MLN Connects™

National Provider Call

CMS Proposals for the Physician Quality Reporting System (PQRS) and Physician Value-Based Payment Modifier (VM) under the Medicare Physician Fee Schedule 2014

July 25, 2013

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Agenda

- Physician Fee Schedule (PFS) Proposed Rule
  - PQRS
    - Changes to Individual Reporting Requirements
    - Changes to the Group Practice Reporting Option (GPRO)
    - Additional Program Changes
  - Medicare Electronic Health Record (EHR) Incentive Program
  - Physician Compare
  - Physician Value-Based Payment Modifier
    - Application of the Value Modifier (VM)
    - VM and PQRS

PQRS PROPOSALS RELATED TO REPORTING AS AN INDIVIDUAL ELIGIBLE PROFESSIONAL (EP)

Qualified Clinical Data Registries

Proposed definition of a "qualified clinical data registry": A CMS-approved entity (such as a registry, certification board, collaborative, etc.) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients.

- Must be able to submit quality measures data or results to CMS for purposes of demonstrating that, for a reporting period, its EPs have satisfactorily participated in PQRS
- Must submit quality measures data on multiple payers
- Must provide timely feedback at least quarterly on the measures for which the qualified clinical data registry would report on the individual EP's behalf for purposes of the EP meeting the criteria for satisfactory participation under PQRS
- Must possess a method to benchmark the quality of care measures an EP provides with that of other EPs performing the same or similar functions

Qualified Clinical Data Registries (cont.)

Proposals on how to become a qualified clinical data registry:

- Meet minimum proposed characteristics
- Self-nomination
  - Deadline: January 31
  - Submission method: Email

2014 PQRS Incentive – Individual EPs

Summary of Major Proposed Changes:

- Measures group reporting *only* available via registry
- For reporting individual measures via registry, propose a 50% threshold
- Increase the number of generally required measures to be reported from 3 to 9 measures, covering at least 3 domains
  - Patient Safety
  - Person and Caregiver-Centered Experience and Outcomes
  - Communication and Care Coordination
  - Effective Clinical Care
  - Community/Population Health
  - Efficiency and Cost Reduction

2014 PQRS Incentive – Individual EPs (cont.)

Proposed Changes to Criteria for Satisfactory Reporting/Participation

2014 Reporting Period	Measure Type	Reporting Mechanism	Proposed Reporting Criteria
12-month (Jan 1 - Dec 31)	Individual Measures	* Claims	Report at least 9 measures covering at least 3 of the National Quality Strategy domains; **OR** If less than 9 measures apply to the EP, then the EP must report 1-8 measures for which there is Medicare patient data; **AND** Report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies.
12-month (Jan 1 - Dec 31)	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the National Quality Strategy domains, **AND** Report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies.
12-month (Jan 1 - Dec 31)	Measures selected by Qualified Clinical Data Registry	Qualified Clinical Data Registry	Report at least 9 measures available for reporting under a qualified clinical data registry covering at least 3 of the National Quality Strategy domains, **AND** Report each measure for at least 50% of the EP's patients. Of the measures reported via a clinical data registry, the EP must report on at least 1 outcome measure.

Note: Additional reporting options were finalized in the 2013 PFS Final Rule

*Subject to Measure Applicability Validation (MAV)

2016 PQRS Payment Adjustment – Individual EPs

Proposed Changes to Criteria for Avoiding the 2016 PQRS Payment Adjustment

2014 Reporting Period	Measure Type	Reporting Mechanism	Proposed Reporting Criteria
12-month (Jan 1 - Dec 31)	Individual Measures	* Claims	Report at least 9 measures covering at least 3 of the National Quality Strategy domains; **OR** If less than 9 measures apply to the EP, then the EP must report 1-8 measures for which there is Medicare patient data; **AND** Report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
12-month (Jan 1 - Dec 31)	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the National Quality Strategy domains, **AND** Report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
12-month (Jan 1 - Dec 31)	Measures selected by Qualified Clinical Data Registry	Qualified Clinical Data Registry	Report at least 9 measures available for reporting under a qualified clinical data registry covering at least 3 of the National Quality Strategy domains; **AND** Report each measure for at least 50% of the EP's patients. Of the measures reported via a clinical data registry, the EP must report on at least 1 outcome measure.

Note: Additional reporting options were finalized in the 2013 PFS Final Rule

*Subject to Measure Applicability Validation (MAV)

PQRS PROPOSALS RELATED TO REPORTING UNDER THE GPRO

Proposed Changes to the PQRS GPRO

Summary of Major Proposed Changes:

- Eliminate the option for group practices of 25-99 to report PQRS measures via the GPRO web interface
- For reporting individual measures via registry, propose a 50% threshold, which is also proposed for the individual satisfactory reporting criteria for the 2014 PQRS incentive
- Groups of 25 or more EPs will have the option to report the Clinician Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS)
- Group practices in the GPRO (including ACOs in the Medicare Shared Savings Program) must meet the criteria for the 2014 PQRS incentive to satisfactorily report to avoid the 2016 PQRS payment adjustment
- Registration:
  - New Proposed Deadline: September 30
  - Same website where quality tiering is elected
  - If the group practice wishes to report the CG CAHPS, the group would be required to indicate its intent to do so at self-nomination

Proposed Changes to the PQRS GPRO (cont.)

Reporting the CG CAHPS Survey for group practices comprised of 25+ EPs:

- 12 Survey Questions:
  - Getting Timely Care, Appointments, and Information
  - How Well Providers Communicate
  - Patient's Rating of Provider
  - Access to Specialists
  - Health Promotion & Education
  - Shared Decision Making
  - Health Status/Functional Status
  - Courteous and Helpful Office Staff
  - Care Coordination
  - Between Visit Communication
  - Helping Your to Take Medication as Directed, and
  - Stewardship of Patient Resources

- Must use a CMS-certified survey vendor
- Please note that CMS will not bear the cost of administering the CG CAHPS survey

2014 PQRS Incentive – GPRO

Proposed Changes to Criteria for Satisfactory Reporting/Participation under the GPRO for the 2014 PQRS Incentive

2014 Reporting Period	Reporting Mechanism	Group Practice Size	Proposed Reporting Criteria
12-month (Jan 1 - Dec 31)	Qualified Registry	2+ EPs	Report at least 9 measures covering at least 3 of the National Quality Strategy domains; **AND** Report each measure for at least 50% of the group practice's applicable patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
12-month (Jan 1 - Dec 31)	Certified Survey Vendor *and* Qualified Registry, direct EHR product, EHR data submission vendor, or GPRO Web Interface	25+ EPs	Report all CG CAHPS survey measures via certified survey Vendor; **AND** Report at least 6 measures covering at least 2 of the National Quality Strategy domains using the qualified registry, direct EHR product, EHR data submission vendor, **OR** all PQRS GPRO measures included in the GPRO Web Interface *(Note: The Web Interface is only available to groups of 100 or more).*

Note: Additional reporting options were finalized in the 2013 PFS Final Rule

2016 PQRS Payment Adjustment – GPRO

Proposed Changes to Criteria for Avoiding the 2016 PQRS Payment Adjustment Under the GPRO

2014 Reporting Period	Reporting Mechanism	Group Practice Size	Proposed Reporting Criteria
12-month (Jan 1 - Dec 31)	Qualified Registry	2+ EPs	Report at least 9 measures covering at least 3 of the National Quality Strategy domains; **AND** Report each measure for at least 50% of the group practice's applicable patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate will not be counted.
12-month (Jan 1 - Dec 31)	Certified Survey Vendor *and* Qualified Registry, direct EHR product, EHR data submission vendor, or GPRO Web Interface	25+ EPs	Report all CG CAHPS survey measures via certified survey Vendor; **AND** Report at least 6 measures covering at least 2 of the National Quality Strategy domains using the qualified registry, direct EHR product, EHR data submission vendor, **OR** all PQRS GPRO measures included in the GPRO Web Interface *(Note: The Web Interface is only available to groups of 100 or more).*

Note: Additional reporting options were finalized in the 2013 PFS Final Rule

ADDITIONAL CHANGES

Proposals Related to PQRS Measures

Summary of Proposed PQRS Measures

- For 2014, we are proposing to add 47 new individual measures and 4 measures groups to fill existing measure gaps and retire a number of claims-based measures to encourage reporting via the registry and EHR-based reporting mechanisms
- Proposed deletion of 46 measures
- Proposed addition of recommended core measures that align with the EHR Incentive Program recommended core measures
- Measures Groups:
  - Proposed change to define a measures group as consisting of 6 or more measures
  - 4 new measures groups: Total Knee Replacement, Optimizing Patient Exposure to Ionizing Radiation, General Surgery, and Gastrointestinal Surgery

2014 PQRS Measures with Reporting Method Update

PQRS#	NQF	Measure Title
6	0067	Coronary Artery Disease (CAD): Antiplatelet Therapy
9	0105	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD
39	0046	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
47	0326	Advance Care Plan
48	0098	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
53	0047	Asthma: Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting
64	0001	Asthma: Assessment of Asthma Control – Ambulatory Care Setting
65	0069	Appropriate Treatment for Children with Upper Respiratory Infection (URI)
66	0002	Appropriate Testing for Children with Pharyngitis
84	0395	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment
85	0396	Hepatitis C: HCV Genotype Testing Prior to Treatment
87	0398	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment
107	0104	Major Depressive Disorder (MDD): Suicide Risk Assessment
116	0058	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use
126	0417	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation
127	0416	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear
130	0419	Documentation of Current Medications in the Medical Record
148	0322	Back Pain: Initial Visit
149	0319	Back Pain: Physical Exam
150	0314	Back Pain: Advice for Normal Activities
151	0313	Back Pain: Advice Against Bed Rest
176	AQA Adopted	Rheumatoid Arthritis (RA): Tuberculosis Screening
177	AQA Adopted	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
178	AQA Adopted	Rheumatoid Arthritis (RA): Functional Status Assessment
179	AQA Adopted	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
180	AQA Adopted	Rheumatoid Arthritis (RA): Glucocorticoid Management
183	0399	Hepatitis C: Hepatitis A Vaccination in Patients with HCV
197	0074	Coronary Artery Disease (CAD): Lipid Control

Measures Reported by Qualified Clinical Data Registries

Proposed Requirements for Measures Reported by Qualified Clinical Data Registries on behalf of Participating EPs:

- The qualified clinical data registry must have at least 9 measures, covering at least 3 of the 6 National Quality Strategy domains, available for reporting.
- The qualified clinical data registry must have at least 1 outcome measure available for reporting, which is a measure that assesses the results of health care that are experienced by patients (that is, patients' clinical events; patients' recovery and health status; patients' experiences in the health system; and efficiency/cost).
- The qualified clinical data registry may report on process measures, which are measures that focus on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome.
- The outcome and process measures reported must contain denominator data. That is, the lower portion of a fraction used to calculate a rate, proportion, or ratio. The denominator must describe the population eligible (or episodes of care) to be evaluated by the measure. This should indicate age, condition, setting, and timeframe (when applicable). For example, "Patients aged 18 through 75 years with a diagnosis of diabetes."

Measures Reported by Qualified Clinical Data Registries (cont.)

Proposed Requirements for Measures Reported by Qualified Clinical Data Registries on behalf of Participating EPs:

- The outcome and process measures reported must contain numerator data. That is, the upper portion of a fraction used to calculate a rate, proportion, or ratio. The numerator must detail the quality clinical action expected that satisfies the condition(s) and is the focus of the measurement for each patient, procedure, or other unit of measurement established by the denominator (that is, patients who received a particular service or providers that completed a specific outcome/process).

- The qualified clinical data registry must provide denominator exceptions for the measures. That is, those conditions that should remove a patient, procedure or unit of measurement from the denominator of the performance rate only if the numerator criteria are not met. Denominator exceptions allow for adjustment of the calculated score for those providers with higher risk populations. Denominator exceptions allow for the exercise of clinical judgment and should be specifically defined where capturing the information in a structured manner fits the clinical workflow. Generic denominator exception reasons used in measures fall into three general categories: Medical, Patient, or System reasons.

- The qualified clinical data registry must provide denominator exclusions for the measures for which it will report to CMS. That is, those patients with conditions who should be removed from the measure population and denominator before determining if numerator criteria are met. (For example, Patients with bilateral lower extremity amputations would be listed as a denominator exclusion for a measure requiring foot exams.)

- The qualified clinical data registry must provide to CMS descriptions for the measures for which it will report to CMS by no later than March 31, 2014. The descriptions must include: name/title of measures, NQF # (if NQF endorsed), descriptions of the denominator, numerator, denominator exceptions and denominator exclusions of the measure.

2017 PQRS Payment Adjustment and Beyond

- Future PQRS Reporting Periods
- Plan for the Future of the PQRS GPRO
- Future of Use of the Claims-based Reporting Mechanism in PQRS
- Future Submission Timelines for the Registry, EHR, GPRO Web Interface and Qualified Clinical Data Registry Reporting Mechanisms
- Integration of Clinical Quality Measures Reported Under the Hospital Inpatient Quality Reporting (IQR) Program
- Feedback Reports

2014 MEDICARE ELECTRONIC HEALTH RECORD (EHR) INCENTIVE PROGRAM

EHR Incentive Program

EHR Incentive Program CQM Reporting Using Clinical Data Registries:

- The EHR Incentive Program is statutorily required to use Certified EHR Technology (CEHRT) as a reporting requirement. The 2014 Edition certification criteria require certification of each individual electronic clinical quality measure (eCQM) that will be reported to CMS. We propose to allow CQM submission using clinical data registries, such as those established for PQRS, as long as the eCQMs are included in the Stage 2 final rule and use the same electronic specifications established for meaningful use (MU).

Comprehensive Primary Care Initiative – Proposed Additional Group Reporting Option:

- The Comprehensive Primary Care Initiative (CPC), under the authority of Section 3021 of the Affordable Care Act, is a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care. The CPC program is already aligned with MU on the eCQMs finalized in the Stage 2 final rule. In a continuing effort to align quality reporting programs and innovation programs, we are proposing to add a group reporting option beginning in CY 2014 for EPs who are part of a CPC site that successfully submit according to their region's CPC reporting requirements to also fulfill the CQM requirement for MU.

EHR Incentive Program (cont.)

eCQM Reporting – Measure Versions:

- Electronic reporting of eCQMs must use the most recent version of the measure (i.e., June 2013 release). In order to use any of the aligned options with MU, EPs must electronically report their CQMs. If the EP is not able to report the most recent version of the measure, then the CQM results must be submitted via attestation in the Registration & Attestation System. Attested data cannot be used for credit in any other quality reporting programs.

2014 PHYSICIAN COMPARE

Public Reporting

The MPFS proposed rule outlines the next phase of the plan to publicly report physician performance information on Physician Compare.

- For 2014, we propose to expand this reporting by publicly reporting all measures collected through the GPRO web interface for groups of all sizes participating in the 2014 PQRS GPRO and for ACOs participating in the Medicare Shared Savings Program. These data would include measure performance rates for measures included in the 2014 PQRS GPRO web interface that met the minimum sample size of 20 patients, and that prove to be statistically valid and reliable. As previously finalized, we will provide a 30-day preview period prior to publication of quality data on Physician Compare so that group practices and ACOs can view their data as it will appear on Physician Compare before it is publicly reported. We also propose to publicly report certain measures that groups report via registries and EHRs for the 2014 PQRS GPRO.

CMS collected patient experience survey data - such as the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) - for group practices participating in the PQRS GPRO and ACOs participating in the Medicare Shared Savings Program, starting with survey data for 2013.

- As previously finalized, we intend to publicly report these measures on Physician Compare in 2014 for data collected for CY 2013 for group practices with 100 or more EPs participating in PQRS GPRO through the GPRO web interface. For CY 2014, we also intend to continue public reporting of these CG-CAHPS data for PQRS GPRO group practices of 100 or more EPs participating in the GPRO web interface and for ACOs reporting through the GPRO web interface.

2014 PFS PHYSICIAN VALUE-BASED MODIFIER

What is the Value-Based Modifier?

- VM assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule
- Begin phase-in of VM in 2015, phase-in complete by 2017
- Implementation of the VM is based on participation in PQRS
- For CY 2015, we will apply the VM to groups of physicians with 100 or more EPs (EPs)

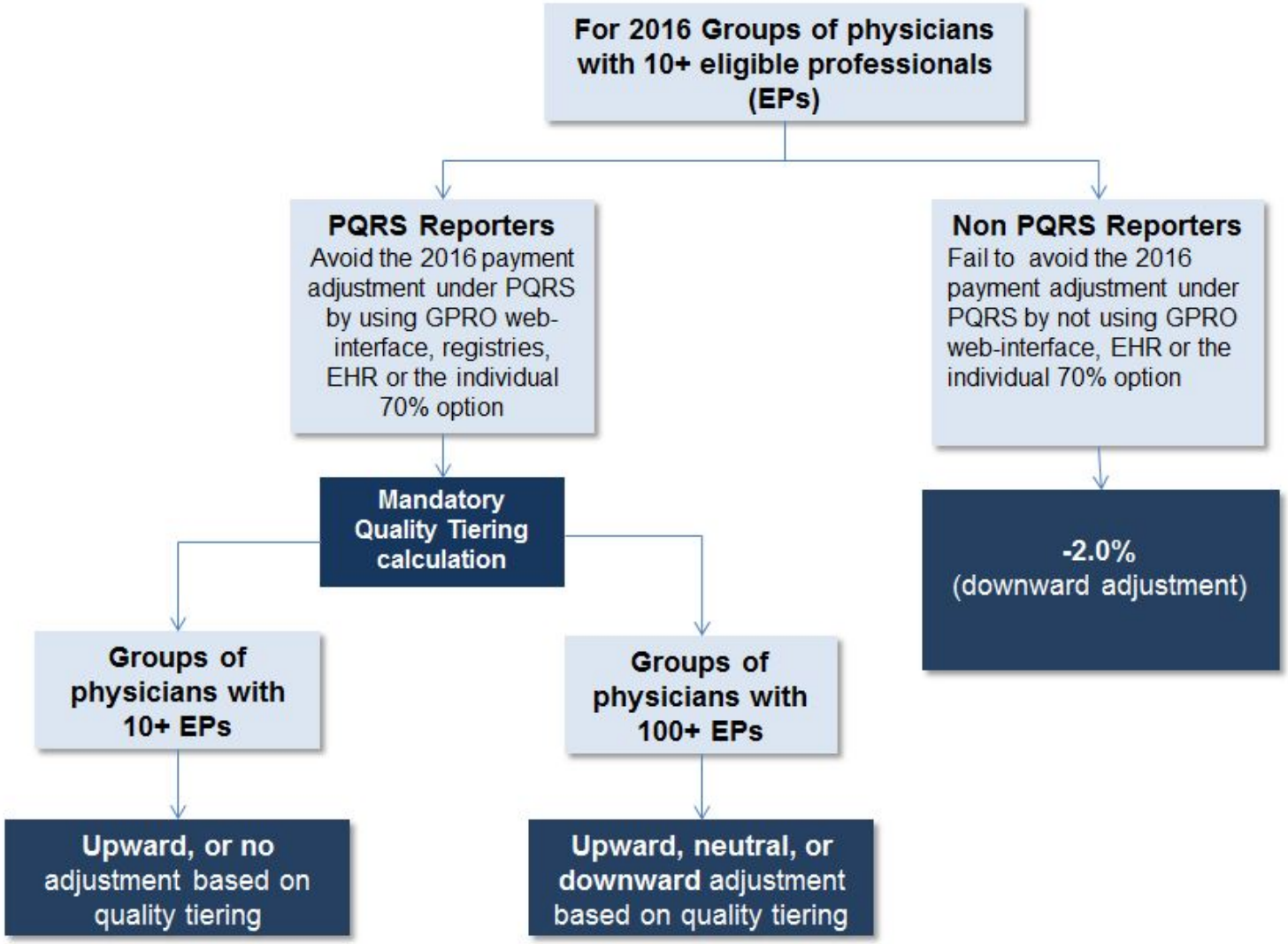
Value Modifier: 2015 Policies & 2016 Proposals

Value Modifier Components	2015 Finalized Policies	2016 Proposed Policies
Performance Year	2013	2014
Group Size	100+	10+
Available Quality Reporting Mechanisms	GPRO-Web Interface, CMS Qualified Registries, Administrative Claims	GPRO-Web Interface, CMS Qualified Registries, EHRs, and 70% of EPs reporting individually
Outcome Measures	All Cause Readmission Composite of Acute Prevention Quality Indicators: (bacterial pneumonia, urinary tract infection, dehydration) Composite of Chronic Prevention Quality Indicators: (chronic obstructive pulmonary disease (COPD), heart failure, diabetes)	Same as 2015
Patient Experience of Care Measures	N/A	PQRS CAHPS: Option for groups of 25+ EPs

Value Modifier: 2015 Policies & 2016 Proposals (cont.)

Value Modifier Components	2015 Finalized Policies	2016 Proposed Policies
Cost Measures	Total per capita costs measure (annual payment standardized and risk-adjusted Part A and Part B costs) Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes	Same as 2015 and Medicare Spending Per Beneficiary measure (includes Part A and B costs during the 3 days before and 30 days after an inpatient hospitalization)
Benchmarks	Group Comparison	Specialty Adjusted Group Cost
Quality Tiering	Optional	Mandatory Groups of 10-99 EPs receive only the upward adjustment, no downward adjustment
Payment at Risk	-1.0%	-2.0%

Value Modifier and PQRS



Reporting Quality Data at the Group Level for the VBM

Groups with 10+ EPs may select one of the following PQRS GPRO quality reporting mechanisms and meet the criteria for the CY 2016 PQRS payment adjustment to avoid the 2.0% VM adjustment.

PQRS Reporting Mechanism	Type of Measure
1. GPRO Web interface	Measures focus on preventive care and care for chronic diseases (aligns with the Shared Savings Program)
2. GPRO using CMS-qualified registries	Groups select the quality measures that they will report through a PQRS-qualified registry.
3. GPRO using EHR	Quality measures data extracted from a qualified EHR product for a subset of proposed 2014 Physician Quality Reporting System quality measures.

Reporting Quality Data at the Individual Level – 70% Threshold Option

CMS proposes to include individual measures reported by at least 70% of the EPs within the group if the group of physicians does not self nominate/ register to participate in PQRS in 2014 as a group.

- EPs must successfully avoid the for the 2016 PQRS payment adjustment
- EPs may report on measures available to individual EPs via the following reporting mechanisms:
  - Claims
  - CMS Qualified Registries
  - EHR
  - Clinical Data Registries (new for CY 2014)

What Cost Measures will be Used for Quality Tiering?

- Measures reported through the GPRO PQRS reporting mechanism selected by the group **OR** individual measures reported by at least 70% of the EPs within the group (70% threshold option)

- Three outcome measures:
  - All Cause Readmission
  - Composite of Acute Prevention Quality Indicators (bacterial pneumonia, urinary tract infection, dehydration)
  - Composite of Chronic Prevention Quality Indicators (COPD, heart failure, diabetes)

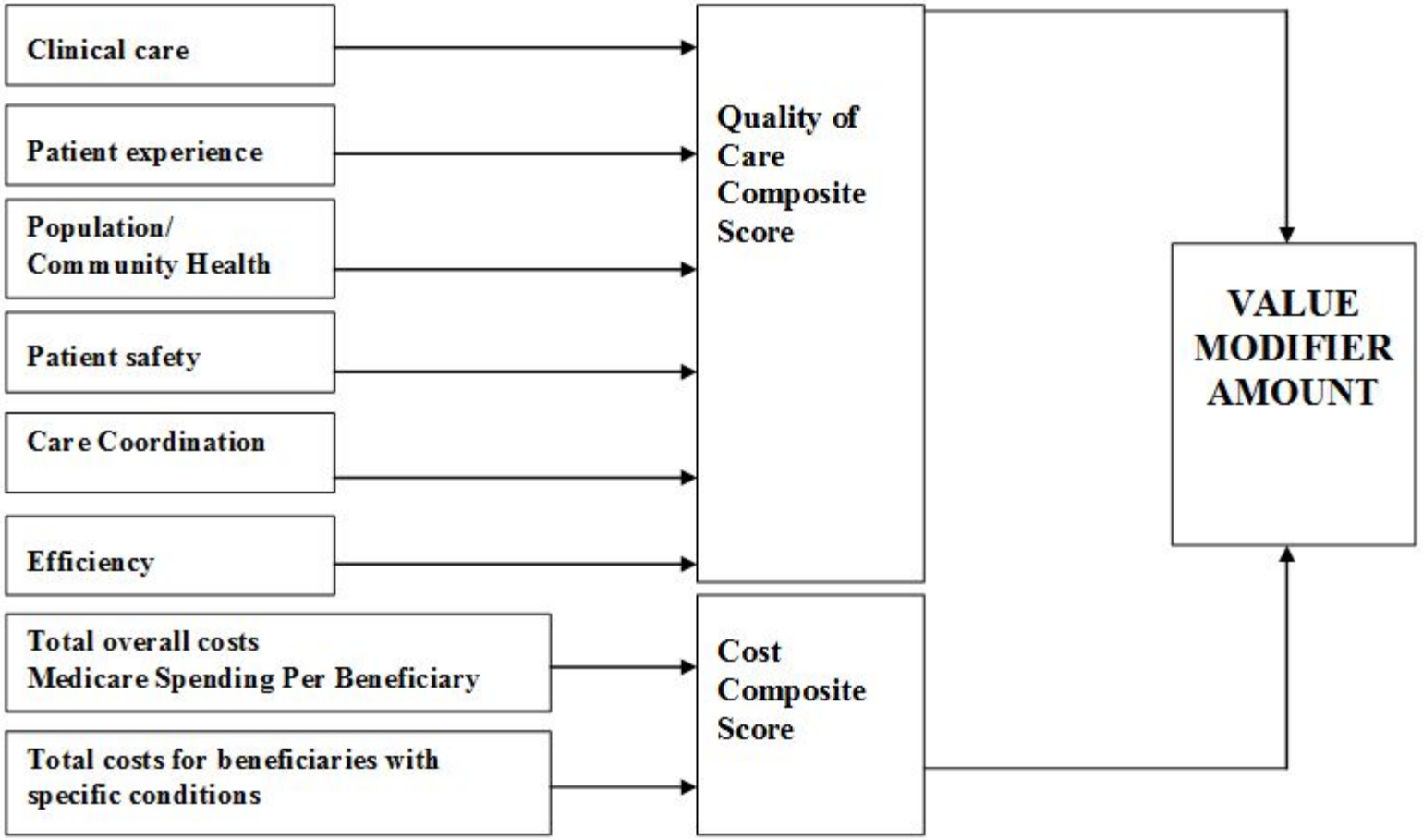
- PQRS CAHPS Measures for 2014 (Optional)
  - Patient Experience of Care measures
  - For groups of 25 or more EPs

What Quality Measures will be Used for Quality Tiering?

- Total per capita costs measures (Parts A & B)
- Total per capita costs for beneficiaries with 4 chronic conditions:
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Heart Failure
  - Coronary Artery Disease
  - Diabetes
- Medicare Spending Per Beneficiary measure (3 days prior and 30 days after an inpatient hospitalization) attributed to all groups providing a Part B service during hospitalization
- All cost measures are payment standardized and risk adjusted
- Each group's cost measures adjusted for specialty mix of the EPs in the group

Quality Tiering Methodology

Use domains to combine each quality measure into a quality composite and each cost measure into a cost composite



Quality Tiering Approach

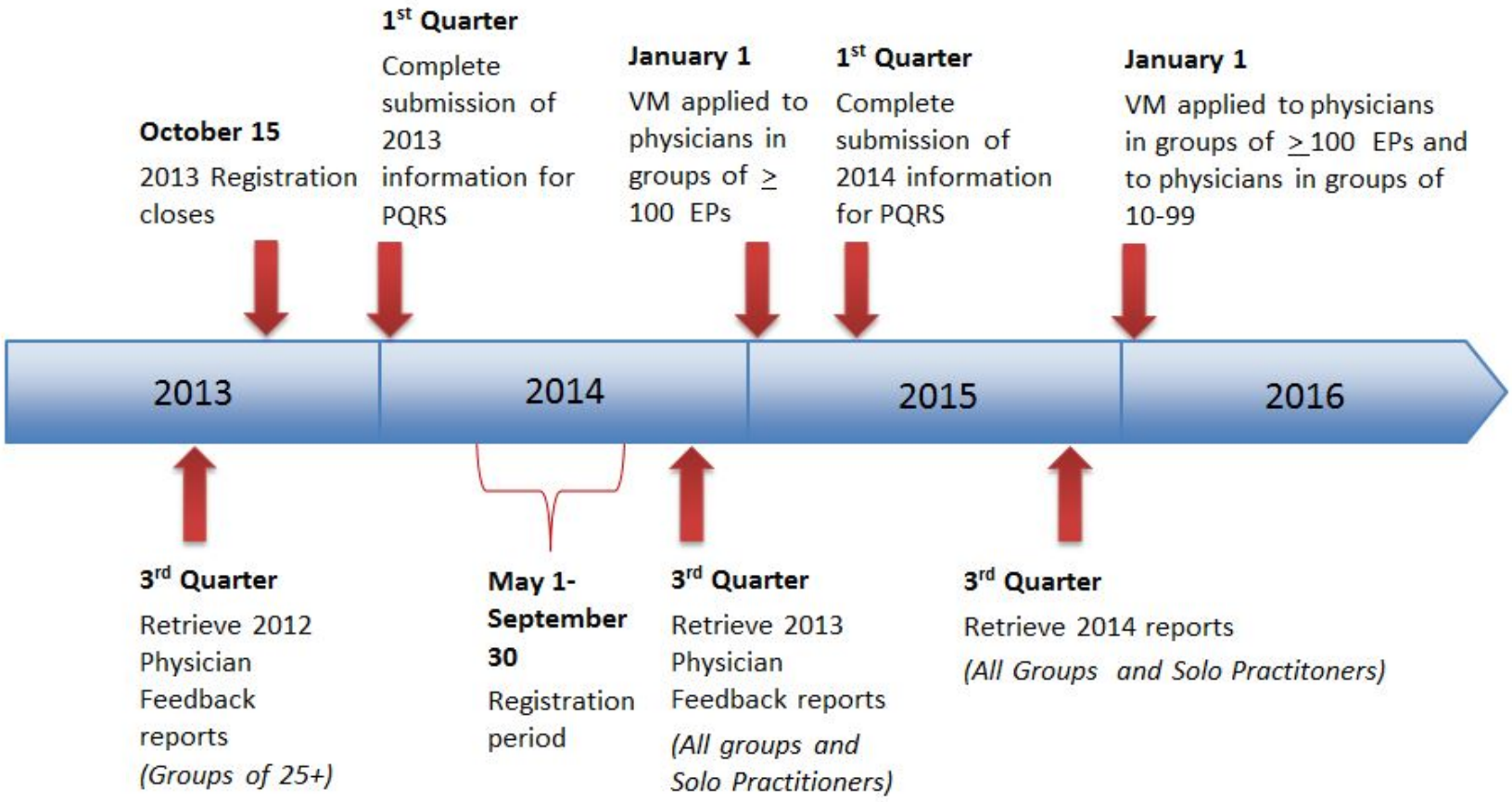
- Each group receives two composite scores (quality of care; cost of care), based on the group's **standardized performance** (e.g. how far away from the national mean).

- This approach identifies statistically significant outliers and assigns them to their respective cost and quality tiers.

Quality/cost	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Medium quality	+1.0x*	+0.0%	-1.0%
Low quality	+0.0%	-1.0%	-2.0%

*Eligible for an additional +1.0x if reporting clinical data for quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores.

Timeline for VM that Applies to Payment Starting January 1, 2016



Actions for Groups of 10+ EPs for the 2016 VM

- Choose a PQRS Reporting Mechanism
  - Web interface
  - Qualified registry
  - EHRs, **OR**
  - Utilize the 70% option (70% of EPs in group must meet the criteria for the CY 2016 PQRS payment adjustment)

- If group selects GPRO reporting mechanism, group must self-nominate/register (May 2014 – September 2014); no need to self-nominate or register for the 70% option

- Meet the satisfactory reporting criteria to avoid the CY 2016 payment adjustment for selected PQRS reporting mechanisms

Physician Feedback Reports

- September 2013: Quality and Resource Use Reports for Groups of 25 or more EPs 2012
  - Drill down table including beneficiaries attributed to the group, their resource use, specific chronic diseases
  - Drill down table including all hospitalizations for attributed beneficiaries
  - Drill down table of individual EP PQRS reporting (December 2013)
- Late Summer 2014: QRURs for all Groups and Solo Practitioners

WHERE TO CALL FOR HELP

How to Submit Comments on Proposals to the CY 2014 PFS Proposed Rule

- You may submit comments in one of four ways (please choose only one):
  - **Electronically.** You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the instructions for "submitting a comment."
  - **By regular mail.** You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1590-P, P.O. Box 8013, Baltimore, MD 21244-8013. Please allow sufficient time for mailed comments to be received before the close of the comment period.
  - **By express or overnight mail.** You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1590-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.
  - **By hand or courier.** If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:
    - For delivery in Washington, DC -- CMS-1590-P, Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201
    - For delivery in Baltimore, MD -- Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850

    Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period

Where to Call for Help

- **QualityNet Help Desk:**
  - Portal password issues
  - PQRS/eRx feedback report availability and access
  - IACS registration questions
  - IACS login issues
  - PQRS and eRx Incentive Program questions

866-288-8912 (TTY 877-715-6222)

7:00 a.m.–7:00 p.m. CST M-F or **qnetsupport@sdps.org**

You will be asked to provide basic information such as name, practice, address, phone, and e-mail

- **Provider Contact Center:**
  - Questions on status of 2012 PQRS/eRx Incentive Program incentive payment (during distribution timeframe)
  - See *Contact Center Directory* at http://www.cms.gov/MLNProducts/Downloads/CallCenterTollNumDirectory.zip

- **EHR Incentive Program Information Center:**

  888-734-6433 (TTY 888-734-6563)

Resources

- **PFS Federal Regulation Notices**
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html
- **CMS PQRS Website**
  http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS
- **Medicare Shared Savings Program**
  http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html
- **CMS Value-based Payment Modifier (VM) Website**
  http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
- **Medicare and Medicaid EHR Incentive Programs**
  http://www.cms.gov/Regulations-and-Guidance/Legislation/ EHRIncentivePrograms
- **Frequently Asked Questions (FAQs)**
  https://questions.cms.gov/
- **Physician Compare**
  http://www.medicare.gov/physiciancompare/search.html

Coming in Late Summer 2013 – The Medicare Administrative Contractor Satisfaction Indicator (MSI)

Attention: Medicare-Enrolled Providers and Suppliers

- Give CMS feedback about your experience with your Medicare Administrative Contractor (MAC), the contractor that processes your Medicare claims
- Your feedback will help CMS monitor performance trends, improve oversight, and increase efficiency of the Medicare program
- Only providers and suppliers who register for the MSI will be included in the random sample to rate their MAC
- For more information and to register today for the 2013 MSI, go to http://www.cms.gov/Medicare/Medicare-Contracting/MI/

QUESTIONS & ANSWERS

Evaluate Your Experience

- Please help us continue to improve the MLN Connects National Provider Call Program by providing your feedback about today's call.
- To complete the evaluation, visit http://npc.blhtech.com/ and select the title for today's call.
- Evaluations are anonymous, confidential, and voluntary.
- All registrants will receive a reminder email about the evaluation for this call. Please disregard the email if you have already completed the evaluation.
- We appreciate your feedback.

Thank You

- For more information about the MLN Connects National Provider Call Program, please visit http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html

- For more information about the Medicare Learning Network (MLN), please visit http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html