Announcement

About Medicare Participation for Calendar Year 2019

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 and Medicaid Services’ (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. CMS strives to empower providers and patients to transform the healthcare delivery system through the individual healthcare decisions made by patients and professionals. Our policies support patient-centered care to improve health outcomes and efficiency. CMS strives to 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 exchange of dialogue and listen to feedback from those who are caring for patients.

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) 2019 Medicare participation decision by December 31, 2018. 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 in CY 2019. The overwhelming majority of physicians, non-physician practitioners and other suppliers have chosen to participate in Medicare. During CY 2018, 97.8 percent of all physicians and non-physician
practitioners furnishing services to Medicare patients are billing 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 5 percent higher than if you do not participate in Medicare. Your Medicare Administrative Contractor (MAC) publishes an electronic directory of providers that choose to participate.

**WHAT TO DO**

If you choose to participate in Medicare in CY 2019:

- 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 2019:

- Do nothing if you are currently not participating, or
- If you are currently a Medicare participant, write to each MAC to which you submit Part B claims, advising of the termination of your participation in the Medicare program effective January 1, 2019. This written notice must be postmarked prior to January 1, 2019.

We hope you will decide to be a Medicare participating physician, practitioner, or supplier in CY 2019. Please call [MACs insert phone number] 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 providers, 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 enroll in the Medicare program may “opt-out” of Medicare. Opting out of Medicare allows the beneficiary and the provider to directly negotiate payment for healthcare services. While Medicare would not pay for services provided by an “opt-out” physician, 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. 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 non-coverage for services. Medicare will still pay 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.

**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.

**New Medicare Cards and Numbers:**

In April 2018, CMS started mailing Medicare cards with new Medicare numbers (known as Medicare Beneficiary Identifiers or MBIs) to all Medicare beneficiaries. The MBI is replacing the Social Security Number (SSN)-based Health Insurance Claim Number (HICN) for transactions like billing, eligibility status, and claim status; however, providers will be able to use either HICNs or MBIs to submit claims during the transition period through December 31, 2019.

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

1. **Ask your Medicare patients**
   Ask your Medicare patients for their new Medicare card when they come for care. If they haven’t received a new card, refer them to 1-800-Medicare (1-800-633-4227).

2. **Use the MAC's secure MBI look-up tool**
   You can look up MBIs for your Medicare patients when they don’t bring them when they come for care. You’ll need your patient’s first name, last name, date of birth, and SSN. Sign up for the Portal to use the tool.

3. **Check the remittance advice**
   Starting in October 2018 through the end of the transition period on December 31, 2019, we’ll also return the MBI on every remittance advice when you submit claims with valid and active HICNs.

Use the MBI the same way you use the HICN today. Put the MBI in the same field where you’ve always put the HICN. You can start using the MBIs even if the other healthcare providers and hospitals who also treat your patients haven’t begun using them. When the transition period ends on December 31, 2019, you must use the MBI for most transactions.
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:

- 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.
- Review our MLN Fact Sheet, Transition to New Medicare Numbers and Cards, which discusses the transition to the MBI.
- Review our MLN Matters® article, The New Medicare Beneficiary Identifier (MBI), Get It, Use It.

Refer your patients to Medicare.gov if they have questions.

Moving toward Year 3 of the Quality Payment Program: Focusing on reducing clinician burden and patients through the Patients Over Paperwork initiative:

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula for clinician payment, and established a quality payment incentive program, which is the Quality Payment Program. 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 the Quality Payment Program was a big change. We designed MIPS in a way that would reduce burden and increase flexibility. As a result, more clinicians were able to successfully participate. With many clinicians participating successfully in this first year, the distribution of MIPS payment adjustments will be spread across many clinicians when the payment adjustments are applied in 2019. Since the MIPS payment adjustments are required by the statute to be budget neutral, a scaling factor may be applied to positive MIPS payment adjustment factors, which may result in a lower adjustment than anticipated in CY 2019. For Year 2 (2018 performance year), we’ve built on what we’ve learned from the first year while ramping up requirements to prepare for a robust program in future years.

During rulemaking for Year 2, CMS launched the “Patients Over Paperwork” Initiative, a cross-cutting, collaborative process that evaluates and streamlines regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience. This effort emphasizes a commitment to removing regulatory obstacles that get in the way of providers spending time with patients. The 2018 Quality Payment Program includes the following consistent with this initiative:
• Excludes individual MIPS eligible clinicians or groups with less than or equal to $90,000 in allowed charges for covered professional services or less than or equal to 200 Part B beneficiaries to whom they furnish services.
• Addresses extreme and uncontrollable circumstances, such as hurricanes and other natural disasters, for both the 2017 and 2018 performance years.

We understand that there may be circumstances out of your control, that make it difficult for you to meet program requirements, so we’ve provided an opportunity for you to apply for Exceptions for MIPS (all performance categories) for extreme and uncontrollable circumstances described above, or for specific hardship exceptions for the Promoting Interoperability performance category for the 2018 performance period. You can read more about the exception criteria and application process here: https://qpp.cms.gov/mips/exception-applications.

As we begin moving into the third year (2019 performance period) of the Quality Payment Program, we have taken all stakeholder input into consideration on issues affecting the Medicare program, including payment policies under Medicare, the factors affecting expenditures for the efficient provision of services, and the relationship of payment policies to access and quality of care for Medicare beneficiaries.

We also encourage you to consider your readiness to participate in the Advanced APM track of the Quality Payment Program. The Advanced APM track provides you the opportunity to earn Qualifying APM Participant (QP) status via sufficient participation in certain types of alternative payment models. QP status exempts you from the MIPS quality reporting program and provides a 5% lump sum APM incentive payment in the applicable payment year.

Also, starting in Year 3 of the Quality Payment Program, you may become a QP through either the Medicare Option, which takes into account participation solely in Advanced APMs within traditional Medicare, or the All-Payer Combination Option, which takes into account participation in both Advanced APMs and Other Payer Advanced APMs, which are payment arrangements that meet certain criteria within Medicaid, Medicare Health Plans (including Medicare Advantage plans), payers in CMS Multi-Payer Models, and other commercial payers. Additionally, in July, 2018, CMS announced the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration. The MAQI Demonstration provides clinicians the opportunity to be eligible for waivers that will exempt them from the MIPS reporting requirements and payment adjustment for a given year if they participate to a sufficient degree in Qualifying Payment Arrangements with Medicare Advantage Organizations, without requiring them to be QPs or Partial QPs, or to otherwise meet MIPS exclusion criteria. The Demonstration will permit consideration of participation in “Qualifying Payment Arrangements” a year before the All-Payer Combination Option is available in 2019. The application period for eligible clinicians to participate in the Demonstration for 2018 has closed, but CMS urges interested health plans to assist individual clinicians in responding to the MAQI application in future years. For additional information please visit the MAQI Demonstration website here.

For more information on how CMS determines qualification for the 5% APM incentive payment please visit the Quality Payment Program website here. We also have a comprehensive list of APMs, Advanced APMs, and MIPS APMs available here on the Quality Payment Program website.