Announcement
About Medicare Participation for Calendar Year 2024

As you plan for 2024 and become familiar with the coming changes for the year ahead, we wish to emphasize the importance and advantages of being a Medicare participating (PAR) provider. We are pleased that the favorable trend of participation continued into 2023 with a participation rate of 98 percent. We hope that you will continue to be a PAR provider or, if you are non-participating (Non-PAR), will consider becoming a PAR provider.

This announcement provides information that may be helpful to clinicians in determining whether to become a Medicare participating provider, or to continue Medicare participation. The Centers for Medicare & Medicaid Services (CMS) pledges to work with you to put patients first. To do this, we must empower patients and providers to work together to make health care decisions that are best for patients. This means providing meaningful information about quality and costs. It also includes supporting innovative approaches to improving quality, accessibility, and affordability, while finding the best ways to use innovative technology to support patient-centered care. We can't do all of this without your involvement. Please visit www.cms.gov to learn more about our efforts to strengthen the Medicare program.

To ensure broad access to COVID-19 and Flu vaccines, Medicare covers Food and Drug Administration (FDA) approved or authorized vaccines as a preventive service at no cost to your patients. Please review our set of toolkits for providers, states and insurers to help you provide COVID-19 vaccines. See here for more information about the Flu shot.

Why Become a Participating Medicare Provider:

All physicians, practitioners and suppliers – regardless of their Medicare participation status – must make their calendar year (CY) 2024 Medicare participation decision by December 31, 2023. Those who want to maintain their current PAR status or Non-PAR status do not need to take any action during the upcoming annual participation enrollment period. If you wish to become a PAR provider, you will need to sign a participation agreement, as described below. To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients in CY 2024. The overwhelming majority of physicians, practitioners and suppliers choose to participate in Medicare each

year. During CY 2023, 98 percent of all physicians and practitioners are billing under Medicare participation agreements.

If you participate in Medicare and bill for services paid under the Medicare physician fee schedule (MPFS), your fee schedule amounts are 5 percent higher than if you do not participate. Your Medicare Administrative Contractor (MAC) publishes an electronic directory of providers that choose to participate.

What to Do:

If you're already participating in Medicare, you don't need to do anything unless you need to revalidate your enrollment record (described below).

If you want to participate in Medicare next year, and you're not currently participating, complete the online enrollment application. You must also complete the Medicare Participating Physician or Supplier Agreement (CMS-460) and mail a copy to each Medicare Administrative Contractor (MAC) that you'll send Part B claims to. Find your MAC's website.

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

If you don't want to participate in Medicare next year, and you're currently participating, write to each MAC that you sent Part B claims to, telling them that you don't want to participate effective January 1, 2024. This written notice must be postmarked before December 31, 2023. Find your MAC's website.

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

Review our provider enrollment resources, and learn about the electronic Medicare enrollment system, called the Provider Enrollment, Chain, and Ownership System (PECOS).

National Plan and Provider Enumeration System (NPPES) Taxonomy:

Please check your data in NPPES and confirm that it still correctly reflects you as a health care provider and correctly reflects your current practice address. There is increased focus on the National Provider Identifier (NPI) as a health care provider identifier for program integrity purposes. Incorrect taxonomy data in NPPES may lead to unnecessary inquiries about your credentials, as it may appear to Medicare oversight authorities that you may not be lawfully prescribing Part D drugs. Comprehensive information about how the NPI rule pertains to prescribers may be obtained here.

Medicare Enrollment Application - Physicians and Non-Physician Practitioners (Revised CMS 855I Form):

Starting November 1, 2023, use the revised CMS-855I posted on the CMS Forms List or accessible via PECOS. MACs will no longer accept the previous version of the form as of October 31, 2023. Starting November 1, 2023, you must use the revised form.

Among other things, form updates:

- Combine the CMS-855I and CMS-855R paper applications and discontinue the CMS-855R
- Remove physician assistant employer arrangements
- Recognize physicians and non-physicians who provide acupuncture services
- Identify compact licenses
- Add new physician specialties
- Expand practice location types to include telehealth

Visit Medicare Enrollment for Providers and Suppliers for more information about Medicare enrollment, including a CMS-855I instructional guide.

Revalidation:

You're required to revalidate your enrollment record periodically to maintain Medicare billing privileges. In general, providers and suppliers revalidate every five years, but Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) suppliers must revalidate every three years. CMS also reserves the right to request off-cycle revalidations.

Visit Revalidations (Renewing Your Enrollment) for information on finding your revalidation due date and how to submit your revalidation.

Your Flu Shot & COVID-19 Vaccine Recommendations Are Critical:

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

More Information:

- Flu Shot webpage
- COVID-19 Vaccine Provider Toolkit

Quality Payment Program 2024 Updates:

Updates to the Quality Payment Program (QPP) for the CY 2024 performance period continue the development and maintenance of MIPS Value Pathways (MVPs), support the use of digital measurement and health information technology, amend requirements for third party intermediaries, and update the performance threshold.

Get All the Details
To learn about all the 2024 program updates, view the Final Rule resources on the QPP Resource Library.

Policy Highlights

Traditional Merit-based Incentive Payment System (MIPS)

- We're **not finalizing** any policies that would result in an increase to the performance threshold. The performance threshold will remain 75 points for the CY 2024 performance period/2026 MIPS payment year.
- We're **not finalizing** increases to the data completeness criteria. The data completeness criteria will remain 75% through the CY 2026 performance period/2028 MIPS payment year.
- Updating MIPS quality measures and the improvement activities inventory. We're also adding 5 new episode-based cost measures beginning with the CY 2024 performance period.
- Increasing the performance period for the Promoting Interoperability performance category to a minimum of 180 continuous days within the calendar year. We're also requiring a "yes" response for the SAFER Guide measure beginning with the CY 2024 performance period.

MVPs

We are finalizing 5 new MVPs, and modifications to the 12 previously finalized MVPs. There will be a total of 16 MVPs available for reporting in the CY 2024 performance period/2026 MIPS payment year.

Advanced Alternative Payment Models (APMs)

- For Advanced APMs, broaden the current definition of certified electronic health record technology (CEHRT) to provide greater flexibility, and remove the numerical 75 percent threshold for performance periods starting in 2025.

Medicare Shared Savings Program

Medicare Shared Savings Program Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who collaborate and provide coordinated, high-quality care to people with Medicare, focusing on delivering the right care at the right time while avoiding unnecessary services and medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, the ACO may be eligible to share in the savings it achieves for the Medicare program. Certain ACOs may share in savings at higher rates in return for taking on risk if costs increase.

Over the past decade, the Shared Savings Program has grown into one of the largest value-based purchasing programs in the country with 573,000 participating clinicians who provide care to almost 11 million people with Medicare. Clinicians can come together to form an ACO or join an ACO in their area during the annual application cycle that begins in May. To learn about how to form or join an ACO, please visit the Shared Savings Program website. CMS is promoting ACO participation among health care providers in rural and underserved areas through new Advance Investment Payments which provide upfront funding to ACOs for increased staffing and infrastructure and providing accountable care to underserved populations.

Beginning January 1, 2024, ACOs have a new method to report quality measures to MIPS using Medicare Clinical Quality Measures for Shared Saving Program ACOs. When an ACO satisfactorily

reports the MIPS quality performance category to meet the Shared Savings Program's quality performance standard, clinicians in the ACO that participate in MIPS can receive the ACO's quality score and credit for MIPS improvement activities. CMS also finalized revisions, effective January 1, 2025, to the methodology it uses to assign beneficiaries to ACOs. The revised methodology provides greater recognition of primary care services furnished by nurse practitioners, physician assistants, and clinical nurse specialists in the assignment process and is expected to increase the number of beneficiaries assigned to ACOs. CMS also made changes to the benchmark methodology used to determine shared savings to encourage participation by ACOs caring for medically complex and high-cost beneficiaries.

Opioid Overdose:

Safe Prescribing Practices

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

- If you are contacted by a Medicare prescription drug plan or pharmacy about the opioid use of one of your patients, please respond in a timely manner with your feedback and expertise to help ensure the safe use of these products and avoid disruption of medically necessary therapy.
- Consider co-prescribing naloxone when prescribing opioids to your patients, in accordance with guidelines and applicable laws; and
- Check your state's Prescription Drug Monitoring Program (PDMP) before prescribing controlled substances.

CMS has implemented several policies to assist Medicare prescription drug plans in identifying and managing potential prescription drug abuse or misuse involving Medicare beneficiaries. These interventions often address situations when a patient may attempt to obtain prescription opioids from multiple prescribers and/or pharmacies, who may be unaware that others are prescribing or dispensing for the same patient.

These policies are not prescribing limits. CMS understands that clinician decisions regarding opioid prescribing—including dosing, tapering, or discontinuation of prescription opioids—are carefully individualized for each patient.

If your patient taking opioids is in a Medicare Part D drug management program (DMP), the plan may offer tools to help manage the patient. These tools may include limiting the patient's opioid coverage to prescriptions written by a specific prescriber and/or dispensed by a specific pharmacy that the patient generally chooses. In addition, the plan may limit the patient's opioid coverage to specific medications or amounts you state are medically necessary.

Medicare drug plans may also send opioid safety alerts for certain patients at the time of prescription dispensing that prompt pharmacists to conduct additional review. Pharmacists may need to consult with the prescriber to ensure that a prescription is appropriate before it can be filled. If the pharmacy cannot

fill the prescription as written, you may contact the plan and ask for a "coverage determination" on the patient's behalf. The plan will notify you of its decision within the required adjudication timeframes. You can also request an expedited or standard coverage determination in advance of prescribing an opioid; you only need to attest to the Medicare prescription drug plan that the cumulative level or days' supply is the intended and medically necessary amount for your patient.

The DMP and safety alerts generally do not apply to residents of long-term care facilities, patients receiving hospice care, patients receiving palliative or end-of-life care, patients with sickle cell disease, and patients being treated for active cancer-related pain. These policies should also not affect patients' access to medication-assisted treatment (MAT) or medications for opioid use disorder (MOUDs), such as buprenorphine.

Access to Medications for Opioid Use Disorder (OUD)

As another critical strategy for reducing opioid overdose, CMS encourages prescribers to consider whether patients with OUD may benefit from MOUDs, such as buprenorphine, which are covered under Medicare Part B and Part D.

A recent Office of Inspector General (OIG) report found that only 18 percent of Medicare enrollees with OUD receive medication to treat their condition. However, the repeal of the Drug Addiction Treatment Act (DATA) waiver in 2022 means that prescribers are no longer required to separately register to prescribe this medication and are not limited to treating a small number of patients. This creates an opportunity for prescribers to increase the number of Medicare enrollees receiving buprenorphine to treat their OUD.

Prescribers who are considering initiating buprenorphine treatment for their patients who are Medicare enrollees should be aware of the low risk of misuse and diversion in this population. An OIG report found that 97 percent of Part D enrollees in 2021 received no more than the recommended amount of buprenorphine.

Prescribers should also strongly consider utilizing buprenorphine combination products, such as buprenorphine-naloxone, rather than monoproducts, to further minimize the risk of misuse and diversion. Combination products are widely used in Part D, and there are generic products available with relatively low copays.

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

Electronic Prescribing in Part D:

Electronic prescribing (e-prescribing) has many benefits compared to paper-based prescriptions and processes, such as enhanced patient safety, reduced errors, workflow efficiencies, fraud deterrence, and reduced burden to patients and providers. CMS adopted e-prescribing standards and requirements to improve electronic communication between Part D sponsors and prescribers and reduce pharmacy rejections and coverage denials for Medicare beneficiaries. CMS' adopted standards and requirements

apply to Part D sponsors, prescribers, and dispensers transmitting prescriptions and related information electronically, including electronic prior authorization (ePA), for Part D drugs prescribed to Part D-eligible individuals.

If you prescribe Schedule II, III, IV, and V controlled substances that are Part D drugs, you are required to prescribe at least 70 percent of these prescriptions electronically, except in cases where an exception or an approved waiver applies. More information about the CMS Electronic Prescribing for Controlled Substances (EPCS) Program requirements and exceptions is available here.

There is no requirement for prescribers to electronically prescribe non-controlled substances or use ePA for Part D prescriptions; however, CMS encourages you to do so, if functionality is available in your electronic prescribing system or electronic health record. When prescribing or prior authorization for Part D drugs is conducted electronically, the transactions must utilize the standards required by CMS. The ePA transactions that are part of the ePA standard adopted by CMS allow prescribers to submit information supporting a Part D sponsor's prior authorization requirements for a product within the electronic prescribing workflow, which may lead to faster coverage determinations.

CMS also encourages you to use electronic real-time benefit tools (RTBTs) if available in your electronic prescribing system or electronic health record. RTBTs provide real-time, patient-specific out-of-pocket costs as though the prescription is being submitted as a claim to the Part D plan at that moment in time. RTBTs also provide information about utilization management restrictions (i.e., prior authorization, step therapy, or quantity limits) and formulary alternatives, if any, for prescribed drugs. You can use RTBTs at the point-of-prescribing to engage in shared decision making when issuing prescriptions for Part D beneficiaries.

More information on e-prescribing standards and requirements is available here.

Cognitive Assessment & Care Plan Services (CPT Code 99483):

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

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

Get details on Medicare coverage and billing requirements at cms.gov/cognitive.

The Medicare Learning Network®:

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