



MLN Connects®

National Provider Call Transcript



**Centers for Medicare & Medicaid Services
2016 PQRS Reporting: Avoiding 2018 Negative Payment Adjustments Call
MLN Connects National Provider Call
Moderator: Aryeh Langer
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This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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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, Holley. As you just heard, my name is Aryeh Langer from the Provider Communications Group here at CMS, and I am your moderator for today's call. I would like to welcome you to this MLN Connects National Provider Call on the Physician Quality Reporting System, or PQRS. Today's topic will be 2016 PQRS Reporting: Avoiding 2018 Negative Payment Adjustments. MLN Connects Calls are part of the [Medicare Learning Network®](#).

Today's MLN Connects National Provider Call gives an overview of the 2016 Physician Quality Reporting System and related resources. The presentation covers guidance and instructions on how individual eligible professionals and PQRS group practices can get started, satisfactorily report or participate, and avoid a 2018 PQRS negative payment adjustment. A question-and-answer session will follow today's presentation.

A few quick announcements—you should have received a link to today's slide presentation in an email earlier this afternoon. 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 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.

Third, this MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit. For additional information, please refer to slide 53 of today's presentation for a link to the [CE activity information and instructions](#) document.

And finally, we received many comments from our previous PQRS National Provider Calls and their evaluations regarding the content of the slides and presentation style. We heard you. We have incorporated those thoughts into our slides today and we hope that you have an improved experience moving forward. Thank you very much.

At this time, I would like to turn the call over to our first presenter, Tim Jackson, from CMS.

Presentation

Timothy Jackson: Thanks, Aryeh. So, this afternoon, we are going to start out on slide 3, which lays out the agenda and learning objectives. This presentation is intended to be at a high level, and we have provided the links and resources where you can learn more. There's an appendix with additional information starting on slide 53. We will not cover these slides as they are intended to serve as a reference for the following call. But, as we start with an overview of CMS and our quality measures, we will then jump in to the PQRS requirements and getting started with reporting. I will touch on the 2016 PQRS reporting mechanisms. And at the end of the session, I will share some PQRS resources starting on slide 47, where you will be able to find help, before we hold the Q&A session.

We are going to go to slide 4. Please note, for your convenience, in the reference at the bottom of each slide is a jump-to link that lays out all the acronyms used in this presentation. Simply click on the word "Acronyms" to come back to this slide, slide 4, at any time during the presentation.

CMS Initiatives and Quality Measurement

Timothy Jackson: Slide 5. So, we are going to quickly cover quality measurement as a CMS initiative. PQRS was originally created under the Tax Relief and Health Care Act of 2006 as a voluntary reporting program. Next legislative program called Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 made the program permanent and authorized incentive payments through 2010. The Patient Protection and Affordable Care Act extended incentive payments through 2014 and also created mandatory reporting beginning in 2015.

Slide 6. The Affordable Care Act requires the Secretary of the Department of Health and Human Services to establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health. The Secretary established this national strategy for quality improvement in health care called the National Quality Strategy, or NQS, setting priorities to guide the effort and includes the strategic plan for achieving those outcomes.

Slide 7. This slide includes a list of the six National Quality Strategy, or NQS, domains. CMS developed a standardized system for developing and maintaining the quality measures used in its various accountability initiatives and programs.

CMS measure focus areas include a quality set of measures that lead to health outcomes, such as measures that have incorporated consumer input into the development and maintenance of measures, outcome or intermediate outcome measures, and measures that focus on the six NQS domains. And those NQS domains are patient safety, person- and caregiver-centered experience and outcomes,

communication and care coordination, effective clinical care, community and population health, efficiency and cost reduction.

Best practices for these processes are documented in the manual "[A Blueprint for the CMS Measures Management System](#)," also known as "The Blueprint." You'll find these in the Resource section of this presentation, which you can look for further information.

Physician Quality Reporting System

Timothy Jackson: Slide 8. Now we are going to provide a brief overview of PQRS, or the Physician Quality Reporting System.

Slide 9. What is PQRS? PQRS is a quality reporting program encouraging individual eligible professionals and group practices to report information on the quality of care to Medicare. The program applies a negative payment adjustment to individual EPs and PQRS group practices who do not satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule services furnished under the Medicare Part B beneficiaries. Those who do not satisfy or report PQRS data in 2016 will be subject to a negative payment adjustment of 2 percent in 2018.

Slide 10. As you can see, PQRS aligns with several other quality programs administered by CMS. Some of these programs also apply negative payment adjustments to EPs and group practices that do not satisfactorily report quality data, while others offer alternate payment models such as Accountable Care Organizations, also called ACOs, and shared savings programs. And still others collect the quality data and report it for consumer use in making health care decisions.

At this point, we are going to pause to conduct the poll.

Keypad Polling

Aryeh Langer: Thank you, Tim. At this time, we will pause a few moments to complete keypad polling. Holley, can you start the keypad polling, please?

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

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

Please continue to hold while we complete the polling.

Again, please hold while we complete the polling.

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

Presentation Continued

Aryeh Langer: Thank you. And I am going to turn the call back to Tim for the next part of our presentation.

2016 PQRS Getting Started

Timothy Jackson: Great. Thanks, Aryeh. So, we are back on slide 11, and we are going to start going through how participating in PQRS occurs.

Slide 12, Eligibility. Most Medicare physicians, practitioners, and therapists are eligible to participate in PQRS. A complete list of eligible medical professionals is available at the [PQRS How To Get Started](#) webpage.

Slide 13. EPs have two options for PQRS participation. They can either participate as an individual with their individual National Provider Identifier (NPI) and tax identification number (TIN), or they can participate as part of a PQRS group practice, which is a single TIN with two or more individual EPs who have been reassigned their billing rights to the TIN.

Note that, if you are reporting for PQRS through another CMS program, such as the Medicare Shared Savings Program, Comprehensive Primary Care Initiative, Pioneer Accountable Care Organization, or other quality reporting program or initiative, check the program's requirements for information on how to report quality data to avoid the PQRS negative payment adjustment. Further note, although CMS has attempted to align or adopt similar reporting requirements across programs, EPs should look at the respective quality program to ensure they satisfy PQRS, EHR incentive program, value-based modifier, or other program requirements for each, as applicable.

Slide 14. Successful participation in the PQRS involves multiple steps. First, individual EPs and group practices must participate by submitting quality measures data. Second, CMS analyzes the submitted data to determine if it meets the criteria for satisfactory reporting. Third, CMS sends feedback to the individual EP or group practice stating whether their reporting was successful or they are subject to the PQRS negative payment adjustment. Fourth, individual EPs and PQRS group practices have the option of requesting an informal review of their reporting performance if they feel that the PQRS negative payment adjustment was assessed in error.

Slide 15. Group practices must [register to participate in PQRS via the group practice reporting option](#), commonly referred to as GPRO, using the [Physician Value—PQRS Registration System](#), which will ask you for all of the group information required for a successful registration of a group. For 2016, GPRO registration occurs from April 1st through June 30th, 2016.

2016 PQRS Reporting

Timothy Jackson: Slide 16. Now, we are going to provide a brief overview of PQRS reporting for 2016.

Slide 17. PQRS offers several reporting mechanisms for reporting measures. Reporting mechanisms are best described as the way an EP chooses to submit their data to CMS. Some mechanisms offer multiple options for satisfactory reporting, but not all reporting mechanisms are available to all participants.

Appendix B of the [2016 PQRS: Implementation Guide](#) contains decision trees that can help you select the reporting mechanism that works best for you. You can find the Implementation Guide on the [PQRS How To Get Started](#) webpage.

Slide 18. Before you decide which mechanism to use, EPs are encouraged to identify which measures will work best for them. Please note not all measures are available for every reporting mechanism. To select measures to report for PQRS, individual EPs and group practices should consider clinical conditions commonly treated; types of care delivered frequently, such as preventative, chronic, or acute; settings where care is often delivered, such as an office, emergency department, or surgical suite; quality improvement goals for 2016; other quality reporting programs in use or considered by the EP or group practice.

Again, there are different measures for different reporting mechanisms, and specifications change year to year. So, be sure to use the current program year specifications for the mechanism chosen. For additional resources to help you select measures, you can find the [2016 PQRS Measures List](#) and the PQRS web-based measures search tool on the [PQRS Measures Codes](#) webpage.

2016 Reporting Mechanisms

Timothy Jackson: Slide 19. Depending on whether you are participating in PQRS as an individual or as part of a group, you have several reporting mechanisms by which you can choose to submit your 2016 PQRS data. Mechanisms available to report information on the individual quality measures or measures groups using one of five mechanisms include Medicare Part B claims, qualified PQRS registry, direct electronic health record, using Certified EHR technology, or CEHRT, CEHRT via data submission vendor, or DSV, and qualified clinical data registry, or QCDR.

Slide 21. Group practices participating via the group practice reporting option may choose to report on information on PQRS quality measures using one of five reporting mechanisms: CEHRT via submission vendor, or DSV; QCDR; qualified PQRS registry; direct EHR using CEHRT; GPRO Web Interface for groups of 25 or more only; CAHPS® for PQRS, which is a survey available to PQRS group practices of two or more EPs to supplement their chosen reporting mechanism. CAHPS for PQRS survey is required for PQRS group practices of 100 or more EPs in addition to reporting via their chosen reporting mechanism.

Slide 22. Crosscutting measures are measures defined as broadly applicable across multiple providers and specialties. Individual EPs and group practices are required to report one crosscutting measure if they have at least one Medicare patient with a face-to-face encounter. CMS defines a face-to-face encounter as an instance in which the EP billed for service such as a general office visit, outpatient visit, and surgical procedure codes under the Medicare Physician Fee Schedule. The [PQRS Measures Codes](#) webpage contains multiple resources regarding crosscutting measures that will help you select crosscutting measures applicable to your practice and identify the corresponding billable codes.

Claims Reporting

Timothy Jackson: Slide 23. The first reporting mechanism we will discuss today, for the 2016 PQRS Medicare Part B claims, is claims.

Slide 24. There are several benefits associated with claims-based reporting, including Medicare Part B claims are already part of the billing processes, there is no need to contact a registry or EHR vendor to submit PQRS data; it's simple to select applicable measures to begin reporting for PQRS.

The claims-based reporting mechanism is only available to individual EPs. Group practices cannot use claim-based reporting for PQRS.

The [2016 PQRS: Implementation Guide](#) contains samples of the 1500 and 1450 claim forms that are used for claims-based reporting. Additional guides for claims-based reporting can be found on the [PQRS Measures Codes](#) webpage.

Slide 25. To get started with claims-based reporting, first determine your eligibility. See the [2016 List of Eligible Professionals](#) on the [PQRS How To Get Started](#) webpage for details.

Next, determine which measures to report. Review the [2016 PQRS Measures List](#) for a comprehensive resource that describes all PQRS measures, including titles, descriptions, numbering, NQS domain, and the reporting mechanisms for which the measure is available. This document is available on the [PQRS Measures Codes](#) webpage. The new

PQRS web-based measure search tool can be used to easily identify applicable PQRS measures as well.

The third step is to satisfactorily report PQRS in 2016. Additional resources are available on the [PQRS Measures Codes](#) webpage for further details. Lastly, establish an office workflow that will allow each chosen measure's patient to be accurately identified on the Medicare Part B claim.

Qualified Registry Reporting

Timothy Jackson: Slide 26. The next mechanism is the qualified registry.

Slide 27. A qualified registry is an entity that collects clinical data on behalf of PQRS participants and submits the data to CMS in a defined format. [Registry reporting](#) is available to individual EPs, PQRS group practices of 2 to 99 EPs, PQRS group practices of 100 or more EPs only when reporting in conjunction with CAHPS for PQRS.

A group practice must have registered to report via [qualified registry](#) under the GPRO for the 2016 PQRS. Individual EPs and PQRS group practices should work directly with their chosen registry in order to submit data satisfactorily on the selected measures and measure groups.

Please note that measure groups are only available to individual eligible professionals, and submission for program year 2016 occurs in the first quarter of the calendar year of 2017. Additional resources can be found on the [PQRS Registry Reporting](#) webpage.

Slide 28. To get started with registry reporting, first, you need to determine eligibility, then determine which measures to report. Once you have selected the measures you would like to report, review the [list of registries](#) that support 2016 PQRS measures. This list is currently available on the [PQRS Registry Reporting](#) webpage. Your registry will provide you specific instructions on how and when to submit data for the selected measures or measure groups you choose to report. Again, you will work directly with your registry to ensure data is submitted appropriately.

Qualified Clinical Data Registry

Timothy Jackson: Slide 29. Qualified clinical data registries.

Slide 30. The QCDR is a CMS-approved entity, such as a specialty society, certification board, or regional health collaborative, that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients. The QCDR will complete the collection and submission of PQRS quality measure data on behalf of PQRS participants. A QCDR reporting is available to individual EPs, PQRS group practices of 2 to 99 EPs, PQRS group practices of 100 or more

EPs only when reported in conjunction with CAHPS for PQRS. A group practice must have registered to report via QCDR under the GPRO for 2016 PQRS.

A QCDR is different from a qualified registry in that it is not limited to measures within PQRS. A QCDR vendor is allowed to submit a maximum of 30 non-PQRS measures. Submission timeframe for program year 2016 is in the first quarter of calendar year 2017. And additional resources can be found on the PQRS [QCDR Reporting](#) webpage.

Slide 31. To get started with a QCDR for reporting, you will need to determine your eligibility, select a QCDR vendor by referring to the 2016 Participating Qualified Clinical Data Registry List on the PQRS [Qualified Clinical Data Registry Reporting](#) webpage, which is posted in the spring of 2016. The QCDR will then provide the individual EP or group practice with specific instructions on how to collect and provide patient data for use by the QCDR.

Slide 32. The table here outlines similarities and differences between qualified registry and a QCDR. Both entities submit PQRS data on your behalf. Registry and QCDR both submit PQRS measures; however, QCDR also supports non-PQRS measures. Qualified registry and QCDR both support individual measure reporting, but only registry allows individual eligible professionals to report measure groups. Both entities are available for PQRS group practices. QCDR also supports the submission of electronic Clinical Quality Measures, or eQMs, which foster alignment with the Medicare EHR Incentive Program.

Electronic Reporting Using an Electronic Health Record

Timothy Jackson: Slide 33. Next, we'll learn about electronic reporting using electronic health records, or EHRs. EHR reporting reduces the burden on providers participating in multiple quality reporting programs. So, CMS has aligned several reporting requirements for those reporting electronically using an EHR.

The first way CMS has aligned reporting requirements is to allowing electronic quality measures, or eQCM, specifications to be used for multiple programs, such as PQRS and the Medicare EHR Incentive Program. Additionally, satisfactory reporting for PQRS EHR quality measures allows individual EPs and PQRS group practices to satisfy the clinical quality measures component of meaningful use. Finally, individual EPs and PQRS group practices are required to submit clinical quality measures using a direct EHR product or EHR data submission vendor that is Certified EHR technology, which we'll describe in greater detail in the next two slides.

It's important to note that the Office of National Coordinator for Health Information Technology certification processes have established standards and other criteria for structured data that an EHR must use. For more information on how to report electronically using an EHR, either as an individual or PQRS group practice, please refer to the PQRS [Electronic Reporting Using the EHR](#) webpage.

Slide 35. There are two types of electronic reporting, the first being direct EHR vendor, which is also known as EHR Direct. EHR Direct, or direct EHR vendors, are those who are certifying an EHR product and version for EPs or group practices to utilize to submit their measure data to CMS in the CMS-specified formats on their own behalf.

Slide 36. The second type of electronic reporting is through a data submission vendor, or EHR DSV. An EHR DSV is an entity that collects an individual EP or PQRS group practice's clinical quality data directly from the EP's EHR. DSVs will be responsible for submitting measure data from an EP's group practice Certified EHR to CMS via a CMS-specified format on behalf of the EP or group practice.

Slide 37. Electronic reporting using an EHR is available to individual EPs, group practices of 2 to 99 EPs, group practices of 100 or more EPs when reporting in conjunction with CAHPS for PQRS. Individual EPs and PQRS group practices select an EHR product based on reporting data submission types. As previously mentioned, you can find detailed reporting information on the [PQRS Electronic Reporting Use an EHR](#) webpage, which is listed on this slide.

Group Practice Reporting Option Web Interface

Timothy Jackson: Slide 38. Another reporting mechanism for 2016 PQRS is the group practice reporting option, or GPRO, Web Interface. This is applicable for group practices with 25 or more EPs, and they must register for this mechanism.

Slide 39. The GPRO Web Interface is a secure internet-based application available in the [PQRS Portal](#) for preregistered users. CMS prepopulates the Web Interface with a sample of the group's patients. Then, PQRS group practices complete the data for a prepopulated patient within the Web Interface. CMS then calculates the reporting and performance rates for this mechanism.

The Web Interface is available to PQRS group practices with 25 to 99 EPs and those with 100 or more EPs when reported in conjunction with CAHPS for PQRS. For more information, see the [GPRO Web Interface](#) webpage.

Slide 40. So, how do you get started with the GPRO Web Interface? First, you will determine your eligibility. Then you will register for this reporting mechanism on the Physician Value-Physician Quality Reporting System (PV-PQRS) registration system during the registration timeframe of April 1st to June 30th, 2016. For further details, see the [GPRO Quick-Reference Guide](#) for registration on the CMS [How To Get Started](#) webpage for more information. There will be another National Provider Call on May 4th covering GPRO registration. The third step—to complete your measures data for preselected patients within the Web Interface. And then, finally, you will submit your Web Interface data to CMS. Submission timeframe for program year 2016 is the

first quarter of the calendar year 2017. There will be additional education support opportunities for this reporting on this mechanism.

Consumer Assessment of Healthcare Providers and Systems

Timothy Jackson: Slide 41. The next section covers Consumer Assessment of Health Providers and Systems, or CAHPS, for PQRS.

Slide 42. CMS-certified survey vendors will then work with CMS to distribute and collect CAHPS for PQRS survey. The survey was developed to collect information about patient experience and care within the group practice. The survey measures patient experience with and ratings of health care providers.

CAHPS for PQRS is optional for group practices of 2 to 99 EPs. It is optional for PQRS group practices of 25 to 99 EPs reporting via the GPRO Web Interface. And it is required for all PQRS group practices of 100 or more EPs, regardless of reporting mechanism selected during registration. This mechanism is not available to individual EPs. And you will find further resources on the [Certified Survey Vendor](#) webpage.

Slide 43. To get started with registry, no – to get started with CAHPS surveys, you will determine your eligibility, register, and select primary mechanisms for submission of the CAHPS for PQRS data. You will do that by selecting a vendor for your primary mechanism and then verifying that the vendor for CAHPS for QPRS is available at the pqrscahps.org website as found on this page.

Resources

Timothy Jackson: Slide 44. We know that many of you are calling for QualityNet Help Desk with questions, and we hear you. Our FAQs—our top five—are listed on slides 45 and 46.

Slide 47. This concludes the formal portion of our presentation. In the following slides, you will find additional resources for you as well as information about where to call for help.

Slide 49. If you have more specific questions, we've listed additional organizations and our contact information here.

Slide 50. Here you'll find useful links to various PQRS webpages that we referenced in this presentation.

Slide 51. Now, we will move on to our Q&A session.

Question-and-Answer Session

Aryeh Langer: Thank you, Tim. 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, Holley. 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.

And our first question will come from the line of Jay Simpson.

That question has been withdrawn. Your next question will come from the line of Cristina Bravo.

Cristina Bravo: Hello.

Aryeh Langer: Hello. Go ahead.

Cristina Bravo: Can you hear me?

Aryeh Langer: Yes.

Cristina Bravo: So, my question is with the hardship exemptions. I'm having some trouble with my organization. We're changing our EHR. We're looking to go to a Certified EHR. But the reality is there will be maybe about 6 to 8 weeks where we will be in transition mode. And in that process, we're concerned that we may not be able to capture all of the data 100 percent to be able to report properly. We've been reporting since 2013. So, how are the exemption hardship laws similar or different to those of a facility? We are a medical group. Sorry. I should have mentioned that at the beginning. Hello?

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

Sophia Autrey: Hello. This is Sophia Autrey from CMS. So, we actually don't have hardship exemptions. So – but for reporting, you know, you're only required to report

50 percent of the provider – I mean – I’m sorry – 50 percent of patients. So, you should be fine even through the transition period for the full reporting year.

Cristina Bravo: Well, the...

Sophia Autrey: Go ahead.

Cristina Bravo: (Off mic)

...take up too much time. Is there any...

(Off mic)

Aryeh Langer: I’m sorry. We’re having trouble hearing you.

(Off mic)

Cristina Bravo: Hello. Do you hear me now?

Aryeh Langer: Okay. Go ahead.

Sophia Autrey: Go ahead.

Cristina Bravo: Yes. Sorry. I was just asking, if there’s no hardship exemption rules or policy that address reporting for PQRS, how do we go about, when we’re unable to sustain or support – you know, the transition is massive. It’s a 6-month rollout program. The – it’s an entire system that’s changed, and we just are – we’re one entity, but the facilities are at different timeframes. So, I’m just wondering if there’s someone I could reach out to outside this call to make sure that I get some clarity on what needs to or not needs to be documented so that we don’t get penalized for, you know, poor documentation or, you know, inability to report, or whatnot, based on this transition.

Sophia Autrey: Yes. So, this is Sophia Autrey again. So, the only thing that I can really tell you is, during the process of transitioning, I’m sure there is a process that you guys have for documenting encounters and claims. So, it’s just making sure that you have that and, as much as possible, once the transition occurs, ensuring that as much data as possible is with the new vendor or new system and then sending that forth.

So, the only thing that – only way that you will know that you’re not – you’re going to be or – receive a payment adjustment will be from the letter that usually comes after the program year. And if you are a provider that receives that letter, then submit an informal review and – detailing exactly what happened so that we can review the information. But we would still need to receive data from you during that – for that performance year.

Cristina Bravo: Okay. Because the current vendor doesn't offer it. So, we have a third-party vendor that we supply access to our record and they – you know, and they submit on our behalf. That vendor's going away. The certified vendor will not be able to get to the PQRS modules until January of 2017. So, effective fourth quarter and a little bit before when the transition begins to roll out, we will no longer be able to submit PQRS data. And that's a concern for us because we are active in the program.

And I'm just wondering, is there a website or – I'm used to the inpatient side where there's a very strict policy—yes, no, yes, no, you qualify, you don't qualify. Is there something like that, a document, an article, or a contact that I can reach out to and say, "This is our scenario. How do we go about this?"

Sophia Autrey: Okay. So, because we – I have limited time on the call, I'm going to ask you to actually contact the [Help Desk](#) so that we can thoroughly talk about and look at your situation. Okay?

Cristina Bravo: Perfect. Okay. Thank you.

Aryeh Langer: And that information's on slide 48. And just reference today's National Provider Call and the subject so we can get to that timely, please. Thank you.

Cristina Bravo: Thank you.

Operator: Our next question will come from the line of Michael Brody.

Michael Brody: Hello. Thank you for taking my question. If a specialist contracts with an ACO and the ACO represents less than 50 percent of the specialist's patient volume but the ACO registers the specialist as part of the group, what ramifications might that have upon the specialist because over 50 percent of their patients would not be reporting with the ACO group but once they've registered as part of the – as part of the group, they are no longer eligible for individual reporting?

Aryeh Langer: Unfortunately, we don't have that specific subject matter expert in the room at this time. So, we cannot address that call right now – that question.

Michael Brody: Okay.

Aryeh Langer: But, if you want to go ahead and send that into the [QualityNet Help Desk](#)—the email that I just referenced on slide 48—and, again, you know, reference today's National Provider Call, we can address that there.

Michael Brody: Thank you.

Aryeh Langer: Thank you.

Operator: Your next question will come from the line of Mimi Verner.

Mimi Verner: Yes. My question is – and it – and it might not be for this call, and I apologize if it is not – is—if there is no face-to-face encounter, there’s no measure that you can participate with, do you need to file something with CMS if you’re a monitoring physician and you never have any interaction with the patient? You are just monitoring the surgery remotely for...

(crosstalk)

Mimi Verner: Yes.

Timothy Jackson: So, this is Tim. So, the question, I think, we need to clarify quickly here is – so, are you submitting a claim for any service?

Mimi Verner: Yes.

Timothy Jackson: But it’s in a non-patient-facing encounter.

Mimi Verner: Yes. Correct. And I tried to work with a vendor and, you know, they couldn’t recognize, you know, our main monitoring code—if it’s anything they can work with.

Sophia Autrey: Hi. So, this is Sophia Autrey again. So, there are measures that would be applicable to you even though you don’t have a face-to-face encounter. So, the only thing that a face-to-face encounter does is adds an additional requirement for crosscutting measures. But there are applicable measures for providers that don’t have face-to-face encounters. So, my suggestion would be to look through the measures and see what would be applicable and find an appropriate vendor that can report for you.

Mimi Verner: Okay. We’ve done that, and we couldn’t find any. But thank you.

Jamie Welch: Hi. This is Jamie. Just to add to that, an additional mechanism you may want to look into is the QCDR. And just see – they have additional measures that aren’t within PQRS; they have non-PQRS measures. So, it’s a broader base of measures that you may be able to choose from to report within PQRS.

Mimi Verner: Okay, great. Thanks.

Operator: And your next question will come from the line of Anath Gardenswartz.

Anath Gardenswartz: Hi. Thank you. We are a two-physician podiatric clinic, and we report PQRS through a qualified EHR. And we have meaningful use but, for some reason, we cannot qualify for PQRS. Who can I reach out to so that I can understand why we are not able to qualify and to further understand this? It seems – this is the second year that they told us we don't qualify for it.

Timothy Jackson: Hi. This is Tim. So, when you received that feedback, did you receive that feedback through a report? Or how did you get that note back? Or did you call the Help Desk yourself? How did you – how did you come to that – or receive that determination?

Anath Gardenswartz: We received a letter. And the letter usually states that you have not qualified and a penalty will be enforced.

Timothy Jackson: This is – yes. This is Tim again. I would encourage you to call the Help Desk to provide details. But there is a feedback report that's available that would help you examine the determination on whether or not you applied and reported correctly to the right measures. But, I'm – based on what you have said with the DSV of the EHR, then I think that you should have...so, I would put in a help desk – a QualityNet Help Desk ticket to...

Anath Gardenswartz: I have – I have done that. The first time that we were denied, I didn't understand why, so I did that, and I did follow up with it. And I sent an appeal, and the appeal said, "You are denied." And so, with this past year, when we – again, when we're trying to report it, we – each time, we think that something's going on.

I don't understand why we wouldn't qualify with PQRS if we do qualify with Meaningful Use and we are with a qualified EHR. So, something's wrong. But every time I submit, you know, through or I call the Help Desk, I don't get anywhere. So, is there somebody that I could speak to or reach out to to speak to in order to get past the point of, you know, this back and forth with the Help Desk?

Timothy Jackson: So, this is – this is Tim again. So, if you could reference this call with a new help desk ticket so we can escalate it further up for addressing your issue. I think that we need to reclarify; based on what you had described as feedback, that would not be feedback that the PQRS system would provide to you. So, there may be some misclarification that occurred that we can resolve to help you understand why you didn't qualify for PQRS.

Anath Gardenswartz: Okay. And when you say reference this call, in what way...

Anath Gardenswartz:...what – I'm sorry, I'm losing you.

Timothy Jackson: So, you would just tell the help desk – so, you would just tell the Help Desk the today's call, MLN National Provider Call for 2016 PQRS.

Aryeh Langer: You can just put that in the Subject line.

Anath Gardenswartz: Okay. Okay. Will do. Thank you very much.

Aryeh Langer: Thank you very much.

Operator: And your next question will come from the line of Constance Berner.

Constance Berner: Hi. Thank you for taking my question. So, my question is—obviously, I'm going to register for GPRO because we have around 23 to 27 provider in mid-levels and CRNAs. My question is if I register us for the 25, the – with the EHR under the GPRO – sorry – with the EHR transmission, then in our – amount of provider drops below the 25 so we're at 23 on reporting in the first quarter, how does that work? Is that okay? Is it based on the number of providers at registration?

Timothy Jackson: So, can you – this is Tim. Can you please repeat the scenario where you dropped from 25 to 22 just one more time, please?

Constance Berner: Right. So, under – for registration through the EHR for reporting under GPRO, I wanted to ask – it says 25 to 29 providers in the – of the GPRO, I wanted to ask, if I drop below the 25, then is that – is that okay? So, to do the GPRO Web Interface, if I register for that and I have 27 providers when I register, that when I go to report, it's only 20 providers or 23 providers, does that make a difference?

Sophia Autrey: Oh, okay. So, hi. This is Sophia Autrey again. And even though some of your providers dropped off during the year, you still have to report for – through the Web Interface for the providers in your group.

Constance Berner: Okay.

Sophia Autrey: Okay?

Constance Berner: Okay. So, I would report for them if they work for us for that time of the year when I register them. That's correct. Okay. All right.

My second question is—real quick, on the CAHPS survey, we are a specialty group. And last year, we paid the amount of money to get the CAHPS survey. But, our amount of beneficiaries were not enough to justify the CAHPS. Therefore, we got a benefit of excluding three measures across one domain. I don't want to pay for the CAHPS survey again this year, although I think they're a great patient quality feedback survey. I don't

want to pay for it this year if I don't get credit for it, because we don't have enough beneficiaries.

Timothy Jackson: This is Tim. Thanks for that feedback. I don't know that you had a question, specifically, there. But we do recognize that that is a constraint on many practices. Was there a question?

Constance Berner: Okay. So, the question was will I again this year reporting get the credit for the three measures across one domain? See, I had asked that question and they said that there was – the guidelines were changing. And so, I may not get the credit. I may pay for the CAHPS but still have to report nine across three and not get the credit for the three across one.

Timothy Jackson: Just one second. Hold one moment, please. So, this is Tim. I just wanted to clarify that that guidance was correct. The policy has not changed. But we do recognize and we are going to go back and do further review on this because your point is well taken. So, thank you for the feedback. But yes, the policy has not changed.

Constance Berner: Okay. Thank you.

Timothy Jackson: All right. Thank you.

Operator: And your next question will come from the line of Sandra Pogones.

Sandra Pogones: Hello. This is Sandy Pogones. I have a question about report once option for the QCDR. I've – it's my understanding that, in order for the report once option under a QCDR to count, that you have to report only from the 64 eCQMs in order for it to count for meaningful use. Is that correct?

Timothy Jackson: This is Tim. That is correct.

Sandra Pogones: Okay. Great. And then I just have one more followup question. If you report through EHR, whether it's EHR direct or data submission vendor, are you still required to report 100 percent of your patients, non-Medicare as well as Medicare, or have you dropped that to 50 percent now?

Timothy Jackson: So, it's still all applicable patients for the measure.

Sandra Pogones: Okay. All right. I guess that was more in referral to the person who said they were switching EHRs midyear and wouldn't have 100 percent. And your reply was that they only had to report on 50 percent. So, that confused me a little bit. But, it is – you still are required to report 100 percent.

Timothy Jackson: Right. So, the 50-percent threshold comes from the PQRS side. But, the 100-percent threshold comes from the meaningful use EHR side. So, that was, hopefully, helping clarify that difference.

Sandra Pogones: Okay. So, essentially, for PQRS, you still have to report 100 percent if you're reporting through EHR.

Timothy Jackson: For reporting once, absolutely. Yes. For reporting once, you have to report 100 percent. Yes.

Sandra Pogones: What if you're not reporting using the report once function? Do you still have to report 100 percent for PQRS?

Timothy Jackson: So, it depends. There's 11 different submission methods. And if you don't have the ability to do so across all measures that are selected for your domains, then you do have the ability to go back to 50 percent. But that's only as it applies and it's subject to the verification.

Aryeh Langer: Okay. Thank you.

Operator: And your next question will come from the line of Ahleah Tagai.

Ahleah Tagai: Hi, everybody. Thank you for taking my question. Right now, for the last couple years, we've been reporting via paper claims. We have two providers—one of them passing for the past couple years, so we're comfortable with what we're doing. The other one has not been, so we want to try something new.

We're going to try doing the registry this year. So, up to this point for this year, he's been doing claims reporting. I guess the first thing is—do we have to let you guys know if we're switching from claims to registry? And then, if so, how?

And I just wanted a little more information regarding the registry reporting. It sounds like it's 20 patients; 11 have to be Medicare, you know, for one group. You know, he's thinking about doing the diabetes group that has six measures. Do you have to find patients that have all of those criteria? Or is it, you know, for each patient, it just depends on what falls into their category? So, just a little more information, if you don't mind.

Timothy Jackson: Okay. So, this is Tim. So, let me just start with your first question. No, you do not need to inform us which way or option you choose to report.

Ahleah Tagai: Okay.

Timothy Jackson: That's not necessary. The second kind of group of questions – make sure I am following them correctly. So, when the registry you select – there's a determination process. And I believe that the numbers that you said are accurate. I don't have them in front of me here. But the registry should be able to work with you to make sure that you are providing data in the correct format and the correct type.

Ahleah Tagai: ...I mean, we – he's looking to do them as a group...

Timothy Jackson: Yes.

Ahleah Tagai: ...looks like there is, you know, we'll say six measures. So, we're just seeing, you know, over 20 patients here, your 20 patients that you have to do. Do you have to do all six measures for each one of those patients? Do you have to find 20 patients that everything applies to or whatever applies to them applies to them?

Timothy Jackson: So, I'd just make sure I am understanding. So, you're talking about, if he or she as a provider only sees 20 patients, if they apply to each measure, or are you saying if they have 20 patients that apply to each measure?

Ahleah Tagai: Yes, 20 patients that apply to each measure.

Timothy Jackson: Yes. That's correct – the last...

Ahleah Tagai: Got it. Got it. Okay, great. Thank you.

Operator: And your next question will come from the line of Felicia Hagan.

Felicia Hagan: Hi. Obviously, I'm Felicia, and I'm calling from Mercy Hospital in Maine. We have 80-plus providers that we submit for; probably half of those are primary care and the other half are specialty. We have previously used the Web Interface, and we are starting to look into using our Certified EHR technology in order to submit PQRS for 2016. Are there any drawbacks? Is there any advantage? Or where could I go to find the information so that we could make a better decision on how we want to submit our data this year?

Timothy Jackson: So, just so I can clarify, so your question is you are looking for input on one option vs. another?

Felicia Hagan: Yes.

Timothy Jackson: Is that correct?

Felicia Hagan: Yes.

Timothy Jackson: So, unfortunately, we don't have anything that actually says in detail what is more or less preferred. We can – there are reports that are available on the website that tell you which options are more or less utilized.

Felicia Hagan: Okay.

Timothy Jackson: There are opportunities and constraints that go with any option that you're going to submit through.

Felicia Hagan: Sure.

Timothy Jackson: But...

Felicia Hagan: Okay. And then...

Timothy Jackson: ...there are reports available on the webpage.

Felicia Hagan: Okay, great. And for 2016, is it still pay for reporting or is some reimbursement based on how well we do with the measures, not just that we're able to report them?

Timothy Jackson: So, it depends on what – because you are in a health system. So, it would depend on what other programs you may or may not be participating in or eligible to participate in.

Felicia Hagan: Okay.

Timothy Jackson: PQRS, specifically, is pay for performance because it's missing the payment adjustment in 2018.

Felicia Hagan: Okay.

Timothy Jackson: That is the purpose. Does that answer your question?

Felicia Hagan: Yes, it does. Great. Thank you so much.

Timothy Jackson: Thank you.

Operator: Your next question will come from the line of LaDonna Willis.

LaDonna Willis: Hello. I represent a Rural Health Clinic with – we have 10 providers that we report for. We've reported for the last 2 years. My question is—what does CMS have in the long-term plan for those Part A claims by the Rural Health Clinic eligible providers? Because right now, we can't use any of their predominant work—clinic

work—to report physician quality. And that, to me, is where the physician quality lives and not in their Part B claims.

Timothy Jackson: We're just going to talk here for a moment.

LaDonna Willis: Are you familiar...

Timothy Jackson: We are familiar. Yes. We are going to discuss it one moment, please.

LaDonna Willis: Okay.

Timothy Jackson: Sure. So, this is Tim again. So, unfortunately, we don't have the ability to kind of cross the line because you are billing in Part A or not Part B for your providers, right? So, PQRS is a Part B on the Physician Fee Schedule. So, when we have claims that come in for Part B, then that's what this program is – was established and currently operates under. However, the measures that are used in PQRS and the measures that are available in the various options we discussed this afternoon would be of value and may be applicable to you in future years. However, we can't discuss that on this call at this point. But I would encourage you to look at those measures and look at their options to evaluate if any of those would be adopted within your own practice within your own workflow. Hopefully, that helps.

LaDonna Willis: Well, not really, because, you see, when we have successfully reported some measures for the last 2 years and we've avoided the MAVs, actually – but, we're not –as far as their clinic work, it's just that's predominantly what they do, you know, 90 percent of their time, and their Part B claims are just a very small portion of their practice. I just wonder how many other RHC-eligible providers are, you know, are you all hearing much from any RHC-eligible providers that are eligible under – you know, that's filed both Part A and Part B claims?

Timothy Jackson: No, we have not heard much from the RHC.

LaDonna Willis: Because I'm just wondering if we're really unique, like, maybe not many RHC-eligible providers even have Part B claims. So, they just don't even – are eligible for the PQRS program anyway, where we happen to be kind of a unique situation where our providers do have both types of claims.

Timothy Jackson: So, I would encourage you to contact the HRSA rep, if you have one available to you. Unfortunately, we can't address that within our work here at CMS because the unique situation that your folks are practicing in is covered under a different – it's covered under a different statute that HRSA manages...

LaDonna Willis: Okay.

Timothy Jackson: ...and runs a program for. So, can you...

LaDonna Willis: Okay. But, you – talk to HRSA?

Timothy Jackson: Yes.

LaDonna Willis: Okay. Thank you.

Timothy Jackson: Sure.

Operator: Your next question will come from the line of Gayle Miller.

Aryeh Langer: Hello. Your line's open.

Operator: That question has been withdrawn. The next question will come from the line of Melanie Savage.

Melanie Savage: Hi. I work with a one-doctor office. It's just the doctor and myself. I'm his practice manager. And he didn't pay attention, I guess, for – in 2014, for what was going to happen in 2016, so he got completely dinged on the penalty. We don't want that to happen for 2018. But, you know, he's a psychiatrist, and he has progress notes that he records electronically. Are those the kinds of things that we would submit through a registry vendor to make sure that we don't get hit again in 2018?

Timothy Jackson: So, it's a great question. It would depend on the registry that you would select. So, you would, I think, find a quick opportunity and value in looking at all the registries that are posted on the site...

Melanie Savage: Okay.

Timothy Jackson: ...and looking at the measures that they address and, then, maybe comparing against the notes that you referenced here. And that would probably give you a contact list of registries that would be worth investigating reporting through for avoiding the 2018 adjustment.

Melanie Savage: Okay. And do – we pay for these, right? We would pay – we would have to pay for a registry – a vendor, right?

Timothy Jackson: Right. The registry does have a fee because they do have some workflow and some consulting and some data management that they do for you.

Melanie Savage: Okay, great. Thanks.

Operator: And the next question will come from the line of Ellen Mauro.

Ellen Mauro: Yes. Hi. We are a New York State–owned rehabilitation hospital, and we have a qualified registry. This is the first time we’ll be submitting PQRS measures. When I went to self-nominate and register through the EIDM, I found out that – and I knew this – but I found out that someone – we share a TIN. Our TIN number was shared with many other New York State–owned facilities.

So, another – a SUNY college down the city has already registered in the EIDM, not to use – to nominate as a GPRO, but for some other reasons. But we contacted them and they don’t have any intentions of registering as a GPRO because that would affect everybody within the system under that TIN. I spoke to a QualityNet representative and she advised that we can still – we can still do the PQRS with the individual EPs because it’s based on the individual NPI and the TIN number.

Now, the TIN number’s still going to be the shared TIN number. It’s our hospital TIN number, but it’s also shared by many other facilities. I just want to make sure that it’s correct because if – the reason we wanted to go as a group is because it – we’re a rehabilitation hospital and it’s very difficult for us to find measures that cover the services that we provide. And the group – you know, being a group would have been an easier way to go. But we can’t go that way. Otherwise, we would have to get all the other facilities – which I don’t know how many would – you know, would be part of that – to be on the same page would be impossible.

So, that’s why we’re going to do the individual EPs. So, I’m just concerned that we’re going to go through all this work to do the measures for the individual EPs and under the NPI and the same TIN and – under our TIN number and then it’ll be all for naught. So, I just wanted to find out if that’s an issue.

Timothy Jackson: Sure. That’s – I think I understand your question and you’re – definitely hear you on that concern. So, the application of the payment adjustment is by TIN NPI.

Ellen Mauro: That’s right.

Timothy Jackson: So, if your – if your individual EPs come in and provide their measure data to CMS and that’s associated with their NPI, they will not be on the payment adjustment. Does that answer your question?

Ellen Mauro: So, they would not be – so, if the measures are met, then they would not be penalized.

Timothy Jackson: Right. They would have to – based on – based on the scenario that you have, I can’t answer on how you should do it. But if someone else is already using that

TIN, if you're providing the individual EPs the ability to come in and report, that TIN NPI combination – it's still going to be driven to that NPI as the final. Right? So, when that NPI has another Part B claim that is submitted in 2018, they're going to see a 2-percent adjustment on that claim if they did not submit their measures for 2016. And it's going to be at the TIN and the NPI.

Ellen Mauro: Okay. Yes, we are still going to go through a registry for the individual EPs.

Timothy Jackson: Sure. And registries do support that. Yes.

Ellen Mauro: Okay. And – okay. And we are going – so, the registry is – so, the individual EP is not submitting the data themselves. It'll go through the registry. So, that doesn't matter. But that's the case, then.

Timothy Jackson: I would say as long as the registry is providing the NPIs, then it sounds like it's going to be a – it'll satisfy the requirements.

Ellen Mauro: Okay. Thank you very much.

Timothy Jackson: Yes. I would just reclarify with your registry. Thank you.

Ellen Mauro: Yes. Thank you.

Operator: Your next question will come from the line of Michelle Anderson.

Michelle Anderson: Hi. This is Michelle. I have a question. What is the purpose – what would the purpose be or reporting a non-PQRS measure?

Timothy Jackson: So, I believe your question's in reference to QCDR measures?

Michelle Anderson: Well, for – there was something on the slide that says non-PQRS measures, and I don't understand what the purpose of that would be. Is that for another registry?

Timothy Jackson: So, qualified clinical data registries, or QCDRs, have the ability to provide non-PQRS measures for satisfying requirements for PQRS.

Michelle Anderson: Can you talk a little bit more about that? I don't understand that. They're non-PQRS measures that we can still report, then?

Sophia Autrey: Okay. Hi. This is Sophia Autrey with CMS. So, the qualified clinical data registries, or QCDRs, are registries specific for some specialties and subspecialties. And so, because of that fact, they can report – EPs that report via that QCDR can report measures that are in the program as well as specific specialty measures that are only

available through that QCDR. So, those measures are not available for people that are not a part of or reporting via that QCDR. So, you have to be – utilize that QCDR in order to report those non-PQRS measures. But the purpose of that is for specialties that don't have a lot of measures in the program to be able to report measures that are specific to their specialty.

Michelle Anderson: Okay. We are a dermatology. Can you give me an example of that? So, I don't have nine measures. I have four. So, I can use four of the measures that are on the PQRS measures, and then I can use five that are non-PQRS measures and satisfy without going through the MAV? Is that correct?

Sophia Autrey: Okay. So, unless you're reporting via a QCDR that has dermatology measures for you that, you know, that you can report, then you cannot report those other additional measures. You can only report the – you can only report the PQRS measures that are within the program.

So, we do have a list of QCDRs that are on our website – on the [PQRS](#) website. So, you can go to the PQRS website under [QCDRs](#), and we have a [list of QCDRs](#). Also, there are lists of measures for each one of those QCDRs. So, you may find a QCDR that have, you know, dermatology measures that you can report. But, you know, unless you're part of that QCDR, you cannot report those measures that are non-PQRS measures.

Michelle Anderson: Okay. I understand now. Also, on the earlier call, the caller was talking about reporting part of the measures by claims and now they are switching. Is it okay to report part of the measures by claims and then part of it through a registry? Or did I misunderstand?

Sophia Autrey: So, I think they were switching the way they were reporting for the next year, so that they wanted to know if they had to let us know. And they don't have to let us know that they are no longer going to report via claims the way that they did previously. But no, we cannot accept – if you report through several different methods in 1 year. So, it has to be one method or another.

Michelle Anderson: Okay. I see. Thank you.

Operator: And your next question will come from the line of Richard Scott.

Richard Scott: Hi. Good afternoon. And thank you for the presentation, including my call. My question is in regard to the crosscutting measures. And my question is—for specialty practices that maybe don't meet any of the crosscutting measure criteria, will they be automatically penalized in 2018? Or are there avenues for those practices to avoid penalties?

Sophia Autrey: Hi. This is Sophia Autrey. So, one of the reasons why we identified the crosscutting measures as such is because they were broadly applicable despite some specialties not being able to report some of the measures and, by broadly applicable, these are usually some screening measures as well as some measures that are preventative that, even if you are a specialty, these are good clinical practices for you.

So, we believe that there are at least one or two measures within that entire set that even a sub-specialty provider can report. So, if you are a provider—even a specialty provider—and you have a face-to-face encounter, you are required to report a crosscutting measure.

Richard Scott: Okay. And just as a followup, you're required to report a crosscutting measure, or it sounds like you will face a penalty in 2018?

Sophia Autrey: If you do not report a crosscutting measure, then you are not considered satisfactorily reporting and will receive a payment adjustment.

Richard Scott: Okay. Thank you very much.

Sophia Autrey: Thank you.

Operator: Your next question will come from the line of Andy Long.

Andy Long: Hello. Thank you. The question I have is with regard to vendor providing EP information for CMS, things like address, phone number, email address. Does that need to be included in the QRDA file that gets submitted? Or do we just store that in case of an audit?

Timothy Jackson: So, this is Tim. So, just to clarify, you're asking if the vendor's information and the EP's information are added to the QRDA for submission to CMS. Is that correct?

Andy Long: Yes. We read or were told that the EP information—mailing address, email address, phone number—their contact information needed to be available. And we just want to know whether we have to include that in the submission file as the vendor.

Timothy Jackson: So – this is Tim. So, I can tell you that, while we don't have the right subject matter expert in the room here, there is something called the QRDA. There is an Implementation Guide that's posted on the – it's called the eCQI Resource Center – eCQI Resource Center. And that shows the requirements for submission of QRDA files. So, if those data are supposed to be appended to the file or, you know, put at the top of the file, or somehow sent after the file, you would find the details on that website. And there's an implementation guide that tells or instructs the vendor on making sure that they have the correct information provided when they submit that XML file.

Andy Long: Yes. It wasn't clear whether we actually had to submit it or just have it available. And I wasn't sure if having it available when we store it – is there any requirement for how it is stored? So, I'll follow up on the Implementation Guide. Thank you.

Operator: And your next question will come from the line of Juan Valle.

Juan Valle: Hi. I actually had a couple of questions. They're fairly simple. But last year, we worked with some – six outpatient clinics, you know, different – like GI, cardiology, neurology, and stuff like that. What we found is that, last year, we tried to do the group measures, like for GI, and we couldn't – for some reason or another, we ended up with preventative measures. And we're in the process of selecting the 2016 measures, and we might fall into the same problem of going into preventative.

So, my first question is—if I were to submit preventative, some measures are for male and some are for female. Let's say we choose 20 male patients. Does that automatically exclude the female measures? Are we penalized for that?

Sophia Autrey: Hi. Okay. And so, I just want to clarify—you tried to report a measures group?

Juan Valle: Yes.

Sophia Autrey: Okay. So, if you're trying to report a measures group and there are – some of those measures that are female only in the group and you have male patients, then you will not get a penalty for that male patient not falling within the denominator of the – or the numerator of that measure that is strictly for the female. So, you're okay. That won't – that's an exclusion for that.

Juan Valle: Awesome. And then, my other question was like – this is an example. I'm working with an oncology outpatient clinic and in the oncology measure groups, it says you have to have a CPT code, a procedure code, and then, a diagnosis code. In that outpatient group, they don't have procedures. You know, they don't do the procedures. They refer them outside.

Now, my biggest concern there is – well, it's not a new problem, but it's like, the doctor doesn't want to do preventative but, unfortunately for him, he doesn't do procedure codes. So, I can't select any oncology measure. What would you suggest on that? Because, like, what we did for him is—we did preventative. But he didn't like it.

Aryeh Langer: We're going to reference you to the Help Desk for that question. If you could send that question in to the [QualityNet Help Desk](#) that's referenced on slide 48.

Juan Valle: Okay. And I guess, sir, my thing was like – the only other option that I can see is doing individual measures for that clinic and doing, like, 50 percent of his patients. The problem is that we have, like, six or seven clinics, and then that would be a lot of extracting for two people because it's just me and my partner Joy.

Sophia Autrey: Yes. I do understand your point. But, because of the complication, we want to make sure that whatever information we give you is specific for you.

Juan Valle: Yes.

Sophia Autrey: So, we're just going to ask you to call the Help Desk and we'll escalate it so we can give you the information that you need.

Aryeh Langer: Actually, email it to the [Help Desk](#) and reference today's National Provider Call. Thank you.

Sophia Autrey: Thank you.

Operator: Your next question will come from the line of Rachel Tinsley.

Rachel Tinsley: Hi. We are an EHR company. We do our claims through data submission for our clients. My question is—we haven't gotten very good clarification on what exactly needs to be sent in order for them to successfully attest for this PQRS. We've had someone at the quality help desk tell us one measure and they will avoid the penalty, and then, we've had nine measures. So, is there any way that you can clarify that?

Timothy Jackson: Sure. So, for the – avoiding the 2018 payment adjustment, it is nine measures across three domains. And that would be if you're looking to do reporting once. So, you're reporting quality for both the PQRS and the EHR Incentive or meaningful use program. Does that answer your question?

Rachel Tinsley: Well, we – the EHR – the meaningful use, we don't do that. They do that one when they're attesting. So, we're just doing the PQRS. Does that make a difference?

Timothy Jackson: So, if they are still attesting, their requirements are still the same. So, nine across three.

Rachel Tinsley: Okay.

Timothy Jackson: But again, you'd be sending it – so, I was a little confused because I think you identified as an EHR DSV. But the...

Rachel Tinsley: Correct.

Timothy Jackson: ...providers are doing the...

Rachel Tinsley: But when a client attests for meaningful use, they do their own CQM measures. They – you know, they attest at that time.

Timothy Jackson: That's correct.

Rachel Tinsley: Okay.

Timothy Jackson: That's correct.

Rachel Tinsley: Okay. So, it is nine measures across three domains, no matter what.

Timothy Jackson: Correct.

Rachel Tinsley: Okay. All right. Thank you.

Operator: And your next question will come from the line of Ana Parrotta.

Ana Parrotta: Yes. Hi. My question is we – I work for a large anesthesia group that's hospital based. There's approximately 40 doctors in the practice. And as far as reporting PQRS, are we able to report through the GPRO? Because we do share a tax ID number but they're not employed by the hospital—it's their own tax ID number. Or should the reporting be by the individual NPI numbers?

Timothy Jackson: So, yes, you are eligible with the 40 providers that you identified. You are eligible.

Ana Parrotta: Okay. And if at any point the group should grow larger than 99, we would still – we have to then add the other – what was it? The other one we had to do.

Unidentified female: The CAHPS.

Ana Parrotta: The CAHPS. Also the CAHPS? But not with the 40?

Timothy Jackson: So, you are correct with the – with 40, you do not have to do CAHPS. But if you go above 99, you will have to do CAHPS.

Ana Parrotta: Okay. Thank you very much.

Timothy Jackson: Thank you.

Operator: And your next question will come from the line of Stella Sheppa.

Aryeh Langer: Your line is open, Stella.

Operator: That question has been withdrawn. Your next question will come from Jillian Baird.

Jillian Baird: Hi. I have a question regarding the crosscutting. I work for a small radiology group, and there're not nine measures that they do. They don't do nuclear medicine. And I'm just wondering, the only face-to-face thing they do are arthrograms. So, would the crosscutting measure only be reported when they do an arthrogram? It wouldn't be reported on every Medicare patient? It would just be added on to the claim when they do that surgical procedure?

Sophia Autrey: So, we do have encounter codes on our list as to what is identified as a face-to-face encounter. And I know a lot of the radiology codes were actually excluded. So, you may want to look at the list of codes to make sure...

Jillian Baird: Is that the Excel file?

Sophia Autrey: Yes.

Jillian Baird: Okay. Yes, I did look at that, and arthrograms are on that list.

Sophia Autrey: Okay. So...

Jillian Baird: I'm sorry. Go ahead.

Sophia Autrey: Okay. So, you can report on any other measures. You don't have to report on them just when you're doing that encounter. You can report on it for any encounter.

Jillian Baird: Okay. I guess I'm trying not to make extra work for myself. So, if someone comes in, say, for a mammogram, do I have to put a crosscutting on for – make the doctor list off their current medications when it has nothing to do with the

mammogram or do – am I only required to add that crosscutting code when they're doing the face-to-face encounter?

Sophia Autrey: So, the appropriate answer is, whenever you're providing the service, we would like you to actually conduct that service with the patient, especially something such as medication documentation. So, at any time possible, then when you can actually conduct those services that are under the crosscutting measure, we would like you to do so.

Jillian Baird: Okay. I'm sorry. I'm just – the crosscutting part of it is what's really confusing me because I just want to make sure that, if they're supposed to put in every single report – the crosscutting measures, I see that we could get the information on is possibly when the PQRS number 112 or 130.

So, I just don't want to tell the radiologist that they have to document current medications on every single patient because that's not something they typically do. It's not something they do on a patient that they don't see face to face. It's more of an E&M type – utilized during an E&M-type service. And so, if they're not seeing the patient and the patient comes in for an abdominal ultrasound or a mammogram or something else, they're not going to see the patient and document the medications.

Do you understand? I mean, I'm just – if they're supposed to say it on every single patient, then I'll ask them to do that. But if they only need to do it when they're doing that face-to-face procedure, then I would only have them add it on then. Am I making sense? I'm sorry.

Sophia Autrey: Yes, sure.

Jillian Baird: I want to make sure we do everything we're supposed to so we're not penalized.

Sophia Autrey: Yes, you are making absolute sense. And I guess because of the special work that radiologists do, they don't always see patients face to face. So, in that instance, that makes sense that they would only do that on the patients that they actually talk to and see.

Jillian Baird: Okay. So then, the crosscutting measure, in our case, would only be added to our claim when – on the particular exams where they see the patient – where it is the...

Sophia Autrey: Yes.

Jillian Baird: Okay. All right. Thank you.

Additional Information

Aryeh Langer: Thank you so much. Unfortunately, that's all the time we have for questions today. If we did not get to your question, please refer to slide 48 for the [Help Desk email](#) address and phone number.

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 that becomes available.

On slide 52 of the presentation, you'll find information and the 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.

As mentioned earlier in today's presentation, our next call is on May 4th. We encourage you to register for that call the same way you may have registered for this call.

Again, my name is Aryeh Langer. I'd like to thank our presenters here at CMS and also thank all of you on the lines for participating in today's [MLN Connects Call](#). Have a great day, everyone.

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

-END-

