Transitioning from the Physician Quality Reporting System (PQRS) to the Merit-based Incentive Payment System (MIPS)

Carol Jones and Molly MacHarris
January 24, 2017
Disclaimer

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Agenda and Learning Objectives

• Wrapping Up the 2016 Program Year for PQRS, Medicare Electronic Health Record (EHR) Incentive Program, and Value-Based Payment Modifier (VM)
  - Completing reporting for PQRS and the EHR program
  - Criteria for avoiding the automatic VM downward payment adjustment and qualifying for upward, neutral, or downward payment adjustments based on performance under VM in 2018

• Transition to the Quality Payment Program
  - Quality Payment Program Basics
    - Timeline
    - Pick your pace
    - Quality Payment Program tracks
      1. The Merit-based Incentive Payment System (MIPS)
      2. Advanced Alternative Payment Models (APMs)
  - How current programs will be streamlined into MIPS
  - Eligibility requirements

• Timeline for PQRS, EHR, VM, and MIPS programs with submission timeframes and other key milestones

• Resources & Who to Call for Help

• Question & Answer Session
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<th>Definition</th>
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<td>Accountable Care Organizations</td>
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<td>CAHPS</td>
<td>Consumer Assessment of Healthcare Providers and Systems</td>
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<td>CEHRT</td>
<td>Certified Electronic Health Record Technology</td>
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<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<td>CPC</td>
<td>Comprehensive Primary Care</td>
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<td>CQM</td>
<td>Clinical Quality Measure</td>
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<td>CY</td>
<td>Calendar Year</td>
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<td>eCQI</td>
<td>Electronic Clinical Quality Improvement</td>
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<td>Medicare Learning Network</td>
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<td>NG</td>
<td>Next Generation</td>
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<td>NPI</td>
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<td>Physician Quality Reporting System</td>
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<td>PY</td>
<td>Performance Year</td>
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<td>Qualified Clinical Data Registry</td>
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<td>Quality Data Codes</td>
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<td>QRDA</td>
<td>Quality Reporting Document Architecture</td>
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<td>QRUR</td>
<td>Quality Resource and Usage Report</td>
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<td>TIN</td>
<td>Tax Identification Number</td>
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<td>VM</td>
<td>Value-Based Payment Modifier</td>
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Physician Quality Reporting System (PQRS)

Presenter: Carol Jones, MSN, Program Analyst
PQRS Overview

Calendar Year (CY) 2018 payment adjustments, based on Performance Year (PY) 2016 reporting: -2.0% Medicare PFS

Find out whether you were eligible to participate in 2016 PQRS to avoid the 2018 downward payment adjustment by viewing the “2016 PQRS List of Eligible Professionals” on the PQRS How to Get Started webpage
Claims-Based Reporting

- Benefits:
  - Readily accessible as it is a part of routine billing processes
  - No need to contact a registry or EHR vendor to submit data
  - Simple to select measures and begin reporting
- Claims-based reporting is only available to individual EPs

- The following resources are available on the PQRS Measures Codes webpage:
  - 2016 PQRS Claims Reporting Made Simple
  - 2016 PQRS Claims Based-Coding and Reporting Principles

- See the 2016 PQRS Implementation Guide on the PQRS How To Get Started webpage for sample 1500 and 1450 claim forms

- Reporting period: January 1, 2016 – December 31, 2016
A qualified registry is an entity that collects clinical data from an individual EP or PQRS group practice and submits it to CMS on behalf of the participants, and is available to:

- Individual EPs
- PQRS group practices of 2-99 EPs
- PQRS group practices of 100 or more EPs when reported in conjunction with CAHPS for PQRS

The following resources are available on the PQRS Registry Reporting webpage:

- List of 2016 Qualified Registries
- 2016 PQRS Registry Reporting Made Simple

Data submission period: January 3, 2017 – March 31, 2017
Electronic Reporting

- Electronic reporting using an EHR is available to:
  - Individual EPs
  - PQRS group practices of 2-99 EPs
  - PQRS group practices of 100 or more EPs when reported in conjunction with CAHPS for PQRS

- Data submission period: January 3, 2017 – March 31, 2017

- Individual EPs and PQRS group practices select an EHR product based on reporting and data submission type

- “2016 PQRS Reporting Using an Electronic Health Record (EHR) Made Simple” is available on the PQRS Electronic Reporting Using an Electronic Health Record (EHR) webpage
Participation via QCDR

- A QCDR is a CMS-approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients; and is available to:
  - Individual EPs
  - PQRS group practices of 2-99 EPs
  - PQRS group practices of 100 or more EPs when reported in conjunction with CAHPS for PQRS

- Data submission period begins January 3, 2017
- Data submission period ends:
  - March 13, 2017 for QCDRs using Quality Reporting Document Architecture (QRDA)
  - March 31, 2017 for QCDRs (XML only)

- Individual EPs and PQRS group practices select a QCDR to work with
  - The QCDR will provide data submission instructions

- The following resources are available on the PQRS Qualified Clinical Data Registry Reporting webpage:
  - List of 2016 QCDRs
  - 2016 PQRS QCDR Participation Made Simple

Acronyms
Web Interface

- The Web Interface is a secure internet-based application available in the PQRS Portal to pre-registered users
  - CMS pre-populates the Web Interface with a sample of the group’s patients
    - PQRS group practice completes data for the pre-populated patients
  - CMS calculates reporting and performance rates

- Data submission period: January 16, 2017 - March 17, 2017

- 2016 PQRS GPRO Web Interface Reporting Made Simple is available on the PQRS Web Interface webpage

- Participation via the Web Interface is available to:
  - PQRS group practices of 25-99 EPs
  - PQRS group practices of 100 or more EPs when reported in conjunction with CAHPS for PQRS

Acronyms
CAHPS for PQRS

- CMS-certified survey vendors will be responsible for distributing the CAHPS for PQRS survey to select patients
  - CMS-certified survey vendor will submit data collected on behalf of the group practice
  - PQRS group practices will be required to select a CMS-certified survey vendor with which to work

- CAHPS for PQRS is:
  - **Optional** for PQRS group practices of 2-99 EPs reporting electronically, using a QCDR, or a Qualified Registry
  - **Optional** for PQRS group practices of 25-99 EPs reporting via Web Interface
  - **Required** for all PQRS group practices of 100 or more EPs, regardless of reporting mechanism

**Note:** CAHPS for PQRS must be reported in conjunction with the mechanism selected during registration.

*Additional resources are available on the PQRS CMS-Certified Survey Vendor webpage*
• In fall of 2017, individual EPs and PQRS group practices will receive PQRS feedback reports on whether they satisfactorily reported and if they are subject to the future downward payment adjustment.
  o 2016 program participation affects PQRS and Value-Based Payment Modifier (Value Modifier) payment adjustments in 2018.

• 2016 Annual Quality Resource and Usage Reports (QRURs) will be available in fall 2017 and will show the TIN’s actual performance on all of the quality and cost measures used to calculate the 2018 Value Modifier.

• There will be an opportunity to submit requests for an Informal Review of 2016 PQRS and Value Modifier results in the Fall of 2017.
Value-Based Payment Modifier (VM)
2018 Value Based Payment Modifier (VM)

• Performance year is 2016 and 2018 will be the final payment adjustment year of VM.

• Applies to physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs) in groups with 2+ EPs and those who are solo practitioners, as identified by their TIN.

• TINs subject to the Value Modifier that do not meet requirements to avoid the PQRS payment adjustment in 2018 (either as a group, a solo practitioner, or by ensuring that at least 50% of individual eligible professionals avoid it) will be subject to an additional automatic downward adjustment under the Value Modifier.

• Quality-tiering is mandatory
  o TINs that consist of non-physician EPs only will be held harmless from downward adjustments under quality-tiering, provided they meet the requirements to avoid the PQRS payment adjustment
  o All other TINs subject to the Value Modifier may earn upward, neutral, or downward adjustments
  o All TINs receiving an upward adjustment are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25% of all beneficiary risk scores nationwide
Application of the 2018 Value Modifier

**PQRS Reporters – 3 types – Category 1**
1a. Group reporters: Report as a group via a PQRS GPRO and meet the criteria to avoid the 2018 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 2018 PQRS payment adjustment
2. Solo practitioners: Report PQRS measures as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment

**Non-PQRS Reporters – Category 2**
1. Groups: Do not avoid the 2018 PQRS payment adjustment as a group OR do not meet the 50% threshold option as individuals
2. Solo practitioners: Do not avoid the 2018 PQRS payment adjustment as individuals

**Mandatory Quality-Tiering Calculation**
- Physicians, PAs, NPs, CNSs, & CRNAs in groups with 2-9 EPs and physician solo practitioners
- Physicians, PAs, NPs, CNSs, & CRNAs in groups with 10+ EPs
- Groups & solo practitioners consisting of non-physician EPs

- Upward, no, or downward VM adjustment based on quality-tiering (-2.0% to +2.0x)
- Upward, no, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x)
- Upward or no VM adjustment based on quality-tiering (0.0% to +2.0x)

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

-2.0% (for physicians, PAs, NPs, CNSs, & CRNAs in groups with 2-9 EPs, physician solo practitioners, & groups and solo practitioners consisting of non-physician EPs)
-4.0% (for physicians, PAs, NPs, CNSs, & CRNAs in groups with 10+ EPs) (Automatic VM downward adjustment)
VM Informal Review

- The Informal Review submission period in fall of 2017 will occur during the 60 days following the release of the Quality Resource and Usage Reports (QRURs).

- Where applicable, changes to the Value Modifier resulting from Informal Review will be handled according to the following scenarios:

<table>
<thead>
<tr>
<th>Scenario 1: TINS Moving from Category 2 to Category 1 as a result of PQRS or VM Informal Review Process</th>
<th>Scenario 2: Non-GPRO Category 1 TINs with Additional EPs Avoiding PQRS payment Adjustment as a result of PQRS Informal Review Process</th>
<th>Scenario 3: TINs with Widespread Quality Data Issues</th>
<th>Scenario 4: TINs with Widespread Claims Data Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Original</td>
<td>Revised</td>
<td>Original</td>
</tr>
<tr>
<td>N/A</td>
<td>Average</td>
<td>Low</td>
<td>Average</td>
</tr>
<tr>
<td>N/A</td>
<td>Average</td>
<td>Average</td>
<td>Average</td>
</tr>
<tr>
<td>N/A</td>
<td>Average</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Cost</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Average</td>
<td>Average</td>
<td>Average</td>
<td>Average</td>
</tr>
<tr>
<td>High</td>
<td>Average</td>
<td>High</td>
<td>High</td>
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</table>
Actions for Physician, NP, PA, CNS, and CRNA Solo Practitioners and Groups for the 2018 VM

- Find PQRS measures on the [PQRS Measures Codes webpage](#).
- Review the [CMS Value Modifier website](#) to learn about quality measure benchmarks under the VM, understand what is required for above average performance, and identify measures for distinguishing your performance.
- Access your 2016 QRUR on the [CMS Enterprise Portal](#) in the Fall of 2017. Detailed Instructions will be made available through the [Value Modifier/QRUR Webpage](#).
Electronic Health Record (EHR) Incentive Program
CMS has aligned several reporting requirements for those reporting electronically:

- The electronic clinical quality measures (eCQM) specifications are used for multiple programs, including PQRS and the Medicare EHR Incentive Program.
- Satisfactory reporting of PQRS EHR quality measures allows individual EPs and PQRS group practices to satisfy the clinical quality measures (CQM) component of the EHR incentive program.
- Individual EPs and PQRS group practices are required to submit CQMs using a direct EHR product or EHR Data Submission Vendor that is Certified Electronic Health Record Technology (CEHRT).
Direct EHR Vendor

- EHR product and version for individual EPs and PQRS group practices to directly submit PQRS measures data to CMS in the CMS-specified format(s) on their own behalf
EHR Data Submission Vendor

- Entity that collects an individual EP’s or group practice’s clinical quality data directly from their EHR
  - DSVs responsible for submitting PQRS measures data from an individual EP’s or PQRS group practice’s CEHRT to CMS in a CMS-specified format(s) on their behalf for the program year
Quality Payment Program

Presenter: Molly MacHarris, Health Insurance Specialist
What is the Quality Payment Program?
The Quality Payment Program

The Quality Payment Program policy will:
- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:

**MIPS**

The Merit-based Incentive Payment System (MIPS)

*If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.*

**Advanced APMs**

Advanced Alternative Payment Models (APMs)

*If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.*
Eligible Clinicians

Medicare Part B clinicians billing more than $30,000 a year AND providing care for more than 100 Medicare patients a year.

These clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetists
Who is excluded from MIPS?

Clinicians who are:

- Newly-enrolled in Medicare
  - Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

- Below the low-volume threshold
  - Medicare Part B allowed charges less than or equal to $30,000 a year  
    OR  
  - See 100 or fewer Medicare Part B patients a year

- Significantly participating in Advanced APMs
  - Receive 25% of your Medicare payments  
    OR  
  - See 20% of your Medicare patients through an Advanced APM
Exceptions for Small, Rural and Health Professional Shortage Areas (HPSAs)

Established low-volume threshold
- Less than or equal to $30,000 in Medicare Part B allowed charges
- Less than or equal to 100 Medicare patients

Reduced requirements for Improvement Activities performance category
- One high-weighted activity
  - OR
- Two medium-weighted activities

Increased ability for clinicians practicing at Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) to qualify as a Qualifying APM Participant (QP).
What is the Merit-based Incentive Payment System?

- Moves Medicare Part B clinicians to a performance-based payment system
- Provides clinicians with flexibility to choose the activities and measures that are most meaningful to their practice
- Reporting standards align with Advanced APMs wherever possible

*This is a new category.*
What are the Performance Category Weights?

Weights assigned to each category based on a 1 to 100 point scale

### Transition Year Weights

<table>
<thead>
<tr>
<th>Category</th>
<th>Weight</th>
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<tbody>
<tr>
<td>Quality</td>
<td>60%</td>
</tr>
<tr>
<td>Cost</td>
<td>0%</td>
</tr>
<tr>
<td>Improvement Activities</td>
<td>15%</td>
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<tr>
<td>Advancing Care Information</td>
<td>25%</td>
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**Note:** These are defaults weights; the weights can be adjusted in certain circumstances.
MIPS Performance Category: Quality

- Category Requirements
  - Replaces PQRS and Quality Portion of the Value Modifier
  - *So what?*—Provides for an easier transition due to familiarity

Select 6 of about 300 quality measures (minimum of 90 days to be eligible for maximum payment adjustment); 1 must be:
  - Outcome measure OR
  - High-priority measure—defined as outcome measure, appropriate use measure, patient experience, patient safety, efficiency measures, or care coordination

60% of final score

Readmission measure for group submissions that have ≥ 16 clinicians and a sufficient number of cases (no requirement to submit)

Different requirements for groups reporting CMS Web Interface or those in MIPS APMs

May also select specialty-specific set of measures
MIPS Performance Category: Advancing Care Information

- Promotes patient engagement and the electronic exchange of information using certified EHR technology
- Ends and replaces the Medicare EHR Incentive Program (also known as Medicare Meaningful Use)
- Greater flexibility in choosing measures
- In 2017, there are 2 measure sets for reporting based on EHR edition:
  - Advancing Care Information Objectives and Measures
  - 2017 Advancing Care Information Transition Objectives and Measures
MIPS Performance Category: Improvement Activities

• Attest to participation in activities that improve clinical practice
  o Examples: Shared decision making, patient safety, coordinating care, increasing access

• *Clinicians choose* from 90+ activities under 9 subcategories:

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<tr>
<td>3.</td>
<td>Care Coordination</td>
<td>4.</td>
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<tr>
<td>5.</td>
<td>Patient Safety and Practice Assessment</td>
<td>6.</td>
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<tr>
<td>7.</td>
<td>Achieving Health Equity</td>
<td>8.</td>
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<tr>
<td>9.</td>
<td>Emergency Preparedness and Response</td>
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MIPS Performance Category: Cost

- No reporting requirement; 0% of final score in 2017
- Clinicians assessed on Medicare claims data
- CMS will still provide feedback on how you performed in this category in 2017, but it will not affect your 2019 payments
- *Keep in mind:*
  - Uses measures previously used in the Physician Value-Based Modifier program or reported in the Quality and Resource Use Report (QRUR)
  - Only the scoring is different
Pick Your Pace for Participation for the Transition Year

**Participate in an Advanced Alternative Payment Model**

- Some practices may choose to participate in an Advanced Alternative Payment Model in 2017

**MIPS**

**Test**
- Submit something
- Neutral or small payment adjustment

**Partial Year**
- Submit a Partial Year
- Neutral or small payment adjustment

**Full Year**
- Submit a Full Year
- Small positive payment adjustment

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

MLN Connects
When Does the Merit-based Incentive Payment System Officially Begin?

Performance: The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, you will record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can provide care during the year through that model.

Send in performance data: To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive payment for participating in an Advanced APM, just send quality data through your Advanced APM.

Feedback: Medicare gives you feedback about your performance after you send your data.

Payment: You may earn a positive MIPS payment adjustment beginning January 1, 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you could earn 5% incentive payment in 2019.
Calculating the Final Score Under MIPS

Final Score =

Clinician Quality performance category score × actual Quality performance category weight

Clinician Cost performance category score × actual Cost performance category weight

Clinician Improvement Activities performance category score × actual Improvement Activities performance category weight

Clinician Advancing Care Information performance category score × actual Advancing Care Information performance category weight

× 100
### Transition Year 2017

<table>
<thead>
<tr>
<th>Final Score</th>
<th>Payment Adjustment</th>
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</table>
| >70 points  | • Positive adjustment  
             • Eligible for exceptional performance bonus—minimum of additional 0.5% |
| 4-69 points | • Positive adjustment  
             • Not eligible for exceptional performance bonus |
| 3 points    | • Neutral payment adjustment |
| 0 points    | • Negative payment adjustment of -4%  
             • 0 points = does not participate |
Quality Payment Program
Transitional Timelines
**2017 – 2019 Overview Timeline**

**MIPS**
- Jan. - Dec.: Performance period for 2019 MIPS

**PQRS/VM/EHR**
- Jan. - Dec.: PQRS, VM, and EHR adjustments effective based on 2015 data
- Jan. - Dec.: PQRS, VM, and EHR adjustments effective based on 2016 data
- Jan. - Dec.: MIPS payment adjustments effective based on 2017 data

**MIPS**
- Jan. - Dec.: Performance period for 2020 MIPS

**MIPS**
- Jan. - Dec.: MIPS report will be issued and targeted review will be available
2017 & 2018 Detailed Timelines

**PQRS/VM/EHR**

**Jan. 1:** For the PQRS and VM programs, CMS begins applying 2017 payment adjustments.

For the EHR program, CMS begins applying 2017 payment reduction on EPs’ claims for not meeting meaningful use/Provider attestation begins.

**PQRS**

**Jan. 3:** For PQRS, 2016 submission period begins for EHR Direct, EHR Data Submission Vendors, Qualified Registries, and Qualified Clinical Data Registries / Feb. 28: QDRA submission period closes / Mar. 31: QCDR and Registry XML submission closes

**EHR**

**Mar. 13:** Deadline for all participants in EHR Incentive Programs to attest successfully to avoid a payment adjustment in 2018 / EP reconsideration period ends

**MIPS**

**Jun. 30:** Last day to register Groups using the CMS Web Interface or CAHPS for MIPS

**Dec. 31:** Sunset of the VM/EHR/PQRS programs

**PQRS/VM/EHR**

**Jan. 16:** For PQRS, 2016 submission period begins for Web Interface / March 17: Web Interface submission period closes

**EHR**

**Mar. 28:** Deadline for appeal filing for eCQM reporting/eligibility/failed reporting to the EHR incentive programs is within 30 days after attestation deadline

**MIPS**

**Oct. 2:** Last start day for a 90 day performance period under MIPS

**PQRS**

**Fall:** PY2016 PQRS feedback reports available / Fall 2017: PQRS and VM Informal Review periods based on 2016 performance

**MIPS**

**Jan.:** MIPS Data Submission begins
Where to Call for Help & Resources
Where to Call for Help

QualityNet Help Desk
(for PQRS questions)

qnetsupport@hcqis.org
866-288-8912 (TTY 877-715-6222)
Monday-Friday 7:00 am-7:00 pm CT

Physician Value Help Desk
(for Value Modifier questions)

pvhelpdesk@cms.hhs.gov
888-734-6433 Option 3

You will be asked to provide basic information such as name, practice, address, phone, and email.

Have a question, but not a lot of time?

Email your questions about today’s National Provider Call with the subject: NPC_0124017
Where to Call for Help (cont.)

- For questions about the Quality Payment Program, contact this Service Center:
  Available Monday – Friday, 8:00 AM – 8:00 PM ET

- For questions about the EHR Incentive Program, contact this Information Center: 888-734-6433 (TTY 888-734-6563)

- For state-specific CMS contractor contact information, see the Review Contractor Directory – Interactive Map

- For questions about the Medicare Shared Savings Program, contact this Help Desk: 888-734-6433 Option 2 or aposd@cms.hhs.gov
  Operational & Program Support: sharedsavingsprogram@cms.hhs.gov

- For resources about electronic clinical quality improvement (eCQI), access the Resource Center: https://ecqi.healthit.gov
  or ecqi-resource-center@hhs.gov

- For questions about the Comprehensive Primary Care (CPC) Initiative, contact this Help Desk: 800-381-4724 or cpcisupport@telligen.org
Resources

- CMS Quality Payment Program website
- Fact sheet: Quality Payment Program
- National Provider Calls
  - 2016 PQRS Reporting: Avoiding 2018 Negative Payment Adjustments
  - How to Report Across 2016 Medicare Quality Programs
- 2016 Medicare PFS Final Rule and 2016 Medicare Physician Fee Schedule Final Rule, Correcting Amendment
- CMS PQRS Website
  - How to Get Started, Statute Regulation Program Instructions, Analysis and Payment, Payment Adjustment Information, Measure Specifications
- PFS Federal Regulation Notices
- Medicare Shared Savings Program
- CMS Value Modifier Website
- Frequently Asked Questions (FAQs)
- MLN Connects™ Provider eNews
- PQRS Listserv
- Quality Payment Program Listserv

Acronyms
Question & Answer Session
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](http://npc.blhtech.com) and select the title for today’s call.
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:


**Please note:** Each call will have a new “CE Activity Information & Instructions” document. Update this slide by adding the URL to the document that is provided by DPIPD in the space above. The slide deck cannot be finalized until this URL is provided.
Thank You

- For more information about the MLN Connects® National Provider Call Program, visit [https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html](https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events.html)


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