Centers for Medicare & Medicaid Services
How to Register Your PQRS Group Reporting Option for 2013
MLN Connects National Provider Call
Moderator: Leah Nguyen
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Contents

Operator: At this time, I would like to welcome everyone to today's 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 Leah Nguyen. Thank you. You may begin.

Announcements and Introduction

Leah Nguyen: This is Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on how to register to select your PQRS group reporting option for 2013. MLN Connects calls are part of the Medicare Learning Network.

During this call, CMS subject-matter experts will walk participants through the Physician Value, or PV, Physician Quality Reporting System, or PQRS, registration system. The PV–PQRS registration system is a new application to serve the physician value modifier and PQRS programs. A question-and-answer session will follow the presentation.

Before we get started, I have a couple of 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 so, please download the presentation from the following URL: www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page, 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 these are available.

And third, registrants were given the opportunity to submit questions in advance of today's call. We thank those of you who took the time to do so. While they may not be addressed today, they will be used for future presentations, frequently asked questions, and other educational material.

At this time, I would like to turn the call over to Sheila Roman from the Performance-Based Payment Policy Group in the Center for Medicare.

Presentation

Sheila Roman: Thank you very much. And good afternoon to everyone, and welcome to the call today.

I would point you to slide 4, which is the agenda for today's call, and point out that there'll really be three segments to the call today. The first part of the call will be an overview of the value-based modifier, and I'll be speaking about the value-based modifier.

The second section of the call will be on IACS and how you register and how you get your IACS account. And that will be presented by Sabrina Ahmed.

And then the third part of the call today will be on the Physician Value–Physician Quality Reporting System registration system. And that will be presented by Tonya Smith.

Overview of the Value-Based Modifier (VM)

Now I'm going to move to slide 5 and talk about the value-based modifier itself.

The value modifier is a separate payment adjustment that will be applied for the first time in 2015. And I want to just point out that it isn't a payment adjustment that is separate from either the PQRS incentives or the PQRS payment adjustment, which will also begin in 2015.

The value modifier assesses performance on both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule. The value modifier will begin to be phased in—in 2015. And in 2015 it will apply to groups of physicians with 100 or more eligible professionals.

The phase-in will be complete by 2017. So what that means is that by 2017, all physicians will have the value modifier applied to their PFS earnings.

Implementation of the value modifier is based on participation in the Physician Quality Reporting System. And on the next slide, we'll take a closer look at that. That's slide 6.

So, this slide looks at the link between PQRS and the value modifier program. And I want to point out that for groups of physicians with greater than 100 eligible professionals, the value modifier implementation in 2015 will be based on their PQRS participation in 2013.

And now, let's look at this slide and look at the right side of this slide, which leads to a minus-1-percent downward adjustment for those groups of physicians of 100 or more eligible professionals where the groups do not register for PQRS—for a PQRS group practice option and do not meet the minimum reporting requirement. Clearly, we would be most happy if no one actually went down the right side of this slide.

Now, let's look at the left side of the slide. And on the—on the left side of this slide, we have representation of what happens with the value modifier for those groups of 100 or more eligible professionals who are participating in PQRS. And that would be those groups that register for PQRS GPRO via one of three reporting options. And that is the web interface, a registry, or CMS-calculated administrative claims option. And they must also meet the minimum reporting requirements for the option that they choose.

If they are successful at registering and meeting the minimum reporting requirement, then they will get no adjustment to their PFS reimbursement. They will also have the option to elect quality-tiering calculation. So, again, if I can just emphasize that by being—by participating in PQRS and meeting the minimum reporting requirements, those groups who will have the value modifier implemented in 2015, of 100 or more eligible professionals, will have no adjustment by simply participating in PQRS.

Now, if you—you do have the option to elect quality-tiering calculation, and—which we will go over shortly, on the next couple of slides. And if you elect the quality-tiering calculation, you possibly could receive an upward, a downward, or no payment adjustment based on your performance both on quality and cost.

Now on slide 7. And slide 7 lays out for you how we use domains in the—in the quality-tiering methodology to combine each quality measure into a quality composite, and each cost measure into a cost composite. So, for quality, what you see is the domains for the National Quality Strategy. And you'll probably note that we don't have measures in PQRS and in the options that I laid out for you for the value modifier for all of these domains.

Consequently, we will use—we will put the measures in the reporting mechanisms into these—into the various domains. But we will only be combining those domains, and they will be weighted equally, for those domains for which you have measures, so that the measures within your domains are all weighted equally, and the domains for which you have measures are all weighted equally, to form your quality of care composite score.

Likewise, for your cost composite score, we will use cost measures that are based on administrative claims and that—those measures include a total per capital cost measure, which has its own domain, and a total per capital cost measure for beneficiaries with four specific chronic conditions in a separate domain. And those will be—again, the four measures will be equally weighted in their domain. And then the two domains will be equally weighted to—and combined for your cost composite score.

On slide 8, we look at the quality-tiering approach that we have finalized for 2015, and that is shown in the grid in the middle of the page. So, essentially, each group receives two composite scores, one for quality and one for cost, based on the group's standardized performance—that is, how far away from the national mean. And that—this approach identifies statistically significant outliers—that is, those outliers are those that are one or more standard deviations away from the national mean—and assigns them to their respective cost and quality tiers of low, average, or high.

Now, if we look at the grid and we look at the lower right-hand corner, this is where you don't want to be if you elect quality tiering. And these are the higher-cost, lower-quality groups based on your performance on your quality and cost measures. And you can see that there is a downward payment adjustment that will be applied if, by quality tiering, that's where you fall in the quality-tiering grid.

If we look at the upper left-hand of the grid, you'll see that's where the higher-quality, lower-cost groups fall. And they will get a bump up in their payments based on where they fall in the grid. You will note that there is an asterisk on the grid. And what the asterisk means is that those groups who report quality measures via the web-based interface or registries, and also have an average beneficiary risk score in the top 25 percent of all beneficiary risk scores—that is, they are taking care of the more complex patients—they will have an additional one plus bump up for caring for complex patients.

On slide 9, there is a timeline for the value modifier that will be applied to payment and which begins to put this all together for you. And as I've already noted, we are already in the reporting year for the January 1st, 2015, value modifier that is applied to physicians in groups of more than 100 eligible professionals. And those groups must register for the report—their quality reporting mechanism. And also at that time, they will have the option to elect quality tiering.

The registration system opened on July 15th and closes on October 15th. And, again, I'll point out that this will be for performance during this year, 2013. On September 20—on September 16th, you will be able to retrieve the—your 2012 Physician Feedback Reports if you're a group of at least 25 eligible professionals. And those reports will contain information on your composites of quality and cost.

In the first quarter of 2014 you must complete submission of your 2013 information for PQRS. And you can see, also, that the registration period for the 2016 value modifier has been moved up and will be May 1st to September 30th in 2014. And in the third quarter of 2014, you—all groups—all groups and solo practitioners will be able to retrieve their 2013 Physician Feedback Reports.

And then, as I've already mentioned, on January 1st, the—of 2015, the value modifier will be applied to physicians in groups of at least 100 eligible professionals. And then you can see that it plays out through the—through 2016 on this slide. And I'll just point out that on January 1st of 2016, we have proposed that the value modifier will be applied to groups of 10 or more eligible professionals so that, if that is finalized, the value modifier will be applied to physicians in groups of 100 or more eligible professionals and to physicians in groups of 10 to 99 eligible professionals.

Next slide, please.

So I'm on slide 10. Slide 10 reviews for you the actions for groups of 100 or more eligible professionals for the 2015 VM. First, you must register as a group in the Physician Value–Physician Quality Reporting System registration system during the period of July 15th through October 15th, 2013. You—at that time, you will be required to select a PQRS GPRO reporting mechanism, one of the three options that I mentioned earlier—that is, the web interface, CMS-qualified registries, or CMS-calculated administrative claims options.

Now, for those groups whose physicians already participate as individuals and want to continue to participate as individuals in PQRS, they must self-nominate in a group option. And if they're going to participate as individuals, I would recommend that they elect the administrative claims for the value modifier.

I would also point out that if I could give you a piece of advice, that this is the year to really begin PQRS if you are already not participating in PQRS. And the administrative claims option will only be available in 2015; it will not be available in 2016. So this would be the year to try out some of the other group options available through PQRS because, as I showed you on the slide linking PQRS to the value modifier, there's really no risk this year. And, finally, if you are a group of 100 or more, you will need to determine whether to elect the quality-tiering approach to calculate your value modifier between July 15th and October 15th of this year.

Now, we're going to move on to IACS, which stands for an Individuals Authorized Access to the CMS Computer Services, account. And that account is required to access the Physician Value–Physician Quality Reporting System registration system.

And at this time, I'll turn to Sabrina Ahmed, who will continue with the presentation about IACS.

IACS Introduction

Sabrina Ahmed: Thank you, Sheila.

In slides 11 through 24, I will provide an introduction to IACS, which, as Sheila mentioned, is the type of user account you will need to access the registration system. And then I will review the IACS roles that are available to group practices and individual EPs, and how you can get an IACS account with an appropriate role.

Slide 11 provides a brief overview of IACS. All IACS users are limited to one account per person. An IACS account can be associated with multiple group practices, which are identified by their Medicare billing TIN, or EPs, who are identified by the combination of their Medicare billing TIN and rendering NPI.

If you have an existing IACS account—for example, if your group self-nominated earlier this year or submits PQRS data as a GPRO, you should already have an IACS account. In that case, you must first ensure that your account is still active. You can verify whether

your account is active by contacting the QualityNet Help Desk. The contact information for the QualityNet Help Desk is listed on slide 45.

And then, you must add a registration system role to your existing account. If you already have an IACS user ID but forgot your password, then you can change the password yourself on the IACS application website. You can also call the QualityNet Help Desk, and they'll be able to walk you through the process.

If you haven't done so already, we strongly urge representatives of group practices and EPs to request a new IACS account with a registration system role or modify an existing IACS account as soon as possible after this call.

Before I get into the details of the IACS roles that are available for groups and EPs and how you can request the appropriate role, I want to provide a high-level overview of how the IACS process works. Each group for each TIN must designate one person who needs to request the primary Group Security Official role. CMS approves this role request. That primary Group Security Official then approves requests for the other two group roles. However, it's not necessary for groups to request any other role other than the primary Group Security Official role in order to access the registration system.

In the case of an EP, the EP must designate one person who needs to request the primary Individual Approver role. CMS approves this role request. The primary Individual Approver then approves requests for the other two EP roles. However, it's not necessary for the EP to request any other role other than the primary Individual Approver role in order to access the registration system.

In slides 12 through 15, I'll talk about the two main categories of roles available in IACS, the group practice roles and EP roles. You must first determine whether you need to request one of the group practice roles or one of the EP roles.

First I will review the IACS roles that are available for group practices. This information is on slides 12 and 13. I'll review three roles that are available for group practices, but you will need to select only one of the roles.

Each group practice is identified in IACS by its Medicare billing TIN. If a group bills Medicare using multiple TINs, then each TIN must be registered in IACS. During this presentation, when I refer to a group or a group practice, I'm referring to a group's TIN.

In order to request one of the group practice roles, the first thing that needs to happen is that one authorized representative of the group practice must sign up for an IACS account with the PV–PQRS Group Security Official role and register the group practice as an organization in IACS. This person will then be considered the group's primary Security Official. In this case, the EPs who bill under the TIN do not have to get an IACS account or register for the PQRS individually.

Each group can have only one primary Group Security Official, but there can be one or more backup Group Security Officials. Most primary Group Security Official role requests are approved by CMS within 24 hours after their request is submitted in IACS. However, in some cases, it may take longer to verify the information provided in the request.

Slide 13 lists the tasks a user with a primary or backup Group Security Official role can perform on behalf of the group practice.

The PV–PQRS Group Representative role is the third type of group role available in IACS. It can be requested only after the group practice has an approved primary Group Security Official in IACS.

So far, I reviewed three roles that are available for group practices. But a group needs to have only one person request the primary Group Security Official role in order to access the registration system. After your request for one of the group roles is approved, you will receive two email messages. The first email will contain your IACS user ID, and the second email will contain a temporary password. You will then need to go back to the IACS application website, log in to your account, and change the password.

Leah Nguyen: Hold on for one moment. Could I ask all of our speakers to please mute their lines? Thank you.

Sabrina Ahmed: I will next review the IACS roles that are available for EPs. This information is on slides 14 and 15. I'll review the three roles that are available for EPs, but you will need to select only one of the roles.

Each EP is identified in IACS by its Medicare billing TIN and rendering NPI. In order to request one of the EP roles, the first thing that needs to happen is that the EP or one authorized representative of the EP must sign up for an IACS account with a PV–PQRS individual role and register the EP in IACS. This person will then be considered the EP's primary Individual Approver. Each EP can have only one primary Individual Approver, but there can also be one or more backup Individual Approvers.

Similar to the primary Group Security Official role, most primary Individual Approver role requests are approved by CMS within 24 hours after their request is submitted in IACS. However, in some cases it may take longer to verify the information provided in the request. Slide 15 lists the tasks that a user with a primary or backup Individual Approver role can perform on behalf of the EP.

The PV–PQRS Individual Representative role is the third type of EP role available in IACS. It can be requested only after the EP has an approved primary Individual Approver in IACS.

So, so far I reviewed three roles that are available for EPs. But an EP only needs to have one person request the primary Individual Approver role in order to access the registration system.

Next, I'll review the steps you need to take in order to request an IACS account with the appropriate role. Slide 16 describes the three steps you need to follow in order to sign up for a new IACS account or to modify an existing IACS account to add a registration system role.

Based on the IACS role you want to request, first gather all of the required information you need to submit your request for a new IACS account or to modify an existing IACS account. These are listed in slides 17 and 18. Please refer to the Quick Reference Guides we have available on our registration website that provide step-by-step instructions for obtaining an IACS account for each type of registration system role and modifying an existing IACS account. The website where the guides are available is listed on slide 45.

Next, enter the required information into the IACS application website. Lastly, verify that you entered all of the required information correctly and submit your request. It's very easy to submit the request in IACS and should take about 5 minutes if you have all of the required information on hand.

Slide 17 lists the information you have to provide for each of the three group practice roles, and slide 18 lists the information you have to provide for each of the three EP roles.

Leah Nguyen: Hello. Again, I need to ask everybody to please mute your lines. Thank you.

Which IACS Role Do You Need?

Sabrina Ahmed: So, in slides 19 through 24, I will go through the specific steps you'll need to take in the IACS application in order to request an IACS account with Group Security Official or Individual Approver role. You'll also see the important IACS screens associated with each role request.

Slides 19 and 20 show the steps you have to complete in IACS regardless of the type of registration system role you are requesting for a new IACS account. Slide 19 shows how you can access the IACS website.

First, you need to go to the applications.cms.hhs.gov website and select "Enter the CMS Applications Portal." Next, select "Account Management" and then "New User Registration." The screen you will then see is shown in figure 1.

Scroll down to the bottom of the screen and select "PV–PQRS Registration System." Please do not select any other applications listed on this page. The steps described in slide 20 also apply to all role types. As shown in figure 2, you will need to enter the required user information and professional contact information, and then select the specific group or EP role you want to request from the Access Request dropdown menu. You can see on

this screen that the Access Request menu has a red circle around it, and it lists the IACS roles available for groups and EPs.

As I mentioned earlier, if you are the first person from your group practice to sign up for an IACS account, you must select the PV–PQRS Group Security Official role. In the case of an EP, if you are the EP or the first person to sign up for an IACS account on behalf of the EP, you must select the PV–PQRS individual role.

Slides 21 through 24 are specific to each group and EP role. Slide 21 shows the screen you have to complete if you are requesting the primary Group Security Official role on behalf of the group practice.

First, you have to select the PV–PQRS Group Security Official role from the Access Request dropdown menu shown in slide 18. Then select the "Create a New Organization" radio button. Then enter the group practice's Medicare billing TIN, rendering NPI, or two different individual physicians who bill under the TIN and their corresponding individual PTANs.

PTAN stands for provider transaction access number. It is not the same as the Medicare PIN, or provider identification number. If you do not know the individual PTANs, then please check the enrollment approval letter the physicians received from the Medicare Administrative Contractor, or the MAC, when enrolling in the Medicare program, or contact the MAC directly. Please do not use the group NPI or group PTAN in this section.

Slide 22 describes the steps and shows figures 4 and 5, which are the screens you have to complete if you are requesting the backup Group Security Official Role. The screens for requesting the Group Representative role also look similar to figures 4 and 5. However, you will first need to select "PV–PQRS Group Representative" from the Access Request dropdown menu that is shown in slide 20.

Slide 23 shows the screen you have to complete if you're requesting the primary Individual Approver role on behalf of an EP. First, you have to select the PV–PQRS individual role from the Access Request dropdown menu shown in figure 6. Then select the "Create a New Individual Eligible Professional" radio button. Then enter the EP's Medicare billing TIN, rendering NPI, and the corresponding individual PTAN. Then enter the remaining required EP information.

As I mentioned earlier, if you do not know the EP's individual PTAN, then please check the enrollment approval letter the EP received from the MAC when enrolling in the Medicare program, or contact the MAC directly.

Slide 24 describes the steps and shows figures 7 and 8, which are the screens you'll have to complete if you're requesting the backup Individual Approver role. The screens for requesting the Individual Representative role look similar to figures 7 and 8, as well.

However, you will need to first select "PV–PQRS Individual Representative" from the Access Request menu that is shown in figure 7.

The remaining slides will describe the registration system, which you will be able to access after your IACS account, with the appropriate group or EP roles, has been approved by CMS.

I would now like to turn the presentation over to Tonya Smith.

PV–PQRS Registration System Introduction

Tonya Smith: Thank you, Sabrina.

Just to recap, Sheila has given an overview of the VM and gave a detailed description of quality care. And Sabrina has also gone over the process for obtaining an IACS account. Now I will discuss the registration process.

Slide 25 gives a brief overview of the PV–PQRS registration system. The system is a new system which allows group practices to select or change their PQRS group reporting mechanism for 2013. It allows groups of 100 or more EPs to elect quality tiering to calculate their value modifier in 2015. For individual EPs, they have the opportunity to select CMS-calculated claims in order to avoid the PQRS payment adjustment in 2016.

On slide 26, this slide lists the group practices and EPs who do not have to register in the registration system. Specifically, group practices that participate in the Medicare Shared Savings Program do not have to register, and EPs who participate in the PQRS in 2013 using either registry, claims, or electronic health records do not have to register in the registration system.

On to slide 27. This slide pertains to groups and EPs that participate in either a Pioneer ACO or the Comprehensive Primary Care Initiative, and it also shows whether or not they need to register in the system. I understand that there is a lot of information on this slide, so you can definitely go over it at your leisure. But for specific questions about these CMS initiatives, please refer to the CMS program contact or to the program-specific help desk.

Slide 28 highlights the steps you will need to take to register in the system. Just as Sabrina mentioned on slide 16 that you will need to gather, enter, and verify to register in IACS, you will need to perform similar steps to register in the PV–PQRS registration system. But before you proceed with these steps, you will need to have completed certain actions or made some key decisions.

For example, if you are a group, you will need to have secured the PV–PQRS Group Security Official role in IACS, as Sabrina discussed. You will also need to have decided as to which PQRS reporting mechanism to select or change. And lastly, you will have needed to decide whether to elect quality tiering. If you are an individual EP, you will need to have decided as to whether you want to select CMS-calculated administrative

claims reporting mechanism. Now, you are ready to gather, enter, and verify the required information.

Slides 29 and 30 list the required information that you will need to enter.

How Do You Register in the PV–PQRS Registration System?

Moving on to slide 31, the highlighted URL at the top of the page is what you will need to select in order to log in. On slide 32, this is where you will enter your IACS user ID and password.

On to slide 33. In order to access the registration portal, please select the PV–PQRS tab. Then select "Registration" on the dropdown.

Group Practice Registration

On to slide 34. This is a screen you were—you will see if you are a group registering in the registration system for the first time. You would select "Register." I would like to add that above the "Register" option, there is an option that says "Modify." This is for groups who self-nominated during the period of December 1st, 2012, to January 31st, 2013. These groups do not have to register again. They have the opportunity to change their reporting mechanism and elect quality tiering. I will speak more to self-nominated groups later in this presentation.

Slide 35 shows the group practice information which will need to be entered. What is important to know on this slide is that if your group practice size is 2 to 24, you can elect admin claims or the registry reporting option. You will not be able to select the GPRO web interface as an option. If your group practice size is a hundred or greater, quality tiering is an option which is—which is available for your group.

On slide 36, you will need to enter the information for the program and technical contacts. For program contact information, you may include the information for the person in your group who is assigned to handle Medicare quality reporting. For the technical contact, you may include the information of the person in your group who is assigned to oversee the computer- or network-related activities.

On to slide 37. In this section displayed, you have an opportunity to edit the information that you have entered. Once you have verified that the information is correct, you will select "Submit."

On slide 38, this shows the confirmation message you will—you will see once you have verified and have submitted your registration.

Self-nominated group practices—we're now on slide 39. As I mentioned on slide 34, groups that self-nominated early in the year do not have to register again. However, these groups can modify their selection that they previously made by changing their 2013 PQRS reporting mechanism or by selecting administrative claims. Groups with 100-plus EPs can also select quality tiering during this time.

Individual Eligible Professional Registration

On to slide 40. Slides 40 to 43 are screenshots you would see if you are an individual EP registering in the system in order to select the CMS-calculated claims to avoid the PQRS payment adjustment in 2015. I won't go through each of the slides for individual EPs, as they are the same screens in which I previewed for groups.

I would like to point out one particular slide, and that is slide 41. Slide 41 is the slide that the individual EPs will see in order to select the CMS-calculated claims option. Let me just reiterate again that individual EPs who participate in claims, registry, or EHR do not have to register.

Next Steps

Moving on to slide 44. Slide 44 lists the next steps you will need to take. You will need to get an IACS account or modify an existing account now if you have not already done so. You will need to then register in the system via the URL listed. And you have until October 15 to register.

On September 16th, CMS will make available the 2012 Quality and Resource Use Report, or the QRUR. CMS produces annual QRURs for physician groups. The 2012 QRURs will be produced for physicians in groups of 25 or more EPs.

What is important about these reports is that they will also contain the medical group's quality of care and cost performance, or measures, that will be used to complete – I mean, to compute the Value-Based Payment Modifier. Sheila alluded to this earlier in her – in her presentation.

Resources

Onward to slide 45. For assistance with registering and the registration system, the QualityNet Help Desk information is listed. The links on this page can further assist you if you need more information regarding the PQRS program, GPRO, or the Value-Based Payment Modifier. We also offer Quick Reference Guides to walk you through the process of obtaining a PV–PQRS system role in IACS. You can also use the link where it says "Quick Reference Guides" to walk you through the process of registering in the PV–PQRS registration system.

Thank you. And I will now turn it over to Leah.

Keypad Polling

Leah Nguyen: Thank you, Tonya.

At this time, we will pause for a moment 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 silence on the line while we tabulate the results.

Victoria, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using only one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in.

If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter—enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling.

Thank you. I would now like to turn the call back over to Ms. Leah Nguyen.

Special Announcement

Leah Nguyen: Thank you, Victoria. Before we start the question-and-answer session, we would like to make a special announcement.

CMS will soon provide a new opportunity for Medicare-enrolled providers and suppliers to give us your feedback about your experience with your Medicare Administrative Contractor, or MAC, the contractor that processes your Medicare claims. This new assessment tool is called the Medicare Administrative Contractor Satisfaction Indicator, or MSI. Your feedback will help CMS monitor MAC performance trends, improve oversight, and increase efficiency of the Medicare program.

Each year, CMS will randomly select its MSI administration sample from a list of providers who register to become a participant. If you would like to register to become an MSI participant, or for more information, please visit the website listed on slide 46.

Question-and-Answer Session

Our subject-matter experts will now take your questions.

I would like to remind everyone that this call is being recorded and transcribed. So before asking your question, please state your name and the name of your organization.

In an effort to get to as many of your questions 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 1 to get back into the queue, and we'll address additional questions as time permits.

All right, Victoria, we're ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key.

Remember to pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard into the conference.

Please hold while we compile the Q&A roster.

Please hold for your first question.

Your first question is from Sheree Vora.

Sheree Vora: Hello?

Leah Nguyen: Hello. Go ahead.

Sheree Vora: Hi. I just want to make sure that on page 26, when they were speaking about how—which group practices and individual EPs do not have to register, if we're a solo practitioner—there's one physician, and it's an individual EP—and we want to participate in the PQRS for 2013 and forward, we can do this by claims only. We don't have to do this value—the value modifier. Is that correct?

Tonya Smith: That is correct. The value modifier will be implemented in 2015 to groups of physicians in groups with 100 or more EPs. So, you mentioned that you were a solo practitioner.

Sheree Vora: Correct.

Tonya Smith: So, for 2015, the VM would not apply to you.

Sheree Vora: OK. Very good. So, we just continue with what we're doing.

Tonya Smith: Yes.

Sheree Vora: OK. And if I have another question, I can just hit star 1 again?

Leah Nguyen: That's correct. Thank you.

Sheree Vora: OK.

Operator: Your next question is from Linda Wood.

Linda Wood: Hi. I have a large group practice at the University of Kansas Medical Center with, like, 600 physicians and other possible eligible professionals. So, if I sign up as the primary Group Security Official, but I have Gloria sign up—Gloria's going to be the one who is actually going to be doing the registration. So is she a Group Representative and the primary Individual Approver?

And then, for example, if Gloria were to leave, because she is considering retiring next year, then can we—is there a way to replace her as the—in these roles?

Sabrina Ahmed: This is Sabrina Ahmed. So, your group needs to have, you know, at least one person who would request the primary Group Security Official role. And let's say, for example, you are that person. And then, the second person can request to be the backup Group Security Official, or they can request to have the Group Representative role. And if she—and, in that case, both of you would be able to, you know, register your group in the registration system.

And if she leaves your group, then you can go back in or, you know, whoever is the primary Group Security Official, you know, you can go back into IACS. And if another person wants to request, you know, a secondary role, then you can approve that role.

Linda Wood: So you don't have to actually eliminate a person who has left the practice, you just have multiple people, and you just use the new person then? And there's—and I'm guessing there's no limit. I mean, there was a problem on—I think it was on the e-prescribing, where you could only have like—no, it was on the MU registration. You couldn't have more than 300 people under your name. So there's no limit to the number?

Sabrina Ahmed: No. There is no limit to the number of backup roles, or the representative roles . . .

Linda Wood: I mean, there is no limit on – of – is there a limit to the number of eligible professionals that the backup Security Official can enroll? So, somebody enrolls all the eligible professionals. It sounds like that's the primary Individual Approver. I'm a little confused because there's so many roles.

Molly MacHarris: Sure. This is Molly MacHarris. So, I just wanted to clarify something, because I heard you say that for MU, you had to sign up 300 folks. So, for the PV–PQRS registration module, it will just be the group contact who is signing up and making the election for their PQRS quality reporting on behalf of the group.

Linda Wood: OK.

Molly MacHarris: So one big difference is in participation—or, in participating as individuals versus groups is, as you know from Meaningful Use, every single one of your providers must separately register and attest to Meaningful Use. For the Group Practice Reporting Option under PQRS and what is being used by the Value-Based Payment Modifier is that one group contact must sign up, and they will make the election for how the quality data will be received by CMS for that entire group.

So, as Sabrina went through the presentation earlier, there are different roles that you need to have to actually make that occur. But, for your 300- or 600-person group, not

every single provider needs to have an IACS account. It's only the representative within your organization who will be signing up that entire group.

Does that help clarify?

Linda Wood: Right. There is one person who signs up as group, and we're going to do administrative claims, so we know that. But then, does that—does the representative have to sign up each eligible professional with their PTAN?

Molly MacHarris: No. No. No, you do not.

Linda Wood: Oh, OK.

Leah Nguyen: Thank you.

Linda Wood: Thank you.

Operator: Your next question is from Mike Deyett.

Molly Minehan: Hello. This is Molly Minehan with ReportingMD. The way—can you hear me?

Leah Nguyen: Yes, we can.

Molly Minehan: OK. The way I am understanding the determination of the value modifier for groups of 100-plus EPs is that September 16th, 2013, a QRUR report will be—based on 2012 PQRS reporting—will be released to groups of 25-plus EPs. And that report will contain cost and quality scores. Will that report include the national mean information that 100-plus EP groups can compare their cost and quality scores to the national mean so they can make an educated decision as to whether or not to elect the quality tiering approach to the value modifier?

Sheila Roman: This is Sheila Roman. Yes, there will be benchmark information within that Physician Feedback Report.

Molly Minehan: OK. Thank you.

Leah Nguyen: Thank you.

Operator: Your next question is from Melody Flores.

Melody Flores: Hello. Yes. Thank you. Can you hear me?

Leah Nguyen: Yes, we can.

Melody Flores: Thank you. I wanted to ask for a bit of clarification around the group practice, the Group Security Official role. Is that different from the security official that we already have in place for our organization?

Sabrina Ahmed: Do you already have an IACS account for PQRS?

Melody Flores: Yes, I do. We've done PQRS for a number of years. We had a GPRO web interface, and so we have multiple individuals who have both the PQRS submitter and PQRS reporting role. And we do have a security official for our IACS account, but it appears that we need a Group Security Official in addition to that person, or not?

Sabrina Ahmed: Yes. So, this is a different role from the PQRS role that you already have for your group. So, in this case, you—someone who already has an IACS account would need to modify their IACS account to add the Group Security Official role to that account. It can be that, you know, it's the same person, if—it can be the same person who's the security official for PQRS if you want that person to have the same . . .

Melody Flores: If we chose. We actually would prefer not to do that for internal reasons. So, just to clarify, I as a PQRS submitter with my IACS account can request that my role be changed to Group Security Official. Will my existing security official need to have oversight over that and approve anything? Or is that strictly through CMS?

Sabrina Ahmed: No. This would be—your primary Group Security Official role will be approved by CMS.

Melody Flores: OK. Not our existing security official?

Sabrina Ahmed: No.

Molly MacHarris: And this is Molly. Again, I just wanted to clarify. You don't need to remove your PQRS role—your PQRS submitter role. You still will need that . . .

Melody Flores: Yes.

Molly MacHarris: . . . if you want to continue to use the web interface for reporting, for example. You will just need to add this additional role that Sabrina talked about earlier.

Melody Flores: OK. And this is the role that will allow us to submit into the additional system what our selection for reporting is for the upcoming year.

Molly MacHarris: Correct.

Melody Flores: OK. Thank you very much.

Operator: Your next question is from Carol Anne Newell.

Carol Anne Newell: Hello. I am really confused now after listening to this call. This will be my first year with GPRO. We have done PQRS on an individual basis through a vendor, but we are electing GPRO this year, and our vendor does not support GPRO, so we're looking at web interface. And then I'm looking at this quality-tiering calculation. And I don't understand. Is this in addition to the web interface? Or is it another choice for us? We are a group of 200-plus EPs.

Sheila Roman: Hi. This is Sheila Roman. Did you finish?

Carol Anne Newell: Yes. Go ahead.

Sheila Roman: OK. As a—as a group of 200-plus, you will be, you know, one of the groups that will have the value modifier implemented in 2015.

Carol Anne Newell: OK.

Sheila Roman: As such—as such, you will need to choose your reporting mechanism, if you have not already done so, by October 15th . . .

Carol Anne Newell: Correct.

Sheila Roman: . . . and register. Now, once you have chosen your reporting mechanism, and if you meet the minimum reporting requirement for PQRS, then, essentially, you get a free pass on your value modifier, unless you decide that you are a higher-quality, lower-cost practice and you would like to elect quality tiering.

Carol Anne Newell: And if we choose—if we do that, then that would replace, like, the web interface?

Sheila Roman: No, no. The reporting mechanisms are separate. The reporting mechanisms occur before you have the option to do quality tiering. We do quality tiering, actually, on the quality measures that you report on in your reporting mechanism.

Carol Anne Newell: OK. So I will not be receiving a report this year on September 16th because I didn't do it last year. Am I right?

Sheila Roman: No . . .

Carol Anne Newell: I only did individ – go ahead.

Sheila Roman: You – go ahead.

Michael Wroblewski: Hi, it's Michael Wroblewski. No. You'll get a report – because you didn't participate as a group in 2012, we'll give you 2012, how you would look under the administrative claims, CMS-calculated administrative claims.

Carol Anne Newell: OK.

Michael Wroblewski: So that will be in your report.

Carol Anne Newell: All right.

Michael Wroblewski: You're welcome. Thank you.

Carol Anne Newell: Thank you.

Operator: Your next question is from Lisa Smith.

Lisa Smith: Hi. Good afternoon. I have a question. We are at the point of setting our group up with the PV–PQRS Group Representative. We had already established the IACS account. We're having a hard time, actually, with timeliness. And according to your slide, I think, if I'm reading it correctly, it's says "must be approved by the primary or backup Group Security Official within 12 calendar days."

Our security official actually contacted the QualityNet Help Desk to find out what the status of our application was to obtain the PV–PQRS Group Representative roles. And they're just saying that they're very backed up. Is that, in fact, the case? Or is there a problem with our application? Or should we start this from scratch? I'm not sure—you know, we're not getting any information other than they're backed up.

Leah Nguyen: Could you hold on for one moment?

Christine Estella: This is Christine Estella. This is Christine Estella. I'm actually—I work with the QualityNet Help Desk. From my understanding, they have been receiving a lot of calls.

Lisa Smith: Yes.

Christine Estella: When—how long ago did you call looking for advice on IACS?

Lisa Smith: It was prior to July 15th. They had actually asked for us to verify two of our providers and their Medicare PTANs and NPIs, which we'd supplied them with immediately. And this is dating back—I think that that was around July 15th. The initial application going for the PV–PQRS was prior to that day. It could have been earlier that day or the day prior, I'm not sure. But, it's obviously well over the 12 calendar days of submission, and they said that they cannot – they cannot tell us when it will be approved.

Christine Estella: Right. How about—OK—well, how about you give them a call again? I'll check to see, you know, how backed up the Help Desk is. If you can give me your name, I can ask about you.

Lisa Smith: Sure. It's actually—it's—I was not—I was not the security officer. I can give you that person's number—name and number, if that's necessary, or I can give you mine. Let me give you his.

Christine Estella: Sure. Whichever. OK.

Michael Wroblewski: Hi, Christine, this is Michael. Can I interrupt for just one quick second? Since this is a National Provider Call, can I ask the caller just to email me at qrur@cms.gov and put that information in that? That would be the better way to do it.

Lisa Smith: Q, r—thank you.

Michael Wroblewski: You are welcome.

Lisa Smith: qrur@cms.gov?

Michael Wroblewski: Yes.

Lisa Smith: I will do that. I appreciate your help.

Tonya Smith: You missed that. I'm sorry. It's qrur@cms.hhs.gov.

Michael Wroblewski: Yes.

Lisa Smith: Dot-HHS-dot-gov. And I'm sorry. Your name again, sir, was?

Michael Wroblewski: It's Michael Wroblewski. But Tonya's going to answer that one for me.

Lisa Smith: All right. OK. Thank you. I appreciate your help.

Leah Nguyen: Thank you.

Michael Wroblewski: Thank you.

Operator: Your next question is from Lita Gill.

Lita Gill: Hi. This is Lita Gill. And I was curious—is there somewhere where I can go to get more information about how to make an informed decision on the method that we choose? I believe our organization has already—we think we're going with the claims-based method. But as a newcomer to this process, I'd like to understand what that entails, why one would be best fit for—you know, for an organization, what implications that might have on future payments or penalties, that sort of thing. Is there some resources out there?

Molly MacHarris: Sure, this is Molly MacHarris. The best place to actually go over where to get started is the QualityNet Help Desk. They have the resources to actually sit with you and to hear what your practice does and help determine what would be the best reporting option for you. And depending upon the reporting option you select, which measures would best suit your practice. And the QualityNet Help Desk information . . .

Tonya Smith: Should be on slide 45.

Molly MacHarris: Slide 45. Thank you.

Lita Gill: OK. I can just call that phone number and ask them these questions?

Molly MacHarris: Yes. You can just give them a call or shoot them an email and explain to them that you want to get started in PQRS reporting and you don't really know where to begin, and they will go over everything about PQRS with you.

Lita Gill: OK. Mostly, it's about the reporting method and which one to choose. It's not, like, everything. It's just the reporting method. So that would—they would be the best people to talk with about that specifically?

Molly MacHarris: That's correct.

Daniel Green: And the method—and the method is partly determined by which measures you all decide to report, because not every measure is reportable, for example, by claims.

Lita Gill: OK. OK, so—and they'll have more detailed information on that. Awesome.

Daniel Green: Yes.

Lita Gill: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question is from Elaine Jorgensen.

Elaine Jorgensen: Hi. I'm calling from a sole proprietor. And I believe the first person's question answered mine, that because we are a single doctor, we don't have to register for the PV–PQRS though we do have an IACS account?

Tonya Smith: That is correct. Just for 2015. But, as Sheila mentioned in the presentation when she went over the timeline, that you—if you—yes, you don't have to do it now, but in upcoming years, you will have to, so . . .

Elaine Jorgensen: Oh, so just as well do it now as waiting for a future one when it's required, right?

Sheila Roman: Yes. The point that I made was that by—legally, by statute, all physicians will have the value modifier applied by January 1st, 2017. So we'll—we are, you know, expanding over the next, you know, 2 years the physician and physician groups that will have the value modifier applied. And you will have the value modifier applied by 2017. So I—you know, I think to participate now and—in PQRS and have practice, you know, with an option is in your best interest.

Elaine Jorgensen: OK. Even though we're still doing the claims submission—putting the values in the claims submission, we still need to eventually register for the PV–PQRS?

Sheila Roman: Well, I did not talk about our proposals for 2016. But, for 2016, the reporting mechanisms for the value modifier will be somewhat different. And there will be an option for those who want to remain as individual reporters. For the group or, in this case, for your solo practice, your solo practitioner would need to fulfill the PQRS requirements, whatever those—whatever those may be for 2017.

Elaine Jorgensen: OK. And we'll probably—right, and we'll probably get some information on that as it comes closer, right?

Sheila Roman: Yes. And we'll—I'd say stay tuned. We really only have made proposals right now to—that include groups of 10 or more eligible professionals. So we really haven't made proposals that are applicable to you as a solo practice.

Elaine Jorgensen: OK.

Leah Nguyen: Thank you.

Elaine Jorgensen: OK. We'll just watch for future notices, then.

Leah Nguyen: That's correct. Thanks.

Sheila Roman: And participate in PQRS, it's in your interest.

Elaine Jorgensen: Right. OK. Thank you.

Operator: Your next question is from Asma Jafri.

Asma Jafri: Hi. A similar question to the previous person. We have a group practice of eight physicians. So, we can defer until next year to get into the requirements?

Sheila Roman: This is Sheila Roman again. And as I've said, you certainly would not come under implementation of the value modifier for 2015 with the performance year of this year, 2013. That value modifier will apply to groups of 100 or more. We have proposed for 2016 that groups of 10 or more eligible professionals—so I don't know if you have 8 physicians and a couple of, you know, other eligible professionals such as nurse practitioners or PAs that would bring you up to 10 in our count. But if that—if that

is so, then what we have proposed, but not, at this time, finalized, is that the value modifier would apply to you in 2016 based on a performance year of 2014. As a group of 8—if you're a group of 8, you would still be less than 10 if that's what we finalize.

Daniel Green: This is Dan Green. Just to be clear, that—what Dr. Roman said applies to the value modifier as it's laid out currently. However, your group of eight would want to still participate in 2013 to avoid a PQRS payment adjustment in 2015. So we would strongly encourage you guys to do something in 2013 because that starts—I mean, that's ongoing right now. If you don't submit something or—through one of the various approved claims by the end of this year, you will see a downward payment adjustment starting in 2015 for your Part B services.

Leah Nguyen: Thank you.

Daniel Green: Thanks.

Operator: Your next question is from Jennifer Pawlowski.

Jennifer Pawlowski: Yes. Hi. I wanted to ask a question about the registration process. I'm wondering whether our group needs to register. We were planning on submitting through our EHR, and I expected that we would have to self-nominate under the PV–PQRS registration system. But it seems from the slides that we don't need to do that. I just wanted to clarify.

Tonya Smith: Hi, yes. This is Tonya. Can you tell me your group size again?

Jennifer Pawlowski: Our what?

Tonya Smith: Did you mention your group size?

Jennifer Pawlowski: Oh, 21 providers.

Tonya Smith: OK. Well, for the—let me address the first part of your question, you said that—well, for 2015, in order to be subject to the value modifier, you have to be a group of 100-plus EPs and submit measures via the web interface, registry, or CMS. So, you said that you submit via EHR?

Jennifer Pawlowski: We're planning on reporting our PQRS measures via our EHR under the reporting option.

Tonya Smith: OK. Well, that's an option that would be available for groups for 2013. And then I think you mentioned that your group size is 24. So, as I just said, that the—that for the value modifier, it will apply to groups of EPs with a—I mean groups with 100 or more EPs.

Jennifer Pawlowski: Right, I understood all that. OK. Well, I'll call the Help Desk, then.

Daniel Green: This is Dan Green. Just to be clear, so you have a group of 24 or 25 and you want to report using your EHR—is this for 2013?

Jennifer Pawlowski: Yes.

Daniel Green: OK. So, for 2013, which you will not—the first year the physician value modifier goes into effect, as you've heard on the call, is 2015, and it's based off of 2013 reporting. But, as you just heard, since your group is less than 100, it will not apply to you guys. Now, we don't have any quote unquote "group reporting" for 2013 using an EHR. Your docs can report individually using their EHR in 2013, and we would love for them to do that. And in that case, there is no need to register for anything. They just would report in in January and February of 2014 for the 2013 data.

Jennifer Pawlowski: OK. That makes sense.

Daniel Green: If you want to report as a group, EHR reporting is not an option in 2013.

Jennifer Pawlowski: OK. For individual reporting, we would be OK.

Daniel Green: That's correct.

Jennifer Pawlowski: OK. That's helpful. Thank you.

Daniel Green: Thank you.

Operator: Your next question is from Jo Anne Sting.

Jo Anne Sting: Hi. I represent a group of over 100. And my question is in regards to the quality tiering. How—basically, I need to present this to the physicians in explaining the benefits and the advantages. We intend on registering through the administrative claims system.

The quality-tiering approach—you're saying that we may elect quality tiering. Reports will be available in September, and I know that we have previous reports. But what's the recommendation on how to present this? What—I mean, it almost sounds like—I guess, the criteria on how to evaluate—is this beneficial to enroll and to elect that or not?

Michael Wroblewski: Hi, it's Michael Wroblewski. That's a great question. I think when you get your—the report on September 16th, you can look to see how your group does. And so, if your group is high quality—you know, because we'll have your group designation, its quality designation as well as the cost designation.

So, if it's a high-quality, low-cost group, I would present it that—you would—in that report, if you've—you didn't participate via the GPRO last year in '12, did you? You—so, we'll have administrative claims in there as your quality measures. Right?

Jo Anne Sting: Right, right.

Michael Wroblewski: Then, actually, you'll have a report. And assuming that your practice patterns haven't changed from '12 to '13, whatever you looked like in '12 is pretty much what you're going to look like in '13, so I'd wait to get the report to see how you do. And if you're high quality, low cost, I'd go for it to get the upward adjustment.

And if you're not—if you are high cost, low quality—really not the place to be—then, I think, you really need to look at the information that we provide in those reports to find out, "OK. Why are we—you know, what's happening, you know, given our beneficiary population?" You know, there'll be a lot of information in there about hospitalizations, how you could avoid hospitalizations, things like that that would be able to kind of assist you in making your score look better, you know, and providing better care at lower cost in future years.

Jo Anne Sting: OK. OK. Thank you.

Michael Wroblewski: You're welcome.

Leah Nguyen: Thank you.

Operator: Your next question is from Vicki Parikh.

Vicki Parikh: Hi. Can you hear me?

Leah Nguyen: Yes, we can.

Vicki Parikh: Hi. I represent a group of radiologists. We have one that is a—he's the sole owner of the practice. And the other physician is actually contracted to us. So, for Meaningful Use, you know, I attested for both of them under one log-in. Now for IACS, do I have to register each of them individually? Or can I register as the PV–PQRS Group Security Official for both of them? I mean, the physician that's contracted to us has reassigned all of his Medicare benefits to the practice.

Sabrina Ahmed: So—yes. I was going to ask, do both physicians bill under the same TIN?

Vicki Parikh: Yes.

Sabrina Ahmed: OK.

Vicki Parikh: We bill under one TIN for the group.

Sabrina Ahmed: OK. So in that case, you can have one person who's designated to be the primary Group Security Official for that TIN, and then that person can make the selection on behalf of the group.

Vicki Parikh: OK, so do I need—do I need to register for both of them individually or no?

Sabrina Ahmed: No, in that case, if you select one of the group reporting options, then only the Group Security Official would make the election for the group.

Vicki Parikh: OK.

Sabrina Ahmed: One election.

Vicki Parikh: OK. And, I – all right. Great. I have actually one more question, also. The CMS claims-based reporting option—is that—I thought I saw somewhere that that was only available for 1 year. Is that true? Or is that available ongoing?

Michael Wroblewski: That is true. We've—it's for calendar year—the year we're in, 2013. And we did not make proposals to extend that for 2014. That's correct.

Daniel Green: This is Dan again. Just to be clear, that's administrative claims. I'm sorry, I thought I heard you just say claims itself. So, it's—administrative claims is only for 2013.

Vicki Parikh: What's the difference between an administrative claim and . . .

Daniel Green: Well, that's a great question. I'm glad you asked that. How—administrative claims are something that you can elect through the—through our web interface. You would sign up and register for administrative claims.

And rather than reporting on a—on a—on a claim form when you submit a bill, a quality data code that says, "Yes, I did this quality action on this patient," or "I didn't, and I had a medical reason," or "I didn't do it, and I have no reason," the administrative claims, we look at, for example, if a patient sees your doctor and your doctor's a primary care provider, for example, we know if that patient—if that patient is a woman and she is between the ages of 40 and 69, we can tell if that patient had a mammogram within the proper time period because we would get a bill for the mammogram, as well.

So, if we don't see a bill, then we know that that patient didn't meet the quality action, and we have a way of, you know—solely through looking at other services and claims, figuring out whether or not the patient met the quality criteria.

Again, with regular claims reporting, you're actively submitting a CPT-II or a G-code, which are quality data codes. They're not reimbursable, but they go on the claim form. And you're telling us, "Hey, I did this," or "I didn't do this and this is the reason why."

Does that make sense?

Vicki Parikh: Yes, it does. And so, but the regular claims option is ongoing?

Daniel Green: Regular claim option is the first option that started with PQRS in 2007 and has been going on every year there since.

Vicki Parikh: OK. Great. Thank you.

Daniel Green: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question is from Esther Kallen.

Esther Kallen: Hello. Can you hear me?

Leah Nguyen: Yes, we can.

Esther Kallen: OK. I'm calling from a sole practitioner—we're actually an occupational therapy office—and I am having a heck of a time figuring out what the measures list qualities choices we can go with are. There are just a—there's actually two that seem appropriate. Everything else really isn't. How do I—how do I—and everywhere I've looked, it says you need to have three in order to participate.

Daniel Green: So, I'm sorry. What kind of practice, again, are you working with?

Esther Kallen: It's an occupational therapy office, and she is the sole practitioner.

Daniel Green: OK. So, just a couple different things. First of all, if less than three measures apply for 2013, you can report the measures that do apply, and you'd be subject to something we call measure applicability validation. So we would look to see—if you reported, for example—I know you wouldn't report this one, but, just for example, if you reported measure number 1 in PQRS, which is a diabetes measure, the denominator for that measure says patients between 18 and 75 and they have a diagnosis of diabetes. Well, measures 2 and 3 have the exact same denominator. So we know if you report measure 1, you could technically report measures 2 and 3.

But if you're reporting on measures like the fall measures or the BMI measure, there are other measures that have similar denominators, but they may be completely out of—out of your scope of practice. So it's not something that's closely clinically related necessarily. And those measures, for example, don't appear in these clusters of measures that we look at under measure applicability validation. So if you only have two measures that truly apply, as long as there's not a third one in that cluster, which it sounds like there wouldn't be, you'd be OK.

But I—the second part of the answer is I would encourage you to look at some of the generally applicable measures like the body mass index or medication reconciliation, which basically is a measure that you document the patient's current medications in the chart when you—when you see him or her. And I think that that kind of measure, for example, can apply to almost any practitioner.

Esther Kallen: Right, but we don't typically check what medications they take. I mean, other than saying, "Are you on something that, you know, is causing pain?" or so forth, they're—they're here for elbow or wrist or those kinds of issues. So, it's really not . . .

Daniel Green: Yes. The—you know, a lot of times, the patient is not going to know if the medication that they're taking necessarily could have an impact on the—on the joint or condition that you're treating. So, it would be—you know, even if . . .

Esther Kallen: Well, but that would be the doctor who would be reporting that. We're the OT side of it.

Daniel Green: I understand that. But the—I mean, I've had occupational therapy for my trigger finger. And, you know, they asked me what medications I was taking just as part of the complete—you know, complete record. But there's also smoking cessation, which you may, you know—may or may not really apply. Probably not so much. But again, it's a broadly applicable measure. You know, depending on what you're working with in terms of occupational therapy, I'm wondering whether, perhaps, obesity might be an issue for some of your patients. And there's a BMI measure also.

Esther Kallen: OK.

Daniel Green: But, still in all, if you feel that there's really only two measures that apply to you guys, report the two measures, and we will check against measure applicability validation. At the least, you'll get out of the 2015 payment adjustment by reporting at least one measure.

Esther Kallen: OK. And then, my other issue is finding a registry.

Daniel Green: So, if you look on our website, there are a list of registries and the measures that they are reporting on behalf of their clients. So you can feel free to contact them. We have contact information listed there. And again, whether they're reporting measures, measure groups, both, and which ones in particular—so, that would be on our PQRS website.

And, is that in the notes, guys? Slide 45. And you can also get that information—excuse me. If you don't want to look on our website and you want a little bit more handholding through it, which is understandable—it's a little bit of a confusing process—you can call our QualityNet Help Desk, and they'll be happy to walk you through it, too.

Esther Kallen: That's great. Thank you so much.

Leah Nguyen: Thank you.

Daniel Green: Thank you.

Operator: Your next question is from Mary Jane Rogers.

Mary Jane Rogers: Yes. I'd like to ask a question, please. I'm with the Greenville Health System, and we have two questions. Can you hear me?

Leah Nguyen: Yes, thank you.

Mary Jane Rogers: OK. Thank you. We have 900-plus providers. We have about a third of those providers that will be doing Meaningful Use for the entire year for 2013. The rest of them will be in another group. And we have chosen the GPRO web interface reporting. But we also see that you have the PQRS Medicare EHR Incentive Pilot Participation Program.

So our question is, if we have to do the GPRO reporting for 900-plus providers with the same TIN number, and then we have to turn around and do it again for Meaningful Use because we have populations in that GPRO that are not on a EHR or did not quality for Meaningful Use, do we have to go and—do we have to do it twice for the quality measures, is our question.

Molly MacHarris: Sure. This is Molly MacHarris. So what you can do for 2013 is, for the 300 participants who are participating in the Meaningful Use PQRS pilot, they can continue to participate that way. To—since your group is over the size of 100, what you can use to avoid the downward Value-Based Payment Modifier to receive that reduction is, as a group practice, elect administrative claims. And that will give you a budget-neutral Value-Based Payment Modifier.

So for 2013, there is still a little bit of duplicative reporting that could occur. It's one of the things that CMS—we are actively working on. And, as we discussed on the National Provider Call last week for our 2014 proposals, we added more alignment language in our proposed regulation, which we feel will decrease burden to folks.

Bu, for 2013, if you elect as a group practice for that TIN the administrative claim, the 300 folks participating in the pilot can continue to do so. The remaining 600, they can still try to earn a PQRS incentive. They can report through any of our other reporting mechanisms available. So that is an option for you.

Leah Nguyen: Thank you. Victoria, it looks like we have time for one final question.

Operator: Your last question is from Barb Anderson.

Barb Anderson: Hello. I just wanted clarification on the 100-plus provider. Is that strictly by number? Or is that FTEs?

Tonya Smith: It's by the number of people who bill under the TIN.

Barb Anderson: OK. Thank you.

Tonya Smith: Thank you.

Leah Nguyen: Thank you.

Additional Information

Unfortunately, that is all the time we have for questions today. If we did not get to your question, please contact the QualityNet Help Desk on slide 45.

On slide 47 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope that you will take a few moments to evaluate your MLN Connects call experience.

Again, my name is Leah Nguyen, and I'd like to thank the presenters and participants of today's MLN Connects call. Have a great day, everyone.

Operator: This concludes today's call.

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