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News & Announcements

Medicare Will Use Private Payor Prices to Set Payment Rates for Clinical Diagnostic Laboratory Tests Starting in 2018

On June 17, CMS released a final rule implementing Section 216(a) of the Protecting Access to Medicare Act of 2014 (PAMA), requiring laboratories performing clinical diagnostic laboratory tests to report the amounts paid by private insurers for laboratory tests. Medicare will use these private insurer rates to calculate Medicare payment rates for laboratory tests paid under the Clinical Laboratory Fee Schedule (CLFS) beginning January 1, 2018.

The final rule includes provisions to ease administrative burdens for physician office laboratories and smaller independent laboratories. The final rule will generally require reporting entities to report

private payor rates and test volumes for laboratory tests if an applicable laboratory receives at least \$12,500 in Medicare revenues from laboratory services paid under the CLFS and more than 50 percent of its Medicare revenues from laboratory and/or physician services.

For the system's first year, laboratories will collect private payor data from January 1, 2016, through June 30, 2016, and report it to CMS between January 1, 2017, and March 31, 2017. CMS will calculate and post the new Medicare rates by early November 2017. These rates will take effect on January 1, 2018.

For More Information:

- [Final Rule](#)
- [Fact Sheet](#)

See the full text of this excerpted [CMS press release](#) (issued June 17).

HHS Announces Major Initiative to Help Small Practices Prepare for the Quality Payment Program

Over the last few weeks, HHS made several important announcements related to the Quality Payment Program, which is proposed to implement the new, bipartisan law changing how Medicare pays clinicians, known as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). On June 20, HHS announced \$20 million to fund on-the-ground training and education for Medicare clinicians in individual or small group practices of 15 clinicians or fewer. These funds will help provide hands-on training tailored to small practices, especially those that practice in historically under-resourced areas including rural areas, health professional shortage areas, and medically underserved areas.

As required by MACRA, HHS will continue to award \$20 million each year over the next five years, providing \$100 million in total to help small practices successfully participate in the Quality Payment Program. In order to receive funding, organizations must demonstrate their ability to strategically provide customized training to clinicians. And, most importantly, these organizations will provide education and consultation about the Quality Payment Program at no cost to the clinician or their practice. Awardees will be announced by November 2016.

For More Information:

- Solicitation on [FedBizOpps.gov](#)
- [Quality Payment Program](#) webpage

See the full text of this excerpted [HHS press release](#) (issued June 20).

Comment on the MACRA Proposed Rule by June 27

CMS invites the public to comment on the [Medicare Access and CHIP Reauthorization Act of 2015 \(MACRA\)](#) proposed rule. Comments are due by 5 pm ET (for mail or courier submissions) and 11:59 pm ET (for electronic submissions) on Monday, June 27, 2016.

MACRA makes three important changes to how Medicare pays those who give care to Medicare beneficiaries. These changes create the [Quality Payment Program](#), which:

- Ends the Sustainable Growth Rate formula for determining Medicare payments for health care providers' services
- Creates a new framework for rewarding health care providers for giving better care not just more care
- Combines our existing quality reporting programs into one new system

These proposed changes replace a patchwork system of Medicare reporting programs with a flexible system that allows participants to choose from two paths that link quality to payments: the Merit-Based Incentive Payment System and Advanced Alternative Payment Models.

2016 PQRS GPRO Registration Open through June 30

Groups of two or more Eligible Professionals (EPs) can avoid the -2.0% CY 2018 Physician Quality Reporting System (PQRS) payment adjustment by meeting the satisfactory reporting criteria through the 2016 PQRS Group Reporting Option (GPRO). The Physician Value - PQRS (PV-PQRS) Registration System is now open through June 30 for groups to select a GPRO reporting mechanism:

- Qualified PQRS Registry
- Electronic Health Record (EHR) via Direct EHR using certified EHR technology (CEHRT) or CEHRT via Data Submission Vendor
- Web Interface (for groups with 25 or more EPs only)
- Qualified Clinical Data Registry (QCDR)
- Consumer Assessment of Health Providers and Systems (CAHPS) for PQRS Survey via a CMS-certified Survey Vendor (as a supplement to another GPRO reporting mechanism)

Avoiding the CY 2018 PQRS payment adjustment by satisfactorily reporting via a PQRS GPRO is one of the ways groups can avoid the automatic downward payment adjustment under the Value Modifier (-2.0% or -4.0% depending on the size and composition of the group) and qualify for adjustments based on performance in CY 2018. Alternatively, groups that choose not to report via the PQRS GPRO in 2016 must ensure that the EPs in the group participate in the PQRS as individuals in 2016 and at least 50 percent of the EPs meet the criteria to avoid the CY 2018 PQRS payment adjustment.

For More Information:

- [2016 PQRS GPRO Registration Guide](#)
- [PQRS GPRO Registration](#) webpage
- [PQRS Payment Adjustment Information](#) webpage
- [CAHPS for PQRS Made Simple](#)

Hospice Quality Reporting: Annual Payment Update

CMS is mailing notifications to hospices that are not in compliance with Hospice Quality Reporting requirements; all notifications will be mailed by June 29. For CY 2015 (FY 2017) and after, CMS considers both Hospice Item Set (HIS) and Hospice CAHPS® survey data from January 1 through December 31 to determine the Annual Payment Update (APU) compliance threshold. If you receive a notice of non-compliance, you have the opportunity to submit a request for reconsideration on quality data submissions affecting your FY 2017 APU. See the instructions in your notification letter and on the [Reconsideration Requests](#) webpage.

Quality Payment Program: What's Available Online

If you have not explored the [Quality Payment Program](#) website, take a look at the information that is available, including:

- [Overview](#) video
- [Support and Flexibility for Small Practices](#) fact sheet
- Overview presentation: [long version](#) and [short version](#)
- [Advancing Care Information](#) presentation
- [Merit-Based Incentive Payment System \(MIPS\)](#) presentation
- [Quality Performance Category under MIPS](#) presentation
- [Resource Use Performance Category under MIPS](#) presentation
- [Clinical Practice Improvement Activities Performance Category under MIPS](#) presentation
- [All-Payer Overview](#) presentation

Claims, Pricers & Codes

Chronic Care Management Payment Correction for RHCs and FQHCs

Effective January 1, Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) began receiving payment for Chronic Care Management (CCM) services. Payment should be calculated based on the Medicare Physician Fee Schedule national average non-facility payment rate. CMS is aware that RHCs and FQHCs have been receiving a locality adjusted payment rate for CCM services. Your Medicare Administrative Contractor will adjust any claim processed incorrectly. No provider action is required.

Upcoming Events

Comparative Billing Report on Diabetic Testing Supplies Webinar — June 27

Wednesday, June 27 from 3 to 4:30 pm ET

Join CMS for an informative discussion of the comparative billing report on Diabetic Testing Supplies (CBR201609), an educational tool for Medicare suppliers who dispense glucose reagent strips and lancets for diabetic testing to Medicare beneficiaries. During the webinar, suppliers will interact directly with content specialists and submit questions about the report. See the [announcement](#) for more information, and find out how to participate.

Understanding the ESRD Measures Manual Webinar — June 28

Tuesday, June 28 from 2 to 3 pm ET

To register, visit the [registration](#) webpage. For questions about registration, email CMSQualityTeam@ketchum.com.

CMS recently released the ESRD Measures Manual, which provides detailed specifications for performance measures used by the ESRD Quality Incentive Program (QIP) and Dialysis Facility Compare. In this webinar, CMS will provide an overview of the Manual. Also, find out how you can offer feedback and propose non-substantive, technical changes to measure specifications through the

JIRA platform. CMS invites attendees to ask questions during the question-and-answer period. A CMS representative will respond in the order questions are received.

For more information, visit the [ESRD QIP](#) website. Attendees are encouraged to review the [ESRD Measures Manual](#) and [JIRA User Guide](#) before the webinar.

Clinical Diagnostic Laboratory Test Payment System Final Rule Call — July 6

Wednesday, July 6 from 2:30 to 3:45 pm ET

To register or for more information, visit [MLN Connects® Event Registration](#). Space may be limited, register early.

During this call, CMS experts provide a high level overview of the final policies in the Clinical Diagnostic Laboratory Test Payment System final rule ([CMS-1621-F](#)). The final rule, issued by CMS on June 17, significantly revises the Medicare payment system for clinical diagnostic laboratory tests and discusses a related data collection system.

Agenda:

- Overview of final policies regarding CMS-1621-F
- Data collection system
- Questions and answers

Target Audience: Clinical diagnostic laboratory industry.

Quality Measures and the IMPACT Act Call — July 7

Thursday, July 7 from 1:30 to 3 pm ET

To register or for more information, visit [MLN Connects Event Registration](#). Space may be limited, register early.

During this call, CMS experts discuss key quality measures related to the Improving Medicare Post-Acute Care Transformation Act of 2014 ([IMPACT Act](#)) and how they will affect you. Also, find out about upcoming stakeholder engagement activities. Following the presentation, participants can share insights and thoughts on the measures during the question and answer/discussion session.

The IMPACT Act requires the reporting of standardized patient assessment data on quality measures, resource use, and other measures by Post-Acute Care (PAC) providers, including skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals.

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

SNF Quality Reporting Program Call — July 12

Tuesday July 12 from 1:30 to 3 pm ET

To register or for more information, visit [MLN Connects Event Registration](#). Space may be limited, register early.

Learn about the reporting requirements for the new Skilled Nursing Facility (SNF) Quality Reporting Program (QRP), effective October 1, 2016. The [Improving Medicare Post-Acute Care Transformation Act of 2014](#) (IMPACT Act) established the SNF QRP and requires the submission of standardized data.

Agenda:

- IMPACT Act
- Measures
- Reporting requirements for FY 2018 payment determination
- Consequences of failing to meet the reporting requirements
- Reconsideration and exception/extension procedures

Target Audience: SNF providers.

Medicare Learning Network® Publications & Multimedia

Video Slideshow for QRUR Webcast — New

The [video slideshow](#) for the May 19 MLN Connects webcast on [2015 Mid-Year QRURs](#) is available. This event gives an overview of the 2015 Mid-Year Quality and Resource Use Reports (QRURs) and explains how to interpret and use the information.

DMEPOS Accreditation Fact Sheet — Revised

A revised [DMEPOS Accreditation](#) Fact Sheet is available. Learn about:

- Accreditation requirement, including types of exempt providers
- Accreditation process for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Resources

MREP Software Fact Sheet — Revised

A revised [MREP Software](#) Fact Sheet is available. Learn about:

- Basic software overview for Medicare Remit Easy Print (MREP)
- Benefits of using the electronic remittance advice information
- Minimum system requirements

Medicare Vision Services Fact Sheet — Revised

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

- Coding requirements
- Coverage guidelines and exclusions

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

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