CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4165	**Date: November 8, 2018**
	Change Request 10942

NOTE: Transmittal 4146, dated October 19, 2018, is being rescinded and replaced by Transmittal 4165, dated, November 8, 2018 to attach the Dear Doc Letter. This Transmittal is no longer sensitive. This instruction may now be posted to the Internet.

SUBJECT: Calendar Year (CY) 2019 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 2019 participation enrollment. The attached Recurring Update Notification applies to Chapter 1, Section 30.3.12.

EFFECTIVE DATE: November 19, 2018 - Upon Issuance of this Instruction
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 19, 2018 - 30 days following the close of the annual participation enrollment process for BR 10942.18; 11/14/2018 for BRs 10942.2, 10942.2.1, 10942.3, 10942.4, 10942.5, 10942.11, 10942.13, 10942.13.1, 10942.14; 11/08/2018 for all other requirements

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: 4165	Date: November 8, 2018	Change Request: 10942

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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 2019 will commence on November 14, 2018, and will run through December 31, 2018.

The purpose of this Recurring Update Notification is to furnish contractors with information needed for the CY 2019 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 8.

The CMS will send all contractors an e-mail notice when the January 2019 MPFSDB files (including anesthesia) are available for downloading, along with the file names, through an email notification via the Functional Workgroups as soon as the 2019 final rule goes on display (around November 1).

Please note, the Participation Announcement goes through a separate clearance process internal to CMS. It will be attached to the CR subsequent to the publication of the MPFS Final Rule, approximately November 1.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10942.1	Contractors shall mail postcards announcing the annual open participation enrollment by November 14, 2018, but not before November 8, 2018. See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1 B1.		X							
10942.2	Contractors shall display the fee data prominently on their Web site. For CY 2019 disclosure reports, contractors shall use the following format for displaying fees on the Web and/or hardcopy: • Procedure code (including professional and technical component modifiers, as applicable); • Par amount (non-facility);		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Par amount (facility-based); • Non-par amount (non-facility); • Limiting charge (non-facility); • Non-par amount (facility-based); • Limiting charge (facility-based); • EHR (Electronic Health Records) Limiting Charge; • PQRS (Physician Quality Reporting System) Limiting Charge; • EHR + PQRS Limiting Charge **NOTE:** The EHR and PQRS payment adjustments do not apply in CY 2019. As a short term solution, Perspecta MCS will initiate a user support problem to move "0" dollar amounts to the EHR, PQRS and EHR + PQRS Limiting Charge fields on the disclosure report for 2019. CMS will create a future CR to implement a permanent solution.									
10942.2.1	Contractors shall delete the following columns from the disclosure reports prior to display on their web pages if they have the capability: • EHR (Electronic Health Records) Limiting Charge; • PQRS (Physician Quality Reporting System) Limiting Charge; • EHR + PQRS Limiting Charge		X							
10942.3	Contractors shall provide a link to the 2019 Medicare Fee Schedule on their Web site. **NOTE:** Disclosure materials may not be posted on your Web site until you receive an email notification from CMS via the Functional Workgroups that the MPFSDB files (including anesthesia) are available for downloading, along with the file names, as soon as the 2019 final rule goes on display (around November 1).		X							
10942.4	For CY 2019 disclosure reports, contractors shall provide the anesthesia conversion factors on their Web site.		X							
10942.5	Contractors shall display the fee schedule using a provider friendly format from which providers can		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	download their particular locality. Providers should not have to download the whole fee schedule file.									
10942.6	Contractors shall 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 ."*		X							
10942.7	Effective immediately, contractors shall educate providers via their Web site and whatever other provider outreach that can be utilized that the fees will		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	be placed on the contractor Web site after the CY 2019 physician fee schedule regulation is put on display.									
10942.8	Contractors shall prominently display the announcement and participation agreement on the Web site.		X							
10942.9	Contractors shall insert their Web site address for providers to use to access the CY 2019 payment rates in the space available at the end of the Participation Announcement sheet.		X							
10942.10	Contractors shall insert their contractor-specific information (i.e., toll-free telephone numbers, etc.) as indicated at the end of the Participation Announcement sheet.		X							
10942.11	Contractors shall inform providers via their listserv when the CY 2019 fees are posted to their Web site**.**		X							
10942.12	Contractors shall **NOT** produce hard copy disclosures until January 1, 2019 unless otherwise notified by CMS. **NOTE**: Contractors have the discretion to produce no more than 2 percent hardcopy if needed.		X							
10942.12.1	Contractors shall keep track of any requests for hard copy paper disclosures.		X							
10942.12.2	Contractors shall not charge providers requesting hard copy disclosures who do not have Internet access.		X							
10942.12.3	Contractors shall mail the hard copy disclosures via first class or equivalent delivery service.		X							
10942.13	The Medicare Physician Fee Schedule Database (MPFSDB) will contain the CY 2019 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 2018 by the American		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 OPPS 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 Eligible Professionals (EPs) that are subject to both EHR and PQRS Negative adjustment program." See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1. **NOTE:** The EHR and PQRS payment adjustments do not apply in CY 2019. CMS will create a future CR to remove the relevant footers from the disclosure reports.									
10942.13.1	Contractors shall delete the following footers from the disclosure reports prior to display on their web pages if they have the capability: "Limiting Charge reduced based on the EHR Negative adjustment program." "Limiting Charge reduced based on the PQRS Negative adjustment program." "Limiting Charge reduced for Eligible Professionals (EPs) that are subject to both EHR and PQRS Negative adjustment program."		X							
10942.14	If contractors choose to use code descriptors on their Web site, they must use the short descriptors		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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).									
10942.15	Contractors shall process participation elections and withdraws post-marked before January 1, 2019.		X							
10942.16	Contractors shall not print hardcopy participation directories (i.e., MEDPARDs) for CY 2019 without regional office prior authorization and advanced approved funding for this purpose.		X							
10942.17	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							
10942.18	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							
10942.19	Contractors shall notify providers via regularly scheduled newsletters as to the availability of the MEDPARD information and how to access it electronically.		X							
10942.20	Contractors shall also inform hospitals and other organizations (i.e., Social Security offices, area Administration on Aging offices, and other beneficiary advocacy organizations) how to access MEDPARD information on your Web site.		X							
10942.21	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							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10942.21.1	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							
10942.22	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							
10942.23	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							
10942.24	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				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"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

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.

We know the program is a big change from previous CMS quality programs, and we're here to help! Technical assistance and support is available to help you navigate the program. To get started, visit the QPP website https://qpp.cms.gov/ or email us at qpp@cms.hhs.gov or call 1-866-288-8292 weekdays from 8 AM to 8 PM Eastern Time.

Key Reminders:

- If you participated in Year 1 (2017 performance period) of MIPS, you will receive a payment adjustment in 2019. Your payment adjustment is determined by the data you submitted on quality measures and activities for performance during 2017. You can review these details by accessing your performance feedback, which you can view by logging in here: https://qpp.cms.gov/.
- You are also encouraged to check your participation status for Year 2 (2018 performance period) to determine if you are expected to participate in MIPS here: https://qpp.cms.gov/participation-lookup.
- You can explore the MIPS measures and activities here: https://qpp.cms.gov/mips/explore-measures/quality-measures?py=2018#measures.
- The deadline to submit the Promoting Interoperability or Extreme and Uncontrollable Circumstances applications is December 31, 2018. https://qpp.cms.gov/mips/exception-applications.

Changes to the Quality Payment Program for Year 3 (2019 performance period) are included in the 2019 Medicare Physician Fee Schedule Final Rule (Available November 2018).

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 care of beneficiaries who are potentially at-risk for prescription drug abuse or misuse, which often involves multiple prescribers and pharmacies who are not aware of each other's prescribing patterns. 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.

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.

FORM APPROVED
OMB NO. 0938-0373

MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

Name(s) and Address of Participant*	National Provider Identifier (NPI)*

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

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 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)		Date
Title (if signer is authorized representative of organization)		Office Phone Number (including area code)
Received by (name of carrier)	Initials of Carrier Official	Effective Date

INSTRUCTIONS FOR THE MEDICARE PARTICIPATING PHYSICIAN AND SUPPLIER AGREEMENT (CMS-460)

To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients.

WHY PARTICIPATE?

If you bill for physicians' professional services, services and supplies provided incident to physicians' professional services, outpatient physical and occupational therapy services, diagnostic tests, or radiology services, your Medicare fee schedule amounts are 5 percent higher if you participate. Also, providers receive direct and timely reimbursement from Medicare.

Regardless of the Medicare Part B services for which you are billing, participants have "one stop" billing for beneficiaries who have Medigap coverage not connected with their employment and who assign both their Medicare and Medigap payments to participants. After we have made payment, Medicare will send the claim on to the Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer must pay the participant directly.

Currently, the large majority of physicians, practitioners and suppliers are billing under Medicare participation agreements.

WHEN THE DECISION TO PARTICIPATE CAN BE MADE:

- Toward the end of each calendar year, all MAC/carriers have an open enrollment period. The open enrollment period generally is from mid-November through December 31. During this period, providers who are currently enrolled in the Medicare Program can change their current participation status beginning the next calendar year on January 1. This is the only time these providers are given the opportunity to change their participation status. These providers should contact their MAC/carrier to learn where to send the agreement, and get the exact dates for the open enrollment period when the agreement will be accepted.
- New physicians, practitioners, and suppliers can sign the participation agreement and become a Medicare participant at the time of their enrollment into the Medicare Program. The participation agreement will become effective on the date of filing; i.e., the date the participant mails (post-mark date) the agreement to the carrier or delivers it to the carrier.

Contact your MAC/carrier to get the exact dates the participation agreement will be accepted, and to learn where to send the agreement.

WHAT TO DO DURING OPEN ENROLLMENT:

If you choose to be a participant:

- Do nothing if you are currently participating, or
- If you are not currently a Medicare participant, complete the blank agreement (CMS-460) and mail it (or a copy) to each carrier 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:

- Do nothing if you are currently not participating, or
- If you are currently a participant, write to each carrier to which you submit claims, advising of your termination effective the first day of the next calendar year. This written notice must be postmarked prior to the end of the current calendar year.

WHAT TO DO IF YOU'RE A NEW PHYSICIAN, PRACTITIONER OR SUPPLIER:

If you choose to be a participant:

- Complete the blank agreement (CMS-460) and submit it with your Medicare enrollment application to your MAC/carrier.
- If you have already enrolled in the Medicare program, you have 90 days from when you are enrolled to decide if you want to participate. If you decide to participate within this 90-day timeframe, complete the CMS-460 and send to your MAC/carrier.

If you decide not to participate:

- Do nothing. All new physicians, practitioners, and suppliers that are newly enrolled are automatically non-participating. You are not considered to be participating unless you submit the CMS-460 form to your MAC/carrier.

We hope you will decide to be a Medicare participant.

Please call the MAC/carrier in your jurisdiction if you have any questions or need further information on participation.

DO NOT SEND YOUR CMS-460 FORM TO CMS, SEND TO YOUR MAC/CARRIER. IF YOU SEND YOUR FORMS TO CMS, IT WILL DELAY PROCESSING OF YOUR CMS-460 FORMS.

To view updates and the latest information about Medicare, or to obtain telephone numbers of the various Medicare Administrative Contractor (MAC)/carrier contacts including the MAC/carrier medical directors, please visit the CMS web site at *http://www.cms.gov/*.