Announcement
About Medicare Participation for Calendar Year 2025

CMS pledges to work with you to put patients first. We must empower patients and providers to work together to make health care decisions that are best for patients. We can't do this without your involvement. Visit cms.gov to learn more about our efforts to strengthen the Medicare Program and how you can help.

As you plan for 2025 and learn about changes for the coming year, we wish to remind you of the importance and advantages of being a Medicare-participating provider. We're pleased that we continued to have a 98% participation rate in 2024. We hope that you'll help us continue this positive trend by remaining a Medicare-participating provider. Or, if you're non-participating, consider becoming a participating provider for calendar year (CY) 2025.

Review this announcement to learn about:

- How to become a Medicare-participating provider or continue Medicare participation
- Program changes for CY 2025

Advantages of Being a Medicare-Participating Provider

When you're a Medicare-participating provider:

- You are paid the full Medicare Physician Fee Schedule allowed amount. If you're a non-participating provider, Medicare pays 5% less than the Medicare Physician Fee Schedule allowed amount.
- Medicare pays you directly (on an assignment-related basis).
- Medicare forwards claim information to Medigap (Medicare supplement coverage) insurance (if any).

What to Do:

By December 31, 2024, all physicians, practitioners, and suppliers – regardless of their Medicare participation status – must decide whether to participate for CY 2025.

If you're already participating in Medicare, and you want to continue your participation, you don't need to do anything.

If you're not currently participating, and you want to participate in Medicare next year, complete the Medicare Participating Physician or Supplier Agreement (CMS-460). By signing this agreement, you agree to accept assignment for all covered services that you provide to Medicare patients in CY 2025. 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, 2025. This written notice must be postmarked before December 31, 2024. 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.

Learn more about Medicare provider enrollment, including the electronic Medicare enrollment system, called the Provider Enrollment, Chain, and Ownership System (PECOS).

National Plan and Provider Enumeration System (NPPES) Taxonomy:

Check your data in NPPES, and confirm that it still correctly reflects:

- Your status as a health care provider.
- Your current practice address.
- Your current taxonomy.

We continue to focus on the National Provider Identifier (NPI) as a health care provider identifier to help prevent Medicare fraud, waste, and abuse. Incorrect taxonomy data in NPPES may lead to unnecessary inquiries about your credentials, as it may appear to Medicare oversight authorities that you're not lawfully prescribing Part D drugs. Learn about how the NPI rule applies to prescribers.

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

View the revised CMS-855I in the CMS Forms List or in PECOS.

The form updates include:

- 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 interstate compact licensure.
- 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.

Update for CY 2025: CMS isn't currently revalidating enrollments for individual physicians or practitioners. We'll communicate any changes to the revalidation process at Medicare Enrollment for Providers and Suppliers.

Recommend Flu & COVID-19 Vaccines – Your Help is Critical

Medicare covers FDA-approved or FDA-authorized vaccines as a preventive service at no cost to your patients. Remind your patients to get flu 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. Get more information about Medicare coverage for flu and COVID-19 vaccines.

Quality Payment Program (QPP)

The Quality Payment Program incentivizes clinicians to provide high-value patient-centered care. QPP aims to:

- Improve the quality of care for all individuals
- Reduce the administrative burden on clinicians, allowing more time to focus on person-centered care and improving health outcomes

Updates for CY 2025: Changes to QPP for the CY 2025 performance period include:

- Continuing to streamline and simplify reporting measures and activities by introducing 6 new Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) related to ophthalmology, dermatology, gastroenterology, pulmonology, urology, and surgical care. Learn more about MVPs.
- Creating the Alternative Payment Model (APM) Performance Pathway (APP) Plus measure set that offers certain MIPS eligible clinicians a more robust opportunity for MIPS quality measurement for APMs. The APP Plus measure set includes the 6 measures currently in the APP quality measure set and will incrementally add 5 Adult Universal Foundation quality measures by the 2028 performance period (2030 payment year).
- Maintaining the current performance threshold policies for MIPS, leaving the performance threshold set at 75 points for the CY 2025 performance period (2027 payment year).

- Keeping the 75% data completeness criteria for the quality performance category through the 2028 performance period (2030 payment year).

To learn about all the 2025 Quality Payment Program updates, view the Final Rule resources in the QPP Resource Library.

Medicare Shared Savings Program Accountable Care Organizations (ACOs)

Medicare Shared Savings Program ACOs are groups of doctors, hospitals, and other health care providers who collaborate and provide coordinated, high-quality care to Medicare patients. The Shared Savings Program is Medicare's largest value-based payment program, with more than 608,000 clinicians in participating ACOs providing care to over 10.9 million Medicare beneficiaries.

We want health care providers in rural and underserved areas to participate in ACOs to provide accountable care to underserved populations. We offer Advance Investment Payments to provide upfront funding for increased staffing and infrastructure. To learn more, or if you want to form or join an ACO, visit Shared Savings Program.

Update for CY 2025: Starting January 1, 2025, we're changing the methodology we use to assign Medicare patients to ACOs. The revised methodology:

- Provides greater recognition of nurse practitioner, physician assistance, and clinical nurse specialist-furnished primary care services in the assignment process.
- Should increase the number of Medicare patients assigned to ACOs.

We also made changes to the benchmark methodology to determine shared savings to encourage participation by ACOs caring for medically complex and high-cost Medicare patients.

Opioids: Safe Prescribing Practices

Opioid overdose remains an urgent public health crisis. Awareness and engagement are crucial to reversing this trend. Use these safe prescribing practices:

- If you're contacted by a Medicare prescription drug plan or pharmacy about the opioid use of one of your patients, respond in a timely manner with your feedback and expertise. This will 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.
- Check your state's Prescription Drug Monitoring Program (PDMP) before prescribing controlled substances.

We implemented several policies to help Medicare prescription drug plans identify and manage potential prescription drug abuse or misuse. These interventions often address situations when a patient may try to get opioids from multiple prescribers or pharmacies who may be unaware that

others are prescribing or dispensing opioids for the same patient. These policies support care coordination rather than establishing prescribing limits. We understand that you carefully make decisions about prescribing opioids —including dosing, tapering, or discontinuation of prescription opioids—for each patient.

If your patient takes opioids and is in a Medicare Part D drug management program (DMP), the plan may offer tools to help manage the patient, like limiting the patient's opioid coverage to prescriptions written by you or dispensed by a specific pharmacy. The plan may also limit the patient's opioid coverage to specific medications or amounts you state are medically necessary.

Medicare prescription drug plans may send opioid safety alerts for some patients during 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 they can fill it. If the pharmacy can't 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 before you prescribe an opioid. You may only need to attest to the Medicare prescription drug plan that the cumulative level or days' supply is the intentional and medically necessary amount for your patient.

DMPs and safety alerts don't usually apply to residents of long-term care facilities, hospice patients, patients getting palliative or end-of-life care, patients with sickle cell disease, or patients being treated for cancer-related pain. These policies also shouldn't affect patients' access to medications for opioid use disorder (MOUDs).

MOUDs

We encourage prescribers to consider whether patients with opioid use disorder (OUD) may benefit from MOUDs, like buprenorphine, which are covered under Medicare Part B and Part D.

The repeal of the Drug Addiction Treatment Act (DATA) waiver on December 29, 2022, means that prescribers are no longer required to separately register to prescribe this medication and aren't limited to treating a small number of patients. This creates an opportunity for prescribers to increase the percentage of Medicare enrollees getting buprenorphine to treat their OUD, which is only about 18%). When considering initiating buprenorphine treatment for a Medicare patient:

- Be aware of the low risk of misuse and diversion in this population.
- Think about utilizing buprenorphine combination products, like buprenorphine-naloxone (rather than buprenorphine-only products). This further minimizes the risk of misuse and diversion. Combination products are widely covered in Medicare Part D and there are generic products available with relatively low copayments.

For more information:

- Visit Improving Drug Utilization Review Controls in Part D for more information on the Medicare Part D opioid overutilization policies.

- Visit Opioid Treatment Programs for information on the Medicare Part B Opioid Treatment Program (OTP).

Part D E-Prescribing

Electronic prescribing (e-prescribing) has many benefits, like enhanced patient safety, reduced errors, workflow efficiencies, fraud deterrence, and reduced burden to patients and providers. We 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 Part D enrollees. Our 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 patients.

If you prescribe Schedule II, III, IV, and V controlled substances that are Part D drugs, you're required to prescribe at least 70% of these prescriptions electronically, except in cases where an exception or an approved waiver applies.

Use real-time benefit tools (RTBTs) and ePA, if available, in your electronic prescribing system or electronic health record. RTBTs provide real-time, patient-specific out-of-pocket costs and information about utilization management restrictions (like prior authorization, step therapy, or quantity limits) and formulary alternatives, if any, for prescribed drugs. Use ePA for faster coverage determinations and access to Part D drugs for your patients.

Get more information about CMS Electronic Prescribing for Controlled Substances (EPCS) Program.

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.