MLN Connects™

National Provider Call - Transcript

Centers for Medicare & Medicaid Services
PQRS: How to Avoid 2016 Negative Payment Adjustments for CMS Medicare Quality Reporting Programs
MLN Connects National Provider Call
Moderator: Charlie Eleftheriou
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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 the call over to Charlie Eleftheriou. Thank you, you may begin.

Announcements and Introduction

Charlie Eleftheriou: Hello, this is Charlie Eleftheriou from the CMS Provider Communications Group, and as today's moderator, I'd like to welcome everyone to this MLN Connects National Provider Call on the Physician Quality Reporting System, or PQRS.

MLN Connects Calls are part of the Medicare Learning Network. This MLN Connects National Provider Call provides an overview of the 2016 negative payments adjustment for several Medicare Quality Reporting Programs.

This presentation will cover guidance and instructions on how eligible professionals and group practices can avoid the 2016 PQRS negative payment adjustment, satisfy the clinical quality measure components of the Electronic Health Records, or EHR, Incentive Program, and avoid the automatic calendar year 2016 Value-Based Modifier, or VM, downward payment adjustment. The presentation also provides various scenarios to demonstrate how eligible professionals and group practices may be impacted by the 2016 negative payment adjustments under the various CMS Medicare Quality Reporting Programs referenced above. A question-and-answer session will follow the presentation.

Before we get started, there are a few items I'd like to quickly cover. Number one, you should have received the link to today's slide presentation and in today's – in an email today. If you have not seen the email and do not have the link to today's slide presentation, you can find it on the Call Details page, which can be found by visiting www.cms.gov/npc, as in National Provider Call.

Again, that's cms.gov/npc. On the left side of that page, select National Provider Calls and Events, then select today's call by date from the list. The slide presentation is located there in the Call Materials section. I'll also note that this call is being recorded and transcribed and an audio recording and written transcript will be posted to the CMS Call Details Web page when it's available, and an announcement will be placed in MLN 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 and instructions available via the link on slide 23.

At this time we'll begin the formal part of our presentation by turning the call over to Molly MacHarris, in the CMS Center for Clinical Standards and Quality.

Presentation

Molly MacHarris: Thank you Charlie. Thank you everyone for joining us today. I'm going to go ahead and jump into the slide deck. I'm going to start on slide 4, the agenda for today's call.

As Charlie mentioned, I will be going over how to avoid the 2016 CMS Quality Reporting Program negative payment adjustment, which will include information related to PQRS, the Medicare EHR Incentive Program, and the Value-Based Payment Modifier. I will also provide some brief information related to reporting the 2015 Quality Measures, and then of course, we'll have the Q&A session.

How to Avoid the 2016 Adjustment

So moving along to slide 6, starting on how to avoid the 2016 adjustment. So I wanted to first start with a brief overview of the reporting process. What you'll see on the slide are three high-level steps that call out participation for the three programs. And you'll notice these are very high level, but we've tried to keep them in that way so – to actually have this apply for all three programs. So for all three programs, the first thing you would do is report and participate. So the eligible professional would submit quality measures data.

The second step is, once CMS receives all of that data through the various reporting methods that are available, depending upon which specific program you're trying to participate in, whether you're working through a report once option et cetera, CMS would analyze the quality measure data for both purposes of an incentive and for purposes of the payment adjustment.

The third step is CMS – we issue results and feedback. We will be issuing feedback on two things:

1. Whether the EP is satisfactorily reported, and
2. Whether the EP is incentive eligible or subject to the payment adjustment.

A couple of things to note is that the few scenarios could be – is that the EP could be subject to one, two, or three negative payment adjustments. The EP could also receive no negative payment adjustment, which, of course, is a good thing. And then, best case scenario, it would be where the EP actually earned an incentive for PQRS. There's still a half-a- percent incentive payment available for the 2014 program, which the 2016 payment adjustments are based off of. And then also for the Value-Based Payment Modifier, you could have up to a 2 percent, I believe, modifier based off of your total charges.

Submitting Quality Measures Data

So moving on to slide 7, so going to talk a little bit in more detail of those three steps that I just talked through. The first, submitting the quality measures data, so how EPs and group practices can report quality measures one time during the 2014 program year.

So this is our report once option that I'm talking about and we've talked about in previous National Provider Calls.

An important thing to note is that failure to report could mean that EPs and group practices could possibly be impacted by three separate payment adjustments. For PQRS in 2016, it's a 2-percent payment adjustment. For the EHR, it's a 2-percent payment adjustment, and for VBM it's a 2-percent payment adjustment as well. So in 2016, if you do nothing, you could be receiving a 6-percent reduction off of your total allowed charges, which those reductions do start to add up, so we really want everyone to meet our satisfactory reporting criteria.

Charlie Eleftheriou: I'd like to just jump in here for our participants. We have identified that there's a little bit of static on the line and we're trying to identify the issue. If you just bear with us, we apologize. I'll return it back to Molly.

Molly MacHarris: OK, thanks Charlie. I will resume the presentation on slide 8. So this is our general disclaimer that you have seen from us through our website, through a lot of our educational materials, through our other National Provider Calls. Since this presentation is focusing on our how to report once methodology, it doesn't really take into consideration participation through another CMS program, such as the Medicare Shared Savings Program, ACO Program, the Comprehensive Primary Care Initiative, or the Pioneer ACO Program. If you are a participant in one of those programs, we do encourage you to contact your program contacts for those programs to see how this can apply to you.

Again, we have attempted to align or adopt similar reporting requirements across programs, but EPs should look to their respective quality program to ensure that they satisfy the requirements for each, because PQRS has separate requirement, as does EHR Incentive Program, as does the Value-Based Payment Modifier.

Moving on to slide 9, so a diagram of how to report once as an individual. I won't go through this entire slide, but this slide may look familiar to many of you. We did talk about this slide during the March National Provider Call. This calls out how as an individual EP you can report once. There are two main options. One is through our EHR-based reporting mechanism and the second is as part of a Qualified Clinical Data Registry.

Through either option you must have certified EHR technology and you would have to report on nine measures covering at least three of the National Quality Strategy Domains. If you do satisfactorily report, a lot of great things could happen:

- You could be PQRS incentive-eligible for 2014,
- You could avoid the PQRS payment adjustment,
- You could satisfy the CQM component of the Medicare EHR Incentive Program, and

- You could satisfy requirements for the 2016 Value Modifier as well if 50 percent of the eligible professionals in the tax identification number, or the TIN, satisfactorily report, the group could avoid the 2016 downward Value Modifier.

One important thing to note is that you would still be required to report the other Meaningful Use objectives through the Medicare and Medicaid EHR Incentive Program Registration and Attestation System.

OK. Sorry, we're still trying to identify the static here in the room.

Moving along to slide 10. So how to report once as part of a group practice. This again was a slide that we talked about during the March National Provider Call. And so the first step is to register under PQRS as a group practice for one of three options. The first is as a group practice for direct EHR product, that is CEHRT. Additionally, what you could select to report on Clinician in Group Consumer Assessment of Health Care Providers and System CAHPS (CG-CAHPS), or we refer to it as PQRS CAHPS. That supplementary reporting option is available for groups 25 and above. And if they choose to report on that, it does lower the reporting threshold slightly. And then the third option is via the GPRO Web Interface. That option as well is available only for groups that are 25 or above.

I will go through the slide because there's a lot of information on here and it is a little bit complex. So handle the first two on the left-hand side together, the direct EHR product and then the direct EHR product along with CAHPS. So if you're purely doing the direct EHR product, or the data submission vendor product that is CEHRT, you would have to report on nine measures covering at least three of the National Quality Strategy Domains. If you're EHR does not have patient data for at least nine measures covering three domains, then the group practice must report the measures for which there is Medicare patient data. The reporting period for which there must be dates of service related to those quality measures is calendar year 2014.

The supplementary option of CG-CAHPS associated with the EHR direct and EHR data submission vendor option is you could report six measures covering at least two of the National Quality Strategy Domains and, additionally, report in the entirety the CG-CAHPS. And then the last option on the right-hand side is the GPRO Web Interface. Again, this option is only available for those groups that are 25 or above. The GPRO Web Interface consists of 22 measures based off of an assignment and sampling methodology. The Web interface is prepopulated, and the GPRO Web Interface reporters would need to report the Web interface in its entirety.

One piece to note with CAHPS related to Web interface: You can additionally elect to have CAHPS available if you are a group that is 100 or above that has elected Web interface, CAHPS reporting will automatically occur for you. And then, same as on the past slide, if you satisfactorily report under PQRS, you could be incentive-eligible, you could avoid the negative payment adjustment, you could satisfy the CQM component of Meaningful Use and avoid a downwards VBM. If you satisfactorily report, you would be

not PQRS incentive-illegible, and you could potentially be subject to all three payment adjustments.

One other piece to note on this slide is that the group reporting options that I've talked about are only available to those EPs who are beyond their first year of Meaningful Use. EPs who are in their first year of Meaningful Use in 2014, including those who are part of a – including those who are part of a group practice that is participating in PQRS GPRO, MSSP ACO, or Pioneer ACO, need to report their CQMs via attestation by October 1st, 2014, to avoid a Meaningful Use payment adjustment in 2015.

OK, moving along to slide 11. So the reason why we're talking about this today is that there is still time to report for the 2014 year. Even though we are in September, you could still report and both earn the PQRS incentive, avoid the PQRS payment adjustment, avoid a negative or downward VBM, and avoid a negative Medicare EHR Incentive Program penalty.

For individuals, they could still report to PQRS via qualified PQRS Registry, through a Qualified Clinical Data Registry or via an EHR that is CEHRT. More information on these options is available in the 2014 PQRS Implementation Guides, so we do encourage folks to look there.

A couple of deadlines that happen for those reporting options I outlined – registries have until March 31st, 2015, to submit. QCDRs have until March 31st, 2015, to submit. EHR reporting. That must occur by February 28th, 2015. And then those EPs who are seeking an additional half-a-percent incentive in addition to their PQRS incentive under the Maintenance of Certification Program have until March 31st of 2015 to submit. So there is still time to participate in 2014 and avoid any 2016 penalty.

Moving on to slide 12. For groups, it's again not too late. Registration for group practices happens through the end of this month, September 30th at 11:59 p.m. eastern. Again, it's September 30th of this month through 11:59 p.m. eastern, group practices can register through the PV-PQRS System, and they could elect the reporting options of qualified registry, EHR, or web interface.

One thing to note is that for all group practices that have elected – for all group practices that have already registered and have elected or are required to report for CAHPS survey, please note that for 2014 CMS has already contracted with a certified survey vendor to implement these surveys on behalf of the group. Additionally, related to CAHPS, please note that some group practices may have insufficient sample sizes as a result of patient attribution and sampling rules that valid and reliable CAHPS results. Therefore, before electing CAHPS, groups should make sure to report sufficient number of measures to meet the programmatic requirements.

The 2016 Payment Adjustment

OK, moving on to slide 13, which is the 2016 payment adjustment. So then, slide 14. So this chart outlines the three programs and the 2016 payment adjustment and who they're

applicable to. For PQRS, it includes all EPs, which include Medicare physicians, practitioners, and therapists. The adjustment amount is 2 percent off of the Medicare Physician Fee Schedule. For the Medicare EHR Incentive Programs that – it applies just to Medicare physicians, and again, that's 2 percent off of the Medicare Physician Fee Schedule.

For the Value-Based Payment Modifier, that applies to Medicare physicians that are in groups of 10 or greater. For those groups that are 10 to 99, they would either receive an upward or neutral Value Modifier adjustment based on quality tiering. For groups with 100 plus EPs, they would receive an upward, neutral, or downward VM adjustment based on quality tiering. And as I mentioned earlier, the payment at risk under the Value-Based Payment Modifier for 2014 for the 2016 payment adjustment is 2 percent.

Example Scenarios

OK, moving on to slide 15. This is where we're going to talk through some scenarios that may occur for eligible professionals and group practices that are subject to the 2016 payment adjustment. We have a Sally scenario and a Bob scenario.

So moving on to slide 16, Sally scenario. So Sally is an individual EP and she's subject to a PQRS negative payment adjustment in 2016. Sally did report in 2014 for PQRS. In November 2015, so next year, she will receive feedback from CMS indicating that she is subject to the negative PQRS payment adjustment due to unsatisfactory reporting.

The Value Modifier does not, however, apply to Sally because she is not in a group of 10 or more EPs. So here's what can happen. In 2014, Sally would have reported on measures for 2014 for PQRS through any of our reporting methods, and then in November of 2015, Sally will receive a feedback report, which will indicate whether or not she earned the incentive and whether or not she's subject to the payment adjustment. And then additionally, Sally will receive a letter from the PQRS Program via mail letting her know if she is subject to the payment adjustment.

Moving on to slide 17, still with our same Sally scenario. So then beginning in 2016, the payment adjustment is applied. So Sally would start seeing the negative 2 percent PQRS payment adjustment on all of her Medicare Part B billings. So anything that she bills under Physician Fee Schedule Part B would have a 2-percent reduction. She can identify the payment adjustment code based off of specific claims adjustment reason codes, or CARCs, and then remittance advice remark codes (RARCs).

All three programs—PQRS, EHR, and VM—will use CARC 237, which will indicate it's a legislated/regulatory penalty to designate when a negative or downward payment adjustment will be applied, and then at least one remark code, and there could be a couple different remark codes that happen, but the PQRS RARC code is N699.

So there are multiple methods that Sally will be able to identify that she is subject to the payment adjustment on the feedback report. The letter we'll be sending, and then additionally, she will see the adjustment on her claims.

OK, moving on to slide 18, this is the Bob scenario, and Bob is a member of a group practice. He's a member of a group practice with 50 or more eligible professionals and is subject to the PQRS payment adjustment, the EHR payment adjustment, and the Value Modifier payment adjustment. So Bob reported in 2014 for PQRS and the Medicare EHR Incentive Program, so he electronically reported his EHR data.

In September 2015, he received feedback from CMS indicating that he is subject to negative payment adjustment for PQRS and the Medicare EHR Incentive Program and an automatic downward payment adjustment for the Value Modifier. He does not request an informal review of his payment adjustment determination because after he reviews the feedback report, he sees that he did not meet the satisfactory reporting criteria.

So what Bob would've done is he would've reported on measures in 2014 for PQRS. In 2015, he would receive his feedback report from PQRS and the Value Modifier as part of a Quality Resource and Use Report because he is part of a group and he would receive negative and downward payment adjustment notification letters from all three programs, one from PQRS, one from EHR, and one from the Value-Based Modifier.

Moving on to slide 19. So again, similar to the Sally scenario, in 2016, all of his Medicare Part B payments would be reduced. They would be reduced 2 percent for each of the programs that he did not meet, so he would have a 2-percent reduction for PQRS. He would also have a 2-percent reduction from EHR, and he would also have a 2-percent reduction from the Value-Based Modifier. Again, he can identify that using the CARC codes and the RARC codes. For CARC it's 237. The RARC codes are for PQRS, N699; for the EHR Program, it's N700; and for Value Modifier, it's N701.

OK, and that covers everything that I had planned for today. So at this point I will go ahead and turn it back over to Charlie for the Q&A session. Thank you.

Keypad Polling

Charlie Eleftheriou: Thank you Molly. Before we move into Q&A, we'll pause for a quick moment to complete keypad polling, just so that CMS has an accurate count of the number of participants on the line with us today. There will be a moment of silence on the line while we tabulate the results. So we're now ready to start polling.

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.

Once again, if you are the only person listening 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, 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 Charlie.

Question-and-Answer Session

Charlie Eleftheriou: Thank you. At this time, we will open the lines for question-and-answer session. But before we do that, I'd like to remind everyone once again that the call is being recorded and transcribed, so please state your name and the name of the organization before asking your question. In an effort to hear from as many of you as possible, we ask that you limit your questions to one question at a time, please. If you do 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 additional questions as time permits. We can now take our first call.

Operator: 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 Sylvia Yaw:

Sylvia Yaw: Hi, yes, I've just got a quick question. You were talking about Bob – let's see, what was it – Bob in scenario two, and you said that he was a group of 50 EPs and he was subject to all of the payment adjustments, and you talked about the Value-Based Modifier payment adjustment. But in your slide that you talked about on number 14, it states that groups of 10 to 99, there would not be – they would only be upward or neutral, but in your example, you said that there was a penalty or adjustment to him.

Molly MacHarris: Sure. That's a really great question. So the way that – if you are in a group of 10 to 99, and you would get a negative Value Based Modifier…

Tonya Smith: Hi, this is Tonya. I just want to further elaborate. OK, for the 2016Value Modifier you will apply to the — to groups of 10 or more.

Sylvia Yaw: We can't hear.

Tonya Smith: Can you hear me now?

Sylvia Yaw: No.

Molly MacHarris: All right, hold on 1 second.

Tonya Smith: OK, can you hear me now?

Sylvia Yaw: A little bit better, yes.

Tonya Smith: OK. Thank you. For the Value Modifier – for the 2016 Value Modifier, it would apply to groups of 10 or more. So for groups who have 10 to 99 EPs, they will be only subject to an upward payment adjustment or no payment adjustment. For groups of 100 or more, they could be subject to an upward payment adjustment, no payment adjustment, or a downward payment adjustment based on their performance on quality and cost measures. Now you asked in reference to the scenario where I think it said Bob had 50 EPs and was subject to the Value Modifier….

Sylvia Yaw: Right.

Tonya Smith: For as part of the 2016 Value Modifier, as I said, you can either submit – report measures as a group, and again, if you have – if you are in a group of 10 or more, you will be subject to the Value Modifier, as I just said. Or if you're in a group of 10 or more, you can also submit measures individually if your group has 50 or more EPs to report individually and meet the PQRS reporting requirements to avoid the 2016 PQRS payment adjustment. Then in that case, again, if you have at least 50 or more EPs in your group who actually submit measures individually for PQRS and do so successfully, then you can also avoid the Value Modifier that way.

But let me also note, you want to kind of make sure that if you are in a group and your group wants to submit measures individually under this 50 percent option, that you actually have a little bit more than 50 percent of your group actually submit and report measures successfully. And again, that's just to make sure that, say that you have one EP who maybe submits measures and there's some kind of submission error, we want – we don't – we want to make sure that all your EPS get counted. So, hopefully, that answered your question.

Sylvia Yaw: I still have a lot of questions about it. It's still not very clear as far as what's on the slide presentation. But that's OK. Let somebody else ask a question.

Operator: The next question comes from the line of Regina Felisa. Regina, your line is open. If you are on a speakerphone, please pick up your handset.

Vijaya Davidoff: Did you say Virginia or Regina?

Operator: Regina, your line is open.

Vijaya Devatha: Hi, this is Vijaya Devatha from New Carlisle Family Practice. Hello?

Molly MacHarris: Yes, we're here. Can you go ahead with your question?

Vijaya Devatha: Yes, I was wondering, we – do we need to register every year for PQRS?

Molly MacHarris: Sure. This is Molly. So if you want to participate as part of a group practice, yes, you do have to register annually. If you want to participate as an individual, no registration is required.

Vijaya Devatha: For individual, no registration is required?

Molly MacHarris: Correct.

Vijaya Devatha: And oh, OK. And the same thing applies, we need to report three measures covering at least three of the nine measures?

Molly MacHarris: So the reporting criteria for PQRS depends based on the reporting option. For claims registry and EHR, it's nine measures covering three domains. For QCDR reporting, it's nine measures covering three domains with at least one outcome measure. And for Web Interface reporting, it's complete the Web interface in its entirety, which includes 22 measures.

Vijaya Devatha: OK, thank you very much.

Molly MacHarris: Thank you. And before we go to the next question, I did want to clarify the first questioner who was asking in the scenario related to Bob. One thing that Tonya and I wanted to note is that if you're part of a group and if you fail – if you either do nothing, you don't participate in PQRS at all, or you do not meet the satisfactory reporting criteria, then you would be subject to a downwards VBM, as well as subject to a PQRS payment adjustment. But that's the scenario that, I think, the initial questioner was trying to get at, so we did just want to clarify that point.

And we can go on to the next question now. Thank you.

Operator: The next question comes from the line of Donna Fickes.

Donna Fickes: Hello?

Molly MacHarris: Hello, we're here.

Donna Fickes: OK. Can you tell us about the VM for like, when is less than 10 providers going to be able – when will they be required to participate?

Tonya Smith: Hi, thank you for your question. Yes. We have made, in our 2015 Physician Fee Schedule Rule, we have actually made proposals for the Value Modifier for groups of less than 10. So please stay tuned to your final rule, which should be released, I believe, November the 1st, for details to that effect.

Donna Fickes: November the 1st of this year?

Molly MacHarris: Yes.

Donna Fickes: OK.

Molly MacHarris: Thank you.

Donna Fickes: Thank you.

Kim Spalding Bush: And hi, this is Kim Spalding Bush. I also wanted to just add on in addition to what Tonya said that we did in the rule make proposals regarding how we would apply the Value Modifier in 2017. So I also just wanted to point out that we are required by law to apply the Value Modifier to all physicians, whether they're solo practitioners or they are in groups, by January 1st of 2017. So you'll see our specific policy proposals, and we will go ahead and finalize those in the final rules as to how we will accomplish that. But just to let you know, that is a requirement by law that by 2017 that the Value Modifier be applied to all physicians.

Donna Fickes: Thanks.

Operator: Your next question comes from the line of Ron Rockwood.

Ron Rockwood: Hi, quick question regarding reporting as a group practice. When you actually go ahead and self-nominate, you have to, at that point, declare which of the options you're going to be using. Is that correct?

Molly MacHarris: Hi, this is Molly. Yes, that's correct. When you register as a group practice, and remember you have until the end of this month to do so, at that point, you would need to indicate which reporting mechanism the group will be participating in. So yes, that's correct.

Ron Rockwood: OK. So right now is there any possibility of changing that before the end of the year, making any changements, or is that – once you're past September 30th, that's where it's set? We have some low confidence in our analytics platform that our EHR CEHRT vendor is using right now, and so we're considering going the GPRO Web Interface but kind of need to, I guess, quickly – make a decision, it sounds like if that's going to be set.

Molly MacHarris: Right. Unfortunately, no, September 30th is the cutoff. What you can do is if you are going to need more time, you don't have to participate as a group. Everyone in your organization could participate as individuals, and when you participate as individuals, no signup is required. So that is an additional option for you. But if you want to participate as a group, you do have to make that selection by the end of the month.

Ron Rockwood: OK, thank you very much.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Janie Whitehead.

Janie Whitehead: Hi, my question is – and I'm sorry if you've already addressed it, but I would like clarification. If the practice is subject to a penalty, whatever the penalties may be in 2016, but redeem themselves in 2015 not to suffer a penalty, will the negative 2, 4, 6 percent stay with them forever and ever, Amen?

Molly MacHarris: This is Molly. Really great question. No, the ability to avoid a payment adjustment is on an annual basis. So you could be subject to a given program's payment adjustment one year, avoid it the next year, and then if you don't report, you could be subject to it again.

The reporting criteria or the reporting periods for the 2015 adjustment were based off of 2013 reporting periods. For 2016, it's the 2014 reporting period, so what's happening now. The 2017 payment adjustment, that is still subject to rule finalization, but it will – it could be the 2015 reporting period. You'll see that when we issue our final rule, but good question.

Janie Whitehead: Thank you.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Bob Still.

Bob Still: Hi, this is Bob, not the Bob in the scenario.

[Presenters laugh.]

Molly MacHarris: We were just thinking that.

Bob Still: But my wife is Sally, and anyway, I just wanted to clarify in group practices of – we have a group practice of seven individuals, so there is no need for them to sign up by September the 30th, unless they wanted to register as a group practice and because we are currently participating on a claims basis as opposed to registry. But if they wanted to register as a group practice, that has to be done by the 30th of September?

Molly MacHarris: Yes, this is Molly again. Yes, that's correct. If you want to participate that way, September 30th is the deadline. But if you still want to participate as individuals, whether that be via claims or registry, no signup is required. Just either keep reporting via claims or work with a registry to have them submit your data on your behalf.

Bob Still: Ok. And we currently report through a certified EHR product, so …

Molly MacHarris: OK.

Bob Still: So that's all good. OK. Thank you very much. I'll let Sally know that. OK.

Molly MacHarris: OK. Thank you.

Bob Still: Great.

Operator: Your next question comes from the line of Robert Ware.

Robert Ware: Yes, I have a question. Our group is a mixed group, per se, it's– there's about 100 providers – over 100 providers within – under the TIN number. There's 13 primary care clinics, there are CRNAs, there's a surgical specialty clinic, and then there are hospitalists. My question is, with the EHR incentive, the clinics are under one program of a system, uses a product. The hospital-based hospitalists, they utilize the EHR that has that Meaningful Use Stage 1. So how do you determine if they're going to – if the hospitalists – how do you break them out, looking from a penalty standpoint, one on an EHR? Then the other part of that is, the measures that you lay out a lot, very few of them really appear to apply directly to hospital-based physicians only. So again, we're trying to figure out, do we report as a group and use the Web-based product, and the hospitalists are a part of that or – what are your recommendations or thoughts on that?

Molly MacHarris: This is Molly. So we understand for hospital-based physicians reporting in PQRS can sometimes be difficult. So I don't have one clear recommendation for you. One of the things that you may want to do is to contact our help desk, the QualityNet Help Desk, and I apologize, I don't see their information in this slide presentation, but we can make that available to this group – apologies on that. And the help desk, they have resources that can go over your particular type of practice, the multispecialty information, and help you determine which measures would apply to you best and then help you determine which reporting mechanism would be the best.

I will say for the GPRO Web Interface, the majority of those measures are primary care focused, so if you have – if your group is specialty focused, that may not be the best option for you. So unfortunately, I can't tell you what to do because there are a lot of different things to consider. So my recommendation would just be to contact the help desk. And we actually have the number, it's 866-288-8912, and the email address is qnetsupport@hcqis.org. Thank you.

Robert Ware: Thank you.

Operator: Your next question comes from the line of Sandra Sieck.

Sandra Sieck: Yes, I have a question for a future proposed consideration, and it really piggybacks with the gentleman before me, is how will the programs really impact the specialty groups that are eliminated from the hospital quality reporting and also eliminated from the physician quality reporting, which, i.e., meaning ED physicians and hospitalists? It seems like they're kind of falling through the cracks, maybe in a good way, but what is the future proposed consideration, including this accountability model, with the ED physicians and hospitalists?

Sofia Autrey: So this is Sofia with the PQRS team. So I just want to address one of the issues and regarding your statement about specialists not being included for PQRS moving forward. So we do recognize that there aren't a lot of opportunities for those, especially specialists in the emergency department, to report on some of those measures in PQRS. However, they can still report measures. They are included in the PQRS system. So that hasn't been eliminated. And if by chance there aren't enough measures for them to report, then they would go through the MAC process. So that would account for any EDs that reports in the PQRS system.

Sandra Sieck: Thank you.

Operator: Your next question comes from the line of Marilyn Nadulek.

Marilyn Nadulek: How do I know if I'm involved in the Meaningful Use? I don't quite understand what that is. And do I have to have Electronic Health Record ability?

Molly MacHarris: Sure, this is Molly. So you're asking whether or not you're eligible to participate in the Meaningful Use Program?

Marilyn Nadulek: Right, is that where I'm reporting? Is that what that is?

Molly MacHarris: So the Meaningful Use Program, it applies to Medicare physicians, so if you're a Medicare M.D. or a D.O., it would apply to you. I might actually encourage you to visit the Medicare EHR Incentive Program website, and they – there are interactive tools on that site, which will actually help you determine whether or not you are eligible and what you need to do to participate in that program.

Marilyn Nadulek: Um hum.

Molly MacHarris: All right, we're trying to pull it up here in the room. The website is www.cms.gov/regulations-and-guidance/legislation/EHRIncentivePrograms. I know that's a long email address or – sorry, a long website, but that really is the best place for you to start to determine whether or not you are eligible for the program.

Marilyn Nadulek: Can you also repeat that phone number that you gave out?

Molly MacHarris: Oh sure. So the phone number for the EHR Incentive Program is – you know we can't find it right now, but I can give you the phone number for the Quality – do you have it Charlie?

Charlie Eleftheriou: For QualityNet.

Molly MacHarris: For QualityNet, and they can transfer you over to the EHR Information Center. It's 866-288-8912. And the email address is qnetsupport@hcqis.org. Thank you.

Marilyn Nadulek: Thank you.

Operator: The next question comes from the line of Heather McCormick.

Heather McCormick: Hi there, you may have just answered this question, but I just want to clarify. We are a physical therapy practice. We have nine therapists here in our practice. We currently just do paper documentation. Do we have to transition to electronic medical records? And if we don't, will we be penalized?

Sofia Autrey: Hello, this is Sofia Autrey with PQRS again, and it would really depend on the measures that are included in the program. There is not a requirement that you transfer to EHR because some measures are reportable in other mechanism; however, if you find that there are more measures for your specialty that are EHR measures than are claims or registry measures, then that may be a better option for you. You would really need to look at the specific measures that we have in the program and then see, based on the measures that your physicians report in your group, and then look at the reporting options for that. And that would determine what method would be best for you.

Heather McCormick: All right, thank you so much.

Sofia Autrey: You're welcome.

Operator: The next question comes from the line of Robin Merrick.

Gabby: Are you there?

Molly MacHarris: Yes, we're here.

Gabby: OK. We are a physical therapy – sorry, this is Gabby, and I'm one of the physical therapists. We're a physical therapy practice of two EPs, and we have been reporting PQRS since July 2013 as a trial, and we became more aggressive in 2014. We never receive any feedback or anything. One of the questions is, how can I know that we're doing fine? There is any place that we can go? There is any feedback that we can receive? That's one question. And the second question is, we never registered in one of the programs that we have; is that mandatory? We're not a group. We're only two EP.

Molly MacHarris: OK, sure, this is Molly. So for your first question, feedback reports are available for EPs under PQRS. You can access that by going to the PQRS portal. The website for that is www.qualitynet.org/pqri. And through that you'll be able to access your feedback report, which will let you know whether or not you earned an incentive for 2013 …

Gabby: OK.

Molly MacHarris: … or avoided the 2015 payment adjustment.

For your second question, you do not have to register if you do not want to participate in PQRS as a group. Again, you can participate in PQRS as an individual, the same for

Value Modifier. That was a requirement last year, that if you wanted to participate or that if you were a group 100 or above, you had to register – that's not the case this year. Because as Tonya answered in one of the earlier questions, if you are a group size that is subject to the Value Modifier, just 50 percent of your EPs would have to meet it. So in answer to your second question, no. Thank you.

Gabby: Thank you very much.

Tonya Smith: Awesome.

Operator: Your next question comes from the line of Laurie Duet.

Laurie Duet: Hello.

Molly MacHarris: Hello.

Charlie Eleftheriou: Hi.

Laurie Duet: OK. If a large group registers as a GPRO but then they decide not to report with the registry, do the providers who are reporting via claims throughout the year still get credit?

Molly MacHarris: No. If you register as a GPRO, whatever reporting mechanism you choose is how you will be analyzed. Thank you.

Laurie Duet: OK, thanks.

Operator: The next question comes from the line of Rachel Connolly.

Rachel Connolly: Hi, this is Rachel Connolly. We are a multipractice specialty and we are currently reporting individual claims. And I was referring to the PQRS adjustment for 2016 version 1.0 that was put out on March 27th of this year. And it actually lists that to avoid the adjustment that the individual EP can report on three measures covering one NQS domain, but I did not hear that mentioned in your presentation today.

Molly MacHarris: Sure, this is Molly again. That is correct. If all you're looking to do is avoid the payment adjustment via claims or registry, you can report just three measures covering one domain. The slides we covered today were talking about our aligned reporting option and the criteria for the aligned the reporting option, whether you're trying to earn the incentive or avoid the payment adjustment is nine measures covering three domains.

Rachel Connolly: Yes, thank you.

Molly MacHarris: Thank you.

Operator: The next question comes from the line of Shelly Stanley.

Shelly Stanley: Hello, I have a practice with five doctors in it, and one of our doctors has – has gone. He's left for a 1-year sabbatical. And we are only going to do the three measures because he has not met his 50 percent because we got a late start with our PQRS this year. And I need to know, the three measures that he is wanting us to use is the 226, 130, and 117. Can you tell me what the domain – a domain – what domain I need to stick with that's something that's going to be easy for him –for us to submit through a registry for him?

Sofia Autrey: Hi, this is Sofia Autrey with PQRS. So I really can't tell you which domain you should stick with, but I would suggest that if you have specific questions about your particular issue, then that can be covered when you call the QualityNet Help Desk. They would have more time to go over that with you.

Shelly Stanley: OK, thank you.

Sofia Autrey: You're welcome.

Operator: Your next question comes from the line of Dora Adden.

Dora Adden: Ah well, yes, they have already answered my question over and over, so never mind.

Molly MacHarris: Thank you.

Charlie Eleftheriou: Thank you.

Dora Adden: Thank you.

Operator: And the next question comes from the line of Lani Borton.

Lani Borton: Hello, for EHR in 2014, we've got several group practices here and the plan was to attest for the objectives and quality measure via attestation and then to attest for PQRS using the GPRO Web Interface. Is that going to meet the requirements for both of these reporting programs?

Molly MacHarris: So this is Molly. So you are planning for the EHR Incentive Program to attest to your eCQM? Is that right?

Lani Borton: Yes, as part of the EHR program for the last couple of years that was how we did it. We would go on to the EHR website and type in all the numerators and denominator for the objectives and then do the same thing for quality measures. So our thought was to go forward, we would do that this year for our providers. And then also we are –we registered for the GPRO Web Interface, and that is how we would satisfy the quality reporting for both programs.

Molly MacHarris: OK, so you can do that. Basically, what you're doing is you're doing duplicative reporting. So you definitely can do that. It's whatever is going to be easier for your organization, your internal workflow. So just to be clear, the attested results of the eCQM would only apply for achieving Meaningful Use for the Medicare EHR Incentive Program. You would still need to separately report under PQRS to avoid the PQRS payment adjustment and the downwards Value Modifier. So you could register as a group and elect one of the group options –you mentioned the Web Interface – or you could report individually.

So you can definitely do that if that's what you would like to do. I just wanted to note that the attested results will not count for PQRS or VM.

Lani Borton: I think the thing that's confusing for 2014 is the fact that the EHR reporting period is only for a quarter unless you're brand new to the program, then it's 90 days. So we know that we have to attest for the providers for the objectives, and part of the application in the EHR system is also quality measures, and we didn't want to leave that information out so that it's an incomplete attestation for EHR. And we understood that we had to do a full year of data reporting for PQRS.

Molly MacHarris: Right.

Lani Borton: So that's where the alignment is a little bit off still.

Molly MacHarris: There is the ability in the EHR Incentive Program to e-report for a year's worth of eCQMs. There is still that ability in place. I know there have been some changes to the EHR Incentive Program, depending upon what stage you are in for a Meaningful Use, and there is a quarter reporting period available. But there is a 12-month reporting period available as well. If you're beyond your first year of Meaningful Use, then you can report on eCQMs for 12 months.

If you choose to do that, you would not attest to your eCQMs through your registration and attestation module. Rather, you would elect that you're e-reporting, and then you would have to e-report through one of the options I talked about on slide 10 – or on slides 9 and 10. And if you have any more questions on this, 'cause I know it can be confusing, the alignment intersection, call the help desk, they can walk you through it. Again, our help desk number is 866-288-8912.

Lani Borton: Thank you.

Molly MacHarris: Thank you.

Operator: The next question comes from the line of Duane Schielke.

Duane Schielke: I have a question related to FQHCs. We have a situation where we're forming an FQHC that will commence operations of our health centers, which are group practices under Medicare B currently, in 2015. So that new organization, being newly

formed, will just start operating in 2015 and will have no opportunity to do any attestation, although it is also part of an ACO. How is that going to affect future penalties of reductions in payments if it's commencing operations in 2015?

Molly MacHarris: I believe FQHCs, at least under PQRS, are not able to participate. You can go to our website, and if you look at our list of eligible professionals, you can check that for confirmation. But I believe that's not the case. If anyone from our help desk who's on the line, if you guys want to confirm that, that would be great.

Duane Schielke: So that means that they're not able to report any of these measures this way because the reporting to CMS site through the EHB and the other mechanisms? Is that what you're seeing?

Molly MacHarris: Right. So since the FQHC is not able to participate in PQRS, you wouldn't be eligible to do so. So you wouldn't be able to participate.

Duane Schielke: OK. OK, thank you.

Molly MacHarris: Thank you.

Operator: The next question comes from the line of Susan Gormsen.

Susan Gormsen: Yes, the EHR Incentive Program you guys have been talking about, is that the same as Meaningful Use or is that something different?

Molly MacHarris: Yes, it's the same, the same program.

Susan Gormsen: OK, awesome. Thank you.

Operator: Your next question comes from the line of Dawn Shaw.

Dawn Shaw: Hi, this is Dawn Shaw from Speedy Recovery Billing Services. I bill for several individual psychologists and licensed medical social workers. And I'm trying to understand how many of the G-codes they need to report for their Medicare patients? Like they all – I've got them trained well to ask about medication changes every time they come in, but they're not – I need to know, because looking through and trying to find assessment codes that qualify for them was hard enough, but I just need to know how many are they supposed to be reporting?

Molly MacHarris: Sure, this is Molly. So if you are reporting via claims, putting the QDC codes on the claims, you have to do it for 50 percent of the eligible cases, so it's not a set number like you only have to do 10. You have to do at least half of every single patient who could be reported on the measure. You have to put a code on at least half of them.

Dawn Shaw: Right. Well, they do that because they ask about the medication every time, so that code – they're good about I'm putting that code on. I'm talking about like a ...…… assessment code and then cigarette smoking code. I mean, how many of those other codes should they be using?

Molly MacHarris: Oh, sorry, you're asking how many measures?

Dawn Shaw: Yes, sorry.

Molly MacHarris: OK, OK, sorry. For claims-based reporting, it's either nine measures covering three domains for 50 percent of eligible patients. That's to both potentially earn the incentive and avoid the payment adjustment. If all you're interested in doing is avoiding the payment adjustment, it's three measures covering one domain.

Dawn Shaw: OK. So I have to figure – how –where do I go to find out what the domains are?

Sofia Autrey: So this is Sofia. So the QualityNet Help Desk can help you sift through all of those measures. There's a number of measures and there are multiple codes for each measure. So to make that easier, especially for the specialists that you work with – the psychologists and social workers – definitely call the help desk, and then they can walk you through which measures would be more applicable for your group.

Dawn Shaw: Wonderful, thank you.

Sofia Autrey: No problem.

Tonya Smith: And hi, everyone, just to repeat the help desk number again, and we'll do that a couple of times throughout Q&A, so the QualityNet Help Desk number is 1-866-288-8912.

Operator: The next question comes from the line of Nicole McShinkse.

Nicole McShinkse: My question's already been answered. Thank you though.

Molly MacHarris: Thank you.

Operator: The next question comes from the line of Jenny Adams.

Jenny Adams: Hi, I just wanted to clarify on slide number14, regarding the Medicare EHR Incentive Program. We're working with a bunch of physical therapists and occupational therapists, and if they're not on an EHR, or if they are and they're not reporting some of the Meaningful Use applications off of that, are they going to be seeing the 2-percent reduction? Or is it just for physicians as the slide shows?

Molly MacHarris: For the EHR Incentive Program, that only applies to physicians.

Jenny Adams: OK, so the therapists are excluded from that one then?

Molly MacHarris: Correct. Under PQRS – so the way you can think of it is that PQRS has the broadest definition. PQRS applies to both physicians, practitioners, and therapists. The Medicare EHR Incentive Program, their definition is probably the narrowest with it just applying to physicians. And then currently, for the Value-Based Payment Modifier, it only applies to physicians, but that is something that the Value-Based Modifier Program did seek comment – or proposed in this year's PFS rule to change for future years. So just something to take note of for the future.

Nicole McKenzie: OK, perfect, thank you.

Operator: Your next question comes from the line of Chris Palenco.

Chris Palenco: Hi, my question is in reference to slide 9, the three for PQRS we chose to report …

Tonya Smith: Sorry, we're having a hard time hearing you.

Chris Palenco: Is that better?

Tonya Smith: Not so much.

Chris Palenco: OK, so my question's in reference to slide 9, bullet 3.

Molly MacHarris: OK.

Chris Palenco: OK. We chose to report on measures group through the registry, and we understand that, that is due by March. But we also participate in Meaningful Use Stage 2 through attestation. So I want to know, do we have to attest the CQMs, or, like bullet 3 says, it satisfies the component of EHR?

Molly MacHarris: So registry – I'm sorry, can you please put your phone on mute? We're getting a pretty bad feedback.

Charlie Eleftheriou: If you're on speakerphone, you might want to shut that off, too.

Chris Palenco: Hello?

Charlie Eleftheriou: Yes, that's much better.

Molly MacHarris: Much better, thank you.

Chris Palenco: Sorry about that. Sorry about that.

Molly MacHarris: OK, so if you report –if you're reporting via registry measure groups, that would apply for purposes of PQRS and for purposes of the Value Modifier. So you would need to separately attest or e-report your eCQMs for the Medicare EHR Incentive program.

Chris Palenco: So it doesn't satisfy it for the Meaningful Use?

Molly MacHarris: No, it does not.

Chris Palenco: OK. And how do I know how many measures are in the measures group and how many domains it covers? Because it just said we have to pick 20 patients for this measure group, so it's not really specific. There's only four measures on, for example, the back pain measure group.

Molly MacHarris: Sure, so the way that the measures group reporting works is that you would report all of the measures for every eligible patient that are available in the measure group. Depending upon the measure group you select – some may have four measures, some may have six measures, some may have eight or more measures. But every patient that comes in that is eligible, you would report all of the measures on that patient and you would do so for at least 20 patients.

Chris Palenco: And that satisfies my nine measures over the three domains?

Molly MacHarris: So the nine measures covering three domains, that's a separate reporting criteria. So you have different options. So you can do registry reporting for nine measures covering three domains or you could report a measure group for at least 20 patients.

Chris Palenco: OK, so then that's separate, and when I do Meaningful Use? I still need to attest my CQMs.

Molly MacHarris: If you choose to report via registry, if you were to report electronically via EHR, then you wouldn't have to do separate attestations for Meaningful Use. But, yes, if you choose registry reporting, you would have to.

Chris Palenco: OK, thank you.

Molly MacHarris: Thank you.

Operator: The next question comes from the line of Heather Shiffer.

Heather Shiffer: Hello.

Molly MacHarris: Hello.

Heather Shiffer: Hi, my question goes back to – really just to ask for a little bit more clarification on the scenario with Bob and the fact that he's in a group that is between 10 and 99 EPs for the Value-Based Modifier adjustment. Still not sure I understand why he's qualifying for a negative adjustment when it sounds like it should be either upward or neutral.

Molly MacHarris: Sure. So this is Molly – and Tonya, jump in here.

Heather Shiffer: OK.

Molly MacHarris: The reason why Bob is subject to a negative Value Modifier is he failed his – he didn't meet the satisfactory reporting requirements.

HeatherShiffer: OK.

Molly MacHarris: So he failed report, didn't get his three measures over one domain. So since he failed, then he is subject to a negative Value Modifier.

Heather Shiffer: OK. So if you did not fail, then would it be neutral or incentive?

Molly MacHarris: It would be neutral or incentive.

Heather Shiffer: OK, and what decides between those two?

Tonya Smith: It's based on your actual performance on quality measures, which are those PQRS measures, in addition to three outcomes that we use, as well as your performance on three cost measures.

Heather Shiffer: OK, so that really – that part of it, determining whether we are allowed the incentive or it's a neutral adjustment, really kind of is – sounds to me like it's not within our control.

Tonya Smith: Well, how you perform on the PQRS measures is within your control …

Heather Shiffer: Right.

Tonya Smith: You pick – you pick the actual reporting mechanism as well as the measures. But, yes, we just – we do – we …

Heather Shiffer: That's just right. So you would think if we were successfully reporting, then there would be – I mean successfully reporting is really not the only criteria that's used to determine whether it's a flat adjustment or an incentive.

Tonya Smith: For the Value Modifier purposes, yes, because we're actually looking at actual quality and cost performance.

Heather Shiffer: Which really is out of our control. What you – the criteria you use to decide between the flat and the incentive seems to be out of our control because that's really criteria that you are looking at our reporting and saying either this is good enough or not good enough. But how can we affect whether or not we get the incentive?

Molly MacHarris: So this is Molly again. So for the Value Modifier, remember, they're looking at quality compared to cost, and we don't have it in our slides today, but in the Value Modifier site there's a grid where if you are low cost, high quality, then you would have – you could potentially earn two – I believe it's two times via – there will be a 2-percent increase on every single claim that you have. So when Tonya's saying it is in your control, it is when you think that how the physician performs on the quality measures, whether or not they're actually doing the quality indicators or not, that is within the physician's control. And whether or not there is low cost based off of the cost metrics, that is within the practice's control as well. So that's what we mean by that.

Kim Spalding Bush: Thanks Molly, and this is Kim. I just want to clarify quickly that the upward adjustment is the quality tiering methodology. And remember that it depends on your group size whether you could be subject to the quality tiering upward, neutral, or downward adjustment. It's actually an increase of two times an adjustment factor, so it's not actually 2-percent increase for the highest performers.

I just wanted to make that clear because the Value Modifier is structured in such a way that it redistributes all of the penalties back to the high performers. We have to wait until after the performance period to know what that adjustment factor will be that will redistribute those funds, so we have to kind of know what they are in order to make sure that we give them all back to the better performers.

So yes, I would totally second everything that Molly just said, that we believe that the performance is absolutely within the physician group's control. And we have a lot of information on our website about how we attribute your beneficiaries to you. You also get a detailed Quality Resource Use Report that gives you all kinds of information about how you performed on your measures and some information that you can use to help improve your performance going forward.

Heather Shiffer: Does that come with our normal feedback report? I haven't seen that.

Tonya Smith: No, that would be in what we have. We have a – what's called a Quality Resource Use Report, which is – for instance our 2013 Quality Resource Use Report will be released this fall, and it will go to all solo physician practitioners and group practices, so you will want to look for that. And again, that will be released later this fall.

Heather Shiffer: Would that be – how would that come to us? Would it come via – would it come on paper via in the mail or …

Tonya Smith: Right, no, you would have to – there is a link that you would have to use and actually that information – let me just give you our website link. I think it's that – is that in the slide Molly?

Molly MacHarris: It's not, but we do have the help desk information for the Value Modifier Help Desk, which is 888-734-6433. And we encourage you to contact them and they can help you with the rest of your questions on accessing the report. Thank you.

Heather Shiffer: OK, thanks.

Operator: The next question comes from the line of Kathy Eben.

Kathy Eben: Hi, hello?

Molly MacHarris: Hi.

Kathy Eben: I have a question. I asked the help desk and they had to refer this up, so I'm going to ask you. The payment Value Modifier is based on the number of physicians that are in your tax ID in PECOS, is that correct?

Tonya Smith: That's correct.

Kathy Eben: Ok, if you have doctors that are in PECOS under you, but they never report any Medicare claims for this year and so you have 20 doctors but only 15 report, is your 50 percent half of the 20 or half of 15?

Tonya Smith: How we determine, like for of the 2015 Value Modifier, how we determine the actual number of physicians is we look at in – on October 15, 2013, we look at – we look at PECOS and see the number of physicians you had in PECOS. And then after we do that, we do a second check later, I think it's usually at the end of December where we look at your claims, and then analyze your claims to make sure that you did have the necessary number of physicians in your group.

Molly MacHarris: So if they don't bill a claim during the performance year at all to Medicare, then they are not counted.

Kathy Eben: That was my bottom line question. Thank you.

Operator: Your next question …

Kathy Eben: Thank you.

Operator: Excuse me, the next question comes from the line of Kim Fransen.

Kim Fransen: Hi, I'm calling because I wanted some information on the – on the September 30th deadline for all changes for the GPRO.Molly MacHarris: OK, what can we help you with?

Kim Fransen: So now let's say we had selected to – we had selected the CAHPS when we were doing our group reporting option selections. Now once I've selected that, and let's say it's after September 30th, can I go back and make a change to that? Or is that the end all deadline, the 30th is it?

Tonya Smith: The 30th of September is the final deadline, yes.

Kim Fransen: OK. So I can't make any changes at all in my GPRO selections?

Tonya Smith: Not after September 30th, that's correct.

Kim Fransen: OK, and just really quick, now when I registered as a GPRO, it only asked me to give two of my providers. So how is it that they identify what other providers are involved in this GPRO?

Molly MacHarris: So I believe what you're referencing is the PTAN verification when you're setting up your IACS account. So that is really just a process we have in place for us to verify that you are who you say you are. So it's not that we would only be looking for those two providers. We, as Tonya has described it, we will be looking for all providers who bill under the TIN.

Kim Fransen: So it happens on your end that you will choose any provider that has submitted a service under the TIN?

Molly MacHarris: Well, the way that group reporting works is that any NPIs that bill under the TIN are part of the group practice. So if you have a hundred NPIs and a hundred of them bill under that TIN, then everyone who bills under Part B is part of that group practice.

Kim Fransen: OK. So for example, I have four providers right now, and they are all billing under that tax ID number that I – and that the PTAN that I have submitted as a GPRO. I have about four other doctors coming onboard in October. They're going to automatically be included in that?

Tonya Smith: I'm sorry, say that question again. I didn't hear it completely.

Kim Fransen: OK. So I registered as a GPRO. I have four providers currently billing under my PTAN and my NPI, so there are four of them altogether. I have four new doctors coming on in October. They will automatically be rolled up in that?

Tonya Smith: Well for the purposes of the 2016 Value Modifier, I would say no because that applies to groups of 10 or more and it sounds like you're saying you would only have eight. So …

Kim Fransen: Right. But as far as PQRS reporting, if I'm reporting as a GPRO and I'm doing a registry reporting, even though these providers weren't a part of my group in that September deadline timeframe, they would still be rolled up and anything they billed for would be included in an incentive that I'd receive.

Molly MacHarris: Yes, that's correct. Anyone who bills under the TIN during the calendar year, so past the registration period, will potentially be assessed as part of the group practice for both incentive calculations, payment adjustment calculations, et cetera.

Kim Fransen: OK, so no additional steps are necessary once the providers become part of that tax ID number?

Molly MacHarris: Correct, they would just need to start reporting. Thank you.

Kim Fransen: Great, thank you.

Operator: Your next question comes from the line of Michelle Wong.

Michelle Wong: I have a question, sorry, my name is Michelle, thank you for taking my question.

On the slide 14, the PQRS is applicable to all EP, including the provider like physician, physician assistant, or more specific. Under the Value-Based Payment Modifier, it says only applicable to physician. So I need to clarify for that.

Tonya Smith: Yes, the 2015 and 2016 Value Modifier is applicable to physicians, but where we say – is this slide 14, I want to make sure I'm on the right slide? OK, yes, I'm sorry, I just wanted to make sure I was on the right slide. However, we use EPs on the column where it says who will apply to all Medicare physicians in groups of 10 EPs. That's correct, in that it will apply to physicians, but we use EPs to actually define the actual group size. So although it will apply to physicians, we – in order to figure out the actual group size, we look at all the EPs in the group.

Michelle Wong: Yes, we have actually size also. We have 10 EPs, including the five physicians and five physician assistants. So in this year, if we were able to have 50 percent of the providers that probably mixed with the physicians and physician assistants, so five out of the 10 successfully report the PQRS and was accepted – was successful. So I mean, then we probably would automatically avoid the 2016 modifier exemption. But how about if the five physician assistants does not want to participate and one of the physicians doesn't want to participant then, which it means like we will get the – for the 2-percent payment adjustment?

Tonya Smith: No, as long as you have at least 50 percent of the EPs who actually submit measures successfully. And let me just add real quick, you want to make sure that you submit a little bit more than – I mean, a little bit more than five EPs actually submit to ensure that you avoid the automatic downward Value Modifier payment adjustment.
Michelle Wong: OK. So the five EPs, actually doesn't matter if it's a physician or physician assistant, as long as they are applicable – I mean EP, that would count toward the 50 percent. Am I correct?

Tonya Smith: That is correct.

Michelle Wong: OK, OK, thank you.

Tonya Smith: Um hum.

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

Kelly Martin: Hello. I have a question on – we're planning on doing registry group measures reporting. We can do that and not be a GPRO, correct?

Molly MacHarris: So when you say registry group measures reporting, do you mean measures group?

Kelly Martin: Yes, measures groups through a qualified registry.

Molly MacHarris: Yes, and actually, you cannot do that as a GPRO. You can only do that as an individual.

Kelly Martin: OK, perfect. And then I want to clarify – I think I know the answer, but if we have a provider join us in 2016 that was not part of us in 2014, since we didn't have any claims under our TIN for that provider, we would not be subject to a penalty for that provider, correct?

Molly MacHarris: You wouldn't for PQRS. However, for the Value Modifier, since theirs is assessed at a TIN level, I believe you will be, but I'll let Tonya answer that.

Tonya Smith: Yes, Kim, are you still on the line? I'm almost positive that it's where you are for the payment adjustment.

Kim Spalding Bush: I am on the line, and I am so sorry, but could you just repeat the question so I make sure that I understand it?

Kelly Martin: Sure. So if we have a provider join us in 2016 that wasn't with us in 2014, we wouldn't have had anything to report on them in 2014 under our TIN. Would we still be subject to any payment adjustments in 2016 on that provider if we didn't report on anything from 2014 for them?

Kim Spalding Bush: That's a really good question. And just because of the technical nature of it, I would like to take it back if that's possible and get back to you with a response. Because I want to make sure that I'm thinking correctly about how we roll out the individual provider's measure performance rates in order to have them reflect upon the group.

Kelly Martin: OK. How do I – how do I find out how to get back with you?

Kim Spalding Bush: Is there – what email address do we usually use for followup questions from these calls?

Tonya Smith: We were just going to have her call the help desk and have them forward the call to us. That might be easier for the calls, if that's OK?

Kim Spalding Bush: OK, OK.

Kelly Martin: Who – so who, tell me specifically who to ask for at the help desk.

Molly MacHarris: So let me give you the number because it's the VM help desk number, and it's 888-734-6433, and you can just ask that the ticket be routed to CMS.

Kelly Martin: OK.

Molly MacHarris: Thank you.

Kelly Martin: All right. And that –so PQRS, it would not be penalized, but Value-Based Modifier, it could be?

Molly MacHarris: Correct.

Kelly Martin: OK. Great, thank you.

Kim Spalding Bush: And I mean – I don't know about penalizing. I mean, I'm so – I think we think we just need to think about how we – we'd love to see your question in writing, so that we could think about it as a group.

Kelly Martin: OK. All right, thanks.

Molly MacHarris: Thank you.

Operator: The next question comes from the line of Jean Scully.

Jean Scully: Hi, thanks for taking my call. We are largely a neurosurgical practice, but we do have an office-based MRI, and so we have some radiologists that we do employ that are also employed by another practice that read our MRIs for us. And as a kind of

unpleasant surprise, we see on our 2013 Feedback Report that apparently, they read – each of them read and MRA that had a quality measure attached to it.

And so I have these radiologists now that had one patient that they read an MRA on, and now they will be subject to the penalty, at least that's what the report is saying. Because we did – they weren't even in our radar for quality reporting because all they do is read some MRIs for us. So is that – is that correct? Because we missed one patient, they will be penalized 2 percent, am I reading that correctly?

Molly MacHarris: Well, if they failed Medicare Part B …

Jean Scully: Correct.

Molly MacHarris: … and they're associated with your practice, as in they bill under a TIN NPI that you take care of billing for, then yes.

Jean Scully: So that one patient that we miss is now going to cost them 2 percent in all their billings for next year?

Molly MacHarris: Unfortunately, yes.

Jean Scully: OK, I'm sorry.

Molly MacHarris: It's actually 1.5 percent in 2015, which I know doesn't make the scenario any better. But yes, unfortunately, the way that the statute of the program works for PQRS is that any provider who bills any Part B service – it could be one service – they would need to have reported a quality measure.

Jean Scully: OK. So when they are assessed that penalty or adjustment, is that on both? Since it's office-based, we get the professional and the technical, is that adjustment on the global payment or just on the professional component of that payment?

Molly MacHarris: It will be based off of any Part B service that is associated with that specific TIN NPI that is subject to the penalty.

Jean Scully: I feared that. OK. And then the last part of the question, so these radiologists, as I stated before are dual employed, and we're seeing on one or two of them a quality measure for fluoroscopy and they never do fluoroscopy with us, so – and that's the only measure that they're showing and therefore getting penalized. So that to me is obviously an error that somehow things have gotten crossed up and that somehow we're getting penalized for a measure that they probably billed the code at under their other tax ID. How do we appeal that? Or how do we get the details behind what patient – so it's again, it's one or two patients?

Molly MacHarris: Sure. So what you can do is you can contact the QualityNet help desk. Again, their numbers is 866-288-8912, or they could be emailed at

qnetsupport@hcqis.org and tell them that you want additional details behind your feedback reports …

Jean Scully: OK.

Molly MacHarris: … and they will be able to provide that to you. If you do believe that there is an error, there is an informal review period, which will start January 1st through February 28th, so you could submit that there. But I'd start with the help desk and have them …

Jean Scully: QualityNet

Molly MacHarris: Right, and have them provide you the additional claims behind the feedback reports.

Jean Scully: And they can also guide us in the informal review process if we determine that's appropriate?

Molly MacHarris: Yes, they can.

Jean Scully: Perfect. Thanks, so much.

Molly MacHarris: Thank you.

Charlie Eleftheriou: All right. And we're pretty much out of time, but I think we'll be able to take one more question.

Operator: And the final question comes from the line of David Kicker.

David Kicker: Hi, yes, I appreciate you taking the call. Clarify something on slide 11 for me. I don't see anything in here where it talks about the ability to claims report. So did that I just miss a technical detail in all of this? Or for an individual EP it lists three different ways to do that, but I thought you could also report on claims.

Molly MacHarris: Sure, so great question. We didn't include that in this presentation because this presentation was focused on ways that as an eligible professional you could report once, and via claims is not one of those ways. Claims reporting is still available to individual providers, so you can still participate that way.

David Kicker: All right, thanks so much.

Molly MacHarris: Thank you.

Additional Information

Charlie Eleftheriou: All right. Unfortunately, that is all the time we have for questions today. As we repeated a couple of times throughout the presentation, additional questions

can be emailed to the QualityNet Help Desk, and that – or you can call QualityNet help desk. Those – the contact information is 866-288-8912. Again, 866-288-8912, or email qnetsupport@hcqis.org.

On slide 22 you'll find information on how to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary, but we do hope you take a few moments to evaluate your MLN Connects Call experience, as we do take your comments into consideration, so all of your feedback is definitely appreciated. Thanks again to our subject matter experts here at CMS and all of our participants who joined us today for our MLN Connects Call. Have a great day, and we'll talk to you next time.

Operator: This concludes today's call.

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