MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
Medicare Quality Reporting Programs: 2016 Physician Fee Schedule
MLN Connects National Provider Call
Moderator: Aryeh Langer
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Aryeh Langer. Thank you, you may begin.

Announcements and Introduction

Aryeh Langer: Thank you. And as you just heard, my name is Aryeh Langer, and I'm from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on Medicare Quality Reporting Programs. Today's topic will be the 2016 Medicare Physician Fee Schedule. MLN Connects Calls are part of the Medicare Learning Network®.

Today's MLN Connects National Provider Call will discuss how the 2016 Medicare Physician Fee Schedule final rule impacts Medicare quality reporting programs. A question-and-answer session will follow the presentation.

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, it's www.cms.gov/npc. Again, that URL is www.cms.gov/npc, as in National Provider Call. At the left side of the webpage, click on National Provider Calls and Events. Then on the following page, select the date of today's call from the list, and the presentation can be found under the Call Materials section.

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.

Finally, this MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credits. For additional information, please refer to slide 60 of today's presentation for a link to the CE activity information and instructions document.

We have another presenter today that's not listed, and her name is Kim Spalding-Bush, who was added to the agenda, and she has nothing to disclose.

At this time, I would like to turn the call over to our first presenter, Alexandra Mugge.

Presentation

Alexandra Mugge: Thanks Aryeh. Can we move to the next slide?

As Aryeh said, we will be covering the 2016 Medicare Physician Fee Schedule final rule, including the quality reporting programs that were covered within that rule. We will also go over some resources you can call for help, and then we will open it up for a question-and-answer session.

Physician Quality Reporting Program Overview

For the PQRS overview, the calendar year 2018 PQRS payment adjustments will be based on reporting that is done for program year 2016. The 2018 payment adjustment is negative 2 percent of the Medicare fee-for-service — I'm sorry, Medicare Fee Schedule. There were very minimal changes to the PQRS program for 2016 reporting year. Some of them are listed on your slide.

Next slide, please. First, there were a few updates to the definition of an eligible professional. Those —the updates are listed here for your reference.

Next slide. As for changes to the PQRS reporting criteria, there were very few changes to the actual reporting criteria. We did add a QCDR reporting option for the GPRO and also several changes to the CAHPS reporting requirement for groups of 25 to 99 and groups of 100 or more. Additionally, there were some changes to the requirements for QCDR vendors and registry vendors and some EHR auditing requirements.

Next, I will go through the reporting criteria for the 2016 reporting year. Next slide. For individual reporting, the available reporting mechanisms for 2016 are claims, registry, EHR, and QCDR, as with previous years. For individual reporting of claims, there were no changes for the 2016 reporting year. The requirements are nine measures covering three domains, with a reporting rate of 50 percent. If an EP sees one Medicare patient face-to-face, they must also report one cross-cutting measure as part of the required nine measures.

Next slide.

Aryeh Langer: And, we're on slide 10 now.

Alexandra Mugge: Yes, on slide 10. This is the reporting criteria for individual reporting using a registry. There were no changes for registry-based reporting for individual EPs. Again, the requirements are nine measures covering three domains, with a reporting rate of 50 percent. Additionally, there were no changes for the measures group reporting via registry.

Moving to slide 11, individual reporting via EHR. Again, there were no changes. The requirements are nine measure covering three domains. And you must report on at least one Medicare patient under this reporting mechanism. We still maintain the requirement to use certified EHR technology for reporting your CQM data to CMS.

Moving on to slide 11, which is QCDR — or, I'm sorry, slide 12, QCDR reporting for individual eligible professionals. The requirements, again, no changes — nine measures covering three domains, with a 50-percent reporting rate and report at least two outcomes measure as two of the nine required measures.

Moving on to slide 13, we will cover the group practice reporting option, or GPRO, reporting mechanisms for 2016. We have one addition to this list. So, the reporting mechanisms for 2016 include the GPRO Web Interface, registry reporting as a GPRO, EHR reporting as a GPRO, the new QCDR reporting option as a GPRO, and then, here is a clarification for CAHPS, which is used in conjunction with one of the other reporting mechanisms. CAHPS for 2016 is optional for groups of 25 to 99. The CAHPS is required for groups of 100 or more eligible professionals, regardless of which reporting mechanism they choose. As a reminder, groups must register to report via the GPRO option.

*****Post-Call Clarification*****

- CAHPS for PQRS is:
    - o **Optional** for PQRS group practices of 2-99 EPs reporting electronically, using a QCDR, or a Qualified Registry
    - o **Optional** for PQRS group practices of 25-99 EPs reporting via GPRO WI
    - o **Required** all PQRS group practices of 100 or more EPs, regardless of reporting mechanism"

On slide 14, we highlight some of the requirements of the Web Interface reporting option. Sorry, just to — just to highlight on here that we have it separated out for — by those groups that are required or not required to report CAHPS. The first category is for those not required to report CAHPS, so that's groups of 25 to 99 who do not select CAHPS. Report on all measures in the Web Interface for the first 248 consecutively ranked and assigned beneficiaries.

The second set of requirements is for those groups that have 100 or more and those groups of 25 to 99 who elected to report CAHPS. The requirements are to report all of the CAHPS measures in addition to reporting on the first 248 consecutively ranked and assigned beneficiaries in GPRO Web Interface.

Moving on to slide 15, this is the registry reporting option for GPRO. For those groups not reporting on CAHPS for 2016, the requirement is to report nine measures covering at least three domains. For group practices electing to report CAHPS or those required

to do so, the requirement is to report on all CAPHS measures for PQRS and report at least six measures covering two NQS domains.

Moving on to slide 16, EHR reporting option for groups. The requirement, again, is to report nine measures covering three domains. For those groups that elect to or are required to report CAHPS, the requirement is to report on all CAHPS measures for PQRS in addition to six PQRS measures covering two NQS domains. And, again, on the EHR option, one of the requirements is to report at least one measure for which there is Medicare patient data.

Moving on to slide 17, we have the new QCDR reporting option for the GPRO. Historically, QCDRs have supported individual reporting only. This will be their first year supporting the GPRO option.

Going into slide 18, we go into the reporting criteria for the GPRO QCDR option, and that is to report nine measures covering three NQS domains. Or for those reporting CAHPS, again, it is to report all the CAHPS measures in addition to six QCDR measures covering two domains.

Moving on to slide 19. For the claims and registry reporting options, we do have the MAV process, which will apply to those EPs who report on fewer than nine measures or fewer than three domains. For more information on that, you can visit the website that is listed on your slide.

OK. Requirements for the QCDR vendor. As I mentioned at the beginning of this section, there were some updates to the requirements for the QCDRs. First, the first function of a QCDR is to submit the quality measure data on behalf of the EPs or group practices. It's important to note that the data for group practices is submitted at the TIN level, not at the individual TIN NPI level. So, thus, if you are reporting on behalf of a GPRO as a QCDR vendor, you must roll up the data so that it's one measures reporting for the entire group.

The second function of a QCDR is to submit the data on multiple payers, not just Medicare patients, to provide timely feedback at least four times a year to the EPs or group practices for which you are submitting on behalf of, and to possess benchmarking capacity on the measures that you report.

Moving on to slide 21, changes for QCDR vendors and qualified registries. We have extended the self-nomination period, which will begin on December 1st of the year prior to the reporting year and ending on January 31st. Additionally, for attestation statements, in lieu of submitting the attestation statement via email, we will now be requiring registries to attest during the submission period.

On slide 22, we highlight some of the changes for QCDRs vendors and registry vendors in terms of the validation requirements. And more information is available on the registry website using the QCDR Criteria Toolkit on cms.gov.

Slide 23. This is just an overview of the changes to the quality measures. From the final rule, there are four additional cross-cutting measures and 37 individual measures for reporting. We have them here in the table broken down by domain. We also removed several measures and made some changes to the reporting mechanisms available for these measures in the final rule.

Moving on to slide 24, the revised auditing requirements. Beginning in 2016, any vendor submitting quality measures for the PRQS must comply with the following requirements:

- The vendor must make available to CMS the contact information for each EP on behalf of whom it submits data.

- Vendors also must retain the data submitted to CMS for a minimum of 7 years.

So that is all for the PQRS section. I am going to move on to the EHR Incentive Program section.

The EHR Incentive Program

On slide 26, we have the certification requirements for electronic reporting of CQM. In 2016 and 2017, CEHRT is required for those reporting their CQMs electronically for us to — for those to be accepted by CMS. In 2018, CEHRT is required for all providers and must — and all providers must create an electronic file that can be accepted by CMS. This last box in here with the small print states that before 2018, providers must use the 2014 or 2015 Edition of certification, and after 2018, they must use the 2015 version of — Edition of the certification only.

Slide 27, PQRS criteria for the EHR Incentive Program. EPs must report using the most recent version of the eCQM if they choose to report electronically, meaning submitting the QRDA data to the PQRS system. For calendar year 2018, payment adjustment is a downward 3-percent adjustment for the EHR Incentive Program. The reporting requirements for the EHR Incentive Program are just, as with PQRS, report nine measures covering at least three NQS domains. And providers must report — may report including zeroes in the numerator or denominator. Providers choosing to submit their CQMs electronically must use a CMS form and manner requirements to submit to CMS.

Moving on to slide 28, we just wanted to highlight that we have taken steps to establish alignment among the various reporting and payment programs that include the

submission of CQMs. So, as you have — you may have noticed, our requirements for the EHR reporting option for both individuals and group practices in the PQRS align with those of the EHR Incentive Program.

I will now turn it over to Sarah Arceo.

PQRS and EHR Incentive Program Aligned Reporting

Sarah Arceo: Thanks Alex. As Alex mentioned, my name is Sarah Arceo, and I work on the Comprehensive Primary Care Initiative Quality Team.

Next slide, please. The Comprehensive Primary Care, or CPC, practice sites are required to report to CMS a subset of clinical quality measures that were selected in the EHR Incentive Program Stage 2 final rule. CMS finalized that in 2016, CPC practice sites, including first year EPs, will satisfy the CQM requirements of the Medicare EHR Incentive Program if the sites satisfy all of the following requirements:

- CPC practices sites must report nine of 13 measures from the CPC Clinical Quality Measure set that cover three National Quality Strategy domains;

- Practices sites must successfully meet the CPC reporting requirements and submit measures electronically via QRDA 3 to the PQRS portal or via attestation to CPC; and

- CPC practice sites must also submit measures for a full calendar year. So, that's January 1st through December 31st.

Additionally, CMS also finalized for 2016 that first year EPs beginning their participation in the Medicare EHR Incentive Program during calendar year 2016 must also successfully attest to continuous 90-day Clinical Quality Measure data by October 1st, 2016, or apply for a significant hardship exemption to avoid to avoid the calendar year 2017 payment adjustment. CPC practice site EPs have the option to separately report their Clinical Quality Measures in accordance with the requirements established for the Medicare EHR Incentive Program. So essentially, CPC practice sites have the option to report their CQMs directly to the Medicare EHR Incentive Program in addition to reporting to the model.

At this time, I will turn it over to Aryeh to conduct a quick survey.

Keypad Polling

Aryeh Langer: Thank you Sarah. Excuse me. At this time, we will pause a few minutes to complete keypad polling. Can we go ahead and start that polling, please?

Operator: CMS appreciates that you minimized 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.

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

Presentation Continued

Aryeh Langer: Thank you. And I will now turn the call over to Fiona Larbi for the next part of our presentation. Fiona?

Value-Based Payment Modifier Policies

Fiona Larbi: Thank you Aryeh. In this segment of the presentation, I will be reviewing all of the finalized Value Modifier policies that are in the 2016 Physician Fee Schedule final rule.

Can we go to slide 33? This slide lists several finalized VM policies that will be applied in 2018. We finalized that the calendar year 2016 would be the performance period for the 2018 VM. We also finalized the policy to apply the VM in 2018 to nonphysician EPs who are physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists in groups of two or more EPs and to those who are solo practitioners.

I want to note that this final policy is different from the policy we finalized in the 2015 PFS final rule, which was to apply the 2018 VM to all of the nonphysician EPs. So under our finalized policy, the 2018 VM would not apply to nonphysician EPs who are certified nurse midwives, clinical social workers, clinical psychologists, registered dieticians, nutritional professionals, audiologists, physical therapists, occupational therapists, or qualified speech-language therapists.

We also finalized to continue to apply a two-category approach for the 2018 VM based on participation in the PRQS by groups and solo practitioners. For the 2018 VM, we finalized to apply the quality-tiering methodology to all groups and solo practitioners in Category 1. I will explain Category 1 in more details on the next slide.

Quality tiering is the methodology we use to calculate the VM. We finalized the groups and solo practitioners that would be subject to upward, neutral, or downward adjustments derived under the quality tiering methodology, with the exception of groups consisting of nonphysician EPs, such as PAs, NPs, CNSs, and CRNAs and PAs, NPs, CNSs, and CRNAs who are solo practitioners. They will be held harmless from downward adjustments under the quality-tiering methodology in 2018.

Slide 34 shows how the VM in 2018 will be applied to physicians, PAs, NPs, CNSs, and CRNAs in groups with two or more EPs and those who are solo practitioners. Similar to the approach established for the 2017 VM and in a continued effort to align the VM with the PQRS, we finalized to use a two-category approach to classify groups and solo practitioners subject to the 2018 VM based on how groups and solo practitioners participate in the PQRS in 2016. Our finalized two-category policies are as follows.

Category 1, as shown on the left-hand side of this slide, would include physicians, PAs, NPs, CNSs, and CRNAs in groups of physicians with two or more EPs and groups consisting of nonphysician EPs, PAs, NPs, CNSs, and CRNAs that meet the criteria to avoid the 2018 PQRS payment adjustment as a group practice participating in the PQRS GPRO reporting option in 2016 or physicians, PAs, NPs, CNSs, and CRNAs in groups of physicians with two or more EPs and groups consisting of nonphysician EPs in which at least 50 percent of the group's EPs met the criteria to avoid the 2018 PRQS payment adjust as individuals.

We are finalizing to apply this policy regardless of where the group — whether the group registered to submit PQRS data through a GPRO. Category 1 would also include physician solo practitioners and nonphysician solo practitioners that met the criteria to avoid the 2018 PRQS payment adjustment as individuals. We finalized that all groups and solo practitioners that are in category 1 would be subject to quality tiering.

Category 2, as shown on the right-hand side of this slide, would include groups and solo practitioners that are subject to the 2018 VM and do not fall within Category 1.

At the bottom of this slide, you can see our final 2018 payment adjustments for groups and solo practitioners that are in Category 1 and 2. I will review these adjustments in more detail on the slides 36 to 38.

Slide 35 describes the cost and quality measures that will be used to calculate the cost and quality composites — component of the 2018 VM. We finalized two policies related to the Medicare Spending per Beneficiary measure. First, beginning in 2017, we will increase the minimum number of episodes for inclusion of the MSPB measure — MSPB measure in the cost composite to 100 episodes. And, beginning with the 2018 VM, we finalized to include hospitalizations at Maryland hospitals as an index admission to the MSPB measure for the purposes of the VM program.

To calculate the quality composite, we finalized that for groups that report PQRS data as a group in 2015 and meet the criteria to avoid the 2017 PRQS payment adjustment, we will use the measures reported under the PQRS GPRO reporting mechanism selected by the group. Alternatively, if at least 50 percent of the EPs in the group report PQRS as individuals and meet the criteria to avoid the 2017 PQRS payment adjustment, then we will use the individually reported PQRS measures to calculate the quality composite. We also finalized that we will consider whether the 50-percent threshold option was met, regardless of whether the group registered for a PQRS GPRO. For solo practitioners, we would use their individually reported PRQS measures as long as they met the criteria to avoid the 2018 PRQS payment adjustment.

In addition to measures reported via PQRS, CMS includes three claims-based outcomes measures in the calculation of the quality composite. These include the All-Cause Hospital Readmission measure, a composite of preventable hospitalizations for acute conditions, and a composite of preventable hospitalizations for chronic conditions. Beginning with the 2017 VM, the All-Cause Readmission measure will not be applied to groups with two to nine EPs and solo practitioners.

We also finalized that, beginning with the 2016 VM, a group or solo practitioner subject to the VM would receive a quality composite score that is classified as average under quality tiering if the group or solo practitioner does not have at least one quality measure that meets the minimum number of cases required for the measure to be included in the calculation of the quality composite.

Also, beginning with the 2018 VM, we will — we will create separate benchmarks for eCQM measures based on the CMS eMeasure ID. These measures are calculated through – are collected through EHRs. We will also exclude eCQM measures from the overall benchmark for a given measure.

The next three slides discuss the final payment adjustment levels under the VM in 2018. Slide 36 shows the final 2018 payment adjustment levels under the VM for physicians, nurse practitioners, physicians' assistants, clinical nurse specialists, and certified registered nurse anesthetists in groups of physicians with 10 or more EPs. We finalized to maintain the 2017 VM payment adjustment levels for the 2018 VM for groups with 10 or more EPs.

For Category 2 groups, this means that we finalized to apply an automatic negative 4 percent VM downward adjustment for not meeting the criteria to avoid the 2018 PRQS payment adjustment as a group or under the 50 percent threshold option.

For Category 1 groups under quality tiering, we finalized that the maximum upward adjustment would be a plus 4x, where x represents the upward VM payment adjustment factor, which is calculated after the performance period has ended, based on the aggregate amount of downward payment adjustments. And the maximum

downward adjustment would be negative 4 percent for poor performance in 2018. High performing groups would continue to be eligible for an additional plus 1x for treating the most clinically complex beneficiaries, as identified by their HCC risk scores.

Slide 37 shows the finalized 2018 payment adjustment levels under the VM for physicians, NPs, PAs, CNSs, and CRNAs in groups of physicians with two to nine EPs and physician solo practitioners. We finalized to maintain the 2017 VM payment adjustment levels for the 2018 VM and to apply both upward and downward adjustments under quality tiering.

For Category 2 groups and physician solo practitioners, this meant that we finalized to apply an automatic negative 2 percent VM downward adjustment for not meeting the criteria to avoid the 2018 PRQS payment adjustment. For Category 1 groups and physician solo practitioners under quality tiering, we finalized the maximum upward adjustment would be up to plus 2x, where x represents the upward VM adjustment factor, and the maximum downward adjustment would be negative 2 percent for poor performance in 2018. High performing groups and physician solo practitioners would continue to be eligible for an additional plus 1x for treating the most clinically complex beneficiaries, as identified by their HCC risk scores.

Slide 38. This shows the finalized 2018 payment adjustment levels under the VM for NPs, PAs, CNSs, and CRNAs in groups consisting of nonphysician EPs and NPs, PAs, CNSs, and CRNAs who are solo practitioners.

For Category 2 groups and solo practitioners, we finalized to apply an automatic negative 2 percent VM downward adjustment for not meeting the criteria to avoid the 2018 PRQS payment adjustment. For Category 1 groups and solo practitioners under quality tiering, we finalized that the maximum upward adjustment would be up to plus 2x, where x represents the upward VM payment adjustment factor. And as finalized in 2015 PFS final rule, these groups and solo practitioners would be held harmless from downward adjustment under quality tiering for poor performance in 2018. Also, with this group, high performing groups and solo practitioners would be eligible for an additional plus 1x for treating the most clinically complex beneficiaries, as identified by their HCC risk scores.

Slide 39 describes our policy related to the finality of the VM upward adjustment factor. Beginning with the 2015 VM, we established that the upward payment adjustment factor, x, would be determined after the performance period has ended, based on the aggregate amount of downward payment adjustments. In the interest of providing EPs that are eligible for an upward adjustment under the VM with finality and to minimize the cost of reprocessing claims, we finalized that we would not recalculate the upward payment adjustment factor for an applicable payment adjustment period after the adjustment factor is made public unless CMS determines that a significant error was made in the calculation of the adjustment factor.

Slide 40 describes our policies related to group size for applying the VM. We finalized in a prior rule that, beginning with the 2016 VM, the list of groups and solo practitioners subject to the VM is based on a query of the PECOS — of PECOS that occurs within 10 days of the close of the PQRS group registration process during the applicable performance period. Groups are removed from the PECOS-generated list if, based on our analysis of claims, the group did not have the required number of EPs that submitted claims during the performance period. Solo practitioners are removed from the PECOS--generated list if, on the claims analysis, the solo practitioner did not submit claims during the performance period for the applicable calendar year payment adjustment period.

We established different payment adjustment amounts under the 2016 VM for:

1. Groups with between 10 to 99 EPs, and
2. Groups of 100 or more EPs.

Similarly, in the calendar year 2015 PFS final rule with comment period, we established different payment adjustment amounts under the 2017 VM for:

1. Groups with between two to nine EPs and physician solo practitioners, and
2. Groups with 10 or more EPs.

We had not previously addressed how we would handle scenarios where the size of the TIN, as indicated on the PECOS-generated list, is not consistent with the size of the TIN, based on our analysis of the claims data. Therefore, we finalized that, beginning this calendar year 2016 payment adjustment period, the TIN size would be determined based on the lower of the number of the — the lower of the number of EPs indicated by the PECOS-generated list or by our analysis of the claims data for purposes of determining the payment adjustment amount under the VM.

We also finalized how we would handle scenarios where the composition of a TIN, that is, whether or not the TIN contains a physician, as indicated on the PECOS-generated list, is not consistent with the composition of the TIN, based on our analysis of the claims data. Therefore, we finalized that beginning with the calendar year 2018 payment adjustment period, we would determine a TIN to be a nonphysician EP TIN if either the PECOS-generated list or our analysis of the claims data indicate that TIN did not contain at least one physician.

Slide 41 describes our policy for applying the VM to TINSs participating in the Pioneer ACO Model, the CPC Initiative, or other similar Innovation Center models. We finalized that, beginning with the 2017 VM, we would waive the application of the VM to groups and solo practitioners, as identified by TIN, if at least one EP who billed for PFS items and services under the TIN during the performance period for the VM participated in

the Pioneer ACO Model, CPC Initiative, or other similar Innovation Center models during the performance period.

Slide 42 describes the VM informal review process. The informal review — the informal review submission period will occur during the 60 days following the release of the Quality and Resource Use Reports for the 2016 VM and subsequent years. In this rule, we finalized that, beginning with the 2016 VM, we would reclassify a TIN as Category 1 when PQRS determines on informal review that at least 50 percent of the TIN's EPs meet the criteria to avoid the PQRS payment adjustment as individuals for the relevant calendar year PQRS payment adjustment.

We note that if the group was initially classified as Category 2, that we do not expect to have data for calculating their quality composite, in which case they would be classified as average quality. However, if the data is available in a timely manner, then CMS would recalculate the quality composite.

Slide 43 describes what groups and solo practitioners would need to do in 2016, which is the proposed performance period for the 2018 VM. They need to select the PQRS reporting mechanism and become familiar with the measures and the data submission timeframe, then decide whether and how to participate in the PQRS in 2016. Groups that want to participate via the PQRS GPRO can register for a 2000 — for a 2016 PQRS GPRO between the spring of 2016 and June the 30th of 2016. We will announce the registration period start date early next year. Solo practitioners and EPs in groups that want to report as individuals do not have to register.

Groups and solo practitioners should download their 2014 Quality and Resource Use Report and their 2014 Mid-Year QRURs now if they haven't done so already. The instructions for accessing a QRUR are provided at the link located under the fourth bullet. They should also review the quality measure benchmarks under the VM. And please refer to Appendix B for a detailed overview of the VM policies across the years.

And now, I would like to hand it over to Rabia Khan to discuss the Medicare Shared Savings Program.

Medicare Shared Savings Program Overview

Rabia Khan: Thank you Fiona. I am Rabia Khan from our Division of Shared Savings Program. And on slide 45, I'll provide a quick overview on the Shared Savings Program.

So, within the Medicare Shared Savings Program, Accountable Care Organizations, or ACOs, create incentives for health care providers to work together voluntarily to coordinate care and improve quality for their patient population. We assess ACO performance annually on their quality performance and against a financial benchmark to determine shared savings.

Meeting the Shared Savings Program quality reporting and performance requirements aligns with other CMS quality reporting initiatives for the EPs that are participating within the ACOs. Those programs include PQRS, the Value-based Payment Modifier, and the Medicare EHR Incentive Program.

I'm now on slide 46. We make annual updates for the Shared Savings Program quality reporting requirements through the annual Physician Fee Schedule rule. In this 2016 Physician Fee Schedule final rule, we finalized adding a new quality measure of Statin Therapy for the Prevention and Treatment of Cardiovascular Disease in the Preventive Health domain within our four domains in our quality measure set. The measure aligns with PQRS and does increase the number — total number of measures within the Shared Savings Program measure set from 33 to 34 quality measures. It does — the measure — the Statin Therapy measure is reported via the GPRO Web Interface. So the total number of measures, beginning with calendar year 2016, for Web Interface reporting will be seven — will move from 17 measures to 18 quality measures.

Although this measure includes multiple denominators, we will be scoring it as a single measure, and it will remain pay-for-reporting, meaning we are not phasing this at this time into performance, and ACOs can earn the full two points on this measure by completely and accurately reporting. We will be providing an oversample of 750 beneficiaries for this measure, as opposed to the 650 beneficiaries that are provided for the other Web Interface measures. However, the consecutive reporting requirement remains the same for all measures. So ACOs must completely report on 248 consecutive beneficiaries for each measure.

In addition, in the final rule, we finalized preserving our flexibility to maintain or revert measures from pay-for-reporting — to pay-for-reporting from pay-for-performance if a measure owner determines the measure no longer aligns with updated clinical practice or causes patients harm.

Slide 47. We also finalized some clarifying language on how PQRS eligible professionals participating within an ACO meet their PQRS reporting requirements when their ACO satisfactorily reports quality. And, finally, we also made amendments to our assignment methodology by amending the definition of primary care services used in the beneficiary assignment methodology to include claims submitted by ETA hospitals and exclude claims submitted by SNFs when the claim contains the place-of-service 31 modifier.

Next slide, please. So now I'll go over policies that were finalized for the Value Modifier that applied to EPs participating in Shared Savings Program ACOs.

In the 2015 Physician Fee Schedule final rule, we established that, beginning in 2017, we will apply the Value Modifier to physicians in groups with two or more EPs and to physicians who are solo practitioners who participated in an ACO under the Shared

Savings Program during the performance period. Beginning with the 2017 VM, we finalized applying the VM adjustment percentage for groups and solo practitioners that participate in TINs that are in two or more ACOs during the applicable performance period, based on the performance of the ACO with the highest quality composite score.

We also finalized that to determine the VM for TINs who participated in a Shared Savings Program ACO in the performance period using policies established for Shared Savings Program participants, regardless of whether any EPs under the TIN also participated in an Innovation Center model or CMS initiative during the performance period. In addition, we finalized that beginning in the 2017 VM, we will apply an additional upward payment adjustment of plus 1.0x to Shared Savings ACO Program participant TINs that are classified as high quality under the quality-tiering methodology if the ACO on which the TIN's VM is based has an attributed patient population with an average beneficiary risk score that is in the top 25 percent of all beneficiary risk scores nationwide, as determined under the VM methodology.

Next slide, please. All right, so slide 49. This slide describes the 2018 VM policies for Shared Savings Program participants. Similar to the policies established for the 2017 VM, groups and solo practitioners participating in an ACO under the Shared Savings Program in the 2016 performance period will have the cost composite component of their 2018 VM classified as average, and their quality composite will be based on the ACO's quality data submitted through the GPRO Web Interface and the ACO All-Cause Hospital Readmissions measure, as calculated under the Shared Savings Program. In this final rule, we finalized to also include the results of the CAHPS for ACOs Survey in the quality composite of the 2018 VM for TINs participating in ACOs in the Shared Savings Program in the 2016 performance year.

For the 2018 VM, we finalized that if the ACO does not successfully report quality data as required by the Shared Savings Program, then all groups and solo practitioners participating in the ACO will fall in Category 2 for the VM and will be subject to the automatic downward payment adjustment.

OK. And now I will turn it over to Alesia Hovatter to go over Physician Compare.

Physician Compare Public Reporting Policies

Alesia Hovatter: Great. Thanks so much Rabia. Again, this is Alesia Hovatter, the CMS lead for Physician Compare. And we will be switching gears now. So we are on slide 50.

Now moving to slide 51. For the 2016 Physician Fee Schedule final rule, we are continuing existing policies for Physician Compare. The following 2016 measures are available for public reporting:

- All PQRS measures for individual EPs and group practices,

- All CAHPS for PQRS measures for groups of two or more EPs who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor,

- All ACO measures, including CAHPS for ACOs.

Now moving on to slide 52, we are finalizing the following proposals:

- Include Certifying Board, and specifically add American Board of Optometry Board Certification and American Osteopathic Association Board Certification,

- Include an indicator on profile pages for individual EPs who satisfactorily report the new PQRS Cardiovascular Prevention measures group in support of Million Hearts.

As required by MACRA, we are finalizing the following proposals:

- All individual and group-level QCDR measures are available for public reporting,
- Adding utilization data to the public downloadable database.

Moving to slide 53, we are also finalizing to publicly report an item-level benchmark for group practice and individual EP PQRS measures using the Achievable Benchmark of Care methodology. We will stratify the benchmark by reporting mechanism to ensure comparability and reduce the interpretation burden for consumers. We will use this methodology to systematically assign stars for the Physician Compare five-star rating. And just to give you a sense of the timeline, this will be using 2016 data. So this wouldn't be reported on Physician Compare until late 2017.

Moving on to slide 54, we are also finalizing to add Value Modifier, or VM, information to the downloadable database. That would include quality tiers for cost and quality, noting if the group practice or EP is high, low, or neutral on cost and quality per the VM; a notation of the payment adjustment received based on the cost and quality tiers; and an indication if the individual EP or a group practice was eligible to but did not report quality measures to CMS. We are not finalizing to include a visual indicator on profile pages for group practices and individual EPs who receive an upward adjustment for the VM.

Now moving on to slide 54, all data must meet the public reporting standards for Physician Compare, which mean measures must be statistically accurate, valid, reliable, and comparable and must resonate with consumers. CMS can publicly report all measures submitted, reviewed, and deemed valid and reliable in the Physician Compare

downloadable file. Not all measures will be included on the Physician Compare profile pages.

Resources and Acronyms

And now, that's all I have for Physician Compare. But, if you will go to slide number 56, a lot of information has been shared with you all today for these quality program. So this is who you can call for help. So this page lists many different resources for the program that we talked about today.

And also then, if you go to slide number 57, this includes additional resources and links to websites that are available for your review for additional information presented today.

And, lastly, slide number 58 has acronyms in this presentation. So you can look through that list of acronyms if you didn't understand one that we had used today.

OK. So now we are on slide 59. And now I will pass it back to Aryeh for the question-and-answer session.

Question-and-Answer Session

Aryeh Langer: Thank you so much. Our subject matter experts will now take your questions. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. In an effort to get to as many participants as possible, we ask that you limit your question to just one.

All right, we are ready to take our first question, please.

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.

Aryeh Langer: And while you do that, we just have one clarification.

Alexandra Mugge: Hi, this is Alexandra Mugge from the PQRS Program. And we just wanted to clarify, on slide 13 of the presentation, it has listed that CAHPS for PQRS — CAHPS is optional for group of 25 to 99 EPs and CAHPS is required for groups of 100 or more EPs. A quick clarification. It's represented in that way because in the proposed rule, we had proposed requiring CAHPS for groups of 25 or more eligible professionals,

and we did not end up finalizing that proposal. So it remains optional for groups of 25 to 99. It's also available to groups of 2 to 24. So we just wanted to make clear that CAHPS is optionally available for groups of 2 to 99 who register to report the CAHPS survey, and it is required for groups of 100 or more eligible professionals, regardless of the reporting mechanism they choose. So I just wanted to make that clarification. Thank you.

Aryeh Langer: Thank you. Now we can go ahead and take our first question as soon as that's ready.

Operator: Your first question comes from the line of Jeanne Chamberlin.

Jeanne Chamberlin: Hi, yes, I'm sorry. When will you have the 2014 benchmarks for quality measures available?

Fiona Larbi: Those should be available by the end of this month.

Jeanne Chamberlin: OK, thank you.

Operator: Your next question comes from the line of Claire Thornton.

Claire Thornton: My question had to do with slide 20. You are talking about reporting for non-Medicare payers. How do we do that?

Alexandra Mugge: This is Alex Mugge, again, from the PQRS Program. For QCDR vendors, they would be reporting on all payer data, not just Medicare. So, that would be all reporting on behalf of — or reporting on all patients seen by a practice for any payer. So, regardless of their Medicare or private insurance, you would be reporting on all of that data for the EP.

Aryeh Langer: Thank you very much.

Operator: Your next question comes from the line of Deborah Gash.

Deborah Gash: My question's already been answered. Thank you.

Operator: Your next question comes from the line of Jennifer Aquilar.

Jennifer Aquilar: Yes, hi, my name is Jennifer Aquilar. And my question is for the reporting year, this year 2015, what is the final date that information has to be submitted as an individual?

Alexandra Mugge: This is Alex Mugge from PQRS. If you are asking about the submission deadlines for the 2015 reporting period, there are different submission deadlines for each of the reporting mechanisms.

Jennifer Aquilar: OK. We report via claims.

Alexandra Mugge: And I would ask you to — sorry?

Jennifer Aquilar: We report via claims.

Alexandra Mugge: OK. So, December 31st would be the last day of – date of — for submission. Claims submission is sort of a funny way to refer to it. But the last day to submit QDC codes on your claims would be December 31st.

Jennifer Aquilar: All right, thank you.

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

Paul Crieser: Hi, this is Paul Crieser. I am with Twin Cities Orthopedics, and I have a question regarding page 41 in the application of the Value Modifier for groups that are participating in Innovative Center models. Our organization is currently participating with the Bundled Payments for Care Improvement Program, BPCI. And we just want to be — make sure we are clear that – under that program, we are participating in this year and next year. Does that imply, then, that the Value Modifier will not be applied to our organization in '17 and 2018?

Aryeh Langer: Can you give us one moment, please?

Kim Spalding-Bush: Sorry. Thank you for the question. This is Kim Spalding-Bush from CMS. To answer your question, participants in the BPCI program are not exempt from the Value Modifier. So the methodology by which we determined other similar models was established in the 2015 PFS rule, and that program was not determined to meet those criteria. So within this year's rule, as described on slide 41, we did identify a number of models that will be waived from the Value Modifier in 2017 and 2018, but the BPCI is not one of those.

Paul Crieser: OK, thank you.

Kim Spalding-Bush: Sure, thanks.

Kim Sullivan: Hi, this is Kim Sullivan. Do we jump back to help clarify the previous question about the deadline to submit claims? Claims dates of services would be through December 31st, but the last Friday in February would be the deadline for having the claims processed.

Female: Complete processing.

Kim Sullivan: Complete processing. Thank you.

Operator: Your next question comes from the line of Rebecca Hancock.

Rebecca Hancock: Hi, my question is regarding slide 27. And I just want to confirm that the EHR Incentive Program penalty based on 2015 participation that falls in calendar year 2018 is 3 percent, because this is the first I have seen this, and I thought it was going up to 4 percent, so I just want to confirm that.

Elisabeth Myers: Hi, this is Elisabeth Myers from CCSQ. I work on the EHR Incentive Program. For — payment adjustment for 2018 is related to participation in 2016. We do note that going forward, the percentage is supposed to go down a year — a percentage point each year – and so cumulative, but that percentage point total, for example, in the first year is 1 percent, 2 percent in the second year, 3 percent in the third year.

And we are anticipating that it will be 3 percent in ’18. There is the possibility that the Secretary could make a different determination on that based on what is in the rule and the law, which allows us to potentially review participation after 2017 and potentially change that 3 percent to a different value. We are anticipating at this point that it will be a 3-percent payment adjustment for the EHR Incentive Programs in 2018.

Aryeh Langer: Thank you very much.

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

Sandy Pogones: Hi, this is Sandy Pogones from Primaris. I just have a quick question. On slide 26, to meet the EHR Incentive Program requirements, you stated that in 2018, they must submit eCQMs using electronic files, and I think it says either QRDA I or III. But my question comes on slide 30, you said CPCIs have to submit using QRDA III files. So I just want to confirm that other non-CPCI participants can submit either QRDA I or III files for — to meet the EHR Incentive Program electronic submission requirement.

Alexandra Mugge: Hi, this is Alex Mugge. And to clarify, for PRQS, if you are submitting for PQRS in alignment with the EHR Incentive Program, you can submit a QRDA I or a QRDA III file. If you are submitting for EHR — for Meaningful Use only, and that would be an indicator that you would include in your QRDA file, for Meaningful Use only, then you must submit a QRDA III file. If you are submitting to the CPC program, you must submit a QRDA III file. So the only way to report QRDA I and get Meaningful Use credit is if you’re reporting through the aligned PRQS Meaningful Use option.

Sandy Pogones: OK. And with the aligned PQRS Meaningful Use option, you still have the opportunity to only submit QRDA III. Is that correct?

Alexandra Mugge: That is also correct, yes.

Sandy Pogones: OK, thank you.

Operator: Your next question comes from the line of Tina Barman.

Patina Barman: Hi, this is Patina Barman from Jefferson University Physicians. I have a question about the specifications for the new Statin Measure for 2016. When should we expect to see the detailed specifications?

Rabia Khan: Hi, this is Rabia Khan from the Shared Savings Program. So those specifications will be available on the GPRO Web Interface webpage by the end of this month. For ACOs, we'll also provide alerts through our weekly ACO Spotlight newsletter, so — where we link ACOs to the Web Interface for the updates on the specifications.

Patina Barman: OK, thank you.

Rabia Khan: Yes.

Operator: Your next question comes from the line of Elizabeth Wilson.

Elizabeth Wilson: Yes, hi. We have a question about the minimum number of encounters for a measure to be reportable. Is there actually a number, or does it — even if just have one encounter, we still have to report on that measure?

Alexandra Mugge: So, this is Alex Mugge. And first, I would say it depends on how or what you are reporting. Certain measures will go into the MAV process. There is a limit for certain like measure groups, whereby if you report on one of those measures, if you have a certain threshold of reporting — or a certain number of instances that you are reporting for another related measure, that would trigger the MAV process. I'm not sure if there is anyone available from PQMM who can better address this question. But, otherwise, speaking for claims reporting or some of the other reporting mechanisms out there — the MAV process, if you have one incentive measure, you should report on that measure.

Again, anyone from PQMM who can better speak to the details of that?

Kim Spalding-Bush: Alex, this is Kim. I don't believe they were able to join today. We can follow up, though.

Debra Kaldenberg: This is Deb Kaldenberg from PQMM. I think a few of us were able to get on. I guess my question about the threshold would be if we are specifically talking about claims or registry, and then we would end up in the MAV process. But my suggestion would be to go ahead an open up a QualityNet Help Desk ticket with the details, and we can certainly get you a response.

Elizabeth Wilson: OK.

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

Jane Park: Hi, this is Jane Park. I have a quick question. Can you hear me, please?

Aryeh Langer: Yes, please go ahead.

Jane Park: Yes, hi. I looked at some information page, and they said on 2016, they are going to reintroduce back measure group for the back pain measure group. Is that the case?

Debra Kaldenberg: This is Deb again from PQMM. I know at this point the back pain measures group is not part of the Measure Group Specification Manual for 2016.

Jane Park: Oh, it's not, OK, um.

Debra Kaldenberg: No, ma'am.

Jane Park: OK. So — all right. So — but someone — you know, someone obviously gave out wrong information. Yes. You know why it was not part of measure group, because there's a lot of people out there using that measure group and it makes perfect sense because there's a lot of patients with back pain, and I don't understand why you guys took it out? It's very complicated without it. It makes a lot of sense, because there are tons of patients out there with back pain.

Alexandra Mugge: Thank you for your feedback. And we can take that into consideration and certainly invite you to comment on future — the measure process or through our proposed rule.

Jane Park: Thank you very much.

Alexandra Mugge: Thank you.

Operator: Your next question comes from the line of Scott Osburne.

Scott Osburne: Yes, as an independent physical therapy practice, PQRS reporting is quite difficult. And all these sessions never really apply to us. Can you direct me to an MLN session that would specifically address PRQS reporting for physical therapists?

Alexandra Mugge: This is Alex Mugge again. We don't currently have an MLN session scheduled specifically for physical therapists. However, if you do call the QualityNet Help Desk, they can walk you through specifically issues or questions related to your specialty.

Scott Osburne: I have tried that. It doesn't work very well. So, OK.

Alexandra Mugge: I would suggest that you submit your specific questions to the QualityNet Help Desk. And if you need further information, you can ask that that be escalated to CMS.

Scott Osburne: All right. Thank you.
Aryeh Langer: Thank you.

Operator: Your next question comes from the line of Julia Kyles.

Julia Kyles: Hi, could you tell me, have you set or announced the Value Modifier amount for 2014/2016? And, if not, when will you be doing that?

Kim Spalding-Bush: Hi, this is Kim Spalding-Bush from Division of Value-based Payment. We have not yet set the date for the final payment adjustment factor. And as we mentioned earlier in the presentation, we have to wait until the end of the performance period. And we are currently in the midst of the informal review period.

Julia Kyles: OK.

Kim Spalding-Bush: So we would like to get as many of those informal reviews in and resolved so that we know what our net downward adjustments are that we will be redistributing as upward payment adjustments for the high performers. So we do not yet have a date in place. But, it will be near the beginning of the year.

Julia Kyles: Thank you so much.

Kim Spalding-Bush: Sure, thank you.

Operator: Your next question comes from the line of Crystal Pike.

Crystal Pike: Yes, this is Crystal Pike from Triad Healthcare Network. We are looking at going to participate in the Next Generation ACO model next year. So how will the

providers in our ACO be affected by the Value-based Modifier? Will they be susceptible to this?

Fiona Larbi: Hi, this is Fiona from the VM team. On slide 41, we actually list all the Innovation Center models that will actually be waived ...

Crystal Pike: Right.

Fiona Larbi: ... from the VM for 2017 and 2018. And the Next Gen ACO model is actually listed there, as well.

Crystal Pike: OK. If a — if a provider comes in during mid-year, will they be susceptible to the VM during that timeframe? Or do they have — do they have to participate for the whole year in the ACO?

Aryeh Langer: Do you — do you mind submitting that question into email address that I can give you and we can have somebody get back to you?
Crystal Pike: OK.

Aryeh Langer: So let me give that to you now.

Crystal Pike: Um-hum.

Aryeh Langer: I apologize. That's mlnconnectscalls@cms.hhs.gov. Again, mln, as in Medicare Learning Network ...

Crystal Pike: Um-hum.

Aryeh Langer: ... connectscalls@cms.hhs.gov.

Crystal Pike: OK.

Aryeh Langer: We'll have somebody get back to you on that. Thank you.

Crystal Pike: OK, thank you.

Operator: Your next question comes from the line of Jody Thibault.

Jody Thibault: Hi, this is Jody Thibault from New Britain Radiological Associates. We are hospital-based radiologists and we participate with an ACO, but we still submit our PQRS through QCDR on our own. But we did think we would be exempt from the VM. But our ACO told us that CMS specifically excludes radiologists as a specialty. Is that — is that so?

Rabia Khan: This is Rabia Khan. Could you clarify if you are a part of the Shared Savings Program ACO or Pioneer ACO?

Jody Thibault: Well, we get shared savings, but through the ACO, not through CMS. It's an indirect — I believe they're probably a Pioneer — Pioneer model.

Fiona Larbi: Hi, this is Fiona with the VM team. We do not exclude radiologists from the Value Modifier.

Jody Thibault: You don't? It seemed kind of odd to me. OK, I'll have to go back to them, then. Is there somewhere I could go for information?

Kim Spalding-Bush: You may want to talk with your ACO because I'm not sure that we are understanding where their response may have originated. So there could be some nuance to it that we are not getting here. So I think that might be the best first step for you …

Jody Thibault: OK.

Kim Spalding-Bush: … is to try to get clarification from your ACO.

Jody Thibault: OK. But, you don't — as a rule, we are not a specialty that's excluded.

Kim Spalding-Bush: No, we don't exclude any ...

Jody Thibault: OK.

Kim Spalding-Bush: ... particular physician specialties from the Value Modifier program.

Jody Thibault: Very good, thanks.

Kim Spalding-Bush: Thanks.

Aryeh Langer: And that was Kim Spalding-Bush. Thank you.

Operator: Your next question comes from the line of Douglas Pogue.

Douglas Pogue: Well, hi, I am Doug Pogue from the BJC Accountable Care Organization in St. Louis. My question is that on the slide 41. Again, you mentioned Pioneer models and Next Generation models and, then, a few slides later, talked about VM rules for Shared Savings Program. We are transitioning to a Track 3 with bidirectional risk, and I didn't know which set of rules Track 3 ACOs should fall under.

Rabia Khan: This is Rabia Khan. Since you are still participating within the Shared Savings Program, just you are going through a different track, the VM will apply the same way as it does to all other Shared Savings Program ACOs. So you should follow the information provided in slides —I think it's 48 and 49.

Douglas Pogue: Forty-eight and 49, yes, OK. Thank you, I appreciate it.

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

Aryeh Langer: Hello, Mary, are you there Mary?

Operator: Mary, if you are on mute, please unmute your line.

Mary Ingstrom: Hello?

Aryeh Langer: Hello.

Mary Ingstrom: Hello, can you hear me now?
Aryeh Langer: We can year you now.

Mary Ingstrom: OK, sorry about that. So we are a multispecialty practice in excess of 100 EPs. We do participate in a Shared Savings ACO. The ACO does report quality data. And then, what they've told me is we report it for the primary care physicians. The practice, of course, has primary care and specialists, but we all bill under the same tax ID number. So, are our specialists exempt from reporting PQRS because they are part of that ACO?

Rabia Khan: So, this is Rabia Khan. So your specialists and your primary care physicians, so long as they are billing through the TIN that's participating in that Shared Savings Program ACO …

Mary Ingstrom: Yes.

Rabia Khan: ... will meet the PRQS reporting requirements when the ACO satisfactorily reports the Web Interface measures. So as long as they complete that, your specialists and primary care physicians will meet the PRQS reporting requirements.

Mary Ingstrom: OK, perfect. Thank you.

Rabia Khan: Yes.

Operator: Your next question comes from the line of Mena Sincar.

Mena Sincar: Hello? Hello?

Aryeh Langer: Hello.

Mina Sincar: Yes, can you hear me now?

Aryeh Langer: Can you speak up a little bit, please.

Mena Sincar: OK, is it clear now?

Alexandra Mugge: Yes.

Aryeh Langer: Yes, thank you.

Mena Sincar: OK, I have two questions. Number one is, for PRQS reporting, do we have to bill a code which is G, as in George, 8485 to our claims just notifying that Medicare that we will be reporting PRQS for the year 2015 next year before February, because until last year there was a rule — I just want to make sure even this year, do we have to bill that code G8485?
Alexandra Mugge: This is Alex. And I would suggest you call the QualityNet Help Desk if you have questions about the code that you are submitting on your claims, particularly if you have questions about 2015 reporting.

Mena Sincar: OK, and my next questions was, we have a nurse practitioner who's really a part time. She doesn't see maybe 15 to 20 Medicare patients. So does she get exclusion for PQRS and Meaningful Use reporting to Medicare?

Aryeh Langer: One moment, please.

Elisabeth Myers: So those are two separate things. This is Elisabeth Myers from (GCSQ) for the EHR Incentive Program. A nurse practitioner is not eligible for the Medicare EHR Incentive Program.

Mena Sincar: OK.

Elisabeth Myers: So they would not be reporting either the Meaningful Use objectives and measures or CQMs for that purpose. However, PQRS is a different story.

Mena Sincar: OK.

Alexandra Mugge: So, for PQRS, they are eligible for —they are an eligible professional for the PQRS program, then they would not be exempt. So they do need to report.

Mena Sincar: Even though she doesn't have that many patients?

Alexandra Mugge: Yes.

Mena Sincar: But, still she has to report, otherwise she will be ending up with a payment adjustment in 2017? Is it correct?

Alexandra Mugge: That's correct, yes.

Mena Sincar: OK, all right. Thank you, I appreciate it.

Aryeh Langer: Thank you.

Operator: Your next question comes from the line of Karen Hampton.

Karen Hampton: Hi, I am a solo practitioner clinical social worker. And in looking at what you — at the diagrams, I have reported PQRS data and it says next year, I can report it via claims or EHR, registry, or QCDR. If — but, if I don't report using EHR, does that mean I am subject to a payment adjustment in 2016? I mean, if I don't report — in 2016, if I don't report using EHR, am I subject to a payment adjustment?
Elisabeth Myers: So, this is Elisabeth Myers from the EHR Incentive Program. If you are not an eligible professional, which means one of the five physician types for the EHR Incentive Program, which is actually a smaller universe than many of the other programs. So, we don't include nurse practitioners. We don't include ancillary care providers, behavioral health, physical therapists ...

Karen Hampton: OK.

Elisabeth Myers: ... a pretty wide range. So you wouldn't be included. If you are not eligible for the program, that means you are also not subject to a payment adjustment.

Alexandra Mugge: That is just under Meaningful Use.

Elisabeth Myers: Under Meaningful Use.

Karen Hampton: OK, got it. Thank you.

Elisabeth Myers: Sure.

Operator: Your next question comes from the line of Jennifer Nelson.

Jennifer Nelson: Hi, this is Jennifer. We are an outpatient physical therapy clinic, and we have been billing PQRS via claims since 2013. And both years, this year included, we have got the payment adjustment — a negative payment adjustment, and nobody can seem to let us know why. And we did talk to QualityNet both years. Is it possible that

because I was not billing a penny on those codes, that they didn't get reported somehow? Is that possible?

Alexandra Mugge: Is Deb from PQMM still on? Can you address that?

Debra Kaldenberg: This is Deb. I guess — and I know that you said that you already went through QNet. But, honestly, we would have to look at the measures that you were reporting, the codes that you were reporting, and maybe even some of the dashboard information that you have possibly gotten for 2013 to be able to determine exactly maybe why you didn't pass. As far as whether or not the penny charge was on there, I know there have been some changes over the last couple of years. So I couldn't say for sure whether or not that penny would have caused the issue.

Jennifer Nelson: OK. Would anybody know for sure? Is there anybody I could ask that would — could tell me that for sure? Because we use WebPT for our coding and ...

Alexandra Mugge: Yes. If you — if you contact the QualityNet Help Desk and ask specifically why …

Jennifer Nelson: I did …

Alexandra Mugge: …you are receiving the payment adjustment, we can look into it. But we would need specific information from you that we can't gather on the call today in order to do that research.

Jennifer Nelson: OK, thank you.

Alexandra Mugge: Sure.

Operator: Your next question comes from the line of Candice Motta.

Candice Motta: OK. So I know that it says to report at least nine measures covering at least three of the NQS domains. And then, later on, it does say that if it doesn't pertain to nine of them for the measures, you can report less. But, I am not really understanding that because the specialty that I am in, there's only about seven measure that we could use for our practitioners. So, I didn't know how to — and we report via claims. So I just want to make sure that we are not going to run into any issues if we don't have nine exact measures.

Alexandra Mugge: This is Alex from the PQRS. And if you only have seven measures that truly apply to your practice, then that would be all you need to report, if you are reporting, through the MAV — I'm sorry, if you're reporting through claims you'd be subject to the MAV process, which would take look at all of your billing throughout the year to determine whether you could have reported on the additional two to get to the

nine measures across three domains. If you have any questions about what measures may apply to your specialty, the QualityNet Help Desk can certainly answer those questions for you.

But, again, the requirement is nine measure across three domains or report CAHPS and six measures across two domains. But it sounds like for your — in your particular case, if you are reporting through claims and you know that only seven measures would ever apply to you, then you would want to report on those seven measures. And then you would be subject to the MAV process at the end of the year.

Candice Motta: OK. And they don't have to be all Medicare ones, though? Is that correct?

Alexandra Mugge: For claims reporting, it would have to be all Medicare.

Candice Motta: They do have to be all Medicare? OK, thank you very much.

Alexandra Mugge: Yes, because they are only putting the CPT codes on claims that you submit to Medicare. That's what we would use to process that.

Candice Motta: OK, thank you.

Alexandra Mugge: Yes.

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

Aryeh Langer: Hello?

Raoul: Yes, yes, hello.

Aryeh Langer: Hello.

Raoul: Hello, yes. I have a question, if the eligible professional already submitted all claims for 2015 but without including the PQRS measures, is there any option available for the provider to resubmit claims with measures by February 2016?

Alexandra Mugge: In order to report through the claims option, you would really need to be submitting those CPT codes on your claims throughout the year. So I would say, no. At this point it will be too late to start reporting claims. But you also have the option to report through an EHR registry or a QCDR.

Raoul: So using a QCDR is an option for the provider in this case?

Alexandra Mugge: A Qualified Clinical Data Registry, yes.

Raoul: OK, good, thank you.

Operator: Your next question comes from the line of Carol Cope.

Aryeh Langer: Carol, are you there?

Carol Cope: Hello, I am. Hi, can you hear me?

Alexandra Mugge: Yes.

Aryeh Langer: We can hear you, yes.

Carol Cope: Thank you. I am starting to look at the 2016 PQRS measures and some of the places of service codes have changed, and I was wondering if it is allowable to use a G0439 in place of service 3132 and 13 to allow PQRS measures, for instance, number 431, to be scored in a nursing facility?

Alexandra Mugge: For your particular question, because you have such level of detail, I'd recommend that you reach out to the QualityNet Help Desk to look at your claims — to look at those particular codes.

Carol Cope: OK, all right. Thank you.

Operator: Your next — your next question comes from the line of Thomas Sebastian.

Aryeh Langer: Are you there?

Thomas Sebastian: Hello, this is Thomas Sebastian. Hello, this is Thomas. I am calling from Holy Cross Physician Partners ACO. I have two questions. The first is, right now we are in the process of, you know, just getting our associates and our team members together for a GPRO reporting, and I wanted to know whether or not CMS will be providing screenshots, or rather a guide, for ACO associates showing them what the GPRO interface looks like. And if that is the case, will they provide — will they be providing any instructions as to where associates can look for these quality measures on their EHR? That's my first question.

And my second question is, what is the maximum number of beneficiaries that ACOs will be required to report on? Because I understand that we are supposed to report on all measures included in the Web Interface for the first 248 consecutively ranked. But I wanted to know what the maximum number of beneficiaries we would have to be required to report on would be.

Rabia Khan: Hi, this is Rabia Khan. So tackling the first question, yes. So I'm sure your ACO's gearing up for Web Interface reporting for the 2015 reporting year, …

Thomas Sebastian: Um-hum.

Rabia Khan: … which begins in January. There will be training or — demonstration videos that will be released later this months, as well as additional training information. There are support calls. I believe the first one is scheduled for next week, but the ACO Spotlight newsletter includes all of the dates and times for all of the Web Interface support calls.

Thomas Sebastian: OK.

Rabia Khan: Now, the primary resource for information is the GPRO Web Interface webpage, where we have all of the specifications and supporting documentation. We have also provided ACOs with quick reference guides for each of the measures …

Thomas Sebastian: Um-hum.

Rabia Khan: … that's available on our ACO portlet.

Thomas Sebastian:Right.

Rabia Khan: And, in terms of Web interface, there is a training environment that we allow ACOs and other group practices to go into prior to the submission period actually opening.

Thomas Sebastian: OK.

Rabia Khan: It's a 5-day window that — and I'm just trying to pull up the date. It's January 11th through the 15th where you can go in and sort of play with dummy data so you can get the look and feel of the Web Interface as you prepare. And the actual submission period for 2015 begins on January 18th, and it's an 8-week period.

In terms of reporting, the reporting requirement is 248 consecutive benes or your entire sample if you have fewer than those who meet the denominator for that measure, so — or 100 percent. And in terms of your total, there are 17 Web Interface measures, so you need to complete reporting for all of those. And I believe we sample — and PQMM can jump in – when they need to. But, we sample for 17 of those — 16 of those 17 measures, and we use a single sample for the diabetes composite. But the total requirement for each measure — or module, is 248 consecutive benes.

Thomas Sebastian: So really, we are reporting on 248 times 17 measures altogether …

Rabia Khan: Well.

Thomas Sebastian: …if we are reporting on 17 measures per bene?

Rabia Khan: No. So we try to use — when we prepare the samples, we try to use benes that meet multiple denominators. So there will be crossing ...

Thomas Sebastian: Got you, OK.

Rabia Khan: ... samples. So, yes.

Thomas Sebastian: OK.

Rabia Khan: So, yes. And you can report on your entire sample if you choose to.

Thomas Sebastian: OK.

Rabia Khan: But the minimum requirement is 248.

Thomas Sebastian:Right. But, you guys are going to be specifying which measure you want us to report on for a specific bene, correct?

Rabia Khan: Right. So the patient ranking file, which will be available on January 4th. Once you have all of your EIDM accounts and roles and can access the Web Interface, you can download it there. And that provides you your entire sample list of benes. And, I believe, it also provides you with the top three providers so you can already start to sort of figuring out who to contact if you are looking for records, as well.

Thomas Sebastian: Excellent. OK. And back to the demonstration videos, will those videos actually show us like how to report the quality measure in terms of like, let's say, we needed to report for HBs and Cs, something like that, like where to put that information on the Web Interface? Will it be that specific and detailed in this demonstration video that will be occurring on…

Rabia Khan: I can't …

Thomas Sebastian: … during the week of January that you told me about?

Rabia Khan: I can't speak right now off the top of my head on what's …

Thomas Sebastian: Um-hum.

Rabia Khan: … specifically in those demonstration videos.

Thomas Sebastian: Um-hum.

Rabia Khan: But I would suggest checking our ACO Spotlight newsletter …

Thomas Sebastian: OK.

Rabia Khan: … for all of the support call information so you can attend one of the support calls. And if you have questions, there is a Q&A session there to ask.

Thomas Sebastian: Right, yes, I am aware of all the support calls. OK.

Rabia Khan: Thank you.

Thomas Sebastian: All right, thank you.

Additional Information

Aryeh Langer: Thank you so much. And unfortunately, that's all the time we have for questions today. If we did not get to your question, please refer to slide 56 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 the MLN Connects Provider eNews when they become available.

On slide 61 of today's presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Aryeh Langer here at CMS. I'd like to thank our presenters and also thank everybody on the lines for participating today and your excellent questions on today's MLN Connects Call. Have a great day everybody.

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

-END-


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