



# MLN Connects<sup>TM</sup>

## National Provider Call - Transcript

*CPT only copyright 2010 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS and DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.*

**Centers for Medicare & Medicaid Services**  
**2012 Quality and Resource Use Reports Overview and December Addendum**  
**MLN Connects National Provider Call**  
**Moderator: Charlie Eleftheriou**  
**January 16, 2014**  
**2:30 p.m. ET**

### Contents

Announcements and Introduction .....	2
Presentation .....	2
QRURs vs. Individual Eligible Provider PQRS Performance Reports.....	4
Accessing and Downloading 2012 QRURs and IEP PQRS Performance Reports .....	5
Overview: How Can I Use the 2012 QRUR? .....	7
Methodology and Data in the QRURs .....	10
Using the Data in the QRUR and IEP PQRS Performance Report .....	17
Next Steps and Resources .....	19
Keypad Polling.....	19
Question-and-Answer Session .....	20
Additional Information .....	30

This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This transcript was prepared as a service to the public and is not intended to grant rights or impose obligations. This transcript may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

**Operator:** At this time, I would like to welcome everyone to today's MLN Connects 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. Thank you, you may begin.

## **Announcements and Introduction**

Charlie Eleftheriou: This is Charlie Eleftheriou from the Provider Communications Group here at CMS. And as today's moderator, I'd like to welcome everyone to this MLN Connects National Provider Call, which will be an overview of the 2012 Quality and Resource Use Report, or QRUR, and the Individual Eligible Professional PQRS Addendum.

MLN Connects Calls are part of the Medicare Learning Network. During this call, CMS subject-matter experts will give an overview of the 2012 QRURs and review the December addendum and how to interpret and use the data in the report. A question-and-answer session will follow the presentation.

Before we get started, there are a few items I'd like to quickly cover. You should have received a link to the slide presentation for today's call in an email today. If you have not seen the email, you can find today's presentation on the Call Details webpage, which can be found by visiting [www.cms.gov/npc](http://www.cms.gov/npc), as in National Provider Call. Again, that's [www.cms.gov/npc](http://www.cms.gov/npc). On the left side of that page, select "National Provider Calls and Events," then select today's call by date from the list. The slide presentation is located there in the Call Materials section.

Second, continuing education credit is available for this call. Please refer to slide 46 of the presentation or visit the Call Details webpage for more information on how to obtain credit for your participation.

I'll also note that this call is being recorded and transcribed, and an audio recording and written transcript will be posted to the Call Details webpage when it's available. And an announcement will be placed in the MLN Connects Provider eNews.

Finally, registrants were given the opportunity to submit questions in advance of today's call. We thank those of you who took time to do so, and while we may not be able to address all of them today, they'll be used for future presentations and to develop frequently asked questions and other educational materials.

At this time, I'd like to turn the call over to Michael Wroblewski from the Performance-Based Payment Policy Group in the Center for Medicare. Michael?

## **Presentation**

Michael Wroblewski: Thanks, Charlie, and good afternoon, everyone. Happy New Year to you as well.

The purpose of today's call is really to go over two reports that Medicare has just released at the end of 2013. And the purpose of these reports is really to introduce physicians and groups of physicians about how Medicare will be phasing in the value-based payment modifier.

The value-based payment modifier is a new per-claim payment adjustment under the Medicare Physician Fee Schedule that Congress has required us to start phasing in in 2015, and then to cover all physicians and groups of physicians starting January 1st, 2017. We'll be phasing in the value-based payment modifier so that in 2015, it will apply to groups of 100 or more eligible professionals based on 2013 performance. And in 2016, we just finalized that we would be applying the value-based payment modifier to all groups of 10 or more eligible professionals based on 2014 performance.

We define a group as a single taxpayer identification number, or TIN, and we'll be applying the modifier at the TIN level to all physician payments under the TIN. So basically, all physicians under the TIN get the same value-based payment modifier.

During 2013, we released two reports, what we call the main Quality Resource and Use Report, which we released in September; and an addendum, which includes individual eligible professional physician quality reporting performance data.

The main QRUR previews how a group of physicians would fare under the value modifier policies that we adopted for the first year of the value modifier, which, as I just indicated, the first year is 2015 based on 2013 performance. And that applies to groups of 100 or more. The addendum, by contrast, shows information about how a group's quality score could be calculated under policies we've adopted just for the second year of the value modifier, which is 2016 based on 2014 performance.

Both reports were produced only for groups of 25 or more. So we produced about 6,700 reports and all of the TINs – because we did them one for each TIN that had at least 25 eligible professionals that billed Medicare during 2012.

For those who are new to the value-based payment modifier or want a little bit more understanding, I'm going to give you a quick little thumb sketch of the value modifier and then we'll start getting into the slides. As I indicated earlier, the value modifier is a new per-claim adjustment under the Medicare Physician Fee Schedule. To come up with a group's value modifier, Congress required Medicare to develop two scores, or two composites, for each group: a quality composite and a cost composite.

My purpose today will be to go over how we actually make these composites and how we compare them to come up with the group's value modifier. I want to make sure that everyone understands what our approach is in terms of developing these cost and quality composites—is we're really trying to identify who the low and high performers are and to adjust *their* payment and their payment only.

The vast majority of the groups will be what we, as I'll indicate a little bit later – are what we call average – are in the middle. We will not be affecting their payment. So our approach is really to identify the high performers and the low performers and to adjust their payment, but to leave the vast majority of payment for physician groups unaffected by the value-based payment modifier.

And before I start into the slides, I would say the question that we get most is, how does the Physician Quality Reporting System interact with the value modifier? I believe the answer is a simple one. The quality measures that a group reports to meet its PQRS obligations will be used to calculate a group's quality composite.

So what I'm going to focus on is how we'll use those quality measures that a group reports under the PQRS to create the value-based payment modifier. The focus of this call is not on how to actually *report* the quality measures under PQRS, but once, rather – once, rather, the quality measures are reported, how we'll use them to actually calculate the value modifier. Of course, I'll also explain our methodologies for deriving the cost composite for each group, and what we do once we have a quality and cost composite for each score.

Towards the end of the call, I'll go over how we use the data in our reports to kind of help people understand how the value modifier will affect their group. My presentation will probably last for another 40 minutes or so, so please get comfortable. And then we'll have a Q&A for the remaining half-hour or so.

### **QRURs vs. Individual Eligible Provider PQRS Performance Reports**

I'm now turning to – what I just went through is really just kind of the objectives of the call, which was slide 4 of the slide deck. I'm now on to slide 5 of the slide deck.

So what are the Quality and Resource Use Reports? We call them QRURs. The main QRURs are annual reports that we provide to groups of physicians. As I mentioned earlier, they provide comparative information about quality of care furnished and the cost of that care. And remember, these are to Medicare fee-for-service patients only. These are not Medicare Advantage patients that your practice may treat.

So in these reports we have the quality measures that a group reports through the PQRS. And I'll explain how we – what we do with them in just a moment. It has five cost measures that I'll explain what those cost measure are and that – what we calculate—when I say “we,” I mean Medicare—that we calculate. The group doesn't really have to do anything. And we use administrative claims data to report – to calculate those cost measures.

The QRURs also include beneficiary-specific information. And this was the first year – the 2012 reports were the first – was the first year that we actually gave beneficiary-specific information, meaning which beneficiaries did we attribute to a group so that the group could actually work with those beneficiaries to help – to coordinate and to improve the quality and efficiency of care furnished.

And, of course, the QRURs preview how the group would fare under the value-based payment modifier. And remember, these reports that we did that went out in 2013 based on 2012 data were under the policies that we've adopted for the 2015 value-based payment modifier. So it really gave you – especially the groups of 100 – it gave a preview on how the value-based modifier would have applied had we been using 2012 data.

As I mentioned earlier, the 2012 QRURs were produced and made available to all groups of physicians with 25 or more eligible professionals. And, just as a quick note, we define an eligible professional not only to include physicians, but other practitioners such as clinicians, physician assistants, nurse practitioners, clinical nurse specialists, and the like, as well as therapists, which include physical therapists, occupational therapists, and qualified speech-language therapists.

OK. I'm now turning to slide 6. What I just went over was the main QRUR. We also, then, released just in December what we call Individual Eligible Professional PQRS Performance Reports. These were made available to all groups of 25 or more that had at least one eligible professional that reported one PQRS measure as an individual—so, an individual eligible professional—and they reported that during 2012.

And so what we were trying to accomplish with these reports is to allow – because we have – we have modified or we have – in our second year of the phase-in for the value modifier, we're allowing groups of physicians to – as long as at least 50 percent of the physicians and other eligible professionals report satisfactorily under the PQRS, we're going to roll up those individually reported PQRS measures and give a group score.

So what we tried to do with these reports is actually apply that policy. So, if there was a group in 2012 that reported on – that had many of its individual eligible professionals report individual PQRS measures and they were incentive-eligible, what this report does is it gives the whole TIN—all of their eligible professionals—and then it rolls all of those EPs up into scores for each of the measures that at least one eligible professional reported on.

This kind of rolling up of individual eligible professional PQRS performance rates is available in performance year 2014 for the value modifier that's available in '16. In the reports that we give out next summer, so in – or, I guess, I should now say *this* summer, the summer of 2014, will be reports based on 2013. And we'll have all of this—the main QRUR, as well as these Individual Eligible Professional Reports—all rolled – all put into one report. So we won't do it in kind of a stepwise fashion; it will be one report that should be available late August of 2014.

### **Accessing and Downloading 2012 QRURs and IEP PQRS Performance Reports**

OK. So I'm now on to slide – slides 7, 8, and 9 are really how do I go about and get my – either the main QRUR or this addendum that I was just talking about?

Step 1 is actually – you have to go to the portal. You will see the address there on slide 7. You have to log in, and you have to use your IACS. An IACS is Individuals Authorized for CMS Computer Services account. And it's basically an account you have to get that links you, a person, to a TIN so we know which TINs, which groups, you're associated with so you can go and pick up those reports.

On slide 40 of this deck are three slides of how you go about getting an IACS account if you don't have one already. And there's a link there for a Quick Reference Guide that's on our website that kind of gives you a step-by-steps on how to get an IACS account.

So, once you have your IACS account, obviously, you use your user ID and your password to log in. And you'll see in step 3 that you'll be in what we call the Physician Value–Physician Quality Reporting Portal. And you'll hit the “PV–PQRS” tab. You'll see that's circled there. You'll click on the “QRUR Reports.”

I'm now turning on to slide 8. You'll make the appropriate attestation. And then you'll see a – you know, a couple of folders there. The first folder you'll see, it says “Access Your QRUR.” I'm looking at – in the kind of the middle of the page. And that's the main QRUR that I was just talking about. The drill-down reports and the individual eligible professional performance reports are over there on the right-hand side.

You click whichever folder you want. You'll get the number – if you're only – if your TIN – if your – excuse me. If your IACS account is associated with multiple TINs, then in this – as it is in this particular example shown on slide 8, you'll get all the groups of physicians that you're tied to. Move the – click on the group of physicians that you want. It will move it over to the right-hand side of the screen. And then in the bottom left-hand corner, hit “Run Report.” I'm now on slide 9. And you'll actually get your Quality and Resource Use Report.

Steps 7 and 8 are really – you know, most people, when they get the main QRUR, they just download it as a PDF. So there's little arrow there – you'll see there on slide 9. So, you know, hit “PDF” and you'll be able to download it.

And for the drill-down reports, these ones that are kind of the supplementary beneficiary-specific information, as well as the individual eligible professional reports, you may actually want to export them into Excel so you can manipulate them and use them and do your own analysis on them. And so there's a way to, you know, download it as Excel – as an Excel file.

OK. I'm now on slide 10. “What if there was no main QRUR for my medical group practice?” This is a question we get a lot. Well, there are three – there are three reasons.

One is that your group didn't have 25 or more eligible professionals that billed under your taxpayer identification number during 2012. And we did get one or two questions in the run-up to the call that asked, you know, how often does a eligible professional have to bill? You know, do they have to be in the group the whole year?

As long as they bill one claim under your group during the year, even if they were there only for a week, then your group had – that eligible professional – that eligible professional counts towards counting up to the 25. So the main reason why people didn't get reports is because they didn't have 25 or more eligible professionals.

But there were some groups that did have at least 25 eligible professionals, but they still didn't get a report. And there are two reasons why that happened. One is that we were unable to attribute any beneficiaries to the group. And if that were the case, then we have a one-pager. And that's really what happens for groups of physicians – you'll see that our attribution methodology really focuses on primary care services. So if you have groups of physicians that don't provide primary care services, and I'll define those in just a moment – so if you have a group, say, of radiologists or anesthesiologists or pathologists, emergency medicine, you're very unlikely to have a report.

Even if we were able to attribute beneficiaries to a group, we also wanted to make sure at least one of the measures had 20 cases. That's our minimum reliability standard. So if a – if we didn't have one measure – even if we were able to attribute beneficiaries, we didn't have one measure that had 20 cases, that group would just get a one-page report indicating that the report was not prepared for them.

### **Overview: How Can I Use the 2012 QRUR?**

I'm now on slide 11. OK, now I'm kind of changing focus here, and I'm going to walk through the main QRUR. You know, how can you use the 2012 QRUR? I – we list there five ways you can do it – what you can do with it.

You can look to see how your group would fare under the value modifier. You can look to see if the number of beneficiaries and who they are, the identity of the beneficiaries that are – that have been attributed to your group. You can understand your performance on the cost and quality measures and how they compare to other groups'. You can understand which attributed beneficiaries are derived – are driving your cost measures, and those that are potentially in need of greater care coordination.

I'm now on slide 12. You can also verify that Medicare did it right in terms of identifying which eligible professionals actually billed under your TIN. And you can see which beneficiaries are driving your group's performance on what we – on three hospital-related care coordination outcome measures that we prepared for every group. So those seven things—the five things from the previous page, as well as these two—you can use the main QRUR to get answers to those things.

The last two bullets on slide 12 are really the individual eligible professionals report that we just put out in December. And this really just shows what – how you would fare if we were to roll up all those individual eligible professionals' performance rates into a group score. So you can see which EPs are driving performance on a particular measure, and then how your group compares to other groups who reported the same measures.

***Performance Highlights Page***

OK. I'm on slide 13 now, and this is my favorite slide of the whole 48-slide deck. OK? Because if you understand this slide, then you're going to be well ahead of the game, and I know you're going to go back and be able to tell everyone in your group how Medicare is doing the value-based payment modifier and what's in the QRURs.

OK. As I indicated earlier, Congress has required us to come up with a cost and a quality composite for each group. So, what this – each report has, as its cover page, a performance highlights page. And the first two things on there are what this particular group's quality and cost composite are.

As I indicated earlier, we divide each cost and quality composite into three categories: high, average, or low. So you can see, on this particular group, this group is average–average. They're – on the quality composite, they're at 0.71, with 1 being the dividing line to get over into the high-quality range. So they are almost high quality, but not yet.

On the cost side, they're 0.42, meaning they're slightly higher cost than average because for cost, you actually want to have a negative number because you want to be low cost. That would be – you know, because ultimately where the biggest value modifier, like, upward adjustment are for those groups that we designate that are high quality, low cost. So this group is almost high cost and kind of in the middle there – excuse me – almost high quality but almost in the middle there for – on the cost side.

The third kind of section of the report talks about how – you know, it gives a little bit of a profile – the risk profile of the beneficiaries that we've attributed to the group. So for this particular group – and we – and we divide – we take an average of all the beneficiaries. We give them a risk score. And then we put them in a percentile from 1 to 100.

So this group has, on average, beneficiaries that are in the 67th percentile, meaning they're, you know – about 2/3 – you know, their patients have probably more chronic conditions. They may be more disabled. They may be older, have additional comorbidities, et cetera. They're in the 67th percentile.

And the reason why we give that information is because if the group is in the 75th percentile or higher, we give an upward kind of a bump for high-quality, low-cost care. So we really were trying to incentivize the care and high-quality care for those who are with the most chronic conditions—truly, the elderly and the most frail.

Slide – or section 4 of the report is that scatter graph. And you'll see that most of the groups are average–average. You'll see that kind of big plus sign, and all those little dots represent groups. This group, if I remember correctly, is a group of 100. So all those other dots are other groups of 100. And so you'll see that nearly every one of those groups is in the average–average category.

And, if you look down at section 5 of the report, that's the payment chart. So – and we highlighted the fact that this group is average–average—that's why it's a little bit

highlighted—and it says “plus 0 percent.” That means no value modifier. Zero, meaning no payment adjustment. There will be – you know, there won’t be any adjustment based on value.

Of course, the place where you want to be is the upper right-hand corner, which is low cost, high quality. And that’s an additional – that’s plus  $2x - 2$  percent  $x$ . And the worst place to be is in the bottom left, which is low quality, high cost. For 2015, the downward adjustment is minus 1 if you are low quality, high cost.

And the reason why we put 2 percent  $x$  – and you’re thinking, “Why didn’t they just tell us what that  $x$  was?” And the  $x$  is we have to – is – the value modifier has to be budget-neutral. So all the money that we take away from the low-quality, high-cost groups has to be redistributed up to the high-quality, low-cost groups. But we have to determine what that pool of money is and who’s eligible for those – for those – for the upward adjustments, so we have to do that kind of each year. So we don’t know what that  $x$  is.

So I think this slide really tries to tell what’s going on in a – in a snapshot. It gives the group’s cost and quality composite, tells them where – how they – where the risk percentile is and whether they get the bump-up for treating high-risk patients. It shows how they compare to other groups, and then shows what their value modifier would be.

#### ***About the Report Introduction***

OK. Slide 14. The reason why we put this – I’m going to now walk through – the report itself has 10 – the main QRUR has 10 exhibits and 3 related tables. And I’m going to walk through them, some of them a little bit more quickly than others.

There’s an introduction, which – in which we indicate how many eligible professionals actually billed under this TIN during 2012. We define an eligible professional not only to include physicians – and you’ll see that the definition of a physician includes not only MDs and DOs but doctors of dental surgery, podiatrists, optometrists, and chiropractors as well, as well as non-physician clinicians that are clinicians and therapists, as well. You’ll see that definition on slide 14.

And in the introduction to the report, there’s a big number that actually shows the number of eligible professionals that billed under your TIN. So if you turn to slide 15, and if you were to click onto that number, you’d get that report, that little chart that’s down there at the bottom of slide 15. And this lists all the eligible professionals, whether they’re a physician or a non-physician, and their specialty and the date of the last claim billed under the TIN.

So what this information – what we’ve found that groups have been using this information – is just to verify that we – that we, Medicare, did it right. And the one thing that we’ve heard is that some of the specialty designations that we have in the report may be out of date.

Listed there on – in the second main bullet is where you can update the PECOS – our PECOS database, which is our enrollment database, to update each of your eligible professionals’ specialty designation to make sure it’s accurate. So we try to give that information so that groups can, you know, double-check us to make sure that we’ve done it right.

### **Methodology and Data in the QRURs**

I’m on slide 16 now. These next couple of slides deal with attribution. One of the questions that we got prior to the call was “Please explain attribution in detail.” OK. I’m not going to go into as probably as much detail as the – as the – as the questioner wanted, but I do think I can give you a quick overview of what we do.

We use an attribution process that focuses on the plurality. And plurality means more than anybody else. It doesn’t mean majority. It means plurality. It means more than anybody else. So we look to see who – which group had the plurality of primary care services rendered by physicians in the group. So we have kind of a pre-step and then a two-step process.

The pre-step is we identify all beneficiaries who had at least one primary care service rendered by a physician in the group. And you’ll see that primary care services – you’ll see that little footnote that’s on the bottom of the slide 16 that primary care services include evaluation and management visits in an office, outpatient services, skilled nursing, et cetera. And in our rule we have specific codes as to what those – what those primary care services are. Basically, E&M visits 99201 through 215 and the like. And we have a couple of other codes that are in the rule.

So, first step, we identify a pool – or the pre-step. We identify a pool of eligible beneficiaries that could be ready for attribution. And then we use a two-step process.

First, we assign the beneficiaries to the group practice that had the plurality of primary care services as we did – as we calculate based on not the number of services, but actually the allowed charges for those services rendered by primary care physicians. And you’ll see footnote 2 on slide 16 defines what we mean by a primary care physician.

If unassigned—meaning, if a beneficiary is unassigned—then we look to step 2 and we’ll assign that beneficiary to the group practice whose affiliated physicians, nurse practitioners, physician assistants, and clinical nurse specialists together provide the plurality of primary care services. We note that at the end of this process, there may be some beneficiaries that had a service with the group but may not be attributed anywhere or may not be attributed to that particular group.

### ***Beneficiaries Attributed to the Group: Overview of Exhibits 1 and 2***

I’m on slide 17 now. So, given that two-step process in your mind, what we do in Exhibits 1 and 2 is give some detail about how that attribution of – process actually affected the group. So for this particular group, we attributed 7,835 beneficiaries to the group. Seventy – 7,585 came through step 1; 200 and – which is the – so this is a group

primarily of primary care physicians. And about 250 of the beneficiaries came through step 2.

Exhibit 2 then shows, you know, how does this attribution compare to other groups of 100? So we make comparisons. And you'll see how your medical group compares to group practices that were – in this report it was to other groups that had 100 or more eligible professionals. That was your peer group. So, slide – Exhibits 1 and 2 really talk about attribution and how the attribution worked for the group.

The interesting thing that I – the part that I really love about this report is if you were to click on the 7,835 on the online version, you'll turn to slide 18 here and you'd get what we call Drill-Down Table Number 1, and that lists all 7,825 beneficiaries that have been attributed to the group. So, obviously, that comes out as – you can download that as an Excel file.

And we give specific information about all the beneficiaries that we've attributed to the group. You can see that we give the HIC number, the gender, the date of birth, what their risk-score percentile was, whether they died in 2012, the last claim filed. So, once again, you can use this information to verify that this beneficiary was actually treated by your TIN, as well as the percent of primary care services provided by the group and by other groups, as well as, then, cost – percentile of cost. So you can see what's driving the cost for this particular beneficiary. Was it E&M services? Was it an inpatient hospitalization? Was it post-acute services, et cetera?

We also indicate when the last hospital admission was for the beneficiary, as well as whether the beneficiary falls – falls into one of four chronic – has one of four chronic diseases. And that's important when I get to the cost measures. And I'll get to that in just a moment. So this information is really kind of really very rich information that a group can use to understand its beneficiary population.

I'm now on to slide 19. Slide 19 gives, really, a national overview of, basically, what Medicare did for these 2012 reports in terms of attribution. Groups of 25 or more provided primary care services to about 24 million beneficiaries. We were able to attribute 11.5 million of those, with the majority of those, 9.9 million, being attributed through the first step, and about 1.636 million attributed through step number 2.

I'm on slide 20. Why are we using this attribution process? We use this process because we believe that the attribution attributes a beneficiary to the group practice that is well positioned to coordinate and oversee the beneficiary's annual total per capita cost. That's kind of a – that's a big statement, what I just said right there, in that we are attributing beneficiaries who – based on plurality of primary care services. And it's our contention, and we believe that those who provide the plurality of primary care services can really control, or have the most control, are well positioned to oversee the total per capita cost—basically all of Medicare spending for that beneficiary during the year. That's why we use this particular measure.

We also believe that this population that we attribute to a group – we calculate three outcomes measures that look, really, at preventable hospital admission, whether it's a readmission or preventable hospital admissions for acute or some chronic conditions, which I'll go over in just a moment. We believe that the group that provides the plurality of primary care services is, once again, well positioned to be able to manage and to care coordinate and to do – have those – have performance on those measures – those outcome measures be done well because they are in the best position to manage those beneficiaries.

***Performance on Quality: Overview of Exhibits 3 and 4***

I'm now on slide 21. OK. Exhibits 1 and 2 all dealt with attribution. Exhibits 3 and 4 deal with quality. So this chart right here on slide 21 talks about, OK, what quality is in the reports? What quality measures are in the reports that we put out in September 2012 in the main QRUR?

Under the policies we adopted for the value-based payment modifier, groups had to choose between – had to choose one of three group reporting mechanisms. They could either report what we call through a GPRO web interface, which is really—and we had – in 2012, we had 67 groups do this—that they had to report on 29 measures. And all of the group had to report on the same measures using a web interface. And those measures were basically primary care and preventive care measures.

The second kind of group of measures that we used were if an ACO – if a TIN was a member of an ACO, we used the ACO's quality data to be part of this report. Although I know many of you know that we're not applying the value-based payment modifier to any ACO participant in 2015 or '16, we still produced a QRUR for them.

The third row there is for the quality measures that we used because we didn't have the roll-up yet of individual PQRS measures. What we did is, for groups that we could attribute beneficiaries to, we calculated 14 CMS-calculated administrative claims–based quality measures. And then of the 6,700 groups or so of 25 or more, about 2,900 of them received a one-pager because we weren't able to attribute beneficiaries to them, and we weren't able to produce a report.

For those groups that got the one-pagers, as well as for those groups that we calculated administrative claims, some of those groups may have actually reported individual PQRS measures. That's the Individual Eligible Report – PQRS Performance Report. That's the second of the two reports that we did that we released in 2012. And you'll be able to get those as well, and I'll go over those at the very end of the call.

For all three of the – no matter what – how the group participated in the PQRS, we also calculated three outcome measures for all groups: an all-cause readmission measure and two composites of preventable hospital admissions, one for acute conditions and one for chronic conditions. And the beneficiaries that we used were the ones that we attributed using that two-step process that I just went through.

OK. On to slide 22. Individually reported PQRS – and I just mentioned this just a second ago – individually reported PQRS measures are not included as part of the main QRUR. And the reason why is because that was not an option for the – is not an option for the 2013 performance period. It is an option, however, for the 2014 performance period, which will be the value modifier in 2016. And that’s why we released these reports in December 2013 that shows how that would work for your particular group. And the addendums that I’ll talk about at the very end can – and I’ll talk about how we rolled up those individually reported PQRS measures.

The next two slides say, “OK. I understand now where the quality information is coming from. Now, what does CMS do with it to get a quality composite?”

The first thing that we do is we put every measure that you’ve reported through the PQRS or the three outcome measures into what we call domains. And domains are really just groupings of quality measures, and they’re groupings of like measures. So you have a domain for care coordination measures. You have a domain for clinical care. You have another one for patient experience. You have another one for patient safety, et cetera.

So what this example shows is the care coordination domain. And the methodology I’m going to talk about is the same methodology regardless of the domain. So what we do is, here you have the three outcome measures. And you’ll see on slide 23, they are listed on the left-hand side there as CMS-1, 2, and 3.

The first one is the acute conditions composite. And you’re thinking, “OK. This is – these are a lot of numbers here. What are we doing here?”

OK. So this particular group’s measure, this acute conditions composite, looks at the rate of hospitalizations per thousand beneficiaries. For this particular group, for CMS measure 1, their rate was 5.6. So they had 5.6 preventable hospital admissions for the 3 acute conditions that are listed right underneath there: bacterial pneumonia, urinary tract infection, and dehydration. So their performance rate is 5.6.

What we then do is we compare it to the benchmark rate. You’ll see in the next column over, the benchmark rate is 8.2. And when I say we compare it, we actually just take the difference. The difference is 2.6. Then we divide it by the standard deviation. The standard deviation for this particular measure is 3.2.

So if you divide 2.6 by 3.2, you look all the way over on the right-hand side there, in that CMS row 1, you’ll see 0.8. Well, that’s the standardized score for that measure. And what that really shows is how far is the group from the mean, given the dispersion of other groups? So this group is within one standard deviation. It’s actually high. So that’s good because it’s on the high-quality side.

On the – if you look at CMS number 2, the chronic conditions composite, it’s 1.3. That means they actually are above the standard deviation, meaning that they’re – they’ve done actually pretty well on this measure.

Unfortunately, they have a negative rate for the all-cause hospital readmission rate, meaning that they're below the average. So what we do is we take a – we make a standardized score for every measure. And you'll see, in this domain, there were four – there were four measures. And you'll see their standardized scores on the far right-hand corner – or the far right-hand column.

If you turn to slide 24, what we did is – oh, let me point out one other thing on 23. At the very top, in the – where it says “Exhibit,” you'll see that what we do is to come – we need to come up with a domain score. And the domain score for the care coordination domain is really – is just the simple average of those four numbers in the right-hand column. So 0.41 is the simple average of minus 0.12, 0.8, 1.3, and minus 0.3. OK?

Now I'm on to slide 24. So what we do is – this group had measures – quality measures that fell into three domains. You'll see there in the middle of the chart—we just went through the care coordination domain. There were four measures we just went through. And that group – and the domain score was 0.41. And you can do the same thing for patient safety and the clinical process/effectiveness domain. And you'll see the number of quality indicators and what the average domain score was.

You see where the number 2 points in at the chart there, and it says 0.44? What we do is we then give an average domain score. And that's just a simple average of the three domain scores. So that's just the average of the ones below it.

And then step 3 is we then look at everybody's average domain score and make a standardized score of that. So, even though they were slightly – this particular group was slightly at better than average, 0.44 – it was higher, when you compare it to everyone else, they were even more above the average than everybody else. So that's why 0.44 was converted into 0.71. And, once again, we just did a standardized score, where we took the difference between the performance rates and then divided by the standard deviation.

If this group had been 1.0, it would have been high. If in – if you're looking at the standardized quality composite score row, where it says 17 and then this group is 0.71, if it had been 1.0, it would have been high. Had it been negative 1.0 or negative 1.1, it would have been low. So, outside the 1 range gets you into high or low.

OK. On to slide 25. The benchmarks are the national average on a quality measure-by-quality measure basis. And they're the national average from the prior year. So for the 2012 report that we've put out, the national – the benchmark was 2011 data.

We had published at the end of last year all of the benchmarks for 2012 that will be used in the reports that we go – that we put out this August. And they're on our website, which is – I always go to it as [cms.gov/physicianfeedbackprogram](http://cms.gov/physicianfeedbackprogram). And then on the left-hand side it says “Value-Based Payment Modifier,” and the list of all the benchmarks is listed there.

And the other thing I want to emphasize is that the minimum case size for each measure is 20 beneficiaries. So if there's a measure that only had 18 beneficiaries, we don't count that measure. We may make a standardized score of it, but we don't roll that into the average domain score and it doesn't get counted. You've got to have at least 20 cases.

And then, you'll see that bullet there. There's a link there for all the means, the standard deviations, and all the measure specifications for all the measures that were used in the report at the bottom there of slide 25.

***Hospitals Admitting Your Beneficiaries: Overview of Exhibit 5***

OK. Slide 26, Exhibit 5. Exhibit 5 gives an indication of – it identifies the hospitals where at least 5 percent of your group's attributed beneficiaries had an inpatient stay. So in this particular – for this particular group, this group had – of its 7,500 or 800 or so beneficiaries, there were 2,498 stays in a hospital, with 1,242 of them occurring at the QFWLT hospital, 414 at another hospital, and 341 at a – at a third hospital.

And if you click on that 2,498 in the online report – if you turn to slide 27, you get the last of the three drill-down tables. And this is a table that lists all of the hospitalizations for all your beneficiaries. So once again, it's a beneficiary-specific table. Beneficiaries listed there on the left-hand side. We indicate, you know, identifying information about the beneficiary, when the date of admission was, what the – what the admitting hospital was, the principal diagnosis, where they were discharged.

And there are two columns in there that talk – it says “ACSC Admission.” That – if you were to click on that, that would explain that those were the beneficiaries that are included in those – the acute composites for preventable hospital admissions. So you'll know – you can track which beneficiaries fell in – you know, were in the numerator, so to speak, and the denominator, for the preventable hospital admissions, as well as the all-cause readmission measure.

***Performance on Costs: Overview of Exhibits 6–10***

Slide 28, Exhibits 7 – 6 and 7. These are the cost measures. And we do the same idea in terms of we have two domains for cost measures and we have – and we calculate – we, CMS, calculate five cost measures for every group in which we can attribute beneficiaries.

We make one measure called the Total Per Capita Cost for All Attributed Beneficiaries. And what that means is we look at the – if we attribute a beneficiary to a group, we then look at all the costs – all the Part A and B costs to Medicare for that beneficiary regardless of whether the group provided all of those costs. Right? So it's all the costs – all Part A and B costs for that beneficiary. We then – and that's in the first domain.

The second domain is what we call the condition-specific domain. And this is beneficiaries that have four chronic conditions: diabetes, COPD, CAD, and heart failure. We look at what their total per capita cost for beneficiaries with those specific conditions.

In order to take these, kind of, amounts and turn it into a cost composite, we use the same process we did with the quality composite. We look at what their performance was for this particular group. The performance for the total per capita cost for all beneficiaries was 11,835. It was a little bit higher than the benchmark rate of 10,265. So the domain score for that one is 1.02. And we do the same thing for the four chronic condition measures, as well.

The one other thing I wanted to point out on this slide is you'll see that there are two columns with – talking about your medical group, that talk about per capita cost *before* risk adjustment and per capita cost *after* risk adjustment. For this particular group, the – we risk-adjust all of our cost measures to take into account the severity, the age, history of chronic diseases, et cetera, so – to make sure we're making an apples-to-apples comparison.

And so what we did is this: What we tried to show here is that we actually raised – after risk adjustment, we raised the actual cost of this group from 11,523 to 11,835. So that means that the average risk profile was lower than the average. Because they had healthier beneficiaries, we had to actually increase the cost to make them accurate – to make an accurate comparison. If the risk adjustment goes down, that means the beneficiaries on average are – have more chronic conditions or are higher-risk beneficiaries. So I just wanted to point out that kind of inverse dynamic.

I'm on slide 29. As you'll see, this slide is very similar to the one that we did for quality in that we have two domains; we take a simple average of the average domain score, which was 0.87; and then we take a standardized score of the average domain score to get the standardized cost composite score, which was 0.42. And, once again, as we talked about earlier, this group was an average – an average group.

And, just like quality, if the score is above 0.1 – or, excuse me, above 1.0, that means it's high cost. And if it's below minus 1.0, that means it would be low cost.

I'm on slide 30. The benchmarks for these, again, are the national year average – or the national average but they're the current year, as opposed to quality, which is the prior year. And the peer groups that we used for cost comparison – we did peer group comparisons for groups of 100 plus to other groups of 100 plus EPs. And for groups 25 to 99, we did all groups 25 and above.

Same minimum case size of 20 eligible cases. And that, for the reports that go out next year, we will further adjust cost benchmarks based on the specialty composition of the group. That's a policy we've adopted for the second year of the value modifier. It's not in the reports that we released earlier this year.

Slide 31 is really just a graph of – showing where this particular group's costs are compared to its peer group. You can see it's over to the right but certainly not as high as the highest one. And it's somewhere in the – what is that, the 87th percentile or something like that. So it's just a graph of cost measures.

Slide 32 shows Exhibit 9, which once again breaks out the total per capita cost but by service category. So we look to see – we’re trying to provide information to the group to say, “Hey, your beneficiaries, on average, have more E&M services provided by your group than average.” But, for this particular group, you’ll see the negative 882. That’s hospital outpatient – outpatient hospital services, meaning that this group had fewer hospitalizations – outpatient hospitalizations than the average group.

Slide 33 gives an additional cost breakdown. Once again, it’s a total benefit – attributed beneficiary level. It breaks down the cost into different types of service categories and the percentage of beneficiaries that have those types of services, and then compares it to your peer group.

***PY2012 Payment Adjustments: Results of the Value Modifier***

Slide 34. People have asked, you know, “How did – you know, since you did a preview of the value-based payment modifier based on 2012 data, what would the – what would the effect on payment actually have been?”

This is for information only, but it shows that for groups of 25 or more, only about 8.1 percent of the groups would receive an upward adjustment. And of those 8.1 percent, 11 percent of that group – set of groups – would get the high-risk bump-up for providing high-quality, low-cost care to high-risk beneficiaries.

Eighty-one percent of beneficiaries wouldn’t receive any – wouldn’t receive any adjustment. The value modifier is zero, meaning no payment adjustment. And about 10.9 percent of the groups would receive a downward adjustment.

For groups of 100 or more, the results were very similar. And I think that the takeaway from this particular slide is that we’re truly identifying, and we’re only adjusting the payment of the true high and low performers.

**Using the Data in the QRUR and IEP PQRS Performance Report**

I have five slides left. And these are what groups can do with the information that is in these drill-down reports. These – I’ve talked a little bit about the first three of these slides because these were the drill-down tables that went with the main QRUR.

***How Can Groups Use Table 1?***

On slide 35, this is Table Number 1. And these are all the beneficiaries that have been attributed to your group. You know, there are four big arrows there. And I think groups can do at least four things with these – with this data.

One, they can verify that the – that we actually attributed the beneficiaries correctly. And we give the information so you can indicate – or you can verify that – you know, when the last claim that the group filed for this particular beneficiary.

I think the neatest piece of information is – see the arrow at the top that points down? It says, “Identify those beneficiaries that may require more care coordination with

physicians outside of your group.” So what this shows is – that column indicates percent of primary care services billed by the TIN. Should you have a high number there, that means all the primary care services for this particular beneficiary were provided by the group.

If, on the other hand, the number is really low, like the third beneficiary there is 51 percent, then you know they’re getting a lot of primary care services outside of your group. And you may want to work with that beneficiary for care coordination purposes.

The next arrow at the top there indicates, you know, what service categories are really driving these particular costs, and it gives the percentage of cost for that beneficiary for E&M services, procedures, et cetera.

Then the last set of columns and the arrow on the bottom, these give which beneficiaries were included in the four specific cost measures for the beneficiary-specific chronic diseases. So you can see, OK, the third beneficiary in this chart was – had diabetes. The first beneficiary in the chart had coronary artery disease.

### ***How Can Groups Use Table 3?***

I’m on slide 36. Slide 36 – this is – you’ve seen this table before. This is the table of all attributed beneficiaries’ hospital admissions. You know, I think that there are a couple of things that folks can do with these. One is that you can look to see what diagnoses are the basis for hospitalizations. So you can sort to see which beneficiaries are really – you know, what types of diseases, diagnoses, are landing folks in the hospital.

The other thing – the other two columns – or, this is the arrow that’s at the very top pointing down that says, “Identify preventable hospital admissions.” So this indicates, you know, whether the beneficiary was actually admitted for something that could have been prevented through primary care in an outpatient setting. And it gives a – it gives an indication as to which – whether it was the acute or the chronic outcome – the preventable hospital admissions measure that that beneficiary was in the numerator. It also indicates which ones had a preventable readmission.

And then the last piece of information there is look to see where your beneficiaries are being discharged to. Are most of them being discharged to the home? Are most being discharged to a skilled nursing facility, et cetera?

### ***How Can Groups Use the IEP PQRS Performance Reports?***

Slide 37. OK. So those are – what I just finished, those – the hospital admissions and the beneficiaries attributed, that was all in the main QRUR. The information that’s on slides 37 and 38, these are what’s in the addendums that we just released in December. And these are the rolled-up PQRS measures.

The slide – slide 37, which has Table A.1, this is the rolled-up group performance. So what we do is we look to see which measures had at least one of your EP’s report information on it. And we took the performance rate and we rolled it up to get a

performance rate at the group level. It's weighted by the number of cases reported by that individual.

And slide 38, which shows Table A.2, is actually – this would be a table for each eligible professional that had reported PQRS measures in 2012. So what you can do is use this – you can download this table, obviously. You can then see – “OK. Well, we had 30 EPs who reported PQRS measure number 1, which is the diabetes measure.”

You can then sort and look to see, “OK. Well, you know, EPs 1, 2, 3, and 4 had really high rates. EPs 5, 6, 7, and 8 had low rates. We can see what's driving our performance.” So, obviously, you can see what's moving towards group performance, or driving the group performance.

### Next Steps and Resources

OK. That's it for the content of the – of the – of the slides. Slides 39 – slide 39 indicates next steps, what you can do in terms of where you can provide additional information in terms of the methodologies. As you know, everything is being driven off the PQRS in terms of the quality measures that we're using, so we give a link there on how to participate in the PQRS if you're not already.

And then at the very – the link at the very bottom is if you have thoughts about content or the format of these reports or the drill-downs, we'd really like to hear you. And so we give you an email address to use.

Slide 40. I'm not going to go through 40, 41, and 42. These are the – how do you get an IACS account.

Slide 43, once again, is more technical assistance information, whether it's related to IACS, whether it's PQRS, whether it's the PQRS group practice reporting option, or whether it's the value-based payment modifier. You'll see the links.

And so now I'm on slide 44, and we can start with the question and answers. Thank you.

### Keypad Polling

Charlie Eleftheriou: And before we start taking questions from callers, we'll pause for a moment to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today.

Please note, there will be silence on the line while we tabulate the results.

And we're now ready to start polling.

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

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

Please hold while we complete the polling.

Thank you. I would now like to turn the call back over to Mr. Eleftheriou.

## Question-and-Answer Session

Charlie Eleftheriou: Thank you. Our subject-matter experts will now take questions. Because this call is being recorded and transcribed, please state your name and the name of your organization before asking your question.

In an effort to hear from as many callers as possible, we ask that you limit to yourself to one question at a time. If you have more than one question, please press star 1 after your first question has been answered to get back in the queue, and we'll address additional questions as time permits.

We're ready to take our first question now.

**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 Sylvia Yaw.

Sylvia Yaw: Hi. Yes. Hi. This Sylvia Yaw from Tanner Health System. I just have a question regarding the all-cause hospital readmission. It's kind of a two-sided one. So, is that based on claims data that comes from the patient once they're admitted to the hospital? And how does that – how does this align with the hospital value-based purchasing?

Michael Wroblewski: It is – the answer is yes, we get it from the claims data. And we look at the number of risk-adjusted unplanned readmissions within a 30-day discharge from the index – from the index admission. And it is basically the same construct as the hospital readmissions measure, but it's calculated – this is calculated on an attributed beneficiary–by–attributed beneficiary basis.

So we look at – you know, we calculate – you know, we look at all of the – I think, the simple way to think of it is we look at all of the admissions and then whether – would that – for beneficiaries that have been attributed to your group, and then look to see if there's been a readmission. And we calculate it that way.

Sylvia Yaw: OK.

Michael Wroblewski: It's the same construct as the hospital VBP readmission, but it's done at the beneficiary level as opposed to the hospital one, which is done at the facility level.

Sylvia Yaw: OK. That makes sense. OK. Thank you.

Michael Wroblewski: You're welcome. Thank you.

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

LaChrissa Patrick: Hello. I have a question regarding how the calculation's going on. In one of the slides it was saying it was being based on the specialty of general, internal med, and so forth. But all our individual – eligible individual – excuse me – individual eligible professionals, they are therapists, and we're trying to figure out how their information is being calculated.

Michael Wroblewski: OK. That's a good question. So with the cost measures, we calculate a cost measure for every beneficiary that's been attributed to a group. And we get – the cost measures really just add up all the Medicare spending for that beneficiary during the year. OK?

LaChrissa Patrick: OK.

Michael Wroblewski: What we do is, for – starting in 2016 based on '14 performance, when we make those comparisons to see who's high and low, we'll take into account what the specialties are of the underlying group, OK?

LaChrissa Patrick: OK.

Michael Wroblewski: That's – so that's what we're doing with specialty adjustment for cost measures.

On the quality measures, which you were looking at your individual eligible professional report, we look to see – we don't make a specialty adjustment for whether it's any type of specialty, whether it's a physician or non-physician. If an EP in a group reports a measure, we – and they, say, report the diabetes measure and, say, they're a nurse practitioner ...

LaChrissa Patrick: Yes.

Michael Wroblewski: ... you also have a couple of folks that are family practice and a couple geriatricians and a couple internists that all report that same measure. When we get the group rate, we don't take into account any specialty composition. We just look at the performance of the group, because if they've chosen to report that measure, we believe that they're choosing that measure because they believe they're showcasing their high performance. So we don't make any specialty adjustment there.

And then we make comparisons at the national average. So anyone nationwide who reports that measure, we'll look at that performance nationwide to see what the national benchmark is. And we'll make the comparison of the group performance versus the national benchmark and go through those steps that – I think they're on the middle of slides 23 and 24.

That's a great question. Thank you.

LaChrissa Patrick: Thank you. Now, when looking at our individual eligible professionals, if we have, like, 47 EPs and we're only seeing 4, should we be concerned?

Michael Wroblewski: Yes. In that – what our rule for the performance period 2014 is that in order for us to count or to use the data that individual eligible professionals report, you have to have at least 50 percent of your eligible professionals. So if you've got 47 eligible professionals, I would like to see 24. I did the math right there, yes. At least 24. That would have been 50 – that would have been 50 percent.

And hopefully on Table A.1, you'll see that if you only had 4 out of 47, that percentage – I'm going to say that's 10 percent-ish or so. That 10 percent number should be on the front of Table A.1.

LaChrissa Patrick: OK.

Charlie Eleftheriou: OK. Thank you. We'll take the next call now.

**Operator:** Your next question comes from the line of Maureen Schwarzer.

Maureen Schwarzer: Good afternoon. I'm with the Carolina Center for Medical Excellence, and I'm referring to slide 19. I was wondering why the 50 percent of all of those beneficiaries were not able to be attributed. What factors into that?

Michael Wroblewski: That – you know, Maureen, that's a great insight. What's happening is they were all – they weren't attributed to groups of 25 or more, but they were attributed, probably, to groups that were under 25. So even though these groups of 25 provided at least one primary care service to 24 million beneficiaries, they only – the groups of 25 only provided the plurality of services to 11.5, and my – and I know just through our analysis that the rest of them went to groups that were under 25.

Maureen Schwarzer: Oh, OK. Now, when – I read something about a time when it's going to be affecting groups of 10 or more.

Michael Wroblewski: For groups of 10 or more, the value modifier will apply to them in 2016 based on performance starting this year, 2014.

Maureen Schwarzer: That's what I thought. OK. Thank you very much.

Michael Wroblewski: You're welcome.

Charlie Eleftheriou: And we'll take the next question.

**Operator:** Your next question comes from the line of Heidi Harting.

Heidi Harting: Yes, I'm sorry. Heidi Harting. I wanted to know why, on the PQRS report – how those measures were listed for the individual providers. Because I don't recall – I mean, is this based on what we really submitted, because ...

Michael Wroblewski: This is what – yes. What's in Table A.2 of the individual eligible professional report is what was submitted to the PQRS system for the 2012 performance year. Just remember, it's 2012 performance year.

Heidi Harting: Right.

Michael Wroblewski: So – and we tried to indicate whether the measure came through – which submission measure came – submission mechanism it came through, whether it was claims, registry, or EHRs.

Heidi Harting: OK. And if we see it as – I mean, I know which measures we submitted for our different doctors, and they're not matching up. So that's why I'm wondering how these are listed.

Michael Wroblewski: I mean – I think, if you want us to look at your particular issue, if you would just give the helpdesk a call, we can put a ticket in, and then we can, you know, examine your particular, you know, TIN's issues to see if there's an issue there. Obviously, I can't answer that on the phone.

Heidi Harting: No, but I meant in general. I'm looking at it from a general perspective.

Michael Wroblewski: Yes. It's the data that was submitted in – for 2012 under the PQRS that your EPs submitted. So if there's an error, we – or if you think there's a discrepancy or something, we'd like to know about it.

Lauren Fuentes: And, hi, this is Lauren Fuentes. Did you participate under the GPRO or, no, your providers participated individually?

Heidi Harting: Our providers participated individually.

Lauren Fuentes: OK. And did you – have you accessed your 2012 PQRS Feedback Report?

Heidi Harting: I have not yet.

Lauren Fuentes: OK.

Michael Wroblewski: OK. So the – just to make sure that the – and this is – this is – Lauren, that's a great point that you've raised. There are two reports kind of out there now for PQRS. The report that I talked about was one that's only prepared for groups of 25 or more, and it's one report per TIN. And we're looking at the performance rates of those measures reported.

The report that Lauren is talking about is available to anyone who participated in PQRS individually. So it could be for – and it's at the TIN-NPI level, so, you know, it's at the individual clinician level. And it actually gives the – not only the reporting mechanism, but gives you the *reporting* rate as opposed to the *performance* rate. And so you can see, you know, which have – you know, I think, for, like, claims-based measures you've got to report on 50 percent of the eligible beneficiaries. It indicates whether that – you know for that measure, that EP met that particular rate.

And to get those, Lauren?

Lauren Fuentes: So, you can go to the PQRS portal to get the TIN-level report, and you'll have to access using – you'll have to get that with an IACS account. Or, if you just want to get an NPI-level report – I'm assuming you probably would want to get it for the whole group. And that TIN-level report will have a breakdown by each NPI. But regardless, you can also get an NPI only-level report through our Communication Support page. You can request a TIN-level report through that method as well.

Heidi Harting: Right. And I've seen them in the – in past years. I definitely have. I just – I guess, I still don't understand the difference, then, how this report reflects – I mean, it's the number of eligible cases, which would be the denominator—right?—of what's in my feedback report on a particular provider anyway. Correct?

Michael Wroblewski: Well, the number of eligible cases here – this is the – this is the difference between a performance rate and a reporting rate. So if you're looking to see what your reporting rate is under the traditional PQRS report that you've gotten over several – the past several years, that you've seen before, your reporting rate denominator will be, say, 100 because those are the number of beneficiaries that qualify for that measure that you could have reported on.

Let's say you then report on 55 of them. Of course, that – it would be the 55 number that would be in the report that I just talked about because that's what's the performance was

calculated on. The performance was calculated on the 55. So if you're thinking, "Why is the  $n$  different?" it's because one's a reporting and one's a performance rate.

Heidi Harting: But if I am submitting for 100 percent of them, they should be the same.

Michael Wroblewski: Correct. That is correct.

Heidi Harting: OK.

Michael Wroblewski: You got it.

Heidi Harting: And, again, you're saying that – and I'll have to verify that – I know which measures we submitted, and they're – it just seems to be broader in this report here than – we did do the EHR incentive, you know, the pilot where they accounted for both. So in most cases, we submitted six measures for PQRS.

Michael Wroblewski: And you're saying there're more measures in the report that I just talked about? Right?

Heidi Harting: Yes.

Michael Wroblewski: Yes. Because we got data on all those measures. Yes.

Heidi Harting: You got data from who – the registry we submitted from on all the measures?

Michael Wroblewski: Yes, yes.

Charlie Eleftheriou: I hope we answered your question satisfactorily. Again, if you have more specific questions, you can find technical assistance information on slide 43.

And we'll take the next question, please.

**Operator:** Your next question comes from the line of Beth Barnett.

Beth Barnett: Hi. I forgot my question. OK. We now have to file as a GPRO because we have more than 100 providers. And I just want to make sure that I'm understanding. As a GPRO, I've been told, you know, not all of my providers have to report PQRS. So the providers that do will cover the providers that don't. How will that work with the value-based modifier? The providers that do report will cover the ones that don't?

Michael Wroblewski: OK. So let me ask you a – one or two clarifying questions real quick. For – so you're saying, for 2014 or for 2013, you are – have or will sign up to be a GPRO?

Beth Barnett: 2013. We did because we had to.

Michael Wroblewski: Yes.

Beth Barnett: But we selected administrative claims.

Michael Wroblewski: OK. Good, good. And so, for 2014, you want to do the individual roll-up, kind of, the 50-percent option?

Beth Barnett: Are you asking or are you telling?

Michael Wroblewski: I'm asking.

Beth Barnett: And the reason I say that is because I'm very confused. I've tried to call the helpdesk numerous times, and they've not been much help. They keep telling me they don't know. And I have a vast, vast array of specialties, which is where my concern is coming in.

Michael Wroblewski: OK. So what this is – what I think – the reason why you, you know, for 2013, you had to – since you were a group of 100 or more, you had to choose one of three group reporting options. And you chose admin claims.

Beth Barnett: Right.

Michael Wroblewski: OK. For 2014, there's no admin claims option.

Beth Barnett: Right.

Michael Wroblewski: So you can choose one of the three – there are now three group reporting options. You can do the web interface – but you said you had multispecialty, so people probably want to report on different quality measures, right?

So what you have to do for the value modifier is to make sure at least – so you have 100 people in your group, just for illustration. As long as 51 of those report satisfactorily to avoid the 2016 PQRS payment adjustment, we'll roll all those up and give your group a group quality score for the value modifier. So you'll be – you'll be set for the value modifier.

All your – the 51 that reported that met the satisfactory criteria to avoid the payment adjustment – those 51 individuals will not get a PQRS adjustment, but those 49 – you see how I got 49?

Beth Barnett: Yes.

Michael Wroblewski: Will. Because they didn't report anything, and you're not reporting as a group.

Beth Barnett: But I am reporting as a group. Right?

Michael Wroblewski: No, because you reported individually and for the value modifier, we rolled you up. But for PQRS purposes, you said, “I’m reporting individually.” And so, if you want to get out of the PQRS adjustment, you’re going to – for every one of your individuals, every one of those individuals is going to have to report. The roll-up is really only – is only available for the value modifier. It’s not a group reporting mechanism in the traditional sense for PQRS, unfortunately.

Beth Barnett: And that’s for ’13 or for ’14?

Michael Wroblewski: ’14.

Beth Barnett: So, because, realistically, I’m looking at 300 doctors in one tax ID. But – and, like I said, you know, I’m a complicated case because I have one set of – one specialty is on one EMR, one specialty is not on EMR, who did claims up until this year. And then, I have – everybody else is on another one. So, I have, like, 12 specialties.

Michael Wroblewski: Right. If you can – you know, I hate to say this because you haven’t gotten – I’ll turn it over to Molly.

Molly MacHarris: Yes, this is Molly. One of the things that you can do – and I understand that you haven’t been getting too far with the helpdesk, but we are finalizing our 2014 education documents. And one of the documents that I think might be really helpful for you is we have a How to Report Once document that will be coming out. Because I’ve heard you mention your EHR, and one of the things that CMS has been striving to do is to reduce reporting burden for providers. And in that document, we, at a high level, describe how you can report once and avoid the PQRS payment adjustment; avoid a negative value-based payment modifier, which Michael was describing; and you can also avoid the negative Medicare EHR Incentive Program penalty.

So that is a document that will be useful for you. We’re still in the process of getting it posted, and it will be up on the PQRS website within the next few days to a week. So I would suggest that you take a look at that. And it can kind of highlight the couple options that will probably be most helpful for you.

Charlie Eleftheriou: OK. And we’ll take the next question, please.

**Operator:** Your next question comes from the line of Rick White.

Rick White: Yes, thank you. I am confused over the filing of claims for 2014. We’re a 75-doctor emergency group, and we’ve been filing in PQRS individual claims. I am told, in order to roll up to value-based, it requires you to register through the – send your claims through the registry. Is that true?

Michael Wroblewski: No. So, just make sure – I’ll try to parse your question real quick. So, in 2013 you submitted – you put G-codes on claims for PQRS purposes. Is that right?

Rick White: Correct.

Michael Wroblewski: OK. And how many of your 75 physicians or EPs – how many did you do that for?

Rick White: All of them.

Michael Wroblewski: OK. So, all 75. OK. Well then, you can do the same thing for 2014. And what that would mean is that if you hit all of them, none of them will get a – assuming you meet the – you do it on three measures – at least three measures ...

Molly MacHarris: To avoid – to avoid the payment adjustment.

Michael Wroblewski: ... to avoid the payment adjustment, and if you actually want to earn an incentive, you have to do it on nine measures across three domains. But assuming you do it on three, there will be no PQRS payment adjustment for any of the 75. We'll roll those up to give you a group score for the value-based payment modifier for quality. And then you're set.

Rick White: OK. Very good. Thank you.

Michael Wroblewski: You're welcome.

**Operator:** Your next question comes from the line of Sandra Pogones.

Sandy Pogones: Hi, this is Sandy Pogones with Primaris in Missouri. I just have a real simple question. The regs, I thought, said that at least 50 percent of your providers have to report individually, but you keep referring to like 51 out of 100. Wouldn't 50 out of 100 be 50 percent, and wouldn't that be enough?

Michael Wroblewski: It's at least 50.

Sandy Pogones: Right. So 50 out of 100 would be at least 50.

Michael Wroblewski: True.

Sandy Pogones: OK. So 50 is enough. So if you have 10, you need at least 5. Is that correct?

Molly MacHarris: Well – and this is Molly. Just to – as Michael kind of noodles on that one – one of the things that we've always encouraged providers to do on the PQRS program is – you may be familiar with one of our measure group reporting options where we've said you only need to report on 30 patients or 20 patients. We always encourage folks to go above and beyond that, because there could be instances that are missed, there could be one reason or another that your claims may be inadvertently stripped. So while there is, you know, that set threshold, and we know that's where folks really want to aim

to, we do always encourage you to go above that to really give you a little bit of buffer. So ...

Michael Wroblewski: Yes. If you – if you – if you did 5 over 10 – if you did 5 over 10, that would work.

Sandy Pogones: OK. So, it is the – it is at least 50 percent, not more than 50 percent.

Michael Wroblewski: Right.

Sandy Pogones: OK. Thank you for your help.

Michael Wroblewski: You're welcome.

Charlie Eleftheriou: And I think we have time for one last question.

**Operator:** Your last question is from the line of Kate Fitzgerald.

Kate Fitzgerald: Hi. I wanted to ask a question about the value-based modifier. And I want to ask the difference between GPRO 2013 to 2014 in how our patient panels are decided—whether it's just any patient that has been seen by a physician in our TIN, or is it patients that are specifically – that we're designated as their PCP?

Michael Wroblewski: I missed the first part of your question, I'm sorry. Will you say that again?

Kate Fitzgerald: I didn't know how our patient panels are being decided—like, which patients are going to be on the panels. I know for 2013, it was kind of – if patients had seen a doctor in our TIN group. I was wondering if 2014 – if that was different, or if it was patients that are assigned to us as PCP.

Charlie Eleftheriou: Can you give us one quick second to confer over on the side?

Kate Fitzgerald: Sure.

Michael Wroblewski: OK. So – all right. We had to figure out – so when you're talking about patient panels, are you talking about the – you – your group had reported using the – what we call the GPRO web interface?

Kate Fitzgerald: I know last year – sorry, I'm new to this. I know last year that patients were assigned to us. And I think it was that there are certain providers who are non-physicians. So people were assigned to us. I just wanted to know more about how that was based – how the patients being assigned to us are determined.

Michael Wroblewski: Oh, OK. So it's really just the attribution for – OK. So the attribution works – we look to see – the first step is if the beneficiary had one primary

care service provided by a physician in the group. Then we identify all those beneficiaries. And then from that pool, we do two steps. We look – we assign – we’ll go beneficiary by beneficiary to see, “OK. Did this group have the plurality, meaning more than anyone else, of primary care services delivered by primary care physicians?” If so, then we attribute the beneficiary to the group.

If not, we go to step 2 and we look to see, “OK. Did the group provide the plurality of primary care services if they were delivered by not only primary care physicians but specialists, as well as PAs and nurse practitioners?” So that two-step – that’s a two-step process, and at the end of the process there may be some beneficiaries who you saw but that just aren’t attributed to your group. They’re gone somewhere – they’ve been attributed somewhere else.

Kate Fitzgerald: OK.

Michael Wroblewski: OK, thank you.

## **Additional Information**

Charlie Eleftheriou: OK. Thank you. Unfortunately, that’s all the time we have for questions today.

I would like to thank our subject-matter experts and all participants who joined us for today’s MLN Connects Call. On slide 45, you’ll find information on how to evaluate your experience with today’s call. Evaluations are anonymous, confidential, and voluntary. We hope you’ll take a few moments to evaluate your MLN Connects Call experience.

With that, we’ll bring today’s call to a close, and thanks one more time.

**Operator:** This concludes today’s call.

**-END-**

