Quality Payment
PROGRAM

FINAL RULE WITH COMMENT PERIOD FOR QUALITY PAYMENT PROGRAM YEAR 2 (2018) DEC. 13, 2017

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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

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Resource Library Update

- To make it easier for clinicians to search and find information on the Quality Payment Program, CMS has moved its library of QPP resources to CMS.gov.

- QPP.CMS.GOV redirects to the CMS.GOV Resource Library:

  - CMS.GOV Resource Library: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Resource-library.html

  - Final Rule Materials Posted: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html

Quality Payment Program

Topics

- Quality Payment Program Overview
- Final Rule Year 2 (Performance Year 2018)
  - Merit-based Incentive Payment System (MIPS)
    - Overview
    - Who is Included?
    - Performance Period
    - Reporting and Data Submission Options
    - Performance Categories
    - Performance Threshold and Payment Adjustment
    - Scoring
  - Alternative Payment Models (APMs)
    - Advanced APMs
    - All-Payer Combination Option & Other Payer Advanced APMs
- Resources
- Questions & Answers

QUALITY PAYMENT PROGRAM

Overview

Quality Payment Program

Considerations

Improve beneficiary outcomes

Reduce burden on clinicians

Increase adoption of Advanced APMs

Maximize participation

Improve data and information sharing

Ensure operational excellence in program implementation

Deliver IT systems capabilities that meet the needs of users

Quick Tip: For additional information on the Quality Payment Program, please visit qpp.cms.gov.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS Performance Categories for Year 2 (2018)

- Comprised of **four** performance categories in 2018.
- **So what?** *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

MIPS YEAR 2 (2018)

Who is Included for Year 2?

MIPS Year 2 (2018)

Who is Included?

***No change** in the types of clinicians eligible to participate in 2018*

MIPS eligible clinicians include:

Physicians

Physician Assistants

Nurse Practitioners

Clinical Nurse Specialists

Certified Registered Nurse Anesthetists

MIPS Year 2 (2018)

Who is Included?

***Change** to the Low-Volume Threshold for 2018.* Include MIPS eligible clinicians billing more than $90,000 a year in Medicare Part B allowed charges **AND** providing care for more than 200 Medicare patients a year.

Voluntary reporting remains an option for those clinicians who are exempt from MIPS.

MIPS Year 2 (2018)

Who is Exempt?

No Change in Basic Exemption Criteria*

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to **$90,000** a year

OR

- See **200** or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

- Receive 25% of their Medicare payments

OR

- See 20% of their Medicare patients through an Advanced APM

**Only Change to Low-volume Threshold*

MIPS Year 2 (2018)

Non-patient Facing

***No Change** in Non-Patient Facing Criteria*

Transition Year 1 (2017) Final

- Individual – If you have ≤100 patient facing encounters.
- Groups – If your group has >75% of NPIs billing under your group's TIN during a performance period are labeled as non-patient facing.

Year 2 (2018) Final

- **No Change to Individual and Group policy.**
- **NEW - Virtual Groups** are included in the definition.
  - Virtual Groups that have >75% of NPIs within a virtual group during a performance period are labeled as non-patient facing

MIPS Year 2 (2018)

Other Special Statuses

Special Status	Component	Year 2 (2018) Final	Application
Small Practice	Definition	• Practices consisting of 15 or fewer eligible clinicians.	• **No change** to the application of these special statuses from Year 1 to Year 2.
Rural and Health Professional Shortage Areas	Rural and HPSA practice designations	• An individual MIPS eligible clinician, a group, or a virtual group with multiple practices under its TIN (or TINs within a virtual group) with **more than 75 percent** of NPIs billing under the individual MIPS eligible clinician or group's TIN or within a virtual group in a ZIP code designated as a rural area or HPSA.	

MIPS YEAR 2 (2018)

Performance Period

MIPS Year 2 (2018)

Performance Period

Change: *Increase to Performance Period*

Transition Year 1 (2017) Final

Performance Category	Minimum Performance Period
Quality	90-days minimum; full year (12 months) was an option
Cost	Not included. 12-months for feedback only.
Improvement Activities	90-days
Advancing Care Information	90-days

Year 2 (2018) Final

Performance Category	Minimum Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Advancing Care Information	90-days

MIPS Year 2 (2018)

Timeline for Year 2

2018
Performance Year

- Performance period opens January 1, 2018.
- Closes December 31, 2018.
- Clinicians care for patients and record data during the year.

March 31, 2019
Data Submission

- Deadline for submitting data is March 31, 2019.
- Clinicians are encouraged to submit data early.

Feedback

- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

January 1, 2020
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2020.

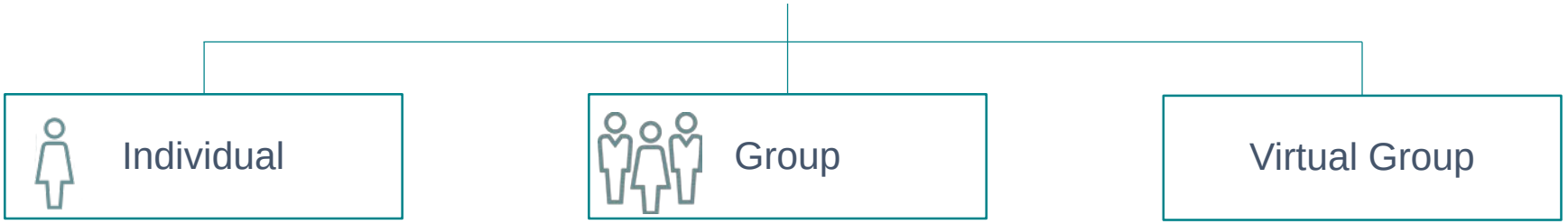
MIPS YEAR 2 (2018)

Reporting and Data Submission Options

MIPS Year 2 (2018)

Reporting Options

OPTIONS



1. Individual—under an National Provider Identifier (NPI) number and Taxpayer Identification Number (TIN) where they reassign benefits

2. As a Group

a) 2 or more clinicians (NPIs) who have reassigned their billing rights to a single TIN*

b) As an APM Entity

3. As a Virtual Group – made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year

* If clinicians participate as a group, they are assessed as a group across all 4 MIPS performance categories. The same is true for clinicians participating as a Virtual Group.

MIPS Year 2 (2018)

Virtual Groups

New: Virtual Groups

What is a virtual group?

- A virtual group can be made up of solo practitioners and groups of 10 or fewer eligible clinicians who come together “virtually” (no matter what specialty or location) to participate in MIPS for a performance period for a year.

- To be eligible to join or form a virtual group, you would need to be a:
  - **Solo practitioners** who exceed the low-volume threshold individually, and are not a newly Medicare-enrolled eligible clinician, a Qualifying APM Participant (QP), or a Partial QP choosing not to participate in MIPS.
  - **Group** that has 10 or fewer eligible clinicians and exceeds the low-volume threshold at the group level.

MIPS Year 2 (2018)

Virtual Groups

New: Virtual Groups

What else do I need to know?

- Solo practitioners and groups who want to form a virtual group must go through the **election process**.
- Virtual groups election must occur ***prior*** to the **beginning of the performance period** and cannot be changed once the performance period starts.
- Election period is October 11 to December 31, 2017, for the 2018 MIPS performance period.

MIPS Year 2 (2018)

Virtual Groups

New: Virtual Groups

What else do I need to know?

- Generally, policies that apply to groups would apply to virtual groups.
- Virtual groups use same submission mechanisms as groups.
- **All** clinicians within a TIN are part of the virtual group.
- Virtual groups are required to aggregate their data across the virtual group for each performance category and will be assessed and scored as a virtual group.
- If TIN/NPIs is participating in both a virtual group and an APM, such TIN/NPI will receive a final score based on the virtual group performance and a final score based on performance in an APM. However, such TIN/NPI will receive a payment adjustment based on the APM score.

MIPS Year 2 (2018)

Virtual Groups

New: Virtual Groups

How do I make an election?

- Each virtual group has to:
  1. Have a **written formal agreement** between each of the virtual group members before election.
  2. Name **an official representative** who e-mails the group's election to MIPS_VirtualGroups@cms.hhs.gov
  3. Each virtual group's official representative must e-mail the group's election by **December 31, 2017.**
  4. Virtual group elections have to include at least the information about each TIN and NPI associated with the virtual group and the virtual group representative's contact information. The virtual group representative would need to acknowledge that a written formal agreement has been established between each member of the virtual group prior to election.
- To learn more, see the 2018 Virtual Groups Toolkit.

MIPS Year 2 (2018)

Submission Mechanisms

No change: *All of the submission mechanisms remain the same from Year 1 to Year 2*

Performance Category	Submission Mechanisms for Individuals	Submission Mechanisms for Groups (Including Virtual Groups)
 Quality	QCDR Qualified Registry EHR Claims	QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
 Cost	Administrative claims (no submission required)	Administrative claims (no submission required)
 Improvement Activities	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)
 Advancing Care Information	Attestation QCDR Qualified Registry EHR	Attestation QCDR Qualified Registry EHR CMS Web Interface (groups of 25 or more)

Please note:

- Continue with the use of **1** submission mechanism per performance category in Year 2 (2018). Same policy as Year 1.
- The **use of multiple submission mechanisms** per performance category is deferred to Year 3 (2019).

MIPS YEAR 2 (2018)

Performance Categories

MIPS Year 2 (2018)

Quality

Basics:

- ***Change***: **50%** of Final Score in 2018
- 270+ measures available
- You select 6 individual measures
  - 1 must be an Outcome measure
    OR
  - High-priority measure
- You may also select a specialty-specific set of measures

Component	Transition Year 1 (2017) Final	Year 2 (2018) Final
Weight to Final Score	• 60%	• 50%
Data Completeness	• 50% for submission mechanisms except for Web Interface and CAHPS. • Measures that do not meet the data completeness criteria earn 3 points.	• 60% for submission mechanisms except for Web Interface and CAHPS. • Measures that to not meet data completeness criteria earn 1 point. • Burden Reduction Aim: Small practices will continue to receive 3 points.

MIPS Year 2 (2018)

Cost

Basics:

- ***Change:* 10% Counted toward Final Score in 2018**
- Medicare Spending per Beneficiary (MSPB) and total per capita cost measures are included in calculating Cost performance category score for the 2018 MIPS performance period.
- These measures were used in the Value Modifier and in the MIPS transition year

- *Change*: Cost performance category weight is **finalized at 10% for 2018.**
- 10 episode-based measures adopted for the 2017 MIPS performance period will not be used.
- We are developing new episode-based measures with significant clinician input and are providing feedback on these measures this fall through field testing.
- This will allow clinicians to see their cost measure scores before the measures are potentially included in the MIPS program.
- We will propose new cost measures in future rulemaking.

MIPS Year 2 (2018)

MIPS: Scoring Improvements

New: MIPS Scoring Improvement for Quality and Cost

- For Quality:
  - Improvement scoring will be based on the rate of improvement such that higher improvement results in more points for those who have not previously performed well.
  - Improvement will be measured at the performance category level.
  - Up to 10 percentage points available in the Quality performance category.

- For Cost:
  - Improvement scoring will be based on statistically significant changes at the measure level.
  - Up to 1 percentage point available in the Cost performance category.

MIPS Year 2 (2018)

Improvement Activities

Basics:

- **15%** of Final Score in 2018
- 112 activities available in the inventory
  - Medium and High Weights remain the same from Year 1
  - Medium = 10 points
  - High = 20 points
- A simple "yes" is all that is required to attest to completing an Improvement Activity

Number of Activities:

- No change in the number of activities that MIPS eligible clinicians must report to achieve a total of 40 points.
- Burden Reduction Aim: MIPS eligible clinicians in small practices and practices in a rural areas will continue to report on no more than 2 activities to achieve the highest score.

Patient-centered Medical Home:

- We finalized the term "recognized" is equivalent to the term "certified" as a patient centered medical home or comparable specialty practice.
- **50%** of practice sites* within a TIN or TINs that are part of a virtual group need to be recognized as patient-centered medical homes for the TIN to receive the full credit for Improvement Activities in 2018.

*We have defined practice sites as the *practice address that is available within the Provider Enrollment, Chain, and Ownership System (PECOS)*.

MIPS Year 2 (2018)

Improvement Activities

Basics:

- **15%** of Final Score in 2018
- 112 activities available in the inventory
  - Medium and High Weights remain the same from Year 1
  - Medium = 10 points
  - High = 20 points
- A simple “yes” is all that is required to attest to completing an Improvement Activity

Additional Activities:

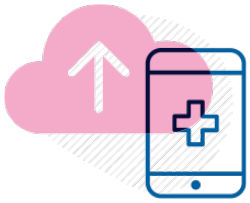
- We are finalizing additional activities, and changes to existing activities for the Improvement Activities Inventory including credit for using Appropriate Use Criteria (AUC) through a qualified clinical support mechanism for all advanced diagnostic imaging services ordered.

Scoring:

- Continue to designate activities within the performance category that also qualify for an Advancing Care Information performance category bonus.
- For group reporting, only one MIPS eligible clinician in a TIN must perform the Improvement Activity for the TIN to receive credit.
- For virtual group reporting: only one MIPS eligible clinician in a virtual group must perform the Improvement Activity for the TIN to receive credit.
- Continue to allow simple attestation of Improvement Activities.

MIPS Year 2 (2018)

Advancing Care Information



Basics:

- **25%** of Final Score in 2018
- Comprised of Base, Performance, and Bonus score
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Two measure sets available to choose from based on EHR edition.

CEHRT Requirements:

- Burden Reduction Aim: MIPS eligible clinicians may use either the 2014 or 2015 CEHRT or a combination in 2018.
- A **10% bonus** is available for using only 2015 Edition CEHRT.

Measures and Objectives:

- CMS finalizes exclusions for the E-Prescribing and Health Information Exchange Measures.

Scoring:

- No change to the base score requirements for the 2018 performance period/2020 payment year.
- For the performance score, MIPS eligible clinicians and groups will earn 10% for reporting to any one of the Public Health and Clinical Data Registry Reporting measures as part of the performance score.
- For the bonus score a 5% bonus score is available for reporting to an additional registry not reported under the performance score.
- Additional Improvement Activities are eligible for a 10% Advancing Care Information bonus for completion of at least 1 of the specified Improvement Activities using CEHRT.
- Total bonus score available is 25%

MIPS Year 2 (2018)

Advancing Care Information

Basics:

- **25%** of Final Score in 2018
- Comprised of Base, Performance, and Bonus score
- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Two measure sets available to choose from based on EHR edition.

Exceptions:

- Based on authority granted by the 21st Century Cures Act and MACRA , **CMS will reweight the Advancing Care Information performance category to 0 and reallocate the performance category weight of 25% to the Quality performance category** for the **following reasons:**

Automatic reweighting:

- Hospital-based MIPS eligible clinicians;
- Ambulatory Surgical Center (ASC)— based MIPS eligible clinicians, finalized retroactive to the transition year;
- Nurse practitioners, physician assistants, clinical nurse specialist, certified registered nurse anesthetists

Reweighting through an approved application:

- **New hardship exception for clinicians in small practices** (15 or fewer clinicians);
- New decertification exception for eligible clinicians whose EHR was decertified, retroactively effective to performance periods in 2017.
- Significant hardship exceptions—CMS will not apply a 5-year limit to these exceptions;

- **New deadline of December 31** of the performance year for the submission of hardship exception applications for 2017 and future years.
- Revised definition of hospital-based MIPS eligible clinician to include covered professional services furnished by MIPS eligible clinicians in an off-campus-outpatient hospital (POS 19).

MIPS YEAR 2 (2018)

Performance Threshold and Payment Adjustment

MIPS Year 2 (2018)

MIPS: Performance Threshold & Payment Adjustment

Change: *Increase in Performance Threshold and Payment Adjustment*

Transition Year 1 (2017) Final

- 3 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 4%

Year 2 (2018) Final

- 15 point threshold
- Exceptional performer set at 70 points
- Payment adjustment set at +/- 5%

How can I achieve 15 points?

- Report all required Improvement Activities.
- Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness.
- Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity.
- Submit 6 Quality measures that meet data completeness criteria.

MIPS Year 2 (2018)

MIPS: Performance Threshold & Payment Adjustment

Change: *Increase in Performance Threshold and Payment Adjustment*

Transition Year 1 (2017) Final

Final Score 2017	Payment Adjustment 2019
≥70 points	• Positive adjustment • Eligible for exceptional performance bonus—minimum of additional 0.5%
4-69 points	• Positive adjustment • Not eligible for exceptional performance bonus
3 points	• Neutral payment adjustment
0 points	• Negative payment adjustment of -4% • 0 points = does not participate

Year 2 (2018) Final

Final Score 2018	Change Y/N	Payment Adjustment 2020
≥70 points	N	• Positive adjustment greater than 0% • Eligible for exceptional performance bonus—minimum of additional 0.5%
15.01-69.99 points	Y	• Positive adjustment greater than 0% • Not eligible for exceptional performance bonus
15 points	Y	• Neutral payment adjustment
3.76-14.99	Y	• Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	Y	• Negative payment adjustment of -5%

MIPS YEAR 2 (2018)

Scoring

MIPS Year 2 (2018)

Complex Patient Bonus

New: Complex Patient Bonus

- Up to **5 bonus points** available for treating complex patients based on medical complexity.
  - As measured by Hierarchical Condition Category (HCC) risk score and a score based on the percentage of dual eligible beneficiaries.

- MIPS eligible clinicians or groups must submit data on at least 1 performance category in an applicable performance period to earn the bonus.

MIPS Year 2 (2018)

Small Practice Bonus

New: Small Practice Bonus

- **5 bonus points** added to final score of any MIPS eligible clinician or group who is in a small practice (15 or fewer clinicians), so long as the MIPS eligible clinician or group submits data on at least 1 performance category in an applicable performance period.

- Burden Reduction Aim:
  - We recognize the challenges of small practices and will provide a 5 point bonus to help them successfully meet MIPS requirements.

MIPS Year 2 (2018)

Facility-based Measurement

New: Facility-based Measurement

Please note:

- Facility-based measurement policies are finalized, but with a **1-year delay to Year 3** (2019).

What you need to know:

- Facility-based measurement assesses clinicians in the context of the facilities at which they work to better measure their quality.
- Voluntary facility-based scoring mechanism will be aligned with the Hospital Value Based Purchasing Program (Hospital VBP) to help reduce burden for clinicians.
- Eligible as individual: You must have 75% of services in the inpatient hospital or emergency room.
- Eligible as group: 75% of eligible clinicians must meet eligibility criteria as individuals.
- Measures will be based on Hospital VBP for quality and cost measures.
- Scores will be derived using the data at the facility where the clinician treats the highest number of Medicare beneficiaries.
- The facility-based measurement option converts a hospital Total Performance Score into a MIPS quality performance category and cost performance category score.

MIPS YEAR 2 (2018)

Seeking Comment

MIPS Year 2 (2018)

Seeking Comment

We finalized many of our proposed policies (CMS-5522-FC), but we do have several policy items open for comment as noted below:

Policy Items	Seeking Comment under Final Rule
Group Definition	Additional ways to define a group, not solely based on a Tax Identification Number (TIN). For example, redefining a group to allow for practice sites to be reflected and/or for specialties within a TIN to create groups.
Low-volume Threshold	Whether to continue the application of the low-volume threshold at the group level, or whether to apply the low-volume threshold at the individual level across the board.
QCDR Measures	New standards for QCDR measures.
MIPS Scoring Methodology	Methods to create a simpler scoring approach, or other ways of creating MIPS quality measure benchmarks.
Bonuses	Aligning bonuses across the Quality Payment Program.
Interim Final Rule	Seeking comment on our 2017 Extreme and Uncontrollable Circumstances policies.

ADVANCED APMs

All-Payer Combination Option & Other Payer Advanced APMs

Advanced APMs

Overview: All-Payer Combination Option

- The All-Payer Combination Option is, along with the Medicare Option, one of two pathways through which eligible clinicians can become a QP for a year.
- QP Determinations under the All-Payer Combination Option will be based on an eligible clinicians' participation in a combination of both Advanced (Medicare) APMs and Other Payer Advanced APMs.
- QP Determinations are conducted sequentially so that the Medicare Option is applied before the All-Payer Combination Option.
- Only clinicians who do not meet the minimum patient count or payment amount threshold to become QPs under the Medicare Option (but still meet a lower threshold to participate in the All-Payer Combination Option) are able to request a QP determination under the All-Payer Combination Option.
- The All-Payer Combination Option is available beginning in the 2019 QP Performance Period.

Advanced APMs

All-Payer Combination Option: Determination of Other Payer Advanced APMs

- Prior to each QP Performance Period, CMS will make Other Payer Advanced APM determinations based on information voluntarily submitted by payers, which we refer to as the Payer Initiated Process.
- This Payer Initiated Process is available for Medicaid, Medicare Advantage, and payers aligning with CMS Multi-Payer Models for performance year 2019. We intend to add remaining payer types in future years.
- APM Entities and eligible clinicians will also have the opportunity to submit information regarding the payment arrangements in which they were participating in the event that the payer has not already done so, which we refer to as the Eligible Clinician Initiated Process.
- For Medicaid payment arrangements, APM Entities and eligible clinicians will be able to submit information prior to the relevant QP Performance Period. For all other payment arrangements, APM Entities and eligible clinicians will be able to submit information after the relevant QP Performance Period.

QUALITY PAYMENT PROGRAM

Help & Support

Technical Assistance

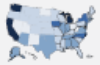
Available Resources

CMS has **free** resources and organizations on the ground to provide help to eligible clinicians included in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISCMail@us.ibm.com for extra assistance.



Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

LARGE PRACTICES

Quality Innovation Networks-
Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

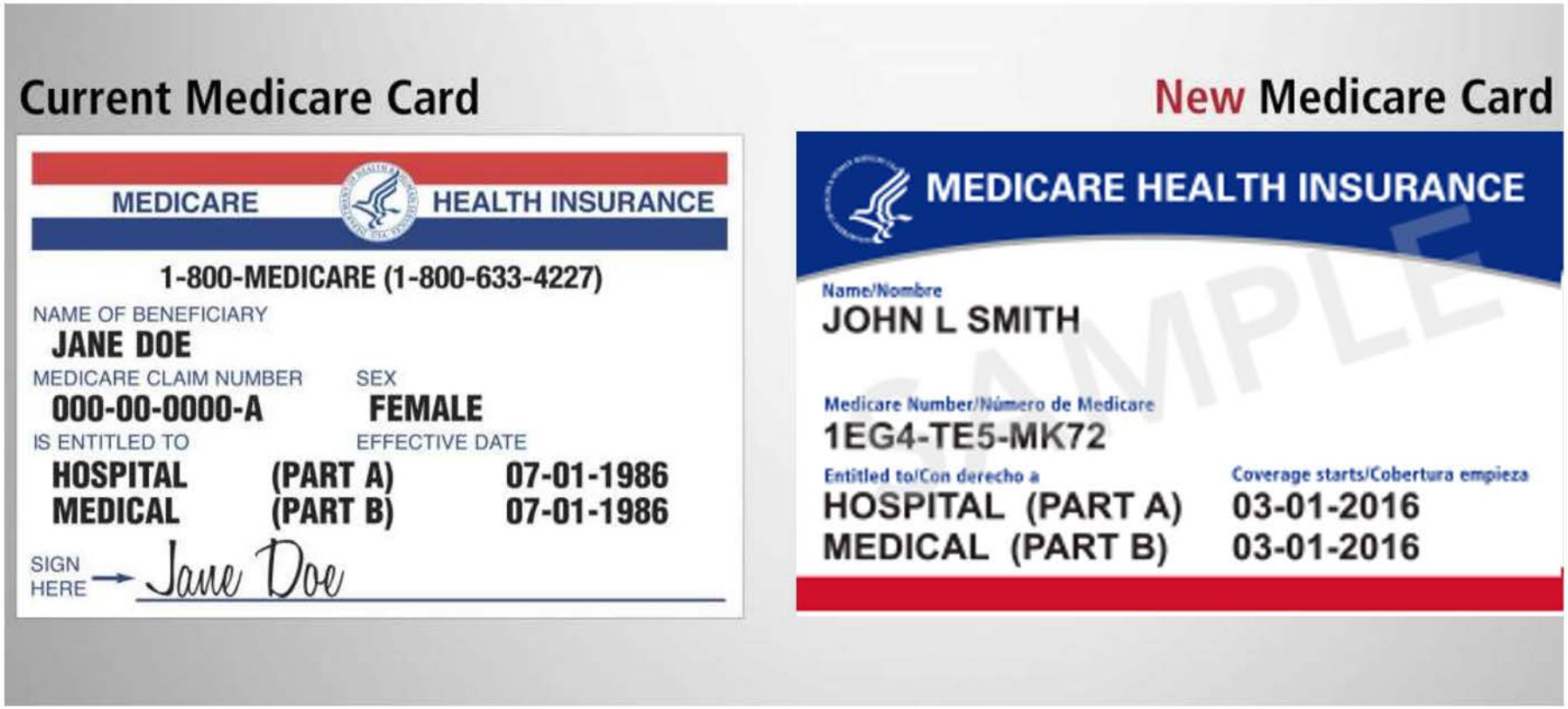
To learn more, view the Technical Assistance Resource Guide: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Technical-Assistance-Resource-Guide.pdf

Final Rule with Comment Period: Comments Due January 2, 2018

- See the Final Rule for information on submitting these comments by the close of the 60-day comment period on January 2, 2018. When commenting refer to file code **CMS 5522-FC.**
- Instructions for submitting comments can be found in the final rule; FAX transmissions will not be accepted. You must officially submit your comments in one of the following ways: electronically through
  - Regulations.gov
  - by regular mail
  - by express or overnight mail
  - by hand or courier

- For additional information, please go to: qpp.cms.gov

New Medicare Card



https://www.cms.gov/medicare/new-medicare-card/nmc-home.html

Operations: Transition Period

- The transition period will run from **April 1, 2018 through December 31, 2019**
- CMS will complete its system and process updates to be ready to accept and return the new Medicare Number on April 1, 2018
- All stakeholders who submit or receive transactions containing the HICN must modify their processes and systems to be ready to submit or exchange the new Medicare Number by April 1, 2018. Stakeholders may submit **either** the new Number or HICN **during the transition period**
- CMS will accept, use for processing, and return to stakeholders **either** the new Medicare Number or HICN, whichever is submitted on the claim, **during the transition period**

Questions

Helpful Resources

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You may also contact: QPP@cms.hhs.gov

The QPP Service Center can be reached at 1-866-288-8912,

TTY: 1-877-715-6222


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