

**CMS Plans for the Initial Implementation in 2015 of the Physician Value-Based Payment
Modifier under the Medicare Physician Fee Schedule
National Provider Call
Moderator: Nicole Cooney
November 28, 2012
3:00 p.m. ET**

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Operator: At this time I would like to welcome everyone to today's National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I would now turn the call over to Nicole Cooney.

Thank you ma'am, you may begin.

Announcements and Introduction

Nicole Cooney: Thank you, Holley. Hello, I'm Nicole Cooney from the Provider Communications group here at CMS and I'll serve as your moderator for today's call. I'd like to welcome you to today's National Provider Call entitled, "CMS Plans for the Initial Implementation in 2015 of the Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule."

Today, we have CMS subject matter experts here to discuss these plans, as well as address questions and comments related to them and the overall physician's feedback program. Before we get started, there are few items that I need to cover. The slide presentation for today's call was posted on the CMS Web site on Friday, November 23. A link to this presentation was e-mailed to all registrants earlier this afternoon.

If you did not receive this e-mail, please check your spam or junk mail folders for an e-mail from the CMS National Provider Calls Resource Box. This call is being recorded and transcribed; an audio recording and written transcript will be posted to the CMS physician feedback programs section. The URL for that section is located on the final slide of today's presentation.

A direct link to the page where these materials will be posted is also included in the e-mail that went out to registrants earlier today. I'd also like to thank those of you who submitted comments or questions when you registered for today's call. Your comments were shared with the speakers to help prepare slides and remarks for today's presentation.

At this time, I'd like to introduce our speakers for today. We are pleased to have with us Michael Wroblewski, Director of the Division of Value-Based Payments in the performance-based payment policy group in the Center for Medicare; as well as Dr. Sheila Roman, Senior Medical Officer in the performance-based payment policy group in the Center for Medicare.

And now, it's my pleasure to turn the call over to Michael Wroblewski, who will begin our presentation. Michael?

Presentation

Michael Wroblewski: Thank you, Nicole, and good afternoon everyone. I'm starting on the slide deck that was Nicole mentioned that was e-mailed out to everyone earlier this afternoon. I'm actually going to turn to start on slide three and give a quick overview of what I plan to cover in about 20 to 25 minutes, and then we'll open it up for questions.

I'd like to share our final policies for the value-based payment modifier that we finalized in the November 2012 final physician fee schedule rule with comment. I'd like to explain how participation in the Physician Quality Reporting System, or PQRS, affects a group participation in the value modifier. I'd like to review the timeframes and deadlines for groups of physicians that groups – and a group of physicians will have to follow relating to the value modifier, and then at the end we'll take any questions that you may have about the presentation.

Turning to slide four, what is the value-based payment modifier? The Affordable Care Act required Medicare to establish a value-based payment modifier that came up with the payment differential based upon the quality of care furnished compared to cost. The statute requires Medicare to face the value-based payment modifier starting January 1, 2015, and to complete the phase-in to all physicians and groups of physicians by January 1, 2017.

Medicare has decided to phase in by applying the group – by applying the value modifier to all groups of physicians with 100 or more eligible professionals. This is a change from our proposal in which we had proposed to apply the value modifier to groups of 25 or more eligible professionals. The value modifier will be applied to the Medicare paid amounts for the items and services under the physician fee schedule and in doing so beneficiary cost sharing for our co-insurance is not effective.

Turning to slide five, so what were the principles that were guiding Medicare's implementation of their value modifier? There were really four principles, and the first one was probably most important, in which we were trying to encourage physician measurement by aligning the value modifier with the physician quality reporting system.

And because we were doing that, we would be offering a choice of quality measures and reporting mechanisms for groups of physicians to choose. We did this because reporting is necessary but not sufficient for quality improvement.

The other two principles that guided our implementation, which we were trying to encourage, shared responsibility and systems base care and through the physician feedback reports to provide actionable information for quality improvement.

Turning to slide six. OK, so as I said, we were going to apply the value modifier to groups of a hundred or more eligible professionals – who is an eligible professional? Three categories: physicians, practitioners and therapists, and you'll see on slide six what is included in each of those three categories.

Turning to slide seven, how do we define a group and determine its size? First, Medicare will define a group by a single taxpayer identification number, a single TIN, and we'll be able to determine if a group has hundred or more eligible professionals using a two-step process.

First, we will query the Medicare PECOS database, and PECOS stands for Medicare's Provider Enrollment Chain and Ownership System, now to identify those groups of physicians with a hundred or more eligible professionals as of October 15, 2013.

In step two, we will wait until the close of the year, close of 2013, and then look to make sure that actually a hundred eligible professionals actually billed under that that TIN during 2013. So we'll only remove groups from that list, we will not add any groups to that list.

Turning to slide eight, the value modifier will not apply to physicians who are not paid under the physician's fee schedule. This means physicians who practice in real health clinics Federally Qualified Health Centers and critical access hospitals.

And for 2015 and for 2016, Medicare will not apply the value modifier to physicians and groups of physicians who are participating in the Medicare shared savings program and the pioneer ACO model or the comprehensive primary care initiative, and that means we won't be applying the value modifier or those ACOs that are the parent, so to speak, as well as any of the participant TINs that make up an Accountable Care Organization.

OK, so turning to slide nine. Now this slide really is my favorite in the slide deck, and it gives a quick overview on how we will apply the value modifier to those groups of a hundred or more eligible professionals. Starting at the top of the diagram – and it also shows the link between the value modifier and PQRS.

So starting at the top of the diagram going down the left-hand side, if the group is a PQRS reporter, meaning that they have self-nominated to participate in the PQRS as a group using the Web interface, the registry method of submission for administrative claims – at that point the value modifier for that group will be zero, meaning no payment affected..

Then we'll be giving those groups an election, whether to have – and election is optional, whether to have the value modifier calculate actually based on the performance of the measures reported through the PQRS. That good result if you look down – going down the left-hand side arrow, that could result in an upward no or downward adjustment based upon the performance. If the group doesn't elect the value-based payment modifier will be zero, meaning no payment adjustment.

If you go back up to the top of the diagram and then go down the right-hand side, these are basically the groups that do not self-nominate to participate in the PQRS and submit at least one measure. If the group does not do that, the group and all the physicians under that TIN will have a -1.0 adjustment meaning they would get a +99.0 percent payment of the allowed amount under the physician fee schedule.

So if the takeaway, I think if you had one takeaway from this slide, is that one member of the group of a hundred or more eligible professionals must self-nominate and choice a PQRS reporting method and, in doing so they will not have a downward value-based payment modifier adjustment. At that point, they can decide whether to elect quality tiering and to actually get an upward, downward, or no adjustment based upon the performance.

OK so turning to slide 10, this is a slide which shows basically a timeline of, when do groups have to do certain things? Starting, actually, this Saturday, December 1, through the end of January 2013, groups can self-nominate for PQRS GPRO and nominate for two reporting methods; either the Web interface or registries, not administrative claims, and they can also self-nominate for e-prescribing GPRO.

We will close that period on January 31 – we will open up another period starting in July for 2013 that will run through October 15. These groups can self – at this point if a group had self-nominated back in December and is happy with their choice about their Web interface and registries, they don't have to do anything.

But for those groups that have not used the first registration period, can actually use the second one, in which point they can elect the GPRO reporting mechanism, whether interface or registries or elect the administrative claims option, as well as to indicate its preference for the – whether to allow quality tiering, that has to be done by October 15, 2013.

During that period, we will also make available a physician feedback report based on 2012 data that can help those groups of a hundred or more, decide whether quality tiering is in their best interest because we will provide a feedback report that shows how they would do under the quality tiering methodology which I'll go over in just a moment to help inform that physician.

Starting in 2014, during the first quarter of 2014 that would be depending upon the PQRS reporting method chosen, whether Web interface or registries, the submission of that data will have to occur during that first quarter. During the third quarter of 2014, Medicare will then provide another physician quality resource use reporter – physician feedback report, then indicates how they did under quality tiering under 2013, and then the value-based payment modifier would start on January 1, 2015.

OK, turning to slide 11, so what are the – and this is going into a little bit more in-depth about the auctions under the PQRS for groups, so really there are three choices that a group has from which to choose one of the methods.

Others use the PQRS GPRO using the Web interface which looks – which measures focus on prevented care and care for prevalent and costly chronic diseases in the Medicare population, they can use PQRS GPRO using registries and these are quality measures of their own selection that will report through PQRS qualified registries or they can elect the PQRS administrative claims option, this option is only available for 2013.

We perceived many questions and actually in the lead up to this call about what if a group of a hundred or more, really wants to continue to participate in the PQRS as individuals and doesn't want to do group reporting either through the Web interface or through CMS-qualified registries at the group level – what is it to do? It is to choose – the answer is – choose option three administrative claims option for 2013.

Turning to slide 12, this really once again – this slide emphasizes and summarizes the link between PQRS and the value modifier. As you'll see along the top of the chart, there are five

columns. Basically, what a group does in terms of whether it's self-nominates or not, that's the first column, second is what the group actually does, do we call that the group reporting action.

What an EP or an eligible professional in that group does and then what the value modifier and what the PQRS payment adjustments would be. OK, I'm going to go row by row – row one, and this is the row we want everyone in. In that row, a group of a hundred or more self-nominates for PQRS GPRO using one of – during one of the two self-nomination periods and chooses either the Web interface or registries.

It then looking at column two, row one, it then meet the PQRS – the satisfactory criteria for the PQRS incentive because that was done at the group level there's no EP reporting action. At that point, the value modifier adjustment is 0.0 and the group – all the members of the group will receive a +.5 upward PQRS adjustment for the incentive.

This is a little asterisk by the value modifier for 0.0 because they would have to choose quality tiering and it could change depending upon the performance for the measures reported through one of those two recording methods.

Looking at row two, say your group self-nominates for PQRS GPRO – submits at least one PQRS measure using the Web interface or registries but does not meet the satisfactory criteria for the PQRS incentive, the EPs in that group don't do anything. The value modifier would be 0.0 and the PQRS, because they didn't earn the incentive and meet the satisfactory reporting criteria, but also be 0.0 as well, meaning no payment adjustment.

Row three, the group self-nominates for PQRS GPRO, but at this time the group doesn't do anything, actually doesn't submit at measure, we hope this does not occur but if it does, EPs in that group don't do anything either. If it does, all the members of their group will have a -1.0 as well as a -1.5 for the PQRS downward adjustment.

OK, row four changes just a little bit – in this scenario, the group self-nominates for the PQRS using the administrative claims option. OK, what does the group do, it doesn't really have to do anything there because the administrative claims options or CMS calculated claims based on administrative and billing data. But in this particular instance, some of the members of that group individually report under the PQRS and they meet the criteria for the PQRS incentive.

So what happens, for the value modifier because it's paid at the TIN level, they've avoided if it's 0.0 and if they're electing, you see those little asterisks there, if they have elective quality tiering

then it could be an upward no, were downward adjustment. And under the PQRS you'll see there's a +.5 percentage; that's because that would be applied to the individual EPs in that group because those EPs that met the satisfactory reporting criteria.

And the last row, in this row the group self-nominates for PQRS administrative claims at the group level during one of those two sign-up periods, the group doesn't report anything and none of the EPs in that group do anything. What happens, a value modifier of 0.0, no PQRS adjustment, 0.0 as well and there's that little asterisks that once again if the group elects quality tiering, we would use the performance on the administrative claims that would be calculated for that group.

Turning to slide 13, this is really what happens between – the link between the value modifier and PQRS for groups of a hundred plus that do not self-nominate and do not report at the group level, OK, so as you remember from my very favorite chart on slide eight, what happens to these groups, all the members of those groups have a value modifier of –1.0, so you'll see in the value modifier column –1.0.

But under PQRS there could be a different payment adjustment depending upon what that individual in the group does. Looking at the first row, if the group – if the individual meet the PQRS reporting requirements at the individual level it could earn an incentive, so you'll see PQRS has +.5 percent. If that individual submits at least one PQRS measure, then under PQRS they would have no payment adjustment.

If the individual under the group elects the administrative claims option, under PQRS once again no payment adjustment. And if the individual in a group that has not self-nominated and in that group hasn't reported anything at the group level and the individuals don't do anything, then under the value modifier –1.0 percent and under PQRS –1.5. I know that those tables are difficult, but hopefully they're very comprehensive in terms of all the scenarios that could occur.

Just looking back on slide 12, we want everyone, and I want to re-iterate, we'd really love everyone in row one, groups self-nominate, they meet the satisfactory reporting criteria, the individuals don't have to do anything at the individual level, they can elect that in modifier in which there would be a possibly an upward adjustment, and then all the members of that group would actually get a PQRS incentive.

OK slide 14, these next series of slides really give a little bit deeper dive into – so what's quality tiering? So the first question is OK, so elect quality tiering, what measure does CMS going to

use? Well first, we're going to use the measures that you report through what you self-nominated for, so if you use – if you sign up for the Web interface, we'll use the performance on the measures in the Web interface.

If you report measures of your selection through a CMS-qualified registry, do we use your performance on those measures. For all groups, we will also use three other measures and the three outcome measures that are listed there on the slide and hospital readmission measure, a composite for the Q-prevention quality indicators, and a composite of chronic prevention quality indicators.

Slide 15, it shows the cost measures that CMS would use, there are five cost measures, one – the first one is total per capita cost for every beneficiary that's been assigned to the group. And total per capita cost mean, all Medicare part A and B cost, it does not include part D or drug cost. And then we'll look at total per capita cost per beneficiaries with four chronic conditions, COPD, heart failure, coronary artery disease, and diabetes. All the cost measures are payment standardized and risk adjusted to make sure that we're making fair comparisons.

Turning to slide 16, so how is Medicare going to attribute beneficiaries to my TIN or the administrative claims if that's what the groups elected or for the cost measures? Attribution will be based on the group that provides the plurality of primary care services to the beneficiary; we'll have a minimum of one primary care service with a physician in that group.

This is the same attribution methodology that we're using for the Medicare Shared Savings Program and if a group of hundred or more EPs does not provide primary care services. Say a group of radiologist or a group of emergency medicine practitioners, that group will not have any beneficiaries attributed to that group, meaning that the cost measure would be – we wouldn't be able to calculate across measure and hence the value modifier score would be 0.0, assuming that they had that going – if you go back to my favorite slide, slide eight, that they had self-nominated for the PQRS and chosen at least one of the three quality reporting methodologies.

So slide 17, what do we do, now that we know what the quality measures are the cost measures, how do we actually kind of come up with a quality tiering score? What this slide shows is that given the measures that had been chosen to be reported, we will classify them, the quality measures, into one of six domains and equally weight the measures within those domains and equally weight the domains.

If the measures that are reported through PQRS do not, say, include efficiency or population community health, then we will just equally weight the remaining domains. We'll classify those five cost measures into two domains: a total overall cost, and a total cost for beneficiaries for specific conditions. We would then weight them equally as well. We'll end up calculating two scores: a quality score and a cost score, which would then feed into the value modifier.

Turning to slide 18, how are we going to actually calculate that quality score – we'll – we would do a measure by measure comparison to create a standardized score for each quality and cost measure. The example of that slide and I'll look at measure one, shows that – and we'll make the comparison to identify how far you basically are or that measure is, performance of the measure is from the national mean.

So what we will do is we'll look at the group's performance script score, compare to the national mean, divide that difference by the standard deviation to come up with the standardized score, we'll do that for every measure that has been reported and we will combine them into the domains that I mentioned before and then create a quality score and then a cost score.

Turning to slide 19, we will then classify each group's quality score and cost score into one of three tiers: high, average, or low, depending upon whether the group score is at least one standard deviation away from the national mean and that we have a 95 percent confidence – interval.

You'll see on the chart there, that really where you want to be in the quality tiering scoring chart on page 19, you want to be in the low-cost, high-quality, that's where you'll get the biggest adjustment. If you have elected quality tiering and you happen to be high-cost, low-quality, which is the bottom right-hand corner. That's where you would have a -1.0 adjustment and we're providing an additional upward incentive for those groups of physicians that treat beneficiaries with the highest risk score.

OK, so these next two or three slides really are kind of just a summary of what I went through and some takeaways – OK, so if you're in a group of a hundred or more, what should you do – you need to participate as a group in PQRS, self-nominate during one of the two periods, December 1 of this year through January 31st of 2013 or during the second period that we open from July through October 15th of 2013.

Select one other PQRS reporting methods, and I'll reiterate, if a group – if the physicians in the group want to contain through report at the individual level, rather than the group level, that group has to choose the administrative claims option for the GPRO, and then decide by October 15, 2013 whether to elect quality tiering.

[Slide] 21 basically says what are the things that should help me decide whether the group should elect quality tiering. It all depends on which measures you decide to choose and how well you do on them, where the methodology is really focusing on statistical outliers. So if you're in a very low-cost area, you're providing very, very high-quality care, very likely that you'll get an upward payment adjustment, and that if you treat beneficiaries that are high-risk for patients and are reporting via the Web interface or registry, there's an upward bonus for high-quality, low-cost care.

Slide 22 is just a quick overview of the feedback reports that I mentioned earlier later this month that we'll be providing reports based on 2011, two physicians in groups of 25 or more EPs in nine states and you see the states listed there on slide 22. It would be previewing some of the policies that we have finalized, not all of them but some of the policies that we finalize with the value modifier.

And then later in 2013, September of 2013 through February of '14, we'll be providing reports for groups of physicians 25 or more and based on 2012 data, using the value modifier policies that we – that had just gone over.

Slide 23, have you know of the big questions whenever we get out there to QRURs, is you know how do you determine my specialty, we used it – we determined it based upon the PECOS database, and so please make sure that this slide is really and urging to make sure that your information, your groups information PECOS is updated and if you see where the web site is.

And then the last slide – slide 24, are contact information points for additional information. And now I'll turn it back over to Nicole for comments and questions.

Nicole Cooney: Thanks, Michael. At this time we will pause for just a few minutes 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 may be moments of silence while we tabulate the results.

Holley, we're ready to start the polling.

Polling

Operator: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one 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 one, if there are between two and eight of you listening in, enter the corresponding number between two and eight, if there 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.

Again please continue to hold while we complete the polling.

Thank you for your participation, we will now move into the Q&A session for the call. To ask a question press star followed by the number one on your touchtone phone, to remove yourself from the queue please press the pound key. Please remember to pick-up your hand set before asking your question to assure clarity.

Please note your line will remain open during the time you were asking your question so anything you say or any background noise will be heard in the conference – please hold while we compile the Q&A roster.

Nicole Cooney: And this is Nicole, I just want to jump in real quick just to remind everybody that the call is being recorded and transcribed and it's very important for all you on the phone as well as everybody in the room with us to state your name when you answer or ask a question. And in an effort to get to as many participants as possible, we ask that you limit your question to just one and you can get back into the queue and we'll take follow up questions as time permits.

Holley, we're ready when you are.

Question-and-Answer Session

Operator: OK, then your first question comes from the line of Nina Ungar.

Nina Ungar: Hi, this is Nina Ungar from John Hopkins. My question is do you know yet how a group actually does the self-nomination?

Michael Wroblewski: There is and I'm going to turn it over, I think Christine Estella from the PQRS is on the line but I believe the PQRS has a – because the legislation period actually the first one opens up this Saturday. On the PQRS Web site, there are instructions on how to get the user I.D. to actually then do the self-nomination, to choose one of the PQRS reporting methods and I'll turn it, if Christine if you're on the line to please fill in any additional details.

Christine Estella: I'm on the line, so actually, with respect to self-nominating, as Michael mentioned, it would be tied to the PQRS self-nomination for the group practice reporting option, or GPRO. Traditionally, and the way we have it right, is that we are going to set up an online database and when envisioning or reviewing something, it would be either the link to our communication support page or something like a page like that.

In the communication support page we currently use to exempt significant [inaudible] for exemption request or E-prescribing Incentive program, as well as request for PQRS and for more review. So basically, what you'd be able to do is, you would, you know, be able to select an option key for GPRO self-nomination when you're self-nominating under the PQRS group practice reporting option, you would have — you would fill in your contact information, basic information about the practice.

You would also get to select the reporting mechanism that you would use under the PQRS and then there will also be an option of, you wanted to elect administrative claims, at the end of that there will be a tied of value-based payment modifier option as well.

Nina Ungar: Is that online database open for this purpose?

Christine Estella: It's not open currently, it will be open – I think it would be open in January for PQRS self-nomination and then it will close for a period to update and then I think around in the fall you'd be able elect your quality tiering for the value-based payment modifier.

Nina Ungar: OK.

Michael Wroblewski: And it actually opens up this Saturday. We'll give you – if you stay on the line I can get you a better link and I'll circle back in just a few moments, so just stay on the line as we're answering other questions, OK.

Nina Ungar: OK, thank you.

Michael Wroblewski: You're welcome. Thank you for the question.

Operator: Your next question comes from the line of Joyce Nurenberg.

Joyce Nurenberg: Hi, this is Joyce Nurenberg for the Medical College of Wisconsin. I am looking at slides 11 and 12 – particularly 12. OK and looking at the first three lines, the first one so it's selecting GPRO, which is what we're thinking about, so it meets criteria for PQRS incentive.

I thought by reporting via Web interface or the quality call defined registries, that if we were successful we would get the incentive. I'm not familiar with how to determine whether we meet the PQRS incentive.

Michael Wroblewski: Joyce, you're right. If you report via the registries or via the Web interface using and meet that satisfactory reporting criteria under the PQRS and you'll get that PQRS adjustment, that's why there's +.5 a percent up in the kind of the very far right-hand column.

Joyce Nurenberg: Right.

Michael Wroblewski: And that your value modifier because you self-nominated and reported at least one measure, your value modifier would be 0.0, and then depending upon whether you'll elect quality tiering, we'd look at the performance rates on those measures that you reported through you know whichever one you chose, whether it's the Web interface or you reported selected or opted to choose (to put measures through) CMS-qualified registry.

Joyce Nurenberg: Well, the confusion is that I understood again most them we've been reporting individually up until this time, OK so meeting criteria for the PQRS incentive, I'm familiar with that because we've had either meet three measures or one of two and meet the MAB, process.

Michael Wroblewski: Right, right, yes.

Joyce Nurenberg: OK, so but in this terminology and their GPRO situation, it's unclear when I look at the – when I compare the other lines on this same slide, I find that I don't understand because it's – you know I thought if we fill out the web interface.

Michael Wroblewski: And then Joyce I will stop you right there. If you fill up the web interface, there are 22 measures.

Joyce Nurenberg: Right.

Michael Wroblewski: For 416 patients or so – right?

Joyce Nurenberg: Yes.

Michael Wroblewski: If you do that, then you meet the satisfactory reporting criteria.

Joyce Nurenberg: OK.

Michael Wroblewski: The reason why we did not put what you know, if you are talking, your familiarity is with the three measures, right, and that's at the individual level, but there's different satisfactory reporting criteria (prodigy) for Web interface or whether you know registries, depending upon you know which one you've chosen. So as long as you fill out the thing, the 416, you'll be set.

Joyce Nurenberg: OK, so, on the second line, OK, where we'd either have to choose the interface for the registry or it looks – and so for those two I'm thinking that line two represents, we would choose web interface or registry.

Michael Wroblewski: Right.

Joyce Nurenberg: OK, then after the group reporting action.

Michael Wroblewski: So let's say you – instead of doing the 416, inadvertently you only did 200, right, so you didn't meet the satisfactory reporting criteria. What would happen in that case? Well on that case, your VM is still 0.0 and because you did not meet the group satisfactory reporting criteria, the group is not going to get a PQRS incentive, so that's why there's a 0.0 in that right-hand column.

Joyce Nurenberg: OK, OK, so we get no incentive, but we get no penalty if we don't need – OK.

Michael Wroblewski: Right, we didn't want to harm people who inadvertently made a mistake.

Joyce Nurenberg: OK.

Michael Wroblewski: But we can't really give an incentive either right?

Joyce Nurenberg: Sure, OK, I understand that. So that "submit at least one PQRS" measure is a little deceiving because it's...

Michael Wroblewski: It's under what a group would do. So it's under that column, so the group reports at least one measure and then this case – my example was they reported 200 of them, OK. So the group reported one measure, it didn't meet the satisfactory reporting criteria for the GPRO web interface.

Joyce Nurenberg: OK.

Michael Wroblewski: And Medicare didn't think it was fair to harm those people by, you know, reducing their payment, so that's why the PQRS adjustment, 0.0.

Joyce Nurenberg: OK, then so the third line is what we skip on the piece or how do you define?

Michael Wroblewski: The third line is – once again, you've signed up for the GPRO Web interface or registries, but then you did absolutely nothing, you decided, "I'm not going to fill-out any of those measures for those 416 patients," OK, what happens to you then? Well, because you're going to get -1.0 for the VM and -1.5.

We hope Joyce that your group will not be in that scenario and that you'll be in the top row.

Joyce Nurenberg: OK, well that helps me. Thank you so much.

Nicole Cooney: OK thanks Joyce.

Operator: And your next question comes from the line of Paulo Andre. Paulo, your line is open.

Nicole Cooney: Paulo, did you have a question for CMS?

OK, Holley next question.

Operator: OK and that question had been withdrawn and your next question has been withdrawn and your next question comes from the line of Jessica Parks.

(Jessica Parks): Yes, hello. Can you hear us?

Nicole Cooney: Hi, yes.

(Jessica Parks): Hang on just one second, we got some questions coming and we think that we were beginning to grasp, the slides are really great of this call, so we appreciate that and we think that we're beginning to grasp for what we need to do, but we just want to do a clarification if we could just give you a scenario who we are. We are a group, emergency physicians, and we do have over 100 physicians in our group and in the past we've been doing claims base reporting successfully.

So starting in 2013, is it a correct understanding that we can continue doing the claims-based reporting and that's going to help us with the 2013 and '14 incentives, but in addition we need to self-nominate and we would choose to do the administrative claims option and we need to do that somewhere before October 13.

And that would set us up for the 2015 +.5 percent incentive, if everything was done successfully, is that accurate for our top physicians and we wouldn't elect this, the quality tiering, the process and emergency physician, we would not be candidates for that kind of review.

Michael Wroblewski: (Jessica), can you put your phone off speaker.

(Jessica Parks): Yes.

Michael Wroblewski: OK, there you go, thank you. We we're getting a lot of feedback here – you have it, I'm going to say 98 percent right.

(Jessica Parks): OK.

Michael Wroblewski: First of all thank you for participating in the PQRS individuals, you're right that the group then has to – one person of the group has to elect the – on behalf of the group has to elect the administrative claims option by October 15th of 2013, that election though really only counts for calendar year 2013.

So that means all those individuals who successfully report at the individual level for PQRS will get an incentive payment in 2014 and then for the value modifier in '15 they've had no payment adjustment. So but you'll have to redo it again in '14 – does that make sense, the election period

that's during '13 really only counts for the peak of one year so to speak. We kind of got to re-up it each year.

(Jessica Parks): OK, so just to make sure that I understand and I think I do, for the 2013 PQRS time period, we actually have to elect the administrative claims option of our group since we're greater than a hundred and that is where we'll get the +.5 percent increase for the 2013 results.

Michael Wroblewski: No, because when you elect say for 2013, calendar year 2013 during '13, your group elects administrative claims. If the group elects administrative claims, the group – make sure I'm kind of stressing the word group for a reason, it's non-eligible for the PQRS incentive. The individuals, in that group are eligible for the PQRS incentive if they reported on the three measures or met the criteria using the reporting mechanism that they're using. Say you're using the CBT two codes or in the EHR or something like that.

(Jessica Parks): Right.

Michael Wroblewski: So the PQRS incentive that would be paid – would be paid as a lump sum in the summer of '14 based on '13, kind of the way we just paid the 2011 PQRS incentives, we paid them during the fall – I'm going to say August, September-ish of 2012 based on 2011.

(Jessica Parks): OK.

Michael Wroblewski: So I think you're all set, you've got the main point, which is keep reporting individually but one member of your group has to sign up for the administrative claims during – by October 15.

(Jessica Parks): OK, very good. Thank you.

Nicole Cooney: Thank you, Jessica. Next question please.

Operator: Your next question comes from the line of Paulo Andre.

Paulo Andre: Can you hear me?

Nicole Cooney: Yes.

Paulo Andre: OK, on slide 17, you mentioned that the group is selecting the registry to do three measures like that three diabetes measures. When you calculate the composite score for quality,

how we're going to this with three diabetes measures, like because we have clinical care, patient experience population?

Michael Wroblewski: Each of the measures in the PQRS, are eligible for reporting are associated with one of those domains, I'm guessing and I'll ask Dr. Roman to jump in and correct me if I'm wrong, that some of the diabetes measures would probably be in the clinical care domain, so those would be weighted equally in the clinical care domain.

Your group also then because every group is going to have those three outcome measures, those three, which is the hospital readmission measure and the two composite measures, they're in the care coordination domain so that your quality score will be based on two domains and the measures in each of those domains would be weighed equally.

Paulo Andre: And so the population patient safety will not be counting because we did not chose that one.

Michael Wroblewski: And that's exactly right, that's exactly right. So you know if you were to report measures that were in all five domains then you know each domain would be made weighted equally, if you report measures only in one domain then you know each domain is weighed 50 percent.

Paulo Andre: And how do you calculate the national standards, like you have a [inaudible] a diabetes measure, you're comparing like with HEDIS criteria, what is – how do you know, are you comparing with the past PQRS performance for nationally the average, how do you?

Michael Wroblewski: That's a great question. The benchmark will be the national average for PQRS reporters from the previous year.

Paulo Andre: OK, thank you very much.

Michael Wroblewski: You're welcome, thank you for the question.

Operator: Your next question comes from the line of Sheila Danielson.

Sheila Danielson: Hi, this is Sheila Danielson from Wenatchee Valley Medical Center. I have a question on slide 20, hoping you can maybe clarify on that point to that note at the bottom of

those groups of physicians participate as individual in PQRS must self-nominate as a group and elect administrator claim.

Can you clarify that a little bit further?

Michael Wroblewski: Sure and this is really the question that we were going over with Joyce and with Jessica, which is if you're a group of a hundred or more, OK and you have been for the past couple of years, all those members had been reporting individually, you know they have picked the various measures and report it. They can keep – continue to do that and they can continue to earn their PQRS incentive at the individual level.

But in order to get out of the value modifier downward adjustment, one member of that group has to elect the administrative claims option during the GPRO self-nomination period, which one opens up this Saturday go through January 31 for the second period that starts in July and end on October 15.

Sheila Danielson: But we actually do it as a group currently as oppose to individual, so we could pick any of those three methods.

Michael Wroblewski: I'm sorry, if you want to report it the group level, rather than at the individual level, then you can pick one or the other two measures – or two methods which is the Web interface which has 22 measures or you can submit measures at the group level using a CMS-qualified registry.

Sheila Danielson: OK, great. Thank you.

Michael Wroblewski: You're welcome, thank you for the question.

Operator: Your next question comes from the line of Dr. Bruce Auerbach.

Bruce Auerbach: Hello – hello, can you hear me?

Michael Wroblewski: Yes.

Nicole Cooney: Yes.

Bruce Auerbach: So I just want to be absolutely clear, so individual physicians or physicians that are part of group of less than 100 basically have no ability to participate in this program and will neither be incented or penalized, for with their payments from their payments?

Michael Wroblewski: If you're a group of 99 or fewer eligible professionals, then the value modifier will not apply based on performance in 2013. You know where this is the first year the phase in, Medicare decided to start with the larger groups, but it's likely that as we move by 2017 we're going to have to cover all group and all physicians.

Bruce Auerbach: OK, so there will be no reduction or incentive payment for those individuals, is that correct?

Michael Wroblewski: Not under the value modifier, there is still though is a PQRS adjustment or if you look at slide – go to slide 13 and pretend that this is a group of 90 or say group of 75 OK.

Bruce Auerbach: OK.

Michael Wroblewski: The value modifier does not apply so strike out – just draw line down that column.

Bruce Auerbach: OK, so if we're doing and we've been doing PQRS and we have the opportunity to get up to +.5 percent if we continue to do that.

Michael Wroblewski: That's right, that's right. And I'm going to add – Dr. Roman I think wants to add one point to as well.

Sheila Roman: I think the point here is that you are – the VM's does not apply if your group is less than a hundred but all the PQRS rules were incentive and for the payment reduction in 2015, for PQRS does apply to you and their performance here for 2015 is also 2013.

Bruce Auerbach: Right, OK. OK, thank you very.

Michael Wroblewski: [You're] welcome, thank you.

Operator: And your next question comes from the line of Charity Singleton.

Charity Singleton: Hi, thank you for taking my call. I feel like I'm beating a dead horse but I just want to clarify one more thing about the group of individuals of over a hundred.

Michael Wroblewski: OK.

Charity Singleton: On slide 12, the bottom row was just a bit confusing to me. If a group self-nominated for administrative claims, the group does nothing.

Michael Wroblewski: Right.

Charity Singleton: The individuals do nothing.

Michael Wroblewski: Right.

Charity Singleton: Why is there no penalty under the value modifier for that?

Michael Wroblewski: Because are using the measures that would be if you decide to elect the quality tiering we would use your performance of those 17 measures in the administrative claims option. To value your – to you know put into the quality tiering you know methodology, you know that's in the slides. So we would actually use the group's performance on those measures to calculate the value modifier.

Charity Singleton: OK, so assuming if they didn't participate then that would end up being negative.

Michael Wroblewski: That's right, if they didn't self-nominate and choose administrative claims, then there's the -1.0 for the value modifier and assuming none of the individuals in that group did anything under PQRS, it [would] be -1.5 as well to all those individuals.

Charity Singleton: But assuming they did self-nominate as administrative claims.

Michael Wroblewski: Yes.

Charity Singleton: But they did nothing.

Michael Wroblewski: Then that's not –

Charity Singleton: I'm wondering why they don't get the -1.0 value modifier.

Michael Wroblewski: That's because we're going to use your – this for the first – for one year we're going to allow you to use performance on administrative claims.

Charity Singleton: OK, OK. Thank you very much.

Michael Wroblewski: Thank you.

Operator: And your next question comes from the line of Sharon Merrick.

Sharon Merrick: Hi, Sharon Merrick with ASA and I'm joining with the crowd that's beating the dead horse. I just wanted to get clarification.

So if you have a group of a hundred or more, who are single specialty that do not provide primary care services so there's no patient attribution, so the cost scores can't be calculated – this group should still self-nominate under administrative claims?

Michael Wroblewski: Yes – you got it.

Sharon Merrick: Oh, OK. Thank you.

Michael Wroblewski: And so Sharon if you look at slide five that really the part that we're trying to get out is to engage with all of these groups regarding quality improvement. And so quality really that's the first step and we realized that the administrative claims may not work for anesthesiologist, we get that but we want to engage with you and so yes, even if the same –

Sharon Merrick: So our members in those large groups before October, the October date of next year, do we need to make sure that they register as a group, elect administrative claims even though it's not applicable so that they are –

Michael Wroblewski: That's right.

Sharon Merrick: Not subject to a downward VBM adjustment.

Michael Wroblewski: And just to make sure only one person and who has authority on behalf of that TIN needs to do it.

Sharon Merrick: Right. Not every practitioner within the [inaudible], they can continue –

Michael Wroblewski: No-no-no, no-no-no.

Sharon Merrick: To report individually under PQRS and continue has they have been for now.

Michael Wroblewski: That's exactly right, so you only need one member to do that self-nomination or the GPRO and the two set administrative claims, it has to be done by October 15.

Sharon Merrick: Great, all right, thanks a lot Mike.

Michael Wroblewski: You're welcome, thank you.

Operator: And your next question comes from the line of Jennifer Martin.

Jennifer Martin: Hi, sorry I'm just going to ask you in a different way. But if you do the administrative claims option to avoid the penalty in PQRS in the value modifier, do you have to meet the criteria for at least one of those administrative claim measures to avoid those penalties, or do simply have to elect the option?

Michael Wroblewski: You just have to elect the options, because what that means is we're using your Medicare claims billing data and we're going to look at using that data whether certain indicators have been met. And we'll be using the quality research reports that we give out next September to all groups of 25 or more, to preview what your group's performance on those measures would be.

Jennifer Martin: OK and you could avoid the PQRS penalty in that manner as well?

Michael Wroblewski: That's – you got it.

Jennifer Martin: OK, thank you.

Michael Wroblewski: I just want to – I also want to make sure, Jennifer this is and only an option for 2013.

Jennifer Martin: To avoid the 2015 penalty.

Michael Wroblewski: That's exactly right.

Jennifer Martin: OK, thank you.

Michael Wroblewski: You're welcome.

Operator: OK and your next question, comes from the line of (Rick Nuel).

(Rick Nuel): My question was just answered. I was asking is the administrative claims option going to be available for 2014 also.

Michael Wroblewski: We could not finalize that for 2014.

Operator: OK and your next question, comes from the line of (Faye Shemanski).

(Faye Shemanski): Hi. Can you hear me?

Nicole Cooney: Yes.

Michael Wroblewski: Yes, Faye.

(Faye Shemanski): Hi. My question has to do with slide number eight, on who the value modifier will apply to? So certain number of pathologist, work, in independent laboratories and they bill under places service 81 and as such they cannot participate in the PQRS they're not eligible to receive the bonus or the penalty.

Will the value-based modifier apply to them and also or not, since you're harmonizing with PQRS, I did it know the fact that they can't report PQRS measures, if that affects whether the valued-based modifier will also apply or not apply to them?

Michael Wroblewski: That's a great question (Faye). Can you hold on for one quick second?

(Faye Shemanski): Sure.

Michael Wroblewski: (Faye) thanks for holding on. Is 81 paid under the physician fee schedule?

(Faye Shemanski): I think so, but they – for some reason they cannot attribute individual services to individual physicians, when the service they don't want is used.

Michael Wroblewski: Let me do this, let me see if we can find an answer, if you'll hold on the line, we see if we can find the answer, I don't want to give you the wrong information right now.

(Faye Shemanski): OK.

Michael Wroblewski: And then – and then we’ll come back and that also reminds me so thanks for that question. And if the first questioner, Nina, was still on the line, I did get an answer, there’ll be a link on the PQRS communications support page starting this Saturday on how to actually get the login information et cetera to get the self-nomination and we go to the next caller.

Operator: And your next question comes from the line of Margo Kolodkin.

Margo Kolodkin: Hello. Can you hear me?

Nicole Cooney: Yes we can.

Margo Kolodkin: OK great. I have a question, if a practice to report via registry, do they just select individual measures or is it measure groups – can you clarify that?

Dan Green: Oh hi, this is Dan Green. So yes if a practice decides that they want to report via registry or an individual professional, they can choose to report three measures, any of the PQRS measures, as long as they report three of them better reportable of course by registry or they can opt to report a measures group.

Which in 2013 will only require that they report of 20 patients and not all those patients, I’ll be at the majority, but not all of them have to be Medicare patients, so in other words 11 of the 20 would have to be Medicare, if all 20 are Medicare that’s fine too but we will accept none Medicare patients that fall on the denominator as well of the measures group.

Margo Kolodkin: So, Dr. Green I know, I bug you all the time. Just a follow question to that, what’s the difference then between individual EP reporting in that case and group PQRS reporting, is it just self-nominating and group PQRS reporting – is it just they self-nominated as a group and you guys are going to look at that TIN on the backend?

Dan Green: Yes, so if a group wants to report via registry, they would be – actually but I probably need to double check because I don’t want to speak – Michael do you know the answer?

Michael Wroblewski: Oh no, I don’t.

Dan Green: I think that it's –

Michael Wroblewski: Christine's on the line too.

Dan Green: Is she – Christine, are you there?

Christine Estella: Yes, I'm here.

Dan Green: Can you answer that question?

Christine Estella: Could you repeat the question actually, – sorry about that.

Margo Kolodkin: Oh no, that's not a problem. So if – I'm trying to understand the difference between individual registry reporting and GPRO registry reporting, if a practice can still just pick any individual measure or measure group – how does CMS know to you know calculate them as group, is it all going to be different, is it gone on the backend?

Christine Estella: I believe the reporting will be the same and it'll just be that you're doing it as a group as a GPRO, so you'll either succeed or fail together.

The registry option for the GPRO is really meant for – we understand that there's, certain practices that kind of the one person doing the reporting or you know one group doing the reporting for a group of individuals. So it's really meant to help those group practices where they're reporting practices are kind of centralized.

Does that answer your question? The specs and everything will still be the same.

Dan Green: Right and just to elaborate, just to touch more, I believe and we'll find out for you to be sure, but I believe that the way the registry would work is if you're group is reporting let's say on three or four measures, let's say not a measures group, we would look to see that at least 80 percent of the patients that fall under the denominator of those three measures were reported by your group.

So it doesn't necessarily mean that you know if 2 of your 10 doctors report and they are only reporting on 80 percent of their patients but the rest of the groups patients are not contained in their registry information, you would not be successful. We would expect again, even if it is only

two of your folks reporting, we would expect that they would have reported data on 80 percent of the groups patients that fall on the denominator of measures.

Margo Kolodkin: OK. And you guys are going to use the TIN to do that calculation, we wouldn't have to change anything, the groups just have – every provider has to pick the same three measures then?

Dan Green: Well if you're reporting for three measures again as a group so yes, everybody would be reporting otherwise you could report individually.

Margo Kolodkin: OK.

Dan Green: You know and that – as Michael said, you know elect administrative, you can still participate in PQRS as an individual, you know those in the group that want to and then the group however would register and sign-up if you will for administrative claims to avoid any problems for the value modifier assuming you're over a hundred NPI's under your TIN.

Have we thoroughly confused you now?

Margo Kolodkin: Just partially. I'll ask on the registry call and I don't think I can be the only one with this question, so I'm sure it will come out next you know next call. Thank you.

Nicole Cooney: Thank you.

Operator: Your next question comes from the line of Karen Miller.

Karen Miller: Hi, my name is Karen Miller I'm from BayCare Clinic in Green Bay. We are a group of little over 100 surgeons of varying specialties and my question is on slide 14, I understand in terms of attribution that we won't be subject to the cost measures but will we be subject to those three outcome measures, because you know if we – you know if we see a patient of removal of gall bladder, are we then caught in this care related to bacteria and pneumonia from an admission two months later?

Michael Wroblewski: If the physician in your group does not provide the primary care service (ENM).

Karen Miller: Yes.

Michael Wroblewski: Then there is no way that that beneficiary could be attributed to that particular position.

Karen Miller: OK, so even for outcome measures?

Michael Wroblewski: That's correct.

Karen Miller: OK, that's my question. Thank you.

Dan Green: Before we move on to the next question, I'm sorry I just want to clarify the last question because I have the answer here.

So again for groups that are reporting for two or more eligible professionals again as a group and want to use a registry, they would report at least three measures and they have to report again as we said 80 percent of the group practices, Medicare Part D, physician fee schedule, patients for the three measures that they are reporting.

So if the group itself has a hundred diabetic patients and they're reporting the diabetes measures, 80 of those patients would need to be reported to that a minimum, to the registry, which in turn would calculate the results and report it to us. The measure groups are not reportable if you will for groups via registry, so I just want to clarify that and sorry it us an extra minute.

Nicole Cooney: Thank you. Holley we're ready for the next question.

Operator: OK your next question comes from the line of Paige Nelson.

Paige Nelson: Hi. Can you hear me?

Michael Wroblewski: Yes.

Paige Nelson: Great, this is Paige Nelson, I'm at the Everett Clinic, we do have a group that is greater than a hundred and we intend to self-nominate and to meet the criteria for PQRS. However, we didn't do this particular program with CMS last year and I'm wondering two things – one, will we get the quality reports, feedback reports based on claims data in 2012 and moving forward and then when will the PQRS incentive be applied to us, is that 2014?

Michael Wroblewski: So the report, if you're in Everett Clinic, so you've done a – so for 2013, you're going to sign-up for one of the self-nominate for one of the two, either the web interface or report measures through a registry right?

Paige Nelson: Correct.

Michael Wroblewski: OK, so the report that you get in September of '13, next September, where we base on how you participated in the PQRS in 2012. So if you didn't participate in the PQRS –

Paige Nelson: So my point was, we do not participate in 2012, we participated in another Medicare program and so would we not get a report from you based on our claims data?

Michael Wroblewski: You would get a report based on the claims data, so you would see how the Everett Clinic faired using the administrative claims measures.

Paige Nelson: OK.

Michael Wroblewski: And the reporting comes in September of '13, we also show how you would fare on the cost measures, obviously using the 2012 data as well.

Paige Nelson: Excellent and then the answer to the question on when would the PQRS incentive apply?

Michael Wroblewski: The PQRS incentives are paid as a lump sum following the close of the year. So since you'll be participating in the PQRS for the first time in 2013, that PQRS you'lone check with the TIN and it will be paid probably I think this past due was in August?

Dan Green: Well, we'll be mailing those checks actually sometime between August and October, give or take a month it could be September through November.

Michael Wroblewski: Yes.

Dan Green: But it will be some time toward the end of 2014.

Paige Nelson: Right, great, that's what I thought. OK, thank you very much.

Michael Wroblewski: You're welcome, thank you.

Operator: And your next question comes from the line of Melody Flores.

Melody Flores: Hi, yes, thank you for taking my call. I just wanted to clarify something, I think I heard you say earlier or earlier on in the presentation which was when we self-nominate for the upcoming year that we should self-nominate for two reporting options – did I hear that correctly?

Michael Wroblewski: No, you just self-nominate for one of the three PQRS Web interface, PQRS registries for the administrative claims options just pick one of the three.

Melody Flores: OK. So if we self-nominate for example for the Web interface as a GPRO and we're unsuccessful in submitting at least one PQRS measure, the process does not automatically default to the administrative claims or it simply just not be successful and well except for the payment adjustment.

Michael Wroblewski: Well actually – actually no, if you look at – if you have the slides by any chance.

Melody Flores: Yes.

Michael Wroblewski: Slide 12.

Melody Flores: I'm looking at it, thank you.

Michael Wroblewski: Row two. You self-nominated for the PQRS GPRO using the Web interface, you – the Web interface has 22 measures and we give you that pre-loaded tool or – actually you'll access it using a Web interface and you submit only say a hundred rather than the 416 even though you could have done the 416 patients right.

None of your individuals do anything, then your value modifier would be 0.0 and your PQRS would be 0.0 as well.

Melody Flores: OK, appreciate that. And just to clarify, the administrative claims option, it's not available or ACO's.

Michael Wroblewski: No if the value – correct, the ACO's and all the TIN's in an ACO are using the basically the web interface for measuring quality for the ACO, so they don't – no

members of an ACO need to self-nominate or to self-nominate I'll just leave it that way, leave it there.

Melody Flores: OK, thank you.

Michael Wroblewski: You're welcome.

Operator: And your next question comes from the line of Heidi Harting.

Heidi Harting: Yes, I have a quick question I think. I had noticed on page eight it says anybody participating in the CPI or CPCI sorry does not get the value modifier, applied to them.

Michael Wroblewski: Correct.

Heidi Harting: Positive or negative I'm assuming?

Michael Wroblewski: Correct.

Heidi Harting: OK. We're multi-specialty organization and it might be just might I need to do more research on my side but multi-specialty location here, one physical – we have several but one our main campus, we have primary care doctors there as well as all the other specialties.

Will that value modifier not applied to any of them?

Michael Wroblewski: We look at it, if we define a group as a single taxpayer identification number, so you'd have to look to see how they bill Medicare, do they all bill under the same taxpayer identification number or TIN?

Heidi Harting: Yes.

Michael Wroblewski: Or do they bill under a separate ones?

Heidi Harting: They bill under the same, so if the bill under the same and if we have any group because right now we have four already, but there are other physical locations in our main campus, so even if they are doing the CPCI, then none of our doctors will be eligible for the value modifier.

Michael Wroblewski: If that TIN is participating in the CPCI in 2013, the day that you don't have to self-nominate and the value modifier will not apply.

Heidi Harting: OK.

Nicole Cooney: Thank you very much. Next question please Holley.

Operator: Your next question comes from the line of (Kim Robertson).

Nicole Cooney: (Kim), what's your question for CMS today?

Ann Heilig: This is actually Ann Heilig at Wake Forest Baptist Medical Center. Could you hear me?

Nicole Cooney: Yes, we can hear you.

Ann Heilig: OK, my question is the final rule and this presentation as they go into great detail about GPRO reporting for groups greater than a hundred, however there is not very clear to me, definition of what the value-based modifier or the downward has just meant, how those apply to individual who were filing claims based measures or reporting claims based measures individually under individual NPI or (TIN)?

Michael Wroblewski: OK, so we defined a group as a single TIN that a group in the broader sense is two or more NPIs under a single TIN.

We will only apply the value modifier to groups of – to a single TIN that has at least 100 eligible professionals who bill under that TIN, so we will not apply the value modifier to a TIN that has only one EP, the bills under it or a TIN that has 99 EPs that bill hundred but that's for the value modifier, all of the regular PQRS rules apply to all of them.

Dan Green: So you know for the example that you gave with one NPI billing under a single TIN, those folks could report the multiple methods under PQRS, they can report via claims as you mention, they can report through a registry– a qualified registry through an EHR if they have a qualified EHR, one that's test the PQRS, so there are several ways that they can get information into CMS.

If they do not report PQRS data in 2013 and they don't elect for administrative claims, they would be subject to a -1.5 percent downward payment adjustment, which would be prospective starting January 1, 2015.

So we would encourage the solo folks while – who are not subject to the value modifier as Michael just mentioned, we would ask that those folks participate in some fashion in 2013 to avoid the payment adjustment in 1015.

Ann Heilig: Right and all of our providers are participating but let me make sure that I understand that if they successfully report in 2013, to receive the incentive then they also qualify or don't get the -1.5 percent penalty. Is that correct for the fiscal year 2015?

Dan Green: That's right, so if they're earning incentive for 2013 reporting, they would also be precluded from the 2015 downward adjustment so it's a "two for"..

Ann Heilig: Thank you very much.

Dan Green: Thank you.

Operator: And your next question comes from the line of Erica Cousins.

Erica Cousins: My question has been answered, thank you.

Nicole Cooney: Thank you. Next question Holley.

Operator: Your next question comes from the line of Susan Dreisel.

Susan Dreisel: We're referring to slide eight about participation in the comprehensive primary care initiative and not having the value based payment modifier apply. Can you speak to the fact that that would be for all the eligible professionals under that TIN?

Michael Wroblewski: That's correct. It would be for – if the TIN, if eligible professionals under that TIN are participating in the CPCI, they will not – that TIN, the value modifier will not apply to that TIN assuming that that TIN as a hundred or more EPs.

Susan Dreisel: But they could still earn incentive under the PQRS program?Michael

Wroblewski: The question – I'm going to direct the question to Dr. Green. The question was,

could they still earn an incentive if this is a TIN that has a hundred or more, we're not applying and they're participating in the comprehensive primary care initiative because that TIN us exempt we're not applying the value modifier to that TIN, but can does members still earn a PQRS incentive?

Dan Green: Christine are you still on the line?

Christine Estella: Yes this is Christine. Hi. For the CPCI, we actually do not have any record with respect to the ACO, for example for 2013 we do not have any way where a group that's participating in CPCI could be – we kind of deem them as group reporting and then we would provide them with the incentives.

The groups participating under the CPCI for 2013 at least they would have to self-nominate under GPRO or they could participate individually but they would have to report PQRS regularly as everybody else does. We'll try to work on that in future years but for 2013 we'll have to report like other professionals, under PQRS.

Susan Dreisel: We have been a GPRO for the last two years and so –

Christine Estella: OK, and then you should to do it of you participate as a GPRO, the way you've been doing it for the past two years then you'd be able to earn an incentive provided that you meet the criteria which is the same criteria from last year.

Susan Dreisel: Great, thank you.

Christine Estella: No problem.

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

Stacie Jones: Yes hi, I just wanted to thank you Mr. Wroblewski for your patience and explaining some of these answers again and again for different scenarios. I just wanted to clarify one point on slide 20.

Michael Wroblewski: OK, go ahead Stacie.

Stacie Jones: OK so for groups of a hundred or more, do you choose either the GPRO Web interface or the GPRO registry, if they did that would that preclude the individuals from receiving the incentive?

Michael Wroblewski: Yes, because you're saying I'm going to act as group and so I'm either doing the Web interface or am doing a CMS-qualified registry and so we're saying OK, you're a group, your TIN is a group so we're going to look at you as a group.

Dan Green: So the whole group if they're successful would receive an incentive of course.

Michael Wroblewski: Yes, exactly.

Dan Green: Which of course would contain the individuals or bigger price of the individuals?

Michael Wroblewski: Of course.

Dan Green: Right, but and boy you should see Mr. Wroblewski's patience has just hit a wild kitty, he's an incredibly patient man, he works with me so the – but the individuals of course would be incentivized in that situation. They can however report that as individuals if the group elects to report as a group.

Michael Wroblewski: Right, using the web interface or registry. The one exception that Stacie and I know you know this because we've answered this many times is that if the group elects the administrative claims, the individuals can still participate in the PQRS individually but if they elect to report quality measures at the group level through the Web interface or through a CMS-qualified registry, then they cannot.

Stacie Jones: OK, if a group's less than a hundred, the same thing applies.

Michael Wroblewski: That's correct, that's correct.

Stacie Jones: That they can still get the +.5 percent incentive in 2014 based on their 2013 claims as a group instead of as individuals?

Michael Wroblewski: That's correct. So if your group, if your group say 75, emergency medicine physicians and you participate – you decide to sign-up or self-nominate during the self-nomination periods for the GPRO and a qualified registry and you indicate what registry you're

going to report measures through that registry at the group level then as long as meet that criteria for those measures then use 80 percent that Dan was talking about, I don't want to get into those exact criteria right now.

Then that whole group would get that half of percent off for incentive as a single check that came in September-ish, November '14 and then would avoid the downward adjustment based on '13 performance in '15.

Stacie Jones: But then what if one rouge person from their group submitted quality data codes for some reason on their individual claims?

Michael Wroblewski: The way we actually do the processing here is because we know who the TIN is, we then when we start looking at – when we start assessing at the individual level, we've taken out, we have eliminated everyone, every TIN who's self-nominated for GPRO web interface or GPRO registries, so we would even look at that, so I mean they could do it I suppose but there would be no effect, if that makes sense.

Dan Green: It wouldn't account for or against them.

Michael Wroblewski: It wouldn't account for or against said as Dan said, right.

Stacie Jones: OK.

Nicole Cooney: OK, thank you so much for your questions.

Operator: Your next question comes from the line of Lonnie Johnson.

Lonnie Johnson: Hi. Yes this is a question, relevant to groups of more than a hundred doctors – hundred or more that do not provide primary care services, since of that a radiology group and then looking at slide nine, these groups or the PQRS reporter looks like should choose no election instead of electing quality tiering calculation.

I wanted to make sure that was correct and then if so how does the group make sure that they are – be choosing no election?

Michael Wroblewski: When you self-nom for that group of, say, I think you said radiologist for that group, would have to self-nominate, choose the administrative claims option or whichever

option and then on that same page if you enter into – if you go during the second registration period, that starts in July, in October, on that same screen where you kind of click the button that says, “Yes, I want Web interface or administrative claims,” just a little bit below that will be quality tiering, if you saying you have to click it, yes, if you don’t click it or you know fill it in so to speak, it automatically is no, meaning no election.

Lonnie Johnson: OK and the link to this portal, is on the presentation?

Michael Wroblewski: It would be on – sure it will be, the link to the portal will be on the PQRS web site and there’ll be a link to the PQRS communications support page which – and that will be up starting on Saturday, December 1.

Lonnie Johnson: That’s great, thanks.

Michael Wroblewski: You’re welcome.

Operator: And your next question comes from the line of Rachel Groman.

Rachel Groman: Hi, I’m calling from Hart Health Strategies and my question is in regards to the clarification you provided earlier about group practices that elect to report via the registry base option.

It was – you had said earlier that every individual within the group would have to report on the measures and from what I read in the rule, I read that not every individual has to necessarily report the measures, so long as 80 percent of the group practices, patients are reported on – is that correct?

Dan Green: Yes that’s – I think there was some confusion perhaps on our part but you know if a group is reporting using a registry then you could have two (docs) out of let’s say a hundred, staff to see all the patients in the practice, they could do all the reporting for the practice.

Again it’s using the example, the diabetes I think we talked about earlier, if there are hundred diabetic patients that are seeing by a group practice in its entirety, as long as 80 of those patients are reported on, it doesn’t matter whether it’s by 1 EP, Eligible Professional, 2, 10 or you know every provider in the group, it doesn’t matter, as long as the 80 patients are reported on.

Rachel Groman: From that right, OK great. And then one other quick clarification regarding the plurality of primary care attribution method, I just wanted to verify, I believe this is true, but that methodology does account for instances where a specialist would provide the plurality of the primary care specialist within the group. Is that correct?

Michael Wroblewski: Yes.

Rachel Groman: It doesn't necessarily only have to be a primary care physician.

Michael Wroblewski: That's correct, it's step two of the process.

Rachel Groman: OK, great. Thank you.

Michael Wroblewski: You're welcome.

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

Judy Burleson: Hi, this is Judy Burleson of The American College of Radiology. Michael, I didn't want you to feel that we weren't participating in this call, it's our hospital-based colleagues are, but....

Michael Wroblewski: Oh I know you were there Judy.

Judy Burleson: Just to ask Rachel's question in a different way and this would be for you Dr. Green for GPRO reporting, three – my registry, three measures on 80 percent of patients. If those measures don't apply, can the group select measures that do not apply to everyone in your group, so they report on 80 percent of the patients that are applicable to three measures but those measures don't apply to everyone in the group.

Dan Green: Excuse me, the answer to that would be yes.

Judy Burleson: OK and then if I could clarify one statement that was – yes.

Dan Green: Can I just make one little qualifying remark about that?

Judy Burleson: Oh sure.

Dan Green: We would not want – we not want you to report on any of those three measures that, has your percent performance rates.

Judy Burleson: Correct.

Dan Green: Now in other words, I think you mentioned – I know you're radiology from anesthesia right?

Judy Burleson: Radiology.

Michael Wroblewski: Radiology, radiology.

Dan Green: Sorry, so we wouldn't want you guys for example to report on – to report that you didn't do a diabetic retinopathy exam, you know if you're providers happen to see a diabetic patient, I mean obviously that's not a service that they would normally provide, so it would be performance failure on every single measure, we wouldn't want you to report a measure like that. The measure would have to be something where you have at least one patient that you need the performance on.

Judy Burleson: Right, the point is this, sub-specialization in the group precludes a number of radiologist from reporting certain measures so having –

Dan Green: Right, right?

Judy Burleson: OK and so if I may ask or get one point of clarification on the value modifier score for groups of a hundred that would not have plurality of primary care services, there's no attribution there, so it's radiologist. So Michael you said that the value modifiers score is 0.0?

Michael Wroblewski: That's correct, meaning no payment adjustment but you've got to make sure Judy that that group of a hundred or more radiologist has selected one of the three methods though.

Judy Burleson: So will you say in the value modifiers, the score is 0.0– is the adjustment is 0.0, so they would still have a quality score?

Michael Wroblewski: That's correct. The adjustment is 0.0, that's correct.

Judy Burleson: OK.

Michael Wroblewski: Yes, you would have a quality score and we'd give you a report that showed you what that quality score was.

Judy Burleson: OK, thanks.

Michael Wroblewski: Sure.

Nicole Cooney: Unfortunately, that's about all the time that we have for today. If we did not get to your question, you can e-mail it to qrur@cms.hss.gov –and again that e-mail address is also on slide 24 of your presentation.

And please note that, while we were not be able to address all questions, received in that mailbox, we will review them all to help developed frequently asked questions, educational product and future messaging on this program.

Additional Information

On slide 26 of today's presentation, you'll find information and a URL to evaluate your experience with today's call. Evaluations are anonymous and strictly confidential, all registrants for today's call will also receive a reminder e-mail from the CMS national provider calls resource box regarding to opportunity to evaluate today's call. You may disregard this e-mail if you've already completed the evaluation, we appreciate your feedback.

We'd like to thank everyone for participating today. An audio recording and written transcript of the call will be posted on the Web in approximately two weeks, at the URL that was included in the presentation e-mail that went out earlier today.

And again my name is Nicole Cooney and it's been a pleasure serving as your moderator today, I'd like to thank Michael Wroblewski, Dr. Sheila Roman, Dr. Dan Green and Christine Estella for their participation. Have a great day everyone.

Operator: Thank you. This does conclude today's conference call. You may now disconnect.

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