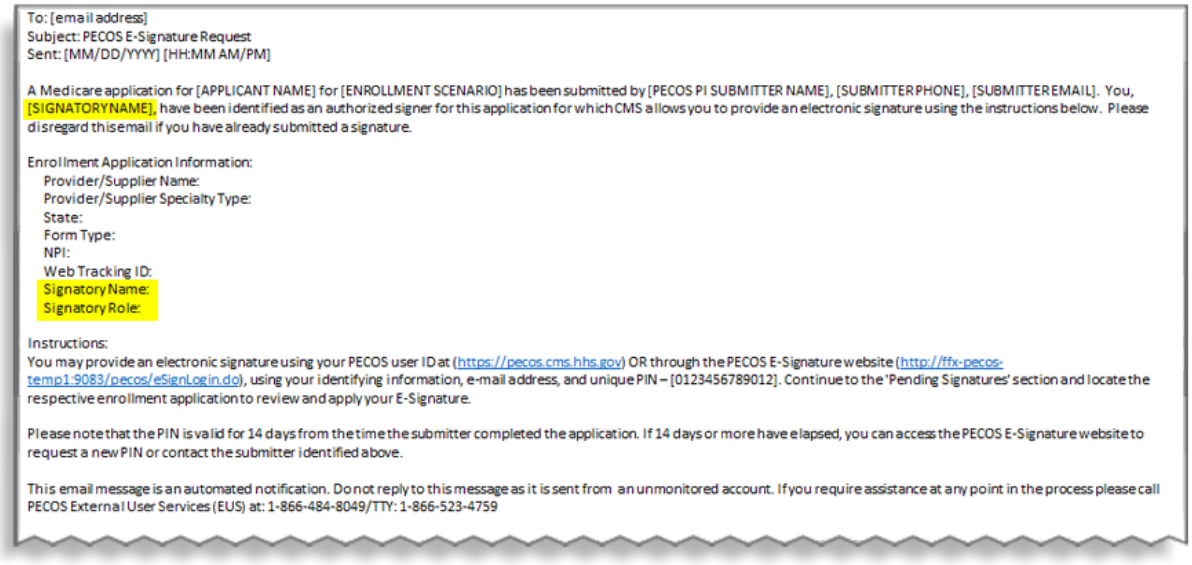
Hot off the Press | April 2018

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



To: [email address]
Subject: PECOS E-Signature Request
Sent: [MM/DD/YYYY] [HH:MM AM/PM]

A Medicare application for [APPLICANT NAME] for [ENROLLMENT SCENARIO] has been submitted by [PECOS PI SUBMITTER NAME], [SUBMITTER PHONE], [SUBMITTER EMAIL]. You, [SIGNATORY NAME], have been identified as an authorized signer for this application for which CMS allows you to provide an electronic signature using the instructions below. Please disregard this email if you have already submitted a signature.

Enrollment Application Information:
Provider/Supplier Name:
Provider/Supplier Specialty Type:
State:
Form Type:
NPI:
Web Tracking ID:
Signatory Name:
Signatory Role:

Instructions:
You may provide an electronic signature using your PECOS user ID at (https://pecos.cms.hhs.gov) OR through the PECOS E-Signature website (http://ffx-pecos-temp1:9083/pecos/eSignLogin.do), using your identifying information, e-mail address, and unique PIN – [0123456789012]. Continue to the 'Pending Signatures' section and locate the respective enrollment application to review and apply your E-Signature.

Please note that the PIN is valid for 14 days from the time the submitter completed the application. If 14 days or more have elapsed, you can access the PECOS E-Signature website to request a new PIN or contact the submitter identified above.

This email message is an automated notification. Do not reply to this message as it is sent from an unmonitored account. If you require assistance at any point in the process please call PECOS External User Services (EUS) at: 1-866-484-8049/TTY: 1-866-523-4759

- ✓ 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

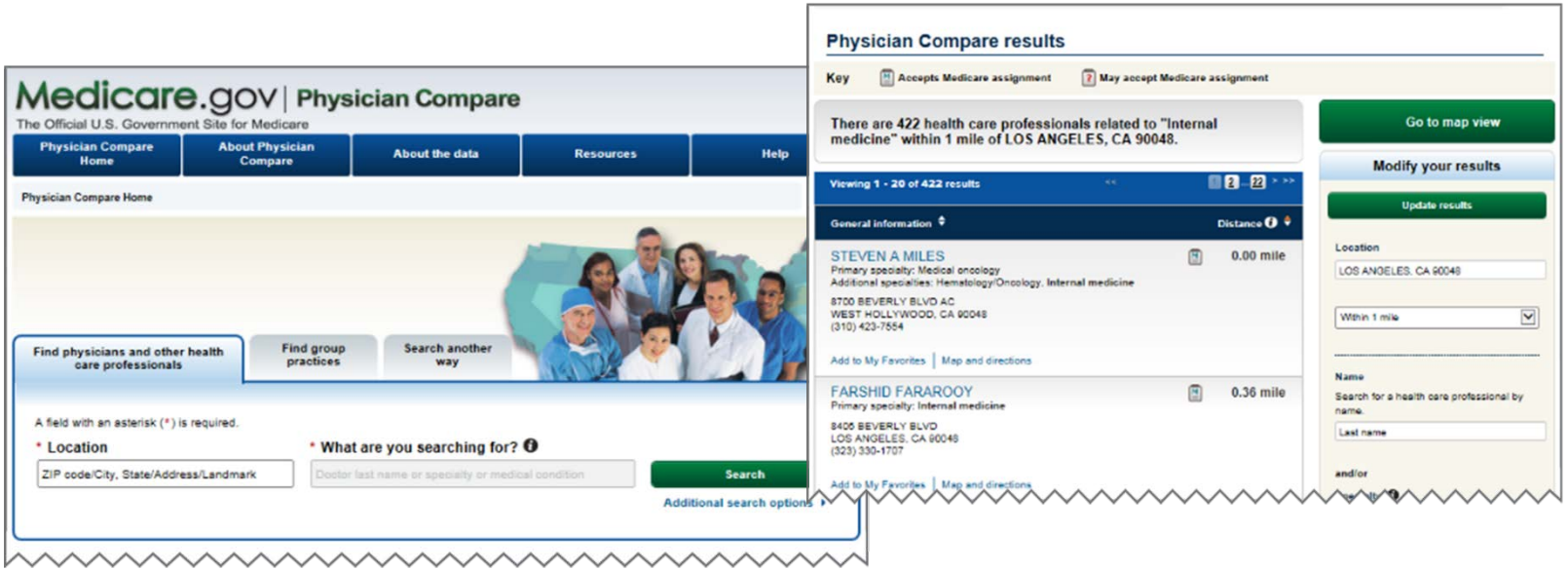
- ✓ PECOS will display two fields: Signatory Name and Signatory Role in the following e-mails:
  - Pending E-Signature E-mail
  - E-signature Reminder E-mail
  - PIN Regeneration E-Mail

Digital Submission

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?

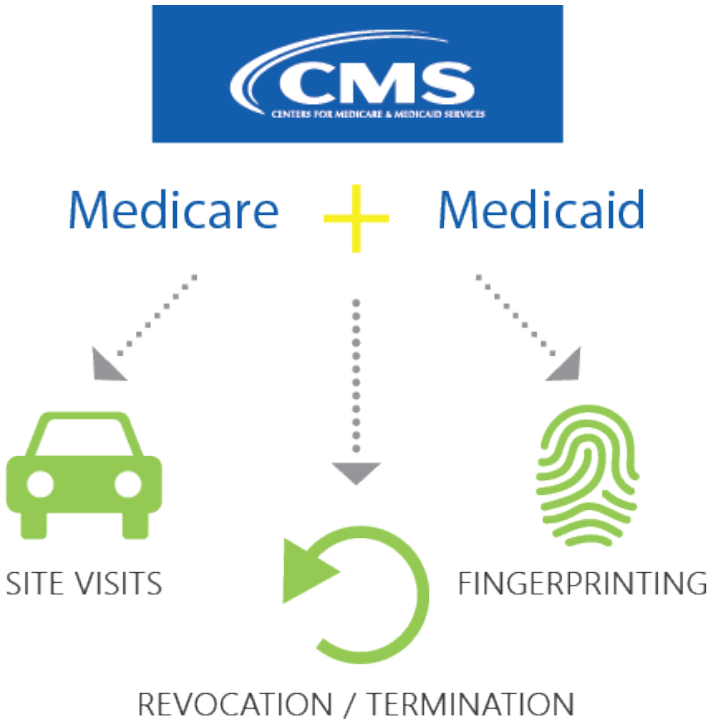
A: We hope to encourage as many users as possible to transition to the online system when they see the simplicity and speed. However, we will continue to allow submission of completed paper applications as we improve the system.

Question & Answer Session

Medicaid Enrollment

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

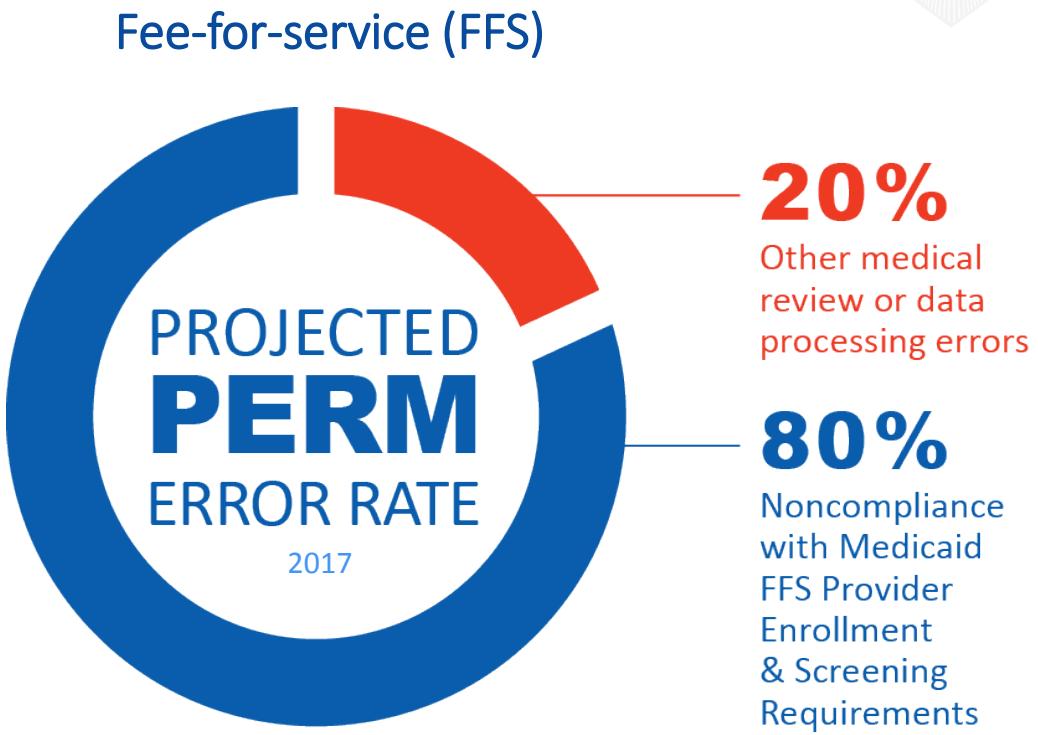
Each state has a CMS point-of-contact

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



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

Medicaid Provider Enrollment Compendium

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
- Find at https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-142017.pdf

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

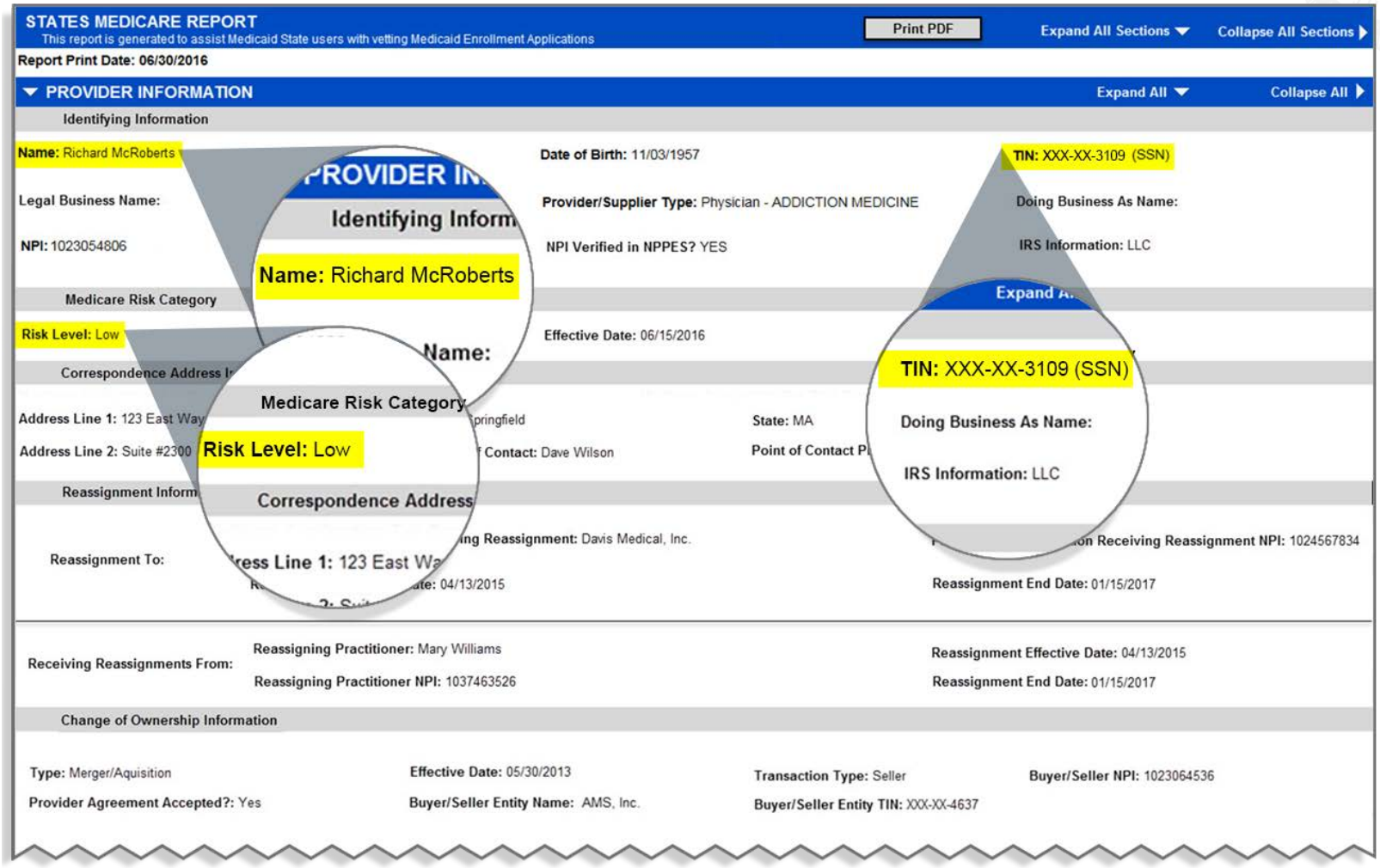
Relying on Medicare Screening

- 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

Risk Category	Comparison	Risk Category	SMA Action
Medicaid Risk Category	=	Medicare Risk Category	None
Medicaid Risk Category	>	Medicare Risk Category	Gap Screening
Medicaid Risk Category	<	Medicare Risk Category	None

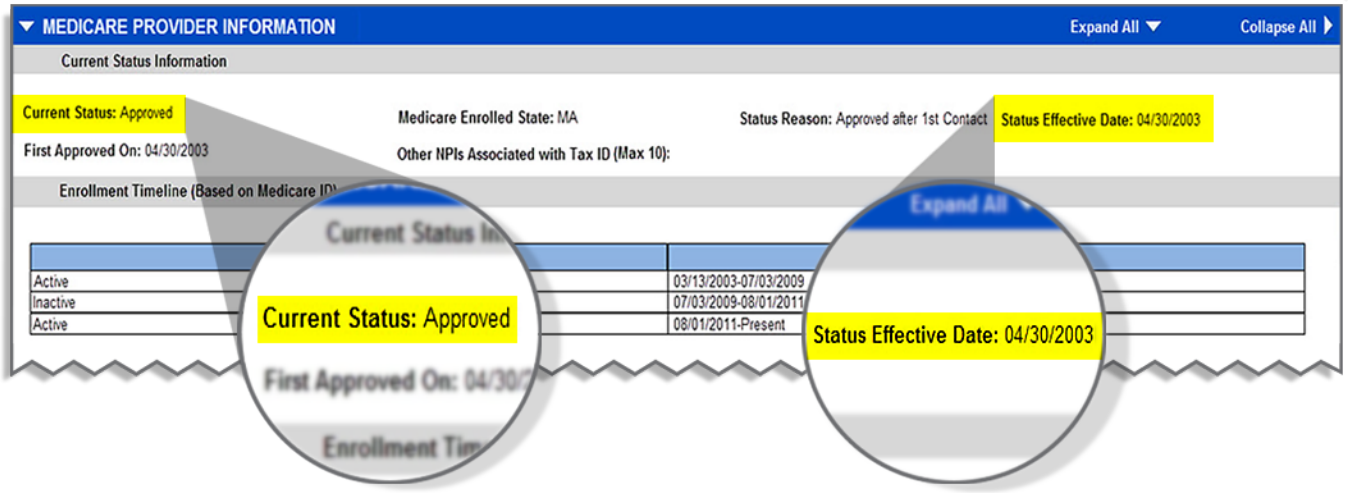
** Exception for DME and HHA risk levels*

PECOS State's Page | Provider Info

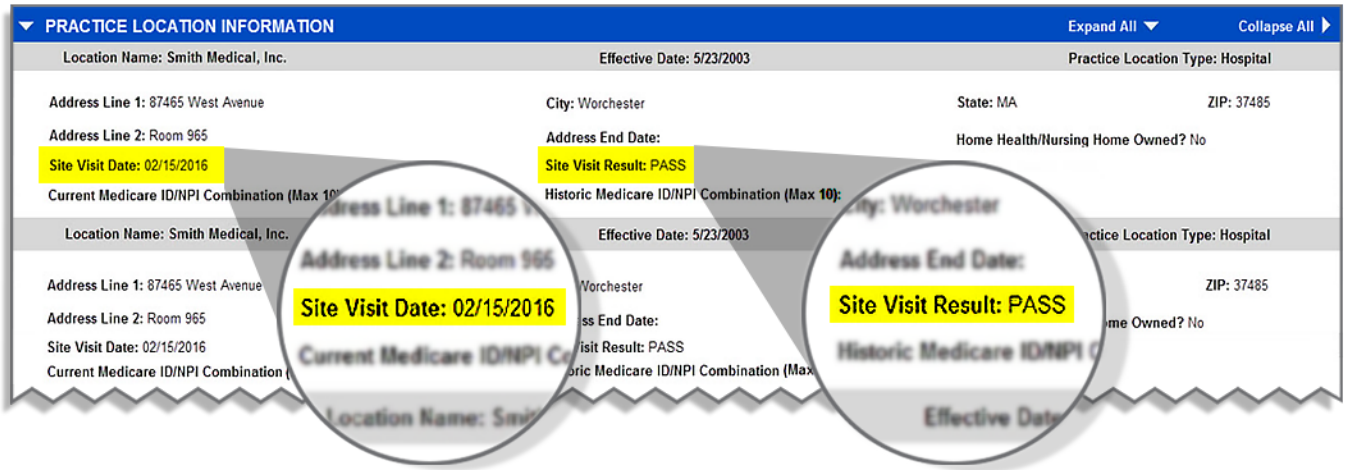


PECOS State's Page | Medicare Details

- **Medicare Provider Info:**

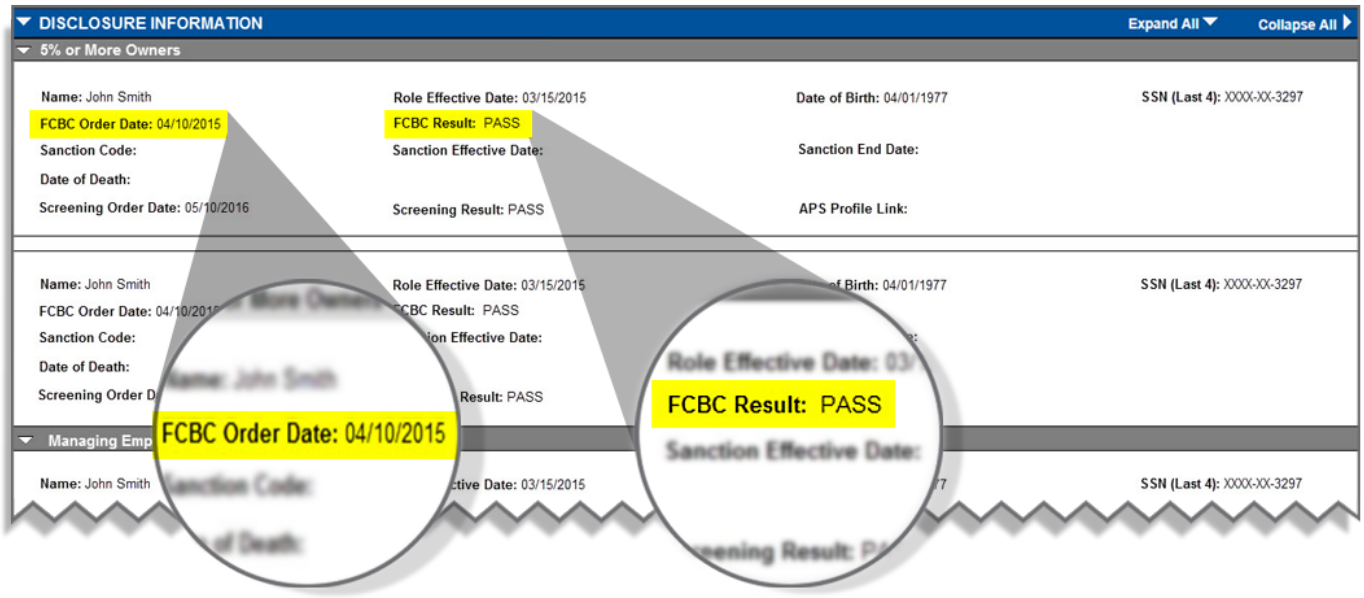


- **Practice Location Info:**



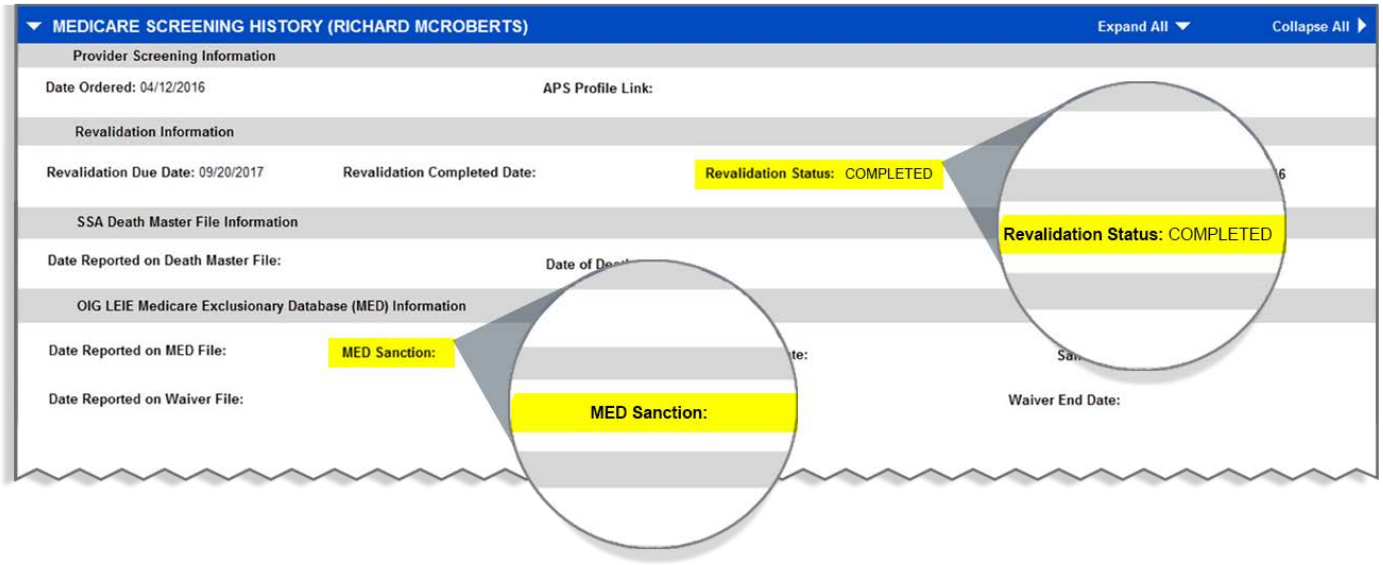
PECOS State's Page | Disclosure Info

Disclosure Info:



PECOS State's Page | Screening History

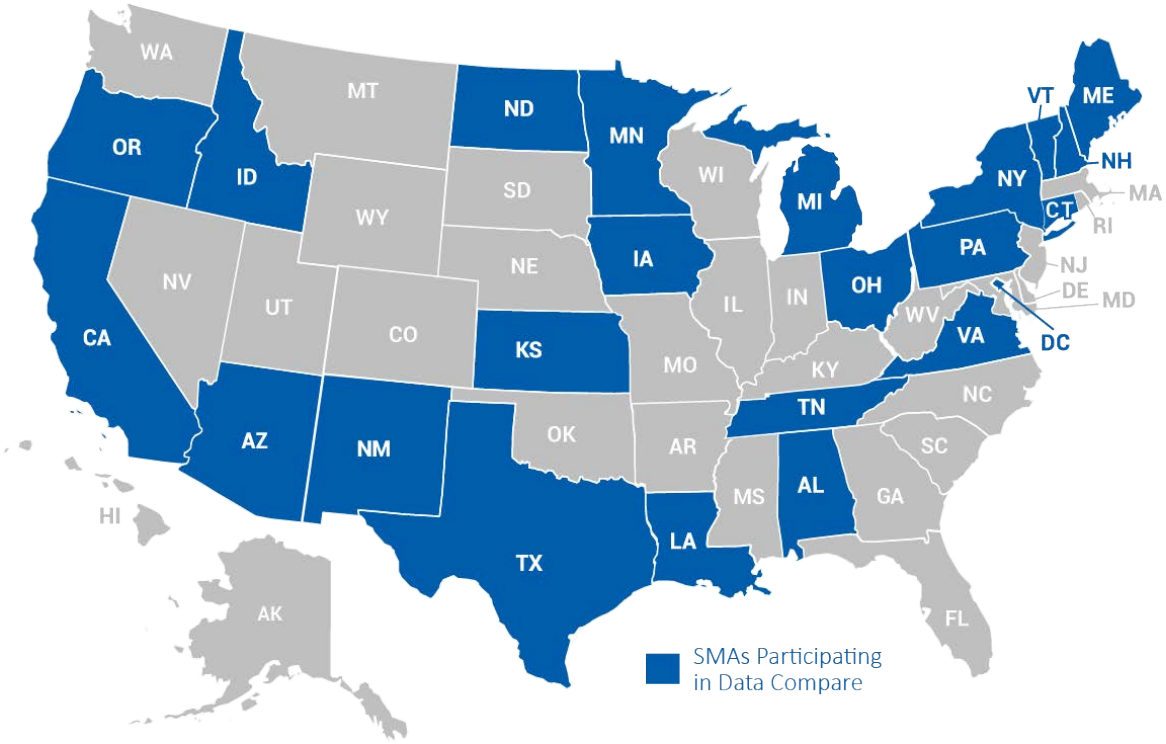
Screening History:



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

52%

Reliable for revalidation

Reliable Data Compare

86,844

Individual Providers

Ohio Reported

69,725

Providers

Data Compare Report Had a Match of

51,837

Providers

73%

Reliable for revalidation

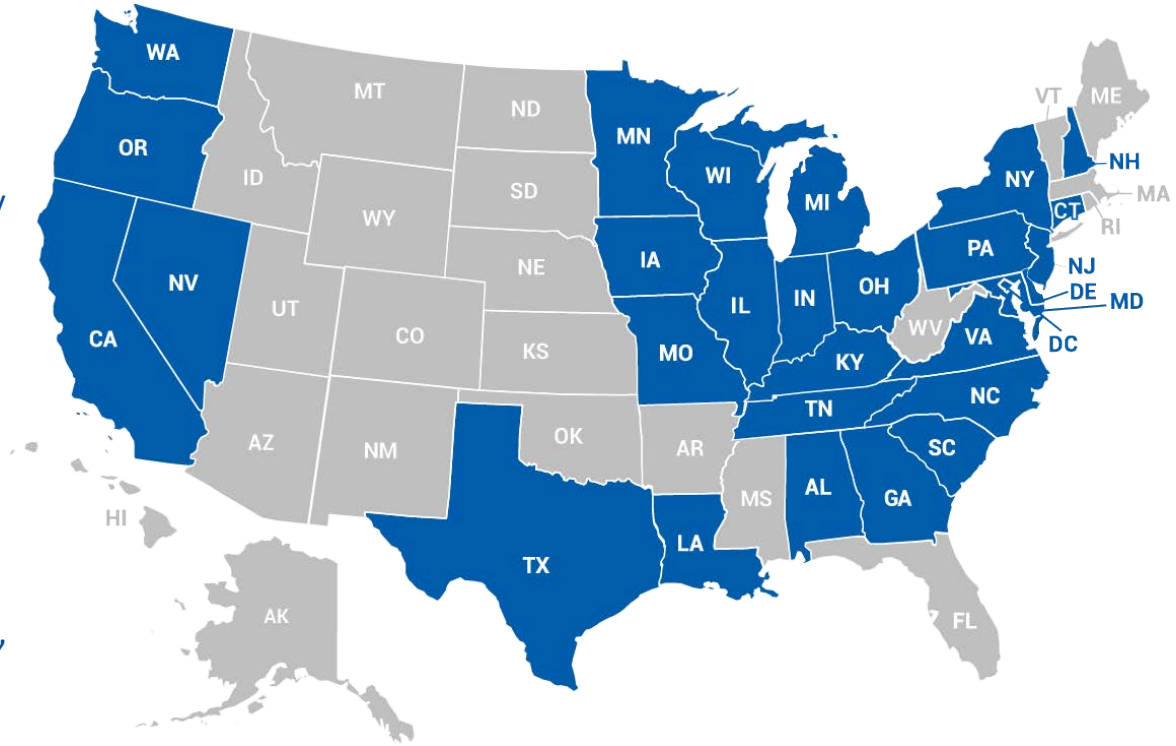
Reliable Data Compare

50,924

Individual Providers

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

BEST PRACTICES

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

BEST PRACTICES

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

BEST PRACTICES

Virginia established a 100% online enrollment process.

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

Authority: 42 CFR 424.517

- All geographical areas
- All provider types

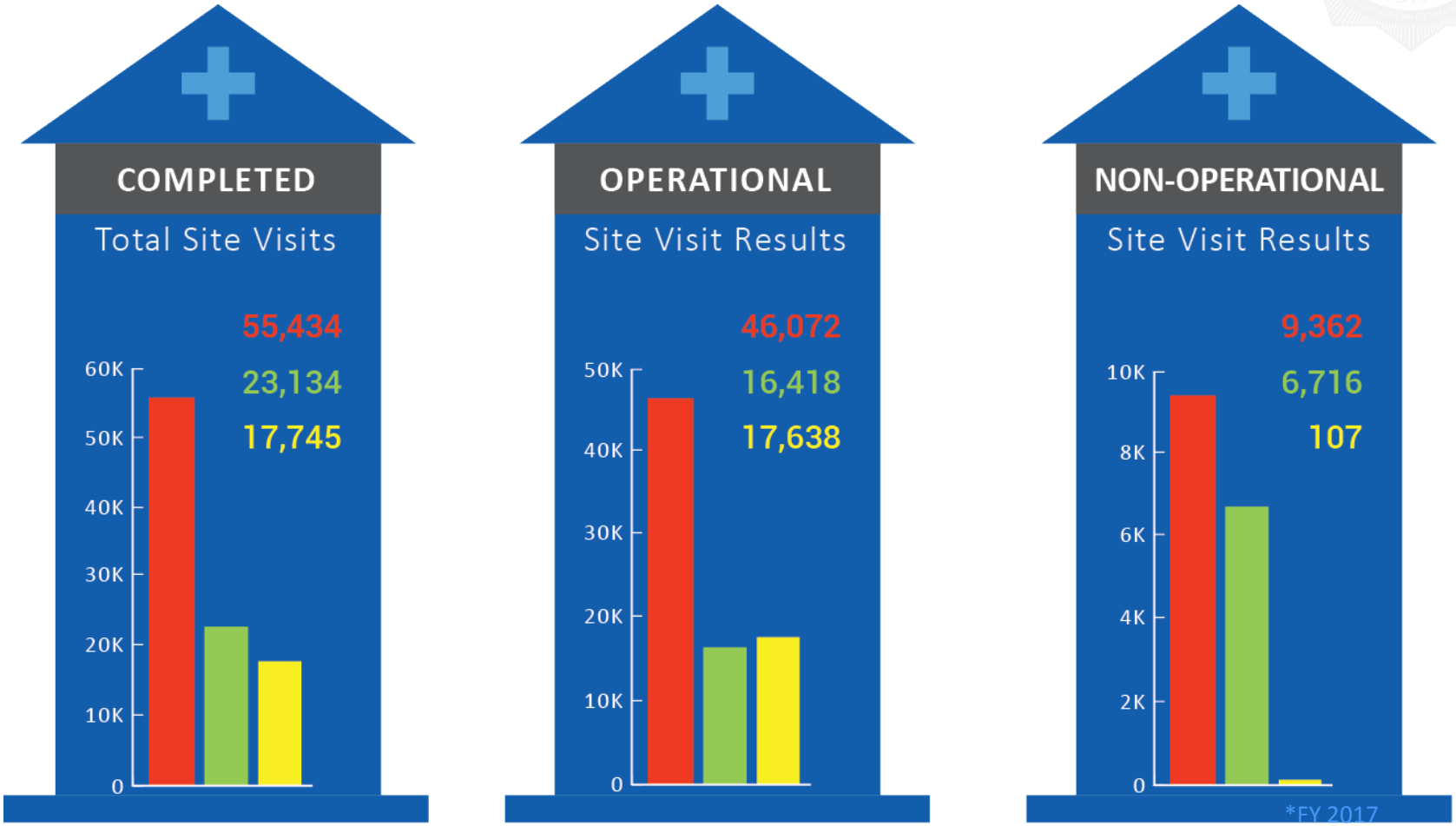
Find Vacant or Invalid Addresses

- 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)

Site Visit Data



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

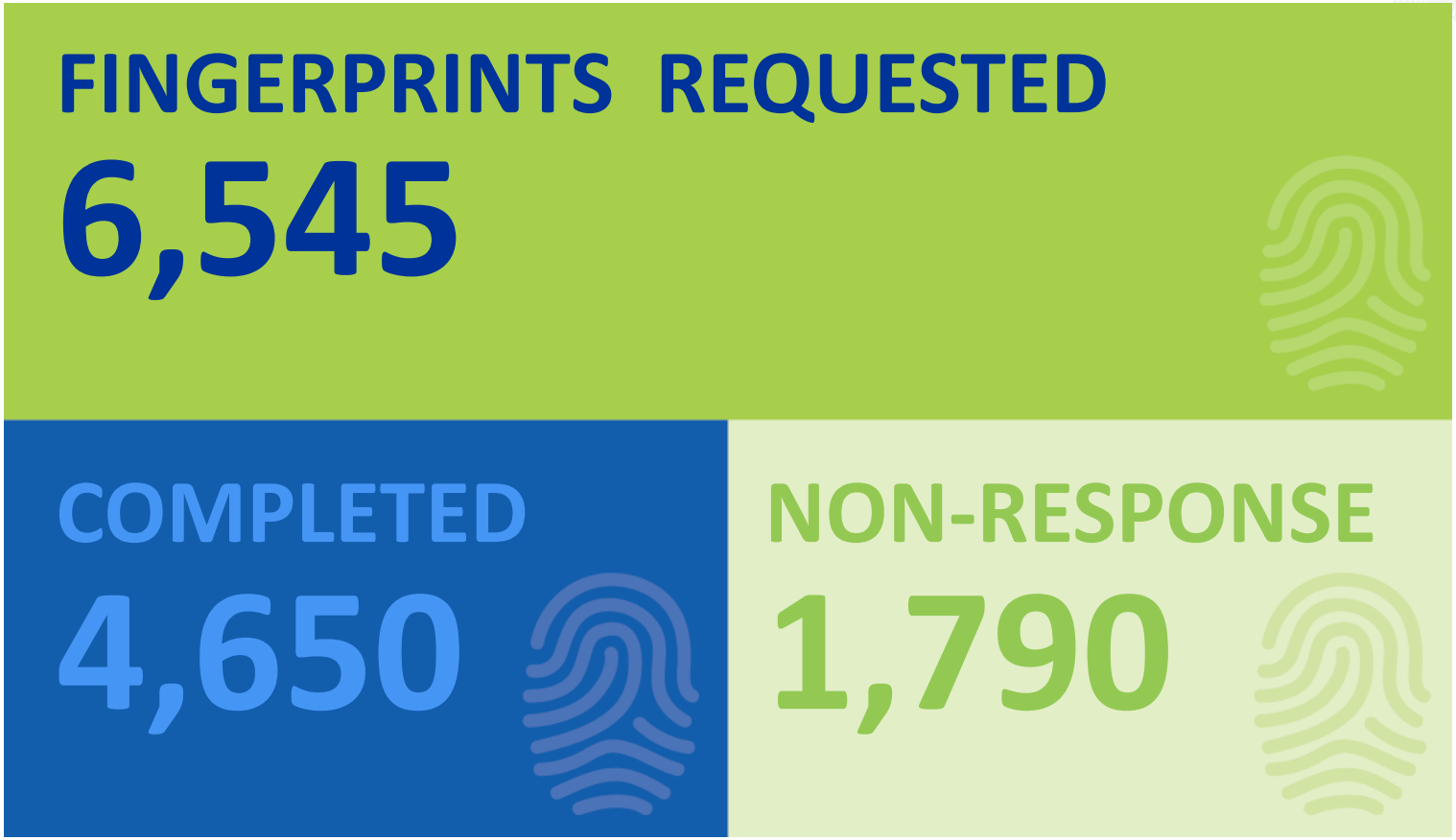
- Letter will be sent giving 30 days to get fingerprinted
- Medicare phased rollout
- SMAs may rely on Medicare's fingerprint results
- SMAs may request fingerprints in advance of Medicare to comply with July 2018 deadline

If the provider/supplier:

- Has a felony conviction
- Refuses fingerprinting

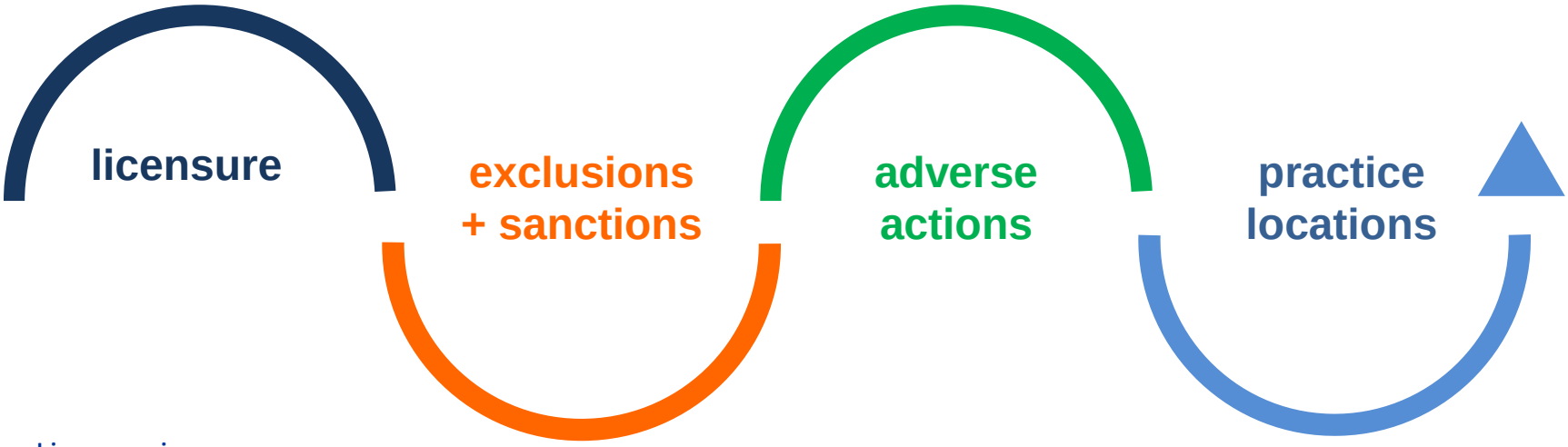
Then CMS or SMA may deny the application, or revoke/terminate their billing privileges

Fingerprint Data



*FY 2017

Continuous Monitoring



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

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 60 days

Ordering Referring File

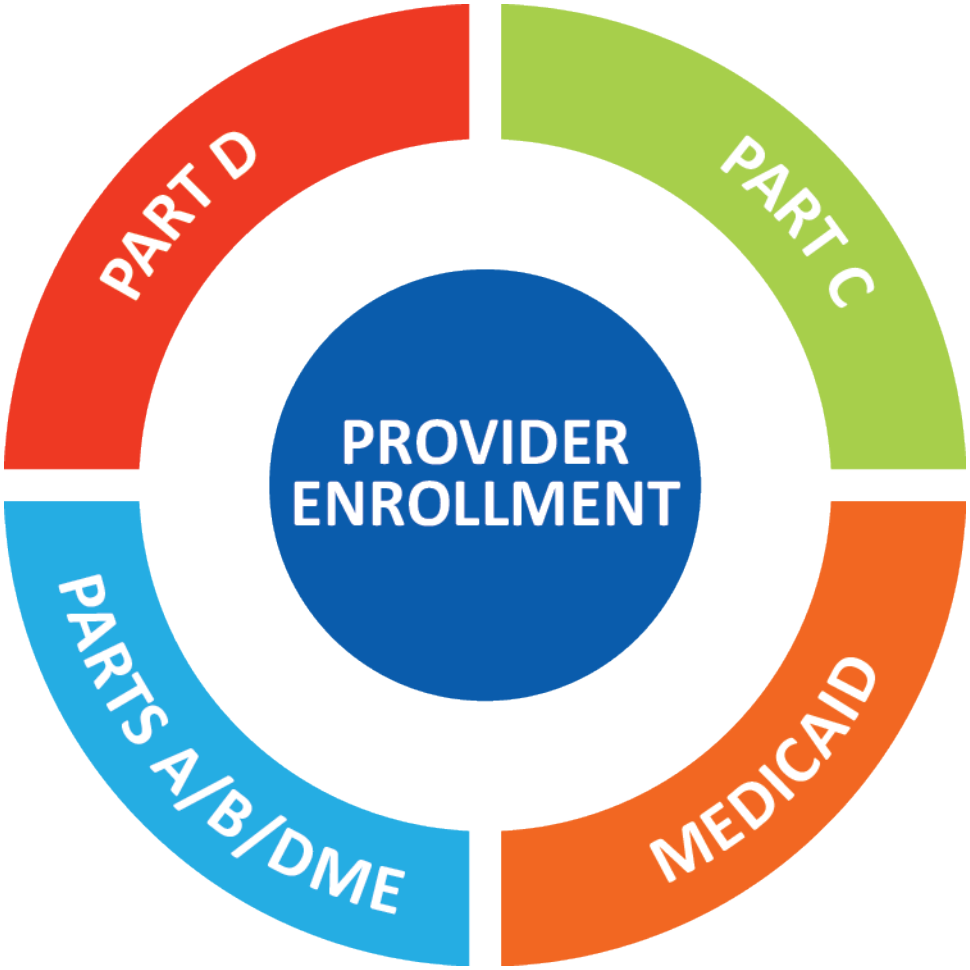
- Currently approved individuals
- Valid opt-out
- Eligible to order/refer
- Updated twice a week

Opt Out File

- Currently opted-out of Medicare
- Updated quarterly

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)*

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

x **Misdemeanor conviction in last 10 years**
  - 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 **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:

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

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

** 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

41%

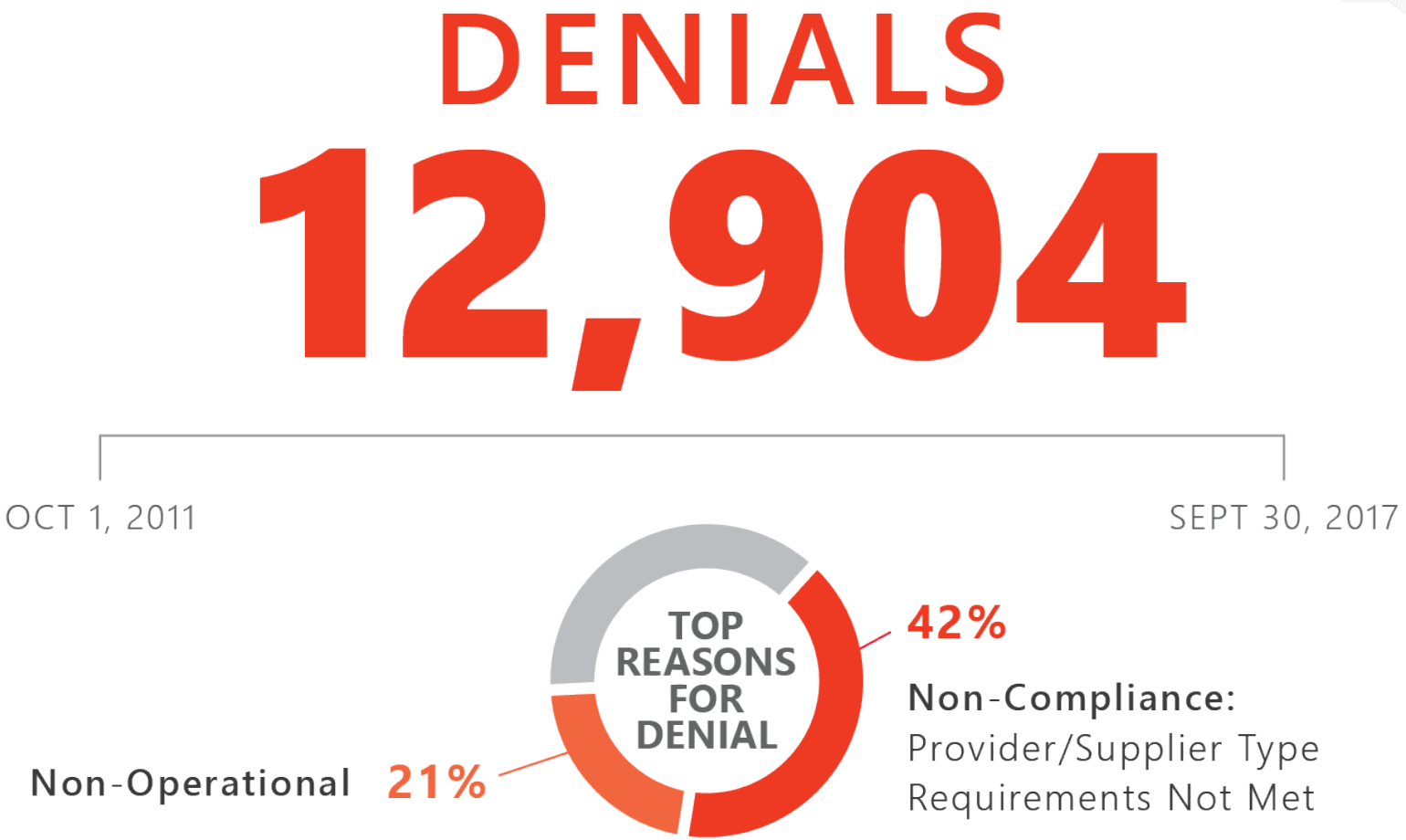
Percent deactivated for failure to respond to revalidation

Reasons to Deny

CMS can deny Medicare applications for:

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

Denials


DENIALS
12,904
OCT 1, 2011
SEPT 30, 2017
TOP REASONS FOR DENIAL
42%
Non-Compliance:
Provider/Supplier Type Requirements Not Met
Non-Operational
21%

Reasons to Revoke

CMS can revoke Medicare billing privileges for:

- x Felony conviction
- x DEA suspended or revoked
- x Medicaid billing privileges terminated
- x Excluded from federal program
- x Abusive prescribing
- x Non-operational (onsite visit)
- x Insufficient capital (HHA)

1–3 Year
Re-enrollment bar

- x Abuse of billing privileges
- x Misuse of billing number
- x **False or misleading information**
- x Fee not paid (including if hardship exception denied)
- x Noncompliance: document requirements
- x **Noncompliance: program requirements**
- x **Failure to report to MAC…**

…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

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

MEDICAID TERMINATION IMPACT ON MEDICAID

MEDICAID TERMINATION IMPACT ON MEDICARE

Medicaid Terminations

more than

600

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

more than

1,900

Total Medicaid **TERMINATION** SUBMISSIONS

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")

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