



**MLN Connects®**

**National Provider Call Transcript**



**Centers for Medicare & Medicaid Services  
How To Register for the 2016 PQRS Group Practice Reporting Option Call  
MLN Connects National Provider Call  
Moderator: Aryeh Langer  
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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, Ronni. And as you just heard, my name is Aryeh Langer from the Provider Communications Group here at CMS. And I'm your moderator for today's call. I would like to welcome you to this MLN Connects National Provider Call on Medicare Quality Reporting Programs.

Today's topic will be How To Register for the 2016 PQRS Group Practice Reporting Option. MLN Connects Calls are part of the [Medicare Learning Network®](#).

Today's MLN Connects National Provider Call gives a walkthrough of the [Physician Value-Physician Quality Reporting System](#), or PV-PQRS, Registration System, an application that serves the PQRS and [Value-Based Payment Modifier](#) programs. You will learn how to meet the satisfactory reporting criteria through the PQRS Group Reporting Option, or GPRO, avoid a calendar year 2018 PQRS payment adjustment, and calendar year 2018 Value Modifier automatic downward payment adjustment. A question-and-answer session follows today's 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: [www.cms.gov/npc](http://www.cms.gov/npc). Again, that URL is [www.cms.gov/npc](http://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.

Third, this MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit. For additional information, please refer to slide 61 of today's presentation for a link to the [CE Activity Information & Instructions document](#).

And finally, we received many comments from our previous Medicare Quality Reporting Programs National Provider Call evaluations regarding the content of the slides and presentation style. We heard your comments. 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'd like to turn the call over to Dr. Dan Green from CMS.

## Presentation

Dr. Daniel Green: Okay. Thanks very much. And welcome everybody to today's call. We're very glad that you could join us. We have an informative call today. But since it's a hockey playoff, first, we're going to have a quick public service announcement. Go Caps. Okay, I'm done now.

So, if you turn to the slides that we've provided, you'll see on slide 2 is the typical disclaimer that we have in all of our presentations. It basically just says that this presentation is current as of the time of – that it was put together.

On slide 3, you can see our agenda and learning objectives for today. So, we're going to be talking about the Physician Quality Reporting System, or PQRS, as well as the Value Modifier. We'll be talking about the incentives and adjustments that are available for these programs. There really are not any incentives for PQRS at this point; it's payment adjustments only for non – and that's for nonparticipation. However, there are both incentives and payment adjustments available on the Value Modifier, which you'll hear about a little bit later.

So, we'll also talk about the reporting criteria for the 2016 program year for group practices who want to report as a group, that is. So, GPRO stands for group practice reporting option. We'll also spend a couple minutes talking about the Consumer Assessment of Healthcare Providers and Systems, or CAHPS®, survey. And this is required for some of our larger groups and is optional for some of our smaller groups.

We'll spend a few minutes talking about our EIDM system, which is our Enterprise Identity Management system, and how you can go about getting an EIDM account, which will be necessary to actually register as a group practice.

Speaking of which, we will talk to you guys about how to register as a PQRS GPRO. And that is done in our PV-PQRS registration system or portal.

There'll also be some slides at the end of that where you can call for help if you need additional assistance with doing this. And then we'll have time at the end for questions and answers.

So if you look on slide 4, you'll see a whole bunch of acronyms. And if you master this, it will be as if you've completed your first 6 months of training as a CMS employee. So, congratulations to you.

## **GPRO Getting Started**

Dr. Daniel Green: On slide 5, we're going to get started with talking about GPRO. And then, again, on slide 6, we'll talk about what a group practice is. So, I alluded to this earlier, again, GPRO, group practice reporting option, and we define it in 2016 for PQRS as a single tax ID number with two or more individual eligible professionals—so, basically two NPIs under a TIN. Now, it could be two NPIs and it could be all the way up to thousands of NPIs, but billing under a single tax ID number. And these NPIs would have assigned or will have assigned their billing rights to that particular tax ID number. And if that's the case, these folks can report all as a group instead of having to report individually. Their quality metrics will be analyzed as a group as well.

Looking on slide number 7, a group has to meet the following requirements in order to be able to participate. So as I mentioned just before, has to be at least two NPIs who have assigned their billing to a particular tax ID number. There's going to be some consideration, of course, to the reporting mechanism, group would have to register, and, of course, obviously, a group would have to choose to participate. We'll talk a little bit – in a little more detail in just a minute about these different requirements.

So, let's move on to slide 8. And by the way, at the bottom of each page of the slides, you probably can see a little tab that says Acronyms. So if you do get lost in our myriad of acronyms, you can click on the bottom of that page and it'll have a little pop-up that'll help translate for you.

So, group size requirements, again, we kind of talked about this, and the requirements, if you will, for group reporting will depend on the number of eligible professionals, or EPs, in the group. So, what I mean by that is the number of NPIs, again, under that tax ID number that are wanting to report as a group. We split these out into categories of 2 to 24 eligible professionals, 25 to 99, and then 100 or more eligible professionals under one tax ID number. And you'll see in just a minute the requirements are slightly different based on the group sizes.

On slide number 9, you can see that, to participate in 2016 PQRS GPRO, the group practice has to meet the following requirements. They have to have billed Medicare Part B Physician Fee Schedule services on or after January 1<sup>st</sup>, 2016, and before December 31<sup>st</sup>, 2016. So they have to – there have to be Part B billable services in the program year, which, again, is defined as the calendar year 2016.

Folks that are participating have to agree to have the results of their performance, of their scores on the quality measures, if you will, publicly posted on the [Physician Compare](#) website. Now, that's not to say that every single measure will necessarily be posted with every single performance rate, but certainly, what you're saying here is CMS has the option to be able to report all of the – all of this information if they so choose.

Groups have to be able to comply with a secure mechanism for their data submission.

They have to register to participate as a group via the Physician Value–Physician Quality Reporting System, or PV-PQRS (say that a hundred times quick). And that registration is open between April 1<sup>st</sup> and June 30<sup>th</sup> of this year. So if you are intending to report as a group, this is like one of those – “make sure you note this” kind of things—you must register by the end of June 2016 to be able to report as a group. Obviously, we’re at May 4<sup>th</sup> today, so we’re not quite halfway through the registration process. But you only have about 8 weeks—little less maybe—to get your registrations in. So, if you do want to participate as a group, please, please, please make sure you log in to the PV-PQRS portal and register as a group.

You will have to provide information in the registration system during the registration process. So you’ll need things like your tax ID number and things of that nature, group size, what have you.

If we look on slide 10, this is a schematic of the different reporting options that are available for groups or GPROs. And you can see at the top, you could use a qualified registry. A list of qualified registries for 2016 is available on the [PQRS](#) website. If you look under alternative reporting options, you should be able to find the registry tab.

Similarly—and this is new for 2016—QCDRs, or Qualified Clinical Data Registries, can also submit information on behalf of groups. There were a tremendous number of stakeholders that had petitioned for this. And we’re happy that, with the passage of the MACRA legislation, that we now have the authority to be able to accept group practice information from QCDRs.

Practices or groups that have more than 25 eligible professionals can elect to use the [GPRO Web Interface](#). And under the Web Interface, as many of you know, CMS would populate several measures with Medicare beneficiaries. And the group would go through their records and have the charts or pull the charts or the information that’s required to answer the measures in the order of the beneficiaries being listed. They’d be able to report the quality information, basically.

If we look up at the about 10:00/11:00 position of this schematic, we can see that folks can report using a direct EHR product, so, a direct electronic health record product. Or if they’re using – in that case, they’d have to be using certified EHR technology, anyway, if they’re using their direct EHR product. But they can also go through a data intermediary, or a data submission vendor as we term them for the program. And again, those have to be certified – ONC-certified EHR technology systems to be able to submit that way.

And then finally, if you look at the bottom, at the 6:00 position, you see the CAHPS survey. And this is – if folks want to report the CAHPS metric, they would have to use a

[CMS-certified survey vendor](#). And again, that information is also available on the [PQRS](#) website.

CAHPS is available for folks – for groups with two or more EPs. It is mandatory for group practices of 100 or more EPs. So if you’re a group—a multispecialty group, let’s say—and you have 115 eligible professionals, or NPIs, billing under your TIN, you would need to do the CAHPS survey as part of your reporting as a group.

Okay, so next slide, please, on 11. This is basically a table kind of talking about what we just mentioned. Groups of 2 to 99 eligible professionals can report individual measures, and they can do so using their direct EHR product or an EHR data submission vendor. They would have to report nine measures covering at least three of the National Quality Strategy domains. And again, this is for groups of two or more that want to use their EHR for reporting.

If your group’s EHR – direct EHR product does not have data for at least nine quality measures covering the three NQS domains, then they have to report all the measures where there is Medicare patient data. At least one of the measures that’s reported has to have at least one Medicare beneficiary for you to use this method to submit data as a group to PQRS.

We also require that groups reporting using this mechanism use the 2015 version of the electronic Clinical Quality Measures, or ECQMs, for 2016 reporting.

I’m now on slide 12. This goes into a little more detail about the EHR method of submission. So, if you’re a group of 2 to 99 and you elect to report CAHPS (remember, as I mentioned, it’s optional for groups under 100) and you want to do individual measures and you’re using the direct EHR product or – I’m sorry, a direct EHR product, you would also have to use a CMS-certified survey vendor for the CAHPS measures.

So, all the CAHPS survey measures have to be reported via the survey vendor. If you’re using this, we count the CAHPS survey as three measures and one quality domain. Therefore, you only have to report an additional six measures covering two quality domains. And again, if less than six measures apply, we would ask that you report all measures where there is Medicare patient data. And again, at least one patient – there has to be at least one Medicare bennie in one of the ECQMs.

On slide 13, for folks that are in groups of 2 to 99, again – oh, I’m sorry, I skipped something. For groups of – back on 12 for just a second. For groups of 100 or more eligible professionals, again, they have to report CAHPS. So they would report using a CAHPS survey vendor, and they would report six additional measures covering two domains. Sorry about that.

So let's move now on to slide 13 and talk about registries for a second. So, if you're in a group of 2 to 99 NPIs, you can use a qualified registry—again, nine measures across three domains. And you have to report on at least 50 percent of the group's Medicare Part B Physician Fee Schedule patients seen during the reporting period. So, just making this up, if I'm reporting Measure 20, let's say, and I have 100 patients that fall in the denominator of that in my group, so my group of 10 docs have seen 100 people that meet the measure – meet Measure number 20, my group has to report on at least 51 of those patients to meet the requirement for having reported that measure satisfactorily.

If there are less than nine measures or less than three National Quality Strategy domains reported, we will put the group through something called MAV, or Measure-Application Validation. And basically, we'll look to see if there were other clinically similar measures that the group could have reported. And if there are not, you're good to go. But if there are, in a cluster of medication – sorry, measures that, again, are clinically similar, you could fail that and be subject to a payment adjustment for not performing or submitting adequately for PQRS.

So, if the group has at least one Medicare patient that is seen in a face-to-face encounter—so, not like a pathologist who's not ever having face-to-face encounter with the patient, but somebody perhaps like an internist who's, of course, having face-to-face encounters—we would require that at least one of the measures be a crosscutting measure. And there are crosscutting measures outlined on the PQRS page if you look under the Measures – on the Measures – I'm sorry, under the Measures tab on the PQRS page.

One other thing to mention, measures that have a 0-percent performance rate that are reported by registries would not count toward meeting your nine required measures. Unless, of course, they're inverse measures, where a lower number's better. In that case, measures that are inverse that have 100-percent reporting rate would not count, which basically means I didn't – I had poor performance on every single patient I saw, if you have 100 percent and it's an inverse measure, and in the case of a normal measure, 0 percent is I never did the quality action. And, therefore, that wouldn't count.

Okay, so let's move on to slide 14. So here again, for registries, just basically splits it out like we did with EHRs. So folks of 2 to 99 who elect to report CAHPS, again, they would have to report six measures across two domains and use the CAHPS survey vendor for the CAHPS survey, which, again, would count for three measures in one quality domain. If they're a group of 100 or more, they have to do the CAHPS survey, so they would need to line up a survey vendor—and again, six across two.

On slide 15, basically, this is the same thing we talked about with registries, but now for QCDRs. With QCDRs, having 2 – if the group has 2 to 99 eligible professionals and they're using a QCDR, they have to report not only on 50 percent of the group's patients, but they have to report on nine measures across three domains. There is no

MAV for QCDRs. They also have to report two outcome measures. And if there are not two outcome measures available for the group, they'd have to report one outcome measure and at least one either resource use, patient experience of care, efficiency/appropriate use, or patient safety.

So, you want to check with the QCDR because they will be able to give you specific instructions based on the measures that they are collecting. Some measures are in every visit measure, as you know, and some are once a year. So, they would have specific instructions in terms of how to collect the data.

On slide 16, you can see QCDRs for two-plus eligible professionals who elect to report CAHPS. So again, it's the same thing as we – that we discussed with registries in the EHR. They're electing to do CAHPS, and you have a group between 2 and 99, survey vendor at the six across two—six measures across two domains. And of course, if you have more than 100 EPs in your tax ID number or – billing under your tax ID number, then you have to do the CAHPS survey.

All right, so on slide 17, we'll spend a minute talking about the Web Interface, and as we mentioned earlier, it's only available for groups of 25 to 99 EPs. These are individual GPRO measures, and they're in the Web Interface. You have to report on all the measures included in the Web Interface, and you have to populate the data fields for the first 248 consecutively ranked and assigned beneficiaries—has to be in the order that they are listed. So it's not like you pick any 248 out of the number that's supplied. You have to do 248 in the order that they're listed on your sheet. And it's 248 for each of the measures.

If the pool of eligible assigned beneficiaries is less than 248—let's say you didn't have 248 bennies that would meet one of the measures—then you have to report on 100 percent of those beneficiaries that are listed.

So, if you are planning to use the Web Interface, you would use the 2016 GPRO Web Interface narrative specifications, and supporting documents, and performance calculation measures – measure flows for reporting. So, there is more information, again, on our website if that's how you're going to report.

On slide 18, you can see if you are – have more than 100 EPs and CAHPS applies, you would report the individual GPRO measures and the CAHPS measure using a certified vendor. And the requirements for the Web Interface would be the same. But – and of course, the CAHPS survey using a certified vendor would also be the same.

I'm going to briefly talk about registration requirements on page 19. And then you'll have the pleasure of being handed off for Value Modifier, in case I didn't confuse you enough. Sorry about that.

So the registration requirements—it has to be completed through the online PV-PQRS Registration System. And again, remember, the deadline is June 30<sup>th</sup>, 2016, at 11:59 pm. So, one more time, if you are planning to report as a group, please make sure that you register before that time.

In order to register, you will have to have this Enterprise Identity Management account. So, you will have to go in and register to get your EIDM. You'll have to indicate your reporting mechanism for the 12-month period. So basically, what we mean by that is, you'll have to select, "Hey, I want Web Interface" or – "and I have more than 25 EPs," or you'll have to say, "I want to use the QCDR," "I want to use a registry"—whatever it is, you'll have to pick that at the time that you register. At least one person from the group practice will need to obtain this EIDM account. And they'll also have to have a Security Official role or a Group Representative role to complete the registration. So, obviously, you want to make sure that the person who registers and has that Security Official role is somebody that you plan to have with the practice at least through the submission period.

There are step-by-step instructions for obtaining these roles. And that can be found in the "Obtain an EIDM Account To Access the Registration System" section of the [PQRS GPRO Registration](#) webpage. And there looks to be a link there in the slides.

Okay. I think I'm finished with my part. So I'm going to turn it over to Aryeh to – for some additional announcements.

## Keypad Polling

Aryeh Langer: Thank you so much, Dr. Green. At this time, we'll pause a few moments to complete keypad polling. Ronni, at this time, can we 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. 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.

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'll now turn the call over to Sabrina Ahmed for the next part of the presentation today. Sabrina?

### **Overview of the 2018 Value-Based Payment Modifier**

Sabrina Ahmed: Thank you, Aryeh. In the next section of this presentation, I will provide an overview of the Value Modifier policy that will apply in 2018, and also explain how the 2018 Value Modifier will interact with the PQRS quality data reported for the 2016 performance period.

I'm on slide 21. So, calendar year 2016 is the performance period for the Value Modifier that will apply in 2018.

In 2018, the Value Modifier will apply to all physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists in groups with two or more eligible professionals, and also to those who are solo practitioners. Groups and solo practitioners are identified under the Value Modifier by their Medicare Taxpayer Identification Number.

Quality tiering, which is the methodology that is used to evaluate a group or solo practitioner's performance on quality and cost measures for the Value Modifier, will apply to all groups and solo practitioners that are subject to the 2018 Value Modifier. So in 2018, groups with physicians and physician solo practitioners will be subject to upward, neutral, or downward payment adjustment under quality tiering based on their performance in 2016. And groups consisting of nonphysician eligible professionals only, and NPs, PAs, CNSs, and CRNAs who are solo practitioners, will be held harmless from downward adjustments under quality tiering in 2018.

2018 is the final year under the Value Modifier. And the Merit-Based Incentive Payment System, also called MIPS, will apply to payments for items and services furnished under the Medicare Physician Fee Schedule beginning January 1, 2019.

So, slide 22 shows how we will apply the Value Modifier in 2018 to physicians, PAs, NPs, CNSs, and CRNAs in groups with two or more eligible professionals, and also to those who are solo practitioners. We will continue to align the Value Modifier with PQRS participation. We'll be using a two-category approach to classify groups and solo practitioners subject to the 2018 Value Modifier based on how they participate in the PQRS in 2016.

So, Category 1, as shown in the left-hand side of this slide, will include groups with two or more eligible professionals that meet the criteria to avoid the 2018 PQRS payment adjustment as a group participating in the PQRS GPRO in 2016, or groups with two or more eligible professionals in which at least 50 percent of the group's eligible

professionals meet the criteria to avoid the 2018 PQR payment adjustment as individuals. Category 1 also includes solo practitioners that meet the criteria to avoid the 2018 PQR payment adjustment as individuals. All groups and solo practitioners that are in Category 1 will be subject to quality tiering in 2018.

Category 2, as shown in the right-hand side of the slide, will include groups and solo practitioners that are subject to the 2018 Value Modifier and do not fall within Category 1—meaning these groups did not meet the criteria to avoid the 2018 PQR payment adjustment as a group, and they also didn't have at least 50 percent of the eligible professionals in the group meet the criteria to avoid the 2018 PQR payment adjustment as individuals. And the solo practitioners in Category 2 are those that did not meet the criteria to avoid the 2018 PQR payment adjustment as individuals.

At the bottom of this slide, you will see the 2018 payment adjustments for groups and solo practitioners that are in Category 1 and Category 2, based on the size and composition of the group. And I'll be reviewing these adjustments in more detail in the next three slides.

Slide 23 shows the 2018 payment adjustment amount under the Value Modifier for physicians, NPs, PAs, CNSs, and CRNAs in groups of physicians with 10 or more eligible professionals.

So for Category 2 groups, meaning groups that did not meet the criteria to avoid the 2018 PQR payment adjustment as a group and also did not have at least 50 percent of the eligible professionals in the group meet the criteria to avoid the 2018 PQR payment adjustment as individuals, we will assign automatic minus 4-percent downward adjustment to these groups.

For the Category 1 groups, meaning groups that avoided the PQR payment adjustment as a group or as individuals, we will calculate their Value Modifier using the quality-tiering methodology. And under quality tiering, the maximum upward adjustment will be plus 4x, where x represents the upward Value Modifier payment adjustment factor, which is calculated after the end of the performance period. And the maximum downward adjustment will be minus 4 percent for poor performance in 2018.

High-performing groups, as marked by the asterisk in the table, will be eligible for an additional plus 1x for treating high-risk beneficiaries.

Slide 24 shows the 2018 payment adjustment levels under the [VM](#) for physicians, NPs, PAs, CNSs, and CRNAs in groups of physicians with two to nine eligible professionals and solo practitioners – physician solo practitioners. And for these groups and solo practitioners that are in Category 2, we will apply an automatic minus 2-percent downward adjustment. And for Category 1 groups and physician solo practitioners

under quality tiering, the maximum upward adjustment will be up to plus 2x, and the maximum downward adjustment will be minus 2 percent for poor performance in 2018.

Slide 25 shows the 2018 payment adjustment levels for NPs, PAs, CNSs, and CRNAs in groups that consist only of nonphysician EPs, and to the NPs, PAs, CNSs, and CRNAs who are solo practitioners.

For the Category 2 groups and solo practitioners, we will apply a minus 2-percent automatic Value Modifier downward adjustment. And for the Category 1 groups and solo practitioners under a quality tiering, the maximum upward adjustment will be plus 2x, and these groups and solo practitioners will be held harmless from downward adjustment under quality tiering for poor performance in 2018.

I mentioned earlier that we will be applying the quality-tiering methodology to all groups and solo practitioners that are in Category 1 for the 2018 Value Modifier. The Value Modifier is based on a quality composite score, and a cost composite score. And slide 26 describes the quality measures that will be used to calculate the quality composite score for the 2018 Value Modifier.

So, to calculate the quality composite for groups that report PQRS data as a group in 2016 and meet the criteria to avoid the 2018 PQRS payment adjustment, we will use the measures reported under the PQRS GPRO. And if at least 50 percent of the EPs in the group reported PQRS data as individuals, and they also met the criteria to avoid the 2018 PQRS payment adjustment, then we'll use the individually reported PQRS measures to calculate the quality composite. For solo practitioners, we will use their individually reported PQRS measures as long as they met the criteria to avoid the PQRS payment adjustment in 2018.

I'm on slide 27. To calculate the quality composite for groups with 10 or more eligible professionals, we will also include three quality outcome measures that we calculate using Medicare claims data. 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.

For groups with two to nine eligible professionals and solo practitioners, we will include only two of these quality outcome measures in their quality composite. And the two we will include are the composite of Preventable Hospitalizations for Acute Conditions and the composite for Chronic Conditions. But we will not include the All-Cause Hospital Readmission measure to calculate the quality composite for groups with two to nine eligible professionals and solo practitioners.

Lastly, we'll use the results of the 2016 CAHPS for PQRS survey to calculate a group's quality composite if the group elects this option when it registers to participate in the

2016 PQRS GPRO in the registration system. And I'll talk about how a group can make this election later in this presentation.

Slide 28 describes the cost measures that will be used to calculate the cost composite score for the 2018 Value Modifier. The cost composite is based on six specialty-adjusted cost measures. The first is the total per capita cost measure, which is based on all Medicare Parts A and B spending for the beneficiaries who are attributed to the group or to the solo practitioner. And then there are four total per capita cost measures for beneficiaries with specific chronic conditions. And the sixth cost measure is the Medicare Spending per Beneficiary measure. And this measure is the cost around hospitalization. So all six cost measures that we use to calculate the cost composite are payment standardized, risk adjusted for beneficiary characteristics, and also adjusted to reflect the specialty mix of the eligible professionals in the group.

I'm on slide 29. In 2018, the Value Modifier will be waived for groups and solo practitioners, as identified by their TIN, if at least one eligible professional who billed for physician fee schedule services under the TIN during 2016 participated in the Pioneer ACO Model, the Comprehensive Primary Care initiative, or other similar Innovation Center models in 2015.

Slides 30 and 31 describe how the Value Modifier will apply to Shared Savings Program participants in 2018—groups and solo practitioners that participate in a Shared Savings ACO.

In 2016, it will be subject to the 2018 Value Modifier based on the ACO's performance in 2016. And if the ACO fails to successfully report on quality measures via the [GPRO Web Interface](#) in 2016, then the participant TINs under the ACO will be subject to an automatic downward adjustment under the 2018 Value Modifier. And the amount of the automatic downward adjustment will depend on the size and composition of the participant TIN. And these adjustments were previously described in slides 23 to 25.

If the ACO successfully reports on quality measures via the [GPRO Web Interface](#) in 2016, then the 2018 Value Modifier for the participant TIN under the ACO will be calculated using the quality-tiering methodology. In this case, the cost composite will be classified as average, and the quality composite will be calculated based on quality data submitted by the ACO via the GPRO Web Interface, the CAHPS measures, and the ACO's All-Cause Hospital Readmission measure for the 2016 performance period. And the [VM](#) will be applied at the participant TIN level based on the size and composition of the TIN.

Slides 20 – slides 32 and 33 describe what groups and solo practitioners need to do in 2016, which is the performance period for the 2018 Value Modifier. First thing, to select a PQRS reporting mechanism and become familiar with the [measures](#) and the data submission timeframes.

Then they would need to decide how to participate in the PQRS in 2016. If a group wants to participate as a group via the PQRS GPRO, then it would need to [register](#) for a PQRS GPRO reporting mechanism prior to June 30<sup>th</sup>. And registration, however, is not necessary if solo practitioners or EPs in groups that – want to participate in the PQRS as individuals in 2016.

Groups and solo practitioners should also review quality measure benchmarks under the [Value Modifier](#). And they should [download their 2014 Annual Quality and Resource Use Report](#), also called QRUR, and the 2015 Mid-Year QRUR if they haven't done so already. The instructions for accessing a QRUR are provided at the link located under the second bullet on this slide. The 2015 Mid-Year QRURs were made available in April of this year. And we'll be hosting a National Provider Call on May 19<sup>th</sup> to provide an overview of the information contained in the Mid-Year QRUR. And then the 2015 Annual QRUR, which will contain information about the 2017 Value Modifier, will be released later this fall.

The remaining sections of this presentation will review how a group can register to participate in the PQRS as a group. You have the PQRS GPRO in 2016.

### **How To Obtain an Enterprise Identity Management Account**

Sabrina Ahmed: First, I'll go over how a representative from a group can get an [EIDM](#) account in order to access the registration system.

So, slide 35 provides an introduction to the EIDM. An EIDM account with the correct role is needed to access the registration system to find out whether there's already someone who can register your group to participate in the PQRS GPRO. You can contact the [QualityNet Help Desk](#) at the number provided in slide 56, and provide the group's TIN and the name of the group. And if someone from your group already accessed the group's 2015 Annual QRUR that was made available in September of 2015, then the same person can register the group to participate in the 2016 PQRS GPRO using their EIDM User ID and password.

You can sign up for a new EIDM account, modify an existing account to add the correct role, or reset your EIDM account password on the [CMS Enterprise Portal](#) website listed on this slide.

Slide 36 discusses the EIDM roles that are available for groups. Groups are identified in the EIDM by their Medicare billing TIN. One person from the group must first sign up for an EIDM account with the Security Official role. And if additional persons are needed to register the group, then they can request the Security Official role or the Group Representative role. If you already have an EIDM account but not one with one of these group roles, then you'll need to modify your existing account to sign up for one of these roles.

So, what does having a Security Official or Group Representative EIDM role allow you to do? With the Security Official role, you'll be able to register a group to participate in the PQRS GPRO and access the group's Mid-Year and Annual [QRURs](#), along with the supplemental QRUR and the PQRS feedback report. You will also be able to submit a Value Modifier informal request on behalf of the group, and also approve requests for the Group Representative role in the EIDM. And with the Group Representative role, you'll be allowed to perform only the first three tasks that are listed on this slide.

Slide 38 describes the steps you need to follow in order to sign up for a new EIDM account or to modify an existing EIDM account to add a group role. First, you'll need to gather all of the required information you need to submit your request for a new EIDM account or to modify your existing EIDM account. And the required information are listed on slide 39. So, we have quick reference guides that provide step-by-step instructions for requesting each role in the EIDM. And the guides are available on the [PQRS GPRO Registration](#) website that's listed on slide 19.

Slide 39 lists the required information you have to provide when requesting one of the group roles. All requesters will need to complete the Your Information and Business Contact Information sections. If you're requesting the Security Official role, then you'll need to enter the group's Medicare billing TIN, name, address, phone number, the rendering NPIs for two different eligible professionals who bill under the TIN, and their corresponding individual Provider TIN – Transaction Access Numbers, also called PTANs.

Please note that the PTAN is not the same as the Medicare Provider Identification Number. And if you do not know who the – if you do not know that EP's individual PTAN, then you can check the enrollment approval letter that they received from the MAC when they enrolled in the Medicare program, or you can directly contact your MAC to get their PTAN. Please do not use the group's NPI or group's PTAN.

If you're requesting the Group Representative role, then you'll need to enter the group's Medicare billing TIN, name, and address.

The next three slides show the screens you'll have to complete when requesting a Security Official role in the EIDM. So, all the users, regardless of the role they request, will need to provide the required information in the Your Information section shown in slide 40. They'll also need to complete the Business Contact Information section shown in slide 41. And then in the screen shown in slide 42, they'll need to enter the group's Medicare billing TIN, the rendering NPIs for the two different EPs who bill under the TIN, and their individual PTAN numbers. And I just want to mention again that we do have guides that provide step-by-step instructions for requesting each role in the [PQRS GPRO Registration](#) website that's listed on slide 19.

## How To Register for the PQRS GPRO in the PV-PQRS Registration System

Sabrina Ahmed: So after you have your EIDM account with the correct role, you will be able to log in to the registration system to register for the PQRS GPRO. So, the next section of this presentation will cover the registration process.

So the registration system is available from April 1, 2016, to June 30<sup>th</sup>, 2016, until 11:59 pm eastern time. And it will allow authorized representatives of a group to select or modify their group's PQRS group reporting mechanism for 2016. As Dr. Green mentioned earlier, the Web Interface option is available for groups with 25 or more EPs. The Registry, EHR, and QCDR options are available for groups with two or more EPs.

If the group has 2 to 20 – 2 to 99 eligible professionals, then the group can elect to supplement its PQRS group reporting option with the CAHPS for PQRS survey in 2016. However, a group with 100 or more eligible professionals will be required to report the CAHPS for PQRS survey in 2016. Groups with two or more eligible professionals that elect or are required to report the CAHPS survey will also have the option in the registration system to elect to include their performance on the 2016 CAHPS survey in the calculation of their 2018 Value Modifier.

Slide 46 lists the groups that do not need to register for the PQRS GPRO. Groups that participate in a Shared Savings Program ACO do not have to register, because they are required to participate in the PQRS GPRO only through their parent ACO. And eligible professionals that choose to participate in the PQRS as individuals in 2016 also do not have to register.

Please note that groups must ensure that at least 50 percent of the eligible professionals in the group must meet the criteria to avoid the 2018 PQRS payment adjustment as individuals in order for the group to also avoid the automatic downward adjustment under the Value Modifier and qualify for adjustments based on performance under the Value Modifier in 2018.

Slide 47 describes the steps you need to follow in order to register your group for a PQRS GPRO in 2016. First, you should gather all of the required information that you need to submit your registration, and this list is provided on slides 48 and 49. Then you can [log in](#) to the registration system, using your EIDM User ID and password, and enter the required information in the registration system. And then you'll need to verify that you entered all of the information correctly and submit your registration to CMS.

You can also refer to the [PQRS GPRO Registration Guide](#), which provides step-by-step instructions on how to register. And that guide is available on the [PQRS GPRO Registration](#) website listed on slide 19.

So, slides 49 – 48 and 49 list the required information you have to provide in the registration system when registering a group to participate in the PQRS GPRO in 2016.

And then slide 50 describes how you can access the registration system. First, you'll need to go to the [CMS Enterprise Portal](#) website, and then select Login to the CMS Secure Portal on the right-hand side of the screen. And next, you can refer to appendix – the appendix is located on slides 63 to 74, and you'll be able to see all of the screens that you have to complete in the registration system in order to submit your 2016 PQRS GPRO registration. And if you registered in the registration system in previous years, you'll see that the screen has not changed much.

Slide 51 addresses what you need to do next if your group decides to participate in the PQRS GPRO in 2016. So if there isn't anyone in your group already with an EIDM account with the correct role, then your group will need to have at least one person [get an EIDM account](#) with the Security Official role. And then that person would need to [register the group](#) in the registration system by June 30<sup>th</sup>. We encourage you to get your EIDM account and register early so that you don't miss the deadline.

And if your group is not able to report on the GPRO reporting mechanism that was selected in the registration system, then we encourage you to still report through another GPRO reporting mechanism, or have the EPs in the group participate in the PQRS as individuals in 2016.

### **Top Five PQRS GPRO-Related Frequently Asked Questions**

Sabrina Ahmed: Slides 53 and 54 contain the top five PQRS GPRO-related frequently asked questions that you may find helpful. The first question that we receive frequently is, is registration needed or required for our group of providers? The answer is, no registration is necessary if the EPs in a group participate in the PQRS as individuals. If your practice is interested in participating as a PQRS group practice for 2016, then you must register via the registration system between – prior to June 30<sup>th</sup>, 2016.

The second question is, what steps are needed to successfully register? And the answer is that the [2016 PQRS GPRO Registration Guide](#) provides step-by-step instructions on how you can register in the registration system. You can click on this link to access this guide, and the guide is also available on the [PQRS GPRO registration](#) website that I mentioned earlier.

The third question is, once successfully registered, what does our group do next? And the answer is that you should visit the [GPRO](#) webpage for more detailed information on the PQRS GPRO reporting mechanism that your group selected during registration. And this website is listed on slide 58.

Okay, the fourth question is, can I change my GPRO reporting mechanism? The answer to that question is, an existing 2016 GPRO registration can be modified by logging into the registration system any time before the registration period closes on June 30<sup>th</sup>

before 11:59 pm eastern. And you should follow the steps that are described in the [PQRS GPRO Registration Guide](#) to change your GPRO reporting mechanism.

The last question is, how do I cancel my GPRO registration? And the answer is that if you – if your group registered to participate in the 2016 PQRS GPRO but wishes to cancel the registration, then you can log in to the registration system and cancel the registration by following the steps described in the [registration guide](#), or you can contact the Physician Value Help Desk before the registration period closes on June 30<sup>th</sup> to cancel your GPRO registration.

## Resources

Sabrina Ahmed: So this concludes the formal portion of our presentation. And in the following few slides, you'll find additional resources as well as information about where to call for help.

We know that many of you are calling our QualityNet and Physician Value Help Desk with questions. If you have any general questions or needed to show clarification regarding the content covered in this presentation, then please contact the help desk whose information is listed here. You can contact the [QualityNet Help Desk](#) with questions about participating in the PQRS as a group or as individuals, and also with questions about obtaining an EIDM account. And you can contact the [Physician Value Help Desk](#) if you have any questions about the Value Modifier or your Quality and Resource Use Report.

If you have more-specific questions, we've listed additional organizations and their contact information on slide 57.

On slide 58, you'll find several useful links to various PQRS webpages and supporting information and resources on GPRO and the Value Modifier.

So, this is the end of our presentation. I would now like to turn it back over to Aryeh.

## Question-and-Answer Session

Aryeh Langer: Thank you very much, Sabrina, for that very comprehensive presentation. 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, Ronni, 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.

Your first question comes from the line of Beth Potratz.

Beth Potratz: Yes, my question is on, like, slide 24 and 23 when you were discussing the Value-Based Modifier adjustment. Does that also include the PQRS adjustment or is that on top of?

Sabrina Ahmed: The adjustments shown in these slides 22 or – in slides 23, 24, and 25 are only the Value Modifier-based adjustments. PQRS adjustments are not included in these amounts.

Dr. Daniel Green: But...

Beth Potratz: Okay.

Dr. Daniel Green: ...just a – I'm sorry, just for clarification, if you successfully report PQRS, so nine measures across three domains—unless you have to do CAHPS, in which case, it's six and two plus CAHPS—you know, PQRS is either neutral, so no payment adjustment, or if you don't successfully or satisfactorily participate, you get a downward adjustment.

The performance scores is what – the part of PQRS that factors into Value Modifier. So if you don't submit anything, then you get a 2-percent adjustment for PQRS and a 2-percent adjustment from Value Modifier.

Beth Potratz: So the automatic—like on the 10-plus EPs—the automatic 4 percent, if you didn't meet your PQRS, that – it wouldn't be 6 percent with a 2-percent PQRS and the 4-percent value-based.

Sabrina Ahmed: This is Sabrina Ahmed. Actually, for a group of physicians with 10 or more EPs, it would be minus 6 percent—2 percent for not meeting the PQRS payment adjustment and then additional minus 4 percent for – under the Value Modifier.

Beth Potratz: Okay, and the two to nine would be the total of the four?

Sabrina Ahmed: Yes.

Beth Potratz: The 2 percent – okay, perfect. Thank you.

Dr. Daniel Green: Thank you.

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

Karen Schnell: Hello. I – on the registration of GPRO, I understand that you don't have to if your group's 2 to 99. But if – I'm trying to figure out, what is the difference if you just go through a registry as an individual or you register as a group and then go through the registry as a group GPRO? What is the difference? It seems like it's still the same measures. I get that, you know, it's 50 percent of each provider's Medicare patients if you're individual and 50 percent of the group if you register and report that way. But what else is the difference? Is it the same measures and that kind of thing?

Dr. Daniel Green: So, thank you for the question. So basically, assuming you're not using the Web Interface, if you're reporting individual measures, then each NPI in your group would report on nine measures covering three National Quality Strategy domains, and they'd have to report on 50 percent. Again, as you said, if you report as a group, those nine measures would cover the entire group.

So, let's say it's a multispecialty group and there's two neurosurgeons in that group, and your group decides to report on diabetic measures and other primary care-type measures. You know, those neurosurgeons would piggyback on the coattails, if you will, of the internists that are reporting the diabetes measures, the, you know, PNEUMOVAX®, the influenza measures. That would be one advantage.

The other thing is, let's say that it's a group of all primary care docs. You know, you wouldn't have to report the mammogram measure both for me and for you if we're two members of that group. We would report the mammogram measure on Mrs. Jones only. Now if we both saw Mrs. Jones, she would only get counted one time anyway. So there are little nuances where it can be easier, if you will, to report as a group than having to report for each individual NPI.

Karen Schnell: But the guidelines for the measures – how many measures you have to report are the same whether you do it individually via registry or a group via registry. Is that correct?

Dr. Daniel Green: That's correct. It's nine measures across three domains.

Karen Schnell: Okay. So, it's just the benefit of doing it as a group 1 time vs. 30 times for your individual providers. Okay.

Dr. Daniel Green: Yes, and again, some of your – you know, that's assuming you're a single-specialty group and you were going to report the same nine measures for everybody. You know, if you get...

Karen Schnell: I'm looking at anesthesia...

Dr. Daniel Green: ...more problems. Sorry.

Karen Schnell: I'm looking at anesthesia, is what I'm looking at—an anesthesia group, so...

Dr. Daniel Green: Okay. So you are a single specialty.

Karen Schnell: Yes. Yes.

Dr. Daniel Green: Okay, very good. Thank you.

Karen Schnell: Thank you.

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

Kristy Young: Hi. Yes. I accidentally signed up late and I would like to know what you all are looking at so that I can view what you're looking at, please.

Aryeh Langer: We're looking at the presentation that is on the CMS website. The exact web address is [www.cms.gov/npc](http://www.cms.gov/npc). So, if you go into the CMS website and you go to the [National Provider Calls](#), you can click on the date of today's call, and you scroll down, and you'll be able to download the presentation from there. Again, it's [www.cms.gov/npc](http://www.cms.gov/npc).

Kristy Young: Thank you very much.

Aryeh Langer: Sure.

**Operator:** Your next question comes from the line of Darlene Phillips.

Darlene Phillips: Hi, my name is Darlene, and I work for a dermatologist, and there's only one dermatologist here. Now, I don't know what happened in the past, but she was registered as a group with Medicare. At one time several years ago, she had one other doctor with her. Now there is only one other doctor. So when I went to submit my PQRS, it kept erroring out. I almost had a nervous breakdown. So when I resubmitted them as a group, it went through.

So my question to you is – I did submit my PQRS as a group for Dr. Trusky. My question to you now is, she is only one doctor, but we are registered with Medicare as a group. Is that a problem? Can I continue that way?

Dr. Daniel Green: So, you're registered as a group for billing purposes? Is that what you're...

Darlene Phillips: Correct, sir, yes.

Dr. Daniel Green: Okay. So, that shouldn't make a difference in submitting your PQRS. You should be able to report as your tax ID number, but it's important to make sure you're submitting your individual and – or Dr.—I thought you said Trusky's—individual...

Darlene Phillips: Correct.

Dr. Daniel Green: ...NPI, not the group – if she had a group – or he or she had a group NPI, you wouldn't want to use the group NPI when you do your billing. You'd want to use the individual NPI when you're submitting Dr. Trusky's data.

Darlene Phillips: Okay. I understand that. When I started here last year in February—so I've been here over a year—when I call the voice response and I put in the group NPI, it works. When I put the individual, it says, no, no, no. So, I was a little confused.

And then, when I tried to submit my PQRS, it told me no, but when I submitted it as the group, it took it. So I guess I didn't want to mess anything up. I'm going to keep it as the group. But I guess my question to you is, is there more work for me to do now for this 2016 as a group? Or I heard them say the nine measures and I know the whole matrix.

Dr. Daniel Green: No, not really. But real quick before you run, what method were you trying to submit for the doctor? Claims? Registry? QCDR? How were you trying to report?

Darlene Phillips: I just reported my PQRSs, and I just went through your Medicare website where it had the 10 measures. And then, I have a system called Nextech. So I was able to extract it automatically and download it right into your system without me doing anything manually.

Dr. Daniel Green: Through your EHR basically, right?

Darlene Phillips: Correct, yes.

Dr. Daniel Green: I mean, the other thing you could do is, you could reach out to the help desk. They should be able to unwind it for you. But if it's working for you, that's fine, too.

Darlene Phillips: Okay. Thank you so much. I appreciate your help.

Dr. Daniel Green: Sure.

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

Rebecca Ticklesimer: Hi. I hope this question isn't repetitious. But I was wondering if you could review again what the advantages are for a single-specialty group with two providers reporting as a group vs. individually.

Dr. Daniel Green: Not again.... I'm just kidding. Happy to do it; I'm teasing with you.

So, sure, I mean, with two docs, it's not that much of an advantage. You would end up reporting on fewer patients insomuch as, again, with my mammogram example, you're only going to report that the group – that Mrs. Jones is up to date on her mammogram, for example. You wouldn't have to report for Dr. X and also report the same patient for Dr. Y.

So there is some economies of scale almost, if you will, for the two docs. But again, with a group of two, you know, you're not saving that much in the way of reporting because, you know, do they all see, you know, the same patients? I know that they're covering one another but, you know, usually Dr. X is going to see mostly Dr. X's patients, and Dr. Y—unless it's a cross-cover situation. So you're not going to have as much of a benefit, but you can elect to do it either way. If you wanted to do the CAHPS survey, certainly you can do it with a group of two or – if you wouldn't do it individually. On the – so that's pretty much it in a nutshell for your situation.

Rebecca Ticklesimer: Okay. Thank you.

Dr. Daniel Green: Thank you.

**Operator:** Your next question comes from the line of Kenton Hungerpillar.

Kenton Hungerpillar: I was looking for clarification on the GPRO Web Interface. So, I understand there's 248 patients, and I believe it's up to 18 measures that fall in the GPRO Web Interface. But is it up to 248 patients for the Disease Module, Care Coordination/Patient Safety and Preventive Care measure, or is it just a total of 248 patients that you may report up to 18 measures on?

Dr. Daniel Green: So, it's 248 patients per measure, so, you know, in the module. So, as you mentioned, there are 18 measures. So, assuming you have enough beneficiaries to populate, let's say, you know, Measure number 1 with 248-plus patients, you know, that's how many you'd have populated. And you'd have to report on, you know, the 248. Same thing for Measure 2, and so on.

So, it's not just 248 instances of reporting across the 18 measures—so maybe, you know, 10 for this measure, 30 for the next one. It's not that. It's 248 per measure, again, assuming you have the beneficiaries that meet the denominator of the measure to, again, populate that Web Interface. If you don't, for a given measure, then you have to

report on 100 percent of those patients that are listed. So if you only had 150 patients for Measure number 6, you'd have to report on all 150.

Kenton Hungerpiller: Okay. And then, can I get clarification on, if you report via the registry in your multispecialty group, do you only pick nine measures – just one set of nine measures that would apply to all physicians in that group, or do the individual physicians pick different sets of nine measures?

Dr. Daniel Green: So, if you're reporting as a group through a registry—you're a multispecialty group, let's say, there's 50 NPIs in it—they would pick nine measures that they want to report. Now, there's no rule that you can't report more than nine, but let's keep it at the – let's assume that you want to do, you know, just enough to make sure that you don't get the penalty. So you would pick nine measures covering the three domains and you would report them. Now, it's possible that, in those nine measures, they're not particularly applicable to some of your providers.

Let's say you're reporting on PNEUMOVAX, or influenza, or even colonoscopy screening, and you have a couple neurosurgeons—just picking on them today—in your group. Well, you know, I'm not saying that neurosurgeons don't care about colonoscopy and PNEUMOVAX and influenza; they do, but not like a primary care doc is. So, you would – you know, again, there would be little reporting, probably, coming from the neurosurgeons contributing to the measures that you selected if that were – in my example.

Kenton Hungerpiller: Okay, so it's just nine measures for the TIN.

Dr. Daniel Green: That's correct, covering the three domains.

Kenton Hungerpiller: Okay, thanks.

Dr. Daniel Green: Sure.

**Operator:** Your next question comes from the line of Tran Day.

Tran Day: Hi. I have a question regarding CRNAs. We are a pain management and anesthesiology practice. We have two ambulatory surgery centers. And our CRNAs work in the surgery centers, but they bill through a different TIN number than the M.D.s that we have. So when I do the group registration, do they get included with the M.D.s on the clinic side, or do they have to be registered as individuals or like their own separate groups if they're under a different TIN?

Dr. Daniel Green: So, the first part I can – well, one part of that question I'm able to answer, and that is, you know, if they're under a separate – billing under a separate

TIN, then you can't include them, necessarily, under your anesthesia's TIN. So if they bill under a separate TIN, that part, you know, I can answer for you.

Is there anybody on the call from the contractor side that's able to shed some light on this with the CRNAs?

Jessica Schumacher: Hi, Dr. Green. It's Jessica Schumacher from the PQPMI contract team. And we're nodding our heads yes. We agree with your statement. Is there any special reason as to why they're on a separate TIN? Are you...

Tran Day: We have multiple locations. So I believe that we bill them based on the facility that they're based out of rather than the clinic because they never work in the clinic.

Jessica Schumacher: Okay, right. Then, yes, we absolutely agree, Dr. Green. We're agreeing with you that the PQRS analysis is based on unique TINs. So if they're a different TIN, it would – and you want to do GPRO with them, you would have to register that tax ID number as a PQRS group practice and they would participate separately from the other physicians under different TINs.

Tran Day: Okay.

Jessica Schumacher: Does that answer your question?

Tran Day: Yes. So I can register them as their own separate group as just the CRNA group, and then the M.D. group would be on the clinic side then.

Jessica Schumacher: So, are only – are the CRNAs, are they all under just one TIN and no one else is under that TIN with the CRNAs?

Tran Day: Well, that's my other – my followup question is also going to say the physicians also perform surgeries in the surgery center side, but what I've been – what my understanding is, if their patient load on that side is less than the clinic side, then I have to report them for just the clinic side and not through the ASC. So the physicians also bill under that TIN, too.

Dr. Daniel Green: So let me see if I can clear this up a little bit. All right, so the docs – so basically, each – if you're to report as a group, each tax ID number, whether it's individual, you know, individually made up only of M.D.s or it's only CRNAs or it's a combination thereof—for each one of those groups, you're going to have to register and report. So at – for PQRS, we look at people at the TIN NPI level. So if we see that you reported for the docs, let's say, in the clinic, but they did work elsewhere under a different tax ID number, they would be okay for their clinic work, but they're going to – if they don't report under the – and the group doesn't successfully report under the ASC TIN, that TIN is going to get dinged.

Tran Day: Well, are there – are the measures different for ASCs then? Because what you're saying is, the combination of the TIN and the NPI—it's not just the TIN number then.

Dr. Daniel Green: Well, so, we're going to – look, if you report under the ASC as a group, as a GPRO, you've got to report again on the nine across three, and you've got to – nine measures, three domains, and for 50 percent of the patients that fall into the denominator of those measures. Now, if you're able to do that with just the CRNAs, and so the anesthesiologists only do a couple cases there and they can hang on the coattails, if you will, of the CRNAs, that's fine. But, you're going to need to report for each of those tax ID numbers. It's not like it's good enough for those guys that are working and ladies that are working at the – in the pain clinic, it's not good enough that you just report under that tax ID number if they do work under another tax ID number.

Tran Day: Okay. Okay. So your clarification is that if they do it under multiple TINs, then they have to report for all of them.

Dr. Daniel Green: They have to participate...

Tran Day: Separately?

Dr. Daniel Green: ...under each of those TINs.

Tran Day: Each one. Okay. Okay.

Dr. Daniel Green: So if I work...

Tran Day: Okay. Each TIN NPI combo is different, and that's why they have to participate.

Dr. Daniel Green: Well, their TIN's going to be different. Their NPI'll be the same. It's like, if I have my own practice 2 days a week and 3 days a week I work with the ABC specialty group, if I report for my own private practice, let's say, I should be good under my private practice. I'm not going to get a ding for nonparticipation under my private practice. But if the group doesn't choose to report, their reimbursement will be affected and subsequently mine is part of that billing group for the 3 days I do it under them or vice versa, of course.

Tran Day: And are you talking mainly about the professional side of it, not the facility or the anesthesia side?

Dr. Daniel Green: Well, the facility side of things is going to be – is completely different. This is an eligible professional–level, provider-level program. So facility fees are – you

know, may be different. I'll have to turf that one, also, to the contractor because I think it sort of depends on the setting. But again, from the quality action, we're talking about at the provider level.

Tran Day: Okay. So on the professional level then?

Dr. Daniel Green: Yes. I have to, again, refer you to the help desk with respect to the facility fee because I think when we – there are some instances where facility fees – but I'm not – really not sure about that. So feel free to write into the help desk if you have questions about facility fees.

Tran Day: Okay, great. Thank you so much.

Dr. Daniel Green: Thank you.

**Operator:** Your next question comes from the line of Travis Albright.

Travis Albright: Yes, this is Travis. We are a critical access hospital, and we have been registering – got about 25 providers. But we've been trying to decide whether to register as a GPRO. We want to register as a GPRO for simplicity. But there is a fear that, because we're critical access and we bill part of our providers out as a department of the hospital, that the Value-Based – the Value Modifier will affect our hospital – could affect our hospital charges or critical access status. Can anybody speak to that?

Aryeh Langer: Could you give us one second, please?

Travis Albright: Yes.

Aryeh Langer: Jeff, are you able to answer that question for us?

Jeff Ballou: Yes, I can certainly take a shot at it. This is Jeff Ballou from Mathematica.

I think that – I – to the extent that I understand the question, it would not affect, threaten, or endanger in any way your critical access hospital status. I think that from the perspective of the [Value-Based Payment Modifier](#), coming back to what Dr. Green was saying earlier, this is a provider-based program. So, you know, services that are billed under the physician fee schedule by a critical access hospital or their providers could, indeed, be subject to the Value Modifier. But it wouldn't affect the hospital status, if I'm understanding the question correctly.

Travis Albright: I think so. If there's additional questions by our administration, do we just call it – contact the QualityNet Help Desk to get clarification on that?

Aryeh Langer: I think that'd be a good idea.

Travis Albright: Okay. Thank you, sir.

Aryeh Langer: And we have time for one final question.

**Operator:** Yes. Your next question comes from the line of Julia Diaz.

Julia Diaz: Hi, this is Julia Diaz with Western Pathology. We registered as a GPRO last year and filed, but given we're in the specialty of pathology, we only had eight measures and none were crosscutting. We don't see any patients. So, of course, we need to fall under the MAV exception.

I'm wondering, are they factoring that into the Value-Based Modifier? Will we still be eligible for an upward adjustment? Because when I looked at the final reporting from the registry that we used, it looked as if, though – it was almost like a null response, meaning – even though we reported 100 percent of claims and in all those claims, we only had one that didn't meet the criteria. All of the scoring was either N/A—there was no scoring—or it said average, even though we were 100-percent successful with what we had reported.

Dr. Daniel Green: So, there's two things here. I'm going to give this to Sabrina in a second. But, you know, just to be clear, 100-percent reporting, of course, is different than 100-percent performance. I'm sure you'd know that.

In terms of the crosscutting measures, the codes that you bill are not in the crosscutting measures and, obviously, you're exempt from the crosscutting measures. So that would not count against you for not reporting.

For more details though, I'm going to give you Sabrina.

Aryeh Langer: One moment, please. And Jeff, could you address the rest of that for us, please?

Jeff Ballou: And actually, I'm going to ask Lara Converse on our team. I think she's best positioned to answer this.

Lara Converse: Yes, thank you. So, I think as long as your TIN or EPs under your TIN are reporting successfully and you're classified as Category 1 either through GPRO participation or 50 percent of the EPs are avoiding the payment adjustment, you would avoid the downward adjustment after the VM.

Julia Diaz: Yes. I'm pretty confident we would avoid a downward adjustment. I just – it doesn't seem clear how we would earn an upward adjustment which, you know, doesn't – I don't know, it seemed – the response I received made it seem like, because of what

we were submitting, that there wasn't potential for an upward adjustment even though – I mean, we submitted 100 percent of our claims—we made sure to do 100 percent, not just a 50 percent. And of those, we only had one claim that failed to meet the performance criteria based upon the PQRS-code entering. Meaning, we did not appropriately do a specific documentation in the past report.

Dr. Daniel Green: So, what was your performance rate? I mean...

Julia Diaz: It said that our CMS performance was 98.61 compared to the 2013 mean of 97 percent, and our deviation was 1.48 percent compared to the 2013 deviation of 11 percent, but our quality tiering was only average. That was just one measure, but it's kind of like that across all the board – across the board.

Dr. Daniel Green: Sorry, go ahead.

Jeff Ballou: No, go ahead, Dr. Green, and I'll follow you.

Dr. Daniel Green: I was just going to say, I mean, you know, the 98 percent, obviously, is super. But if the benchmark for the measure is 97 percent, it's not super enough necessarily to get you out of the average category. So – and of course, don't forget the cost – and again, the VM folks can speak more intelligently than I can about the cost part. But that part also would factor into where you're tiered. But I'm sorry, go ahead.

Jeff Ballou: Right...

Julia Diaz: ...since when our CMS perf – so that was the one instance where we did have one measure – one patient that didn't meet the criteria. But all of the others, our CMS performance was 100 percent, which was above whatever the mean performance was. And we still had a quality tiering of either average or, for three of the measures, possibly because they were new—395, 96, and 97—there's null. It says N/A and then null.

Jeff Ballou: Right. The only thing to add to that – yes, so if the measures are new or, for whatever other reason, don't have a prior-year benchmark, then CMS doesn't have a basis for essentially assessing performance on those measures. So those would not have been included in a quality composite or Value Modifier score under the Value Modifier.

For the other measures, I guess I would just pick up on and amplify a little bit the point that Dr. Green was making. You know, without knowing exactly what those measures are, but even if you have very high performance, again, first of all, if the benchmark is high, it might not be possible to sufficiently differentiate yourself from, really, the mean performance to be ultimately classified as a particularly strong, high-quality performer. Obviously, as Dr. Green said, you're doing very well on those measures. But in terms of differentiating yourself from the crowd, that's more difficult.

The other piece of information there—and you mentioned standard deviations—is the standard deviation. And so the way that the Value Modifier formulas work is that if you report on a measure where there is a lot of dispersion in how people perform—you know, folks are sort of all over the map on their performance rates—it's also more difficult for CMS to judge when they see a high score: Well, is this truly a high score? So, high benchmarks and high standard deviations can make it less likely that you are able, depending on the measures you report, to be considered a strong quality performer even if your performance rates on the measures you reported are quite high.

I said a mouthful there, but I'm not sure if some of that makes sense.

## Additional Information

Aryeh Langer: Yes, I think unfortunately we've run over time, and I think some of those answers were very helpful. If you need further help, please contact the help desk, that's on slide 56.

If we didn't get to your question—I'm sure there're many people still in the queue—you can feel free to either email or call the QualityNet or Physician Value Help Desk, whatever your question pertains to.

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 60 of the presentation, you will find information and the URL to evaluate your experience of today's call. Evaluations are anonymous, confidential, and voluntary. We hope you'll take a few moments to evaluate your [MLN Connects Call](#) experience today.

Again, my name is Aryeh Langer. I'd like to thank our presenters, Dr. Green and Sabrina Ahmed here at CMS. And thank you all on the lines for taking time out of your busy schedules today to join us for today's call. Have a great day, everybody.

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

-END-

