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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
The 2015 Medicare PFS Proposals for PQRS, EHR Incentive Program, and the Physician Compare Website
MLN Connects National Provider Call
Moderator: Aryeh Langer
July 24, 2014
1:30 p.m. ET

Contents

Operator: At this time, I would like to welcome everyone to today's MLN 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 today's conference call over to Aryeh Langer. Thank you. You may begin.

Announcements and Introduction

Aryeh Langer: Thank you Selema. This is Aryeh Langer from the Provider Communications Group here at CMS and as today's moderator, I'd like to welcome everyone to this MNL Connects National Provider Call on the 2015 Medicare Physician Fee Schedule Proposals for Quality – for Physician Quality Reporting Systems, or PQRS, Value Modifier, Electronic Health Record, or EHR, Incentive Program, and the Physicians Compare website.

MNL Connects Calls are part of the Medicare Learning Network. During today's call, CMS subject matter experts will provide an overview of the 2015 Physician Fee Schedule proposed rule. This presentation will cover potential program updates to the Physician Quality Reporting System as well as an overview of the proposals for the Value-Based Payment Modifier. The presentation also describes how the Value-Based Payment Modifier is aligned with the reporting requirements under the PQRS. Lastly, this presentation will cover proposals related to the Shared Savings Program Quality Policies.

Updates to Physician Compare and the EHR Incentive Program will also be provided. This overview will be followed by a question-and-answer session. Before we get started, there are few items I'd like to quickly cover. You should have received a link to the slide presentation for today's call and an email today. If you've not seen the email, you can find today's presentation on the Call Details webpage of the CMS website, which can be found by visiting www.cms.gov/npc. Again, that URL is www.cms.gov/npc.

On the left side of that page, you'll see a link that says National Provider Calls and Events. You can select the call by date from that list. The slide presentation is located there in the Call Materials section. I'll also note that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the CMS Call Details webpage within 2 weeks of this call. An announcement will be placed in the MNL Connects Provider eNews.

Finally, this call is being evaluated by CMS for CME and CEU continuing education credit. For more information about continuing education credit, please review the CE activity information and instructions available via the link on slide 24 – 42 of today's presentation. At this time, I would like to begin the formal part of the presentation by turning the call over to Christine Estella, Christine.

Presentation

Christine Estella: Thanks. So today we're going to start with slide number 4 on here. I'm going to quickly run over the agenda for today. So this is to cover, as Aryeh mentioned,

the 2015 Medicare Physician Fee Schedule Proposed Rule; specifically, we are going to cover the quality reporting or quality program components related to the 2015 PFS.

So under the agenda, first off, we have, you know, kind of a general overview of the 2017 payment adjustments, then we'll go over our proposals for the PQRS, the Physician Quality Reporting System, then our proposals for the EHR Incentive Program, our proposals for public reporting, the Value-based Payment Modifier, or the VM, and then finally, our proposals for the Medicare Shared Savings Program.

In the back of the slides, we also have slides for comments and resources and then after our presentation, we'll have a Q&A session.

Overview of PQRS Payment Adjustments

So to go on to slide 5, we have kind of an overview of the different payment adjustments that will occur in 2017 related to quality. First off, you can see here, all of these quality reporting or quality payment adjustments are based on performance year reporting period 2015. So that is why these proposals for the 2017 payment adjustment are found in the 2015 PFS, because they relate to something that you have to do in 2015 for an adjustment potentially in 2017.

First off, for PQRS, we have a 2 percent Medicare Physician Fee Schedule payment adjustment for not satisfactorily reporting or satisfactorily participating in PQRS. We also have, depending on your participation in the EHR Incentive Program, we have a negative 1 percent, 2 percent, or 3 percent payment adjustment related to the Medicare EHR Incentive Program under the Physician Fee Schedule. Now the percentage adjustment depends on when the Medicare physician started Meaningful Use. So the earlier you start, the less of an adjustment you would get.

Third, for the Value-Based Payment Modifier, there are different adjustments related to the VM. This would apply to all Medicare physicians and nonphysician EPs in groups of two or more, EPs as well as solo practitioners. First off, for non-PQRS reporters there's a potential of a negative 4 percent adjustment on the Medicare Physician Fee Schedule. Then for mandatory quality tiering calculations for three groups of PQRS reporters, you either have 4 percent incentive, or increase, or a negative 4 percent adjustment for the PFS.

For groups of two to nine EPs and solo practitioners, you can get an upward or neutral Value Modifier adjustment based on quality tiering, and this is for 2015 related to the 2017 adjustment. In groups with 10 or more EPs, you can either get an upward, neutral, or downward VM adjustment based on quality tiering. So groups of two to nine will not get a downward adjustment for 2017. Groups and solo practitioners are eligible for an additional 1 percent if their average beneficiary score is in the top 25 percent of all beneficiary scores nationwide.

So looking at this payment adjustment table, you'll see that all of these payment adjustments are kind of individual of each other. So for example, just because you have

reported satisfactorily under PQRS doesn't mean you won't get an adjustment under the Medicare EHR Incentive Program or the VM. You have to make sure that, you know, you're participating sufficiently in all these programs to avoid each of the separate adjustments.

Proposed Changes for PQRS Reporting

So we'll move on to our proposals for the PQRS now that we have explained that table. So starting with slide 7, we have an overview of the proposed PQRS changes. So the proposed rule addresses changes to the PQRS for the 2017 PQRS payment adjustment. The 2017 PQRS payment adjustment is based on reporting in 2015. This is actually – this following year is actually going to be the first year in which for PQRS we don't have an incentive reporting period, so you will no longer be receiving incentives under the PQRS. This is the first year –next year – that you will be reporting strictly to avoid a payment adjustment in 2017.

So a couple of our proposals, first off, if you look to the top left, EPs in critical access hospitals are now able to participate in PQRS using all reporting mechanisms, including claims. So last year we had introduced EPs in cause, but we stated that they could use any other reporting mechanism, except for claims. And this year we are proposing that EPs in cause can use any reporting mechanism, including claims. So claims is now included as a method of reporting for cause – for EPs in cause.

And if we look over to the next box, to the right of that, CMS has not proposed a change – does not propose a change to claims or certified surveys and their reporting mechanisms for PQRS at this time. So those – if those are left alone, those will remain likely the same and consistent as we had had for the 2014 PQRS incentives.

Finally, at the bottom, CMS seeks comment on whether to propose in future rulemaking to allow more frequent submissions of data, such as quarterly or year-round submissions rather than annually. This is not a specific proposal that will take place in 2015, but we are seeking comment on these, I guess, ideas to see how the public feels and we appreciate any comments that you can provide to us related to future years.

I do want to point out, these are just an overview of the changes. The proposed rule does cover, you know, certainly detailed satisfactory reporting criteria. This presentation is meant to really be a high level overview of the major proposed changes in the rules. So if you want to look fully into the rules, there are additional appendices – slides in this presentation. And you can look at the proposed rule and there's a link to that on the PQRS website.

Onto the next slide, slide 8, Proposed PQRS Updates and Changes. Let's start with the box on the left, Measures Added. So we are proposing to add 28 measures for individual reporting and to measures groups. We are proposing that – have measures address all NQS domains. So these measures address, you know, there are six patient safety measures that we're proposing to add, eight affecting clinical care, five patient and caregivers – caregiver-centered experience and outcome, one efficiency in cost reduction

proposed measure, five communication and care-coordination measures, and three community population health measures. So these new 28 measures that we are proposing kind of span the broad six NQS domains.

With respect to the measures, we are proposing to remove from the PQRS that middle box. We are proposing to remove 73 measures that were mostly measures from claim or registry. We're proposing to remove 38 measures that were a part of a measures group. So a couple of the measures groups we're proposing to remove:

- Back pain,
- Perioperative care,
- Cardiovascular prevention, and
- Ischemic vascular disease.

Onto the right box, Proposed Changes to the Measures. We are proposing to remove claims-based only reporting options for new measures. We are also proposing to remove claims-based reporting options for measures group, so basically the measure groups will only be reportable via registry. We are also – we're proposing to define a measures group as a subset of six or more PQRS measures. So traditionally, in years prior, the measures group contained four or more measures. We are increasing that and proposing to define – redefine the measures group as containing six or more measures.

We are also proposing two new measure groups available for PQRS reporting beginning in 2015 – sinusitis and otitis.

Onto the next slide, slide 9, Reporting through a Qualified Registry. This is different from our Qualified Clinical Data Registry option, QCDR, that I'll mention later on in this presentation. So this is just the traditional registry option that we've had since 2010.

We are proposing to do the following. So first off, that left top box, we are proposing to require that an EP or group practice who sees at least one Medicare patient in a face-to-face encounter to report on at least two cross-cutting PQRS measures. So the cross-cutting PQRS measures set is new for PQRS. It contains a set of a little over 20 measures and it's, you know, specific in terms of the set that is provided in the proposed rule. And basically, if you are an EP or practice that sees at least one Medicare patient in a face-to- face encounter, you would be required to report on at least two cross-cutting PQRS measures. So within the nine that we propose that you report, two of those would have to be in the cross-cutting measure set.

If we look at the next box to the right of that, we are proposing to add surgical procedures to the face-to-face encounter list along with existing visit codes, like general office visit codes, outpatient visits, and surgical procedures. So the face-to-face – this kind of gives you an overview of what we mean by face-to-face encounter in terms of our proposals for this.

If you look at the box on the bottom left, we are proposing to require that qualified registries be able to report and transfer data on all 18 cross-cutting measures in addition to collecting and transmitting the data for at least nine measures covering at least three of the NQS domains.

This is a proposed requirement related to the registry vendor, so I'll just – EP, or group practice themselves. So basically, this is saying that the registry should be able to meet our proposed requirements and be able to submit data related to our proposed requirements for the 2017 PQRS payment adjustment.

So for example, they have to be able to report nine measures covering at least three of the NQS domains because that is our proposed satisfactory reporting criteria through registries for the 2017 PQRS payment adjustment. And they should also be able to transmit data on all 18 of the cross-cutting measures because, as I mentioned earlier, of the nine measures you would have to report, if an EP sees at least one Medicare patient in a face-to-face encounter, they would need to report at least two cross-cutting measures.

Again, another proposal we have related to the Registry Vendor, bottom right of – the box on the bottom right. We are proposing to extend the deadline for qualified registry to submit quality measures data including but not limited to calculations and results to March 31st. This is a change in – what we have established currently is that Registry Vendors would be required to submit data to us by February 28th. We've heard from stakeholders so that's a little too early for some of the registries, so we are proposing to extend the deadline to March 31st.

Onto the next slide, slide 10, proposals related to our direct EHR and EHR data submission vendor products. So these are two other reporting mechanisms for which you can report under the PQRS. So for 2015 and beyond, we are proposing it to have the EP or group practice provide the CMS EHR Certification Number of the product used by the EP or group practice for direct EHRs and EHR data submission vendors.

In addition, I just want to note, too, for the direct EHR and EHR data submission vendors that the criteria we are proposing for the 2017 PQRS payment adjustment is kind of the same as we have for Meaningful Use and the same criteria that we'd had for the 2014 PQRS incentives. So it would be to report nine measures covering three domains via EHR.

Onto to slide 11, Reporting through QCDR, proposed criterion for the satisfactory participation for the 2017 PQRS payment adjustment. Now the QCDR is different from our other reporting mechanisms that I covered in that for the QCDR, the standard is not satisfactory reporting, it's satisfactory participation, which is why you see these proposals are related to satisfactory participation.

First off, the box on the left, we are proposing that an EP report on at least nine measures available for reporting under a QCDR covering at least three NQS domains and report each measure for at least 50 percent of the EP's patients. This is kind of the same as what

we established for the 2014 PQRS incentive in terms of reporting nine measure covering three domains. It's also consistent with what we're requiring for the other reporting mechanisms.

On to the right – the box on the right. Of the measures, an EP would report on at least three outcome measures or if three outcome measures are not available, report on at least two outcome measures and at least one related to resource use, patient experience of care, or efficient and appropriate use. Now this proposal is a little different from what we established for the 2014 PQRS incentives. For 2014, we stated you only need to report on one outcome measure. And this is bringing that up – this proposal is bringing that up from one to three outcome measures or two plus another type of measure.

Additional proposals related to the QCDR, for example, this is related to vendors, the QCDR vendors that are qualified, not the EPs. We are proposing new parameters for a non-PQRS measure. Basically, we are saying that a measure – a non-PQRS measure is a measure that is not in the PQRS measure set – measures set and has substantive differences in the manner it is reported by the QCDR.

So for example, let's say, you know, we have a measure within the measures group and within the PQRS measure set. It's only reportable via the measures group and now a QCDR wants to report that as an individual measure separate from the measures group. That to us would be considered a non-PQRS measure according to the proposed definition.

In terms of the number of measures a QCDR can report to us, last year we stated that for the 2014 PQRS incentive, a QCDR can give us – although the minimum threshold was nine measures covering three domains – a QCDR can give us up – data for up to 20 measures. We are proposing to increase that to 30. There are also additional requirements that an entity must meet to serve as a QCDR as proposed. For example, the entity must make available to the public the quality measures data for which it's eligible. So this is kind of a public transparency requirement.

An entity may become a QCDR in conjunction with another entity. So for example, if there's a specialty society that wants to combine with, you know, one of our qualified registries or a vendor to become a QCDR, that we are proposing to be permissible to qualify the QCDR. An entity is considered to be in existence in case of a break up of a larger organization at the earliest day the larger organization begins continual existence.

The quality measures data publicly reported by April 30 of the year following the applicable reporting period or there's a – that's the deadline for publicly reporting quality measures data for a QCDR. The quality measures data must be continuously available and updated on a continuous basis when they publicly report. So again, this is kind of related to public transparency. We are also extending the submission deadline for QCDRs to report quality measures data from February 28th to March 31st, like the registry deadline as well as the EHR deadline.

QCDRs must provide to CMS descriptions for the measures for which they will report to CMS for a particular year no later than March 31st of the year in which it seeks to be a QCDR. Now this proposed requirement in terms of providing to CMS measure descriptions, this means that we are proposing that by March 31st, a QCDR would give us full measure specification for when they want to qualify to become a QCDR.

Onto the next slide, slide 12. Now I'm going to cover our group practice reporting option. Now this is different from the individual EP reporting option. Just letting you know though – some of our reporting mechanisms, you can use either group reporting option or individual reporting option, depending on how you want to participate. For example, the EHR reporting option, you can use as either an individual or a group or your traditional registry you can use as either an EP or as a group.

So CMS proposes to do the following. First off, on the top left, we are proposing to modify the deadline for group practice registration to June 30th of the year in which the group practice will report. Second, if you go the right of that box, we're proposing to change the measure applicability analysis, or MAV, process to check whether an EP or group practice should have reported any of the proposed cross-cutting measures. So this is to ensure that you are reporting on those cross-cutting measures if you can report on those cross-cutting measures.

Another proposal on the bottom left is to require group practices to report on at least two cross-cutting measures if they see at least one Medicare patient in a face-to-face encounter. This is the same criteria basically as the individual EP criteria.

And then the fourth proposal, we are proposing to make a group practice subject to MAV if it does not report on one cross-cutting measure if they have at least one EP who sees at least one Medicare patient in a face-to-face encounter.

The 2015 Medicare EHR Incentive Program Proposals

Now, I am done with the PQRS proposals. I'll briefly cover the 2015 Medicare EHR Incentive Program proposals, starting on slide 14. There's only one slide, so I'll take a little bit of time on this.

First off, proposals related – so proposals related to the EHR Incentive Programs. On the left box are proposals related to the Comprehensive Primary Care Initiative Reporting. I'm actually going to cover that second bullet. So we are proposing to relax the reporting of NQS domains from three to at least two NQS domains as CPCI practice sites must report at least 9 of 11 measures and may not have measures to cover three domains. So this is a change from last year and so that second bullet is really what we want you to focus on in terms of the CPC proposal related to the EHR Incentive Program.

For the middle box, the Medicare Insured Savings Program, CMS proposes that EPs participating in an ACO satisfy the CQM reporting component of Meaningful Use of a Medicare EHR Incentive Program when:

1. The EP extracts data from the EHR necessary for the ACO to satisfy its GPO quality reporting requirement, and
2. The ACO satisfactorily reports the ACO GPRO measures through a CMS web interface.

On the right, Physician Compare proposals related to the EHR Incentive Program. So for Physician Compare, we are proposing that successful participation in the EHR Incentive Program be based on 2014 – '15 data will be reflected on the Physician Compare website in 2016. So basically, data that you report for the EHR Incentive Program next year will be included in Physician Compare in 2016.

Those are all the proposals that I have related to the EHR Incentive Program. So we're going to move on to public reporting, and so slide 16 covers our brief proposals related to public reporting.

Proposals for Public Reporting

So the rule provides several proposals related to Physician Compare. Just remember that this slide, slide 16, is a kind of an overview of Physician Compare and to get more detail you can either look at the appendices in the back or you can go ahead to the proposed rule and look specifically at our proposal.

So first off, on the left side we have our proposals for groups. So related to Physician Compare, all PQRS GPRO measures via the GPRO web interface, registry, and claims for group-level measure ACOs will be posted on Physician Compare. Benchmarks mirroring the Shared Savings Program would also be posted on Physician Compare. And this is data that's reported in 2015 as well as CAHPS information that's reported for the PQRS as well as for ACO.

Moving on to the individual's box on the right. For Physician Compare we are proposing to post data report for 2015 for the following: on 2013 individual-level PQRS measures, all 2015 individual-level PQRS measures via registry, EHR, and claims. So that's significantly upping the number and types of data available under Physician Compare. We are proposing to post benchmarks for PQRS as well as QCDR measures data, individual or aggregate, either PQRS or non-PQRS, so basically, QCDR measures data in general.

So I'm now done with our proposals for Physician Compare. I'm going to turn it over to Aryeh. He's going to talk more before we move on to the Value-based Payment Modifier slides.

Keypad Polling

Aryeh Langer: Thank you Christine. Before we more into the next portion of the presentation, we'll pause for a moment to complete keypad polling so CMS has an accurate count of the number of participants on the line with us today. Please note there will be silence on the line while we tabulate the results. Selema, we're ready to start polling please.

Operator: CMS appreciates that you minimize the government's teleconference expense 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 hold while we complete the polling. Please hold while we complete the polling. Please hold while we complete the polling. Please hold while we complete the polling. Please continue to hold while we complete the polling.

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

Presentation continued

Aryeh Langer: Thank you, and I'm going to turn the call over to Kim Spalding Bush from CMS for our next part of our presentation. Kim.

The Value-Based Payment Modifier

Kim Spalding Bush: Thank you. On slide 18, you will see an overview of what we will cover in the Value-Based Payment Modifier section of this presentation. So the presentation will focus on the proposed policies for the Value Modifier in the 2015 Physician Fee Schedule NPRM. I also want to take this opportunity to be sure that you're aware that the registration for selecting a PQRS GPRO reporting mechanism for 2014 is now open. It remains open until September 30th. We strongly encourage you to register and successfully report as a group or to ensure that at least 50 percent of the eligible professionals in your group report successfully in order to avoid the PQRS payment adjustment in 2016. For groups of 10 or more eligible professionals, the 2014 data will also be used for the 2016 Value Modifier.

To qualify for the upward adjustments under the 2016 Value Modifier and to avoid classification into our Category 2 – receiving a penalty for not reporting PQRS –you must register and successfully report as a group or have at least 50 percent of the eligible professionals within your TIN report successfully as individuals.

Onto the next slide. On slide 19 we provide background on the Value Modifier, which is an adjustment made to the Medicare Physician Fee Schedule payment on a claim-by-claim basis. The adjustment is made at a Tax Identification Number, or TIN, level and the amount of the adjustment reflects performance on quality cost measures. In this year's Physician Fee Schedule proposed rule, we propose to clarify that the VM would not be applied to non-assigned services for which Medicare makes payments directly to beneficiaries.

These claims represent less than 1 percent of the physician services billed to Medicare and, based on previous public comments and consistent with our previously finalized policy, supply of Value Modifier to Medicare paid amounts rather than allowed amounts.

This proposal also would apply the Value Modifier to avoid any impact to beneficiary cost-sharing.

So the Value Modifier, as you see on the slide, continues to be aligned with and based on participation in the PQRS program. And at the bottom of this slide 19, you'll find some helpful links to additional resources on the Value Modifier.

On slide 20 we begin to take a look at the policies proposed for Calendar Year 2017 Value Modifier payment adjustments, which are based on performance period proposed for Calendar Year 2015. For comparison of the 2017 Value Modifier proposals to those that were previously finalized for the 2015 and 2016 payment adjustments, you can refer to the helpful comparison tables found on slides 45 through 48 in the Appendix of this presentation.

We are proposing that the 2017 Value Modifier will apply to physicians and also to non-physician eligible professionals, including nurse practitioners, physician assistants, occupational, physical, and speech therapists. And this proposal would apply to solo practitioners who are non-physician eligible professionals as well as – and to non-physician eligible professionals who are in groups comprised solely of non-physician eligible professionals or comprised both of non-physician eligible practitioners and physicians.

We also propose that in 2017, the Value Modifier will be based on mandatory, quality tiering for all groups and solo practitioners. Consistent with our previous practice of allowing groups to become familiar with their quality reports and with the Value Modifier program, we are proposing to hold the solo practitioners and the smaller groups – those with two through nine eligible professionals – harmless from any downward adjustment based on quality tiering.

Those solo practitioners and groups of two through nine will be eligible only for a neutral, meaning no adjustment, or an upward adjustment. These proposals continue our gradual phase-in of the Value Modifier, which allows progressively smaller groups to gain experience with the program before downward adjustments for quality tiering would be applied to them.

The table on slide 45 of the Appendix illustrates this gradual phase- in by comparing quality tiering policies and proposals across program years. We've been conscious of concerns with rolling out the Value Modifier to smaller groups.

We risk adjust our payment and outcome measures to remove outliers and we retain the case minimum so that we're confident we're using reliable data. Further, through the quality-tiering approach, we adjust payments only for those solo practitioners and groups whose performance varies significantly from the average. Under our proposal for the 2017 Value Modifier, all groups and solo practitioners would also be eligible for the additional plus 1x upward adjustment for treating the highest risk beneficiaries.

This adjustment aims to recognize and reward those groups involved in providing high quality care to the most complex of Medicare beneficiaries and also to ensure there are not incentives to avoid taking on those complex cases. The x in the plus 1x represents the adjustment factor, which will be calculated at the end of each performance year for the Value Modifier. It enables us to apply adjustments to the Physician Fee Schedule payments in such a way that they're estimated to redistribute the aggregate amount of downward payment adjustments to those groups that fall into our Category 2 and – and receive downward adjustment under quality tiering. That is the group that failed to register and successfully report under PQRS and also those that performed poorly under the quality tiering methodology.

On slide 21 you will see that the quality measure reporting mechanisms and the cost measures we are proposing for 2017 Value Modifier are the same as those previously finalized for the 2016 and 2017 – I'm sorry, for the 2016 Value Modifier Program.

For the 2017 Value Modifier we are proposing that groups of two or more eligible professionals can report through GPRO web interface, a qualified PQRS registry, or EHR, and can also meet the reporting requirement by having at least 50 percent of their eligible professionals successfully report as individuals. We are proposing that solo practitioners can report PQRS as individuals via a qualified PQRS registry, EHR, claims or a qualified clinical data registry. You can see the tables on Appendix slides 46 and 47 for a comparison of these proposals to the 2015 Value Modifier policies.

For the 2017 Value Modifier we are proposing that for PQRS would be optional for solo practitioners and for groups of two through 99 eligible professionals, while it would be required for groups of 100 or more eligible professionals.

This proposal continues the gradual phase- in of the Value Modifier by expanding on our previously finalized policy for inclusion of CAHPS for PQRS in the 2016 modifier. For 2016 a survey will be optional for groups of 25 or more and required for groups of 100 or more that report to the GPRO web interface.

On slide 22 we present our proposals on the informal inquiry process. For the 2017 Value Modifier we're proposing an expanded informal inquiry process through which solo practitioners and groups can request that CMS review their Value Modifier if they believe that an error was made. Despite the preclusion of judicial review for many aspects of Value Modifier, we want to provide an avenue for solo practitioners and groups to report suspected errors to us. In the 2013 Physician Fee Schedule rules, we stated that we would make the help desk available for questions and in this rule we are going further by proposing to allow recalculation of the Value Modifier in the event that an error is brought to our attention through this process.

On this slide you will see the deadline for submitting informal inquiries and also our proposals for how to handle them. In the proposed rule we provide examples of Value Modifier errors that might be corrected through this process, such as errors made by CMS in computing standardized scores, composite scores, or outcome or cost measures. We

note that suspected errors in calculating PQRS performance would continue to be addressed at the PQRS informal review process. We do not yet have a process in place to recalculate the quality composite during informal inquiry process for the first year of the Value Modifier, so we are proposing to reclassify the TIN composite as average quality in the event that an error in the quality composite is discovered.

For the 2016 and future years Value Modifier calculations, we are proposing to recalculate the quality composite. We are proposing to recalculate the cost composite for the 2015 Value Modifier and for future years in the event that an error affecting the cost composite is discovered through this process.

On slide 23 we present our proposal that that payment now at risk for the 2017 Value Modifier will be 4 percent for the potential upward adjustment and four times the adjustment factor. We are proposing that the negative 4 percent adjustment to payments would apply to those solo practitioners and groups of two or more eligible professionals that fall into our Category 2, that is those that do not register and satisfactorily report data through PQRS or participate in a PQRS Qualified Clinical Data Registry or have at least half of their eligible professionals successfully report individually. It would also apply, as shown in the table here, to those groups with 10 or more eligible professionals that are determined to be high cost and low quality.

As I mentioned earlier, we're proposing that for the 2017 Value Modifier, solo practitioners and groups of two through nine eligible professionals would be held harmless from any downward adjustment under quality tiering. We want to encourage eligible professionals to be actively engaged with us in participating in quality reporting, which is why we align with and reinforce the quality reporting incentive under the PQRS system.

For the 2017 Value Modifier, we're proposing that those solo practitioners and groups of any size that are subject to the Value Modifier will be eligible for the upward adjustment of up to plus 4x under quality tiering. In addition to the upward adjustment for those solo practitioners and groups determined to have high quality and average or low cost and also for those that have average quality and low cost, we are proposing to expand the applicability of the additional plus 1x adjustment for treating the highest risk beneficiaries to all solo practitioners and groups of 10 or more.

On slide 24 we discuss our attribution proposals for the 2017 Value Modifier. We're proposing to use the revised attribution process for the total per capita cost measures and for three outcome measures. The five total per capita cost measures include the overall total per capita cost measure and four condition-specific total per capita cost measures. The three outcome measures are the all-cause readmission measure, the composite of acute prevention quality indicators, and a composite of chronic prevention quality indicators.

For the 2015 and 2016 Value Modifier we use a two-step assignment process that focuses on a delivery of primary care services by physicians. This assignment process also

identified the group that provided the plurality of primary care services. For the 2017 Value Modifier we're proposing to modify the two-step attribution process in response to input from our stakeholders, including the national quality forum and also in the interest of recognizing the nurse practitioners, physician assistants, and clinical nurse specialists providing primary care services. Accordingly, we're proposing to eliminate the pre-step and to move the NPs, PAs, and CNSs to Step 1 of our attribution methodology.

Consistent with the previous attribution methodology, we're still proposing that those beneficiaries who remain unattributed after Step 1 would be attributed to the solo practitioner or groups that provided the plurality of primary care services rendered by non-primary care physicians in the group. We note that this attribution methodology change does not affect the attribution of the Medicare spending for beneficiary measure for which beneficiaries continue to be attributed based on the plurality of Part B services.

This differential attribution enables us to expand the number of TINs that are able to have a cost composite calculated under the Value Modifier. On slide 25 we summarize our proposals for applying the Value Modifier in 2017 to physicians and non-physician eligible professionals who participate in the Shared Savings ACO Program.

As noted here, we're proposing that the cost composite would generally be classified as average cost for TINs that participate in a Shared Savings Program during the payment adjustment period. The quality composite will be calculated under the quality tiering methodology based on ACO quality data from the performance period. For example, the cost composite of a TIN that participates in the Shared Savings Program in 2017 will be classified as average cost. And their quality composite will be calculated under the quality tiering methodology based on the ACO's quality data from 2015.

We are proposing that the determination to apply average cost will based on whether the TIN is in a Shared Savings Program ACO during the payment period, regardless of whether it was in Shared Savings Program ACO during the performance period. This proposal is consistent with our policy not to track or carry an eligible professional's performance data from one TIN to another between the performance and payment period. In addition to the fact that Shared Savings Program ACOs are eligible to receive Shared Savings payments under their program, the rationale for our proposal to assign average cost to these TINs is that they're part of a Shared Savings Program ACO during the performance period where there are significant differences in the methodology used to calculate our cost benchmarks. Shared Savings Program cost benchmarks are based on the ACO's actual historical expenditures whereas the Value Modifier benchmarks are based on national averages.

As noted on the slide, we make proposals for special situations where ACO participants' TINs leave or join ACOs before or during the payment adjustment period and those special situations are detailed on slides 49 through 50 in the Appendix and, of course, also in the proposed rule. As noted on slide 26, in this rule we also proposed to apply the Value Modifier to TINs that participate in certain innovation center models during the performance period. We address three different situations that occur – could occur for a

TIN that is part one of the specified models during the performance period but is neither in one of the models nor in a Medicare Shared Savings Program ACO during the payment period. The situations are based on how the eligible professionals within the TIN reported quality during the performance period.

First, if the entire TIN satisfactorily reports as a group through GPRO, we're proposing to calculate the group's quality composite using our quality tiering methodology. If at least 50 percent of the eligible professionals within the TIN successfully report quality data as individuals and others report quality data through their demonstration, then we propose to use the higher of either average quality or the group's actual quality classification under our quality tiering methodology.

The reason for this proposal is that we don't want to disadvantage model participant TINs whose highest performing professionals might be reporting quality through the model while less than average quality performance could be reported by non-demonstration-eligible professionals who report quality through the PQRS. If the entire TIN reports quality measures through their demonstration, then we are proposing to assign them average quality.

In each of the three scenarios I just described, we're proposing that we would use the TIN's performance period cost data to calculate a cost composite using our quality tiering methodology and also that we would apply the negative 4 percent downward adjustment if the TIN does not meet reporting requirements either under the PQRS or their model.

If a TIN participates in one of the specified innovation center initiatives during the performance period and during the payment period, then we are proposing to calculate the quality composite depending on the three reporting mechanisms – as I – reporting situations that I just described and we are proposing to assign them average cost consistent with our proposal for assigning average cost to Shared Savings Program ACOs. This is because we believe that there may be conflicting incentives for cost performance under the model.

Finally, if one of the TINs participates in one of the models during the performance period and is then in a Shared Savings Program ACO during the payment period, we are proposing to use the Shared Saving Program, ACO's quality data and to assign average cost. In the event that the Shared Savings Program ACO TIN didn't exist during the performance period, we're proposing we would assign them average quality consistent with our proposal for applying the Value Modifier to Shared Savings Program ACOs.

You'll find helpful tables summarizing proposals on slide 51 through 54 of the Appendix. And please note that there is an omission on slide 53. For letter B in the TIN quality composite column, the table should state that the quality composite calculation would be based on the three scenarios above and the cost column should state average cost. You can find the complete tables in the rule and I'll provide you the citations since the Appendix table is incomplete. It's located at 79 FR 40503 through 40504.

Slide 27 shows the interaction between the Value Modifier and the PQRS. Our objective here is to align with and reinforce PQRS in order to reduce administrative burden and emphasize the importance of quality reporting and quality improvement. We're proposing to apply the Value Modifier to groups of physicians and non-physician EPs in groups of two or more EPs, and also to solo practitioners we're proposing if a group of two or more EPs or an individual EP participates in the PQRS as listed on the left-hand side and avoids the PQRS payment adjustment, the group or EP would not be subject to the automatic negative 4 percent downward payment adjustment under the Value Modifier in 2017. We are proposing that if the group or EP does not participate in PQRS on the right-hand side of this chart, then they would be subject also to the automatic VM downward payment adjustment.

Slide 28 gives the visual picture of the timeline for 2017 Value Modifier. And you'll see in January of each of these years is when we begin to apply the Value Modifier to different size groups of physicians. So in 2015 it's groups of at least 100 EPs, 2016 it is 10 to 99, and then for 2017 we're proposing it would be applied to groups of two or more EPs. You'll see in the spring and summer of each year the proposed group registration period. And in the first quarter of each year is the time to complete the submission of the PQRS information. Oh, and then the third quarter at the bottom of this timeline, you'll see the third quarter of each year is the time to retrieve your physician feedback reports for the previous year, and those are the reports containing the data that would be used in your Value Modifier the following January.

So slide 29 describes what a medical group practice or solo practitioner should do in 2015. So group practices with two or more EPs should decide upon a reporting mechanism. If reporting as a group, they need to register for the selected group reporting option by June 30th – between the spring until June 30th of 2015. And for individual reporting, there's no registration necessary. If the group practice does not seek to report quality measures as a group, we propose to calculate the group quality score if at least 50 percent of the EPs in the group report measures individually and successfully avoid the 2017 PQRS payment adjustment.

We also propose to calculate a quality score for a solo practitioner if the solo practitioner reports measures individually and meets the criteria to avoid the PQRS adjustment. And group practices and solar practitioners should decide which PQRS measures to report and understand the specifications. They can do this by reviewing the measure specifications located on the PQRS website and can contact the Quality Net help desk if they need specific measure-related clarification. Contact information for Quality Net is located on slide 39.

Groups should also be prepared to submit PQRS measures groups and solo practitioners should be prepared to submit PQRS measures for the reporting mechanism chosen during the first quarter of 2017. In the late summer of 2016, the 2015 QRUR reports will be available for group practices and solo practitioners and will show the group practice how their payments will be affected by the Value Modifier, including any upward, neutral, or downward payment adjustment based on their 2016 Value Modifier policies.

It's beneficial for solo practitioners and group practices to also obtain the 2015 QRUR, which will show them how they performed on quality and cost measures that will be used to calculate Value Modifier performance in 2016.

So we've reached the end of the slides for our portion of this presentation.

Again I just want to remind you, as I stated at the beginning of this section, that the registration system is now open through September 30th for groups to register and select their group reporting mechanism. And we would encourage you to do that or ensure that at least 50 percent of your eligible professionals do successfully report on PQRS. So thank you and I'm going to turn the presentation over to Terri Postma.

Proposals for Shared Savings Program Quality Issues

Dr. Terri Postma: Thanks Kim. This is Terri Postma, I'm a medical officer in the Center for Medicare and I'm going to be reviewing today the proposals in the 2015 PFS for the Shared Savings Program quality issues. We do intend to publish a notice of proposed rulemaking to address other issues with the Shared Savings Program later this year. The PFS is specific only to the quality reporting standards for the Shared Savings Program.

As you may know, the Shared Savings Program is a national voluntary program in which groups of Medicare enrolled providers and suppliers can join together to form what are known as ACOs, or Accountable Care Organizations. In those ACOs they work together to coordinate care and improve quality for fee-for-service beneficiaries. Individual providers and suppliers within the Accountable Care Organization continue to bill and receive Medicare fee-for-service payments as usual. But at the end of each year CMS assesses ACO performance on quality and against the financial benchmarks to determine whether shared savings have been earned.

Slide 32. The Shared Savings Program is aligned with other – other CMS quality initiatives. And when ACOs meet the Shared Savings Program requirements for quality reporting and performance, eligible professionals within the ACO can satisfy quality reporting requirements for a number of these other initiatives, such as PQRS, EHR Incentive Program, and the Value-based Payment Modifier. And you've heard about those along the way. This reduces reporting burden and streamlines reporting requirements for EPs.

Slide 33. In the 2015 PFS rule we're proposing a number of changes to the quality reporting requirements for ACOs. First, we're proposing a number of changes to the set of measures that the ACO must report. We're proposing to update that quality reporting standard for a number of reasons. We're proposing to incorporate more claims-based outcomes measures that focus on post-acute and chronic conditions. We're proposing to remove a number of redundant measures so that ACOs don't have to report on the same information for multiple measures.

We're proposing to remove clinically outdated measures, specifically those measures involving LDL reporting. And we're also proposing to revise some of the measures to

align more closely with PQRS, the Value-based Modifier, and EHR Incentive Program measures. We're also seeking comment on any other future quality measures we should consider for purposes of the Shared Savings Program. We're really interested in what other measures folks think that it's important for ACOs specifically to be reporting.

Slide 34. Second, we're making a number of proposals to the quality assessment and scoring. We're revising the quality – we're proposing to revise the quality scoring strategies to recognize and reward ACOs that make year-to-year improvements in quality performance scores. So what we do is we look at the level of reporting on that measure the year before and compare it to the level of reporting in the next year and determine if a quality improvement has been made. And if it has, we're proposing to reward ACOs that show improvement.

Further, we're proposing to modify the benchmark methodology to take into account topped out measures. Specifically for measures where the benchmark has been determined to be greater than or equal to 95 percent at the 90th percentile, we're proposing to set benchmarks on a sliding scale. In other words, for these topped out measures an ACO that gets 90 percent on a topped out measure would get full points for that measure.

We're also proposing to assess the quality of ACOs in subsequent agreement periods based on the standard that would apply to the third year of the previous agreement period. Within the ACO's agreement period, which is 3 years long, the first year of ACO reporting is set at the level of accurate and complete reporting only. After that, for the second and third years, the performance standard phases in pay-for-performance.

So by the time the ACO is at its third year of the agreement period, the ACO is – almost all the measures the ACO reports are pay-for-performance. If the ACO decides to renew its agreement and continue participation in the program for another 3 years, what we're proposing is that the ACO would continue to have to meet the standard for pay-for-performance for that second agreement period. In other words, the first year of their second agreement period wouldn't revert to pay-for-reporting only.

Slide 35. Finally, we make proposals designed to continue to align with and streamline reporting for other CMS quality initiatives. Specifically, we're proposing to continue to align with the PQRS, including reducing the number of measures that the ACO is required to report under the GPRO web interface and the sample size to be reported on using the GPRO web interface. We're also proposing to permit eligible professionals to satisfy their eCQM portion of the EHR Incentive Program requirements if the eligible professional extracts data necessary for the ACO to report to CMS from certified EHR technology and the ACO satisfactorily reports those quality measures. We're also seeking comment on how to implement EHR reporting of quality measures in the future. More information on Shared Savings Program can be found on our website at www.cms.hhs.gov/sharedsavingsprogram/. Thanks.

Question-and-Answer Session

Aryeh Langer: Thank you very much Terri. Our subject matter experts will now take your questions. Because this call is being recorded and transcribed, please state your name and the name of your organization before asking your question. In an effort to hear from as many callers as possible, we ask that you limit yourself to one question at a time. If you have more than one question, please press star 1 after your first question is answered to get back in the queue and we'll address questions as time permits. We are ready to take our first question, please.

Operator: Please hold for your first question. To ask a question press star followed by the number 1 on your touchtone 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. The first question comes from the line of Marty Ugarte.

Marty Ugarte: Good afternoon. I have a question on slide number 23, where you have the different quality – low, average, and high. How do you determine because from the PQRS scores what's low quality, average, or high? How's that determination made?

Aryeh Langer: Give us one moment please.

Ing Jye Cheng: This is Ing Jye Cheng. For the purposes of the Value Modifier, when we calculate a composite score we create a categorical variable where we assign a score to high, low, or average based on whether or not it is 1 standard deviation above or below the national mean.

Marty Ugarte: So I'm reporting on my PQRS codes, you know, by my measures for all my patients, can I, you know, and so I'm not getting the penalty because I'm reporting more than 50 percent correctly, does that qualify as high quality then or could I possibly fall into low quality or average?

Ing Jye Cheng: PQRS is a reporting program, so to the extent that you are successfully reporting your measures you would be a successful reporter under PQRS. Under the Value Modifier what we do is we actually take the rates, the actual scores, so how well you're doing for the measures that you're reporting. We have benchmarks from the prior year, which are available on our website. We compare your rates compared to our benchmarks. We roll all of that up – we develop a standardized score – we roll all of that up within each of the six quality domains that we have and then we calculate a composite quality score. We take everyone's composite quality scores and then we determine if you're high, average, or low based on whether or not you're above or below by 1 standard deviation, the national average.

Marty Ugarte: And that's for each individual measure. Is it done like that?

Ing Jye Cheng: We calculate a standardized score for each individual measure. So we take that specific measure rate and we calculate a standardized score relative to last year's benchmarks. Then we roll everything up so we don't look at necessarily on a measure-by-measure basis, your low, average, high. We don't do this grid on an individual measure-by-measure basis.

The grid on page 23 – slide 23 – applies an aggregate, so it's to your composite score. So you could do very poorly on one measure but do very, very well on all the other measures that you report and still wind up as high quality.

Marty Ugarte: OK, OK, so for example, I'm reporting on BMI, all right? One of my measures, so there's like 4 or 5 possible different answers or codes I would submit. The code, it's like, the code they're like patient failed to cooperate, is that considered like a poor quality score and all the other ones are good quality or …?

Ing Jye Cheng: There are a number of different measures under the PQRS. What I would suggest you do is take a look at the measures that your practice is reporting. And if you've got measure-specific questions, you can contact our Quality Net help desk and they can work with you as far as the specifications on those measures. And your local QIOs can also work with you as far as improving your quality on those measures.

Marty Ugarte: So I want to look at the benchmark section on the website for PQRS or for Value-based Modifiers? They'll tell me about the difference on quality ratings?

Ing Jye Cheng: Yes, there are –on our website we do have prior year benchmarks for each of the PQRS measures. That'll give you a sense of what your – what you should be, how high the bar is for next year.

Marty Ugarte: OK, we'll take a look. This will be our first year of doing it, that's why …

Ing Jye Cheng: OK, sure.

Marty Ugarte: You know I'm not familiar with the criteria. But we'll look for the website then, thank you.

Ing Jye Cheng: I really encourage you to contact the Quality Net help desk. They have a wealth of information at their fingertips for each of the different measures.

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

Operator: Your next question comes from the line of Byn Tre Singh.

Aryeh Langer: Hello, your line is open.

Dr. Soraya: Hello.

Aryeh Langer: Go ahead please.

Dr. Soraya: Yes, This is Dr. Soraya. I didn't quite sure my name was pronounced correct, sorry about that. So just a clarification, I heard in the reporting for ACOs regarding the alignment of the EHR as the PQRS, what I wanted to know is that ACOs will continue – the all eligible professionals will need to continue to report for the PQRS and the EHR relative quality measures like they were doing before or reporting for ACO satisfies the other two. I need a clarification on that.

Dr. Terri Postma: Yes, thanks for your question. This is Terri. So when the ACO reports, it's reporting quality on behalf of all the eligible professionals that have joined to form the ACO, OK?

Dr. Soraya : Correct.

Dr. Terri Postma: So the eligible professional will not have to report PQRS separately from the ACO. Now you need to make sure though that the ACO is actually reporting quality because if the ACO fails in that reporting, then all EPs in the ACO fail…

Dr. Soraya: Correct.

Dr. Terri Postma: For that year as well.

Dr. Soraya: How about EHR?

Dr. Terri Postma: For EHR there are a number of different criteria to satisfy for the EHR quality incentive. One of those – one of the, one criterion is that you report eCQMs. And so the individual – the individual provider has to satisfy the other criteria by themselves. They have to do that individually. But when the ACO reports quality, then the eCQMs can be satisfied on behalf of the EP if the EP is pulling that data to help with ACO reporting out of a certified EHR – EHR.

Dr. Soraya: OK, so one measure out of the EHR can be done– through the ACO and everything else individually, OK?

Aryeh Langer: Thank you.

Dr. Soraya: Thank you.

Operator: The next question comes from the line Kim Sweet.

Kim Sweet: Yes, hi. It was mentioned that – I can't remember what slide it was, I think it was up through 9 or 10, but PQRS cross-cutting measures. Could you please define what you mean by cross-cutting? Hello.

Christine Estella: Sorry. Sorry, this is Christine. So for the cross-cutting measures we have a measure set of about 18 proposed measures and they're basically general measures so just a possibility a general to practices. They may not apply to all EPs, like there are certain sub-specialists for which the cross- cutting measures don't apply. What kind of – are you trying to see whether or not it would apply to you or –

Kim Sweet: I just don't understand what you're talking about when you said that they're going to have to meet two cross-cutting measures.

Christine Estella: So.

Kim Sweet: It's like what are you talking about?

Christine Estella: There is that. So we are proposing a new cross-cutting measure set so it's, you know …

Kim Sweet: So this is a term that you already always had, you're just redefining it in another – in another way?

Christine Estella: No.

Kim Sweet: I've never heard the word cross-cutting measures before.

Christine Estella: This is a different – this is actually a new set that we've never proposed before under PQRS.

Kim Sweet: OK.

Christine Estella: So this is a specific set. It's in the proposed rule. I believe if you look under slide 38 we have under that second link PFS *Federal Regulation* Notices that could give you a link to the proposed rule. And we have a table in the proposed rule that is a – that provides you the cross-cutting measures set.

Kim Sweet: OK.

Christine Estella: I believe it's the first – if you look in the PQRS section it's the first table you will see in the PQRS section.

Kim Sweet: OK, great.

Christine Estella: 18 measures in there.

Kim Sweet: All right, wonderful. Thank you.

Christine Estella: No problem.

Operator: The next question comes from the line of Joshua Lapps.

Joshua Lapps: So did I hear you– understand you correctly, that any new measures will not be allowed to have claims reporting? In other words, are you phasing – essentially phasing out claims reporting?

Christine Estella: Hi, this is Christine again. So we are trying to move away from claims-based reporting. We're not phasing it out just yet. We just feel like there's more value in using other reporting mechanisms and we found that there's more accuracy in reporting when you use other reporting mechanisms. You know we will consider new claims-based measures for proposals. I can't remember specifically whether we have any new measures that are being proposed under the claims–based reporting mechanism, but my thinking right now with the 28 measures, I don't think we do. But that doesn't necessarily mean that we were trying to get rid of claims-based reporting completely. But we are, you know, little by little trying to move away from claims-based reporting.

Joshua Lapps: Thanks.

Christine Estella: No problem.

Operator: The next question comes from the line of Scott Barrette.

Scott Barrette: Hi, this is Scott Barrette. I had a question on the CPCI. There were some measures that they had to report on because they are part of a CPCI. But our CPCI is also part of GPRO. So we were wanting to submit as a GPRO, which may not have the same measures. So I was wondering, do you have to pick the CPCI measures for the entire GPRO? Does that make sense?

Patrice Holtz: This Patrice Holtz from CPC. And if you are a CPC site you have to report to CPC the measures that are required by that program. If you're in a group practice where it contains a CPC site and you want to report to GPRO, the entire TIN then reports to GPRO and that's fine. It's just that the CPC practice sites also have to report the required measures under the CPC program separately.

Scott Barrette: So that there has to be two separate submissions then?

Patrice Holtz: That's correct. And in the GPRO submission you get to select whatever measures you want to select from the PQRS program

Scot Barrette: Oh wow, so then would the CPCI then be individually on top of that then? Is that…

Patrice Holtz: Well the CP – so the CPC as being part of the CPC model, you have to submit quality measures at the practice site level to the CPC program, no matter what. If the CPC practice is part of a TIN that wants to submit as a GPRO to the PQRS program,

that's perfectly acceptable. They can submit a separate submission for the TIN to the GPRO and use any measures under the PQRS program that are accepted.

Scott Barrette: OK. Now how do they do the CPCS submission? Is that through the portal or …

Patrice Holtz: CPC has a whole instruction manual on how to submit measures for the program and are you a CPC practice site?

Scott Barrette: Yes, we have one.

Patrice Holtz: You have one, OK. So if you're a CPC practice site we have an entire manual and program information that tells you how you can submit to CPC. We will also have information in this Friday's roundup newsletter to the CPC practice sites.

Scott Barrette: Hey I just wanted to ask one more thing. I'm sorry, but when you're saying this information's going to be available to the public, are you going to have to have a user name and password for the clinic to get that information or is that information just going to be available to the general public?

Ing Jye Cheng: Which information are you referring to? Are you referring to, are you referring to …

Scott Barrette: The compare – the compare information I think is what they called it on this –

Christine Estella: The physician compare?.

Scott Barrette: Yes.

Christine Estella: So in terms of what information will be available or how?

Scott Barrette: I'm just wondering if it's going to be mailed to the general public, are you going to have to have a user name and password to go in and look at that information?

Dr. Terri Postma: This is Terri. Physician Compare is a website that's up and running on medicare.gov.

Christine Estella: It's on the CMS website.

Dr. Terri Postma: Right, on medicare.gov and it essentially lists a lot of different information about providers and practices and the quality.

Christine Estella: I don't think you need a user name and password …

Dr. Terri Postma: No, you don't. No you don't.

Christine Estella: For the Physician Compare, so you can just view. It's kind of like, you know, if you were to log on to just like a general like kind of like Yelp-type, you know, physician website like lists physician practices, it's kind of like that.

Ing Jye Cheng: In regard to the quality measures, I think you've been asking about the GPRO measures and the CCPI, those measure performance rates will be made available on the Quality and Resource Use report. And those are – those are not available to the public. So anybody going on to the CMS website, going on to what Christine was just talking about to look more probably at physician compare could not see individual EP's performance rates on all of the measures listed. To get access to those reports each TIN would have to go in through our registration system, get a user account and password in order to download those reports.

Scott Barrette: OK, so what is it – what they are actually seeing on the Physician Compare that the general public is able to look at? What type of information are they comparing?

Christine Estella: So this is Christine again. So our proposal for Physician Compare, they haven't been designed yet on the websites as far as what the design will look like. We're not sure for 2015 on either kind of a proposal in terms of the data. There will be a preview period for Physician Compare. So if these proposals were to be finalized, for example, I believe it's in slide – I don't know 15 or so related to Physician Compare, 16. If you look at those proposals and those proposals were to be finalized, you would basically work on the design of the website and have that information and you would have a preview period in terms of seeing what actually – how the information would look like and what the details of the information would be.

Scott Barrette: OK.

Aryeh Langer: Thank you very much for your question.

Dr. Terri Postma: And this is Terri, I just want to jump in and make a clarification to an earlier question about EHR Incentive Program reporting in the eCQM through the Shared Savings Program ACO. Similar to the CPC site, the shared savings per – the ACOs are required to report quality. They do that by gathering up information – clinical information from the – from the eligible professionals that are – that have joined to form the ACO. And they gather up that clinical information and they submit it to us through the GPRO web interface. So for the proposal to align with the EHR Incentive Program, this proposal says that for EPs to satisfy the eCQM portion of the EHR Incentive Program, when the EP extracts data out of their certified EHR technology and gives it to the ACO who in turn then reports it to CMS, then that EP has satisfied the eCQM portion of the EHR Incentive Program requirements. I hope that helps.

Elisabeth Myers: Yes, and this is Elisabeth Meyers from the EHR Incentive Program just so you're aware of how it works in the back end. For the EHR Incentive Program for anyone who selects electronic reporting when they attest to Meaningful Use of EHR

technology, if you select electronic reporting we have an automated system that allows us to on our back end identify you with the various programs. So we work on the back end to change lists back and forth. You don't need to notify us whether you're reporting is through PQRS, through GPRO, through an ACO, through a hospital IQR. All of those different programs, we on the back end connect those systems to identify the providers who successfully submit it to clinical quality measures.

Aryeh Langer: Thank you and we'll take our next question please.

Operator: The next question comes from the line of Pam Bolling.

Pam Bolling: Hi, I'm calling from Florida Neurology Group. My question is, we are obviously a specialist with neurology so it was very hard for us to find everything that we needed for PQRS so we picked a measures group. So is Value-based Modifier going to be based on PQRS or CQMs?

Aryeh Langer: Give us one moment please.

Ing Jye Cheng: Hi, this is Ing Jye Cheng. Are you participating in both the EHR Incentive Program as well as PQRS?

Pam Bolling: Yes.

Ing Jye Cheng: So to that extent, your PQRS measures will be the ones used to determine you Value-based Modifier.

Pam Bolling: OK. OK, that's what I needed to know. Thank you.

Operator: And the next question comes from the line of Jennifer Montgomery.

Jennifer Montgomery: Hi, this is Jennifer Montgomery. I just wanted to know if somebody can go over – somebody said something about the payment adjustment as opposed to the paid –what the doctor is actually paid and how they're going to calculate. Could you repeat that? I did not quite get it. I think it was slide 19.

Kim Spalding Bush: Hi, this is Kim Spalding Bush. I think you're asking which part of the payment we apply the Value Modifier to. And I mentioned that in relation to a new proposal – a proposal that applies to a very small portion of Medicare claims and those – and those claims that are not assigned and we are proposing that we would not apply the Value Modifier to those and the rationale is that the Medicare makes payment directly to beneficiaries for those claims.

Jennifer Montgomery: Right.

Kim Spalding Bush: And I only mentioned the application of the Value Modifier to the paid amount in relation to that just to say that it's consistent with that policy and that we

apply, the Value Modifier to the paid amount rather than the allowed amount so that it doesn't affect the beneficiary's portion.

Jennifer Montgomery: I see, OK.

Kim Spalding Bush: Does that answer the question?

Jennifer Montgomery: Yes, so it's not assigned claims only?

Kim Spalding Bush: We apply the Value Modifier only to – we're proposing to apply the Value Modifier only to assigned claims. But for all Physician Fee Schedule claims to which we apply the Value Modifier, which is just those – currently, it's the assigned – we're proposing, it would just be the assigned claims. But whenever we apply the Value Modifier, it's only to the Medicare paid amount.

Jennifer Montgomery: OK. So the Value Modifier's only to the Medicare paid amount.

Kim Spalding Bush: That's right.

Jennifer Montgomery: OK, got it. Thank you.

Kim Spalding Bush: Thanks.

Operator: The next question comes from the line of Darlene Lackey.

Darlene Lackey: Good afternoon, this is Darlene Lackey and I have another question that's related to the CPC program. We have more than a hundred providers that are under the same TIN and probably more than 50 percent of those are in the CPC program. And so those providers were satisfying PQS through the portal putting in their clinical quality measures and then remaining providers are reporting individually through a PQRS registry. My questions is, is there any benefit to us reporting as a GPRO.

Patrice Holtz: No. It's totally your decision as to how you want to report. I will say that CPC offers a PQRS waiver, which means that if your group wants to report – your CPC practice wants to report to CPC and take the C – and take the PQRS waiver, then their CPC submission provides them credit for PQRS reporting. They don't submit twice to CPC and PQRS.

In your situation, you have a group practice with CPC and non-CPC providers. The – if your CPC practice site takes that waiver where they report once to CPC and get credit for PQRS, the other non-CPC providers will have to report to the PQRS program as individual EPs or they will be subject to a payment adjustment.

Darlene Lackey: OK, that part, I understand, so there's really not a negative impact to my group for not doing GPRO versus just doing the CPCI – PQRS reporting through the CPCI program and doing the individual reporting.

Ing Jye Cheng: This is Ing Jye Cheng. There's one small exception. In general yes, there's really no downside. It is really up to your group to choose – the individual practitioners in your group to choose. The only thing I would say though is, if you as – if your TIN decides to report through GPRO and successfully report through GPRO, you will avoid the PQRS negative – downward adjustment of PQRS. You will also avoid being considered Category1 for VM.

Category 1 people get a negative adjustment for the Value Modifier. So you're able to sort of make sure you get into a quality tier. If, however – I'm sorry, Category 2 – if, however, you decide to not report through GPRO and rely on individual practitioners reporting – for those CPC participants they could certainly elect a waiver for non-CPC participants they could report through any of the mechanism available to them through the PQRS program.

If a totality less than 50 percent of your individual practitioners report, so fewer than half of your practitioners report, you could be subject to a negative adjustment under the Value Modifier. So I guess to put it a different way, if you're sure that more than half of the EPs in your group will report and report successfully through PQRS either by waiving it through CPC or by submitting measures, there is no downside one way or the other.

Darlene Lackey: OK, thank you very much.

Patrice Holtz: And I just – this is Patrice again, I just want to add one thing. Credit for PQRS is contingent upon successful submission of CPC measures. So it's not just you submit to CPC and elect the waiver and that gives you credit for PQRS, you must also meet the CPC reporting requirements if you elect that waiver.

Darlene Lackey: Yes and I believe – I mean we're doing that. We've been reporting I think quarterly onto the portal.

Patrice Holtz: No, that's not electronic Clinical Quality Measures that you've been reporting. You've been reporting milestones for CPC. So I think – I would take a look at the CPC newsletter this Friday for the requirements for CPC reporting.

Darlene Lackey: OK. Thank you.

Patrice Holtz: You're welcome.

Additional Information

Aryeh Langer: Thank you and unfortunately, that's all the time we have for questions today. As a reminder, this call is being evaluated by CMS for CME and CEU continuing education credit. For more information about the continuing education credit, please review the CE activity information instructions available via the link on slide 42 of today's presentation. On slide 41, you'll find information on how to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary and we hope you'll take a few moments to evaluate your MNL Connects Call experience.

Again, my name is Aryeh Langer from the Provider Communications Group and I'd like to thank our subject matter experts here at the CMS and all the participants who joined us on the line today for today's MNL Connects Call. Have a great day.

Operator: This concludes today's call.

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