Announcement
About Medicare Participation for Calendar Year 2021

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 put patients first. To do this, we must empower patients to work with their clinicians and make health care decisions that are best for them. This means giving them meaningful information about quality and costs to be active health care consumers. 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. But we can't do all of this without your involvement. Please visit www.cms.gov to learn more about our efforts to strengthen the Medicare program.

To ensure broad access to the coronavirus disease 2019 (COVID-19) vaccine, Medicare will cover 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 prepare to swiftly administer the vaccine once it is available.

IMPORTANT INFORMATION REGARDING THE 2021 MEDICARE PHYSICIAN FEE SCHEDULE

In the CY 2020 PFS final rule, we finalized significant changes in valuation and coding for the office/outpatient Evaluation and Management (E/M) visits beginning in CY 2021. Specifically, the changes in valuation will increase payment rates for the office/outpatient E/M visits, reflecting that these services are generally more complex and require additional resources for most clinicians. The changes in coding are consistent with the Agency's goals to reduce documentation burden and will allow clinicians to choose the office/outpatient E/M visit level based on either medical decision making or time.

By law, CMS must adjust the valuation of other PFS services so that the forthcoming E/M changes are implemented in a budget neutral manner. Physicians should consult the 2021 PFS final rule to better understand the impacts on their specialties.

BURDEN REDUCTION EFFORTS

Eliminating Unnecessary Regulations and Focusing on Patients over Paperwork

CMS solicited feedback on how providers and patients were impacted by CMS regulations. CMS heard from providers that not only were regulations failing to increase the quality of care or improve health outcomes, but many of these regulations were also duplicative and at times contradictory.

- Based on this stakeholder feedback, in 2019, CMS finalized the Omnibus Conditions of Participation Final Rule to eliminate outdated and burdensome regulations across hospitals, surgery centers, hospices, transplant programs, home health agencies, Religious Nonmedical Health Care Institutions, psychiatric hospitals, community mental health center, rural health centers, and federally qualified health centers. In total, the revised rules **saved providers an estimated 4.4 million hours of time previously spent on paperwork and $800 million annually**.
- To reduce burden and direct clinician focus on patient care, CMS launched the Patients over Paperwork initiative. CMS burden reduction efforts under this initiative, including streamlining conditions of participation and modernizing quality measurement, are estimated to save the medical community $6.6 billion and 42 million burden hours in administrative burden through 2021, with additional savings expected as additional burden reduction measures are finalized.

- The Interoperability and Patient Access final rule (CMS-9115-F) puts patients first by giving them access to their health information when they need it most and in a way they can best use it. This final rule is focused on driving interoperability and patient access to health information by liberating patient data using CMS authority to regulate Medicare Advantage (MA), Medicaid, CHIP, and Qualified Health Plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs). CMS announced that it will exercise enforcement discretion for a period of six months in connection with these two API provisions. Therefore, as a result of COVID-19, and to provide additional flexibility to payers, CMS will not enforce the API requirements until July 1, 2021.

BECOMING A PARTICIPATING MEDICARE PROVIDER

All physicians, non-physician practitioners and other suppliers – regardless of their Medicare participation status – must make their calendar year (CY) 2021 Medicare participation decision by December 31, 2020. 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.

If you participate in Medicare and bill for services paid under the Medicare physician fee schedule, your Medicare physician fee schedule amounts are five percent higher than if you do not participate in Medicare. Your Medicare Administrative Contractor (MAC) publishes an electronic directory of participating physicians, non-physician practitioners and other suppliers.

WHAT TO DO

If you choose to participate in Medicare in CY 2021:

- Do nothing if you are currently participating, or
- If you are not currently participating, complete the agreement and mail it (or a copy) to each MAC to which you will 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 2021:

- Do nothing if you are currently not participating, or
- If you are currently participating in Medicare, write to each MAC to which you submit Part B claims, advising them of the termination of your participation in the Medicare program effective January 1, 2021. This written notice must be postmarked prior to December 31, 2020.

Please call Palmetto GBA at 877-567-7271 for Jurisdiction or 855-696-0705 for Jurisdiction M 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).

OPTING OUT OF MEDICARE

The Medicare Program offers a number of benefits to physicians, non-physician practitioners and other suppliers, 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 engage with the Medicare program may opt out of Medicare. Opting out of Medicare allows the provider to directly negotiate with Medicare beneficiaries regarding payment for their health care services. While Medicare would

not pay for services provided by an "opt-out" physician or practitioner except for urgent or emergency medical care, 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. Opt-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 opt-out providers for emergency or urgent care services rendered to beneficiaries without a private contract. 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.

YOUR FLU AND COVID-19 VACCINE RECOMMENDATIONS ARE CRITICAL:

As a health care professional, your strong recommendation is a critical factor in whether your patients get a flu and COVID-19 vaccine. Research indicates that most adults are likely to get their flu vaccine if their doctor or health care professional recommends it to them. Most adults believe vaccines are important, but they need a reminder from you to get vaccinated. CMS has developed this toolkit to help you stay informed.

CMS released a set of toolkits for providers, states and insurers to help the health care system prepare to swiftly administer the COVID-19 vaccine once it is available. The toolkits include information to describe how heatlh care providers can enroll in Medicare to bill for administering COVID-19 vaccines when available, the COVID-19 Vaccine Medicare coding structure, the Medicare reimbursement strategy for COVID-19 vaccine administration, and how health care providers can bill correctly for administering vaccines, including roster and centralized billing.

QUALITY PAYMENT PROGRAM UPDATES FOR 2021: A FOCUS ON REDUCING BURDEN TO ENSURE PATIENTS GET THE CARE THEY NEED:

Updates to the Quality Payment Program for 2021 focus on ensuring your patients get the care they need—which is our number one priority at CMS as we confront the COVID-19 pandemic.

We're committed to reducing the administrative burden related to participation in the Merit-based Incentive Payment System (MIPS), so you can focus on patient care during the COVID-19 public health emergency.

To that end, we're making the following changes for next year, as outlined in the CY2021 Physician Fee Schedule (PFS) Final Rule:

- **MIPS Value Pathways (MVPs) will be implemented in 2022**, instead of 2021 as originally planned.

- **The 2021 performance threshold will be 60 points**, not 50 points as we previously proposed. At 60 points, the threshold is 15 points higher than the 2020 performance period threshold.

- **Third parties like Qualified Registries and Qualified Clinical Data Registries are subject to new guidance** related to remedial action, termination, and reapproval of participation. The intent is to reduce reporting burdens by improving the services clinicians receive from third parties.

- **The complex patient bonus increased from a 5- to 10-point maximum** for clinicians, groups, virtual groups, and Alternative Payment Model (APM) Entities for the ***2020 performance period only*.** We made this change to offset the additional difficulty of treating complex patients during the COVID-19 public health emergency.

- **APM Entities, such as ACOs, can use the Extreme and Uncontrollable Circumstances Reweighting Application to request reweighting of all MIPS performance categories,** starting with the 2020 performance period. If the request is approved, the APM Entity group would receive a score equal to the performance threshold, even if data are submitted. This new policy applies to APM Entities only, while a previously established policy applies to individuals, groups, or virtual groups.

Other key changes to the Quality Payment Program for the 2021 performance period are:

- **Delaying the sunset of the CMS Web Interface until 2022.** The CMS Web Interface will continue be an optional, alternative collection type for the 2021 performance period only. Starting with the 2022 performance period, the CMS Web Interface for groups and virtual groups will no longer be available for collecting and submitting data for reporting MIPS Quality measures. We believe that the transition to alternate mechanisms for reporting will reduce burden for groups and virtual groups.

- **Discontinuing the Alternative Payment Model (APM) Scoring Standard**. MIPS eligible clinicians will have the option to participate in MIPS under their APM Entity. APM Entities will be able to report to MIPS on behalf of their clinicians, and a new optional pathway is established, called the Alternative Payment Model Performance Pathway (see below), which would be available to participants in MIPS APMS.

- **Introducing the Alternative Payment Model Performance Pathway (APP).** Developed in response to clinician feedback, the APP is:

- Complementary to MVPs, with a fixed set of six specific measures in the Quality performance category. The Cost performance category is reweighted to 0% because APMs already hold MIPS APM participants responsible for cost containment
- Available only for MIPS eligible participants in MIPS APMs
- Reported by MIPS eligible individual clinicians, groups, or APM Entities who are participants in MIPS APMs
- Required for Medicare Shared Savings Program reporting on Quality measures
- The CMS Web Interface will be an optional, alternative collection type for a sub-set of quality measures in the APP for ACOs during the 2021 performance period only.

MIPS Performance Categories: Key Updates

The following are highlights of updates to MIPS performance categories for the 2021 performance period.

- **Quality.** The Quality performance category weighting toward participants' final score will be 40%, down from 45% in the 2020 performance period. We have also determined that we have sufficient data for the 2019 performance period to calculate historical benchmarks for the 2021 performance period, although we previously proposed using performance period, not historical, benchmarks to score Quality measures for the 2021 performance period due to PHE concerns.

- **Cost.** The Cost performance category weighting toward participants' final score will be 20%, up from 15% in the 2020 performance period. We've updated existing measure specifications to include telehealth services that are directly applicable to existing episode-based cost measures and the total per capita cost (TPCC) measure.

- **Improvement Activities.** We have established new policies for the Annual Call for Activities, including an exception to the nomination period timeframe during a public health emergency and flexibility for Agency-nominated Improvement Activities.

- **Promoting Interoperability.** We've retained the Query of Prescription Drug Monitoring Program measure as optional and increased its worth from 5 to 10 bonus points. We are also adding an optional new Health Information Exchange (HIE) Bi-Directional Exchange measure worth 40 points.

Advanced Alternative Payment Models (APMs)

Updates for Advanced APMs focus on Qualifying APM Participant (QP) determinations:

- Beginning in the 2021 QP Performance Period, for **calculating QP threshold scores**, Medicare patients who have been prospectively attributed to an APM Entity will not be included as attribution-eligible Medicare patients in the denominator for any APM Entity that is participating in an Advanced APM that does not allow for attribution of Medicare patients that have already been attributed to other APM Entities.

- A **new targeted review process** allows that an eligible clinician or APM Entity may request review of a QP or Partial QP determination if they believe in good faith that, due to a CMS clerical error, an eligible clinician was omitted from a Participation List used for purposes of QP determinations.

Medicare Shared Savings Program

Key changes for the 2021 performance period for Medicare Shared Savings Program Accountable Care Organizations include:

- ACOs are required to report quality data using the new APP that focuses on patient outcomes and reduces the number of measures ACOs are required to actively report. Under the APP, ACOs may choose to continue to report either the 10 measures under the CMS Web Interface or the 3 eCQM/MIPS CQM measures for performance year 2021. In addition, ACOs must field the CAHPS for MIPS survey. Two additional outcome measures will be calculated for each ACO using CMS administrative claims data. Based on the ACO's chosen reporting option, either 6 or 13 measures will be included in the calculation of the ACO's MIPS Quality performance category score. Please note that the CMS Web Interface reporting option will only be available for performance year 2021 reporting and will sunset in 2022.
- The quality standard ACOs must meet in order to share in savings or avoid owing maximum losses will be updated and gradually phased in over three years. For performance year 2021 and 2022, ACOs must achieve a quality performance score that is equivalent to or higher than the 30th percentile across all MIPS Quality performance category scores. ACOs meeting or exceeding the updated quality standard will share in the maximum sharing rate or owe losses based on their quality score or at a fixed percentage based on Track.

Find Out More

To find out more about 2021 program updates, visit the QPP Resource Library.

PRESCRIPTION DRUG ABUSE:

Prescription opioid drug abuse remains a public health emergency. Continued prescriber awareness and engagement are crucial to reversing this trend. To help combat this epidemic, CMS encourages prescribers to:

- 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 therapy;
- If your patient has opioid use disorder (OUD), consider whether they may benefit from medication-assisted treatment (MAT), which is covered under Medicare Parts B and D;
- Consider co-prescribing naloxone when prescribing opioids to your patients;
- Check your state's Prescription Drug Monitoring Program before prescribing controlled substances.

CMS has implemented several policies to assist Medicare prescription drug plans in identifying and managing potential prescription drug abuse or misuse involving Medicare beneficiaries in their plans. These interventions often address situations that involve multiple prescribers and pharmacies who are not aware of each other prescribing for the same patients.

If your patient taking opioids is under review by a Medicare Part D drug management program, the plan may offer you tools to help you manage the patient. These tools include limiting the patient's opioid coverage to prescriptions written by a specific prescriber and/or dispensed by a specific pharmacy that the patient may generally choose. In addition, the plan can limit the patient's opioid coverage to the specific amount you state is medically necessary.

To facilitate safer opioid prescribing, Medicare drug plans also may trigger opioid safety alerts for certain patients at the time of dispensing for pharmacists to conduct additional review, which may require consultation with the prescriber to ensure that a prescription is appropriate before it can be filled. If the pharmacy cannot fill the prescription as written, you may contact the plan and ask for a "coverage determination" on the patient's behalf. You can also request an expedited or standard coverage determination in advance of prescribing an opioid; you only need to attest to the Medicare prescription drug plan that the cumulative level or days' supply is the intended and medically necessary amount for your patient.

The drug management programs and safety alerts generally do not apply to residents of long-term care facilities, those in hospice care, patients receiving palliative or end-of-life care, and patients being treated for active cancer-related pain. Patients with sickle cell disease should be excluded from safety edits. These policies should also not impact patients' access to MAT, such as buprenorphine.

These policies are not prescribing limits. CMS understands that decisions to prescribe opioids, including the dose, taper, or discontinue prescription opioids are carefully individualized between you and your patients.

Additional information on Medicare Part D's opioid overutilization policies, including "Information for Prescribers" and "A Prescriber's Guide to Part D Opioid Policies," are available here. The CMS webpage also includes information about the dispensing and administration of MAT medications (if applicable) now covered under the new Opioid Treatment Program (OTP) benefit under Medicare Part B here.

REAL TIME BENEFIT TOOLS:

Beginning January 1, 2021, Medicare Part D plans will be required to adopt a prescriber real time benefit tool (RTBT) capable of integrating with at least one prescriber's e-prescribing system or electronic health record (EHR). This RTBT will be required to include the following patient-specific real-time formulary and benefit information: cost, formulary alternatives, and utilization management requirements. While these RTBTs may not be available with respect to all beneficiaries, we encourage prescribers to use these RTBTs, when available, to support their decisions about which medications to prescribe.

More information about e-prescribing and RTBTs is available here.

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. Please subscribe at https://www.palmettogba.com/listserv for Palmetto GBA's electronic mailing list to get information on program and policy news.