



MLN Connects®

National Provider Call Transcript



**Centers for Medicare & Medicaid Services
2015 Annual QRURs Webcast
MLN Connects National Provider Call
Moderator: Aryeh Langer
September 29, 2016
1:30 pm ET**

Contents

Announcements and Introduction	2
Presentation	3
Overview of the 2017 Value-Based Payment Modifier	3
Overview of the 2015 Annual Quality and Resource Use Report	5
Accessing the 2015 Annual QRUR.....	6
Information Contained in the 2015 Annual QRUR.....	7
Accompanying Tables for the 2015 Annual QRUR.....	14
Question-and-Answer Session	17
Additional Information	29

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.

This transcript was prepared as a service to the public and is not intended to grant rights or impose obligations. This transcript may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

This document has been edited for spelling and punctuation errors.

Operator: Hello and welcome to today's event. My name is Jen, and I'll be your web event specialist today. All lines have been placed on mute to prevent any background noise. Please note that today's event is being recorded.

During the presentation, we'll have a question-and-answer session. You can ask questions at any time. Click the green Q&A icon on the lower left-hand corner of your screen. Type your question in the open area and click submit. We will also be taking questions via the phone lines during the question-and-answer session.

If you would like to view the presentation in a full screen view, click the full screen button in the lower right-hand corner of your screen. Press the escape key on your keyboard to return to your original view.

For optimal viewing and participation, please disable your pop-up blocker. And finally, if you need technical assistance, as a best practice we suggest you first refresh your browser. If that does not resolve the issue, please click on the support option in the upper right-hand corner of your screen for online troubleshooting.

It is now my pleasure to turn today's program over to Aryeh Langer. Aryeh, the floor is yours.

Announcements and Introduction

Aryeh Langer: Thank you so much. And as you just heard, my name is Aryeh Langer from the Provider Communications Group here at CMS, and I'm your moderator today.

I would like to welcome you to this MLN Connects® event on the 2015 Annual Quality and Resource Use Reports or QRURs. MLN Connects events are part of the Medicare Learning Network®.

During today's webcast, CMS will discuss the 2015 QRURs available to all group practices and solo practitioners nationwide. This event provides an overview of the report and explains how to interpret and use the information.

2015 Annual QRURs show how groups and solo practitioners performed in 2015 on the quality and cost measures used to calculate the 2017 Value-Based Payment Modifier and how the Value Modifier will be applied to physician payments.

Before we get started, I have a few short announcements. Today's event uses webcast technology. We recommend streaming the audio through your computer speakers. Two, those of you participating via webcast can download a copy of today's slide presentation by clicking the blue Files button on the left-hand side of the screen.

This document has been edited for spelling and punctuation errors.

Please note that this event is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects call website at go.cms.gov/npc, again, go.cms.gov/npc. Registrants will receive an email when these materials become available.

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

Finally, the purpose of today's call is to address questions related to the 2015 Annual QRUR and the 2017 Value Modifier. We received a number of questions related to the Merit-based Incentive Payment System, also known as MIPS, and Alternative Payment Models, or APM. We will not be addressing these questions during today's webcast. Please direct questions related to MIPS and APM to the Quality Payment Program Service Center helpdesk by calling 866-288-8292 or emailing your questions to gppsupport@hcqis.org. Again, that's gppsupport@hcqis.org. And limit the questions you ask please during this call to questions related to the QRUR and Value Modifier.

At this time, I would like to turn the call over to our first presenter, Sabrina Ahmed from CMS's Division of Value-Based Payment. Sabrina?

Presentation

Sabrina Ahmed: Thank you, Aryeh, and thank you everyone for joining us on this call this afternoon. My name is Sabrina Ahmed and I work in the Division of Value-Based Payment in the Center for Medicare.

So the objectives for today's presentation are listed on slide 4. In the first part of this presentation, I'll provide an overview of the 2017 Value Modifier and the 2015 Annual Quality and Resource Use Reports, also known as the QRURs, and then I'll review what you need to do in order to access your QRURs. And then in the second part of this presentation, Fiona Larbi will review the information contained in this year's Annual QRUR along with how you can request an informal review of your TIN 2017 Value Modifier. And then we'll have a question-and-answer session at the end of this presentation.

Overview of the 2017 Value-Based Payment Modifier

So, slide 6 provides an overview of the 2017 Value Modifier policies. Calendar year 2015 is the performance period for the Value Modifier that will apply in 2017. In 2017, the Value Modifier will apply to all physicians in groups with two or more eligible professionals and to physicians who are solo practitioners, including those that participated in a Shared Savings Program ACO in 2015. Eligible professionals are designed in appendix slide 48 and include physicians, practitioners, and therapists. However, in 2017, the Value Modifier will only apply to the physicians as defined in that

This document has been edited for spelling and punctuation errors.

slide. So physicians include Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, and then you'll see the other physicians that are included that the Value Modifier will apply to in 2017 on slide 48.

Groups and solo practitioners are identified by their Medicare taxpayer identification number, which I'll refer to as the TIN in this presentation. So for a TIN that is subject to the 2017 Value Modifier, the Value Modifier – Value Modifier will be based on the TIN's participation in the Physician Quality Reporting System, also known as PQRS, in 2015. And also please note that the 2017 Value Modifier is waived for a TIN if at least one eligible professional who billed for Medicare Physician Fee Schedule items and services under the TIN during 2015 participated in the Pioneer ACO Model or the Comprehensive Primary Care Initiative in 2015.

Slide 7 shows the interaction between the 2017 Value Modifier and a TIN's participation in the 2015 PQRS.

So as I mentioned earlier in 2017, the Value Modifier will apply to physicians in groups with two or more eligible professionals and to physician solo practitioners. We use a two-category approach to classify groups and solo practitioners that are subject to the 2017 Value Modifier based on how they participated in the PQRS in 2015.

So Category 1, as shown in the left-hand of this slide, includes physician groups with two or more eligible professionals that met the criteria to void the 2017 PQRS payment adjustment as a group practice participating in the PQRS group practice reporting option, also known as GPRO, in 2015 or physician groups with two or more eligible professionals in which at least 50 percent of the groups' eligible professionals met the criteria to void the 2017 PQRS payment adjustment as individuals. Category 1 also includes physician solo practitioners that met the criteria to void the 2017 PQRS payment adjustments as individuals.

All groups and solo practitioners that are in Category 1 will be subject to quality-tiering. Quality-tiering is a methodology that we use to evaluate TIN's performance on quality and cost measures for the Value Modifier. And it's applied to all Category 1 TINs that are subject to the 2017 VM.

Under quality-tiering in 2017, physicians in groups with 10 or more eligible professionals will be subject to upward, neutral, or downward payment adjustments based on their performance in 2015, while physicians in groups with two or more eligible professionals and physician solo practitioners will only be subject to upward or neutral adjustment under quality-tiering in 2017.

Category 2, as shown in the right-hand side of this slide, will include physician groups and physician solo practitioners that are subject to the 2017 Value Modifier and do not fall within Category 1, meaning that these groups did not meet the criteria to void the

This document has been edited for spelling and punctuation errors.

2017 PQRS payment adjustment as a group. And it did not have at least 50 percent of the eligible professionals in the group meet the criteria to void the 2017 PQRS payment adjustment as individuals.

Physician solo practitioners are also in Category 2 if they did not meet the criteria to void the 2017 PQRS payment adjustment as individuals.

At the bottom of this slide, you can see the 2017 Value Modifier payment adjustment amount where physician groups and physician solo practitioners that are in Categories 1 and 2. The specific payment adjustment amounts are provided in appendix slide 49.

I would also like to point up that appendix slides 50 and 51 describe how the 2017 Value Modifier will apply to groups and solo practitioners that participated in the Shared Savings Program in 2015 based on the ACO's quality performance in 2015.

Overview of the 2015 Annual Quality and Resource Use Report

Slide 9, so on September 26 CMS made available the 2015 annual QRUR for groups and solo practitioners nationwide as identified by their Medicare TIN. QRUR was provided for each TIN.

These reports show how TINs performed in 2015 on the quality and cost measures used to calculate the 2017 Value Modifier. So for TINs that are subject to the 2017 Value Modifier, the QRUR shows their 2017 Value Modifier payment adjustment and how the Value Modifier will apply to physician payments under the Medicare Physician Fee Schedule for physicians who bill under the TIN in 2017.

The data as shown in the QRUR and used to calculate in the 20 – and used to calculate the 2017 Value Modifier is based on all services provided from January 1, 2015, through December 31, 2015.

So the cost, claims-based outcome measures, and the utilization data that are shown in the QRUR are all based on all services provided to a TIN's attributed patients. And the quality of data is based on PQRS quality data submitted by the TINs.

Slide 10. So CMS made available the 2015 Annual QRUR to TINs nationwide that had at least one eligible professional that billed under the TIN in 2015—that billed Medicare under the TIN in 2015. These reports are also available for TINs that participated in the Shared Savings Program, the Pioneer ACO model, or the Comprehensive Primary Care initiative in 2015.

TINs that did not have at least one eligible professional bill Medicare under the TIN in 2015 received a one-page report that contains general information about their report and general information about the 2017 Value Modifier, while all other TINs received the full report showing the TIN's performance on quality and cost measures.

This document has been edited for spelling and punctuation errors.

Accessing the 2015 Annual QRUR

So in the next section of this presentation, I'll review how you can access your TIN's QRUR.

So as you can see on slide 12, an identity – an enterprise identity management account, or also known as an EIDM account, with the appropriate role is required to access your TIN's QRUR. The EIDM roles needed to access groups' or solo practitioners' QRUR are described in appendix slides 53 through 55.

To find out whether there's already someone who can access your TIN's report, you can contact the QualityNet Help Desk at the number provided on this slide and provide the TIN and the name of the group or solo practitioner.

If someone was able to access your TIN's 2015 Mid-Year QRUR that was made available in April or registered your group to participate in the 2016 PQRS GPRO earlier this year, then that same person can also access the 2015 Annual QRUR using their EIDM user ID and password.

You can sign up for a new EIDM account if you don't have one already or modify an existing EIDM account to add the correct role. Or to reset your EIDM account password, you'll need to go to the CMS Enterprise Portal website that's listed on this slide. And the instructions for doing those things are available on the How to Obtain a QRUR webpage.

Once you have the appropriate EIDM account, then you can access the report on the CMS Enterprise Portal website and the How to Obtain a QRUR webpage contains the instruction for accessing a 2015 Annual QRUR.

OK, slide 13. So for those of you who do not have an EIDM account with the correct role, to access your TIN's QRUR, slide 13 describes the steps that you'll need to follow in order to sign up for a new EIDM account or to modify an existing EIDM account to add a group or solo practitioner 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 for the group and solo practitioner roles are listed in the next two slides.

A guide that provides step-by-step instructions for requesting each of the EIDM roles are available on the How to Obtain a QRUR website that's listed on this slide.

Slides 14 and 15 list the required information you have to provide to CMS when requesting one of the group or solo practitioner roles. Please keep in mind that as long as the group has one person with the security official role then that person will be able to access the group's QRUR. For a solo practitioner as long as one person has the

This document has been edited for spelling and punctuation errors.

individual practitioner role then that person would be able to access the solo practitioner's QRUR.

Slides 16 through 18 show the screens that you have to complete when requesting a security official role and new EIDM. All new users regardless of the role they request will need to provide their required information and that your information section that's shown in slide 16, all new users will need to also provide the required information in the business contact information section that's shown in slide 17.

In the screen shown in slide 18, you'll need to enter the group's Medicare billing TIN, the name of the TIN, the rendering NPI for two different eligible professionals that bill under the TIN, along with their corresponding individual provider transaction number. And you also need to enter the group's address and phone number.

Please note that Provider Transaction Access Number, which is also known as the PTAN, is not the same as the Provider Identification Number. Also please do not use the group's NPI or the group's PTAN in this section.

If you do not know that eligible professional's individual PTAN, then please check the enrollment approval letter that they received from their MAC when they enrolled in the Medicare program or you can contact the MAC directly.

The guides that provide step-by-step instructions for requesting each role in EIDM for a new or existing EIDM account are available on the How to Obtain a QRUR website. That's listed on slide 13.

So now on slide 19. So after you have an EIDM account with the correct role, you'll be able to log into the CMS Enterprise Portal website with your EIDM user ID and password, as shown in slide 19, to access your QRUR. And for step-by-step instructions on how to access your 2015 Annual QRUR, please refer to the Guide for Accessing the 2015 Annual QRURs. That's available on the How to Obtain a QRUR website.

OK, slide 20. So after you access your QRUR, you'll have the option to either view it online or to download the report to a PDF document, as shown in slide 20.

I would like to now turn the presentation over to Fiona Larbi, who's also in the Division of Value-Based Payment in the Center for Medicare. She will be covering the remaining information in this presentation.

Information Contained in the 2015 Annual QRUR

Fiona Larbi: Thank you, Sabrina. And as you said, I'm Fiona Larbi and I work in the Division of Value-Based Payment here at the Center for Medicare. Over the next few slides, I will walk through a PDF export of a hypothetical TIN's QRUR, who I will refer to as TIN A. I will highlight the most important information in each section of the report

This document has been edited for spelling and punctuation errors.

and describe how you can use it to understand your TIN's 2017 Value Modifier and improve your practice in the future.

On slide 22, the chart on this slide gives a high-level description of the information available in each section of the 2015 Annual QRUR. This year the data in the report is organized so that your 2017 Value Modifier appears on the cover page, and Exhibit 1 will explain how the Value Modifier applies to your TIN.

Information on your TIN's quality performance can be found in Exhibits 2 and 3. The quality measures included in your QRUR come from three sources: data your TIN reported on your patients by PQRS, your data on patients' outcomes according to claim billed by your TIN, and feedback provided by your patients through the CAHPS for PQRS survey, if applicable.

Information on your TIN cost performance can be found in Exhibits 4 and 5. All six cost measures included in this report are calculated using administrative claims. Unlike previous reports, all exhibits in the 2015 Annual QRUR are directly relevant to the calculation of the Value Modifier. However, you can also access additional information and tables that accompany the QRUR.

These tables need to be downloaded separately from the main report. These tables provide readers with detailed information about the eligible professionals, beneficiaries, and measures that were used to evaluate your TIN for the 2017 Value Modifier and that are shown in the QRUR.

After each section in the main body of the report, the QRUR tells readers which accompanying tables will be most useful to understanding the exhibits in that section.

The report also provides links to glossary terms that are relevant to each section of the report. The information in the tables is for informational purposes only. We will not actually discuss these tables in this presentation, but screenshots are available in the appendix. For instructions on how to access the annual QRUR, refer to the How to Obtain a QRUR webpage.

Next slide. The cover page of the report provides a brief overview of what the Value Modifier is, shows how the Value Modifier applies to a TIN, and provides resources that can be used if you have questions or would like to submit an informal review.

This slide shows the top section of the cover page that contains your TIN's identifying information and the period of performance covered by this report, which is calendar year 2015. It also shows the middle section of the cover page that details your TIN's 2017 Value Modifier.

This document has been edited for spelling and punctuation errors.

This data plot on this page shows the TIN's quality and cost composite scores and how they compare to a representative sample of their peers. Each diamond on the figure represents one Medicare TIN. The largest diamond displayed in red represents the TIN's Value Modifier, though not all TINs will have their scores displayed on the scatter plot.

In this example, TIN A has high quality and average cost and will receive an upward payment adjustment of three times the adjustment factor applied to their physician payments under the Medicare Physician Fee Schedule payments in 2017.

Detailed information about the TIN's quality and cost performance that contributed to these composite scores is shown in other exhibit that will be reviewed later in this presentation.

Next slide, please. This screenshot shows the top – the text at the top of the second page of the QRUR and describes how the Value Modifier applies to your TIN in more detail than was given on the cover page. This section of the QRUR will tell you whether or not your TIN participated in the Pioneer ACO Model or the CPC initiative in 2015, how many eligible professionals were in your TIN in 2015, and whether your TIN will be subject to an automatic downward VM payment adjustment or to quality-tiering based on your TIN's participation in the PQRS in 2015.

The 2017 Value Modifier will be applied to physicians with groups of two more EPs and to physician solo practitioners. However, the magnitude of the Value Modifier payment adjustment depends in part on the number of eligible professionals in a TIN.

As you can see, the Value Modifier applies to TIN A as they had at least one physician bill Medicare under their TIN in 2015, and none of their EPs billing under that TIN participated in the Pioneer ACO Model or the Comprehensive Primary Care initiative in 2015.

TIN A had 53 eligible professionals in 2015 and 77.63 percent of their EPs met the criteria to avoid the PQRS payment adjustment as individuals. So this TIN avoided the automatic downward payment adjustment under the VM and will therefore qualify to have VM calculated using quality-tiering based on its quality and cost performance in calendar year 2015.

Next slide please.

Aryeh Langer: We're on slide 25.

Fiona Larbi: If your TIN is subject to the 2017 Value Modifier, then Exhibit 1 will show the Value Modifier payment adjustment that will be applied to your TIN in 2017. The exhibit also shows the alternative VM adjustments given to your TIN's size based on all possible combinations of quality and cost tiers.

This document has been edited for spelling and punctuation errors.

The adjustment factor derived from actuarial estimates of projected billings will determine the precise size of the reward for higher performing TINs in a given year. The adjustment factor for the 2017 Value Modifier will be posted on CMS's website linked in your QRUR.

If an asterisk appears in the highlighted cell, it indicates that an additional upward adjustment of one times the adjustment factor was applied to your TIN for serving a disproportionate share of clinically complex beneficiaries.

As you can see, TIN A did receive this additional upward adjustment. So because they are a TIN with 10 or more EPs, TIN A received two times the adjustment factor upward adjustment for having high quality average cost plus the additional one times the adjustment factor high-risk bonus, totaling in three times the adjustment factor.

In order to calculate your TIN's Value Modifier or the percentage adjustment to your TIN's 2017 Medicare Physician Fee Schedule claim, for TINs with an upward adjustment factor, TINs' base adjustment is multiplied by the adjustment factor.

Can we go to slide 26? This section of the QRUR shows whether the high-risk bonus applies to your TIN. The high-risk bonus is an additional one times the adjustment factor upward adjustment for TINs receiving an upward payment adjustment that have attributed beneficiaries with the mean CMS hierarchical condition category risk goal at or above the 75th percentile of all beneficiaries scored nationwide.

For TINs not participating in a Shared Savings Program ACO, the risk score calculation includes the beneficiaries attributed to the TINs for the claims-based quality and cost measures.

The TINs participating in a Shared Saving ACO, this includes beneficiaries assigned to the Shared Savings Program ACO. You can see that TIN A met both the criteria to receive a high-risk bonus. They had strong quality and cost performance, as evidenced by an output payment adjustment under quality-tiering, and they had an average beneficiary score that is at or above the 75th percentile of beneficiaries nationwide. This bonus is why this TIN is receiving a three times adjustment factor upward payment adjustment rather than the two times upward – two times the adjustment factor upward payment adjustment in 2017.

Slide 27, please. This slide displays Exhibit 2, which summarizes your TIN's performance on quality by displaying your TIN's Standardized Quality Composite Score.

A TIN's Quality Composite Score is classified into one of three quality tiers—high, average or low—based on how the score compares to the means for the TIN's peer group. To be considered either high quality or low quality, a TIN's score must be at least

This document has been edited for spelling and punctuation errors.

one standard deviation from the peer group mean and statistically significantly different from the mean.

That is, a TIN with a statistically significant positive Quality Composite Score of one or higher would be classified as high quality. And a TIN with a statistically significant negative score of one or lower would be classified as low quality.

A TIN with a Quality Composite Score in the range between but not including negative one and positive one would be classified as average quality because its score is less than one standard deviation from the mean. A TIN with a score of negative one or lower or positive one and higher that is not statistically significantly different from the mean would also be classified as average quality.

The TINs subject to the 2017 Value Modifier – the peer group includes all TINs subject to the 2017 Value Modifier for which a Quality Composite Score could be calculated. For TINs that are not subject to the 2017 Value Modifier, the peer group includes all TINs for which a Quality Composite Score could be calculated with the exception of the TINs that participated in the Pioneer ACO Model or the Comprehensive Primary Care initiative in 2015.

TIN A has a Quality Composite Score of 1.29 and it is statistically significantly different from the mean. This number was the quality coordinate in this scatter plot on the cover page. It also corresponds to the high quality column in Exhibit 1 shown on slide 25.

Slide 28, please. Your Quality Composite Score is based on quality measures from up to three sources. Data your TIN reported to – on your patients via PQRS, feedback provided by your patients through the CAHPS for PQRS survey, and your data on patient outcomes according to claims billed by your TINs.

These claims-based outcome measures are the 30-day All-Cause Hospital Readmission measure, hospital admissions for Ambulatory Care-Sensitive Conditions, Acute Conditions Composite, and the hospital admissions for ACSC Chronic Conditions Composite.

CMS calculates these three claims measure – three claims-based quality outcome measures, which reflect Medicare fee-for-service claims submitted by all providers including beneficiaries attributed to your TIN. Claims-based quality outcome measures will be automatically calculated for your TIN by CMS regardless of how your TIN reports PQRS. Other measures are only included in your QRUR if your TIN reports them.

TIN A reported to PQRS as individuals rather than using a group practice reporting option. Therefore, quality measures reported by the 50 percent or more of the EPs in this TIN who met the criteria to avoid the 2017 PQRS payment adjustment as individuals

This document has been edited for spelling and punctuation errors.

will be eligible for inclusion in your TIN's Quality – in their TIN's Quality Composite Score. This language will vary depending on how your TIN reports quality data to PQRS.

Although not shown in this presentation, Exhibit 3 details your TIN's performance on quality measures and indicates which measures were included in the calculation of the Quality Composite Score. All quality measures are classified into six quality domains: effective clinical care, person and caregiver-centered experience and outcomes, community population health, patient safety, communication and care coordination, and efficiency and cost reduction.

In a series of tables to each of these quality domains, Exhibit 3 presents your TIN's Quality Domain Score and measure-level performance rates each quality measure in each domain providing there was at least one measure in the domain that had at least one eligible case.

The TINs participating in the Shared Savings Program, Exhibit 3 will display only the 30-day All-Cause Hospital Readmission measure and the ACO performance on any GPRO Web Interface measure submitted.

For TINs participating in the Pioneer ACO Model or the CPC initiative, Exhibit 3 displays PQRS data reported outside of the model or initiative, as well as performance on the three claims-based outcome measures and, if applicable, the CAHPS for PQRS survey for informational purposes only.

Slide 29, please. This slide details your – and explains your TIN's Cost Composite. So Exhibit 4 summarizes your TIN's performance on cost by displaying your TIN's Standardized Cost Composite Score that was used to calculate the Value Modifier. The score shows how far your overall performance on cost measures was from the mean for your peer group with the mean represented as zero. For all TINs subject to the Value Modifier, the peer group consists of all TINs who are subject to the 2017 Value Modifier and for which a Cost Composite Score can be calculated, excluding TINs that participated in the Shared Savings Program.

The TINs that were not subject to the Value Modifier, the peer group consists of all TINs for which a Cost Composite Score can be calculated with the exception of those participating in the Shared Savings Program, the Pioneer ACO Model, and the CPC initiative.

CMS uses the same criteria to classify the Cost Composite Score as high or low cost as it does for the Quality Composite Score. That is, the Cost Composite Score must be at least one standard deviation away from the mean and statistically significant in order to be considered either high cost or low cost. For the Quality Composite Score, a high score – a higher score is better. However, for the Cost Composite Score, a lower score is better.

This document has been edited for spelling and punctuation errors.

TIN A has a score of negative 1.54, which was statistically significant. This score corresponds to the low-cost classification shown in Exhibit 1 during this presentation. For TINs that participated in a Shared Savings Program ACO in 2015, their cost performance is classified as average cost under quality-tiering. The Cost Composite Score shown in Exhibit 4 and information on performance on cost measures as shown in Exhibit 5 are provided in this report for informational purposes only and is based on the cost performance, not to the ACO cost performance. On the TIN's cost performance, not the ACO's cost performance.

Slide 30, please. Although not shown in this presentation, Exhibit 5 details your TIN's cost performance. All six cost measures included in this report are calculated using administrative claims. Like the three claims-based quality outcome measures, these measures are based on Medicare fee-for-service claims submitted by all providers treating Medicare beneficiaries or Medicare Spending per Beneficiary episodes attributed to your TIN.

These measures are the per capita costs for all attributed beneficiaries; per capita costs for beneficiaries with specific conditions—diabetes, chronic obstructive pulmonary disease, coronary artery disease, and heart failure; and the Medicare Spending per Beneficiary measure.

All cost measures are classified into one of two cost domains—the cost for all attributed beneficiaries domain and the cost for beneficiaries with specific conditions domain. All stages of the per capita cost of all attributed beneficiaries measure and the four per capita costs for – four per capita costs –four per capita costs for beneficiaries with specific conditions measures are based on Medicare-allowed charges for Medicare Part A and Medicare Part B claims during the period of performance that was submitted by all providers for Medicare beneficiaries attributed to your TINs for these measures.

CMS attributes beneficiaries for these measures to a single TIN through a two-step process that takes into account the level of primary care services received and the provider specialties that perform these services. This is the same attribution system that is used for the claims-based quality outcomes measures.

Additional information on those attribution methodologies is available in the Fact Sheet for Attributions in the 2017 Value Modifier located at the – on the 2015 QRUR and 2017 Value Modifier website. This website also contains measure information forms for the five per capita cost measures. For the MSPB measure, per episode costs are based on Medicare Part A and Medicare – Part A and Part B allowed amounts surrounding specific in-patient stays 3 days prior to admission through 30 days post-discharge for episodes attributed to your TIN for this measure.

CMS attributes MSPB episodes to the one TIN responsible for the plurality of carrier services as measured by Medicare-allowed amounts performed by EPs during the

This document has been edited for spelling and punctuation errors.

episode's index hospitalization. For more information on the MSPB measure, please refer to the measure information form Medicare Spending per Beneficiary Measure available on the 2015 QRUR and 2017 Value Modifier website.

All cost measures do not reflect the actual cost billed through claims but instead reflect prices that have been standardized to facilitate more accurate comparisons to peers. Specifically, CMS standardizes cost data from claims to account for differences and allow charges that are unrelated to the care provided—for example, regional variations in costs—and then risk adjusts and specialty adjusts the data to account for beneficiary-level risk factors and TIN-level differences in specialty mix that can affect medical cost.

For more information on the risk adjustment and specialty adjustment, how it applies to these cost measure, please refer to the fact sheets for risk adjustment in the 2017 Value Modifier and the fact sheet for specialty adjustment in the 2017 Value Modifier, which are both available on the 2015 QRUR and 2017 Value Modifier website.

Slide 37. So this concludes our discussions on the information contained in the body of the 2015 Annual QRUR. Next – there's a slide missing.

Aryeh Langer: Give us one moment please.

Fiona Larbi: So slide 32. This concludes our discussion on the information contained in the body of the 2015 Annual QRUR. Next, I'll review some of the information available in the tables that accompany the QRUR, though I will not walk through each table individually.

Accompanying Tables for the 2015 Annual QRUR

As we mentioned earlier in this presentation, these tables are referenced throughout the QRUR after each exhibit where they might be helpful to understand the data that went into the exhibit. Details on these tables with screenshots are available in the appendix to this presentation.

The 2015 Annual QRUR tables supplement the information provided in the annual QRUR exhibit. You'll have a better sense of your TIN's beneficiary population, their use of health-care services, and an awareness of the other EPs involved in your TIN's beneficiaries' care.

The tables' primary sources of information are the Medicare Part B and Medicare Part A claims from the performance period submitted by the EPs who treated beneficiaries attributed to your TIN, even if the EPs were not affiliated with your TIN.

You can use data from the tables to improve quality of care, streamline resource use, and identify care coordination opportunities for your TIN's beneficiary. For example,

This document has been edited for spelling and punctuation errors.

Tables 2 and 3 provide data that you can use to improve care coordination for beneficiaries attributed to your TIN.

Table 1 displays data to support your TIN's practice management system. You can use Tables 3 and 5 to better understand your TIN's performance on the MSPB measure and the Per Capita Cost for All Attributed Beneficiaries measure.

Table 6 is only populated for TINs that participated in an SSP ACO during 2015. It contains information on the hospitalizations of beneficiaries attributed to the TIN for the cost measures except MSPB and on beneficiaries attributed to the ACO for the All-Cause Readmission measure that were also attributed to your TIN for the cost measures.

For TINs with EPs who reported to PQRS as individuals, Table 7 displays the numerator and denominator for the percentage of EPs that avoided the PQRS payment adjustment as individuals and also displays information on their EP-level measure performance.

For more information on how to understand and use the information in each of these exhibits and associated tables, please refer to the documents understanding your annual QRUR, which is available in the CMS website. You can download these tables in Microsoft® Excel® and analyze the data. For Excel analysis using the beneficiary-level data, you may remove personally identifiable information by deleting the first three columns of the exhibit and relying instead on the non-personally identifiable index column to link beneficiaries through exhibits.

So, yes. Next slide please, which I believe slide 33. If your TIN – actually you can go to slide 34. Thank you. If your TIN is subject to the Value Modifier in 2017 and you disagree with the VM calculation, then a representative from your TIN with one of the group or solo practitioner roles in EIDM can submit a request for an informal review through the CMS Enterprise Portal.

The 2017 Value Modifier formal review period began on September the 16th – September the 26th, 2016—the day the annual QRURs were released—and it ends on November the 30th, 2016, at 11:59 pm eastern standard time. The same EIDM account, user ID, and password can be used to access the QRURs and submit an informal review request.

Slide 34. So this slide shows how you would have to go into it to submit a request in an informal review. You will need to navigate to the CMS Enterprise Portal at the website listed on the slide here and select login to the CMS Secure Portal, which is highlighted by the arrow on the screenshot, on the right of the screenshot.

Slide 35. Once you log in, you will see the Terms and Conditions screen. You have to please read the terms and conditions and select "I Accept" to continue. Note that

This document has been edited for spelling and punctuation errors.

selecting “Decline” will end the session and return you to the CMS Enterprise landing screen.

Slide 36. After accepting the Terms and Conditions, you will need to enter your EIDM user ID and select “Next.”

Thirty-seven. This slide highlights the Multi-Factor Authentication or MFA Process that will need to be completed each time you log into the CMS Enterprise Portal. Note that you previously registered to complete the MSA process when setting up your Physician Quality and Value Program account. Please ensure that you select the same MSA device type selected during your initial account setup. Once you select MSA device type, select “Send” to receive the security code. Retrieve and answer the security code and select “Login.”

Slide 38. Once you are logged into the portal, select “Value Modifier Informal Review” from the PV-PQRS drop down menu.

Slide 39. This slide shows the Value Modifier Informal Review interface. On the Value Modifier History table, you will see a list of the TIN or TINs that are associated with your EIDM account. To request an informal review for the 2017 Value Modifier, select “Request Informal Review” under the action column on the right of the TIN for which you want to request an informal review. A message will be displayed providing information for you to review before beginning an IR request.

After reading the information provided, select “OK” to continue. The IR request screen will be displayed. There are three sections to a VM IR request. Requested Contact Information—you will need to re-verify the EIDM pre-populated information.

Informal Review Information—you’ll need to select “Add” to add a reason for informal review and “User Attestation.” You must accept the user attestation when all relevant reasons for informal review have been added prior to submitting the informal review request. And the “Submit” button will be disabled until the user attestation has been accepted.

For more details and step-by-step guides on how to request an informal review, modify, or cancel the informal review please refer to the 2017 Value Modifier and informal review request quick reference guide which is available on the 2015 QRUR and 2017 Value Modifier website.

Next slide, which is slide 40, please.

This slide details next steps and what you can do. The most important thing will be to download your TIN’s 2015 Annual QRUR and 2015 PQRS feedback reports so that you can review your TIN’s performance on the quality and cost that is – for 2017 VM. And

This document has been edited for spelling and punctuation errors.

also you will find a link to review the frequently asked questions, fact sheet, detailed methodology, and other QRUR supporting documents, which will be very beneficial while reviewing your 2015 Annual QRUR.

Next one.

And this last slide just explains and gives information for technical assistance should you need help with accessing or downloading any of your reports. Thank you.

Question-and-Answer Session

Aryeh Langer: Thank you very much, Fiona.

Our subject matter experts will now take your questions about the 2015 QRURs. Throughout the question-and-answer session, we will ask webcast participants to provide feedback about their experience with the technology used today. Remember to disable your pop-up blockers for best results. We will begin our session by fielding a few questions that we received from webcast participants, and we'll then alternate to questions from the phone.

We will also address some of the questions asked during the registration. Operator, could you please prompt the telephone users and begin to compile that Q&A roster?

Operator: Certainly. If you would like to ask a question, simply press star then the number one on your telephone keypad. Again that's star one on your telephone keypad. If you would like to withdraw your question press the pound key.

Our first question on the phones will come from the line of Sharon Marcolina.

Sharon Marcolina: Hi. Thank you so much for everything, you're helping us very nicely. I just wanted to know how it would work when it comes to this payment adjustment? Hello?

Aryeh Langer: Hello. Can you hold one moment please?

Sharon Marcolina: Sure.

Sabrina Ahmed: So the Value Modifier payment adjustment is applied to claims that physicians would bill under a TIN that's subject to the Value Modifier in 2017. And the Value Modifier would apply to the physicians' payments for items and services that are furnished under the Medicare Physician Fee Schedule.

Sharon Marcolina: In other words each individual claim would see this adjustment or at the end of the year?

This document has been edited for spelling and punctuation errors.

Sabrina Ahmed: Yes. Yes. So, it's made on a claim-by-claim basis. The adjustment ...

Sharon Marcolina: It is.

Sabrina Ahmed: ... is made on a claim-by-claim basis.

Sharon Marcolina: All right. I had pulled out my report, the Annual Quality and Resource Use Report, and mine is saying neutral adjustment 0.0.

Sabrina Ahmed: Yes. So your physician's payments in 2017 will not be adjusted.

Sharon Marcolina: Thank you so much.

Aryeh Langer: OK, thank you very much. We're going to take one of the questions now that was submitted. We received several questions about how beneficiaries are attributed to the five per capita cost measures and the Medicare spending per beneficiary measure.

Please refer to the fact sheet for attribution in the 2017 Value Modifier for an overview of the two-step attribution methodology used to attribute beneficiaries to TINs for the claims-based quality outcome measures and five per capita cost measures in the 2017 Value Modifier.

Please also refer to measure information for Medicare spending per beneficiary measure for information on how MSPB episodes are attributed to TINs. These documents can be found on the 2015 QRUR and 2017 Value Modifier website.

We also have a question: Can you please indicate where the list of beneficiaries attributed to a given TIN appears for the MSPB and other direct cost of care measures on the QRUR?

And the answer is table 5B in the 2015 Annual QRUR displays the beneficiaries and episodes attributed to your TIN for the MSPB measure. Refer to table 3B for information about the beneficiaries attributed to your TIN for the per capita cost measures. You may filter by the column included in the per capita cost for all attributed beneficiaries to identify the subset of beneficiaries who are included in this measure.

You may continue to filter by chronic condition subgroup to determine beneficiaries who are included in each per capita cost for beneficiaries with specific conditions measure. For additional details, please see the How to Understand Your 2015 Annual QRUR document available on the 2015 QRUR and 2017 Value Modifier website.

Let's take another question now. How are the cost of Part B drugs factored into the QRUR, and will these cost be visible to all physicians treating the Medicare patient?

This document has been edited for spelling and punctuation errors.

The answer is Part B covered drugs are included in the cost measures in the same way as other Part B covered costs. Tables 3A, 4A, 4B, 4C, 4D, and 5C display your TIN's risk and specialty adjusted cost by service category for each of the cost measures displayed on your QRUR.

This includes chemotherapy and other Part B covered drugs under "all the other services" heading. The cost of care for a beneficiary or episode of care are only shown in the QRUR and associated tables of the TIN to which that beneficiary or episode was attributed. Therefore, these costs will not be visible to a TIN that treated a patient if the TIN was not attributed to the beneficiary or episode.

Our next question is, if we were a member of an MSSP in 2015, will our payments in 2017 be based on the performance of the whole ACO or is it based on the performance at the NPI level?

And the answer is for TINs that participated in a Medicare Shared Savings Program ACO in 2015, quality-tiering will be based on the performance of the entire ACO, specifically performance of the ACO on the GPRO Web Interface measures and the 30-day All-Cause Hospital Readmission measure. However, please note that the magnitude of your TIN's Value Modifier will still depend on the size of your TIN.

For more information, please see the document title Medicare Shared Savings Program Interaction with the 2017 Value Modifier Frequently Asked Questions, which is available on the 2015 QRUR and 2017 Value Modifier website.

Let's go ahead and take a question from the line please.

Operator: All right. Our next question will come from the line of Sandy Pogones.

Sandy Pogones: Hi, this is Sandy, and my question was just answered. Thank you very much.

Aryeh Langer: I'm sorry, we can't hear you. Could you speak up, please?

Sandy Pogones: Yes, my question was just answered. Thank you.

Operator: Our next question will come from the line of Misha Diden.

Misha Diden: Hi. I had a question regarding the actual results of our QRUR. We have submitted via GPRO through our EHR and on our PQRS Payment Adjustment Feedback Report, it indicates that, you know, the method of reporting, that we report as a group practice, and it says "Payment adjustment assessment rational, insufficient number of domains in Medicare patients." However, when you scroll over to the total measures

This document has been edited for spelling and punctuation errors.

reported it indicates nine, the total measures reported satisfactorily, it indicates nine, and the domain measures satisfactorily reported, it indicates three.

When we look at our actual QRUR, it indicates that we were subject to the automatic downward adjustment of 4 percent because, you know, we did not report through the GPRO and less than 50 percent of eligible professionals in our TIN met the criteria.

And so, I'm not sure why there's a discrepancy, and additionally when we look at the detail on the adjustment measure performance detail report there are measures that are captured that we didn't report on and then other measures that we did report on are not reflected.

Sophia Autrey: Hi, this is Sophia Autrey, and it sounds like we probably need to do a more thorough review of your submission. So, I'm going to ask that you submit an informal review. It seems that there are some discrepancies in what you guys reported as well as what is indicated on the report. So we want to makes sure...

Misha Diden: OK.

Sophia Autrey: ...that that's correct. So if you can do that that will be great.

Misha Diden: OK, sounds good, thank you.

Fiona Larbi: This is Fiona from the VM team. If you do that, could you submit an informal review for PQRS and the VM—they have to be done separately—please?

Misha Diden: Oh, OK. Is it done in the same place on the portal?

Fiona Larbi: The VM one is down the portal, but you have to go to the CSP page, which is the Communications Support Page, for the PQRS, to do the PQRS informal review.

Misha Diden: The Communications Support Page. Is it in the same portal.cms.gov?

Fiona Larbi: I don't think so.

Misha Diden: Yes, I don't think it is either. Can you point me to where that would be?

Aryeh Langer: One moment please.

Sophia Autrey: We'll look it up and provide the information later on in the call.

Misha Diden: OK, thank you.

This document has been edited for spelling and punctuation errors.

Aryeh Langer: Thank you. We'll go ahead and take another question from the webcast. How is the performance rate calculated when a provider reported a PQRS measure using more than one method, for example, via direct EHR and a measure group?

Lara Converse: Hi, this is Lara Converse from the VM team. So for TINs evaluated based on PQRS data submitted by individual eligible professionals, the performance rate on PQRS measures for the Value Modifier is calculated as a weighted average of the performance rate submitted via any reporting method for all EPs in a TIN who avoided the PQRS payment adjustment.

Aryeh Langer: Thank you. Next question, our report says that our EPs are eligible for 2017 PQRS payment adjustment assessment. What does this mean?

Lara Converse: So the 2017 PQRS payment adjustment is a downward payment adjustment that applies to individual eligible professionals or PQRS group practices that have not satisfactorily participated in PQRS in program year 2015. For the purposes of the Value Modifier, if a TIN does not meet PQRS reporting requirements as a group practice or at least 50 percent of EPs in the TIN do not meet the criteria to avoid the PQRS payment adjustment, the TIN is classified as Category 2 for the VM and it's subject to the automatic downward Value Modifier payment adjustment.

Aryeh Langer: Thank you. Next question: We submitted per individual providers, not per group. So does the payment adjustment only applied to certain individuals who score less than 50 percent in only one measure or does the payment adjustment apply to the entire facility? Also, if an individual physician passes four out of five measures, do they pass or not?

Jeff Ballou: An individual provider that fails to report PQRS measures satisfactorily to avoid the PQRS payment adjustment will be – will have a PQRS penalty as an individual; the entire group won't be penalized for that. However, if fewer than 50 percent of individuals reporting PQRS for the group fail to avoid the PQRS payment adjustment, I should say if more than 50 percent fail to avoid the PQRS payment adjustment, then there will be a Value Modifier payment adjustment that will be applied to the entire group, not just to the individuals.

Aryeh Langer: Thank you. The next question in the webcast: Does the Value Modifier apply to critical access hospitals who bill under Method II billing?

Jeff Ballou: And the answer is that it does not. If individual providers participate or provide care through a Method II critical access hospital but also provide care in another location that is not a critical access hospital and bill Physician Fee Schedule services there, those providers could be subject to the Value Modifier. But if they provide services only in a critical access hospital setting that bills under Method II, it would not be subject to the Value Modifier.

This document has been edited for spelling and punctuation errors.

Aryeh Langer: Thank you. Our next question is: My TIN is comprised of both – is comprised, excuse me, of both physicians and non-physicians. However, we registered and reported PQRS as a GPRO in calendar year 2015. We received a negative 2 percent penalty adjustment for the calendar year 2015 QRUR. Will this penalty only apply to the individual physicians in the TIN or will it apply to all providers within the TIN since we reported as a GPRO? Please answer in detail.

Jeff Ballou: The Value Modifier payment adjustment will only apply to physicians billing for Medicare Physician Fee Schedule services under the TIN in 2017.

Aryeh Langer: Thank you. Our next question is: What if the practice did not participate in PQRS in 2015?

Sophia Autrey: If eligible professionals within your practice had Medicare Part B claims in 2015 and they did not participate in PQRS, they will receive a 2 percent payment adjustment, a negative 2 percent payment adjustment.

Female: On the PQRS.

Sophia Autrey: On the PQRS, sorry.

Aryeh Langer: Thank you. Our next question: What if the practice did not part – I'm sorry. Why would a provider not associated with my TIN appear on the detail list? What would cause that error?

Jeff Ballou: The answer is that a provider not associated with the TIN that could appear on Table 1, detailed Table 1 associated with the QRUR if they were, at one point, associated with the practice and were associated with the practice in July of last year when CMS checked to assess which providers were associated in the provider in the PECO System with the practice. If they have since left the practice and are no longer billing, they might still appear in Table 1 of the detailed tables.

Aryeh Langer: Thank you. Another question that was received on the registration site. How are measures group results benchmarked and evaluated for under quality-tiering for the Value Modifier?

And the response is, for measures in a PQRS measure group, each individual measure is treated as a separate measure, like any other measure, for purposes of benchmarking and for computing a TIN's quality composite score.

Our next question from the webcast: How will Value-Based Modifier be applied to providers who have recently joined the organization who were not with us in 2015?

This document has been edited for spelling and punctuation errors.

Jeff Ballou: Providers who joined the organization after 2015, if they are physicians billing under that organization's taxpayer identification number, in 2017 they will receive the Value Modifier payment adjustment on the 2015 QRUR based on the performance of those who were participating in that group practice during 2015.

Aryeh Langer: Thank you. Our next question: If your vendor reported more than nine measures, does CMS pick the best nine?

Jeff Ballou: The answer is no, not necessarily. If the vendor reported more than nine measures and avoided the PQRS payment adjustment, then all measures meeting the minimum case size, which is 20 for PQRS measures, which have a benchmark, will be included in Value Modifier calculations.

Aryeh Langer: Thank you. Our next question from the webcast: Can more than one person have this security role for EIDM?

Sabrina Ahmed: Yes. So, in order to access the TIN's QRUR, you need to have at least one person from their group get the correct EIDM account, but more than one person from a group can request EIDM accounts in order to access the group's QRUR.

And I just want to mention that if you look at appendix slide 53, you'll see that the first person from the group, if you're a group practice, the first person from the group who gets an EIDM account must first sign up for an EIDM account with the Security Official role and then all other subsequent people can request either the Security Official role or the Group Representative role in the EIDM.

And if you're a solo practitioner, then the first person on behalf of the solo practitioner who wants to access the QRUR needs to sign up for the Individual Practitioner role and then all other subsequent people who want to access that solo practitioners' QRUR would need to get either the Individual Practitioner role or the Individual Practitioner Representative role in the EIDM.

And if you look at slide 55 in the appendix, you'll see, you know, what you can do with the group and the individual roles and how they differ from each other.

Aryeh Langer: Thank you very much. Let's go ahead and take a question from a caller, please.

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

Rebecca Hancock: Hello. My question is, are the QRURs the only way for practices to find out if they are subject to a negative Value Modifier payment adjustment? Or will there also be a letter sent out to those practices like is, you know, like is currently done for the PQRS program?

This document has been edited for spelling and punctuation errors.

Sabrina Ahmed: So yes, so in order for a group to know, in order for a TIN to know whether it's subject with the – a Value Modifier or not, someone from the TIN would need to access the QRUR. We're not sending out letters to the group similar to the PQRS payment adjustment letters.

Rebecca Hancock: OK, thank you. I have one follow up question. Earlier I heard someone mentioned that you have to file an informal review for both PQRS and the Value-Based Modifier separately. So if you find out that you are subject to a negative PQRS adjustment, but you think that's an error so you request an informal review, should you also request one for the Value-Based Modifier or would your Value-Based Modifier score automatically be updated after the PQRS informal review is complete?

Kimberly Spalding Bush: Thanks, this is Kim Spalding Bush, and that was a great question. While we do coordinate with the PQRS team, I work on the VM side, we would advise you to go ahead and file both through PQRS and Value Modifier informal reviews just to make sure that you've got sort of a double check, that your issue is going to be caught on both sides. But we do work with the PQRS team. We coordinate with them if a PQRS decision were to result in a change to the Value Modifier.

For example, if the PQRS team determines that they were going remove a number of eligible professionals from their downward adjustment file and that resulted in a group meeting the 50-percent requirement threshold for the Value Modifier, then the Value Modifier would accordingly remove that group from the Value Modifier downward adjustment. But we would still advise you to go ahead and file your informal review request on both sides just to make that you've got both of the bases covered.

Rebecca Hancock: OK, thank you.

Aryeh Langer: Thank you very much. Our next question that was submitted through the webcast: Can other individuals be granted access to the information in the portal? Or is it a one person access only?

Sabrina Ahmed: Yes, so I kind of addressed this question earlier. So, at least one person from the group needs to have an EIDM account with the Security Official role, but any number of groups can request access to the QRURs by requesting either the Security Official role or the Group Representative role.

So after the first person is approved for EIDM role on behalf of the TIN, all the subsequent requests will be routed to the group Security Official. And that person will need to approve all other requests for EIDM accounts.

This document has been edited for spelling and punctuation errors.

Aryeh Langer: Thank you very much. Our next question: I have an EIDM account for our ACO but I'm not able to get the QRUR for the TINs that are in our ACO. How can we get the QRUR for the TINs in our ACO?

Sabrina Ahmed: So the QRURs are not provided directly to the ACOs. They are provided to the participant TINs. So, if a group want to give access – so if a participant TIN wants to give access to its QRUR to its ACO, then the ACO would first – a representative from the ACO would first need to submit a request for an EIDM account with the appropriate role to the participant TIN's Security Official.

And that request would need to be done through the EIDM, and then the participant TIN Security Official would have to approve that request. And then after the request is approved for the EIDM account, then a representative from the ACO would be able to access the participant TIN's QRUR. But it is a process that the ACO would need to work out with their participant TIN because we don't directly provide QRURs to the ACOs.

Aryeh Langer: Thank you. Our next question that was submitted through our registration site: Do critical access hospitals that have rural health clinics get QRURs?

And the answer is, the 2015 Annual QRURs are provided to groups and solo practitioners as identified by their Medicare-enrolled TIN with at least one eligible professional who billed Medicare Part B during 2015. Thus, critical access hospitals identified by a CCN rather than a TIN would not get a QRUR.

Another question that was submitted: Please provide an explanation on how to interpret the results and how to make changes.

Several documents on the 2015 QRUR and 2017 Value Modifier website can assist you in understanding the information provided in the 2015 QRURs.

For example, Questions and Answers about the 2015 QRURs and 2017 Value Modifier How to Understand Your 2015 Annual Quality and Resource Use Report, and several fact sheets and measure information forms.

Our next question is submitted through the webcast: If reporting a measure group as an individual practitioner, how does this affect this?

Sophia Autrey: Affect the QRUR?

Aryeh Langer: One moment, please.

Sophia Autrey: Hi. Yes, so PQRS measures supported through the measures group reporting option are treated like any other measure for the purposes of the Value Modifier. That is, if the Value Modifier is calculated based on PQRS data reported by individual eligible professionals, the VM will take a weighted average of all performance

This document has been edited for spelling and punctuation errors.

rates for that measure submitted by EPs to avoid the PQRS payment adjustment. If there's a benchmark for the measure and the TIN has at least 20 eligible cases, the weighted average performance rate is used to compute the quality composite.

Aryeh Langer: Thank you very much.

Our next question: What is the adjustment factor equal to? If we have a one-time adjustment factor what does that mean?

Kimberly Spalding Bush: Thank you. So, we have not yet calculated the upward adjustment factor under the Value Modifier. But if you have one TIN in the adjustment factor that means that for your 2017 payment to physicians in – under your taxpayer ID number, under the Medicare Physician Fee Schedule, you're going to see an upward adjustment for each claim.

Now, the adjustment factor gets calculated after the end of the performance period and as we've completed as many of our informal review request determinations as possible, because the way that the Value Modifier program is set up, it redistributes all of the downward adjustments to those physicians who performed well under our cost and quality measures.

So we have to wait until all the performance is calculated and as many of the informal review requests are processed as possible to make a determination of what factor it will be that would redistribute all of those downward adjustments to our high performers.

Aryeh Langer: Thank you. Our next question submitted through the webcast: Why are only certain measures included in the domain score? Did CMS include highest scores? We performed high on one of the measures but it was not included in the domain score.

Jeff Ballou: There are couple of reasons – go ahead, please.

Kimberly Spalding Bush: Go ahead, Jeff.

Jeff Ballou: There are a couple of reasons why you might not have a measure included in the domain score. There is a minimum case size that must be met. So if you had fewer than the required number of eligible cases for the measure, even if you performed well, that would not be included in the domain score. And also if there wasn't a benchmark for that measure, it would not be included in the domain score.

Aryeh Langer: Thank you very much. Our next question submitted through the webcast: Why would you not show up on the scatter plot?

Sabrina Ahmed: So, you would show up on the scatter plot only if we were able to calculate a quality composite score and a cost composite score for your TIN. So, if we

This document has been edited for spelling and punctuation errors.

were not able to calculate either of those scores for your TIN, then it would show up in the scatter plot.

Aryeh Langer: Thank you. Our next question submitted: I find it extremely frustrating to open QRUR reports and find that I need up to nine landscape pages to print them. Do you have any suggestions on how I can print them on a minimum number of pages?

Kimberly Spalding Bush: Thanks for the question. We actually don't have a way for you to be able to print the tables on fewer pages. You can print the body of the QRUR report as a PDF. And that would minimize the number of pages and it would come out in an easily printable format. But because of the volume of data that's included in the tables, unfortunately they do take a lot of pages to print.

Aryeh Langer: Thank you very much. Let's take one final question from the phone lines, please.

Operator: Our question will come from the line of Stephanie Wizner.

Stephanie Wizner: Hello. Can you hear me?

Aryeh Langer: Yes, go ahead.

Stephanie Wizner: Well this is kind of a followup to the question a couple of questions ago where one of the measures we submitted is not appearing. But we know that there is a benchmark and we know that we would've had more than 20 eligible cases. It's actually for breast cancer screening. Are there any other reasons why it wouldn't show up there or what can we look into to understand that better?

Lara Converse: Hi. So this is PQRS number 112 that you think is missing?

Stephanie Wizner: Yes.

Lara Converse: So that measure, I believe is excluded from the Value Modifier for reporting via Electronic Health Record or for QCDR due to some technical issues with that measure.

Lara Converse: OK.

Stephanie Wizner: OK.

Lara Converse: Thank you.

Stephanie Wizner: Thank you.

This document has been edited for spelling and punctuation errors.

Aryeh Langer: OK, thank you very much. Our next question submitted through the webcast: If more than 50 percent of your group submitted PQRS data – I'm trying to ascertain what's written here. Will those who did not submit receive a downward PQRS adjustment?

Sophia Autrey: No. So if you have more than 50 percent of your group practice that actually reported, and the group did not receive a payment adjustment, those members or EPs within your group that did not report will not receive a payment adjustment.

Aryeh Langer: Thank you. Our next question: When will the adjustment factor for 2017 be published?

Sabrina Ahmed: So, as we mention earlier, the adjustment factor has not yet been calculated. Once it's available, we will post it on the 2015 QRUR and 2017 Value Modifier website. And we'll also announce the availability of the adjustment factor through notices that will be sent through the PQRS Listserv and through eNews.

Aryeh Langer: Thank you. Our next question: How does the beneficiary's high-risk get calculated?

Jeff Ballou: Each Medicare beneficiary is assigned a risk score that indicates their relative risk based on their age, sex, medical conditions, and so on. Roughly speaking, how much Medicare expects that that beneficiary might cost in the future.

To determine the high-risk bonus adjustment or the additional payment for treating high-risk beneficiaries, we look at all of those Medicare beneficiaries' risk scores nationwide and we determine the 75th percentile of that distribution. We then take the beneficiaries attributed to a group practice or solo practitioner physician and take the average of those beneficiaries' risks scores. If that average is higher than the 75th percentile, then assuming the group or solo physician is subject to the Value Modifier in that and performs well, then that group or solo physician will be eligible to get the additional adjustment for treating high average-risk beneficiaries.

Aryeh Langer: Thank you very much. Our next question: How is an EP considered high or low cost?

Jeff Ballou: An EP technically by him or herself is not high or low cost; the Value Modifier evaluates entire groups or solo physicians as identified by their medical – Medicare-enrolled taxpayer identification numbers. And that cost determination is based on the taxpayer identification number's performance on a variety of cost measures.

This document has been edited for spelling and punctuation errors.

Each physician then billing under that taxpayer identification number in 2017 will have their Value Modifier applied to them accordingly based on how that group performed in 2015 on both cost and quality.

Aryeh Langer: Thank you very much. We have time for one final question submitted through the webcast. How our peer groups defined? If we have nine providers, is our peer group – excuse me – all TINs with the same number of providers.

Jeff Ballou: And the answer is that it is not. Peer groups vary on a measure-by-measure basis. For a given measure that is either reported by a group or calculated by CMS from claims, the peer group is all entities with the same measure and with the minimum number of required cases for that measure. That would be the peer group for each measure and, obviously, because through PQRS different groups can report different measures, the size and composition of a peer group will vary from measure to measure.

Sophia Autrey: Hi. This is Sophia Autrey again. I just want to go back to the question that asks how to submit an informal review for PQRS. You can go to the Quality Reporting Communication Support page on cms.gov and submit an informal review. If you don't know where that page is, we have An Informal Review Made Simple on the PQRS website where you can go there and there's a link on that document that takes you directly to the informal review page. Thank you.

Fiona Larbi: The other thing with the – submitting an informal review on the CSP page, there is actually a drop down for the VM informal review on the CSP page. If you actually click on to that, a little box will pop up and then there'll be a link to click on to which will take you actually our portal. So if you're already in the PQRS CSP page you can then, once you submitted your PQRS informal review, click on the informal review tab and get transferred to the portal that way.

Additional Information

Aryeh Langer: And unfortunately we have run out of time today. On Slide 44, you'll find information to evaluate your experience with today's event. We will also push out the link for our webcast participants. The evaluations are anonymous, confidential, and voluntary. As a reminder, disable your popup blockers for best results.

I'd like to thank our presenters here at CMS. And also thank you for participating in today's MLN Connects event on the 2015 QRURs. Have a great day, everyone.

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

-END-

