CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10511	**Date: December 9, 2020**
	Change Request 12005

Transmittal 10385, dated October 9, 2020, is being rescinded and replaced by Transmittal 10511, dated, December 9, 2020 to add the Dear Doc Letter as an attachment. This Transmittal is no longer sensitive. This instruction may now be posted to the Internet. All other information remains the same.

SUBJECT: Calendar Year (CY) 2021 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 2021 participation enrollment. The attached Recurring Update Notification applies to Chapter 1, Section 30.3.12.

EFFECTIVE DATE: October 9, 2020 - Upon Issuance
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 9, 2020 - 30 days following the close of the annual participation enrollment process for BR 12005.18, 12005.19, 12005.20; November 16, 2020 for BRs 12005.2, 12005.3, 12005.4, 12005.5, 12005.11, 12005.13, 12005.14; November 9, 2020 for all other requirements

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 10511	Date: December 9, 2020	Change Request: 12005

Transmittal 10385, dated October 9, 2020, is being rescinded and replaced by Transmittal 10511, dated, December 9, 2020 to add the Dear Doc Letter as an attachment. This Transmittal is no longer sensitive. This instruction may now be posted to the Internet. All other information remains the same.

SUBJECT: Calendar Year (CY) 2021 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures

EFFECTIVE DATE: October 9, 2020 - Upon Issuance
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 9, 2020 - 30 days following the close of the annual participation enrollment process for BR 12005.18, 12005.19, 12005.20; November 16, 2020 for BRs 12005.2, 12005.3, 12005.4, 12005.5, 12005.11, 12005.13, 12005.14; November 9, 2020 for all other requirements

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 Participating (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 websites.

B. Policy: The annual participation enrollment program for CY 2021 will commence on November 14, 2020, and will run through December 31, 2020.

The purpose of this recurring update notification is to furnish contractors with information needed for the CY 2021 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 website 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 website:

"We encourage you to visit the Medicare Learning Network® (MLN) (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html) the place for official CMS Medicare Fee-For-Service provider educational information. There you can find one of our most popular products, MLN Matters national provider education articles. These articles help you understand new or changed Medicare policy and how those changes affect you. A full array of other educational products (including

Web-based training courses, hard copy and downloadable publications, and CD-ROMs) are also available and can be accessed at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/index.html. You can also find other important websites by visiting the Physician Center webpage at: http://www.cms.gov/Center/Provider-Type/Physician-Center.html, and the All Fee-For-Service Providers webpage at https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html.

In addition to educational products, the MLN also offers providers and suppliers opportunities to learn more about the Medicare program through MLN National Provider Calls. These national conference calls, held by CMS for the Medicare Fee-For-Service provider and supplier community, educate and inform participants about new policies and/or changes to the Medicare program. Offered free of charge, continuing education credits may be awarded for participation in certain National Provider Calls. To learn more about MLN National Provider Calls including upcoming calls, registration information, and links to previous call materials, visit https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events."

In CR 7412 (Postcard Mailing for the Annual Participation Open Enrollment Period), CMS directed contractors to mail a postcard instead of a Compact Disc (CD). The postcards should be mailed in time for physicians, practitioners, and suppliers to receive the participation enrollment material by November 14, but should not be mailed before November 8.

The CMS will send all contractors an e-mail notice when the January 2021 Medicare Physician Fee Schedule Database (MPFSDB) files (including anesthesia) are available for downloading, along with the file names, through an email notification via the Functional Workgroups as soon as the 2021 final rule goes on display (around November 1).

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

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12005.1	Contractors shall mail postcards announcing the annual open participation enrollment by November 14, 2020, but not before November 8, 2020. See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1 B1.		X							
12005.2	Contractors shall display the fee data prominently on their website. For CY 2021 disclosure reports, contractors shall use the following format for displaying fees on the Web and/or hardcopy:		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	• 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); • Non-par amount (facility-based); • Limiting charge (facility-based)									
12005.3	Contractors shall provide a link to the 2021 Medicare Fee Schedule on their website. **NOTE:** Disclosure materials may not be posted on your Web site until you receive an email notification from CMS via the Functional Workgroups that the MPFSDB files (including anesthesia) are available for downloading, along with the file names, as soon as the 2021 final rule goes on display (around November 1).		X							
12005.4	For CY 2021 disclosure reports, contractors shall provide the anesthesia conversion factors on their website.		X							
12005.5	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							
12005.6	Contractors shall post the following language on your website: *"We encourage you to visit the Medicare Learning Network® (MLN) (http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html) the place for official CMS Medicare Fee-For-Service provider educational information. There you can find one of our most popular products, MLN Matters national provider education articles. These articles help you understand new or changed Medicare policy and how those changes affect you. A full array of other educational products (including Web-based training courses, hard copy and downloadable publications, and CD-ROMs) are also available and can be accessed at: http://www.cms.gov/Outreach-and-*		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Education/Medicare-Learning-Network-MLN/MLNProducts/index.html. You can also find other important websites by visiting the Physician Center webpage at: http://www.cms.gov/Center/Provider-Type/Physician-Center.html, and the All Fee-For-Service Providers Web page at https://www.cms.gov/Center/Provider-Type/All-Fee-For-Service-Providers-Center.html . *In addition to educational products, the MLN also offers providers and suppliers opportunities to learn more about the Medicare program through MLN National Provider Calls. These national conference calls, held by CMS for the Medicare Fee-For-Service provider and supplier community, educate and inform participants about new policies and/or changes to the Medicare program. Offered free of charge, continuing education credits may be awarded for participation in certain National Provider Calls. To learn more about MLN National Provider Calls including upcoming calls, registration information, and links to previous call materials, visit https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events."*									
12005.7	Effective immediately, contractors shall educate providers via their website and whatever other provider outreach that can be utilized that the fees will be placed on the contractor website after the CY 2021 physician fee schedule regulation is put on display.		X							
12005.8	Contractors shall prominently display the announcement and participation agreement on the website.		X							
12005.9	Contractors shall insert their website address for providers to use to access the CY 2021 payment rates in the space available at the end of the Participation Announcement sheet.		X							
12005.10	Contractors shall insert their contractor-specific information (i.e., toll-free telephone numbers, etc.) as indicated at the end of the Participation Announcement sheet.		X							
12005.11	Contractors shall inform providers via their listserv when the CY 2021 fees are posted to their website**.**		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12005.12	Contractors shall **NOT** produce hard copy disclosures until January 1, 2021 unless otherwise notified by CMS. **NOTE**: Contractors have the discretion to produce no more than 2 percent hardcopy if needed.		X							
12005.12.1	Contractors shall keep track of any requests for hard copy paper disclosures.		X							
12005.12.2	Contractors shall not charge providers requesting hard copy disclosures who do not have Internet access.		X							
12005.12.3	Contractors shall mail the hard copy disclosures via first class or equivalent delivery service.		X							
12005.13	The Medicare Physician Fee Schedule Database (MPFSDB) will contain the CY 2021 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 shall be included on the fee disclosure reports: "All Current Procedural Terminology (CPT) codes and descriptors are copyrighted 2020 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.) See the Internet Only Manual (IOM) Pub. 100-04, Chapter 1, section 30.3.12.1.		X							
12005.14	If contractors choose to use code descriptors on their Web site, they shall use the short descriptors contained in the Healthcare Common Procedure Coding System (HCPCS) file and the MPFSDB. If contractors find		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	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 websites, CD-ROMs, bulletin boards, and other electronic communications (refer to the IOM Publication 100-04, Chapter 23, section 20.7).									
12005.15	Contractors shall process participation elections and withdraws post-marked before January 1, 2021.		X							
12005.16	Contractors shall not print hardcopy participation directories (i.e., MEDPARDs) for CY 2021 without regional office prior authorization and advanced approved funding for this purpose.		X							
12005.17	If contractors receive inquiries from a customer who does not have access to the contractor website, they shall ascertain the nature and scope of each request and furnish the desired MEDPARD participation information via phone or letter.		X							
12005.18	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							
12005.19	Contractors shall notify providers via regularly scheduled newsletters as to the availability of the MEDPARD information and how to access it electronically.		X							
12005.20	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 website.		X							
12005.21	Contractors shall make sure that the Form CMS-460 is readily available on their web sites in order for their providers to complete needed information and download for their use.		X							
12005.21.	Contractors shall allow providers to enter all required		X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
1	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.									
12005.22	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							
12005.23	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							
12005.24	Contractors shall refer to the IOM Pub. 100-04, Chapter 1, section 30.3.12.1 for more information about the postcard mailing and website.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Mark Baldwin, 410-786-8139 or Mark.baldwin@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 2

Announcement
About Medicare Participation for Calendar Year 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 [MACs insert phone number] if you have any questions or need further information on participation.

The Medicare Learning Network® (MLN) offers many products on how providers and suppliers can enroll in the Medicare Program. These products include specific information for physicians and other Part B suppliers; ordering/referring providers; institutional providers; and Durable Medical Equipment, Prosthetics, Orthotics and Supplies suppliers, as well as information on the electronic Medicare enrollment system, Provider Enrollment, Chain and Ownership System (PECOS).

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 [MAC insert link] to our electronic mailing list to get information on program and policy news.

FORM APPROVED
OMB NO. 0938-0373
EXPIRES 10/31/2022

MEDICARE PARTICIPATING PHYSICIAN OR SUPPLIER AGREEMENT

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

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

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. **Meaning of Assignment:** For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the MAC/carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.
2. **Effective Date:** If the participant files the agreement with any MAC/carrier during the enrollment period, the agreement becomes effective _____.
3. **Term and Termination of Agreement:** This agreement shall continue in effect through December 31 following the date the agreement becomes effective and shall be renewed automatically for each 12-month period January 1 through December 31 thereafter unless one of the following occurs:
    a. During the enrollment period provided near the end of any calendar year, the participant notifies in writing every MAC/carrier with whom the participant has filed the agreement or a copy of the agreement that the participant wishes to terminate the agreement at the end of the current term. In the event such notification is mailed or delivered during the enrollment period provided near the end of any calendar year, the agreement shall end on December 31 of that year.
    b. The Centers for Medicare & Medicaid Services may find, after notice to and opportunity for a hearing for the participant, that the participant has substantially failed to comply with the agreement. In the event such a finding is made, the Centers for Medicare & Medicaid Services will notify the participant in writing that the agreement will be terminated at a time designated in the notice. Civil and criminal penalties may also be imposed for violation of the agreement.

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

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

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

WHY PARTICIPATE?

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

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

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

DO YOU WANT TO OPT OUT OF MEDICARE?

Certain physicians and practitioners who do not want to engage with the Medicare program when treating Medicare beneficiaries may choose to "opt out" of Medicare. While Medicare does not pay for covered items or services provided by an "opt-out" physician or practitioner, beneficiaries and opt-out physicians or practitioners have the flexibility to set mutually acceptable payment terms through a negotiated private contract. Medicare will still pay opt-out physicians or practitioners for emergency or urgent care services rendered to beneficiaries with whom they have not privately contracted. The opt-out decision applies to all items and services provided by the physician or practitioner to any Medicare beneficiary for the entire opt-out period. A physician or practitioner who chooses to opt-out must do so for a two-year period, which automatically renews for successive two-year periods unless the physician or practitioner affirmatively requests that his or her opt-out status not be renewed. Opt-out physicians and practitioners can offer and enter into arrangements with beneficiaries that would otherwise be prohibited under Medicare. Opt-out physicians and practitioners also need not consider certain Medicare requirements, such as deciding on a case-by-case basis whether to provide an advance beneficiary notice of Medicare non-coverage for services in compliance with Medicare rules and guidance. More information can be found by visiting *Opt-Out Affidavits*
WARNING: YOU CANNOT USE THIS FORM TO OPT OUT!

WHEN THE DECISION TO PARTICIPATE CAN BE MADE:

- Toward the end of each calendar year, all MAC/carriers have an open enrollment period. The open enrollment period generally is from mid-November through December 31. During this period, providers who are currently enrolled in the Medicare Program can change their current participation status beginning the next calendar year on January 1. This is the only time these providers are given the opportunity to change their participation status. These providers should contact their MAC/carrier to learn where to send the agreement, and get the exact dates for the open enrollment period when the agreement will be accepted.

- New physicians, practitioners, and suppliers can sign the participation agreement and become a Medicare participant at the time of their enrollment into the Medicare Program. The participation agreement will become effective on the date of filing; i.e., the date the participant mails (post-mark date) the agreement to the carrier or delivers it to the carrier.

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

WHAT TO DO DURING OPEN ENROLLMENT:

If you choose to be a participant:

- Do nothing if you are currently participating, or
- If you are not currently a Medicare participant, complete the blank agreement (CMS-460) and mail it (or a copy) to each carrier to which you submit Part B claims. (On the form show the name(s) and identification number(s) under which you bill.)

If you decide not to participate:

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

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

If you choose to be a participant:

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

If you decide not to participate:

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

We hope you will decide to be a Medicare participant.

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

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

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