

**Centers for Medicare & Medicaid Services
Physician Quality Reporting System and Electronic Prescribing
National Provider Call
Moderator: Charlie Eleftheriou
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Operator: At this time, I would like to welcome everyone to the Physician Quality Reporting System and Electronic Prescribing 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. Thank you for your participation in today's call.

I will now turn the call over to Charlie Eleftheriou. Thank you, sir. You may begin.

Introduction

Charlie Eleftheriou: Thanks, Holley. As Holley just mentioned, this is Charlie Eleftheriou from the Provider Communications Group here in CMS, and I'm going to be serving as your moderator today. I'd like to welcome everyone to this Physician Quality Reporting System and Electronic Prescribing Incentive Program National Provider Call.

Today we'll be presenting on the Calendar Year 2013 Medicare Physician Fee Schedule Proposed Rule, Quality Reporting Initiatives. Once the presentation is complete, we'll have a question and answer session for participants to provide input and ask questions.

Before we get started, there are few items I'd like to cover. There is a slide presentation for this session. A link to the presentation and today's announcements was mailed to all registrants at approximately 12:30 today. If you did not receive the e-mail, please check your spam or junk mail folders for an e-mail from the CMS National Provider Call Resource Mailbox.

The presentation can also be found by visiting www.cms.gov/npc, as in National Provider Call. Again, that's cms.gov/npc. Then click the National Provider Calls and Events link at the left side navigation panel and then find today's call by date in the list.

Next, a quick reminder: This call is being recorded and transcribed. An audio recording and written transcript will be posted to the Physician Quality Reporting System and National Provider Calls Web pages on the CMS Web site. Lastly, we would like to thank those of you who submitted questions when you registered for today's call. Your questions were shared with the speakers to help prepare for this and future calls.

Now I'd like to turn it over to Dr. Dan Green.

Dr. Green, take it away.

Daniel Green: Thank you, Charlie. So today there's going to be a bonus. If anybody can spell Charlie's last name correctly, you get an extra call out. Sorry, Charlie.

Charlie Eleftheriou: That's OK.

Daniel Green: Start the tuna commercial – never mind. OK. That's the joke for today. So hopefully I've got your attention now.

Anyway, I'd like to welcome everybody to the National Provider Call today. We do appreciate your continued interest in PQRS. We have a riveting conversation today and presentation. We will be giving an overview of the Proposed 2013 Medicare Physician Fee Schedule Proposed Rule as it pertains to the Physician Quality Reporting System as well as the Electronic Prescribing Incentive Program.

I'm going to limit my remarks, but I do want to mention that the rule went on display on July 6, and as I said, we will be presenting an overview of the rule today and we will be happy to entertain questions folks have about the rule. Last thing I'd like to say before I turn it over to Lauren is if you do have comments about the rule, rather than make them on today's call, we would love it if you guys would submit them in written form, and there'll be information as to how you can go about doing that.

Comments that we consider for the rule need to come in writing. While we're happy to listen to them, we also want to make sure that folks that do have

questions and have issues about clarification have plenty of time to address those on today's call.

So thank you again for your attendance and interest, and I'll turn it over to Lauren now.

Announcements

Lauren Fuentes: Thank you, Dr. Green. And before we get started with our presentation for today, I just wanted to make a few announcements. Our first announcement is that CMS is no longer accepting measures suggestions for possible inclusion in the Physician Quality Reporting System for future rulemaking years. The deadline for submitting measures closed on August 1, 2012.

Secondly, we'd like to remind eligible professionals that it's not too late to start participating in the 2012 Physician Quality Reporting System to potentially earn a 0.5 percent incentive.

Eligible professionals should note that 2012 is the last reporting period that will not be tied to a PQRS payment adjustment. CMS is mandated to apply a payment adjustment beginning in 2015 to those eligible professionals who do not satisfactorily report data on quality measures for covered professional services.

Applicability of the 2015 PQRS payment adjustment will be assessed using data reported during calendar year 2013.

The list of EHR data submission vendors that have been qualified to submit quality data to CMS by eligible professionals for the 2012 PQRS program year is now available on the CMS Web site. Each of these EHR data submission vendors has completed a thorough vetting process to verify they have the capability to provide the required data elements for the measures they intend to submit.

Some EHR data submission vendors are also capable of reporting the electronic prescribing measure to CMS. Please refer to the document entitled

“2012 EHR Data Submission Vendor Qualified Posting,” which is located on the Alternative Reporting Mechanism section page at www.cms.gov/pqrs.

OK. And we would also like to remind eligible professionals that it is time again to review your remittance advice to ensure you receive the N365 code when reporting eRx codes or PQRS quality data codes, or QDCs, through your claims. Again, this procedure code is not payable, but it is your indication that your reporting codes did pass into the national claims history database. So it is important that you review your remittance advices for those claims that you’re trying to report on to make sure that those codes did go through and were received by CMS.

And lastly, our next National Provider Call is scheduled for September 18, 1:30 to 3:00 p.m. Eastern Time, and our topic is 2011 PQRS and eRx Incentive Payment and Feedback Report.

That concludes my announcements for today. I’ll go ahead and turn the call over to Christine Estella.

Presentation

Christine Estella: Thanks, Lauren. Today we’re going to be discussing, as Dr. Green had mentioned, the Calendar Year 2013 Medicare Fee Schedule Proposed Rule. And this discussion will mainly focus on the quality reporting initiatives and the proposals related to those.

On slide 3 you’ll see our agenda. First I’ll be discussing our proposals for PQRS, and then secondly, for the e-Prescribing Incentive Program – which we have a few, although most of our requirements for the e-Prescribing Incentive Program were established in last year’s Physicians Fee Schedule Rule. Then I’ll be going over our proposals for the Medicare EHR Incentive Program as well as Physician Compare. Lastly, there are slides on how to submit comments to the Federal database, also information for where to call for help on any of the topics that we discuss. And lastly, we’ll have a question and answer session following our discussion.

If you guys follow with me on slide 4, we're going to start with our discussion for PQRS. Generally, we wanted to note: This slide discusses alignment. PQRS is dedicated to aligning our proposals and requirements with those of other quality reporting programs – for example, the EHR Incentive Program. As you can see on slide 4, we are proposing a few things that kind of align with the requirements for the EHR Incentive Program.

First, we're proposing to extend the PQRS Medicare EHR Incentive Pilot that we established last year to 2013. So we're going to give you another year to use that pilot. And this will allow EPs to report for PQRS and the EHR Incentive Program using one set of data.

Second, we are proposing to align quality reporting requirements for reporting via EHR Incentive Program. So as you can see later on in our proposals for satisfactory reporting, we have our traditional proposals for satisfactory reporting as well as the requirement to report via the EHR Incentive Program that align with that program.

Third, we propose to align measures available for reporting via the EHR-based reporting mechanism. So as you will see a lot of our EHR measures are now aligned with the EHR Incentive Program.

Also we're proposing to align PQRS with certain requirements for the Medicare Shared Savings – the ACO program. For example, we're proposing to align measures reported via the group practice reporting option Web interface for PQRS with the measures that you find reportable under the Medicare Shared Savings Program – there's about 18 of them.

Also we're proposing to align beneficiary assignment methodology for the GPRO Web interface for PQRS and the Medicare Shared Savings Program.

And lastly, we are proposing – we have several proposals that align with the proposals mentioned in the Physician Fee Schedule relating to the Value-Based Payment Modifier. For example, for the 2015 and the 2016 PQRS payment adjustments, we're proposing to incorporate the Value-Based

Payment Modifiers administrative claims option as a method for being excluded from the PQRS 2015 and 2016 payment adjustments.

Now on to slide 6, “Goals Considered While Establishing Proposals for PQRS.” We wanted to give you guys a sense of what we were – what our thoughts were when we were establishing proposals for PQRS. So this slide 6 kind of gives you an overview of that. First is our goal to increase participation to 50 percent by Calendar Year 2015, which is the first year PQRS will not offer incentives for reporting, only payment adjustments.

According to our 2010 Experience Report, which is the last year for which we have valid data, our participation rates circle around – a little bit above 25 percent so we’re hoping that, you know, in a couple of years, we will increase participation to 50 percent. And we hope that our proposals for PQRS will move us towards this goal.

Second, we are proposing to align with other Medicare quality reporting programs that have quality reporting requirements, as I mentioned earlier, such as the EHR Incentive Program, the Medicare Insurance Saving Program, and Value-Based Payment Modifier.

Third, we are proposing to establish reporting requirements for the remaining incentives. There are only two more years for which an EP could receive a PQRS incentive, and that’s 2013 and 2014.

Lastly, we are hoping that these proposals will ease eligible professionals into reporting for the PQRS payment adjustment by providing alternative means to avoiding the 2015 and 2016 PQRS payment adjustments, which are the first two years PQRS is implementing a payment adjustment, other than using the traditional incentive criteria that we’ve established in the prior years.

On slide 7, we have an overview of our proposed reporting mechanism. These are pretty similar to what we have established in prior years. You will still be able to report via claims, qualified registry, direct EHR product, or EHR data submission vendor, or using the GPRO Web interface. There is a new reporting mechanism that we have proposed, and that’s the administrative

claims reporting mechanism. This administrative reporting mechanism is only available for use for reporting for the 2015 and 2016 PQRS payment adjustments. It would only be available for use by all EPs or CMS-selected group practices. EPs and group practices – unlike the other reporting mechanisms, where you could just start reporting – to use this reporting mechanism, EPs and group practices would have to elect to use this reporting mechanism, so indicate to CMS that they would like to use the administrative claims reporting mechanism for the payment adjustment.

Also, the difference between this administrative claims reporting option and the traditional claims reporting option is that, unlike the traditional claims-based reporting option, an EP or group practice would not be required to submit QDCs on claims to CMS for analysis. Rather, CMS would analyze certain measures to determine whether or not an EP has met the clinical quality actions indicated in certain proposed PQRS measures for the administrative claims reporting option.

Although the claim, qualified registry, and direct EHR and EHR data submission vendor reporting mechanisms are reporting mechanisms we've established in previous years, I did also want to mention that we are opening up the claims, qualified registry, EHR products, and EHR data submission by vendor reporting mechanisms to groups of 2 to 99. Beforehand, only individual EPs could report via claims, registry, or EHR. We're now opening that up to group practice as well.

On slide 8, we begin our discussion with the PQRS 2013 and 2014 incentives. Slide 9 discusses our proposed criteria for satisfactory reporting data on PQRS quality measures by individual EPs for the 2013 incentive. These proposed reporting criteria are pretty similar to what we have established last year.

So one thing to point out is for the direct EHR product or EHR data submissions vendor reporting criteria, you would still have that option to report traditionally, which is report three PQRS measures and report each measure for at least 80 percent. Alternatively, you can also report via the method that EPs would use to report for Meaningful Use. And that's option number 1 on this slide.

There are other changes that I want to note – would be the reporting of measures group via registry. We are proposing to drop down the number of patients from last year from 30 to 20, so an EP would only have to report on 20 patients. Also, last year, all 30 patients were required to be Medicare Part B FFS patients. This year, similar to what we did in 2010, I believe, we are proposing that not all patients have to be Medicare Part B FFS patients. Instead, only a majority of those 20 patients would be required to be Medicare Part B FFS patients. So if we had – if an individual EP reported on 20 patients, 11 would be the majority.

On slide 10, we have our proposals for the 2014 incentive. These reporting criteria are pretty similar to what is being proposed for the 2013 incentive. The only thing I want to point out here that's different from the rest is, again, the reporting criteria for EHR.

As you can see, we have an option 1a and an option 1b. These were the reporting requirements that were proposed under the EHR Incentive Program Proposed Rule. We are proposing these reporting options as well, with the intent that we will finalize – depending on the comments received, we will finalize whichever reporting option or reporting requirement is chosen by the EHR Incentive Program when they come out with their final rule.

On slide 11, we have our proposed criteria for satisfactory reporting of data for CMS-selected group practices using the group practice reporting option for the 2013 incentive. So last year we only had the group – the GPRO Web interface available for groups to report. And also last year, group practices were limited – only groups of 25 or more EPs were allowed to participate in PQRS as a group.

Now we are expanding that, or we're proposing to expand that, so that group practices of 2 to 24 could also participate as a group – so essentially, that's all groups could participate as a group practice using the group practice reporting option.

And also, as I mentioned earlier, we're expanding the number of reporting mechanisms that a group could choose to report under. So the GPRO Web

interface reporting criteria is similar to what was established in last year's Physician Fee Schedule Rule.

Essentially, the GPRO would be required to report on all measures that are included in the GPRO Web interface. And, again, that's a – we're proposing that those measures align with the measures available for reporting under the Medicare Shared Savings Program. And depending on your group practice size, you would have to report on a certain amount of patients.

For the reporting – satisfactory reporting criteria for claims, qualified registry, direct EHR products, or EHR data submission vendor for groups, this criteria is largely similar to the criteria we have proposed for individual EPs. For example, for claims, EPs will report on three measures for at least 50 percent of the group practice's Medicare Part B PFS patients. For qualified registry, group practices would report on three measures for at least 80 percent of the group practice's Medicare Part B PFS patients, and then for the EHR reporting option, you have an option 1 and an option 2, similar for reporting for the 2013 incentive as an individual eligible professional.

On slide 12, we have our criteria for satisfactory reporting for the 2014 incentive for GPROs. These are largely similar to the proposals for the 2013 incentive. Again, the other exception is with the EHR reporting option, we are – we put down our two proposals for the EHR Incentive Program, that option 1a and 1b. And again, our intent – to the extent that we receive comments and – it is our intent to align with the EHR Incentive Program with respect to the reporting option that they eventually choose and establish under their final rule.

On slide 13, we begin our discussion on the PQRS payment adjustment. As I noted earlier, 2015 is the first year in which PQRS will implement the payment adjustment. But our reporting period for the 2015 payment adjustment occurs two years prior. So the reporting period would actually occur in 2013 for the PQRS – for the 2015 payment adjustment, and then in 2014, for the 2016 payment adjustment.

Slide 14 gives you an overview of the reporting criteria for the 2015 and 2016 payment adjustments. Essentially, it would be to report one measure or measures group via claims, qualified registry, direct EHR product, or EHR data submission vendor.

As you know – as you can see, this is a significantly lower threshold than the incentive criteria. Our notion is that we would encourage EPs and group practices to report for the incentive but do not want to penalize or adjust EPs PFS charges for not meeting the threshold. We see this as a temporary option, so we are proposing this for the 2015 and 2016 payment adjustments only.

For the GPRO Web interface, the criteria would remain the same as the incentive. So to get out of the payment adjustment using the GPRO Web interface, a group practice would need to meet the criteria for satisfactory reporting for the respective 2013 and/or 2014 PQRS incentive.

We also have a new option on the bottom that I mentioned earlier – the administrative claims option. Basically our proposal for the reporting criteria would be to report on all measures that are indicated on table 63 of the proposed rule, for 100 percent of the cases in which the measure applies. Know again that, with the administrative claims reporting option, an EP or group practice wouldn't be attaching a G-code on a claim like they would normally do for the claims-based reporting mechanism. Rather, CMS would calculate and analyze an EP or group practice's claims data to determine whether or not they've met any of the clinical quality actions indicated in the measures – the administrative claims measures.

Slide 15 gives you an overview of our proposed measures. We're proposing several measures for 2013 and beyond, and we are proposing these measures to be included or retired within a span of two years. So over two years, 2013 and 2014, we are proposing to include a total of 264 measures, categorized under six proposed domains – patient and family engagement, patient safety, care coordination, population and public health, efficient use of healthcare resources, clinical processes and effectiveness. And last year, we had finalized a total number of measures that I believe was 210, so this would bump up our number of individual measures by over 50.

The total number of measures we are proposing for the GPRO, as I mentioned earlier, is 18. That aligns with the Medicare Shared Savings Program. In the Medicare Shared Saving Program, the final rule indicates that they had finalized 22 measures, and I'm saying right now that we're proposing to establish – to have 18 measures in the GPRO Web interface. There is a discrepancy in terms of the number for that. They are the same measures, we just count them differently. I believe they separate out one measure that we count as one into several different measures. So they are the same measures under the ACO program.

The total number of proposed measures available for reporting using the admin claims reporting option is 19. That would be 19 – you would require 19 measures if you wanted to use the admin claims reporting option for the 2015 or 2016 PQRS payment adjustment.

On slide 16, we continue our discussion on the proposed quality measures. There are a total of 26 proposed measures groups. There were 21 previously established. For 2013 we are proposing a new measures group – it's oncology – and the – for 2014 we are proposing four new measures groups – osteoporosis, total knee replacement, radiation dose, and preventive cardiology.

On slide 17, we provide our other proposals related to PQRS. One is the Maintenance of Certification Program Incentive. Essentially, if an EP report's satisfactory using any of the proposed mechanisms or criteria I described earlier, the EP would be eligible for an additional 0.5 percent under the Maintenance of Certification Program Incentive. The proposals for meeting that 0.5 incentive are in the PFS Proposed Rule.

Also we are clarifying or establishing proposals for the informal review process for the PQRS payment adjustment. Last year we had established a process for informal review for the PQRS incentive, and so in this year's proposed rule we are establishing the requirements and deadline and timelines for the informal review for the PQRS payment adjustment.

On slide 18, we will begin our discussion on the e-Prescribing Incentive Program. So slide 19 basically covers our proposals for the eRx Incentive Program. As I noted earlier, most of the requirements for the eRx Incentive Program were established in the Physician Fee Schedule Final Rule. So this rule only covers a few proposals related to the eRx Incentive Program.

First, based on our proposal to expand the definition of group practice to incorporate the smaller groups of 2 to 24 EPs, we're proposing criteria for becoming a successful electronic prescriber for these smaller groups with respect to the 2013 incentive and 2014 incentive. So for the larger groups we had – depending on your group size, a group practice would report the electronic prescribing measure either 625 times or 2,500. For groups of 2 to 24, we are proposing that their reporting threshold would be 225.

Also, we're proposing to establish an informal review process for the 2013 incentive and 2014 payment adjustment. In addition, we are proposing to provide two additional hardship exemption categories for the 2013 and 2014 payment adjustments. And these relate to the EHR Incentive Program.

The first is eligible professionals or group practices who achieve Meaningful Use during certain eRx payment adjustment reporting periods, and the second is EPs or group practices who demonstrate intent to participate in the EHR Incentive Program and adoption of Certified EHR Technology. So these two additional hardship exemptions, if finalized, would be added to our previously established four significant hardship exemption categories.

On slides 20 and 21, we have our discussion on the Medicare EHR Incentive Program. Essentially for that, one major proposal: We are proposing to extend the PQRS EHR Incentive Pilot, which we established last year, and this would allow EPs a means to meet the criteria for satisfactory reporting for the 2013 PQRS incentive and achieve Meaningful Use for the EHR Incentive Program.

The proposed rule continues to use – continues to propose to use – the EHR direct product that is PQRS qualified, or EHR Data submission vendor that is also PQRS qualified, to submit this data and to submit one data for both

programs. In addition, for the 2013 payment year, we're also proposing to continue using attestation as a method of reporting CQMs to meet the CQM component of Meaningful Use.

And lastly, for slides 22 and 23, we have a proposal for Physician Compare. For Physician Compare we are proposing to continue to incrementally expand public reporting of performance information on Physician Compare.

In addition to continuing to post performance rates on the measures that CMS-selected group practices and ACOs report via the GPRO Web interface, we have a – we propose a five-year plan that includes the following:

- 2013 patient experience data for CMS-selected group practices and ACOs,
- names of participants who earn a 2013 PQRS Maintenance of Certification Program Incentive (that 0.5 percent that I've mentioned earlier),
- measures that have been developed and collected by specialty societies, as deemed appropriate,
- 2014 group-level ambulatory care sensitive condition measures of potentially preventable hospitalizations, and
- 2015 PQRS and Value-Based Modifier quality measures for individuals.

Slide 24 gives you an overview of how to submit comments to the 2013 PFS Proposed Rule. So as you can see under this slide, the scheduled publication date says July 30, 2012. The – this proposal actually did get published on July 30th, so if you wanted to reference the Federal Register version of the published proposed rule, please do so using that. The public comment ends September 4, 2012. All comments that are received in the Federal database will be responded to in a final rule with comment period, and the final issued by November 1, 2012. You may submit comments are one of four ways: electronically, by regular mail, by express or overnight mail, or for those more antiquated folks, by hand or courier.

Slide 25 provides you with an overview of where you should call if you have any questions about any of the proposals I've just mentioned. Our go-to contact is QualityNet Help Desk, and they can help you with any of the issues

provided below. Their phone number is 866-288-8912, and their e-mail address is qnetsupport@sdps.org.

That ends my presentation.

Polling

Charlie Eleftheriou: Alright, thank you, Christine. At this time, we're going to – before we move in to our question and answer session, we're going to pause for a moment to complete keypad polling so CMS has an accurate count of the number of participants on the lines with us today. Please note: There's going to be a moment of silence on the line while we tabulate the results. Holley, I think we can perform keypad polling now.

Operator: CMS greatly appreciates that many of you minimized the Government's teleconference expense by listening to these calls together in your office using only one line. Today we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine. Please hold while we complete the polling.

Charlie Eleftheriou: While we're holding, before we move to questions and answers, I'd like to take this time to remind everyone that the call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. And in an effort to get as many of your questions as possible in, we ask that you limit your questions to just one. If you do have

more than one question, you may press star one to get back into the queue, and we'll address additional questions as time permits.

Operator: Please continue to hold while we complete the polling.

Please continue to hold while we complete the polling.

Thank you for your participation. We will now move in to the Q&A session for this call.

To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking you question and pick up your handset before asking your question to ensure 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 in the conference. Please hold while we complete the Q&A roster.

Your first question comes from the line of Lisa Pothen.

Question and Answer Session

Lisa Pothen: Hello?

Charlie Eleftheriou: Hi.

Lisa Pothen: Hi, I have a question. I have four providers – my name is Lisa, and I'm calling from the Retina Center in Minnesota. And so we're a specialist clinic, and we have four providers and we do individual measures. So my providers, do they have to meet 2013 and 2014 in order to avoid the adjustments?

Christine Estella: Are you – so for the PQRS payment adjustment, they're different for each year.

Lisa Pothen: Correct.

Christine Estella: Basically, to avoid the PQRS payment adjustment for 2015, as I noted earlier, the proposed criteria would be report one measure or measures group just for

the payment adjustment. That's on slide 14. If you wanted to try and report for the incentive, it would be a little bit – the criteria's a little bit beefed up, and that's on slide 9. And again, if you – for the 2016 PQRS payment adjustment, you would have to report a separate time. So just reporting for the one year doesn't get you out. For example, future payment adjustments you'd have to report each year.

Daniel Green: So if you report 2013 adequately, you would get out of 2015, and if you report 2014, that would get you out of the 2016 payment adjustment.

Lisa Pothen: OK. That's how it works. That's where I was getting confused. And that's why I'm curious. OK.

Daniel Green: So remember this – oh I'm sorry, I didn't mean to interrupt you. What we're talking about now is PQRS, so remember that there will be a – in the future there'll be also the value-based modifier coming into play. So the answers we gave you are strictly about PQRS.

Lisa Pothen: Yes. Alright. Thank you.

Daniel Green: Thank you.

Operator: Your next question comes from the line of Betty Kunc.

Betty Kunc: Yes. My question is: Where do we find – I'm in an anesthesia group, Marshalltown Anesthesiologists – and where do we find the specific information regarding the measures that we would report?

Daniel Green: So we post our measures annually. They will be updated in, likely in November for the 2013 reporting period. And they're on our PQRS Web site. And we encourage folks, even if they've participated in the past, to please check the measures each year, because sometimes measures either are retired if the developer no longer is supporting them or fails to indicate it. Sometimes measures are not retired but they're – they change, because the medical information that does support the measure recommends either inclusion of additional services or new treatment modalities. So please do – even if you have been reporting – please do check for an update each year.

Christine Estella: And to piggyback on what Dan said, our Web site is www.cms.gov/pqrs. Additionally, if you have any questions about our measure, you can also contact our QualityNet Help Desk, and their information is on slide 25, as I indicated earlier.

Betty Kunc: OK. Thank you very much.

Daniel Green: Thank you.

Operator: Your next question comes from the line of Jennifer Huff.

Jennifer, your line is open.

Daniel Green: Hi, Jennifer.

Operator: And that question had been withdrawn. Your next question comes from the line of Stacie Jones.

Stacie Jones: Yes, hi. This is Stacie Jones from ACEP. I just first of all want to thank everyone from CMS for providing these open door forums to take these questions and also thank them for being willing to – and other forums. And we understand that there are a lot of changes in this year's Physician Fee Schedule that may be overwhelming, so we hope that our questions are not.

My primary question relates to Tables 63 and 64. It was stated in the slide presentation that the administrative claims option for 2015 and 2016 will be those measure that are contained in Table 63, but Table 64 also has a list of proposed measures for the administrative claims option. And it looks like there is quite a bit of overlap. And it says for 2015 and 2016. So there is quite a bit of overlap in these tables, and I'm not sure if one of these applies to group practices and one of these tables applies to individuals, or one is for PQRS and one is for another purpose. But I was just wondering if you could comment on how – what the different purposes for each of these tables within the administrative claims option.

Christine Estella: Sure. So Table 63 is strictly for PQRS, and Table 64 is the table for the Value-Based Payment Modifier, and they both deal with administrative

claims. However, the way PQRS has proposed the administrative claims reporting option is a little different from what has been proposed under the Value-Based Payment Modifier. For example, the Value-Based Payment Modifier only applies to group practices of 25 or more EPs.

For the payment – PQRS payment adjustment – the payment adjustment applies to individual EPs and group practices regardless of size. And we are proposing under PQRS only, that the administrative claims reporting option be able to be used by both individual EPs and group practices.

There are slight differences between Table 63 and 64. As you indicated, they are largely the same. On our Table 63, we have 19 proposed measures for the admin claims reporting option, and that's only for the – we're only using this reporting option for the PQRS payment adjustments in 2015 and 2016.

On Table 64, I believe, instead of 19 measures, I believe we have about 15, and there are four additional measures that are discussed below the table. So the proposed measures are largely similar, but not entirely the same under those Tables 63 and 64. We would invite public comment as to which measures to finalize for the admin claims reporting option. But please remember that these measures that are proposed in those two tables are strictly proposed measure, they haven't been established yet, and we're seeking comments on those measures. Our intent is to eventually align with the administrative claims measures that are chosen for the Value-Based Payment Modifier.

Daniel Green: But with that nice preamble, in terms of the great things you said about these calls and whatever, please feel free to question often.

Stacie Jones: Thank you.

Charlie Eleftheriou: We'll take our next question.

Operator: Again, if you would like to come into the queue to ask a question, please press star one on your telephone keypad. Again, to come into the queue for a question, press star one.

And your next question comes from the line of Cathy Abben.

Cathy Abben: Hi. Hello?

Charlie Eleftheriou: Hi. Yes, we're here. Hi.

Cathy Abben: Hi. Where can I find the proposed measure for the oncology? And is that medical oncology or radiation oncology? It's on slide 16.

Christine Estella: Is that the proposed measures group? Is that what you're referring to?

Cathy Abben: Yes.

Christine Estella: That's actually in the proposed rule. We have a link to our proposed rule on – let me see – slide 24. This is the display version, I believe, they are in the Federal Register – published version of the rule that is also on display in the Federal Register as well.

Cathy Abben: OK.

Christine Estella: But this would get you there.

Daniel Green: And this will just list the measures. It won't give you the full specifications until the measures are either included or eliminated from the final rule.

Cathy Abben: Let me ask another question. When you, we're going on an EMR – we're in the process, we just went on it, to attest for this year. And when you – in the future I'm assuming when you're saying you can attest for PQRS through your EMR – do you have to do that, or would you still be able to do it by claims?

Christine Estella: Actually, if this is with respect to the PQRS EHR pilot I just mentioned, I believe, this is actually not new. Actually this pilot actually started this year. Attestation doesn't apply to getting a PQRS incentive. We are proposing under the 2013 PQRS EHR Pilot, there is a proposal to continue attestation, but only for the EHR Incentive Program, so it's only to meet the CQM component for the EHR Incentive Program stage 1.

For – if you wanted to earn both a PQRS incentive and an incentive for achieving Meaningful Use under the EHR Incentive Program, you would actually have to report data via EHR, not just attest. And you would have to use a PQRS-qualified direct EHR or a PQRS-qualified EHR data submission vendor.

Daniel Green: And if you're trying to get both EHR and PQRS, it would also have to be an ONC-certified product, as well, for the Meaningful Use.

And then one other thing to point out, as Christine mentioned, there is no attestation for PQRS but you can – I'm sorry – so if you want to get – either earn an incentive for 2013 and/or get out of the 2015 payment adjustment, simply attesting for the EHR Incentive Program would not satisfy your needs. So you would need to participate in some manner in PQRS, either directly from the – I'm sorry, directly from the PQRS-qualified HER, or you could report via claims, particularly if none of the measures that you – that are applicable to you are electronically specified and therefore available for EHR reporting.

Cathy Abben: But you have the option. You don't have to use EHR, you can still use – do it through claims.

Daniel Green: That's correct.

Christine Estella: Right. So if you wanted to, for example, attest for the EHR Incentive Program and then use claims for PQRS, that's fine.

Cathy Abben: OK. The link on page 24 – is that where you said to go at the proposed rule?

Christine Estella: Yes.

Cathy Abben: Because it's not working. It's telling me it can't be found.

Christine Estella: We will get back to you then on an updated link. I believe this link was to the display version, and the actual rule was published July 30th.

Cathy Abben: OK.

Christine Estella: So we will have to get back with you on a correct link. And we'll post it on our Web site – our PQRS Web site.

Cathy Abben: And do you make the changes to existing PQRS measures very distinct when you print them? Or – you know what I mean – like if there is a change? I know some of the ones we did for the last several years have not changed at all. Do they have to be very distinct?

Daniel Green: Usually what we do is when we post the new measure specifications, we also post something called release notes. So that's an abbreviated version – not of the entire list of measures, but it would call out any of the changes that have taken place for some of the existing measures.

Cathy Abben: OK. One other thing: Thank you when you're doing your demonstrations for saying what page you're on, because a lot of times it's very confusing to follow. So I appreciate that. Thank you so much.

Daniel Green: Thank you.

Operator: Your next question comes from the line of LaChrissa Patrick.

LaChrissa Patrick: Hello.

Daniel Green: Hi.

Christine Estella: Hi.

LaChrissa Patrick: Hey. I have a question and – excuse me, and excuse me to your callers – but I am walking in Lala Land trying to understand everything I need to know regarding PQRS. When it comes – earlier, in slide 7, you were saying regarding the claims reporting – you were saying that that is reporting – and I have written on notes, and I understand what you're saying – the reporting period for 2013 basically is the adjustment period that reflects 2015. But as far as us being a huge provider – well, we've got about 37 providers, but what we're trying to figure out is what is the best reporting, I guess, the registry that we need to be looking at? And it was quite confusing when you were going over that slide to say – which one do we choose?

Daniel Green: I'm sorry. You're trying to select the – you want to report via registry? Is that what you're saying?

LaChrissa Patrick: Yes, because when I was listening to – I think it was Christine that was speaking – it seems – I understand what she was saying about the 2015 to 2016 – the payment adjustment? But as far as reporting in 2013 – if we're reporting in 2013 – I need to know exactly what was she saying, because I'm trying to figure out which one do we choose – the register, the claims, or the direct EHR product?

Christine Estella: So I am assuming that you are a first-time reporter?

LaChrissa Patrick: Right.

Christine Estella: OK. And for your group of 37 EPs, roughly. Again, these are just proposals, so actually these reporting mechanisms have not been established yet. What – the final reporting mechanisms will be established around November. You'll be able to get a better sense of what the reporting mechanisms will be.

We traditionally have the claims, qualified registry, and EHR-based reporting mechanisms, as well as the GPRO Web interface. The admin claims reporting mechanism is new.

However, for a first-time reporter, I would recommend that you go on our CMS Web site – www.cms.gov/pqrs – and we actually have a page, a section on how to get started.

LaChrissa Patrick: OK.

Christine Estella: And I think that that would be a good basis for you to start – to determine how to report. Again, this is for the 2013 Calendar Year. If you guys are first-time reporters, I would sincerely recommend that you report – try to report for this year, so you could get our feedback report late next year, so you could see how you're reporting methods are – how – if there's anything that you need to correct.

LaChrissa Patrick: OK.

Christine Estella: Also on slide 25, we have our information for our QualityNet Help Desk.

LaChrissa Patrick: OK. I'm familiar with that. I'm registered with that.

Christine Estella: So with the QualityNet Help Desk, if you just tell them that you're a first-time reporter, and you would like help reporting, they'll be able to walk you through the steps on how to report, and which measures to select, and which reporting option would be most beneficial to you.

I will say that the majority – the large majority of EPs who do report for PQRS use the claims-based reporting mechanism.

LaChrissa Patrick: The claims – OK and just – let me piggyback what you just said. You recommend that we do report for 2012 to get the feedback in 2013.

Christine Estella: Yes.

LaChrissa Patrick: Do you – Do we receive that feedback late 2013, or is it – how long does it take to get the feedback?

Christine Estella: So for 2012 data, it would be probably around the fall of 2013.

Daniel Green: So what reporting in 2012 would help you with is getting used to – if you're doing it via claims, for example, you would have the opportunity to fix your quality data codes to the claims, and then you would also get – it's not really a feedback report, but it would tell you the – a code would come back to you to tell you that your quality data codes did make it into our quality data warehouse.

You would get an N365 code on your remittance advice, so that would be one way to provide a little test for you, if you will, if you're submitting via claims. But it is not too late to participate for a possible incentive in 2012, especially if you were thinking about using a registry.

I think, just to elaborate a little bit more what Christine was describing for you, in terms of choosing which method to – by which method to report –

meaning claims, registry, EHR data submission vendor – some of it will be dependent on which measures you choose.

For example, there are – only 51 of our measures are electronically specified. So if you're not reporting three of those 51 measures, you really couldn't report using your EHR directly to CMS because, let's say, you want to do the chiropractic measures, for example, those are not electronically specified. So you would have to use either claims or a registry to report those measures.

So what I would suggest is: First, figure out which measures would be applicable to your group, that you want to submit. And then go see which – on our PQRS Web site, if you look at the measures, each measure has a – it's listed in terms of can be reported via claims, registry, electronic health record, or maybe a common – maybe all three. And that will kind of help you, narrow it down a little bit for you in terms of which method you might select to report.

But if you're going to report via registries, a lot of registries collect their data through the end of the year, so you might still be able to report and earn an incentive for 2012 which, you know, would at least we reimburse you to some degree for your efforts.

LaChrissa Patrick: OK. Alright. I thank you both for your time and your knowledge.

Daniel Green: Thank you. Good luck.

LaChrissa Patrick: Thank you.

Operator: Your next question comes from the line of Carrie Jordan.

Carrie Jordan: Hi. I'm calling from a primary care office, and we've been reporting via claims under preventative care measure groups. And I was wondering if in the proposed rule, if you were aware if any CPT patient encounter codes have been added to reflect some of the G annual wellness visit codes to the generic 992 codes and the 99213 codes.

Daniel Green: Great question. I can tell you that, you know, basically really what's proposed in the rule – in the rule we don't necessarily address specific measure codes except for the eRx measure. So more than that I'm really able to tell you. Some of it will be up to the measure developers in terms of – in fact most of it – in terms of whether they think that those codes would be applicable to their particular measures.

Carrie Jordan: It just seems odd that they'd be left off...

Daniel Green: No, I totally ...

Carrie Jordan: ... considering under preventative care measures group ...

Daniel Green: I totally get where you're coming from. But if you look in our – on our measures information on the PQRS Web site, it will tell you who the measure's owner and developers are.

Carrie Jordan: OK.

Daniel Green: And certainly, you could feel free to e-mail those folks and either inquire about it and/or, you know, recommend that they consider adding those codes. I mean, what you say makes great sense.

Carrie Jordan: OK. Thank you.

Daniel Green: Thank you.

Operator: Your next question comes from the line of Stacie Jones.

Stacie Jones: Yes, hi.

I had a question that's related to PQRS, also the Value-Based Modifier. Again, I wanted to thank CMS for allowing us to ask these questions. For the – it appears that the PQRS measures will be used to calculate the quality composite of the Value-Based Modifier, but – so there are a number that are listed for care coordination as well as clinical care, and the other national quality strategy domains.

My question was in regard to table 66, for the Value-Based Modifier. Will that be used to calculate the care coordination domain, those measures in table 66, or will the care coordination measures we report from the PQRS be used to calculate that domain?

And I understand the cost composite is a separate – is a separate issue with its own separate measures, but I’m just trying to discern if the – if all of the quality composite is going to be calculated based on the PQRS submission or not. Because several folks have pointed out to me that it’s straightforward, it’s just the PQRS measures that go into the quality composite. But then there is a reference to Table 66, which indicates that those measures will be calculated for everyone, regardless of what they submit for PQRS. So it’s a bit confusing, and again, I greatly appreciate your willingness to answer questions.

Tonya Smith: Hi, thank you. This is Tonya Smith.

To answer your first questions regarding Table 66, those are – a table with four outcome measures ... yes, there are measures that we are actually proposing to be calculated as part of the Value Modifier. So I know that answers one part of your question.

I think, if I’m understanding the second part, you wanted to know whether the Value Modifier will also be calculating the PQRS measures as part of the quality composite – the answer to that is yes.

Stacie Jones: OK. So, again, with those – those four composite measures in 66 which are labeled as care coordination domain, how will that – how will they be weighted against your PQRS care coordination domain measures? Will it be on a measure-for-measure basis?

Tonya Smith: Correct. It’ll be on all the measures, and the care coordination domain will be weighted on a measure-by-measure basis. That is correct.

Stacie Jones: OK. And are there any other measures extraneous to the PQRS system ...

Tonya Smith: No.

Stacie Jones: ... that will figure into the quality composite?

Tonya Smith: No.

Stacie Jones: OK. Thank you.

Operator: Your next question comes from the line of Crystal Cortez.

Crystal Cortez: Hello.

Charlie Eleftheriou: Hi.

Crystal Cortez: Hello.

Daniel Green: Hi, we're here.

Charlie Eleftheriou: We're here.

Crystal Cortez: Sorry. You know, with the eRx in 2013, am I understanding correctly, that it says you have to report 225 – gosh, I just lost the slide right now – in one year?

Christine Estella: So, for the ePrescribing Incentive Program, we finalized most of our requirements in last year's Physician Fee Schedule Final Rule. The 225 threshold is a new threshold we are proposing that only applies to group practices of two to 24 EPs.

Crystal Cortez: I see. Perfect. OK, thank you.

Christine Estella: Thanks.

Operator: Your next question comes from the line of Kathy Anderson.

Kathy Anderson: Hello, this is Kathy Anderson. Can you hear me?

Charlie Eleftheriou: Yes, we can.

Kathy Anderson: OK, great.

I think that my question may have something to do with a couple of questions earlier with the Value-Based Modifiers, which I'm totally lost on. But, my question was about Maintenance of Certification Program and or the MOC program, I guess it's called. And my understanding is that that is an additional program that the providers can participate in.

But I heard that it's tied to the PQRS as far as penalty goes, and that if we're not participating in the MOC plus the PQRS, then the provider will be penalized in 2015. Is that true?

Christine Estella: So, the Maintenance of Certification Program Incentive is actually – it's not really tied to the PQRS payment adjustment. Basically, if you are a satisfactory reporter for the 2013 or 2014 PQRS incentive, you can also earn an additional 0.5 percent incentive under the Maintenance of Certification Program Incentive. So, it kind of gives you an additional incentive if you – if you satisfactorily report for the PQRS incentive.

Kathy Anderson: Right. But if I didn't – if the provider does not participate in the MOC program, but he does participate in the PQRS in 2013, then he shouldn't be penalized. Is that correct?

Christine Estella: Right. So, that's – the MOC program incentive is different from the PQRS payment adjustment criteria.

Kathy Anderson: Right. And there's no – there's no penalty phase for the Maintenance of Certification portion?

Christine Estella: No, the maintenance – the Maintenance of Certification Program Incentive is actually only authorized to 2014.

Dan Green: So, the MOC is basically just an additional bonus that your eligible professional can get if they satisfactorily participate, one, in PQRS. If they don't do PQRS, they can't get an MOC additional incentive. If they do PQRS, they can earn an additional half percent as Christine said. But if they don't do the MOC, there's no – there's no penalty or anything on the part of

CMS. It's just an additional way to earn another half percent, again, but the first and the primary thing you have to do is participate in PQRS.

Kathy Anderson: OK. And then, as far as the Value-Based Modifiers, is that sold out pretty well in the CMS Web site, and is that under the PQRS information?

Christine Estella: The Value-Based Modifier is not actually under the PQRS Web site. It's a separate program. We are trying to move our proposal to align with the Value-Based Payment Modifier. If you have any – if you have any questions regarding the Value-Based Payment Modifier ...

Pamela Cheetham: Actually, the proposed rule is the best way to read about what's being proposed.

Kathy Anderson: OK. So, it's not really in effect at all yet. It's all in the planning stages at this point.

Pamela Cheetham: That's correct.

Kathy Anderson: OK, great. Thank you very much.

Charlie Eleftheriou: If you'd like to read a little bit more about the Physician Feedback Program/Value-Based Modifier and related items, go to cms.gov/physicianfeedbackprogram, all one word – cms.gov/physicianfeedbackprogram.

Operator: Your next question comes from the line of Therese Blalock.

Therese Blalock: Hi. Can you hear me?

Daniel Green: Yes.

Christine Estella: Yes.

Therese Blalock: I just wondered, if we're just now beginning to report, so that our first actual incentive here will be 2013, how do we sign up for the Maintenance of Certification Program? Or can you only do that after you've successfully reported for a year?

Daniel Green: No. It can be a simultaneous process. So you're talking about actually reporting for 2012, then? Because that's the current year.

Therese Blalock: Right, just to make sure we've got everything worked out. But, if we wanted to sign up for Maintenance of Certification for 2013, how would we do that?

Daniel Green: So – what you need to do, well, there's two things. First of all, I'm assuming your eligible professionals are board certified – is that correct?

Therese Blalock: Yes.

Daniel Green: OK. So, one thing you need to do – and Molly probably can answer this better than me, but – is make sure that your board is one of the participating boards, and I believe we will be publishing that. Let me let you answer, Molly, because you know better ...

Molly MacHarris: Sure.

Daniel Green: ... sorry.

Molly MacHarris: So there is no sign up or preregistration required for participation in the Maintenance of Certification Program, as Christine and Dan mentioned on the previous question. To get this additional incentive, you first must be PQRS-incentive eligible, and then, you must, more frequently than required, participate in the Maintenance of Certification Program.

So how you can go about participating is by going to our Web site. Again, it's www.cms.gov/pqrs. On the left-hand side, we have a page that's called the Maintenance of Certification Program Incentive. If you click on that, it will take you to that site. And on there, there is a list of qualified Maintenance of Certification boards. So you'll want to make sure that the board your physicians are board certified under are actually participating in the CMS Maintenance of Certification program.

Therese Blaylock: Oh, OK. OK, OK.

Molly MacHarris: So, I suggest that you contact the board directly to determine the particular MOC more frequent participation requirement. But you can do that now. You don't have to wait to submit in all of your PQRS data.

Therese Blalock: OK.

Molly MacHarris: (Inaudible)

Therese Blalock: And that was – cms.gov/pqrs.

Molly MacHarris: PQRS, and then on the left-hand side of the page, there should be a link called Maintenance of Certification Program Incentive.

Therese Blalock: Oh, I see. OK, thank you.

Molly MacHarris: You click on that, there should be a document that is called the Qualified Maintenance of Certification Program Entities, and you'll want that for 2012.

Therese Blalock: OK. Got it. Thank you.

Molly MacHarris: Thank you.

Operator: Your next question comes from the line of Terry Magellan.

Terry, your line is open.

That question has been withdrawn. Your next question comes from the line of Kathy Krey.

Kathy Krey: Hi.

I just have one eligible professional, and I was wondering how his payment-based value will be measured. Is that just on PQRS?

Tonya Smith: In reference to the Value Modifier, we are proposing that it will apply to groups of eligible – eligible professionals of 25 or greater. So, I think you said that you only have one provider?

Kathy Krey: Yes.

Tonya Smith: So for the initial phase, which will take effect in 2015 based on 2013 performance data, you will not be – well, your physician and your practice will not be included, because you only have one – you’re on a single practice with one physician, right?

Kathy Krey: Yes. And a nurse practitioner, but she doesn’t qualify.

Tonya Smith: Well ...

Pamela Cheetham: That’s correct.

Kathy Krey: OK. So, in other words, if I just keep reporting my PQRS, that’s about all I can do, and I won’t be entitled to any additional payment-based value?

Pamela Cheetham: Not for the initial phase-in year in 2015.

Kathy Krey: OK. Would I qualify for the Maintenance of Certification Incentive?

Molly MacHarris: That only applies for providers.

Kathy Krey: OK. So, one provider would be able to qualify?

Daniel Green: Yes. Your provider if – if he or she is board certified ...

Kathy Krey: OK.

Daniel Green: ... you know, you could check the Maintenance of Certification tab on the PQRS Web site that Molly was mentioning earlier.

Kathy Krey: OK.

Daniel Green: And you could see if his or her board is one of the self-nominated and approved boards. And then you would want to contact the board directly to find out what their quote unquote “more frequently requirement” is, and they could give you more information in terms of what you would need for Maintenance of Certification.

But your doc could get the 2013 PQRS incentive if he or she reports satisfactorily, and 2014. The Value-Based Modifier for individual doctors won't take effect in 2015 based off of 2013 data. So, they're definitely good at least through the 2013 reporting period.

Christine Estella: And just the – just a point of clarification about the Maintenance of Certification Program Incentive: That incentive is actually only available to physicians. PQRS, we allow reporting of all EPs and physicians at one of the groups that are – within our list of professionals – that are eligible to participate in PQRS.

The Maintenance of Certification Program Incentive is exclusive, so it would be – for your practice, it would be exclusive to your physician, not your nurse practitioner.

Kathy Krey: OK. So, Medicare switches from private fee-for-service over to value-based. How will they calculate that on an individual physician?

Tonya Smith: Well, what ...

Christine Estella: I believe that that's – that's actually – we haven't provided any proposals for that issue.

Daniel Green: That's a TBD, but that'll keep you coming back to reading next year's rule or the year after.

Kathy Krey: OK. Thank you.

Daniel Green: Thank you.

Kathy Krey: Bye.

Operator: Your next question comes from the line of Dawn Wang.

Dawn Wang: Hi. Can you guys hear me?

Daniel Green: Yes.

Dawn Wang: I actually – I guess, my question – I have a couple of questions. One is regarding slide 4, Proposal to Align PQRS With the Value-Based Modifier. So is – currently the only alignment is between the Value-Based Modifier administrative claims option? That’s the only way that you can avoid the PQRS adjustment?

Christine Estella: That’s actually an example of ways that we are proposing to align. So this – this slide 4 is not all-inclusive with respect to our alignment efforts.

Dawn Wang: OK.

Christine Estella: So, actually the main way PQRS and the Value-Based Payment Modifier is proposing to align – and again, the Value-Based Modifier only applies to groups of 25 or more, whereas PQRS, it applies – the payment adjustment applies to all EPs.

The way we are really intending to align is using our satisfactory reporting criteria. And the way PQRS has proposed that group practices report on – for the 2013 incentive.

Dawn Wang: So is a group – they’re not reporting as a self-elected GPRO, but they satisfactorily reported, every physician, and the group is greater than 25 physicians, does that automatically exclude them from the Value-Based Modifier, or no?

Tonya Smith: It doesn’t necessarily exclude you, but if you satisfactorily report using one of the five PQRS reporting options for groups, then you have the option as to whether to elect quality tiering for the Value Modifier.

Christine Estella: And please remember that also these proposals are still on its proposed stages. So what comes out in the final rule may be different from the proposals. Also, if you have questions or comments regarding our proposal, you may submit a public comment to the Federal database.

Dawn Wang: So, I guess – I’m sorry, I may be repeating the same question, but I’m just trying to really understand both of them. So if a physician group, they’re reporting – so for each of their physicians, they elected to report different

measures for each physician, but they are reporting as physicians with an NPI and a tax I.D., that's for the practice, so, for 2012 and 2013, and if each physician satisfactorily reports, what does that ... ?

Pamela Cheetham: No. It still doesn't work for the Value-Based Modifier.

Dawn Wang: OK.

Pamela Cheetham: You need to report as a group.

Dawn Wang: OK. So you actually need to select one of the group reporting options.

Christine Estella: That's right. And I indicated earlier, we had expanded the group practice reporting option to include different reporting mechanisms and different satisfactory reporting criteria.

Dawn Wang: ... report as a group, you have to pick the same measures for the entire group?

Pamela Cheetham: That's correct.

Dawn Wang: OK, OK. Thank you so much.

Operator: Your next question comes from the line of Nancy Limbaugh.

Charlie Eleftheriou: Hello.

Nancy Limbaugh: My question has already been answered. Thank you.

Charlie Eleftheriou: Thank you.

Operator: Your next question comes from the line of Kathleen Stanton.

Kathleen Stanton: Hello. I want to ask: If you report through an ACO in the future, will each eligible provider still have to continue to report?

Molly MacHarris: In what regard, for your question? For the physician quality report Value-Based Modifier, or can you please provide some more context?

Kathleen Stanton: I've been reporting them all together, but I suppose PQRS as a start.

Pamela Cheetham: No, participating in the – in the ACO reporting option counts as having participated in PQRS.

Kathleen Stanton: OK.

Pamela Cheetham: You wouldn't do both.

Kathleen Stanton: Alright. Thank you.

Daniel Green: Thank you.

Operator: Your next question comes from the line of (Jackie Brown).

(Jackie Brown): Yes. I have two questions. My first one is: I work for one provider. So he would have to report 25 for the eRx, not to be penalized?

Christine Estella: For the eRx payment adjustment ...

(Jackie Brown): Right.

Christine Estella: ... and so, for next year? Is that for next year or this year?

(Jackie Brown): I guess, for this year affects next year, right?

Christine Estella: OK. So, the reporting period for the 2013 payment adjustment is actually over. It ended June 30th. So it would only be, I guess, for the 20th – or the 2014 payment adjustment is what you were talking about. For this year, if you wanted to report for the 2014 payment adjustment using this full-year reporting period – yes, the threshold is 25, and that would also – to report the, the measures for 25 denominator-eligible instances, that would also qualify you for a 2012 year eRx incentive.

However, there is another reporting period for the 2014 payment adjustment that will occur in 2013. It's the first six months of 2013, and that threshold is – reporting threshold is 10. And that would be ...

(Jackie Brown): How much was it for this year? Was it 25?

Christine Estella: For the – for the reporting period, it's a full year. So, there's a difference. There's a 12-month or 6-month reporting period. For the 12-month reporting period, the threshold is 25. For the 6-month reporting period, the threshold is 10.

(Jackie Brown): OK. So it's the same for this year and next year. It's not changing. Or the year after.

Christine Estella: We actually – for our proposals, we have established all of our requirements for the eRx Incentive Programs for the most part in last year's Physician Fee Schedule rule.

(Jackie Brown): OK. But it hasn't changed – the 10 for half a year, or the 25 for the full year?

Christine Estella: Right.

(Jackie Brown): OK. And then, for the PQRS, if you don't do it in 2013, you'll be penalized in 2015?

Christine Estella: So, yes. If you do not participate in PQRS and meet the payment adjustment threshold, then, yes, you would be penalized in 2015 for our performance period, which is calendar year 2013.

(Jackie Brown): Now, if I want to do it for this year, do I have to start by a certain date?

Christine Estella: No. There's no date that you need to start. Actually, we do have a – kind of a slogan “it's not too late to participate in PQRS.” So you can start in 2012 and try and earn a PQRS incentive for 2012.

(Jackie Brown): What would be the simplest thing for me to look at or to – because it's all very confusing, all of this, and there are so many Web sites, so – and what will be the easiest for me in order to figure out how to get started?

Christine Estella: Sure. So, our Web site www.cms.gov/pqrs. On the left side of that page, there's a how-to-get-started section. So I would look at that section. And also, if you have questions on how to start, you could also call our QualityNet

Help Desk. And if you have the slide in front of you, it is slide 25 that has their contact information.

(Jackie Brown): What is for – if there's only one provider, what is usually the easiest? Is it claims, or is it the registry?

Christine Estella: I believe the Help Desk would usually go over what your options are.

(Jackie Brown): OK.

Christine Estella: As I indicated earlier, actually, the majority of people do report via claims according to 2012 data. There are some people that report via registry according to also to Dr. Green. It also depends on what measures are applicable to your practice.

(Jackie Brown): Alright. And so, as far as the eRx, they're not going to make any changes with for this ...

Christine Estella: No, not for – not for an individual provider.

(Jackie Brown): OK. So the 225 is for groups?

Christine Estella: Yes, the group – groups of 2 to 24 is what we're proposing.

(Jackie Brown): OK. Alright, thank you.

Christine Estella: Thank you.

Charlie Eleftheriou: Thank you for your question. I'd just like to remind everyone, since we are running short on time and have many calls left in queue, if you could just limit your questions to one at a time. If you have a followup question, press star one, after we answer your initial question to jump back in line. We'd appreciate it, to hear from as many people as possible. We'll take the next call.

Operator: Your next question comes from the line of Blanca Cortes.

Blanca Cortes: My question was already answered.

Charlie Eleftheriou: Thank you.

Operator: Your next question comes from the line of Judy Burleson.

Judy Burleson: Hello.

Christine Estella: Hello.

Charlie Eleftheriou: Yes.

Molly MacHarris: We're here.

Judy Burleson: I have a question on the proposed reporting criteria for the 2015 and '16 payment adjustments. You said for claims, for example, report one measure or one measures group. Could you be a little more specific by what you mean by "reporting"? Is that under the same sample size as required for the incentive? So are you saying report one measure at – for claims – at 50 percent, or any data that's submitted on one measure would satisfy the requirement for avoiding that payment adjustment?

Christine Estella: So, to meet the criteria for the 2015 and 2016 PQRS payment adjustment, it's a lower threshold than you mentioned for the 2013 and 2014 PQRS incentive. And it is to only report one measure or measures group. There is no incentive. There is no threshold requirement.

Daniel Green: So, basically, it's pretty much as stated in the rule, to report one measure or one measures group. Beyond that, we cannot – there's nothing that's mentioned in the rule that we can elaborate on.

Judy Burleson: OK. Thank you.

Daniel Green: Thank you.

Charlie Eleftheriou: Thank you. Take the next question.

Operator: Your next question comes from the line of Leslie Witkin.

Leslie Witkin: Hi, good afternoon. Leslie Witkin from Orlando, Florida.

On slide number 9, Christine, in the “direct EHR product or EHR data submission vendor,” would it be a correct statement that option 1 is a description of the PQRS pilot program?

Christine Estella: For option one for the 2013 incentive, is that what you’re looking at?

Leslie Witkin: Yes, on slide 9.

Christine Estella: Yes, that’s a description of the PQRS EHR incentive pilot.

Leslie Witkin: OK.

Christine Estella: So for that option 1, for example, it’s report three, three, and three for the EHR Incentive Program. We’re proposing that same criteria, so that’s the pilot criteria that you would use in order to – if you use an EHR to – for that data, the PQRS, and also to satisfy the PQRS component for the EHR Incentive Program, you would use that option 1 for the pilot.

Leslie Witkin: Yes. I just wanted to clarify that, because I had some folks who read it and said, oh, if I do my attestation with three core, three alternate core, and three CQMs, then I’m going to be good to go for PQRS. So that’s why I just wanted to clarify it. It is a description of really that pilot project that they would have to be a part of.

Christine Estella: Yes. Thanks for – yes, thanks for asking that actually. That’s why it’s actually under our EHR reporting mechanism. I will say, though, if for some reason EP – I mean, if an EP wanted to participate in the pilot, and let’s say – I don’t know – they weren’t sure if their data would be submitted properly via EHR, they could also attest and use the pilot – so the attestation would cover them for the EHR Incentive Program, and then they can use the pilot to try and submit data via EHR to CMS.

Leslie Witkin: But they’d have to have a PQRS-certified vendor.

Christine Estella: Right. So, regardless, for PQRS, they would have to actually report data via HER, not attestation.

Leslie Witkin: OK. Thanks very much for that clarification.

Christine Estella: No problem.

Charlie Eleftheriou: Thank you. We'll take the next question.

Operator: Your next question comes from the line of Janet Schumacher.

Janet Schumacher: Thanks for taking my call.

I have – one thing I need to clarify – I think I know the answer, but I don't like the answer. We're currently reporting individ – via claims for PQRS. And as I understand it now, we need to switch down to GPRO if we want to avoid the Value-Based Modifier issue. But when I switched to GPRO, I can no longer report the group measures, the preventive group measures, is that correct?

(Tonya Smith): No. When you – you are correct in that for the Value Modifier, yes, you have to – you have to report as a group using one of the five options for groups. You mentioned the preventive care option. I think that – I mean, it measures – I think that's in the GPRO Web interface ...

Christine Estella: Actually ...

Christine Estella: No?

Christine Estella: ... it's the measures group.

Janet Schumacher: Right, the preventive measures group, that's what...

Janet Schumacher: So, then...

Christine Estella: Right, yes, you would have to actually – yes, you would not be able to report the measures group. However, I will say that most of the measures contained within our measures groups are available for reporting individually. Maybe that would help you.

Janet Schumacher: So ...

Molly MacHarris: And I did want to clarify as well as these are currently proposals, and we are seeking comment on these proposals. And Christine went over in her presentation earlier today, where you can send in your comments to proposals. So we do strongly encourage providers to send in comments if they have them.

Charlie Eleftheriou: And those questions can go – you can use slide 25 to get all that contact information, as appropriate.

Janet Schumacher: Yes.

Charlie Eleftheriou: And I think – I think we have time for one more question after this one.

Janet Schumacher: I'm sorry – you still there?

Charlie Eleftheriou: Yes.

Janet Schumacher: Oh, OK. I thought you were moving on, because I want to...

Charlie Eleftheriou: Oh, I thought – I thought you were finished. My mistake.

Janet Schumacher: No. I just want to clarify – so if I'm going to – I'm going to – if I choose to report three measures under the group – I have one physician who's a great reporter and one who's a bad reporter. That all gets averaged together? Is that point of the group, or does each physician still have to meet half of his 50 percent?

Molly MacHarris: So the way that it's currently proposed – remember that the Value-Based Payment Modifier is currently proposed only for groups that have 25 or more NPIs.

Janet Schumacher: Right.

Molly MacHarris: So, if that is your situation, you could report, as Christine mentioned earlier, on three individual measures. And Christine mentioned that the majority of the measures that are available within the measures group are available to be reported as individual measures.

Janet Schumacher: Alright.

Molly MacHarris: So we would need to have your physicians report those three individual measures. And we would – if it's reported via claims, it would be at a 50 percent reporting rate. If it's registry or EHR, as currently proposed, it would be at an 80 percent reporting rate. And we would look at all of the denominator-eligible instances ...

Janet Schumacher: Yes.

Molly MacHarris: ... for the group.

Christine Estella: Right. So, we're looking at applicable patients.

Daniel Green: So if your group has 200 people that – for whom the measure would apply, and they're doing claims, they would need to report on at least 100 of those patients. And if one of your docs is a superstar reporter, and they report 99 – let's say it was a group of two – I know, Molly just said 25, but just for the example ...

Janet Schumacher: Yes.

Daniel Green: ... and so one of your doctor reported on 99 of those patients, and the doctor reported only on one – on the other one to get to you to 100. That would be OK. They might fight amongst each other, but that would be fine to satisfy the requirement.

Janet Schumacher: That's why – so, and then, it's by patient or by encounter? You said, all denominator, but then someone said patients. So, is it denominator by individual unique patients or individual encounters?

Daniel Green: It's patients.

Janet Schumacher: Patients. So, if I see the same patient five times, that's one in my denominator?

Molly MacHarris: It depends on the measures.

Daniel Green: But for the prevention measure group – I’m sorry, for the prevention measures, typically, those are once per reporting period that you have to report them, so.

Janet Schumacher: So, that’s why you need to look at the reporting. OK. OK, that makes sense. Thank you.

Christine Estella: Thank you.

Daniel Green: Thank you.

Charlie Eleftheriou: Thank you. And now, unfortunately, we won’t have any time for additional questions. We’ve run into the end of our time today. If we did not get to your question and you’d like to send one in, or send comment in, please use the contact information on slide 25, and contact the Quality Support Help Desk.

Please note that we might not be able to get to every question. We’ll review them all to help us develop Frequently Asked Questions, educational products, and future messaging.

On the last slide of the presentation, you’ll find information and a URL to evaluate your experience with today’s National Provider Call. Evaluations are anonymous and strictly confidential. We appreciate that feedback.

And I should also point out that all registrants for today’s call will receive a reminder e-mail from CMS within two business days regarding the opportunity to evaluate this call. You may disregard the e-mail if you’ve already completed the evaluation.

And I’d like to thank everyone one last time for participating in today’s call. An audio recording and written transcript will be posted to the Physician Quality Reporting System and National Provider Calls Web pages on the CMS Web site within approximately three weeks.

I hope everyone has a great day and we’ll talk to you next time.

This document has been edited for spelling and grammatical errors.

Operator: Thank you for your participation in today's call. You may now disconnect.

END