



# MLN Connects<sup>TM</sup>

National Provider Call - Transcript

**Centers for Medicare & Medicaid Services**  
**CMS Proposals for the Physician Quality Reporting System (PQRS) and Physician Value-Based Payment Modifier (VM) under the Medicare Physician Fee Schedule**  
**2014 Proposed Rule**  
**MLN Connects National Provider Call**  
**Moderator: Charlie Eleftheriou**  
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**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 Charlie Eleftheriou. You may begin.

## **Announcements and Introduction**

Charlie Eleftheriou: Thank you. This is Charlie Eleftheriou from the Provider Communications Group here at CMS, and I'll be your moderator today. I'd like to welcome you to this MLN Connects National Provider Call on CMS proposals for PQRS and the Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 proposed rule. MLN Connects calls are part of the Medicare Learning Network.

During this call, CMS subject-matter experts will discuss the 2014 Physician Fee Schedule proposed rule, potential program updates to PQRS, how CMS proposes to continue to phase in and expand application of the Value-Based Payment Modifier in 2016 based on 2014 performance, and how the Value-Based Payment Modifier is aligned with PQRS reporting requirements. A question-and-answer session will follow the presentation.

Before we get started, I have a couple announcements. You should have received the link to the slide presentation for today's call in previous registration emails. If you do not have the presentation, please find it at [cms.gov/NPC](http://cms.gov/NPC)—"N" as in Nancy, "P" as in Paul, "C" as in Charlie. Again, that's [www.cms.gov/NPC](http://www.cms.gov/NPC). On the left side of the web page, select "National Provider Calls and Events," then select today's call by date from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Calls website when they're available, and an announcement will be released in the MLN Connects Provider eNews.

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, and while they may not all be addressed today, they will be used to inform future presentations, frequently asked questions, and other educational materials.

At this time, I'd like to turn the call over to Christine Estella.

## **Presentation**

Christine Estella: Thanks, Charlie. Today we're going to be covering a few topics related to the Physician Fee Schedule proposed rule and our proposals for some of the quality reporting programs we have for Medicare.

I'm going to be covering proposed changes to the PQRS, the Physician Quality Reporting System, the Medicare Electronic Health Record (EHR) Incentive Program, as well as

Physician Compare, and then I'm going to turn it over to Michael Wroblewski, who will cover proposals for the Physician Value-Based Payment Modifier.

### **PQRS Proposals Related to Reporting as an Individual Eligible Professional (EP)**

So I'm going to start with slide 5, "PQRS Proposals Related to Reporting as an Individual EP." We've kind of divided the PQRS presentation up into two parts, so it's individual reporting and group reporting. So first off, we're going to cover individual reporting.

The first topic that I'm going to cover, on slide 6, is our proposed qualified clinical data registries option. This is a new option for this upcoming year under the American Taxpayer Relief Act of 2012.

We had the authority to implement a new qualified clinical data registry option. We sought, actually, public comment through a request for information, or an RFI, in February, received comments – comments which closed in April. We basically used comments received from the RFI to kind of shape our proposals related to this new qualified clinical data registry option.

So starting with slide 6, we have the proposed definition for qualified clinical data registry. We're proposing to classify a qualified clinical data registry as a CMS-approved entity (such as a registry, certification board, collaborative) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients.

A qualified clinical data registry would be required to perform the following functions below: First, the qualified clinical data registry must be able to submit quality measures data or results to CMS for purposes of demonstrating that, for a reporting period, its EPs have satisfactorily participated in PQRS.

The clinical data registry must also be able to submit quality measures data on multiple payers, so not just Medicare payers. The qualified clinical data registry must also provide timely feedback at least quarterly on the measures for which the qualified clinical data registry would report on the individual EP's behalf for purposes of the EP meeting the criteria for satisfactory participation under PQRS.

This is a little bit more robust than our traditional registry option, whereas in a registry option we only require that registries provide feedback reports twice a year. So here we're asking for at least quarterly feedback reports.

In addition, the qualified clinical data registry must possess a method to benchmark the quality of care measures an EP provides with that of other EPs performing the same or similar functions.

On slide 7 we have a couple of additional details on proposals on how to become a qualified clinical data registry. First of all, a clinical data registry must meet the minimum

proposed characteristics. With respect to the proposed characteristics, some of them are similar to the registry—traditional registry requirements that have been established in last year’s rule.

However, for the qualified clinical data registries, CMS envisions that this option would be a little bit more robust than the traditional registry option. So, for example, whereas in the traditional registry option we require that a registry have at least 25 participants, in the qualified clinical data registry option, we require – we would require – propose to require that the qualified clinical data registry have at least 100 participants.

So we’re looking at an entity who seeks to become a qualified clinical data registry as an entity that is more robust in terms of its participants and the systems it has in terms of methods to improve quality of care.

For self-nomination, we are proposing to require that, like a traditional registry, a qualified clinical data registry would self-nominate for each year for which the qualified clinical data registry seeks to become qualified.

The deadline for self-nomination would be the same as others, so it would be January 31st. And we are proposing that the self-nom – we would accept the self-nomination statement via email.

On slide 8, we move over to a summary of our major proposed changes to the criteria for individual EPs to meet the 2014 PQRS incentive. First of all, for measures groups reporting, last year we’d finalized that measures group reporting would be available via claims. This year, we are actually proposing to eliminate that measures group claims-based option. Therefore, the measures groups reporting would only be available via registry if that proposal were to be finalized.

Secondly, for reporting individual measures via registry, we are proposing a 50-percent threshold instead of an 80-percent threshold. Last year – in last year’s final rule, we finalized a percentage threshold of 80 percent. So this year, we’re actually dropping it down, or proposing to drop it down, to 50 percent.

However, we are proposing to increase the number of generally required measures to be reported, from three to nine measures, covering at least three domains, the domains of which are below: patient safety, person- and caregiver-centered experience and outcomes, communication and care coordination, effective clinical care, community/population health, efficiency, and cost reduction.

So if we look on slide 9, we see some of the major proposals that are changing. So, for example, on that first claims-based option, for here what we proposed in the 2014 – for the 2014 PQRS incentive last year, is that an EP would report nine measures – or three measures, sorry, for 50 percent of their patients.

For this year, there's a change in that we're proposing that EPs reporting via claims would report nine measures—not just three but nine—covering at least three of the NQS domains that I mentioned prior, and the MAV would also change, the measure applicability validation process.

On the MAV prior to this year, basically if you reported less than three measures, the MAV would kick in to determine whether or not an EP would have – should have reported on more than one or two measures. So the MAV would actually kick in to see whether or not an EP could have reported on one to eight measures instead of just one to two measures. And again, the percentage threshold is the same. An EP would report each measure for at least 50 percent of the EP's patients.

For that second qualified registry option, we're making a couple of changes from what we had finalized last year. If you look at the proposed reporting criteria, we're proposing that if you're an EP who wants to report via qualified registry, you would report at least nine measures, covering at least three of the NQS domains, and report each measure for at least 50 percent of the EP's Medicare Part B patients.

So as you can see, we're proposing to increase the number of measures an EP would report from three to nine, and in addition we are proposing to lower the percentage threshold from 80 percent to 50 percent for that option.

For the qualified clinical data registry option, keep in mind for the qualified clinical data registry option the – the criteria is for satisfactory participation in a qualified clinical data registry. That standard is different from satisfactory reporting, which was – or is the standard for the other claims-, qualified registry-, and EHR-based reporting mechanisms.

For the qualified clinical data registry, an EP would report at least nine measures available for reporting under a qualified clinical data registry, covering at least three NQS domains, and report at least – each measure for at least 50 percent of the EP's patients. Of the measures reported via a qualified clinical data registry, the EP must report on at least one outcome measure.

So this qualified clinical data registry option is different in a few ways. First of all, as I mentioned earlier, the standard is satisfactory participation and not satisfactory reporting. Second, for this qualified clinical data registry option, an EP wouldn't necessarily be reporting measures from the proposed PQRS – or finalized PQRS measure set. As I mentioned earlier, a qualified clinical data registry is actually able to select and report on measures that are outside of the PQRS measure set.

Third, we are proposing that the qualified clinical data registry, or EPs within that, report on at least one outcome measure whereas, if you see with the claims and qualified registry options, there's no indication that you're required to report on an outcome measure. You can report on any measures of your choosing as long as the measures fall within the PQRS measure set.

Now keep in mind that the options on table 9 are only our proposed options. We actually finalized a couple of other options in last year's rule that we are not proposing to make changes to, so that would be, you know, reporting via measures groups via registry, and also the two EHR-based options of reporting nine measures across three domains that align with the Medicare EHR Incentive Program.

On slide 10, we have our proposed options for the 2016 PQRS payment adjustment for individual EPs. As you can see, for the first option, for the claims-based option, we're making similar changes as we did for the 2014 PQRS incentive. So basically this claims-based option for the 2016 PQRS payment adjustment mirrors the reporting option for the 2014 PQRS incentive to give claims for individual EPs because the reporting period for the 2016 PQRS payment adjustment is the same as the 2014 PQRS incentive.

The same with the qualified registry—we're proposing the same changes as we proposed for the 2014 PQRS incentive, and then as well with the qualified clinical data registry. And remember, for the 2016 PQRS payment adjustment, we have a couple of options that we finalized in last year's rule that are not – that are not on this table because this table only contains proposed changes to the 2016 PQRS payment adjustment.

So the criteria that we finalized in last year's rule, we finalized criteria for measures groups via registry. We also finalized satisfactory reporting criteria for the 2016 PQRS payment adjustment using the two EHRs, a direct EHR product or an EHR data submission vendor.

And we also finalized a claims – a less stringent claims-based option, which is the traditional—you would report three measures for 50 percent of your patients. Again though, that would only be to satisfy the 2016 PQRS payment adjustment and not for the 2014 PQRS incentive.

### **PQRS Proposals Related to Reporting Under the GPRO**

On slide 11 we're going to move on to our proposals related to reporting under the group practice reporting option, or the GPRO. I just want to remind everyone that for the group practice reporting option, you would be required to register for the group practice reporting option. Just because you're a group practice doesn't mean you're actually participating in the GPRO. You actually have to affirmatively register and say that you want to participate as a group rather than just individual EPs within a group for this option.

So, a summary of the major proposed changes to the GPRO: First of all, we are eliminating the option for group practices of 25 to 99 to report PQRS measures via the GPRO web interface. So basically if, you know, if this – we were to finalize this proposal, that means that only group practices of 100 or more EPs would be able to report via the GPRO web interface.

In addition, for reporting individual measures via registry we're proposing a 50-percent threshold. This is consistent with what we proposed for the qualified registry option for the 2014 PQRS incentive for the individual EPs.

Third, groups of 25 or more EPs will have the option to report the Clinician Group Consumer Assessment of Healthcare Providers and Systems, or CG CAHPS, survey. Fourth, group practices in a GPRO, including ACOs in the Medicare Shared Savings Program, must meet the criteria for the 2014 PQRS incentive to satisfactorily report to avoid the 2016 PQRS payment adjustment.

The last year group practices were able to report – or, this year for the 2015 payment adjustment, group practices are able to report on one measure and that would get them out of the 2015 PQRS payment adjustment.

For this year, we are proposing for 2016 that a group practice would actually have to meet the criteria for the incentive in order to avoid the 2016 PQRS payment adjustment. So we are not proposing the reporting of one measure.

In addition, we are proposing a new registration process. The newly proposed deadline is September 30th. As you know, this year if you want to participate in the GPRO, the deadline is October, so we're actually pushing the deadline forward. The registration – you would register on the same website where quality tiering is elected.

And third, if the group practice wishes to report the CG CAHPS survey, the group would be required to indicate its intent to do so at self-nomination. So for example, if you're one of these groups of 25 to 99, or the CG CAHPS is now available to you, then you would be able to indicate that you would like to report the CG CAHPS survey during your self-nomination statement.

On slide 13, we have more information about the CG CAHPS survey. There are 12 survey questions, 12 which are listed below. For this option, a group practice would be required to use a CMS-certified survey vendor. This is actually a new reporting mechanism for the PQRS, and we have proposed requirements to be a CMS-certified survey vendor in the proposed rule.

And also please note that if CG CAHPS is voluntary—because for groups of 100 or more using the GPRO web interface, it's not voluntary—please note that CMS will not bear the cost of administering the CG CAHPS survey. So the cost of administering the CG CAHPS survey if it's voluntary would be handled by the group practice.

On slide 14, we have the proposed changes to the criteria for satisfactory reporting for the 2014 PQRS incentive for the GPRO. First off, we have the change to the qualified registry option, and this covers just like the individual EP option that we are increasing the number of measures that a group practice must report from the three to nine, and we are lowering the percentage threshold from 80 to 50 percent.

The second new option is the CMS-certified vendor option. This is if you want to report CG CAHPS. This is a new way to report. This is for groups of 25 or more EPs. For this option, we are proposing that a group practice would report all CG CAHPS survey measures via a CMS-certified vendor, survey vendor, and report at least six measures covering at least two of the NQS domains using a qualified registry, direct EHR product, EHR data submission vendor, or all PQRS GPRO measures included in the GPRO web interface.

So basically, if you are a group practice of 25 or more and you want to report CG CAHPS, you would have to do so in conjunction with another reporting mechanism because CG CAHPS would only get you to one part. You would still need to report on an additional six measures. So you would still need to use CG CAHPS in conjunction with one of the reporting mechanisms that are listed under the reporting mechanism – under this option.

On slide 15, we have the same proposed changes to the 2016 PQRS payment adjustment. Again, please note that for the 2016 PQRS payment adjustment, a group practice would be required to meet the criteria for the 2014 PQRS incentive in order to get out of the 2016 PQRS incentive payment – or payment adjustment.

### **Additional Changes**

On slides 16 and 17, we have additional proposals for the PQRS. On slide 17, we have a summary of our proposed PQRS measure changes. Please remember that we did finalize measures for 2013 or 2014 and beyond in last year's rule. So this year covers additional proposals to the measures.

So for 2014, we are proposing to add 47 new individual measures and 4 measures groups to fill existing measure gaps and retire a number of claims-based measures to encourage reporting via the registry and EHR-based reporting mechanisms.

We are proposing to remove 46 measures from the PQRS measures set. We are also proposing the addition of recommended core measures that align with the EHR Incentive Program—recommended core measures. So these would be on top of the Million Hearts—recommended measures that we – were proposed and finalized last year.

For measures groups, we're proposing to change the definition of a measures group to consisting of six or more measures. Currently, a measures group contains four or more measures. We are proposing to increase the number of measures in a measures group particularly because we are proposing to increase the number of measures – individual measures that would be reported in the PQRS measures set using claims registry – claims or registry.

So four new measures groups that we are proposing are: total knee replacement, optimizing patient exposure to ionizing radiation, general surgery, and gastrointestinal surgery.

Slide 18 gives you a list of the measures that we are actually proposing to move away from claims-based reporting. This is really important because if we finalize, you know, the reporting method change of these measures, then that means that these measures under this table would no longer be available for claims-based reporting.

So when the final measures list is out, we encourage you to take a look at the final measures list to see what updates have been made to the measures. Not just which measures have been added or removed, but also what reporting mechanisms are available for each measure.

Slides 19 and 20 cover the requirements for having measures reported by a qualified clinical data registry. As I mentioned earlier, qualified clinical data registries would not be required to report measures in the PQRS measure set, although they would be able to still.

So these proposals contain parameters under – contain parameters around what types of measures may be reported by a qualified clinical data registry. As noted on slide 19, a qualified clinical data registry must have at least nine measures, one being an outcome measure. The qualified clinical data registry can have process and outcome measures. Also on slide 19 – 20, on slide 20, you have parameters regarding the specifications of the measure. So for example, the outcome and process measures reported would be required to contain numerator and denominator data.

On slide 21, we have our proposals for the 2017 PQRS payment adjustment and beyond. For the 2017 PQRS payment adjustment and beyond, we are actually seeking comment on a number of topics listed on slide 21, and – for example, the future of the PQRS reporting period; plan for the future of the PQRS GPRO; future of use of the claims-based reporting mechanism in PQRS; future submission timelines for the registry, EHR, GPRO web interface, and qualified clinical data registry reporting mechanisms; the integration of clinical quality measures reported under the Hospital Inpatient Quality Reporting, or IQR, Program; and comments on feedback reports.

These are not specific proposals we're making to the PQRS, but we are actually seeking comment on these topics.

### **2014 Medicare Electronic Health Record (EHR) Incentive Program**

Beginning with slide 22, I'm going to cover proposals for the Medicare EHR Incentive Program. So on slide 23, you know, there are only a few proposals related to the EHR Incentive Program.

First off is the proposal related to the qualified clinical data registry. As I mentioned earlier, PQRS is proposing a qualified clinical data registry option, and to align with PQRS, the EHR Incentive Program is also proposing to – is also proposing a qualified clinical data registry option. Note, though, that there are some caveats in the EHR Incentive Program with respect to reporting eCQMs that are not found under the PQRS.

In addition, the EHR Incentive Program is also proposing an aligned option with the Comprehensive Primary Care Initiative. This is a proposed additional group reporting option. And in addition to this, aside from the two bullets provided here, there are a couple of updates to the EHR Incentive Program that are being proposed. For example, there's some clarification regarding versions – what versions to be reported when reporting eCQMs for 2014.

### **2014 Physician Compare**

On slide 25, we have our proposals for Physician Compare. On slide 26, it notes that the MP – MPFS proposed rule outlines the next phase of the plan to publicly report physician performance information on Physician Compare.

We are proposing to expand the Physician Compare website by publicly reporting all measures collected through the GPRO web interface for groups of all sizes participating in the 2014 PQRS GPRO and for ACOs participating in the Medicare Shared Savings Program.

We would provide a 30-day preview period prior to publication of the quality data on Physician Compare so that group practices and ACOs would have the opportunity to review their data as it will appear on Physician Compare before it is publicly reported.

We are also proposing to publicly report certain measures that groups report via registries and EHRs for the 2014 PQRS GPRO. With respect to the CG CAHPS survey, we intend to publicly report these measures on Physician Compare in 2014 for data collected for 2013 for group practices with 100 or more EPs participating in the PQRS GPRO through the GPRO web interface.

For 2014, we also intend to continue public reporting of the CG CAHPS data for PQRS GPRO group practices of 100 or more EPs participating in the GPRO web interface and for ACOs reporting through the GPRO web interface.

And that covers my sections. I'll turn it over to Michael Wroblewski, who will cover the proposals related to the Physician Value-Based Modifier.

### **2014 PFS Physician Value-Based Modifier**

Michael Wroblewski: Thank you, Christine, and good afternoon everybody. The next couple of slides that I'm going to go through will be to help you understand what our proposals are for the 2016 Value-Based Payment Modifier, which will be a modifier that's separate and apart from the PQRS payment adjustments and incentive payments that Christine just went through.

And hopefully after the presentation, you'll have a better understanding of what our proposals are, and so you can craft your comments for – based on our proposals, and comments are due on this proposed rule by September 6th.

OK. So I am on slide 28, so “What Is the Value-Based Payment Modifier?” It’s a new payment adjustment under the Medicare Physician Fee Schedule that assesses both the quality of care furnished and the cost of that care.

We’re beginning to phase the value modifier in starting in calendar year 2015, and we are required by statute to have it completely phased in for all physicians by 2017. What we’d like to do also is – you know, to minimize burden on providers – and so what we’ve – all of our proposals and what we finalized last year for the first year of the value modifier, we have aligned our quality reporting requirements that Christine just went through with the Value-Based Payment Modifier. And I will go through all of those as we get to them.

And as I – as we finalized last year, we will be applying the value modifier to groups of physicians with 100 or more eligible professionals, or EPs, starting in 2015.

I’m now on slide 29, and slides 29 and 30 really give a quick overview of the – of our proposals and contrast them to what we have – what we finalized for the first year of the modifier. So starting – I’m on slide 29, the performance year. For the performance year for the 2015 value modifier is the year we’re currently in, 2013. We have proposed that 2014, next year, would be the performance period for the value modifier that applies in calendar year 2016.

In last year’s rule, we had finalized that we would start the Value-Based Payment Modifier with groups of 100 or more eligible professionals. We’re proposing in this year’s rule to lower the group size down to groups of 10 or more eligible professionals.

In terms of what quality measures and reporting mechanisms could those groups use who would be subject to the Value-Based Payment Modifier, for the 2015 modifier, groups of 100 have to choose one of three reporting options: the GPRO web interface, they could use CMS-qualified registries, or they could use CMS-calculated administrative claims.

There were three group reporting options and a group – for this year, the group for this year, 2013, has to choose one of those, and that will be the quality that will be used in the value modifier to be applied in 2015.

What we’re prop – we’re proposing a change to that for the 2016 modifier, which would be based on performance during next year, 2014. Groups could take any of the group reporting options that Christine just went over. And there are three of them: the GPRO web interface, CMS-qualified registries, and electronic health records, EHRs, as a group.

If a group does not want to report – if a group of 10 or more does not want to report at the group level but would rather have all of their individual eligible professionals continue to report individual measures, that will be allowed. We’re proposing it to be allowed. And we will roll up the score for a group if at least 70 percent of the individual eligible professionals who are reporting individually meet the criteria to avoid the payment adjustment in 2016.

And you may be thinking, “Why do you say the payment adjustment in 2016?” And that’s because the payment adjustment, the PQRS payment adjustment in 2016 is also based on performance during 2014. So we’ve aligned – we’re proposing to align with the PQRS proposals.

We also use – for all groups subject to the Value-Based Payment Modifier, we, CMS, calculate three outcome measures based on claims: an all-cause readmission measure, a composite of acute prevention quality indicators, and a composite of chronic prevention quality indicators. We are proposing to use those same three outcome measures to be included in the quality part of the Value-Based Payment Modifier for 2016.

As Christine indicated, we didn’t have patient experience with the CG CAHPS measures as a part of the value modifier for 2015, but we’re proposing that if a group wants to voluntarily elect to fund a CG CAHPS survey, we will use those results as a part of the quality score for the value modifier in 2016.

Turning to slide 30: Okay, so what I just went over were the cost measures – excuse me, the quality measures. What I’m turning to now are the cost measures. For the groups of 100, the value modifier for 2015 includes five cost measures that we calculate from administrative claims. It’s a total per capita cost measure that really looks at all the beneficiaries who’ve been attributed to your group, and it adds up all the Part A and Part B costs. We payment-standardize them to make sure that we’re taking out different geographic adjustments that we do, and we risk-adjust them to take into account certain patient characteristics to make sure that we’re comparing physician groups on a level playing field.

So we have that one total per capita cost measure, and then we take – we calculate four additional total per capita cost measures for beneficiaries that have four – one of four chronic conditions: COPD, heart failure, coronary artery disease, and diabetes.

We’re proposing to use those same five cost measures in 2016, but to add one as well. The one that we’re proposing to add is what we call the Medicare Spending per Beneficiary cost measure. And this is a cost measure that we’re using in the Hospital Value-Based Purchasing Program already, and it looks at the cost of – to Medicare surrounding an inpatient hospitalization. So what we do is we take all the Part A and Part B costs starting 3 days before an inpatient hospitalization up through 30 days after the inpatient hospitalization.

We’re proposing to – every – so you’ll have a cost for every inpatient hospitalization, and we are – and we’ll call that an episode. We’re proposing to attribute those episodes to any group of physicians that provides a service, a Part B service, during the inpatient hospitalization. So that means that a – this measure, or an index or – an episode could be attributed to multiple groups rather than just to one group.

In terms of the cost benchmarks, we are looking – what we finalized in last year’s rule for 2015 is that we would make cost comparisons at the group level. We’re proposing to

continue to do that for 2016 but also to add one adjustment for the specialty composition of the group of physicians.

The last two things I want to highlight as summary points are what we call quality tiering. And when I looked through the questions in preparation for the – in preparing for the call, there were a number of questions about “what is quality tiering?”

Quality tiering is what we at Medicare – when we look at actually what is the performance rate on the quality or cost measures that I just went over. For 2015, we allowed groups of 100 to elect quality tiering, meaning that if they did not elect it, then they would have a zero Value-Based Payment Modifier, meaning no payment adjustment.

In 2016, we are proposing to eliminate that election, but to phase in mandatory quality tiering such that groups of 100 or more would have mandatory quality tiering, meaning that those – they would be subject to a possible upward, no adjustment, or a downward adjustment actually based on the performance on the quality measures that they report through the PQRS and on the cost measures that I just went through.

For groups between 10 and 99—these are the new groups that we’re rolling into the value modifier for 2016—we are proposing to only give them the upside or no adjustment. If a group between 10 and 99 – a group of 10 or 99 eligible professionals actually qualified for, say a downward adjustment—and I’ll explain how we get to those in a moment—but they had – if they had one of those, we would hold them harmless. We would not – we would not – we’re proposing not to apply that downward payment adjustment to those groups between 10 and 99. And then the amount of payment at risk in – for the 2015 value modifier was 1 percent, and we’re proposing to increase it to 2 percent for 2016.

I’m on slide 31. This really kind of gives a graphical depiction of the linkage between what you’re doing under the PQRS and what a group of physicians is doing under the PQRS, and how it funnels in or feeds the Value-Based Payment Modifier.

So if you start at the top of the graph, these are groups of physicians of 10 or more—and this is the value modifier in 2016, once again, based on performance next year, 2014. So start with your groups of 10 or more eligible professionals at the top of the graph. Go down the right-hand side. This is the side I don’t want to see anybody on. These are the groups of 10 or more that don’t do what – don’t do one of two things. They – well really, they don’t do one thing. They don’t qualify – they don’t avoid the PQRS payment adjustment. At the end of the day, the group has to avoid the PQRS payment adjustment. How do you do that?

OK. They can do it a couple ways. One, they can register for a GPRO reporting option, which Christine went over, and there are three of them. They’re – they are the GPRO web interface, GPRO registries, or GPRO using an electronic health record. Or if the group wants to not use group reporting, but to report – have all the individual eligible professionals continue to report individually, and at least 70 percent of those individual

eligible professionals have to individually avoid the PQRS payment adjustment in 2016, which is – which, as you know by now, is based on 2014.

If a group does not do those things, then its value modifier's automatically minus 2 percent. And remember, this is a different adjustment than the PQRS payment adjustment that you would have for failing to meet the payment adjustment or meet the criteria to avoid the 2016 PQRS payment adjustment.

So let's go down the left-hand side. So we call these the PQRS reporters. These are the people who successfully avoided the PQRS payment adjustment because either they registered for one of the three group reporting options or they had 70 percent of their individual eligible professionals meet the criteria to avoid the 2016 payment adjustment.

What happens is, then, for those – all of those groups, we have mandatory quality tiering, and if you go down the very left-hand side, for those groups between 10 and 99, there'll be an upward or no adjustment. If you kind of go down the right-hand side, coming down at mandatory quality tiering, those are the groups of 100 plus. They will have mandatory quality tiering, meaning that they would be at risk for a downward adjustment but also would earn possibly an upward adjustment as well—once again, based on the performance on the quality and cost measures.

OK, slide 32. This may sound like a broken record, but – OK, in terms of what do groups of 10 or more have to do to – if you go back one slide, trying to stay on the left-hand side of the slide. Once again, I'll repeat it one more time, that a group can do one of two things. They can either register for one of the three PQRS group reporting options that are listed there on the slide, or—and I'm turning to slide 33 now—they can have the individual eligible professionals in the group make sure 70 percent of those eligible professionals meet the criteria to avoid the 2016 payment – PQRS payment adjustment.

And you can do that by – as Christine went through, individuals can avoid the PQRS payment adjustment in 2016 by reporting via one of four reporting mechanisms—traditional claims, CMS-qualified registries, EHRs, and the new clinical data registries—which Christine just laid out the criteria for.

You'll notice there is no CMS-calculated administrative claims on this list. We are not proposing to – that was only for 2015, performance period 2013—we are not proposing that moving forward. So groups would either have to, in order to qualify for the value modifier, to get out of the – kind of the automatic minus-two value modifier, it's either report as a group or have at least 70 percent of the individual eligible professionals meet the criteria to avoid the payment adjustment in '16.

I'm on slide 34 now. So I just told you how they were aligned. So what do we do with these measures? What measures will we actually use in the – in the value modifier? We will use the PQRS measures on the quality side—the PQRS measures that you've reported—and we will add three additional outcome measures: all-cause readmission and then two composites, one of acute prevention quality indicators and one of chronic

prevention quality indicators. And we'll use the CAHPS measures if you've elected to satisfy your PQRS requirements using the patient experience CG CAHPS survey.

In terms of the cost measures—I'm on slide 35—we'll use six cost measures: the total per capita cost measure; total per capita cost for beneficiaries with four specific conditions, and they're listed there on slide 35; as well as the Medicare Spending per Beneficiary measure.

All the – as I mentioned earlier, all the cost measures will be payment standardized, meaning we take out different geographic adjustments, and they're also risk adjusted, so we take into account the patient characteristics.

And then for the cost measures, we will also be adjusting the group-level cost measures for the specialty mix of the – of the group.

OK. So – I'm now on slide 36. So you may understand, “OK, well I understand what quality measures they're going to use for my group, I understand what cost measures they're going to use, but how do they actually combine them? Because can't people report different quality measures? So how do I get a kind of a fair comparison here?”

This is what this diagram hopefully will show you. What we do for each measure is we calculate a standardized score for each measure, which really looks to see how your group's performance rate differs from the national mean. And we look basically to see if you're one standard deviation away from it, either you're high or you're low, one standard deviation away.

But we'll calculate one of the – a standardized score for every measure that you report, and we'll put them into – if you look at – if you look at the left-hand side of the chart there, the first six boxes are the same quality domains that align with the National Quality Strategy, and we will put your measures that you report through the PQRS into one of those six domains.

We'll weight each of this – those measures' standardized scores equally within those domains and come up with a domain score, and then we'll weight – weight each of the domain scores equally to come up with a quality of care composite score.

As you heard Christine talk about, you know, you have to – what we're proposing for the group practice reporting options and for the individual reporting options or mechanisms that you have to do – for many of them – you have to do three measures – or excuse me, nine measures in three domains.

So you'll be – the groups will be reporting measures in multiple domains. And if you have a domain that is not – in which there are no measures, then the rest of the domains are equally weighted.

In terms of the cost, as you know there are six cost measures that we're using for the value modifier. We'll put the first two measures, the total per capita cost measure as well as the Medicare Spending per Beneficiary measure, in one domain, and then the other four measures, the total costs for beneficiaries with specific conditions, in the other domain.

We once again calculate a standardized score for each of the measures, equally weight the standardized scores in the domain, equally weight the domains to come up with a quality – excuse me – a cost composite score.

So at the end of this process, each group will have a quality composite score and a cost composite score. And turning to slide 37, we then look to see – we then divide everyone's quality scores into three groups and the cost scores into three groups: high, average, and low. And as I mentioned before, it really looks to see how far away you are from the national mean.

So what we then do is give every group of 10 or more a – two scores—a cost score and a quality score, and we put them on this grid that you'll see there on – kind of in the middle of slide 37. Then obviously the best place to be is in the upper left-hand corner, that is, you are high quality/low cost. And you'll see that the adjustment is  $+2.0x^*$ . I'll explain what the “x” and the asterisk mean in just a second.

The worst place to be is high cost/low quality. That's the bottom right-hand corner. And you'll see that's minus 2 percent. That's an automatic minus 2 percent if you are high cost/low quality.

Let me explain what the “x” and asterisk mean. The value modifier by statute has to be budget neutral, so we have to determine how much money is being basically taken away from the poor performers before we are able to calculate what the upward adjustment is for the – for the high performers.

And so what we were trying to illustrate through the use of the “x”—and I'll call that the payment adjustment factor—is that those groups that are low cost/high quality will get two times “x” compared to those groups that are low cost but only medium quality or those groups that are high quality but average cost.

The asterisk means that if a group cares for beneficiaries that have – that are – are complex beneficiaries in that the conditions that they're being treated, you know, multiple co-morbidities – have a risk score that we would say is in the top 75 percent of risk scores for beneficiaries nationwide, we'll actually bump up the payment – because we want to encourage high-quality, low-cost care for beneficiaries with the – you know, who – with multiple chronic diseases. So we'll give you, actually, an additional “x” if you are – if you are earning an upward adjustment.

On slide 38, here's the timeframe of how this is all going to work. And I started from where we are right now all the way through the value modifier that would apply in 2016. So bear with me for just a moment as I walk through this.

So where are we right now? We are in 2013, and the – the registration process that groups of 100 or more must use in order to evaluate – to avoid the minus-one value modifier adjustment that applies in '15 must register by October 15th, 2013, so in a couple months.

And we actually have a call, a National Provider Call, scheduled next week, July 31st, from 2:30 to 4:00, to actually walk through groups on how you get – you know, to once again go over what groups of 100 have to do, how do you get an access account to access the registration system, and then how you actually fill out the screens on the registration system.

In the third quarter of this year, so September 16th actually, all groups of 25 or more will be able – be able to download from this same system that we're talking about next week—we call it the Physician Value PQR system—will be able to get their – what we call their Quality Resource and Use Reports. They'll be available for all groups of 25 or more.

In 2014, the first quarter of 2014, that's when groups have to complete submission of their 2013 information for PQR. There'll be a registration process for the 2016 PQR payment adjustment and the value modifier in '16, which will open in May of 2014 and close, as Christine indicated earlier, on September 30th.

In the third quarter of 2014 – and we don't have a date yet, but all groups, all – and we identify a group by a taxpayer identification number – all groups will be able to pick up a Quality and Resource Use Report, which shows how they will be doing under quality tiering and how the value modifier could apply to them, so get – they'll get to see, you know, what their cost composite is and what their quality composite is and whether they're high, average, or low.

In 2015 (that's when the value modifier applies to groups of 100 or more) – during the first quarter of '15, all groups and individuals still can submit their 2014 PQR information. In the third quarter of 2014 – excuse me, 2015, all groups and solo practitioners can pick up their QRURs, and then the value modifier applies beginning January 1st, 2016. What we're proposing is to groups of 10 or more, with only upside adjustments for groups 10 to 99, and upside and downside adjustments for groups of 100 or more.

Slide 39. So what do act – what actions do groups of 10 or more have to do for the 2016 value modifier? They're going to have to choose a PQR reporting mechanism. They can choose one of the three group reporting mechanisms or utilize the 70-percent option. They'll have to use the registration system that opens up next year, May 2014, that'll be open through September 2014.

There's no need to self-nominate or register if you're choosing the 70-percent option, meaning that if you all – if you want your group – your eligible professionals to continue to report individually, no need to register for that.

And of course, we want you to meet the satisfactory reporting criteria to avoid the 2016 payment adjustment for whatever PQRS reporting mechanism that you have selected.

Slide 40. I just wanted to reiterate what I mentioned on the timeline. This September, groups of 25 or more will be able to get their Quality and Resource Use Reports that show how the group will fare under the value modifier, so there will be a cost and a quality composite score.

But we're also including, for those who have received QRURs in the past, we're actually including three drill-down tables which indicate which beneficiaries have been attributed to your group as well as their resource use and specific chronic diseases. We're including drill-down tables to include all those beneficiaries and their hospitalizations during the year, and then we'll also indicate which other eligible professionals billed under that TIN.

These reports that we're putting out in September '13 will be based on 2012 data. And then late in the summer of 2014, we'll do QRURs for all groups and solo practitioners.

## **Resources**

That concludes the main content of the presentation. Just – these next couple slides are really just informational in terms of how to file comments and where to go for more information.

So on slide 42, you'll see there are four ways in which commenters can submit their comments on our proposals. And as I indicated earlier, they have to be submitted by September – Friday, September 6th, 2013.

Slide 43 indicates where to call for help if you have – regarding PQRS or about the value modifier. You'll see all the different contact information on slide 43. On slide 44, these are links to all the resources for the PQRS Shared Savings Program, for Physician Compare, for the value modifier. And then slide 45, I will turn it over to Charlie again to finish off that and to start our Q&A. Thank you.

## **Keypad Polling**

Charlie Eleftheriou: Thank you very much, Michael. At this time, we're going to pause for a moment and complete keypad polling before moving on so that CMS has an accurate count of the number of participants on the line with us today.

Please note, there will be some silence on the line while we tabulate the results. And Victoria, we're ready to start polling please.

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

If you're 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 the corresponding number. And 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 Mr. Eleftheriou.

### **Special Announcement**

Charlie Eleftheriou: Thank you. Before we start the question-and-answer session, I'd like to make a special announcement. CMS will soon provide the new opportunity for Medicare-enrolled providers and suppliers to give your feedback about your experience with your Medicare Administrative Contractor, or MAC, the contractor that process your – which is the contractor that processes your Medicare claims.

The 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 registered to become – become a participant. If you'd like to register to become a MSI participant or for more information, please visit the website, which is listed on slide number 45.

### **Question-and-Answer Session**

Now our subject-matter experts will begin taking your questions momentarily. I'd like to remind everyone that this call is being recorded and transcribed, again, so please before asking your question, state your name and the name of your organization. And in an effort to get to as many of your questions as possible, we ask that you limit to just one question at a time. 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.

Victoria, we're now 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.

Your first question is from Dawn Gates.

Dawn Gates: Hi. This is Dawn. Can you hear me?

Charlie Eleftheriou: Yes, we can. Hi.

Dawn Gates: OK. Thank you. For PQRS measures, we've been reporting through claims, but now we're part of a Pioneer ACO that has been group – reporting group – group reporting for us, sorry. We're just wondering, do we need to stop doing it through the claim process? Or is there any ramifications of us being – going both – entering both?

Daniel Green: Is there anybody from PMBR on that can answer that question?

Michael Wroblewski: Hey, Dawn, this is Michael Wroblewski. Let me ask you a quick – let me ask you a quick question— are all your eligible professionals – are all your NPIs in your TIN participating in the Pioneer, or are only a select few?

Dawn Gates: All of them are. There's just five of them.

Michael Wroblewski: Right. Then no. You report through – if all of them – I want to – I'm stressing – I want to make sure it's all of them.

Dawn Gates: All of them are, yes.

Michael Wroblewski: If all of them are in a Pioneer, then they do not have to report separately through PQRS – how they report – they'll – the whole Pioneer uses what we – the web interface and reports on behalf of all the Pioneer, and that will take the – that will satisfy your PQRS requirements for '13 and what we're proposing for '14. And I just – but I'm stressing that is all the NPIs under that TIN.

Dawn Gates: That's correct. But – and our problem was – like we're not sure how long we stay in this Pioneer, so we were thinking we wanted to keep reporting through claims so that we didn't stop the process.

Michael Wroblewski: You . . .

Christine Estella: You don't get penalized for reporting twice if you don't know how long you'll be participating in the Pioneer ACO, and we don't have any subject-matter experts here on the Pioneer ACO program. So I would certainly check with them as well. But with respect to PQRS, if you wanted to report via the Pioneer ACO, we do have some sort of aligned option where you can report Pioneer ACO and it would count for PQRS.

But if you, you know, wanted to report twice, you wanted to report through the Pioneer ACO and then report via our claims-based method, you can go ahead and do so twice, if you're worried about, you know, how long you would stay in the Pioneer ACO.

Dawn Gates: OK. Thank you. That answers my question.

Christine Estella: Sure.

Charlie Eleftheriou: Thank you.

**Operator:** Your next question is from Mike Rhodes.

Mike Rhodes: Hi. Thanks for taking my call. For specialty physician groups, I'm the office manager for a rehabilitation physician group. We struggled with coming up with three individual measures that were applicable, and it looks like most of this is really geared for primary care physicians that service the chronic conditions or the acute conditions, where we're on the other end of the world, where people have survived their catastrophic illness and stroke.

So we can report on individual measures like stroke. But any advice for specialty group physicians and the – we use the – we're going to be using the registry to report and – but we've – we're struggling because so many of the – so many of the measures are primary care family medicine type measures.

Daniel Green: You bring up a good point, and we're aware of that. We're working with specialty societies and others to try to broaden, if you will, the measures for the different specialties where – you know, where there are perceived or known gaps.

But in the interim, you know, one thing that you could do – excuse me – you know, there's reporting to earn the incentive and there's reporting also to avoid the penalty. Obviously, we would prefer you all to earn the incentive, you know, or to be slightly rewarded for your efforts.

But, you know, there are some broadly applicable measures that may not necessarily, you know, be the first thing you would ask a patient when he or she comes to see you or is in your rehab center, but things like smoking, for example, smoking cessation. I mean, I think we could all agree that all medical providers should be inquiring about smoking. And I mean, it's not a long, lengthy, you've got to prescribe 30 medications for smoking cessation and spend an hour counseling the patient. The measure doesn't require anything like that.

Similarly, there's the BMI measure, and, you know, with the obesity epidemic in the country, that's a broadly applicable measure that your docs may be able to report on.

There's also blood pressure measures. There's fall measures, which probably would pertain to PM&R and, again, those are the ones that come to mind off the top of my head, but there are some other also broadly applicable measures.

Mike Rhodes: Sure. I appreciate that.

Christine Estella: Keep in mind, too, with our proposed option, at least for claims-based reporting, you know, we did propose to increase the number of measures to be reported from three to nine. But again, we have that measure application validation process, the MAV process, that will check to see whether you could have reported on any – on nine measures or if you report on less. So there is that MAV process that we are proposing that would also help you in case you do have fewer than nine measures, and if it happens to be three, or two.

Mike Rhodes: OK. Thank you.

Daniel Green: Right, and again there's – you know, under the current proposal, you would need to report three measures to avoid the payment adjustment. So, again, that's not been finalized but that is what's proposed.

**Operator:** Your next question is from Amy Levine.

Amy Levine: Hi. I listened to the entire seminar, obviously, and all I kept hearing was for 10 or more, or 100 or more, EPs. We only have four doctors on our practice. Where do I stand in this? Do I even need to do PQRS or what – does this seminar not apply to our practice?

Christine Estella: Sure. So if you have four – I know you said you had four, you know, physicians. Just to let you – just to remind you, the PQRS – so the Value-Based Payment Modifier applies to physicians, but the PQRS applies to eligible professionals. That doesn't necessarily mean physicians. It also means, for example, nurse practitioners and other clinicians.

I'm sorry. . . .

Amy Levine: But we don't have any of those.

Christine Estella: OK.

Amy Levine: We're an ophthalmology/optomet- – well, an ophthalmology practice, so we have doctors; that's it.

Christine Estella: So – OK. So the PQRS still applies to you, that you could actually still report using either an individual reporting option or as a group, because as a group we consider anyone with two or more EPs as eligible to participate in PQRS as a group

practice. It's just that the only group practice reporting option that would be available to you would be the registry option or the EHR option.

Michael Wroblewski: And do you want to tell them what happens if they don't report?

Daniel Green: But again, you could – your doctors could report as individuals using either the claims method, the registry method, or using the electronic health record option. And again, if they don't report PQRS in 2014 at least as proposed, they would be subject to a 2-percent payment adjustment.

Amy Levine: Oh, we've been reporting and we plan on continuing reporting, but like I said, I was a little bit confused there. So you said that we can continue to report on claims even during the . . .

Christine Estella: Yes.

Amy Levine: . . . 2014, 2015, 2016, 2017. I mean, as of now for the future, I can continue doing it via claims?

Christine Estella: Right. You could continue to do so via claims as we've proposed. However, I would urge you to check – you know, once the final rule comes out, to check the claims-based measures that you would be reporting for updated measure specifications and changes to the measures.

Because as we – as I mentioned in the proposed rule, we are actually proposing updates and changes to a lot of those claims-based measures where they would no longer be reportable via claim.

Amy Levine: OK. Thank you.

Christine Estella: Sure.

**Operator:** Your next question is from Kim Eitzmann.

Kim Eitzmann: My question was answered by the previous person. Thank you.

Charlie Eleftheriou: Great. Thank you.

**Operator:** Your next question is from Jill Young.

Jill Young: Good afternoon. I wondered if – I just wanted to be sure I heard you correctly when you said – when you were talking about compiling the cost 3 days before and 30 days after – that you're indicating that those costs would be potentially shared in one of your calculations over all specialties that took care of a patient regardless of their role. Is that correct?

Michael Wroblewski: What the question was, is we're including – we're proposing to include a new cost measure for the – in our value modifier cost composite starting in 2016, which will be based on 2014. And as you – as you said, it's called the Medicare Spending per Beneficiary measure, and it looks – it's a measure that looks at every inpatient hospitalization and looks at the total – what we call total Part A and B cost from 3 days before, following 30 days afterwards.

And what we would do is, you have that episode, OK? And you've got to think, well, who – who are we going to assign responsibility to that episode to? And what we're proposing is if any physician group provides a service during the inpatient hospitalization, that episode would be attributed to that group. So then in order to get the group score, you would just add up all of those episodes that have been attributed to that group.

Jill Young: So even if it's just a con- – well, I know we don't do consults, but even if it's just a one-time visit, that group will bear the same responsibility as . . .

Michael Wroblewski: If that episode would be attributed – what we've proposed – so that episode would be attributed to that group, that's correct.

Jill Young: So the neurosurgeons spend gazillions of dollars doing their care and a pulmonary group comes in and does a one-time visit, they're – they're going to get the same weighted value attributed to them from a cost perspective.

Michael Wroblewski: That's what we've proposed. The episode would be included in that group's – when we calculate the measure for that group. You know, obviously we would add up all of the episodes that have been attributed to that group, but that's what we've proposed. You've got it.

Jill Young: But the same weight, though – I mean that just seems a little unfair, that's why I'm trying to make sure I'm getting my head wrapped around that part of it. OK.

Michael Wroblewski: Yes.

**Operator:** Your next question is from Jean Bourque.

Jean Bourque: Good afternoon. I was wondering, we are a billing service, and I have educated all of my clients to the best of our abilities. And is there somewhere I can go plug in an NPI number and see what our status is as far as meeting all of these qualifications?

I have doctors who have been doing it since February. I have some doctors who have just started. So is there somewhere we can go to monitor progress in – in achieving these goals?

Christine Estella: This is Christine. Unfortunately we don't have any sort of real-time, you know, check to see how you're reporting or how your status is on PQRS. Are you reporting via claims, registry, EHR? How are you reporting?

Jean Bourque: Claims.

Christine Estella: Claims? So under claims, I know there's a bit of a gap but traditionally, you should see – when you're reporting a G-code, you should see an N365 code which says that your reporting has passed through the NCH database.

From my understanding, so there are time – right now currently you're not able to see that N365 – or you were not able to see that N365 code for a little bit. So there are – there are instances this year where you will have reported but may not necessarily have seen that code. But traditionally speaking, you should see that N365 code every time you're reporting.

Jean Bourque: OK. Excellent. Thank you so much.

Christine Estella: No problem.

**Operator:** Your next question is from Obi Egonu.

Obi Egonu: Yes. I have a question. We have been filing claims – PQRS via claims, and this is a solo practice in Chicago, so we – I actually have been doing this since 2012, and to my understanding – OK. I also have the IACS account where all the reports are loaded. But for the 2012 PQRS reporting, when I look up on the IACS dashboard, all that I see there is January through September. But I understand that the PQRS reporting is a yearly thing, which is January through December.

So my question is, when is Medicare going to give us an update which will be October, November, December, so at least we will know what our scores are? We are still reporting the PQRS via claim; you know, it is a solo practice and I've chosen to do it on my own.

Christine Estella: So the dashboard only contains a snippet of your reporting. The actual full feedback report will come in the fall of this year for your 2012 reporting.

Obi Egonu: Oh, fall of this year for the 2012?

Christine Estella: Yes. Yes.

Obi Egonu: OK.

Christine Estella: Arriving early fall.

Daniel Green: You're right. It is a full-year reporting program, and the measure information is being calculated, and those that are earning an incentive – you know, that number is being calculated and in the process of – we're working with the contractors to get them the files to be able to issue the payments. Once the payments are issued, those feedback reports in their entirety will become available.

Obi Egonu: OK. Thanks. That's it.

Christine Estella: No problem. So suffice it to say, if you get a payment, then that's a good thing because you'll get the feedback report afterwards.

Daniel Green: Or you can access it to get your feedback report.

**Operator:** Your next question is from Rachel Obbenhower.

Rachel Obbenhower: Yes. I just wanted to go back and clarify about the comment about a practice being under 10. It was clearly defined that for PQRS, but what about for this Value-Based Modifier?

Michael Wroblewski: So for under 10, that's a great question. We are phasing in the Value-Based Payment Modifier, and by law, we have to apply to everyone by – starting in 2017. We've just made our proposals on our – really our second, you know, our second year of the phase-in, and we have not yet made proposals on how to phase in the value modifier for groups smaller than 10, although we did ask for comment in the rule that we – you know, we've asked for whether we should keep aligning – you know, so the quality measures that you report through PQRS would then be – when the value modifier does apply, would then be used.

So no proposals yet.

Rachel Obbenhower: Excellent. OK. Thank you.

Michael Wroblewski: But by statute, it has to apply by 2017. OK?

Rachel Obbenhower: Great. All right. Well, I'll keep it on my docket then.

Michael Wroblewski: All righty. Sounds good.

Rachel Obbenhower: All right. Thank you.

**Operator:** Your next question is from Ariann Polasky.

Ariann Polasky: Hi. Thank you so much. My question is, it wasn't clear to me when we were going through the presentation whether practices of 10 or more that choose the 70-percent reporting option, if they're required to report on individual measures as

individual eligible professionals, or if they are also permitted to report on measure groups as individual – individual eligible professionals?

Michael Wroblewski: That's a great question. As long as they meet the criteria to avoid the 2016 payment adjustment as individuals, and you can do that via reporting individual measures or through measure groups. That's a great question. Thank you for asking it.

Ariann Polasky: Thank you.

**Operator:** Your next question is from Amanda Hutchins.

Amanda Hutchins: Hi. This is Amanda Hutchins from Spectrum Health Medical Group. We're a large multispecialty medical group and we plan on reporting the – all the Meaningful Use quality measures that our EHR offers.

And I was wondering – so say we have a specialist where only five of those measures are applicable, and they're meeting those at the 50-percent threshold, but due to maintenance it's easier for us to report just all of the measures, and so they have other measures that they're not meeting the 50-percent threshold. Will they not meet PQRS because we're reporting nine measures, and they're only meeting five at 50 percent?

Christine Estella: So for PQRS reporting, so you're saying that you are reporting CQMs for the EHR Incentive Program, right?

Amanda Hutchins: Correct.

Christine Estella: We have an aligned option where that – if you are reporting using a certified EHR technology and it's also EHR reporting mechanism under the PQRS, that you would get credit for both PQRS and the EHR Incentive Program.

It's not – as I mentioned earlier, it's not in these slides because it was actually finalized in last year's final rule. So it's not going to be on this table, for example, on slide 9 or 10, but we do have an aligned option where if you're using EHR that's cert, you'd report nine measures covering three domains.

And the only caveat we have of the difference between how you're reporting under PQRS and versus the EHR Incentive Program is that for PQRS, you would just need to make sure that you report on at least one Medicare patient.

Daniel Green: So, and there's one other point I want to just ask—you said you're going to report nine measures, or all the measures for a given specialist, but not all the measures would necessarily apply. Is that correct?

Amanda Hutchins: Right.

Daniel Green: OK. So, you know, right now if you report, let's say, for Dr. Jones who's an ophthalmologist and you report on all of the – all the diabetic patients, it may affect Dr. Jones's performance for those – for those diabetic patients, but it wouldn't affect their reporting. They would still meet the 50 percent because they would have reported on all the diabetics in the system.

Amanda Hutchins: OK.

Daniel Green: Does that make sense to you?

Amanda Hutchins: Sort of.

Christine Estella: There is no percentage threshold for that EHR option under the PQRS, that option that aligns with the EHR incentive program—basically the same option.

Daniel Green: And you're – I think you're mixing performance and reporting rates up.

Amanda Hutchins: OK.

Daniel Green: Because their performance rate might be low because they didn't, you know, check a mammogram, let's say. But their – but their reporting that they didn't check the mammogram would count even in the other scenario where you're looking to try to get 50 percent.

Amanda Hutchins: Oh, I see. Yes, I see what you're saying. OK.

**Operator:** Your next question is from Jason Shropshire.

Jason Shropshire: Hi. I have two questions. The first is a quick question. Can you tell me when we have to have the comments and questions in to you? What is the date that we have to have them back to you?

Michael Wroblewski: Friday, September 6th.

Jason Shropshire: September 6th. OK. And I have one more question.

Male 1: This is actually a quick followup to the previous question about the alignment between PQRS and Meaningful Use. How do the reporting periods line up?

So if I understood correctly, you're saying if I report clinical quality measures under Meaningful Use, that can be used as PQRS reporting. But for the 2014 year, Meaningful Use would have quarter reporting periods and not the full year. Would that still be satisfactory for PQRS?

Maria Michaels: So this Maria Michaels with the Meaningful Use program. If you are wanting to use one of the aligned options, we actually stated in the Stage 2 rule that you would have to use the reporting period for the other program.

Male 1: OK.

Maria Michaels: So in the case of PQRS, it requires a 12-month reporting period, and therefore you would need to use a 12-month reporting period even in 2014.

Male 1: OK. Thank you.

Maria Michaels: Sure.

Daniel Green: Just because the comments aren't due till September 6th, doesn't mean you've got to wait until September 6th. Christine is so anxiously awaiting the first comment. So comment early and comment often.

**Operator:** Your next question is from Daneen Grooms.

Daneen Grooms: Hi. Yes. Thank you for taking my call. I have a quick question that I was hoping you could answer for me. The Medicare e-Prescription Incentive Program wasn't mentioned in the proposed fee schedule, so I was wondering if CMS intends to stop the program.

Christine Estella: So the program is only authorized to provide incentives until 2013 and payment adjustments until 2014, so basically we do not have a reporting period for the eRx incentive program in 2014. The program essentially ends that year, and that's the year where we're dishing out payment adjustments.

Daneen Grooms: OK. Thank you.

Christine Estella: Yes.

Daneen Grooms: OK.

**Operator:** Your next question is from Melissa Unger.

Melissa Unger: Hello. My name is Melissa Unger from OSU Wexner Medical Center, and we are a multispecialty group with different billing TINs, and our groups utilize different PQRS reporting options. Some do claims, administrative claims, and others do the GPRO web.

If we utilize the EHR with the QRDA III format to report on our 2014 eCQMs in PQRS, I heard that we have to upload a file; it doesn't come directly from the HER, we actually have to upload the file through the PQRS web portal. And I wanted to know if I needed an IACS account for each billing TIN with separate QRDA III files, or if I can just have

one IACS account associated to all the groups or billing TINs in order to upload one file for all of our EPs?

Michael Wroblewski: Sabrina, correct me if I'm wrong, but you can have an IACS account associated with multiple TINs.

Sabrina Ahmed: Yes. That's correct.

Lisa Lentz: This is Lisa Lentz. Let me try to address this one. I believe you're referring to the new group reporting option under Meaningful Use 2 that would allow a group practice or an ACO to report through the GPRO web interface to meet the Meaningful Use criteria?

Melissa Unger: No. They were telling me that it's still what they call EHR Direct, but that it's – CMS isn't able to receive a file directly from the certified EHR technology. It has to actually be a file extracted from the certified EHR technology and then uploaded via the PQRS web portal.

Daniel Green: This is Dan. So it's true that if you're doing EHR Direct, your system should generate a file—a QRDA III file—and you would log in to our PQRS portal using an IACS account and upload – upload that file. So that part of your question is absolutely correct. I mean whether you did it, whether it came from a data submission vendor, somebody's got to, you know, have our two systems communicate with each other and upload the information, and you would need an IACS account to be able to do that.

Melissa Unger: But I can – if we have multiple groups, though, will it still qualify those EPs in all of the billing TINs?

Daniel Green: You would need a file, obviously, for each separate TIN. You know that, right?

Melissa Unger: No. I thought we could have just one file for all EPs no matter what billing TIN they fall in.

Daniel Green: Not for PQRS. PQRS is considered at the – at the TIN–NPI level, and are you guys nominating as a group to report?

Melissa Unger: Some of our groups are and some are not. So I guess we need to have separate QRDA III files from our certified EHR technology based on billing TIN, and that should qualify the EPs for both MU, CQMs, and PQRS?

Christine Estella: I think your question's a little bit more complicated just because it sounds like you, first of all, have different reporting mechanisms for each TIN. PQRS treats each TIN as a different group practice or as different individuals. There's different way you – EHR incentive program calculates folks via not a TIN but just the NPI. So I think it would more adequately answer your question if I could direct you to the

QualityNet Help Desk, and then they would be able to funnel your question through the different tiers, and we can get your question worked out more appropriately.

Melissa Unger: OK.

Charlie Eleftheriou: And that information can be found on slide 43.

Melissa Unger: All right. Thank you very much.

Charlie Eleftheriou: You're welcome. Victoria, we have time for one more question.

**Operator:** Your last question is from Maria Tiberend.

Maria Tiberend: Hello, my name is Maria Tiberend, and I'm with BJC Medical Group in St. Louis. My question is regarding our ACO participation as a Medicare – in the Medicare Shared Savings Program.

We submitted our ACO performance data for year 2012 this past spring, and I want to confirm whether by submitting that data for all of our participants for ACO Medicare Shared Savings that we've met our PQRS reporting requirements for 2012.

Christine Estella: Lisa, could you answer that question, please?

Lisa Lentz: Sure. Yes. So the Medicare Shared Savings Program is in the process of aggregating all of the 2012 reporting results, and I believe distributing those reports either by the end of this month or next week, early August. And they're actually scheduling a presentation with the ACOs to go over those.

So, if – when you receive your report from the Shared Savings Program, if it shows that you did completely and accurately report all of the GPRO web interface measures, then that will qualify all of your ACO's participant TINs that have PQRS-eligible professionals for the 2012 PQRS incentive.

Maria Tiberend: Thank you. And then that – we plan on – you know – that was year 1 for us, so we have years 2 and 3, so we'll report the ACO performance standards for 2013 and 2014. And if everything is correct and – will that – because I guess I'm worried, will we – I don't want to miss anything that would harm us with the Value-Based Modifier or the 2016 penalty, so . . . .

Lisa Lentz: Right. So if you're participating in the Medicare Shared Savings Program, the Value-Based Payment Modifier would not apply until – actually it does not – it does not apply at any point before 2017.

Maria Tiberend: OK.

This document has been edited for spelling and punctuation errors.

Lisa Lentz: For the PQRS payment adjustment for 2013 reporting, your ACO will have to report on at least one measure in the GPRO web interface in order to avoid the PQRS payment adjustment.

You still need to report on all of the measures for your shared savings criteria, as well as for the PQRS incentive criteria.

Maria Tiberend: Right. So we'll need one separate measure to avoid the pen – PQRS penalty, other than the ACO performance measures?

Lisa Lentz: No, no, no. One of those measures.

Maria Tiberend: Oh, OK.

Lisa Lentz: Yes, one of those measures. And then the 2014 proposal was that, you know, all measures need to be reported for both purposes of the incentive and to avoid the payment adjustment. So those are all the measures you're reporting anyway to meet your Shared Savings Program criteria.

Maria Tiberend: OK. That's very helpful. Thank you.

Lisa Lentz: Sure.

Michael Wroblewski: Just one quick clarification on the value modifier and ACO participants—we are not applying the value modifier in '15 – in 2015 or 2016 to ACO participants. We have not yet made any proposals on what to do in 2017 moving forward.

## Additional Information

Charlie Eleftheriou: OK. Thank you, Michael. Unfortunately, that's all the time we have for questions today. If we did not get to your question, please contact the QualityNet Help Desk using slide number 43.

On slide number 47 of the presentation, you'll find information and a web link to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you'll take – you'll take a few minutes to evaluate this MLN Connects call experience.

Again, this is Charlie Eleftheriou and I'd like to thank the presenters and participants of today's call. Thank you and have a great day, everyone.

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

-END-

