MLN Connects™
Provider eNews

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

Thursday, October 9, 2014

MLN Connects™ National Provider Calls

Overview of the 2013 Quality and Resource Use Reports — Registration Now Open

Thursday, October 23; 2:30-4pm ET

To Register: Visit MLN Connects Upcoming Calls. Space may be limited, register early.

On September 30, CMS made 2013 Quality and Resource Use Reports (QRURs) available to group practices and physician solo practitioners nationwide. This MLN Connects™ National Provider Call will provide an overview of the 2013 QRUR and explain how to interpret and use the information in the report.

The 2013 QRURs contain quality and cost performance data for CY 2013, which is the performance period for the Value-Based Payment Modifier (VM) that will be applied to physician payments for items and services furnished under the Medicare Physician Fee Schedule for groups of 100 or more eligible professionals in 2015. The 2013 QRUR can be used to plan for improving the quality and efficiency of care provided to Medicare beneficiaries, and also to understand and improve performance on quality and cost measures for the 2016 VM. The 2013 QRURs include data assessing a group practice or solo practitioner's performance on cost measures, information about the services and procedures contributing most to beneficiaries' costs, as well as performance on quality measures including performance on three outcome measures.

The call will be more meaningful if you have your QRUR in front of you to follow along. We strongly encourage authorized representatives to sign up for a new Individuals Authorized Access to the CMS Computer Services (IACS) account or modify an existing account at https://applications.cms.hhs.gov as soon as possible in order to be able to access the QRURs prior to the call.

Quick reference guides that provide step-by-step instructions for requesting each Physician Value-Physician Quality Reporting System (PV-PQRS) system role for a new or existing IACS account are available in the "Downloads" section on the Self Nomination/Registration web page. Visit the Medicare FFS Physician Feedback Program/Value-Based Payment Modifier web page for more information on the 2013 QRURs.

Agenda:

- Opening Remarks
- Overview of the 2013 QRUR
- How to understand and use the 2013 QRURs
- Question and Answer session

Target Audience: Physicians, practitioners, therapists, medical group practices, practice managers, medical and specialty societies, payers, insurers.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

CMS 2014 Certified EHR Technology Flexibility Rule — Registration Now Open

Thursday, October 30; 2-3pm ET

To Register: Visit MLN Connects Upcoming Calls. Space may be limited, register early.

This MLN Connects™ National Provider Call provides an overview of the 2014 Certified Electronic Health Record (EHR) Technology (CEHRT) Flexibility Rule that went into effect on October 1, 2014. Some eligible professionals and eligible hospitals were unable to fully implement the 2014 Edition CEHRT for an EHR reporting period in 2014 due to delays in the 2014 Edition CEHRT availability. This presentation will cover guidance and instructions on how these eligible professionals and eligible hospitals can use the rule's flexibility to report for 2014.

The presentation also provides information about the extension of Stage 2 through 2016. A question and answer session will follow the presentation.

Agenda:

- CMS 2014 CEHRT Flexibility Rule overview
- Stage 2 extension
- 2014 flexibility options

- Attestation System updates
- CMS responses to public comments
- Resources
- Q&A

Target Audience: Physicians and hospitals eligible to participate in the Medicare and Medicaid EHR Incentive Programs, practice managers, medical and specialty societies, and vendors.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

Transitioning to ICD-10 — Register Now

Wednesday, November 5; 1:30-3pm ET

To Register: Visit MLN Connects Upcoming Calls. Space may be limited, register early.

HHS has issued a rule finalizing October 1, 2015 as the new compliance date for health care providers, health plans, and health care clearinghouses to transition to ICD-10. During this MLN Connects™ National Provider Call, CMS subject matter experts will discuss ICD-10 implementation issues, opportunities for testing, and resources. A question and answer session will follow the presentations.

Agenda:

- Final rule and national implementation
- Medicare Fee-For-Service testing
- Medicare Severity Diagnosis Related Grouper (MS-DRG) Conversion Project
- Partial code freeze and annual code updates
- Plans for National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs)
- Home health conversions
- Claims that span the implementation date

Target Audience: Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories, and all Medicare providers.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the Continuing Education Credit Information web page to learn more.

MLN Connects™ Videos

Monthly Spotlight: Physician Quality Reporting System

Want to learn more about the Physician Quality Reporting System (PQRS)? Watch The CMS Physician Quality Reporting System (PQRS) Program: What Medicare Eligible Professionals Need to Know in 2014 video. This MLN Connects™ video presentation gives an overview of the Medicare PQRS program requirements. Eligible professionals who successfully participate in the PQRS program can earn incentives that are available in 2014 and avoid the payment adjustment in 2016 for not reporting this year. Runtime: 1 hour 36 minutes. Visit the video web page to learn how you may receive Continuing Education (CE) for viewing this video.

Check out the MLN Connects Calls and Events web page where you will find slide presentations, audio recordings, and written transcripts from previous MLN Connects Calls on the PQRS as well as a listing of upcoming MLN Connects Calls. Be sure to visit the PQRS website for the most up-to-date information and additional educational resources.

Announcements

CMS Announces Two Medicare Quality Improvement Initiatives

Administration redoubles its efforts to improve quality of post-acute care for Medicare beneficiaries

On October 6, CMS announced two initiatives to improve the quality of post-acute care. First, the expansion and strengthening of the agency's widely-used Five-Star Quality Rating System for Nursing Homes will improve consumer information about individual nursing homes' quality. Second, proposed new conditions of participation for home health agencies will modernize Medicare's Home Health Agency Conditions of Participation to ensure safe delivery of quality care to home health patients.

Nursing Home Five-Star Rating System
Beginning in 2015, CMS will implement the following improvements to the Nursing Home Five-Star Quality Rating System:

- Nationwide Focused Survey Inspections: Effective January 2015, CMS and States will implement focused survey inspections nationwide for a sample of nursing homes to enable better verification of both the staffing and quality measure information that is part of the Five-Star Quality Rating System.
- Payroll-Based Staffing Reporting: CMS will implement a quarterly electronic reporting system that is auditable back to payrolls to verify staffing information. This new system will increase accuracy and timeliness of data, and allow for the calculation of quality measures for staff turnover, retention, types of staffing, and levels of different types of staffing.
- Additional Quality Measures: CMS will increase both the number and type of quality measures used in the Five-Star Quality Rating System.
- Timely and Complete Inspection Data: CMS will also strengthen requirements to ensure that States maintain a user-friendly website and complete inspections of nursing homes in a timely and accurate manner for inclusion in the rating system.
- Improved Scoring Methodology: In 2015, CMS will revise the scoring methodology by which we calculate each facility's quality measure rating, which is used to calculate the overall Five-Star rating.

Home Health Conditions of Participation
The proposed Home Health Conditions of Participation would improve the quality of home health services for Medicare and Medicaid beneficiaries by strengthening patient rights and improving communication that focuses on patient wellbeing. The proposed regulation would modernize the home health regulations for the first time since 1989 with a focus on patient-centered, well-coordinated care. Elements in the regulation include expansion of patient rights requirements; refocusing of the patient assessment on physical, mental, emotional, and psychosocial conditions; improved communication systems and requirements for a data-driven quality assessment; and a performance improvement program. For more information, visit the Home Health Agency Center.

Full text of this excerpted CMS press release (issued October 6).

New Outreach & Education Page at CMS.gov

Learn, reach out, and partner with us

CMS.gov is the official online source of information about CMS programs. Because your time is important, CMS redesigned the Outreach & Education page to make it faster and easier for you to find the information you are looking for. These changes allow you to find:

- Program updates, educational materials, and outreach events without needing to understand how CMS is structured
- All of our training and events in one place
- Outreach and education by topic or provider type

Check out the changes and let us know what you think by contacting us at Outreachandeducation@cms.hhs.gov.

Work with Older Adult Patients? New Medscape Video for CME Credit

Patient Goal-Directed Care for Older Adults With Multiple and Complex Conditions is now available on Medscape. Gain Continuing Medical Education (CME) credits while watching this video on patient goal-directed care, focusing on older adult patients with multiple and complex conditions. To view the video, you must be a registered Medscape user. There is no cost to join.

Presenters share case studies and present approaches to care that have the potential to improve quality of life and outcomes.

- Dr. David Reuben, Chief, Geriatric Medicine, David Geffen School of Medicine, University of California
- Dr. Mary Tinetti, Gladys Phillips Crofoot Professor of Medicine and Epidemiology/Public Health, Division of Geriatrics, Yale School of Medicine
- Dr. Shari Ling, Deputy Chief Medical Officer, CMS

Electronic Funds Transfer Upgrades to the Internet-based PECOS System

Over the last year, CMS listened to your feedback about Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) and made improvements to increase access to more information. PECOS is easier to use than ever with Electronic Funds Transfer (EFT) upgrades that are now available.

If a provider/supplier wishes to submit a change to the EFT information, they should select "Perform a change of Information to Current Enrollment Information." *Note:* All EFT changes must be made through the Change of Information scenario.

Providers/suppliers are able to edit all EFT Information, except the Routing Transit Number and/or Depositor Account Number, once entered and saved. Once saved, if a provider/supplier needs to update the Routing Transit Number and/or Depositor Account Number, the providers/supplier must delete all information and re-enter new information. PECOS will now collect an EFT Effective Date and Termination Date to capture the timeframe when the Financial Information is valid. The Effective Date is the date on which funds will be directed to the account information entered. The Termination Date is the date on which funds will no longer be directed to the account information entered.

PECOS has also been updated to display the most current CMS-588 form which now collects the Financial Institution's Street Address and Financial Institution's Zip Code under "Financial Institution Information."

Open Payments: Know the Numbers and Decode the Data

Know the Numbers
Use the new Data Fact Sheet from CMS to get the details about the September 2014 publication of 2013 Open Payments data. The fact sheet summarizes the entire dataset included in the recent data publication. Know the numbers for:

- Records published in September 2014
- Identified and de-identified data
- Data that was not included in the September 2014 publication
- Reviewed and disputed records

The Data Fact Sheet is located in the Explore the Data web page.

Decode the Data
CMS has developed directions to help you search the Open Payments data on the How to Filter Data Using Data Explorer Tool web page. Through these step-by-step instructions, you can learn how to search for specific data: find doctors by first and last name, search by drug or medical device name, and much more. Plus, learn how to save your searches and print the results.

For more information about Open Payments, please visit the Open Payments website. If you have any questions, you can submit an email to the Help Desk at openpayments@cms.hhs.gov. Live Help Desk support is available by calling 855-326-8366, Monday through Friday, from 7:30am to 6:30pm CT, excluding Federal holidays.

CMS is Accepting Suggestions for Potential PQRS Measures

CMS is accepting quality measure suggestions for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System (PQRS) for future rule-making years. Quality measures submitted in this Call for Measures may also be considered for use in other quality programs for physicians and other eligible professionals (e.g. Value Based Modifier, Physician Compare, Medicare Shared Savings Program, etc.).

The PQRS Call for Measures is now conducted in an ongoing open format, remaining open indefinitely. The month that a measure is submitted for consideration will determine when it may be included on the Measures Under Consideration (MUC) list. Measures submitted prior to June 15, 2015 may be considered for inclusion on the 2015 MUC list for implementation in PQRS as early as 2017.

CMS will give priority to measures that are outcome-based, answer a measure gap, and address the most up-to-date clinical guidelines. Measures submitted for consideration will be assessed to ensure that they meet the needs of the PQRS. As time permits, feedback will be provided to measure submitters upon review of their submission. When submitting measures for consideration, please ensure that your submission is not duplicative of another existing or proposed measure. Additionally, CMS is *not* accepting claims-based only reporting measures in this process. Note that measures already included in previous PQRS MUC lists may only be re-submitted for consideration if the measure has undergone substantive changes.

Each measure submitted for consideration *must* include all required supporting documentation. Documentation requirements and the submission timeline are posted on the Measures Management System Call for Measures web page Questions about this Call for Measures or the required documentation may be submitted to C4M@wvmi.org.

Note: Suggesting individual measures or measures for a new or existing measures group does not guarantee the measure(s) will be included in the proposed or final sets of measures of any Proposed or Final Rules that

address the PQRS. Additionally, measures submitted for consideration are not guaranteed to be put forth on the MUC list for MAP review. CMS will determine which individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, the agency will make the final determination with regard to the final set of quality measures for the PQRS.

PQRS: Physician Compare 2013 Group Practice Quality Measure Preview Period through November 7

As finalized in the 2013 Physician Fee Schedule (PFS) rule (CMS-1590-FC), CMS began publicly reporting a sub-set of the 2013 Physician Quality Reporting System (PQRS) Group Practice Reporting Option (GPRO) web interface measures for groups of 25 or more eligible professionals on Physician Compare starting October 6, 2014. This 30-day preview period for these quality measures which will continue through November 7, 2014. In accordance with the PFS final rule, this preview period provides an opportunity for group practices to review their measures before they are publicly reported on Physician Compare. CMS is reaching out via email to the 139 group practices that satisfactorily reported 2013 Diabetes and Coronary Artery Disease (CAD) PQRS GPRO measures via the web interface. If you are a GPRO group practice representative and have any questions about the preview process or public reporting on Physician Compare, please contact the Physician Compare Support Team at PhysicianCompare@Westat.com.

New FAQs for PQRS

To keep you updated with information on the Physician Quality Reporting System (PQRS), CMS has recently added two new FAQs to the website.

- CEHRT Day 1 FAQ: This FAQ provides information regarding when Certified Electronic Health Record Technology (CEHRT) must be implemented to be successful for 2014 PQRS reporting.
- 2014 Registry XML NPI Validation FAQ: This FAQ provides guidance on the error message received when registries are submitting National Provider Identifiers (NPIs) for group practices participating via the group practice reporting option (GPRO) for 2014 PQRS.

Want more information about PQRS? Make sure to visit the PQRS website for the latest news and updates on PQRS. You can also contact the QualityNet Help Desk at 866-288-8912 or via qnetsupport@hcqis.org. They are available from 7am to 7pm CT Monday through Friday.

EHR Incentive Programs: Hardship Exception Applications to Avoid 2015 Payment Adjustment due November 30

CMS is announcing its intent to reopen the submission period for hardship exception applications for eligible professionals and eligible hospitals to avoid the 2015 Medicare payment adjustments for not demonstrating meaningful use of Certified Electronic Health Record Technology (CEHRT). The new deadline will be November 30, 2014. Previously, the hardship exception application deadline was April 1, 2014 for eligible hospitals and July 1, 2014 for eligible professionals.

As part of the American Recovery and Reinvestment Act of 2009 (Recovery Act), Congress mandated payment adjustments under Medicare for eligible hospitals, critical access hospitals, and eligible professionals that are not meaningful users of CEHRT. The Recovery Act allows the Secretary to consider, on a case-by-case basis, hardship exceptions for eligible hospitals, critical access hospitals, and eligible professionals to avoid the payment adjustments.

This reopened hardship exception application submission period is for eligible professionals and eligible hospitals that:

- Have been unable to fully implement 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability; *and*
- Eligible professionals who were unable to attest by October 1, 2014 and eligible hospitals that were unable to attest by July 1, 2014 using the flexibility options provided in the CMS 2014 CEHRT Flexibility Rule.

These are the only circumstances that will be considered for this reopened hardship exception application submission period. Applications must be submitted *by 11:59pm ET November 30, 2014.*

More Information
More information about the application process will be shared soon. CMS intends to address this issue in upcoming rulemaking. Visit the Payment Adjustments and Hardship Exceptions web page for more information about Medicare Electronic Health Record (EHR) Incentive Program payment adjustments.

EHR Incentive Programs: Eligible Hospitals and Requirements for CEHRT to Participate in 2015

The 2015 program year for the Electronic Health Record (EHR) Incentive Programs begins on October 1, 2014 for eligible hospitals. Medicare eligible hospitals beyond their first year of participation have a 365-day EHR reporting period. All eligible hospitals are required to have 2014 Edition certified EHR technology (CEHRT) to be able to successfully participate in 2015. Some hospital objectives require that 2014 Edition CEHRT be in place for the entire reporting year, while others may only need to be in place for part of the year.

Objectives that require 2014 Edition CEHRT be in place for the entire reporting year:

- Stage 1 Drug-Drug / Drug-Allergy Interaction Checks
- Stage 2 Clinical Decision Support for Drug-Drug / Drug-Allergy

Please note: interruption during the reporting period is allowed for reasons such as system maintenance.

Public Health Objectives Flexibility
Some objectives require a test for the first demonstration, and then require ongoing submission. These objectives give eligible hospitals 60 days from the start of the reporting period to allow time for things like successfully registering, onboarding with the registry, and submitting a test. This inherently provides some flexibility for getting their 2014 Edition CEHRT in place later and submit ongoing from that point forward:

- Stage 1 and Stage 2 Immunization Registries Data Submission
- Stage 1 and Stage 2 Electronic Reportable Lab Results
- Stage 1 and Stage 2 Syndromic Surveillance Data Submission

This flexibility is only allowed if it complies with local and state laws. Some states may require retro-active submission of the data from the beginning of the year if there is a delay in implementation.

Threshold Objectives Flexibility
For all of the threshold objectives (those with a numerator and denominator), the eligible hospital must meet the threshold to meet the measure(s) and objective. Eligible hospitals may not need to have 2014 Edition CEHRT in place for the full year to be able to meet the threshold for these objectives.

If the eligible hospital meets the threshold during the reporting period, it meets the measure whether or not the function was in place for the full year.

For More Information
To learn more about the requirements for each objective, review the Stage 1 and Stage 2 specification sheets. Visit the EHR website for more program information and resources.

EHR Incentive Programs: Learn How to Report 2014 eCQMs through the QualityNet Portal

Overview of 2014 Clinical Quality Measure (CQM) Requirements
Eligible professionals attesting to 2014 CQMs are required to report 9 from a list of 64 approved CQMs for the Electronic Health Record (EHR) Incentive Programs. The CQMs reported must cover at least 3 of the 6 available National Quality Strategy (NQS) domains, which represent the HHS NQS priorities for healthcare quality improvement. Unlike 2013, 2014 CQM reporting does not require the submission of a core set of CQMs. CMS has instead identified two recommended core sets of CQMs—one for adult populations and one for pediatric populations—that focus on high-priority health conditions and best-practices for care delivery.

Reporting 2014 CQMs
Medicare eligible professionals have several options for submitting their 2014 CQMs. In addition to attesting through the CMS Registration and Attestation System, they can electronically report their data. Even if eligible professionals are not participating in the 2014 Physician Quality Reporting System (PQRS) program, they can electronically submit their 2014 electronic CQMs (eCQMs) in the Quality Reporting Document Architecture (QRDA) III format using the QualityNet Portal. Eligible professionals who would like to submit their 90 days (first year of participation) or one quarter (second year and beyond) of 2014 eCQM data through the Portal must use the most recent version of the 2014 eCQMs (June 2013), except for measure CMS140 (the December 2012 version, or CMS140v2, must be used to report this measure).

2014 Electronic CQM Reporting Resources
CMS has several resources for electronically submitting 2014 CQMs through the QualityNet Portal:

- 2014 CQM Electronic Reporting Guide
- QualityNet Portal User Guide
- 2014 CMS QRDA III Implementation Guides for Eligible Professionals Clinical Quality Measures
- eCQM Library

2014 QRDA III SEVT Testing Now Available
The Submission Engine Validation Tool (SEVT) for 2014 QRDA III submission is now available on the QualityNet Portal. CMS recommends QRDA submitters and certified EHR technology vendors use this tool for 2014 submission testing.

Medicare Learning Network® Educational Products

"Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs" Fact Sheet – Revised

The "Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs" Fact Sheet (previously titled "Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance") (ICN 006977) was revised in September 2014 and is now available in downloadable format. This fact sheet is designed to provide education on dual eligible beneficiaries under the Medicare and Medicaid Programs. It includes the following information: the Medicare and Medicaid Programs; dual eligible beneficiaries; assignment; and prohibited billing.

Medicare Learning Network® Products Available in Electronic Publication Format

The following product is now available as an electronic publication (EPUB) and through a QR code. Instructions for downloading EPUBs and how to scan a QR code are available at "How To Download a Medicare Learning Network® Electronic Publication."

The "Medicare Enrollment and Claim Submission Guidelines" Booklet (ICN 906764) is designed to provide education on applying for enrollment and submitting claims to Medicare. It includes the following information: enrolling in the Medicare Program; private contracts with Medicare beneficiaries; Medicare claims; deductibles, coinsurance, and copayments; Beneficiary Notices of Non-coverage; and billing requirements.

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