

Thursday, March 10, 2016

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Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21
Quality of Patient Care Star Ratings TEP Call for Nominations through March 18
Home Health Agencies: Register for HHCAHPS before April 1
Next Generation ACO Model Second Application Cycle: Letter of Intent due May 2
New ST PEPPER Available
Five Ways Patients Can Become Informed Medicare Consumers
March is Colorectal Cancer Awareness Month

Claims, Pricers, and Codes

April 2016 Average Sales Price Files Available

MLN Connects[®] Events

Medicare Shared Savings Program ACO: Preparing to Apply for 2017 Call — Registration Opening Soon

Tuesday, April 5 from 1:30 to 3 pm ET

To Register: Visit [MLN Connects Event Registration](#). Registration will be opening soon.

During this call, CMS subject matter experts provide information on what you can do to prepare for the Medicare Shared Savings Program (Shared Savings Program) application process for the January 1, 2017, program start date. A question and answer session will follow the presentation.

Call participants are encouraged to review important information, dates, and materials on the [Shared Savings Program Application](#) webpage prior to the call.

Agenda:

- Introduction to the Shared Savings Program
- What is an Accountable Care Organization (ACO)?
- ACO organizational structure and governance
- ACO governing body template
- Skilled Nursing Facility (SNF) 3-day waiver application information
- Antitrust and ACOs
- Application process for January 2017 starters

Target Audience: Potential 2017 Shared Savings Program initial applicants.

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

IMPACT Act: Data Element Library Call — Registration Now Open

Thursday, April 14 from 2 to 3 pm ET

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

During this call, CMS subject matter experts discuss the development of the Data Element Library. A question and answer session will follow the presentation, including an opportunity for registrants to provide feedback on the Library.

The [Improving Medicare Post-Acute Care Transformation](#) (IMPACT) ACT requires the reporting of standardized patient assessment data by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. It specifies that certain data elements must be standardized and interoperable to allow for the exchange and use of data among these PAC and other providers to facilitate coordinated care and improved beneficiary outcomes.

Agenda:

- Data Element Library: details, purpose, and overview of content
- Type of Library information that could be publicly available
- Value of reusing standardized data elements
- Updates on upcoming stakeholder engagement activities

Target Audience: PAC providers, health IT vendors, healthcare industry professionals, and other interested stakeholders.

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

Medicare Shared Savings Program ACO Application Process Call — Registration Opening Soon

Tuesday, April 19 from 1:30 to 3 pm ET

To Register: Visit [MLN Connects Event Registration](#). Registration will be opening soon.

During this call, CMS subject matter experts cover helpful tips to complete a successful application for the Medicare Shared Savings Program (Shared Savings Program). A question and answer session will follow the presentation.

Call participants are encouraged to review important information, dates, and materials on the [Shared Savings Program Application](#) webpage prior to the call.

Agenda:

- Accountable Care Organization (ACO) participant list and participant agreements
- ACO Skilled Nursing Facility (SNF) affiliate list and SNF affiliate agreements (Track 3 ACOs only)
- Beneficiary assignment

Target Audience: Potential 2017 Shared Savings Program initial applicants.

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

Medicare Learning Network® Publications and Multimedia

Videos on Medicare Quality Reporting — New

Watch seven new MLN Connects videos on the Medicare Quality Reporting Programs, focusing on the requirements you need to meet in 2016:

- Introduction: [Medicare Quality Reporting Programs: What Eligible Professionals Need to Know in 2016](#). Run time: 15 minutes.
- Module 1: [Medicare Access and CHIP Reauthorization Act \(MACRA\) Preview](#). Run time: 6 minutes.
- Module 2: [2016 Incentive Payments and 2018 Payment Adjustments](#). Run time: 9 minutes.
- Module 3: [2016 Physician Quality Reporting System \(PQRS\) Updates](#). Run time: 20 minutes.
- Module 4: [2018 Value-Based Payment Modifier \(VM\) Policies](#). Run time: 17 minutes.
- Module 5: [Physician Compare Updates in 2016](#). Run time: 6 minutes.
- Module 6: [Meaningful Use of Certified Electronic Health Record Technology \(CEHRT\) in 2016](#). Run time: 16 minutes.

Visit [MLN Connects Videos](#) for a complete list of videos on the Medicare Quality Reporting Programs.

Swing Bed Services Fact Sheet — Revised

A revised [Swing Bed Services](#) Fact Sheet is available. Learn about:

- Swing bed services background
- Requirements that apply to hospitals and Critical Access Hospitals
- Payments

Rural Health Clinic Fact Sheet — Revised

A revised [Rural Health Clinic](#) Fact Sheet is available. Learn about:

- Rural Health Clinic (RHC) background
- Services
- Medicare certification as a RHC
- Visits and payments
- Cost reports
- Annual reconciliation

Diagnosis Coding: Using the ICD-9 Web-Based Training — Revised

With Continuing Education Credit

A revised Diagnosis Coding: Using the ICD-9 Web-Based Training (WBT) course is available through the [MLN Learning Management and Product Ordering System](#). Learn about:

- Definitions and uses of diagnosis coding
- Characteristics of the ICD-9 coding volumes
- ICD-9 terminology

Announcements

CMS Proposes to Test New Medicare Part B Prescription Drug Models

On March 8, CMS announced a proposed rule to test new models to improve how Medicare Part B pays for prescription drugs and supports physicians and other clinicians in delivering higher quality care. Medicare Part B covers prescription drugs that are administered in a physician's office or hospital outpatient department. The proposed rule seeks comments on testing six different alternative approaches for Part B drugs to improve outcomes and align incentives to improve quality of care and spend dollars wisely:

- Improving incentives for best clinical care
- Discounting or eliminating patient cost-sharing
- Feedback on prescribing patterns and online decision support tools
- Indications-based pricing
- Reference pricing
- Risk-sharing agreements based on outcomes

For More Information:

- [Proposed Rule](#)
- Fact Sheet: [CMS proposes to test new Medicare Part B prescription drug models to improve quality of care and deliver better value for Medicare beneficiaries](#)
- [Part B Drugs Payment Model](#) website
- [Medicare Part B Drugs: Pricing and Incentives](#) HHS webpage
- [Observations on Trends in Prescription Drug Spending](#) HHS webpage

See the full text of this excerpted [CMS press release](#) (issued March 8).

HHS Reaches Goal of Tying 30 Percent of Medicare Payments to Quality Ahead of Schedule

Thanks to tools provided by the Affordable Care Act, an estimated 30 percent of Medicare payments are now tied to alternative payment models that reward the quality of care over quantity of services provided to beneficiaries, HHS announced on March 3. In January 2015, the Administration announced [clear goals and a timeline](#) for shifting Medicare reimbursements from quantity to quality, setting a goal of 30 percent of Medicare payments through alternative payment models by the end of 2016.

- With the January 2016 announcement of 121 [new Accountable Care Organizations \(ACOs\)](#), as well as greater provider participation in other models, HHS estimates that it has achieved that goal well ahead of schedule
- As of January 2016, CMS estimates that roughly \$117 billion out of a projected \$380 billion Medicare Fee-For-Service (FFS) payments are tied to alternative payment models

For More Information:

- Fact Sheet: [Overview of Select Alternative Payment Models](#)
- Fact Sheet: [Better Care. Smarter Spending. Healthier People: Improving Quality and Paying for What Works](#)
- Memo: [Methodology and Calculations for the 2016 Estimate of FFS Payments to Alternative Payment Models](#)

See the full text of this excerpted [HHS press release](#) (issued March 3).

2016 Value Modifier Results and Upward Payment Adjustment Factor

CMS announced [results](#) from the implementation of the 2016 Value-based Payment Modifier (Value Modifier) and the [adjustment factor](#) that will be applied to physician groups that are subject to upward payment adjustments under the Value Modifier in 2016. The upward payment adjustment factor in 2016 is +15.92%. The Value Modifier adjustment factor is determined after the close of the performance period and is based on the estimated aggregate amount of downward payment adjustments.

There are 13,813 physician group practices with 10 or more eligible professionals that are subject to the 2016 Value Modifier based on performance in 2014:

- Physicians in 128 groups exceeded the program's benchmarks in quality and cost efficiency and will receive an increase in their payments under the Medicare Physician Fee Schedule
- Physicians in 59 groups will see a decrease in their Medicare payments in 2016 based on their performance
- Physicians in 5,418 groups that failed to meet minimum reporting requirements will see a decrease in their Medicare payments in 2016
- Medicare payments for most physician groups nationwide (8,208 groups) that met the minimum reporting requirements will remain unchanged in 2016 because of their performance on quality and cost efficiency measures or because there was insufficient data to calculate the groups' Value Modifier

For more information, see [CY 2016 Payment Adjustment – Physician Groups of 10 or more Eligible Professionals](#). For questions, contact the Physician Value Help Desk at 888-734-6433 (select option 3) or pvhelpdesk@cms.hhs.gov.

Open Payments System Registration for Physicians and Teaching Hospitals

Industry is currently submitting data to the Open Payments System on payments or transfers of value made to physicians and teaching hospitals during 2015. When data submission ends, physicians and teaching hospitals can review and dispute records attributed to them. The review and dispute period will begin in April 2016 and last for 45 days. CMS will publish the 2015 payment data and updates to the 2013 and 2014 data on June 30, 2016.

The Open Payments system is available for physician and teaching hospital registration. Registering in the Open Payments system is voluntary for physicians and teaching hospitals, but it is required to review and dispute data attributed to you. Initial registration is a two-step process that takes about 30 minutes. You should have your National Provider Identifier (NPI) number, Drug Enforcement Agency (DEA) number and state license number (SLN) available.

1. Register in the [CMS Enterprise Identity Management System \(EIDM\)](#)
2. Register in the Open Payments system (accessible via the EIDM).

If you registered last year, you are not required to register again this year. However, if it has been over 180 days since you logged onto the EIDM, your account has been deactivated for security purposes. Contact the Help Desk.

For More Information:

- [EIDM Registration](#): Quick Reference Guide
- [Physician Registration](#): Quick Reference Guide
- [Teaching Hospital Registration](#): Quick Reference Guide
- [Open Payments Resources](#) webpage
- [2015 Open Payments Program Overview and Enhancements](#)

For questions, contact the Help Desk at openpayments@cms.hhs.gov or 855-326-8366, Monday through Friday from 8:30 am to 7:30 pm ET.

2015 PQRS Data Submission Deadlines

2015 Physician Quality Reporting System (PQRS) data submission ends at 8 pm ET on the end date listed:

- Electronic Health Record Direct or Data Submission Vendor (QRDA I or III) – March 11
- Qualified Clinical Data Registries (QCDRs) (QRDA III) – March 11
- Group Practice Reporting Option Web Interface – March 11
- Qualified Registries (Registry XML) - March 31
- QCDRs (QCDR XML) – March 31

An Enterprise Identity Management (EIDM) account with the “Submitter Role” is required for these PQRS data submission methods. See the [EIDM System Toolkit](#) for additional information.

The Physician and Other Health Care Professionals Quality Reporting Portal may be unavailable due to maintenance during these times:

- March 11 at 8 pm through March 14 at 6 am ET
- March 16 at 8 pm through March 21 at 6 am ET

For questions, contact the QualityNet Help Desk at 866-288-8912 or Qnetsupport@hcqis.org from 7 am to 7 pm CT. For complete information, visit the [PQRS](#) website.

EHR Incentive Programs: Attest to 2015 Program Requirements by March 11

Eligible professionals, eligible hospitals, and Critical Access Hospitals (CAHs) participating in the Medicare Electronic Health Record (EHR) Incentive Program must attest using the [EHR Incentive Program Registration and Attestation System](#) by Friday, March 11, 2016, at 11:59 pm ET. Medicaid EHR Incentive Program participants should refer to their respective [states](#) for attestation information and deadlines.

To attest to the EHR Incentive Programs in 2015:

- Eligible Professionals may select an EHR reporting period of any continuous 90 days from the start of the 2015 calendar year (January 1, 2015) through December 31, 2015
- Eligible Hospitals/CAHs may select an EHR reporting period of any continuous 90 days from October 1, 2014 (the start of the federal fiscal year) through December 31, 2015

Attestation Resources:

- [Preparing to Participate in the EHR Incentive Programs Fact Sheet](#)
- Eligible Professionals: [Attestation Worksheet](#) and [User Guide](#)
- Eligible Hospitals/CAHs: [Attestation Worksheet](#) and [User Guide](#)

For more information, visit the [Registration and Attestation](#) webpage. For attestation questions, contact the EHR Information Center Help Desk at 888-734-6433/ TTY 888-734-6563 and select option 1, Monday to Friday from 8:30 am to 7:30 pm ET.

Hospice, IRF, LTCH, SNF, HHA: QIES System Downtime from March 16 through 21

All Quality Improvement and Evaluation System (QIES) systems will be unavailable from Wednesday, March 16 after 8 pm ET through Monday, March 21, 2016. This downtime will affect all QIES connectivity and systems. The national database, Certification and Survey Provider Enhanced Reporting (CASPER) reports, and quick reference (QW) will not be available during this time. In addition, the following submission systems will be unavailable:

- Hospice Item Set
- [Inpatient Rehabilitation Facility \(IRF\) -Patient Assessment Instrument \(PAI\)](#)
- Long-term Care Hospital (LTCH) Continuity Assessment Record and Evaluation (CARE) Data Set
- Minimum Data Set (MDS) and Payroll-Based Journal
- Outcome and Assessment Information Set (OASIS)

Affected providers should make contingency plans to accommodate for this downtime.

Quality of Patient Care Star Ratings TEP Call for Nominations through March 18

CMS is accepting nominations for a Technical Expert Panel (TEP) to evaluate the methodology for calculating the Quality of Patient Care Star Ratings on the Home Health Compare website and

identify options for improvement. Self-nominate or nominate others for consideration through March 18. For additional information, visit the [TEP](#) webpage.

Home Health Agencies: Register for HHCAHPS before April 1

The next annual payment update period for the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) Survey starts April 1, 2016. Contact HHCAHPS@RTI.ORG to register. Visit the [HHCAHPS Survey](#) website for more information and to choose a survey vendor.

Next Generation ACO Model Second Application Cycle: Letter of Intent due May 2

The application for the second and final round of the Next Generation Accountable Care Organization (ACO) Model is available on the [Next Generation ACO Model](#) webpage. The Model will begin its second performance year on January 1, 2017. All organizations interested in applying must submit a Letter of Intent by May 2, 2016.

The CMS Innovation Center is holding an informational Open Door Forum (ODF) on March 22 to help guide applicants through the application process and provide more detailed information on the Model. Visit the [Next Generation ACO Model](#) webpage for information on the ODF and additional resources.

New ST PEPPER Available

The Short-Term (ST) Acute Care Program for Evaluating Payment Patterns Electronic Report (PEPPER) with statistics through the fourth quarter of FY 2015 is available for ST acute care hospitals nationwide. PEPPER files were recently distributed through a QualityNet secure file exchange to hospital QualityNet Administrators and user accounts with the PEPPER recipient role. Revised in this release:

- Both “Readmission” target areas now exclude rehabilitation and primary psychiatric Clinical Classification Software diagnosis categories from the numerator and from the denominator
- Both “Readmission” target areas now exclude patient discharge status code 07 (left against medical advice) from the numerator and denominator

PEPPER summarizes hospital-specific data statistics for Medicare severity diagnosis-related groups and discharges at risk for improper payments. It is distributed by TMF® Health Quality Institute under contract with CMS. Visit PEPPERresources.org to access resources, including the [user guide](#), recorded training sessions, information about QualityNet accounts, [frequently asked questions](#), and examples of how other hospitals are using PEPPER.

If you have questions or need help obtaining your report, visit the [Help Desk](#). Send us your [feedback or suggestions](#).

Five Ways Patients Can Become Informed Medicare Consumers

During National Consumer Protection Week, March 6 through 12, CMS is educating beneficiaries on becoming informed Medicare consumers, including how to protect their identity and report fraud. See the Medicare [blog](#).

March is Colorectal Cancer Awareness Month

Colorectal cancer is the third most common cancer for men and women. It is most often found in people aged 50 years and older and affects all racial and ethnic groups. Help protect your Medicare patients by recommending colorectal cancer screening if appropriate.

For More Information:

- [Medicare Preventive Services](#) Educational Tool
- [Screen for Life: National Colorectal Cancer Action Campaign](#) - Centers for Disease Control and Prevention

Visit the [Preventive Services](#) website to learn more about Medicare-covered services.

Claims, Pricers, and Codes

April 2016 Average Sales Price Files Available

CMS posted the April 2016 Average Sales Price (ASP) and Not Otherwise Classified (NOC) pricing files and crosswalks on the [2016 ASP Drug Pricing Files](#) webpage.

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