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National Provider Call Transcript

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Centers for Medicare & Medicaid Services
2014 Mid-Year QRURs
MLN Connects National Provider Call
Moderator: Amanda Barnes
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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 Amanda Barnes. Thank you, you may begin.

Announcements and Introduction

Amanda Barnes: Thank you Holley. I'm Amanda Barnes from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on 2014 Mid-Year QRURs.

MLN Connects Calls are part of the Medicare Learning Network.® During this call CMS subject matter experts will give — will provide an overview of the 2014 My QRUR — My QRUR and explain how to interpret and use the information in the report.

Before we begin, I have a few announcements. You should have received a link to the — to today's slide presentation email. If you have not already done so, you may view or download the presentation from the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page select National Provider Calls and Events, then select the date of today's call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. Registrants will receive an email when these materials are available.

Registrants were given the opportunity to submit questions. We thank you — everyone who submitted questions today.

And lastly, this MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit. For additional information, please refer to slide number 48 of today's presentation for a link to the CE Activity Information and Instructions document. At this time — at this time, I would like to turn the call over to Sabrina.

Presentation

Sabrina Ahmed: Thank you Amanda. Good afternoon everyone, my name is Sabrina Ahmed. So I'm starting on slide 3, which lists learning objectives for today's call.

So as Amanda said earlier, the main objectives for today's call are to provide an overview of the 2014 Mid-Year QRUR. I'll also be providing an overview of the 2016 Value Modifier policies. I will review how you can access the Mid-Year QRUR and also discuss the information contained in the Mid-Year QRUR and the supplementary

exhibits. And then we'll have a question-and-answer session at the end of the presentation.

Overview of the 2016 Value Modifier

So now I'm on slide 5. Slide 5 provides an overview of the Value Modifier program. The law requires us to publish a Value Modifier that assesses both the quality of care and the cost of that care furnished during a performance period. The 2016 Value Modifier will be based on performance in 2014.

The Value Modifier is a per claim adjustment made under the Physician Fee Schedule and is applied at the Taxpayer Identification Number, or the TIN, level. Under the Value Modifier, TINs that are classified as high quality and/or low cost can qualify for upward adjustments. Also, TINs that are classified as low quality and/or high cost and TINs that failed to satisfactorily report under the PQRS are subject to downward adjustments.

In 2016 Medicare will apply the Value Modifier to physician payments under the Medicare Physician Fee Schedule for physicians in groups with 10 or more eligible professionals. Eligible professionals, as shown in slide 6, consist of physicians, practitioners, physical or occupational therapists, qualified speech-language pathologists, and qualified audiologists.

Now on slide 7. This slide provides — it shows the interaction between the 2016 Value Modifier and the 2014 PQRS and provides a general framework of how the Value Modifier will be applied in 2016.

So as I mentioned earlier, calendar year 2014 was the performance period for the Value Modifier that will be applied in 2016 to physicians in groups with 10 or more eligible professionals. In order to avoid an automatic negative 2 percent Value Modifier payment adjustment in 2016 that is shown in the right side of this slide, eligible professionals in group of 10 or more EPs must have participated in and satisfied the PQRS requirements as a group or as individuals in 2014.

As shown in the left-hand side of the slide, groups with 10 or more eligible professionals have the option to avoid the automatic 2 percent Value Modifier payment adjustment in 2016 by participating in the PQRS as a group practice via the Group Practice Reporting Option, also called GPRO, in 2014 and meeting the criteria to avoid the 2016 PQRS payment adjustment. These groups also had the option to avoid the automatic 2 percent Value Modifier payment adjustment in 2016 if the EPs in each group participated in the PRQS as individuals in 2014 and at least 50 percent of the EPs in each group met the criteria to avoid the 2016 PQRS payment adjustment.

Groups that satisfied one of the two options are considered to be the PQRS reporters. And they will avoid the automatic 2 percent Value Modifier downward adjustment in 2016 that's shown in the right-hand side of the table.

In 2016, groups with 10 or more eligible professionals that are considered to be the PQRS reporters will be subject to quality tiering. Quality tiering is the methodology we use to calculate the Value Modifier. So in 2016, groups of physicians with hundred or more eligible professionals will be subject to upward, neutral, or downward Value Modifier adjustment based on quality tiering. And groups of physicians with 10 to 99 eligible professionals will be held harmless from any downward Value Modifier adjustment under quality tiering. And we will only apply any upward or no Value Modifier adjustment to these groups in 2016.

Please note that Medicare will not apply any 2016 Value Modifier to a group of physicians if one or more physicians in the group participated in the Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care Initiative in 2014.

Overview of the 2014 Mid-Year QRUR

I'm now on slide 9. So in late April, CMS made available the 2014 Mid-Year QRURs for physician solo practitioners and groups of physicians may, as identified by their Medicare billings, Taxpayer Identification Number. The performance period used for the Mid-Year QRUR is July 1st, 2013, through June 30th, 2014.

The 2014 Mid-Year QRUR provides a preview of a TIN's performance on the three quality outcome measures and the six cost measures that CMS calculates using Medicare claims data, and are a subset of the measures that will be used to calculate the 2016 Value Modifier.

The Mid-Year QRUR does not contain the following information: Information about a group's 2016 Value Modifier payment adjustment, quality composite, and cost composites scores for the 2016 Value Modifier, nor does it contain information on the PQRS GPRO and individual PQRS measures, including CAHPS measures that were reported by the group. Please note that the Mid-Year QRUR is provided for informational purposes only and does not affect a group's Medicare payments.

I'm now on slide 10. The 2014 Annual QRUR, which will be based on a performance period from January 1, 2014, to December 31st, 2014, will be available in the fall of 2015 and will show the TIN's actual performance on all of the quality measures and cost measures that will be used to calculate the 2016 Value Modifier. Please note that all of the quality outcome and cost measures that are included in the Mid-Year QRURs will be recalculated in the 2014 Annual QRUR using claims data from calendar year 2014.

Accessing the 2014 Mid-Year QRUR

I'm now on slide 11. So CMS made available, the Mid-Year QRURs to physician group practices and physician solo practitioners nationwide that met two criteria:

1. They had at least one physician who billed for Medicare-covered services under the TIN between July 1st, 2013, and June 30th, 2014, and

2. They had at least one quality or cost measure with at least one eligible case for a given measure.

Please note that the 2014 Annual QRURs, which will be released later this fall, will also be available for all groups and solo practitioners that consist only of non-physician eligible professionals.

In slides 13 and 14, I will review how you can access your TIN's Mid-Year QRUR.

I'm now on slide 13. You can access a QRUR on the CMS Enterprise Portal website that's listed on this slide using an IACS account. One person from a group or solo practice will first need to obtain this account with the correct role to access a group's QRUR, meaning a TIN with two or more eligible professionals. One person from the group will first need to sign up for an IACS account with a group security official role. And then to access the solo practitioner's QRUR, that is a TIN with only one eligible professional, one person will need to sign up for an IACS account with the individual approver role.

If you want to know whether there's already someone who can access the group or solo practitioner's QRUR, then you can contact the QualityNet Help Desk and provide the TIN and name of the group or the solo practitioner. And QualityNet help contact information is listed at the end of this presentation on slide 44. We have detailed instructions on how to obtain a QRUR using the appropriate IACS role on our How to Obtain a QRUR website. The link to this website is listed on the last bullet on this slide.

And now on slide 14. Once you have the appropriate IACS account, then you can access the QRUR by following the steps shown in slide 14. We also have a quick reference guide for accessing the Mid-Year QRURs, the How to Obtain a QRUR website that I mentioned on the previous slide.

I also wanted to note that in the middle of July, we will be ending the use of IACS accounts and transitioning to using EIDM accounts for accessing QRURs. Please check the How to Obtain a QRUR website at that time for the latest instructions on how to obtain your QRUR if you are planning on waiting until July to access your QRUR.

The remaining slides in this presentation will cover the information contained in the Mid-Year QRUR.

Information in the 2014 Mid-Year QRUR

Slide 16 summarizes the information contained in each of the exhibits that are part of the QRUR. And then slide 17 summarizes the information contained in the five

supplementary exhibits that are available as part of the Mid-Year QRUR. These supplementary exhibits can be downloaded as Excel files.

I'll go over each of the exhibits and supplementary exhibits in the next section of this presentation. At this time, I'm going to pause and turn the call back over to Amanda.

Keypad Polling

Amanda Barnes: Thank you Sabrina. At this time, we will pause for a few minutes to complete keypad polling. Holley, we're ready to start polling.

Operator: CMS that — 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.

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 continue to hold while we complete the polling.

Thank you, I'd now like to turn the call back over to Amanda Barnes.

Amanda: Thank you Holley. Sabrina, we're ready to resume.

Presentation Continued

Sabrina Ahmed: OK, thanks Amanda. So slide 19 shows Exhibit 1 of the Mid-Year QRURs. Exhibit 1 displays the count of the physicians and non-physician eligible professionals that billed under the TIN from July 1, 2013, through June 30th, 2014. Eligible professionals include physicians, practitioners, and therapists that are listed on slide 6 of this presentation.

Attributing Medicare Beneficiaries to Your TIN

Now on slide 20. Exhibits 2 and 3 provide information on the beneficiaries attributed to the TIN for the five per-capita cost measures and the three quality outcome measures. Before we look at Exhibits 2 and 3, I want to provide an overview of the two-step attribution methodology we use to attribute beneficiaries to the TIN for the five per-capita cost measures, quality outcome measures. This information is provided on slide 20.

So under Step 1 of the attribution methodology, a beneficiary was assigned to the TIN if the beneficiary receives the plurality of primary care services, as measured by allowable charges, from the primary care physicians within the TIN. The second step, is applied to beneficiaries who did not receive a primary care service from any primary care physician between July 1, 2013, and June 30th, 2014. So under Step 2, a beneficiary was assigned to a TIN if the beneficiary received at least one primary care service from a physician of any specialty within the TIN and also received the plurality of the primary care services from specialist physicians, nurse practitioners, clinical nurse specialists, and physician assistants within the TIN.

Please note that beginning with the 2017 Value Modifier, we're revising Step 1 so that we will assign a beneficiary to a TIN in Step 1 if the beneficiary uses a plurality of primary care services as measured by allowed charges from physicians — from primary care physicians and also nurse practitioners, physician assistants, and clinical nurse specialist within the TIN.

I'm now on slide 21. So Exhibit 2 shows the number of Medicare Fee-for-Service beneficiaries who are attributed to the TIN for the claims-based cost and quality outcome measures that are included in the Mid-Year QRURs, and it shows whether the beneficiaries were attributed in Step 1 or Step 2 of the attribution methodology, which I described in the previous slide.

Exhibit 3 provides information on the average number of primary care services provided to beneficiaries attributed to the TIN. It includes the average counts of primary care services provided by the eligible professionals in your TIN and by eligible professionals outside of your TIN. If you observed that a large percentage of primary care services provided to your attributed beneficiaries is provided by eligible professionals outside your TIN, then you may wish to coordinate with these eligible professionals to ensure that your TIN's attributed beneficiaries are receiving efficient and effective care.

I'm now on slide 22. Exhibit 4 provides information on the hospitalization episodes attributed to your TIN for the MSPB measure, as well as the number of unique beneficiaries associated with these attributed episodes. The methodology we use to attribute beneficiaries to TINs for the MSPB measure is different from the two-step attribution methodology described in slide 20, which is used for the five per-capita cost and three outcome measures.

A hospitalization episode is attributed to a TIN if, during the hospitalization, the TIN provides more Part B-covered services as measured by Medicare-allowed charges than any other TIN. A lower number of unique beneficiaries associated with attributed episodes relative to the total number of MSPB episodes of hospital care attributed to your TIN would indicate that some beneficiaries experience multiple MSPB hospitalization episodes during the performance period and that these

beneficiaries may benefit from enhanced care management support provided by the TIN.

Quality Performance in the Mid-Year QRUR

I'm now on slide 24. Exhibit 5 provides a preview of the TIN's performance on the three CMS-calculated claims-based outcome measures using Medicare claims data from July 1st, 2013, through June 30th, 2014. These outcome measures, in addition to the PQRS quality measures reported by the TIN, are used to calculate the quality composite score for the Value Modifier. Please note that these measures will be recalculated in the 2014 Annual QRUR using data from calendar year 2014, which is the performance period for the 2016 Value Modifier.

Exhibit 5 presents the TIN's performance category, the number of eligible cases, and the benchmark for the three outcome measures, which are the 30-day all hospital readmission measure, the acute ACSC composite, and the chronic ACSC composite.

For the outcome measures, the benchmarks shown in this exhibit are the same benchmarks that will be used in the 2014 Annual QRUR. For the 2016 Value Modifier, the benchmarks were the quality measures in 2014, or the case-weighted peer group mean, based on 2013 data.

You can review each measure within Exhibit 5 to identify those for which your TIN's performance rates compare least favorably compared to your TIN's peers. The peer group for the quality measures is all TINs nationwide with at least 20 eligible cases for each measure.

Since lower performance rates indicate better performance for the three outcome measures, you can identify the measures for which your TIN's performance rate exceeds the benchmark and then use this information to develop a targeted quality improvement strategy.

I'm now on slide 26. Exhibit 6 identifies the hospitals that had at least 5 percent of your TIN's attributed beneficiaries' inpatient stays from July 1, 2013, through June 30th, 2014. This information is based on Medicare Part A claims. This exhibit provides the hospital name, the CMS Certification Number, and the location of the hospital. This information shows the TIN which hospitals most frequently admitted their attributed beneficiaries and can help the TIN target care coordination efforts more appropriately.

Cost Performance in the Mid-Year QRUR

Slides 28 and 29 provide information on the six cost measures that are included in the Mid-Year QRURs and will be used to calculate the cost composite scores for the 2016 Value Modifier. The five per capita cost measures are based on payments for all

Medicare Part A and Part B claims submitted by all providers who treated the beneficiaries attributed to the TIN, including providers that did not bill under the TIN. And then the MSPB measure, which is a new cost measure that will be included in the calculation of the cost composite beginning with the 2016 Value Modifier, is based on all Part A and B expenditures for services surrounding inpatient hospital stays from 3 days before admission to 30 days after a discharge.

Part D prescription drug costs are not included in any of the cost measures. All six cost measures have been — came in standardized risk and adjusted for the TIN's mix of medical specialties.

On slide 29, Exhibit 7 provides a preview of the TIN's performance using claims data from July 1, 2013, to June 30th, 2014, on the six cost measures that will be used to calculate the cost composite of the Value Modifier in 2016. Please note that these measures will be recalculated in the 2014 Annual QRUR using data from calendar year 2014, which is the performance period for the 2016 Value Modifier.

Exhibit 7 shows, for each cost measure, the payment standardized risk-adjusted and specialty-adjusted per capita — or per episode cost, the number of eligible cases, or episodes, and the benchmark for each of these measures. Unlike the outcome measures, the benchmark for cost measures is the case-weighted peer group mean for the performance period, which is calendar year 2014 for the 2016 Value Modifier.

So this means that the cost benchmark that will be included in the 2014 Annual QRUR will be different from the one shown in the Mid-Year QRUR. The cost benchmarks shown in the Mid-Year QRUR are based on data from July 1, 2013, to June 30th, 2014.

So you can compare your TIN's cost for each measure, within — with the benchmark to better understand your — how your TIN fared relative to your TIN's peers. The peer group in this case includes all TINs that had at least 20 eligible cases for the measures.

Exhibit 8 on slide 30 is a graphical representation of the difference between the per capita costs of specific types of services for beneficiaries attributed to your TIN and the corresponding cost for your TIN's peer group. Your TIN's peer group is defined for each cost category as all TINs that had at least 20 eligible cases for the given cost category. So the bars extending to the left of the vertical axis denote cost categories for which TIN's per capita costs are lower than those of the peer group. And then the bars extending to the right of the vertical axis denote cost categories for which the TIN's per capita costs are higher than the peer group's costs.

You can use this exhibit to identify potential areas for cost reduction, for example, the per capita cost. If the per capita cost for inpatient care or emergency services are higher for your TIN compared to your TIN's peers, then you can – then you may want to engage

in additional care coordination or chronic illness management efforts to improve your TIN's cost performance.

Additional Information in the Mid-Year QRUR

I mentioned earlier in this presentation that the MID-Year QRUR contains five supplementary exhibits that can be downloaded as Excel spreadsheets. In slides 32 through 42, I will review the information contained in each of these supplementary exhibits.

Slide 32 shows Supplementary Exhibit 1. Supplementary Exhibit 1 provides information about the eligible professionals who billed under the TIN between July 1, 2013, and June 30th, 2014. For each eligible professional, the table lists the National Provider Identifier, number, and name, whether the eligible professional is a physician or non-physician eligible professional, specialty designation, whether the provider was identified as part of the TIN through PECOS and/or Medicare billing over the performance period, and the date of the last claim billed under the TIN.

If you see that one of your eligible professional's specialties listed incorrectly, then you should update their record in PECOS. You should also alert any eligible professionals who are still associated with your TIN in PECOS but who no longer belong to your TIN to update their PECOS record.

Slides 33 to 35 show information contained in Supplementary Exhibit 2A. Supplementary Exhibit 2A provides information about the Medicare beneficiaries attributed to your TIN. This table is divided into sections that describe beneficiary characteristics, specific Medicare claims data, the eligible professionals inside and outside of your TIN that billed the most services for the beneficiary, the date of the last hospital admission, and whether the beneficiary had one or more of the four chronic conditions requiring more integrative care.

These data can be downloaded in Excel so that you can analyze the data and focus on specific groups of beneficiaries, such as those in the four chronic conditions approved whose care delivery process you may want to examine more closely to determine whether there is potential to improve their quality of care.

Slides 36 and 37 show the information contained in Supplementary Exhibit 2B. Supplementary Exhibit 2B provides information about the cost of the care provided to the Medicare beneficiaries attributed. It provides both the beneficiaries' total CMS-standardized Fee-for-Service Medicare cost and the distribution of these costs across categories of service.

You can use this information, as well as the information in Supplementary Exhibit 3 about the hospitals admitting your TIN's attributed beneficiaries to learn general information about the types of services used by specific beneficiaries. By reviewing

your TIN's own records and the records of hospitalizations, you can determine, for specific beneficiaries, the services provided by eligible professionals who billed under your TIN and the services billed by eligible professionals outside of your TIN.

Slides 38 and 39 show the information that's contained in Supplementary Exhibit 3. Supplementary Exhibit 3 provides details about each attributed beneficiary's hospitalizations over the performance period. Data are broken down by beneficiary and the admitting hospital, along with the principal diagnosis associated with the admission.

As you can see on slide 39, Supplementary Exhibit 3 also shows whether the hospital admission was the result of an emergency department evaluation, an ambulatory care sensitive condition, or readmission within 30 days of prior admission. This exhibit also indicates the date of discharge and the subsequent care environment.

Slides 40 and 41 show the information contained in Supplementary Exhibit 4. Supplementary Exhibit 4 displays information on the beneficiaries attributed to your TIN for the MSPB measure. Data are presented at the beneficiary-episode level. So if a beneficiary has more than one episode that was eligible measure, then the beneficiary will appear in the exhibit for each episode.

This table is organized into four sections: Beneficiary characteristics, the apparent lead eligible professional, features of the hospital — features of the episode hospitalization, and the episode cost by category of service. For each episode, the total payment-standardized episode cost is also displayed.

Similar to Exhibit 2B, Supplementary Exhibit 5 on slide 42 displays your TIN's attributed beneficiaries' costs for various services performed by eligible professionals both within and outside of your TIN. This exhibit shows the percentage of your TIN's attributed beneficiaries using a service in a given category, your TIN's payment-standardized risk-adjusted per capita cost, and the difference between your TIN's beneficiary per capita cost and the per capita cost of your TIN's peers as defined — which is defined as all TINs with at least 20 eligible cases for that category. You can review this exhibit to identify those services and procedures that are contributing most to the cost per beneficiary.

Next Steps

I'm now on slide 43. So now that you've become familiar with the information contained in the 2014 Mid-Year QRUR, what do you need to do next? And that is what it covers.

So as you note, calendar year 2015 is the performance period for the Value Modifier that will be applied in 2017. The 2017 Value Modifier will apply to physicians in all groups and to physician solo practitioners. Groups with two or more eligible professionals have to decide whether they want to participate in the PQRS as a group or as individuals in 2015. A group that wants to participate in the PQRS as a group in 2015

must register to participate in one of the GPRO reporting mechanisms by June 30th, 2015.

Please refer to the registration website listed under the first bullet on this slide for additional information about how to register to participate in the PQRS GPRO in 2015. Registration is not necessary for solo practitioners and eligible professionals in groups to participate in the PQRS as individuals in 2015.

Groups and solo practitioners also need to choose a PQRS reporting mechanism and become familiar with the measures and data submission timelines applicable to their chosen reporting mechanism. And groups also can review the quality measure benchmark under the Value Modifier.

So in addition to downloading your 2014 Mid-Year QRUR, you should also download your 2013 QRUR. If you haven't done so already, the 2013 QRUR is based on data from calendar year 2013, and it shows a TIN's performance on the quality and cost measures used to calculate the 2015 Value Modifier. And then in the fall, you should download the 2014 Annual QRUR, which will be based on data from January 1, 2014, to December 31st, 2014. This report will show the TIN's actual performance on all of the quality and cost measures that will be used to calculate the 2016 Value Modifier.

Resources

Slide 44 lists all of the technical assistance resources available for you. You can contact the Physician Value Help Desk if you have any questions about the Value Modifier or your QRUR. You can contact the QualityNet Help Desk with questions about the PQRS program or obtaining an IACS account that you'll need to access your QRUR. And the contact information for both of these help desks are listed on slide 44. The 2014 QRUR website that's listed on this slide is an excellent source of information for obtaining detailed information about the Mid-Year QRUR. The website contains a Frequently Asked Questions-and-Answers document about the 2014 Mid-Year QRUR and the 2015 Value Modifier.

There's another document on that website that provide tips on how groups and solo practitioners can use the Mid-Year QRURs and the supplementary exhibits to understand their performance and how they can identify opportunities for improvement. The website also contains a sample report that you can download to see what the Mid-Year QRUR looks like, including what the supplementary exhibits look like.

For more information about the Value Modifier and the PQRS program, you can also refer to the websites that are listed at the bottom of this slide.

So this concludes our presentation today. I would now like to turn it back over to Amanda.

Question-and-Answer Session

Amanda Barnes: Thank you Sabrina. Our subject matter experts will now take your questions about the 2014 Mid-Year QRURs. Before we begin, I would like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. In an effort to get to as many participants as possible, we ask that you limit your questions to just one.

All right, Holley, we're ready to take our first question.

Operator: To ask a question, please press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity.

Please know your line will remain open during the time you are asking a question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question comes from Patty Rose.

Patty Rose: Yes hi, this is Patty Rose. I'm with Purdue Healthcare Advisors, and I was just curious. You had mentioned earlier that in mid-July, IACS is going to be changing over — will be retiring so to speak and changing over to EIDM, and that the process and how to access your QRUR will be changing as well. Is that correct?

Sabrina Ahmed: I'm sorry. Could you say the last part of that again?

Patty Rose: That the process and how to access your QRUR will be changing after the new EIDM guidelines become effective mid-July?

Sabrina Ahmed: That's correct. So in mid-July, around mid-July, we'll be transitioning from using IACS accounts to EIDM accounts. And so at that time you will need to obtain a EIDM account and log in to the portal — CMS Enterprise Portal website with an EIDM account to access your QRUR. And once we finalize that transition, we will be providing additional information about how you can obtain the appropriate EIDM account on our – How to Obtain a QRUR website, and the link to that website is listed on slide 13 — bottom of slide 13.

Patty Rose: OK, so if we have an IACS account now, it would be highly recommended to get your QRURs at least for mid-year now because all that's going to change, and after mid-July, you're going to have to get a new account in order to access your Annual QRUR, which comes out in fall 2015?

Sabrina Ahmed: So, OK, once the transition happens from IACS to EIDM in mid-July, you can — you'll still be able to obtain your Mid-Year QRUR, but you will just no longer be able to use your current IACS account. You would need to get an EIDM account. But your access to QRURs will not end after that transition occurs, like you'll still be able to access it, but using a different – using the EIDM account. And then once the Annual QRURs are released in the fall, then you'll be able to continue using your EIDM account to access your Annual QRUR.

Patty Rose: OK, so it is — there is kind of a big change there. You'll have to get a new user account from EIDM in order to access your fall QRURs.

Sabrina Ahmed: That's correct.

Amanda Barnes: Thank you.

Patty Rose: OK, thank you.

Sabrina Ahmed: Thanks.

Operator: Your next question will come from Paulo Andre.

Paulo Andre: Hi, this is Paulo Andre from Metro West. I have a question. We are a group of doctors that belong to a Medicare Shared Savings, and so we have multiple — our group has one tax ID, but the Shared Savings ACO has several tax IDs. The quality I know you get from the GPRO report from the ACO. When you calculate our cost measures, are you using our tax ID for each grouping size ACO or are you going to use the ACO data?

Sabrina Ahmed: So for group and solo practitioners that participate in the Shared Savings Program, the Value Modifier will begin applying to them from 2017 and the cost composite for Shared Savings participants will be classified as average cost. So we will not be calculating cost measures for you. And then your quality composite score for the Value Modifier will be based on the ACO's report — the PQRS GPRO measures that the ACO will report in addition to the ACO-level hospital readmission measure that CMS calculates for you.

Paulo Andre: OK.

Sabrina Ahmed: So that information is not contained in the Mid-Year QRURs. So the Mid-Year QRURs contain the outcome measures data calculated for the TIN using the claims data. But for ACOs, when the VM applies beginning in 2017, we'll be using a different methodology to calculate their quality composite, as I just described.

Paulo Andre: OK, OK. Thank you very much.

Amanda Barnes: Thank you.

Sabrina Ahmed: Thanks.

Operator: Your next question will come from Melissa Unger.

Melissa Unger: Hi, this is Melissa Unger with the Ohio State University Wexner Medical Center and OSU Physicians, Inc. And my question was in regards to, we have a specialty group of anesthesiologists, and they have over 100 eligible professionals in their group under their billing TIN. And my question was, last year they had not — insufficient data in order to participate in the CAHPS survey. And it's my understanding they'll be required this year because they have over 100 eligible professionals. So if they have insufficient data again because they do not provide primary care services, will that have any impact on their Value Modifier score or their reporting — PQRS reporting?

Sabrina Ahmed: So — OK, so for the 2016 Value Modifier, so when you — so if CAHPS is not required for the Value Modifier, for the 2016 Value Modifier, unless you indicated in the registration system last year that you wanted to use the CAHPS results in the calculation of the 2016 Value Modifier. Within that, we don't have anyone here from the CAHPS team who can address your question. So I would suggest that you contact the QualityNet Help Desk.

Melissa Unger: OK, thank you.

Sabrina Ahmed: And their contact information is listed on slide 44.

Melissa Unger: Thank you.

Amanda Barnes: Thank you.

Operator: Your next question will come from Max Baldinger.

Max Baldinger: Yes, thank you. I'm Max Baldinger from Beacon Health Partners. My question is for the physicians that we have, who are part of MSSP — we're an Accountable Care Organization. So for the ones that are participating in MSSP, they're not prone to be subject to the decrease for the modifier, is that correct? Or they're exempt from that for now but they'll be — the Value Modifier for them is going to start applying in 2017? That's what I got from a previous question.

Sabrina Ahmed: Yes, that's correct. The Value Modifier in 2016 will not apply to groups that participate — that participated in the Shared Savings Program in 2014.

Max Baldinger: OK.

Sabrina Ahmed: However, beginning with the 2017 Value Modifier, groups that participated — groups and solo practitioners that participated in the Shared Savings Program during 2015 …

Max Baldinger: Um-hum.

Sabrina Ahmed: … the Value Modifier will apply to them.

Max Baldinger: OK, and the performance year for the 2017 Value Modifier is 2015, the calendar year?

Sabrina Ahmed: It's 2015, yes.

Max Baldinger: OK, and then just my next question was, as the Accountable Care Organization, are we going to be able to access our physician QRURs or the individual practices will have to access them so that we can review them for them?

Sabrina Ahmed: No, only the participants as identified by their TIN will be able to access the QRURs.

Max Baldinger: OK, thank you.

Amanda Barnes: Thank you.

Operator: Your next question will come from Peggy Bennett.

Peggy Bennett: Hi, this is Peggy Bennett with California Vein and Laser Center. My physician does not provide any primary care, yet he has patients attributed to him for certain diagnoses, and I don't understand.

Amanda Barnes: One second, please.

Peggy Bennett: Um-hum.

Kim Spalding-Bush: Hi, this is Kim Spalding-Bush, and I'm Director, Division of Value-Based Payment and — the reason that a physician who doesn't perform primary care services could be attributed patients on a claims-based cost and outcome measures would be that — if that patient did not receive any primary care services during the performance period from a primary care provider type …

Peggy Bennett: Um-hum.

Kim Spalding-Bush: … then they would be attributed to their physician who provided the plurality — or provided more primary care services in the group. So they could get

attributed to a specialist. So my suspicion is that, even though it sounds like your physician is a specialist, that they probably did provide some office-based E&M services.

Peggy Bennett: Um-hum.

Kim Spalding-Bush: And there's a list of those codes that we use to attribute beneficiaries for the claims-based measures.

So first we attribute the beneficiary to the group that provided most primary care services by a primary care provider type. And then in the second step, we would attribute that beneficiary to a non-primary care provider type that's in the group that provided the most primary care office-based E&M services.

So the reason would be that that beneficiary really didn't see anyone else. So this doctor was sort of their — kind of their link to the medical world. So during that performance year, that would be the group that got attributed the beneficiary. So – and if you think it could be a mistake, you could certainly call the PV Help Desk if you don't think they billed any office-based E&M codes. But I suspect that is probably why they got attributed to your tax ID number.

Peggy Bennett: OK, thank you very much.

Kim Spalding Bush: Sure.

Amanda Barnes: Thank you.

Operator: Your next question comes from Joan Trenkle.

Joan Trenkle: Hi, can you hear me?

Amanda Barnes: Yes, we can.

Joan Trenkle: OK, my question — I'm from Winthrop University Hospital on Long Island. And we have several practices with multiple TINs. So is there a way that I can register in EIDM, because I'm not in access yet, so that I would be able to see all of the QRUR's multiple TINs without having a zillion passwords?

Amanda Barnes: One second, please.

Amanda Barnes: I'm sorry, 1 second please.
Amanda Barnes: OK.

Sabrina Ahmed: OK. Hi, this is Sabrina Ahmed. So we haven't finalized our instructions for obtaining EIDM accounts yet, but we will have the instructions finalized by end of

this month or early next month. And once the instructions are finalized, we will update our How to Obtain a QRUR website with that information. And that website is listed on — on slide 13.

Joan Trenkle: So do you know …

Sabrina Ahmed: So I would encourage you to check that — check that site at the end of this month, early next month for updated instructions about obtaining EIDM accounts.

Joan Trenkle: OK, obtaining the account is not so much a concern of mine, it's being able to see multiple QRURs for our organization, and our organization is multiple TINs. And would I be able to see them using one access or do I need to have security clearance and passwords to the various TINs?

Kim Spalding-Bush: So this is Kim. And I would just echo what Sabrina said, which is that we've not yet finalized the materials, and I'm not sure for the EIDM system. I can tell you that for the current system, the IACS system, there's no direct functionality that allows you to register to view multiple TINs' QRUR reports, but there is — if you visit the website that they just listed, there is a way that the group is able to designate someone as a group representative. So it talks all about the roles that you need to access the report and once you've got the group security official role. Hopefully, I'm getting that terminology correct. But it's all right there on that website.

Joan Trenkle: OK.

Kim Spalding-Bush: They — that person has the ability to designate someone else to be a group representative. So that's one way that you could do it — is like have your group designate you as a representative. And then you would be able to access the reports. But I — there's not a functionality under the current system that would allow you to view multiple reports.

Now we're not sure yet for the EIDM transition. Unfortunately, I wish we could tell you, but we'll have that – those instructions up soon. You know there may be a similar functionality or maybe something even easier. I'm not sure though under the EIDM system.

Joan Trenkle: OK, thank you very much.

Operator: Again, if you would like to ask a question, press star 1 on your telephone keypad. If you would like to withdraw a question or your question has been answered, you may remove yourself from the queue by pressing the pound key.

And your next question will come from the line of Mary Turner.

Mary Turner: Hi, I was — wanted to ask about Exhibit 8. It lists the cost per capita for major procedures vs. minor procedures. And I wanted to know what the — what the definition is between major procedure vs. minor procedure.

Kim Spalding-Bush: Looking for the definition?

Amanda Barnes: Would you mind repeating your question one more time?

Mary Turner: Sure. In Exhibit 8 on the Mid-Year QRUR, it lists the per capita costs for major procedures billed within our TIN and outside our TIN and then minor procedures billed within our TIN and outside our TIN. And I was just looking for what major vs. minor procedures are. Where are those definitions?

Kim Spalding-Bush: Well thank you for that question. This is Kim here at CMS, and I'm going to ask our experts at Mathematica Policy Research if they could weigh in on that question. They're the technical expert so, hopefully, they can give you some guidance.

Mai or Wil, can you response to that?

Mai Hubbard: Hi Kim, I'm going to turn this over to Jeff Ballou.

Kim Spalding Bush: Oh, thanks.

Jeff Ballou: And thank you for the question. These are codes that are — they are available on some of the education and outreach materials that CMS has online. But the major procedures and the minor procedures are differentiations that were established by the Berenson-Eggers Type of Service categorization. The major procedures are cardiovascular sorts of procedures, such as aneurysm repairs, cabbages, and so on.

Minor procedures — I'm going to see if I can find a couple examples of these here. You know, again, are not precisely defined by BETOS, but they're classified as certain skin, musculoskeletal, and other procedures. But this is basically the BETOS characterization, and there's additional detail on this in the education outreach document CMS has online.

Mary Turner: So is there a listing of which CPT codes fall within each of those categories on —in the education materials then?

Jeff Ballou: We would have to go back and check that. I don't believe that there is.

Amanda Barnes: Thank you so much for your question. Holley, we'll take the next one, please.

Operator: All right. Your next question will come from Mary Arrowood.

Mary Arrowood: Hi, yes, this is Mary. I'm calling from Augusta Care Partners. We're an ACO, an MSSP ACO that started in 2014. And my question is about the IACS accounts. I was set up to have access as our group practice administrator for our ACO in anticipation of the GPRO reporting. And while we were going through this process I had one practice who is a member — participating member of ACO, who told me, "Hey, I tried to register to report PQRS and they told me I was not allowed to do that because my TIN is already associated with an ACO." And she just didn't understand the overlap in the process, which we clarified with her.

But my question is, are our participating providers going to be able to obtain this PQRS PV-PQRS role in IACS in order to view their QRURs since we cannot? I just got the feedback from that one practice that they had difficulty, and were already attached to something and they were not permitted to get the role.

Rabia Khan: Hi, this is Rabia Khan from the Division of Shared Savings Program. So they should be able to create an IACS account for them to access their Mid-Year QRUR that they received. We — for the Shared Savings Program as well, we'll all be migrating over to EIDM, as Sabrina mentioned. But they will need to register for an EIDM account for their annual QRUR to be able to access that when it is available. But there should not be any issues with them being able to access now.

I would suggest that they contact the QualityNet Help Desk if they're having issues with trying to access their Mid-Year QRUR. And that is on slide — and so the QualityNet Help Desk contact information is available on slide 44.

Mary Arrowood: OK, thank you, and just a little bit of feedback. Just as part of the entire ACO enterprise, you know, part of the beauty of it is saving physicians and their practices from having to set up accounts and do things like that. We are able to do a whole lot of reporting and exciting things for them and take the administrative burden off their hands. And this sort of just hands it right back to them by not allowing the ACO to pull the data for them. But that's just feedback from our participants and our organizations I thought I'd pass along.

Rabia Khan: We appreciate the feedback, thank you.

Operator: Your next question will come from Angela Fix.

Angela Fix: Hi, this is Angela Fix at the Portland Knee Clinic. I first just wanted to mention that I did actually receive one of the daily digest bulletins from CMS that indicates that your existing PQRS IACS users and data and roles will be moved to the ED — EIDM. So it sounds to me as though you don't have to set up a new account, that your data is going to be rolled over. Is that accurate?

Sabrina Ahmed: So, yes, so that's correct that existing IACS users will be migrated over to the EIDM. So you may not need to, like, set up a new account. But there is still an additional verification process that you will need to go through before your EIDM account is activated.

Angela Fix: OK, and is that something that's going to be emailed to us? To go through that process, will we get an email that tells us to do that?

Sabrina Ahmed: Yes, we'll put outreach out through the listservs and promotion on our website because I don't think you'll be able to just like use your IACS account log in, like your username, password probably won't just work.

Angela Fix: OK.

Sabrina Ahmed: So, yes, we'll send out that …

Angela Fix: OK.

Sabrina Ahmed: … information.

Angela Fix: So my real question is actually around how the QRUR data is used in the Value Modifier and how the, you know, what kind of number is used to decide whether — I mean, I understand when the penalty comes when you're not, you know, meeting PQRS. But then there's also the ability to potentially increase and have a positive adjustment. But what I've found on the Physician Feedback Program, on that website, doesn't really indicate how that happens — or how it happens or why it happens, that you may get an increase, you know, a positive adjustment based on your Value Modifier. And it doesn't really indicate how QRUR reports or numbers play into that. It just says that they do.

Kim Spalding-Bush: OK, thank you for the question. So, right, you're correct in that if you don't report to PQRS, you could be — you would be subject to, if you don't successfully report to avoid the PQRS penalty, you would be subject to the additional penalty under the Value Modifier program. But if you do submit successfully, then you would be a part of our quality tiering methodology. And, depending on the group size, are subject to either just upward or neutral adjustments or else, for the larger groups, you know, after the first year of the program, then they are subject to both upper, neutral, or downward adjustments.

We don't have a lot of information about that in this presentation because this one was specific to the Mid-Year QRURs. And, of course, we don't include the quality measures in the Mid-Year QRUR because those are only calculated on an annual basis. We don't include the PQRS quality measures I should say.

So there is a lot of information on the Value Modifier website about how we actually calculate the Value Modifier using PQRS quality measures. So we calculate what we call a standardized score, and then each measure is included in a domain, then the domains are weighted together to come up with a quality composite.

And then, depending on whether a group had high, average, or low quality — and combined with high, average, or low cost, that will determine what their payment adjustment is under the Value Modifier. So for PQRS measures, there's no additional reporting requirement. We do have some case minimums for the measures. Generally, if you have 20 cases, then the measure gets included in the Value Modifier program. But there's a lot more detail around that are — on our — on the Value Modifier website.

Angela Fix: OK, so I have — can you give me the name of the specific document? I mean, I feel like I've poked around the website quite a bit. And, yes, if you could point me to the specific document, that would be awesome.

Kim Spalding-Bush: So I am sorry, I don't have my computer in front of me. But the people who could certainly point you in the right direction would be the Physician Value Help Desk. And their number is there on slide 44, it's the first — the first …

Angela Fix: OK.

Kim Spalding-Bush: … phone number. Push option 3, and they could certainly point you in the right direction of the documentation that would have that kind of how the Value Modifier is calculated information. I think there's actually a how the VM is calculated fact sheet that's up there — that's a sort of a simple version. And I believe that will link you out to a more complicated version. But the PV Help Desk can certainly help you if you're having trouble locating the correct document.

Angela Fix: Great, thank you.

Amanda Barnes: Thank you so much.

Operator: Your next question comes from the line of Heidi Harting.

Heidi Harting: Ah, yes, hi. We are part of a — I just want to reiterate or get confirmation. We're part of a Shared Savings Program. Our participation in 2015 with PQRS will avoid the penalty and with VBM we'll be at 0 percent then for 2017, which is what the average

is for cost and quality together, is that correct or is that incorrect? And if you need me to clarify that question, I can, because I know I was jumbled.

Sabrina Ahmed: So a – OK, so for the 2017 Value Modifier, if your ACO successfully reports the PQRS GPRO quality measures data, then the ACO participants will be subject to quality tiering. The cost composite would be average cost. So we would not calculate any cost measures for ACO participants, but the quality composite would be calculated using the ACO's reported GPRO Web Interface measures data and also the ACO-level hospital readmissions measure that CMS will calculate for the ACO.

So your — so the 2017 Value Modifier would be based on, you know, your quality performance.

Heidi Harting: In 2015?

Sabrina Ahmed: In 2017, based on 2015 performance.

Heidi Harting: That's what I'm saying, 2015 performance on quality alone, and then you said also hospital — what will it take from the ACO?

Sabrina Ahmed: So CMS calculates the ACO-level's hospital readmissions measure. So in order to determine your quality composite, we will use the ACO-level hospital readmissions measure in addition to the ACO-level — the PQRS GPRO measures that the ACO will base the quality composite.

Heidi Harting: OK, and we are – we're not in an ACO. We're — I'm sorry, we're in CPCI. Similarly it will take from CPCI?

Sabrina Ahmed: No. So in 2017 — so groups and solo practitioners that participate in CPCI or a Pioneer ACO model in 2015, their 2017 Value Modifier will be — it will just be average quality and average cost, so you will not get any Value Modifier adjustment.

Heidi Harting: OK.

Amanda Barnes: Thank you so much for your question.

Operator: Your next question will come from the line of Angela Neal.

Angela Neal: Hi, sorry, I was on mute. I had a question. I am from — calling from TMF Health Quality Institute, the QIO for Oklahoma. And I have a provider practice, they're a facility that, in reviewing their QRUR report, they showed providers in there that we weren't understanding how they were listed because they're pediatricians.

Could you — I know that you had mentioned something about reviewing the — in your slides —reviewing the providers, and then having an update in the PECOS if it's not correct. But could you kind of reiterate or — or restate how some providers might be on there and they may be incorrect?

Sabrina Ahmed: Yes, so if you look at slide 32, so that shows screenshot of Supplementary Exhibit 1. Supplementary Exhibit 1 provides information about the eligible professionals that billed under the TIN between July 1, 2013, and June 30th, 2014. And then this exhibit shows, like, the EPs, NPI name, whether they are physicians or not.

So what I said earlier was that if you see that one of the eligible professional's specialty, for example, the specialty's listed incorrectly, then you can go into PECOS to update the EP's record to reflect the correct specialty. And also I mentioned that if you see any eligible professionals in the TIN who are associated with your TIN in PECOS but the eligible professional no longer belongs to your TIN, then you should update that eligible professional so that they can go and — go ahead and update their PECOS record to remove their association from your TIN.

Angela Neal: OK, what if the specialty is correct, because they're showing a pediatrician who was listed as a pediatrician on that list of the eligible providers?

Sabrina Ahmed: OK, well if the specialties are correct for the EPs, then you don't need to make any changes to their specialty.

Angela Neal: So this is not specific to just Medicare Part B. I know you said Medicare Part A as well. So this is just all providers who billed under that Tax ID Number, regardless of — I guess, that's what I – what I'm not understanding because a pediatrician would not necessarily be seeing Medicare Part B.

Kim Spaulding-Bush: Yes, is there anyone from Mathematica on the phone who could possibly give us an example of why a pediatrician provider-type might show up in Exhibit 2A …

Sabrina Ahmed: And Supplementary Exhibit 1.

Kim Spaulding-Bush: Supplementary, oh, Supplementary Exhibit 1.

Wil Lim: Sure, hi, this is Wil. So I guess two points are related to that question. So the first point is that Supplementary Exhibit 1 lists all providers that are associated with the TIN in PECOS. So there it's not based on billings. And then confirming that in terms of an NPI being associated with the TIN via billings, that — that is solely based on Part B. Does that help to clarify why, I guess, these pediatrician NPIs might be associated – what might be listed in that exhibit?

Angela Neal: It does because you're saying that Exhibit 1 would just be associated to all bills — all NPIs to bill to that TIN, so it will show every NPI associated to that tax ID number, regardless of billing. Correct?

Wil Lim: Correct. So for the identified via PECOS, that's everyone associated with the TIN and PECOS. So that's correct.

Angela Neal: OK. OK, wonderful, yes that answers my question. Thank you so much.

Wil Lim: Thank you.

Operator: And your next question will come from the line of Linda Drummond.

Linda Drummond: Hi, this is Linda Drummond from UW Health in Madison, Wisconsin, and I just want to thank you for having this call today. And my question relates to — we're also a Medicare Shared Savings Plan ACO, and we're seeing some differences in denominators and kind of the per capita cost measures. And we're just wondering — between what we saw on our ACO reports — and so we're just wondering, what's the best way for us to understand what's causing these differences in those denominators and actually the per capita cost is different?

Amanda Barnes: One second.

Kim Spalding-Bush: So this is Kim, I can speak to what you're — the QRUR report is going to provide you with the TIN level. So if the ACO is comprised of multiple Tax ID numbers, your QRUR report is going to be showing you the TIN level of beneficiaries that were — excuse me, attributed to the Tax ID number based on our two-steps attribution approach. So it sounds like that probably would differ from what you're receiving at the ACO-level report, though I'm not familiar with what type of reports exactly the SSP ACO is providing. But does that answer your question?

Linda Drummond: I think that's probably part of — but then we also — we're just wondering – because there is one place in the definitions where it says that the denominator is based on providers who billed E&Ms in your TIN and providers who've billed outside of your TIN, so that's a little bit confusing, that definition.

Kim Spalding-Bush: So I'm not sure which exhibit your looking at?

Linda Drummond: Exhibit 7.

Kim Spalding-Bush: OK.

Linda Drummond: So it says, like in the educational materials that come with the report talks about performance on costs, and cost information is derived in two ways, and the

per capita costs says it's based on Parts A and B by all providers who bill through your TIN. But it also includes providers who do not bill under your TIN. So we're just trying to understand, like, what's in that denominator on Exhibit 7 for your eligible cases or episodes.

Sabrina Ahmed: So this is Sabrina Ahmed. So when we calculate the per capita cost measures, we look at payments for all Medicare Part A and Part B claims submitted by all providers who treated the beneficiaries attributed to the TIN. So that includes providers you know, of course, the providers that billed under your TIN. But we also include providers that billed – that are part of other TINs but provided services to the beneficiaries.

So the per capita cost measures looks at services — looks at all services provided to the beneficiary or, as you said, looks at costs for all services provided to the beneficiary, regardless of whether the EP was billing under your TIN or a different TIN.

Linda Drummond: Yes, so that's why we kind of think it should match closer what the ACO numbers are.

Kim Spalding-Bush: I mean, so one thing could be that the beneficiary is not required to only be treated within the ACO, of course. So if there's providers outside of the SSP ACO that the beneficiary saw, all of those costs would still be included when we calculate the annual total per capita cost for that beneficiary that got attributed to the TIN. So it's not limited by providers within the Share Savings Program.

Linda Drummond: OK.

Kim Spalding-Bush: These are also payment standardized, you know, risk-adjusted and specialty-adjusted total per capita cost. So I'd imagine there's some difference between that and what you're receiving from the SSP.

Linda Drummond: So kind of going — so in the future, in 2017, will those differences still be in play? Do you know what I mean, because when we — so we have an ACO, and we're working towards improving quality for those patients. And it feels like then it doesn't include these patients from the QRUR perspective. So we feel a little bit like, how do we determine if our programs are reaching all patients that we care for? And it just feels like it's not consistent. So I don't know, like, what are the plans in the future to make it more consistent between the MSSP program and the QRUR program, because basically it's the same patients we're taking care of?

Kim Spalding-Bush: Thank you. So I think part of the reason why the Shared Savings Program ACOs are going to be receiving average cost composite is because there are already, you know, incentives in place for you to provide efficient care and to control cost within the SSP ACO. And so because we didn't want to create conflicting incentives

for you to try to perform well on these Value Modifier measures to the extent that they might cause you to sort of have to shift your focus or shift focus in two places or have sort of conflicting incentives, we wanted to avoid that. So that's sort of the rationale on why you'll be receiving average cost once the Value Modifier is applicable to the Shared Savings Program.

So I think you can take the QRUR reports as really good pieces of information to help you understand what's driving total per capita cost for your beneficiaries with the understanding that it's not going to actually impact your Medicare payments under the Value Modifier program or under the Shared Savings Program, because they separately have their own metrics for determining whether you share in savings.

So I think this is still valuable for you, though. I mean, you can see whether your beneficiaries are mostly being treated within your TIN or whether other providers outside of your TIN are increasing costs for them. It can help you as a tool to try to better coordinate care for those beneficiaries if you're seeing some where perhaps they're seeing a lot of providers outside of the ACO.

I think that's, you know, outside of your TIN, you know, that's probably useful information for you. But I think your point's well taken in that it doesn't align with the information, you know, — it's not aligning directly with the information you're receiving from SSP. And I think that's just sort of further support for why it made sense for us to do average cost for Shared Savings Program ACOs.

Amanda Barnes: Thank you so much for your question.

Operator: Your next question will come from Kris Elliot.

Kris Elliot: Hi, hello, are you still there?

Operator: Yes, go ahead.

Kris Elliot: Oh, OK, thank you. It sort of dovetails on the question from the caller just previous, because when you're on slide 7, we are an ACO — Shared Savings Program ACO as well. So for all of our ACO participants in 2014, their TIN numbers rolled out to the ACO's TIN for their GRPO/PQRS reporting. So that includes some solo practitioners and small, you know, in that 10-to-99 size practice for their eligible professionals. So when they go and get their QRUR report for their quality tiering — and it looks like they're doing wonderfully because that might include some specialists in that as well. If that — if they look like they're doing well, will they get a separate payment outside of the ACO when it's time for their PQRS or Value-Based Modifier or value-based payment to be made?

Kim Spalding-Bush: So at the time that the TINs do begin to receive the Annual QRUR Reports — so currently SSP TINs have not received Annual QRUR Reports in the past. And the quality data is not included in the Mid-Year QRUR, which is what we are focusing on today. But as at such time as they do receive the Annual QRUR Reports, it's going to give them information about how the TIN performed. But no, the TIN doesn't receive a separate adjustment.

It's TIN-level performance, so the quality tiering is going to look the same. It's GPRO data reported by the ACO on the behalf of the underlying TIN. So they're going to receive the same adjustment that the SSP ACO as a whole receives under the Value Modifier program, which could potentially be upward if the ACO did well on quality tiering on the quality composite.

Additional Information

Amanda Barnes: Thank you so much for your question. Unfortunately, that's all the time we have for questions today. If we did not get to your question, you can email one of the addresses listed on slide 44.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 47 of the presentation you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience. Again, my name is Amanda Barnes, and I'd like to thank our presenters and also thank you for participating in today's MLN Connects Call on 2014 Mid-Year QRURs.

Have a great day everyone.

Operator: Thank you, that will conclude today's conference call. You may now disconnect. Presenters please hold.

-END-


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