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National Provider Call Transcript

Centers for Medicare & Medicaid Services
Overview of the 2014 Annual Quality and Resource Use Reports — Webcast
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® Event. All lines will remain in a listen-only mode until the question-and-answer session. This event is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

You can ask text questions — click the green Q&A icon on the lower left-hand corner of your screen. Type your question in the open area and click Submit. We will also be taking questions via the phone line, and instructions on how to do so will be given at the appropriate time. If you would like a copy of today's presentation, please click on the blue Files button in the lower left-hand corner of your screen to download a copy.

If you would like to view the presentation in a full screen view, click the Full Screen button in the lower right-hand corner of your screen. Press the Escape key on your keyboard to return to your original view. For optimal viewing and participation, please disable you popup blockers. And finally, should you need technical assistance, as a best practice, we suggest you first refresh your browser. If that does not resolve the issue, please click on the Support option in the upper right-hand corner of your screen for online troubleshooting.

I will now turn the call over to Amanda Barnes. Thank you, you may begin.

Announcements and Introduction

Amanda Barnes: Thank you Paula. I am Amanda Barnes from the Provider Communications Group here at CMS, and as today's moderator, I'd like to welcome everyone to this MLN Connects Event on the Overview of the 2014 Annual Quality and Resource Use Reports. MLN Connects is part of the Medicare Learning Network®.

During this event, CMS subject matter experts provide an overview of the 2014 Annual QRURs and also explain how to interpret and use the information in the report. Before we get started, there are a few items I'd like to cover.

Today's event uses webcast technology. We recommend streaming the audio live through your computer speakers. And please note that this event is also being recorded and transcribed. The audio file and transcript of this event will be posted to the Event Detail page in approximately 7 business days.

You can find the Event Detail page by going to www.cms.hhs.gov/npc. Click on the Calls and Events link on the left navigation bar and then look for the date of today's event. At this time I would like to turn the call over to Sabrina Ahmed. Sabrina?

Presentation

Sabrina Ahmed: Hey, thank you, Amanda, and thank you everyone for joining us on this call today. I am starting on slide 3, which lists the objectives for this presentation.

So during this presentation, I will review the 2016 Value Modifier policies and provide an overview of the recently released 2014 Annual Quality and Resource Use Reports. These reports are also called the QRURs. And then I will also review how you can access the 2014 Annual QRUR and discuss the information contained in the report and the supplementary exhibits that are part of the report. And then at the end of the presentation, we will have a question-and-answer session.

Overview of the 2016 Value Modifier Program

So slide 5 provides an overview of the Value Modifier Program. The Value Modifier is a payment adjustment established by the Affordable Care Act and provides for differential payment to a physician or group of physicians based on the quality of care and the cost of care furnished to Medicare Fee-for-Service beneficiaries during a performance period. The Value Modifier is a per claim adjustment made under the Physician Fee Schedule and is applied at the taxpayer identification level, also called the TIN. The Value Modifier took effect on January 1, 2015, for physicians in groups with 100 or more eligible professionals and, as required by statute, it must be applied to all physicians and groups of physicians by January 1, 2017.

In 2016, the Value Modifier will apply to physician payments under the Medicare Physician Fee Schedule for physicians in groups with 10 or more eligible professionals. However, the Value Modifier will not apply 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. And lastly, calendar year 2014 is the performance period for the Value Modifier that will be applied in 2016.

Slide 6 shows the types of providers that are considered to be an eligible professional. Eligible professional can — eligible professionals consist of physicians, practitioners, and therapist, as shown in this slide. To determine the size of the group, we looked at all of the eligible professionals that are part of the TIN or billed under the TIN during the performance period. However, in 2016 the Value Modifier, as I noted earlier, will only apply to the physicians billing under the TIN that are subject to the Value Modifier. The Value Modifier in 2016 will not apply to the types of practitioners and therapists that are listed on this slide.

Slide 7 shows how we'll apply the Value Modifier in 2016 to physicians in groups with 10 or more eligible professionals. We used a two-category approach to classify groups that are subject to the 2016 Value Modifier based on how the groups participated in the PQRS in 2014, which was the performance period for the 2016 Value Modifier.

As shown in the left-hand side of the slide, category 1 groups include physician groups with 10 or more eligible professionals that participated in the PQRS GPRO in 2014 and met the criteria to avoid the 2016 PQRS payment adjustment. Also part of the category 1 groups are physician groups with 10 or more eligible professionals that had

at least 50 percent of the group's eligible professionals participate in the PQRS as individuals in 2014 and met the criteria to avoid the 2016 PQRS payment adjustment.

All groups that are category 1 avoided the automatic Value Modifier downward payment adjustment and were subject to quality tiering, which is the methodology used to evaluate a group's performance on quality and cost measures for the Value Modifier. Under quality tiering, physicians in groups with 100 or more eligible professionals could receive an upward, neutral—meaning no adjustment, or downward adjustment in 2016, based on the group's performance on quality and cost measures in 2014. And also physicians in groups with between 10 to 99 EPs could receive an upward or neutral adjustment in 2016 and are held harmless from any downward adjustment derived under the quality tiering methodology.

So now, looking at the right-hand side of this slide, you can see that category 2 groups include physician groups with 10 or more eligible professionals that are subject to the 2016 Value Modifier and that did not meet the criteria to be considered part of category 1, meaning that the group did not meet the criteria to avoid the 2016 PQRS payment adjustment as a group or did not have at least 50 percent of the eligible professionals in the group meet the criteria to avoid the 2016 PQRS payment adjustment as individuals. Physicians in groups that are considered to be category 2 will be subject to an automatic negative 2 percent Value Modifier payment adjustment in 2016.

Overview of the 2014 Annual QRUR

So now I'm on slide 9. So what are the 2014 Annual Quality and Resource Use Reports? The 2014 Annual QRURs are confidential feedback reports provided to groups and solo practitioners nationwide under the Medicare Physician Feedback Program.

Groups and solo practitioners are identified in the QRURs by their TINs, or their taxpayer identification number. The information contained in the QRURs is used to calculate the Value Modifier that will be used to adjust Medicare Physician Fee Schedule payments to physicians in groups with 10 or more EPs, based on the quality and cost of care delivered to Medicare beneficiaries. The QRURs contain quality and cost data based on calendar year 2014, which is the performance period for the 2016 Value Modifier.

Amanda Barnes: And just to jump in real quick, I'm sorry Sabrina. If you are not seeing the slides progressing, can you please refresh your browser, and that should fix the issue? Sabrina.

Sabrina Ahmed: OK, so moving on. So I'm still on slide 9. So for groups with 10 or more eligible professionals that are subject to the Value Modifier in 2016, the QRURs provide information on how the group's performance will affect their physicians' payments under the Medicare Physician Fee Schedule in 2016. And then for groups with less than 10 eligible professionals and solo practitioners, the QRURs are for informational

purposes only. And their Medicare payments will not be affected by the Value Modifier in 2016. The QRURs are also provided for informational purposes to groups and solo practitioners that participated in the Shared Saving Program, the Pioneer ACO Model, and the Comprehensive Primary Care Initiative in 2014. Lastly, the QRURs serve as PQRS feedback reports for groups that registered to participate under the PQRS GPRO in 2014.

I'm now on slide 10. So a full-length 2014 Annual QRUR is available for all groups and solo practitioners nationwide, as identified by their TIN, that met the following two criteria:

- The TIN had to have at least one physician or nonphysician eligible professional that billed for Medicare-covered services under the TIN between January 1 and December 31st, 2014.

- And also, the TIN had to have at least one eligible case for at least one quality or cost measure included in the 2014 Annual QRUR.

TINs that did not meet both of these criteria received a one-page explanatory summary 2014 QRUR.

As I mentioned earlier, QRURs are now also available for groups and solo practitioners that participated in the Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care Initiative in 2014, including those TINs consisting only of nonphysician EPs.

Accessing Your TIN's Annual QRUR

In slides 12 and 13 I will review how you can access your TIN's Annual QRURs, starting with slide 12. So in previous years you had to use an IACS account to access the QRURs. However, in July of this year, CMS transitioned all IACS accounts to the Enterprise Identity Management System, also called the EIDM. So an EIDM account is now required to access the QRURs. An authorized representative of a group or solo practitioner can access the TIN's QRUR on the CMS Enterprise Portal website that's listed on this slide using an EIDM account with a correct role.

On the How to Obtain a QRUR website, which is shown on this slide, we provide the instructions for setting up an EIDM with the correct role. To find out whether there's already someone who can access your TIN's QRUR, then you can contact the QualityNet help desk at the number provided on slide 66. And provide them with your TIN and the name of your group or your name if you're a solo practitioner. And the QualityNet help desk can also help address questions about setting up an EIDM account.

I'm now on slide 13. Once you have an EIDM account with the correct role, then you can access the QRUR by following the steps shown on this slide. For detailed step-by-step instructions on how to access an annual QRUR, you can refer to the guide for accessing the 2014 Annual QRURs that's available on the How to Download — on the How to Obtain a QRUR website in the download section.

Information in the 2014 Annual QRUR

So the remaining slides in this presentation will cover the information contained in the QRURs. Slides 15 and 16 list all of the sections contained in the QRUR, along with the exhibits shown in each section. You can view each of these sections on the CMS Enterprise Portal website or, once you're in the portal, you can also download a PDF document that contains the TIN's entire QRUR.

The instructions for downloading the report as a PDF are provided in the Guide for Accessing the Annual QRURs that's available on the How to Obtain a web — that's available on the How to Obtain a QRUR website, which I referred to on slide 13.

Slides 17 and 18 list additional supporting information that's available as part of the QRURs. The supplementary exhibits provide detailed information about the eligible professionals in the TIN as well as those eligible professionals outside of the TIN who provided care to the TIN's attributed beneficiaries. These supplementary exhibits also provide detailed information about the beneficiaries who are attributed to the TIN. All of these exhibits can be downloaded as Excel files.

I will review the information provided in the report exhibit and the supplementary exhibits in the remaining portion of this presentation.

So the first section of the QRUR is the cover page. Unfortunately, we do not have a screenshot of the cover page in this presentation, but I'll review the information that the cover page contains.

So the cover page provides an overview of the 2014 Annual QRUR and the 2016 Value Modifier. It tells you how the Value Modifier applies to your TIN in 2016. It provides the contact information for the help desk and also, for groups that are subject to the Value Modifier, it provides instructions for requesting an informal review of the Value Modifier.

So for a TIN that does not have at least one eligible professional that billed under the TIN during the performance period and didn't have at least one eligible case for at least one quality or cost measure, the TIN's QRUR will contain only the cover page. And for the TINs that meet both of these criteria, the TIN will receive a full QRUR that consists of the cover page, the performance highlights page, and all of the exhibits and supplementary exhibit.

So slides 19 and 20 show the performance highlights section of the QRUR. On slide 19 you can see that the performance highlights section shows the TIN's quality composite score and whether it's considered high, low, or average quality. This section also shows the TIN's cost composite score and whether it's high, low, or average cost. And if there is insufficient data to calculate either the quality or cost composite, then that is also stated in this section. The third item shown on this slide is a scatter plot distribution chart that shows the TIN's performance on quality and cost composites in relation to a sample of other TINs in the TIN's peer group.

Slide 20 shows the remaining information that's included in the performance highlights section of the QRUR. For TINs with 10 or more eligible professionals that are subject to the 2016 Value Modifier, the fourth section here shows whether the TIN was eligible for an additional upward adjustment for treating high-risk beneficiaries. And then for all other TINs that are not subject to the Value Modifier, this section shows the TIN's average beneficiary risk percentile. The last item shown in the performance highlights section is the actual 2016 Value Modifier payment adjustment for groups with 10 or more eligible professionals that are subject to the Value Modifier in 2016 and are in category 1, meaning that they avoided the automatic downward adjustment.

For groups that will receive an upward Value Modifier payment adjustment in 2016, we will have the information about the Value Modifier adjustment factor later this year, once the informal review period ends and we've made the final payment adjustment determinations for all of the groups that are subject to the Value Modifier in 2016. And like last year, the adjustment factor for the 2016 Value Modifier will be posted on the Value Modifier website.

Exhibit — slide 22 shows Exhibit 1 of the Annual QRUR. This exhibit displays the count of physician and nonphysician eligible professionals that billed under the TIN during the performance period. This exhibit indicates the number of eligible professionals that billed under the TIN during the performance period, as well as the number of eligible professionals that are associated with the TIN in PECOS as of October 16, 2014. In order to determine the size of a TIN for purposes of the Value Modifier, CMS used the lower of the two eligible professional counts that are shown in this exhibit. The list of the eligible professionals associated with your TIN in PECOS and claims is available in Supplementary Exhibit 1, and I'll talk about that later in this presentation.

Slide 23 describes the two-step attribution methodology that's used to attribute beneficiaries to the TIN for the five per capita cost measures and the three claims-based quality outcome measures. The attribution methodology is based on the plurality of primary care services provided by the primary care physicians within the TIN.

So now I'm on slide 24, which shows Exhibits 2 and 3. Exhibit 2 shows the number of Medicare-Fee-for-Service beneficiaries who are attributed to the TIN for the claims-based per capita cost and quality outcome measures that are included in the QRUR and

also shows whether the beneficiaries were attributed in step 1 or step 2 of the attribution methodology that I described in the previous slide.

And then Exhibit 3 presents information on the average number of primary care services provided to beneficiaries attributed to the TIN. It includes average counts of primary care services provided by the EPs in the TIN and by EPs outside of the TIN.

Slide 25 shows Exhibit 4. So Exhibit 4 provides information on the hospital episodes attributed to the TIN for the MSPB measure, as well as the number of unique beneficiaries associated with these attributed episodes. And more information on the beneficiaries associated with each episode as well as other information relevant to the TIN's performance on the MSPB measure can be found in Supplementary Exhibit 4.

Quality Measures Used in the Annual QRUR

So now I'm on slide 27. Slide 27 describes the quality measures that are used to calculate the quality composite of the 2016 Value Modifier and the quality measures that are shown in the QRURs for TINs with at least one eligible case for at least one quality measure. For groups that reported PQRS data as a group in 2014 and met the criteria to avoid the 2016 PQRS payment adjustment, we used the measures reported under the PQRS GPRO reporting mechanism selected by the group. And alternatively, if at least 50 percent of the EPs in the group reported PQRS data as individuals and met the criteria to avoid the 2016 PQRS payment adjustment, then we used that individually reported PQRS measures to calculate the quality composite. For solo practitioners we used the individually reported PQRS measures to calculate the quality composite as long as the criteria to avoid the 2016 PQRS payment adjustment was met.

For all groups and solo practitioners, we also calculated three claims-based outcome measures, which are the All-Cause Hospital Readmission measure, a Composite of Preventable Hospitalizations for Acute Conditions, and a Composite of Preventable Hospitalizations for Chronic Conditions. And we also used the results of the 2014 CAHPS for PQRS survey to calculate a TIN's quality composite if the group elected this option.

So I just wanted to describe an exception to these polices. So please note that the PQRS measures submitted in 2014 through the Qualified Clinical Data Registry or EHR reporting options, including GPRO EHR submissions, were not included in the 2014 Annual QRURs and were not used to calculate the 2016 Value Modifier because we were unable to determine the accuracy of these data. For TINs that reported — for TINs in category 1 that reported only through the EHR or QCDR option, the TIN's quality composite score will be based on the three claims-based outcome measures and the CAHPS for PQRS survey measure, if it's applicable.

And if calculating the quality composite score based on these limited measures would result in classifying the TIN as low quality for purposes of calculating the Value Modifier, then the TIN will instead be classified as average quality. And then using the limited

measure of this, we determine that the TIN's quality composite score would be classified as high quality, then the TIN will retain the high quality designation. And then using these limited measures, if we determine that the TIN quality composite score would be classified as average quality, then the TIN will continue to be classified as average quality.

So if a TIN reported via other PQRS reporting mechanisms in addition to EHR or QCDR, then the TIN's quality composite score will be based on the other PQRS measures and also the claims-based quality outcome measures and the CAHPS for PQRS survey measures, if applicable.

We are aware that some TINs who reported via EHR were classified as category 2 under the Value Modifier due to submission error. While the exception policy I just described applies to category 1 TINs, CMS is currently working through the issue for category 2 TINs.

So for TINs that participated in the Medicare Shared Savings Program in 2014, in the QRURs we display only the 30-day All-Cause Hospital Readmission measure for the ACO and the ACO's performance on any GPRO Web Interface measures that were submitted. And then for TINs that participated in the Pioneer ACO Model or the CPC Initiative in 2014, we display only the PQRS data reported outside of the model or the initiative as well as performance on the three claims-based outcome measures and the CAHPS measures, if applicable.

So I'm now on slide 28. So the quality composite of the Value Modifier consists of six domains that are shown in this slide. Exhibit 5 displays your TIN's domain score for each of the quality domains included in the Value Modifier, as well as the resulting quality composite score and the quality tier designation — high, average, or low. The quality composite score summarizes the TIN's performance on quality measures across up to six equally weighted domains.

I am now on slide 29. So Exhibit 5 is only populated for the TINs that either reported quality data through the PQRS GPRO option and met the criteria to avoid the 2016 PQRS payment adjustment or had at least 50 percent of the eligible professionals in the TIN report PQRS data as individuals and meet the criteria to avoid the 2016 PQRS payment adjustment. And then also, Exhibit 5 is populated for TINs that participated in the Shared Savings Program in 2014 and met the PQRS reporting requirements under the Shared Savings Program.

I'm now on slide 30. So in a series of tables organized by quality domain, Exhibit 6 presents the TIN's performance rate and the number of eligible cases for each quality measure as long as there were at least one measure with at least one eligible case.

The quality measures included in this exhibit are the three claims-based outcome measures, PQRS measures either submitted through the PQRS GPRO or by individual eligible professionals who met the criteria as individuals to avoid the 2016 PQRS payment adjustment, and also CAHPS measures if those were applicable. Please note that PQRS measures submitted in 2014 via QCDR or EHR reporting options are not included in this exhibit for reasons I mentioned earlier. For eligible professionals reporting as individuals, information about the performance on their QCDR and EHR measures is available in the PQRS Feedback Report.

For TINs that participated in the Shared Savings Program in 2014, Exhibit 6 displays the ACO-level 30 day All-Cause Hospital Readmission measure and the ACO's performance on any GPRO Web Interface measures that were submitted. And then for TINs that participated in the Pioneer ACO Model or the CPC Initiative in 2014, this exhibit displays only the PQRS data reported outside of the model along with the three outcome measures and CAHPS measure, if applicable.

Amanda Barnes: Just to pause real quick, we are experiencing technical difficulties. If you could please just refresh your browser, we are aware of the issue. If you could refrain from sending tech questions via the Q&A button, we'll let you know if there's any further resolution. Sabrina?

Sabrina Ahmed: So on slide 31, you can see the information contained in Exhibit 6. The exhibit shows your TIN's performance rate and the number of eligible cases for each quality measure. And then the standardized score column displays the standardized score for each measure, and then Included In Domain Score column indicates whether the measure was included in your TIN's domain score, which was — which are shown in Exhibit 5. Only the measures for which the TIN had 20 or more eligible cases are included in the TIN's domain score. This exhibit also shows the benchmark performance rate, which is the case-weighted average performance rate for the peer group based on 2013 data.

I'm now on slide 33. Exhibit 7 identifies the hospitals that provided at least 5 percent of the TIN's attributed beneficiaries' inpatient stays over the performance period. This exhibit includes only the beneficiaries attributed to the TIN for the three claims-based outcome measures and the five per capita cost measures. This exhibit provides the hospital name, the CMS certification number, and also the location of the hospital.

Exhibit 8, as shown in slide 34, identifies the hospitals that were associated with at least 5 percent of the episodes of care attributed to your TIN for the MSPB measure during the performance period. And like Exhibit 7, this exhibit also shows the hospital name, CCN, and the location of the hospital.

In the next couple of slides, I will review the cost performance information that's contained in the Annual QRUR.

Cost Performance Information in the Annual QRUR

Slide 36 describes the cost measures that are used to calculate the cost composite of the 2016 Value Modifier and are shown in the QRURs for all TINs with at least one eligible case for at least one cost measure. The first measure is the total per capita cost measure, which is based on all Medicare Parts A and B spending for the beneficiaries who are attributed to the TIN using the two-step attribution methodology I described earlier on slide 23. Then there are four total per capita cost measures for beneficiaries with specific chronic conditions. The conditions are COPD, heart failure, chronic artery disease, and diabetes. And then the sixth cost measure is the Medicare Spending per Beneficiary, or MSPB measure. The MSPB measure is based on all Parts A and B expenditures for services surrounding inpatient hospital stays from 3 days before admission to 30 days after discharge. And all six cost measures are payment-standardized, risk-adjusted for specific beneficiary characteristics, and also adjusted to reflect the specialty mix of the eligible professionals in the group.

I am now on slide 37. The cost composite of the Value Modifier consists of two domains — the per capita cost for all attributed beneficiaries domain and the per capita cost for beneficiaries with specific conditions domain. Exhibit 9 displays the TIN's domain score for each of the cost domains included in the Value Modifier, as well as the resulting cost composite score and quality — and cost tier designation, which can be high, average, or low. The cost composite score summarizes the TIN's performance on up to six measures across two equally weighted domains.

Slides 38 and 39 describe the information contained in Exhibit 10. Exhibit 10 shows the cost measures that were included in the cost domain scores shown in Exhibit 9.

So on slide 39, you can see that Exhibit 10 shows the five per capita cost measures and the MSPB measure that are included in the Value Modifier. It displays for each measure the payment standardized, risk-adjusted, and specialty-adjusted per capita or per episode cost and the number of eligible cases or episodes. The last column indicates whether each measure is included in the TIN's domain score that's shown in Exhibit 9. And only the measures for which the TIN had 20 or more eligible cases or episodes were included in the TIN's domain score.

You can compare your TIN's cost for each measure with the benchmark that's in the third column of this exhibit to better understand how your TIN fared relative to the benchmark, which is the case-weighted average cost for the peer group based on 2014's data.

Slides 40 and 41 show Exhibit 11. For the Per Capita Cost for All Attributed Beneficiaries measure and the four Per Capita Cost for Beneficiaries with Specific Conditions measures, Exhibit 11 displays the dollar difference between the TIN's attributed beneficiaries per capita cost performance by selected category and the corresponding

cost for the TIN's peer group. And the TIN's peer group is defined for each cost category as all TINs that had at least 20 eligible cases for the given measure.

So in this exhibit, bars extending to the left of the axis denote cost categories for which the TIN's per capita cost are lower than those of the peer group. And 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. And you can refer to Supplementary Exhibit 5and Supplementary Exhibits 7 through 10 for more comprehensive cost of services breakdown for each per capita cost measure.

Slides 42 and 43 show Exhibit 12 for the MSPB measure. Exhibit 12 displays the dollar difference between the TIN's per episode cost performance by select category and the corresponding cost for the TIN's peer group, which is defined as all TINs that had at least 20 eligible cases for the measure. And you can refer to Supplementary Exhibit 6 for a more comprehensive cost of services breakdown for the MSPB measure and Supplementary Exhibit 4 for a distribution of cost at the episode level.

So I mentioned earlier in this presentation that the annual QRUR also contains 13 supplementary exhibits that can be downloaded as Excel spreadsheets. In slides 45 to 46, I'll review the information contained in each of these supplementary exhibits.

The Supplementary Exhibits

So slide — on slide 45, you can see Supplementary Exhibit 1. Supplementary Exhibit 1 provides a list of the EPs that were in the TIN based on October 16, 2014, PECOS data and the EPs that submitted Medicare claims under the TIN between January 1, 2014, and December 31st, 2014. For each of the EPs, the table lists the National Provider Identifier Number and the name of the EP along with whether the EP was a physician or a nonphysician EP, their specialty designation. You can use the data in this exhibit to verify information about the eligible professionals in your TIN and understand how CMS determined that these eligible professionals are associated with the TIN.

Slide 46, 47, and 48 show Supplementary Exhibit 2A. This supplementary exhibit provides information about the Medicare beneficiaries attributed to your TIN for the five per capita cost measures and the three claims-based quality outcome measures. The table is divided into sections that describe beneficiary characteristics, specific Medicare claims data, the EPs that billed the most services for the beneficiaries within the TIN and outside of the TIN, the date of the last hospital admission, and whether the beneficiary had one or more of the four chronic conditions requiring a higher level of care.

Slides 49 and 50 show Supplementary Exhibit 2B. This supplementary exhibit provides information about the cost of care provided to the Medicare beneficiaries attributed to your TIN for the five per capita cost and three claims-based outcome measures that are also shown in Supplementary Exhibit 2A. This exhibit provides both the beneficiaries'

total payment standardized Fee-for-Service Medicare cost and the distribution of these costs across various categories of service.

Slides 51 and 52 show Supplementary Exhibit 3. This exhibit provides details about hospitalizations over the performance period for beneficiaries attributed to your TIN for the five per capita cost and three claims-based outcomes measures. The beneficiaries in Supplementary Exhibit 3 are a subset of all of the beneficiaries attributed to your TIN that are shown in Supplementary Exhibit 2A. For TINs that are not participating in a Shared Savings Program ACO, the exhibit also shows whether the hospital admission was the result of an emergency department evaluation, an ACSC admission, or a readmission within 30 days of prior admission. And for TINs participating in a Shared Saving Program in 2014, data on 30-day readmissions are available in Supplementary Exhibit 13.

Slides 53 and 54 show Supplementary Exhibit 4. This exhibit displays information on the beneficiaries attributed to your TIN for the MSPB measure. So I just wanted to mention that in Supplementary Exhibits 2 through 3 that I just reviewed, beneficiaries attributed to the TIN for the MSPB measure were not included in those exhibits. So the data presented in Supplementary Exhibit 4 are at the beneficiary episode level. If a beneficiary has more than one episode that was eligible for the MSPB measure, then that beneficiary will appear in this exhibit for each episode.

Slides 55 and 56 show Supplementary Exhibit 5, and similar to Supplementary Exhibit 2B, Supplementary Exhibit 5 displays the TIN's attributed beneficiaries' costs for various types of services performed by providers both within and outside of the TIN.

Slide 57 shows Supplementary Exhibit 6, similar to Supplementary Exhibit 4. This exhibit displays the per episode cost for various types of services for the episodes of care attributed to the TIN for the MSPB measure.

So now slides 58 and 59 describe information contained in Supplementary Exhibits 7 through 10. These exhibits mirror Supplementary Exhibit 5 and provide information on the various types of services performed by both providers within the TIN and outside of the TIN for the beneficiaries included in each of that chronic specific total per capita cost measures.

Supplementary Exhibit 11 is shown on slide 60. This exhibit displays performance on PQRS measures for each eligible professional who participated in the PQRS as an individual under the TIN in 2014. And it also displays whether each eligible professional met the criteria to avoid the 2016 PQRS payment adjustment. And I just want to note here that PQRS measures submitted in 2014 through the QCDR or EHR reporting options are not included in this supplementary exhibit. Information about performance on these measures is available in the PQRS Feedback Report.

Slide 61 shows Supplementary Exhibit 12. This supplementary exhibit provides details about any incentive the TIN may have earned by participating in the PQRS GPRO in 2014. This table reports the TIN's total incentive amount and shows the incentive as a percentage of the TIN's total Part B Physician Fee Schedule allowed charges.

Slide 62 shows Supplementary Exhibit 13. So for TINs participating in a Shared Savings Program ACO in 2014, this supplementary exhibit provides details about hospitalizations during the performance period for beneficiaries who are assigned — who are both assigned to the ACO and who are either attributed to the TIN based on the two-step attribution rule or are associated with the MSPB episodes that are attributed to the TIN.

Slide 63 describes what a group can do if it doesn't agree with the Value Modifier indicated in its 2014 Annual QRUR. So for groups with 10 or more eligible professionals that are subject to the 2016 Value Modifier, CMS established a 60-day informal review period that began after the release of the QRURs to request a correction of a perceived error in their 2016 Value Modifier calculations. The timeframe for requesting an informal review is open now through November 9th, 2015. And information on how to request an informal review is available on the 2014 QRUR website that's shown on this slide.

Next Steps

So now that I've covered all of the information contained in the QRURs, on slide 64 we describe the next steps that you can take. So if you haven't done so already, please download your TIN's QRUR. We have a number of educational documents available on the 2014 QRUR website that provide detailed information about the QRURs.

There is a document called Understanding Your QRUR, which I suggest you look at while you review your own QRUR. It describes information contained in each exhibit and also provides tips on how you can use that information. We also have a detailed methodology document and sample report and sample supplementary exhibits available on the QRUR — on the 2014 QRUR website. On the Value Modifier website that's listed on slide 66, we have fact sheets available on the 2016 Value Modifier, information on how we apply the attribution methodology, risk adjustment, and specialty adjustment. And we also have detailed specifications for the three quality outcome measures and the six cost measures that are shown in the QRURs and included in the 2016 Value Modifier.

I also want to mention that 2015 is the performance period for the Value Modifier that will be applied in 2017 to physicians in groups with two or more eligible professionals and to physician solo practitioners, so we encourage these groups and solo practitioners to satisfactorily participate in the PQRS in 2015 either through the group practice or individual reporting option. More information about the 2017 Value Modifier is available on the Value Modifier website. And you can contact the QualityNet help desk for information on how you can still participate in the PQRS in 2015.

Slide 65 shows the timeline for phasing in the Value Modifier and when the Mid-Year and Annual QRURs will be available in the future. I want to note here that with the passage of the Medicare Access and CHIP Reauthorization Act of 2015, also known as MACRA, the Value Modifier will sunset at the end of 2018 and the Merit-Based Incentives Payment System will be applied to physicians — will be applied to payments for items and services furnished on or after January 1, 2019.

So slide 66 lists all of the technical assistant resources that are available to help you understand your QRURs and understand the Value Modifier. You can submit questions about the content of the QRUR or the Value Modifier by emailing or calling the Physician Value help desk. You can contact the QualityNet help desk with questions about the PQRS program or if you need assistance setting up an EIDM account that you can use to access your QRURs. And we also have listed here the address for the 2014 QRUR website containing the educational documents — the How to Obtain a QRUR website, the Value Modifier website, and also the PQRS program website.

So slide 67 lists all of the acronyms that were used in this presentation. So this concludes our presentation today. I would now like to turn it over to Amanda.

Question-and-Answer Session

Amanda Barnes: Thank you Sabrina. Our subject matter experts will now take your questions about the 2014 Annual Quality and Resource Use Reports. As I mentioned when we started, we've been collecting questions from the webcast participants during today's presentation. Please continue to submit any content-related questions that you have. During our question-and-answer session, we will be asking you to provide your feedback with the technology used today by clicking links on your screen. Please remember to disable your popup blockers for the best results.

Our first question comes from — a question, excuse me, that was submitted during registration, which is: How do the domains compare to last year's? The language is slightly different and since benchmarks are based on previous year's data, we're curious as how — curious as to how that is reconciled.

The answer to that is, although the domain names changed widely between 2013 and 2014, and new measures were added to some domains, no existing measures were reclassified between 2013 and 2014. New measures for which no prior year benchmark is available are not included in the calculation of the VM. The NQS domain classification for each PQRS measure available for the reporting is listed in tables 51 and 52 and also 80 of the 2014 final rule, and they're also in tables 95–96 of the 2013 final rule.

Our next question also comes from registration: Will providers who practice solely in a secondary certification be compared with like providers? Example, board-certified and

family medicine with additional certification in sports medicine, the physician works in an orthopedic practice and solely practices nonsurgical orthopedics, no family medicine.

The answer to that question is that peer groups for purposes of comparison are not restricted to like providers. But all claims-based cost and quality outcome measures are specialty adjusted to reflect the mix of specialties within a TIN. Physician specialties are based on self-reported data, namely the specialty code, and most often for that provider, a Medicare Fee-for-Service claims comparisons on those quality measures are with other providers reporting that measure.

And another question from registration: Are comparisons regional or national? For example, reimbursement and cost in certain parts of the country are different than in other parts of the country.

All comparisons are national; however, all cost data are price-standardized to account for geographic variations in the Medicare payment rates.

Our next question will come from an online participant. The question is: What costs are included in inpatient hospital trigger?

Kim Spalding Bush: I think our experts from Acumen are going to answer that question as we believe that it relates to the Medicare Spending per Beneficiary measure, which is included as a part of the cost composite for the Value Modifier. Acumen?

Acumen: Hi, this is Acumen. Thank you. All costs that are included in the inpatient hospital trigger service category include Medicare Part A allowed charges paid to the inpatient hospital that triggered the MSPB episode.

Amanda Barnes: OK, great. Thank you. So our next question also comes from an online participant. This is from Katina Burton: Can I add another tax ID for a group practice that we are affiliated with to my current CMS portal access?

Kim Spalding Bush: So the answer to that question is, yes, that the user can add an additional group practice to the profile by following the EIDM Quick Reference Guide. And I am just checking to see whether the address for finding that quick reference guide is located within the presentations. And, yes, you can find that address on slide number 12.

Amanda Barnes: Great, thank you. Our next question also comes from an online participant, Rebecca O'Brien. She asks, "Where can I find the supplemental reports?"

Sabrina Ahmed: Yes, so in order to access the supplementary exhibits that I reviewed, so you can basically follow the same steps that are listed on slide 13, and it's the slide that covers how you can access your reports. You log into the portal with your EIDM account,

follow the steps listed here, and then I would suggest that you look at the Quick Reference Guide for Accessing the Annual QR — Annual QRUR, and in that guide you'll — that guide will tell you how you can specifically access the supplementary exhibits.

Amanda Barnes: Great, thank you. Our next question comes from Darla Charles: What if a physician group is less than 10 EPs?

Sabrina Ahmed: So if the group has less than 10 EPs, then the group will not be subject to the Value Modifier in 2016 because the Value Modifier in 2016 will apply only to physicians in groups with 10 or more eligible professionals. But if you had — if your TIN had eligible professionals that billed under the TIN during 2014 and the TIN had at least one eligible case or at least one quality or cost measure from 2014, then you should have a full quality — a full QRUR that you can access for your TIN.

Amanda Barnes: Great, thank you. Our next question is also an online participant, Stacey Ervin. What causes the report to have insufficient data in the cost composite score and/or the performance section?

Sabrina Ahmed: So when you are looking at your QRUR and if you see that it says that you have insufficient data for either quality composite or the cost composite, then it means that the TIN has fewer than 20 eligible cases for all of the measures that were included in the — in either the quality composite score or the cost composite score. So that could be one reason. The other reason why you can see insufficient data is that if the quality or cost composite score is more than one standard deviation away from the mean but it is not statistically significantly different from the mean at the 5 percent level of significance. So in that case you could also see that you had insufficient data. But for either composite, if you do see the insufficient data, then it means that you are classified as average for that composite.

Amanda Barnes: OK, great. Paula, could you please prompt the telephone users and begin to compile that Q&A roster?

Operator: For those of you participating via telephone only, 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.

You have a question from the line of Jen Robinson.

Jen Robinson: Hi, as a specialist we have been assigned several patients, and I understand that this means that we saw them more than their PCP. We are trying to understand. Obviously, as a specialist we don't treat those conditions. What are we to

do to get them removed from the list, or what are we to do if they are assigned to us so they don't affect our score as far as quality because we cannot control what those doctors are doing when they do see them in the hospital as we do not see them in the hospital?

Kim Spalding Bush: Thanks. And so we use an attribution methodology for our claims-based outcomes measures and for the total per capita cost measures that involves first looking to see whether the patient was treated by a physician and then we attribute that patient to the TIN from which the primary care provider types provided more primary care services than any other TIN. So if that patient did not see a primary care provider or a primary care service, then that patient is appropriately attributed in step 2 of our attribution methodology to the TIN from which a specialist provider provided the plurality of their services there. So I think if the patient was attributed to you — your group, what that means is that they did not receive a primary care visit from any primary care provider during that whole performance year. And so you really were their contact with the outside — with the medical community. So that's why the attribution approach works in the way that it does so that, you know, someone is taking responsibility for that patient's care, and your group being the one because the patient didn't see a primary care provider that was appropriately attributed the patient.

Jen Robinson: Great thank you.

Operator: Your next question comes from Joy Henson.

Joy Henson: Yes, my question is in reference to how you are not using the registry data for the QRUR. If we did not report as a GPRO in '14, but we plan to report as a GPRO in 2015, will that data — because you can only report GPRO data for 2015 in a registry, will that data be used for the 2015 QRUR?

Kim Spalding Bush: Thanks for the question. So yes, we've actually had a number of questions regarding the data that we are not going to use to calculate the 2016 Value Modifier so — reported during the 2014 performance period. And the data issue that we're seeing — and it's hopefully only a problem for the 2014 reporting period. So it wasn't our intent at the outset to not utilize that data, nor do we have any intent not to use it for the calculation of the 2017 Value Modifier that's calculated based on the 2015 performance. So this was just based on an issue that was identified with the data where we couldn't determine whether the data were useable. But we don't anticipate — as people become more familiar with the use of EHR and work closely with their vendors and CMS works with the vendors as well to help, hopefully, eliminate these sorts of issues in the future. We do anticipate being able to use that data in the future.

Joy Hanson: OK, good. Can I ask one more question?

Kim Spalding Bush: Sure.

Joy Henson: There is — on our 2014, we also did claim-based in 2014, but we were concerned we may not have done enough, so we had done some registry as well. There was a measure in here — a drug measure — do you only include measure references that the group reports? Or do you also include measures that they could have reported, but they didn't?

Kim Spalding Bush: Yes, I am not sure that we fully understand the question.

Joy Henson: OK.

Joy Hanson: First of all, I'd like to clarify it, there is one on ours called measure reference 21. We may have reported that in '14, I'd have to ask my billing company. We're not reporting that in 2015 as one of our nine measures. So do we get penalized for that in 2015 if we're not reporting measure 21?

Alex Mugge: You can — so this is Alex Mugge from the PQRS Program. And each new is a — each year is a new year …

Joy Henson: Right.

Alex Mugge: … for PQRS reporting. So you do not have to report on the same measures year over year. You can select a different reporting mechanism or different measures within the same reporting mechanism, it's really your choice.

If you have particular questions about what measures would work best for your practice, you can reach out to the QualityNet help desk, and they are an excellent resource for helping determine which measures would be best to report — or what works best for your situation.

Joy Henson: Yes, it's not mainly what we can or can't. I just want to make sure that this quality domain, indeed, doesn't come in and scoop up measures that we chose not to report and penalize us for it.

Amanda Barnes: Yes, if you can go ahead and send that question to the QualityNet help desk, I think that would be the best way to go for this.

Joy Hanson: OK.

Kim Spalding Bush: Thanks. And I guess also — this is Kim, again, really this is to your first question, I just want to also say that CMS is aware that this — there has been an issue identified, we've received a number of questions on this as well, so I figure we'll cover that here. There has been an issue identified as well with the EHR reporting for

some of the TINs who then were classified as category 2, meaning they didn't meet the PQRS reporting requirements and then consequently they are subject to an automatic downward adjustment under the Value Modifier. We've just become aware of the situation, and we are working through it. So I know that's a question on lots of people's minds. So we are aware that it's there, and we are working on how to address that situation as well. Thank you.

Amanda Barnes: Thank you. We are going to take a question from one of our online participants that comes from Sarah Leek. On page 28, what measures and domains were included in the tiering? More than nine were reported, so what is done with the additional measures reported?

Sabrina Ahmed: Thank you. So if you report more than the required number of measures for PQRS, the Value Modifier does utilize all of the PQRS measures that you reported that meet our case minimum for the Value Modifier. So those measures that you reported above your nine required would also be used in the calculation of the Value Modifier, just as any other PQRS reported measure would be.

Amanda Barnes: Great, thank you. Another one of our online questions comes from the line of Marley Cole. Our group will become 10 in October, but two of the physicians are not claims-based, they are cosmetic providers only. Is the group determined by the number of providers under the TIN?

Sabrina Ahmed: OK, so — OK, so this question is in reference to group size in 2015, which is a performance period for the 2017 Value Modifier. So how we determine — how we'll determine group size for the 2017 Value Modifier is that the list of the groups and solo practitioners that will be subject to the Value Modifier in 2017 will first be based on a query of PECOS that occurs within 10 days after the close of the registration period for registering for PQRS GPRO.

So this year, the PQRS GPRO registration period closed on June 30th. So the first step in determining group size will be to pull the PECOS data within 10 days after that and then we will make sure that for the 2015 performance period we will identify how many EPs billed under your TIN during the 2015 performance period. And then we will take the lower of the number identified from the PECOS data and the number of EPs that submitted claims under the TIN in 2015 to determine your group size for the 2017 Value Modifier.

Amanda Barnes: Thank you. Due to the technical difficulties we were having advancing the slides, we are not able to provide you with the feedback questionnaires. So we won't be able to send those out via the popup screens.

Our next question comes from online registration: When will benchmarks through clinical quality measures be released?

The answer to your question is the quality benchmarks for the 2015 performance period will be released late fall of 2015.

Another question from registration: Do you take into account during the verbal CAHPS for PQRS surveys that are performed, many of these elderly patients cannot hear accurately, have cognitive deficits, which alter their responses and many have barriers that limit them from accurately being able to respond to the questions asked of them?

CAHPS for PQRS survey scores are case-mix adjusted to ensure that a level playing field and the data represents the group practices fairly. Adjustments done on a number of patient characteristics, including, but not limited to, age, education, self-reported health, and self-reported mental health. For more information, please contact the CAHPS for PQRS technical assistance email at pqrscahps@hcqis.org.

Let's take another question from one of our online participants, Alexis Isabelle. When will the quality benchmarks from the 2014 data used for 2015 reporting year be released?

Fiona Larbi: That will be released in the late fall of 2015.

Amanda Barnes: Great, thank you. The next comes from the line of Marissa Furman. Do the peer groups for the quality and cost composite scores — they include all groups with 10 plus providers or is it separated between groups with 10 to 99 providers and groups with a hundred or more providers as a separate peer group?

Sabrina Ahmed: OK, so at the quality composite level, the peer group for TINs with 10 or more eligible professionals is all TINs with 10 or more EPs that are subject to the Value Modifier. And then the peer group for TINs were between one to nine eligible professionals is all TINs with one or more eligible professionals and at least — and the TIN had at least one physician in the TIN. However, it excludes TINs with physicians that participated in the Shared Savings Program, the Pioneer ACO Model, or the CPC Initiative in 2014.

Amanda Barnes: Great, thank you. One more from the online participants: We are a group of dermatologists and do not have admitting privileges. How does this affect us since Value-Based Modifier is based so heavily on hospital admissions?

Kim Spalding Bush: Thank you for the question. So your group's Value-Based Modifier, like others, is comprised of the quality composite. It is all the PQRS measures that your TIN reports. Also the Claims-Based Outcome measure, which are based on provision of primary care services not on hospitalizations. And there is one measure in the program in the cost composite — the Medicare Spending per Beneficiary measure, which is attributed based on plurality of Part B services that are provided during a

hospitalization. So if a group like yours does not get attributed any measures — any cases under that measure, rather, then that measure just would not be scored for you. You wouldn't be penalized; you would just not receive a score for that measure. So it wouldn't factor into your calculation. And you could potentially be attributed the other total per capita cost measures, which are also based on the provision of primary care services.

Amanda Barnes: Great, thank you. The next comes from the line of Michelle Ellich. Can you provide us an update as to when the Shared Savings Program rule will grant EIDM accounts? If we register for an EIDM to obtain QR reports, will it be the same as account for the Medicare Shared Savings Program?

Rabia Khan: Hi, this is Rabia Khan from the Shared Savings Program. So ACOs can set up their EIDM accounts now. The Shared Savings Program will have a demonstration for ACOs in October to help them get ready for the submission period that will begin in January 2016 for GPRO Web Interface measures. So just to also clarify, TINs — participating TINs within an ACO would receive their QRURs. And this — for an ACO to be able to act as a QRUR, they must be a single TIN entity.

So you can set up your EIDM account if you're a single TIN ACO for accessing your QRURs, but just note the accounts and roles will be different when you were registering for quality reporting for the GPRO Web Interface. You use the same EIDM user information, it's just that your accounts and roles will be different.

Amanda Barnes: Great, thank you. Paula, we're going to take one phone — one question from the phone, please.

Operator: Your next question comes from Kathleen Riley.

Kathleen Riley: Hello, can you hear me?

Amanda Barnes: We can.

Kathleen Riley: My question is about the supplemental reports as well. I have been able to log into EIDM and pull up our 2014 QRUR reports for both hospitals, but there is no supplemental report available in that system, is that where I would find it?

Kim Spalding Bush: That should be where you would find it. I think our best suggestion to you would be to contact the PV help desk.

Sabrina Ahmed: Yes, yes, and the PV help desk contact information is listed on slide 66.

Kathleen Riley: OK. I see that, OK.

Sabrina Ahmed: You are looking in the right place.

Kathleen Riley: OK, all right I just wanted to make sure I was looking in the right place. Thank you very much.

Amanda Barnes: You're welcome. Our next question will come from the participant line: Can you please elaborate on the issue mentioned in which some EHR reporters are being categorized under category 2 and CMS is working on it? Can you provide additional information?

Kim Spalding Bush: Sure, thank you. This is the issue that I had just spoken to you a bit earlier that CMS is working on. We've just become aware of it, so we will be notifying affected groups if there is any change to their Value Modifier payment adjustments as CMS does determine the best course of action. So we will certainly let those affected groups know if there is a change to their Value Modifier payment adjustment.

Amanda Barnes: Great, thank you. So another question comes from the line of Laura Adams: We have two family medical sports medicine physicians who function exclusively as sports medicine nonsurgical orthopedists. How can we have their data appropriately applied instead of being applied to the family medicine?

One second.

Sabrina Ahmed: OK, sorry, thank you, just orienting to the question. And so the Value Modifier is applied at the tax payer ID number level, so those providers that are within your group will — within that same TIN, will receive the same Value Modifier payment adjustment. So under the program there is not a way to separate certain providers within your TIN so that they don't receive the Value Modifier payment adjustment that is applicable to the TIN.

Amanda Barnes: OK, great. It looks like we have time for maybe one more question: And can you clarify why beneficiaries in Supplemental Exhibit 4 are not in Exhibits 2 or 3?

Kim Spalding Bush: Thank you. Could our experts from Mathematica Policy Research on the line please answer that question for us?

Wilfredo Lim: Sure. And for the reason why beneficiaries in Supplementary Exhibits 2, 3, and 4 differ are because these exhibits are related to measures with different attribution methodologies. So Supplementary Exhibits 2 and 3 contain beneficiaries attributed under the two-step attribution rule. So these are the beneficiaries that apply to the claims-based quality measures as well as the per capita cost measures. Supplementary Exhibit 4 contains beneficiaries that are attributed for the Medicare Spending per Beneficiary measure. So these are — so the reason for the different beneficiaries is because they apply to different — the reason for the different

beneficiaries for the different supplementary exhibits are because they are tied to the different measures.

Additional Information

Amanda Barnes: OK, wonderful, thank you. Unfortunately, that's all the time we have for questions today.

On slide 66 you will find information on how to evaluate your experience with today's call. We'll also push out — actually, I'm sorry, we can't push out the link to the evaluation, but we will email you the link to participate in that evaluation. Evaluations are anonymous and confidential. We hope you take a few moments to evaluate your experience with today's event.

I'd like to thank our subject matter experts and all participants who joined us for today's MLN Connects Call. Have a great day everyone.

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

-END-


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