



Announcement

About Medicare Participation for Calendar Year 2022

As you plan for 2022 and become familiar with the coming changes for the year ahead, we wish to emphasize the importance and advantages of being a Medicare participating (PAR) provider. We are pleased that the favorable trend of participation continued into 2021 with a participation rate of 98 percent. 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.

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 work with you to put patients first. To do this, we must empower patients and providers to work together to make health care decisions that are best for patients. This means providing meaningful information about quality and costs. 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. 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.

To ensure broad access to the coronavirus disease 2019 (COVID-19) vaccines, Medicare covers FDA-approved or authorized vaccines as a preventive service at no cost to your patients. Please review our [set of toolkits](#) for providers, states and insurers to help you provide the vaccines.

WHY BECOME A PARTICIPATING MEDICARE PROVIDER:

All physicians, practitioners and suppliers – regardless of their Medicare participation status – must make their calendar year (CY) 2022 Medicare participation decision by December 31, 2021. Those 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 2022. The overwhelming majority of physicians, practitioners and suppliers choose to participate in Medicare each year. During CY 2021, 98 percent of all physicians and practitioners are billing under Medicare participation agreements.

If you participate in Medicare and bill for services paid under the Medicare physician fee schedule (MPFS), your 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:

Do you want to participate in Medicare for the 2022 calendar year?

If you're already participating in Medicare, you don't need to do anything.

If you want to participate in Medicare next year and you're not currently participating, complete the [Medicare Participating Physician or Supplier Agreement \(CMS-460\)](#) and [mail a copy to each MAC](#) to which you'll send Part B claims.

If you're a newly enrolling Medicare provider, you can submit the agreement electronically with your enrollment application.

If you don't want to participate in Medicare next year and you're currently participating, [write to each MAC](#) to which you send Part B claims telling them that you don't want to participate in Medicare effective January 1, 2022. This written notice must be postmarked before December 31, 2021.

If you're not currently participating and you don't want to participate, you don't need to do anything.

More Information:

- Review our [provider enrollment resources](#) and learn about the electronic Medicare enrollment system and the Provider Enrollment Chain and Ownership System (PECOS)
- For questions about participating, [find your MAC's website](#).

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 and correctly reflects your current practice address. 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](#).

YOUR FLU & COVID-19 VACCINE RECOMMENDATIONS ARE CRITICAL:

As a health care provider, please recommend and remind your patients to get flu and COVID-19 vaccines. Research shows that most adults believe vaccines are important, and they are more likely to get vaccines if their provider recommends it.

More Information:

- Flu: visit [cms.gov/flu-provider](https://www.cms.gov/flu-provider)
- COVID-19: visit [cms.gov/covidvax-provider](https://www.cms.gov/covidvax-provider)

QUALITY PAYMENT PROGRAM 2022 UPDATES:

Updates to the Quality Payment Program (QPP) for 2022 focus on ensuring your patients get the care they need—which is our top priority at CMS as we continue to confront COVID-19.

Merit-based Incentive Payment System (MIPS)

To meet the requirements of the statute, we're establishing for the CY 2022 MIPS performance period/2024 MIPS payment year the:

- Performance threshold using the mean final score from the CY 2017 MIPS performance period/ 2019 MIPS payment year, which results in a performance threshold of 75 points.
- Additional performance threshold at 89 points, which is the 25th percentile of the actual final scores from the CY 2017 MIPS performance period/2019 MIPS payment year at or above 75 points.

For the CY 2022 MIPS performance period/2024 MIPS payment year, the performance category weights (specified in statute and codified in prior rulemaking) are:

- 30% for the quality performance category
- 30% for the cost performance category
- 15% for the improvement activities performance category
- 25% for the promoting interoperability performance category

We're also updating the quality measure scoring and using performance period benchmarks (or a different baseline period) for scoring quality measures.

Additionally, to be responsive to stakeholder requests to be included in the program, we're revising the definition of a MIPS eligible clinician to include clinical social workers and certified nurse midwives.

MIPS Value Pathways (MVPs)

We're committed to providing more meaningful participation for clinicians in MIPS. As we progress toward the future state of MIPS, we're focusing the majority of our 2022 changes on MVPs. There will be 7 MVPs available, beginning with the CY 2023 MIPS performance period, that align with the following clinical topics:

1. Rheumatology
2. Stroke Care and Prevention
3. Heart Disease
4. Chronic Disease Management

5. Emergency Medicine
6. Lower Extremity Joint Repair
7. Anesthesia

Each MVP will include complementary measures and activities that:

- Support patient-centered care; and
- Emphasize the importance of patient outcomes, population health, health equity (including measures and activities that assess health disparities and socioeconomic factors), interoperability, and reduced reporting burden for clinicians.

Furthermore, because we want to provide clinicians and third-party intermediaries the time they need to review requirements, update workflows, and prepare their systems as needed to report MVPs, we are implementing MVPs gradually.

Alternative Payment Model (APM) Performance Pathway (APP)

In response to Accountable Care Organizations' (ACOs') concerns regarding the transition to reporting on electronic clinical quality measures (eCQMs)/MIPS CQM quality measures, which require the submission of all-payer quality data under the APP, we're allowing a longer transition for Shared Savings Program ACOs eCQMs/MIPS CQM quality measure reporting by extending the CMS Web Interface as an option for 2 years.

Find Out More

To find out more about 2022 program updates, view the Final Rule resources on the [QPP Resource Library](#).

OPIOID OVERDOSE:

Opioid overdose remains an urgent public health crisis. Continued prescriber awareness and engagement are crucial to reversing this trend. CMS encourages the following to help combat this epidemic:

- If you are contacted by a Medicare 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 ensure the safe use of these products and avoid disruption of medically necessary therapy;
- If your patient has opioid use disorder (OUD), consider whether they may benefit from medication-assisted treatment (MAT), which is covered under Medicare Parts B and D;
- Consider co-prescribing naloxone when prescribing opioids to your patients in accordance with guidelines and laws; and
- Check your state's Prescription Drug Monitoring Program before prescribing controlled substances.

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 where a patient may attempt to obtain prescription opioids from multiple prescribers and/or pharmacies, which may be unaware that others are prescribing or dispensing for the same patient.

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 may 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 may 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 that require 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. The plan will notify you of its decision within the required adjudication timeframes. You can also request an expedited or standard coverage determination in advance of prescribing an opioid; you only need to attest to the Medicare prescription 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 with sickle cell disease or being treated for active cancer-related pain. These policies should also not impact patients' access to MAT, such as buprenorphine.

These policies are not prescribing limits. CMS understands that clinician decisions regarding opioid prescribing – including dosing, tapering, or discontinuation of prescription opioids – are carefully individualized between you and your patients.

Additional information on the Medicare Part D opioid overutilization policies is available [here](#). Information about the Medicare Part B Opioid Treatment Program (OTP) benefit under Medicare Part B, is available [here](#).

ELECTRONIC PRIOR AUTHORIZATION:

Pursuant to a final rule promulgated by CMS in late 2020, beginning January 1, 2022, Medicare Part D plans will be required to support the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard version 2017071 for electronic prior authorization. The new electronic prior authorization transactions are part of the widely-used electronic prescribing (ePrescribing) standard, which will allow prescribers to see if a drug is subject to prior authorization while they are prescribing it. These new transactions will allow a prescriber to satisfy any prior authorization requirements at the time of prescribing or consider an alternative drug. This regulatory change helps ensure that there are secure electronic transactions between prescribers and Part D plan sponsors, and that patients will not experience delays when picking up their prescriptions.

More information about this requirement is available in the Final Rule available [here](#).

COGNITIVE ASSESSMENT & CARE PLAN SERVICES (CPT Code 99483):

Do you have a patient with a cognitive impairment? Medicare covers a separate visit for a cognitive assessment so you can more thoroughly evaluate cognitive function and help with care planning.

- If your patient shows signs of cognitive impairment at an [Annual Wellness Visit](#) or other routine visit, you may perform this more detailed cognitive assessment and develop a care plan
- Any clinician eligible to report evaluation and management (E/M) services can offer this service, including: physicians (MD and DO), nurse practitioners, clinical nurse specialists, and physician assistants

Get details on Medicare coverage requirements and proper billing at [cms.gov/cognitive](https://www.cms.gov/cognitive).

THE MEDICARE LEARNING NETWORK® (MLN):

The MLN offers free educational materials for health care providers on CMS programs, policies, and initiatives. Visit the [MLN homepage](#) for information, and [subscribe to an electronic mailing list](#) for the latest Medicare news.

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