CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3102	**Date: November 3, 2014**
	Change Request 8967

NOTE: This Transmittal is no longer sensitive and is being re-communicated 11-12-2014. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Calendar Year (CY) 2015 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 2015 participation enrollment. The attached Recurring Update Notification applies to Chapter 1, Section 30.3.12.

EFFECTIVE DATE: November 3, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 7, 2014

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 obliged 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: 3102	Date: November 3, 2014	Change Request: 8967

SUBJECT: Calendar Year (CY) 2015 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

EFFECTIVE DATE: November 3, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 7, 2014

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 2015 will commence on November 14, 2014, and will run through December 31, 2014.

The purpose of this Recurring Update Notification is to furnish contractors with information needed for the CY 2015 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://go.cms.gov/MLNGenInfo) 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://go.cms.gov/MLNProducts . You can also find other important physician Web sites by visiting the Physician Center Web page at: http://www.cms.gov/Center/Provider-Type/Physician-Center.html?redirect=/center/physician.asp .

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 plans to release the 2015 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			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8967.1	Contractors shall mail postcards announcing the annual open participation enrollment by November 14, 2014, but not before November 8, 2014. See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1 B1.		X							
8967.2	Contractors shall display the fee data prominently on their Web site. For CY 2015 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); • Par amount (facility-based); • Non-par amount (non-facility); • Limiting charge (non-facility);		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• Non-par amount (facility-based); • Limiting charge (facility-based); • EHR Limiting Charge; • PQRS Limiting Charge; • EHR/ 2014 eRx-Limiting Charge; • EHR + PQRS Limiting Charge and • EHR/ 2014 eRx + PQRS Limiting Charge									
8967.3	Contractors shall provide a link to the 2015 Medicare Fee Schedule on their Web site. **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.		X							
8967.4	For CY 2015 disclosure reports, contractors shall provide the anesthesia conversion factors on their Web site.		X							
8967.5	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							
8967.6	Contractors shall post the following language on your Web site: "We encourage you to visit the Medicare Learning Network® (MLN) (http://go.cms.gov/MLNGenInfo) 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://go.cms.gov/MLNProducts . You can also find other important physician Web sites		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	by visiting the Physician Center Web page at: http://www.cms.gov/Center/Provider-Type/Physician-Center.html?redirect=/center/physician.asp . 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 ."									
8967.7	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 2015 physician fee schedule regulation is put on display.		X							
8967.8	Contractors shall prominently display the announcement and participation agreement on the Web site.		X							
8967.9	Contractors shall insert their Web site address for providers to use to access the CY 2015 payment rates in the space available at the end of the Participation Announcement sheet.		X							
8967.10	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							
8967.11	Contractors shall inform providers via their listserv when the CY 2015 fees are posted to their Web site**.**		X							
8967.12	Contractors shall **NOT** produce hard copy disclosures until you receive notification from CMS. **NOTE**: When notified, contractors have the		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	discretion to produce no more than 2 percent hardcopy if needed.									
8967.12.1	Contractors shall keep track of any requests for hard copy paper disclosures.		X							
8967.12.2	Contractors shall not charge providers requesting hard copy disclosures who do not have Internet access.		X							
8967.12.3	Contractors shall mail the hard copy disclosures via first class or equivalent delivery service.		X							
8967.13	The MPFSDB will contain the CY 2015 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 2014 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 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 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.		X							
8967.14	If contractors choose to use code descriptors on their		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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).									
8967.15	Contractors shall process participation elections and withdraws post-marked before January 1, 2015.		X							
8967.16	Contractors shall not print hardcopy participation directories (i.e., MEDPARDs) for CY 2015 without regional office prior authorization and advanced approved funding for this purpose.		X							
8967.17	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							
8967.18	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							
8967.19	Contractors shall notify providers via regularly scheduled newsletters as to the availability of the MEDPARD information and how to access it electronically.		X							
8967.20	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							
8967.21	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		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	download for their use.									
8967.21.1	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							
8967.22	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							
8967.23	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							
8967.24	If possible, contractors shall provide a count of the number of page views that the 2015 Participation Announcement receives from your Web site.		X							
8967.24.1	This count shall begin November 14, 2014, through December 31, 2014.		X							
8967.24.2	Contractors shall email results of the count to the central office (CO) contact no later than January 31, 2015. The CO contact is: Mark.Baldwin@cms.hhs.gov		X							
8967.25	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				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
	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

Announcement
About Medicare Participation for Calendar Year 2015

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 2014 with a participation rate of 96.6 percent. As you plan for 2015 and become familiar with the coming changes, we are hopeful that you will continue to be a PAR provider or, if you are non-participating (Non-PAR), will consider becoming a PAR provider.

With the help of health care professionals across the country, the Medicare program is improving faster than ever. The growth in spending per beneficiary is at an all-time low, which means that the part B beneficiary premium will not increase in 2015. At the same time, the quality of care received by Medicare beneficiaries continues to improve as indicated by lower hospital readmission rates, significant reductions in health care acquired conditions, and other measures. And, with your help, we can build upon these successes in the coming year by promoting the use of new preventive services and other strategies geared toward disease prevention, early detection, and lifestyle modifications that support a healthier life.

WHY BECOME A PARTICIPATING MEDICARE PROVIDER

All physicians, practitioners and suppliers must make their calendar year (CY) 2015 Medicare participation decision by December 31, 2014. 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 2015. The overwhelming majority of physicians, practitioners and suppliers have chosen to participate in Medicare. As indicated, during CY 2014, 96.6 percent of all physicians and practitioners are billing under Medicare participation agreements.

If you participate and you 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.

WHAT TO DO

If you choose to be a PAR physician in CY 2015:

- 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 Medicare Administrative Contractor (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 2015:

- 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, 2015. This written notice must be postmarked prior to January 1, 2015.

We hope you will decide to be a Medicare participant in CY 2015. Please call _______________ if you have any questions or need further information on participation.

The Medicare Learning Network® (MLN) has developed products in an effort to educate Medicare providers about important Medicare enrollment information. These MLN® products 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 products is available at http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Medicare_Provider-Supplier_Enrollment_National_Education_Products.pdf on The Centers for Medicare and Medicaid Services (CMS) website.

To view updates and the latest information about Medicare, or to obtain telephone numbers of the various MAC contacts including the MAC medical directors, please visit the CMS web site at http://www.cms.gov/. For ____(MAC name) _____, you may contact the following toll-free number(s) for assistance:

Ebola Information and Resources

The Centers for Medicare and Medicaid Services (CMS) are working with our federal partners, in particular the Centers for Disease Control and Prevention (CDC), to respond to and prevent the further spread of the Ebola Virus Disease (Ebola) within the United States.

The CDC has developed resources and recommendations on Ebola transmission infection prevention and control. We encourage you to visit the CDC Ebola Virus Disease website frequently for the latest information including screening and other recommendations and fact sheets for the healthcare community and updated Ebola case information. Updated information from CMS on this topic will be shared through the Medicare Learning Network (MLN), such as the MLN Connects Provider eNewsletter.

There are a number of actions that you can put into practice in your healthcare setting that include the following:

- Be sure to reach out to, and coordinate with, your local public health and emergency management colleagues. Acquaint yourself with emergency plans, and best points of contact.
- Post the CDC checklist and Do's and Don'ts in patient care areas.
- Ensure that you take a travel history from any patient presenting with a febrile illness or gastrointestinal symptoms. **If a patient has been in Liberia, Sierra Leone or Guinea in the past 21 days, OR has had contact with a healthcare worker who was taking care of EVD patients in the past 21 days AND is febrile, they require immediate special precautions.** It can be challenging to differentiate flu-like illness from the early symptoms of Ebola Virus Disease. A travel history is essential!
- Make sure that your practice setting can implement your plan to handle patients who are ill and can appropriately isolate the patient in a private room with a private bathroom if possible. Use the highest level of personal protective equipment available in your setting until you consult with your local health department or the CDC.
- And as always, remember the importance of protecting your patients from seasonal influenza. Encourage them to take the annual flu vaccine that is appropriate for them. You, your staff and their family members should receive flu vaccines, as well. For more information on the seasonal flu and the flu vaccine visit Flu.gov.

For additional, specific guidance read the CDC's Infection Prevention and Control Recommendations. The checklist can be found at http://www.cdc.gov/vhf/ebola/pdf/could-it-be-ebola.pdf. The Do's and Don'ts can be found at http://www.cdc.gov/vhf/ebola/pdf/ambulatory-care-evaluation-of-patients-with-possible-ebola.pdf.

The Health Insurance Marketplace – Expanding Health Insurance Coverage:

A primary goal of the Affordable Care Act is to help uninsured and other eligible Americans gain access to quality, affordable health care. Central to this goal was the creation of the Health Insurance Marketplace. Through the Marketplace, more than 8 million eligible Americans enrolled in a private health plan. Now no one will be denied coverage on the basis of pre-existing conditions and there are no more lifetime or annual limits. As with last year, expect to see a growing number of previously uninsured patients newly covered by private health insurance plans and, in a growing number of states, expanded Medicaid eligibility. Many of these private health plans continue to develop their provider networks.

For those of you whose practices are considered small businesses, please be aware of exciting enhancements to the Small Business Health Options Program (SHOP). Beginning on November 15, 2014, new online functionality and tools will be launched. In some states, employers will be able to provide multiple plan options to employees while receiving one bill and making one payment each month. For 2014 and 2015, the SHOP Marketplace is open to employers with 50 or fewer employees (FTEs). If you have fewer than 25 employees, you may qualify for tax credits if you buy insurance through SHOP. For more information on SHOP, please see: https://www.healthcare.gov/small-businesses/. To see how much the tax credit could be worth to your bottom line, click on this SHOP tax credit estimator: https://www.healthcare.gov/small-business-tax-credit-calculator/.

This year, the Open Enrollment period for 2015 coverage is November 15, 2014 to February 15, 2015. New consumers may apply for coverage in a Marketplace plan with coverage beginning as early as January 1, 2015.

You may want to inform your patients who are currently enrolled in Marketplace plans that they should make sure they are in the right plan for 2015. They can visit HealthCare.gov or call the Marketplace Call Center to report a change or view their 2015 Marketplace application. During the Open Enrollment Period from November 15, 2014 to February 15, 2015, they can shop in the Marketplace to find a plan that meets their needs for the new coverage year. After February 15, 2015, most people can't enroll or make changes to their plan until the next Open Enrollment Period starting in late 2015.

As a trusted source for health information, your patients may look to you for help navigating the Marketplace. Resources concerning the Marketplace that you may find helpful to direct them to may be found at:

Marketplace.cms.gov: Where organizations and individuals looking for help can get the latest resources and learn more about the Marketplace.

HealthCare.gov: Where individuals can learn about the Marketplace and the upcoming benefits (including where they can find local assistance), or be connected to appropriate resources in states that are running their own Marketplace.

Health Insurance Marketplace Call Center: If you have questions, call 1-800-318-2596. TTY users should call 1-855-889-4325.

SHOP (Small Business) Marketplace Call Center: If you have questions, call **1-800-706-7893 (TTY: 711).**

At **Marketplace.cms.gov**, there are two articles particularly relevant for clinicians: "10 Things Providers Need to Know" and "10 Things to Tell Your Patients," both available at http://marketplace.cms.gov/outreach-and-education/new-to-marketplace.html.

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

Physicians can directly participate in health care transformation through the CMS Innovation Center which is charged with identifying, testing, and evaluating new 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 37,000 providers in all 50 states, the District of Columbia, and Puerto Rico are currently participating in over twenty 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. Health care transformation initiatives at the state level now encompass more than 60 percent of providers nationwide and over 60 percent of the US population. These models are reducing costs in Medicare, Medicaid, and CHIP and enhancing the quality of care that our beneficiaries receive.
The broad engagement of providers across the country in innovative 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. We encourage you to visit the CMS Innovation Center website—at www.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. The result would be transformed clinical practices characterized by the delivery of high quality care, population-based care, cost-savings, and improved workflow.

We also encourage physicians to join Million Hearts, a U.S. Department of Health and Human Services initiative co-led by the Centers for Disease Control and Prevention and CMS. This initiative is aimed at preventing 1 million heart attacks and strokes by 2017. Joining this effort means working with your staff and patients to excel in the ABCS: aspirin for those patients at risk; blood pressure control; cholesterol management; and smoking cessation. The initial milestone in Million Hearts is better blood pressure control for the 67 million Americans with hypertension, 36 million of whom are not yet under control. Please visit http://millionhearts.hhs.gov for resources that can be helpful. For questions, contact the Million Hearts team at millionhearts@cms.hhs.gov.

Primary Care Incentives:

In 2015, CMS will continue to make a 10 percent incentive payment for primary care services furnished by primary care practitioners as authorized by the Affordable Care Act. To be eligible for this incentive payment, a physician's Medicare specialty needs to be family medicine, geriatric medicine, pediatric medicine, or internal medicine, and primary care services need to constitute 60 percent of Medicare Part B outpatient services (excluding services provided to hospital inpatients or those in emergency departments) in 2012. Nurse practitioners, clinical nurse specialists, and physician assistants are also eligible for these incentive payments. Also please see the Special Edition MLN Matters® Article developed by the Medicare Learning Network®. The article provides a list of questions and answers that respond to the inquiries CMS has received about the Primary Care Incentive Program. The article can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm7060.pdf on the CMS website.

New for 2015, Medicare will pay for the care coordination for Medicare beneficiaries with two or more chronic conditions. Payments will be made for calendar months in which at least 20 minutes of care are furnished, but a face-to-face visit is not required. In 2015, Medicare will continue to make payments to physicians to coordinate a patient's care during their transition back to the community following a discharge from a hospital or nursing facility. More information on billing for this service is available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf. We also answer frequently asked questions on billing for this service: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf.

Medicare Shared Savings Program:

Currently, over 135,500 physicians participate in Accountable Care Organizations (ACOs) in the Medicare 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 the first year of the program, we shared over $300 million in savings with 53 ACOs.

Eligible professionals (EPs), (i.e. physicians and other practitioners), in an ACO that successfully reports the Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) option web interface quality measures required under the Shared Savings Program in any year of the program will be deemed eligible for the PQRS bonus and/or 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 satisfy your Clinical Quality Measure (CQM) reporting requirements for the Electronic Health Record (EHR) Incentive Program if the ACO satisfactorily reports quality measure data via the ACO GPRO web interface ***and*** the EPs meet the other program requirements for Meaningful Use Stage 2. Groups of physicians that participate in an ACO are also exempt from the application of the 2016 Value-Based Payment Modifier (VM) adjustment.

We encourage physicians and other practitioners to collaborate with your ACOs so that together you can achieve the goals of the program including successful reporting and performance on quality measures.

We encourage you to consider forming or joining an ACO under the Medicare Shared Savings Program. Please visit the Medicare Shared Savings Program webpage for more information about the program including how to apply or learn about ACOs in your area - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/

Engaging Physicians in Quality:

CMS recognizes that physician practices vary and measurement must be meaningful and relevant to clinical practice. Engaging in quality reporting and improvement requires significant time and resources from providers and their practices. Thus, developing quality programs that maximize flexibility, while minimizing burden, is critical. This principle is reflected in ongoing improvements to CMS quality programs, such as:

- Providers can choose quality measures that best reflect their practice and how they are reported to CMS;
- Many providers may be able to report quality measures one time during the 2015 program year in order to avoid the 2017 PQRS negative payment adjustment, satisfy the CQM component of the Medicare EHR Incentive Program, and satisfy requirements regarding the 2016 VM adjustment. 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;
- CMS is aligning related measures across CMS programs and collaborating with private payers to reduce provider reporting burden;
- Providers have over 5 mechanisms available for PQRS reporting, allowing providers to choose a mechanism that works best for them;
- The availability of the MLN® YouTube video regarding “Implications for the Value-Based Payment” Modifier can be found at: http://www.youtube.com/watch?v=ZxIiW33jkSs.

CMS believes that providers are leaders in quality improvement. CMS will continue its efforts to collaborate with physicians and other healthcare professionals to facilitate quality improvement through quality reporting programs such as the PQRS and pay for performance programs such as the VM program. The VM program links quality to payment by providing differential payment to physicians based on the quality and cost of care furnished to Medicare patients.

Availability of the 2013 Quality and Resource Use Reports (QRURs):

On September 30, 2014, CMS provided QRURs to all groups of physicians and to solo practitioners. The 2013 QRURs contain data regarding quality and cost of care for calendar year 2013. This is the same performance period that was used to calculate the VM that will be applied to physician payments for items and services furnished under the MPFS for groups of 100 or more EPs in 2015. For physicians and groups of physicians in groups of 100 or more EPs, the QRURs will provide information on how the group's quality and cost performance will affect their 2015 Medicare payments through the application of the VM. VM payment adjustments will not be applied to groups of fewer than 100 EPs in 2015.

For group practices with fewer than 100 EPs and for solo practitioners, the QRUR is for informational purposes. It can help your group understand and improve the quality and efficiency of care it provides to Medicare beneficiaries. The reports provide detailed information about the beneficiaries your practice services including information on where they were hospitalized and for what conditions. You may get information on how to access your report at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html.

Medicare and Medicaid EHR Incentive Programs:

In 2015, providers will report using the 2014 edition of the Certified Electronic Health Record Technology (CEHRT) and will use the 2014 definition of meaningful use for Stage 1 or Stage 2 as appropriate. Returning providers will report for the entire calendar year and attest between January 1 through February 29, 2016. Providers who are attesting for the first time will report for any consecutive 90 days in the calendar year to avoid a Medicare payment adjustment. These providers are not eligible for Medicare incentives, but may be eligible for a Medicaid incentive.

In order to align programs and reduce the burden on physicians and providers, physicians may simultaneously submit CQM data for both the Medicare EHR Incentive Program and the PQRS program electronically. Eligible hospitals and critical access hospitals may do the same through the Inpatient Quality Reporting Program. All physicians and providers beyond the first year of demonstrating meaningful use will be able to report clinical quality measures electronically. For more information about the EHR Incentive Programs visit www.cms.gov/EHRIncentivePrograms.

Those who fail to meet meaningful use for the applicable period may be subject to a payment adjustment to their Medicare claims. In 2015, the result will be payment of 99% of the MPFS amount. EPs must successfully demonstrate meaningful use every year to avoid the Medicare payment adjustments. Demonstration of meaningful use in 2015 will enable providers to avoid the payment adjustment in 2017. Providers who did not successfully demonstrate meaningful use in 2014 will receive a payment adjustment in 2016. Providers also have the option of filing a significant hardship exception application by July 1, 2015. Don't wait until the last minute to meet meaningful use! For more information about payment adjustments, please visit http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_HardshipExcepTipSheetforEP.pdf.

The MLN® has also developed a quick reference guide about EHR reporting. This educational tool is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/PQRS-EHR-Incentive-Pilot-Quick-Ref-Guide.pdf on the CMS website.

Incentives and Payment Adjustments for Quality Reporting:

EPs should note that 2015 will also serve as the reporting period for the 2017 PQRS payment adjustment. The payment adjustment for 2017 based on 2015 reporting is negative 2.0%. The reporting requirements to avoid the 2017 PQRS payment adjustment are detailed in the CYs 2014 and 2015 MPFS Final Rules. More information will be available on the program websites (links below) soon.

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

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

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, 2015 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. 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. A provider may enroll or opt out of Medicare by submitting to their MAC one of the following documents:

- A CMS-855I application (allows the physician to enroll in Medicare to bill for services; order and certify services and items; and to prescribe Part D drugs): or
- 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 (physician agrees to opt out of the Medicare program for a period of two years and to meet certain other criteria).

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' 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;

- Encourage your colleagues who are not enrolled in Medicare to enroll in advance of June 1, 2015. The options available for enrolling or opting out are identified above. For more information, please refer to the enrollment product entitled, **Medicare Enrollment Guidelines for Ordering/Referring Providers** at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedEnroll_OrderReferProv_FactSheet_ICN906223.pdf or **SE1311** - Opting out of Medicare and/or Electing to Order and Refer Services at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1311.pdf;and

- If you supervise residents as a teaching physician, and the resident writes prescriptions for Medicare beneficiaries under your name and National Provider Identifier (NPI) number, beginning June 1, 2015, the resident should enroll in Medicare (if eligible). CMS encourages prescribers to include your individual NPI on prescriptions in order to avoid follow up from pharmacies and Part D prescription drug benefit plans when processing a Medicare beneficiary's prescription. Residents may also refer to the document at the link noted just above for more information about enrollment in Medicare.

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 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 from the CMS website 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.

Many states have operational Prescription Drug Monitoring Programs (PDMPs). PDMPs are tools used by states to reduce prescription drug abuse and diversion. We encourage you to actively participate in your state's PDMP. For more information about your state's PDMP program and how to obtain access, please visit the following website: http://www.pmpalliance.org/content/pmp-access.

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' 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. 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:

Over the coming months, many providers will receive requests from their respective MACs to revalidate their Medicare enrollment information. Providers can revalidate their enrollment information using either the Internet-based Provider Enrollment, Chain and Ownership System 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 on the CMS website.

The Medicare Learning Network®:

The MLN® now offers a weekly electronic newsletter, the *MLN Connects Provider eNews.* View past editions at http://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive.html. The clickable table of contents allows health care professionals to move directly to items of interest, such as upcoming calls and events; and CMS program information, including ICD-10, EHR incentive programs, Medicare enrollment, CMS quality incentive programs and MLN® educational materials. To subscribe, go to https://public.govdelivery.com/accounts/USCMS/subscriber/new?pop=t&topic_id=USCMS_7819. All you need is a valid e-mail address.

The MLN® also provides two electronic mailing lists to help health care professionals stay informed about the latest MLN® educational products and MLN Matters® articles.

- **MLN® Educational Products Electronic Mailing List**: MLN® Products are designed to provide education on a variety of CMS programs, including provider supplier enrollment, preventive services, provider compliance, and Medicare payment policies. All products are free of charge and offered in a variety of formats to meet your educational needs. For information on how to subscribe to this mailing list, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MLNProducts_listserv.pdf on the CMS website.

- **MLN Matters® Articles Electronic Mailing List**: MLN Matters® are national articles that educate health care professionals about important changes to CMS programs. Articles explain complex policy information in plain language to help health care professionals reduce the time it takes to incorporate these changes into their CMS-related activities. For information on how to subscribe to this mailing list, go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/What_Is_MLNMatters.pdf on the CMS website.

For more information about MLN® products and services, visit the MLN® General Information web page at http://go.cms.gov/MLNGenInfo on the CMS website.

OMB No. 0938-0373

MEDICARE
PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

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

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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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0373. The time required to complete this

information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, 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.