



# MLN Connects<sup>TM</sup>

National Provider Call - Transcript

**Centers for Medicare & Medicaid Services**  
**PQRS: Reporting Across Medicare Quality Reporting Programs in 2014**  
**MLN Connects National Provider Call**  
**Moderator: Aryeh Langer**  
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## Contents

Announcements and Introduction .....	2
Presentation: 2014 Medical Quality Reporting Programs .....	3
Eligible Professionals.....	3
Group Practices .....	5
Medicare Shared Savings Program ACOs .....	7
Pioneer ACOs .....	7
Resources .....	8
Keypad Polling.....	9
Question-and-Answer Session .....	9
Additional Information .....	30

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**Operator:** At this time, I'd like to welcome everyone to today's MLN Connects National 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 Aryeh Langer. Thank you. You may begin.

## Announcements and Introduction

Aryeh Langer: Thank you. This is Aryeh Langer 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 on PQRS: Reporting Across Medicare Quality Reporting Programs in 2014. MLN Connects Calls are part of the Medicare Learning Network.

During this call, CMS subject-matter experts will give an overview of how to report across various 2014 Medicare Quality Reporting Programs, including the Physician Quality Reporting System (PQRS), Electronic Health Record (EHR) Incentive Program, Value-Based Modifier (VBM), and Accountable Care Organizations (ACOs).

CMS subject-matter experts will guide individual eligible professionals, group practices, Medicare Shared Saving Program ACOs, and Pioneer ACOs wishing to report quality measures one time during the 2014 program year to maximize the participation in the various Medicare reporting programs.

A question and answer session will follow the presentation today.

Before we get started, there are a few items I'd like to quickly cover. You should have received the link to the slide presentation for today's call in an email this afternoon. If you have not seen the email, you can find today's presentation on the Call Details webpage on the CMS website, which can be found by visiting [www.cms.gov/npc](http://www.cms.gov/npc). Again, that URL is [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 26 of the presentation, or visit the Call Details webpage for more information on how to obtain credit for your participation in today's call.

I'll also note that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the Call Details webpage when it becomes 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 the time to do so. While we may not be able to address all of them today, they will be used for future presentations or to develop Frequently Asked Questions and other education materials.

At this time, I would like to turn the call over to Molly MacHarris from the Division of Electronic and Clinician Quality. Molly?

## **Presentation: 2014 Medical Quality Reporting Programs**

Molly MacHarris: Thank you. And thank you, everyone, for joining us today. We're excited to be able to go over the Reporting Once opportunities for eligible professionals. One of the things we've tried to do within CMS for our 2014 year is to align the quality programs wherever possible.

So I'm going to go ahead and jump in to slide 4, and as Aryeh mentioned earlier, we're going to cover four main quality reporting programs. They include the Physician Quality Reporting System, or PQRS; the Medicare Electronic Health Record Incentive Program; the Value-Based Payment Modifier; and then reporting via Accountable Care Organizations, which will cover both Pioneer ACOs and Medicare Shared Savings Program ACOs. And we have this broken out by the different methods, including reporting as an individual EP, as a group practice, or as one of the two types of ACOs.

So moving on to slide 5, we're going to – the presentation today is structured where it's broken out by each type of reporting option, whether it's individuals, group practices, or different ACOs. So starting with how to report once as an individual EP: slide 6.

## **Eligible Professionals**

So again, we are covering how individual EPs who want to report once on their quality measures during the 2014 program year. And those EPs who would like to do that can become incentive-eligible for the 2014 PQRS program, which is also the last year that an incentive payment is associated for PQRS; it's a half-a-percent incentive payment. So we do strongly encourage all folks to try to earn that incentive for the last year.

EPs who participate will also be able to avoid the 2016 PQRS payment adjustment. 2014 is the reporting period for the 2016 PQRS payment adjustment. And those EPs who do not meet satisfactory reporting criteria would have a 2-percent reduction off of their Physician Fee Schedule-allowed charges during calendar year 2016. We do really want all EPs to satisfactorily report to both earn the incentive for PQRS and to also avoid the 2016 PQRS payment adjustment.

EPs can also report once and satisfy the clinical quality measure, or CQM, component of the Medicare EHR Incentive Program. They would still have to attest to the rest of the functional objectives under the Meaningful Use Program. But by reporting once, they can satisfy the clinical quality measure component. And then lastly, individual EPs can satisfy the requirements for the 2014 Value-Based Payment Modifier, which would impact 2016 payments.

So moving on to slide 7. So just to briefly go through this graph at a high level. This is the scenario where the provider is an individual eligible professional. We do strongly encourage everyone to review the list of eligible professionals on the How to Get Started page of the CMS PQRS website.

One thing to note is that the definition of an eligible professional is different amongst the PQRS program and the EHR Incentive Program. The PQRS program is a little bit broader; it includes both physicians and other types of therapists. And the other situation in this first bubble here is that the EP must participate in PQRS as an individual and not as a member of a group practice who has registered as part of a PQRS GPRO. And I'll talk about GPROs a little bit later in the presentation today.

So then the two options where EPs as an individual can report once is either through the EHR-based reporting options or as – or via a qualified clinical data registry. So talking first about the two EHR options: The first one is direct EHR product that is certified EHR technology (or CEHRT), or using an EHR data submission vendor that is CEHRT.

So the differences between these two: The direct EHR is where the EP or their practice manager themselves would submit the data directly to CMS. The data submission vendor method is where the EP goes into an appropriate business arrangement with a data submission vendor, and the data submission vendor would submit the data to CMS on the EP's behalf.

The qualified clinical data registry option is new for 2014. And this is an option where these entities can self-nominate to CMS, and they have the ability to report on measures that are not contained within the PQRS program.

For both of these options, however, under the Report Once option, they would need to report at least 9 of the 64 eCQMs that have been finalized in the Stage 2 final rule for a full 12-month reporting period. So again, reporting on nine measures covering at least three of the National Quality Strategy domains. And if an EP's certified EHR technology does not contain patient data for at least nine measures covering at least three domains, then the EP must report the measures for which there is Medicare patient data. The reporting period, again, is calendar year 2014.

And so then the options there are: you would either satisfactory report, either yes or no. If it's a "yes," the EP would be PQRS incentive-eligible. They would avoid the 2016 PQRS payment adjustment. They would satisfy the CQM component of the Medicare EHR Incentive Program. They would satisfy the requirements for the 2016 Value Modifier. And if 50 percent of the EPs within a given TIN, or tax identification number, satisfactorily report, that entire TIN would avoid the 2016 Value-Based Payment Modifier.

And then under the "no" arrow, if satisfactory reporting does not occur, they would not be PQRS incentive-eligible, they would be subject to the 2016 PQRS payment adjustment, and they would not satisfy the CQM component of the Medicare EHR Incentive Program.

So moving on to slide 8, just a couple other notes we wanted to call out because there is a lot of information on that slide.

For the 2014 program year, group practices of 10 or more individual EPs that do not register for PQRS GPRO will be subject to the Value-Based Payment Modifier payment adjustment if at least 50 percent of the individual EPs within the group practice successfully avoid the 2016 PQRS payment adjustment.

And what this means is that if there is a tax – or there's a TIN, a tax identification number, and there're 10 or more EPs within that, they don't have to register to be part of a group practice. Rather, they can report individually. And if at least 50 percent of those individual EPs meet the 2016 PQRS payment adjustment criteria, they would avoid the negative Value-Based Payment Modifier.

The other note we wanted to call out is that the PQRS EHR reporting option for Meaningful Use is only available to EPs with EHR certified to the June 2013 version of the eCQMs. The one exception is CMS140, the Breast Cancer Measure, which would need to be certified to the December 2012 version.

EPs whose EHRs are not certified to the version of eCQMs required by PQRS will still need to attest to their CQMs for Meaningful Use and select a different reporting method of PQRS reporting. So essentially what that means is that if your EHR is not certified to the most recent versions of the measure, there are still opportunities to avoid these negative payment adjustments. What you would have to do is to attest to your eCQMs for Meaningful Use and then choose a different reporting mechanism under PQRS, and we have a variety of reporting mechanisms available.

And then lastly, an important note is that the reporting period for the 2014 PQRS program is 12 months. Under the EHR Incentive Program, they do have a 90-day reporting period, but that will not apply to PQRS.

### **Group Practices**

OK. Moving on to slides 9 and 10, reporting once as a group practice. Slide 10. So what I'm going to cover in these next few slides are how a group practice can become incentive-eligible for the 2014 PQRS program, how a group practice can avoid the 2016 PQRS payment adjustment, how the group can satisfy the CQM component of the EHR Incentive Program, and how the group can satisfy requirements regarding the 2016 Value-Based Payment Modifier adjustment.

OK. Moving on to slide 11. So the first bubble – so this is a scenario where you are a PQRS-eligible professional, and you have assigned your billing over to a group practice TIN. And a group practice is defined as a single TIN, or tax identification number, with two or more individual EPs, as identified by their individual national provider identifier, who have reassigned their billing rights to the TIN.

And from there, the group practice would have to register for PQRS under one of the following reporting options. And so there are three options available. The first is using direct EHR – certified EHR technology or using a data submission vendor that is certified EHR technology. The second is adding, in addition to that, CG-CAHPS (Clinician and

Group Consumer Assessment of Healthcare Providers and Systems). And then the third is using the GPRO Web interface.

So I'm going to first focus on the bubbles on the left-hand side—so, the EHR submission, whether it be direct or using a data submission vendor. And these options are available to all group sizes, so groups two or above. So first the group would have to register within the PV-PQRS Registration System, and then the group would have to report on nine measures covering at least three of the National Quality Strategy domains. And that applies for all of the applicable patients for the nine selected measures within the group.

The middle option, the CG-CAHPS, this is only available to group practices that are 25 or greater. And the way that this particular option would work is that it would be in addition to one of the other options. So the example we have is that the group would report on six measures, covering at least two National Quality Strategy domains, using EHR technology. Or the alternate option is to report all of the Web interface measures, and in addition to that, CG-CAHPS reporting could occur.

And then, the last option, the GPRO Web interface. This is only available to group practices that are 25 or greater. So it's 25 to 99, or 100 or above. And the group would have to report on all measures included in the Web interface for the prepopulated beneficiary sample.

And all three of these reporting options are for calendar year 2014. So it's a 12-month reporting period.

So then moving down to our satisfactory reporting, either yes or no.

If it's a "yes," the group would be PQRS incentive-eligible. They would avoid the 2016 PQRS payment adjustment. They would satisfy the CQM component of the Medicare EHR Incentive Program. Groups that are 10 to 99 EPs will be subject to a neutral or positive Value-Based Modifier adjustment based on quality tiering, and groups of 100 or above will be subject to either negative, neutral, or positive Value-Based Payment Modifier adjustment.

And then if satisfactory – satisfactorily reporting does not occur under PQRS, they would not be incentive-eligible. They would not – or they would be subject to the 2016 PQRS payment adjustment. They would not satisfy the CQM component of Meaningful Use. And group practices of 10 or more could be subject a downward VBM.

So, a couple more important notes for the group practice option on slide 12. This is only available to EPs who are beyond their first year of Meaningful Use. EPs who are in their first year of Meaningful Use in 2014, including those who are part of a group practice that is participating either in PQRS GPRO or in an ACO, would need to report their CQMs via attestation by October 1st, 2014, to avoid a Meaningful Use payment adjustment. So again, if you are an EP and you are in your first year, to not be subject to

the Medicare EHR Incentive Program negative payment adjustment in 2015, attestation must occur by October 1st, 2014.

### **Medicare Shared Savings Program ACOs**

OK. Moving on to Report Once via the Medicare Shared Savings Program ACOs, slide 14. So we're going to cover here how to satisfy quality performance standards for the Shared Savings Program, how to become incentive eligible for the 2014 PQRS, how to avoid the 2016 PQRS payment adjustment, and how to satisfy the CQM component of the EHR Incentive Program.

And a note: The ACOs will not be subject to the 2016 Value-Based Payment Modifier. That applies both to MSSP ACOs and Pioneer ACOs.

Moving to slide 15. So the scenario is that you are a PQRS-eligible professional who has assigned billing to a Shared Savings Program ACO participant TIN. ACO participants provide information to the primary TIN, and the primary TIN reports information on participants' behalf.

So there's only one scenario that ACOs – or Shared Savings Program ACOs can report once for 2014, and that's where the ACO Primary TIN reports on all measures included in the GPRO Web interface. And that's, again, for a 12-month reporting period.

So then there are two options: either they do so or they do not do so. So down the "yes" path, the ACO primary TIN satisfactorily reports, therefore they would be PQRS incentive-eligible. They would avoid the 2016 PQRS payment adjustment. And they would satisfy the CQM component of the Medicare EHR Incentive Program.

And then, under the "no" path, the ACO primary TIN does not satisfactorily report for PQRS, therefore the participants TINs are not PQRS incentive-eligible. They are subject to the 2016 PQRS payment adjustment. And they would not satisfy the CQM component of the Medicare EHR Incentive Program.

Slide 16. So this is same note that I talked about a little bit earlier, that EPs who are within their first year of Meaningful Use, they cannot participate in the group options to report once. Rather, they would need to attest to their eCQM results by October 1st, 2014, to avoid a 2015 Medicare EHR Incentive Program or Meaningful Use payment adjustment.

### **Pioneer ACOs**

Moving on to slides 17 and 18, so reporting once for Pioneer ACOs. So we're going to cover how to satisfy quality performance standards for the Pioneer ACO model, how to become incentive-eligible for the 2014 PQRS incentive, how to avoid the 2016 PQRS payment adjustment, how to satisfy the CQM component of the EHR Incentive Program.

And a note here: Non-participating providers in Pioneer ACO TINs – they would need to refer to GPRO requirements for submission. We're not going to cover non-participating

providers in the Pioneer ACO TINs today. So we do encourage those folks to take a look at the link that's available on slide 18, and/or they could contact one of the help desks which we have available on the reference slide. And then, as I mentioned earlier, ACOs will not be subject to the 2016 Value-Based Payment Modifier.

So moving on to slide 19. The scenario is I am a PQRS-eligible professional who has assigned billing to a Pioneer ACO participant TIN, and the ACO participants provide information to the primary TIN, and the primary TIN reports information on participants' behalf.

So, similar to the SSP ACOs, the Pioneer ACOs only have one option to report once, and that's where the ACO primary TIN reports on all measures included in the Quality Measures Assessment Tool, or the QMAT tool. And that's based off of a 12-month reporting period, so January 1st, 2014, through December 31st, 2014. And then there are two options: either the ACO primary TIN satisfactorily reports or completes the QMAT, or they don't.

So going down the happy path, the "yes" path, the ACO primary TIN satisfactorily reports for PQRS, therefore the participant TINs are PQRS incentive-eligible. They avoid the 2016 PQRS payment adjustment, and they satisfy the CQM component of the Meaningful Use Program.

If they don't satisfactorily complete QMAT reporting, down "no" path, they are not PQRS incentive-eligible. They would be subject to the 2016 PQRS payment adjustment, and they would not satisfy the CQM component of the Medicare EHR Incentive Program.

And slide 20, this is the same note that we've had on the last couple of slides. So again, EPs who are within their first year of Meaningful Use need to attest to their CQMs by October 1st, 2014, to avoid a Meaningful Use payment adjustment. So they would need to choose a different reporting option under – or they wouldn't be able to report once for all of the programs.

## Resources

OK. And then, to close out the presentation and then we can take your questions. I'm sure there are quite a few questions on today's presentation.

So, slides 21, 22, and 23, Where to Call for Help. So slide 22, we have the QualityNet Help Desk. They deal with PQRS or e-prescribing issues as well as IACS registration or login issues. The Provider Contact Center—they deal with receiving incentive payments. Then we also have the EHR Incentive Program Information Center; the ACO Help Desk, which covers both Pioneer ACOs and Medicare Shared Savings Program ACOs; and the Value-Based Payment Modifier Help Desk. So there are quite a few different help desks, so make sure you're contacting the right one in regards to your question.

And then slide 23, we have a variety of resources for these different programs. The first deals with PFS Federal Regulation Notices. The second is the PQRS website. The next is

the Medicare Shared Savings Program website. The next is the Value-Based Payment Modifier website. The one following that is the Medicare and Medicaid EHR Incentive Programs, Frequently Asked Questions, and then the PhysicianCompare site.

So at this point, I – oh, and then slide 26 – so before we start the question-and-answer session, just a reminder that this call has been approved by CMS for CME and CEU continuing education credit. To obtain the continuing education credit, review the CE Activity Information and Instructions for specific details, and there is a link available on slide 26.

At this point, I'll turn the call back over to Aryeh.

## Keypad Polling

Aryeh Langer: Thank you. Before we move into the question-and-answer portion of today's call, we'll pause for a moment to complete keypad polling so 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. We're ready to start the polling, please.

**Operator:** CMS appreciates that many of you minimize the Government's teleconference expense by listening to these calls together in your office 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 between – 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 between two and eight. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling.... Please continue to hold while we complete the polling.... And that concludes the polling portion of today's call. I'll turn the call back over to you, Aryeh.

## Question-and-Answer Session

Aryeh Langer: Our subject-matter experts will now take your 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 yourself to one question at a time.

If you have more than one question, please press star 1, and you'll be put back into the queue, and we'll address your question as time permits. We're ready now to take our first question. Thank you.

**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 in the conference. Please hold while we compile the Q&A roster.

Your first question will come from the line of Janie Whitehead.

Janie Whitehead: Hello?

Aryeh Langer: Hello.

Janie Whitehead: Hi. My question is, we have 12 eligible professionals. We are wanting to report individually, and was hoping to do so through an EHR-based reporting option. However, I'm a little bit confused. Do I understand correctly that we need to report at least nine of the eCQMs out of three domains? And how is that data submitted? I mean, we reported Meaningful Use. We attested already for Stage 1. For Stage 2 we're only doing the 90-day reporting. Is it through the same portal that we could report for PQRS?

Molly MacHarris: Sure. This is Molly. Great question. So if you actually go over to slide 7, that will be the one that will work for your particular practice. So just a couple things to keep in mind: If – so, under PQRS, 90-day reporting period would not count. You would have to report for the 12-month reporting period, which I do believe is an option under the Medicare EHR Incentive Program.

Janie Whitehead: Yes, it is.

Molly MacHarris: So if you would like to report electronically, there are really two ways that you can get that data in to us. One is directly, where you all – the practice, you guys would submit the data directly to CMS, and it goes to the PQRS portal, so where you sent your PQRS data in the past; or by working with a data submission vendor.

Janie Whitehead: We've always done claims-base reporting for PQRS.

Molly MacHarris: OK. Have you ever accessed your PQRS feedback report before?

Janie Whitehead: Yes, through the IACS.

Molly MacHarris: Right. So that's where you would go to submit the data if you want to do so directly.

Janie Whitehead: OK.

Molly MacHarris: Otherwise, you could work with a data submission vendor, and they would submit it on your behalf. So what I would do – I would recommend that you work with your EHR vendor. I'm assuming that they are considered CEHRT, certified EHR technology. And then they can help you decide what would be the better path for you—whether or not you submit it directly, or if they submit it on your behalf. And you would want to just make sure it's the nine measures covering three domains.

Janie Whitehead: But the nine eCQM measures, not the nine PQRS measures, because they're a little bit different, I've noticed, in ophthalmology. They don't correspond.

Molly MacHarris: So you would want to report on nine measures from the 64 eCQM set.

Janie Whitehead: OK. Thank you.

Molly MacHarris: Thank you.

**Operator:** Your next question will come from the line Gina Sahni.

Gina Sahni: Hello?

Molly MacHarris: Hello.

Gina Sahni: Hi, how are you? OK, so I have two – really – I have one question. When it said that your EHR has to be in tune with the eCQM standards of 2013, what does that exactly mean?

Molly MacHarris: Sure. This is Molly. So what we mean by that is that it has to be considered certified EHR technology, so it has to be certified by the Office of the National Coordinator, and it has to be to the 2014 set. And then what we mean by the specific measures, I think you're probably looking at slide 8—is that correct?—where we're talking about the versions of the eCQMs?

Gina Sahni: Yes, exactly.

Molly MacHarris: OK. So what we mean there is that to report once for both PQRS and Meaningful Use, you would need to use the June 2013 version of the eCQMs, except for the CMS140, the Breast Cancer Measure, which is the December 2012 version.

So if you have certified EHR technology right now, again, similar to the previous caller, I'd recommend that you work with your EHR vendor, and let them know that you want to participate in CMS programs reporting once for both PQRS and Meaningful Use. And you want to use the correct versions of the eCQMs. Your certified EHR technology should already have the correct versions of the CQMs built in, but you can call it out to them that you want to make sure you're using the right version.

Gina Sahni: OK, because after looking at the CMS website, there was an updated eCQM for 2014 for eligible professionals, which I think was – actually – like, I think it was February was the release date. So would we be – would we be reporting based on those eCQMs, or is it just sufficient to have your EMR up to date with the June 2013?

Molly MacHarris: So for PQRS and – so for PQRS and Meaningful Use in the Reporting Once construct, you would need to use the June 2013 version of the eCQMs, except for this one measure, CMS140, which is the Breast Cancer Measure, which you would use the December 2012 version.

Gina Sahni: I see. OK, great. Thank you.

Molly MacHarris: Thank you.

**Operator:** Your next question will come from the line of Claire Cieri.

Claire Cieri: Hello. I was wondering—today is March 18th, and this was supposed to start on the 1st of January. Is it too late to sign up as a group for GPRO, or what are the deadlines?

Alex Mugge: Thanks. This is Alex Mugge. And the registration for 2014 GPRO actually starts on April 1st and will run through September 30th. So while your data collection and seeing your patients has been ongoing since January 1st, the reporting period is not until the beginning of 2015 for program year 2014. So you're still on good shape. You would register—again, those dates were between April 1st and September 30th of this year—in order to participate as a GPRO for this year.

Claire Cieri: Oh, OK. Even though it was said, one – starting at 1/14, and we have to submit data for 12 months starting January 1st?

Alex Mugge: Right. So you've been – if you've been seeing patients since January 1st, that's what we mean. Our reporting period is for one calendar year...

Claire Cieri: OK.

Alex Mugge: ...so that would be January 1st through December 31st of 2014.

Claire Cieri: OK. Thank you.

**Operator:** Your next question will come from the line of Diane Nowak.

Diane Nowak: Hi. I think I have a similar question to the previous caller. We registered for PQRS in the middle of the February. We're a new practice. And will that affect our reporting from – because we won't be doing our PQRS reporting as of February – I mean, January 1st? Hello?

Alex Mugge: Yes, hi. This is Alex Mugge again. So when you said that you registered on – in February of this year, did you register for GPRO?

Diane Nowak: No. For PQRS, with our electronic – with our vendor, because we're doing PQRS based on our claims.

Alex Mugge: So – so the submission period that we had that ran from January 1st through February 28th of 2014 was actually for data that was collected in 2013. Again, the registration for PQRS GPRO begins on April 1st and runs through September 30th of this year. So there has been no registration PQRS GPRO yet for 2014.

Diane Nowak: OK.

Alex Mugge: And that registration period is – is just if you want your group to participate as a group practice, as a GPRO. Individual EPs do not need to register for PQRS.

Diane Nowak: Thank you.

Aryeh Langer: Can we take the next question, please?

**Operator:** Yes, your next question will come from the line of Sandra Keller.

John: Hello, this is John with Lafayette General Health. I was wondering when you guys were talking about e-submission of data, do you mean having a vendor directly connected through you guys, or is it simple running our reports, getting our data, and then submitting it electronically?

Alex Mugge: Sure. This is Alex Mugge. If you – you have the option to submit your data directly through the portal that Molly was speaking about earlier, in which case, you would submit the data directly from your own EHR. If you have a data submission vendor submit the data on your behalf, then you would work with your vendor that you are already working with, or that services your EHR, and they would submit that data for you to PQRS. So it's not a relationship that CMS has necessarily with the vendors. It would be the relationship that you have with the vendor to submit your data on your behalf.

John: OK. So it's not interface data, it's more the relationship that we have with our vendor.

Alex Mugge: Yes.

John: OK. Thank you.

**Operator:** And your next question will come from the line of David Duncan.

Sandy Duncan: Hi, this is Sandy Duncan, and the question that we have is we're wondering if there has been any changes, or if there will be any changes for the requirements of PQRS for 2014, or if what was sent out in January is the final requirements.

Molly MacHarris: Hi, this Molly. So, great question. This one actually has a very easy answer—no. We finalized our criteria in the 2014 Physician Fee Schedule, which I believe was made available towards the end of November. So all of the requirements that we have out there now, they are final for the 2014 program year.

We do go through an annual rulemaking cycle where we establish requirements for the future year. So everyone on this call, yourself included, please take a look at the upcoming 2015 Physician Fee Schedule Proposed Rule, which should be available at some point over the summer.

Sandy Duncan: Thank you.

Molly MacHarris: Thank you.

**Operator:** And your next question will come from the line of Brett Winkeler.

Brett Winkeler: Hello. I have a question about the individual measures. So you have – we have to report on nine measures. Is there a certain percentage of patients that have to meet those measures in order to qualify, or is it just reporting the number of patients that we have?

Molly MacHarris: So this is Molly again. Good question. So if you take a look at slide 7, I believe it is, again, this calls out the Reporting Once threshold. So if you're asking question within the context of how do I do report once: For the two EHR options, direct EHR and data submission vendor EHR, there is no percentage threshold. It would just be nine measures covering three domains for all of the patients that correspond to the measures.

If you are asking just generally for PQRS, some of our other reporting options does have a patient threshold. We've aligned them all at 50 percent. So if, for example, you are asking in regards to the qualified clinical data registry option or for the traditional registry option or claims-based reporting, it would be nine measures covering three domains for 50 percent of the patients.

Brett Winkeler: OK.

Molly MacHarris: Under the EHR options, it's just for as many patients fall into the measures' denominator.

Brett Winkeler: OK. And usually they say the numerator has – can't be zero, but other than that, everything else qualifies. OK.

Molly MacHarris: Thank you.

Brett Winkeler: Thank you.

**Operator:** Your next question will come from the line of Jeanne Blake.

Jeanne Blake: Excuse me. Hello. My question is this. I have a multispecialty group, and the nine measures over three domains—does that have to be – and again, it’s kind of like what the previous caller was talking about, like the total numbers that we would need.

Some of the measures that one – one part of my physicians would have would not be appropriate for others, but it’s all billed under the same – or we all have to share the same tax ID number. For example, we have OB/GYNs, general surgery, orthopedics, urology, a variety of different types of specialties. Do all have to do – like, if we pick nine measures and three domains, would the denominator be all the physicians, even though some of them definitely – like, say, some of the measures might be appropriate to OBG, for example. I’m just confused on how we – or do we need nine specific measures for each specific provider type?

Molly MacHarris: OK. That’s another great question. This is Molly again. So let me ask you, are you trying to participate as – was your practice trying to participate as individual eligible professionals or as a group practice?

Jeanne Blake: We were hoping to do it as a group practice, if we’re allowed.

Molly MacHarris: OK. So the group practice – those slides are on slide 11. And so, to answer to your question, you know, very shortly: The nine measures covering three domains that your practice selects would apply to all physicians under that practice and for all patients that fall under those measures.

So one of the things you would want to look at when selecting those nine measures is we do have some broadly applicable measures that would apply for really all types of providers. We have smoking cessation measures. There’s a medication reconciliation measure. So for those types of measures, pretty much all providers are able to report on those. So that’s participating as a group.

I do just want to make you aware that if you do decide to report as individual eligible professionals, it would be nine measures covering three domains for each distinct TIN-NPI combination. So some multispecialty practices find that a little bit easier because then each provider would select the nine measures that are more focused to their particular patients that they see. So it’s just different options that are available.

Jeanne Blake: OK. Again, that – that’s kind of still confusing. The nine measures, if we do it like the second scenario you just said, each of them – but – let’s say there’s a 50-percent domain, or a 50-percent denominator, or a 50-percent participation numerator, or

whatever. If – if, for example, we pick something, and one provider isn't – doesn't get enough, but the others do in the group, we would still count that as a group?

Molly MacHarris: Yes. So this is Molly again. So, you would. So if your – if your practice—let's say it's 50 different providers and they all have different specialties—if you decide to participate as a group practice, you would need to make sure that you register during the – at the PV-PQRS website during the timeframe that Alex mentioned earlier, which was April 1st through September 30th. And you would select nine measures covering three domains for all providers within the practice.

So there could be a scenario where – let's say you have a pathologist, where the nine measures that you select, those patients – or the pathologist just wouldn't really apply – any of the services the pathologist has wouldn't apply for those nine measures. That's OK because the reporting at the group level is at the group level. So we're looking at the reporting across all of the providers. Does that help clarify?

Jeanne Blake: Yes. Except like, if you're factoring in, like – like so – the percentage and that like, say, using your example, the pathologist, would that lower the percentage if, you know, of the total? Like when you're looking at the numerators and denominators, if he's factored in, is that going to be...

Molly MacHarris: OK. I'm not sure if we lost you, but I'll just answer the question. Under the EHR reporting option, there is no percentage threshold. So again, it would be nine measures covering three domains for all of the applicable patients for the measure. And if this doesn't answer your question, I would suggest that you give the QualityNet Help Desk a call. Their information is available on slide – sorry, trying to find it – slide 22. And they can help walk you through this in a little bit more detail. But again, for EHR reporting, there is no percentage threshold; it's nine measures, covering three domains, for all patients that fall into the denominator of those measures. Thanks.

**Operator:** All right. And your question will come from the line of Sharon Gray.

Sharon Gray: Yes. This Sharon Gray calling from Hand Center of Evansville. And we are a subspecialty, hand and upper extremity. It – I've look over the measures, and it seems rather difficult for us to get the nine measures across the three different domains. Would we possibly qualify for the measure applicability validation, the MAV process, or through the claims-based reporting?

Molly MacHarris: Sure. So this is Molly again. So the measure applicability validation process only applies to the claims or registry reporting option. So it doesn't actually apply to what we're talking about here today. But that's OK.

So for – if you're trying to report once as in you're trying to report for multiple programs at one time, you would need to really to look at the 64 eCQMs that were finalized in the Stage 2 Meaningful Use rule. If when looking at those measures, none really apply to you, but you have found some measures that would apply under the claims or registry

options, you can choose to report those. And if you don't find that there are nine measures covering three domains that would apply, you would want to report on as many measures as you can. And then the MAV process, the measure applicability validation process, would occur. And that happens when a given EP or group practice, say, report either less than 9 measures covering 3 domains, or it could be a little bit different, where they're reporting 10 measures but still covering less than 3 domains. So we'd look to see if there were other measures that could have been applied.

Just one thing to note with that is that if you want to look within the claims or registry set, which is understandable, there's around 300 measures available in those which are applicable to many more specialties than what we have currently available within the eCQM set. You would just need to make sure that you attest to your eCQMs through the Meaningful Use Program so you wouldn't be subject to the Meaningful Use penalty.

Sharon Gray: OK. Thank you.

Molly MacHarris: Thank you.

**Operator:** And your next question will come from the line of Janet Palazzo.

Janet Palazzo: Hi. I'm calling from Advanced ENT. We're a group of 15 eligible professionals, and we attest to Meaningful Use each year through a certified EHR we have. And I also then separately report through a registry for PQRS. So you're saying that we can just do one of these. And if we report through the EHR – certified EHR, we don't have to do the separate registry reporting.

Alex Mugge: This is Alex Mugge, and that is correct. If you are reporting, just to be clear, the 1 year of data electronically through your EHR, then that would count for both PQRS and Meaningful Use. You would not have to separately report through a registry for PQRS.

Janet Palazzo: So it'll all go to CMS and – and they will – the PQRS department will get their piece?

Alex Mugge: Right, yes. We do want to point out, though, if you're reporting on behalf of a group practice and your individual EPs are hoping to get Meaningful Use credit through a group reporting—so for example, if you do the group EHR reporting option and submit all of that data as a group, your individual EPs do still have to come in to the Meaningful Use Registration Application System and attest to their Meaningful Use objectives.

So the CQM portion of Meaningful Use is covered by your electronic data submission but the Meaningful Use objectives are also part of Meaningful Use, and your individual EPs would have to do that each themselves.

Janet Palazzo: OK. And one of the EPs in my group is new. This will be – 2014 will be his first year of reporting through the EHR for Meaningful Use. You did say something about the first year – somebody in their first year....

Alex Mugge: Yes. If you have an EP who is in their first year – so because our data submission timeline – our submission period for 2014 actually occurs starting January 1st, 2015, that happens after the deadline for those folks that are in their first year to avoid the Meaningful Use payment adjustment. So that EP that is in their first year would need to separately report and attest Meaningful Use before October 1st of 2014.

Janet Palazzo: OK. Got it. All right, thank you.

Alex Mugge: Thank you.

**Operator:** And your next question will come from the line of Deana Juergens.

Deana Juergens: Yes. I have a question regarding the Value-Based Modifier. Everything I find on that is large groups. Is that going to change in 2016?

Tonya Smith: Yes. Hi. This is Tonya Smith. Yes. The Value Modifier for 2016 will apply to groups of eligible professionals – groups with 10 or more eligible professionals.

Deana Juergens: OK. So anything less than 10, you still don't have to worry about that?

Tonya Smith: Not for 2016.

Deana Juergens: OK. Thank you.

**Operator:** Your next question will come from the line of Machael Robinson.... Machael, your line's open.

Machael Robinson: Hi. How are you? I'm sorry. We are a small group of pediatric ophthalmologists, and only 5 of our physicians – we do have more than 10 EPs, but only 5 are par with Medicare. Will that change anything with how we need to register, report, or sign up with – for the PQRS?

Molly MacHarris: Hi, this is Molly. So, great question. So if your providers are par under Medicare or non-par, it actually doesn't make a difference.

Machael Robinson: OK.

Molly MacHarris: So both the par and the non-par Medicare physicians would still need to meet the reporting requirements under either PQRS or the other programs. So if you're participating as a group practice, again, you would want to look at the slides that are on – sorry, I just had them – slide 11 for the different options to report once.

Machael Robinson: And actually we do not have the EHR, we're not EHR. We don't – we don't have EHR. We just report, you know, via the HCFA-1500s. We don't have any EHR, so will that affect anything with us? Will we do anything differently because of that?

Molly MacHarris: Well, so statutorily, the Medicare EHR Incentive Program does apply to all physicians, and they have to achieve Meaningful Use, and if they do not, they would receive a negative payment adjustment under the Medicare EHR Incentive Program.

Machael Robinson: OK.

Molly MacHarris: So if you – if you have specific questions on whether or not you guys would apply or not apply to that, I'd contact their information center.

Machael Robinson: OK.

Molly MacHarris: But for the other programs, so for PQRS and the Value-Based Payment Modifier, the status as a par provider or non-par provider doesn't make a difference. You can still report on the CMS-1500 claims form for via claims for PQRS, that's fine. Just one thing to note is that that option is only available to individual eligible professionals under the PQRS program, not as a group practice. So it would be that every provider would have to meet the reporting criteria on their own.

Machael Robinson: OK, and that's what I'm unclear on still. I don't even think we can sign up as a group. That's what I'm trying to figure out for us. I don't think we can.

Molly MacHarris: Yes. So what I would actually do is I'd suggest that you call the QualityNet Help Desk because they – you definitely can participate, but the Help Desk can actually stick with you and, you know, walk through your particular situation and give you guidance on how to participate. And again, their information is on slide 22, and they should be able to give you some suggestions for your particular practice.

Machael Robinson: Thank you.

Molly MacHarris: Thank you.

**Operator:** Your next question comes from the line of Andrea Hefner.

Andrea Hefner: Hey, yes. We are a clinical psychologist practice, and so therefore, we do qualify to report PQRS via the claims, but we do not qualify to report for Meaningful Use. We don't qualify for any EHR incentives or anything like that. Do we need to do both attestation processes, or are we covered from having any payment reduction by only reporting via claims?

Molly MacHarris: I'm sorry, can you repeat the last part of your question? I heard you up to the part where you were asking about how you don't qualify under Meaningful Use but you do under PQRS. So, I'm sorry.

Andrea Hefner: Right. Sure. I'm submitting, right now, three measures on – through my EHR on my 1500 forms. So is that sufficient to keep us from having a payment reduction, or do I need to go ahead and report once?

Molly MacHarris: Sure. So thanks for clarifying, and this is Molly. You can keep reporting on the three measures. For PQRS, you would avoid the PQRS payment adjustment if you do that. And the Value-Based Payment Modifier, they will be looking at the payment adjustment criteria when they do their analysis, so they'd only be looking for the three measures. We do strongly encourage all EPs to report on nine measures covering three domains if possible. If you don't actually have nine measures that would apply to you...

Andrea Hefner: Right.

Molly MacHarris: ...report on as many as possible because, again, you do have this last opportunity to earn a half-a-percent incentive.

Andrea Hefner: OK. OK. So just as many as qualified to him, but I don't need to worry about doing the once because we don't qualify for Meaningful Use.

Molly MacHarris: Right. But the whole Report Once is something that CMS were trying to do to reduce burden...

Andrea Hefner: Sure.

Molly MacHarris: ... on providers. We understand you guys have a lot going on, so we wanted to try to streamline our reporting criteria as much as possible.

Andrea Hefner: Awesome. OK, thank you.

Molly MacHarris: Thank you.

**Operator:** Your next question comes from a line of Sherry Nicks.

Sherry Nicks: Yes. This practice has one EP, and I think I'm understanding that we can report the measures through our electronic claims submission. What I'm wondering is where to find the CQM codes and modifiers information?

Alex Mugge: So this is Alex Mugge. We have – the list of available measures for the CQMs is available on the – in the CQM library on cms.gov. So that would be one place to go and look for those. Have you been participating in PQRS in the past? I thought I understood ...

Sherry Nicks: No. This would be the first time.

Alex Mugge: OK. So then you may want to reach out to the QualityNet Help Desk to help you determine which measures to report on that would best fit your practice.

Sherry Nicks: OK. Thank you.

**Operator:** And your next question comes from the line of Kala Ramesh.

Kala Ramesh: Yes, hello. I have a question on the nine measures that you were –you said the EPs need to cover on to – to report. Do the denominators for those measures need to be – have only the Medicare Part B patients? Because from past years I've learned that PQRS is associated only with Medicare Part B patients.

Alex Mugge: This is Alex Mugge again, and yes, we look primarily at your Part B claims, so this should be on your Part B patients as well.

Kala Ramesh: So you're saying that all the nine measures, the denominators need to contain only Medicare Part B patients?

Molly MacHarris: It has to be at least for one. So you can report on all of the payers. If you receive other insurance payments from private carriers, then you can include those as well, but it must include at least one Medicare Part B patient.

Kala Ramesh: OK. And regarding the zero-percent performance rule, another caller had asked and I just wanted to clarify that it's OK to have a zero numerator as long as we can report – the denominator should – should be a non-zero, right?

Alex Mugge: So the zero rule is actually that as long as you show intent to report a measure for PQRS, so as long as you include the object identifier for that measure, then you can report zeroes on that measure, be it zeroes in the numerator and the denominator, as long as you're showing intent to report that measure. However, we do encourage you to report on measures for which you do have patients.

Kala Ramesh: OK, I appreciate it. Thank you so much.

Alex Mugge: Thank you.

**Operator:** And your next question will come from the line of Tony Newton.

Tony Newton: Hi. We're a well-seasoned GPRO Web interface user. And I'm trying to understand the – the requirements of our certified EHR technology, whether it needs to be – to report still, for 2014, Web interface for a group practice of greater than 100, that the CEHRT needs to be to a 2014 edition of CEHRT or a 2011 edition of CEHRT. And being that not all 22 measures for the GPRO Web interface are necessarily an eCQM for the Meaningful Use purposes, is it still acceptable and satisfactory to do a manual data

entry? And also if you could touch base on does that negate Medicare administering and bearing the cost of the CG-CAHPS survey requirement?

Alex Mugge: Hi, Tony, this is Alex Mugge, and...

Tony Newton: Hi, Alex.

Alex Mugge: ...to answer your questions, it sounds like you will be reporting to the Web interface again for 2014. Is that your intention?

Tony Newton: Well, we're really exploring that opportunities to end and to meet both Meaningful Use, Value-Based Modifier, PQRS.

Alex Mugge: Right. So there are two ways that you can do that. If you report to the Web interface, you would do the traditional Web interface reporting, which is to report on the 22 measures using either manual data entry or XML upload. And that reporting to the Web interface would count for the CQM portion of Meaningful Use. If you go that route, do keep in mind that, you know, your individual eligible professionals in your group would still have to register and attest to Meaningful Use and to meet the Meaningful Use objectives in that portion of Meaningful Use.

So that's your Web interface option. If you prefer to report via your EHR, then your EHR, yes, must be certified to the 2014 version, and must – you must submit the measures on behalf of your group for the group. And again, in this instance – you know, whenever you're reporting as a group, the individual EPs within the group practice must still register and attest in the Meaningful Use system in order to meet the Meaningful Use objectives.

Tony Newton: Is that for just the EHR Direct that needs to be to the 2014 edition? It doesn't apply for the Web interface?

Alex Mugge: If your – for the – if your providers are going to attest, then yes, your EHR still needs to be up to date, but if you're going through the Web interface and since you won't be submitting data through your EHR, then we wouldn't – you know, that won't impact your Web interface submission.

Tony Newton: OK. Now, the CG-CAHPS survey, does that get affected for 2014? Will CMS still administer that for the GPRO Web interface greater than 100 EPs?

Alex Mugge: Yes.

Tony Newton: OK. All right. Thank you.

**Operator:** And your next question will come from the line of Nancy Nelson.

Nancy Nelson: Hi. I have a question in regards to your once-time reporting of nine measures and three domains, how that compares to your 20-patient sample method for 20 unique patients? Because that one you can do a 6-month reporting period, correct?

Molly MacHarris: Sure. This is Molly. So the 20-patient method I think you're referring to is – well, OK. So under the – so this is separate and distinct from the reporting once piece here, just to kind of clarify for both. But under PQRS, we do have a registry reporting option where registries can report – or an EP can report through a registry on measures groups. And they can do so either for the 12-month reporting period for 20 patients, or for a 6-month reporting period for 20 patients.

Doing that, though, would only apply for – again, as an individual EP – for PQRS only. That participation could count for the Value-Based Payment Modifier as well. But it will not count for the Meaningful Use Program. Does that answer your question?

Nancy Nelson: Yes, I think it does. Thank you.

Molly MacHarris: OK, thank you.

**Operator:** And your next question will come from the line of Lisa Santiago.

Lisa Santiago: Hi.

Aryeh Langer: Hi.

Lisa Santiago: I'm at the office of a solo practitioner primary care, so we would be an individual eligible professional. And, you know, last year in the 2013 PQRS, we picked one measuring tool and then reported on patients. But this year, the difference is it's nine measures over three domains?

Molly MacHarris: Hi, Lisa, this is Molly. So yes, you are correct. In 2013, the reporting criteria to avoid the 2015 PQRS payment adjustment was one measure. Now for the 2016 PQRS payment adjustment based off of reporting that would occur in 2014, just to avoid the payment adjustment, it's three measures. However, if you would actually like to earn the incentive, which we over here at CMS strongly encourage all EPs to seek, it's nine measures covering three domains.

Lisa Santiago: OK. And then is that for 50 percent of patients or all patients? I am getting conflicting info.

Molly MacHarris: Sure. So it depends upon the reporting mechanism that you choose. If you choose the EHR...

Lisa Santiago: We do it via claims.

Molly MacHarris: OK, so via claims there would be a 50-percent threshold. Whether you're doing it for the three measures just to avoid the payment adjustment, or if you're doing the nine measures to earn the incentive, it would still be across 50 percent of all applicable patients.

Lisa Santiago: OK. And "all applicable patients," like I just heard you tell another lady, is including all insurances, with at least one Medicare patient being included.

Molly MacHarris: So that depends upon the reporting mechanism, because when you think about it, for claims-based reporting for PQRS, we can only look at Medicare claims. So that would of course be Medicare only. But for EHR, you know, it's looking at the global picture of the care that your provider gives to their patients. So there could be, you know, Blue Crosses, there could be all kinds of different types of health insurance as well as Medicare. So if they were doing an EHR option, it would be all payers with one Medicare beneficiary. But if you're just doing claims, that would of course be Medicare only.

Lisa Santiago: OK, that makes more sense now. Thank you.

Molly MacHarris: Thank you.

Lisa Santiago: And then as an individual professional, we don't need to worry about the Value Modifier.

Molly MacHarris: So the Value-Based Payment Modifier applies to group practices that are 10 or above for the 2016 Value Modifier.

Lisa Santiago: OK, thank you.

Molly MacHarris: Thank you.

**Operator:** And your next question will come from the line of Karen Ryker.

Karen Ryker: Hi, this is Karen Ryker with RC Billing. And I believe that you just answered our question, and it's our understanding – we have many physicians who are not able to meet Meaningful Use yet because they're in a hospital environment as contractors. And they're looking at what they can do through registry to be compliant, to not receive the penalty only at this point. So we're understanding that it is three measures by claims or three measures by vendor registry and reporting—is that 50 percent for both of those?

Molly MacHarris: Yes, this is Molly. That's correct.

Karen Ryker: OK, Molly. Thank you so much.

Molly MacHarris: Thank you.

**Operator:** And your next question will come from the line of Linda Nolton.

Linda Nolton: Well, I think that I got most everything answered. Thank you so much. So, for our physicians, I'm a – hospital system that I represent and it has a huge med staff, so we're just trying to get some advice from PQRS. If they wanted to use their certified EMR they should contact their vendors, and that PQRS measure will be one more report as – in addition to the Meaningful Use report that they're submitting. Is that how you are picturing that this is going to work with the EMR?

Molly MacHarris: Sure. Hi, this is Molly. So yes, you know, I don't know that I made this clear earlier, so let me just try to make this clear now. So the alignment pieces, you know, that we've been talking about, how to report once—under Meaningful Use that only applies to the eCQM component. So each EP under – who, you know, is eligible to participate in the Medicare EHR Incentive Program would need to still meet all of the other objectives under the Medicare EHR Incentive Program.

So then – so you would still have to register and attest under Meaningful Use. And then when you get to the CQM component, you can elect to e-report, and by e-reporting you would get credit at once for reporting under PQRS, the CQM component of Meaningful Use, and then, depending upon your group size, you could also avoid the negative Value-Based Payment Modifier. So I hope that helps.

Linda Nolton: So you would envision they're going to do this Report Once at the same time they do their attestation [inaudible]. OK, so is that a period that's going to be similar? Like, it will go from January to the end of February of 2014 for their attestation period [inaudible]?

Molly MacHarris: The submission of eCQMs will be January 1st, 2015 through February 27th, 2015. EPs – I'm not – do you – do you know when they can start attesting for Meaningful Use?

Aucha Prachanronarong: It's the same time period. This is Aucha. It's the same time period, but I'm not sure exactly when the January release for the registration and attestation is going to go out. It may not be exactly on January 1st but shortly thereafter.

Molly MacHarris: Did you hear all that?

Linda Nolton: Yes, and actually now that I think about it out loud, since 2014 is the rare Meaningful Use 90-day period, probably most of our physicians will do their attestations and, you know, maybe they're going to do July to September, so they'll do their attestation for 2014 in October, and then they'll wait to do the PQRS submission report once in January. So they can represent the entire year. Right?

Molly MacHarris: Yes. That is an option. Just, you know, one thing to clarify, that if they want to go ahead and attest to Meaningful Use early, which they definitely can, the 90-day reporting period does not apply for PQRS or the Value-Based Payment Modifier. We

would need to have 12 months' worth of data received for assessment under PQRS in the Value-Based Payment Modifier. Thank you.

**Operator:** And your next question will come from the line of Sue Schultz.

Sue Schultz: Yes. We have seven providers, and one of them I just attested for her first year. She's new, last year. Can we still do the GPRO with her this year? So can she be part of the GPRO as long as she's in her second year?

Alex Mugge: This is Alex Mugge again. And yes, she can – anybody who's part of your practice during the program year can – is considered, you know, part of your GPRO when you report. One thing that we would just mention is that you know, for Meaningful Use, because you said that she is new, I would just say, you know, for GPRO, that will get your PQRS credit and that would include her. But then for Meaningful Use, you would want to figure out which year of Meaningful Use she's in and report accordingly. So this is her first year of Meaningful Use, she will need to separately report to Meaningful Use prior to October 1st.

Sue Schultz: Ok, thank you.

Sofia Autrey: You say that she got a 2013 Meaningful Use incentive?

Aryeh Langer: Are you still on the line?

**Operator:** All right, your next question will come from the line of Linda Powell.

Linda Powell: Yes, I'm calling from Neurology and Pain Management Center, and my question was, whenever you're reporting these measures and it – the nine measures, and then it has – you have to have three domains. What are the domains? Is that like diagnosis codes that have to go with the measures? Is that what that means?

Sofia Autrey: Hello, this is Sofia Autrey.

Linda Powell: Hello. Yes, ma'am. We are a pain management and neurology company, and my question was on the measures. It has to have, like, the nine measures. You have to have the three domains. Is the domains the diagnosis that goes with whatever measure you're submitting?

Sofia Autrey: Hello, this is Sofia Autrey. And we have identified under the measures list the National Quality Strategy domains, and there are six for the PQRS program. So if you were to look in the PQRS website under the measures list, you would actually see what domains we have for each measure. And so when we reference three domains, we're talking about one of those six.

Linda Powell: OK. One of those six. And also, where do we go to register for the PQRS?

Lauren Fuentes: Hi, this Lauren Fuentes. So you only need to register if you're going to participate as a group practice. Is that your intention, to participate as ...?

Linda Powell: We're not really sure yet because it's – there's so much information. We're trying to get it all consumed so we can figure out what is the best possible way for us to report.

Lauren Fuentes: OK.

Linda Powell: And if it's better to go through a vendor or exactly how – like I said, we're still just trying to figure out and sort what's the best for us.

Lauren Fuentes: OK. So if you are going to participate as a group, then you would need to register. And in terms of registration, I'll let one of my own colleagues answer that for you.

Linda Powell: OK.

Sabrina Ahmed: Yes, so if you look at slide 23, it's the Resources slide, and the fourth bullet down, you'll see the website for CMS Value-Based Payment Modifier Program. And if you go to that website, there is the Self-nomination/Registration subpage. If you click there, then you'll – before April 1st, you'll find information on that subpage that has all of the information about where you'll need to go to register.

Linda Powell: OK, thank you very much.

**Operator:** And your next question will come from the line of Sandra Pogones.

Sandra Pogones: Hello, this is Sandy. I have a question regarding the qualified clinical data registry. If you choose to report via qualified clinical data registry, but that qualified clinical data registry doesn't seek certification by ONC, will that still count as part of Meaningful Use, for meeting the clinical quality measures for Meaningful Use?

Molly MacHarris: Sure. This is Molly. So that's actually a really great question. And no, that would not count. So for the qualified clinical data registries, they – these particular entities have an option to either report purely for PQRS or to report on the 64 eCQMs. And to do that, they have to be considered certified EHR technology. So if the QCDR that you're working with is not CEHRT, then you would not be able to report once for the Meaningful Use Program; you would have to separately report under that program.

Sandra Pogones: OK, thank you.

Molly MacHarris: Thank you.

**Operator:** Your next question will come from the line of Tracy Fitzgerald.

Tracy Fitzgerald: Hi. Quite a few of the questions have been answered, but I'm – I'm still a bit confused. We are a – we have finished Stage 1. We are in Stage 2, Year 1 for Meaningful Use. We have been successful with PQRS for quite a few years as EPs. I guess I have a multi-phased question of, if we were just going to try and avoid the penalty and use the claim-based for three measures, we don't need to re-register, but we're already to March 18th. And unfortunately we were still using a group measure of a G8501 for the perioperative, which took care of number 20, 21, 22, and 23. But if you're an EP doing individual measures, it's my understanding that that doesn't count. Is that correct?

Molly MacHarris: Sure. So this is Molly. That particular G code that you referenced, I'm not familiar with it. If I'm understanding you correctly, it sounds like that's a G code associated with one of our measures, but....

Tracy Fitzgerald: It's a care measure group that took care of measures 20, 21, 22, and 23.

Molly MacHarris: OK, so one of the things we did do, in 2014 we no longer have claims-based reporting of measure groups. We found participation in claims-based reporting of measure groups was very minimal. So measure groups reporting is still available under PQRS. It would have to be reported via a registry, though.

Tracy Fitzgerald: Only. And also, let's say that you are – we wanted to do claims-based. Is it possible to do the claims-based but also run the information through our clinical quality measures EHR and – so if we missed on one, we can get it on the other, or is it either/or?

Molly MacHarris: Sure. So this is Molly again. So under the PQRS program, you can report through as many different methods as an individual as you would like. We would actually look at the different reporting to determine which is most satisfactory. So for example, if you, you know, failed via claims but you also reported via registry, and you did via registry successful, we would look at your registry data.

One thing to note just in case I can't answer all of your questions here today, I would encourage you to contact the QualityNet Help Desk—their information is on slide 22—because they can take a look at those measures you were reporting on, the care measure set, to see if they are reportable as individual measures. Because that could be another option for you, if you decide to continue reporting via claims and you don't want to report via registry.

Tracy Fitzgerald: OK, thank you.

Molly MacHarris: Thank you.

**Operator:** Your next question will come from the line of Lisa Chase.

Lisa Chase: Hello. I'm going back to the notes throughout the presentation that said that EPs who are in their first year of Meaningful Use in 2014 that need to report CQMs via attestation by October 1st to avoid a Meaningful Use payment adjustment in 2015. Does this mean that they need to complete their entire Meaningful Use attestation by October 1st?

Alex Mugge: Hi, this is Alex Mugge, and the answer to your question is yes.

Lisa Chase: So they need to begin their reporting period by—what?—July 1st or so, yes? Is that correct?

Alex Mugge: That's correct.

Lisa Chase: Do you know if that's going to ...?

Alex Mugge: ...we encourage you to do it before then so that you're not being forced to report at that last hour.

Lisa Chase: Right, well, I'm with a vendor, so this is something that I'm going to passing along to our customers.

Alex Mugge: OK, well, then yes, you – that sounds like you understand that correctly. You do start reporting in July, so that you can – or start collecting the data in July so that you can submit your data by October 1st.

Lisa Chase: OK. So do you know if that's going to continue in future years? Like, if someone were beginning in 2015, would the deadline for the 2016 Meaningful Use payment adjustment be October 1st of 2015?

Alex Mugge: Yes, for 2015 we would have the same policy of needing to report by the October 1st deadline for EPs.

Lisa Chase: OK, great. Thank you.

Aryeh Langer: And we have time for one more call.

**Operator:** Your final question will come from the line of Dawn Coghlan.

Dawn Coghlan: Yes, hello. My question is similar to the one just prior, but I have an orthopedic surgeon coming out of his fellowship effective August the 1st and joining our practice then. He will not have participated in Meaningful Use at all, and I had hoped to get him started in the – for the last 90-day period, the last calendar quarter from that, for Meaning Use. However, that then I had thought I would give him a – try and get a hardship exemption for him for PQRS. Is that what I would need to do? Because he would not be able to meet that – that other requirement.

Molly MacHarris: Hi. So this is Molly. So just one clarification then unfortunately we're going to have to ask you to contact the EHR Incentive Program Help Desk because we don't have those particular SMEs in the room here, and their information is, again, on slide 22. I do just want to clarify that under the PQRS program there are – are no hardship exemptions available. They are available under the Medicare EHR Incentive Program. But again, they're not available under PQRS, and they're not available under the Value-Based Payment Modifier. So I just want to make that clear to all folks. Thank you.

## Additional Information

Aryeh Langer: And unfortunately that's all the time we have for questions today. There is some information on the website that I mentioned at the beginning of the call, where there's further announcements regarding some dates that were mentioned today, including the 2014 GPRO registration period and upcoming 2013 and 2014 added submission deadlines for GPRO Web interface registry reporting, maintenance of certification program entities, and qualified clinical data registries. Again, that website is [www.cms.gov/npc](http://www.cms.gov/npc), [www.cms.gov/npc](http://www.cms.gov/npc), and if you click on the left side of the page, you'll see "National Provider Calls and Events," and then select today's date. So you can access that document, and then the transcript and audio also be available within 2 weeks.

I'd just also like to mention that on slide 25 you'll find information on how to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary, and we hope you take a few minute to evaluate your MLN Connects Call experience today with us.

Again, my name is Aryeh Langer. I'd like to thank our subject-matter experts here – here at CMS and all of you on the line for taking time out of your busy schedules today to join us. Thank you so much.

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

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