Event ID: 2944560
Event Started: 5/25/2016 3:50:08 PM ET

Please stand by for realtime captions. Good afternoon hello and welcome to this months the QRS LA and Patty can you hear me okay?

Yes.

Thank you Patty. Thank you all for attending the mountain Pacific's PQRS learnings of event we appreciate the value my your time and we are pleased that you have turned us for important information and timely up date on what is happening with the various quality programs and initiatives we also want to hear from you on your successes, lessons learned barriers and hurdles. This event is a joint effort, the health technology services department and the Quality Improvement Organizations department. This event is being recorded and will be on our website MPQ HF.com in a week or two. Unfortunately we cannot get our phones muted today so we would appreciate all of you putting your phones on mute and tell you have questions. Our agenda for today has input from you, those of us who attended last month at opportunities at the end of the survey to give us information on what was important for you to hear about. This is about how PQRS influenced quality payment we asked Patty to provide information on the topic today as a speaker. We will also give you a high-level summary of the macro proposed rule released on April 27 and we haven't you other the less we have a few other shore update items.

Housekeeping details.

In the survey that people took after last month LA and they were allowed to select which day of the month would be best for the LAN to be determined Wednesday would be the best day of the week for the LAM to go enforce [INAUDIBLE]. Sendoff notices will be sent out as a reminder each month.

The next item that we have, [INAUDIBLE] specific is in the middle of changing their listserv vendor and we will be adding some groups for the QRS to the list -- from PQRS to the list. So if you received an email from me for the PQRS you will automatically be added to our Google group and you will keeping the rest getting an email from us. Please use this listserv address questions of us or your peers. This will not be moderated so emails will go directly to the list numbers without being screened. This is a close to list of numbers have to be added by one of the group owners are they have to have permission to join the list.

Our first topic today is the macro proposed rule, this is the rule that was released on April 27. We wanted to give you a high-level review of this rule. This is a very complex rule and encompassing 962 pages. What we're giving you today is not going to get into the details it is just some of the highlights of the program. It is only a proposed rule and not the final rule, it does give us far more detail on how CMS is planning to implement macro. For CMS this rule is needed to propose policy to improve physician payment to change the way Medicare

incorporates quality measurement into payment and by developing new policies to address and incentivize alternative payment models. This notice of proposed rulemaking has a comment period which closes in the end of June. Several staff from mountain Pacific quality health are reading through the entire rule and we will be drafting comments to submit to CMS by June 27. Our goal today is to give you a high-level overview and then during June we will share with you our draft comments to gather your input to form final comments that we will submit. Many of you have shared your difficulties in complying with the current quality and payment programs and we want to ensure the practices are shared with EMS and so the final rule is completed sometime this fall. One of the first changes to note is that CMS's rebranding this to the quality payment program. LAN started seeing the language in use already and you will see it even more in the future. Before we dive right into the rule let's talk a little bit about the history of how we got to macro. Medicare payment has largely been fee-for-service raised in air quality rather than quality and value this led to a situation where growth was unsustainable so Congress enacted legislation to use a sustainable growth rate starting in 1997. This formula set targeted expenditures each year with adjustments in future payment rates to govern cost. The flaws in the approach became apparent within a few years in Congress then enacted temporary legislation delaying those adjustments every year since 2003 to avoid payments to physicians and providers. This is called a doc fix and if there had been no fix it would have meant it 21% cut in Medicare payment to physicians and providers have is not been done in 2015.

Currently there are three quality value and incentive programs for Medicare eligible providers. These include DP QRS program, the value-based modifier or VN program in the electronic health record incentive program commonly known as meaningful use. Each program came about from different legislation and they use the fair reporting mechanism. Each program that independent and has undergone change during construction. This had led to a complex reporting environment and ecology lesson the burden off clinicians by merging the programs together.

Enter the Macra legislation which was signed in 20 -- 2015, April 2015 this is as by broad bipartisan support and criminal repeals the sustainable growth. With prior CMS will Laughmac with clinicians. [INAUDIBLE] has been clinicians, the advanced alternative payment model. Otherwise known as 8 PM. The overall goal of both of these practices the same Medicare by paying for what works the things that add quality and value on by decreasing things that are costly or have not been proven to work.

We will start today by reviewing and ET. This will engulf the QRS volume modifier and meaningful use into one program and will add a fourth component called clinical practice improvement activity. Scoring will be comprised of four components. Quality measures, these will be measures that are selected and reported by individuals and groups, currently under PQRS each year nine measures are due under [INAUDIBLE] there will be six measures with no domain requirement. Research uses calculated by Medicare claims and include total per capita cost with all contributes to beneficiaries, Medicare spend per beneficiary, and applicable episode-based measures.

Clinical practice improvement activities is the new category, this category allows clinicians to select activities from a variety of subcategories which include ask and it practice, population management, care coordination, beneficiary engagement, achieving health equity, emergency

preparedness, and more. There are over 90 proposed [INAUDIBLE] for this category and to not receive a zero score a minimum of one act must be selected. Credit will be given for patients and four 8 PM participation. Some activities are weighted higher than other activities. The advancing care information performance categories focused on the use of electronic health records. This will replace the meaningful use program for Medicare physicians. The proposal is designed to simplify requirements, support patient care, and be flexible to meet the needs of physician practices with an emphasis on measures to [INAUDIBLE] and improve patient improvement and interoperability. An important goal of CMS and designing is to allow for flexibility, select quality measures and improvement activities that make sense for each practice based on the characteristics of their clinic and their specialty. It is very important to note that the payment program has meaningful use for eligible professionals but it does not pull in meaningful use for eligible hospitals. The proposed rule does include language about adding several new a statistician statements for meaningful use for all Medicare eligible providers, hospitals and critical hospital access but macra does not change any of the components of meaningful use for hospitals. We will not be covering those out of station changes to date. Back another thing to consider the quality payment program addresses meaningful use as it is detected for Medicare, each state is still in control of meaningful use under Medicaid. If you have enrolled in the Medicaid EHR incentive program and are receiving payment incentives through Medicaid you will need to continue to attest separately with your state to receive the Medicaid payments. This will not meet the criteria for Medicaid EHR incentive program attestation.

Okay who gets to participate? The macra proposal focuses on clinicians who will Medicare for parts be services. CMS is using the new term of eligible clinician to describe who is affected by MEP. There has been confusion with eligible provider or eligible professional as that term encompasses different providers within the three current programs. Eligible clinician is being used by the quality payment program to provide a better clarity. Who is in this group? For the first two years eligible clinicians will include physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registrable -- registered nurses. Starting in year three CMS has the authority to ask them the provider types who will participate in MEP and you can see the list of possibilities there on your site.

Hey Sharon? This is Patty I want to make a clarifying statement if you do not mind. I was on a CMS call today regarding MVPs and this was pretty important, in the final rule this slide right now and years one and two is what is in the final rule as well but really who has to participate in MEPs in years one and two are all of the same people who are doing the QRS now -- PQRS now. Even though they are not identified on the slide, optometrists, chiropractors cops if they are doing this in our eligible for PQRS they will be for MEPs as well. I just wanted to make that statement Sharon.

Thank you Patty I appreciate that.

Okay. Who will not participate in MEP? There are three types of clinicians will not be subjected to MEP. Clinicians who are in their first year of Medicare part B participation and then those below a certain threshold uncertain participants in advance payment models. Let's talk a little bit about the low volume threshold. Eligible clinicians need to have Medicare billing charges less than or equal to $10,000 and provide care for 100 or fewer patients in one year. Note, this is an

and not a and or you need to meet both conditions to have the exception. Second, APM participations, not all -- alternative payment models are an exception for MEP, it must be considered and declared an advanced APM and even then not all participants make qualify as a given threshold of patients volume may be required to be in the APM. The last thing I want to point out on this slide is that the sentence at the bottom can be a little bit misleading as I mentioned earlier macra on the quality payment program do not address meaningful use for eligible hospitals nor does it address hospital quality reporting however if you have hospital-based physicians or providers for whom you are billing professional services to Medicare part B, if you are a hospital, they will be participating in MEPS the sites I use today come from [INAUDIBLE] and I don't want you to be confused but providers and hospitals are not affected because they are.

Reporting, reporting for MEPS can be as an individual or a group it is similar to the current PQRS program. Definition of the group is defined as a [INAUDIBLE] where two or more eligible clinicians have a signed their billing right however please note that MEPS will assess the groups across all four categories which is different than what we are currently seeing with the three individual sub plans. If you elect to participate as a group you would be doing that group across all four categories.

CMS is proposing to continue the to your look for payments that it is currently in use. That means in order to be able to start MEPS the premier in 2019, 2017 to be the first performance period. CMS is proposing an entire calendar year for the 20 2017 performance period and I would include all four performance categories.

Upward and downward payment adjustment over MEPS start at 4% in 2019 and will increase each year from 2019 until they reach 9% in 2022. These payment adjustments will affect Medicare part D payments to eligible clinicians. MEPS is designed to be budget neutral , upward adjustments could go higher depending on the actual amount of money received from the downward adjustments that are calculated each year.

The specifics for the scoring proposed for the performance year 2017, sorry I moved to the wrong slide, the payment adjustments are based on the next composite performance score which is calculated from the score from each of the four main categories. Each category receives the way and all -- not all categories are weighted equally. CMS is proposing to change the waiting from year-to-year as if the emphasis on resource use more going forward. Some of the specifics on the scoring proposed for the performance year 2017 and the payment year of 2019, note that quality has a weight of 50% in 2017 while cost only has a weight of 10%. Advancing care information has a weight of 25% and clinical practice improvement activities have a weight of 15%. By 2021 the resource or cost category is cited to increase to 30% while the category of quality is cited to decrease down to 30%. The aggregate MEPS composite score will be compared against the MEPS performance threshold to compute the adjustment as an upward downward or mutual. CMS will update those thresholds on an annual basis.

The next two slides show how you can report for the different categories whether you are doing individual reporting or group reporting. For example, for polity, we see the -- for quality, we see the qualified clinical data and the registry, EHR, administrative claims, and claims under the

individual, then we see CMS web interface and see APS for the survey under group reporting. As you can see that stays somewhat the same. Individuals and groups will not need to submit anything for the resource use category because that is calculated from claims.

Here are the submission for reporting options under advancing care information and clinical practice improvement activities. You will see those are very similar to what we saw before. I am not going to get into any more specifics about this I just wanted to see that a number of things are seeing the same going forward but overall mainly what is changing is trying to streamline and coordinate things together to make it be less of a burden to providers to actually report.

[INAUDIBLE] the great majority of eligible clinicians will be reporting under MEPS in the first two years of the program and the requirements for participation of involvement with an advance APM, are far more involved there is a lot more than there is to MEPS and they do not anticipate that very many people will be ready and able to do that. We suspect a grand majority will be under MEPS for the first two years. Will talk a little about alternative payment models, APM's have new approaches for paying for Medicare, medical care through Medicare, this incentivizes quality and value. The intent of macra is to move clinicians towards all turn it -- alternate payment models as they expand opportunities for a broad range of providers to participate in APM's overtime. APM's have varying levels of provider risk and rewards to tie payment, where we see alternative payments coming from we see the CMS innovation Center model, demonstrations and greedy healthcare quality program, and other demonstrations as required by federal law.

And advanced APM has to meet additional criteria, advanced APM's must require participants to use certified EHR technology. Database payments on quality measures that are comparable to those in the next performance category. And APM either requires the APM entity to bear more than nominal financial risk for monetary losses or is a medical home expanded under CMMI authority.

This is not change how any particular APM functions or rewards value, macra creates extra incentive for APM participation. The potential for greater financial award under the quality payment program increase is eligible clinicians are involved with APM and then advanced APM's with fully qualified participants in an advanced APM getting an annual 5% lump sum bonus.

Okay. If all of this is new and unknown to you here are a few mean -- key points. CMS is very focused on improving quality but also wanting to decrease cost while the quality payment program is budget neutral from the standpoint of the upward and downward payment adjustment there is funding out there from CMS to provide additional extra rewards to those who show exceptional performance with high quality and low cost. Medicare part B clinicians are the ones who will be participating in MEPS unless they meet some of the exception criteria and payment adjustments and promises -- bonuses will begin in 2019.

Also included in the proposed rule, or in the legislation that gave us macra was funding to help small practices with technical assistance in meeting MEPS. CMS certainly understands that for a lot of small places they do not have a lot of resources locally or the ability to purchase resources.

They are putting funding out to help them. One specific will be reviewing the options of how we can be key to support the funding and support you as the quality payment program is implemented.

Those with a -- this was a very quick high-level overview of how CMS put macra in as a payment program. We wanted to share this with you as mountain Pacific will be drafting comments for this rule to submit to CMS. We will share the comments with you doing the June LA and and we invite you to send the comments if you want them to be included. Ultimately you are able to submit comments directly to CMS yourself and here is the information to do that. We look forward to your questions and plan to bring you more information as the quality payment program develops.

For the next slide I will turn this to Patty to talk about. Thank you Patty.

Sure. Thank you Sharon, I think that is the overview that is at the end for Macra and MEPS . Is that correct?

That is correct.

, To turn your attention to 2016 PQRS reporting and I thought it was important, am working with a lot of organizations around these the and we run into the same thing with everybody that we work with which is all of the quality reporting is becoming an wielding. There are too much things being asked for an too many different things being asked for. There are different data elements and the reason I want to talk about PQRS and other programs is , if you have to report for PQRS you should look at other quality reporting that you may be doing in your organization and it might be either an alternative payment model like Medicare shared savings program or other ACO's like the world ACO. It could be that you are submitting data for PCMH if you are in am PQ a or other patient certified center home there is ongoing data submission requirements to maintain certification and there are also state programs. I know Wyoming and Montana but I don't know about other states that are represented on this call, but you should check and see. You may also be submitting data to a payer program such as Blue Cross DeShields, Pacific sewers, I am not sure what other payers are offering incentives, based on quality reporting but it would be important for you to know. Also are meaningful use programs and there are quality measures that you are required to submit. The reason I bring all of this up is when you are doing PQRS, when you are choosing your measures, what you are going to report on, if you can look at the other quality reporting requirements that you have and they all have certain measures that they are interested in reporting try to outline PQRS with those reporting with Armand and they will do a couple of things for you. Number one it will streamline your focus to you don't have 80 different quality measures you are trying to track but maybe you have 12 or 15 or something more manageable. Also inequality and improvement that you do on the measures will effect most of the programs that you are already submitting data for. If you are doing quality improvement, let's say you are just working on your you let Tronic work load in your EHR to collect data correctly for PQRS, even if you are just doing that, that helps with other quality reporting that you have to do. The only reason that I asked to put the slide in is if you are responsible for choosing the measures for PQRS I encourage you to check what other programs you are reporting to. Often whoever is doing PQRS is not even aware of all of the other ones that are happening. If you think

everybody in a room, line your measures, look at your data, and focus on the most effective ones for your organization and work on them for tracking and improving for the PQRS program. That is only going to make sense as we move into next year.

That was really it, share and. I just wanted to remind people to do that if you are in your choosing your measures section of your project plan for PQRS this year.

Does anyone have any comments or questions about that?

Okay, Sharon go ahead.

Thank you Patty, I think you used a key term there, you use the term alignment. As I read through the proposed Macra rule they use the term often and that is a message that CMS has heard. There are multiple programs and unless you really sit down and talk them through with everybody who is involved and look at what the specific requirements art is pretty easy to feel like they are all taking you in different directions. I appreciate that you emphasize alignment because I know that is the direction in which CMS is trying to go with the whole MEPS and AP a program. The next speaker today is going to be Sarah Leake. Go-ahead Sarah.

I hope you can hear me, I took myself off meet. -- Mutes this is a site I wanted to show because of the changes in 2016 and who is eligible and how they are going to up by the penalties for the positive upward adjustments. The key here is it is being expanded and I will go through the left-hand side. If you have groups with 279 and do not the less to 29 you will get a negative to. You will get a negative to peak URS adjustment that you will get a -2 poly modifier adjustment as well and that will apply to all of the group. If you do report you could do be [INAUDIBLE] depending on how your quality tearing comes out, you could get a -2 or no adjustment up to a positive to. The clincher is if there are goup two the only nonphysician EP's got if you have a group that is only consistence of PAs, NCS, you will not move to the negative adjustment. You would if you do not participate at all but if you participate you cannot get a negative adjustment. That is a key item to think about in 2016 reporting. I wanted to bring this one up. Next slide.

Did I do that, Sharon? A key thing that you need to remember, it is pertinent and close, if you are a group in deciding if you want to do group reporting, the G Pro is a group reporting option. Registration is open now and it closes June 30, 2016. This means you really need to start making your decision now if you have not been thinking about it or do not know which way you are going to report. You need to register into the enterprise identity management account and I notice I am getting messages that they are fixing problems with it, it is okay now, the earlier the better because you never know when they may have a problem with that system. If you are a group of two or more EP's you can participate as a group and you need to register and when you register you also have to indicate the way you are going to submit your PQRS measures. Again, for this year, it is qualified PQRS registry that is individual measures, direct DHR or through a data submission web interface and then a new one is the QC DR if you decide you want to do it through qualified clinical data registry if you are a specialist or if there is a specific measure that you really are key on and want to work through QC DR in reporting those. They put a link here to the training guide and it is an intermediate level resource to provide information about requirements and options for participating and choosing group methods versus individual.

This is pros and I do not want to do necessarily the cons it's necessarily things you need to think about but I put together pros and cons or pros and important items, these are things to think about when you are choosing group or individual. The pros and successes [Indiscernible-multiple speakers]

Please make sure your mute is on your phone we can hear someone in the background.

If you report as a group you are reporting for everybody who falls under that if you successfully report it covers everybody. If you are doing a registry it is nine measures over three domain and it does not have to have every provider in there, if one provider is a specialist in the measure and the one you picked is not have them measures for that provider or that he has patients on than that is acceptable. Then individual providers have difficulty reporting and they would fall under this. Again they would be under that PIN. More important items are if you do group practices you must, if you are 100 or more you have to do a CAP survey and you would have to take that and bear the cost of it. For groups of two or more providers you have -- you can choose individually but you have to report at least 50% of the providers to avoid value modifier adjustments. Then, in addition those that you do not report on will get a 2% peak URS adjustment -- PQRS adjustment, they will not get a value modifier adjustment but they will get the 2% PQRS adjustment. You must register the group at the end of June and some of the measures that you would record on as a group may not be applicable to everybody. You just have to be very careful picking them out. Again, consider provider turnover, I put this in because this is two years, so if you report this year it is a affecting 2018 and it is the PIN NPI that is under this.

A list of G Pro resources, I wanted to put them here because it is a hot topic and very important before the end of June, a lot of very helpful documents on the website. The link to the website is on the bottom in bright blue and then this is just a picture of what that website looks like and what is on it.

One other thing that is going to be really helpful for you is they did release the MIDI year Q are you are and it can give you a lot of good information on the number of providers that CMS has noted that are under your PIN again it is not up-to-date as of today but it gives you a good idea of what they are looking at, who they are looking at as far as [INAUDIBLE] identified or claims identified under your PIN.

Here is a link to information to your QRUR and if you have a person that you have identified as your group representative. Your is also a link to information about where you can get your midyear QRUR . I think that is it. Sharon, I think is your your turn the last I think it is your turn -- share and I think it is your turn.

And need to advance the slide.

There you go thank you Sarah.

The next item we want to talk about, some of you may have attended a clinical access PQRS office hours that was held via webinar on February 8 on February 8, 2016. One of the things that they asked for before the webinar happened was they wanted people to submit questions. So we finally have gotten the question and answer document VAC and there are 36 questions and it covers a number of PQRS issues pertaining to clinical access hospitals and general PQRS issues. We have a link there so you can go in and see that document and read it to see what pertains to you. There are two important things to know as you read through this that I want to point out to you. First, in a question number 15 and repeated again in question number 27 there is language that implies the value modifier payment adjustment is not applying to professional services provided in critical access hospitals when the services are billed and paid under method to payment methodology. This is the first that we have heard of this and it seems to be a deviation from other things that we have seen. We have asked for clarification on that question and I do not want anybody to think while this does not apply to us because it showed up in the Q&A document, the Q&A document really is just more of a reference document and I would not consider it to be an actual legal document. I wanted to point that out as a caution. The second item that we saw in the question number 23 stated something like services rendered under frequent access hospitals method one billing and filling methodologies other than part B will not be included in PQRS analysis. Our understanding is method one is the standard healing process for Medicare part D and as such it should be subjected to PQRS analysis . We agree that methodologies other than part B are not included and an example of that would be rural health clinics or SQ HC and we know those are not subjected to PQRS so again caution on the question. Both of these have been asked to be clarified from the folks that provided the document to us and we want to update this with you when we get the answers back.

For the next couple of slides we have educational materials for you. We have the implementation guide for 2016 for PQRS. We have the measures code link as well.

More recent documents that we find it new documents out there on the PQRS spotlight webpage quite often so please check that regularly for updates. CMS has given us a couple of new tools this year, first is the web based measures searches tool which allows you to filter by measure number. Each measure has a link where you can go see the detailed specifications for each measure. Second is the single source measure list reachable by CVT and ICD 10 code you can use the report to search for measures that have the most requested CPT codes that your providers use to help track, trend and [INAUDIBLE].

Now we are going to turn this over to Amber to run the question and answer part of this. I think the first question that I will let Amber, well before we turn this over to Amber I think we need to go back and look at Eric's question in the chat box. Air it can you jump in? -- Eric can you jump in? I think you were talking about this when we were talking about MEPS but can you clarify the question for us ?

This is mostly for Patty, our understanding from listening to the big universals CMS webinars on Macra is that in year one at least it would be mostly or completely MDs that would participate on a mandatory basis and then all of the other eligible clinicians would be optional in year one. Is

that what Patty was saying? Or is she saying that all of the other folks that are currently in PQRS will be mandatory as well ?

This is Patty, share and I don't know if you want to take that.

I can and I can tell you everything that I have read and most of the CMS sessions that I have been on point out that it will be those folks that will be reviewed, physicians, PAs, nurse practitioners, certified nurse specialist and CRA's, the CMS event that I was on earlier today I think the same one as Patty, they were using the term M.D. but I will tell you when you read the proposed rule they are including and peas and PAs in addition to MDs were the ones considered most eligible clinicians from year one.

[Indiscernible-multiple speakers]

What about social workers, dietitians, people like that who are currently in PQRS ?

The reading I have done in the rules states that those folks, I am trying to get back to the slide where it shows that, I think it is this one, there we go, those folks are certainly invited to participate in this and they can the -- but they will not be subjected to payment adjustments like those who are required are. If you have people like physical pit -- therapist or clinical social workers who are currently reporting, they encourage those people to continue to report to stay familiar with the MEPS teen -- MEPS, but they will not be subjected to the adjustment in the first two years.

Okay that makes sense thank you.

Patty do agree with what you have heard?

It is one of the questions I have for CMS, Sarah, I do not know if you had this in your slides, the chart that shows everyone who is eligible for PQRS and meaningful use value-based modifier, it is bigger than the one showed on the CMS slide, my understanding and I am not clear if they are saying people who are already participating now in PQRS need to continue that were not it is just they are not adding any more . I do not know that we have clarity on that, honestly.

Thank you Patty.

I am not sure if that was helpful, it is still a proposed rule with some holes in it like that is a hole in my opinion. So we will try to get answers.

That helps and I understand that it is only a proposed rule.

Thank you.

Thank you Eric and thank you Patty. Number over to you. -- Amber over to you.

The webinar series we're going to be doing is very dependent on what your specific needs are. Feel free to jump into the chat box for your phone lines are open so feel free to let us know what kind of outstanding questions you have, what are some gray areas that you might have, and we will certainly try to accommodate your needs and future webinars and even do some one-on-one research for you. One of the specific questions that I had, I put it in the chat box, we have listed a little bit of all of the various ways you can report via AEG Pro I wondered if some of that was alphabet soup to you is that an area that you would like to see some additional webinars about, because you do have to apply for your G pro by June 30 as was presented. I would also like to open it up for additional questions.

Hi this is surely with the [INAUDIBLE] clinic physicians, it would be nice if we had somebody with the expertise helping us determine what would be best for our organization as far as reporting as a G Pro for for promoting -- reporting individually. It would be nice if we had the help up there.

I know we don't give concrete that using a G Pro registering as a group is definitely adventitious for most groups. The next thing to do is probably to run a list of your CPT codes and see which measures actually work. There are multiple different types of registries out there and perhaps we could do some additional research on you on that. Are you asking about G Pro versus individual or the different types of registries that are out there?

It would be G Pro versus individual because with our group as you know we have clinic physicians and we have ER physicians and we have cRNA's and the ER physicians and this cRNA's are on the different systems that are clinic physicians are. If we were to do any kind of reporting, the reporting would be based on just the clinic physicians because I do not know that the hospital is able to do any kind of reporting on the physicians and cRNA's within that EMR. Our reporting methods would end up being different because through our clinic weekend report via EHR it on the hospital side they would have to report registry so collectively we have to do it as a group, we would have to say we have to do registry or EHR and if we do EHR we would just be reporting on our clinic physicians but if we did registry we would have to report on all of our physicians and throw our EHR reporting out the window which I really do not want to do for the clinic side.

[Indiscernible-multiple speakers]

Remember your G Pro is by the tax ID number so you do not have to include all providers in your G Pro reporting it is only 50%. As long as your numbers work out you have the ability to only select your clinic providers and they will carry your hospital-based practices. Sharon, Abby [Indiscernible-multiple speakers]

Can I clarify that, this is Sarah, if you do a group, I have seen times where I've seen that the group should be using the EHR so I think we would need to look into that in more detail. If everyone is under one pin then that's one way but if they are under different PIN that is a different way of reporting. Individual reporting is when you have to come in and do 50% of them but the remaining ones will have you get the PQRS penalty still. They will not get the value modifier penalty if you are successful, greater than 50% but they will get the PQRS penalty if

you do not submit. I am happy to talk with you a little bit about some pros and cons and what I have run into so if you would like to give me a call that would be great.

Was that Sarah?

This is Sarah.

Okay we are all under the same PIN. So I guess I need some clarification, so if we report individually that even though we are look at as a group, a 50% of us successfully report PQRS than the whole group does not get the value modifier but those physicians that did not report PQRS on the hospital side would get a PQRS penalty correct?

Correct.

This is Sharon and that is correct, one other thing I want to throw out there for you to consider if you are doing a group, is that, I mentioned, the single source list of measures, you can use that to look at [Indiscernible-multiple speakers] that are being used by your providers in the clinic. You can also use that to see what CPT codes are being used by your hospital side providers. If you select a measures that only effect your providers in the clinic and your hospital providers have no patience that would be affected by that particular measure because they are common CPT codes and the CPT codes that they use are not in their than you have covered the patient population that is looked at for EHR reporting. EHR reporting looks more to what the patient population is for a given measure than it looks to which physicians in your group are affected by that measure.

Sharon, this is Patty, can I read state that if I understand you correctly -- can I restate that if I understand you correctly, if you do group reporting out of your EHR you submit all of the data out of your EHR and it covers everybody under that PIN, it does not matter if a certain provider does not have encounters in those measures it would cover everybody. Isn't that true, Sarah?

Yes, there is a caveat and I will look into it further, but the wording that all of the providers are supposed to be using is the EHR. If you are saying that you have two separate different EHR I am not sure that fits under the comment.

That is correct. We use two different ones one on the clinic side one on the hospital site. The clinic side use a beautiful job for PQRS reporting, CPSI on the hospital site does nothing. So we have

---

You would be doing what Sharon says if you did registry if it did not even falling with what you would be doing with your providers on the hospital side because registry is not pulling out of your EHR. If you pick a measure that is only ambulatory it would never ever be used by the hospital side, you can do that. So I will check to see if I can find is the wording again and begin to check into it a bit more if not I will call QualityNet on not wanting get back with you.

So you are saying registry reporting. So if [INAUDIBLE] Captioner data and did registered reporting for all of the clinic providers, under G Pro it would cover the hospital unless we are supposed to be on the same EHR, right?

If you pick a measures that fall into what a hospital does not even do, if your providers would not even be counted in it and I think you would be fine.

Okay.

But if you are doing EHR methods I think that would be tricky and that is what I need to call QualityNet about.

Okay. Take you.

Are there any other questions?

Next slide?

I think you have the ball Amber.

So June LAN remember there will be a survey monkey at the end of this webinar and please select your options.

[Indiscernible-multiple speakers]

Then just to follow up here is our acronym list since we do toss around a lot of them but you might even want to share this with some of years have members of they get used to the upper rooms -- so they can get used to the acronyms as well. That concludes our LAN webinar for the month of May look for the survey monkey that will pop up as soon as we close the webinar. Thank you everyone.

Thank you.

[Event concluded]