MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
2016 PFS Proposed Rule: Medicare Quality Reporting Programs
MLN Connects National Provider Call
Moderator: Aryeh Langer
July 16, 2015
1:30 p.m. ET

Contents

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Operator: At this time, I would like to welcome everyone to today's MLN's Connects® National Provider Call. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Aryeh Langer. Thank you, you may begin.

Announcements and Introduction

Aryeh Langer: Thank you Kalia. And as you just heard, my name is Aryeh Langer from the Provider Communications Group here at CMS, and I'm your moderator for today's call. I would like to welcome you to this MLN Connects National Provider Call on the 2016 Medicare Physician Fee Schedule proposed rule regarding certain Medicare quality reporting programs.

MLN Connects Calls are part of the Medicare Learning Network®. During today's call, CMS subject matter experts will provide an overview of the 2016 Medicare Physician Fee Schedule proposed rule. This presentation covers proposed updates to the Physician Quality Reporting System, or PQRS, Value-based Payment Modifier, or Value Modifier, Electronic Health Record, EHR, Incentive Program, and Comprehensive Primary Care, or CPC, Initiative. A question-and-answer session follows the presentation.

A few quick announcements before we begin the formal part of the presentation. You should have received the link to today's slide presentation in an email earlier today. If you've not already done so, you may view or download the presentation from the following URL, that's www.cms.gov/npc. Again, that URL is www.cms.gov/npc, as in National Provider Calls. At the left side of the web page, select National Provider Calls and Events. Then select the date of today's call from the list, and the presentation will be listed under Call Materials.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. Registrants will receive an email when these materials are available, generally within 2 weeks of today's call. Finally, this MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit. For additional information, please refer to slide 63 of today's presentation for a link to the CE activity information and instructions documents.

At this time, I would like to turn the call over to Christine Estella, health insurance specialist here at CMS. Christine?

Presentation

Christine Estella: Thank you. So we're going to be going over, you know, the proposals related to the Physician Fee Schedule that have to deal with quality. If you go over to slide 4, we can take a look at our agenda for today. So first off, we are going to cover

some of the questions that we are seeking comment on related to the new legislation that was passed, the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA. So that will cover, you know, proposals related or — comments related to the Merit-based Incentive Payment System, or MIPS, and the Alternative Payment Models, APMs, that are mentioned under MACRA. Then we're going to move on to the Physician Quality Reporting System and reporting for PQRS in 2016 for the 2018 PQRS payment adjustment. Then we're going to go into the EHR Incentive Program, and we have a couple of proposals and updates there — one of them relates to the CPC. Then we'll go into, you know, aligned reporting for the CPC. Following that, we'll go into the Value-based Payment Modifier, and then proposals related to the Medicare Shared Savings Program.

Towards the end of the slides, we do have several resources for who to call for help. We also have a couple of appendices that could help you with our proposals related to these several programs that we will mention.

The Medicare Access and CHIP Reauthorization Act

So without further ado, we'll first start off with the Medicare Access and CHIP Reauthorization Act, or MACRA, of 2015, so that's slide 5. And our slide 6, it just notes here that, you know, that MACRA amends the Social Security Act and affects several quality reporting programs, for example, the PQRS — the payment adjustments for PQRS actually end in 2018 according to MACRA. So that means that actually the proposal that I will go over related to the PQRS, that will be for the last payment adjustment that will occur under the PQRS, and then the PQRS is kind of going to get, you know, subsumed or swallowed by the new Merit-based Incentive Payment System, which I'll talk about later.

The EHR Meaningful Use Incentive Payments will also be made under MIPS, so we'll talk about — a little bit more about that later as well. The Value-based Payment Modifier adjustments will also be combined under MIPS, and the payment modifier will not be applied for items and services furnished on or after January 1st, 2019. So it looks like basically a number of quality reporting programs or components of the quality reporting programs are going to be subsumed under the Merit-based Incentive Payment System.

Merit- Based Incentive Payment System

This Merit-based Payment — Payment System is set to begin in 2019. It's called the SGR bill –so it does, you know, replace the sustainable growth rate, and it has a couple of other components related to it. On to slide 7, this talks a little bit about the MIPS adjustment factor and, basically, kind of related to, you know, what payment adjustment or adjustments you would see to your payments related to the new implementation of the MIPS. Again, this won't happen until 2019. So you'll see, you know, on the bottom of the slide, there it has the percentages for each year, so 2019, we start at 4 percent.

If we go to slide 8, we note that we're not actually making any specific proposals yet related to the Merit-based Incentive Payment System, or the MIPS. We're just seeking comment on how to implement the program. So, for example, we are seeking comment on low-volume threshold related to MIPS, what the definition of a clinical practice improvement is, and, you know, the incentive payments for participation in certain models and how that would relate to participation in MIPS. And also, you are free to bring in any comments you have related to MACRA — that is kind of the catchall that we have towards the end of that proposed section.

Slide 9, I'm not going over too quickly, but it does go over, you know, what's in the MIPS related to low-volume threshold or clinical practice improvement activities. So if you do have a comment or suggestion as to how to implement these two issues related to MIPS, please feel free to send that over to the *Federal Register*.

I'll now turn it over to Allison, who will talk about APMs.

Alternative Payment Models

Allison Falb: Thanks. So we're on slide 10. Promoting alternative payment models is another part of MACRA. On the left, you'll see the different provisions that relate to this, that you're welcome to comment on in the *Federal Register*. Alternative payment models are models including medical homes standards under 1115A, Shared Saving Program demonstrations under 1866C, and any demonstration required by Federal law. An eligible APM entity is an entity participating in a particular type of APM. Their requirements are outlined in the statute, as well as on the slide.

Going on to slide 11, under MACRA, if you're what's called a qualifying APM participant, you are eligible for an incentive payment. This would be from 2019 to 2024. It would be an annual lump-sum payment of 5 percent of PFS payment. On the right are the requirements to be a qualifying APM participant of note. In later years, beginning in 2021, qualifications will be either through Medicare revenue or they might be through revenue that would be through a combination of Medicare and other payers.

Moving on to slide 12, the way that APMs interact with MIPS is that if you are a qualifying APM participant or a partial qualifying APM participant, you will be excluded from MIPS. Another exclusion would be if you do not meet the low-volume threshold. And all of these are going to be more detailed in our forthcoming RFI, but we do have them in the PFF, and you're welcome to comment in both of those venues.

OK. So, now back over to Christine.

Proposed Changes to 2016 PQRS

Christine Estella: So we're now done with our MACRA provisions. We're now going to on to slide 13, proposed changes to PQRS. So as I mentioned, if you look at our slide 14, it

gives you kind of an overview of the different adjustments that will be set in 2018. The PQRS is 2 percent. Remember, these will be kind of the last adjustments under these programs and then these adjustments will occur under the newly formed MIPS program.

So under slide 15, proposed changes to PQRS. First off, I do want to say that, you know, this year 2015, was the first year in which we were actually implementing the PQRS payment adjustment. So we received a lot of calls and questions related to what is the definition of an eligible professional under the PQRS. I know it was unclear as to whether or not certain folks should have been participating in the PQRS.

So under this proposed Physician Fee Schedule, it's not necessarily a proposal, per se, but we do kind of try to clarify what the definition of an EP is for purposes of participating in PQRS, so especially related to, you know, comments and views, folks billing in RHCs or FQHCs, independent labs, topics such as those. So if any those kind of different scenarios apply to you and you're not sure whether or not you're participating — you should be participating in PQRS, you could take a look at our proposed rule and we have some statements related to participation there.

In addition, we are making proposed changes to requirements for the Qualified Clinical Data Registry and Qualified Registry option. I do want to note, one of the important things that we are proposing in this proposed rule for PQRS is that we do have a Group Reporting Option, or GPRO, option that coincides with participating in using a Qualified Clinical Data Registry, or QCDR. Before we actually only had the QCDR option as an individual reporting option, so now, if you report as a group you can use QCDR in the proposal.

OK. PQRS qualified registries have more time also in which to self-nominate. So the self-nomination time actually for PQR and qualified registries are — they will start — or we're proposing that they would start in December of this year. So the deadline would still be the same, it would be January 31st, but you'd basically get an extra month to start self-nominating, starting in December instead of January 1st.

So, changes to the PQRS reporting criteria under slide 16. Where, in fact, a group practice participating in the GPRO. Again, you will be able to report via a QCDR if you're a group practice and you want to participate as a GPRO. And then group practices of 25 or more EPs that are using the GPRO Web Interface to report measures, they are required to report on CAHPS for the PQRS — CAHPS for the PQRS, so this is a new change.

Last year, we noted that large groups, regardless of how — what reporting mechanism you're using in the GPRO was required to report on CAHPS for PQRS. Now, we are lowering the group size so groups 25 or more instead a hundred or more are required to report CAHPS. But we are limiting that only to groups that are using the GPRO Web Interface.

Next, for the Qualified Clinical Data Registry entities, there's a new process for self-nomination and attestation, which you could read about and submit comment on. With respect to Qualified Registry Entities, there is, again, a new process for self-nomination and attestation. This mainly has to do with — instead of submitting your attestation or self-nomination piece via email, we do have — we are proposing some sort of online form where you can go ahead and check boxes and you could do self-nomination that way via the web. So, hopefully, that will be easier for Qualified Registry Entities and QCDRs.

No changes on the EHR part. With claims and registry, there's no new proposals related to them.

On slide 17, the PQRS Criteria for Claims and Registry-Based Reporting for Individual EPs. Again, this is reporting in 2016 for the 2018 PQRS payment adjustment. And we – our intent when we were proposing these criteria were to kind of stabilize the program, propose criteria that was similar to criteria in years past, so you'll see that here. You know, we are mainly proposing that an EP will report nine measures covering three domains. This is the same criteria that we used for the 2017 payment adjustment and then also our 2014 incentive criteria.

So on slide 18, Measures Groups via Registry for Individual EPs. Reporting one measures group for 20 applicable patients for each EP, that's that light blue box if you're looking at the slide on slide 18. Again, this is nothing new from criteria that we had proposed in previous years.

We go to slide 19, Individual EP EHR (Direct or DSV) Reporting. Again, this is similar to the proposal for claims and registry and has not changed from the reporting criteria we finalized for the 2017 PQRS payment adjustment. So, it'd be reporting nine measures, covering at least three NQS domains. This EHR reporting option, just to remind you, is also the same criteria — or similar criteria for if you were to report – actually report eCQMs, or Clinical Quality Measures, via the EHR Incentive Program. So this is kind of our aligned option if you want to report once for both the EHR Incentive Program and the PQRS. And remember that doesn't include attestation and the EHR Incentive Program, you'd actually have to report the eCQMs.

We go to slide 20, Satisfactory Participation in a QCDR by Individual EPs. Again, this is still similar — reporting nine measures covering three NQS domains. So you kind of see – there's kind of, you know, a similar criteria across all reporting mechanisms, as we're trying to keep it simple and easy for everyone to report under PQRS.

We go to slide 21, GPRO Reporting via the GPRO Web Interface. So for groups of 25 or more, they're to report all measures in the GPRO web interface, same for 25 – it's same for, you know, the reporting criteria below. You would populate data fields for 248 patients and you would need to report on at least one measure for which there is

Medicare patient data. So, meaning you have to have at least multiple patients to those GPRO Web Interface measures, so you can't basically report a zero performance rate for all the GPRO Web Interface measures in order to get credit for reporting via the GPRO Web Interface.

And also remember that if you're reporting via the GPRO Web Interface, you also would be required to report CAHPS for PQRS, so that's that CAHPS patient satisfaction survey that we are proposing that you report.

If you go to the next slide, slide 22, GPRO via registry. Again, there's a lot of information on here, but mainly it's the same criteria as the criteria for individual reporting. So you're reporting nine measures covering three domains for 50 percent of your patients. And then GPRO via EHR on slide 23, same thing, reporting nine measures covering three domains for as many patients as there are applicable data.

We go to slide 24, GPRO via a QCDR. This is this new reporting option that I mentioned that was new — that was actually authorized under MACRA. Again, kind of the same concept, report nine measures covering three domains for at least 50 percent of your patients. And again with QCDRs, you do not need to report only PQRS measures that are in the PQRS measures set. QCDR are kind of different in that you can report measures that are outside of the PQRS measure set as long as CMS allows and approves the measure that is being reported by the QCDR.

On slide 25, we have our proposals for requirements related to the QCDR. So I'll take a moment for you guys to look over that, but it's nothing new from what we've had before. This is kind of all surrounding, you know, how the quality measures related to the QCDR that are not related to the PQRS measure set. We just want to make sure that we can analyze the data, so that your measures are conforming enough so that PQRS has the ability to analyze the data that are coming in through the QCDR for these measures.

And we also, you know, have a proposal in there about providing timely feedback. So I think this is something that we've also proposed in years prior.

Slide 26, Proposed Changes for QCDR Vendors and Qualified Registries. As I mentioned, a couple of things, self-nomination period timeframe now begins December 1st. And then with your attestation statement, in lieu of submitting an attestation statement via email, you can now check a box that kind of says, you attest that, you know, everything you submit is true and accurate when you are submitting data during the submission period.

Slide 27, Data Validation Requirements. We're proposing to add a couple of minor things in terms of QCDRs and registries, giving us information so that we can perform data validation more properly and efficiently. So, for example, providing us the

organization name, program year, and vendor types; methods for data collection, TIN verification, data reporting and verification, rate calculation, and PQRS measure specification confirmation; and process for data auditing and sampling methodology. This will help us for the 2018 PQRS payment adjustment, but it will also help us next year or the following year, when we do start implementing the MIPS so that we can see how your reporting mechanism kind of verifies and checks the data that you're receiving from providers and that you are calculating.

Slide 28, Group Practices Reporting via GPRO Web Interface, EHR, and Registry. Again, there's nothing really new here on this slide, so we can go ahead and move on.

Slide 29, the Proposed Quality Measures Updates. So every year, PQRS, you know, looks at our measures set to determine, you know, which measures we should propose to remove or add or change, you know, in order to keep up with evidence-based practices to replace one measure for one that's new and more robust. So with that in mind, we are — under our proposed new measure column on the left, we are proposing 46 new individual measures for reporting and three new measures groups. We're also proposing one new measure for the GPRO Web Interface. And it also has the list of the NQS domains that these new measures are covered under.

If we look at the middle column, Proposed Measures for Removal, we are proposing to remove 12 from claims or registry and one measure was part of a measures group only measure. And then changes to existing measures, we have four measures that we'll be changing its NQS domains, too. Again, the rationale for adding the new measures, removing the new measures, or changing measures could be found in the proposed rule.

And with that, that ends our summary of our PQRS proposals, so now we're going to move on to the EHR Incentive Program and the proposals under there.

Proposed Changes to the EHR Incentive Program

So Certification Requirements for Electronic Reporting of Clinical Quality Measures, this is slide 31. We have a couple of updates to the EHR Incentive Program. And for this, basically what we're trying to say is, last year we required that an EP report on the most recent version of the eCQM but did not require that the CEHRT be certified to the most recent version of the eCQM. So basically, if you're looking at this, if you're looking in the middle column, we're proposing that in 2018, the CEHRT will be required, and all providers must create, an electronic file that can be accepted by CMS. This basically means you're reporting using the most recent version of the measure and the CEHRT that's the most recent version — that certifies the most recent version of the measure as well.

So if you look at slide 32, the EHR Incentive Program criteria for electronic reporting. This is nothing new again. It's just kind of reiterates that if you are actually reporting eCQMs, you'd report nine measures covering at least three NQS domains.

And so now I'll turn over to Sarah, who will talk about the CPC aligned reporting option with the EHR Incentive Program.

CPC Aligned Reporting Option

Sarah Arceo: Thank you Christine. So we are on slide 35. For the Comprehensive Primary Care Initiative, or CPC, practice sites are required to report to CMS a subset of the Clinical Quality Measures that were selected in the EHR Incentive Program Stage 2 Final Rule. So we're proposing that in 2016, CPC practice sites have to report at least nine CQMs of the 13 CPC measures across three NQS domains using our Certified EHR technology and meet the CPC reporting requirements in order to receive Medicare EHR Incentive Program CQM credit.

The CQMs must be submitted electronically or via attestation for a full calendar year. And this group reporting option is eligible to first time — to EPs in their first year of Meaningful Use, which has not been the case previously. CPC practice sites though who are unable to meet the reporting requirements of the initiative will have the opportunity to report their quality measures in accordance with the current requirements established for the Medicare EHR Incentive Program and the Stage 2 Final Rule.

And with that, we'll turn it over to Aryeh.

Keypad Polling

Aryeh Langer: And we're going to take a brief pause now to complete keypad polling. Can we start that keypad polling, please?

Operator: CMS appreciates that you minimize the Government's teleconference experience by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Aryeh Langer.

Presentation Continued

Aryeh Langer: Thank you. And for our next part of the presentation on Value-based Payment Modifier, I'll turn the call over to Sabrina Ahmed.

Proposals for the Value-Based Payment Modifier

Sabrina Ahmed: Thank you Aryeh. So in this portion of the presentation, I'll be reviewing all of the proposals related to the Value Modifier that we have in the 2016 Physician Fee Schedule proposed rule.

So slide 37 provides an overview of the Value Modifier. The Value Modifier assesses the quality and cost of care furnished to Medicare fee-for-service beneficiaries during a performance period. The Value Modifier is a per claim adjustment made under the Physician Fee Schedule and is applied at the TIN level to physicians and certain nonphysician EPs that bill under the TIN during the payment year. As Christine mentioned earlier in the presentation, with the passage of MACRA, the Value Modifier will sunset at the end of 2018 and the Merit-based Incentive Payment System will be applied to payments for items and services furnished on or after January 1, 2019.

Slide 38 shows the definition of an eligible professional. Eligible professionals consist of physicians, practitioners, and therapists. Slide 39 lists several proposals that are related to the Value Modifier that will be applied in 2018. We propose that the calendar year 2016 would be the performance period for the 2018 Value Modifier. We finalized in the 2015 PFS Final Rule that, beginning in 2017, the Value Modifier will apply to all physicians in groups with two or more eligible professionals and to physician solo practitioners.

So in this rule, we propose to also apply the Value Modifier in 2018 to nonphysician eligible professionals who are physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists in groups with two or more eligible professionals and to those who are solo practitioners. I want to note that this proposal is different from the policy we finalized in the 2015 PFS Final Rule, which was to apply the 2018 Value Modifier to all of the nonphysician eligible professionals that are listed on slide 38.

So under our proposal in this rule, the Value Modifier would not apply to the nonphysician eligible professionals who are certified nurse midwives, clinical social workers, clinical psychologists, or any of the therapists that are listed on slide 38. We also propose to continue to apply a two-category approach for the 2018 Value Modifier based on participation in the PQRS by groups and solo practitioners.

For the 2018 Value Modifier, we propose to apply the quality-tiering methodology to all groups and solo practitioners that are in Category 1. And I will go over what I mean by Category 1 on the next slide. Quality tiering is a methodology that we use to calculate

the Value Modifier. We propose that groups and solo practitioners would be subject to upward, neutral, or downward adjustments under quality tiering, with the exception finalized in the 2015 PFS Final Rule, that groups consisting only of nonphysician eligible professionals such as PAs, NPs, CNSs, and CRNAs and also PAs, NPs, CNSs, and CRNAs who are solo practitioners will be held harmless from downward adjustments under the quality-tiering methodology in 2018.

Slide 40 shows how we propose to apply the Value Modifier in 2018 to physicians, PAs, NPs, CNSs, and CRNAs in groups with two or more eligible professionals and to those who are solo practitioners based on their performance in 2016. Similar to the approach established for the 2017 Value Modifier, and in a continued effort to align VM with the PQRS, we propose to use a two-category approach to categorize groups and solo practitioners that would be subject to the 2018 Value Modifier based on how they participate in the PQRS in 2016.

So we propose that Category 1, as shown at the left-hand side of the slide, would include groups with two or more eligible professionals that meet the criteria to avoid the 2018 PQRS payment adjustment as a group practice participating in the PQRS GPRO in 2016 or groups with two or more eligible professionals in which at least 50 percent of the group's eligible professionals meet the criteria to avoid the 2018 PQRS payment adjustment as individuals.

So under this proposal for the 2018 VM, in determining whether a group would be included in Category 1, we would consider whether the 50 percent threshold has been met, regardless of whether the group registered for a PQRS GPRO. Category 1 would also include solo practitioners that meet the criteria to avoid the 2018 PQRS payment adjustment as individuals. As I mentioned earlier, we proposed that all groups and solo practitioners that are in Category 1 would be subject to quality tiering.

And then Category 2, as shown in the right-hand side of the slide, would include groups and solo practitioners that are subject to the 2018 Value Modifier and do not fall within Category 1. At the bottom of the slide, you can see our proposed 2018 payment adjustments for groups and solo practitioners that are in Category 1 and 2. And I'll review these adjustments in more details later in this presentation.

So now I'm on slide 41. As I said earlier, we propose to apply the quality-tiering methodology to all groups and solo practitioners that are in Category 1 for the 2018 Value Modifier. Slide 41 describes the quality measures that will be used to calculate the quality composite component of the 2018 Value Modifier. So to calculate the quality composite, we propose that for groups that report PQRS data as a group in 2016 and meet the criteria to avoid the 2018 PQRS payment adjustment, we'll use the measures reported under the PQRS GPRO reporting mechanism reported on by the group. Also, if at least 50 percent of the eligible professionals in the group report

PQRS data as individuals and meet the criteria to avoid the PQRS payment adjustment, then we'll use their individually reported PQRS data to calculate the quality composite.

For solo practitioners, we would use their individually reported PQRS measures as long as they met the criteria to avoid the 2018 PQRS payment adjustment. For all groups and solo practitioners subject to quality tiering, we will also calculate three outcome measures using administrative claims. These include the all-cause hospital readmission measure, a composite of preventable hospitalizations for acute conditions, and a composite of preventable hospitalizations for chronic conditions.

Lastly, we'll use the results of the 2016 CAHPS for PQRS Survey to calculate a group's quality composite if the group elects this option. We proposed in this rule that beginning with the 2016 Value Modifier, a group or solo practitioner subject to the Value Modifier would receive a quality composite score that's classified as average under quality tiering if the group or solo practitioner does not have at least one quality measure that meets the minimum number of cases required for the measure to be included in the calculation of the quality composite.

For quality measures, the minimum number of cases required for the measure to be included in the quality composite is 20 cases, except for the all-cause hospital readmissions measure, which has a minimum case size threshold of 200 cases, beginning with the 2017 Value Modifier. We also proposed that, beginning with its 2018 Value Modifier, we would create separate benchmarks for eCQM measures based on the CMS eMeasure ID. These measures are collected through EHRs. We would also exclude eCQM measures from the overall benchmark for a given measure.

Slide 42 describes the quality composite measures — describes the cost composite — the cost measures that will be used to calculate the cost composite of the Value Modifier. The cost composite is based on six specialty-adjusted cost measures. Five of the six measures are based on total per capita cost and the sixth cost measure is the Medicare spending per beneficiary measure.

All six measures that we used to calculate the cost composite for the Value Modifier are payment standardized, risk adjusted, and adjusted to reflect the specialty mix of the EPs in the group. In this proposed rule, there are two proposals related to the MSPB measure. Beginning with the 2017 Value Modifier, we propose to increase the minimum number of episodes for inclusion in the MSPB measure in the cost composite to hundred episodes. And also, beginning with the 2018 Value Modifier, we propose to include hospitalizations at Maryland hospitals as an index admission for the MSPB measure for the purposes of the Value Modifier program.

Proposed Payment Adjustment Levels under the VM in 2018

The next three slides discuss the proposed payment adjustment levels under the Value Modifier in 2018.

Slide 43 shows the proposed 2018 payment adjustment levels under the Value Modifier for physicians, nurse practitioners, physician assistants, clinical nurse specialists, and certified registered nurse anesthetists in groups with 10 or more eligible professionals. We propose to maintain the 2017 Value Modifier payment adjustment levels for the 2018 Value Modifier for groups with 10 or more eligible professionals.

So for Category 2 groups that I talked about earlier, this means that we propose to apply an automatic minus 4 percent Value Modifier downward adjustment for not meeting the criteria to avoid the PQRS payment adjustment as a group or under the 50 percent threshold option. For Category 1 groups, under quality tiering, we propose that the maximum upward adjustment would be up to plus 4x, where x represents the upward Value Modifier payment adjustment factor, and the maximum downward adjustment would be minus 4 percent for poor performance in 2018. High performing groups would continue to be eligible for an additional plus 1x for treating high-risk beneficiaries.

Slide 44 shows the proposed 2018 payment adjustment levels under the Value Modifier for physicians, NPs, PAs, CNSs, and CRNAs in groups with two to nine eligible professionals and physician solo practitioners. We propose to maintain the 2017 Value Modifier payment adjustment levels for the 2018 Value Modifier, but we did propose to apply both the upward and downward adjustments under quality tiering to these groups and solo practitioners.

So for Category 2 groups and physician solo practitioners, this means that we propose to apply an automatic minus 2 percent Value Modifier downward adjustment for not meeting the criteria to avoid the 2018 PQRS payment adjustment. And for Category 1 groups and solo practitioners under quality tiering, we propose that the maximum upward adjustment would be plus 2x and the maximum downward adjustment would be minus 2 percent for poor performance in 2018.

Slide 45 shows the proposed 2018 payment adjustment levels under the Value Modifier for NPs, PAs, CNSs, and CRNAs in groups consisting of nonphysician EPs and to those who are solo practitioners. For Category 2 groups and solo practitioners, we propose to apply an automatic minus 2 percent Value Modifier downward adjustment. And then for Category 1 groups under quality tiering, we propose that the maximum upward adjustment would be plus 2x. And as finalized in last year's rule — final rule, these groups and solo practitioners would be held harmless from downward adjustments under quality tiering for poor performance in 2018.

Slide 46 describes our proposal related to the finality of the Value Modifier upward adjustment. Beginning with the 2015 Value Modifier, we had established that the upward payment adjustment factor, the x factor, would be determined after the performance period has ended, based on the aggregate amount of downward payment adjustments. And in the interest of providing eligible professionals that are eligible for an upward payment adjustment under the Value Modifier with finality, we propose that

we would not recalculate the upward payment adjustment factor for a given payment year after the adjustment factor is made public unless CMS determines that a significant error was made in the calculation of the adjustment factor.

Slide 47 describes our proposals related to group size for determining the Value Modifier. Beginning with the 2016 Value Modifier, we propose that the TIN's size would be based on the lower of the number of eligible professionals, as indicated by PECOS or our analysis of the claims data for purposes of determining the payment adjustment level under the Value Modifier. And as I said earlier, we propose to apply the Value Modifier in 2018 to nonphysician eligible professionals who are NPs, PAs, CNSs, and CRNAs in groups with two or more EPs and those who are solo practitioners.

And I describe on slide 45 that we're proposing different payment adjustments for these groups and solo practitioners. So for the 2018 Value Modifier, we propose to identify TINs that consist of nonphysician EPs if either PECOS or claims data show that the TIN consists only of nonphysician eligible professionals and no physicians. We also propose to not apply the Value Modifier to TINs if either PECOS or claims data shows that the TIN consists of nonphysician eligible professionals who are not PAs, NPs, CNSs, or CRNAs. And we have several examples of how these proposals would work in the proposed rule.

So, now I'm on slide 48. In the 2015 PFS Rule, we established that, beginning with the 2017 Value Modifier, we would apply the Value Modifier to physicians and groups, with two or more eligible professionals and to physician solo practitioners who participated in an ACO under the Shared Savings Program during the performance period. There are three proposals in this rule related to the application of the Value Modifier to these groups and solo practitioners, beginning with the 2017 Value Modifier.

So we propose to apply the Value Modifier adjustment percentage for groups and solo practitioners that participate in two or more ACOs during the performance period, based on the performance of the ACO with the highest quality composite score. We also proposed to determine the Value Modifier for TINs that participated in a Shared Savings Program ACO in the performance period using policies established for Shared Savings Program participants, regardless of whether any of the eligible professionals under the TIN also participated in an innovation center model or another CMS initiative during the performance period.

And we also propose that, beginning in the 2017 Value Modifier, we would apply an additional upward payment adjustment of plus — one times the adjustment factor to Shared Saving ACO program participant TINs that are classified as high quality under the quality-tiering methodology if they treat high-risk beneficiaries.

Slide 49 describes the Value Modifier policies for Shared Savings Program participants for 2018. Similar to the policies established for the 2017 Value Modifier, groups and solo practitioners participating in an ACO under the Shared Savings Program in 2016 will

have their cost composite component of the Value Modifier classified as average and their quality composite will be based on the ACO's quality data submitted through the web interface and also the ACO all-cause hospital readmissions measure, as calculated under the Shared Savings Program.

In this rule, we also propose to include the results of the CAHPS for ACO survey in the quality composite of the 2018 Value Modifier for TINs that participated in the Shared Savings Program in 2016.

Slide 50 describes our proposals for applying the Value Modifier to TINs participating in the Pioneer ACO Model, the CPC Initiative, or other similar Innovation Center models. So for these programs, we propose that, beginning with the 2017 Value Modifier, we would waive application of the Value Modifier to TINs if at least one EP who billed for Physician Fee Schedule items and services under the TIN during the performance period participated in the Pioneer ACO Model, the CPC Initiative, or other similar Innovation Center models during the performance period.

Slide 52 describes the Value Modifier and formal review process. In this rule, we propose that beginning with the 2016 Value Modifier, we would reclassify a TIN as Category 1 when PQRS determines on informal review that at least 50 percent of the TIN's eligible professionals meet the criteria to avoid the PQRS payment adjustment as individuals for the relevant calendar year PQRS payment adjustments.

We note that if the group was initially classified as Category 2, then we do not expect to have data to calculate the group's quality composite, in which case, the group would be classified as average quality. However, if data is available in a timely manner, then we would recalculate the group's quality composite.

Slide 52 describes what groups and solo practitioners would need to do in 2016 for — which is a proposed performance period for the 2018 Value Modifier.

And then, Slide 53 shows the timeline for phasing in the Value Modifier and when the mid-year —– and annual QRURs will be available.

This is the end of the Value Modifier portion of the presentation. Before we move to the next section, I want to mention that on slide 65 we listed the contact information for the Physician Value help desk. You can contact them with any questions you have about the Value Modifier or QRUR. The Value Modifier website is listed on slide 66. And then on slides 72 to 76, we have tables that summarize the policies we established for the 2016 Value Modifier, the 2017 Value Modifier, and also our proposals for the 2018 Value Modifier. I will now turn the call over to Rabia Khan.

The Medicare Shared Savings Program

Rabia Khan: Thanks Sabrina. I'm on slide 55, we have an Overview of the Medicare Shared Savings Program. So ACOs create incentives for health care providers to works together voluntarily to coordinate care and improve quality for their patient population. We at CMS assess ACO performance annually on their quality performance and also against the financial benchmark to determine their shared savings. Meeting the Shared Savings Program requirements for quality reporting and performance aligns with other CMS quality reporting initiatives for those EPs who participate within an ACO. And programs include PQRS, the Medicare EHR Incentive Program, and the Value-based Payment Modifier.

I'm on slide 56. In the 2015 PFS proposed rule, we included proposals specific to certain sections of the Shared Savings Program regulations. And starting with the quality measures, we are proposing to add a measure of statin therapy for the prevention and treatment of cardiovascular disease in the preventive health domain within the Shared Savings Program. And this is an effort to align with PQRS and the Million Hearts initiative.

In the 2015 PFS rule — PFS Final Rule, we retired a few cholesterol measures since they no longer aligned with updated clinical guidelines and recommendations. As a result, CMS, in collaboration with other Federal agencies, developed a statin therapy for prevention and treatment of cardiovascular disease quality measure, and that better aligns with updated clinical practice. We are proposing this in alignment with PQRS, and this would add an additional measure for our total measure set, which would increase it from 33 measures to 34 measures.

And this measure would be phased into pay per performance after being paid for reporting for 2 years. In addition, we're seeking comments on the actual implementation of the measure and how it's phased in. In addition, we are seeking comment on our EHR measure, which is ACO 11 in our measure set, and how it could evolve to further encourage providers to adapt and use health IT. We are not proposing any changes to our EHR measure, but we are seeking comment on its evolution.

We are also proposing to preserve flexibility to maintain measures of pay for reporting or reverting measures from pay for performance to pay for reporting if a measure owner determines the measures no longer aligns with updated clinical practice or that the measure may cause patient harm. We're proposing this flex — flexibility — proposing to maintain the flexibility so we can more quickly respond to clinical guideline recommendations and updates that could occur during the reporting year where scientific evidence may change mid year, resulting in a measure that may cause patient harm. This proposal is similar to other existing policies that exist for other qualities — the CMS quality reporting initiatives such as the Ambulatory Surgical Center and Quality Reporting Program.

In addition, we're proposing to clarify how PQRS eligible professionals participate within an ACO to meet their PQRS reporting requirements when their ACO satisfactorily reports quality. We're proposing to clarify our Shared Savings Program alignment with PQRS by stating that eligible professionals who bill under the TIN of an ACO participant will meet their PQRS reporting requirements when the ACO completely reports the web interface measures on their behalf.

Being more explicit about EP billing under the TIN of an ACO participant helps clarify for ACOs and their participants how the Shared Savings Program aligns with PQRS and their payment adjustment methodology. And in addition, we are proposing to amend the definition of primary care services used in the beneficiary assignment methodology to include claims submitted by ETA hospitals and to exclude claims submitted by SNFs when the claim contains the place-of-service code — a place-of-service 31 modifier.

In the 2014 Shared Savings Program proposed rule, we welcome comments from stakeholders on the implications of retaining certain evaluation and management codes used for physicians and SNFs in the definition of primary care services. As a result of stakeholder feedback, we're proposing to exclude claims submitted by SNFs that include the POS 31 modifier from our beneficiary assignment process. This will be effective in the 2017 performance year. We're also proposing to include claims for primary care services performed by physicians at ETA hospitals in beneficiary assignment. As a result of the proposal, we're also proposing to include ETA hospitals to the list of ACO participants eligible to form an ACO that may apply to participate in the Shared Savings Program.

And now, I will turn it over to Alesia Hovatter for public reporting.

Public Reporting

Alesia Hovatter: Thank Rabia, this is Alesia Hovatter. So we are now on slide 57. CMS proposes to continue its phased approach to public reporting on Physician Compare. In addition to continuing existing policies for Physician Compare, new proposals for calendar year 2016 include an indicator on profile pages for individual EPs who satisfactorily report new PQRS cardiovascular prevention measures groups in support of Million Hearts, group practices and individual EPs who receive an upward adjustment for the Value Modifier, also known as VM, publicly report an item-level benchmark for group practice and individual EP PQRS measures using the achievable benchmark of care, also known as the ABC methodology based on the 2016 PQRS performance rate.

The ABC methodology would generate a benchmark, which can be used to systematically assign stars for the Physician Compare five-star rating. As previously finalized, individual-level Qualified Clinical Data Registry, or QCDR, measures are available for public reporting. Per MACRA, we now propose to publicly report group level QCDR measures. Per MACRA, we also propose to add utilization data to the public downloadable database and also add to the Physician Compare downloadable database

for group practices and individual EPs, quality tiers for cost and quality, noting if the group practice or EP is high, low, or neutral, on cost and quality per the VM.

A notation of the payment adjustment received based on the cost and quality tiers, an indication if the individual EP or group practice was eligible to, but did not report, quality measures to CMS, include certifying board in addition to ABMS board certification currently available on Physician Compare and specifically add American Board of Optometry Board Certification and American Osteopathic Association Board Certification. Consistent with these policies, all data must meet the minimum sample size of 20 patients and prove to be statistically valid and reliable.

For individual and group level measures, we will publicly report all measures submitted, reviewed, and deemed valid and reliable in the Physician Compare downloadable file. However, not all measures will be included on the Physician Compare profile pages. And if you refer to slide 58 for additional details for Physician Compare. And we look forward to your comments and I will now pass it along to the next presenter. Thank you.

Question-and-Answer Session

Aryeh Langer: Well that's all we had our formal part of the presentation today. We're going to open up the call now for the question-and-answer session. Before we start, I'd like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. In an effort to get to as many participants as possible, we ask that you limit your question to just one.

All right Kalia, can we start with the first question, please?

Operator: To ask a question, press star followed by the number 1 on your touchdown phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Andy Perez.

Andy Perez: Yes, good afternoon, and thank you for taking the call. My question is in all the various measures and quality measures, what is going to be the impact of ICD-10 and what do you foresee having requirements for ICD-10 accuracy coding and compliance?

Rabia Khan: Hi, this is Rabia Khan from CMS. So in terms of implementation of ICD-10, it does become effective October 1, 2015. We have for most of the measures provided crosswalks from ICD-9 to ICD-10. We are going to be assessing the impact when ICD-10

does become effective. There will be additional crosswalks provided prior to and following the transition. But at this point in time, we don't have any definitive information to provide you as far as the impact it would have on the quality measures.

Andy Perez: OK, thank you.

Operator: You next question comes from the line of Mary Ann Kramer.

Mary Ann Kramer: Hi, this is Mary Ann from Advanced Dermatology Associates, and this question is on PQRS going forward. If you have a group practice of say 20 physicians or extenders physicians, does every provider in the group have to meet the nine measures, or is it 50 percent of the group?

Christine Estella: Sure, this is Christine. So it really just depends on how the group is going to report. So if everybody wants to report as an individual reporter under PQRS, then each person would have to report nine measures covering three domains for 50 percent of their patients.

Mary Ann Kramer: OK.

Christine Estella: But – and here's the beauty of the GPRO option. If you do the group reporting option, it's not necessarily that every provider needs to report, they just need to make sure that at least 50 percent of the group's patients are accounted for when they report the measure.

Mary Ann Kramer: OK.

Christine Estella: Does that make sense to you?

Mary Ann Kramer: Yes, yes. Thank you.

Christine Estella: Um-hum.

Operator: You next question is coming on the line on Lynn Ruckert.

Lynn Ruckert: Hi, my name is Lynn, I'm calling from Steckler Eye Center. I have a question about the measures for quality reporting Meaningful Use, where we have to use our direct messaging from one EMR to another provider's EMR, and we're having trouble with no one else having that setup and we're unable to meet that measure. And the way I understand it is, there isn't any other way for us to meet that right now. Is there anything out there that you can help us with?

Elisabeth Myers: Hi, this is Elisabeth Myers from the EHR Incentive Program. The purpose of this call is to discuss the PFS and Quality Measurement Program. The

proposals for Meaningful Use are in separate rules, which have recently closed for public comment.

There is more information coming out on those final policies in those rules as those are developed and the final policies are set. However, for the time being, if I can refer you to our website for the EHR Incentive Programs, there is an exchange — Health Information Exchange tip sheet on that website. That site is cms.gov/ehrincentiveprograms. If you look on the left-hand side under Educational Resources you can find a number of tip sheets, including one on Health Information Exchange on that page.

Aryeh Langer: Thank you. We'll take our next caller, please.

Operator: Your next question comes from the line of Robin Hook.

Robin Hook: Hi, this is Robin Hook. It's kind of a two-tiered question. First of all, the portals for the vendors, when will those be available as a vendor to test our output to make sure that it's correct and secure for our clients to use? And then the second question, really ties to it, is there is a separate portal for PQRS and also for the GPRO?

Alex Mugge: Hi, this is Alex Mugge from PQRS. And I believe you're asking about our SVTT testing tool, the submission validation testing tool for PQRS, where vendors can test — vendors and eligible professionals submitting their files can test to see if their files are formatted correctly.

Robin Hook: Yes.

Alex Mugge: That tool is currently available. There are some updates planned for the December timeframe, but it is currently available in the QualityNet portal for testing, and the second — I'm sorry?

Robin Hook: Go ahead.

Alex Mugge: Just to the second part of your question, it is the same portal for individual eligible professionals as well as GPROs.

Robin Hook: That is the same, OK. So back to QualityNet round, the PQS portal. The way to do that, you have to have an NPI or TIN number, and as a vendor we really don't have that. We don't — it's a provider NPI and a provider TIN. So how do we get around that?

Alex Mugge: This is Alex again. If you go to QualityNet and you look at the SVTT link, which is on the – on the PQRS page, it's on the left-hand side, there's actually a user guide for SVTT that will show you how to do testing. And I believe that you just need an

EIDM account in order to do that. You don't need a provider TIN or like an actual submission account.

Aryeh Langer: OK, thank you. Let's take our next question, please.

Operator: Your next question comes from the line Cathy Wolf.

Cathy Wolf: Yes, hi this is Cathy Wolf and I'm with Dr. Peter Click, MDPC. And I guess I'm really going back to another question about the 2015 EHR thing, which you said this webinar isn't really about. But that there should be some more notices. I'm wondering when those are going to come out.

Elisabeth Myers: The Administrative Procedural Act has a set policy in place for how we in the Federal government have to draft regulations. So we propose the rules through the notice of proposal making. We had a 60-day comment period. At this point, we are reviewing those public comments and determining what the final policies will be.

We did receive over 2,000 comments on the two rules, so it is taking time and we are required by that law to read every single one and consider it in the process. So we are working through that process. We anticipate we'll get it out as quickly as we can. And we will keep everyone updated.

For the considerations around the 2015 reporting period, I do want to redirect people to remember the announcements that was made by Patrick Conway, who is the CMS Deputy Administrator, making a commitment about some of the changes that we would making, including the 90-day reporting period in 2015. So while we do not have a final rule, that statement from the Deputy Administrator is still a clear statement of our intent. Thank you.

Cathy Wolf: Where is that? I haven't received it on —

Elisabeth Myers: It's on our website. It was posted in January. It is on the CMS blog, the HHS blog, …

Cathy Wolf: Oh.

Elisabeth Myers: And there's a copy of it on the website. I cannot, unfortunately, …

Cathy Wolf: OK.

Elisabeth Myers: Remember the exact page. But I will check that real quick and try and find it before the end of this call.

Cathy Wolf: OK, thank you.

Operator: Your next question comes from the line of Julie Lundburg.

Julie Lundburg: Hello, thank you very much. I am seeking some clarification on slide 56 regarding my providers who are participating with an ACO. Can you confirm that if my practice TIN is associated with the ACO TIN that they are considered to be participating in PQRS and they do not need to report separately?

Rabia Khan: Hi, this is Rabia Khan from the Shared Savings Program. So if the TIN is a participant on your ACO list and the ACO completely reports all the GPRO Web Interface measures on behalf of all of the participants, the EPs will meet their PQRS reporting requirements.

Julie Lundburg: Thank you very much.

Rabia Khan: Yup.

Operator: Your next question comes from the line of Jamie Sergeant.

Jamie Sergeant: Hi, this is Jamie, I'm calling from Milestones. And, did I hear right that the eligible practitioners will no longer include clinical social workers?

Aryeh Langer: Could you give us 1 second please?

Jamie Sergeant: Sure.

Sabrina Ahmed: Hi, this is Sabrina Ahmed. I just want to clarify that for the purposes of determining group size under the Value Modifier, clinical social workers will be included. However, our proposal for the 2018 Value Modifier is that we would apply the Value Modifier only to the nonphysician eligible professionals who are physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. The Value Modifier would not apply to other nonphysician eligible professionals who are not one of those four types of EPs that I just mentioned.

Jamie Sergeant: So can you dummy that down for me? I didn't understand that. So we're a practice, we have two psychiatrists, MDs, and the rest are LCSWs.

Aryeh Langer: One moment, please.

Sabrina Ahmed: HI, this is Sabrina Ahmed again. So the Value Modifier would apply to the physicians that bill under your TIN in 2018, but it would not apply to the social workers.

Jamie Sergeant: OK. So should the social work — so we currently participate, the social workers do, in PQRS.

Lauren Fuentes: They still need to report. Hi, so this is Lauren Fuentes with PQRS, yes, you still the social workers do still need to report PQRS to avoid the negative payment adjustments under PQRS.

Jamie Sergeant: Right, but they are not going to get the Value-based Modifier adjustments, the positive side, right? Is that what I'm hearing?

Lauren Fuentes: Yes, that's correct. Yes, they wouldn't be subject to the positive or negative or neutral, yes, adjustments under the VM.

Jamie Sergeant: OK.

Aryeh Langer: OK, thank you so much for your question.

Operator: Your next question comes from the line of Nora Nagrood.

Nora Nagrood: Hi, this is Nora from Dr. Allen Geed's office in Forest Hill. My question is, on slide 32 there is a statement saying that providers are able to make a single submission of CQM data for both PQRS and EHR. I'm wondering how that's possible. I tried to do that last year and was told that the file requirements for both programs were different, so I need some help on that.

Alex Mugge: Hi, this is Alex Mugge with PRQS and the EHR Incentive Program.

Nora Nagrood: Um-hum.

Alex Mugge: And if you submit a QRDA file for the purposes of meeting the CQN requirements of Meaningful Use and you submit that through that through the PQRS portal, it will count for both programs. They are the same file requirements. The only difference is — well there's quite a bit of difference, but the program identifier name that you use if you want to submit to both programs is PQRS_MU and either send them next year as individual or group, depending on how you're reporting. And if you want to submit that file to Meaningful Use only you would use the program identifier of MU only. All other requirements are the same. And if you submit one file to PQRS, it will be counted for the CQM component of Meaningful Use as well.

Nora Nagrood: I got an error saying for the PQRS that — that there was no XML file. For the EHR it was an XLS file that was created and accepted. But PQRS required an XML file.

Alex Mugge: Yes, if you have an instance where you're submitting the file — well again, let me suggest that you use the submission validation testing tool that we have available on the PQRS portal now to test your files and make sure that they're in the right format for submission in 2015.

If you have a problem like that again, you should contact the help desk and explain the error message that you're seeing and they should be able to help you there on the call, connect you with the right people. Again, one file submission should work for both programs.

Nora Nagrood: Actually, my vendor is telling me that their file is only good for EHR, that we have to use a registry for PQRS.

Alex Mugge: That is incorrect. But if you could contact the QualityNet help desk and submit a ticket with the information, there may be something unique to your situation that we're not understanding here on the phone.

Nora Nagrood: OK, all right.

Alex Mugge: But your files should work again for both programs. So definitely contact the help desk.

Nora Nagrood: OK, thank you.

Aryeh Langer: Thank you.

Operator: Your next question comes from the line of Betty Evans.

Betty Evans: Thank you so much. I was from Oakship Medical, and I was calling with regards to a question with regards to slide 50, where it talks about the CPCI initiative. We are part of that program. And so I'm trying to understand exactly what the slide indicating with regards to the 2017 and 2018 Value-based waiver. And so, I guess, I'm trying to understand if that really means that we aren't — we're kind of exempt from that for 2017 and '18 because we are participating in CPCI?

Sabrina Ahmed: Hi, this is — hi, so you're correct. So what we proposed is that for 2017 and 2018 Value Modifier, if a TIN has at least one eligible professional in the TIN who participated in the CPC or Pioneer ACO model during the performance period, then that — then the Value Modifier will be waived for that TIN.

Betty Evans: Oh, sweet. Thank you so much, appreciate it. Bye.

Operator: Your next question comes from the line of Reporting MD.

Female: Hi, we were just wanting clarify that for practices of 25 or more EPs, is it only those that are doing the GPRO Web Interface that have to do CAHPS or is it all practices of 25 EPs or more?

Christine Estella: Yes, this Christine, that's correct. It's only the group practices that will be using the GPRO Web Interface for 2016.

Female: OK, thank you.

Christine Estella: And remember in 2015, because we are in the 2015 reporting period currently, that it's different. That if you're a large group, a hundred or more, you report CAHPS for PQRS, regardless of the reporting mechanism.

Female: OK, thank you.

Aryeh Langer: Thank you.

Operator: Your next question comes from the line of Kelly Sharon.

Kelly Sharon: Hi, my question is, this year do PTs count towards the VM in groups but next year they won't?

Aryeh Langer: One moment please.

Sabrina Ahmed: Hi, this is Sabrina Ahmed. So for purposes of determining group size under the Value Modifier for both the 2017 — for the Value Modifier, in general, all of the eligible professionals that are listed on slide 38 count towards making that determination and — and beginning in 2018, only physicians, PAs, MPs, CNSs, and CRNAs will be subject to the Value Modifier. PTs will not be subject to the Value Modifier in 2018.

Kelly Sharon: And they are on that slide, so they are this year though, correct? For 2017?

Sabrina Ahmed: No, so this slide lists all of the eligible professionals. So for performance year 2015, which — the Value Modifier in 2017 will be based on the 2015 performance year, only the physicians that bill under the TIN in 2017 will be subject to the Value Modifier, not the practitioners or the therapists that are listed on slide 38. However in 2018, physicians, along with NPs, PAs, CNSs, and CRNAs will be subject to the Value Modifier, but not the other EPs that are listed on this slide.

Kelly Sharon: So you're saying this year only the physician's count towards the Value Modifier?

Sabrina Ahmed: So when you …

Kelly Sharon: Or is it every — or is it every eligible professional listed on slide 38?

Sabrina Ahmed: So are you asking about the 2017 Value Modifier or the 2018 Value Modifier?

Kelly Sharon: 2017.

Sabrina Ahmed: OK, so for 2017, only the physicians in the — billing under a TIN will be subject to the Value Modifier.

Kelly Sharon: OK, so the — even though it says EPs, you're just considering an EP a physician, and that's it.

Kim Spalding Bush: So this Kim Spalding Bush, I'm not sure if I can clarify the answer. Just building on what Sabrina said, the EPs listed on that slide are used for the purpose of determining the group size under the Value Modifier. And if you'll remember from earlier in the presentation, the size of a group determines what payment adjustment that they're subject to and whether or not their subject to the Value Modifier in a given year. However, …

Kelly Sharon: OK.

Kim Spalding Bush: … those EP types — that's why it's not showing you who is actually going to receive a payment adjustment in a given year.

Kelly Sharon: OK. So therapists will count as an EP towards the group size?

Kim Spalding Bush: They do.

Kelly Sharon: But not –

Kim Spalding Bush: They also count when we are looking to determine whether or not 50 percent of the eligible professionals in a given group successfully reported to the PQRS program in order to avoid the PQRS adjustment. So beginning with the 2016 Value Modifier, groups have the option to either report as a group or to make sure that at least 50 percent of the individual eligible professionals in the group reported PQRS. So in determining that count of 50 percent of the EPs, we do use all of those EP types. But they will – the therapists are not currently proposed to be subject to the Value Modifier, even in 2018 for payment outcome.

Kelly Sharon: OK, OK, thank you.

Kim Spalding Bush: Sure.

Operator: Your next question comes from the line of George Coutros.

George Coutros: Yes, thank you. My question concerns on page 56. Again, this is George Coutros with Sanofi. The new measure for statin therapy — I believe you mentioned that this was coordinated with other Federal agencies — if you could clarify that and share with us those other agencies? Thank you.

Rabia Khan: Yes, this is Rabia Khan from the Shared Savings Program. So, yes, this is coordinated in development with AHRQ as well as CDC and other CMS — I'm sorry other HHS sister agencies. It was the GPLs that led the development from CMS side — work on PQRS. So this – if you have more specific questions about the measure itself, you can send those questions to the QualityNet help desk, and I believe their contact information is provided in one of the resource slides in this presentation — slide 65.

Aryeh Langer: And we have time for one final question, please.

Operator: And that question comes from the line of Camille Montes.

Camille Montes: Hi, thank you. This is Camille Montes with Healthcare Consulting. Thank you for your presentation today. And this comes from a question that was asked earlier, and I wanted to go back and look 'cause it's an important distinction. On page — on slide 22, in talking about the GPO — GPRO via registry, it states in the third bullet that the group needs to report each measure for at least 50 percent of the EPs. But if you go down to slide 70, it's 50 percent of the group — of the group practice cases. So I just want to, you know, make sure that I'm understanding correctly that it's the latter as included in the table in slide 70 and also in the *Federal Register* because it is a really important distinction for those who decide to report using the GPRO.

Christine Estella: Sure, this is Christine Estella. So we're going to take a look at it, but basically what the reporting criteria says in the proposed rule is that if you have — if a group practice has less than nine measures that are applicable to their practice, again you need to — at least nine measures are applicable to your practice, then you have to report at least nine measures covering three NQS domains. If you have less than nine measures that cover less than three NQS – you know, that covers three or less NQS domains, you need to report as many measures as are applicable to your practice and report them for at least 50 percent of the group's patients.

Camille Montes: Right, so — and I'm sorry. That was slide 71, not 70.

Christine Estella: Right, yes.

Camille Montes: Right, so that's probably stated on 71. So I'll just go back and double check slide 22.

Christine Estella: OK, great. Thank you for that — for noticing that. But yes, that is what was stated in the proposed rule.

Camille Montes: OK, great. Thank you.

Elisabeth Myers: This is Elisabeth Myers. To answer the person who had asked for the link referencing Patrick Conway's blog. The easiest way is to go to blog.cms.gov. The date is January 29th, the author is Patrick Conway. If you go to that site, all of our blog postings for CMS are listed there. That is one of them. Again, it was January 29th, Patrick Conway.

Additional Information

Aryeh Langer: And, unfortunately, that's all the time we have for questions today. If we did not get to your question, please reference slides 65 and 66, where you can find more information about getting your questions answered and CMS resources on the different topics covered today.

As a reminder, an audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement on the MLN Connects Provider eNews when this information is available. Also, as a reminder, this call is being evaluated for CME and CEU credit. For more information about that, please see the link on slide 63 of today's presentation.

On slide 62, you'll find information and a URL to evaluate your experience with today's call. As a reminder, evaluations are anonymous, confidential, and voluntary. We hope you'll take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Aryeh Langer. I'd like to thank our presenters here at CMS and thank you all on the line for participating in today's MLN Connects Call. Have a great day everyone.

Operator: This concludes today's call. Presenters, please hold.

-END-


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