

Thursday, February 25, 2016

## MLN Connects<sup>®</sup> Events

Provider Enrollment Revalidation Call — Last Chance to Register  
Medicare Shared Savings Program Listening Session: Proposed Rule on Revised Benchmark  
Rebasing Methodology— New

## Medicare Learning Network<sup>®</sup> Publications and Multimedia

Guidance on the PQRS 2014 Reporting Year and 2016 Payment Adjustment for RHCs,  
FQHCs, and CAHs MLN Matters<sup>®</sup> Article – Released  
Ambulatory Surgical Center Fee Schedule Fact Sheet — Revised  
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## MLN Connects<sup>®</sup> Events

### Provider Enrollment Revalidation Call — Last Chance to Register

Tuesday, March 1 from 2 to 3:15 pm ET

To Register: Visit [MLN Connects Event Registration](#). Space may be limited, register early.

What's ahead for your next Medicare enrollment revalidation? Learn what you need to do and about the new resources available to help you stay on top of the process every step of the way. Join CMS experts as they discuss the timing, improvements, and updates for the second round of revalidations required by the Affordable Care Act and [42 CFR §424.515](#). A question and answer session will follow the presentation.

Target Audience: All Medicare fee-for service providers and suppliers. Note: providers enrolled solely to order and refer items or services to Medicare beneficiaries and practitioners who have opted out of the Medicare program are not required to revalidate.

Continuing education credit may be awarded for participation in certain MLN Connects Calls. Visit the [Continuing Education Credit Information](#) webpage to learn more.

## Rebasing Methodology— New

Thursday, March 3 from 2 to 3:30 pm

To Participate: Visit the [March 3](#) call webpage for instructions.

This listening session is an opportunity for CMS to receive early feedback from stakeholders on proposed policy changes to the Medicare Shared Savings Program. Participants are encouraged to review the proposed rule ([CMS-1644-P](#)) prior to the listening session.

Feedback received during the listening session will not be considered formal comments on the rule. See the proposed rule for information on submitting these comments by the close of the 60-day comment period on March 28, 2016 at 5 pm ET.

Agenda:

- Introduction to the proposed policy changes
- Feedback on proposed revisions to the benchmarking methodology: Proposals for incorporating regional Fee-For-Service (FFS) expenditures into the methodology for resetting the Accountable Care Organization's (ACO's) historical benchmark and proposals for a streamlined approach to adjusting the ACO's benchmark for changes in its composition of ACO participants
- Feedback on other proposed revisions, including an additional option to facilitate ACOs' transition to performance-based risk and administrative finality of financial calculations

Target Audience: Medicare FFS providers; ACOs currently participating in the Medicare Shared Savings Program and organizations considering applying to the program; state and national associations that represent healthcare providers and ACOs; and other stakeholders.

## Medicare Learning Network® Publications and Multimedia

### Guidance on the PQRS 2014 Reporting Year and 2016 Payment Adjustment for RHCs, FQHCs,

An MLN Matters Special Edition Article on [Guidance on the Physician Quality Reporting System \(PQRS\) 2014 Reporting Year and 2016 Payment Adjustment for Rural Health Clinics \(RHCs\), Federally Qualified Health Centers \(FQHCs\), and Critical Access Hospitals \(CAHs\)](#) is available. This article includes answers to frequently asked questions from RHCs, FQHCs, and CAHs.

### Ambulatory Surgical Center Fee Schedule Fact Sheet — Revised

A revised [Ambulatory Surgical Center Fee Schedule](#) Fact Sheet is available. Learn about:

- The definition of an Ambulatory Surgical Center (ASC)
- ASC payment and payment rates
- Updates to the ASC Fee Schedule
- ASC Quality Reporting Program

## New Educational Web Guides Fast Fact

A new fast fact is available on the [Educational Web Guides](#) webpage. Learn about:

- Evaluation and Management services
- Guided Pathways resource booklets
- Health care management, billing, and coding products

## Announcements

### Alignment and Simplification of Quality Measures

On February 16, CMS and America's Health Insurance Plans (AHIP), as part of a broad Core Quality Measures Collaborative of health care system participants, released seven sets of [clinical quality measures](#). These measures support multi-payer alignment, for the first time, on core measures primarily for physician quality programs. Partners in the Collaborative recognize that physicians and other clinicians must currently report multiple quality measures to different entities. Measure requirements are often not aligned among payers, which has resulted in confusion and complexity for reporting providers. To address this problem, CMS, commercial plans, Medicare and Medicaid managed care plans, purchasers, physician and other care provider organizations, and consumers worked together through the Collaborative to identify core sets of quality measures that payers have committed to using for reporting as soon as feasible.

The core measures are in the following seven sets:

- Accountable Care Organizations, Patient Centered Medical Homes, and Primary Care
- Cardiology
- Gastroenterology
- HIV and Hepatitis C
- Medical Oncology
- Obstetrics and Gynecology
- Orthopedics

For more information:

- Fact Sheet: [Core Quality Measures Collaborative Release](#)
- [Core Measures](#) webpage

See the full text of this excerpted [CMS press release](#) (issued February 16).

### CMS Publishes Medicare FFS Provider and Supplier Lists

Posting of Ambulance, Home Health Utilization Data Follows Recent Provider and Supplier Moratoria Extension

CMS released two public data sets on the availability and use of services provided to Medicare beneficiaries by ground ambulance suppliers and home health agencies, as well as a list of Medicare Fee-For-Service (FFS) providers and suppliers currently approved to bill Medicare.

- The [Moratoria Provider Services and Utilization Data Tool](#) was created using ground ambulance and home health agency paid claims data that reside in CMS systems for Medicare FFS beneficiaries

- The [public provider data](#) consist of individual and organizational provider and supplier enrollment information and includes names, National Provider Identifier and other unique identifiers, enrollment type, specialty, and limited address information

For more information

- Federal Register Notice: [Extended Temporary Moratoria on Enrollment of Ground Ambulance Suppliers and Home Health Agencies in Designated Geographic Locations](#)
- Fact Sheet: [Moratoria Provider and Supplier Services and Utilization Data Tool](#)
- Fact Sheet: [Public Provider and Supplier Enrollment Files](#)

See the full text of this excerpted [CMS press release](#) (issued February 22).

## **Strengthening Provider and Supplier Enrollment Screening**

CMS is strongly committed to protecting the integrity of the Medicare program and making sure only qualified providers and suppliers are enrolled. We have implemented four tactics to reinforce provider and supplier screening activities:

- Increase the number of site visits to Medicare-enrolled providers and suppliers
- Enhance address verification software in the Provider Enrollment, Chain, and Ownership System (PECOS) to better detect vacant or invalid addresses or commercial mail reporting agencies
- Deactivate providers and suppliers that have not billed Medicare in the last 13 months
- Monitor and identify potentially invalid addresses on a monthly basis through additional data analysis by checking against the U.S. Postal Service address verification database

If you are a provider or supplier, you can help us protect the integrity of the Medicare program by informing us promptly of any changes to your enrollment, as required.

For more information, see the [fact sheet](#). See the full text of this excerpted [CMS blog](#) (issued February 22).

## **CMS Seeks Public Comments on Draft Quality Measure Development Plan by March 1**

CMS is soliciting comments on the [Draft Quality Measure Development Plan \(MDP\)](#) through March 1, 2016. The MDP, as mandated by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), builds on our efforts to shift Medicare payments from volume to value. After taking all public comments, CMS will post the Final MDP on the CMS website by May 1, 2016.

For More Information:

- Blog: [CMS Quality Measure Development Plan Supporting the Transition to the Merit-Based Incentive Payment System \(MIPS\) and Alternative Payment Models \(APMs\)](#)
- [MIPS and APMs](#) webpage

## **Quality of Patient Care Star Ratings TEP: Nomination Period Open through March 18**

CMS is evaluating the methodology for calculating the Quality of Patient Care Star Ratings on the [Home Health Compare](#) website and identifying options for improvement. The Technical Expert Panel

(TEP) nomination period is open through March 18, 2016. For more information, visit the [TEP](#) website.

### **EHR Hardship Exception Application: New FAQ**

If I submit a hardship exception application by the March 15, 2016 deadline, does that mean that I cannot attest for the 2015 Electronic Health Record (EHR) reporting period and possibly receive an incentive payment?

No. Submission of a hardship exception application does not prevent a provider from attesting and receiving an incentive payment if meaningful use requirements are met. See [FAQ #14357](#) for the complete response.

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