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National Provider Call

How to Meet Quality Reporting Requirements, Earn Incentives, and Avoid Negative/Downward Payment Adjustments in 2017 for CMS Medicare Quality Programs

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CMS
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Agenda

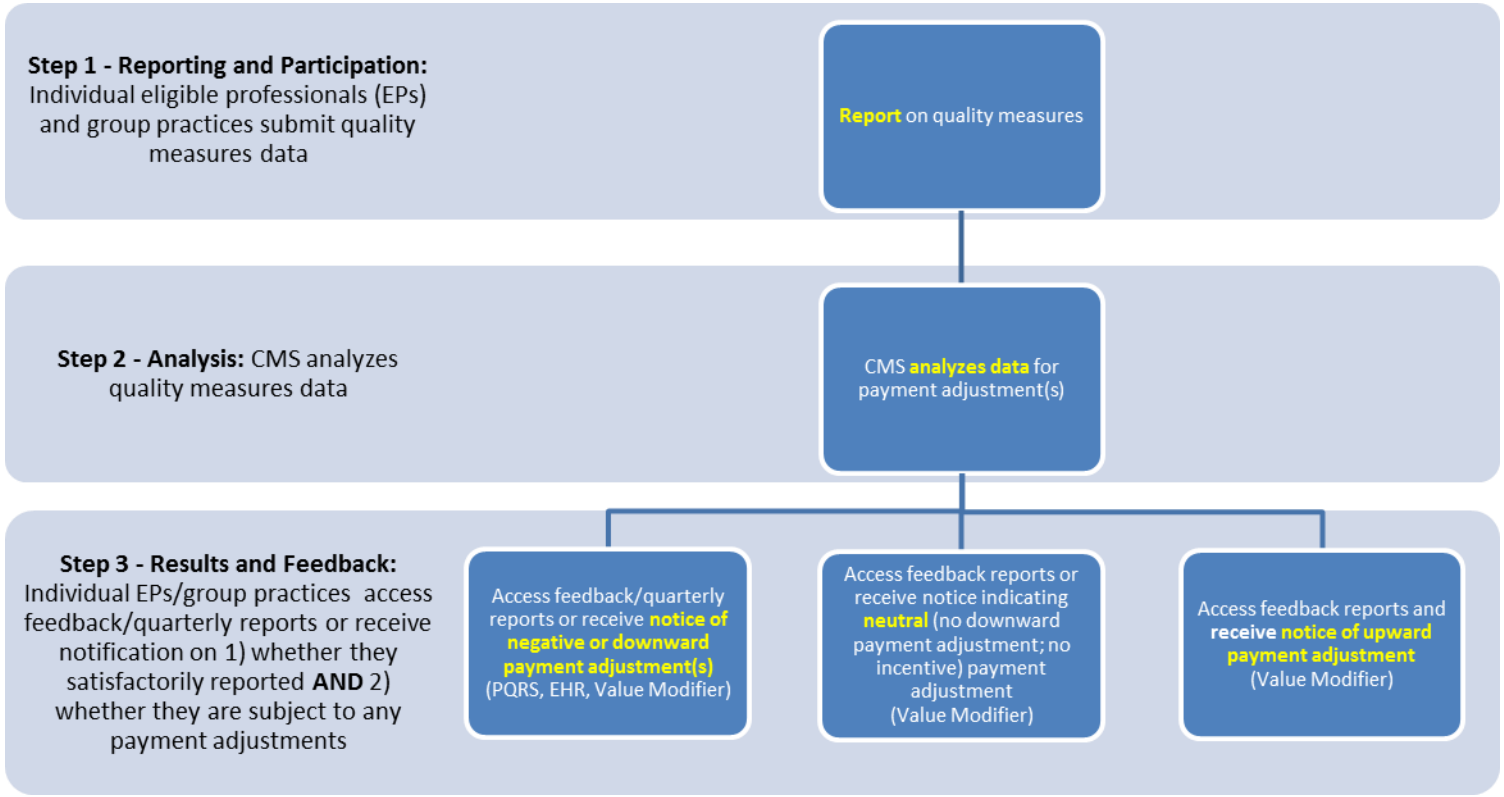
- How to Meet Quality Reporting Requirements, Earn Incentives, and Avoid Negative/Downward Payment Adjustments in 2017 under:
  - Physician Quality Reporting System (PQRS)
  - Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs
  - Value-Based Payment Modifier (VM)
- Understanding the 2017 Payment Adjustments
- Resources & Who to Call for Help
- Question & Answer Session

Physician Quality Reporting System (PQRS)

Presenter: Alexandra Mugge

Overview of the Reporting Process

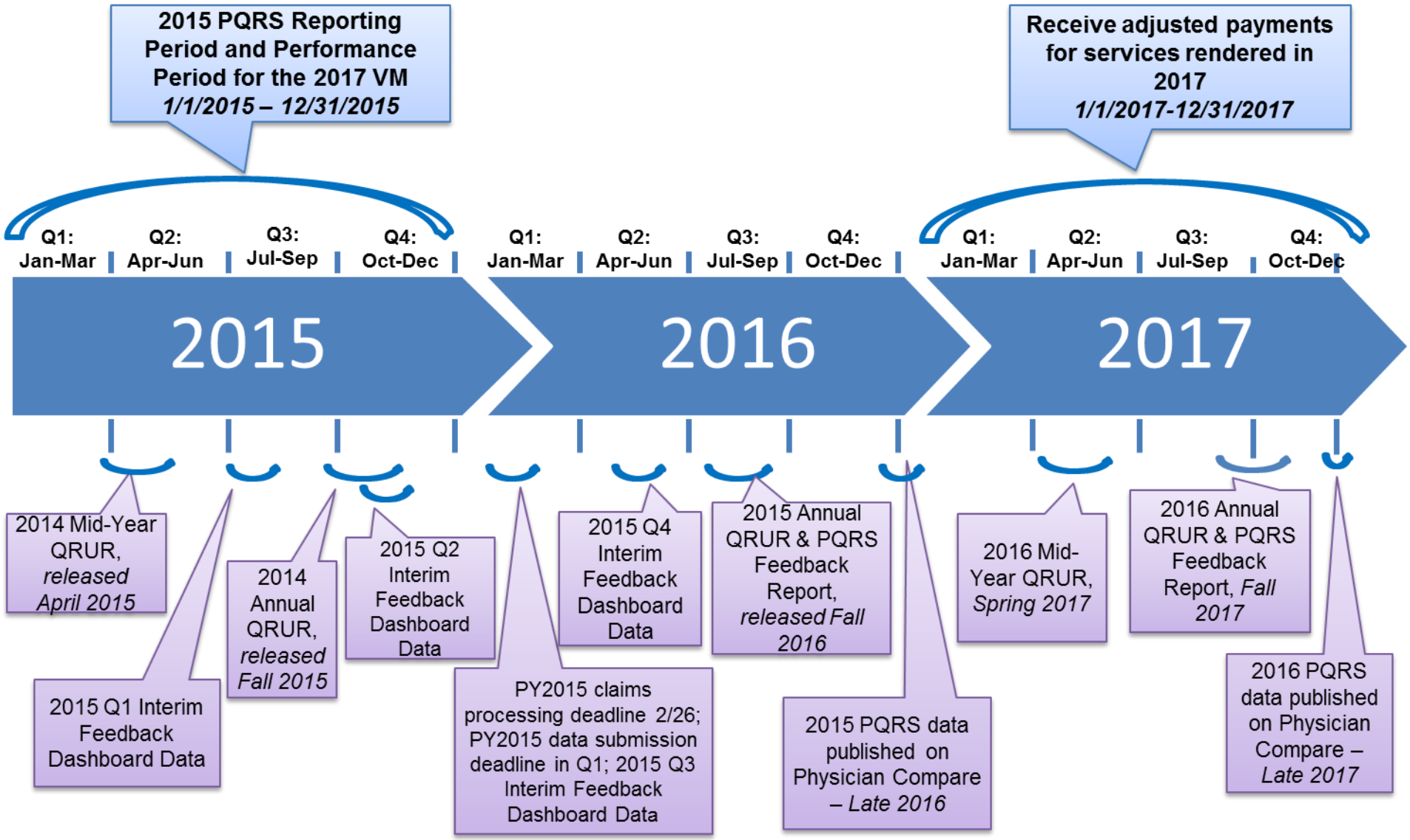
- Below are the 3 high-level steps for participation in the PQRS, Medicare EHR Incentive Program, and VM



Step 1 – Submit Quality Measures Data

- Learn how individual EPs and group practices can report quality measures one time during the 2015 reporting period in order to:
  - Avoid the 2017 PQRS negative payment adjustment
  - Satisfy the clinical quality measure (CQM) component of the Medicare EHR Incentive Program to avoid the 2017 EHR Incentive Program negative payment adjustment
  - Earn an incentive based on performance and avoid the automatic 2017 downward payment adjustment under the VM

PQRS Feedback Timeline



Disclaimer

- If reporting for PQRS through another CMS program (e.g., Medicare Shared Savings Program, Comprehensive Primary Care initiative, Pioneer Accountable Care Organizations), contact the program for more information regarding the Medicare Quality Reporting Program's payment adjustments.

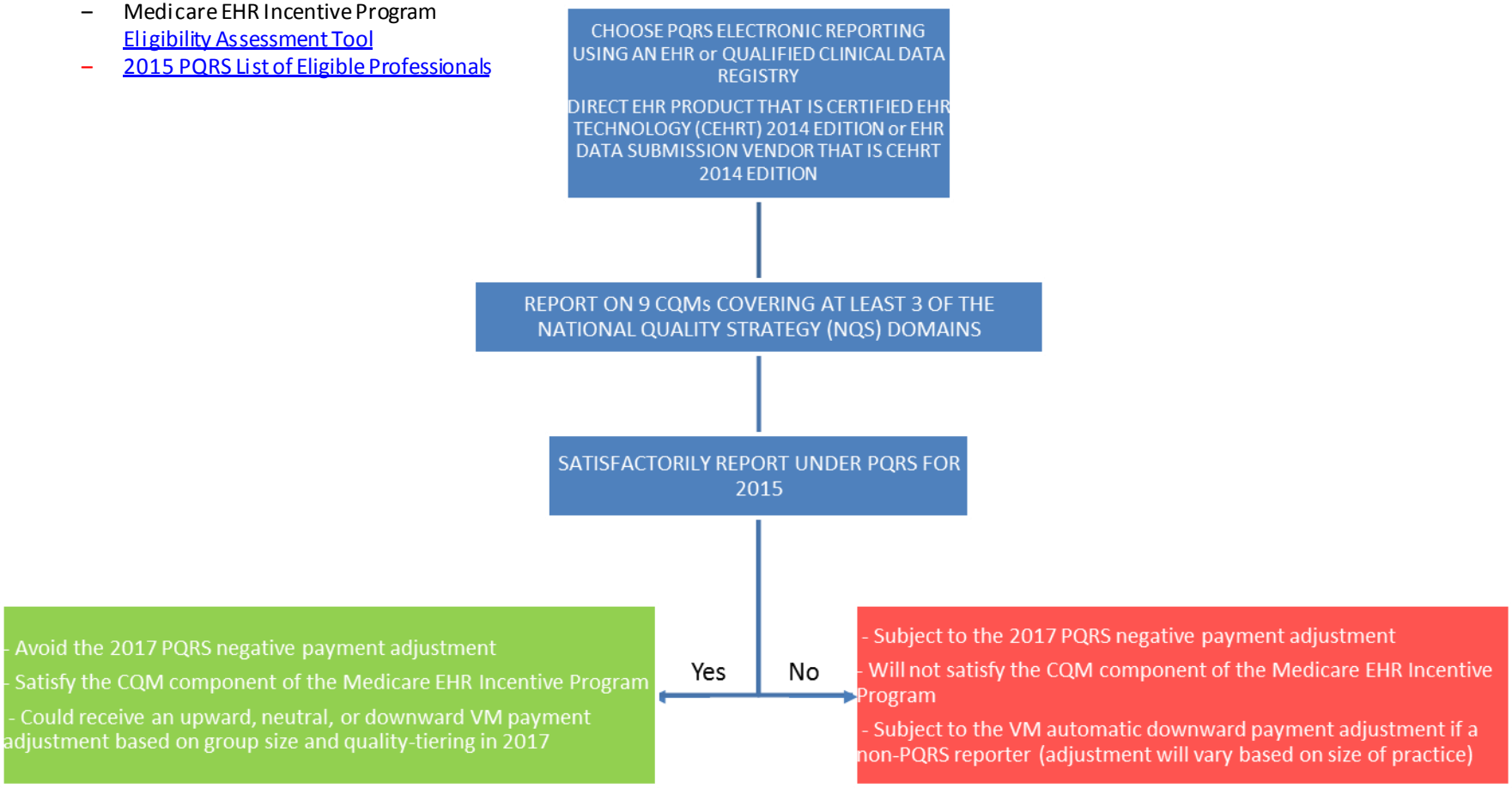
- Medicare Shared Savings Program: http://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

- Comprehensive Primary Care initiative: CPC Support: 1-800-381-4724 or cpcisupport@telligen.org

- Pioneer Accountable Care Organizations: http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/

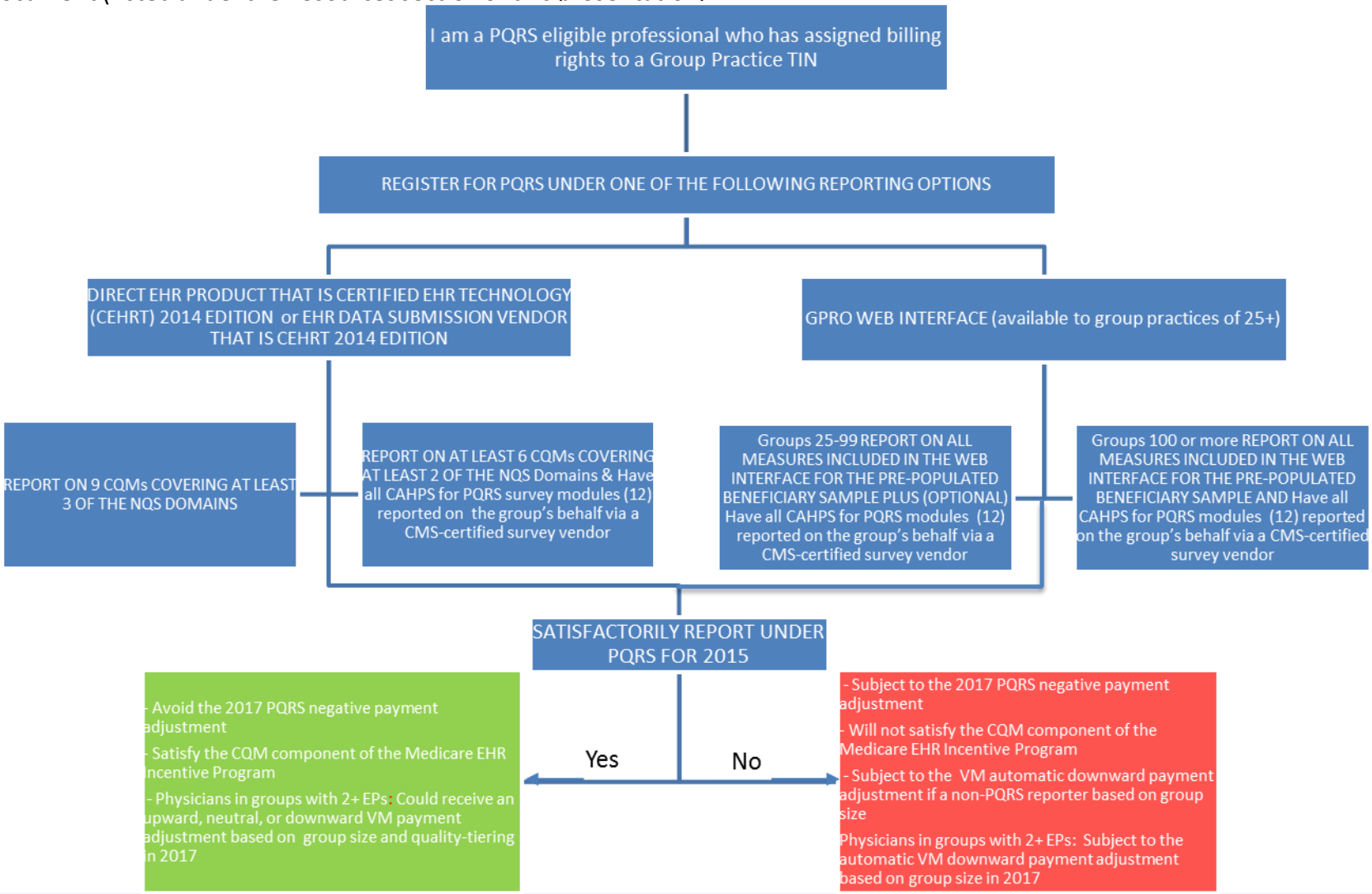
How to Report Once as an Individual EP

- Review the 2015 PQRS List of Eligible Professionals on the "How to Get Started" page of the CMS PQRS website
- A more detailed version of the below graphic can be found on the "How to Report Once for 2015 Medicare Quality Reporting Programs" document (listed under the Resources section of this presentation)
- Providers who are eligible to participate in both PQRS and the EHR Incentive Program can report once for both programs. Go to the following sites to determine your eligibility:
  - Medicare EHR Incentive Program Eligibility Assessment Tool
  - 2015 PQRS List of Eligible Professionals



How to Report Once as a Group Practice

A more detailed version of the below graphic can be found on the "How to Report Once for 2015 Medicare Quality Reporting Programs" document (listed under the Resources section of this presentation).



You Still Have Time to Report PQRS in 2015

- Individual EPs can still report for 2015 PQRS via:
  - Registry-based reporting
  - Electronic Health Record (EHR) [via Direct EHR product that is Certified EHR Technology (CEHRT) or via EHR Data Submission Vendor that is CEHRT]
  - Qualified Clinical Data Registry (QCDR)
- Group practices can still report for 2015 PQRS via the mechanism chosen during registration
- See Decision Trees in 2015 PQRS Implementation Guide on the "How to Get Started" webpage
  - Participation criteria to avoid the 2017 PQRS payment adjustment

Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs

Presenter: Elizabeth Holland

EHR Incentive Programs

- Medicare payment adjustments
  - American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111–5) amended Titles XVIII and XIX of the Social Security Act (the Act)
  - Sections 1848(a)(7),1853(l) and (m),1886(b)(3)(B), and1814(l) of the Act establishes downward payment adjustments, beginning with calendar or fiscal year 2015

EHR Incentive Programs

- Successfully attest to the requirements of the EHR Incentive Programs to avoid a payment adjustment
  - Attest to the Medicare or Medicaid programs (adopt, implement, upgrade under Medicaid does not result in avoiding the Medicare payment adjustment)
  - If you attest for 2015, you avoid a payment adjustment in 2017
  - Attestation for 2015 will open January 4, 2016
  - Proposed changes for 2015:
    - For new and returning EPs and Eligible Hospitals (EHs)/Critical Access Hospitals (CAHs), the deadline is February 29, 2016 to avoid 2017 payment adjustments
    - Changes to the definition of meaningful use (modifications for 2015-2017)

EHR Incentive Programs

- If you do not successfully attest, you may apply for a hardship exception
  - Apply in 2016 to avoid the 2017 Medicare payment adjustments
    - Infrastructure
    - Lack of control
    - Lack of face-to-face interaction
    - Unforeseen and/or uncontrollable circumstances
  - Deadlines for application submission:
    - Eligible hospitals – April 1, 2016
    - Eligible professionals – July 1, 2016
    - Critical access hospitals – November 30, 2017 (currently)

EHR Incentive Programs

- Medicare Payment adjustments for eligible professionals are applied to the Medicare Physician Fee Schedule and the amounts were established in the law
  - For 2015 – 99% of MPFS
  - For 2016 – 98% of MPFS
  - For 2017 – 97% of MPFS

- Additional Information on EHR Incentive Program Payment Adjustments
  - https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html

Value-Based Payment Modifier (VM)

Presenter: Fiona Larbi

What Is the VM?

- The VM assesses the quality of care and the cost of care furnished to Medicare Fee-for-Service (FFS) beneficiaries during a performance period
- The VM is an adjustment made on a per-claim basis to Medicare payments for items and services furnished under the Medicare Physician Fee Schedule (MPFS)
- The VM is applied at the Taxpayer Identification Number (TIN) level
- In 2017, the VM will apply to physicians in groups with 2+ EPs and physician solo practitioners billing under the TIN based on their performance during 2015
- Additional reporting outside of the PQRS is not required under the VM

2017 VM and the 2015 PQRS

CY 2017 VM payment adjustment, for physicians in groups with 2+ EPs and physician solo practitioners

PQRS Reporters – 3 types

1a. Group reporters : Register for a PQRS GPRO AND meet the criteria to avoid the 2017 PQRS payment adjustment

OR

1b.Individual reporters in the group: at least 50% of EPs in the group report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment (50% threshold option)

2. Physician solo practitioners: Report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment

Mandatory Quality-Tiering Calculation

Physicians in groups with 2-9 EPs and physician solo practitioners

Upward or no VM adjustment based on quality-tiering (+0.0% to +2.0x)

Physicians in groups with 10+ EPs

Upward, no, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x)

Non-PQRS Reporters

1. Groups: Do not avoid the 2017 PQRS payment adjustment as a group **OR** do not meet the 50% threshold option as individuals

2. Physician solo practitioners: Do not avoid the 2017 PQRS payment adjustment as individuals

-2.0% (for physicians in groups with 2-9 EPs and physician solo practitioners)
-4.0% (for physicians in groups with 10+ EPs)
(Automatic VM downward adjustment)

Note: The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

What Measures will be Used to Calculate the 2017 VM under Quality-Tiering?

- Quality Measures:
  - Groups with 2 or more EPs: Measures reported through the PQRS Group Practice Reporting Option (GPRO) selected by the group OR individual PQRS measures reported by at least 50% of the EPs in the group (50% threshold option)
  - Physician solo practitioners: Individual PQRS measures reported by the solo practitioner
  - Three claims-based outcome measures: All-Cause Hospital Readmissions, Composite of Preventable Hospitalizations for Acute Conditions, and Composite of Preventable Hospitalizations for Chronic Conditions
  - CAHPS for PQRS survey measures (Applicable only for groups that elected to use their 2015 CAHPS results in the calculation of their 2017 VM)
- Cost Measures:
  - Total per capita costs measure (Parts A & B)
  - Total per capita costs for beneficiaries with 4 chronic conditions (COPD, HF, CAD, and DM)
  - Medicare Spending Per Beneficiary measure (3 days before and 30 days after an inpatient hospitalization)
  - All cost measures are payment-standardized, risk-adjusted, and adjusted for the specialty mix of the EPs in the group

2017 VM Policies for Physicians in Groups with 2-9 EPs and Physician Solo Practitioners

- An automatic -2.0% VM downward adjustment will be applied for not avoiding the 2017 PQRS payment adjustment
- Under quality-tiering, the maximum upward adjustment is up to +2.0x ('x' represents the upward VM payment adjustment factor)
- Groups with 2-9 EPs and physician solo practitioners are held harmless from any downward adjustments under quality-tiering in 2017

CY 2017 VM Amounts

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x*	+2.0x*
Average Cost	+0.0%	+0.0%	+1.0x*
High Cost	+0.0%	+0.0%	+0.0%

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores*

2017 VM Policies for Physician Groups with 10+ EPs

- An automatic -4.0% VM downward adjustment will be applied for not avoiding the 2017 PQRS payment adjustment
- Under quality-tiering, the maximum upward adjustment is up to +4.0x ('x' represents the upward VM payment adjustment factor), and the maximum downward adjustment is -4.0%

CY 2017 VM Amounts

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	+0.0%	+2.0x*
High Cost	-4.0%	-2.0%	+0.0%

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores*

Actions for Physician Groups with 2+ EPs and Physician Solo Practitioner in 2015 for the 2017 VM

- Choose a PQRS reporting mechanism and become familiar with the measures AND data submission timeframes
  - http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_2015_Measure-List_111014.zip
- Decide whether and how to participate in the PQRS in 2015
  - Group reporting – Registration for the 2015 PQRS GPRO closed on June 30, 2015
  - Individual reporting – No registration necessary
- Download your 2014 Annual Quality and Resource Use Report (QRUR), which shows 2016 VM payment information, now at https://portal.cms.gov using an Enterprise Identity Management (EIDM) account
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html
  - For groups with 10 or more EPs subject to the 2016 VM, last day to submit an informal review of the VM is November 9, 2015
- Review quality measure benchmarks under the VM
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Technical Assistance Information

- For VM and QRUR questions, contact the Physician Value Help Desk:
  - Phone: 1(888) 734-6433 (select option 3)
  - Monday – Friday: 8:00 am – 8:00 pm EST

- VM: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
- 2014 QRUR: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html

Pioneer Accountable Care Organization (ACO) Model

Presenter: Terry Ng

Pioneer ACO Model

- For 2017 (PY 2015 reporting) EPs in a Pioneer ACO group practice participating via GPRO can be subject to the PQRS and EHR negative payment adjustments
- The reporting period for 2015 PQRS is 12 months; the EHR Incentive Program's 90-day reporting period only applies to first-time participants, so all other providers must report a full year of data
- Non-participating providers in Pioneer ACO TINs should refer to the "PQRS GPRO 2015 Criteria document" document, available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html
  and
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015HowtoReportOnce.pdf

Pioneer ACO Model 2015 Reporting

PQRS	Medicare EHR Incentive Program	VM
EPs in a Pioneer ACO group practice (participating via GPRO) can avoid the 2017 PQRS negative payment adjustment by satisfactorily reporting in 2015 and meeting PQRS criteria.	EPs in a Pioneer ACO group practice can avoid the 2017 EHR Incentive Program payment adjustment by meeting the 2015 GPRO Web Interface satisfactory reporting requirements, and individually attesting through the EHR Incentive Program Attestation System by February 29, 2016.	In the 2016 Medicare PFS Proposed Rule, CMS proposed to waive the application of the VM beginning in CY 2017 to groups and solo practitioners, as identified by their TIN, if at least one EP who billed for PFS items and services under the TIN during the applicable performance period for the VM participated in the Pioneer ACO Model during the performance period

Pioneer ACOs and "Split" Participation TINs

- For Pioneer ACOs, providers in "split" participation TINs (participating TINs under which only some providers [identified by NPIs] opt to participate in the ACO) can participate in PQRS outside of the ACO via the options below:
  1. Split TINs can participate as an entire group (both ACO and non-ACO participating providers) by reporting via one of the PQRS GPRO reporting options, **or**
  2. Non-ACO participating providers in split TINs can participate as PQRS individuals via EHR, registry, QCDR, or claims-based reporting

Medicare Shared Savings Program

Presenter: Rabia Khan

Shared Savings Program 2015 Reporting

- If the ACO satisfactorily reports measures via the GPRO web interface, then the PQRS eligible professionals (EPs) within ACO participant TINs will not be subject to the 2017 PQRS payment adjustment, and avoid the automatic downward payment adjustment and may earn an incentive under the VM in 2017.
  - Shared Savings Program ACO participant TINs may only participate in PQRS via the Shared Savings Program. No separate PQRS registration is required.
- EPs participating in the Shared Savings Program can satisfy their CQM reporting for the EHR Incentive Program if EPs use Certified EHR Technology (CEHRT) and the ACO satisfactorily reports via the GPRO web interface.
  - EPs must separately attest to the other requirements for the EHR Incentive Program to successfully demonstrate meaningful use.

Shared Savings Program 2015 Reporting

- Beginning in 2017, CMS is applying the Value-based Payment Modifier (VM) to physicians in group practices with 2 or more EPs and to physician solo practitioners. Groups and solo practitioners (as identified by their TIN) participating in a Shared Savings Program ACO in 2015 will be subject to the 2017 VM based on their performance in calendar year 2015.
- The VM is determined by calculating a cost composite and a quality composite.
  - For TINs participating in a Shared Savings Program ACO, the cost composite will be classified as "Average," but the quality composite will be calculated using the data reported by the ACO through the GPRO Web Interface and the ACO's All-Cause Hospital Readmission measure.
  - If an ACO fails to successfully report on quality measures, then the participant TINs under the ACO who are subject to the VM will be subject to an automatic downward adjustment under the VM. In 2017, the automatic downward adjustment is -4.0% for physicians in groups with 10 or more EPs and -2.0% for physicians in groups with between 2 to 9 EPs and physician solo practitioners.

Understanding the 2017 Payment Adjustments

Presenter: Alexandra Mugge

CY 2017 Payment Adjustments

Program	Applicable to	Adjustment Amount (of Medicare Physician Fee Schedule [MPFS] allowed charges)	Based on PY
PQRS	All EPs	-2.0% of MPFS	2015
Medicare EHR Incentive Program	Medicare physicians (if not a meaningful user)	-3.0% of MPFS	2015
Value-based Payment Modifier	All physicians in groups with 2+ EPs and physicians who are solo practitioners	**Mandatory Quality-Tiering for PQRS Reporters (Category 1):** **Groups with 2-9 EPs and physician solo practitioners:** Upward or neutral VM adjustment based on quality-tiering (+0.0% to +2.0x of MPFS) **Groups with 10+ EPs:** Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS) **Groups and solo practitioners receiving an upward adjustment under quality-tiering are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide.** **Non-PQRS Reporters (Category 2):** **Groups with 2-9 EPs and physician solo practitioners:** Automatic -2.0% of MPFS downward adjustment **Groups with 10+ EPs:** Automatic -4.0% of MPFS downward adjustment	2015

Example Scenarios for Individual EPs and Group Practices Subject to 2017 Payment Adjustments

Participants in 2015 Medicare Quality Reporting Programs	PQRS	VM	Medicare EHR Incentive Program
Dr. Sally Smith	X (As an individual EP/ solo practitioner)	X (As an individual EP/ solo practitioner)	X (As a professional)
Dr. Bob Jones	X (via 2015 PQRS GPRO)	X (via 2015 PQRS GPRO)	X (As a professional)

Example Scenario for Individual EP/solo practitioner Subject to 2017 Payment Adjustments

- During 2015, Dr. Sally Smith participated in both PQRS as an individual EP/solo practitioner and in the EHR Incentive Program as a professional by taking the following actions:
  - For PQRS, she reported a couple PQRS measures that were of interest to her via the claims-based reporting mechanism.
  - For the EHR Incentive Program, she attested to CQMs through the EHR Registration & Attestation System.
- In fall 2016, Dr. Smith accessed her 2017 PQRS Payment Adjustment Feedback Report and receives a PQRS-related letter in the mail from CMS which indicated that she will be subject to a PQRS negative payment adjustment due to unsatisfactory reporting. During program year 2015, EPs were required to report on at least 9 measures covering 3 National Quality Strategy (NQS) domains for at least 50% of the EP's Medicare Part B FFS patients (and EPs who see 1 Medicare patient in a face-to-face encounter must also report on 1 cross-cutting measure). Since she submitted quality data for less than 9 PQRS measures, her claims data underwent the Measure-Applicability Validation (MAV) process to determine if there were additional measures that she could have reported. Analysis determined that there were several other measures that she could have reported; therefore, her participation failed MAV so she will be subject to the 2017 PQRS payment adjustment.
- Dr. Smith also accessed her 2015 Annual Quality and Resource Use Report (QRUR) which notified her that a 2017 Value Modifier automatic downward adjustment also applies. As she failed to meet the PQRS reporting requirements which is the criteria for avoiding the Value Modifier automatic downward payment adjustment.
- By accessing her EHR Incentive Program feedback via the attestation system, Dr. Smith saw that she is not subject to payment adjustments under that program as she is a meaningful user of EHR technology and demonstrated meaningful use before the 2017 calendar year.

Example Scenario for Individual EP/solo practitioner Subject to 2017 Payment Adjustments (cont.)

Here is the order of events for Dr. Sally Smith:

- 2015: Reporting
  - Reported on measures for 2015 for PQRS
- 2016: Received feedback
  - Accessed the 2017 PQRS Payment Adjustment Feedback Report and the 2015 Annual Quality and Resource Use Report (QRUR)
  - Received PQRS negative adjustment notification letter and does not submit an informal review request
  - Received VM automatic downward payment adjustment notification in QRUR.
  - Accessed feedback in the EHR attestation system indicating she has achieved meaningful use
- 2017: Separate payment adjustments are applied
  - PQRS negative payment adjustment is applied to Part B MPFS reimbursements
  - Value Modifier automatic downward payment adjustment is applied to all Part B MPFS reimbursements
  - Dr. Smith can identify the 2017 payment adjustment codes based on the CARC and RARC
    - The PQRS and Value Modifier currently use CARC 237 – Legislated/Regulatory Penalty, to designate when a negative or downward payment adjustment will be applied.
    - At least one Remark Code will be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT) in combination with the following RARCs:
      - PQRS, N699
      - VM, N701

Example Scenario for Group Practices Subject to 2017 Payment Adjustments

- Dr. Bob Jones is a physician who participated in 2015 PQRS via GPRO (group size of 50 EPs), and in the EHR Incentive Program as a professional. He participated in Medicare quality reporting programs by doing the following:
  - PQRS: The group practice electronically reported 12-months of data via a direct EHR product.
  - EHR Incentive Program: Dr. Jones successfully attested to eCQMs through the EHR Registration & Attestation System.
- In fall 2016, the group accessed its feedback report from CMS, which indicated that the TIN will avoid a negative payment adjustment for PQRS and avoid the automatic VM downward payment adjustment and earn an upward adjustment based on performance for VM.
- In addition, Dr. Jones received the incentive payment for the Medicare EHR Incentive Program as he was able to successfully attest. Through electronic reporting using an EHR product that is CEHRT, group practices can meet the CQM component of Meaningful Use and get credit for PQRS. Dr. Jones' group practice reported 12 months of eCQMs via EHR and met the CQM requirements, so he was able to attest and is now also able to receive the EHR Incentive Program incentive payment.

Example Scenario for Group Practices Subject to 2017 Payment Adjustments (cont.)

Here is the order of events for Dr. Jones and his group practice:

- 2015: Reporting
  - Electronically reported measures for 2015 PQRS and the Medicare EHR Incentive Program.
- 2016: Received feedback
  - Accessed the 2015 Annual QRUR for PQRS and Value Modifier, and checked attestation status in the EHR Attestation System.
  - Feedback report indicates the TIN avoided the PQRS negative payment adjustment, and received notification of an upward VM payment adjustment in QRUR
- 2017: Payment adjustments are applied
  - Value Modifier upward payment adjustment is applied to all Medicare payments for items and services furnished under the 2017 Part B MPFS. An additional EHR Incentive Program incentive payment is applied to all of Dr. Jones' 2017 Part B MPFS reimbursements as he achieved meaningful use.
  - Dr. Jones can identify the 2017 payment adjustment codes based on the CARC and RARC.
    - The PQRS, EHR Incentive Program, and Value Modifier currently use CARC 237 – Legislated/Regulatory Penalty, to designate when a negative or downward payment adjustment will be applied.
    - At least one Remark Code will be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT) in combination with the following RARCs:
      - PQRS, N699
      - EHR, N700
      - VM, N701

Resources

Beginner Reporter Toolkit
https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-16875.pdf

Understanding the 2017 Medicare Quality Reporting Payment Adjustments
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html

PQRS GPRO 2015 Criteria
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html

PQRS How to Get Started (includes 2015 PQRS Implementation Guide and Measures List)
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html

Medicare Electronic Health Record (EHR) Incentive Program
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

Medicare EHR Incentive Program Payment Adjustments
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PaymentAdj_Hardship.html

Medicare Shared Savings Program
http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html

Physician Compare
http://www.medicare.gov/physiciancompare/search.html

Value-based Payment Modifier Website
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

How to Obtain a QRUR
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html

2014 QRUR
https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html

Resources (cont.)

CMS Enterprise Portal
https://portal.cms.gov/wps/portal/unauthportal/home/

Frequently Asked Questions (FAQs)
https://questions.cms.gov/

MLN Connects™ Provider eNews
http://cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Index.html

PQRS Listserv
https://public-dc2.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_520

2016 MPFS Proposed Rule
https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-16875.pdf

2015 MPFS Final Rule
https://s3.amazonaws.com/public-inspection.federalregister.gov/2014-26183.pdf

PQRS Website
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS

PFS Federal Regulation Notices
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html

Comprehensive Primary Care (CPC) initiative
http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/

Who to Call for Help

- **QualityNet Help Desk:**

  866-288-8912 (TTY 877-715-6222)

  7:00 a.m.–7:00 p.m. CST M-F or qnetsupport@hcqis.org

  You will be asked to provide basic information such as name, practice, address, phone, and e-mail

- **Provider Contact Center:**

  Questions on status of 2014PQRS incentive payment (during distribution timeframe)

  See *Review Contractor Directory – Interactive Map* at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

- **EHR Incentive Program Information Center:**

  888-734-6433 , press option 1 (TTY 888-734-6563)

- **Comprehensive Primary Care (CPC) initiative:**

  800-381-4724 or cpcisupport@telligen.org

- **ACO Help Desk via the CMS Information Center:**

  888-734-6433 Option 2 or cmsaco@cms.hhs.gov

- **Physician Compare Help Desk:**

  E-mail: PhysicianCompare@Westat.com

- **Physician Value Help Desk (for VM and QRUR questions)**

  Phone: 888-734-6433, press option 3

  Monday – Friday: 8:00 am – 8:00 pm EST

Question & Answer Session

Commonly Used Acronyms

ACO: Accountable Care Organization
APM: Alternative Payment Model
CAHPS: Consumer Assessment of Healthcare Providers & Systems
CEHRT: Certified EHR Technology
CPC: Comprehensive Primary Care
CMS: Centers for Medicaid & Medicare Services
CY: Calendar Year
CQM: Clinical Quality Measure
DSV: Data Submission Vendor
eCQM: Electronic Clinical Quality Measure
EIDM: Enterprise Identity Management
EHR: Electronic Health Record
EP: Eligible Professional
FFS: Fee-for-Service
GPRO: Group Practice Reporting Option
MACRA: Medicare Access and CHIP Reauthorization Act of 2015
MIPS: Merit-based Incentive Payment System
MLN: Medicare Learning Network
MPFS: Medicare Physician Fee Schedule
NPI: National Provider Identifier
PQRS: Physician Quality Reporting System
PY: Program Year
QCDR: Qualified Clinical Data Registry
QRDA: Quality Reporting Data Architecture
RARC: Remittance Advice Remark Code
TIN: Taxpayer Identification Number
VM/Value Modifier: Value-based Payment Modifier
WI: Web Interface

Evaluate Your Experience

- Please help us continue to improve the MLN Connects® National Provider Call Program by providing your feedback about today's call.

- To complete the evaluation, visit http://npc.blhtech.com and select the title for today's call.

CME and CEU

This call is being evaluated by CMS for CME and CEU continuing education credit. For more information about continuing education credit, review the *CE Activity Information & Instructions* document available at the link below for specific details:

http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/TC-L09242015-Marketing-Materials.pdf

Thank You

- For more information about the MLN Connects® National Provider Call Program, please visit http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html.

- For more information about the Medicare Learning Network®, please visit http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html.