

**PQRI
2007 Physician Quality Reporting Initiative National Provider Conference
Call**

**Moderator: Robin Fritter
March 27, 2007
3:00 p.m. ET**

Operator: Good day and welcome to today's 2007 Physician Quality Reporting Initiative National Provider Conference Call. As a reminder, today's call is being recorded.

At this time for opening remarks and introductions, I would like to turn the call over to Robin Fritter. Please go ahead.

Robin Fritter: Thank you, Gwen. Good afternoon everyone and welcome to the 2007 PQRI National Provider Call. My name is Robin Fritter, and I, along with Geanelle Griffith, will be the moderator for today's call. We would like to welcome everyone to the first in a series of calls on the Physician Quality Reporting Initiative.

Our presenters, Dr. Tom Valuck and Dr. Susan Nedza, will be using a PowerPoint slide presentation during the call. The presentation was posted to the PQRI web page at www.cms.hhs.gov. You should have downloaded this presentation prior to the call so that you can follow along with them. The title page of the presentation reads "2007 Physician Quality Reporting Initiative National Provider Call, March 27, 2007". If you haven't already done so, please take this time to download a copy of the presentation.

Before we begin, I would like to remind everyone that the call is being recorded and transcribed, so please identify yourself before you speak. After the presentation, we will open the call for questions. After the question-and-answer session, please stay on the line for final comments.

At this time, I would like to introduce our presenters, Dr. Tom Valuck and Dr. Susan Nedza. Drs. Valuck and Nedza are with our Office of Special Programs and Value-Based Purchasing here at CMS.

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

Tom Valuck: Thank you, Robin. This is Tom Valuck and as Robin said, I'm the Director of CMS' Special Program Office for Value-Based Purchasing, which has responsibility for implementing physician and hospital pay-for-performance for the agency, and joining me is the Co-Lead for our Outreach and Education subgroup of our PQRI work group, Dr. Susan Nedza, who's the Chief Medical Officer in our Chicago Regional Office.

The way that we're going to divide up the presentation today is I'm going to be presenting the overview, except for a piece of it related to how to successfully report under the Quality Reporting Initiative, and Susan Nedza is going to pick up from where I leave off and both explain how to successfully report at a high level and then take questions about the whole presentation and explain how you can get further information and explanation of where we're headed with the Physician Quality Reporting Initiative.

Before I dive into the presentation, as some of you might still be downloading and printing that, I just wanted to remind everyone that value-based purchasing really is a reform that's happening in all of our Medicare payment systems. We have a report to Congress

that we're currently working on that was authorized by the Deficit Reduction Act of 2005 that will present a plan, should Congress choose to accept it, for implementing hospital value-based purchasing in 2009. We also have demonstration projects happening in many of our other payment systems, including nursing homes, home health, and end-stage renal disease facilities.

So what we're talking about today is the first building block toward value-based purchasing in the physician practice, and it's one of, as I pointed out, several efforts in order to transform Medicare from being a passive purchaser, which we've been since the inception of the program – I'm sorry, a passive payer, to an active purchaser of services. So an active purchaser of high-quality, efficient healthcare. So that is the transformation that's happening here through an evolutionary process, and for the physician setting, the Quality Reporting Initiative is the start of that process toward value-based purchasing for physician services.

So what did Congress authorize back in December, when they passed the Tax Relief and Health Care Act of 2006 in Section 101? Well, the fourth slide after the title page and the two disclaimer slides, the fourth slide in the slideshow that's posted on our website, really lays out all the different elements that will need to be put in place in order to bring up the Physician Quality Reporting Initiative. First, we must understand who is eligible to report, then they have to have quality measures upon which to report, and they have to understand the form and manner for doing that so that they can be successful in reporting. Success in this program will equal a bonus payment, and then we'll also have to validate that the measures were reported correctly and have some simple form for accepting appeals for those who disagree with the amount of their bonus payment.

We expect to provide confidential feedback reports for 2007 reporting period, and very importantly, I'll end my piece of the presentation with a look toward the future, the 2008

considerations and beyond, as we attempt to take this very first step several steps further over the coming years to a reporting program that will be more sophisticated, more meaningful, more actionable, more useful to the eligible professionals who participate.

The next three slides – five, six and seven – cover the different types of professionals who are eligible to participate in the Quality Reporting Initiative. There are basically three categories of professionals under this statute who are eligible to participate, and they're displayed on the three slides. The first would be the Medicare definition of physician as an eligible participant. The MDs and DOs are eligible as Medicare physicians, as are podiatrists, optometrists, oral surgeons, dentists and chiropractors. Other groups of eligible professionals are listed on slide six – physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, clinical social worker, clinical psychologist, registered dietician and nutrition professional. That's another nine categories of eligible professional, and then on slide seven, we also have included under the statute as eligible professionals three categories of therapist – physical therapist, occupational therapist and qualified speech language pathologist.

The measure sets are being refined and expanded to include as many professionals for reporting as possible for the 2007 first year of this, but again, as I've mentioned already, as we look toward 2008 and beyond, we will be expanding our measure set, along with making the rest of the program more sophisticated.

So how is an eligible professional going to be determined under the program besides just the category of – the categories that I've just mentioned? If we look together at slide eight, you see that there are a couple of additional considerations. One – these are some of the most frequently asked questions that we're getting about the program, the first being do I have to be a participating professional? In other words, do I have to have signed a participation agreement to accept assignment on all claims in order to

participate? The answer is no. The professional must be Medicare enrolled, for obvious reasons, since this is about Medicare patients and providing high-quality care to Medicare patients. But the professional does not have to have signed a participation agreement to accept assignment in order to participate.

Neither does the professional who would be participating have to register in some way in order to begin participating in the program. This is another frequently asked question. Some are assuming because there was an intent to participate for the 2006 voluntary reporting program that we have continued that for 2007, and that's not the case. There's no registration required to participate. There may, however, be an authentication process in order to download confidential feedback reports, which we're going to be talking about later on, or we may find another way to distribute those. But that should not be equated with the registration to participate.

In terms of the program – the measures that are going to be reported, on slide nine lays out the 74 quality measures that are going to be a part of the 2007 PQRI. We had 66 measures that were referred to in statute that pointed to 66 that we had posted on our website as of December 5. The statute also allowed us to add additional measures during January as a result of a consensus-based meeting. So we added eight measures that were adopted by the AQA Alliance at that time, a consensus-based organization.

So we now have 74 measures. This is the complete and final measure set for 2007 PQRI. That is posted on the same website where you downloaded this presentation on the "Measures and Codes" page under that PQRI address. We are in the process of finalizing the specifications for the 74 measures, so right now what's posted are the measure statements and the measure descriptors. The actual specifications that give the detailed coding information and certain instructions for the use of the measure will be posted within the next two weeks. So well in advance of that July 1 statutory deadline

that we have for posting the measure specifications, we will be posting those within the next probably 10 days, and you should be checking back regularly on the PQRI website for all publicly available information, including the posting of the specifications.

The form and manner of reporting, as described on page 10, is claims-based reporting. The reporting period is July 1 through December 31, and I am not going to dig anymore deeply into the form and manner of reporting and how to be successful under reporting because, as I said earlier, Dr. Susan Nedza, who is leading our Outreach and Education Effort to, at a basic level, help the participating professionals and their office staff, who will be assisting the professionals in participating in this program to be successful. That's a part of the duties of the Outreach and Education Group that we have associated with this initiative, and so Dr. Nedza is going to be picking up on the discussion after I finish the overview and really getting down into what it's going to take to successfully participate in the program.

So she's going to be covering slides 10, 11, 12 and 13. So I'm moving on then to slide 14, and once there's an understanding of what it takes to be successful in reporting, how is the determination going to be made that the eligible professional is – has actually earned the potential bonus under this program? Well, that depends on the number of measures that apply to that professional's practice during the reporting period. If there are no more than three measures that apply – in other words, one, two or three – then each of those measures must be reported at least 80 percent of the times in which it was reportable. If four or more apply, at least three must be reported.

So in no case is any participating professional required to report more than three measures, although that professional may choose to do that. But in case there are only one or two, that's still very possible to be successful by reporting just one or two, depending on how many actually apply to the patients. So I am guessing there will be

some questions in our question-and-answer about how that plays out, but that's basically the statutory requirements for the determination of successful reporting.

Now, on slide 15, a very important point to make because we recognize that not everyone has yet applied for and received their individual National Provider Identifier, or NPI. This is a heads-up that our analysis is going to be performed at the individual level, so the individual NPI must be on the lines of service for the information that's going to be analyzed for successful reporting in this program. So we have to be able to, under the statute, do the analysis at the individual level. So we need the individual NPI to be used on those claims. If you haven't applied for the individual-level NPI, you need to do that to be able to participate in this program.

So how does that reporting and determination of success then play into an actual bonus payment? Well, participating eligible professionals who successfully report according to statutory requirement, the 80-percent threshold for one, two or three or more measures, the professional may earn a bonus of up to 1.5 percent subject to a cap, and I'm going to briefly discuss the cap on the next slide.

But it's important to note that that 1.5-percent bonus is based on all allowed charges during the reporting period, not just the charges that are associated with the quality codes that need to be reported on the claims. It's also important to note that the claims must reach the National Claims History file by February 29 to be a part of the calculation of the total allowed charges during the reporting period. So those claims for services toward the end of the year need to be submitted promptly in order to make it through the carrier system and into the National Claims History. The bonus payments will be made in a lump sum in mid-2008 to the holder of record of the tax identification number. It's important to note also that no beneficiary coinsurance is required on the part of the beneficiary.

So I mentioned on slide 16 that the bonus was potentially subject to a cap. On slide 17, I'm going to describe the purpose of the cap and how the cap is calculated. Now, you may not get the cap calculation the first time around, but I do want everyone to go away with a complete understanding of the purpose of the cap, and then the next time or two that the calculation is explained to you it should be clear.

The purpose of the cap is dual-fold. One, the cap actually encourages more instances of reporting measures. So this is, after all, a pay-for-reporting type of program, and the intention that Congress had in putting it in place was that providers would have incentives to report measures. So as the number of instances of reporting increases; the payment increases.

That's one purpose. The second purpose is that the cap attempts to draw sort of a rough equity between providers who are reporting on different levels of measures, and let me give an example of that. You might have two eligible professionals who have the very same type of patient practice, and one might pick a couple of measures to report on where they only have maybe 50 or so patients that they can report those measures on. Well, the other gentleman, who has a similar type of practice, or the other lady, might pick measures to report on that requires reporting hundreds of times in order to get to the 80-percent threshold. Well, the cap payment – I mean the cap calculation is an attempt to cap that person that's reporting relatively few instances, whereas the person who has a much higher number of instances of reporting, or basically has put more effort into it, might not be affected by the cap.

So let me tell you how the calculation works. The calculation is –the primary driver of the calculation is the amount of reporting that the individual participating professional has done. So the first factor in the calculation that you see there on slide 17 is the individual's

instances of reporting quality data. The second factor is a constant – 300 percent or a factor of three. The third factor is the national average per measure payment amount, and that's calculated as is described below – the national charges associated with all quality measures divided by the national instances of reporting.

So let me just run through a quick hypothetical that has no basis in reality, but it's just an attempt to explain this calculation. So if you assume that the national charges associated with quality measures, the numerator of the national average per measure payment amount is \$100 million – just a hypothetical. Let's say that all the charges associated with all the quality measures that were submitted is \$100 million, and the number of instances of reporting that were associated with those charges was a million. So you have \$100 million in charges divided by a million instances of reporting. That gives you a national average per measure payment amount of \$100. Now, in the end, after the end of this year, when that number is actually calculated, it may be \$10, it may be \$1,000. But I'm just using \$100 for the estimate here for a hypothetical.

So if you plug that in as the third factor, \$100 under the cap calculation, you multiply that by 300 percent, or by a factor of three, that gives you \$300. So what that tells you is that under this hypothetical, every time I, as an individual physician, would report an instance of a quality measure, my cap would increase by \$300. So my cap for one – reporting one measure, one instance of a measure, would be 300, then 600, 900, 1,200 and so on until that cap is raised to the point where the cap was actually higher than the 1.5 percent, at which point the 1.5 percent is the maximum that an individual can earn under this program. So I wanted to take a little bit of time to delve into the cap calculation even though it's a little bit complicated because I wanted to make sure that you all were able to ask your questions about that because it may take a few times going through it in order to understand how the cap works as part of the bonus payment calculation.

Let's move on to slide 18. We've got the two issues here of validation and appeals. The statute does require us to do a simple validation mechanism. We're likely to use sampling. The plan for validation is under development, but it becomes clear very quickly that since the program allows reporting of one or two measures in instances where only one or two apply, then we're going to have to do some sort of validation for those who only report one or two measures to make sure that more than one or two didn't apply. In other words, if an – if an eligible professional only reported one measure, we need to look for others that might have been applicable and – to make sure that others didn't apply so that we can confirm that all opportunities were taken advantage of for reporting up to the three measures that's the most that is required.

Now, in terms of appeals, we're also excluded under the statute from any formal administrative or judicial review of our decisions under this program, but in order to meet our due process requirements we will have some sort of inquiry process to handle appeals about payment amounts and that sort of thing.

I want to mention also on slide 19 that in addition to a potential bonus payment, there's also another benefit from the program, and it's the expectation that we'd be putting out some feedback reports to the individuals in a confidential manner who participate that could guide them in finding ways to improve their practice. So for 2007, this will – information will not be publicly reported. It is expected to be confidential feedback reports, and those reports are expected to be available at or near the time of the bonus payment in 2008.

Unfortunately, we won't be able to provide any interim reports during 2007. We would like to be able to do that so that participating professionals could get some feedback as to how they're doing along the way, but given the short timeframe we've been given for implementation by Congress under this statute, there's just no way that we could bring up

any kind of meaningful interim reporting during 2007. And in the end, we're hoping to be able to include not only the reporting rates upon which the quality bonus would be based, but also the performance rates that might be available out of the quality reporting that Susan is going to describe next.

I would like to end my portion of the overview with the two slides that have 2008 considerations, slides 20 and 21, and I really think that it's important already to begin to think about the future of our Quality Reporting Initiative because, as I said previously, this really is just the first step toward moving the physician payment system from a quantity-based payment, where CMS is a passive payer, into a quality-based and performance-based payment, where CMS is actually the active purchaser of care seeking to use incentives to encourage improvements in quality and avoiding unnecessary cost. This is the first step in that.

So what are we going to be doing on the way in order to make this program – take this program to the next level? Well, we're going to be expanding and refining our measure set for 2008. We're required to do that by statute through the rule-making process, and the first step in that will be the publication of the proposed physician fee schedule rule in August of 2007. We're already working on that and will be looking forward to your comments in August/September and then finalizing that rule by November.

The four bullets under the title "Statutory Requirements for 2008" outline how we go about, according to the statute, the measure development for 2008, and you can see there that these measure sets have much involvement from consensus-based organizations that represent all aspects of the physician community and other stakeholders along the way, and we'll be, of course, complying with our statutory requirements there. One other thing to note is that the statute requires – that last bullet –

that we include structural measures in the 2008 measure set such as electronic health record use or electronic prescribing technology and its functionality.

So for 2008, considerations, on slide 21, a couple of other channels that we might consider for reporting in addition to the claims-based reporting that I mentioned would be registry-based reporting and/or electronic record-based reporting. We weren't able to include these in the program for 2007, but we're working to open these channels for 2008. I would like to share what we're thinking about in terms of registry-based reporting, for those physicians and other health professionals who are already reporting into some sort of a patient registry or a clinical database. We would like to allow for the databases, on behalf of the professionals, to be able to transmit information directly to CMS. We could then incorporate the data into our measures and use it as part of scoring this analysis for successful reporting. So those are some things we're looking at doing over time to make the best use of the data that's out there.

And with that, I'm going to turn it over to Dr. Susan Nedza, who's going to talk about how to be successful in reporting and how we're going to be, through the group that she's co-leading at CMS, reaching out to the various providers and providing education and tools that would help enable successful reporting. Susan?

Susan Nedza: Thank you, Tom. I appreciate the opportunity to share with all of you both our thoughts and the items that we've put in place to enable successful reporting. We're going to go back into the presentation now, and I'm going to take you – I'd like you to refer back to slide 10, which is entitled, "The Form and Manner of Reporting", and I'd like to spend just a few minutes going through the processes that we have put in place using our claims systems.

The first thing to recognize, is that this is new groundwork, where we are linking the clinical care that's captured in the performance measures and the quality data codes into the claims system. We're using codes that many of you utilize and that the coding and billing professionals who may have joined us today that we are very familiar with; these are CPT codes. In this program, we'll be using the CPT II codes or temporary G-codes where CPT II codes are available for reporting the quality data related to the measure. This is a reminder to think about the fact that this is a new program and a new initiative and how we are working to link the claims and clinical processes together.

The quality codes can be reported in a number of ways, and on the next slide, on slide 11, what I'd like to do is take you through the process that we envision in a clinical practice. Now, this practice could be in an office. It might be in a hospital setting, it could be in a home health setting, or it could also be in an ancillary or else a nursing facility. There are no limitations specifically. This program is addressing the various places where care is provided.

In an office-based setting, we envision, as you'll see in the first box, a visit is planned or a visit is scheduled with a physician or other eligible professional. The practice recognizes that they're participating in the program and there is a process in place to identify patient records, be they electronic or be they paper records. This would include that visit for possible coding for quality code. So these patient records are identified.

The next step in the process would be during the patient encounter or the beneficiary encounter, where the eligible professional would document in the medical record the fulfillment of the measure requirement or the action. So to put this in terms of a performance code, the first step is identifying which patients and which patient visits are eligible for inclusion in the denominator, and the second phase is the action step that taken regarding quality that's coded in the numerator. In that particular case, you see

this documentation is important and required as it is in all of our Medicare programs. We are not identifying where that documentation needs to occur. We're asking that it be documented within the in the medical care process that makes the most sense for the care setting, for the patient, and for the eligible professionals providing the service.

You now see a small gap between the clinical and administrative sides, and this is where CMS is concentrating a great deal of our educational efforts and also our efforts of developing tools to cross this boundary. As the eligible professional captures their effort related to both the denominator inclusion and inclusion of the service as the numerator, that information needs to be translated to the claims process.

It also needs to follow along with the complete care process. So the quality code that was associated with the measure (CPT II codes or temporary G code) are then captured for the claims submission process. We recognize the capture coding is done in a variety of ways across settings. We're actively working with our stakeholders in professional associations and in practices and hospitals to understand how this capture occurs and to make sure that we have those educational materials and tools available to help the eligible professionals capture and translate this information to the claims submission process.

The next step occurs, as happens with any other coding that is done in Medicare, the coding or billing professional will enter the quality code and data on the claim in the same location used for other (HCPCS) code. If you're using the electronics claims process, which many of our practices do and most of our professionals do, you can see illustrated here where this would go, in the segment of the 2400 service loop, (SV 101-1) or (SV 101-2). For those services that are still being provided and captured and entered into the claims service on the – through a paper filing, the CMS 1500 form, field 24D, which is what you see on the next slide on slide 16. We have provided a website link in the slides

so that you can get a better view of where these codes would be captured within the form.

I'd like to take a second to reiterate the reason we're using the claims process and the reasons for concurrent submission of the quality data codes associated with the service codes. This is necessary so that when we do the data analysis to determine successful reporting, there are certain elements present on the claim to identify patients for inclusion in the denominator. . For instance, in some of the codes, we may need to know the patient's gender, their age or other demographic information that's captured within the claim. The denominator also includes the E&M services and ICD-9 services that are being provided.

When capturing these codes, it's important to recognize a submitted charge field cannot be left blank. They should contain a dollar amount of \$0.00. We have some experience with this in the program that we had in place last year- the PVRP program. We are actively reaching out to those entities that work in the billing process, such as clearinghouses, to ensure that these codes and these charges can be accepted. We are also including the carriers as critical partners in this process, and we'll be working closely with them to ensure that the code can be accepted in their system.

If for some reason billing software does not accept the dollar – or the zero dollar line item charge, a small amount can be substituted. I would like to finish by saying that eligible professionals cannot collect any money from beneficiaries for quality data codes. CPT II codes do not have a dollar value assigned to them.

I'd like to stop there regarding the actual methodology. The three slides that I've given to you are a taste of some of the educational materials that Robin and Tom referred to early in our process. Both of these speakers have indicated the breadth of our upcoming

provider outreach. We are anticipating additional slide sets, including one that will be specifically related to the measures and the specifications. As you heard today, they will be available relatively soon. Slides specific to the reporting process will be included. We anticipate in that process having a nuts-and-bolts concrete view from the practice, where individuals will be able to follow an encounter through and follow the codes and the capture of those codes from the eligible professionals selecting the codes that are appropriate for their practice and the patients; through the successful submission into our claims process.

In addition, we are working to develop tools that will bridge the gap that you saw between the clinical process and the claims process. These tools will allow practices and professionals to both understand and to have paper-based tools available that they can incorporate into their practice for capturing this information.

With that, I think I will finish with my formal comments. Again, say thank you to everyone for attending our call and for your efforts in improving the quality of care we provide to our beneficiaries and the patients; that is the long-term goal of this program. I will ask our moderator to open up the lines for any possible questions that would like – that are being submitted. Thank you.

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.