

Centers for Medicare & Medicaid Services
2007 Physician Quality Reporting Initiative National Provider Conference Call
Moderator: Robin Fritter
April 19, 2007
12:00 p.m. CT

Operator: Hello everyone. Thank you very much for holding and welcome to the second National Provider call to discuss the Physician Quality Reporting initiative. Just a reminder that today's call is being recorded.

Now, I'd like to turn it over to Robin Fritter for opening remarks and introductions. Please go ahead.

Robin Fritter: Thank you. Welcome to the 2007 PQRI National Provider conference call. My name is Robin Fritter and I, along with Geanelle Griffith will be your moderators for today's call. We would like to welcome you to the second in a series of national conference calls held by CMS on the 2007 Physician Quality Reporting Initiative.

Today's call will focus on the preparation and participation strategies physicians and eligible professionals may want to consider in order to successfully report Quality Data codes for the Physician Quality Reporting Initiative.

Our speakers, Dr. Tom Valuck and Dr. Susan Nedza from the Office of Special Programs, and Value-Based Purchasing, are using a PowerPoint slide presentation that is available on the CMS website. The title page reads "2007 PQRI Module 2: Preparation and Participation Strategies for

Successful Reporting, April 19, 2007.” If you haven’t already done so, you may wish to download a copy of the presentation to follow along with during the call. The website address is www.cms.hhs.gov/pqri.

After the formal presentation, you will have an opportunity to ask questions of our speakers. Because of limited time, we will reserve the question-and-answer portion of the call for provider or provider organization listeners. We will also ask that you identify yourself and the name of the organization you represent.

I will now turn the call over to Dr. Valuck.

Tom Valuck: Thank you, Robin, and I would like to add my welcome and thanks to everyone who’s joined the call today. We’re well on the way toward implementation of the 2007 Physician Quality Reporting Initiative, and we’re ready now to launch into a discussion of strategies for successful reporting.

I’m going to be presenting first. If you’ll look at overview slide number two, I will cover the topics on the relationship between value-based purchasing and the PQRI and also PQRI introduction, which should catch us up to the material that we covered in the first National Provider call.

Then Dr. Susan Nedza is going to cover the next two bullets, the PQRI preparation and participation strategy. And then depending on the time available, she may cover the answers to the most frequently asked questions as well, or she may choose to open it up for general questions. We want to leave plenty of time for all of the participants on the line, to the extent possible, to have an opportunity to ask their specific questions.

On slide number three, the first slide in establishing the relationship between value-based purchasing and PQRI, you’ll note that we’re characterizing value-based purchasing as a key

mechanism for transforming Medicare from a passive payer to an active purchaser. We have traditionally been a payer for services according to the Physicians Fee Schedule based on quantity and resources consumed without attention to the quality or the value of care that's being provided to Medicare beneficiaries. And that will be changing over time with the implementation of various value-based purchasing programs for our different payment systems, this one of course, addressing the physician payment system.

The goal is to enhance the value. We see on slide three the value equation there. A value depends both on quality and cost. Higher quality enhances value, as does the avoidance of unnecessary cost in care. And that's really what we're trying to accomplish here through value-based purchasing, and the PQRI is one of the initiatives in order to move in that direction.

On slide four, we lay out a number of different policy makers and important decision makers in terms of the direction of the Medicare program weighed in support of value-based purchasing. The president's budget over the last several years has indicated that value-based purchasing is a direction that the Medicare program will be moving. Congressional interest has certainly been demonstrated through their last several acts pertaining to Medicare: the Medicare Modernization Act of 2003, the Deficit Reduction Act of 2005 and most recently the Tax Relief and Health Care Act, which was passed last year and established the authority for the Physician Quality Reporting Initiative that we're discussing today.

The MedPAC reports to Congress. Congress policy advisors -- the Medicare Payment Advisory Commissioners, have made several recommendations related to the adoption of value-based purchasing tools in an initiative for Medicare payment systems. The Institute of Medicine expert policymakers have also made a similar recommendation in their recent report entitled "Rewarding Provider Performance: Aligning Incentives in Medicare." And as many of you have already experienced, the private sector has been using value-based purchasing tools for some time now.

On slide five then, this relatively dense slide is to demonstrate that we have a lot going on at CMS, a lot of investment of time, energy, money, and we're really trying to figure out how to do value-based purchasing right. And we want to learn from these various demonstrations and pilots you see listed here, find out what the best way to implement this is, how to get to those goals of enhancing quality and avoiding unnecessary cost through the use of value-based purchasing incentives. You can see that we're looking at settings across the board: hospital, physicians, nursing home, home health, end stage renal disease, care coordination and then combinations of settings like physician and hospital alignment.

Slide five then brings home the relationship between quality and the PQRI, and it's important to remember several things. First of all, the measures that we're using that form the foundation of PQRI are evidence-based and developed by professionals. It's really a professionalism issue for the professions to be accountable to the Medicare program and beneficiaries for the care that they're providing. They're going to do that by reporting data for quality measurement and they receive a potential incentive bonus related to that reporting according to the way the statute is structured. That measurement then will ultimately enable improvements in care over time. I want to also remind everyone that we're in the evolutionary implementation phase for value-based purchasing with reporting just being the first step toward a pay-for-performance for physicians as well as all of the other settings that I've been talking about.

On slide seven, you'll see what might be thought of as a more traditional performance improvement cycle. We've been working under performance improvement principles now in health care for over 20 years and this should look familiar to most of you, but I wanted to tie it back to the PQRI. So as I said, professionals have been developing measures based on best practices and we're going to be collecting data and reporting results all through the PQRI. In the future, we'll be setting targets for pay-for-performance that actually will align incentives and help us to improve systems over time. And that all will be reassessed periodically such that the improvements that we're making will inform best practices so that we continue to enhance the

measure sets in the data collection mechanisms for more meaningful reporting and so on through the continuation of the cycle.

In terms of the benefits of PQRI participation, on slide eight, you see we lay out three primary benefits, and you may be able to think of others. The first really being about that professionalism issue that I mentioned previously. First, the providers participating in the Quality Reporting Initiative will receive confidential feedback reports related to their own reporting rates and performance rates to support their quality improvement. They can also earn a bonus, and we've talked about both of these things, but I want to make the point that it's important to think about the future. Given the direction that the industry is heading in terms of higher bonus incentives over time for pay-for-performance and that we're moving in the direction of public reporting of performance results for greater transparency for consumer decision making and professional decision making, this – participation in this program is truly an investment in the future and in the future of the practice.

So now let me move from – overall context material into an introduction to the PQRI itself. As I mentioned previously, the Tax Relief and Health Care Act of 2006 established the statutory authority for this program, and it defines the basic structure of the program: who the eligible professionals are, who can participate, what quality measures we'll be using, the form and manner of reporting, how satisfactory reporting is determined and how to calculate bonus payments based on that satisfactory reporting with a simple validation and appeals process associated with the PQRI.

Slide 10 then captures the various categories of the eligible professionals. Obviously, as it's called the "Physician Quality Reporting Initiative," various categories of physician are eligible. Beyond the MD/DOs is there are also other categories of Medicare-defined physicians. There are other members of the health care team that are also eligible to participate in the PQRI, as you see listed there, including several categories of therapists and several categories of practitioners.

The quality measures discussed on slide 11 are also defined in statutes. There were seven – I'm sorry, there were 66 measures that were posted on our website as 2007 measures at the time the statute was passed, and then an additional eight measures were adopted as part of the consensus-based process as allowed under the statute during January of this year, which totals then to a final list of 74 quality measures that now are listed along with their statements and descriptors and detailed specifications on the PQRI website, and you see the web address there. We're going to be referring to the website several times throughout the presentation, and that is where all the publicly available information on the PQRI is – can be found.

The specification may be updated and reposted prior to the actual start date as allowed by the statute. In order to allow the broadest application of the measures, certain codes may still be added to the denominators of the measures, and those updates will be reposted prior to the July 1st start date, hopefully with at least a month's notice.

On slide 12 then, we get into the form and manner of reporting. The reporting period is July 1st through December 31, 2007, and it will be a claims-based reporting using CPT Category II quality codes. And Susan is going to spend time talking about how that reporting works and some strategies for success.

On slide 13, in terms of calculating satisfactory reporting as laid out by the statute, for participating professionals who have no more than three measures that apply to the patients that they see during the six-month reporting period, each of those measures must be reported for at least 80 percent of the cases. So one, two or three measures must be reported depending on how many are applicable for at least 80 percent of the cases. Now if four or more apply, then at least three must be reported at the 80-percent level.

That then translates -- satisfactory reporting can translate into a bonus payment calculation, and that's discussed on slide 14. The bonus payment calculation is also set by statute, which provides that professionals who successfully report may earn a 1.5 percent bonus subject to cap, calculated based on their total allowed charges during the reporting period for their covered professional services under the Physician Fee Schedule. Bonus payments will be made to the holder of the taxpayer ID in a lump sum in mid-2008.

Now there's a potential cap calculation that goes along with the bonus calculation, and the purpose of the cap is going to be discussed in a later part of the program, but if you'll look with me at the calculation formula on slide 15, you'll see that the last two factors, factors two and three listed there, 300 percent and the national average per measure payment amount, both will be numbers that are determined for everyone participating in the program. So the real variable in the cap calculation is the individual's instances of reporting quality data. The more times the participating professional reports instances of quality data, the higher the cap will go up to 1.5 percent. So that's basically how the cap works. It increases with each instance of reporting up to 1.5 percent, and some considerations related to the strategy for successful reporting will be discussed as a later part in the presentation.

Two other things that are required by the statute that are listed on slide 16 are validation; we must validate that in situations where participating professionals may report on only one or two measures in a satisfactory way during the reporting period, we need to validate that no more measures apply because then everyone would just report one or two measures rather than reporting three or more as may be applicable, with three being the minimum for those that have three or more. The appeals process that will be established in order to answer questions about reporting rates and about how those reporting rates are used to calculate the bonus payment, and validation and appeals are both things that we're still working on in terms of setting up the structure of the program. So refer back to the website for more information about those aspects of the program.

And now, I'm going to turn it over to Dr. Susan Nedza, who will discuss preparation and participation strategies for success for the PQRI.

Susan Nedza: Thank you, Tom and thank you Robin, for the introduction. I'd like to resume the presentation on slide 17, where we begin to talk about how you can successfully integrate PQRI quality data into your care delivery process. There are three topics that I'll be discussing: selecting measures, defining team roles and modifying work flows and billing systems in order to successfully participate.

On slide 18, you begin to see the actions that we believe are most important in a practice for determining how they will select measures. The first step in this process is to review the 2007 PQRI measure list that Dr. Valuck already had mentioned, and secondly to look at that list in consideration of the type of services you provide to patients. This includes the conditions you treat frequently so that you'll have multiple instances where you'll be eligible to report, as Dr. Valuck mentioned. The type of care you provide. Do you concentrate on preventive services? Are you involved in acute care or chronic care management? That will help to determine and to focus your choices.

And finally, to think about the setting of care where you work. For many of the professionals, those settings will vary, so you'll need to be able to identify measures that will fit into your office practice, into your emergency medicine practice, or perhaps for capturing data and in participating in your processes for a surgical suite or procedure lab.

So please consider your quality improvement goals for 2007. You see this as the last bullet listed, but I think this is based on the comments Dr. Valuck has made earlier, is the most important thing to consider in the context of why you might want to participate.

On the next slide on slide 19, we're discussing measures and plan approach to you capturing the quality data we've discussed. The second thing that I would like to think about and like you to think about is determining what part each team member will play in the reporting process. As we've often discussed, care is taking place in an office or other settings and requires multiple members of a team. PQRI reporting is similar, so you'll need to have members of your team such as your office managers, your front office staff, your physicians and, in the case of other allied health professionals who will be participating, recognizing that you'll need to include all members of the team who make decisions related to participation and participate in that care process. And then you need to assign responsibilities and provide education. CMS will be working with the professional associations for various members of the team to provide education specific to their needs for successful reporting.

Then you need to walk through the approach to determine what system changes will be required to capture quality data. In considering this we're recommending worksheets and encounter forms, screen templates or other tools for data capture. At the end of the presentation, I'll be discussing some of the support tools that CMS is developing in order to help you with your data capture needs.

Next step is to discuss system capabilities with practice management software vendors and third-party billing vendors or clearinghouses. This is an important step. We have learned that through the question-and-answer period and through our efforts in the PQRI program that this is an important linkage that needs to be put in place and to be fully understood in order to enable successful reporting. So understanding how your practice management software will manage multiple diagnoses, multiple quality codes and also how they will manage zero dollar billing codes – or charges needs to be defined early in the practice.

You can also test your systems prior to July 1, 2007 for secure start date. And when we talk about testing the systems, we are thinking in terms of testing how it will flow in your office practice

as a place to start. We will have further guidance on how you might test submission of codes that have already been included in the CMS PQRI page so that we can complete testing the entire process. At this time, we would really – we would recommend that you begin to test how you would capture PQRI data from the beginning of the identification of the measures through the submission and to the submission of your claims.

On slide 21, you see a visual depiction of the PQRI process. So it begins with a medical record that may be identified by multiple different individuals in your practices. That medical record would then be used during the encounter with the eligible professional and codes the actions that qualifies that professional for submission of the CPT II or G-code when no CPT II code is available, would be captured in the medical record and documented as all other actions are required for the Medicare program.

That information, those quality codes or the action would be captured on the encounter form or through a screen or through another flow sheet as I've mentioned previously. This then transfers the information necessary for PQRI into the coding and billing process. The coding for the CPT Category II codes or other quality data codes then are submitted concurrently with the claim for service into the carrier or MAC for submission into the National Claims History file. We've been receiving a lot of questions related to the role of the carrier in this process, and I'll be addressing that issue as we move towards the end of the call.

Once the claims have successfully transferred through the carrier to the National Claims history file, our analysis contractor will then begin to do the analysis. So the analysis for successful reporting is done at the back end of the process. Confidential reports will be generated, which will be available for the eligible professionals to understand both performance and reporting rates.

In addition, information will flow back from the analysis contractor for those who have successfully met the performance goals of reporting on three measures when four or more are appropriate or

three or less when that is the appropriate number for an eligible professional. That information will then be transferred back to your carrier or Medicare Administrative Contractor and the bonus payment will be offered in 2008.

I'm going to switch now to talk about participation strategies, and this is on slide 22. There are three areas that we would like to emphasize and that's reporting quality data, understanding the analysis of satisfactory reporting and understanding the bonus calculations. We are becoming more granular and recognize that some of the information becomes much more specific. Future presentations will cover areas specific to these three areas.

On slide 23, we refer you to the measure specifications, which are also posted on the PQRI website, so in the first decision-making process, we talked about looking at the measures, looked at the office practice, and now we're going to drill down into the specifications.

The specifications that are documented on the website contain all of the information that's necessary for reporting quality data. These specifications include identifying opportunities to report. So you begin by looking at the denominator and recognizing ICD-9 and CPT Category I codes that make that particular service and claim eligible for a quality data code. The quality data code is then selected, which is in the numerator, is a CPT II Category code or a temporary G-code as previously mentioned.

There is also information about using modifiers. There are two different kinds of modifiers, the 1P, 2P and 3P modifiers that are attached to the CPT II codes in order to submit information related to performance of the measure. In addition, there is an additional modifier called the "Action Not Performed Modifier." This is an 8P modifier. CMS will be providing further information on the use of these modifiers other ways. We are developing a coding for quality document, which is called "The Coding for Quality of PQRI Implementation Guide," that will define

how these are used in the process. Additional reporting instructions are under development and will be posted on the CMS website when available.

On slide 24, you see the – how these are – how these quality data codes are reported. In the CPT Category II codes may report in on paper-based claim, the 1500 form, or electronically. These codes do supply the denominator, and I'd like to emphasize that they must be reported on the same claim form as the payment for the ICD-9 and CPT Category I codes and are concurrent. These are necessary for us to calculate the measures and to determine successful reporting. We frequently receive questions regarding whether or not these can be – the CPT Category II codes can be submitted separately. They do need to be submitted on the original claim form.

In addition, we often receive questions related to the multiple CPT Category II codes and whether or not more than one can be coded on the same claim, and yes they can as long as the corresponding denominator codes are also on that claim. So therefore, if there is a denominator code that identifies a visit for being eligible and the eligible professional provides two different actions that qualify for CPT Category II submission, the can be submitted on the same claim. I would also like to emphasize that the individual NPI of the participating professional must be properly used on the claim. In this program under the statute, we are required to calculate the success for reporting at the level of the individual professional and the NPI number is essential for that program. Therefore, it is imperative that everyone have their NPI number and be prepared to use it at the beginning of the program.

Slide 25 gives you more granular information about how to fill out either the 1500 form or to file electronically. Submitted charge fields cannot be left blank, so a line item charge of \$0.00 should be added. In some cases, a billing system may not allow a \$0.00 line item charge, so this is the reason why you need to have a conversation with those entities prior to the – the starting the submission of data, and you can use a small amount like one cent, \$0.01. Again, any claims with a zero charge will be rejected at the Carrier, so if you were to try to submit CPT Category II codes

after a service and they were coded as zero – a \$0 charge for the entire claim, it would be rejected. The quality data code lines will be denied for payment, but then are passed through the NCH file for PQRI analysis. So here you begin to get a better sense of where in the process the analysis will take place.

So here's a scenario for successful reporting, and we will be developing scenarios for each of the measures that will help you in understanding how to develop your own tools for successful reporting and also in relationship to the tools that CMS will be – designing.

So let's say Mr. Jones presents for an office visit with Dr. Thomas. He has a known diagnosis of coronary artery disease. When his chart is pulled for the visit – this is in a primary care setting or in a cardiology setting, Mr. Jones's chart is flagged for possible inclusion and submission of data codes. Dr. Thomas sees Mr. Jones and in situation one, documents that he is receiving anti-platelet therapy. So he would code – or the system in the office would code CPT II – code 4011F.

In situation two, Dr. Thomas documents that anti-platelet therapy is contraindicated for Mr. Jones because of bleeding disorder. In this case a 1P modifier would be attached to the 4011F code, therefore, indicating that Dr. Thomas has not prescribed the anti-platelet therapy for a clinical reason associated to his judgment.

In situation three, there's no documentation that Dr. Thomas or other eligible professional has addressed anti-platelet therapy for Mr. Jones. Therefore, this claim that will be submitted and would make it eligible for a CPT Category II code to be submitted. It would be included in the calculation toward the 80 percent, and an 8P modifier code may be appended to the 4011F that indicates that no documentation – that no action was undertaken, no other reason specified. So this gives you a set of modifiers that successfully exclude all possibilities and allow for successful reporting on that particular claim.

On slide 27, again in discussing the claims process in the analysis, the claims must reach the National Claims History file by February 29, 2008 to be included in the analysis. So we are recommending that the professionals submit these claims as soon as possible after the end of the period of December 31, 2007 so that they will be included for the calculation.

Again, claims that are resubmitted only to add CPT Category II codes will not be included in the analysis, so this is one more reason to begin to prepare now to be ready to submit successfully in July of 2007.

On slide 28, a little bit more information about the analysis about individual NPIs and under each tax ID number. We've received a number of questions regarding these two areas which were defined under the statute. So again, participating professionals must have and correctly use their individual NPIs. The analysis is required to be done at that initial provider and it needs to be identified on the claim. So the NPI number for the individual eligible professional should be present on the claims that are submitted for the PQRI program.

Providers who bill more than one tax ID number will have a separate analysis for each TIN. So in the case of a provider who switches positions or who works for two different entities with different TINs, there will be a separate calculation for each. Therefore, as an example as an emergency physician, if I'm working in two different settings with two different tax ID numbers, I will have different reporting rates at each institution. If one institution supports the programs, supports quality practice and I've reached the reporting threshold of 80 percent, there will be a bonus available based on the number of instances I've reported in that particular setting that will return to the holder of that tax ID number. If in the other facility where I am practicing I am – I do not meet the threshold for successful reporting, there will be no bonus payment allowed. So we will not be rolling these particular payments up.

Participating professionals must reach the 80-percent threshold. So if you only pick three – if you're eligible for more than three measures and you choose to only pick three, which is the minimum, if for some reason you do not make the 80 percent on one of those measures, you would not be eligible for the bonus. So we are asking professionals to consider reporting on more than three measures, if applicable, to maximize the likelihood of reaching the 80-percent threshold on three.

On slide 29, I'll delve a little bit further into validation. We have begun to develop our validation strategy, and it is required when only one or two measures are successfully reported to determine whether at least one other measure should have been reported. So the example I used previously of being an emergency physician, or this might hold for a primary care physician or some of the allied professionals who see multiple – or care for patients with multiple eligible conditions under PQRI, if I were to choose only one or two measures, I would be at risk for validation questions and possible non-payment of the bonus because, in fact, I had three or more measures applicable to my practice.

So participating professionals – should consider the validation issue before determining that only one or two measures are reportable. In many cases, specialty societies or professional organizations are helping professionals in determining how many of these measures are applicable to their practice. So before you choose only one or two, make sure that no more than those – that, in fact, no more than two apply.

The validation plan will be posted on the website prior to that beginning of our reporting period of July 1st of 2007.

Slide 30 will now transition to talk about the bonus payment. The potential payment of a 1.5-percent bonus is based on total allowed charges paid under the Physician Fee Schedule. We continue to receive questions and ask for clarification regarding whether or not this is only for

claims with quality data codes attached. In fact, it is for all total allowed charges paid under the Physician Fee Schedule. It includes the patient portion, technical components, anesthesia service, drug administration and railroad retirement board charges. Certain things are excluded from the calculation, including laboratory services, drugs, HPSA bonuses and denied line items.

A new development in additional information that we would like to share with you since our last presentation is that an actuarially determined national applicable amount will be added to the charges for the services furnished during the reporting period prior to calculations bonus to account for clean claims submitted but not in the NCH files. So we recognize that there may be claims that have not yet reached the NCH file, that were eligible for inclusion, so a national applicable amount will be calculated and payment will be made associated with that in order to rectify that situation.

On slide 31, we will revisit the cap and the reasons for the cap. As Dr. Valuck mentioned, the one factor that is a variable in the calculation is the number of instances that an eligible professional reports. So the cap is designed to encourage more instances of measure reporting. So in measure selection, choose measures for which you will have multiple opportunities to report quality data codes and thus, increase the amount of dollars eligible for your bonus.

The other thing the cap does is promotes rough equity between those who have reported relatively few instances and those who've reported many instances. So in some cases, there will be professionals who won't have few measures available and fewer opportunities to report quality data codes and not to penalize them and not to penalize those that may have multiple codes available, multiple instances. So one professional may be reporting appropriately so on one or two measures and only have 100 or 200 instances, but another primary care physician or other eligible professional may have multiple instances, and this will allow for rough equity between those individuals.

Please consider the cap on selecting measures to report as more instances will make the cap less likely to apply. So if you report appropriately early and often, the cap is less likely to apply to your practice.

On slide 32, the bonus payments will be made at the tax ID number holder of record. It's important that you insure that your Carrier or your Medicare Administrative Contractor has an accurate TIN for your claims. This is another preparatory step that you can take, and as I've mentioned in the previous example, if a professional reports under more than TIN, the analysis will be done under each and a bonus will be earned by each holder of the TIN. If you have assigned Medicare payments, that payment will be made to the employer facility to whom you have assigned your payments.

CMS will provide an inquiry process for questions about bonus payment amounts. That's under development and we will have more information about that as the program moves forward.

So we're back to slide 33, which is, again, the depiction of the system we've walked through in this presentation; identifying your measures, capturing them in the medical record and the actions related to the quality data codes, methods that you can use in your practice or methods that CMS and others will be providing to help you capture that information, transfer through encounter forms into the coding and billing system, through the Carrier/MAC and through the process of analysis and finally, the bonus payment.

On slide 34 is some additional information about the confidential feedback reports. 2007 PQRI quality data will not be publicly reported. This is another one of the frequently asked questions that we have received, and I'll take this opportunity to ask everyone to visit the PQRI Website where we are continually adding additional FAQs related to the program. If you look at the specific tabs that are found on that website including those for eligible professionals, form and manner of reporting, measures and codes, the FAQs are now listed and can be linked from those

specific pages. So if you have reporting questions, you can go to that particular website and find the FAQs.

Reports will be available at or near the time of the bonus payment in 2008. This is required and we anticipate having those available including – and they will include both performance rates and reporting rates by NPI for each TIN. If a group has multiple professionals participating under the program, they will be able to determine from the reports that they receive which of those eligible professionals didn't indeed successfully report. Those tax ID holders will then have the opportunity to distribute the bonuses at the local level.

I would like to step back for just a moment and talk about interim reports. We have received questions about whether we will have interim reports available, and unfortunately, due to the short time period for implementation, those will not occur.

Just a short message about 2008. We're already thinking about it and are moving forward through the process, and on slide 35, you see that the measures must be established through rule-making. So by August 15, 2007, through the process of proposed rule-making, propose measures for 2008. And that list must be finalized by November 15th of 2007. And you see the type of measures that we are looking at including that will be defined specifically by the statutory requirements of the Tax Relief and Health Care Act of 2006.

Registry-based reporting. I would like to announce today that we will be holding a – a special open door on May 14th to discuss registry-based reporting within the constructs of the PQRI program. We encourage your participation in this particular open door and more information is available through CMS and our various communication channels.

We are not, due to short lead times, able to use this channel as logistics have precluded using registry-based reporting as a channel for 2007. However, we are working vigorously to include

this in the 2008 reporting. We recognize that standardized specifications for centralized reporting could reduce the burden of reporting for participants in CMS and other programs. We look forward to and will give thoughtful consideration to input from various stakeholders through the open-door mechanism on May 14th.

I'll finish up before I transition to the question-and-answer session to remind you of how we will be continuing to engage all of you through communication in order to facilitate your successful participation, planning and, in the end, to ensure successful meeting of thresholds within the PQRI program. The website should be visited early and often. It contains all publicly available information and is changed regularly. If you have specific questions regarding the PQRI program, we are working with the Medicare Carriers and Medicare Administrative Contractors in an inquiry management process. If they cannot answer the question that you have placed, they are forwarding those questions to CMS and we are using those to develop all of our FAQs and will be giving you feedback through the national communications channels as to the answers to some of those frequently asked questions.

We also encourage you to join our CMS provider list so that you'll receive notification of all of our various PQRI products that will be coming out.

So I think I'll transition there to the FAQs. I think we have covered a number of them in the presentation. Many of these came up through our first National Provider call and also in calls and input that we received from the professional community. We very much appreciate that input. It has allowed us to rapidly respond to your needs and to develop frequently asked questions and to post those in order to help others who are also working to implement this program successfully.

As we have a few minutes available here at the end of the presentation, I believe I will go through the FAQs with you and highlight those that were not included within the program.

So on slide 38, you see the first question “Where can I get additional information about the PQRI?” Again, this is about where to find information and to emphasize that our main source of information is the website and that your second line is to contact your Carrier and Medicare Administrative Contractor.

The second question, “Do I have to register to participate in the PQRI?” Although this is no longer covered in the presentation slides, we have been indicating through all channels that, no, you simply begin submitting claims with quality data codes through the claims process on July 1, 2007. I hope that at the end of the presentation, you understand the need for the individual NPI to participate, and again, we are recommending that everyone have their NPI and be prepared to use it to participate in this program on July 1, 2007.

You do not need to accept assignment on claims to participate in PQRI and – so that if you were a Medicare-enrolled professional, you can participate in the program regardless of whether or not you accept assignment.

On slide 39, we have some answers to questions that were posed in this forum and in others. The first is “Can professionals at Federally Qualified Health Clinics or Rural Health Clinics participate?” Unfortunately, no; FQHCs and RHCs do not bill under the Physician Fee Schedule. Therefore, those claims will not be eligible for inclusion in the program.

Another question that has been brought up to us is “Regarding Critical Access Hospitals billing method II, SNFs using consolidated billing, or outpatient facilities billing FIs participate, can they participate in PQRI?” Again, this is a variation of the prior question. We have no way to identify these individual professionals under these billing methods to complete the analysis, successful reporting that you’ve seen documented in the slides and the presentation today. Therefore, we would not be able to calculate bonus payments required by the statute.

On slide 40, you see we've talked about the reasons that the quality data codes and CPT Category II codes need to be submitted concurrently for analysis. I will add that claims that are resubmitted for additional data code will not be included in the analysis.

Another question that we frequently see and this is probably our second most frequent question is "Can more than one participating professional reporting quality codes on the same patient?" So in each of these cases, the professional has recognized that this is within the scope of the service they're providing to their patients, and therefore, they may be eligible for measures that may overlap one professional with another.

In a second instance, there may be two professionals in a similar group with a similar practice who may be reporting on the same measurement. So yes, every participating professional who furnishes services for a patient may report according to the measure instructions. We will not be undertaking attribution to specific professionals within the PQRI program.

Another very frequently asked question specifically related to measures (and there are a number of them these types of measures) that are required to be performed within a 12-month period. "If measure instructions indicate that a measure is properly reported once during the reporting period, must a quality code be submitted on every claim that contains the denominator ICD-9 and CPT II codes?"

The question might be rephrased, "As there will be subsequent claims to the one on which the I document a quality code which might be included for the calculation of successful reporting; will it be necessary for the professional to continue to document something on each subsequent claim?", The answer is no. The CPT Category II code need only be reported once during the reporting period.

The instructions for each measure will contain information regarding both performance and reporting periods and the difference. Our analytic process will be able to determine and to

identify the original claim, so any subsequent claim for that individual patient for that service by that professional that could potentially be included for the calculation for the bonus will not be included.

On slide 41, the question of group practices is the second question that you see, and again, if they're in a group practice, and there is one tax ID number, the group practice will receive the payment, but the analysis of successful reporting will be at the individual NPI level.

I think I'll finish there and ask Tom if he has additional comments to make at this time.

Tom Valuck: No. Thank you, Susan. I would turn it back over to Robin and our conference call coordinator in order to begin to take the questions from the participants.

Robin Fritter: Thank you, Dr. Valuck and thank you, Dr. Nedza.

NOTE: Answers provided to questions asked during the call will be officially incorporated as new or updated Frequently Asked Questions (FAQ) on the CMS website. The FAQs can be accessed by visiting, www.cms.hhs.gov/PQRI, on the CMS website. Go to the "Related Links Inside CMS" section on any of the PQRI pages to link to the most current FAQs.