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National Provider Call Transcript

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Centers for Medicare & Medicaid Services
Medicare Quality Reporting Programs: 2017 Payment Adjustments
MLN Connects National Provider Call
Moderator: Diane Maupai
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Contents

Operator: At this time, I would 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 would now turn the call over to Diane Maupai. You may begin.

Announcements and Introduction

Diane Maupai: Well, thank you Kalia. Hi everyone. My name is Diane Maupai. I'm from the Provider Communications Group here at CMS in Baltimore, and I'll be your moderator today. I'd like to welcome you to this MLN Connects National Provider Call on Medicare Quality Reporting Programs 2017 Payment Adjustments. MLN Connects Calls are part of the Medicare Learning Network®.

Today's MLN Connects® National Provider Call will provide guidance and instructions on how individual eligible professionals and group practices can avoid the 2017 Physician Quality Reporting System negative payment adjustment, satisfy the clinical quality measure component of the Medicare Electronic Health Records' Incentive Program, earn an incentive based on performance, and avoid the automatic 2017 downward payment adjustment under the Value-Based Payment Modifier.

Various scenarios on how EPs and group practices will be affected by the 2017 payment adjustments will be presented, along with a preview of the remittance advice messaging that EPs will receive in 2017.

First, a few quick announcements. You should have received a link to today's slide presentation in an email earlier today. 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, and the presentation will be listed under Call Materials.

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.

This MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit. For additional information, please refer to slide 45 of today's presentation for a link to the CE activity information and instructions document.

At this time, I'd like to turn the call over to Alexandra Mugge.

Presentation

Alexandra Mugge: Thank you. Hello, everyone on the phone. For those of you following along, I'm going to skip over slide 2, which is the disclaimer notice, and moving on to the agenda, we will be covering how to meet quality reporting requirements, earn incentives, and avoid negative or downward payment adjustments in 2017 under our PQRS, EHR Incentive Program, and the Value Modifier. And we will also go over how to avoid the payment adjustment using — reporting through some of our aligned ACO programs. Then we will have a quick section on understanding the 2017 payment adjustments and some resources and where to call for help.

The Physician Quality Reporting System

Moving on to slide 4. A lot of the — there's a lot of information on these slides, and so, I encourage those of you who are listening in and following along to think about how you are reporting for the 2015 program year. If you are in one of our aligned ACO programs, you should already know that you — that that's how you're participating, so when those slides come up, that would certainly be something to pay attention to.

If you're reporting as a PQRS GPRO or through the group practice option, you'll want to focus on some of that information. And again, you should already know that you're participating as a PQRS, GPRO, or group practice, because registration for that has already closed. So just something to keep in mind going to the presentation, so not all the information that you're learning will pertain to everyone out there, but please consider your individual circumstances.

Slide 5. We have an overview of the reporting process and the three main steps for participation in PQRS, the Medicare EHR Incentive Program, and the Value Modifier. So these slides assume that you are trying to report once for all three of those programs. You can, of course, also report directly to PQRS without participating in Medicare EHR Incentive Program, or you can report once to get credit for both.

So the first step here is to report or submit the measure data. The second step is that CMS will analyze that data. And the third step is the feedback and results that are distributed to providers and EPs through feedback reports and QRUR. So that's as a visual of the steps of reporting. We're going to focus mainly on step one for the subsequent slide.

So on slide 6, reviewing step 1, we will review how to report for multiple programs and how to avoid the PQRS payment adjustment and the EHR Incentive Program payment adjustment and how to earn incentives based on performance and avoid the automatic 2017 downward adjustment under the Value Modifier.

Moving on to slide 7, we have the PQRS feedback timeline. This timeline shows the progression from 2015 reporting or performance period through the 2017 payment

adjustment and all the ways the providers could check their status or reporting feedback during that time. Some of the text on that slide is a little small, but it is there for your reference. And it does show that progression from the reporting period all the way through when the payment adjustment is actually applied.

Slide 8, there is a little disclaimer about reporting through some of the other CMS programs, like the Medicare Shared Savings Program, Comprehensive Primary Care Initiative, or Pioneer ACO program, and just a note that you should always — if you are participating in one of these programs, always check the individual program requirements when reporting to PQRS to make sure that you're meeting the requirements for all the programs you are attempting to report to.

Moving on to slide 9 — this is a slide that highlights how to report once as an individual eligible professional. The text is tiny, but, of course, it is there for your reference. And there is a more detailed version of this graphic that can be found in the "How to Report Once" document that is on the CMS website.

And, I believe, if you go to cms.gov and just type in the search box "how to report once," this would be — this will be the first document that comes up, so you can take a closer look at this. And again, the programs that we are focusing on here are PQRS, the EHR Incentive Program, and the Value Modifier.

So just starting on the first box, I'll move through the diagram quickly. You will choose a PQRS reporting option, either an EHR reporting option or the Qualified Clinical Data Registry option and report nine CQMs covering at least three of the National Quality Strategy Domains. If you satisfactorily report through one of those options, again, the EHR Reporting option or the Qualified Clinical Data Registry option, you would avoid the 2017 PQRS downward adjustment, satisfy the CQM reporting requirement of the Medicare and CHR Incentive Program, and you could risk even upward, neutral, or downward payment adjustment based on the data that you submitted to PQRS.

If you are not successful, you would not avoid any of those payment adjustments. You would be receiving the 2017 PQRS payment adjustment. You would not satisfy the CQM reporting requirement of the EHR Incentive Program, and you would be subject to an automatic downward adjustment on the Value Modifier.

So we're going to move on to the next slide, slide 10, and this is how to report once as a group practice. So one thing I want to highlight here is that all of the individual eligible professionals under a TIN — whoever signs their billing rights with the TIN — are part of the group practice. Depending on how the group practice registers, that is how they are required to report.

So the first step in this slide is really to register using one of the two reporting options, either the EHR Group Practice Reporting option or the GPRO Web Interface option.

Either allow the group to both report to PQRS and meet the CQM requirements for the EHR Incentive Program.

As you can see on either of those, if you meet the reporting requirements and satisfactorily report to PQRS under these options, all of the EPs in the group would avoid the 2017 PQRS payment adjustment to satisfy the CQM component of the EHR Incentive Program and be eligible for an upward, neutral, or downward adjustment under the Value Modifier. If you aren't – not satisfactorily report, of course, you get none of those and would be subject to the downward adjustment.

Moving on to the next slide, slide 11. All that said, you still have time to report to PQRS in 2015. For individual eligible professionals out there who have not started reporting yet, you still can report through a registry-based option or through an EHR or through a qualified clinical date registry, QCDR.

Group practices can still report for 2015 PQRS, provided that they have registered during our registration period as a group practice. And, of course, submission will start in January of 2016. And just a note, again, at the bottom of the slide, you see the decision trees in the 2015 PQRS Implementation Guide on the "How to Get Started" web page. And there will be other references at the end of this presentation to help you learn other ways to report or to go into more detail on the "How to Report" options that I covered in the previous slide.

So I am now going to hand it over to Elizabeth Holland for the Medicare and Medicaid EHR Incentive Program.

Medicare and Medicaid Electronic Health Record Incentive Programs

Elizabeth Holland: Thanks Alex. So the Medicare payment adjustments I'm going to talk about are not CMS trying to be harsh. It's actually CMS just trying to implement the law. This is part of the American Recovery and Reinvestment Act of 2009, which is also the law that created the Medicare and Medicaid EHR Incentive Programs to begin with.

So there are downward payment adjustments for Medicare, but there are no payment adjustments for the Medicaid side of the program. And note that these are called the Medicare EHR Incentive Program payment adjustments, but the incentive payments from this program are actually sunsetting for Medicare. So even though you can't start to earn an incentive payment under Medicare anymore, you can still — you still have to attest every year because, otherwise, you're going to be subject to the payment adjustment. So just keep that in mind.

So what — I'm going to slide 14 now. What do you have to do to avoid the EHR payment adjustment? Well, if you successfully attest to the requirements of the EHR Incentive Programs, you can avoid a payment adjustment, and that means attesting to both the

functional measures and submitting your clinical quality measures either through one of the electronic options or through attestation.

If you happen to be attesting for — under Medicaid for adopting, implementing, or upgrade, that does not get you out of the — of the Medicare payment adjustment. You have to be demonstrating meaningful use.

So if you attest for 2015 — for a reporting period in 2015 — you will avoid the payment adjustment in 2017. So I know you're hearing this and you're all excited, you want to attest right now for 2015, but you cannot. The attestation for 2015 reporting period is going to open on January 4, 2016, and that's basically because we have proposed a number of changes in our policies for 2015, so we need to finalize those and then make all the appropriate changes to the attestation system. So we expect that it will be open in January.

So — and, right now, just so you know, it opens January 4, and — it does — it is scheduled to close on February 29, 2016. So we strongly recommend that people do not wait until February 29. You do get that extra bonus day this year — but — next year — but do not wait until the last minute. OK.

So what happens if you — slide 15 — if you don't successfully attest? Well, if you didn't attest for 2014, you would get the payment adjustment in 2016. So we've already mailed letters to hospitals that are getting the payment adjustment in 2016, and we plan to mail letters to eligible professionals later this year to inform them that they are going to get the payment adjustment.

So, if you don't get a letter, that means you're not subject to the payment adjustment. But if you do happen to get a letter, I suggest that you read it very carefully. It will have instructions in it on what you need to do to file for a reconsideration request, and all that information will be in the letter.

So this call is about avoiding the payment adjustments for 2017. So if you don't attest for 2015, you still have time to pop up for a hardship exception. The hardship exception period opens in 2016, and so, we have listed on slide 15 the categories under which you can file for a payment adjustment: either infrastructure, lack of control, lack of face-to-face interactions, or unforeseen or uncontrollable circumstances.

So we post all that information on our website, including the application. So if you file the application for hospitals — eligible hospitals — it's April, but for EPs — it's — they're not due until July and, after that, you'll get a letter explaining whether you are approved or disapproved for a hardship exception.

So my last slide, slide 16 — just to talk about what the payment adjustments are for eligible professionals. So they're actually applied to the Medicare Physician Fee

Schedule amount. So the amount is taken off of your fee schedule for the appropriate year, and so — all your claims — all your Medicare claims will be subject to that reduction, and the reduction in 2016 is 2 percent, and in 2017, it's 3 percent.

And so, if you need more information about our payment adjustments or about our program at all, please visit our website, because we have lots of great information, and we're in the process of reorganizing it to make it easier to use. So we have a lot of coming soons on there right now.

So now I'm going to turn it back over to Diane.

Keypad Polling

Diane Maupai: Thank you Elizabeth. And at this time, we're going to pause for a few minutes to complete keypad polling. Kalia, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in.

If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you for your participation. I would now like to turn the call back over to Diane Maupai. Diane Maupai, the polling is complete.

Presentation Continued

Diane Maupai: I'm sorry. I thought I hit the mute button, but not quite hard enough. So I'm going to turn it over to Fiona Larbi who's going to talk about Value-Based Payment Modifier.

The Value-Based Payment Modifier

Fiona Larbi: Good afternoon. I'm Fiona Larbi and, as Diane said, I will be talking about the Value-Based Payment Modifier.

Beginning on — beginning on slide 18 — this briefly describes how the VM is assessed and how it is applied. In 2017, the VM will apply to physicians and groups with two or more EPs and physician solo practitioners billing under their TIN, based on their

performance during 2015. Additional reporting outside of the PQRS is not required under the VM.

On slide 19, this shows how the VM will be applied in 2017 to the physician groups with two or more EPs and to physician solo practitioners. On the left side of the slide, you can see that for 2017 — for the 2017 VM, based on 2015 performance, groups with two to nine EPs and physician solo practitioners can qualify for an upward or no VM adjustment based on quality-tiering. Quality-tiering is the methodology that we use to calculate the Value Modifier.

Groups with 10 or more EPs can qualify for an upward, no, or downward VM adjustment based on quality-tiering. This is dependent on successfully reporting under the PQRS and meeting the criteria to avoid the 2017 PQRS payment adjustment by either reporting as a group or by ensuring that at least 50 percent of the EPs in the group report as individuals and meet the criteria to avoid the 2017 PQRS payment adjustment or by physician solo practitioners reporting PQRS measures as individuals.

On the right side of the slide, you can see that the groups of solo practitioners who do not avoid the 2017 PQRS payment adjustment are subject to the following automatic adjustments under the VM: for groups with two to nine eligible professionals and physician solo practitioners, the automatic downward adjustment is negative 2 percent of the Medicare Physician Fee Schedule amount. For groups with 10 plus, use the automatic downward adjustment as negative 4 percent.

Next, we'll go to slide — slide 20 — I'm sorry. This slide focuses on the quality and cost measures that will be used to calculate the 2017 Value Modifier based on 2015 performance. The Value Modifier is based on two composites: the quality composite and the cost composite. The quality composite is calculated based on either group or individual EP reported data.

The groups that report PQRS data as a group in 2015 — we will use the measures reported under the PQRS GPRO reporting option selected or, if at least 50 percent of the EPs in the group report PQRS data as individuals, we will use the individually-reported data to calculate the quality composite, providing the group meets the satisfactory reporting criteria to avoid the 2017 PQRS payment adjustment. For solo practitioners, we will use their individually reported PQRS data, providing they meet the satisfactory reporting requirements to avoid the 2017 PQRS payment adjustments.

All groups and solo practitioners subject to quality-tiering will be — we will also calculate three outcome measures using administrative claims. These are the composites of preventable hospitalizations for acute conditions, chronic conditions, and the all-cause readmission measure.

Finally, we will include the results of the 2015 CAHPS PQRS survey in a group's quality composite if they elected this option when registering to participate in the 2015 PQRS GPRO. The cost composite is based on six — specially — specialty-adjusted cost measures, and these are the total per capita cost for all attributed beneficiaries measure. The four total per capita cost measures the beneficiaries with specific conditions, and these conditions are listed in the slide and the Medicare spending per beneficiary measure, or MSPB.

All six cost measures included in the calculation of the Value Modifier are payment standardized, meaning we account for differences in Medicare payment rates for different group types and geographic location. They are risk-adjusted for specific beneficiary characteristics and adjusted to reflect the specialty mix of the eligible professionals in the group.

Slide 21 shows the 2017 Value Modifier amount applicable to physicians in groups of two to nine EPs and physician solo practitioners. These groups and solo practitioners will be subject to an automatic negative 2 percent Value Modifier downward payment adjustment for not meeting the satisfactory reporting criteria to avoid the 2017 PQRS payment adjustment.

Groups and solo practitioners that do avoid the automatic Value Modifier payment adjustment will be subject to quality-tiering. And the table shows that, under quality-tiering, the highest potential upward adjustment for a group or solo practitioners in 2017 will be two times x, x being the Value Modifier upward adjustment factor if they are classified as high quality, low cost.

Physician solo practitioners and groups with two to nine EPs will be held harmless from any downward adjustment under quality-tiering. We will only apply an upward or neutral adjustment to them in 2017.

Additionally, groups and solo practitioners who are subject to upward adjustments are also eligible for an additional upward adjustment of one times the Value Modifier adjustment factor if their beneficiary risk scores fall into the top 25 percent of all beneficiary risk scores.

Now, moving to the next slide, which is slide 22, this looks at the 2017 Value Modifier amount applicable to physician groups with 10 or more EPs. These groups will be subject to an automatic negative Value Modifier downward payment adjustment for not meeting the satisfactory reporting criteria to avoid the 2017 PQRS payment adjustment as a group or by not having at least 50 percent of the EPs in the group avoid the PQRS payment adjustment.

Under quality-tiering, these groups are subject to an upward, neutral, or downward payment adjustment in 2017, based on their performance on quality and cost measures for the Value Modifier.

The table shows that, under quality-tiering, the highest potential upward adjustment will be four times the Value Modifier upward adjustment factor if they are classified as high quality, low cost. And the highest potential downward adjustment factor is negative 4 percent if the group is classified as low quality, high cost in 2017.

Additionally, groups who are subject to upward adjustments are also eligible for the extra upward adjustment of one times the Value Modifier adjustment factor if their beneficiary risk scores fall into the top 25 percent of all beneficiaries' risk score.

Moving to slide 23. This slide is a slide that — there's helpful resources available to groups and solo practitioners related to PQRS and the downloading of the Annual Quality and Resource Use Report. And we — the links are here to be able to help you access those.

And then, slide 24 is the slide that gives information about our helpdesk, who you could contact should you need any more information or you have any questions about the Value Modifier or the QRUR.

And now, I'll hand it back to Alex who is going to talk about the Pioneer ACOs.

The Pioneer Accountable Care Organization Model

Alexandra Mugge: Thanks Fiona. So this is Alex Mugge again, and I will be covering the slides for the Pioneer ACO Model. Starting on slide 26, for 2017, the performance year 2015, which is what we've been talking about on today's call, eligible professionals in Pioneer ACOs will be reporting to PQRS through the GPRO Web Interface under their Pioneer ACO participation. The — Pioneers must meet the reporting requirements for PQRS and submit the 12 months of data that is required by the PQRS program.

The third bullet on the slide refers to nonparticipating providers of Pioneer ACOs. So I just want to clarify that Pioneer ACOs have a special circumstance where they are made up of split TINs, which means that under a Pioneer TIN, there may be NPIs or eligible professionals who participate in the Pioneer ACO and some who do not.

Those who do not are still required to report to PQRS through traditional PQRS channels and are not covered under the Pioneer reporting that the other eligible professionals and their TIN are — would be reporting. So there are a couple of links at the bottom of this slide to access PQRS GPRO criteria and other reporting criteria, and those are there for your reference.

Moving to slide 27 for the Pioneer ACO 2015 reporting. For PQRS, EPs in a Pioneer ACO will avoid the 2017 PQRS payment adjustment through their reporting to the Pioneer. So as long as they are successful — as they successfully report through the Pioneer ACO, they will be covered for their PQRS participation.

Under the Medicare EHR Incentive Program, by virtue of reporting satisfactorily to PQRS through the Pioneer ACO — you would — the EPs who are participating providers in the Pioneer would meet the CQM reporting requirements of the EHR Incentive Program.

Just to note, in this slide, each individual eligible professional must still attest to the meaningful use core measures and other objectives in the Registration & Attestation System. But their CQM reporting requirements would be met by reporting in the GPRO Web Interface for the Pioneer ACO.

Under the Value Modifier for 2017, any TINs that are associated with a Pioneer ACO Program are waived within a Value Modifier, so there would be no adjustments there. However, they would still receive any quality resource use reports to reference how they would have done under — the Value Modifier — would — should have applied to that TIN.

Moving on to slide 28, we have a little more information on the split TINs. The split TIN situation that I was talking about earlier — for Pioneer ACOs that are in split TINs — again, what this means is that some of the NPIs that report under the TIN are part of the Pioneer ACO and some of the NPIs under the TIN are not part of the Pioneer ACO, and those NPIs must report to PQRS and meet the PQRS reporting requirement, or they will be subject to the 2017 downward payment adjustment.

So this slide just notes that if you are in a split TIN, it is the TIN's decision whether they decide to report as an entire group, which would include the participating and the nonparticipating NPIs, and go with the PQRS group reporting option, or if the group decides not to do that, then the individual NPIs who are nonparticipating — meaning they are not part of the Pioneer ACO — would need to report individually to PQRS in order to avoid the 2017 payment adjustment.

I am now going to hand it over to Rabia Khan to talk more about the Medicare Shared Savings Program.

The Medicare Shared Savings Program

Rabia Khan: Thanks Alex. So, yes, I'm Rabia Khan from the Medicare Shared Savings Program, and I'll provide an overview on how the Shared Savings Program aligns with PQRS, the Value Modifier, and the EHR Incentive Program, so that EPs who are participating within the Shared Savings Program ACOs for 2015 reporting can avoid those negative payment adjustments that were just covered.

So moving to slide 30, if the ACO satisfactorily reports measures through the GPRO Web Interface, then the PQRS eligible professionals who are participating within the ACO — so through the ACO participant TINs — will not be subject to the 2017 PQRS payment adjustment, and they would avoid the automatic downward payment adjustment for the VM, but they may be able to also earn an incentive under the VM in 2017.

So just to note though that — previously, ACO participants were not subject to the Value Modifier, so this is the first time those ACO participants for the Shared Savings Program will be subject to the Value Modifier, which is based on 2015 reporting, but the payment adjustment, as Fiona went over earlier, is for 2017.

Also, I want to note that, for Shared Savings Program ACO participant TINs, you can only meet the PQRS reporting requirements through the Shared Savings Program. So there's no other registration that was required for TINs for PQRS. So by the ACO completely reporting those GPRO Web Interface measures on behalf of their participant TINs, you will meet the PQRS reporting requirements.

For the EHR Incentive Program, EPs participating in the Shared Savings Program through their ACOs can satisfy the CQM reporting requirement for the EHR Incentive Program if those EPs use certified EHR technology, and the ACO satisfactorily reports through the GPRO web interfaces.

But please note again — so what Elizabeth Holland went over earlier was that EPs have to attest to — all of the — all of the EHR Incentive Program requirements according to their timelines to demonstrate that they are meaningful users. So even though you can meet your CQM reporting requirement through your ACO, you still need to attest to all of the other EHR Incentive Program requirements.

So moving to slide 31. I'll go over a little further on the application of the VM to the ACO participant TINs, since this is a new adjustment that will be applied to ACO participant TINs. So like I mentioned earlier, beginning in 2017, the Value-Based Payment Modifier will be applied to physicians in groups with two or more EPs and physician solo — to groups and solo practitioners participating in the Shared Savings Program ACO for 2015 will be subject to that 2017 Value Modifier, based on the calendar year 2015 performance. As Fiona mentioned earlier, the VM is calculated by a cost and a quality composite, so what's slightly different for a Shared Savings Program ACO participants is that — so the cost composite will be classified as average. But the quality composite will be calculated using the data that was reported by the ACOs through the GPRO Web Interface and the claims-based ACO All-Cause Hospital Readmission measure.

If an ACO, though, fails to successfully report on those GPRO Web Interface quality measures, then the participant TINs under the ACO who are subject to the VM will be subject to that downward — automatic downward adjustment. In 2017, that automatic downward adjustment is minus 4 percent for physicians and groups with 10 or more

EPs, and it's negative 2 percent for physicians and groups with between two to nine EPs and physician solo practitioners.

Now, I'm going to turn it back to Alex Mugge, who is going to go over more about the 2017 payment adjustment.

Understanding the 2017 Payment Adjustment

Alexandra Mugge: Thank you Rabia. And there is quite a bit of text on the next few slides. I'm going to go through these quickly so that we can get to the question-and-answer session, and you can all ask your burning questions on the phone.

So slide 33 is a summary of the payment adjustments that we have discussed throughout this presentation. As you can see for PQRS, the 2017 payment adjustment is negative 2 percent of the Medicare Physician Fee Schedule allowed charges. For the Medicare EHR Incentive Program, that's negative 3 percent. And for the Value-Based Modifier, it depends on what category you fall into and the size of your group, but I will leave that there for your reference — and I — and I know that Fiona covered a triple amount of that earlier.

Moving on to slide 34. We've got a couple of examples of scenarios for EP reporting, either as individual EPs or as part of a group practice. Just on this slide, I want to quickly highlight — because it may not seem completely obvious to folks, but what we're talking about here is Dr. Sally Smith, who is reporting as an individual professional, and Dr. Bob Jones, who is reporting as part of a group practice.

And so, you'll see that under PQRS, it knows that Sally Smith is reporting as an individual practitioner; Dr. Jones is reporting as a PQRS GPRO. Same under the Value Modifier — it shows that Dr. Smith is reporting as an individual, and Dr. Jones is reporting as a PQRS GPRO.

But when you get to the Medicare EHR Incentive Program, both are reporting as an individual eligible professional. And the reason for that is that the Medicare EHR Incentive Program is an individual-eligible professional-based program. It's an NPI-level based program, and you have to attest to the core objectives and measures for the meaningful use program individually.

So even if you submit your CQM data as a group practice or as part of one of the ACOs that we've discussed, you still have to individually attest to those core main meaningful use measures in order to receive credit for the EHR Incentive Program.

OK. Not to belabor that point any longer, we will move on to slide 35, where we talk through Dr. Sally Smith's reporting scenario. And Dr. Smith, in 2015, reported a couple of PQRS claims measures; however, she did not report the required nine measures covering three domains, and she did also attest to the EHR Incentive Program through

the EHR Incentive Program's Registration and Attestation System. So she would have attested her CQMs — the quality measures — as well as the meaningful use core measures and objectives — to the Registration and Attestation System.

So Dr. Smith does receive the 2017 PQRS payment adjustment because she did not report satisfactorily to PQRS, and she — and she will also be subject to a Value Modifier downward adjustment. But because she met all of the objectives for meaningful use through the Registration and Attestation System, she will not be subject to the EHR Incentive Program payment adjustment.

The next slide, slide 36, is a summary of the timeline of the events for Sally Smith. You'll see in 2015 she did her reporting. In 2016, she would receive her feedback explaining which payment adjustments apply and did not apply to her. And, in 2017, a separate payment adjustment would be applied, so, in 2017, she would see the downward PQRS adjustment and Value Modifier adjustment, but she would not see a downward adjustment for the EHR Incentive Program because of her attestation.

Slide 37 talks about Dr. Jones and his experience reporting through a group practice. So Dr. Jones is in a group practice of about 50 EPs. And the group decides to report electronically for the — through the EHR option to PQRS. Dr. Jones also reports his CQMs and other meaningful use objectives through the Registration Attestation System. Just of note here, Dr. Jones did not need to attest to the eCQMs, since his group practice was already electronically submitting to PQRS, but he chose to report through both options.

So he successfully participated in PQRS through his group practice EHR reporting, and also successfully reported to the EHR Incentive Program for his attestation. So Dr. Jones would not receive any payment adjustment for 2017.

Slide 38 shows the timeline, again, of Dr. Jones's experience with reporting to PQRS in 2015. Of course, gathering the data for reporting — that is the reporting period. In 2016, his group practice would have submitted their EHR data, and he would receive feedback on that on his performance. And, on 2017, Dr. Jones would not be seeing the payment adjustments — I'm sorry — would not be seeing any downward payment adjustments, because he satisfactorily reported to all of the programs, so would see an upward adjustment as part of his Value Modifier.

Slide 39 contains a list of resources, many of which we have referred to in one or the other throughout the presentation, and as well, on slide 40, there are some additional resources.

And on slide 41, we have the slide for who to call for help. And for — note the QualityNet Help Desk can certainly answer many of your questions on how to get started with PQRS if you have any questions that are particular to how to get started, or

you're struggling with which reporting option to choose. And then, there are other resources on this list, particularly those that are specific to some of the other aligned programs that we talked about today.

And I will hand it back over Diane for the question and answer.

Question-and-Answer Session

Diane Maupai: Thank you Alex. Our experts will now take your questions. But before we begin, I'd 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, Kalia, we're ready to take our first question.

Operator: To ask a question, press star, followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster. Please continue to hold while we compile the Q&A roster. Please continue to hold while we compile the Q&A roster.

You have your first question from the line of Karla.

Karla: Hello?

Diane Maupai: Hello.

Karla: Hi. I have a question. So if we have the EHR Incentive Program, do we have to report the CQM and through the EHR or just through the EHR attestation?

Alexandra Mugge: If — so, if you are trying to participate in the EHR Incentive Program, you can report your CQMs two different ways. You can report your CQMs to PQRS through the EHR reporting option, through a QCDR if you're reporting as an individual eligible professional, or through the GPRO Web Interface if you're reporting as a group practice.

And if you report your CQMs to PQRS through one of those methods, then you do not need to attest to them in the Meaningful Use Registration Attestation System. However, if you are reporting to one of our other reporting options, like the traditional registry or claims-based reporting options, then you would need to separately attest your CQMs to meaningful use.

Karla: OK. That's all I have.

Alexandra Mugge: Thank you.

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

Kelly Magan: Hi. I'm questioning — I missed what you had just said. But I'm questioning — we're attesting to Meaningful Use for the first time this year using this last quarter as what we're attesting to, and we're doing our PQRS on our Medicare HIPAA forms. What else do I need to be doing before the end of the year?

Alexandra Mugge: So this is Alex Mugge, and I'm sorry, I missed what you said on how you're participating in PQRS.

Kelly Magan: We're submitting it on our claims through Medicare at this point.

Alexandra Mugge: OK. So if you are submitting to PQRS on claims, and that would not count towards Meaningful Use, but it sounds like you've already decided to attest to Meaningful Use for your CQMs and the core objective in the Registration Attestation System. Is that correct?

Kelly Magan: Correct. We were planning on doing that in January. Then, have I met all the requirements I need to meet at this point so the doctor doesn't get pinged next year?

Alexandra Mugge: Assuming that you would satisfactorily report through the methods that you were just talking about, then, yes. Then, you would meet the requirements to avoid the payment adjustment.

Kelly Magan: OK.

Elizabeth Holland: This is Elizabeth. Let me just clarify — because you're attesting for the first time for 2015, so that officially would not get you out of the payment adjustments, because the payment adjustments start January 1. But if — because if you are special because normally you could have attested earlier in the year, so…

Kelly Magan: Right.

Elizabeth Holland: …when you attest in January, we will take — if you're successful, we will take you off the payment adjustment list, and we will reprocess your claims to make you whole.

Kelly Magan: Oh cool. It's just been so complicated.

Elizabeth Holland: Yes.To make it even more complicated, we're actually working, as I mentioned, to change the requirements for Meaningful Use for 2015, and we should be releasing those shortly.

Kelly Magan: OK.

Elizabeth Holland: But it should be easier, not harder.

Kelly Magan: I know. I just — you know, it's just all of the stuff, and then, the terminology of SNOMED — I'm just getting very lost right now.

Elizabeth Holland: We try to — we're redoing our website to try to make it possibly as easy as possible. You know …

Kelly Magan: OK.

Elizabeth Holland: …we're trying to simplify, simplify, simplify.

Diane Maupai: Well, thanks, Elizabeth.

Operator: Your next question comes from the line of Jason Shropshire.

Jason Shropshire: Hi. Can you hear me?

Diane Maupai: Yes.

Jason Shropshire: So I have a question in regards to — and I have called the Physician Value Help Desk, and I can't seem to get any help, so I'm hoping someone here can help. So I have a question about the TIN, the NPI combination, and how that relates to merged TINs.

So my question is, I have two TINs that are merging this year or did merge in August. TIN A has 50 providers, TIN B has 90 providers. TIN A is merging into TIN B, so the total for TIN B will become 140 providers.

So we plan to report PQRS in calendar year 2015 for those 140 providers, but we are not planning to report PQRS for TIN A, which was comprised, again, of 50 providers out of that 140 for the first 8 months of the year.

So my understanding is, for PQRS, there will be no penalty to be applied in 2017, because that TIN-NPI combination for TIN A with those 50 providers will not exist in 2017. What I need to make sure is, is the Value Modifier set up the same way, meaning there will be no penalty applied in 2017 because that TIN-NPI combination will no longer exist?

Diane Maupai: MPR, are you on the phone?

Wil Lim: Yes, we are.

Diane Maupai: Could you reply to this please?

Wil Lim: Sure. So — and just to clarify — just to clarify the example, was there a penalty? So the— basically, the idea is, a Value Modifier would be computed for TIN A and then separately computed for TIN B, based on performance in 2015. In 2017, when the payment adjustment — Value Modifier payment adjustments are applied, based on your example, it sounds like the providers will only be billing through TIN B. In that case…

Jason Shropshire: Correct.

Wil Lim: …when they bill through TIN B, the Value Modifier that is associated with TIN B will apply. It's directly tied to the TIN. So to the extent that they do not bill through TIN A, the Value Modifier that was calculated for TIN A will not apply in 2017.

Jason Shropshire: Thank you. So where can I find language that clearly states this? Because I have tried and tried and tried, and I don't find anything in regards to the website that is even close to spelling this out in writing.

Fiona Larbi: Wil, this is Fiona again. Do we — do we have to send out detailed methodology, by any chance?

Wil Lim: I'm not sure at this point if that scenario is specifically covered in the detailed methodology. It's possible…

Jason Shropshire: All I've — all I've been able to find is detail about merging TINs as it relates to PQRS, not — there's no information about merging TINs as it relates to the Value Modifier. So if that doesn't exist, can that be completed and put on the website?

Fiona Larbi: We will definitely look into this, then — we can get back to you. We can get the detail.

Jason Shropshire: And is there someone — is there a person or a number I could call to speak directly to someone rather than trying to go through the Physician Value Help Desk and getting referred to different tiers and never getting an answer?

Fiona Larbi: If —when you go through the Help Desk, you can ask to be escalated to CMS, but we'll try and get you information, and then get back to you with this.

Jason Shropshire: OK. Do you need my information now?

Fiona Larbi: No. No.

Diane Maupai: Just if you could call the Physician Value Help Desk and give them your information and say that you're asking to be escalated — part of this conversation on the National Provider Call — we'll follow up with them and try to get your information. But, for now, we are going to move to the next question.

Operator: And your next question comes from the line of Therese Kegg.

Therese Kegg: Hi. Thanks for taking my call. I was wondering — you made a comment about the EHR Incentive Program and that letters would be sent out to eligible providers later this year.

Two questions with regards to that — do you have any more specific window? And secondly, I'm going to guess that those are going to go to the address that we completed in our EHR registration. I'm curious because I have over 800 providers that I'm responsible for.

Elizabeth Holland: OK. So I do not have a definite window yet of when the letters will go out. There's a lot of letters, and they're all mailed by the MACs, and so — it — when the letters are mailed will vary by the individual MAC. And I do believe the letters get sent to the address that we have on record.

Therese Kegg: OK. Thank you so much.

Diane Maupai: Thank you Elizabeth.

Operator Your next question comes from the line of Analisa Martin.

Analisa Martin: Hi. Earlier it was mentioned that the final rule would be released shortly. Is there a timeframe or a definition of when "shortly" would occur?

Elizabeth Holland: OK. So I have a standard remark that I'm supposed to make: "We appreciate provider interest in the EHR Incentive Programs and in our final regulations in particular. We have submitted the final rule to the Office of Management and Budget for review. CMS intends to finalize a set of requirements that addresses attestation deadlines and reduces the overall reporting burden on providers and provides flexibility for reporting periods in 2015. And generally, we have been expecting it in fall of 2015." And, yes, I do understand that it is now officially fall, but it's not today.

Diane Maupai: Thank you Elizabeth.

Operator: Your next question comes from the line of Naomi Malid.

Naomi Malid: Hi. Thanks for taking my call. My question is about — I represent a behavioral health provider, and they report PQRS through their EHR vendor's registry. Now, the EHR vendor does not support all of CMS's registry measures, and so, they're having trouble finding through their vendor supported registry list measures that they can meet for PQRS reporting.

So my question is, are you aware of this problem with certain vendors not supporting all of CMS's measures? And, you know, it just doesn't seem fair that these providers will be penalized because they aren't able to report successfully because of that.

Alexandra Mugge: OK. This is Alex Mugge again. And, are you referring to the EHR vendor, not the Registry, correct?

Naomi Malid: Yes, the EHR vendor.

Alexandra Mugge: Yes. So the EHR vendors currently are only required to certify their systems for the minimum of nine measures, and we don't specify which nine measures that is, so they are able to select that minimum of nine measures to certify their products to, which understandably, can make it difficult for certain providers to find nine measures within one EHR that all applies to them.

You — for your practice, as long as you can report on at least one Medicare patient on at least one measure in your EHR, you can submit zeros for the other eight measures. And outside of that, I would encourage you certainly to work with your EHR vendor to — and ask them to certify to as many measures as possible or to the particular measures that you feel will best serve your practice.

Naomi Malid: Thank you. And we have tried to do that with them and, you know, it's a small group and the vendor doesn't seem to be interested. I mean, perhaps we have to switch vendors, but it's obviously very frustrating because they want to participate, but they're hitting these roadblocks.

Alexandra Mugge: Yes. Absolutely. And it's something that we continue to work on and engage with the vendors on as well, so we hear you and understand and appreciate…

Naomi Malid: And I guess — I'm sorry — just one more. The — so the MAV process — will the MAV process take that into account when looking at how many measures they could have reported on? Do they look at the fact that the vendor only provided, you know, six that they could report on — or is — or does the MAV process look at CMS's measures that —in determining that?

Alexandra Mugge: The MAV process does not apply for EHR reporting, but again, you can report zeros for the other measures to complete your nine-measure requirement. So even though you would not have any patients in the denominator, you can report the object identifier for that measure to meet your nine-measure requirement.

Diane Maupai: Thank you, Alex.

Naomi Malid: OK.

Diane Maupai: Thank you for your questions. If you have anything else, please hit star 1, and we'll come to you as time permits. We'll take our next question.

Operator: Your next question comes from the line of Sylvia Young.

Sylvia Young: Hi. Yes. Hey. I have got a quick question about the Value-Based Modifier. When you look at the quality outcome measures — the all-cause hospital readmissions — as you're aware, I'm assuming, that we also, in the hospital, have a Value-Based Purchasing.

So the question is, and there is — and then, we have also the readmission penalty for the hospital. But as far as the readmission penalty, are the same patients affected by the Value-Based Modifier, as well as the readmission and penalty that is driven in the hospital setting? Are they included in both places?

Rabia Khan: So this is Rabia Khan. So I don't think we can actually speak for the hospital Value-Based Purchasing Program and how they apply or use the all-cause readmission measure for their program. But I think – if Wil from MPR could help explain how we use the all-cause readmission measure for the Value Modifier…

Sylvia Young: I mean, because it'd be the same patient, really — is Readmission Penalty Program versus Value-Based Purchasing. But — the — I didn't know if the same patient can be affected in both programs or included in both programs.

Alexandra Mugge: And I think, to Rabia's point, we can't speak to the attribution of the patients — the two programs. Unfortunately, we don't have anyone from the hospital side in the room to help speak to that, so apologies for that one.

Sylvia Young: Yes. OK.

Wil Lim: And so, for the attribution for the Value Modifier program for the all-cause readmissions measures — so beneficiaries are attributed to the TIN based on primary care services provided by the providers and the TIN according to two-step attribution rule.

So on the first step, the beneficiaries attributed to the TIN who is a primary care physician account for the largest share of charges for primary care services for that beneficiary than the primary care physicians of any other TIN, and to the extent that beneficiary do not receive primary care services from a primary care physician — then that — then, in step two, that beneficiary is assigned to the TIN whose physician specialist, nurse practitioner, physician assistant, and clinical nurse specialist accounted for more Medicare-allowed charges for primary care services than for any other TIN.

Sylvia Young: OK. I was just thinking of hospitals that have — physicians — physician practices, as well as the hospital, because I touch both, and so, you know — there's that —there's that overlap of patients going in and out of the hospital and to those physician practices, and just trying to get an understanding whether that same patient can be hit by two different programs, so it sounds like they can. Thank you.

Diane Maupai: Thank you Wil.

Operator: Your next question comes from the line of Sarah Goult.

Sarah Goult: Hi. Yes. Thank you. The Value Modifier shows that we did not hit 50 percent of providers doing PQRS satisfactorily, but my PQRS feedback report shows a list of providers, all of whom are not subject to an adjustment. How do I find out which providers did not do PQRS satisfactorily?

Diane Maupai: One moment.

Fiona Larbi: I think with this one, you should call the Physician Value Help Desk, and they can actually walk you through your QRURs and give you some more information.

Sarah Goult: Thank you very much.

Diane Maupai: Thank you, Fiona.

Operator: Your next question comes from the line of Jane Chapman.

Jane Chapman: Yes. We're a group of four physical therapists in private practice. We're reporting PQRS by claims based, and I'm looking to see if you can confirm for us that we are not eligible to participate with the EHR program or the Value Modifier program.

Alexandra Mugge: That sounds like a very group-specific question, so I think we need to refer you to the Help Desk so they could take a look at your individual situation and confirm that information for you.

Elizabeth Holland: So you're talking physical therapists, not physicians?

Jane Chapman: That's correct.

Elizabeth Holland: Yes. Physical therapists are not currently eligible for the EHR Incentive Program.

Jane Chapman: OK. Or the Value-Based Modifier?

Fiona Larbi: Or the Value-Based…

Jane Chapman: I'm sorry?

Fiona Larbi: Or the Value-Based Modifier.

Jane Chapman: OK. Thank you very much. Thank you.

Diane Maupai: Thank you Fiona.

Operator: Your next question comes from the line of Sue Gordon.

Sue Gordon: Hi. Appreciate you taking my call. We've got — we had submitted PQRS for our hospitalists as individual providers, but a lot of those hospitalists under that TIN are part-time providers.

Now, I know that the full-time providers we were able to submit PQRS successfully on, but a lot of those part-time providers might have only had a few claims submitted over the year, yet when we got our QRUR report, it showed that we were in the penalty, because 50 percent of the providers did not successfully submit.

So is there no volume-based look at, you know — "these 10 providers only submitted three claims, but these five providers submitted hundreds"? It just looks like all of my part-time docs who may work elsewhere, if they didn't successfully submit in their other organizations as well, I can't tell whether they are achieved or not, and yet, my QRUR looked at everyone as a group, and individual docs counted for the 50 percent. Is that how that works?

Fiona Larbi: Wil, could you take this question please?

Wil Lim: Sure. So the Value Modifier is applied at the TIN level. And so, the size of the TIN is determined — and the providers, I assume, from the TIN — are determined based on two factors. So the size is based on the TIN NPIs that are in PECOS. And then, they are also determined based on the providers that bill under the TIN during the year. So if — even the part-time providers billed under their TIN, they would be considered as part of the TIN for Value Modifier purposes.

Sue Gordon: So it really doesn't matter that the part-time providers might have only worked 1 day out of the year? If my part-time providers make up the bulk of my TIN, they can totally influence and don't successfully achieve PQRS submission, they — even though they're — may be 10 percent of my volume of patients seen, QRUR is still looking at each of them with the same weight that they look at my individual physicians as far as whether hits that 50 percent threshold.

Wil Lim: That is correct.

Sue Gordon: OK. Thank you.

Operator: Your next question comes from the line Dustin Derve.

Dustin Derve: Hi. We are reporting on the PQRS via the registry method using the 20-patient sample, and earlier someone had said that zeros are OK. Like, we're going to choose the asthma measures group, but we don't see any adolescents, and that's one of the measures.

Is it OK to continue reporting on that measures group and just report zero, or — if — what happens if our providers only see maybe 10 patients under a certain condition? Is that still OK to choose that measures group and submit that way?

Alexandra Mugge: I'm sorry. Can you repeat the question?

Dustin Derve: Yes. We're going to report PQRS using the clinical data registry method using the 20-patient sample. And in — choosing — looking at measures groups, some of the measures groups that we're going to look at, we don't see 20 patients in a particular measure.

We know we have to choose to report all the measures, so if we don't have 20 patients, for example, 20 adolescents who are on asthma medication, because we don't see any adolescents, will we be penalized, or is it OK to report a zero for zero patients as one of the measures? I mean, again, this is the measures group reporting where we're required to report every single measure in a group for a minimum of 20 patients.

Alexandra Mugge: So I'm going to ask you to call the QualityNet Help Desk. You can see their information on slide 41 because, unfortunately, we don't have a measures folks from the room available to answer your specific question.

Dustin Derve: So does the Value-Based Modifier work — how does that work with the measures groups? I mean — sorry —maybe that's for them again, but I didn't see that on that slide for Value-Based Modifier on how it specifically works with this 20-patient sample.

Diane Maupai: Wil, can you take this one, as well, please?

Wil Lim: Sure. So for the purposes of quality-tiering where measures are used to calculate the composite —quality composite, in this case, for PQRS measures, measures —as part of measures groups — are treated as individual measures — as if they were individual measures.

Dustin Derve: OK. So if you score 100 percent on this 20, you should be in great shape.

Wil Lim: That sounds like that would be the case.

Dustin Derve: Great. Thank you.

Diane Maupai: OK. Next question?

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

Heidi Hardy: Yes. Hi. Quick followup question from Elizabeth's answer earlier. You said that the finalization of the two Meaningful Use or the EHR Incentive Program 2015/ '17 is coming out in the fall — got that.

Do you know if for the Meaningful Use Year One providers — that 90-day period as it stands under the current information we have — do they no matter what — even if this release goes — if the final rule is clarified, will they have until the end of the year for their 90-day period, or do they still have to have their end of the reporting period — by the end — by September 30 or October 1? Do you know if that requirement — not when they actually turn it in…

Elizabeth Holland: Yes. That's why we don't have that requirement in place this year, because no one can attest. So, what we're going to — they're going to be able to attest starting January 4 through February 29, and then, if they're successful, we'll retroactively remove them from the payment adjustment file.

Heidi Hardy: So the reporting period, though, can be anywhere up to December 31, not just when they attest and say, "Hey, this…

Elizabeth Holland: It has to be 90 days in 2015 — in the calendar year 2015.

Heidi Hardy: Any time in 2015?

Elizabeth Holland: Yes.

Heidi Hardy: Any time in the 2015 — OK. That does add flexibility. OK. Great. Thank you.

Elizabeth Holland: Mm hmm.

Operator: Your next question comes from the line of Marsha Bastik.

Marsha Bastik: Good afternoon, guys. Elizabeth, I feel sorry for you for all the questions and I also was surprised that it was going to be coming out on the Friday of Labor Day weekend because…

Elizabeth Holland: I wish I could get it out. It would make my life so much easier.

Marsha Bastik: And mine. And you have no idea how many emails I get with offices all around the country.

Diane Maupai: This is Diane. Did you have a question?

Marsha Bastik: Yes, I did. For the PQM —PQRS —can a measure out of the nine — can one or two of them be not at 50 percent for the Medicare and them not end up getting dinged in the value measure?

Alexandra Mugge: Can you repeat the question and tell us which program you're referencing?

Marsha Bastik: For individual providers.

Alexandra Mugge: Reporting to PQRS?

Marsha Bastik: Reporting to PQRS. For example, they are doing the high risk to the elderly. That number seems to always stay very low; it doesn't go to 50 percent. Will they end up —if the rest of their numbers are 50 percent to Medicare patients, will they end up being able to avoid the ding of the value measure?

Alexandra Mugge: I think that we are going to refer your question and — to get a few more specifics from you — to the Physician Value Help Desk. And again, that's on …

Marsha Bastik: OK.

Alexandra Mugge: …slide 41. Thank you.

Marsha Bastik: OK. Thank you.

Operator: Your next question comes from the line of Mary Lee Cole.

Mary Lee Cole: Hi. Thank you for taking my call. The measures for the calendar year 2015 for 2017 — they seem to be all hospital-based claims. Our group is a dermatology

group. We don't really do much in the hospital. We certainly don't even have admission privileges, so how will that — will affect us?

Fiona Larbi: Are you referring to the three claims-based measures related to the Value Modifier, for instance, the…?

Mary Lee Cole: Yes.

Fiona Larbi: Those measures will — you have — correct me if I'm wrong, Wil, but those measures will only be applicable if they have at least 20 cases. And then, with the 20 cases, then, they will be calculated in the quality composite. Is that correct?

Wil Lim: That's right. So for the — ambulatory care sensitive condition composite — so for all the measures, in order to be included — sorry — at least for the 2016 Value Modifier based on 2014 performance, the minimum case size threshold for the — all the measures is 20. I guess the only thing to add to that — so there are the ambulatory care sensitive condition measures, as well as the — sorry — excuse me — the hospital readmissions measures, but there are also the PQRS measures that could potentially get included in the quality composite for following internal purposes as well.

Mary Lee Cole: So I guess if we don't meet that threshold — if we don't have a minimum of 20 cases, we would just — we would be — not in the negative, but we would just remain the same. We wouldn't have a negative or a penalty?

Wil Lim: So, as I know — measures — no quality measures with at least 20 cases — then, in that case, the quality composite would be classified as average quality. And similarly, the analogous threshold and cost is that — if the —if there are no cost measures, that means — the case size threshold, then — the cost composite would be classified as average cost, and to the case that —or in the case that the tier is average quality and average cost, that's correct. The Value Modifier would be zero, reflected in neutral adjustment.

Mary Lee Cole: OK. Thank you.

Operator: Your next question comes from the line of Dr. Mosier.

Diane Maupai: Hello.

Alexandra Mugge: Hello.

Dr. Mosier: Yes. Hi. I had a question. It says the incentive has to do with a decrease of 2 percent to 4 percent — 2 percent to 3 percent of physician's fees. Now, what does that include in physician's fees? Does that include the charge for — che... — I'm an

oncologist — the chemotherapy drugs, lab, or is it just my fees —consult services, offices, that kind of thing?

Alexandra Mugge: It includes any of Medicare Part B charges.

Dr. Mosier: So…

Elizabeth Holland: For EHR, it's anything billed under the Medicare Physician Fee Schedule.

Dr. Mosier: I see. So that includes taking it off the reimbursement for chemotherapy?

Elizabeth Holland: Is that reimbursement with a CPT code?

Dr. Mosier: Yes.

Elizabeth Holland: OK.

Diane Maupai: Thank you.

Alexandra Mugge: Thank you.

Dr. Mosier: Thank you.

Operator: Your next question comes from the line of Ruth Eastham.

Ruth Eastham: Hi. Good morning from the West Coast. I represent three individual specialists. So I'm looking at page 33 — the payment adjustments that will be coming in 2017 —and it says the PQRS applicable to all EPs will be a negative 2 percent based on 2015. So that's across the board, regardless of whether we attest or not — is that correct?

Alexandra Mugge: For PQRS, that is — and you did not report in 2015, or you do not report in 2015, then that would apply to all of your charges for 2017.

Ruth Eastham: We are reporting, but it just didn't specify on page 33 whether it affects those who are or are not. So that's just those who are not reporting that get that 2 percent negative?

Alexandra Mugge: Or who are not satisfactorily reporting. So if you don't — if you report but don't meet the reporting requirement, and each reporting mechanism has its own nuances of requirements. But if you report and don't meet the reporting requirements, then, therefore, reported but failed, you would still be subject to the payment

adjustment. If you report satisfactorily and meet all the requirements, then you would avoid the PQRS payment adjustment.

Ruth Eastham: Thank you. And then, secondly, it's unrelated, but do you happen to know if sequestration will still be in effect next year and through 2017?

Alexandra Mugge: We — I — we can't speak to the future. I can tell you that it's still in effect now.

Ruth Eastham: OK. Thank you so much.

Diane Maupai: Thank you, Alex.

Alexandra Mugge: Yes.

Operator: Your next question comes from the line of Kathy Keefer.

Kathy Keefer: Hello. Thank you for taking my call. I — part of my question I believe has been answered before. We are ADPs. We submit PQRS through — claims-based — nine measures across three domains, and we have attested to EHR.

Now, I am confused about the Value Modifier and the Shared Savings. Are we to be participating in those two programs as well, or is the Value Modifier — is under the PQRS? That's a different program for reporting PQRS — is that right?

Alexandra Mugge: This is Alex Mugge, and I just, first, want to say like I said early on in the presentation, and you may have missed it as it was in one of the first slides, there is a lot of information in this slide deck, and some of it does not apply to everyone.

If you are participating in one of the ACO programs — the Medicare Shared Savings Programs or the Pioneer ACO program — or if you're …

Kathy Keefer: We're not.

Alexandra Mugge: …reporting as a PQRS GPRO, you'd know by now. So, if you're not, then, don't worry about it.

Kathy Keefer: OK.

Alexandra Mugge: You don't need to participate through those methods. And in terms of the Value Modifier — the data used for the Value Modifier — the quality data that you — so the quality component of the Value Modifier is based on the PQRS data that you submit to the PQRS program. It's not a separate program that you need to report to separately, but the data is shared, for lack of a better term.

Kathy Keefer: OK. And then, to get a report for that, I can go on for the QRUR?

Alexandra Mugge: Yes. That's correct.

Kathy Keefer: OK. Great. Thank you very much.

Diane Maupai: Thanks Alex.

Alexandra Mugge: Thank you.

Operator: Your next question comes from the line of William Jargon.

William Jargon: Yes. My question has to do with the hospital-based EP such as radiologists. We currently go through claims and have qualified for PQRS, no problems. We're not eligible on the EHR side. And then, now, I drip down to the Value Modifier. How does —how does all of this affect a radiologist-type EP?

Elizabeth Holland: So you're not eligible for EHR because you're hospital-based?

William Jargon: Yes.

Elizabeth Holland: OK.

Alexandra Mugge: OK. So that's part of your answer. In terms of how the PQRS and Value Modifier apply to you, I'd encourage you to reference our eligible professionals' document that's located on CMS.gov. You can also contact the QualityNet Help Desk to understand whether this impacts your particular case.

William Jargon: Well, looking at slide 20, you know, after I've gone through all those things, like I said, I'm good —I'm good. Now, I'm into, OK, we're going to take a look at the value measure. And I know I've heard the three claims —the outcome measures of the hospital readiness and et cetera, et cetera.

So I'm assuming at this point from what I've heard, and I will reference your websites and emails and such, but it assumes if we don't —if we don't meet any of these, CMS will look at it and say, "OK. Good. They don't have any rule. We'll just move on," so we would be at a zero.

Fiona Larbi: So you're reporting measures through PQRS. Is that correct?

William Jargon: Yes.

Fiona Larbi: So the measures that you report through PQRS will go towards your quality composite for the Value Modifier. We will also look at the three claims-based measures, and depending on the case count of the claims-based measures, they will either be included or not included in your quality composite. And as Wil explained earlier, if you do not have more than enough cases for these measures, then, you will be given an average quality. Is that correct, Wil?

Wil Lim: Correct.

William Jargon: And that's what I understood, and —it — I guess the part as everybody has pointed out how confusing all this is — we don't have the nine measures across three domains because we're, you know, radiology. And so, we're into the MAV situation where we have less than — and we do what we're supposed to do. So, again, we just — if we do PQRS correctly, you'll evaluate everything else. We don't have to really do anything else beyond that.

Fiona Larbi: Yes. And the caveat to that is that you have to do PQRS correctly.

William Jargon: Yes, we should.

Fiona Larbi: And you've met the necessary reporting requirements. Otherwise, you would get the automatic downward adjustment to the VM.

William Jargon: Right. As long as we do PQRS, we're good. All right. Very good. Thank you.

Diane Maupai: Thank you, Fiona.

Operator: Your next question comes from the line of Sheryl.

Sheryl: Hi.

Diane Maupai: Hi.

Sheryl: Hi. My question is about PQRS. We submitted last year, but, since then, we've acquired two mid-level providers. Would they be included in that 50 percent of the group that has to submit successfully for the quality measures — for the VM?

Alexandra Mugge: Just 1 second while we confer in the room. Can you clarify what you mean by a mid-level provider?

Sheryl: Nurse practitioner and a physician's assistant.

Alexandra Mugge: Nurse practitioner and physician's assistant. And so, you're asking whether the nurse practitioner and physician's assistant would be counted as part of the 50 percent that will be applied towards the Value Modifier?

Sheryl: Yes.

Diane Maupai: Wil, could you take this please?

Wil Lim: Sure. So it would depend on — so again — the criteria in terms of the providers and the TIN. So it would depend on whether these two providers were in PECOS at the time that the — at the time that providers are identified from PECOS, as well as it depends on whether these providers bill on the TIN. So, to the extent that they are billed under the TIN, they would count towards the size of the group based on billings, and then, to the extent that they are in PECOS under the TINs, then they would count for the size of the TIN based on PECOS.

Sheryl: All right. Thank you.

Diane Maupai: Thank you Wil.

Operator: Your next question comes from the line of Andrew Barna.

Andrew Barna: Hello. We're a large MSSP ACO, and this 2015 is our first year of participation, so we will be submitting our PQRS scores through the GPRO interface. And because it's our first year, we are in a pay-for-reporting situation. But I see under the VM slides that it appears that our results will be judged on a pay-for-performance basis, and I just wanted to make sure that's the case and that all of our TINs — we have several TINs in our ACO —they will all be — get the same score based on the score that the ACO receives.

Rabia Khan: OK. So this is Rabia Khan. So —and in terms of how you will meet —the — I believe — this reporting requirement — for — to avoid the PQRS adjustment — yes — so you will report all of the — you must completely report all of the measures through the GPRO Web Interface on behalf of your ACO participants.

And, yes — so in terms of your — since you're a 2015 starter, yes, all of your measures are paper reporting. So as long as you complete reporting — on all of our, you know — for our entire measure set, which would mean, yes, you select the CAHPS vendors — you complete the CAHPS measures and you complete the GPRO Web Interface measure reporting, and internally we calculate all of the claims-based measures. You would then be eligible to share in savings.

And as far as how it applies to the VM, yes, it would be a performance-based application for your participant TIN — participant into — they would all have the same ACO results;

however, one difference is that there are some EPs or providers who — or TINs that may be a part of multiple ACOs.

So the way the VM will be applied to them is they would use the best score — for that — for that TIN. So if there are multiple — and Wil, please correct me if I'm wrong here — but some TINs — report through — can meet requirements through multiple ACOs for the VM, and — they — you would just choose the higher scorer for applying that.

Wil Lim: That is correct. So if there is a participating TIN under multiple ACOs, it's the quality composite score or the highest quality composite score that will be applied to that TIN.

Diane Maupai: Thank you. This is Diane. We have time for one more question.

Operator: And that question comes from the line of Brandy Dunn.

Diane Maupai: Hello, Brandy? Brandy?

Operator: Brandy, if you're on speaker phone…

Brandy Dunn: Hello? Can you hear me?

Diane Maupai: Yes.

Brandy Dunn: OK. The question that I had — you had answered it in part earlier, but the question is in regards to the Meaningful Use program, and I just wanted to follow up to the comment about first-time attesters for 2015. And if a provider has never attested before and would be planning to do so for this calendar year, are they avoiding penalties they would have received in 2016 and 2017?

So that sounded that — they would — if they are successful in the attestation, any penalties they would get for 2016, if they are successful, will be retro payment back to them to make them whole. But what about for 2017?

Elizabeth Holland: Yes. That would — that would count for 2017 as well.

Brandy Dunn: OK. Perfect. OK. Thank you.

Additional Information

Diane Maupai: Thank you Elizabeth. Unfortunately, that's all the time we have for questions today. If we didn't get to your question, please refer to slide 41 for further help.

As a reminder, 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 MLN Connects Provider eNews when these are available.

On slide 44 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'll take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Diane Maupai. I'd like to thank our presenters here at CMS, and also thank all on the lines for participating in today's MLN Connects Call. Have a great day.

Operator: This concludes today's call. Presenters, please hold.

-END-


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