Announcement
About Medicare Participation for Calendar Year 2018

CMS's goals include (1) empowering patients and doctors to make decisions about their healthcare, (2) ushering in a new era of flexibility and local leadership (3) improving the CMS customer experience, and (4) supporting innovative approaches to improve quality, access, and affordability. We wish to emphasize the importance and advantages of being a Medicare participating (PAR) provider, and we are pleased that the favorable trend of participation continued into 2017 with a participation rate of 97.5 percent. As you plan for 2018 and become familiar with the coming changes, we hope that you will continue to be a PAR provider or, if you are non-participating (Non-PAR), will consider becoming a PAR provider.

CMS strives to empower providers and patients to transform the healthcare delivery system through the individual health care decisions made by patients and professionals. Our policies support patient-centered care to improve health outcomes and efficiency. CMS will ensure each beneficiary is empowered to select and access the care that is right for them by protecting the doctor-patient relationship; reducing burden on providers and patients; empowering seniors and increasing satisfaction; advancing innovation; and fighting fraud. CMS will actively engage stakeholders to enhance the dialogue and listen to feedback from those who are caring for patients.

WHY BECOME A PARTICIPATING MEDICARE PROVIDER

All physicians, practitioners and suppliers – regardless of their Medicare participation status – must make their calendar year (CY) 2018 Medicare participation decision by December 31, 2017. 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 in CY 2018. The overwhelming majority of physicians, practitioners and suppliers have chosen to participate in Medicare. During CY 2017, 97.5 percent of all physicians and practitioners are billing under Medicare participation agreements.

If you participate and bill for services paid under the Medicare physician fee schedule (MPFS), your Medicare fee schedule amounts are 5 percent higher than if you do not participate. Your Medicare

Administrative Contractor (MAC) publishes an electronic directory of providers that choose to participate.

WHAT TO DO

If you choose to be a PAR physician in CY 2018:

- Do nothing if you are currently participating, or
- If you are not currently a Medicare participant, 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 CY 2018:

- Do nothing if you are currently not participating, or
- If you are currently a participant, write to each MAC to which you submit claims, advising of the termination of your participation in the participating physician program effective January 1, 2018. This written notice must be postmarked prior to January 1, 2018.

We hope you will decide to be a Medicare participant in CY 2018. Please call 1-800-454-9007 (Florida, U.S. Virgin Islands) or 1-877-715-1921 (Puerto Rico).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 Enrollment:

Enrollment in Medicare offers a number of benefits to providers, including timely reimbursement for services rendered. However, enrollment in the program does carry a number of requirements. For example, providers must comply with numerous reporting requirements that consume time that they would rather spend with patients. We seek to reform the Medicare program to allow providers more flexibility to meet the needs of patients.

Certain physicians and practitioners who do not wish to enroll in the Medicare program may "opt-out" of Medicare. Opting out of Medicare allows the beneficiary and the provider to directly negotiate reimbursement for healthcare services. While Medicare would not reimburse for services provided by an "opt-out" physician, beneficiaries and providers would have the flexibility to set mutually acceptable reimbursement 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. Opted 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 noncoverage. Medicare will still reimburse providers for services

rendered to beneficiaries with whom they have not privately contracted as a result of a medical emergency. More information can be found by visiting Opt-Out Affidavits.

New Medicare Cards and Numbers:

In April 2018, CMS will start mailing Medicare cards with new Medicare numbers (known as Medicare Beneficiary Identifiers or MBIs) to all Medicare beneficiaries. The MBI will replace the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) for transactions like billing, eligibility status, and claim status after a transition period. Make sure your systems are ready by April 2018:

- Accept the new MBI Format. Ask your billing and office staff if your systems will be ready to accept the 11 digit alphanumeric MBI. If you use vendors to bill Medicare, ask them about their MBI practice management system changes and make sure they are ready for the change. Make and internally test changes to your practice management systems and business processes by April 2018, before we mail the new Medicare cards.
- Verify your Medicare patients' addresses; they will not get a new card if their address is not correct. If the address you have on file is different from the address you receive in electronic eligibility transaction responses from us, encourage your Medicare patients to correct their address in Medicare's records through the Social Security Administration. This may require coordination between your billing and office staff.
- Identify your Medicare patients who qualify for Medicare under the Railroad Retirement Board (RRB). You will no longer be able to distinguish RRB patients by the number on the new Medicare card. You will be able to identify them by the RRB logo on their card, and we will return a message on the eligibility transaction response for an RRB patient. You must identify them differently to send Medicare claims to the RRB Specialty Medicare Administrative Contractor (MAC), Palmetto GBA.
- Update your practice management system's patient numbers to automatically accept the new MBI from the remittance advice (835) transaction. Beginning in October 2018 through the transition period, we will return your patient's MBI on every remittance advice for claims you submit with a valid and active HICN.
- Attend our quarterly calls to get more information. We will let you know when calls are scheduled in MLN Connects.
- Visit our New Medicare Card Overview and Provider webpages for the latest details.

Transitioning from a Patchwork of Reporting Programs:

The Medicare Access and CHIP Reauthorization Act of 2015 implemented the Quality Payment Program, which started on January 1, 2017. Doctors and other clinicians are able to practice as they always have, but may receive higher Medicare payments based on their performance and engagement in key activities.

There are two paths in this program:

- The Merit-based Incentive Payment System (MIPS), which replaces the Physician Quality Reporting System (PQRS), Value Modifier (VM) and Medicare Electronic Health Records (EHR) Incentive program for Eligible Professionals (EPs) and;
- Advanced Alternative Payment Models (Advanced APMs)

For the first year of MIPS, you are considered eligible to participate if you are a physician, physician assistant, nurse practitioner, clinical nurse specialist, or a certified registered nurse anesthetist who bills more than $30,000 a year in Medicare Part B allowed charges **and** provides care for more than 100 Medicare patients annually. If you are not sure of your eligibility, please visit the Quality Payment Program website and use the MIPS look-up tool.

For the transition year, MIPS offers flexibilities for clinicians that have 100 or fewer patient-facing encounters (referred to as non-patient facing clinicians), clinicians with 75% or more of their Medicare services performed in the inpatient, on campus outpatient department or emergency department (referred to as hospital- based clinicians), clinicians practicing in a MIPS APM (such as the Next Generation Accountable Care Organization (ACO) Model and the Medicare Shared Savings Program) as well as clinicians in small practices, rural areas, and designated Health Professional Shortage Areas (HPSA).

Though the first performance year began January 1st, it is not too late to get started. You can submit data as late as Dec 31st, and still avoid the negative payment adjustment. However, more data increases your likelihood of earning a positive payment adjustment. If you are eligible to participate but choose not to submit data, you will get a **negative 4% payment adjustment**, which will go into effect on January 1, 2019.

Stakeholder feedback is the hallmark of the Quality Payment Program. We use a user-centered approach to ensure that we design a program based on clinician feedback that reduces unnecessary burden, while keeping Medicare beneficiaries as the primary focus. A few highlights of our efforts include the following:

- As of September 2017, CMS has conducted and/or participated in approximately 630 stakeholder training and outreach events including webinars, national provider calls, listening sessions and individual speaking engagements in 2017.
- Measures and activities to be included in the program are proposed by or developed in collaboration with stakeholders. Most recently, CMS made available episode-based cost measure field test reports to groups and solo practitioners to gather feedback on 8 cost measure specifications and report formats before the measures are considered for use in the Quality Payment Program. These 8 measures were developed with input from nearly 150 clinicians affiliated with 100 national specialty societies.

As we move into year 2 of the program, CMS is continuing to gather stakeholder feedback, starting with the release of the Quality Payment Program year 2 proposed rule, in June 2017, in which we solicited and reviewed nearly 1,300 comments.

We are encouraging you to consider your readiness to participate in an APM, a care organization, or approach that let practices earn more for taking on some risk related to their patients' outcomes. You

may earn a 5% incentive payment by going further in improving patient care and taking on risk through an Advanced APM. To qualify for the 5% incentive payment, you must receive at least 25% of Medicare covered professional services or see at least 20% of your Medicare patients through an Advanced APM in 2017. Examples of Advanced APMs include Medicare Shared Savings Program Track 2 and 3. A full list of Advanced APMs is available here.

Technical assistance and support is available to help you navigate the program. To get started, visit the QPP website, email us at qpp@cms.hhs.gov or call 1-866-288-8292 weekdays from 8 AM to 8 PM Eastern Time.

Availability of the 2016 Annual and Supplemental Quality and Resource Use Reports (QRURs):

We encourage all groups and solo practitioners nationwide to access their 2016 Annual QRURs, which were made available in September 2017. The 2016 Annual QRURs show how groups and solo practices performed in 2016 on the quality and cost measures used to calculate the 2018 Value Modifier and indicate if physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists will receive an upward, neutral or downward Value Modifier adjustment to their payments for items and services rendered under the Medicare Physician Fee Schedule in 2018. Detailed information about the 2016 Annual QRURs is available on the 2016 QRUR and 2018 Value Modifier website.

Please note that the amount of the Value Modifier payment adjustment shown in the 2016 Annual QRURs is based on proposals that were included in the 2018 Medicare Physician Fee Schedule (PFS) Proposed Rule and is subject to change. The 2018 Value Modifier proposals included reducing by half the automatic downward payment adjustment for practices that did not meet the minimum quality reporting requirements; holding all practices that met the minimum quality reporting requirements harmless from downward payment adjustments based on performance; and reducing the maximum upward payment adjustment for performance for large practices to align with the adjustment for small and solo practices.

The Annual QRURs are available on the CMS Enterprise Portal and can be accessed by an authorized representative of the practice using an Enterprise Identity Management (EIDM) account with the correct role. Please see the How to Obtain a QRUR website for instructions on how to set up an EIDM account and access your practice's QRUR. There is a new feature available on the CMS Enterprise Portal that will allow a representative of a practice to look up the practice's current and prior years' Value Modifier and Physician Quality Reporting System (PQRS) payment adjustments, and find out which feedback reports are available for the practice (i.e., the Annual QRUR, PQRS Feedback Report, Mid-year QRUR, and Supplemental QRUR). Please note that an EIDM account is not needed to use this feature. Instructions for using this feature are available in the Guide for Accessing the Payment Adjustment and Reports Lookup Feature.

For more information on CMS Quality Programs:

PQRS

Medicare EHR Incentive Program

Value-Based Programs

Long-Term Care Hospital Quality Reporting Program

Skilled Nursing Facility Quality Reporting Program

Inpatient Rehabilitation Facility Quality Reporting Program

Hospice Quality Reporting Program

Home Health Quality Reporting Program

National Plan and Provider Enumeration System (NPPES) Taxonomy:

Please check your data in NPPES 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 NPPES 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.

Prescription Drug Abuse:

Prescription drug abuse is the nation's fastest growing drug problem. Additional prescriber awareness and engagement are crucial to addressing this problem. CMS has implemented an approach to help Medicare prescription drug plans identify and manage the most egregious cases of opioid overutilization, which often involves multiple prescribers and pharmacies who are not aware of each other. If you are contacted by a prescription drug plan about the opioid use of one of your patients, please take the time to provide your feedback and expertise to help assure the safe use of these products.

Prescriber Identifiers in Research:

You should be aware that CMS now allows researchers to request the release of unencrypted prescriber identifiers contained in Medicare Part D data. This change in policy now gives researchers the ability to conduct important research that involves identified prescribers, which will increase the positive contributions researchers make to the evaluation and function of the Part D program. This access supports CMS's growing role as a value-based purchaser of health care, and is only granted pursuant to CMS's policies and procedures for release of such data to researchers.

Simplifying Identification of Qualified Medicare Beneficiaries (QMBs):

Many Medicare beneficiaries with limited incomes and resources are also covered by their state's QMB program. This means that the state Medicaid agency is responsible for these beneficiaries' Medicare cost sharing. We encourage all Medicare physicians and other practitioners to serve individuals eligible for the QMB program.

We also remind all Medicare physicians and other practitioners that they may not bill their QMB patients for Medicare cost sharing, including deductibles, coinsurance, and copayments. These rules apply to all QMB patients, including those enrolled in a Medicare Advantage (Part C) plan. Under federal law, Medicare payment plus any Medicaid payment are considered payment in full for services rendered to a beneficiary participating in the QMB program.

CMS is implementing several systems changes to simplify providers' ability to identify which of their patients have QMB status. As of October 2, 2017, each Medicare Remittance Advice for all Parts A and B original Medicare claims now inform providers of the beneficiary's QMB status and will also indicate $0 cost-sharing liability. Also starting October 2, 2017, the Medicare Summary Notices sent to Medicare beneficiaries identify whether they are enrolled in the QMB program and protected from being billed for cost sharing. Beginning November 4, 2017, Medicare providers and their authorized billing agents (including third party vendors) can use eligibility data from CMS's HIPPA Eligibility Transaction System (HETS) to identify beneficiaries' QMB enrollment status. HETS will also indicate that QMBs are not responsible for Medicare deductibles, coinsurance, or copays.

We encourage all providers take advantage of these system changes to identify QMB status prior to billing patients for items and services. We also recommend that providers refresh their understanding of how their state handles QMB cost sharing claims. In most states, claims submitted to Medicare are crossed over automatically to the state Medicaid agency. States may require providers to register with their State payment system in order to receive cost sharing payments. Additional information can be found on the QMB Program webpage and in a recently updated MLN Matters memo.

Revalidation:

CMS has mailed revalidation letters to all 1.6 million providers and suppliers by the March 23, 2015 deadline. CMS is resuming regular revalidation cycles every 3 years for Durable Medical Equipment (DME) suppliers and every 5 years for all other providers and suppliers.

CMS has implemented several revalidation processing improvements to include establishing due dates by which a provider or supplier must revalidate. Revalidation due dates will fall on the last day of the month (i.e.: June 30, 2018, July 31, 2018, August 30, 2018) and are posted to the Medicare Revalidation List. Providers and suppliers are expected to submit their revalidation application by this date. Generally, this due date will remain with you throughout subsequent revalidation cycles.

In addition to the posted lists, providers and suppliers will still receive email or mailed revalidation notices from their MACs when they are due to revalidate. Providers can revalidate their enrollment information using the Internet-based PECOS or the CMS-855 paper application. CMS encourages all practitioners to respond timely to revalidation requests received by their MAC. Failure to submit a

complete revalidation application, including all supporting documents, may result in deactivation of your Medicare billing privileges.

For more information on the revalidation process, please refer to the Revalidations website and this MLN Matters Special Edition Article.

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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2018 Payment Rates

When available, 2018 payment rates for First Coast Service Options, Inc. will be at: https://medicare.fcso.com/Fee_news/. First Coast may be contacted at 1-800-454-9007 (Florida, U.S. Virgin Islands) or 1-877-715-1921 (Puerto Rico). Additional information will be posted to https://medicare.fcso.com/ as it becomes available.