

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3397	Date: November 5, 2015
	Change Request 9368

Transmittal 3372, dated October 9, 2015, is being rescinded and replaced by Transmittal 3397, dated November 5, 2015 to include the annual Participation Announcement and to remove the Sensitive/Controversial disclaimer. All other information remains the same.

SUBJECT: Calendar Year (CY) 2016 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

I. SUMMARY OF CHANGES: This instruction furnishes contractors with the information needed for the 2016 participation enrollment. The attached Recurring Update Notification applies to Chapter 1, Section 30.3.12.

EFFECTIVE DATE: October 9, 2015

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: November 9, 2015

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3397	Date: November 5, 2015	Change Request: 9368
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SUBJECT: Calendar Year (CY) 2016 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

EFFECTIVE DATE: October 9, 2015

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IMPLEMENTATION DATE: November 9, 2015

I. GENERAL INFORMATION

A. Background: Contractors conduct an enrollment period on an annual basis in order to provide eligible physicians, practitioners and suppliers with an opportunity to make their calendar year Medicare participation decision by December 31. Providers (physicians, practitioners, or suppliers) who want to maintain their current PAR status (PAR or non PAR) do not need to take any action in the upcoming annual participation enrollment program. To sign a participating agreement is to agree to accept assignment for all covered services that are provided to Medicare patients. After the enrollment period ends, contractors publish an updated list of participating physicians, practitioners, and suppliers in their local MEDPARDs on their Web sites.

B. Policy: The annual participation enrollment program for CY 2016 will commence on November 14, 2015, and will run through December 31, 2015.

The purpose of this Recurring Update Notification is to furnish contractors with information needed for the CY 2016 participation enrollment effort. The following documents are attached:

- A Participation Announcement; and
- A Blank Participation Agreement.

Contractors shall mail the participation enrollment postcard as directed in Publication 100-04, Chapter 1, section 30.3.12. **Contractors shall place the new fees (physician fee schedule fees and anesthesia conversion factors) on their Web site for providers to access and download. The information contained in this Recurring Update Notification must be kept CONFIDENTIAL until the Physician Fee Schedule Final Rule is put on display. Fees should not be posted on the Web or be mailed until after the final rule is put on display.**

Contractors will not receive a Special Edition (SE) Medicare Learning Network (MLN) Matters article related to this Change Request (CR), however, be sure to post the following language on your Web site:

"We encourage you to visit the Medicare Learning Network® (MLN) (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html>) the place for official CMS Medicare Fee-For-Service provider educational information. There you can find one of our most popular products, MLN Matters national provider education articles. These articles help you understand new or changed Medicare policy and how those changes affect you. A full array of other educational products (including Web-based training courses, hard copy and downloadable publications, and CD-ROMs) are also available and can be accessed at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html>. You can also find other important Web sites by visiting the Physician Center

Web page at: <http://www.cms.gov/Center/Provider-Type/Physician-Center.html> , and the All Fee-For-Service Providers Web page at <https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html> .

In addition to educational products, the MLN also offers providers and suppliers opportunities to learn more about the Medicare program through MLN National Provider Calls. These national conference calls, held by CMS for the Medicare Fee-For-Service provider and supplier community, educate and inform participants about new policies and/or changes to the Medicare program. Offered free of charge, continuing education credits may be awarded for participation in certain National Provider Calls. To learn more about MLN National Provider Calls including upcoming calls, registration information, and links to previous call materials, visit <http://www.cms.gov/Outreach-and-Education/Outreach/NPC/index.html> ."

In CR 7412 (Postcard Mailing for the Annual Participation Open Enrollment Period), CMS directed contractors to mail a postcard instead of a CD. The postcards should be mailed in time for physicians, practitioners, and suppliers to receive the participation enrollment material by November 14, but should not be mailed before November 9.

The CMS plans to release the 2016 Medicare Physician Fee Schedule File, including the anesthesia file, to contractors electronically in late October. This data must also be kept confidential until the physician fee schedule final rule is put on display. CMS will send all contractors an e-mail notice when the Physician Fee Schedule Final Rule has been put on display.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility									
		A/B MAC			D M E M A C	Shared- System Maintainers				Other	
		A	B	H H H		F I S S	M C S	V M S	C W F		
9368.1	Contractors shall mail postcards announcing the annual open participation enrollment by November 14, 2015, but not before November 9, 2015. See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1 B1.		X								
9368.2	Contractors shall display the fee data prominently on their Web site. For CY 2016 disclosure reports, contractors shall use the following format for displaying fees on the Web and/or hardcopy: <ul style="list-style-type: none"> • Procedure code (including professional and technical component modifiers, as applicable); • Par amount (non-facility); • Par amount (facility-based); 		X								

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	<ul style="list-style-type: none"> • Non-par amount (non-facility); • Limiting charge (non-facility); • Non-par amount (facility-based); • Limiting charge (facility-based); • EHR Limiting Charge; • PQRS Limiting Charge; • EHR + PQRS Limiting Charge 									
9368.3	<p>Contractors shall provide a link to the 2016 Medicare Fee Schedule on their Web site.</p> <p>NOTE: Disclosure materials may not be posted on your Web site until you receive notification from CMS that the Physician Fee Schedule Final Rule has been put on display.</p>		X							
9368.4	For CY 2016 disclosure reports, contractors shall provide the anesthesia conversion factors on their Web site.		X							
9368.5	Contractors shall display the fee schedule using a provider friendly format from which providers can download their particular locality. Providers should not have to download the whole fee schedule file.		X							
9368.6	<p>Contractors shall post the following language on your Web site:</p> <p><i>"We encourage you to visit the Medicare Learning Network® (MLN) (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html) the place for official CMS Medicare Fee-For-Service provider educational information. There you can find one of our most popular products, MLN Matters national provider education articles. These articles help you understand new or changed Medicare policy and how those changes affect you. A full array of other educational products (including Web-based training courses, hard copy and downloadable publications, and CD-ROMs) are also available and can be accessed at:</i></p>		X							

Number	Requirement	Responsibility							
		A/B MAC		D M E M A C	Shared- System Maintainers				Other
		A	B		H H H	F I S S	M C S	V M S	
	<p>http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html. You can also find other important Web sites by visiting the Physician Center Web page at:</p> <p>http://www.cms.gov/Center/Provider-Type/Physician-Center.html, and the All Fee-For-Service Providers Web page at https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html.</p> <p><i>In addition to educational products, the MLN also offers providers and suppliers opportunities to learn more about the Medicare program through MLN National Provider Calls. These national conference calls, held by CMS for the Medicare Fee-For-Service provider and supplier community, educate and inform participants about new policies and/or changes to the Medicare program. Offered free of charge, continuing education credits may be awarded for participation in certain National Provider Calls. To learn more about MLN National Provider Calls including upcoming calls, registration information, and links to previous call materials, visit http://www.cms.gov/Outreach-and-Education/Outreach/NPC/index.html."</i></p>								
9368.7	Effective immediately, contractors shall educate providers via their Web site and whatever other provider outreach that can be utilized that the fees will be placed on the contractor Web site after the CY 2016 physician fee schedule regulation is put on display.		X						
9368.8	Contractors shall prominently display the announcement and participation agreement on the Web site.		X						
9368.9	Contractors shall insert their Web site address for providers to use to access the CY 2016 payment rates in the space available at the end of the Participation Announcement sheet.		X						
9368.10	Contractors shall insert their contractor-specific information (i.e., toll-free telephone numbers, etc.) in the blank lines as indicated at the end of the Participation Announcement sheet.		X						
9368.11	Contractors shall inform providers via their listserv		X						

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	when the CY 2016 fees are posted to their Web site.									
9368.12	Contractors shall NOT produce hard copy disclosures until you receive notification from CMS. NOTE: When notified, contractors have the discretion to produce no more than 2 percent hardcopy if needed.		X							
9368.12.1	Contractors shall keep track of any requests for hard copy paper disclosures.		X							
9368.12.2	Contractors shall not charge providers requesting hard copy disclosures who do not have Internet access.		X							
9368.12.3	Contractors shall mail the hard copy disclosures via first class or equivalent delivery service.		X							
9368.13	The MPFSDB will contain the CY 2016 fee schedule amounts. Contractors shall include fee amounts for procedure codes with status indicators of A, T, and R (if Relative Value Units (RVUs) have been established by CMS). The following statements must be included on the fee disclosure reports: “All Current Procedural Terminology (CPT) codes and descriptors are copyrighted 2015 by the American Medical Association.” “These amounts apply when service is performed in a facility setting.” (This statement should be made applicable to those services subject to a differential based on place of service.) “The payment for the technical component is capped at the OPPTS amount.” (This statement should be made applicable to services in which the technical portion was capped at the Outpatient Prospective Payment System amount.) "Limiting Charge reduced based on the EHR Negative adjustment program." "Limiting Charge reduced based on the PQRS Negative adjustment program." "Limiting Charge reduced for EPs that are subject to		X							

Number	Requirement	Responsibility								Other
		A/B MAC			D M E M A C	Shared- System Maintainers				
		A	B	H H H		F I S S	M C S	V M S	C W F	
	both EHR and PQRS Negative adjustment program." See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1.									
9368.14	If contractors choose to use code descriptors on their Web site, they must use the short descriptors contained in the Healthcare Common Procedure Coding System (HCPCS) file and the MPFSDB. If contractors find descriptor discrepancies between these two files, use the HCPCS file short descriptor. NOTE: The CMS has signed agreements with the American Medical Association regarding use of CPT, and the American Dental Association regarding use of Current Dental Terminology (CDT), on Medicare contractor Web sites, CD-ROMs, bulletin boards, and other electronic communications (refer to the IOM Publication 100-04, Chapter 23, section 20.7).		X							
9368.15	Contractors shall process participation elections and withdraws post-marked before January 1, 2016.		X							
9368.16	Contractors shall not print hardcopy participation directories (i.e., MEDPARDs) for CY 2016 without regional office prior authorization and advanced approved funding for this purpose.		X							
9368.17	If contractors receive inquiries from a customer who does not have access to the contractor Web site, they shall ascertain the nature and scope of each request and furnish the desired MEDPARD participation information via phone or letter.		X							
9368.18	Contractors shall load their local MEDPARD information for providers on their Web site within 30 days following the close of the annual participation enrollment process.		X							
9368.19	Contractors shall notify providers via regularly scheduled newsletters as to the availability of the MEDPARD information and how to access it electronically.		X							
9368.20	Contractors shall also inform hospitals and other organizations (i.e., Social Security offices, area Administration on Aging offices, and other		X							

Number	Requirement	Responsibility							
		A/B MAC		D M E M A C	Shared- System Maintainers				Other
		A	B		H H H	F I S S	M C S	V M S	
	beneficiary advocacy organizations) how to access MEDPARD information on your Web site.								
9368.21	Contractors shall make sure that the Form CMS-460 is readily available on their web sites in order for their providers to complete needed information and download for their use.		X						
9368.21.1	Contractors shall allow providers to enter all required information (except for the signature and effective date in item 2) before printing. Then, the provider will only have to print out the Form CMS-460, sign it, and mail it to the contractor.		X						
9368.22	Contractors shall protect all parts of the Form CMS-460 that do not require data entry from being altered. (The provider can only be allowed to enter their required information, and not change any other parts of the Form CMS-460).		X						
9368.23	Contractors shall continue to plug-in the January 1, (appropriate year), effective date in item 2 of the Form CMS-460 included on your web site.		X						
9368.24	If possible, contractors shall provide a count of the number of page views that the 2016 Participation Announcement receives from your Web site.		X						
9368.24.1	This count shall begin November 14, 2015, through December 31, 2015.		X						
9368.24.2	Contractors shall email results of the count to the central office (CO) contact no later than January 31, 2016. The CO contact is: Mark.Baldwin@cms.hhs.gov		X						
9368.25	Contractors shall refer to the IOM Pub. 100-04, Chapter 1, section 30.3.12.1 for more information about the postcard mailing and Web site.		X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility
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		A/B MAC			D M E	C E D I
		A	B	H H H	M A C	
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Mark Baldwin, 410-786-8139 or Mark.baldwin@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 2

MEDICARE
PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*

National Provider Identifier (NPI)*

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. **Meaning of Assignment** - For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the Medicare Administrative Contractor (MAC)/carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.

2. **Effective Date** - If the participant files the agreement with any MAC/carrier during the enrollment period, the agreement becomes effective _____.

3. **Term and Termination of Agreement** - This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:

a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every MAC/carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.

b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

Signature of participant
(or authorized representative
of participating organization)

Title
(if signer is authorized
representative of organization)

Date

(including area code)
Office phone number

*List all names and the NPI under which the participant files claims with the MAC/carrier with whom this agreement is being filed.

CMS-460 (4/10)

Received by
(name of MAC/carrier)

Effective date

Initials of carrier official

gather the data needed and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



Announcement

About Medicare Participation for Calendar Year 2016

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 2015 with a participation rate of 96.9 percent. As you plan for 2016 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.

It is in the interest of patients and providers to build a health care delivery system that's better, smarter and healthier – a system that delivers better care; a system that spends health care dollars more wisely; and a system that makes our communities healthier. Next year will be the first time since 1999 that physicians will no longer have to worry about the flawed Sustainable Growth Rate (SGR) formula and potentially devastating cuts in physician payment. Bipartisan legislation passed by Congress repealing the SGR provides added momentum to the changes underway in Medicare payment to support physicians in improving care to Medicare beneficiaries. We look forward to working with providers in the coming year to achieve our common goals.

WHY BECOME A PARTICIPATING MEDICARE PROVIDER

All physicians, practitioners and suppliers – regardless of their Medicare participation status – must make their calendar year (CY) 2016 Medicare participation decision by December 31, 2015. 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 2016. The overwhelming majority of physicians, practitioners and suppliers have chosen to participate in Medicare. During CY 2015, 96.9 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 2016:

- 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 2016:

- 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, 2016. This written notice must be postmarked prior to January 1, 2016.

We hope you will decide to be a Medicare participant in CY 2016. Please call _____ if you have any questions or need further information on participation.

The Medicare Learning Network® (MLN) has developed publications in an effort to educate Medicare providers about important Medicare enrollment information. These MLN publications also provide education to Medicare providers on how to use the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) to enroll in the Medicare Program and maintain their enrollment information. A list of publications is available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf.

To view updates and the latest information about Medicare, please visit [Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](http://www.cms.gov/Medicare/FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/). For _____ (MAC name) _____, you may contact the following toll-free number(s) for assistance:

New Payment and Care Delivery Model Tests at the CMS Innovation Center:

Physicians can directly participate in health care transformation through the efforts of the CMS Innovation Center which is charged with identifying, testing, and evaluating innovative payment and service delivery models that show promise of providing better access to quality care at lower costs for beneficiaries of Medicare, Medicaid and the Children's Health Insurance Program (CHIP). The Innovation Center offers opportunities for innovators working in the field to share ideas, contribute to the discussion of improvements in health care, and participate in model tests.

More than 60,000 providers in all 50 states, the District of Columbia, and Puerto Rico are currently participating in over 25 Innovation Center payment and service delivery model tests, serving an estimated 2.5 million beneficiaries of Medicare, Medicaid, and CHIP. Participants include states, organizations, and a broad array of health care professionals, as well as other stakeholders in the health care community. Millions of other Americans are benefiting from Innovation Center quality improvement initiatives and the engagement of other payers in model tests.

The broad engagement of providers across the country in alternative payment and service delivery models is leading to improvement. Medicare per capita spending growth rates have reached historic lows, and hospital readmission rates have declined meaningfully. All alternative payment models and payment reforms that seek to deliver better care at lower cost share a common pathway for success. Providers, payers, and others in the health care system must make fundamental changes in their day-to-day operations that improve quality and reduce the cost of health care.

This work is aligning with the goals the Department of Health and Human Services (HHS) set in January of 2015 of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as physician value-based payment modifier (VM).

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was enacted into law in April 2015 and further facilitates the Department's goals of paying for value. MACRA replaces the SGR with new payment policies for physicians that support delivery system reform and streamline the programs Medicare uses to reward eligible professionals for improving care. This is a major opportunity to put a broad range of physicians and other practitioners on the pathway to value and to promote the adoption of alternative payment models.

We encourage providers to join the [Health Care Payment Learning and Action Network](#) that brings together private payers, providers, employers, state partners, consumer groups, individual consumers, and many others to accelerate the transition to alternative payment models. If you would like to join the Network, please complete the [online form](#).

We also encourage you to visit the CMS Innovation Center website—at [innovation.cms.gov](#)—for further information and for announcements of new opportunities including large scale transformation of clinical practices to accomplish our aims of better care and better health at lower costs.

Medicare Shared Savings Program:

Currently, over 125,000 physicians participate in ACOs in the Medicare Shared Savings Program (Shared Savings Program). When an ACO succeeds in both delivering high-quality care and lowering growth in Medicare spending on patients its providers serve, it may share in the savings it achieves for the Medicare program. In performance year 2014, we shared more than \$341 million in savings with 86 ACOs.

When a Shared Savings Program ACO successfully reports required quality measures through the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) web interface, Eligible professionals (EPs), (i.e. physicians and other practitioners) in the ACO will be deemed eligible to avoid the PQRS payment adjustment, regardless of whether the ACO qualifies to share in savings. In addition, EPs participating in the Shared Savings Program will have their Clinical Quality Measure (CQM) reporting requirements satisfied for the Medicare Electronic Health Record (EHR) Incentive Program if they extract the data necessary for the ACO to satisfy the quality reporting requirements for the Shared Savings Program from certified EHR technology *and* the EPs meet all other requirements of the Medicare EHR Incentive Program.

We encourage you to consider joining or forming an ACO under the Shared Savings Program. We also encourage physicians and other practitioners to collaborate with ACOs in your area so that together they can achieve the goals of the Shared Savings Program including successful reporting and performance on quality measures.

Please visit the Shared Savings Program webpage for more information about the program including how to apply, join or learn about ACOs in your area - <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/>.

Engaging Physicians in Quality:

CMS recognizes the time and resources spent by providers and their practices to meet the requirements of various federal and state mandated quality reporting programs. As the largest payer of healthcare services in the United States, we continuously seek ways to improve healthcare quality while reducing the burden felt by providers. Several efforts have been made to meet this goal, and the needs of providers, including:
(As a continuation from CY 2015)

- Providers can choose quality measures that best reflect their practice and how they are reported to CMS.
- Many providers may be able to report their 2016 performance on quality measures one time during 2016 in order to avoid the 2018 PQRS negative payment adjustment, satisfy the CQM component of the Medicare EHR Incentive Program, avoid the automatic 2018 downward adjustment under the Value Modifier, and based on performance earn an incentive in 2018. Please note that this option applies to specific reporting options. Please read program requirements for more information; website URLs for each program are listed below;

- Providers and others can contribute new quality measures through open calls for measures and advocate for measures through the Measures Application Partnership (MAP). For More information about the MAP, please visit:
http://www.qualityforum.org/Setting_Priorities/Partnership/Measure_Applications_Partnership.aspx.

New for CY 2016:

- For the qualified clinical data registry (QCDR) reporting mechanism, which was introduced in 2014, we increased the minimum number of non-PQRS measures that a QCDR may report for PQRS to 30 measures beginning with CY 2015 reporting. By increasing the minimum number of non-PQRS measure accepted, EPs are provided with more flexibility to meet satisfactory participation requirements and another avenue to submit measures that are meaningful to their specific specialty.
- Knowledge levels (i.e. Beginner, Intermediate, and Advanced) were established to assist providers with reporting by providing educational resources that range from basic program awareness to reporting via an aligned reporting mechanism to meet the requirements of several quality programs. Prominent icons are used on educational materials displaying these knowledge levels.
- In addition to the traditional channels used, CMS began the use of new forums to receive stakeholder feedback including: hosting virtual office hours, which are smaller virtual sessions in which stakeholders can talk directly with CMS subject matter experts, and hosting in-person vendor summits, in which vendors who support EPs in quality reporting attended and provided insight from their perspective and areas of improvement for CMS.
- The development of the Physician Quality Reporting Programs Strategic Vision, which is a document that describes how CMS will build on its current successes in quality measurement and public reporting to advance the goals and objectives for quality improvement outlined in the CMS Quality Strategy (available here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/Physician_Quality_Reporting_Programs_Strategic_Vision_Document.pdf)

As noted above, MACRA repeals the SGR formula for Medicare physician payments. It also establishes a new Merit-based Incentive Payment System (MIPS) for MIPS eligible professionals (MIPS EPs) under the MPFS beginning January 1, 2019. Section 101 of the MACRA sunsets payment adjustments under the current PQRS, the VM, and the EHR Incentive Programs on December 31, 2018.

Availability of the 2014 Mid-Year, Annual, and Supplemental Quality and Resource Use Reports (QRURs):

In April 2015, CMS made available the 2014 Mid-Year QRURs to all groups of physicians and physician solo practitioners nationwide, as identified by their Taxpayer Identification Number (TIN). The Mid-Year QRURs provide interim information to TINs about their performance on the three claims-based quality outcome measures and six cost measures. These measures are a subset of the measures that will be used to calculate performance under the Value Modifier and can provide physician groups and physicians insight into their potential performance under the Value Modifier. We encourage you to look at your 2015 Mid-Year QRUR when it is available in April 2016.

In September 2015, CMS made available the 2014 Annual QRURs to all groups and solo practitioners nationwide. These QRURs are also available for groups and solo practitioners that participated in the Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2014. The 2014 Annual QRURs show how groups and solo practitioners, as identified by their TIN, performed in 2014 on the quality and cost measures used to calculate the 2016 Value Modifier. For TINs with 10 or more EPs who are subject to the 2016 Value Modifier, the QRUR shows how the Value Modifier will apply to physician payments under the MPFS for physicians who bill under the TIN in 2016. For all other TINs, the

QRUR is for informational purposes only and will not affect the TINs' payments under the Medicare MPFS in 2016.

In September 2015, CMS made available the Supplemental QRURs. These QRURs are confidential feedback reports provided to group practices with payment-standardized, risk-adjusted cost information on the management of their Medicare fee-for-service (FFS) patients based on episodes of care. The Supplemental QRURs are currently for informational purposes only and complement the per capita cost and quality information provided in the QRURs.

The Mid-Year, Annual, and Supplemental QRURs are available at <https://portal.cms.gov> and can be accessed by an authorized representative of the TIN using an Enterprise Identity Management (EIDM) account. Please see the [How to Obtain a QRUR](#) website for instructions on how to set up an EIDM account and access your TIN's QRURs. Detailed information about the QRURs is available on the [2014 QRUR](#) website.

Medicare and Medicaid EHR Incentive Programs:

In 2015, EPs will use EHR technology certified to the 2014 Edition to meet the objectives and measures of meaningful use as modified in a recent final rule¹, which includes alternate exclusions for EPs scheduled to be in Stage 1. EPs will have a 90-day EHR reporting period within CY 2015 and attest between January 4 through February 29, 2016. For more information about the EHR Incentive Programs, including the 2015 definition of meaningful use, visit www.cms.gov/EHRIncentivePrograms.

In order to align programs and reduce the burden on physicians and other eligible professionals, physicians may submit CQM data for both the Medicare EHR Incentive Program and the PQRS program electronically.

Physicians who fail to demonstrate meaningful use for the applicable EHR reporting period may be subject to a payment adjustment to their Medicare claims. In 2016, the result will be payment of 98% of the MPFS amount. Physicians must successfully demonstrate meaningful use every year to avoid the Medicare payment adjustments. Successful demonstration of meaningful use for an EHR reporting period in 2015 will enable physicians to avoid the payment adjustment in 2017. Physicians also have the option of filing a significant hardship exception application by July 1, 2016. Don't wait until the last minute to meet meaningful use or file a hardship exception!

Payment Adjustments for Quality Reporting:

EPs should note that there is still time to report quality measures for 2015, which will also serve as the reporting period for the 2017 PQRS payment adjustment. The deadline is December 31, 2015. The payment adjustment for 2017, based on 2015 reporting, is negative 2.0%. The reporting requirements to avoid the 2017 PQRS payment adjustment can be found at 42 C.F.R. § 414.90, and guidance materials are available on the PQRS webpage of the CMS website.

Likewise, 2016 will also serve as the reporting period for the 2018 PQRS payment adjustment, which remains at negative 2%.

The reporting requirements to avoid the 2018 PQRS payment adjustment are detailed in the CY 2016 MPFS Final Rule. More information will be available on the PQRS webpage soon.

Please use the links below for more detailed information about CMS quality reporting programs.

PQRS webpage: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>

¹ Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 Through 2017; Final Rule, 80 Fed. Reg. 62,762 (Oct. 16, 2015).

Medicare EHR Incentive Program: <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms/>

VM: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>

Information Related to Medicare Prescription Drug (Part D) Coverage:

Prescriber Enrollment in Medicare

Beginning June 1, 2016 physicians and EPs who write prescriptions for Part D drugs are required to be enrolled in Medicare in an approved status or have a valid record of opting out of Medicare for their prescriptions to be covered under Part D. Any physicians and EPs not in compliance with these requirements should submit their paper Medicare enrollment applications or opt-out affidavits to their Part A/B MACs or complete their Internet-based PECOS applications by January 1, 2016, or earlier, to ensure sufficient processing time. Medicare prescription drug benefit plans will validate whether the prescriber is enrolled or has opted out of Medicare as part of determining whether the drug is coverable under Part D when the beneficiary's prescription is filled at the pharmacy. Providers may enroll by completing their Internet-based PECOS application or may enroll or opt out of Medicare by submitting to their MAC one of the following documents:

- A CMS-855O application (allows the physician to enroll in Medicare to order and certify services and items, and to prescribe Part D drugs; however, this option does not confer billing privileges): or
- An opt out affidavit.

If you are unsure if you are compliant with this requirement, please review the prescriber enrollment file located at <https://data.cms.gov/dataset/Medicare-Individual-Provider-List/u8u9-2upx>. The file identifies those providers who are currently in compliance with the prescriber enrollment requirements.

As part of the enrollment process, provider credentials and eligibility are verified. Requiring Medicare prescription drug benefit plans to validate a provider's Medicare enrollment status improves CMS's ability to protect the Part D program from fraud and abuse. To avoid the denial of coverage of Part D prescriptions due to your failure to enroll or opt-out, please note the following information:

- Be sure to maintain an active enrollment or opt out status with Medicare;
- If you haven't enrolled, please do so and encourage your colleagues who are not enrolled in Medicare to enroll by January 1, 2016. The options available for enrolling or opting out are identified above. Please visit the prescriber enrollment website to obtain additional information at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Prescriber-Enrollment-Information.html>.
- Interns, residents, and fellows who are prescribers of Part D drugs may enroll in Medicare to prescribe if the state licenses these prescribers. Licensure can include a provisional license or similarly-regulated credential. Otherwise, un-licensed interns, residents, and fellows must specify the teaching physician as the authorized prescriber on the prescription. Licensed residents have the option to either enroll or use the teaching physician on claims.
- Pharmacists need not enroll or opt out for their prescriptions to be covered under Part D. More information is available by visiting <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Prescriber-Enrollment-Information.html>.

NPPES Taxonomy

Please check your data in the National Plan and Provider Enumeration System (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 at: <http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/Downloads/NPI-Requirements-for-Prescribers.pdf>.

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.

Serving Qualified Medicare Beneficiaries (QMBs):

Many Medicare beneficiaries with limited incomes and resources are also covered by their state's Qualified Medicare Beneficiary (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 balance bill their QMB patients for Medicare cost sharing, including deductibles, coinsurance, and copayments. 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. Physicians and other practitioners may want to 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. Providers can also query their state's Medicaid eligibility verification system to identify QMBs. More information on billing procedures for QMBs is available at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf>.

We understand that the intersection between Medicare and Medicaid is complex. If you have any questions about serving QMBs, please contact MedicareMedicaidCoordination@cms.hhs.gov.

Revalidation:

CMS has met the requirements established in section 6401(a) of the Affordable Care Act (ACA) and 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.

When undergoing a revalidation, providers will receive requests from their respective MACs to revalidate their Medicare enrollment information. Providers can revalidate their enrollment information using the Internet-based PECOS found at <https://pecos.cms.hhs.gov/pecos/login.do> or the CMS-855 paper application found at <http://www.cms.gov/CMSForms/CMSForms/list.asp>. 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.

Please refer to the MLN Matters Special Edition Article on this subject at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1126.pdf>.

The Medicare Learning Network:

Medicare Learning Network® (MLN) educational resources provide health care professionals comprehensive, easy-to-understand information on CMS program and policy changes, regulations, and initiatives.

Publications & Multimedia

- **MLN Publications** come in a variety of formats on topics such as provider enrollment, preventive services, claims processing, compliance, and payment policies.
 - <http://go.cms.gov/MLNProducts>
- **MLN Matters® Articles** are prepared in consultation with clinicians, billing experts, and CMS subject matter experts; they are tailored to specific provider types affected by complex program changes.
 - <http://go.cms.gov/MLNMattersArticles>
- **Videos & Podcasts** offer additional educational options in multimedia formats.
 - <http://go.cms.gov/mlnmultimedia>
 - <http://go.cms.gov/MLNplaylist>

Training & Events

- **MLN Connects® National Provider Calls & Events** cover new policies and changes to the Medicare program, and typically include Question & Answer sessions for participants.
 - www.cms.gov/npc
- **Web-Based Trainings** are self-paced online courses on a broad range of Medicare and other health care-related topics.
 - <http://go.cms.gov/MLNTraining>

Newsletter & Mailing Lists

- **MLN Connects Provider eNews** is a weekly newsletter for health care professionals containing CMS program and policy news, announcements, upcoming events, claim, pricer, and code information, and MLN updates.
 - <http://go.cms.gov/enews>
- **Educational Products Mailing List** subscribers are emailed when new and revised MLN Publications are released.
 - <http://go.cms.gov/mlnproductslist>

- **MLN Matters Mailing List** subscribers are emailed when new and revised MLN Matters Articles are released.
 - <http://go.cms.gov/mlnmatterslist>

Continuing Education (CE) Credit

CMS is an accredited provider of IACET continuing education units (CEUs) and ACCME continuing medical education (CME) offering AMA PRA Category 1 Credits™. In addition, many professional associations offer continuing education credit for the completion of training activities designed for health care professionals including physicians, nurses, billers, coders, and other clinicians. You can find a broad range of courses that focus on staying abreast of Medicare updates, meeting professional development goals, and state license renewal requirements.

Please visit <https://www.cms.gov/Outreach-and-Education/Learn/Earn-Credit/Earn-credit-page.html> for more information about earning CE credit for CMS training.

For more information about MLN products and services, visit <http://go.cms.gov/MLNGenInfo>.

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