



## **Announcement**

### **About Medicare Participation for Calendar Year 2023**

As you plan for 2023 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 2022 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](http://www.cms.gov) to learn more about our efforts to strengthen the Medicare program.

To ensure broad access to COVID-19 vaccines, Medicare covers 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 the vaccines.

#### **Why Become A Participating Medicare Provider:**

All physicians, practitioners and suppliers – regardless of their Medicare participation status – must make their calendar year (CY) 2023 Medicare participation decision by December 31, 2022. 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. To sign a participation agreement is to agree to accept assignment for all covered services that you provide to Medicare patients in CY 2023. The overwhelming majority of physicians, practitioners and suppliers choose to participate in Medicare each year. During CY 2022, 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:**

**Do you want to participate in Medicare for the 2023 calendar year?**

**If you're already participating in Medicare,** you don't need to do anything.

**If you want to participate in Medicare next year, and you're not currently participating,** complete the [Medicare Participating Physician or Supplier Agreement \(CMS-460\)](#) and mail a copy to [each MAC](#) that you'll send Part B claims to.

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, 2023. This written notice must be postmarked before December 31, 2022.

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

More Information:

- Review our [provider enrollment resources](#), and learn about the electronic Medicare enrollment system, the Provider Enrollment Chain and Ownership System (PECOS)
- Find your [MAC's website](#) for questions about participating.

### **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](#).

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

As a health care provider, please recommend and 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 vaccines if their provider recommends it.

More Information:

- Flu: visit [cms.gov/flu-provider](https://www.cms.gov/flu-provider)
- COVID-19: visit [cms.gov/covidvax-provider](https://www.cms.gov/covidvax-provider)

## **Quality Payment Program 2023 Updates:**

Updates to the Quality Payment Program (QPP) for 2023 focus on our commitment to promoting more meaningful participation for clinicians and ensuring our policies continue to drive us toward value and improved health outcomes for patients.

### **Get All the Details**

To learn about all the 2023 program updates, view the Final Rule resources on the [QPP Resource Library](#).

### **Policy Highlights**

#### **Traditional Merit-based Incentive Payment System (MIPS)**

We're implementing limited changes in traditional MIPS to provide clinicians continuity and consistency while they gain familiarity with MIPS Value Pathways (MVPs). Please note we're continuing to use the mean final score from the 2017 performance year/2019 payment year to establish the performance threshold for the 2023 performance year/2025 payment year (the performance threshold would be 75 points).

#### **MVPs**

MVPs provide clinicians with the opportunity for more meaningful participation by reporting a more connected, cohesive set of measures and activities and allowing for comparative feedback that will be more beneficial to patients. We're:

- Introducing the following 5 new MVPs:
  1. Advancing Cancer Care
  2. Optimal Care For Kidney Health
  3. Optimal Care For Patients With Episodic Neurological Conditions
  4. Supportive Care For Neurodegenerative Conditions
  5. Promoting Wellness
- Revising 7 previously established MVPs for reporting.
- Calculating administrative claims measures at the affiliated group Taxpayer Identification Number (TIN) level (of the affiliate group) when reporting as a subgroup.

## Advanced Alternative Payment Models (APMs)

We've also finalized several policies to reduce burden and facilitate participation in APMs.

### Opioid Overdose:

Opioid overdose remains an urgent public health crisis. Continued prescriber awareness and engagement are crucial to reversing this trend. CMS encourages the following 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, where use of such products is medically necessary and appropriate, to avoid disruption of medically necessary 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, in accordance with guidelines and laws; and
- 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. These interventions often address situations when a patient may attempt to obtain prescription opioids from multiple prescribers and/or pharmacies, which 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 under review by a Medicare Part D drug management program, 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 the specific amount your 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 that require 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. 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 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 with sickle cell disease or being treated for active cancer-related pain. These policies should also not affect patients' access to MAT, such as buprenorphine.

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 Prior Authorization:**

Pursuant to a final rule promulgated by CMS in late 2020, Medicare Part D plans are required to support the National Council for Prescription Drug Programs (NCPDP) SCRIPT standard version 2017071 for electronic prior authorization. The new electronic prior authorization transactions are part of the widely-used electronic prescribing (ePrescribing) standard, which allows prescribers to see if a drug is subject to prior authorization while they are prescribing it. These new transactions allow a prescriber to satisfy any prior authorization requirements at the time of prescribing or consider an alternative drug. This regulatory change helps ensure that there are secure electronic transactions between prescribers and Part D plan sponsors, and that patients will not experience delays when picking up their prescriptions.

More information about this requirement is available in the Final Rule available [here](#).

### **Part B Immunosuppressive Drug Benefit:**

Find out about a new Medicare benefit that could help to continue to pay for immunosuppressive drugs beyond 36 months.

If your patient only has Medicare because of ESRD, their Medicare coverage, including immunosuppressive drug coverage, ends 36 months after the month they receive a kidney transplant.

Beginning January 1, 2023, Medicare will offer a new benefit that helps continue to pay for their immunosuppressive drugs beyond 36 months, if they don't have, and don't expect to have, certain other types of health coverage.

To learn more, including how they can sign up, visit the [ESRD](#) webpage.

### **Real-Time Prescription Benefit Tools in Medicare Part D:**

CMS is taking action to improve electronic communication between Part D sponsors and prescribers to reduce avoidable pharmacy rejections and coverage denials for Medicare beneficiaries.

Part D sponsors are required to implement one or more electronic real-time benefit tools (RTBT) that are capable of integrating with at least one electronic prescribing system or electronic health record. These tools provide prescribers with enrollee-specific cost-sharing information, clinically appropriate formulary alternatives, when available, and the formulary status of each drug presented, including any utilization management requirements (i.e., prior authorization, step therapy, or quantity limits) applicable to each alternative drug. CMS encourages prescribers to utilize such tools for Medicare beneficiaries if they are available in their electronic prescribing systems. Using RTBTs at the time of prescribing can enable prescribers to engage in shared decision making with their patients, identify lower-cost alternative formulary medications, and either select formulary medications that do not have utilization management restrictions or know when to proactively address utilization management restrictions, including initiating electronic prior authorization (ePA), if possible. Utilizing RTBTs to select a favorable formulary medication may increase patients' medication adherence by reducing unexpected costs or restrictions.

Starting in 2023, Part D sponsors must also make such tools directly accessible to their enrollees. Patients may contact prescribers as a result of using these beneficiary RTBTs to discuss alternative medications on their Part D plan's formulary that may be less costly or available without utilization management restrictions.

### **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 routine visit, you may perform this more detailed cognitive assessment and develop a care plan
- Any clinician eligible to report 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](https://www.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.

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