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National Provider Call Transcript

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Centers for Medicare & Medicaid Services
2015 Physician Fee Schedule Final Rule:
Changes to Physician Quality Reporting Programs
MLN Connects National Provider Call
Moderator: Aryeh Langer
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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 Aryeh Langer. Thank you, you may begin.

Announcements and Introduction

Aryeh Langer: Thank you very much. Again, 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 MLN Connects National Provider Call on the "2015 Physical Fee Schedule Final Rule: Changes to Physician Quality Reporting Programs."

MLN Connects Calls are part of the Medicare Learning Network. During today's call, CMS subject matter experts will provide an overview of the changes to the Physician Quality Reporting Programs and the 2015 Physician Fee Schedule Final Rule, including the Physician Quality Reporting System, or PQRS, Value-based Payment Modifier, Physician Compare, Electronic Health Record, EHR, Incentive Program, and Comprehensive Primary Care Initiative, CPC, as well as the Medicare Shared Savings Program.

A question-and-answer session follows today's presentation. Before we get started, there are a few items I'd like to quickly cover. You should have received the link to the slide presentation for today's call in an email earlier today. If you have not seen that email, you can find today's presentation on the Call Details web page, which can be found by visiting the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. On the left side of that page, select National Provider Call and Events, and then select today's call by the 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 web page that I just referenced when it is available, generally within 2 weeks of today's call. An announcement will be placed in the 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 information and instructions available via the link on slide 39 of today's presentation.

At this time, I'd like to begin the formal part of our presentation by turning the call over to Lauren Fuentes.

Presentation

Lauren Fuentes: Thanks Aryeh, and good afternoon and good morning to all of our listeners, depending on where you're joining us from today. As Aryeh indicated, today we will be covering the 2015 Medicare Physician Fee Schedule Final Rule.

Our agenda, starting on page 4: Today we plan to touch on the 2017 payment adjustments for the different quality reporting programs, then we will go into detail on the Physician Quality Reporting System, followed by the Electronic Health Record, or EHR, Incentive Program. We will also discuss updates in the rule on public reporting and then we will continue to discuss Value-based Payment — the Value-based Payment Modifier, as well as the Medicare Shared Savings Program. After the presentation, we will have an opportunity for a question-and-answer session from our participants.

The 2017 Payment Adjustments

OK, so moving on and beginning on slide 6. So on slide 6, we have laid out — a — basically the 2017 payment adjustment for the various quality reporting programs. So for PQRS, this program is applicable to all eligible professionals and the adjustment amount is negative 2 percent of Medicare Physical Fee Schedule payment. And this payment is — the 2017 payment adjustment will be based on quality reporting for 2015. So, therefore, you need to meet the satisfactory reporting requirements for PQRS to avoid a 2 percent payment adjustment in 2017.

The next program is the Medicare EHR Incentive Program, and this program is applicable to Medicare physicians who do not achieve meaningful use, and the adjustment amount for this is negative 3 percent of the Physician Fee Schedule amount, and this is also based on 2015 reporting.

The next program that we have on this slide is a Value-based Payment Modifier, and this is applicable to all physicians in groups with two or more eligible professionals and physicians who are solo practitioners.

And for the Value-based Payment Modifier, it's a little different than PQRS and the Medicare EHR Incentive Program in that it depends on — there's a quality tiering that will dictate your adjustment amount. So for groups of two to nine EPs and solo practitioners for 2017, there could be an upward or neutral VM adjustment only based on quality tiering. So that could be anywhere from zero to a positive or an addition of a 2 percent of your Physician Fee Schedule amount.

For groups with 10 or more EPs, there could be an upward, neutral, or downward VM adjustment based on quality tiering. So that could equate to either negative 4 or a positive 4 percent on your Physician Fee Schedule amount. And groups and solo practitioners receiving an upward adjustment are eligible for an additional 1 percent if

their average beneficiary risk score is in the top 25 percent of all beneficiary risk scores nationwide.

And then for non-PQRS reporters, so if the Value Modifier — if you do not report PQRS quality data in 2015, groups of two to nine EPs and solo practitioners would receive an automatic 2 percent — downward 2 percent for their Medicare Physician Fee Schedule, and groups with 10 or more EPs would receive an automatic negative 4 percent on their Physician Fee Schedule amount.

PQRS Updates

OK, so moving on to the next slide. I'll pick back up on slide 8 to discuss the PQRS updates in the 2015 PFS Final Rule. So for claims-based reporting mechanism, CMS has not made any changes to this particular reporting mechanism. EPs in Critical Access Hospitals billing method II are able to participate in PQRS using all reporting mechanisms, and this is including claims. Another important update is that the deadline for the group practice registration in the Physician-Value PQRS registration system has been moved to June 30th of the year in which the reporting period occurs. So for 2015, that would be June 30th, 2015, to regis … — would be the deadline for group practices to register and let CMS know that you want to report as a group practice in 2015.

Another update for PQRS in the 2015 Final Rule is that the measure applicability validation, or MAV, process will now check whether an EP or group practice should have reported on any of the cross-cutting measures.

OK, so moving on to slide 9. On slide 9 we briefly touch on the measure updates in the Final Rule, and for these we added 23 measures for individual and measure groups reporting. Two new measure groups are now available for PQRS beginning in — sorry — beginning in 2015 are available. For removal from PQRS, there were 50 measures to be removed, 38 measures within the measures group and four measure groups overall to be removed in 2015.

And then final changes to our measures groups option is that the 6-month reporting option for measure group has been removed, and a measure group has been defined as a subset, or six or more PQRS measures that have a particular clinical condition or focus in common. And I also just want to note that the measures codes page of our PQRS website contains specialty measure sets. So these specialty measure sets are to be utilized as a guide to assist eligible professionals to choose measures applicable to their specialty beginning in program year 2015.

So you can go on our website, on the measures page you'll see that we have posted these specialty measures sets. And they cover specialties such as cardiology, emergency medicine, gastroenterology, general practice, internal medicine, just to name a few. We have 12 different specialty measure sets that we've compiled for you to use as a suggested measure set.

OK, so moving on to slide 10 regarding the registry reporting option. For our qualified registries, the updates that we have made in the 2015 PFS rule are that an EP or group practice who treats at least one Medicare patient in a face-to-face encounter will be required to report on at least one cross-cutting PQRS measure, and we've also extended the deadline for qualified registries to submit quality measures data, including but not limited to the calculations and results to March 31st, 2016, and this is for the reporting period of 2015.

OK, moving on to slide 11 for our clinical — our Qualified Clinical Data Registries, or QCDRs. There were a few updates in the 2015 PFS Rule, and these include that the limit on the number of non-PQRS measures that a QCDR can submit on behalf of an EP is — has been increased to 30 for the 2015 program year and additionally, there — it is required that the QCDR on behalf of their EPs to report on at least two outcome measures or, if less than two outcome measures, then they must report on at least one outcome measure and at least one of the following types of measures. And these include patient safety, resource use, patient experience of care, or efficiency/appropriate use.

OK, next slide, slide 12 regarding the EHR reporting mechanism. The updates for this — for the 2015 PFS is really a clarification in the 2015 rule that an EP's certified EHR technology, or CEHRT, does not need to be retested and recertified to the most recent version of the measure. So the vendor can update the product, but the EHR does not have to go through a recertification process. And just a note for this is that for — for PQRS reporting, it is required that the most recent version of the eCQMs are reported on.

OK, next slide, slide 13. This is regarding the GPRO, or Group Practice Reporting Option Web Interface updates. And for this — for the next — for the 2015 Final Rule, a few updates include that if a group practice does not have any Medicare patients for any of the GPRO measures, the group practice will not meet the criteria for the satisfactorily reporting using the web interface, and this is really a clarification. The GPRO Web Interface has a set — set of measures that must be reported on, and the beneficiaries will be assigned to you by CMS and, therefore, if your group practice signs up for this — the GPRO Web Interface — and CMS finds that there are not any beneficiaries that can be assigned to you for those particular measures, we just wanted to clarify that the group practice will not be able to meet the criteria for satisfactorily reporting using the web interface.

Hey, additionally, we have updated that the group practices of 25 or more must report on all measures in the web interface and populate data fields for the first 248 consecutively ranked in the group sample for each module or preventive care measure. If the group has less than 248, the group practice would need to report on 100 percent of assigned beneficiaries. So the update here is really just a change in the number of beneficiaries and the supplies for all group practices using the web interface. This option

is available for group practices of 25 or more. So this is just an update on the number of patients that must be reported on. Previously, there was dependency on your group size, and that's no longer the case, and 248 is the number now that must be reported on for this reporting option.

OK, next slide, slide 14. This is for CAHPS for PQRS. So in the final rule, updates on the CAHPS for PQRS option are that the Consumer Assessment of Healthcare Providers and Systems, CAHPS, for PQRS is required for group practices of 100 or more. And this is regardless of your reporting method. Previously, only those using the GPRO Web Interface were required of 100 or more — with 100 or more group size were required to report the CAHPS for PQRS survey. And this update is to extend that requirement to groups of 100 or more for all reporting methods. And CAHPS for PQRS is optional for group practices of 2 to 24 EPs and 25 to 99 EPs. And also beginning in 2015, group practices will be required to contract with the CMS certified vendor, and group practices will be required to bear the cost of administering the CAHPS for PQRS survey measures.

Medicare EHR Program Updates

OK, next slide, slide 16. We'll be talking about the Medicare EHR Incentive Program updates. And in the 2015 Final Rule there were further expansions of a Medicare EHR Incentive Program. So in regard to the Comprehensive Primary Care Initiative, or CPC, reporting, CPC practice sites are required to report a subset of the Clinical Quality Measures, or CQMs, that were selected in the EHR Incentive Programs Stage 2 Final Rule for EPs to report under the EHR Incentive Program beginning in calendar year 2014. So the key here for 2015 is that CPC practices for this year only must report a subset of nine of those — of those measures across two domains.

OK, and for the Medicare Shared Saving — Shared Saving Program, CMS finalized that EPs participating in an Accountable Care Organization, or ACO, under the Shared Saving Program satisfy the CQM reporting components of meaningful use of the Medicare EHR Incentive Program when the EP either extracts data from the EHR necessary for the ACO to satisfy its GPRO quality reporting requirements and when the ACO satisfactorily reports the ACO GPRO measures through the CMS — a CMS web interface.

OK, and for Physician Compare, CMS finalized that successful participation in the EHR Incentive Program based on their 2015 reporting will be reflected on the Physician Compare website in 2016.

Public Reporting Updates

OK, and moving on to slide 18, and this is around public reporting and if the 2015 Final Rule did expand the public reporting requirements for Physician Compare. And so for groups — for group practices, all PQRS GPRO measures via the GPRO Web Interface registry and EHR, and all ACO measures will be available for public reporting, as well as the CAHPS for PQRS and CAHPS for ACO. And for individuals, all 2015 individual PQRS

measures reported via registry, EHR, and claims would be available for public reporting, as well as 2015 QCDR measures data, which would be at the EP level, include both PQRS and non-PQRS measures. However, we would not report any first-year measures for the QCDRs. So those measures that are only being utilized for — or in the first year of use would not be available for public reporting.

And just to clarify with these policies, basically what this means is that all of these measures that I just went over and that are listed on slide 18 are available for public reporting. It does not necessarily mean that all the measures will be included on the group or individual profile pages on the website. Of course, you know, testing will need to be done to ensure the measures are found to be statistically valid and reliable and — as well as suitable for public reporting, but we will make — those measure that do not meet the criteria for public reporting on the profile pages will be available in a downloadable database.

OK, so this concludes the first portion of our call, and I will turn it back over to Aryeh.

Keypad Polling

Aryeh Langer: Thank you very much Lauren. Before we move into the next portion of the call, 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. Salema, 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.

Once again, 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 continue to hold while complete the polling. Please continue to hold while complete the polling.

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

Presentation continued

Aryeh Langer: Thank you very much Salema. I'm going to now turn the call over to Kim Spalding-Bush here from CMS for our Valued-based Payment Modifier updates.

Value-Based Payment Modifier Updates

Kim Spalding Bush: Thank you Aryeh. So we're beginning back on slide 20, which highlights some key points about the Value Modifier policies for payment adjustment occurring in calendar year 2017, as well as 2018. A key point to note here is that the policies we finalized in this year's Physician Fee Schedule Rule continue the gradual phase-in of the Value Modifier, and they reflect our stakeholders' input, as well as our own commitment to engaging groups and individual practitioners in the Value Modifier Program by providing them with detailed data that they can use to understand and gain experience with the measures included in the Value Modifier and to improve the care that they provide to Medicare beneficiaries.

As you see here, in 2017 — the first year that the Value Modifier becomes applicable to groups of fewer than 10 eligible professionals and to solo practitioners — they can earn upward adjustments for performing well on our cost and quality measures, but they'll be protected from any downward adjustments as they continue to gain experience with the program.

Likewise, for groups comprised solely as nonphysician eligible professionals and to the nonphysician eligible professional solo practitioners, our final policy will allow them additional time to receive and understand our Quality Resource Use Reports before they becomes subject to the Value Modifier in 2018. In this final rule we also finalized policies that apply the Value Modifier to 2017 payments made to physicians participating in these CMS initiatives during the applicable performance period, which is calendar year 2015.

So this section of today's call focuses primarily on the policies finalized in the Physician Fee Schedule Rule. In Appendix B, you'll find helpful tables summarizing Value Modifier policy changes across the program years.

Moving to slide 21. As you probably know, the Value Modifier enables groups and solo practitioners to earn increases in Medicare payments under the Physician Fee Schedule for performing well on cost and quality measures. Those increases are funded by payment reductions to poor performers and also from those who failed to report successfully under the Physician Quality Reporting System.

The Value Modifier continues to be aligned with the PQRS system in 2017 in order to further emphasize and incentivize quality reporting and to minimize the burden on groups and solo practitioners who are subject to the Value Modifier. You can see on the left side of this slide that for the 2017 payment adjustment based on 2015 performance,

as will be the case for the 2016 payment adjustments that will be based on 2014 performance, groups will have the option of either reporting as a group or as individuals in order to qualify for upward adjustments under the Value Modifier and to avoid that downward payment adjustment under the Value Modifier for not successfully reporting under PQRS. And you can see that automatic downward adjustment on the right side of this slide. The automatic downward adjustment under the Value Modifier is separate from and is in addition to the downward adjustment that groups or solo practitioners would receive for not successfully reporting under the PQRS program.

Again, though today's presentation is focused on policies finalized in the 2015 rule, which primarily relate to our payment adjustments in 2017, I'd like to take this opportunity to remind participants about reporting your 2014 quality performance for the 2016 Value Modifier payment adjustment. So the time to elect group reporting for calendar year 2014 performance has passed. Groups still have the option to ensure that at least 50 percent of their eligible professionals report as individuals in order to qualify for those upward adjustments and to avoid the automatic downward VM adjustment for not successfully reporting to PQRS. I'll cover the quality tiering payment adjustments that you see at the lower left on the following slide.

Slide 22. As noted in the first bullet here, the automatic downward adjustment for groups of two to nine eligible professionals and also solo practitioners — I'm sorry, this should be specific to physicians for 2017. So the automatic downward adjustment for those physicians that do not successfully report PQRS and are either solo practitioners or are in groups of two through nine eligible professionals — so the automatic downward adjustment is a negative 2 percent.

So also on this slide, we present the quality tiering policy that applies to those physicians and solo practitioners in groups of — I'm sorry, the physicians in these groups of two to nine and also solo practitioners in 2017 based on their 2015 performance. While quality tiering continues to be mandatory in 2017, as it will be in 2016, we're continuing our gradual phase-in by holding the newest participants in the Value Modifier Program harmless from downward adjustments under the quality tiering methodology.

So as you see in this table, the only potential adjustments are upward or neutral, meaning no adjustment. The highest potential adjustment will be two times an adjustment factor to be determined after the conclusion of the performance period. The adjustment factor is a percentage that will redistribute the downward reductions from the payment of poor performers and those who do not successfully participate in PQRS.

So just to be clear, the upward adjustment is a plus 2x, not a plus 2 percent. You will note here also that solo practitioners and groups subject to upward adjustments for either having average quality and low cost, average cost and high quality, or low cost and high quality will continue to be eligible for an additional upward adjustment if the

beneficiaries that they are attributed fall into the top quarter of all Medicare beneficiaries in terms of risk scores. This is an additional incentive for treating those Medicare beneficiaries who have the most complex clinical presentations.

On to slide 23. On this slide, you can see the full range of payment adjustments available under quality tiering for groups of 10 or more — for physicians in groups of 10 or more eligible professionals in 2017. So these are the potential adjustments that those physicians are subject to depending on their quality and cost measure performance. As you can see, physicians in these groups of 10 or more can earn a higher upward adjustment for performing well on cost and quality measures that is up to four times that adjustment factor, and they are also subject to a higher potential downward adjustment for not reporting PQRS or for poor performance on cost and quality measures.

Again, these groups are eligible for an additional upward adjustment for treating the most complex Medicare beneficiaries if they first attain an upward adjustment under quality tiering, and they are also subject to that automatic downward adjustment if they do not successfully report through PQRS.

On to slide 24. As required by law, we've expanded the Physician Value Modifier Program in 2017 to apply to all physicians based on their 2015 performance. This includes participants in the Shared Savings Program ACOs as well as other CMS initiatives that I will discuss on the next slide.

Physicians in Shared Savings Program ACOs in 2015 will receive a cost composite under the 2017 Value Modifier Program that is classified as average. This is to help avoid conflicting incentives for cost savings as those groups already have targets and incentives under the Shared Savings Program.

Their quality composite will be based on the ACO's performance on the quality measures that it already reports to the PQRS as an ACO. The benchmarks will be the same as those used in the Value Modifier Program for all other groups and solo practitioners. We will determine whether a group or solo practitioner is part of a Shared Savings Program ACO for the purpose of applying the Value Modifier to its payments in a given year based on whether it participated in the Shared Savings Program in the relevant performance year.

So for 2017 payments, we determine whether the group or solo practitioner was a part of a Shared Savings Program ACO in 2015. If the ACO does not successfully report through PQRS, then it will be subject to the downward adjustment, and the physicians in the group will receive an automatic downward adjustment, as we discussed on slide 21.

Slide 25 details the application of the Value Modifier to payments in 2017 for physician solo practitioners and groups participating in the Pioneer CPC and other similar

initiatives during the 2015 performance period. As you see here, physicians in these groups will have both their cost and their quality composites classified as average.

On slide 26 we provide a summary of the quality measures that will be used in the 2017 Value Modifier. Again, these will be based on a 2015 performance period, and will continue our alignment with the PQRS program using all the reporting mechanisms available under PQRS. We will also continue to use the three outcomes measures, which are:

- A composite of preventable hospitalizations for acute conditions,
- A composite of preventable hospitalizations for chronic conditions, and
- An all-cause hospital readmission measure.

And groups can still elect to use the CAHPS for PQRS measures in the calculation of Value Modifier for 2017. And finally, as noted here, we've increased the case minimum for the all-cause hospital readmission measure for 2017 to 200 cases.

Slide 27 presents the cost measures used for the 2017 VM. The same specialty adjusted cost measures used for the 2016 VM will be used in 2017, with some refinements that respond to input from the National Quality Forum:

- The first change is to our attribution methodology, and it seeks to recognize the role of nurse practitioners, physician assistants, and clinical nurse specialists in the provision of primary care services to Medicare beneficiaries.

- The second change is to include certain part-year Medicare beneficiaries in order to count for a more complete picture of the cost of care.

And on slide 28 you will find details of the expansion of the informal inquiry process for the Value Modifier. For the 2015 payment adjustment, we finalized that the last day a group could submit a request for correction of a perceived error made by CMS in the determination of its Value Modifier would be February 28th, 2015. We would classify a TIN as average quality in the event that we determined there was an error in the calculation of the quality composite, and we would recalculate the cost composite in the event that we found an error there.

Now beginning with the calendar 2016 payment adjustment period, the deadline to submit informal review requests will be 60 days after the release of the QRURs. And beginning also in 2016, we will recompute the quality composite to correct errors that were made by CMS or a third-party vendor. And you'll note here that in the event that it wouldn't be possible for us to recompute the quality composite, we would continue our approach from 2015 by assigning average quality.

And that concludes the Value-based Payment Modifier section of this presentation. I will now turn the presentation over to Rabia Khan to provide you with information on policies related to the Medicare Shared Savings Program.

The Medicare Shared Savings Program

Rabia Khan: Thank you Kim. You can go to slide 30. I'll just provide an overview of the Medicare Shared Savings Program. Accountable Care Organizations, or ACOs, create incentives for providers to work together voluntarily in efforts to coordinate care and improve quality for their patient population. We assess ACO performance annually on quality performance and against the financial benchmarks to determine their shared savings.

Slide 31. It's important for us to continue alignment with other quality initiatives. So by meeting program requirements for the Shared Saving Program, we've aligned with the PQRS Program, the EHR Incentive Program, and the Value-based Payment Modifier for EPs participating within an ACO.

Slide 32. Within the Physician Fee Schedule Rule, we updated the quality measures set for the Shared Savings Program. The updates include that we incorporated more claims-based outcome measures we — that focus on care coordination and patient safety. Among those we've added are the skilled nursing facility 30-day all-cause readmission measure and three all-cause unplanned admission measures for patients — one for diabetes, another for heart failure, and then the third for patients with multiple chronic conditions.

We also updated the measure set by removing any redundant or clinically outdated measures, those measures that may not align with the current clinical guidelines. And we aligned the measure set with the PQRS Program, the Value Modifier, and EHR Incentive Program measures all — to continue that alignment effort that we've been making for the past few years. We also added stewardship of patient resource measure, which is among the questions within the CAHPS for ACO survey. Although we've made these updates to the measure set, the total number of quality measures remained at 33 measures within our measure set, and it does span across four quality domains.

Slide 33. In addition, we revised the quality scoring strategy to recognize and reward ACOs that make year-to-year improvements in quality performance scores within each domain. Although we proposed a reward of 2 points, we received feedback suggesting up to 4 points per domain. So we finalized in this rule increasing the quality improvement rewards up to 4 points per domain, but the total points within — but the total points an ACO can receive cannot exceed the total points possible within that domain.

We also modified the benchmarking methodology to take into account topped-out measures. We finalized that flat percentages will be used when the national

fee-for-service data results in the 90th percentile per measure are greater than or equal to 95 percent. Benchmarks will also be updated every 2 years, and that's in effort to be consistent and allow for ACOs to work on improving.

Any newly introduced measures will be paid for reporting for 2 years before being phased into pay-for-performance. So the new measures that we finalized in this — in this final rule are pay — are paid for reporting for the first 2 years before being phased in, unless otherwise noted that they would be paid for reporting throughout the entire agreement period. In addition, an ACO quality performance in the subsequent agreement will be assessed and based on the standard that would apply to the third year of the first agreement period.

Slide 34. So continuing with our efforts to align with other CMS quality reporting initiatives, we continue to align with the PQRS Program. We did reduce the number of GPRO Web Interface measures from 22 to 17 and better aligned between the two programs. We've also reduced the required number of consecutive patients to be reported from 411 to 248 per module, or measure, or 100 percent of the assigned beneficiaries if that's less than 248.

We're also continuing to align with the EHR Incentive Program by codifying the requirements for participating EPs to meet the eCQM when the ACO reports quality on their behalf. The EPs must extract the data from certified EHRs, and the ACO must satisfactorily report through the GPRO Web Interface. I do want to note though that EPs must still meet other requirements for the EHR Incentive Program by the ACO satisfactorily reporting, you're meeting only the eCQM Requirements Incentive Program.

Resources

And that concludes the updates for the Medicare Shared Savings Program as a part of this rule. We do have additional resources here in the presentation. So, if you see on slide 36, there are acronyms in this presentation. So you'll see throughout the presentation we have a number of acronyms.

We also have on slide 37 support information. So if you have questions relating to these programs, please use the identified contacts, email addresses, and phone numbers, as well as relying on the times available. So please send in your questions and inquiries that you have regarding the programs and the measures.

And I'll turn it back to Aryeh.

Question-and-Answer Session

Aryeh Langer: Thank you Rabia. 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 additional questions as time permits.

We are now ready to take our first question, Salema.

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 that 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 Kim Sweet.

Kim Sweet: Yes, hi, my name is Kim Sweet. And on slide 10, you made reference to the qualified registry updates and the cross-cutting measures, and it sounded as though the cross-cutting measures only applied to registry reporting and did not apply to claims-based reporting. Is that true?

Sophia Autrey: Hello, this is Sophia Autrey with the PQRS team and, no, the cross-cutting measures do not just apply to registry. They also apply to claims-based reporting.

Kim Sweet: OK, thank you.

Sophia Autrey: You're welcome.

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

Sandra Pogones: Yes, hi, this is Sandy Pogones from Primaris. On slide 9, you made reference to a set of — to measure sets that are applicable for specialists. If a specialist reports only measures within that measure set, will the MAV apply to them for other measures or will the MAV only consider measures within those sets that you defined for specialists?

Sophia Autrey: Hi, this is Sophia Autrey again, and I just want to clarify that the list of the specialty measure sets that are located on the PQRS website are recommended measures for the specialty, and that list is not required for that specialty. However, for the MAV, or the Measure Applicability Validation, process, there are clusters such as for claims and registry that are clinical clusters and which, if you apply or report one of the measures for a clinical cluster, you're required to report the other measures in that clinical cluster.

So for specifics, I would suggest for your specialty that you actually call the QualityNet Help Desk so that they can identify which measures would be applicable for you. But the measures on the specialty list are recommended for your specialty, but they are not all of the measures that would apply in reference to the MAV process.

Sandra Pogones: OK, thank you.

Sophia Autrey: You're welcome.

Operator: Your next question comes from the line of Richard Fairley. Mr. Fairley, your line is open.

Richard Fairley: Hi, with Dubuque Internal Medicine and we're a 35-provider group practice, and we signed up for the group practice reporting option, web-based reporting for 2014. And for 2015, we signed up for an ACO with a Medicare Shared Savings Program. Does that mean — I think you said this, but I wanted to clarify — does that mean, that you do not — that we do not have to sign up for this GPRO Web Interface for 2015, it's automatically done through the ACO?

Rabia Khan: Hi, this is Rabia Khan. So if you are participating within an ACO, you do not have to register separately for PQRS for GPRO Web Interface reporting. When the ACO must satisfactorily report the GPRO Web — through the GRPO Web Interface for participating EP TINs to be — to avoid the PQRS payment adjustment and receive PQRS Incentives.

Richard Fairley: OK, thank you.

Aryeh Langer: Thank you.

Operator: Your next question comes from the line of Jean Ortega.

Jean Ortega: Hi, my name is Jean Ortega, Foothill Cardiology. I have a quick question regarding page 16 wherein the mention of the CQMs came up. We are trying to do the C16 measure group for that CQM wherein immunization registry is required. Unfortunately, our group is unable to do the 2014 MU 2. So we're doing the MU 1 in 2014 for the first quarter. The question is, do we need to test the immunization in 2014 because that was a requirement for 2013, you have to test the immunization registry. So that's my question. If somebody can refer me to an expert so we can kind of figure out what we're going to do.

Patrice Holtz: Could you state which group — which program you're participating in regarding this question? This slide 16 refers to CPC and Medicare Shared Savings Programs.

Jean Ortega: It's — it's the meaning — the CQM, the meaningful use, CQM, and the measure group is C16 wherein immunization registry is required.

Patrice Holtz: You're talking about one of the meaningful use functional measures, not the CQM measure set?

Jean Ortega: OK.

Lauren Fuentes: So if you …

Jean Ortega: OK.

Lauren Fuentes: So this is — this is Lauren Fuentes. I don't think we, you know, we have anyone here right now that will be able to address your question regarding the EHR Incentive Program. So what I would suggest, slide 37, we do have a phone number for the EHR Incentive Program Information Center. So I think that would probably be your best course of action to get this answered — this question answered.

Jean Ortega: OK, thank you then.

Lauren Fuentes: You're welcome.

Operator: Your next question comes from Rosalie Riley. Rosalie, your line is open.

Maureen Cook: Hi, this is Maureen Cook from Commonwealth Orthopedics. My question pertains to slide 14, the CAHPS, and it's a two-part question. Can we do the CG-CAHPS Survey, and how do we find a CMS-certified vendor?

Lauren Fuentes: Hi, this is Lauren Fuentes. So to answer your first question, you actually need to use the CAHPS for PQRS Survey. It is based on the CG-CAHPS version 2.0, I believe, but there are some additional questions that have been added to this — to this survey. But you do need to use the specific CAHPS for PQRS Survey and that is — we do have a copy of that on our website, so you can go look at that.

And your second question in terms of how to find a vendor, CMS will be training vendors in the summer of 2015, and then we'll post the list of qualified vendors for groups to choose from.

Aryeh Langer: Does that answer your question?

Lauren Fuentes: Hello?

Aryeh Langer: OK, let's go ahead and take the next question.

Operator: Your next question comes from Darlene Lackey.

Darlene Lackey: Good afternoon, this is Darlene with Arkansas Health Group. And I have more than a hundred providers that report under a single TIN, and I have 54 of those that are reporting CPCI. And my question is, would the GPRO registration be mandatory for us in 2015? And the second part of that is, I understood from the CPCI slide that we would be excluded from the downward VBM percentage.

Patrice Holtz: Hi, this is Patrice Holtz from the CPC team. So your group practice needs to make a decision whether they want to all report to PQRS under the GPRO option. To make that decision you would have already had to register the GPRO in the PQRS Program. The CPC participants in your practice site, if you have not registered as a GPRO, will report directly to CPC, and the rest of the participants in your TIN could report to the PQRS Program as individuals.

As far as the Value-based Modifier in 2015 with application of a modifier in 2017, if they are CPC participants, the CPC Program will collect those CPC Practice TINs and report them to the program, so they would be exempt from application of the Value Modifier in 2017.

Darlene Lackey: OK, so for 2015, which — should we report as a GPRO for 2017?

Patrice Holtz: Well if you haven't already reported as a GPRO — if you haven't registered as the GPRO, you can report to CPC. If you registered to report as a PQRS GPRO, you have to stick with that decision. And as far as the Value Modifier in 2015, you're not exactly exempt. You're assigned a negative — an average cost, average quality, which provides you with a neutral payment adjustment.

Darlene Lackey: OK.

Patrice Holtz: We suggest you contact the CPC Help Desk and we can help you further.

Darlene Lackey: OK, thank you.

Patrice Holtz: Um-hum.

Operator: Your next question comes from the line of Delores Johnson. Delores, your line is open.

Carla Pratt: This is Carla Pratt. We are an outpatient behavioral health organization and we do claims-based reporting for the PQRS, and I was wondering, did you say that there had not been any updates that were finalized, and if so, do we just continue reporting as we are right now?

Lauren Fuentes: Hi, this is Lauren Fuentes. So, yes, there have not been any updates for the claims — the claims reporting. You need to report on nine measures covering at least three of the National Quality Strategy domains and then report on each of those measures for at least 50 percent of your eligible Medicare Part B patients. So no changes to that.

The only change I would say is that with the — if you see at least one Medicare patient in a face-to-face encounter, then you do need to report on one measure that is contained in the cross-cutting measure set, which is specified in the rule so …

Carla Pratt: Yes.

Lauren Fuentes: … other than that, there is no changes. And I just wanted to point out that any slides in the appendix, we do have a summary of the requirement for reporting for 2015. So I forgot to mention that, but I just wanted to point that out as well.

Carla Pratt: Thank you.

Operator: Your next question comes from A.J. Hernandez. A.J., your line is open.

A.J. Hernandez: Hi, thank you. I work for Vantage Radiology, and I just wanted to find out if there's any more discussion about radiology, pathology, and laboratory possibly being exempted from this Value Modifier.

Kim Spalding Bush: Hi, this is Kim Spalding Bush. I'm not aware of having discussed exempting any particular specialties from the Value Modifier or that we would have any intentions of doing that.

We certainly encourage specialists to work with their societies to develop measures that might be applicable to your specialties. I know we've had some conversations with some of our groups about coming up with new measures in the future. And we would certainly encourage you to continue to work with your societies to come up with measures that might be more applicable to the specialists if that's the concern. But to answer your question, no, we don't intend to exempt any medical specialties from the Value Modifier.

A.J. Hernandez: OK, because we have been reporting since 2007 for PQRS, so I'm just concerned about how we're going to report the Value Modifier.

Kim Spalding Bush: So we just use the PQRS reporting. You don't have to do any additional reporting for the Value Modifier so long as you avoid the downward adjustment under the PQRS Program. Then you would not be subject to any additional downward adjustment under the Value Modifier.

If the concern is that you don't have applicable measures, you know, we have some cost measures that we calculate based on claims if any of those were applicable to you. And certain specialties we recognize may not be attributed cost measures because they don't provide primary care services generally.

A.J. Hernandez: Um-hum. Um-hum.

Kim Spalding Bush: So I think in the event that there are not enough measures and you do avoid the downward adjustment under the PQRS, that you'll just end up with a neutral adjustment under the Value Modifier. As I said, certainly going forward we're very interested in engaging all of our specialist groups to the extent that we can. So we hope that we're — we'll be able to extend our measures to include the measures that are tailored for your specialties.

A.J. Hernandez: Right. Thanks for the information, Kim.

Kim Spalding Bush: Sure, thank you.

Operator: Your next question comes from Gary Gelbart. Gary, your line is open.

Gary Gelbart: Yes. It's Gary Gelbart from Reimbursement Technologies. I just want to make sure my understanding is correct that the new measures for 2015 have not been released yet, and can you tell me when you expect them to be published, you know, so we can plan ahead?

Sophia Autrey: So if you're talking about the 2015 measure specifications of — for PQRS, they are actually listed on the website, so they are available for review currently.

Gary Gelbart: OK. We'll have to look again because we found the deleted codes and a complete list, but not the — there's no separate, like, appendix — these are the new codes.

Sophia Autrey: Can you — Can you say that again because, are you talking about the new codes for the new specs or ...

Gary Gelbart: For the …

Sophia Autrey: Go ahead.

Gary Gelbart: The new — the new PQRS measures, like here's new, you know, number 300 and something, here's a new measure.
Sophia Autrey: Right. Those measures are listed on the PQRS website.

Gary Gelbart: OK. We'll — we'll have to search again. Thank you.

Sophia Autrey: OK.

Operator: Your next question comes from the line of Cheri Riley. Cheri, your line is open.

Cheri Riley: Hi, this is Cheri, I'm Highlands Oncology Group. I have received some information from our vendor. He's telling us that PQRS and Clinical Quality Measures have merged in 2015 and as long as we meet the Clinical Quality Measures we don't have to do the PQRS. Is that anywhere correct?

Sophia Autrey: OK, this is Sophia Autrey, and if you're referring to the fact that the EHR measures and the eCQM measures are the same, that EHR measures for PQRS, that is correct. They are the same.

Cheri Riley: OK, great.

Sophia Autrey: Thank you.

Cheri Riley: Thank you.

Operator: Your next question comes from the line of Jennifer Aquilar. Jennifer, your line is open.

Jennifer Aquilar: Yes, hi, I had a question regarding page — the slide on page 6. I was curious, how do we know what our beneficiary risk score is? How is that found?

Kim Spalding Bush: Hi, this is Kim Spalding Bush. That information is in the Quality and Resource Use Report that you receive after the conclusion of each performance period.

Jennifer Aquilar: OK.

Kim Spalding Bush: And do we have anyone from Mathematica on the line that could specifically direct them to which section of that report they could find the beneficiary risk scores?

Mai Hubbard: Yes, so this is Mai Hubbard from Mathematica. If you take a look at your performance highlights page from the 2013 QRURs …

Jennifer Aquilar: OK.

Mai Hubbard: … there would be an indication of whether or not you actually met the 75thth percentile or above.

Jennifer Aquilar: Oh, OK. This is our first year participating so I don't believe we received any of those reports yet.

Mai Hubbard: I see. And then if you do want to take a look at a mock report, I believe that's also available on the CMS website …

Jennifer Aquilar: OK.

Mai Hubbard: … through the Value-based Payment Modifier Program site and that would have information as to how you might be able to find the HCT score in future years.

Jennifer Aquilar: OK, I appreciate it. And I also — to clarify what the previous gentleman just asked regarding the list being out on the website of the measures, in terms of — usually you don't have a subset or recommendation, recommended group. We're a podiatric clinic, is there still going to be the MAV process, because this year we just reported on three PQRS measures in order to avoid the payment adjustment? Now it sounds like we're going to have to report on nine, which is very difficult for a specialty such as ours. Is there still going to be evaluation on —we may not be able to find eight or nine to report on?

Sophia Autrey: So if you find that as your specialty you don't have nine measures that you can report on, then you report on the measures that are applicable to your specialty and then that report will go through the measure applicability validation process, so ...

Jennifer Aquilar: Do I need to call the QualityNet Help Desk to get them to help me evaluate that because even now we're reporting on things that most podiatric clinics never would even consider doing on a daily prac — basis for their practice, but we're having to do it to fulfill these requirements …

Sophia Autrey: Right.

Jennifer Aquilar: … and our APMA, our national organization said, "OK, you guys can do these three. It may seem silly to you to be reporting on this, but in order to participate in this program and not receive an adjustment you have to." So now it's being expanded to nine.

Sophia Autrey: So, yes, this is Sophia again. So, yes, I think that you need to definitely call the QualityNet Help Desk because we want to make sure that providers are reporting what is relevant for them, and they can help you look through that for your specialty.
Jennifer Aquilar: OK.

Sophia Autrey: OK.

Jennifer Aquilar: I appreciate it. Thank you.

Sophia Autrey: No problem.

Operator: Your next question comes from Dawn Cooke. Dawn, your line is open.

Dawn Cooke: Hello.

Aryeh Langer: Go ahead.

Dawn Cooke: Can you hear me? Yes, actually I think the question was answered, but I'm trying to report for meaningful use Stage 2, and I'm having problems because a lot of the specialists we refer to do not have the capabilities of direct messaging, and I didn't know if there's an exemption for that or a workaround.

Molly MacHarris: Hi.

Dawn Cooke: Hello.

Molly MacHarris: This is Molly MacHarris. We don't have any subject matter experts here in the room that can address that question, so I'd recommend that you contact the EHR Information Center. This information is available on slide 37.

Dawn Cooke: OK, and the only other question — part to that would be, we are part of the ACO so that means that we do not get the 2 percent discount, we would be considered average, correct? Neutral?

Kim Spalding Bush: If you're talking about the automatic downward adjustment under the Value Modifier …

Dawn Cooke: Yes, ma'am.

Kim Spalding-Bush: … Shared Savings Program, ACO participants are subject to it in the event that the ACO fails to successfully participate in the PQRS Program.

Dawn Cooke: OK, so it's the ACO. We've got to ask if they are up to snuff on what they're doing. OK.

Kim Spalding-Bush: Right, you'd have to work with your ACO.

Dawn Cooke: I thank you very much.

Kim Spalding-Bush: Sure.

Dawn Cooke: Yes, thank you very much.

Operator: Your next question comes from Kevin Craig. Kevin, your line is open.

Kevin Craig: Yes, hi, Kevin Craig from Specialty Care in Massachusetts. Can you tell me what is a cross-cutting measure and where can I find more information on this, including what it is and what the list is? You have a reference to Table 52 in your appendix for cross-cutting measures, but I don't see a Table 52 in the presentation.

Sophia Autrey: Hi, this is Sophia Autrey and the cross-cutting measures are what we define as measures that can be applicable to many specialties and general practitioners. They are not specific to a specific specialty. And we have a list of specialties — I mean, I'm sorry, we have a list of cross-cutting measures in our rule. And there are 19 measures that we consider cross-cutting for PQRS.

Kevin Craig: OK, the table and the rule is so blurred out you can't read it. This is in the Federal Register?

Sophia Autrey: Yes, it is.

Kevin Craig: Is there anything posted on the web?

Molly MacHarris: Sure, this is Molly. So we will be posting the list of the cross-cutting measures on our website as well. It will be on the Measure Section page of the PQRS website.

Kevin Craig: OK, so it's not there yet?

Molly MacHarris: Not yet. We're posting things daily, so check back. It will be up before the end of this month, though.

Kevin Craig: OK, thank you.

Molly MacHarris: Thank you.

Operator: Your next question comes from Joy Hanford.

Joy Hanford: Yes, I was just curious, for ACOs, do they have to report through a web interface their PQRS or can it be through EHR? Can it be through a registry? Can it be through claims?
Rabia Khan: Hi, this is Rabia Khan. So ACOs must report through the GPRO Web Interface. That's the only — besides us collecting and calculating claims and

administrative data and the CAHPS for ACO Survey — that's the only other form of submitting data to CMS for the Shared Savings Program.

Joy Hanford: Can we use a registry to submit those through the interface?

Rabia Khan: If you're talking about having a third party, for instance like a vendor that will go in and submit through the GPRO Web Interface, that is acceptable. But ACOs must satisfactorily report through the GPRO Web Interface to meet the reporting requirements.

Joy Hanford: And that's for next year?

Rabia Khan: That's current and for next year.

Joy Hanford: OK.

Aryeh Langer: Thank you.

Operator: Your next question comes from the line of Tonya Walerko. Tonya, your line is open.

Tonya Walerko: Hi, thank you. I believe my question was already answered.

Operator: Your next question comes from the line of Andy Guevara. Your line is open.

Donna Kinney: This is actually Donna Kinney of Texas Medical Association. Since both cost and quality are going to be adversely affected by patient socioeconomic measures, our physicians who are serving disadvantaged populations will be highly likely to be getting penalties or at least no incentives. Since the NQS has now endorsed risk adjustment on socioeconomic measures, are there plans at CMS to go forward with incorporating, you know, educational attainment and poverty and those — and, you know, those kinds of measures into the risk adjustment scores?

Rabia Khan: Hi, this is Rabia Khan. So yes, NQS recently did change their policies around not risk adjusting for socioeconomic status for quality measures, but they are looking further into that at seeing which measures that would be applicable to. Here at CMS we're working with NQS, and we're partnering with them looking at how we should risk adjust our quality measures for all of our different programs.

So at this time, I can't provide any additional information. We do provide the specification publicly for our quality measures, so please refer to those. And we will continue to update you if we do end up changing any of our specifications due to policy changes around risk adjustments.

Donna Kinney: Thank you.

Rabia Khan: Yes.

Operator: Your next question is from Amanda Dumas. Amanda, your line is open.

Amanda Dumas: Hi, I wanted to know, can a practice report on claim-based reporting for PQRS and a registry if there aren't measures available for claim-based reporting?

Sophia Autrey: So if a measure is listed reportable via claims, it is reportable via registry. So you can report …

Amanda Dumas: OK.

Sophia Autrey: … as a registry for a measure that's reported via claim.

Amanda Dumas: And can we simultaneously bill for a claim, like through claims and registry, or does it have to be one or the other?

Molly MacHarris: This is Molly. So you can't report through two different reporting mechanisms for your data to be analyzed as one. So for example, if you're trying to report on the nine measures covering three domains, you can't report four measures via claims and then five different measures via registry. We don't have the ability to combine two different sets of reporting. So your practice would need to look at the different measures, as Sophia mentioned, and determine whether or not the claims-based reporting mechanism would be more appropriate for your practice or the registry-based reporting mechanism, and then report through that way.

Amanda Dumas: OK, and then she said that the claims can be reported via registry the ones that are, you know, that says that you can report it via claims, but does it go the other way around? If it's saying that registry reporting is the only option, could you do that on the claim?

Sophia Autrey: No, if registry reporting is the only option, then that is the only option. It's not …

Amanda Dumas: OK.

Sophia Autrey: … the other way around.

Amanda Dumas: Thank you.
Operator: Your next question comes from Leah Fisher. Leah, your line is open.

Leah Fisher: Hi, thank you. The question has been answered.

Operator: Your next question comes from the line of Judith Shubow. Judith, your line is open.

Judith Shubow: Yes, is registry only for groups? Do you have to register as a GPRO to do registry?

Lauren Fuentes: Hi, this is Lauren Fuentes. No, registry reporting is available for both individuals and group practices who register as a GPRO.

Judith Shubow: OK, because we were doing claim-based for 2014.

Lauren Fuentes: OK.

Judith Shubow: But there's some concern that some of our providers may need to do registry. We have kind of a convoluted practice structure. Without going through all of that, can you do both?

Lauren Fuentes: Oh.

Judith Shubow: The thing is we have some doctors that are hospitalists, some that are clinics, so we have kind of a convoluted situation.

Lauren Fuentes: So it depends. If you're going — if your providers in your group are going to report as individuals, then, yes, each individual EP can report the way they want.

Judith Shubow: Right, which is what we've done for claims, and so I never signed — set up for GPRO, and now it's too late to do that. Correct?

Lauren Fuentes: For 2014, yes.

Judith Shubow: Right.

Lauren Fuentes: So, but if you're going to report as a group practice, then the whole group, the TIN, the Tax ID Number, has to report, you know, one way — the same way. As Molly indicated earlier, we would not …

Judith Shubow: Um-hum.

Lauren Fuentes: … combine data from different reporting methods for a group …
Judith Shubow: OK, so …

Lauren Fuentes: … or for individuals for that matter, so …

Judith Shubow: So if I signed up for a GPRO, set up as a GPRO and did registry, would that have to be for every provider in the group, or could I still do some as claim based?

Lauren Fuentes: No, it would need to be for the whole group. I mean that's — that's how we're going to — that's how we'll assess you. So if you're signed — if you signed up as a group practice, those providers under that group practice, we're not going to look at them individually, we're going to look at them as part of a group.

Judith Shubow: OK, so it's too late to do registry and I can't have some doctors do it one way and some do it the other.

Lauren Fuentes: No, it's too late — it's too late for group practice reporting for 2014. So if you're …

Judith Shubow: Right.

Lauren Fuentes: So now you're talking about 2014 individual reporting, correct?

Judith Shubow: If I wanted to still do individual reporting through a registry for some of the docs for 2014, is that still possible?

Lauren Fuentes: Yes, you can do that.

Judith Shubow: Individuals through a registry is still possible?

Lauren Fuentes: Yes. Right, yes, that data would just need to be submitted by March 31st, 2015.

Judith Shubow: Submitted by what date March what, 31st?

Lauren Fuentes: 31st, yes.

Judith Shubow: And that's for the registry.

Lauren Fuentes: Yes.

Judith Shubow: OK, and there's no signing up on IACS for that?

Lauren Fuentes: No, you just need to pick a …

Judith Shubow: OK, and what is the deadline? Pardon me.

Lauren Fuentes: I said you just need to pick a registry and then work with that registry.

Judith Shubow: OK, and one more question. The submitting of PQRS claims-based for 2014, what is the deadline to get those in to you?

Lauren Fuentes: So all of your claims need to have reached the warehouse processing center …

Judith Shubow: Um-hum.

Lauren Fuentes: … by February 28th.

Judith Shubow: By 2/28/15.

Lauren Fuentes: So…

Judith Shubow: In registry, we have. I'm sorry.

Lauren Fuentes: So I mean, you'll just want to make sure, you know, your claims are submitted definitely before. I would say, you know, by early February to be safe.

Judith Shubow: Sure, right, right, because 2/28, you're not going to get there. So registry, you have till March 31st, and claims, you have until 2/28 …

Lauren Fuentes: Yes.

Judith Shubow: … given that it needs time.

Lauren Fuentes: Yes.

Judith Shubow: OK.

Aryeh Langer: All right. Thank you so much for your call.

Operator: Your next question is from Pam Underwood. Pam, your line is open.

Pam Underwood: Hi, this is Pam Underwood from Tennessee Oncology, and I just want a clarification on the claim-based reporting. And I could be incorrect, but I was under the impression that CMS was not going to allow any claim-based reporting for PQRS in 2015.

Molly MacHarris: This is Molly. So for PQRS, we do still have the claims-based reporting option. We have indicated in previous years' rulemaking that we are looking to move away from the claims-based reporting mechanism and more towards electronic-based ways of getting the quality measures data in, such as registries, Electronic Health

Records, or Qualified Clinical Data Registries. So that's something that you will want to pay attention to for the future, but we do still have the claims-based option in 2015.

Pam Underwood: Thank you.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Eileen Carlson. Eileen, your line is open.

Aryeh Langer: Eileen, are you there?

Operator: Eileen? Eileen, your line is open.

Eileen Carlson: Yes, sorry we couldn't get it off mute. We have a question about what the adjustment factor was for this year. We recognize that you can't know what it's going to be in the following years, but for 2015 some people are getting it. Just so we have an idea of what the impact of that is, can you tell us what the automatic adjustment factor was for 2015?

Kim Spalding Bush: Hi, this is Kim Spalding Bush. We are still working with our actuaries to calculate the adjustment factor. So we will publicly post that so it will be available for everyone to see as soon as we have it calculated.

Eileen Carlson: Do you have an estimated time?

Kim Spalding Bush: It will be in the near future. I'm sorry, I can't give you any more information than that.

Eileen Carlson: OK, thank you.

Kim Spalding Bush: Sure.

Operator: Your next question comes from the line of Lisa Sagwitz. Lisa, your line is open.

Lisa Sagwitz: Hi, I was just wondering if you have any insight on when the 2015 measure applicability verification process will be put out on the CMS website?

Sophia Autrey: We are estimating that the revised MAV process will be available at the beginning of 2015, so maybe in — January 15th, but that is an estimation.
Lisa Sagwitz: Thank you.

Sophia Autrey: You're welcome.

Operator: Your next question is from Tessa Logan. Tessa, your line is open.

Tessa Logan: Yes, we are reporting — we have over a hundred providers, and we are reporting via EHR and plan to do so in 2015, so we'll be required to report the CG-CAHPS?

Lauren Fuentes: Hi, yes, this is Lauren Fuentes. So, yes, if you are a group with a hundred and more providers and you report as a group practice, you will be required to have the CAHPS for PQRS Survey completed by '15.

Tessa Logan: Can you tell us the timeframe that we need to survey those patients, because if you're not going to publish a list of certified vendors until the summer, what dates of service will we be surveying patients for?

Lauren Fuentes: Right, so we — CMS will be conducting — will be polling a sample assignment of those beneficiaries for you that will be provided to the vendors. So that will be based on 2015 services that you provide, and then the survey will be until early — so probably early 2015. And then late 2015 those surveys will — we project that that's when those surveys will go out to your patients.

Tessa Logan: So we're going to be surveying patients in the fall based on a visit they had 6 months earlier?

Lauren Fuentes: Right.

Tessa Logan: And is that only Medicare patients that will be included …

Lauren Fuentes: Yes.

Tessa Logan: … or all patients?

Lauren Fuentes: Medicare.

Tessa Logan: Very good. Thank you.

Lauren Fuentes: Sure.

Operator: Your next question is for — is from Heidi Harting.

Heidi Harting: Yes, hi, Heidi Harting, Summit Medical. I want to go back to something somebody had said before regarding CPCI participation in 2015 and the impact on VBM in 2017. My understanding from slide 20 is that we're in the mix with everybody else independent of any of our providers participating in the CPCI initiative. But then Patrice, I think your name is, mentioned that there would be an average that was applied to us.

Maria Alexander: Hi, this is Maria Alexander from the Value Modifier Program. So the distinction we're making on slide 20 is that in previous years, so for the 2015 Value Modifier and the 2016 Value Modifier, we stated that those groups and these programs were exempt and we have — we've changed that policy. They are no longer exempt under the 2017 Value Modifier.

The new policies differ for the Shared Savings Program versus the other programs listed there. So for the Comprehensive Primary Care Initiative, if you have at least one eligible professional under the TIN that's participating in that initiative, then you would receive a Value Modifier of average-average, so it will be a neutral Value Modifier in 2017.

Heidi Harting: I'm sorry, I just — I just heard conflicting information, but that could be me. So if I have a person — a provider participating in the CPCI initiative in 2015, what will be the impact on the TIN for VBM in 2017?

Maria Alexander: You will receive a neutral Value Modifier, so there's no impact to the TIN. So I think your confusion is warranted in that it — the effect is the same under our 2017 policy and our 2015 and 2016 policy. The kind of the way that we get there is different in 2017, but the effect is that it's a 0 percent change.

Heidi Harting: OK, so we also have no possibility then of — we're a group of a hundred plus — so we also have no possibility of getting the 4 percent in that case as well, is that correct?

Maria Alexander: Right, you are not eligible for any upward adjustments or downward adjustments …

Heidi Harting: Or downward.

Maria Alexander: … in terms of the Value Modifier.

Heidi Harting: OK, thank you.

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

Operator: And the final question comes from the line of Jessica Stanley. Jessica, your line is open.

Jessica Stanley: Hi there. This will be the first year we are participating in Medicare Shared Savings. Can you explain the CAHPS process for ACOs? Will that be the same as PQRS, that we will use a certified vendor or will CMS survey for us as an ACO?

Rabia Khan: So for the — are you asking — sorry, this is Rabia Khan — for the 2014 reporting period?

Jessica Stanley: ’15.

Rabia Khan: 2015.

Jessica Stanley: 2015, um-hum.

Rabia Khan: We will continue with — we will be providing a list of vendors, and ACOs will be contracting with the vendors to survey the beneficiaries for the CAHPS Survey.

Jessica Stanley: OK, the same as for PQRS.

Rabia Khan: Yes.

Jessica Stanley: OK.

Rabia Khan: Well.

Jessica Stanley: Thank you.

Additional Information

Aryeh Langer: Thank you, and unfortunately that’s all the time we have for questions today. I want to remind everybody that if they didn’t get a chance to ask a question, if they need more help — if they can refer to slide 37. That has some information about different help desks that are available. And then also, again, I want to remind everybody about slide 39, about the continue — continuing education credits that are possibly available.

Again, on slide 38, we hope that you evaluate your experience today with the call. The calls are — the evaluations are anonymous, confidential, and voluntary and we hope you take a few minutes to take that evaluation and help us share your call experience today.

Again, my name is Aryeh Langer. I’d like to thank our subject matter experts here at CMS as well as all the participants who joined us on the line for today’s MLN Connects Call. Have a great day everybody.

Operator: This concludes today’s call.

This document has been edited for spelling and punctuation errors.

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