

Thursday, July 7, 2016

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News & Announcements

HHS Announces Physician Groups Selected for an Initiative Promoting Better Cancer Care

HHS Oncology Care Model Attracts Almost Twice the Expected Number of Physician Group Practices

On June 29, HHS announced that it selected nearly 200 physician group practices and 17 health insurance companies to participate in a care delivery model that supports and encourages higher quality and more coordinated cancer care. The Medicare arm of the Oncology Care Model includes more than 3,200 oncologists and will cover approximately 155,000 Medicare beneficiaries nationwide. The Oncology Care Model begins on July 1, 2016, and runs through June 30, 2021.

The Oncology Care Model encourages practices to improve care and lower costs through episodic and performance-based payments that reward high-quality patient care. As part of this model, physician practices may receive performance-based payments for episodes of care surrounding chemotherapy administration to Medicare patients with cancer, as well as a monthly care management payment for each beneficiary. The two-sided risk track of this model will be an Advanced Alternative Payment Model under the newly proposed [Quality Payment Program](#), implementing provisions from the Medicare Access and CHIP Reauthorization Act of 2015.

Practices participating in the five-year Oncology Care Model will provide treatment following nationally recognized clinical guidelines for beneficiaries undergoing chemotherapy, with an emphasis on person-centered care. They will provide enhanced services to beneficiaries who are in the Oncology Care Model to help them receive timely, coordinated treatment.

For More Information:

- [Fact Sheet](#)
- [Oncology Care Model](#) webpage, including names of participating practices and payers

See the full text of this excerpted [HHS press release](#) (issued June 29).

Open Payments Program Posts 2015 Financial Data

On June 30, CMS published 2015 Open Payments data, along with newly submitted and updated payment records for the 2013 and 2014 reporting periods. The Open Payments program requires that transfers of value by manufacturers of drugs, devices, biologicals, and medical supplies that are paid to physicians and teaching hospitals be published on a public website. For Open Payments program year 2015, health care industry manufacturers reported \$7.52 billion in payments and ownership and investment interests to physicians and teaching hospitals. This amount is comprised of 11.90 million total records attributable to 618,931 physicians and 1,116 teaching hospitals. The amount and distribution of payments and ownership and investment interest categories remained consistent between the 2014 and 2015 reporting periods.

For More Information:

- [Open Payments Data](#) website
- Blog: [CMS Releases Third Year of Open Payments Data](#)

See the full text of this excerpted [CMS press release](#) (issued June 30).

Hospice CAHPS® Exemption for Size Deadline: August 10

The application deadline for a size exemption from the Hospice CAHPS Survey is August 10, 2016. For the CY 2016 data collection period, Medicare-certified hospices that served fewer than 50 survey-eligible clients in CY 2015 can apply for exemption from the CAHPS Hospice Survey. Exemptions on the basis of size are active for one year only; you must resubmit an application even if you applied last year.

For More Information:

- [Hospice CAHPS Survey](#) website
- [Participation Exemption for Size](#) webpage: Application form and instructions
- Contact the CAHPS Hospice Survey Project Team at hospicecahpsurvey@HCQIS.org or 844-472-4621

Help Us Improve Access to DMEPOS

On June 24, CMS posted the End Stage Renal Disease Prospective Payment System (ESRD PPS) proposed rule ([CMS 1651-P](#)). This rule includes provisions related to Durable Medical Equipment,

Prosthetics, Orthotics, and Supplies (DMEPOS). You have an opportunity to submit comments, concerns, and suggestions for improving access to DMEPOS for beneficiaries enrolled in both Medicare and Medicaid. [Comments](#) will be accepted through August 23.

Revised CMS-855R Application: Reassignment of Medicare Benefits

Physicians and non-physician practitioners must use the revised CMS-855R (Reassignment of Benefits) application beginning January 1, 2017. The revised application will be posted on the [CMS Forms List](#) by mid-summer. Medicare Administrative Contractors will accept both the current and revised versions of the CMS-855R through December 31, 2016. Visit the [Medicare Provider-Supplier Enrollment](#) webpage for more information about Medicare enrollment.

The revised form made the primary practice location section optional. However, this information is shared with other programs, such as the Physician Compare Initiative, to help beneficiaries identify your practice.

July Quarterly Provider Update Available

The July [Quarterly Provider Update](#) is available. Find out about:

- Regulations and major policies currently under development during this quarter
- Regulations and major policies completed or cancelled
- New or revised manual instructions

Rule Gives Providers/Employers Improved Access to Information for Better Patient Care

MACRA provides expanded opportunity for the use of Medicare and private sector claims data to drive higher quality, lower cost care

On July 1, CMS finalized new rules that will enrich the Qualified Entity Program by expanding access to analyses and data that will help providers, employers, and others make more informed decisions about care delivery and quality improvement. The new rules, as required by the Medicare Access and CHIP Reauthorization Act (MACRA), allow organizations approved as qualified entities to confidentially share or sell analyses of Medicare and private sector claims data to providers, employers, and other groups who can use the data to support improved care. The rule also includes strict privacy and security requirements for all entities receiving patient identifiable and beneficiary de-identified analyses or data.

Qualified entities must combine Medicare data with other claims data (e.g., private payer data) to produce quality reports that are representative of how providers and suppliers are performing across multiple payers. Currently, 15 organizations have applied and received approval to be a qualified entity.

For More Information:

- [Final rule](#)
- [Qualified Entity Program](#)

See the full text of this excerpted [CMS press release](#) (issued July 1).

Claims, Pricers & Codes

Modifications to HCPCS Code Set

The scheduled release of modifications to the Healthcare Common Procedure Coding System (HCPCS) code set are available on the [HCPCS Quarterly Update](#) web page. Changes are effective on the dates indicated on the update.

Upcoming Events

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.

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Medicare Quarterly Provider Compliance Newsletter Educational Tool — New

A new [Medicare Quarterly Provider Compliance Newsletter \[Volume 6, Issue 4\]](#) is available. Learn about:

- How to avoid common billing errors and other erroneous activities when dealing with the Medicare Program
- How to address and avoid the top issues of the particular Quarter

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- [MLN Matters Articles Electronic Mailing List](#): MLN Matters are national articles that educate health care professionals about important changes to CMS programs.

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