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National Provider Call Transcript

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Centers for Medicare & Medicaid Services
How to Report Across 2016 Medicare Quality Program Call
MLN Connects National Provider Call
Moderator: Aryeh Langer
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call.

All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

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

Announcements and Introduction

Aryeh Langer: Thank you, Holley. And as you just heard, my name is Aryeh Langer from the Provider Communications Group here at CMS, and I am your moderator for today's call. I would like to welcome you to this MLN Connects National Provider Call on the Physician Quality Reporting System or PQRS.

Today's topic will be How to Report across 2016 Medicare Quality Programs. MLN Connects Calls are part of the Medicare Learning Network®. During today's call, CMS subject matter experts will help you learn how to report quality measures during the 2016 program year to maximize your participation in Medicare quality programs, including the Physician Quality Reporting System or PQRS, Medicare Electronic Health Record for EHR Incentive Program, Value-Based Payment Modifier or Value Modifier, and the Medicare Shared Savings Program. A question-and-answer session will follow today's presentation.

Before we get started, I have a couple of brief announcements.

You should have received a link to the slide presentation for today's call in previous registration emails. If you have not already done, please download the presentation now from the following URL: http://www.cms.gov/npc, as in National Provider Call. Again, that URL is http://www.cms.gov/npc. At the left side of the webpage, select National Provider Calls and Events, then select the date of today's call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when materials become available.

Finally, this MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit. For additional information, please refer to slide 37 of today's presentation for a link to the CE activity information and instructions document.

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

Presentation

Tim Jackson: Good afternoon, everyone. So, we're going to go ahead and get started.

We are on slide 3, which lays out our agenda and learning objectives. And today we will review how to report across the 2016 Medicare quality programs for individual professionals or EPs, as we refer to them, group practices, Medicare Shared Savings Program, accountable care organizations, and Pioneer and Next-Generation accountable care organizations. This is what we call an intermediate-level national provider call. It is designed for participants who have 1 to 3 years with the Physician Quality Reporting System Program and have knowledge and experience at that level.

This presentation addresses more complex program information. If you're a beginner-level participant, please refer to the CMS PQRS How to Get Started webpage. At the end of this session, we will review some resources, including How to Get Started webpages and other websites to get help. And we will do that before we open the floor for our Q&A. So, there's about 35 slides, if I recall correctly, that we're going to go through together. And, then, we will engage in that Q&A.

Please note, if you're reporting for PQRS through another CMS program as the CPC or Comprehensive Primary Care initiative, please check your own program requirements for information on how to report quality data to avoid the PQRS downward payment adjustment. Let me just speak to that for a minute.

So, functionally, PQRS has 28 different ways to report. Nine of those are for individual options and 19 are for group options. So, just want to make sure that if you have a question and it's not addressed here, remember, there's 28 different ways to turn in your information to avoid that payment adjustment, and there are a lot of specifics at the program level.

Please note -- and we are aligning and adopting as many reporting requirements across the programs as possible. And we do know that it is a burden, and we do hear you on the challenges that are involved with that. Particularly, we should look at respective quality programs, ensuring that the -- you can satisfy the PQRS, the Electronic Health Care Record Incentive Program and the Value-Based Payment Modifier or Value Modifier requirements. And we will review that in our slides today.

Now, we're moving on to slide 4. Slide 4 is a lot of the acronyms that I had just referenced and a few others. Again, for your convenience, at the bottom this slide deck, there's a slide with all the acronyms, and you can click on Acronyms and that slide will take you at any point back here during the presentation if you are going through it in view mode on a desktop or on a screen somewhere.

2016 Reporting: Individual EPs

So, slide 5. We are now going to get started with looking at eligible professionals and reporting across Medicare quality programs in 2016.

Slide 6. Individual eligible professionals can satisfactorily report quality measures in 2016 to avoid the 2018 PQRS downward payment adjustment, satisfy clinical quality measure components of the Medicare EHR Incentive Program and avoid the automatic downward adjustment and quality for upward, neutrals, or downward adjustments based on performance under the Value Modifier also in 2018 if at least 50 percent of the EPs in a TIN satisfactorily report as individuals in order to avoid the PQRS payment adjustment.

Please note, in 2018, the Value Modifier will apply payments made under the Medicare Physician Fee Schedule. So all physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists in groups of two or more, and those who are also solo practitioners – that's important to note that solo practitioners is a change. Groups and solo practitioners are identified by their Medicare-enrolled taxpayer identification number, which we call a TIN or T-I-N -- TIN. And physicians, PAs, nurse practitioners, CNSs, and CRNAs who are solo practitioners can avoid the automatic downward 2-percent Value-Modifier payment adjustment in 2018 by participating in PQRS as individuals in 2016 and by meeting the satisfactory reporting criteria to avoid the 2018 PQRS downward payment adjustment.

Physicians, PAs, NPs, CNSs, and CRNAs in groups can also avoid the negative 2 and negative 4 Value Modifier payment adjustment, depending on the composition and size of the group, by participating in the PQRS Group Practice Reporting Option, which we'll cover later, and meeting the satisfactory reporting criteria to avoid the 2018 downward payment adjustment from PQRS.

Alternatively, they can ensure that the group participating in PQRS as individuals in 2016 and at least 50 percent of the EPs in the group meet the satisfactory reporting criteria to avoid the 2018 PQRS downward payment adjustment.

There's a lot on that slide. And I'll take one second here to review again, and then we'll go ahead and go to slide 7.

Slide 7 is starting a table that describes how to report across programs for individual EPs. I know I referenced a little bit about groups. We're going to cover those in a few slides. Here on slide 7, we kind of walk the process through step-by-step.

First, determine if you are an individual eligible professional by reviewing the list on the Get Started webpage. Remember, this means you are not a member of a group, registered by a group, and did not sign over your taxpayer ID or billing rights to any other element. You bill yourself.

Second, choose the PQRS electronic reporting using the direct EHR product certified electronic health care record, or CEHRT, or an EHR data submission vendor that is CEHRT or qualified clinical data registry. So those are your options under two.

And then what you're submitting in number three is at least nine measures covering at least three of the National Quality Strategy, or NQS, domains. If an eligible provider's CEHRT does not contain patient data for at least nine measures covering at least three NQS domains, then the EP must report the measure or measures for which there is a Medicare patient data. An EP must report at least one measure containing Medicare patient data. Reporting data on all payers is also required.

The reporting period is 12 months. That starts from January 1, 2016, and runs through December 31, 2016. Refer to the EHR Incentive Program website documents for a listing

of measures that satisfy the CQM component, and then utilize the ECQMs for those measures.

So before we move on to slide 8, we're going to pause. Quick correction. After slide 8, we're going to pause.

So, we are on slide 8. If an individual EP satisfactorily reports under PRQS for 2016, he or she will avoid the 2018 PQRS downward payment adjustment of negative 2 percent, satisfy the CQM component of the Medicare EHR Incentive Program, and avoid the automatic downward payment adjustment and quality for upward, neutral, or downward adjustment based on performance under the Value Modifier in 2018 if at least 50 percent of the EPs in a TIN satisfactorily report as individuals in order to avoid the 2018 PQRS downward payment adjustment. Amounts will vary by the composition and size of a TIN. Please, again, refer to the "How to Report Once for 2016 Medicare Quality Reporting Programs" documents for further details.

If an EP does not satisfactorily report for PQRS in 2016, he or she will be subject to the 2018 PQRS downward payment adjustment, not satisfy the CQM component of the Medicare EHR Incentive Program, and be subject to the automatic downward Value Modifier payment adjustment in 2018 if less than 50 percent of the EPs in the TIN satisfactorily report as individuals in order to avoid the 2018 PQRS downward payment adjustment. Amounts here, again, will vary by composition and size of the TIN.

Keypad Polling

Aryeh Langer: Okay. Thank you, Tim.

Before we get into our next section of the presentation, we'll pause a few moments to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note, there will be a few moments of silence while we tabulate the results.

Holley, we're ready to start the 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 one. 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 nine. Again, if you are the only one in the room, enter one. 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 nine.

Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Again, continue to hold while we complete the polling.

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

Aryeh Langer: And I'm going to go ahead and turn the call back over to Tim for the next portion of our presentation.

Presentation Continued

Tim Jackson: Great. Thank you.

So, we are on slide 10, everyone. I think the number of folks on the call today is a little over 2,000. So, thank you very much. And we look forward to going through the rest of this together and getting to that Q&A.

Group Practices

So on slide 10, we are starting to discuss the group practices and the reporting satisfactory requirements for quality measures. And this involves avoiding the downward payment adjustment, again, satisfying the CQM component of the Medicare EHR Incentive Program, and avoiding the automatic downward payment adjustment and qualifying for upward, neutral, or downward adjustment in the performance of the Value Modifier in 2018.

We are moving on to slide 11. So this is, again, the step-by-step. I am a PQRS EP who has assigned billing rights to a group practice taxpayer ID number or TIN. I have registered for PQRS under one of these reporting mechanisms, a product that is CEHRT or EHR data

submission vendor that has CEHRT, qualified clinical data registry, QRDA III format, or a group practice of GPRO Web Interface.

We can move on to slide 12. Slide 12 lays out the requirements for PQRS group practices with 2 to 99 eligible professionals reporting electronically. This requires reporting on nine measures covering at least three of the NQS domains. And if the group practice's CEHRT does not contain patient data for at least nine measures covering at least three NQS domains, then the group practice must report the measure or measures for which there is a Medicare patient data available and report on all payers. Requirements for the PQRS group practice reporting -- the Consumer Assessment of Healthcare Providers and Systems, or CAHPS, for PQRS, in conjunction with reporting electronically, are optional for group practices of 2 to 99 EPs and required for group practices of 100 or more EPs. So, if you're in the 2 to 99 group, it is optional. And if you have 100 or more EPs in your group, it is required.

Finally, if you have all 12 CAHPS for PQRS summary survey measures reported on the groups that have the CMS-certified survey vendor and report on at least six of the additional measures covering two NQS domains, then you would also be satisfactory. If the additional six measures that must be reported -- a group practice is required to report on at least one measure for CEHRT Medicare patient data. If a group practice's CEHRT does not contain data for at least six measures covering at least two NQS domains, then the group practice must report for the measure or measures for which there is Medicare patient data. So, essentially, if you have it, you need to send it -- if you have that Medicare patient data. It's very, very important.

All right. Slide 13. Requirements for PQRS group practices of 2 to 99 EPs reporting via a qualified clinical data registry, or QCDR. Report on nine measures covering at least three of the NQS domains. If a group practice's CEHRT does not contain patient data for at least nine measure covering at least three NQS domains, then the group practice must report the measure or measures for which there is Medicare patient data, and you report data on all payers. Requirements for the PQRS group practices reporting CAHPS for PQRS in conjunction with reporting via a QCDR to have all 12 CAHPS for PQRS summary survey measures and report on at least six additional measures covering two of the NQS domains.

Slide 14. The requirements for PQRS group practices of 25 to 99 EPs reporting via the GPRO Web Interface is to report on all measures included in the Web Interface for the pre-populated beneficiary sample. The requirements for PQRS group practices reporting CAHPS for PQRS in conjunction with reporting via the GPRO Web Interface are – the exact is the last slide, but I will review them again for you -- 12 CAHPS for PQRS summary survey measures reported on the group's behalf via a CMS-certified survey vendor and reporting on all measures included in the Web Interface for the pre-populated beneficiary sample.

Slide 15. If a group practice satisfactorily reports under PQRS for 2106, it will avoid the 2018 PQRS downward payment adjustment of negative 2 percent, the group practice will satisfy the CQM component of the Medicare EHR Incentive Program, and the group practice will avoid the automatic downward payment adjustment and qualify for upward, neutral, or downward adjustments based on performance under the Value Modifier in 2018. Again, amounts will vary based on the composition and size of the TIN. If a group practice does not satisfactorily report under PQRS for 2016, it will be subject to the 2018 downward payment adjustment, it will not satisfy the CQM component of the Medicare EHR Incentive Program, and it will be subject to the automatic downward Value Modifier payment adjustment in 2018.

Medicare Shared Savings Program Accountable Care Organizations (ACOs)

Slide 16. Now, we will discuss how Medicare Shared Savings Program accountable care organizations, or ACOs, can report across the 2016 Medicare quality programs.

Slide 17. When Medicare Shared Savings Program ACOs satisfactorily report Web Interface quality measures during the 2016 program year, then ACO participant TINs with EPs will avoid the 2018 PQRS downward payment adjustment, they will satisfy the CQM component of the Medicare EHR Incentive Program, and they will also avoid the automatic downward payment adjustment and qualify for upward, neutral, or downward adjustments based on performance under the Value Modifier in 2018.

Note, ACO participant TINs can report out of the ACO as individual EPs or as groups practices to avoid the 2018 PQRS downward payment adjustment and avoid the automatic downward VM payment adjustment. We may have some questions on that. We will look for those in the Q&A. But here on slide 17, that's a very important note.

Slide 18. This is our step-by-step, as we've done previously twice. So, first, determine if you are a PQRS EP who has assigned billing rights to a Shared Savings Program ACO participant TIN. ACO participants provide information to the primary TIN, and the primary TIN reports this information on the participant's behalf. Then the ACO reports on all measures included in the GPRO Web Interface.

Slide 19. If the ACO satisfactorily reports on all measures included in the GPRO Web Interface, then the ACO participant TINs will avoid the 2016 -- or 2018 PQRS payment adjustment, they will satisfy the CQM component of the Medicare EHR Incentive Program, and they will avoid the automatic downward payment adjustment and receive upward, neutral, or downward adjustments based on performance under the Value Modifier in 2018. If the ACO does not satisfactorily report on all measures included in the GPRO Web Interface, then the ACO participant TINs are subject to the 2018 PQRS downward payment adjustment. They will not satisfy the CQM component of the Medicare EHR Incentive Program, and they will be subject to the automatic downward Value Modifier payment adjustment in 2018. Please reference the "How to Report Once for 2016 Medicare Quality Reporting Program" document for detail specifics.

Pioneer and Next Generation (NG) ACOs

Slide 20. Next, we will discuss how Pioneer and Next-Generation—or NG—ACOs can report across the 2016 Medicare quality programs.

Slide 21 presents the Pioneer and Next-Gen ACO quality measure reporting requirements to avoid the 2018 downward payment adjustment and satisfy CQM components of the Medicare EHR incentive Program. Note that the 2018 Value Modifier is waived for a TIN if at least one EP who bills for the Medicare Physician Fee Schedule items and services under the TIN during 2016 is a participant in a Pioneer or Next-Gen ACO in 2016.

Slide 22. Our step-by-step. Determine if you are PQRS EP who has assigned billing rights to a Pioneer or Next-Gen ACO participant TIN. Provide your information to the primary TIN, which is the ACO. And, then, the ACO then reports the information on the participant's behalf. And the Pioneer and Next-Gen ACO report on all measures in the GPRO Web Interface.

Slide 23. If the Pioneer and Next-Gen ACO satisfactorily reports, the participant TINs will avoid the 2018 PQRS downward payment adjustment and satisfy the CQM component of the Medicare EHR Incentive Program. If the Pioneer or Next-Gen ACO does not satisfactorily report for PQRS, the TINs will be subject to the 2018 PQRS downward payment adjustment and not satisfy the CQM component of the Medicare EHR Incentive Program.

FAQs

Slide 24. The following are the top five frequently-asked questions about reporting across Medicare quality programs that you might find helpful.

Slide 25. The first question asks how to report for both Medicare EHR Incentive Program and PQRS. The answer, CMS created a "How to Report Once for Reporting Programs" that outlines the various ways providers can report across the multiple programs. This document is available online. There is a link provided in the answer on slide 25, which you can click on.

Other participants asked if there are reporting -- if they are reporting as an ACO, do they have to register to report via the Group Practice Reporting Option? The answer is that participants in ACO programs will not need to register as a GPRO. Note, in 2016, ACO participant TINs will also be allowed to report outside of the ACO as individual EPs or group practices. We referenced that back on slide 16, and it's referenced here again on slide 25. Again, we will review that further in the Q&A.

Slide 26. This is a very long question and answer. We will kind of briefly –quickly here. So, some participants asked if they will be able to satisfactorily report for 2016 PQRS if nine different measures do not apply to their practice. And the answer is that in situations where nine measures cannot be reported, PQRS has the Measure Applicability Validation Process, or MAV. The MAV 2016 process for claims-based reporting of individual measures and MAV process for registry-based reporting of individual measure documents are found on the link that is selectable in the slide 26 and also on the PQRS Analysis and Payment webpage. For more information, see the process flows depicting the MAV process for both registry-based reporting and claims-based reporting.

Slide 27. Participants asked if combining reporting options—registry, claims, EHR—would successfully meet the requirements for PQRS. And the answer to that question is

although CMS will review all reporting, you cannot combine data from multiple reporting mechanisms for PQRS reporting requirements.

And the last question is, other participants had asked where to obtain 2015 PQRS feedback reports. For information on how to access them, please visit the PQRS payment adjustment information webpage and the How to Obtain Quality Resource and Usage Reports, or QRUR, webpage. Both those links are also selectable by clicking on the web links posted on slide 27 if you're viewing this from a laptop or workstation.

Additional Resources

Slide 28. So, this concludes the formal portion of our presentation. And, now, the following slides – we're going to review a couple of additional resources and information on where you can call for help.

Slide 29. Let's discuss the information you can get through the eCQI Resource Center or Electronic Clinical Quality Improvement Resource Center. So, in response to stakeholder requests to centralize eCQI information, the resource center is the product of a plan and collaboration across CMS and ONC, with input from other Federal agencies. The resource center has been set up to support Federal quality improvement initiatives in health care facilities across the country. It aims to provide users with the information and tools to support implementing eCQMs, or Electronic Clinical Quality Measures, that facilitate effective, safe, and patient-centered timely care.

The resource center was designed to serve as a one-stop shop for the most-current resources to support electronic clinical quality improvement. It can claim -- I'm sorry -- it contains the measure along with links to tools, resources such as the Quality Data Model, eCQM testing tools, Clinical Vision, Physicians Support, and the Measure Authoring Tool, the Value Set Authority Center, or VSAC, and the United States Health Information Knowledgebase, or USHIK, a registry and repository of health-care-related metadata, specifications, and standards. Additionally, the resource center can be -- I'm sorry -- the resource center has added an Implementer's Corner and Education section for stakeholders.

Slide 31. We hope this resource center will help to unify the eCQI community by connecting related activities. Your feedback is essential to our success. And users are

encouraged to use the eCQI Resource Center to provide feedback on electronic clinical quality improvement and program implementation to help ensure program success.

Slide 31 provides the email address, and the web link was also provided on slide 30. Thank you.

Slide 32. Where to call for help? We know that many of you are calling our QualityNet and Physician Value help desks with questions. And we hear you. If you have general questions or need additional clarification regarding content covered in this presentation, please call or email either help desk. The content -- contact information is listed here, both phone and email addresses. Please also reference the National Provider Call if you have a certain question that is not addressed in the Q&A or is not reviewed in the content we've already gone over.

Slide 33. Here, we have some more details on where to call for help.

Slide 34. And the useful links to various webpages and supporting information, again, all clickable from the browser that you may be reviewing with us as we go along here.

Slide 35. We're now going to go ahead and move to our Q&A session. Please note, if you have very in-depth questions, we may refer you to the QualityNet help desk to receive personal attention and answer your specific situation.

Question-and-Answer Session

Aryeh Langer: Great. Thank you so much, Tim.

Our subject matter experts will now take your questions. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your question as possible, we ask that you limit your question to just one. If you would like to ask a followup question or have more than one question, you may press star one to get back into the queue, and we will address additional questions as time permits.

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

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

And our first question comes from the line of Dr. Deborah Tracy.

Dr. Deborah Tracy: Hello. Can you hear me?

Aryeh Langer: Yes. Go ahead, please.

Dr. Deborah Tracy: Thank you. I noticed in my QRUR report for 2015 that if you hadn't established a benchmark for the particular measure or if there wasn't 20 at least reportable, it wasn't counted in my quality composite score. For example, eCQM 166v4, imaging for low back pain in less than 50 years old not ordered, was not counted. And I'm in an 80-percent Medicare environment, so it was a good number to have a low score. And medications used in the elderly, eCQM 156v3, was also a very low number but not counted in my domain score because it was less than 20. Thank you.

Tim Jackson: So, this is Tim. So, thanks, Dr. Tracy. I think your question is why you did not have those count. And the threshold is 20, which you, correctly, had already identified. If that is an error, you can contact Tier Two for an assessment on that determination. So, I want to make sure that you understand that you do have everything to my knowledge. I'm not sure that was actually a question. I think you're just restating what is in fact. If that is a determination that has put you, you believe, into a payment adjustment status, again, you can contact Tier Two for that followup and a determination. And we can send out an update on how to submit an informal review request.

Are you -- are you familiar with that process, Dr. Tracy?

Dr. Deborah Tracy: Well, I've been to other webinars, and we weren't sure we should submit or not...

Tim Jackson: Yes.

Dr. Deborah Tracy: ...because there were multiple that weren't counted. And I don't want to get into a situation where I get a negative 2 percent because I asked the wrong question. But, medications in the elderly -- I have 3,000 Medicare patients, and it's very rare that I have, you know, medications in the elderly that are consequential. And, so, I had a very low number, and less than 20. So I thought that that should be counted even though it was less than 20 and it would be a positive in my composite score.

Fiona Larbi: So, this is Fiona from the VM team. So we would only include measures if you had 20 eligible cases. And, also, we would -- there are certain measures that we did not include in the QRUR this year because either they had an issue with the specifications and last year we did not have -- we did not use any EHR data.

So, a lot of the EHR-only measures -- because we did not use EHR data last year, we couldn't create a benchmark. So, that maybe why you are seeing that in your QRUR this year. Your QRUR should tell you whether you actually have a downward adjustment or not. It should tell you what your actual Value Modifier is. If you have questions and you would like more in-depth answers about your QRUR, then I would go to the PV help desk, which is actually on slide 32. And they will be able to give you more information about what you see in your Quality and Resource Use Report.

Dr. Deborah Tracy: Thank you.

Operator: Our next question will come from the line of C.J. Blanc.

C.J. Blanc: Hi. Good afternoon. Thank you for the call and the question-and-answer session. Our question is about group reporting for PQRS and also meeting the requirements for the Meaningful Use quality measure component. So, our question is, when we submit our group PQRS GPRO Web Interface submission, and then we go to the attestation process and indicate that we've submitted those quality measures electronically, how does the Meaningful Use Program connect that individual provider with the group PQRS submission?

Tim Jackson: Thanks, C.J. This is Tim. So, how that is connected is, is what you submit through the Web Interface goes in for back-end processing that then gives a

concurrence to the Meaningful Use Program that you have successfully completed that. So, there is definitely...

C.J. Blanc: And I guess...

Tim Jackson: Yes. Go ahead.

C.J. Blanc: I'm sorry. Just more specifically, so some of our providers were a large group practice, a large academic medical center. So some of our providers might in PECOS be associated with multiple billing NPIs or billing TINs. But, you know, we've only submitted PQRS data for maybe one of those TINs. So, I guess, my fear is if for PQRS we submit under one TIN at the NPI -- individual NPI is part of but, maybe, in the Meaningful Use Program, their registration is for a different billing TIN, would it still make that connection if, maybe, their Meaningful Use funds are registered to go to one TIN while their PQRS group submission was made under another TIN? If their NPI is associated with both, would they still get credit in the Meaningful Use Program? Does that make sense?

Tim Jackson: Yes. So, it would only make – it'll only follow through. So the PQRS group reporting Web Interface will not add what is not already there. So, if the additional TINs are part of that group and they were not part of what was included in the Web Interface when you registered for that, then they would not be identified with the transmission. So, to get that reconciled, you would need to submit a ticket or a help desk ticket to follow up on that.

C.J. Blanc: Okay. Thank you.

Tim Jackson: But during your registration, you should be able to go back at the point of registration for the Web Interface and have that documentation as the starting point.

C.J. Blanc: Got you.

Tim Jackson: All right?

C.J. Blanc: Yes.

Okay, thank you very much.

Tim Jackson: Thank you very much.

Operator: Our next question will come from the line of Lisa Gall.

Lisa Gall: Hi. Thank you for taking my question. My question has to do with critical access hospitals who do have some eligible clinicians who bill under method two Part B for their facility. However, those charges would be under professional fees. So, the question is, how do the organizations and hospitals who generally hire these individuals -- would they be required to report those individual professionals who bill Part B? Thank you.

Tim Jackson: Yes. So, this is Tim. Thanks for your question, Lisa. So, the CAH II or critical access hospital—we call them method two reporters in PQRS—are required to report. They can do that. The most common method for them is to use the claims -- individual claims method for reporting. And, then, that does transfer back through the same billing process that you had accurately described. So they would be assessed with a downward 2 percent if they were not successful in 2016. There are registries available as well. I know giving guidance now and telling you to go back and try and fix claims is not an answer. But there are other options available for those CAH Two providers to employ to satisfactorily report. And we covered those, I want to say back on slides 8 through 10.

Hopefully, that answers your question. Thank you.

Operator: And our next question will come from the line of Sherry Brady.

Sherry Brady: Yes. I was just wondering. As far as our area hospital is reporting for us the ACO PQRS and, then, as individual eligible providers, do we then still have to do the CQMs?

Rabia Khan: Hi. This is Rabia Khan from the Shared Savings Program. If you're participating in the Shared Savings Program, your ACO will report the Web Interface measures. And if your providers are participating in the ACO use -- certified EHR technology to abstract that data for the ACO report, then you can meet the Medicare EHR Incentive Program CQM portion. And like Tim mentioned earlier, no additional

reporting is necessary for the CQM portion when you attest -- when your providers attest, that is.

Sherry Brady: Because we are in the ACO.

Rabia Khan: Right.

Sherry Brady: They actually take care of both pieces.

Rabia Khan: Yes. But, you'll still need -- the providers will still need to meet all of the other EHR Incentive Program reporting requirements.

Sherry Brady: Right. Just not the CQMs.

Rabia Khan: Correct.

Sherry Brady: Okay. Perfect. Thank you.

Operator: Your next question will come from the line of Courtney Bertrand.

Courtney Bertrand: Hi. Thank you. I have a question. For those provider TINs participating in an MSSP -- I understand that they have the option to report separately for the upcoming year. Can you tell me is that only if the ACO fails to report, or is there a date that they need to make that decision and notify you of that?

Rabia Khan: Hi. This is Rabia. Yes. So, in the PFS proposed rule, there was a special -- PQRS special reporting period for ACO participants whose ACO failed reporting for the 2015 performance year. Now, the reporting period, as proposed, aligns -- coincides with the 2016 submission period. So it would also occur from January 2017 through March 2017. And it would be based off of 2016 performance year data -- so, from January 1, 2016, through December 31, 2016. Now, there are limited reporting options for these participant TINs who are a part of this ACO failed 2015 reporting. And those are limited for PQRS in terms of -- it is only limited to EHR, QCDR, and registry reporting at a group or individual level.

Tim Jackson: Right. And this is Tim. Just to follow up, so, for folks that may be listening into this Q&A particular piece -- and I mentioned it before -- where we are at in the performance year, you know, claims is not an option. So, the same applies for this kind of new option, that it is part of the public rulemaking period. So, again, claims is not an option. We understand that it is a burden. But, that's the best we can do as we kind of make this adaption to kind of help support a lot of folks that need some support.

Thank you. Thanks, Courtney.

Operator: Our next question will come from the line of Jeannette Place.

Jeannette Place: Hi. I am calling about an individual EP who's been reporting Meaningful Use with CQMs and PQRS for a couple of years. Chronologically, those submissions have been Meaningful Use first with the CQMs included and then about a month later or so PRQS submission. So, I'm hearing – I'm confused about, for the future, now, if we submit for Meaningful Use, will we not be completing CQMs or will we be completing CQMs and they will populate our account when we register at PQRS submission?

Tim Jackson: Hi, Jeannette. This is Tim. So, to answer your question.

Aryeh Langer: I don't know if your phone is on speaker. But maybe you can pick that up? We were just getting some feedback there.

Jeannette Place: Okay.

Tim Jackson: Jeannette, are you still there?

Jeannette Place: I'm here. Can you hear me?

Aryeh Langer: Yes. Thank you.

Tim Jackson: Okay. Great. Thank you. So, we can go back and review one of the slides real quick or you can just kind of move back to the PQRS and Meaningful Use layout that kind of says how it occurs. I think, you're looking for details on how that process occurs. There is no requirement that you do one or the other in sequence. So there is a reporting period for the Meaningful Use Program and there is a reporting period for the

PQRS Program. Right? So, there is a performance period and, then, there is the reporting period. And the first couple of months of 2017 will be the reporting period based off of the performance that your individual EP completed in 2016.

So if they complete the CQMs, if they submit -- or you have a registry or a data submission vendor send the eCQM data to QualityNet for the PQRS portion, that will satisfy the CQM portion for the Meaningful Use Program. There is no kind of interface at this point that tells you or the EP when you go to look at the Meaningful Use attestation portal where you're going to attest for the first two elements or the first two components of Meaningful Use that you CQM data is accepted anywhere else.

So, I understand the sequence you laid out. You can do that sequence. You can reverse it. It doesn't matter just as long as you have both elements done within that submission time period for both programs. The reporting...

Jeannette Place: But the...

Tim Jackson: Go ahead.

Jeannette Place: But the CQMs are not the same as the PQRS measures.

Tim Jackson: So, they are – that's the reporting once capability. So when you submit the CQMs across the nine measures and three domains for PQRS, if they are CQMs, as in they are a QRDA I or a QRDA III format and they come to the program, you have reported those measures successfully. You only need to submit them once.

Jeannette Place: Okay.

Tim Jackson: There is no Meaningful Use eCQM XML individual process for someone. You can go in and attest. But I believe that you said you've been in it for several years. So you're no longer in year one, stage one of Meaningful Use. You are much more advanced.

Jeannette Place: Right.

Tim Jackson: So when you send that, it's a data file. When you send that data file into PQRS for those eCQMs -- again, nine measures across three domains including the other requirements we covered in the slide -- those satisfy the eCQM requirements for Meaningful Use.

Jeannette Place: Perfect. Thank you.

Tim Jackson: Then you would go -- yes. Thanks, Jeannette.

Operator: And our next question will come from the line of Marie Harris.

Marie Harris: Hi. Thank you. I work for a community hospital and we have about 20 hospital-owned clinics. And I'm wondering if you can report a group reporting when there are various clinics and various specialties.

Jessica Schumacher: Hi, Tim. This is ...

Tim Jackson: Hi, Marie. This is Tim. Was there someone else?

Jessica Schumacher: Yes.

Tim Jackson: Yes. Go ahead.

Jessica Schumacher: Hi. It's Jessica Schumacher from the PQPMI Contract team. I can take a first stab at this if you'd like.

Marie Harris: Sure.

Jessica Schumacher: So, Marie, when you say community hospital, are you affiliated with a rural health clinic or a critical access hospital?

Marie Harris: It's not a critical access hospital.

Jessica Schumacher: Okay.

Marie Harris: We have -- our primary care are rural health clinics and then our specialty are not. They're provider-based clinics.

Jessica Schumacher: Right. So -- and are all the different various clinics, are they associated to the same TIN or do they have separate TINs?

Marie Harris: I believe -- that I have to confirm. If they have the same TIN, then are you able to?

Jessica Schumacher: So, the current CMS guideline is that for those organizations that would like to report at the TIN level, they would have needed to go through the GPRO registration process, which was April 1st through June 30th. And that would have allowed those eligible professionals under the tax ID number report at the group level so you'd only have to select, you know, nine measures for the whole group...

Marie Harris: Okay.

Jessica Schumacher: ... and report for applicable or eligible encounters. So, those encounters under, for example, the rural health clinics that are not paid under Medicare Part B, those would not have, you know, been taken into account for purposes of PQRS. So, at this point in time, we are working with CMS to further look at this requirement.

So, I think, that the current practice is to have you -- if you've not registered for GPRO but you would like to submit at the TIN level, to contact the QualityNet help desk. And we'll work with you and your organization and present the case to CMS to see if there's anything else that we can do in terms of 2016 reporting.

Marie Harris: Okay. Thank you very much.

Jessica Schumacher: Thank you.

Operator: Your next question will come from the line of Molly Helsman.

Aryeh Langer: Molly, your line's is open.

Molly Helsman: I have a question about individual practitioners who started reporting claims for the beginning of this year -- realized that, you know, maybe a measures group would be a better option. It is possible to switch and report differently throughout the rest of the year?

Tim Jackson: So, this is Tim. I think that we would probably suggest you open up a ticket to review that because there might be some more detail that would better suit the answer that you're looking for because I don't know that we have the Measures group experts with us on the call today.

Molly Helsman: Oh, okay.

Tim Jackson: Thanks, Molly. Sorry about that.

Molly Helsman: That's okay.

Operator: And your next question will come from the line of Jeanne Skelly.

Jeanne Skelly: Hi. I had a question on the slide where you brought up MAV. And it is my understanding since we were talking about reporting once, we're actually looking at a data submission vendor. And my understanding that was in using a DSV or doing EHR direct that the MAV process is not applicable because of the ONC certification of the products. Could you speak to that?

Tim Jackson: All right. Thanks, Jeanne. Yes. This is Tim. So, the MAV does not apply because of the certification does the -- it kind of checks on the -- it kind of -- the veracity of your data is run through that certification either through the vendor or the EHR system. And that process accounts for making sure that all of the eligible measures would have been satisfied. So, when we did cover that slide, we only covered it for two prospects. And that was for registries and for claims. So you are correct, and it does not apply for the data submissions under DSV. Thanks, Jeanne.

Jeanne Skelly: So, that's a way that our process as a nurse surgery specialty -- because when I look at those eligible measures, I don't see nine that even make remote sense for a nurse surgery practice. And so we were concerned about getting to nine, but the fact

that the MAV process isn't in there and we just let the certification work, it is -- do its work within our EHR and we can rely on that.

Tim Jackson: Correct.

Jeanne Skelly: Okay. Thank you.

Operator: Our next question will come from the line of Sheila Sylvan.

Sheila Sylvan: Hello. Thank you. I'm calling with regards to accountable care organization and the comment of ACO participant TINs can report outside the ACO as individual providers. I first want to apologize if you have covered this. I had to quickly put you on hold and take a call earlier and then come back to the call. But we're wondering really why an ACO participant TIN, if the ACO has successfully been reporting -- what would be the benefit to them to additionally report as individuals or as a group?

Rabia Khan: Hi. This is Rabia from the Shared Savings Program. So, yes, there have been instances where ACOs have failed quality reporting. In those instances, we've had providers who are participating in those ACOs who were subject to the PQRS and VM adjustment. As such, we are changing our policies to align and allow for these participant TINs to be able to report PQRS outside of the ACO to avoid adjustments in case the ACO does fail. Now, we do note that we have each year 97-plus percent of ACOs completely report, but these are for those providers who may be encountering issues where an ACO may be terminated or…

Sheila Sylvan: Okay. Because we had noticed last year we had a couple of newer practices who had attempted to submit and, of course, it bounced it back to them and would not permit individual submission for a TIN that was enrolled in an ACO.

Rabia Khan: Right. So, in the 2017 proposed Physician Fee Schedule rule, we did put in place a policy where we have removed that prohibition preventing those participants from reporting outside of the ACO through another mechanism to PQRS. So, now that bounce-back will no longer occur. But, as I mentioned earlier, there are limited reporting options for those participants TINs who are reporting outside of the ACO. And it is limited to QCDR registry and EHR reporting.

Sheila Sylvan: Thank you.

Rabia Khan: Yes.

Operator: And our next question will come from the line of Colleen Quintal.

Keisha Orr: Hi. Thank you. This is Keisha Orr, one of Colleen's colleagues from Altarum Institute. I had a question that surfaced from -- excuse me, I'm pulling it back up -- that surfaced from a non-physician provider, he's a clinical social worker. What he wanted to know -- it's because he got conflicting information from the help desk -- is how many measures covering how many domains must he report on to be in compliance not to receive penalties? And he is reporting via claims because the situation is we have pulled his QRUR report and his feedback report and his PQRS and it told him that he didn't successfully report the measures. However, the measures that they listed are something that he cannot provide as a non-physician provider. And he is all -- he is 100 percent Medicare billing.

Tim Jackson: It's Keisha, right? This is Keisha?

Keisha Orr: Yes.

Tim Jackson: Hi, Keisha. This is Tim. So it sounds like you have a question on 2015 reporting. I would recommend that you open up an informal review request, an IR request. For the purposes of today's call, for the 2016 reporting, we covered the individual reporting options on slide 7 and 8. And the requirements are, again, nine measures across three domains.

Keisha Orr: I just have one question in regards to that. Are they taking into accountability the non-physician providers who see patients on their own that cannot -- those measures don't qualify for them to report on or, you know, should that -- the MAV come into play in regards to those measures?

Tim Jackson: So, the answer is yes to both questions. So, the MAV could come into play if there -- the denominator thresholds do not reach a certain level. I believe it's 15 encounters. It depends on certain measures, if I recall correctly. And, then, alternate options -- I would, again, refer you back to the help desk. But, for your purposes, for the

2015 reporting, I would go to the informal review help desk to get those details. Unfortunately, we don't have our Measure's specific content lead here in the room this afternoon. So, I apologize for that.

Thanks, Keisha.

Keisha Orr: Thank you.

Operator: Your next question will come from the line of Leigh Young.

Raymond: Hi. This is Raymond. I'm calling from a solo practice. I just have a question regarding slide number 7. It's the Medicare patient data. When I report a measure, we don't see the percentage -- the performance rate based on Medicare patient only. We only see the performance rate based on all payers. Does it mean that we have to have at least 50 percent of all Medicare patients in that measure in order to pass?

Tim Jackson: Hi, Raymond. This is Tim. So, the requirement is an EP must report at least one measure containing Medicare patient data. So, that doesn't mean it needs to be 50 percent of all your Medicare patient data. It just means if you're submitting to demonstrate that you have a Medicare patient in your patient data encounter history. So, if you think about it, what is the practice performing? If they are treating Medicare patients, we need evidence of that within the Medicare program. That's as far as that data review goes. It doesn't mean that you need to have, you know, 1 out of 2 or 1 out of 48 or 36 out of 72. You just need one.

Does that answer your question, Raymond?

Raymond: Yes, sir. You did. Thank you very much. I really appreciate that. Thank you for taking my call.

Tim Jackson: Yes. Sure. Thank you.

Operator: And your next question comes from the line of Denise Scott.

Denise Scott: Hi. I have a question as a data submission vendor. As you know, there are -- we submit electronic clinical quality measures. And if we have a provider organization

that wants to report and they try to find measures that meet their specialties, such as anesthesia, hospitalists, urgent care, etc., there are not nine eCQMs that they would have data for. I was curious on your slide 27 where it says, "Can I combine reporting mechanisms to successfully meet the requirements?" The answer was no. But then, in turn, it said CMS will review all data. Does that mean that we could submit a QRDA file for some measures and an XML file for other measures for those providers who come up with the nine measures or do they just submit data that's eligible to be provided via the eCQMs whether it really turns up any usable data or not?

Tim Jackson: So, the technical answer at this point is the latter, Denise. The requirement is best fulfilled under the latter characterization that you just laid out, the reporting requirements for multiple mechanisms. It's because the actual measure specifications across different mechanisms are different. Right? So, thresholds for breast cancer screening under one mechanism have a different numerator and denominator and, in many cases actually have a different eligibility criteria for an age range. So we....

Denise Scott: I thought CMS would only -- I thought CMS would only accept one electronic file. So, if ...

Tim Jackson: That is correct.

Denise Scott: Okay. So, it -- so, that is no different, that we would not successfully be able to submit two electronic files, one being an XML and one being a QRDA file.

Tim Jackson: Right. For the same TIN NPI?

Denise Scott: Right.

Tim Jackson: Yes. You have it correct. There is -- we can only accept one.

Denise Scott: Okay. And, then, I just want to make note that on your slide 7 under individual reporting, it says QRDA III. Should that say QRDA I?

Tim Jackson: I don't know. But, thanks for pointing that out. We will clarify. Thank you very much. That's helpful, Denise.

Denise Scott: Okay. Thank you.

Operator: Your next question will come from the line of Melanie Gordon.

Melanie Gordon: Hi. I have a question regarding your slide 7 in the block 3 where it goes on to reporting three -- nine measures. And it does say on to the right, "Report data on all payers." What does that mean "Report data on all payers?"

Tim Jackson: So reporting data -- this is Tim. Thanks for your question, Melanie. So, reporting data for all payers is for most EHR products, they aggregate all payers and the Meaningful Use Program has statutory authority to review all payer data.

Melanie Gordon: Okay.

Tim Jackson: So they can submit all payer data. They don't need to try and parse out Medicare versus another plan's data for an encounter and a claim to another paying entity like Medicaid.

Melanie Gordon: Okay. So, that pertains basically only to EHR reporting?

Tim Jackson: That is correct. Yes.

Melanie Gordon: Okay.

Tim Jackson: If you think about it, it wouldn't apply to claims because you're already just submitting claims to your Medicare Administrative Contractor for Part B only. So, you are not...

Melanie Gordon: Right. That is why I needed that clarification. I am like, why would they be expecting, you know, on all payers. But it makes sense.

Tim Jackson: Okay. Thanks for your question, Melanie.

Melanie Gordon: All right. Thank you.

Operator: Our next question will come from the line of David Lind.

David Lind: Yes. I had a question regarding -- for the years 2014 and 2015, we submitted claims-based reporting as individual EPs as it did not seem we qualified for the group-based, and the QCDRs at that time for us did not seem set up very well. We are an anesthesiology group. For reasons that aren't exactly clear, a few of our providers did not meet the qualifications and despite appeals, it didn't go through.

Thus, they -- those individuals were assessed at 2 percent, I believe -- is that correct -- for 2014 would be this year and 2015 would be next year as far as the CMS thing. This year, for 2016, we've selected the QCDR option to report as a group. Do those 2 percents follow that individual? Or since we are now changed over to report as a group through a QCDR, is it kind of reset?

Tim Jackson: So—this is Tim. Thanks for your question, David. So, we have -- I just want to make sure I understand. So, you were reporting individually, and, now you're reporting as a group. So it really boils down to understanding if they signed over their billing rights to a particular TIN.

David Lind: Yes.

Tim Jackson: So, the...

David Lind: All of our individuals have -- we are a group of 60. So, we report through the same TIN.

Tim Jackson: Okay. So, for kind of awareness purposes, understanding on how the application of the payment adjustment when you shift from individuals to group, if it applied to everything when you sign over that billing right. So the challenge is, is when you get it correct, there could be benefits at the TIN level.

But if it's incorrect, I would encourage you to make sure you are very detailed in your review of your QRUR and, if you have concerns, you send your informal review request because if there are errors or you find that there is something that is missing with that QCDR, I mean, that's another entity you paid for its service from. We want to make sure

that you get the representation correct. But, that TIN is responsible at the group level for reporting.

So when it comes through that QCDR for that TIN -- payment adjustments are applied at the TIN NPI level. So, if you have multiple NPIs within the same TIN and the TIN totally is subject to the payment adjustment, then every NPI in that TIN would be subject to the payment adjustment.

David Lind: So, is that -- the TIN would only have to have 50 percent of the NPIs report successfully? Is that correct?

Tim Jackson: Correct.

David Lind: So...

Fiona Larbi: That is -- this is Fiona from the VM team. That is just for the Value Modifier payment adjustment or to avoid the Value Modifier payment adjustment.

David Lind: Okay. But, for PQRS then?

Jessica Schumacher: Hi. This is Jessica Schumacher from the PQPMI Contract team. So, real quick, David, the reporting requirement for program year 2016 for group practices participating in GPRO via QCDR is to report at least nine measures covering at least three NQS domains for 50 percent of the applicable patients, and at least two outcomes measures must be part of those measures. And if you have trouble finding two outcome measures, then we strongly encourage you to contact the QualityNet help desk and they will go through your other options.

David Lind: And I believe we have those handled. But it's still the 50 percent of the NPIs within our group have to successfully do that to avoid any payment adjustment. Is that correct or not?

Jessica Schumacher: No. You would have to report those measures for 50 percent of the applicable patients seen during the 2016 participation period. So if your group picks nine measures and, let's say, that there's a thousand patient visits that are applicable to

those measures, then you need to report on 50 percent of those visits. That would only be 500 or more visits. Does that make sense?

David Lind: Yes. If we're reporting more than nine but within three domains and have two outcomes, is that still -- do you have to successfully report on only 50 percent of those?

Jessica Schumacher: Applicable patients.

David Lind: Applicable patients.

Jessica Schumacher: Yes.

David Lind: Okay.

Jessica Schumacher: And that...

David Lind: And do...

Tim Jackson: David… David, this is Tim. So, understanding the applicable patients means that that's what attributes to your measures. So, it's the encounter that drives your denominator for those measures.

David Lind: Okay. And the previous downward adjustments from previous years do not carry forward for those individual NPIs since the -- all the NPIs are wrapped within the group in the QCDR?

Tim Jackson: So, this is -- I just want to make sure I restate your question because this is a challenge for some of our -- some of our participants. So, when you -- if you decide to change your billing rights, as in you join a TIN or you -- maybe you have a practice that you -- have joined your practice, whatever payment adjustment is applied to them for that year—and the billing year is the calendar year for the application of the payment adjustment—they would still be subject to it. Right? So just because they joined a new LLC or they joined a new health system, their Part B claims are still going to be adjusted even if they are under a new TIN because it's applied at the TIN NPI level.

David Lind: Okay. But, for claims-based, my understanding was that, is that, we haven't changed TINs or anything. So it's always been a group under a single TIN. But, under claims-based, my understanding was -- is that individual NPIs failed. And so those individual NPIs under claims-based only receive the payment adjustment...

Tim Jackson: That is correct.

David Lind: ...2 years after, 2013 and '15. Correct?

Tim Jackson: That's correct. There's a 2-year cycle. So, if you think about it, you report for 2016 in 2017, you would do an informal review to change or review your status. And, then in 2018, your payment adjustment would be implemented if you did not successfully participate the 2 years prior.

David Lind: Okay. But, if we did -- all those NPIs did change to the QCDR format as opposed to claims for 2016, that previous transgression is wiped and they're -- for 2018 and on, is either they qualified or they didn't quality under the QCDR and TIN...

Tim Jackson: So, David, this is Tim. Let me just kind of try and re-wrap this up for us here. So, the challenge is that you said that these individual EPs are now going to join at the group, they are reporting to QCDR. So, when the submission window opens for 2016 in early 2017, they will report as a TIN. And that TIN, when it is successful, would avoid the payment adjustment for 2018. So, that is correct.

David Lind: Okay. Thank you very much.

Tim Jackson: All right. Thank you, sir.

Operator: And our next question comes from the line of Juan Valle.

Juan Valle: Hello.

Aryeh Langer: Go ahead.

Juan Valle: Can you guys hear me?

Aryeh Langer: Yes, sir.

Juan Valle: Yes. This is Juan Valle. And I'm calling from Doctors Hospital at Renaissance. I have a question in regards to -- it's slides 6, 8, and 11. It's in regards to Value-Based Modifiers in 50 percent of the EPs in a certain TIN. So, I'm trying to make this question simple. When I got my feedback reports, I noticed that I got a Value Modifier in one of my clinics of 4 percent. This clinic would be the Renaissance Medical Foundation. So, when I looked at all my TIN numbers, I've seen maybe 60 providers there. We reported only maybe on 10 of them. And reasons for that is because some providers are maternal fetal medicine. Some are pediatrics. Others are school-based clinics. Some of them are -- some are doing inpatient and outpatient visits -- some are doctors and some are PD neurosurgery. So they asked us -- the hospital asked us to report only on certain providers. So, I guess, my question -- one question is that I'm assuming the 4 percent negative Value Modifier adjustment is because less than 50 percent providers in that TIN reported. So, anyway, I guess I'm seeking clarification on that. That's what I think.

And, number two, is there a certain resource that I can go to that I can give whoever is assigning these TIN numbers? I want to give it to that department so that they can read on it because I'm thinking there has to be more thought into assigning TIN numbers for this hospital because we have about 550 inpatient doctors and about -- I don't know -- 600 employees in outpatient clinics.

Fiona Larbi: This is Fiona from the VM team. So, to answer your first question, yes, the downward adjustment was applied because less than 50 percent of the EPs in your TIN reported to PQRS and failed a PQRS reporting requirement. On our Value Modifier website at cms.gov, there is a Value Modifier fact sheet, which can sort of give you some information on how we look at the 50-percent reporting threshold. We look at the EPs that have assigned the billing to the TIN in PECOS. And we normally do that sort of 10 days after the registration period has closed, which for this year was probably around about the 10th of July. Because registration closed on the 30th of June this year. And we also look at the claims that are billed for your TIN. And, then, we take the lower of those numbers to assign the group size and then determine what the 50 percent is. But, there is an explanation about that in the VM fact sheet, and we also have it explained in our FAQs that we have on our Value Modifier website. And you will see the links to that on page 34.

Juan Valle: Page 34. Okay.

Fiona Larbi: Yes.

Juan Valle: Okay. All right. Thank you.

Aryeh Langer: Thank you very much.

Operator: And our next question comes from the line of Sandi White.

Sandi White: Hello. Hello.

Aryeh Langer: Hello, Sandi.

Sandi White: Hi. This is Sandi White from Lake Cardiology. I've heard talk that the 2016 reporting period for all EPs may change to any consecutive 90-day period. Is this true?

Tim Jackson: Hi, Sandi. This is Tim. That is not true. There is a requirement for a full year. That is still the requirement. The 90-day reporting period you're referring to is in reference to a future program, which is not in effect for 2016.

Sandi White: Thank you.

Operator: Your next question comes from the line of Betty Evans.

Betty Evans: Hi. This is Betty, and I have a couple of questions that -- we have a larger group that we just added a new practice into that has two providers that have come on board that will all be under one TIN. They joined the practice on September 1st.

And, so, my first question is they, apparently, when they were on their own, did not meet the requirements. And, so, we just got letters recently that they are eligible for the 2-percent penalty payment. And so -- but, now, they are going to be underneath our TIN going forward and from September 4 -- through the end of the year are on our TIN.

So my first question is how does the negative payment adjustment impact them or impact the new practice? And, then, on the reporting side, because it has to be a full year, how do we do that?

Tim Jackson: Hi, Betty. This is Tim. So, to your first question, with those two providers moving under one new TIN, then the payment adjustment would not be able to -- if you -- it makes sense, it wouldn't be able to find them. Right? So, if they signed over their billing rights to the same TIN NPI, and one of those TIN NPIs was subject to the payment adjustment, then it would be applied to them.

Does that answer your first question?

Betty Evans: Oh. Okay. So, basically -- so, basically, it negates it then, since we have -- since the rest of the practices have made it applicable, then we -- then we're okay.

Tim Jackson: Correct.

Betty Evans: Okay.

Tim Jackson: For the purposes of the payment -- the application of the payment adjustment, that is correct. And can you restate your second question again? I'm sorry. I lost it.

Betty Evans: So, because they came on September 1st, from a reporting standpoint, the reporting period needs to be from January 1 through December 31st. So, I'm trying to determine how do we do that because, obviously, they weren't part of our practice from January through August 31st, but -- or have been since September 1 forward.

Tim Jackson: Betty, this is Tim again. So, it depends on how they're reporting. There are – there's a little bit more nuance here. So, if you want to put in a help desk ticket to review this, based on the reporting options that we reviewed -- remember I covered quite a bit under...

Betty Evans: Right. Right.

Tim Jackson: There is -- so, there's different rules that apply. But, they need to report on the best extent possible to meet whatever thresholds, granted they will not be at the same levels. But, depending on whether or not and how you guys are reporting as a group…

Betty Evans: So, we're not – we're not group reporting. We would be individually reporting.

Tim Jackson: So, for individual reporting, they would just need to report on the best extent possible and understand that certain measures -- they may actually be successful because they only need to hit so many encounters -- have so many patient encounters to get to that 30 -- or, I'm sorry -- 20-patient threshold when submitting via claims.

Betty Evans: Oh, okay. So, maybe we are okay then by using the -- our new one from September forward. Okay. Awesome. Thank you so much.

Tim Jackson: Thank you.

Operator: Your next question will come from the line of Jennifer Summar.

Jennifer Summar: Hi. Can you hear me?

Aryeh Langer: Yes, Jennifer.

Jennifer Summar: I've always been confused with the EHR-based reporting. If a practice or physician has less than nine measures available in their EHR with patient data that they can report and they meet all the other aspects of EHR-based reporting, they just don't submit nine measures, is it possible that they could still pass PQRS?

Tim Jackson: Hi, Jennifer. Yes. It is -- it is very possible and it happens every year.

Jennifer Summar: Okay. That's all I needed. Thank you.

Aryeh Langer: Thank you so much. And, Holley, we have time for one final question.

Operator: All right then. Our final question will come from the line of Pat Harrod.

Pat Harrod: Thank you very much. I'm calling from an ACO. And my question is, if our ACO successfully submits our measures but one of our practices on their own decides -- due to habit, I guess -- to submit measures directly, what would happen?

Rabia Khan: Hi. This is Rabia. So, the ACO-reported data would be used for PQRS and the Value Modifier.

Pat Harrod: Okay. And if it was not successfully reported and they reported, would it then revert to their individual reporting?

Rabia Khan: Yes. So, if the ACO fails to report and the participant TIN reports outside of the ACO, if the PFS policies are finalized, yes, they would look at the participant TIN-reported data.

Aryeh Langer: Can you give us one moment, please. One moment, please. Don't hang up.

Pat Harrod: Okay.

Aryeh Langer: Just give us one more second, please.

Pat Harrod: Okay.

Rabia Khan: Yes. So, this is Rabia. I just wanted to close the loop on that one. So, yes, if your ACO fails to report, whatever -- well, if the participant TIN reported data successfully to PQRS through the limited mechanism that -- which are QCDR registry and EHR, then PQRS will take a look at that reported data to see if that meets the reporting requirements to avoid the adjustment and so will the VM.

Pat Harrod: Thank you very much.

Rabia Khan: Yes.

Additional Information

Aryeh Langer: Okay. Thank you very much.

Unfortunately, that's all the time we have for questions today. If we did not get to your question, you can email it to the appropriate address listed in slide 32. 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 those materials become available.

On slide 36 of today's presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you'll take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Aryeh Langer. I'd like to thank our presenters here at CMS as well as our presenters on the line. And we thank you for participating in today's MLN Connects Call. Have a great day, everyone.

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

-END-


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