Medicare Provider Enrollment Compliance Conference

March 18-19, 2026

Presented by

Zabeen Chong, Director

Provider Enrollment & Oversight Group

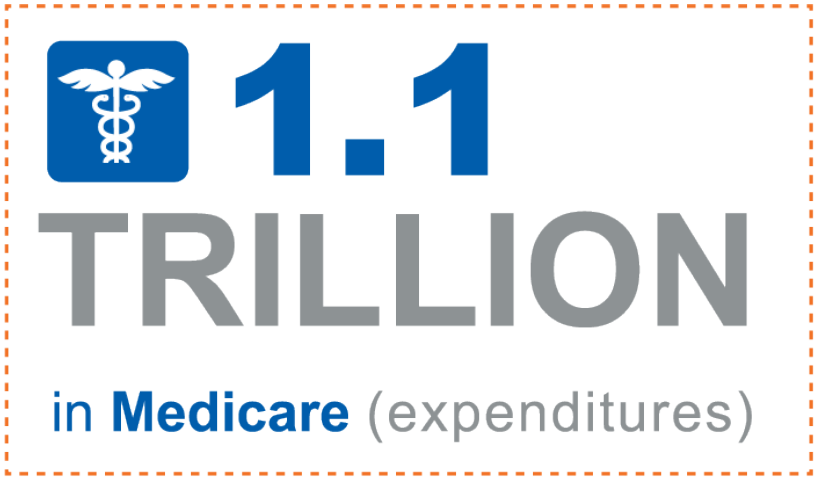
Centers for Medicare & Medicaid Services

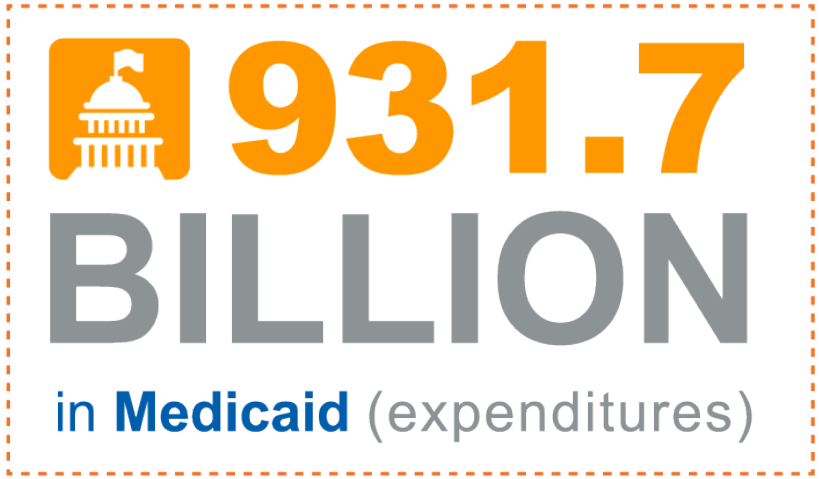
Session Overview

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

Putting Patients First

By the Numbers





Why We're Here

LISTENING TO YOU

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

FINDING A BALANCE

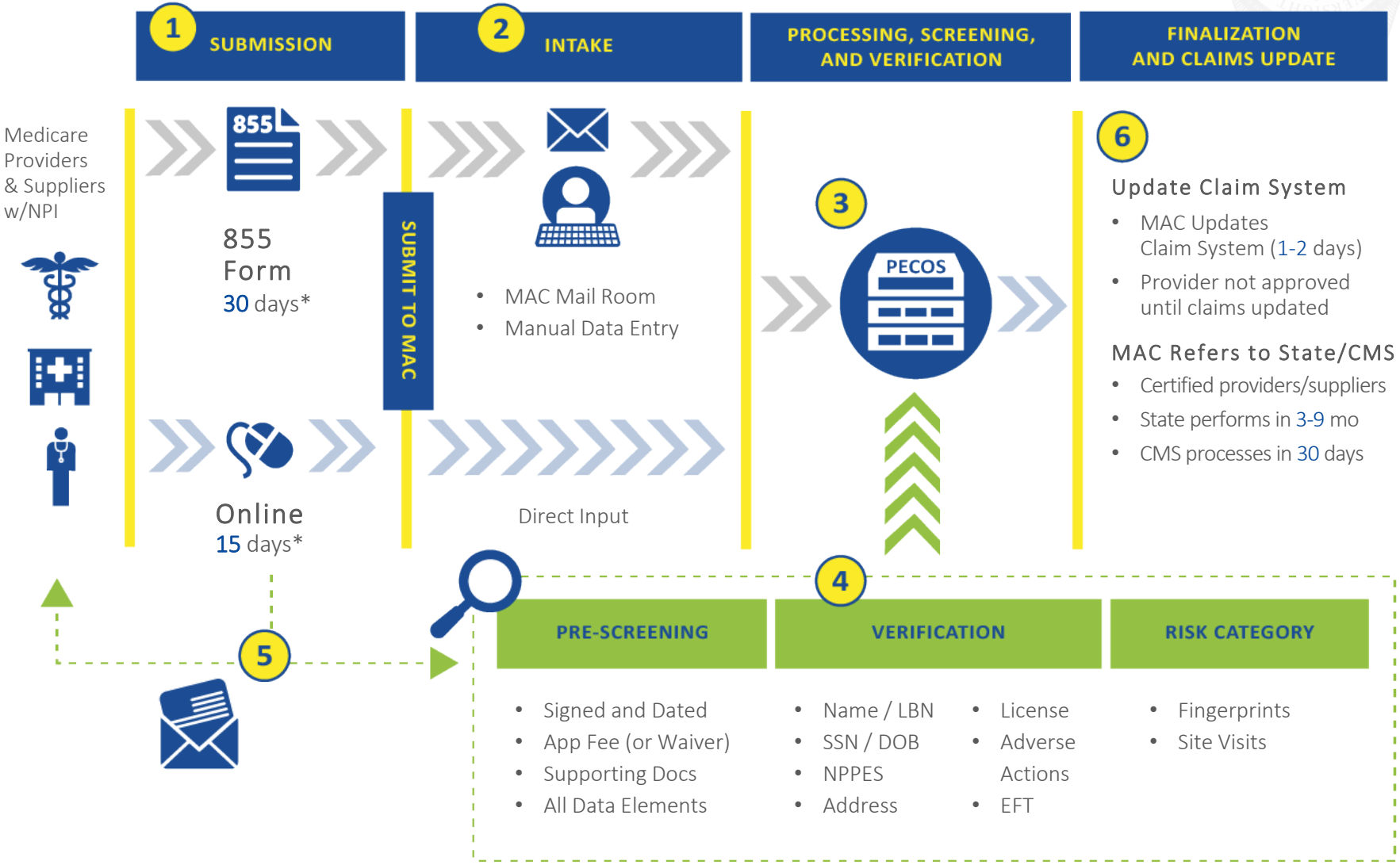
We believe enrollment should be **easy** for most providers, and **hard** for bad actors

ALWAYS IMPROVING

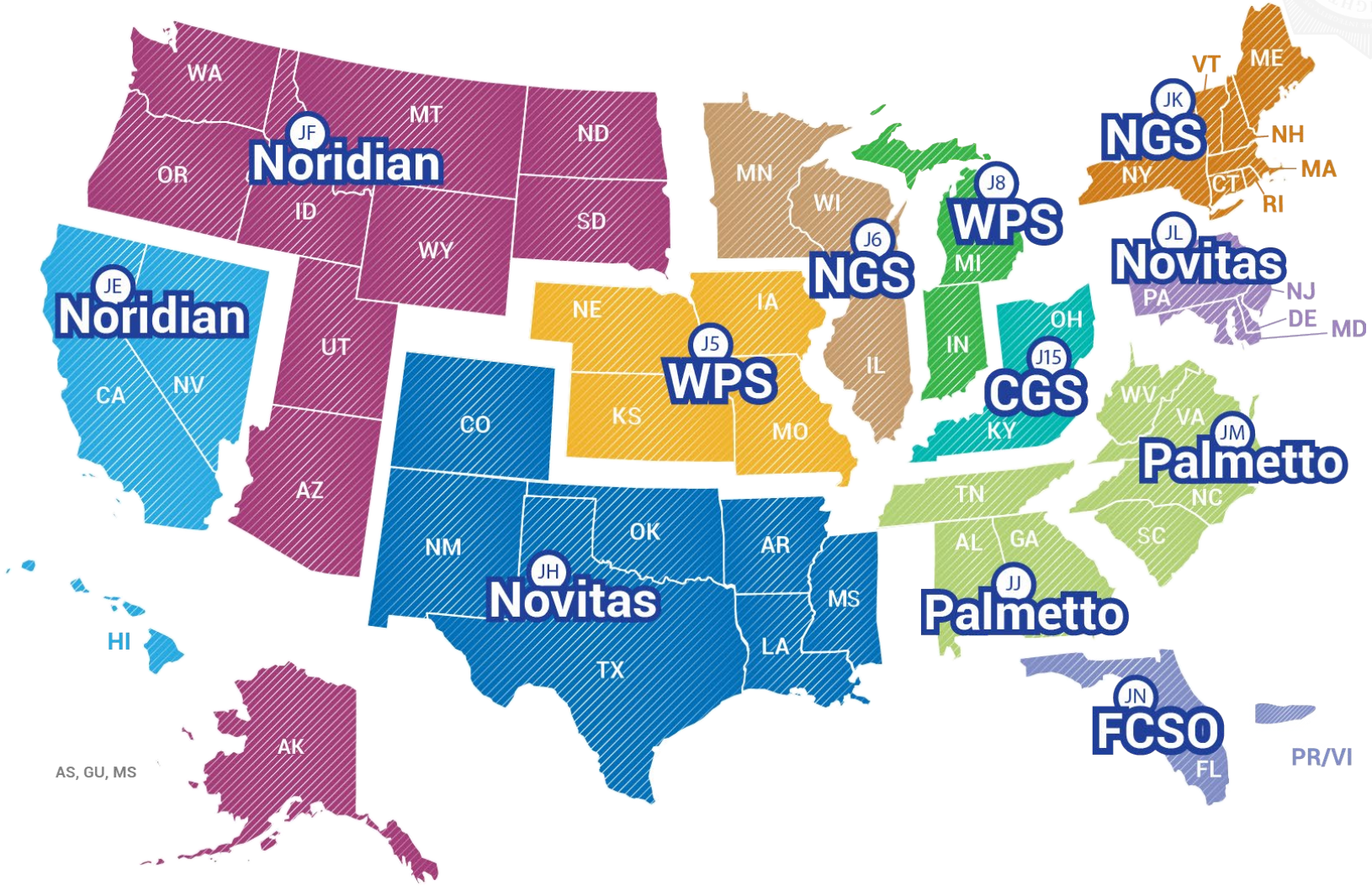
We will keep refining our systems, policies, transparency, and our vision

How Enrollment Works

How Enrollment Works

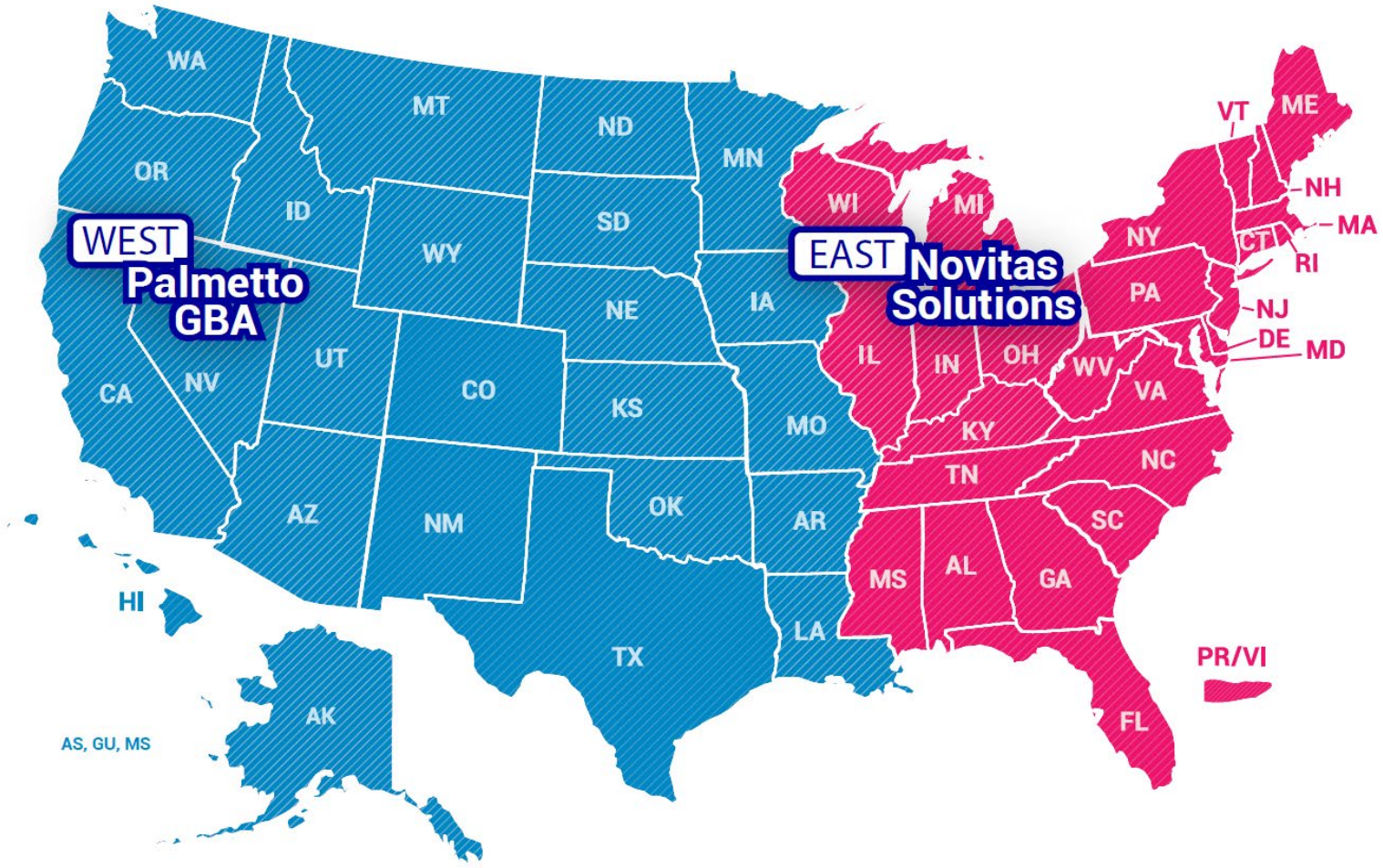


MAC Jurisdictions



National Provider Enrollment (NPE) East/West

National Provider Enrollment Contractor for DMEPOS suppliers in Medicare



Map As of November 2022

Medicare Policy Updates

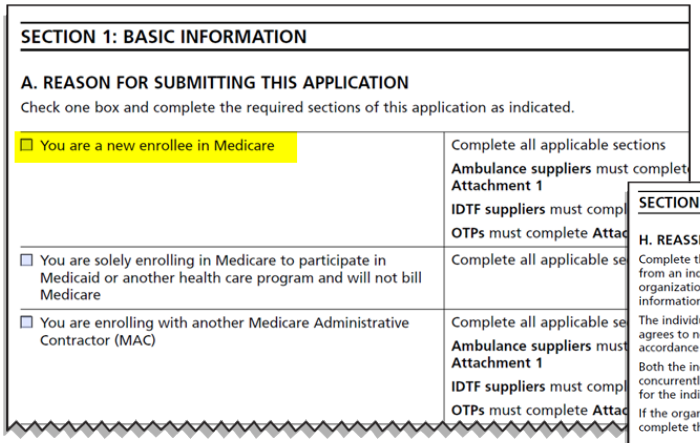
CMS-855B Revisions

855B Federal Register Notice

- Groups can establish, terminate or change reassignments using the 855B
- Removes physician assistant employer relationship
- Adds submittal reason: *You are solely enrolling in Medicare to participate in Medicaid or another health care program*
- Adds practice location types: Business Office for Administrative/Telehealth Use Only and Home Office for Administrative/Telehealth Use Only
- Tentative release in April 2026

CMS-855B/855R Consolidation

SCENARIO #1: Jones Medical Group is a new enrollee and is accepting a reassignment of benefits from Dr. Smith



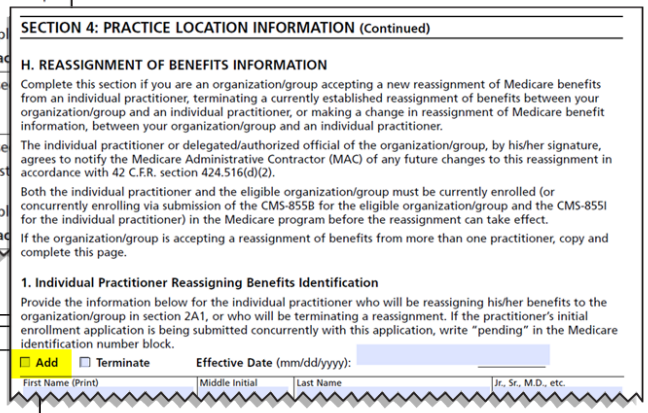
SECTION 1: BASIC INFORMATION

A. REASON FOR SUBMITTING THIS APPLICATION

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

☐ You are a new enrollee in Medicare	Complete all applicable sections **Ambulance suppliers** must complet **Attachment 1** **IDTF suppliers** must compl **OTPs** must complete **Attac**
☐ You are solely enrolling in Medicare to participate in Medicaid or another health care program and will not bill Medicare	Complete all applicable se
☐ You are enrolling with another Medicare Administrative Contractor (MAC)	Complete all applicable se **Ambulance suppliers** must **Attachment 1** **IDTF suppliers** must compl **OTPs** must complete **Attac**

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



SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

H. REASSIGNMENT OF BENEFITS INFORMATION

Complete this section if you are an organization/group accepting a new reassignment of Medicare benefits from an individual practitioner, terminating a currently established reassignment of benefits between your organization/group and an individual practitioner, or making a change in reassignment of Medicare benefit information, between your organization/group and an individual practitioner.

The individual practitioner or delegated/authorized official of the organization/group, by his/her signature, agrees to notify the Medicare Administrative Contractor (MAC) of any future changes to this reassignment in accordance with 42 C.F.R. section 424.516(d)(2).

Both the individual practitioner and the eligible organization/group must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible organization/group and the CMS-855I for the individual practitioner) in the Medicare program before the reassignment can take effect.

If the organization/group is accepting a reassignment of benefits from more than one practitioner, copy and complete this page.

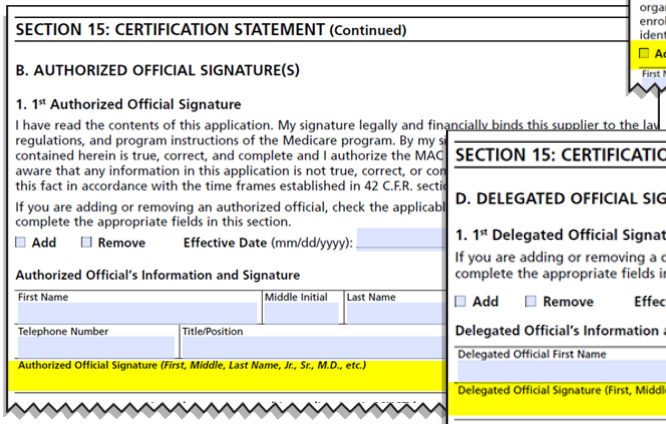
1. Individual Practitioner Reassigning Benefits Identification

Provide the information below for the individual practitioner who will be reassigning his/her benefits to the organization/group in section 2A1, or who will be terminating a reassignment. If the practitioner's initial enrollment application is being submitted concurrently with this application, write "pending" in the Medicare identification number block.

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

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

- In section 4H1 select **Add** and provide information for Dr. Smith



SECTION 15: CERTIFICATION STATEMENT (Continued)

B. AUTHORIZED OFFICIAL SIGNATURE(S)

1. 1st Authorized Official Signature

I have read the contents of this application. My signature legally and financially binds this supplier to the law regulations, and program instructions of the Medicare program. By my s contained herein is true, correct, and complete and I authorize the MAC aware that any information in this application is not true, correct, or cor this fact in accordance with the time frames established in 42 C.F.R. secti

If you are adding or removing an authorized official, check the applicab complete the appropriate fields in this section.

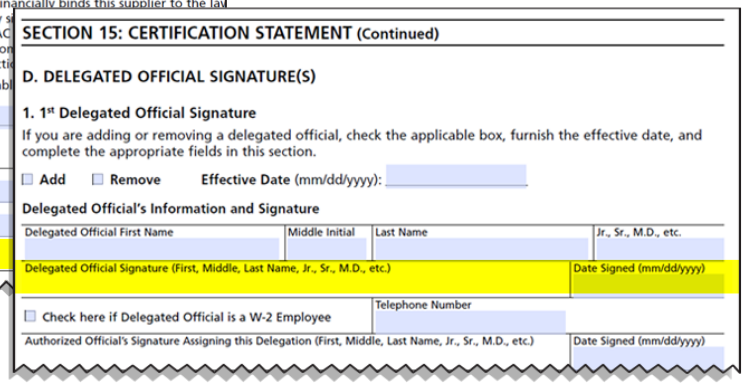
☐ Add ☐ Remove Effective Date (mm/dd/yyyy):

Authorized Official's Information and Signature

First Name | Middle Initial | Last Name

Telephone Number | Title/Position

Authorized Official Signature (First, Middle, Last Name, Jr., Sr., M.D., etc.)



SECTION 15: CERTIFICATION STATEMENT (Continued)

D. DELEGATED OFFICIAL SIGNATURE(S)

1. 1st Delegated Official Signature

If you are adding or removing a delegated official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Add ☐ Remove Effective Date (mm/dd/yyyy):

Delegated Official's Information and Signature

Delegated Official First Name | Middle Initial | Last Name | Jr., Sr., M.D., etc.

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

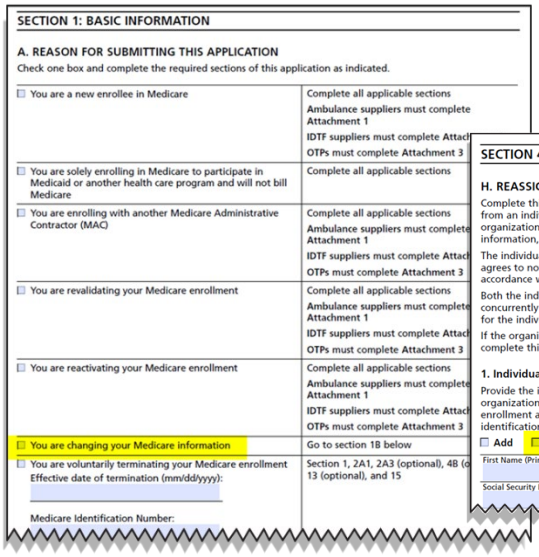
☐ Check here if Delegated Official is a W-2 Employee | Telephone Number

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

- The authorized/delegated official for Jones Medical Group signs 15B/15D
- Dr. Smith **signs** section 15E

CMS-855B/855R Consolidation

SCENARIO #2: Healthcare Center Inc. is terminating an existing reassignment of benefits with Dr. Brown and accepting a new reassignment from Dr. Hall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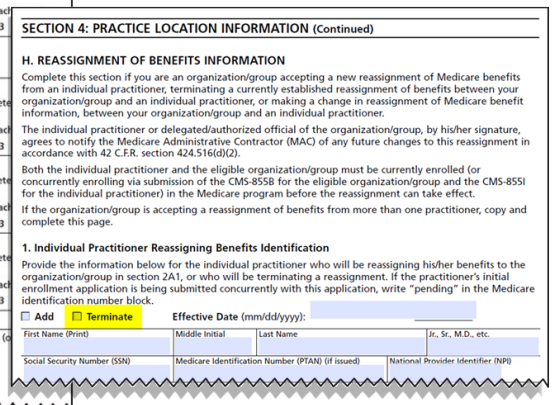
☐ You are a new enrollee in Medicare	Complete all applicable sections Ambulance suppliers must complete Attachment 1 IDTF suppliers must complete Attach OTPs must complete Attachment 3
☐ You are solely enrolling in Medicare to participate in Medicaid or another health care program and will not bill Medicare	Complete all applicable sections
☐ You are enrolling with another Medicare Administrative Contractor (MAC)	Complete all applicable sections Ambulance suppliers must complete Attachment 1 IDTF suppliers must complete Attach OTPs must complete Attachment 3
☐ You are revalidating your Medicare enrollment	Complete all applicable sections Ambulance suppliers must complete Attachment 1 IDTF suppliers must complete Attach OTPs must complete Attachment 3
☐ You are reactivating your Medicare enrollment	Complete all applicable sections Ambulance suppliers must complete Attachment 1 IDTF suppliers must complete Attach OTPs must complete Attachment 3
☐ You are changing your Medicare information	Go to section 1B below
☐ You are voluntarily terminating your Medicare enrollment Effective date of termination (mm/dd/yyyy):	Section 1, 2A1, 2A3 (optional), 4B (o 13 (optional), and 15

Medicare Identification Number:


SECTION 4: PRACTICE LOCATION INFORMATION (Continued)

H. REASSIGNMENT OF BENEFITS INFORMATION

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The individual practitioner or delegated/authorized official of the organization/group, by his/her signature, agrees to notify the Medicare Administrative Contractor (MAC) of any future changes to this reassignment in accordance with 42 C.F.R. section 424.516(d)(2).

Both the individual practitioner and the eligible organization/group must be currently enrolled (or concurrently enrolling via submission of the CMS-855B for the eligible organization/group and the CMS-855I for the individual practitioner) in the Medicare program before the reassignment can take effect.

If the organization/group is accepting a reassignment of benefits from more than one practitioner, copy and complete this page.

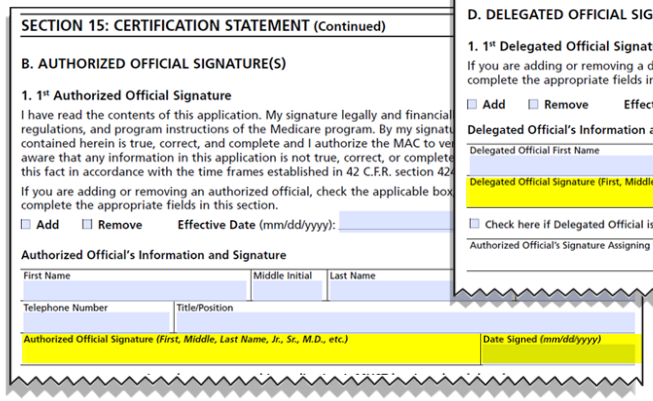
1. Individual Practitioner Reassigning Benefits Identification

Provide the information below for the individual practitioner who will be reassigning his/her benefits to the organization/group in section 2A1, or who will be terminating a reassignment. If the practitioner's initial enrollment application is being submitted concurrently with this application, write "pending" in the Medicare identification number block.

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

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

Social Security Number (SSN) | Medicare Identification Number (PTAN) (if issued) | National Provider Identifier (NPI)


SECTION 15: CERTIFICATION STATEMENT (Continued)

B. AUTHORIZED OFFICIAL SIGNATURE(S)

1. 1st Authorized Official Signature

I have read the contents of this application. My signature legally and financial
regulations, and program instructions of the Medicare program. By my signatu
contained herein is true, correct, and complete and I authorize the MAC to ve
aware that any information in this application is not true, correct, or complete
this fact in accordance with the time frames established in 42 C.F.R. section 42

If you are adding or removing an authorized official, check the applicable box
complete the appropriate fields in this section.

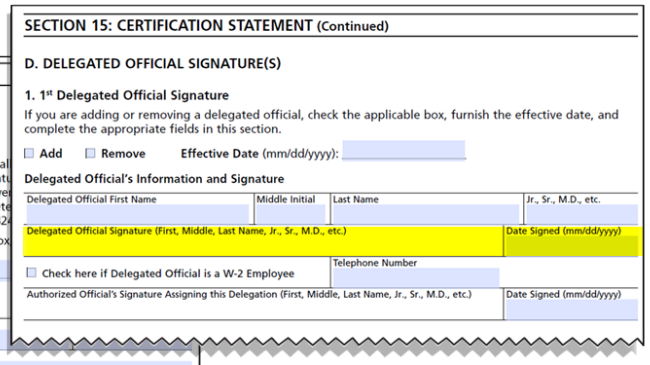
☐ Add ☐ Remove Effective Date (mm/dd/yyyy):

Authorized Official's Information and Signature

First Name | Middle Initial | Last Name

Telephone Number | Title/Position

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


SECTION 15: CERTIFICATION STATEMENT (Continued)

D. DELEGATED OFFICIAL SIGNATURE(S)

1. 1st Delegated Official Signature

If you are adding or removing a delegated official, check the applicable box, furnish the effective date, and complete the appropriate fields in this section.

☐ Add ☐ Remove Effective Date (mm/dd/yyyy):

Delegated Official's Information and Signature

Delegated Official First Name | Middle Initial | Last Name | Jr., Sr., M.D., etc.

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

☐ Check here if Delegated Official is a W-2 Employee | Telephone Number

Authorized Official's Signature Assigning this Delegation (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 4H1 select **Terminate** and provide information for Dr. Brown
- Copy section 4H1, select **Add** and provide information for Dr. Hall
- The authorized/delegated official for Healthcare Centers Inc. **signs** 15B/15D to add the new reassignment and terminate the existing reassignment
- Dr. Hall **signs** section 15E to add the new reassignment

CMS-855I Revisions

855I Federal Register Notice

- Adds new submittal reasons:
  - *You are solely enrolling in Medicare to participate in Medicaid or another health care program,* and
  - *You are enrolling to file claims for emergency/ urgent care services while Opted-Out*
- Adds new physician types (marriage and family therapist, mental health counselor, dental specialties)
- Tentative release in fall 2026

CMS-855S Revisions

855S Federal Register Notice

- Adds submittal reason: *You are solely enrolling in Medicare to participate in Medicaid or another health care program*
- Adds new products: Oral HIV PrEP Drugs, Cognitive Behavioral Therapy Devices, External Electrical Stimulation Devices, Multi-Function Respiratory Devices, and Urinary Suction Pumps
- Adds ownership percentages for individuals and organizations
- Adds additional supporting documentation to be submitted with the 855S (liability insurance, warranty, complaint log, maintenance)
- Tentative release in spring 2026

DME Moratorium

- On February 27, 2026, CMS implemented a temporary nationwide enrollment moratorium on DME medical supply companies
  - Applies to initial applications and changes in majority ownership that violate the 36-month rule requirements
  - Applications submitted after February 27, 2026, will be denied
  - The moratorium lasts for 6-months but can be extended if CMS deems it necessary
- Refer to the Federal Register Notice and Moratorium Q&As

Critical Access Hospital (CAH) Method II Billing

- CAHs can only bill for facility and professional outpatient services when the physician/practitioner has reassigned their billing rights to the CAH
- Letters mailed in November 2025 to CAHs to set up their reassignments
- Effective January 1, 2026, CMS began denying CAH Method II claims for professional services if the reassignment didn't exist in PECOS
- Refer to Information for Critical Access Hospitals and MLN006400

Reporting Changes of Information

- **Within 30 days**
  - Changes of ownership or control, including changes in authorized or delegated official(s)
  - Additions/changes in Adverse Legal Action (e.g., suspension or revocation of any state or Federal license)
  - Changes in practice location (includes any new reassignments)
- **Within 90 days**
  - All other changes to enrollment

42 CFR 424.516

Ownership & Managing Employee Reporting

- Hospice and SNF medical directors and administrators are required to be reported as managing employees
  - Letters mailed in March 2024 to remind providers of the managing employee requirement and to report any changes via PECOS or the paper CMS-855A
- MACs/NPEs will compare the Secretary of State websites against the CMS-855 for reportable roles/titles
  - Applies to initials, COIs, revalidations and reactivations
  - MACs/NPEs will develop for any discrepancies found

SNF 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 owners, operators and related parties (management, administrative, consulting, financial services)
  - Defines private equity company and real estate investment trusts
- Nursing homes must report disclosures on the CMS-855A attachment or PECOS during:
  - Initial enrollment
  - Revalidation
  - Change of ownership (CHOW)
- Public release of the nursing home data on data.cms.gov

SNF Ownership & Additional Disclosable Party Reporting

- Off-cycle revalidation efforts began in October 2024
- Revalidation due dates were extended multiple times to allow SNFs to collect and report the data (May 2025, August 2025, January 2026)
- Revalidation deadline submission was suspended in December 2025
  - Skilled Nursing Facilities: January 1 Revalidation Deadline Indefinitely Suspended

SNF Ownership & Additional Disclosable Party Reporting

- MACs will continue processing initial and pending revalidation applications
- SNFs that did not submit their revalidation application are encouraged to submit, however, a new due date has not been determined
- Updates will be communicated through Guidance for SNF Attachment on Form CMS-855A (PDF)
- Policy questions can be sent to SNFDisclosures@cms.hhs.gov

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 (e.g. non-response to revalidation, non-response to revalidation development, ownership discrepancies)
  - Pauses enrollment temporarily while the provider comes into compliance
  - Provider remains enrolled in Medicare during the stay (enrollment status will remain in an approved status)
  - Claims submitted with dates of service during the stay period are rejected
  - Not considered a sanction or adverse action
  - Stay lasts no longer than 60 days
- MLN13449

CMS-588: Electronic Funds Transfer (EFT) Agreement

- All providers/suppliers must receive Medicare payments via 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

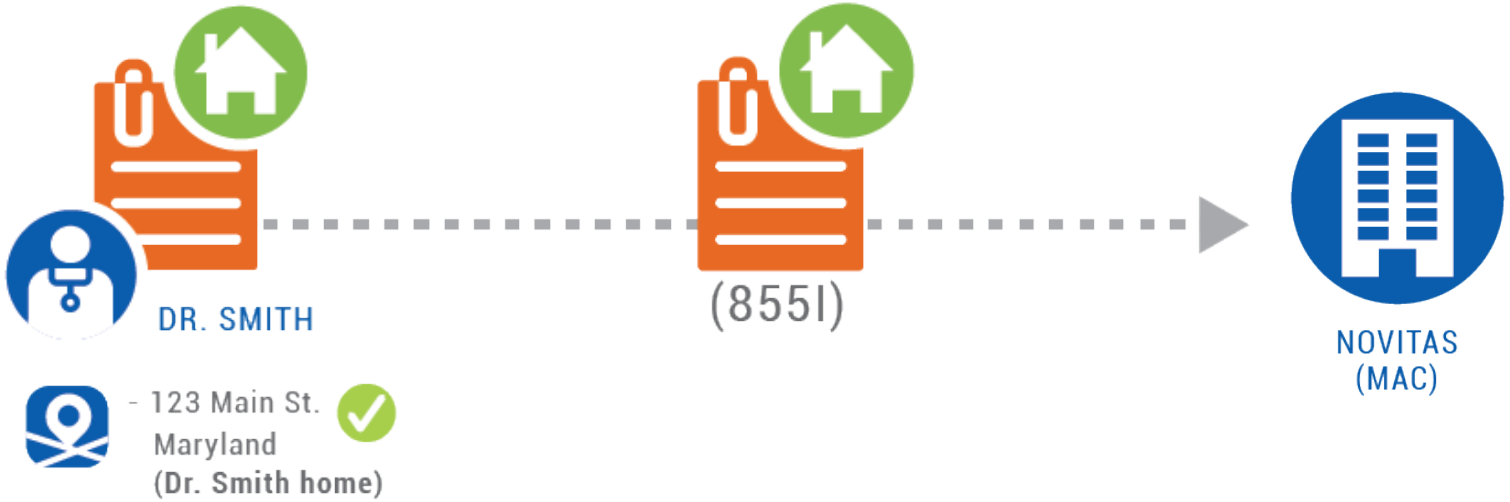
CMS-588: Electronic Funds Transfer (EFT) Agreement

- MACs/NPEs will verify EFT changes directly with:
  - Individual physician
  - Non-physician practitioner
  - Authorized Official
  - Delegated Official
  - Or contact person that existed in PECOS for at least one year
- MACs/NPEs will notify providers of closures/routing changes reported by the banks
  - 90 days to comply before deactivation

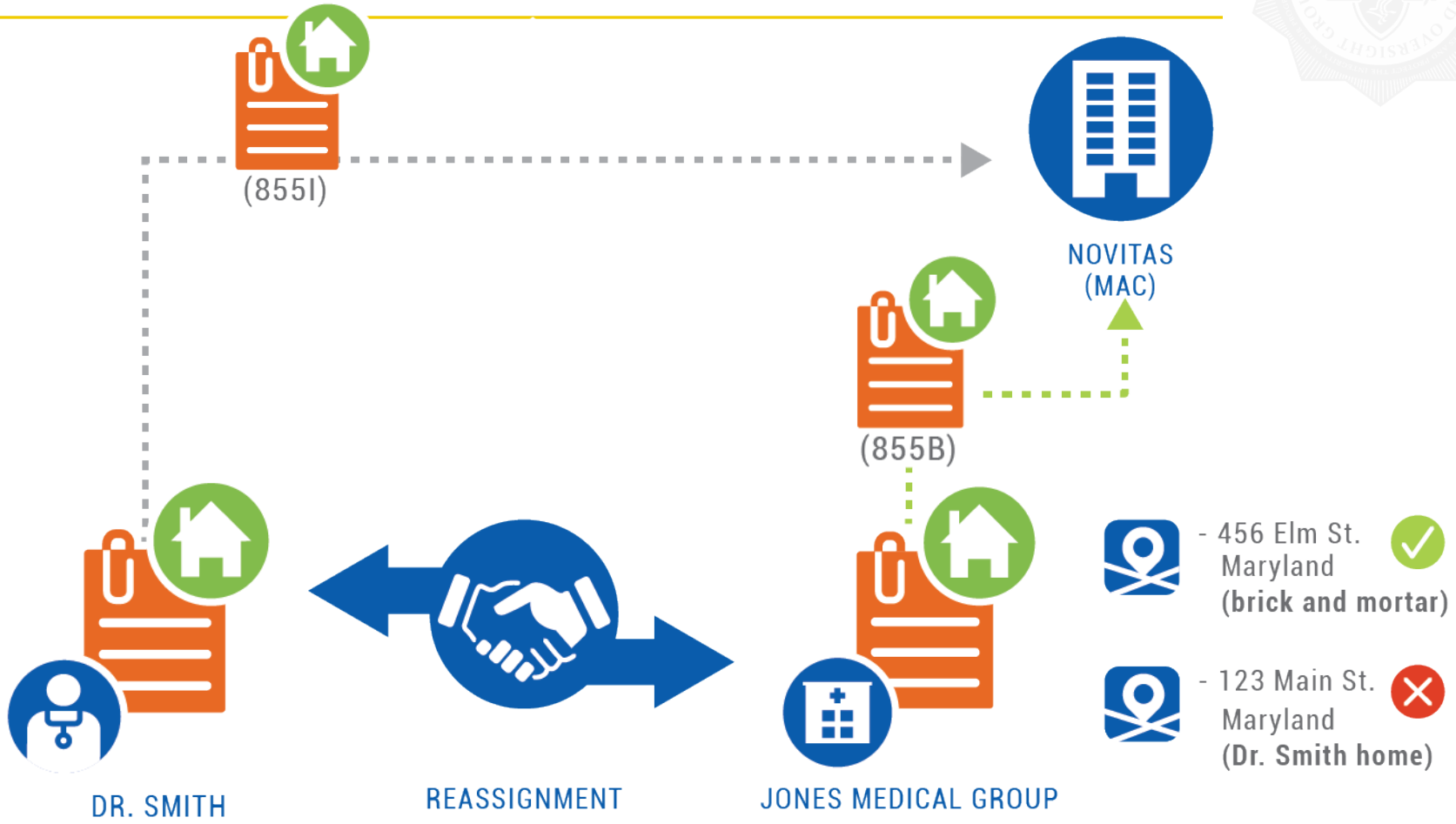
Telehealth

- Practitioners who provide telehealth services from their homes, but have a physical practice location, do not need to report their home address on their Medicare enrollment application
  - Practitioners can enroll and bill from their physical practice location as if the service was provided in person
- Virtual-only telehealth practitioners whose only physical practice location is their home address must report their home address as a practice location
- https://www.cms.gov/medicare/coverage/telehealth

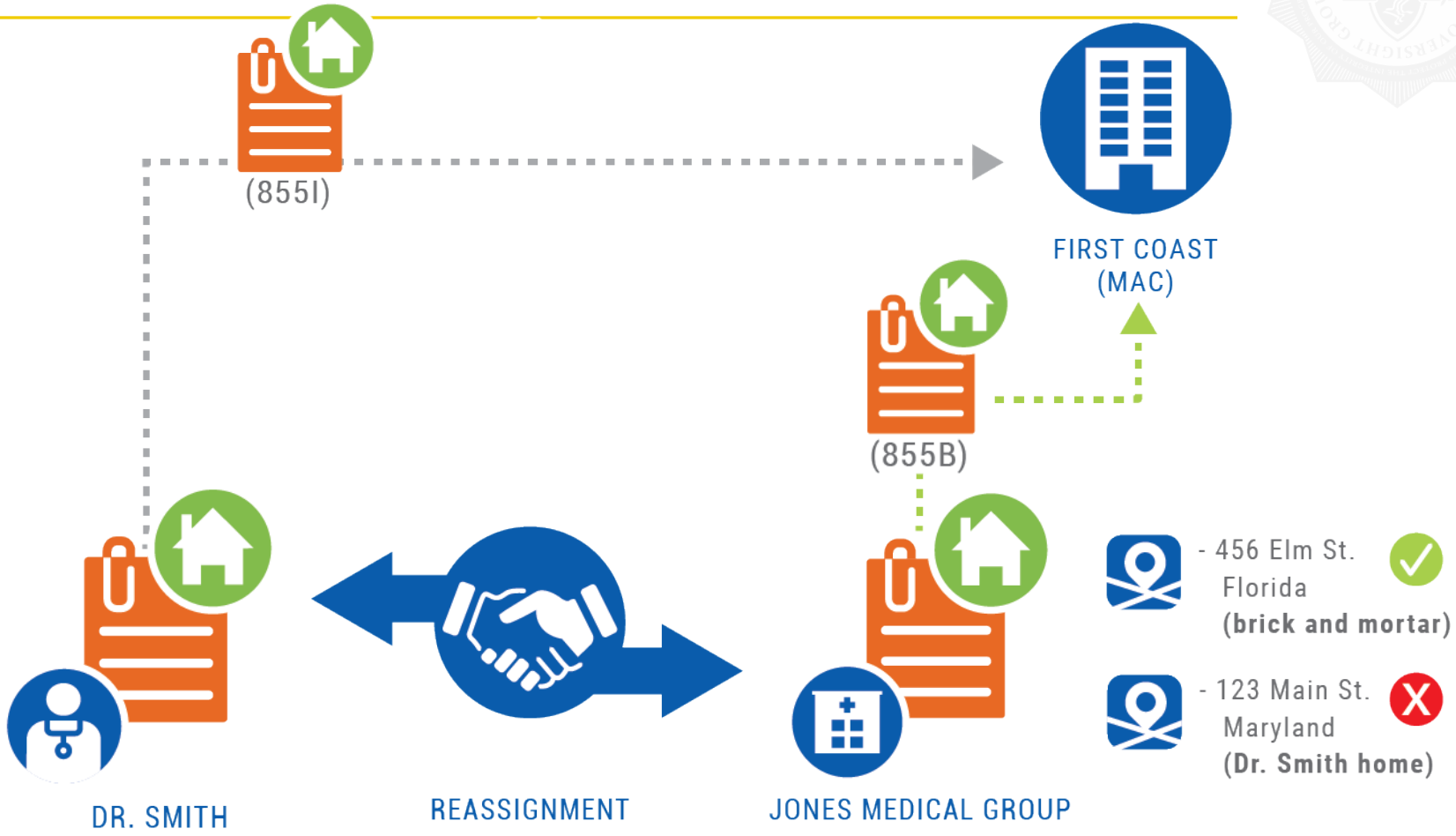
Telehealth – Private Practice



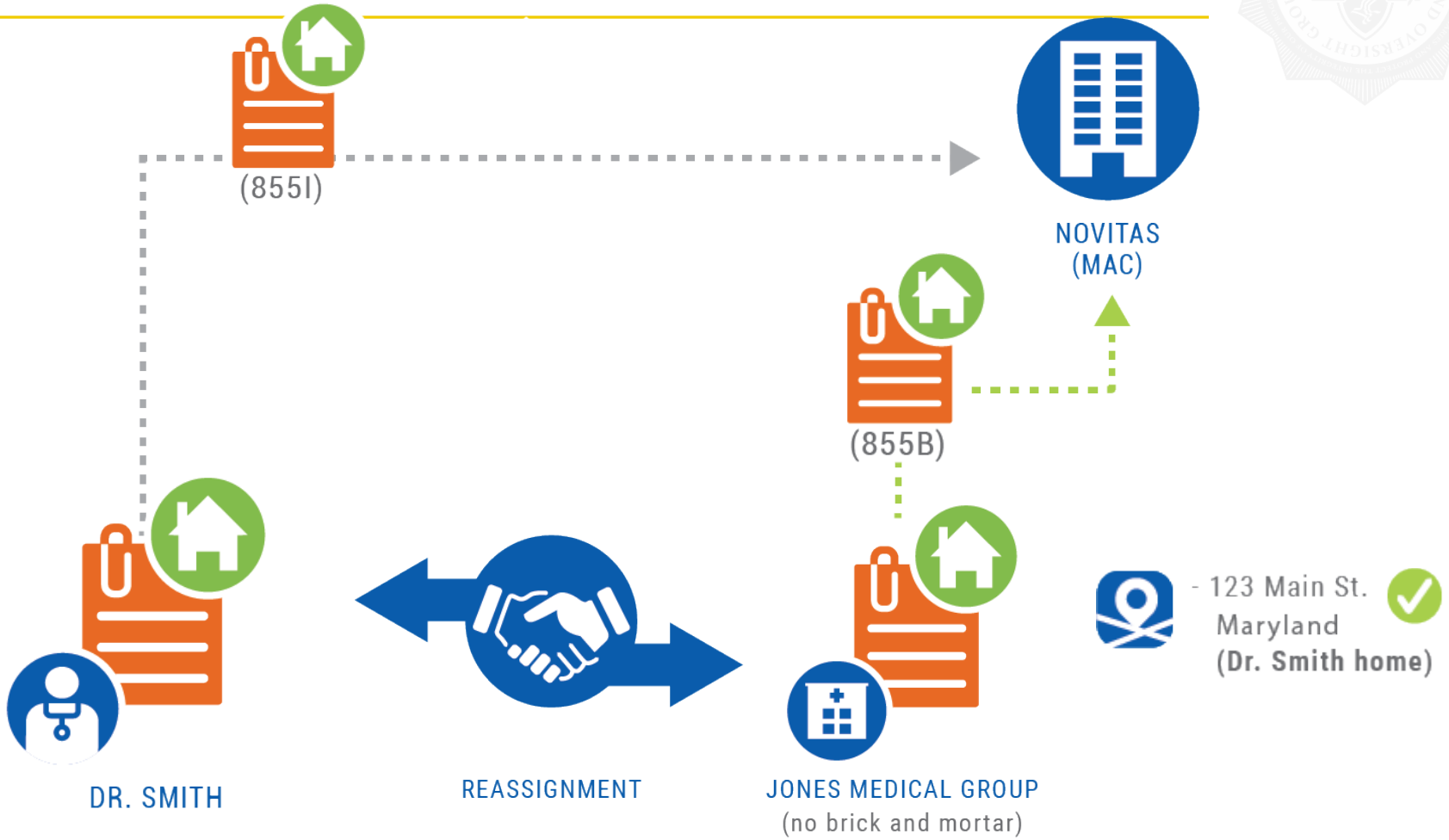
Telehealth – In State Reassignment



Telehealth – Out of State Reassignment



Telehealth – Virtual Group with Reassignment



Home Addresses on Care Compare

- Care Compare now hides practice locations that are designated as home addresses
- You can update your practice location type through PECOS or by submitting the CMS-855 application
- For assistance with suppressing your home address while you're updating your enrollment, reach out to QPP@cms.hhs.gov

Authorized Official (AO)

- An appointed official with the legal authority to enroll, make changes and ensure compliance with enrollment requirements (CEO, CFO, partner, chairman, owner, Administrator, President)
  - Individuals with approved titles will be accepted as AOs
  - Individuals without approved titles and lack signature authority will require a different AO be submitted (e.g. charge nurse, purchasing agent, claims processor)
  - If MACs are unsure of an individual's authority, they will develop for more information (1) the individual's role within the organization; and (2) why the provider believes the individual has signature authority

Delegated Official

- Appointed by the Authorized Official with authority to report changes to enrollment information
  - Owner, control interest, or W-2 managing employee
  - Multiple delegated officials are permitted
  - May sign changes, updates, and revalidations but not initial applications

Who Can Sign the Enrollment Application?

Non-Billing Deactivations

- CMS may deactivate a provider who has not submitted any Medicare claims for 6 consecutive calendar months
- MACs issue a deactivation letter with rebuttal rights
- Provider must submit a complete CMS-855 to reactivate
- Effective date is based on the receipt date of the application
- You will be issued a new Provider Transaction Access Number (PTAN) upon reactivation
  - Except for certified providers (e.g., hospice)

Non-Billing Criteria – Hospices and HHAs

- CMS began deactivating hospices in March 2024 and home health agencies in January 2026, after 6-months of non-billing if:
  - ✓ Enrolled in Medicare for at least 6 months
  - ✓ No Medicare or Medicaid billing activity in the last 6 months
  - ✓ No revalidation due date assigned in the last 30 days and no in-progress revalidation status in the last 30 days.
- Medicare certification and provider agreement are not impacted by the deactivation
- A new survey is not required to reactivate

Non-Billing Criteria – Other Part A Providers

- Other Part A providers (e.g., SNFs) are deactivated after 13 consecutive months of non-billing if:
  - ✓ Enrolled in Medicare for at least 13 months
  - ✓ No Medicare or Medicaid billing activity in the last 13 months
  - ✓ No Part C billing activity
  - ✓ No revalidation completed in the last 13 months, no revalidation due date assigned in the next month, or no in-progress revalidation status in the last 3 months.
  - ✓ No history of deactivation for non-billing in last 2 years
- Certain part A providers are excluded:
  - Children's Hospital, Histocompatibility Laboratory, and Organ Procurement Organization (OPO)
  - Part A providers that submitted a cost report in the latest fiscal year

Non-Billing Criteria – DME Suppliers

- DME suppliers are deactivated after 13 consecutive months of non-billing if:
  - ✓ Enrolled in Medicare for at least 13 months
  - ✓ No Medicare or Medicaid billing activity in the last 13 months
  - ✓ No revalidation completed in the last 13 months, no due date in the next month, or no revalidation in progress in the last 3 months
- Certain DME supplier types are excluded: Optician, Optometrist, and Hospital

Non-Billing Criteria – Part B Providers

- Part B providers are deactivated after 13 consecutive months of non-billing if:
  - ✓ Enrolled in Medicare for at least 13 months
  - ✓ No Medicare or Medicaid billing activity in the last 13 months
  - ✓ No Part C billing activity
  - ✓ No Part A hospital billing has taken place in the last 13 months under the TIN of the Part B supplier
  - ✓ No revalidation completed in the last 13 months, no due date in the next month, or no revalidation in progress in the last 3 months
  - ✓ No history of deactivation for non-billing in the last 2 years
- Certain Part B organization providers are excluded:
  - Mass Immunization Roster Billers, Centralized Flu Billers, CLIA

Non-Billing Criteria – Individuals

- Individual providers (855I only) are deactivated after 13 consecutive months of non-billing if:
  - ✓ Enrolled in Medicare for at least 13 months
  - ✓ No Medicare or Medicaid billing activity in the last 13 months
  - ✓ No Medicare FFS claim during an Inpatient Stay or Outpatient Visit at a Children's Hospital in the Last 2 Years
  - ✓ No Part C billing activity
  - ✓ No revalidation completed in the last 13 months, no due date in the next month, or no revalidation in progress in the last 3 months
  - ✓ No history of deactivation for non-billing in the last 2 years

Non-Billing Criteria – Individuals *cont.*

- Certain individual providers are excluded:
  - Dentists, Pediatricians, Pediatric related sub-specialties, IDTF Interpreting Physicians, Supervising Physicians, Technicians, Mass Immunization Billers
  - Sole owners of organizations that are billing

- Effective January 2026, individual providers enrolled using the CMS-855O (ordering/referring only) will be deactivated if not identified on claims after 13 consecutive months

Opt-Out of Medicare

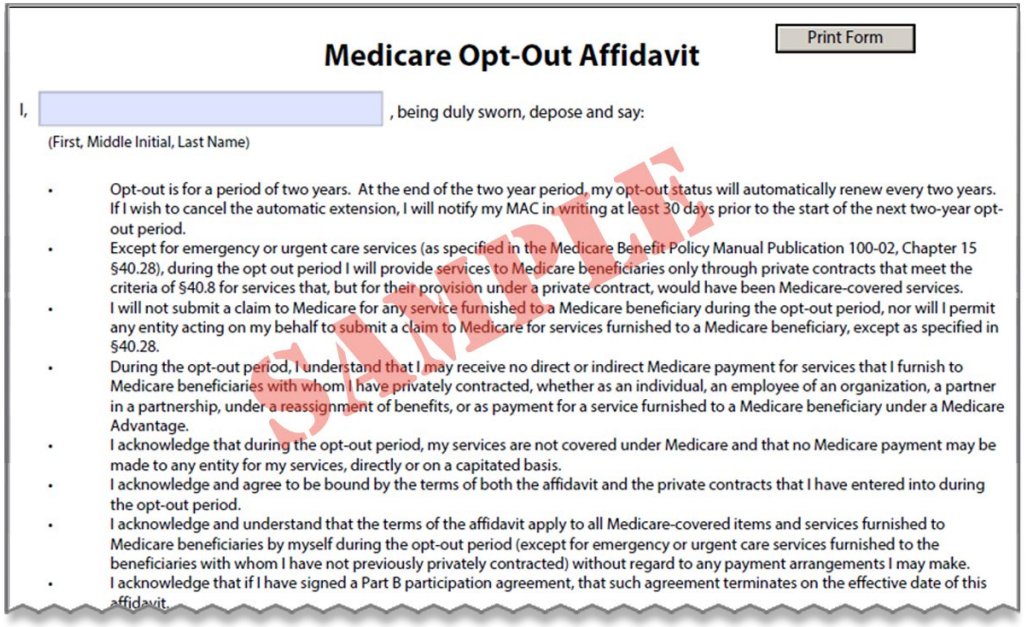
Physicians or practitioners who choose not to participate in the Medicare program can "opt-out"

What this means:

- Neither the physician/practitioner nor the beneficiary submits a claim to Medicare, and Medicare does not reimburse for services provided (the patient pays out-of-pocket)
- A private agreement is established between the physician/practitioner and the patient
- The physician/practitioner submits an affidavit with 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 the following:
  - NPI
  - Date of Birth
  - Social Security Number

Survey and Certification

Survey and Certification

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)

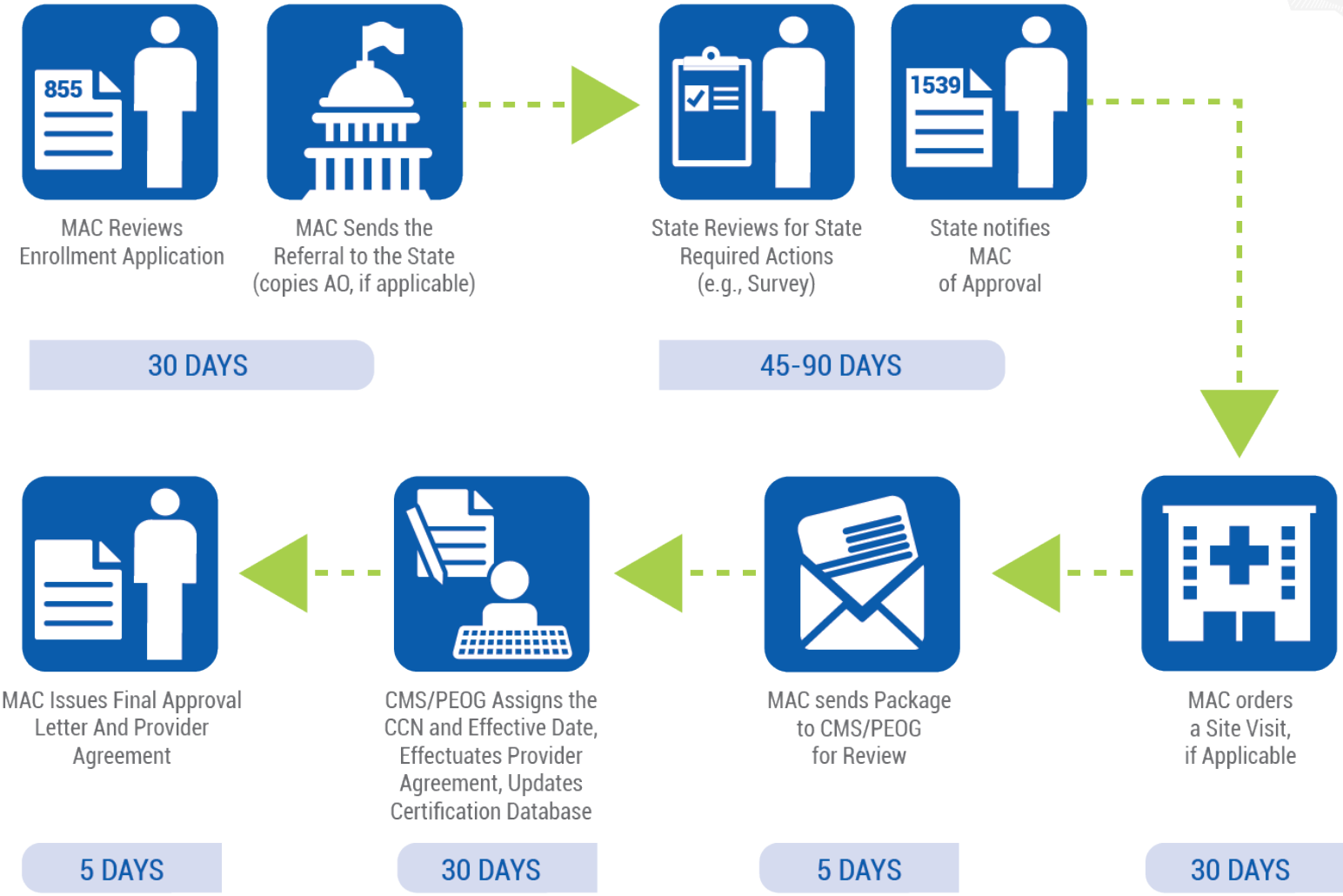
Survey and Certification

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

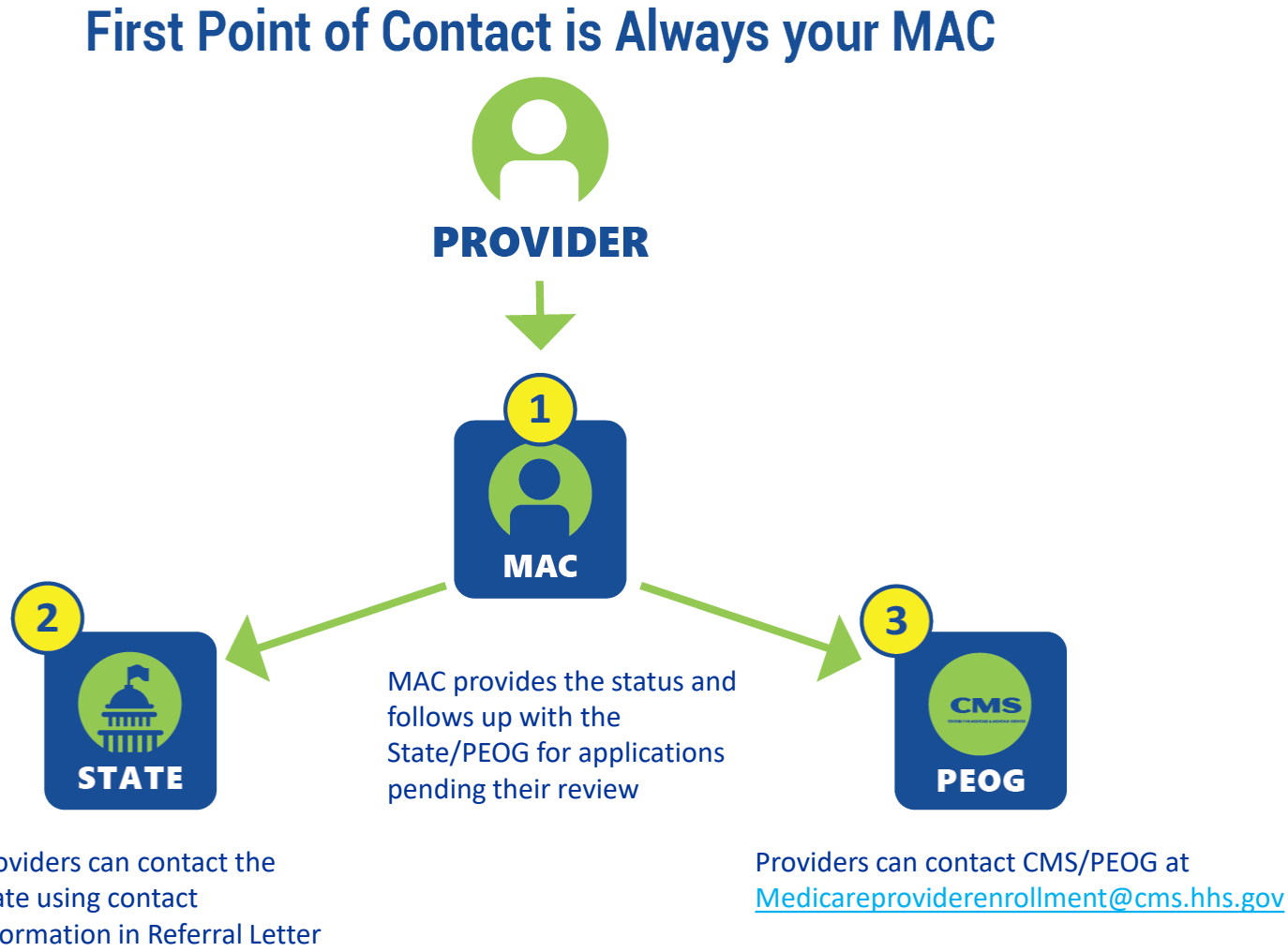
Process improvements and efficiencies

- Implemented approval letter updates (December 2023)
- Implemented MAC checklists to ensure complete packages are sent to PEOG (March 2024)
- Published roadmap with each step of the enrollment and certification process with timeframes and POCs per step (May 2024)
- Added PECOS status “Referred to State Agency for Review” (April 2025)
- Created required document list in PECOS to address commonly missed documents (April 2025)
- Reduced post survey processing times
- Collaborated with provider associations and groups to solicit feedback on the efficiencies

Survey and Certification



Who Should I Call?



Question & Answer Session

Revalidation

Revalidation

- Revalidating organizations, no individual due dates currently
- Use the Revalidation Look Up Tool or Revalidation Notification Center in PECOS to find your due date
  - Due dates posted 6-7 months in advance
  - A due date of “TBD” means that we haven’t set your due date
  - No action needed until you see a revalidation due date on the revalidation look up tool and/or receive a letter from your MAC/NPE
- MACs/NPEs issue letters 90 days in advance of due date
- Implement stay of enrollments and deactivations for non-response to revalidation or revalidation development

Stay of Enrollment – Non-Response to Revalidation

Began May 2024	MAC/PROVIDER ACTION	TIMEFRAME	SAMPLE TIMELINE
REVALIDATION DUE DATE: AUGUST 31, 2026	MAC APPLIES THE STAY AND SENDS NOTICE	10 DAYS AFTER	SEPTEMBER 10 2026
SCENARIO (1) STAY APPLIED & PROVIDER RESPONDS	PROVIDER SENDS REVALIDATION	WITHIN 30 DAYS	SEPTEMBER 25 2026
	MAC REMOVES THE STAY CLAIMS WITH DOS DURING THE STAY ARE ELIGIBLE FOR PAYMENT	WITHIN 10 DAYS	OCTOBER 5 2026

Stay of Enrollment – Non-Response to Revalidation

	MAC/PROVIDER ACTION	TIMEFRAME	SAMPLE TIMELINE
 REVALIDATION DUE DATE: AUGUST 31, 2026	 MAC APPLIES THE STAY AND SENDS NOTICE	 10 DAYS AFTER	 SEPTEMBER 10 2026
SCENARIO (2) STAY APPLIED & PROVIDER DOESN'T RESPOND	 PROVIDER DOES NOT RESPOND	 WITHIN 30 DAYS	 OCTOBER 10 2026
	 MAC DEACTIVATES BACK TO THE REVALIDATION DUE DATE CLAIMS WITH DOS DURING THE STAY AND AFTER DEACTIVATION ARE INELIGIBLE FOR PAYMENT	 WITHIN 10 DAYS	 OCTOBER 20 2026

Stay of Enrollment – Non-Response to Revalidation Development

Begins April 2026

REVALIDATION DEVELOPMENT
DUE DATE: OCTOBER 15, 2026

SCENARIO (3)
STAY APPLIED & PROVIDER RESPONDS

MAC/PROVIDER ACTION	TIMEFRAME	SAMPLE TIMELINE
 MAC APPLIES THE STAY AND SENDS NOTICE	 10 DAYS AFTER	 OCTOBER 25 2026
 PROVIDER SENDS MISSING INFO	 WITHIN 30 DAYS	 NOVEMBER 5 2026
 MAC REMOVES THE STAY CLAIMS WITH DOS DURING THE STAY ARE ELIGIBLE FOR PAYMENT	 WITHIN 10 DAYS	 NOVEMBER 15 2026

Stay of Enrollment – Non-Response to Revalidation Development

REVALIDATION SUBMITTED: SEPTEMBER 1, 2026	MAC/PROVIDER ACTION	TIMEFRAME	SAMPLE TIMELINE
REVALIDATION DEVELOPMENT DUE DATE: OCTOBER 15, 2026	MAC APPLIES THE STAY AND SENDS NOTICE	10 DAYS AFTER	OCTOBER 25 2026
SCENARIO (4) STAY APPLIED & PROVIDER DOESN'T RESPOND	PROVIDER DOES NOT RESPOND	WITHIN 30 DAYS	NOVEMBER 25 2026
	MAC REJECTS THE APPLICATION AND DEACTIVATES BACK TO THE DAY AFTER REVALIDATION DEVELOPMENT DUE DATE CLAIMS WITH DOS DURING THE STAY AND AFTER DEACTIVATION ARE INELIGIBLE FOR PAYMENT	WITHIN 10 DAYS	DECEMBER 5 2026

Revalidation

- Providers may be asked to revalidate off-cycle (in advance of or beyond their 3- or 5-year due date)
  - Off-cycle revalidation notifications will be sent out at least 90 days in advance
- CMS will continue to communicate changes to the revalidation process through MLN newsletters, Open Door Forums, provider enrollment website

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 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:

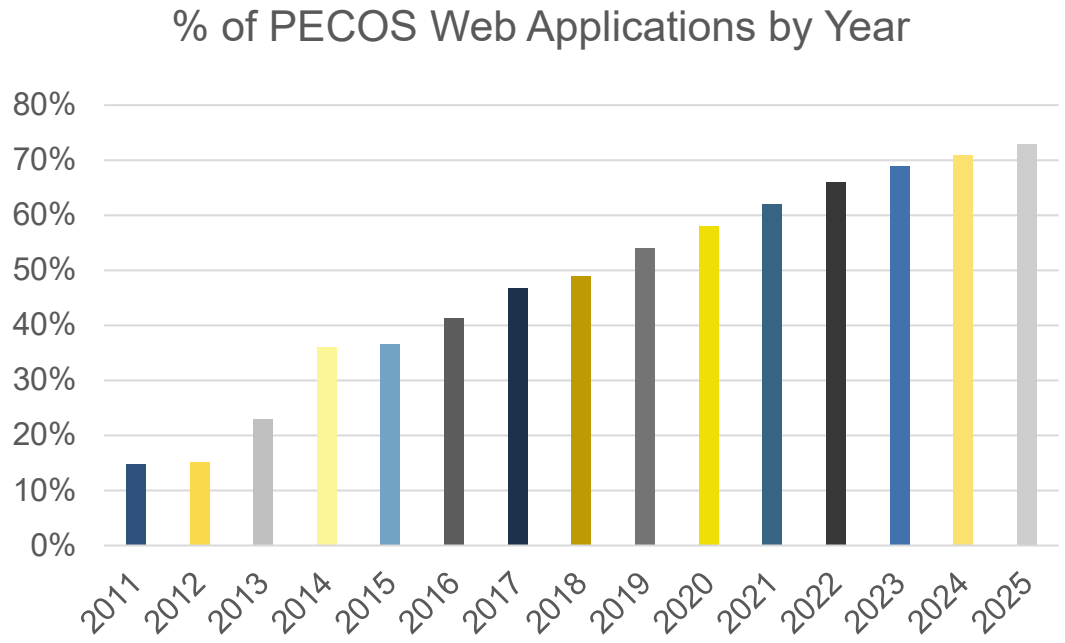
- ✓ Submit an initial Medicare enrollment application
- ✓ View or submit changes to your existing Medicare enrollment information
- ✓ Submit a Change of Ownership (CHOW) of the Medicare-enrolled provider
- ✓ Add or change reassignment of benefits
- ✓ Reactivate an existing enrollment record
- ✓ Withdraw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

PECOS Today

Over 2.9 Million Enrollments

Every month…

19,000 new enrollments



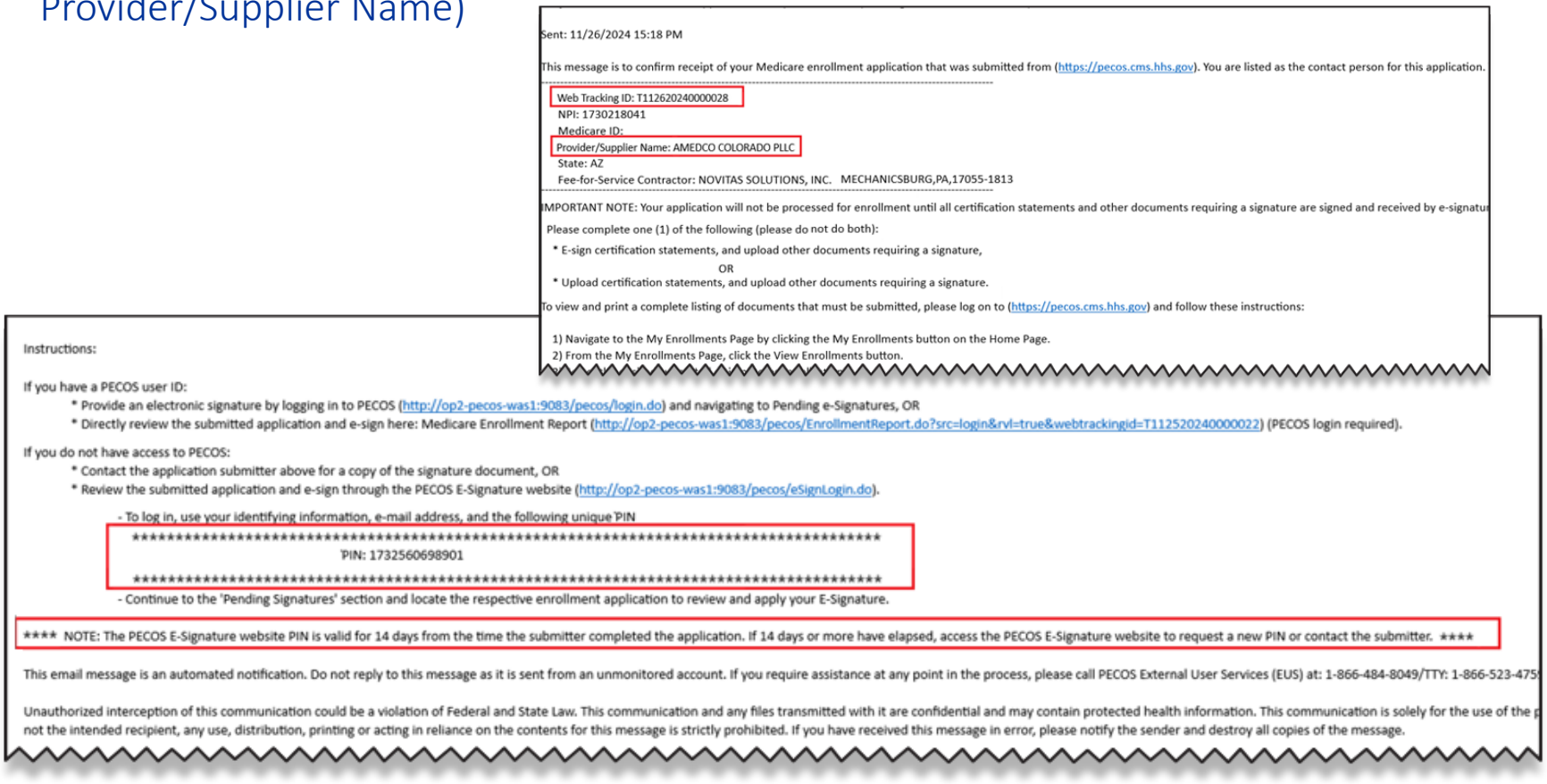
Encouraging Online Applications

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

PECOS 2025 Enhancements

Enhanced E-Signature Notifications

- Made PIN information more prominent in e-signature notification emails
- Updated enrollment receipt email field names for clarity (e.g., Web Tracking ID, Provider/Supplier Name)



Sent: 11/26/2024 15:18 PM

This message is to confirm receipt of your Medicare enrollment application that was submitted from (https://pecos.cms.hhs.gov). You are listed as the contact person for this application.

Web Tracking ID: T112620240000028
NPI: 1730218041
Medicare ID:
Provider/Supplier Name: AMEDCO COLORADO PLLC
State: AZ
Fee-for-Service Contractor: NOVITAS SOLUTIONS, INC. MECHANICSBURG,PA,17055-1813

IMPORTANT NOTE: Your application will not be processed for enrollment until all certification statements and other documents requiring a signature are signed and received by e-signatu

Please complete one (1) of the following (please do not do both):

* E-sign certification statements, and upload other documents requiring a signature,
OR
* Upload certification statements, and upload other documents requiring a signature.

To view and print a complete listing of documents that must be submitted, please log on to (https://pecos.cms.hhs.gov) and follow these instructions:

1) Navigate to the My Enrollments Page by clicking the My Enrollments button on the Home Page.
2) From the My Enrollments Page, click the View Enrollments button.

Instructions:

If you have a PECOS user ID:
* Provide an electronic signature by logging in to PECOS (http://op2-pecos-was1:9083/pecos/login.do) and navigating to Pending e-Signatures, OR
* Directly review the submitted application and e-sign here: Medicare Enrollment Report (http://op2-pecos-was1:9083/pecos/EnrollmentReport.do?src=login&rvl=true&webtrackingid=T112520240000022) (PECOS login required).

If you do not have access to PECOS:
* Contact the application submitter above for a copy of the signature document, OR
* Review the submitted application and e-sign through the PECOS E-Signature website (http://op2-pecos-was1:9083/pecos/eSignLogin.do).

- To log in, use your identifying information, e-mail address, and the following unique PIN

****

PIN: 1732560698901

****

- Continue to the 'Pending Signatures' section and locate the respective enrollment application to review and apply your E-Signature.

**** NOTE: The PECOS E-Signature website PIN is valid for 14 days from the time the submitter completed the application. If 14 days or more have elapsed, access the PECOS E-Signature website to request a new PIN or contact the submitter. ****

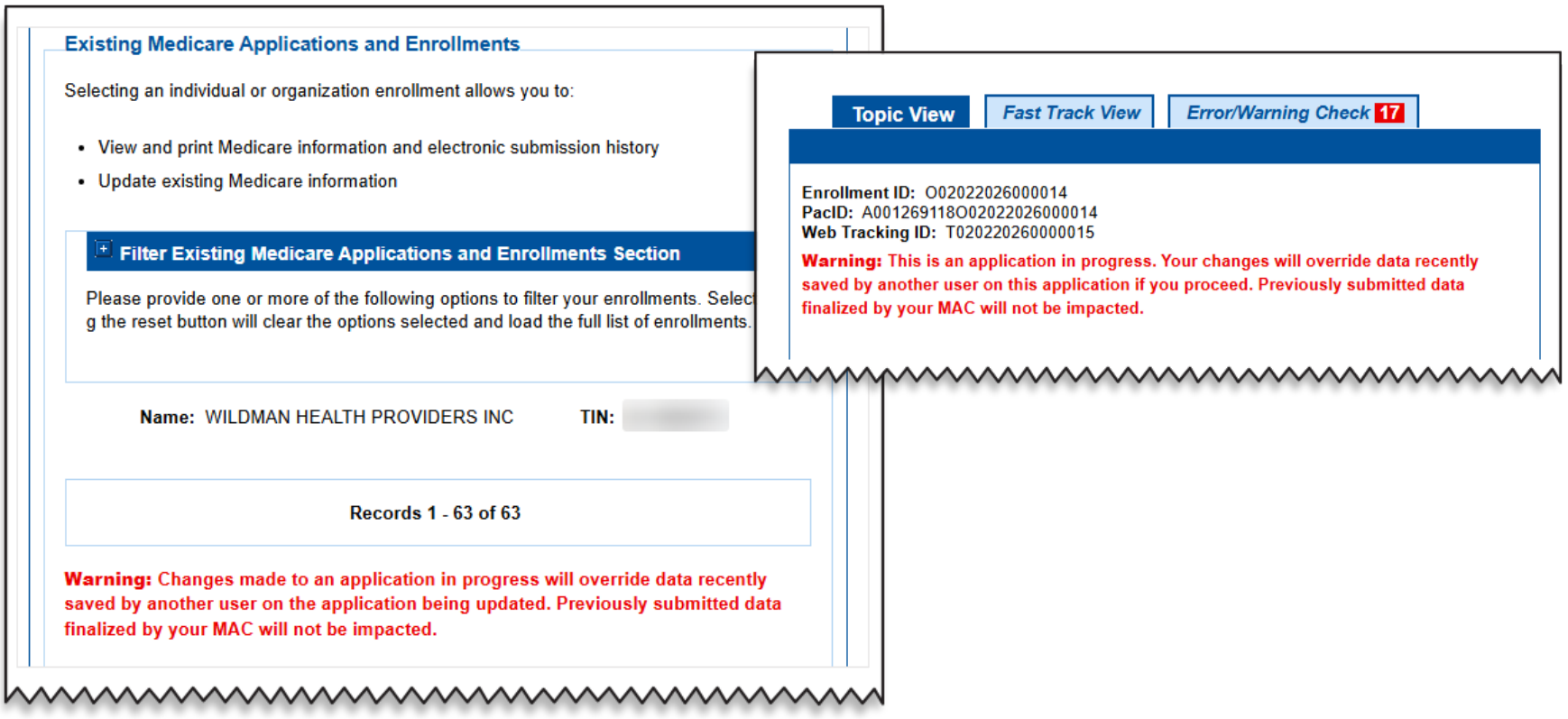
This email message is an automated notification. Do not reply to this message as it is sent from an unmonitored account. If you require assistance at any point in the process, please call PECOS External User Services (EUS) at: 1-866-484-8049/TTY: 1-866-523-475

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the p
not the intended recipient, any use, distribution, printing or acting in reliance on the contents for this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy all copies of the message.

PECOS 2025 Enhancements

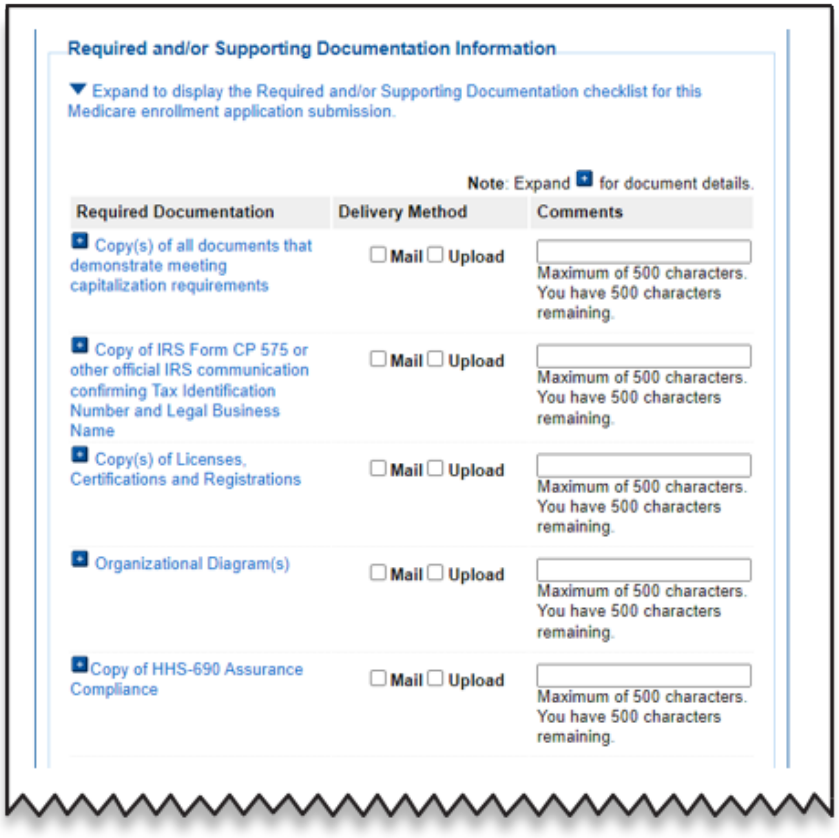
In-Progress Application Safeguards

- Added informational messaging to prevent overwriting saved application data
- Displayed on My Enrollments, Topic, View, Fast Track View, and Documentation pages



PECOS 2025 Enhancements

Certified Provider Required Documentation Checklist

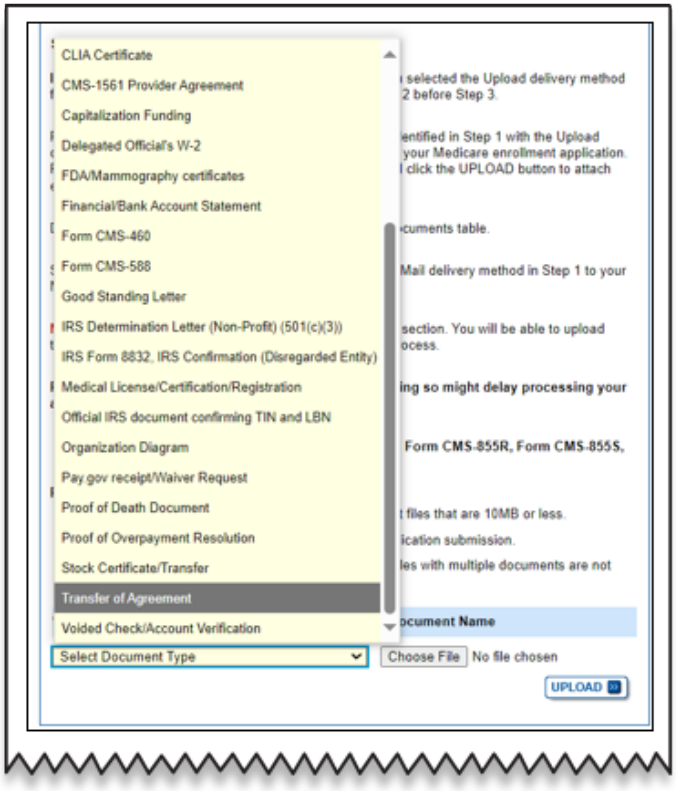


Required and/or Supporting Documentation Information

▼ Expand to display the Required and/or Supporting Documentation checklist for this Medicare enrollment application submission.

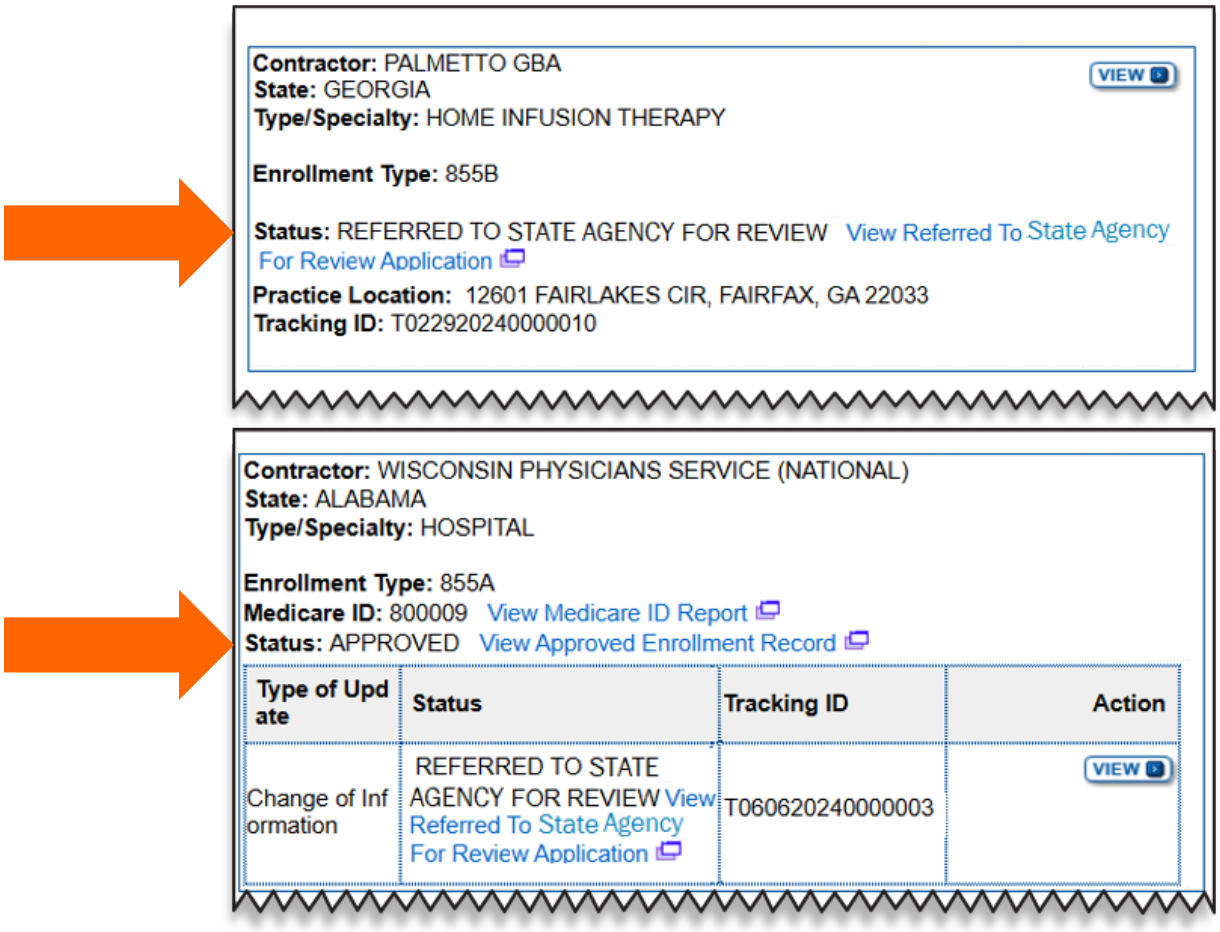
Note: Expand ■ for document details.

Required Documentation	Delivery Method	Comments
■ Copy(s) of all documents that demonstrate meeting capitalization requirements	☐ Mail ☐ Upload	Maximum of 500 characters. You have 500 characters remaining.
■ Copy of IRS Form CP 575 or other official IRS communication confirming Tax Identification Number and Legal Business Name	☐ Mail ☐ Upload	Maximum of 500 characters. You have 500 characters remaining.
■ Copy(s) of Licenses, Certifications and Registrations	☐ Mail ☐ Upload	Maximum of 500 characters. You have 500 characters remaining.
■ Organizational Diagram(s)	☐ Mail ☐ Upload	Maximum of 500 characters. You have 500 characters remaining.
■ Copy of HHS-690 Assurance Compliance	☐ Mail ☐ Upload	Maximum of 500 characters. You have 500 characters remaining.



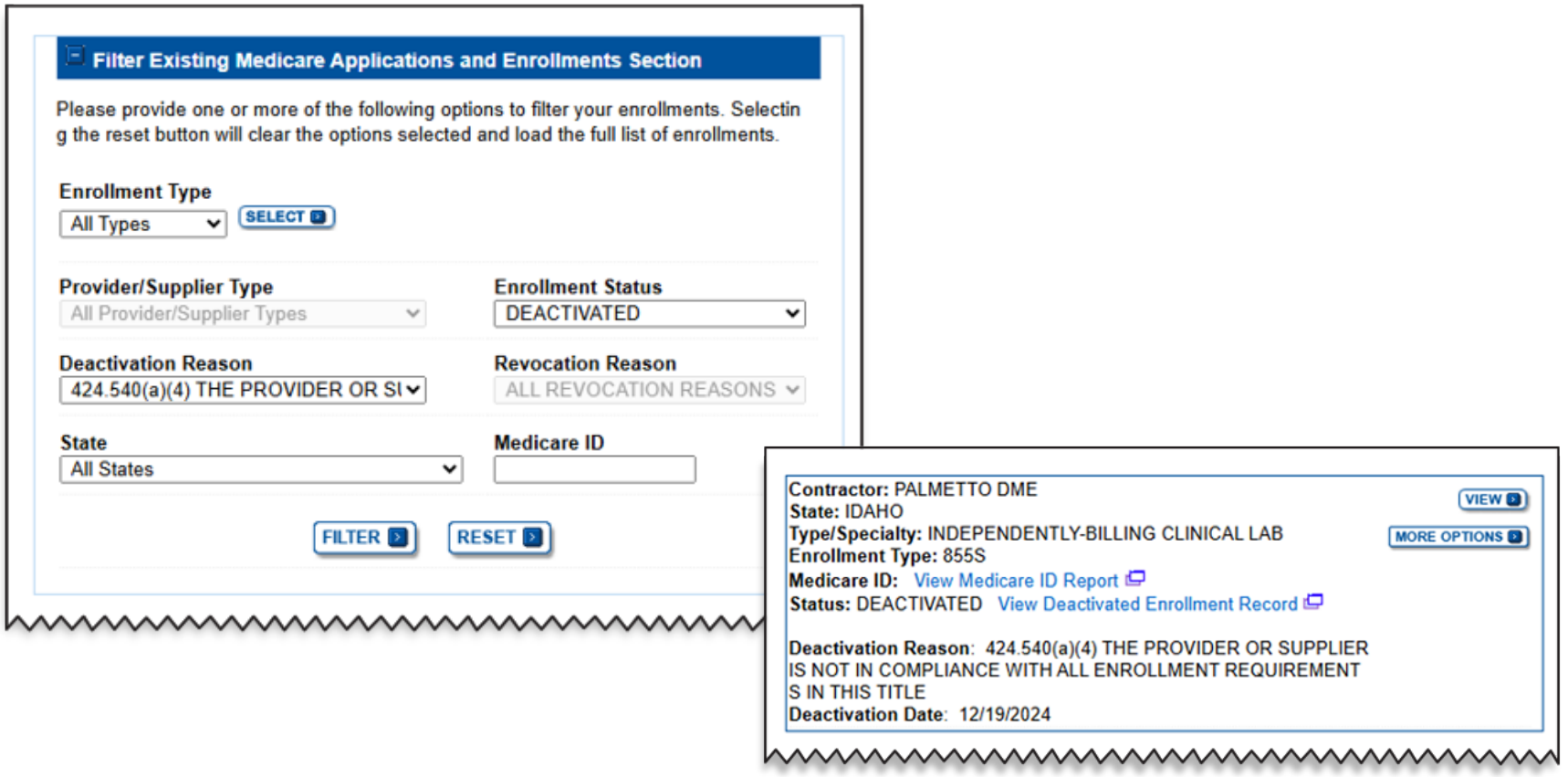
PECOS 2025 Enhancements

Enrollment status is updated after referral to the State



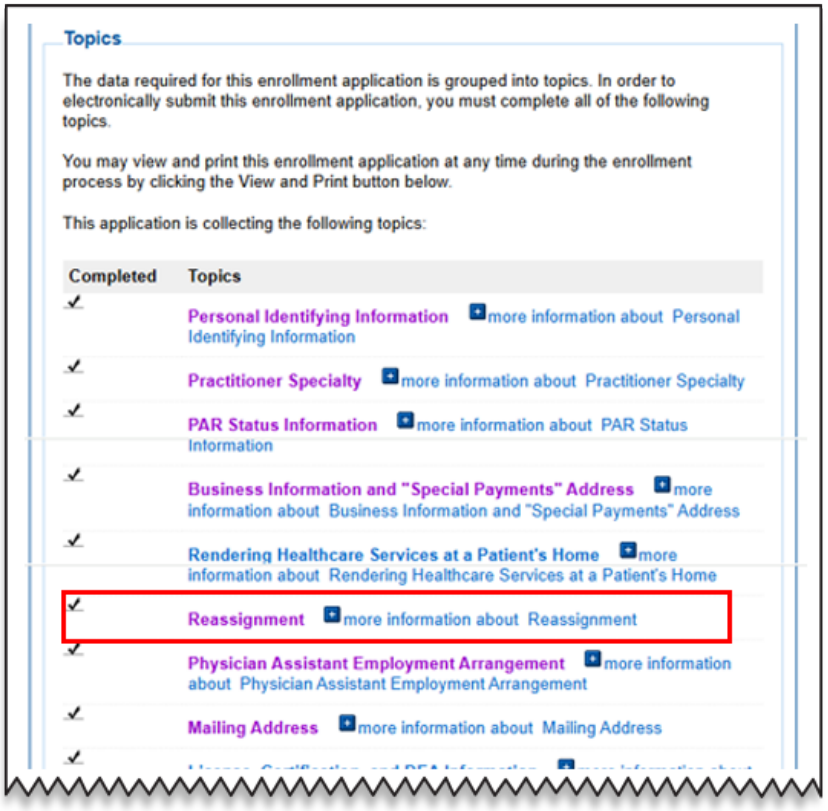
PECOS 2025 Enhancements

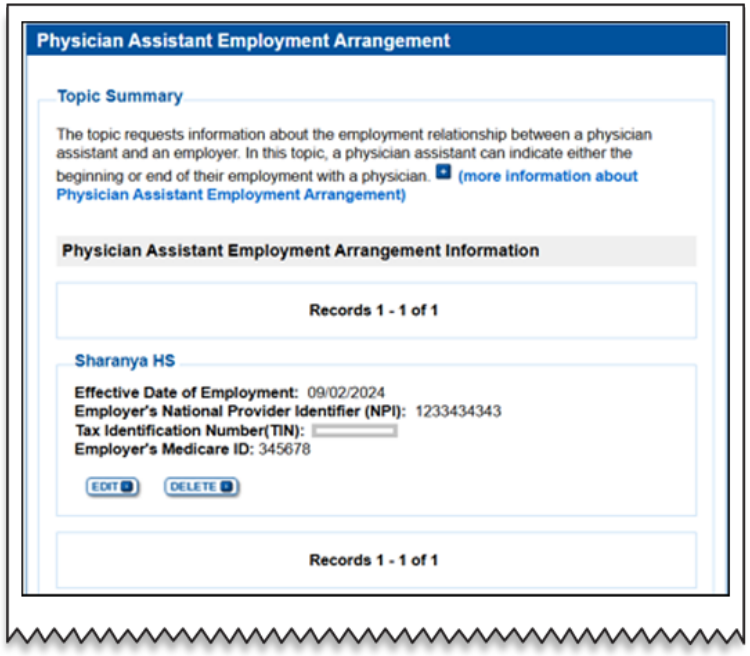
Improved Filtering of Enrollment Status for Deactivated and Revoked Enrollments



PECOS 2025 Enhancements

Physician Assistant Reassignment Modernization



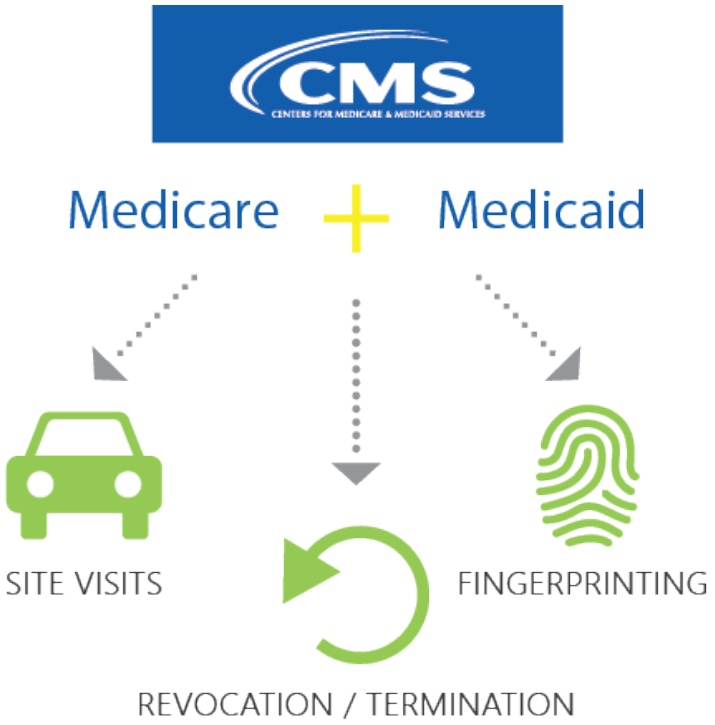


Question & Answer Session

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 to alter their enrollment process
- Align the enrollment process across all states
- Require timeframes for processing applications
- Define how states implement Federal regulations

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

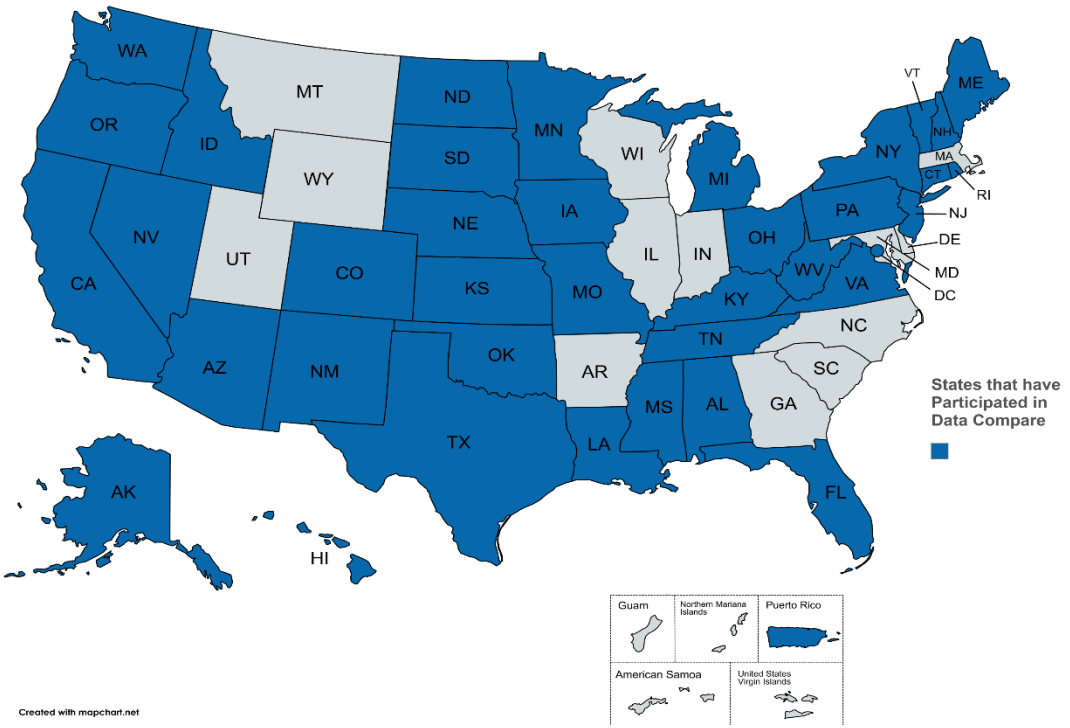
Screening Risk Levels (Section 1.3(D))

- 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

New York Reported

224,960 Providers

Data Compare
Report Had a Match of
177,839 Providers

79.1% Match Rate

Reliable Data Compare
142,828 Limited Risk Providers

North Dakota Reported

23,706 Providers

Data Compare
Report Had a Match of
18,391 Providers

77.6% Match Rate

Reliable Data Compare
15,295 Limited Risk Providers

New Hampshire Reported

13,953 Providers

Data Compare
Report Had a Match of
13,600 Providers

97.5% Match Rate

Reliable Data Compare
12,641 Limited Risk Providers

Question & Answer Session

Protecting the Program

Stronger Screening

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

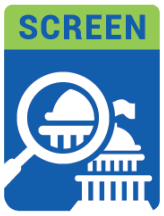
- For high Medicare reimbursements
- In high risk geographic areas

Find Vacant or Invalid Addresses

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

Deactivations

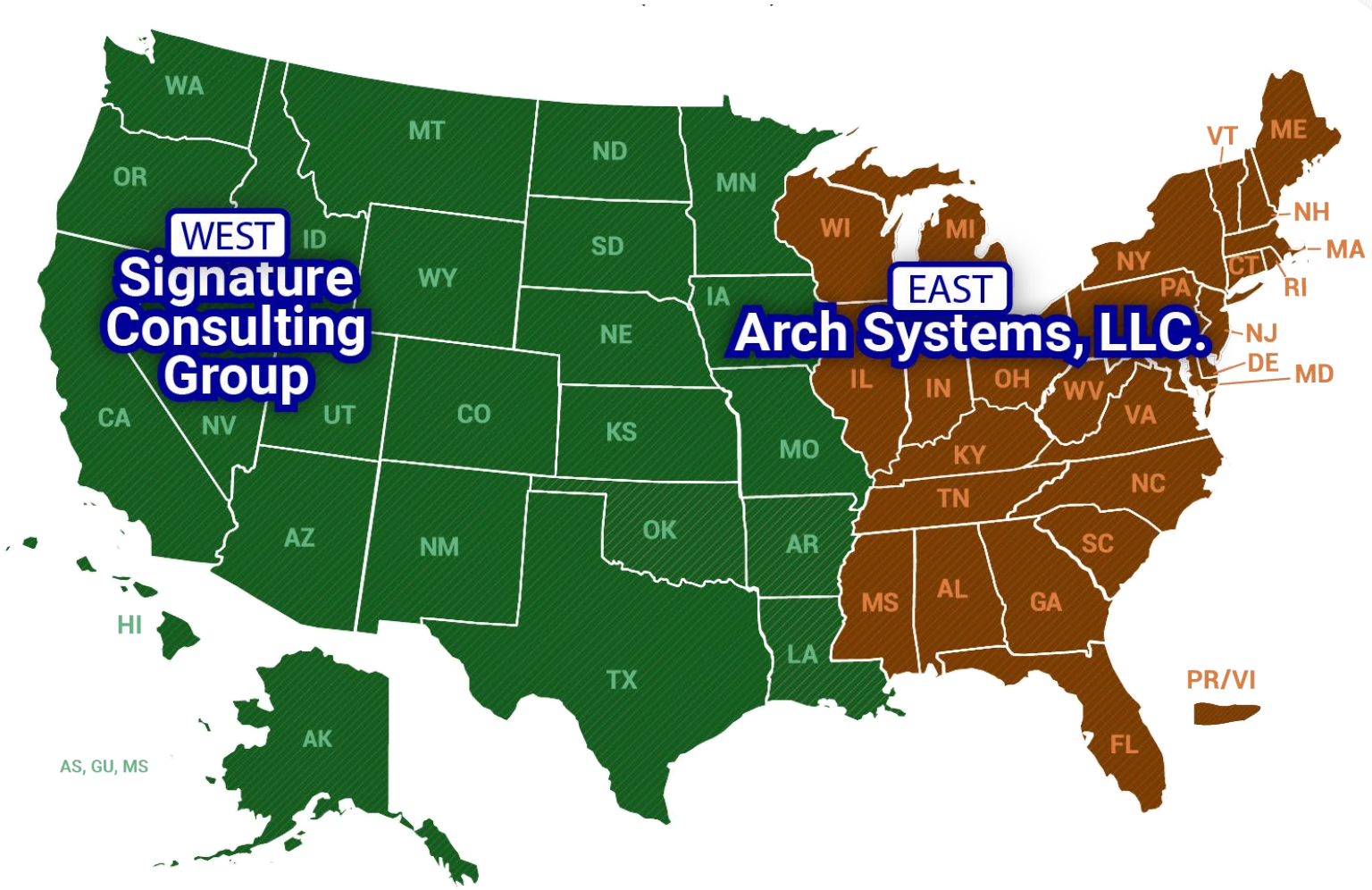
- Non-billing
- Inactive NPIs
- Deceased associates
- No active practice locations or reassignments for more than 90 days



Screen Medicaid-only Providers

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

National Site Visit Contractor (NSVC)



Site Visits | National Site Visit Contractors (NSVCs)

- All enrollment site visits are 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

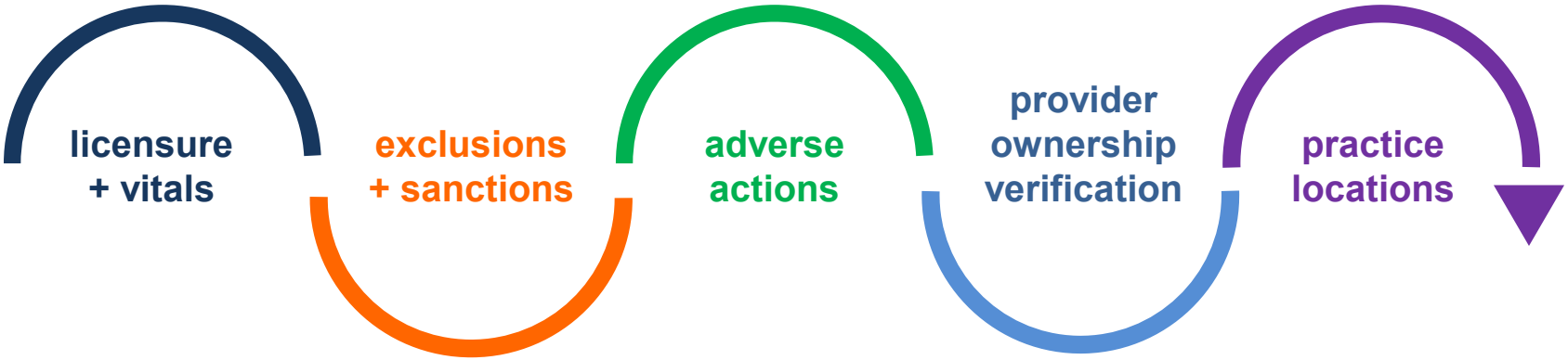
If the provider/supplier:

- 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



License via Automated screening

SSA Death Master File

NPI and LBN Integrated via NPPES

OIG and GSA websites Integrated in PECOS Monthly checks

Criminal alerts via Automated screening

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

Ad hoc site visits

Data Sharing

Public data files from PECOS

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

Public Provider Enrollment File

- Currently approved individuals and orgs
- Reassignments
- Practice location data (limited)
- Primary and secondary specialty
- Updated quarterly

Revalidation File

- Currently approved, and due for revalidation
- Individuals and orgs
- Revalidation due date
- Reassignments
- Updated every 30 days

Ordering Referring File

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

Data Sharing

Public data files from PECOS

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

Opt Out File

- Currently opted-out of Medicare
- Updated quarterly

Hospital , SNF All Ownership File Change of Ownership File

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

HHA, Hospice, FQHC, RHC

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

Question & Answer Session

Resources

cms.gov

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

cms.gov/Revalidation

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

PECOS.cms.hhs.gov

account creation, videos, providers resources , FAQs

888-734-6433

PECOS Help Desk

ProviderEnrollment@cms.hhs.gov

Provider Enrollment contact

FFSProviderRelations@cms.hhs.gov

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

cms.gov MLN Matters® Articles

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

Thank You

March 2026 | This summary material was part of an in-person presentation. It was current at the time we presented it. It does not grant rights or impose obligations. We encourage you to review statutes, regulations, and other directions for details.

If you need more accessibility options for the material, contact providerenrollment@cms.hhs.gov

Centers for Medicare & Medicaid Services