



Announcement

About Medicare Participation for Calendar Year 2020

This announcement provides information that may be helpful to clinicians in determining whether to become a Medicare participating provider, or to continue Medicare participation. The Centers for Medicare & Medicaid Services (CMS) pledges to put patients first. To do this, we must empower patients to work with their clinicians and make health care decisions that are best for them. This means giving them meaningful information about quality and costs to be active health care consumers. It also includes supporting innovative approaches to improving quality, accessibility, and affordability, while finding the best ways to use innovative technology to support patient-centered care. But we can't do all of this without your involvement. Please visit www.cms.gov to learn more about our efforts to strengthen the Medicare program.

WHY BECOME A PARTICIPATING MEDICARE PROVIDER

All physicians, non-physician practitioners and other suppliers – regardless of their Medicare participation status – must make their calendar year (CY) 2020 Medicare participation decision by December 31, 2019. Participating providers (those with PAR status) have signed an agreement to accept assignment for all Medicare-covered services provided to Medicare patients. Assignment means that the provider agrees (or is required by law) to accept the Medicare-approved amount as full payment for Medicare-covered services. Non-participating providers (those with Non-PAR status) have not signed an agreement to accept assignment for all Medicare-covered services, but they can still choose to accept assignment for individual services.

Providers who want to maintain their current PAR status or Non-PAR status do not need to take any action during the upcoming annual participation enrollment period. To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients. The overwhelming majority of physicians, non-physician practitioners and other suppliers choose to participate in Medicare. For example, during CY 2019, 97.8 percent of all physicians and non-physician practitioners who furnished services to Medicare patients did so under Medicare participation agreements.

If you participate in Medicare and bill for services paid under the Medicare physician fee schedule, your Medicare physician fee schedule amounts are five percent higher than if you do not participate in

Medicare. Your Medicare Administrative Contractor (MAC) publishes an electronic directory of participating physicians, non-physician practitioners and other suppliers.

WHAT TO DO

If you choose to participate in Medicare in CY 2020:

- Do nothing if you are currently participating, or
- If you are not currently participating, complete the available [blank agreement](#) and mail it (or a copy) to each MAC to which you submit Part B claims. (On the form, show the name(s) and identification number(s) under which you bill.)

If you decide not to participate in Medicare in CY 2020:

- Do nothing if you are currently not participating, or
- If you are currently participating in Medicare, write to each MAC to which you submit Part B claims, advising them of the termination of your participation in the Medicare program effective January 1, 2020. This written notice must be postmarked prior to January 1, 2020.

We hope you will decide to be a Medicare participating physician, practitioner, or supplier in CY 2020. Please call [1-855-609-9960](tel:1-855-609-9960) if you have any questions or need further information on participation.

The Medicare Learning Network® (MLN) offers many [products on how providers and suppliers can enroll in the Medicare Program](#). These products include specific information for physicians and other Part B suppliers; ordering/referring providers; institutional providers; and Durable Medical Equipment, Prosthetics, Orthotics and Supplies suppliers, as well as information on the electronic Medicare enrollment system, Provider Enrollment, Chain and Ownership System (PECOS).

Opt Out of Medicare:

The Medicare Program offers a number of benefits to physicians, non-physician practitioners and other suppliers, including timely payment by Medicare for services rendered. However, the Medicare program does carry a number of requirements. For example, providers often must comply with quality reporting requirements.

Certain physicians and non-physician practitioners who do not wish to engage with the Medicare program may opt out of Medicare. Opting out of Medicare allows the provider to directly negotiate with Medicare beneficiaries regarding payment for their health care services. While Medicare would not pay for services provided by an “opt-out” physician or practitioner except for urgent or emergency medical care, beneficiaries and providers would have the flexibility to set mutually acceptable payment terms through a negotiated private contract. Providers that opt out can offer and enter into arrangements with beneficiaries that would otherwise be prohibited under Medicare. Opt-out physicians also need not follow certain Medicare requirements, such as deciding on a case by case basis whether, in compliance with Medicare’s rules and guidance, to provide an advance beneficiary

notice of non-coverage for services. Medicare will still pay opt-out providers for emergency or urgent care services rendered to beneficiaries without a private contract. More information can be found by visiting [Opt-Out Affidavits](#).

National Plan and Provider Enumeration System (NPES) Taxonomy:

Please check your data in NPES and confirm that it still correctly reflects you as a health care provider. There is increased focus on the National Provider Identifier (NPI) as a health care provider identifier for program integrity purposes. Incorrect taxonomy data in NPES may lead to unnecessary inquiries about your credentials, as it may appear to Medicare oversight authorities that you may not be lawfully prescribing Part D drugs. Comprehensive information about how the NPI rule pertains to prescribers may be obtained [here](#).

New Medicare Cards and Numbers:

Use Medicare Beneficiary Identifiers (MBIs) now for all Medicare transactions. CMS finished mailing new Medicare cards in January 2019. The new Medicare cards each feature a unique, randomly-assigned Medicare number known as a Medicare Beneficiary Identifier (MBI). The MBI is a combination of letters and numbers that helps protect against personal identity theft and fraud to beneficiaries. Help protect your patients' personal identities by getting their MBIs and using them for Medicare business, including claims submission and eligibility transactions.

Starting January 1, 2020, even for services provided before this date, you must use the MBI when submitting claims. With a few exceptions, Medicare will reject claims you submit with Health Insurance Claim Numbers (HICNs) after December 31, 2019. In addition, Medicare will reject all eligibility transactions you submit with HICNs after this date.

There are three ways to get your Medicare patients' new MBIs:

1. Ask your Medicare patients

Ask your Medicare patients for their new Medicare cards when they come for care. If they didn't get a new card, give them the Get Your New Medicare Card flyer in [English](#) or [Spanish](#).

2. Use the MAC's secure MBI look-up tool

You can look up MBIs for your Medicare patients when they don't or can't give them. [Sign up](#) for the Portal to use the tool. You can use this tool even after the end of the transition period – the tool doesn't end on December 31, 2019.

3. Check the remittance advice

We'll also return the MBI on every remittance advice when you submit claims with valid and active HICNs through December 31, 2019. Get the MBI from the remittance advice and save it in your systems to use with your next Medicare transaction.

Use the MBI the same way you used the HICN. Put the MBI in the same field where you always put the HICN. Don't use hyphens or spaces with the MBI.

Protect the MBI as Personally Identifiable Information (PII); it is confidential like the HICN.

Medicare Advantage and Prescription Drug plans continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans' health insurance cards.

For more information read our [MLN Matters® article, New Medicare Beneficiary Identifier \(MBI\), Get It, Use It.](#)

Refer your patients to [Medicare.gov](https://www.medicare.gov) if they have questions.

Moving toward Year 4 (2020) of the Quality Payment Program: Focusing on patients and reducing clinician burden by transforming MIPS and facilitating movement to APMs:

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula for clinician payment under the Medicare physician fee schedule, and established a quality payment incentive program—the Quality Payment Program (QPP). This program provides clinicians with two ways to participate: through Advanced Alternative Payment Models (APMs) and the Merit-based Incentive Payment System (MIPS).

It's important to remember that for the first transition year of MIPS, we started slowly because we understood that QPP was a major transition from legacy programs such as the Physician Quality Reporting System (PQRS). In 2017, MIPS eligible clinicians had flexible participation options under the “pick your pace” approach to help ease their transition into the program and encourage robust participation. In 2018, we introduced the “Patients Over Paperwork” Initiative to reduce regulatory burden so providers could spend more time with patients. In 2019, we added new MIPS eligible clinician types and introduced an opt-in policy to allow clinicians who would have been excluded from QPP the option to participate in MIPS. We have also been working through our Meaningful Measures framework to remove low-bar, standard of care, process measures and focus on outcome and high-priority measures that will improve care for patients. As a result of these flexibilities, more clinicians have been able to successfully participate. Since 2017, we've built on what we've learned while ramping up requirements to prepare for a more robust program in future years.

For the 2020 performance year, we are making key changes to continue moving QPP forward while easing burden on clinicians:

- Increase the performance threshold (which is the minimum number of points to avoid a negative payment adjustment) from 30 points to 45 points;
- Streamline measures and activities for each performance category.

We also encourage you to learn about opportunities for participation in Advanced APMs in QPP. For payment years through 2024, clinicians participating in QPP through Advanced APMs must achieve threshold levels of payments or patients through their Advanced APMs to be considered qualifying APM participants (QPs) in a performance year. If you achieve either of these thresholds, you may be excluded from the MIPS reporting requirements and payment adjustment and eligible to earn a five

percent APM Incentive Payment. Eligible clinicians in certain APMs who must participate in MIPS may be considered MIPS APM participants and receive special scoring in MIPS under the APM scoring standard.

Key changes for APMs for the 2020 performance year include the following:

- Add a new definition of medical home models to include certain arrangements by commercial and other payers to allow clinicians more options to meet the “medical home” financial risk criterion in making Other Payer Advanced APM threshold determinations for payment arrangements;
- Allow MIPS eligible clinicians participating in MIPS APMs the option to separately report for the MIPS Quality performance category; and
- Give a MIPS APM Quality Reporting Credit for APM participants in MIPS APMs where scoring of quality measures reported through the APM is not technically feasible.

The methodology CMS uses to identify eligible clinicians who, through their participation in Advanced APMs, are QPs for the 2019 QP Performance Period is available in the [2019 QP Methodology Fact Sheet](#). These clinicians will receive the five percent APM Incentive Payment in the 2021 payment year. This fact sheet is only applicable to QP determinations using the Medicare Option (Advanced APMs).

Information on the All-payer Combination Option is available on the [Quality Payment Program website](#). We also have a list of Advanced APMs and MIPS APMs available on [the APMs Overview](#) page of the QPP website. One option for APM participation is through an Accountable Care Organization (ACO). To learn how to get started as an APM participant in an ACO, please visit the CMS ACO web page at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html>.

Looking ahead to the 2021 performance year, we anticipate that we will begin to implement MIPS Value Pathways (MVPs), a participation framework that aims to move away from siloed activities and measures and move towards a set of measures that are clinically related to one another, relevant to a clinician’s scope of practice, and meaningful to patient care. The MVP framework aims to align and connect measures and activities across the Quality, Cost, Promoting Interoperability, and Improvement Activities performance categories of MIPS for different specialties or conditions. We anticipate that a clinician could participate through an MVP that is relevant to their specialty or to a condition often cared for by their specialty, and they would report on the same measures and activities as other clinicians participating through the same MVP.

Final changes to QPP for Year 4 (2020 performance period) have been included in the 2020 Medicare Physician Fee Schedule Final Rule. We encourage you to visit the [QPP Resource Library](#) on qpp.cms.gov for available resources related to the final rule.

Important QPP Reminders:

- If you participated in Year 2 (2018 performance year) of MIPS, you will receive a MIPS payment adjustment in 2020. Your payment adjustment is determined based on the data you submitted on measures and activities for performance during 2018. You can review these

details by accessing your performance feedback, which you can view by logging in here:
<https://qpp.cms.gov/login>

- You are also encouraged to check your Quality Payment Program participation status for Year 3 (2019 performance period) to determine if you are expected to participate in MIPS with the [QPP Participation Status Tool](#).
- You can explore the MIPS measures and activities with the [QPP Explore Measures & Activities Tool](#).
- The deadline to submit the [Promoting Interoperability or Extreme and Uncontrollable Circumstances applications](#) is December 31, 2019.
- The 2019 data submission period will begin on January 2, 2020.
- The Quality Payment Program Service Center is available to help answer your questions. Email us at qpp@cms.hhs.gov or call [1-866-288-8292](tel:1-866-288-8292) weekdays from 8 AM to 8 PM Eastern Time.

Prescription Drug Abuse:

Prescription opioid drug abuse remains a public health emergency. Continued prescriber awareness and engagement are crucial to reversing this trend. CMS has implemented several policies to assist Medicare prescription drug plans in identifying and managing potential prescription drug abuse or misuse involving Medicare beneficiaries in their plans. These interventions often address situations that involve multiple prescribers and pharmacies who are not aware of each other prescribing for the same patients. If you are contacted by a prescription drug plan or pharmacy about the opioid use of one of your patients, please respond in a timely manner with your feedback and expertise to help assure the safe use of these products and avoid disruption of therapy.

If your patient taking opioids is under review by a Medicare Part D drug management program, the plan may offer you tools to help you manage the patient. These tools include limiting the patient's opioid coverage to prescriptions written by a specific prescriber and/or dispensed by a specific pharmacy that the patient may generally choose. In addition, the plan can limit the patient's opioid coverage to the specific amount you state is medically necessary.

To facilitate safer opioid prescribing, Medicare drug plans also may trigger opioid safety alerts for certain patients at the time of dispensing for pharmacists to conduct additional review, which may require consultation with the prescriber to ensure that a prescription is appropriate before it can be filled. If the pharmacy cannot fill the prescription as written, you may contact the plan and ask for a "coverage determination" on the patient's behalf. You can also request an expedited or standard coverage determination in advance of prescribing an opioid; you only need to attest to the Medicare drug plan that the cumulative level or days' supply is the intended and medically necessary amount for your patient.

The drug management programs and safety alerts generally do not apply to residents of long-term care facilities, those in hospice care, patients receiving palliative or end-of-life care, and patients being treated for active cancer-related pain. These policies should also not impact patients' access to medication-assisted treatment (MAT), such as buprenorphine. Lastly, these policies are not prescribing

limits. CMS understands that decisions to prescribe opioids, including the dose; to taper; or to discontinue prescription opioids are carefully individualized between you and your patients.

Information for Prescribers and A Prescriber's Guide to Part D Opioid Policies are available [here](#).

The Medicare Learning Network® (MLN):

The MLN offers free educational materials for health care professionals on CMS programs, policies, and initiatives. Visit the [MLN homepage](#) for information. [Subscribe](#) to our MLN Connects® weekly email newsletter for health care professionals to get information on CMS program and policy news; announcements; upcoming events and training; claim, pricer, and code information; and MLN publication updates.

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Providers may access the CY 2020 payment rates at the following address: <https://med.noridianmedicare.com/web/jeb/fees-news/fee-schedules/mpfs>. Please feel free to reach out to our Provider Contact Center at 1-855-609-9960, for additional information.