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National Provider Call Transcript

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Centers for Medicare & Medicaid Services
Overview of the 2013 Quality and Resource Use Reports
MLN Connects National Provider Call
Moderator: Charlie Eleftheriou
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Contents

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

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

Announcements and Introduction

Charlie Eleftheriou: This is Charlie Eleftheriou from the Provider Communications Group here at CMS. And as today's moderator, I would like to welcome everyone to this MLN Connects National Provider Call titled, "Overview of the 2013 Quality and Resource Use Reports or QRURs." A question-and-answer session will follow the presentation. This MLN Connects Call is brought to you by the Medicare Learning Network.

Before we get started, there are a few items I'd like to quickly cover. You should have received a link to the slide presentation for today's call in an email today. If you have not seen the email, you can find today's presentation on the Call Details web page, which can be found by visiting www.cms.gov/npc, as in National Provider Call. Again, that's 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 51 of the presentation or visit the Call Details web page that I just mentioned for more information on how to obtain credit for your participation.

Lastly, please note that this call is being recorded and transcribed. An audio recording and written transcript will be posted to the Call Details web page when it's available and an announcement will be placed in the MLN Connects Provider eNews.

At this time, I would like to turn the call over to Kim Spalding-Bush, Director of the Division of Value-Based Payment in the Performance-Based Payment Policy Group in the Center for Medicare. Kim.

Presentation

Kimberly Spalding-Bush: Thank you Charlie. So I want to welcome and thank everyone for participating in today's call on the Quality and Resource Use Reports, which are part of CMS's Physician Feedback Program.

We recently made available to all physician groups and solo practitioners their Quality and Resource Use Reports that provide important and actionable information about the patients that your group practices serve. The reports you will see today provide information about your performance compared to national benchmarks on the quality

measures you reported under the Physician Quality Reporting System, as well as on three outcomes measures that look at avoidable hospitalization, also your performance on cost and utilization measures, including information about the care that's delivered to your patients outside of your practice, including information on where your patients were hospitalized and whether they were readmitted as well as information about your performance or your projected future performance under the Physician Value-Based Payment Modifier.

The reports can help you to better understand the expenditure and utilization pattern for your patients. They can help you to identify gaps in care and opportunities to better coordinate care that can be used to improve your performance under the Value Modifier and, more importantly, to improve the quality and efficiency of the care that you deliver to Medicare Fee-for-Service beneficiaries.

These reports will be made available to groups and to solo practitioner physicians annually hereafter and we're also exploring ways to provide the report more frequently. We hope that at the end of the call and over the next week you will take time to view and download the reports. So if you're participating today as a representative of physician groups, we hope that you'll share the information on how to access the reports with them and encourage the groups and the physicians that you work with to access their reports.

We also hope that you'll take some time to share your ideas and suggestions with us on how the reports could be improved and enhanced, including any detailed information on specific claim fields that you'd like to see or aggregated information that would be helpful to you to see in the future. We'd also like to hear what fields are most beneficial to you and how your groups and/or solo practitioners have found the reports to be useful.

We may not be able to include every suggestion that you provide to us immediately, but the feedback is really valuable to us as we plan for future revisions to the report. And later in the presentation we'll provide you with the phone number for the Physician Value Help Desk and you can give us your feedback on the reports using that phone number.

So thank you again for participating in today's call. And at this time I 'm going to turn the presentation over to Sabrina Ahmed, who will begin.

Sabrina Ahmed: OK, thank you Kim. I will begin with slide 4. So our objectives for today's call are to provide an overview of the 2015 Value Modifier policies and discuss the interaction between the 2015 Value Modifier and the 2013 Quality and Resource Use Reports, which were made available on September 30th. I will also provide an overview of the 2013 QRUR, discuss how a group or a solo practitioner can access their QRUR. I'll be reviewing the methodologies and the data in the QRURs. And also, we would like to

get your suggestions on ways to use the data obtained — contained in the QRURs. Lastly, we'll end with a question-and-answer session.

The 2015 Value Modifier

Slide 5 talks about what is the Value Modifier. The law requires us to establish a Value Modifier that assesses both the quality of care and the cost of that care furnished under the Medicare Physician Fee Schedule. The Value Modifier is a per claim adjustment made under the Physician Fee Schedule that is applied at the group level, where a group is identified by its Medicare Taxpayer Identification Number, or TIN.

The Value Modifier only applies to physicians that are billing under the TIN but not to other nonphysician eligible professionals. The definition of an eligible professional is provided on the next slide. CMS defines a group of physicians as a single TIN with two or more individual eligible professionals as identified by their individual NPI who have re-signed their Medical billing rights to the TIN.

In terms of the 3-year phase-in of the Value Modifier, during the first year, which is 2015, we will be applying the Value Modifier based on performance in 2013 to physicians and groups with 100 or more eligible professionals. Then during the second year, which is 2016, we will be applying the Value Modifier to physicians in groups with 10 or more eligible professionals based on their performance in 2014. The 2013 QRURs are based on policies we finalized for the 2015 VM.

For the third and final year of the phase-in, the Affordable Care Act requires CMS to apply the Value Modifier to all physicians and groups of physicians starting in 2017. Please look for final 2017 policies and the 2015 Physician Fee Schedule Final Rule that will be released in early November. Please note that the Value Modifier in 2015 and 2016 will not apply to groups that participated in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care Initiative during the respective performance period.

On slide 6 we define an eligible professional. For purposes of establishing group size, we use the definition of an eligible professional that is listed on this slide. Eligible professionals contain — eligible professionals consist of the type of physicians, practitioners, and therapists shown in this slide. However, in 2015 and 2016, the Value Modifier will only apply to the physicians billing under the group's TIN, such as a doctor of medicine and the other types of physicians listed on this slide.

Slide 7 shows the interaction between the 2015 Value Modifier and PRQS for groups with 100 or more eligible professionals in 2013 and provides a general framework of how the Value Modifier will be applied in 2015. You will see that PQRS, in some ways, is a (cascading) mechanism.

So starting with the left-hand side of this diagram, if a group self-nominated for the PQRS group practice reporting option and reported at least one measure via the GPRO Web Interface or a registry or the group elected the CMS-calculated administrative claims option as a group in 2013, then that group will avoid the minus 1 percent automatic Value Modifier downward adjustment.

If the group did not participate in the PQRS in 2013 — and now I'm referring to only groups with 100 or more eligible professionals. Looking at the right-hand side of the diagram, if the did — did not — if the group did not self-nominate for the PQRS GPRO or did not elect the CMS-calculated administrative claims option, then not only would the eligible professionals in the group be subject to the PRQS penalties, but there will also be a minus 1 percent automatic Value Modifier payment adjustment to physician payments in 2015 for the physicians in groups with 100 or more eligible professionals.

Now I'm going back to the left-hand side of the diagram to talk about the details of what it means to be a PQRS reporter. When a group with 100 or more eligible professionals self-nominated for the PQRS GPRO or elected the CMS-calculated administrative claims option in 2013 in the registration system, the group also has the option to elect Quality Tiering.

Quality Tiering is a methodology we use to calculate the Value Modifier. Groups of 100 or more eligible professionals that elected the Quality Tiering option will be subject to an upward, neutral, or downward Value Modifier adjustment in 2013 based on their performance on quality and cost measures in 2013. Groups that did not elect Quality Tiering will receive a neutral payment adjustment in 2015.

The 2013 QRURs

Slide 8 talks about what are the QRURs. So on September 30th we made available the 2013 QRURs to every physician group practice and solo practitioner nationwide. We identified group practices and solo practitioners in the QRURs by their Taxpayer Identification Number. The 2013 QRURs contain data regarding the quality and cost of care for calendar year 2013.

This is the same performance period that CMS will use to calculate the Value Modifier applicable to physician payments under the Medicare Physician Fee Schedule for groups of 100 or more eligible professionals in 2015. For groups of 100 or more eligible professionals that elected to have their Value Modifier calculated using this Quality Tiering methodology, the 2013 QRUR shows how payments to physicians in the group will be affected by the — by the Value Modifier in 2015, including any upward, neutral, or downward payment adjustment.

For groups of 100 or more eligible professionals that did not elect to have their Value Modifier calculated using the Quality Tiering methodology — OK. So for groups of 100 or more – for groups of 100 or more eligible professionals that did not elect to have their

Value Modifier calculated based on their quality and cost performance will have a neutral payment adjustment under the Value Modifier, so as long as they registered for a PQRS Group Practice Reporting Option and successfully reported quality measures under the PQRS in 2013.

Lastly, for groups with fewer than 100 eligible professionals and solo practitioners, the QRUR is for informational purposes only and payment will not be affected by the VM in 2015. The QRURs provide these groups and solo practitioners with a preview of their performance based on 2013 data.

Slide 9 talks about who will receive the 2013 QRURs. So in September of this year we provided QRURs based on care provided in 2013 to physician group practices and solo practitioners nationwide that met two criteria. One, they had at least one physician who billed for Medicare-covered services under the Taxpayer Identification Number in 2013 and they had at least one quality or cost measure with at least one Medicare Fee-for-Service case.

Groups and solo practitioners that participated in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care Initiative in 2013 will not receive QRURs. Nonphysician solo practitioners or groups that did not have at least one physician billing under the group, for example, a group consisting only of nurse practitioners will also not receive 2013 QRURs.

Slide 11 talks about how you can access your QRUR. The 2013 QRURs can be accessed only by an authorized representative of a group or solo practitioner through the CMS Enterprise Portal website using a valid IACS user ID and password. The QRUR for a group that is a TIN with two or more EPs billing under the TIN can only be accessed by an authorized representative of the group that has an IACS account with either the PV-PQRS group security official role or the PV-PRQS group representative role.

The QRUR for a solo practitioner — that is, a TIN with only one physician billing under the TIN — can only be accessed by an authorized representative of the solo practitioner that has an IACS account with either the PV-PQRS individual role or the PV-PQRS individual representative role. For more information on how to access the 2013 QRUR, please refer to the How to Obtain the 2013 QRUR web page listed on slide 14.

Once an authorized representative of a group or solo practitioner has the appropriate IACS account, then the QRUR can be accessed by following the steps shown in slides 12 and 13. Slide 14 lists some useful information that can be used to successfully access a QRUR. The remaining slides in this presentation will cover the information contained in the QRUR. I'll cover slides 18 to 21 first and then come back to slides 16 and 17.

Slides 18 to 20 list all of the sections contained in the QRUR, along with the exhibits shown in each section. You can view each of these sections in the CMS Enterprise Portal

website or, once you're in the portal, you can also download a PDF document that contains the entire QRUR for the TIN.

We think of the 2013 QRURs as having three parts. The first part is the cover page and performance page. The second part would be the body of the QRUR or the 14 exhibits listed in slides 18 to 20. We sometimes refer to the first and second parts as the main QRUR. Lastly, the third part consists of the six supplemental exhibits listed on slide 21.

The cover page gives a brief description of what the QRUR is and why you're receiving it. It also gives a brief explanation of the Value Modifier. Your TIN's QRUR will consist only of the cover page if the TIN had no physicians billing under the TIN in 2013; if the TIN participated in the Shared Savings Program, the Pioneer ACO Model, or the CPC Initiative in 2013; or if the TIN did not have any data to evaluate its quality and cost performance, meaning it did not have at least one eligible case for at least one measure.

The performance highlights page shows an overview of the group's 2013 performance on the quality and cost measures that are used to calculate its 2015 Value Modifier. Specifically, for groups with 100 or more eligible professionals, this page includes any applicable Value Modifier payment adjustments that will be made in 2015. Exhibits 1 through 12 will show the TIN's quality and cost performance information based on the 2015 Value Modifier — Value Modifier policies. Please note that exhibits 13 and 14 as listed on slide 20 are informational only and provide a preview of the TIN's performance based on policies established for the 2016 Value Modifier.

Slide 21 lists additional supporting information that is available in the QRURs. The supplemental exhibits provide detailed information about the eligible professionals in the TIN as well as those eligible professionals outside of the TIN who provided care to the TIN's attributed beneficiaries. The supplemental exhibits also provide detailed information about the attributed beneficiaries — about the beneficiaries that have been attributed to the TIN.

The QRUR Performance Highlights Page

So now I 'm going back to slide 16. Slides 16 and 17 show the information that is included in the Performance Highlights page of the QRUR. Please note that the screenshots shown in this presentation are for a sample group with 100 or more eligible professionals that elected Quality Tiering in 2013.

The Performance Highlights page shows the TIN's quality composite score and whether it's considered high, low, or average quality. In this case, the TIN has a quality composite score of .24, which is considered average. The TIN's cost composite score is also shown on this page along with whether it's considered high, low, or average. In this case the TIN has a cost composite score of .23, which is also considered average. If there was insufficient data to calculate the quality or cost composite for a TIN, it is stated in this section.

The third item shown is the scatter plot distribution chart that shows the TIN's performance on quality and cost composites in relation to other TINs in the peer group. The TIN's performance is highlighted in red unless there was insufficient data to determine the score. For a group with 100 or more eligible professionals, its performance is shown in relation to other groups with 100 or more eligible professionals.

Now I'm on slide 17. The fourth section of the highlights — Performance Highlights page shows for a group with 100 or more eligible professionals that elected Quality Tiering if it was eligible for the high-risk bonus adjustment. For other groups, this section shows the group's average beneficiary risk percentile.

The last section of the Performance Highlights page show the group's Value Modifier adjustment if the group had 100 or more eligible professionals and elected Quality Tiering. Please note that the adjustment factor that will determine the actual upward payment adjustments for the high-performing groups in 2015 will be posted on the Value Modifier website and will not be shown in the QRUR.

For groups with 100 or more eligible professionals that successfully registered in 2013 and met the minimum reporting requirements but did not elect Quality Tiering, section 5 will state that because your group did not elect Quality Tiering, the payment adjustment applied to your Medicare Physician Fee Schedule reimbursement in 2015 will be zero, meaning no adjustment. For groups with less than 100 eligible professionals, section 5 will state that because the Value-Based Payment Modifier will not apply to you in 2015, your Medicare Physician Fee Schedule reimbursement will not be affected.

The QRUR Quality Exhibits

I already covered slides 18 through 21, so now I'm on slide 22. The next two slides review the quality exhibits that are included in the QRUR. Before I start with slide 22, which provides an overview of exhibit 4, I would like to mention that the QRUR contains exhibits 1 through 3 in the section of the QRUR titled, "Your Medicare Beneficiaries and The Eligible Professionals Treating Them." These exhibits are not shown in this slide desk. We will add the screenshots for those exhibits to this deck and post the updated deck on the Value Modifier website:

- Exhibit 1 shows how many eligible professionals, including physicians, billed to your TIN in 2013;
- Exhibit 2 shows the number of beneficiaries attributed to you for cost and quality measures in 2013 and the basis of their attribution; and
- Exhibit 3 shows the average number eligible professionals treating beneficiaries attributed to you in 2013 and the number of primary care services provided to your beneficiaries.

So now I'm back on slide 23. This slide shows the screenshot of exhibit 4. Exhibit 4 summarizes the TIN's overall quality performance in 2013. The TIN shown in this screenshot has a standardized quality composite score of .24, which is considered average quality. The quality composite score summarizes performance on quality measures across up to six equally weighted quality domains and shows the number of valid measures that the group reported under each quality domain. In this case you can see that the standardized quality composite score of .24 was based on nine measures reported under three of the six quality domains.

Exhibit 4 displays the TIN's standardized score for each of the quality domains included in the Value Modifier as well as their resulting standardized quality composite score. Standardized scores represent the difference between the TIN's performance rate and the peer group benchmark, expressed as number of standard deviations above or below the mean.

For purposes of calculating the quality composite score, performance rates are standardized at the measure domain and composite level. So in order to have a high-quality performance, a group needs a standardized quality score that is plus 1 or higher, representing composite performance across all domains that is at least 1 standard deviation better than the benchmark or the peer group mean and is also statistically significantly different from the benchmark. In order to have a low-quality performance, the group needs a standardized quality composite score that is minus 1 or lower and statistically significant different from the benchmark. Average quality performance would results from a standardized quality composite score that is either within 1 standard deviation of the benchmark or not statistically significantly different from the benchmark.

For groups with 100 or more eligible professionals that elected Quality Tiering, exhibit 4 summarizes the domain-level 2013 performance data on which the quality composite score used for Quality Tiering for the 2015 Value Modifier is based. And this information is consistent with what is shown in the Performance Highlights page. For all other groups, meaning groups with less than 100 or more eligible professionals or groups that did not elect Quality Tiering, this exhibit shows how the group would perform under the Quality Tiering option based on 2013 data.

Slide 24 provides an overview of exhibit 5. Exhibit 5 shows the group's performance on the measures reported under each quality domain. Only those measures for which a benchmark — for which benchmarks are available and the group had 20 or more eligible cases count towards the domain score.

In the screenshot on slide 24 you can see that there were three claims-based outcomes measures that were calculated for this group and the measures were categorized in the care coordination domain. All the measures had benchmarks available and had 20 — at

least 20 eligible cases. Therefore, the standardized scores for each of the measures were used to calculate the care coordination domain score shown in slide 23.

There is an exhibit 5 for each quality domain in which the group had at least one measure with at least one eligible case comparing the group's performance to the benchmark. Exhibit 5 shows the benchmark rate standard deviation and the group's standardized scores for each measure. The 2013 benchmark performance rate is the case-weighted peer group mean for 2012, that is, the year before the performance year.

Cost Performance Information

Slide 26 provides an overview of exhibit 7, which is our first exhibit containing cost performance information. Exhibit 7 summarizes the TIN's overall cost performance in 2013 on the five per capita cost measures that were used to calculate the cost composite of the 2015 Value Modifier. The TIN shown in the screenshot has a standardized cost composite score of .23, which is considered average cost. The standardized cost composite score is based on performance on cost across two equally weighted cost domains, the per capita cost for all attributed beneficiaries domain, and the per capita cost for beneficiaries with specific conditions domain. The second domain contains four condition-specific measures related to diabetes, coronary artery disease, COPD, and heart failure.

The cost information in this report is derived from payments for all Medicare Parts A and B claims submitted by all providers who treated Medicare Fee-for-Service patients attributed to the TIN in 2013, including providers that do not bill under your TIN. Outpatient prescription drugs or Part B — Part D cost are not included. In order to have low-cost performance, a group needs a standardized cost composite score that is minus 1 or lower than the benchmark, which is a peer mean, and be statistically significantly different from the benchmark. In order to have high-cost performance, the group needs a standardized quality composite score that is plus 1 or higher than the benchmark and be statistically significantly different from the benchmark. Average cost performance would result from a standardized cost composite score that is either within 1 standard deviation of the benchmark or not statistically significantly different from the benchmark.

For groups with 100 or more eligible professionals that elected Quality Tiering, exhibit 7 summarizes the domain-level 2013 performance information on which the quality — on which the cost composite score used for Quality Tiering for the 2015 Value Modifier is based. For all other groups, this exhibit shows how the group would perform under the Quality Tiering option based on 2013 data.

Slide 27 provides an overview of exhibit 8. Exhibit 8 displays the TIN's risk-adjusted and payment-standardized per capita cost for each domain. Exhibit 8 shows each cost domain in which the group had at least one measure with at least one eligible case comparing the group's performance to the benchmark. However, only those measures

for which the group had 20 or more eligible cases count towards the domain score. Exhibit 8 shows benchmark rate standard deviation and the TIN's standardized scores for each measure. Unlike quality measures, the 2013 benchmark performance rates for cost measures is the case-weighted peer group mean for 2013.

Before I move to slide 29, I would like to mention that the QRUR also contains exhibits 9 through 12, which are not shown in the slide desk. We plan to add these screenshots to this slide deck and post the updated slide deck on the Value Modifier — on the Value Modifier website. Exhibits 9 and 10 provide more detailed information about the group's per capital broken down by category of service. Exhibits 11 and 12 show the effects of risk adjustment on the three claims-based outcome measures and the five per capita cost measures that are used in the VM.

So moving on to slide 29. This slide provides an overview of exhibit 6. Exhibit 6 identifies the hospitals that had at least 5 percent of the TIN's attributed beneficiaries' inpatient stays in 2013. This information is based on Medicare Part A claims. This exhibit includes the hospital name, CMS certification number, and location of the hospital. This information shows the group which hospitals their attributed beneficiaries are most frequently admitted to. In this screenshot we see that 80 percent of the TIN's inpatient stays occurred in one hospital.

So now I'm on slide 30. Additional information about Medicare Fee-for-Service patients attributed to the TIN who were hospitalized in 2013 is available in supplementary exhibit 3. Supplementary exhibit 3 contains patient-level information about each hospital admission, including admitting hospital, admission and discharge dates, principal diagnoses, and the discharge disposition.

Additional Information in the QRUR

Exhibit 13, as shown in slide 32, presents information related to the future calculation of the cost composite measure for calculating the Value Modifier in 2015. This information, based on 2013 performance, is presented for informational purposes only and will not affect the TIN's VM in 2015.

Two changes will be made to the calculation of the cost composite score for the 2016 VM. First, Spending per Hospital Patient with Medicare, also known as Medicare Spending per Beneficiary, is a new cost measure that will be included in the per capita cost for all beneficiaries' cost domain based on the TIN's performance in 2014. This measure reflects all Parts A and B expenditures for services surrounding specified inpatient hospital episodes from 3 days before admission to 30 days after discharge for patients treated by physicians in the TIN during the inpatient stay. Exhibit 13 shows the group's performance on this new measure based on the group's 2013 cost performance data.

The second change is that, unlike the per capita cost measures used to calculate the cost composite score in 2015, the cost measures used for the 2016 Value Modifier will be adjusted to reflect the mix of physician specialties within a physician group. Exhibit 13 also shows the TIN's specialty adjusted cost performance for the per capita cost for all attributed beneficiaries and per capita cost for the beneficiaries with specific conditions measures based on 2013 data. You can compare this to the information presented in exhibit 8 to see how a specialty adjustment affects your TIN's cost.

Exhibit 14, as shown in slide 33, presents information related to the future calculation of the quality composite score for calculating the Value Modifier in 2016. This information is based on 2013 performance and is presented for informational purposes only. For calculation of the quality composite score that will be used for the 2016 Value Modifier based on 2014 performance for groups of 10 or more eligible professionals that do not report under the PQRS as a group, CMS will use individually reported PQRS quality data to calculate and aggregate group-level quality composite score if at least 50 percent of the EPs in the group reported as individuals and met the criteria to avoid the 2016 PQRS payment adjustments.

Exhibit 14 shows the aggregate group-level 2013 PQRS performance for eligible professionals in the group by quality domain and measure. More detailed information about the performance of individual eligible professionals in the group on these measures can be found in supplementary exhibit 5.

Slide 34 talks about how you can use supplementary exhibit 1. As noted earlier, the physician groups that will be subject to the Value Modifier in 2015 are those that have 100 or more eligible professionals that submitted claims to Medicare under the group's TIN in 2013. Supplementary exhibit 1 shows the physician and nonphysician eligible professionals who submitted claims under the group's TIN in 2013, their specialty designation, and the date of the most recent claim they billed in 2013.

Slide 35 addresses how you can use supplementary exhibit 2. Supplementary exhibit 2 provides patient-level information about the Medicare beneficiaries that were attributed to the TIN for the cost measures and claims-based quality outcomes measures in the 2013 QRUR. The first part of supplementary exhibit 2, shown in slide 35, identifies individual beneficiaries attributed to the TIN using an index number with information about their gender, date of birth, and HCC risk score ranking. It also shows the basis of their attribution, more primary care services provided by primary care physicians billing to the TIN, Step 1, or more primary care services provided by specialists physicians in the TIN, Step 2.

Continuing on to slide 36. The next part of the supplementary exhibit 2 identifies by name, NPI, and specialty the eligible professionals billing under the group's TIN that provided the most primary care and nonprimary care services to each attributed beneficiary.

Slide 37. The next column of supplementary exhibit 2 identify by name, NPI, and specialty the eligible professionals billing outside of your physician group's TIN who provided the most primary care and nonprimary care services to each beneficiary attributed to the TIN.

Slide 38. The next column of supplementary exhibit 2 shows which attributed beneficiaries were included in each of the disease categories included in the per capita cost for beneficiaries with specific conditions domain and also the percentage breakdown of total per capita cost for each attributed beneficiary by category of service.

Slide 39 addresses how you can use supplementary exhibit 3. As noted earlier, supplementary exhibit 3 provides detailed information about the Medicare Fee-for-Service patients attributed to your group practice who are hospitalized in 2013. This includes patient-level information about each hospital admission, including the name and location of the admitting hospital, admission and discharge dates, principal diagnoses, and where the beneficiary was discharged. Please note that for purposes of confidentiality, patient-level information about hospital admission for alcohol or substance abuse-related problems are not shown in supplementary exhibit 3, but they are included in the calculation of the cost and claims-based outcome measures.

Slide 40 addresses how you can use supplementary exhibit 4. Supplementary exhibit 4 provides more detailed information about the hospital episodes and Medicare Fee-for-Service beneficiaries that would be attributed to you — to your TIN based on 2013 data with a new Spending for Hospital Patient with Medicare cost measure that will be introduced in 2014 for calculating the Value Modifier in 2016. This is provided for informational purposes only and will not affect your Value Modifier in 2015.

The first part of supplementary exhibit 4, shown in slide 40, identifies the beneficiaries attributed to your physician group for this measure, the NPI name and specialty of the EP associated with the largest share of Part B cost during the hospital stay, and the total standardized episode cost from 3 days prior to admission to 30 days after discharge for each beneficiary. Please note that because of the method of attributing patients to a TIN is different for this measure than for the other cost measures, the patient shown in supplementary exhibit 4 may not correspond to those shown in exhibit 2.

So now I'm on slide 41. The next part of supplementary exhibit 4, shown in slide 41, identifies the name and location of the admitting hospital, admission and discharge dates, principal diagnoses, and where the beneficiary was discharged.

Slide 42 addresses how you can use supplementary exhibit 5. As noted earlier, supplementary exhibit 5 provides detailed information about the 2013 performance of eligible professionals in the TIN who participated in the PQRS as individuals in 2013. In 2014, individual PQRS performance data will be aggregated to the group level for

purposes of satisfying group reporting mechanism — for purposes of satisfying group reporting requirements in calculating the 2016 Value Modifier.

Slide 43 addresses how you can use supplementary exhibit 6. For physician groups satisfactorily reported PQRS data via GPRO in 2013 and were eligible to earn an incentive, supplementary exhibit 6 shows the amount of the group's GPRO incentive. Please note that this is separate from any payment adjustment made under the Value Modifier in 2015.

Slide 44 shows several important dates to remember. As we already said, the 2013 QRURs became available to physician group practices and physician solo practitioners on September 30th. Registration to participate in the 2014 GPRO closed on October 3rd. January 1st, 2015, is when the Value Modifier will first apply to physicians in groups with 100 or more eligible professionals. And then the first quarter of 2015 is when groups will need to complete their quality reporting for 2014.

Registration to participate in the 2015 PQRS GPRO will open in the spring and close in the summer of 2015. The QRURs based on 2014 data will be released during the third quarter of 2015. Lastly, beginning January 1, 2016, the Value Modifier will apply to groups with 10 or more eligible professionals.

Next Steps

Slide 45 addresses several next steps. If you haven't done so already, we strongly encourage you to go and download your 2013 QRUR, located on the CMS Enterprise Portal website using a valid IACS user ID and password. You should also review the detailed methodology, tip sheet, Frequently Asked Questions, and other QRUR supporting documents on the 2013 QRURs that we made available on the Physician Feedback Program website.

If you have any questions about your QRUR or to provide feedback to CMS, please contact the Physician Value Help Desk at the telephone number provided on slide 45. You can also share your ideas for additional data elements and information you want included in upcoming reports along with ideas on how to better display the information in the report by contacting the Physician Value Help Desk.

For technical assistance with obtaining an IACS account, please contact the QualityNet Help Desk at the number or email shown in slide 47. For additional information about the PQRS and the Value Modifier programs, please refer to the website listed on this slide, 47.

Lastly, slide 48 lists the acronyms that we've used throughout this presentation. This is the end of the presentation portion of this call. I will now turn the call back over to Charlie.

Keypad Polling

Charlie Eleftheriou: Thank you. And before we move into our question-and-answer session today, we'll pause for a quick moment to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there will be a moment of silence on the line while we tabulate the results. And we're now ready to start polling.

Operator: CMS appreciates that you minimize the government's teleconference expense by listening to these calls together using one phone line. At this time please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling. Please continue to hold while we complete the polling. Thank you. I would now like to turn the call back over to Mr. Eleftheriou.

Question-and-Answer Session

Charlie Eleftheriou: Our subject matter experts will now take your questions. Because this call is being recorded and transcribed, again, I'll just ask that you state your name and the name of your organization before asking your question. And in an effort to hear from as many of you as possible, we ask that you limit yourself to one question at a time. And if you do have a second question or a followup question, please press star1 after your first question has been answered to get back into the queue and we'll address additional questions as time permits.

And we're now ready to take our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard into the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Jacqueline Matthews.

Jacqueline Matthews: Hi, good afternoon. I actually have several questions, but I will limit myself to one. The first question is the per capita cost measure. When we compare our GPRO over the last 4 years we've seen a significant change. And I'm wondering if

that methodology changed at all from even ’11 or ’12 to the current 2013 methodology of the per capita cost?

Kimberly Spalding-Bush: This is Kim Spalding-Bush. I am not aware of any significant changes to the total per capita cost measure. But I would ask whether our colleagues on the line, Mai Hubbard or Jeff Ballou, could speak to that question?

Mai Hubbard: Hi Kim, thanks so much. This is Mai Hubbard. And I think we can do a quick walkthrough between 2011 to ’13 of the changes that we’ve had in the total per capita cost calculation. I think primarily the change has been related to the attribution process of beneficiaries. So if you were a GPRO group back in 2011, we used what was called the one-touch attribution rule, where as long as there was one physician that had taken care of your — of a beneficiary, that beneficiary was then attributed to the group practice. And then, I believe in 2012, we revised the attribution process to what it currently is, which is the two-step attribution approach in which the plurality of primary care services is the emphasis of that attribution process.

And finally, in 2013, there was a slight modification in who is actually attributed beneficiaries. And that’s to say that Federally Qualified Health Centers, critical access hospitals can also be attributed beneficiaries in the 2013 per capita cost measure.

Jacqueline Matthews: OK, great.

Mai Hubbard: And Jackie, if you’re interested in seeing other changes as well, I believe there is a — and, Kim, I think, you probably may have pointed to this in the slide. There are changes between the 2012 and ’13 reports up on the CMS website that, I think, goes through some of the details.

Jacqueline Matthews: Great, great, great because we see changes also in the ambulatory sensitive care measure. I know that changed, I think, in ’11 to ’12. So …

Mai Hubbard: I think that’s right. I think some of the conditions may have changed as well as the approach for how we weighted the composite changed across the 2 years.

Jacqueline Matthews: Great, OK. Thanks so much.

Charlie Eleftheriou: Thank you.

Operator: Your next question comes from the line of David Sobczak.

David Sobczak: Hi, good afternoon. I’m calling from Toledo, Ohio. We have a group that is less than 100 physicians, but we’re not familiar with the Quality Tiering process. How would one elect that when it is required and what does it entail?

Kimberly Spalding-Bush: So for 2013, groups with 100 or more eligible professionals, when they came into our registration system to select their PQRS group reporting option for 2013, they also have the option to elect whether they wanted to elect Quality Tiering or not. So that option was only available for groups with 100 more eligible professionals in 2013 for purposes of the 2015 Value Modifier.

However, beginning — however, for the 2016 Value Modifier based on performance in — based on performance in 2014, Quality Tiering will not be an option anymore. All groups with more — with 10 or more eligible professionals will be subject to Quality Tiering.

David Sobczak: I see. OK, thank you.

Kimberly Spalding-Bush: And we would also just add that for the first year that the Value Modifier is applicable to the next smaller groups, that they would be held harmless from downward adjustment under the Quality Tiering methodology. So they'll only be eligible to — so, while the Quality Tiering is mandatory, they would only be eligible to receive either a neutral or an upward adjustment under that methodology.

David Sobczak: OK.

Kimberly Spalding-Bush: Yes.

David Sobczak: OK, thank you.

Sabrina Ahmed: And I just want to add that the hold harmless policy Kim just described will apply to groups with between 10 and 99 eligible professionals in 2014 for the 2016 Value Modifier.

David Sobczak: OK, very good.

Operator: Your next question comes from the line of Dana Garay. Dana, your line is open.

Operator: Your next question comes from the line of Julie Cantor-Weinberg.

Julie Cantor-Weinberg: Yes, can you hear me?

Charlie Eleftheriou: We can, yes.

Julie Cantor-Weinberg: Can you hear me?

Charlie Eleftheriou: Yes, we can.

Julie Cantor-Weinberg: OK, great. I — this is Julie Cantor-Weinberg with the College of American Pathologists. Could you remind me how this works if there are no primary care beneficiaries that can be attributed to your practice because you're like one of our members not engaged in primary care or office-type practice generally and you have no control over, you know, whether your patients are hospitalized or not? Thank you.

Charlie Eleftheriou: Give us 1 quick second so we can confer. We'll be right back with you.

Julie Cantor-Weinberg: Sure.

Sabrina Ahmed: So for the — starting with the calculation of the cost composite, if you don't have any of the cost measures with at least 20 eligible cases, then we would not calculate a cost a composite for you. You would have insufficient data and you will also receive, you know, basically, average cost.

Julie Cantor-Weinberg: Thank you. Yes, that's what I recall. And the quality is based on — purely on your PQRS scores, then?

Sabrina Ahmed: Yes, the quality composite score is based on the measures the group reported under PQRS if they selected the GPRO Web interface or the registry option or if they elected the CMS-calculated administrative claims option in addition to the three outcomes measures. So those measures would form the basis of the quality composite score.

Operator: Your next question comes from the line of Jean Acevedo.

Jean Acevedo: Thank you. So the presenter clearly stated that the Value Modifier is applied at the group level. So my question relative to that is, so I'm a group of whatever number of eligible professionals in whatever year it is. The Value Modifier is going to impact where I work, my group practice. So, and based on the performance year, let's just assume that we're going to be penalized by 1 percent for the sake of my question. There is new physician that joins the practice, maybe straight from fellowship that year. Is he or she then subject to a downward 1 percent if it's applied to the TIN?

Sabrina Ahmed: Yes. So as long as that new physician bills under the TIN in 2015, then that physician would be subject to the Value Modifier downward adjustment.

Jean Acevedo: OK, thank you.

John Pilotte: But the good news is that if you get a bonus, he would be subject to the upward adjustment.

Jean Acevedo: Right. Let's hope that's where that doctor goes. Thank you.

Operator: Your next question comes from the line of Megan Musick.

Megan Musick: Hi, can you guys hear me?

Charlie Eleftheriou: Yes, we can.

Megan Musick: OK. My question is actually a technical question. We had a — our security officer loose access to their account, and I was wondering, when we reinstate that, do we need — we have multiple, like, practices. And you might not know this, but do we need to send an IRS document for each TIN to get them added under all?

Sabrina Ahmed: So, is this for your group to access …

Megan Musick: The IACS account. Yes, exactly to actually access it to look at and set up the IACS account.

Sabrina Ahmed: OK, so for that you don't need to submit any tax records. I would suggest that you contact the QualityNet Help Desk for help. Their contact information — oh, their contact information is listed on slide 45.

Megan Musick: OK, great. Thanks.

Operator: Your next question comes from the line of Amanda Hutchins.

Amanda Hutchins: Hi, this is Amanda Hutchins from Spectrum Health. We are a large medical group with more than 100 EPs. And for last year we reported individually via claims and then chose the administrative claims method. On the QRUR portal, I can download the QRUR report just fine, but I don't have the supplementary exhibit 5 or 6, so I wasn't sure if I was supposed to have one or the other. I have other TINs that are in our organization and I do have access to supplementary exhibit 5.

Sabrina Ahmed: So thank you. In order to address your specific question, I think we have to refer you to the PV Help Desk because they can look into exactly what happened and whether or not you should have received a certain exhibit or not.

Amanda Hutchins: OK.

Sabrina Ahmed: And their contact information is on slide 45.

Amanda Hutchins: No, I called one of the help desks and they weren't able to help me. So, it's the …

Sabrina Ahmed: The Physician Value Help Desk.

Amanda Hutchins: The Physician Value — OK, I'll try them.

Sabrina Ahmed: And that's the number you will also find in the first section of your QRUR report for questions.

Amanda Hutchins: OK, all right. Thank you.

Sabrina Ahmed: Sure.

Operator: Your next question comes from the line of Lisa Nunnery.

Lisa Nunnery: Yes, I noticed in the 2012 report that the benchmarks were based off of 1,032 groups, but I did not see a number for the 2013 report. Can you — can you provide that?

Kimberly Spalding-Bush: So can anyone — can Mai, are you able to respond to that question?

Mai Hubbard: Sure, I don't have the specific number in front of me, but I'll say that it was right around that same ballpark in terms of the 100 plus TINs for which your cost measure would have been compared against if you are in the 100 plus ACO.

Lisa Nunnery: Yes, we are. OK.

Mai Hubbard: OK, and I'll try to get to the specific number right now while I put you on mute.

Lisa Nunnery: Thank you.

Mai Hubbard: Thanks. And, Kim, I wasn't sure if you all wanted to go on to the next question. And I'll try to get that response back to you all.

Charlie Eleftheriou: Sure, we'll take the next question.

Mai Hubbard: Thank you.

Operator: Your next question comes from the line of Rod Baird.

Rod Baird: Good afternoon, can you hear me?

Charlie Eleftheriou: We certainly can.

Rod Baird: Great. I work in a large group practice and we focus on taking care of patients in nursing homes. We, and many of our other partners across the country, have received

QRUR reports for the past 2 years and we are uniformly high-cost providers. That high-cost variation is all due to the fact that we only take care of patients in nursing facilities so we have a high variance for post-acute care. And anybody getting into a skilled nursing facility per force has had a preceding hospitalization, which again adds to the cost of our patients. Is there any consideration for coming up with a more accurate benchmark so people who work in an institutional setting like a skilled nursing facility are not being assigned a cost over which they have no control?

Kimberly Spalding-Bush: So thank you for that comment. We actually have given a lot of thought to this. And in the next year's QRURs — so, the 2016 QRUR that's based on 2014 performance — we did make some changes to the cost measures in which we're comparing your group's cost to a specialty-adjusted benchmark. So under that approach, we take into consideration the types of specialists that are in a group and we compare them — we case weight the national benchmark for the individual specialties — I'm sorry, we weight the national benchmark into your group based on the number of each of those specialties that you have. And so we think that that may help address some of those concerns.

Rod Baird: We're also primary care, so we're either family doctors or internal medicine physicians. So we are really still just ambulatory care doing primary care. It's the setting that costs — that creates the cost, not the provider.

Kimberly Spalding-Bush: OK. So at this time, I mean, we are still considering ways that we could continue to refine our risk adjustment to account for the more expensive patients. And we would have to propose something like that through future rulemaking. So, I mean, we would encourage you to submit your suggestions to us and then as we propose those policies, certainly we'd be open to any comments that you may have on the subject.

Rod Baird: We have — we just hope that you consider that as you're making these rules because it is — there is no way for our doctors to avoid being classified as high cost if 100 percent of your patients have a hospitalization before we even see them.

Kimberly Spalding-Bush: OK. Well thank you for that comment.

Rod Baird: Oh you're welcome. Thanks for making — having an open mind. I appreciate it.

Operator: Your next question comes from the line of Carol Coates.

Carol Coates Hi, I am calling from Extended Care Physicians. I have pulled down our QRUR and we had 41.94 percent of our eligible professionals PQRS incentive-eligible in 2013. And so we did not have enough data for a quality composite score. And I was just wondering, then — we have a group of less than 100 providers, does that mean that we

will have a downward adjustment for PQRS even though we don't have an adjustment for the Value Modifier program?

Charlie Eleftheriou: All right. If you could give us 1 quick second.

Lauren Fuentes: Hi, this is Lauren Fuentes with the Centers for Clinical Standards and Quality. So are you talking about 2013 performance year? Correct?

Carol Coates: Yes, um-hum.

Lauren Fuentes: And you — did you register to report as a PQRS GPRO or no?

Carol Coates: No, this was administrative claims.

Lauren Fuentes: OK. And so as individuals?

Carol Coates: Yes, um-hum.

Lauren Fuentes: OK, so, with that …

Carol Coates: And we thought we had had 50 percent reporting. But when we pulled the QRUR, it said we only had 41.94 of eligible professionals PRQS incentive eligible.

Lauren Fuentes: So — yes. So I just want to make sure. So there's a few options. So there is the CMS Calculated Administrative Claims — and that's what you did — you actually went on a website and selected that rather than append G-codes to your claims?

Carol Coates: No, we had appended G-codes on our claims.

Lauren Fuentes: OK. So for that option, if you — for the number for EPs that did so satisfactorily, they would earn the incentive, assuming that they did meet the reporting requirements for PQRS. But your other EPs that didn't do — that didn't report at all for PQRS would — would potentially be subject to a PQRS payment adjustment for 2015. And I think you said your group was less than 100.

Carol Coates: It is, but we didn't get any kind of quality score composite. We had insufficient data to determine — on our QRUR. And so we were trying to figure out, well goodness, why did we not get a quality score this year when we did last?

Kimberly Spalding-Bush: So I think that that question would have to probably come to the PV Help Desk. It may be that you had insufficient numbers of cases on the measures that you did report. So all you — even for the percentage that met the PQRS reporting requirement, you may not have had the minimum cases that we require for reliability

purposes to calculate the Value Modifier. But, since we'd sort of would be speculating about what happened, I would encourage you to please call the PV Help Desk and they can look into your specific situation and help you understand what happened with the measures.

But for a group of less than 100 for 2015, you're not subject to a payment adjustment under the Value Modifier, which is separate from the payment adjustment that happened in the PQRS Program. And, also, sort of the 50-percent reporting requirement is something that we didn't have in place for 2013, whereas going forward in the Value Modifier in future years, we will take a look and see whether a group had at least 50 percent of their eligible professionals report for the purposes of calculating the Value Modifier. But that sort of construct didn't exist for the 2013 performance and the 2015 modifier. So just to sort of separate those two ideas.

But, again, we'd ask you to please send your specific question. They can help you understand what happened with the quality composite in this year's QRUR for you.

Carol Coates: OK, thank you very much.

Kimberly Spalding-Bush: Sure.

Operator: Your next question comes from the line of Janice Beck.

Janice Beck: Hi, this is Janice from Ann Arbor, Michigan. We — in 2013, our providers were part of a group less than 100. And in June of 2014, they joined a group of greater than 100 eligible professionals. So in 2015 they are going to be submitting claims under that group's TIN. Are they — are these providers going to, then, be subject to that larger group's Value Modifier payment adjustment in 2015 based on that other group's 2013 performance?

Kimberly Spalding-Bush: So I 'm not — if I understood your scenario correctly, that the group in 2013 — so, the Value Modifier is applied at the Tax ID Number level.

Janice Beck: Right, so we had about 40 providers in 2013 under a different Tax ID. And in June of this year, those 40 providers joined another group of about 300 providers and are now submitting claims under that larger group provider's TIN.

Kimberly Spalding-Bush: Right, so I think this is similar to a question that came up earlier on the call, which has to do with where you're located during the payment adjustment year.

Janice Beck: Um-hum.

Kimberly Spalding-Bush: So because we apply the Value Modifier is at the TIN level, in that payment year, they will be receiving adjustments to Medicare payments that are made to that TIN. So, if they bill to that TIN, then, yes.

Janice Beck: Based on that one. OK, all right. Thank you.

Kimberly Spalding-Bush: Sure.

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

Therese Kaag: Hi, thank you very much for today's presentation. I personally find it very helpful. So I have a question for you. I work for a large academic medical center. We have about 1,700 eligible professionals and we have multiple specialties and even more subspecialties. So on our 2013 QRUR report exhibit 5, we submitted some measure where the peer group says not applicable or not available.

So I wonder what this means. I assume it means that no other group submitted the same PQRS measure. But then I wonder what the impact is to our quality composite.

Kimberly Spalding-Bush: Thank you for that question. I think we'll ask our colleagues on the phone line. Mai, are you able to respond to what that would mean if they had a not available peer group?

Mai Hubbard: Sure. So because of — the quality measures are calculated based off the prior year's performance — so for the 2013 QRURs, the benchmarks are based on 2012 quality metrics. If there was no measure reported under — within 2012, then it would show up as not applicable or as a dash in your report. So it's possible that that PQRS measure just wasn't reported in 2012.

Therese Kaag: OK, and then what's the impact to our quality composite on something like that?

Mai Hubbard: There would be no impact since as long as there is no benchmark calculated for that measure, it would not be included in the quality composite score.

Therese Kaag: OK, thank you so much.

Mai Hubbard: Um-hum.

Operator: Your next question comes from the line of Mercedes Weston.

Mercedes Weston: Hi, my question is, our group, along with others here at our institution, has unknowingly been linked to an ACO and now we're unable to view our

QRUR report. Is there going to be an option to view any of the data at a later time or is there an option?

John Pilotte: Hi, this is John Pilotte. So in — for 2013 performance year, if you were in a — if the TIN was in an ACO, it was not subject to the Value Modifier and, therefore, we did not provide QRUR reports to those TINs. However, your ACO that you participate in did actually receive a quality feedback report based on its quality reporting for 2013 as well as a financial reconciliation report as well for its financial performance for 2013. So I would encourage you to talk to your ACO about the performance on those results. I would also point out that next year — for 2014 — we actually will be providing QRURs to all TINs and solo practices, regardless of whether they're participating in a Shared Savings Program ACO.

Mercedes Weston: Thank you.

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

Sandy Pogones: Yes, I'm sorry. I tried to — I tried to cancel my question.

Operator: Your next question comes from the line of Priya Lamba.

Priya Lamba: Hi, So I have a question related to something that was asked earlier about the cost measures and not having 20 cases for the cost measures. So if you in the quality measures as well — if you don't have 20 cases for the measures and then you don't have 20 for the cost as well, would you receive a score of average and average for both and then be subject to the zero percent?

Kimberly Spalding-Bush: Yes, you would. If you had insufficient cases to have any quality measures or any cost measures calculated, then you would receive an average quality and cost composite.

Priya Lamba: OK.

Kimberly Spalding-Bush: And it's — and it's neutral adjustment under the Value Modifier.

Priya Lamba: OK, great. Thank you.

Operator: Your next question comes from the line of Kevin Craig.

Operator: You next question — you do have a followup from Jacqueline Matthews.

Jacqueline Matthews: OK, next question is CG-CAHPS. I know for groups greater than 100, we — you guys undertook the baseline CG-CAHPS survey and will be undertaking

the next one in a few months. Are we going to get those reports for our baseline CG-CAHPS results?

Lauren Fuentes: Hi, Jacqueline, this is Lauren Fuentes. So this — you – this is for PQRS CAHPS, right?

Jacqueline Matthews: Right.

Lauren Fuentes: Right. Yes, those reports will be going out for 2013 program year in early 2015.

Jacqueline Matthews: Great, OK. And, then — and, then, we'll see our '15 and the '16 QRUR maybe? I would — or will you send separate reports?

Lauren Fuentes: I think — you know I mean — no. I guess you elected to include CAHPS in your Value Modifier?

Jacqueline Matthews: We did.

Lauren Fuentes: For 2016?

Jacqueline Matthews: Yes.

Lauren Fuentes: OK, so you'll probably still receive a detailed CAHPS report that will be separate. But, I mean, yes, there will be — there will be CAHPS data in your QRUR since you — since you elected to include that.

Jacqueline Matthews: OK, great. Thanks so much.

Lauren Fuentes: You're welcome.

Operator: You do have a followup question from the line of Dana Garay.

Dana Garay: Yes, this is Dana. I'm sorry I couldn't get through earlier. I forgot to unmute. We are a large — over 100 — eligible professionals and we reported using the calculated administrative claims for 2013. My question is, now in 2014, we have elected to report our PQRS using the EHR. My CMO — CMIO wants to know what the difference in our quality composite score will look like from 2013 to 2014. In other words, what will that quality score be based on coming from 2013, using administrative claims, to 2014, using just PQRS?

Kimberly Spalding-Bush: So your quality composite would then reflect the performance on the measures for which you reported through EHR under PQRS.

Dana Garay: OK.

Kimberly Spalding-Bush: And then you'd also have — if the claims-based outcome measures that we calculate outside of PQRS for the Value Modifier ...

Dana Garay: Claims based ...

Kimberly Spalding-Bush: So we're no longer doing the administrative claims but we have — I think that might — maybe that's the source of confusion, that there are three claims-based outcome measures that we calculate for the Value Modifier. So you would see those as well as the EHR measures that you reported.

Dana Garay: Where can I get more information about what those claims-based outcome measures are?

Kimberly Spalding-Bush: So there's information on the Value Modifier website and we are looking to see if we can give you a more specific page to check out. So …

Tonya Smith: Right now, they're on our — 2012 QRUR page. I could tell you which document specifically or we can go on to another question.

Kimberly Spalding-Bush: We can go on to the next question if we have time for one more, and then we 'll get you the — the more direct place to look for that information.

Dana Garay: Oh, that would be so nice. Thank you so much.

Charlie Eleftheriou: OK, and we just have a couple of minutes for one last question.

Operator: Your last question comes from the line of Kathy Brady.

Kathy Brady: Hi, this may have been answered, but I just need some clarification. On my 2013 self-nomination I included three measures. And when I look at my reports on my performance and quality measures, they are not the three that we submitted. Hello?

Charlie Eleftheriou: Yes, we're here. Give us 1 quick second.

Kimberly Spalding-Bush: We're having a little trouble understanding your question. So, you self-nominated as a group?

Kathy Brady: Yes.

Kimberly Spalding-Bush: And then you reported three measures through GPRO?

Kathy Brady: Correct.

Kimberly Spalding-Bush: Registry?

Kathy Brady: Yes.

Kimberly Spalding-Bush: Yes.

Kimberly Spalding-Bush: And then the measures you're seeing in the QRUR are not the ones that you believe you reported through the registry?

Kathy Brady: They are not. I mean, I know what ones I reported and I see 43, 44, and 45 in here. They are not what I reported.

Kimberly Spalding-Bush: And you only did one registry?

Kathy Brady: Correct.

Kimberly Spalding-Bush: So I think we'd have to ask you to call the help desk and they can look at the specific measures.

Kathy Brady: Well, I actually have submitted a ticket and I haven't heard back yet. I suppose my ….

Kimberly Spalding-Bush: We 're going to give you an additional email address so that just — so we can make sure we follow up with you.

Tonya Smith: Yes, you can — you can send your question to qrur@cms.hhs.gov.

Kathy Brady: OK.

Kimberly Spalding-Bush: And if you have the ticket number that you receive, that would be helpful for us, too.

Kathy Brady: OK.

Tonya Smith: And for that previous caller who asked about where are the outcome — the three claims-based outcome measures that Kim spoke of. On the 2012 QRUR page, there is document that says "Ambulatory Care Sensitive Conditions and Care Coordination Outcome Measures for the 2012 (Inaudible)" The document contains it there and we'll have a similar document updated on the 2013 QRUR page.

Additional Information

Charlie Eleftheriou: OK, thank you. So that's — I guess we've reached the end of our time today.

So on slide 50 you'll find information on how to evaluate your experience with today's call. We'd appreciate it. Evaluations are anonymous, confidential, and voluntary. We do hope you'll take a few moments to evaluate your MLN Connects Call experience.

I'd like to thank our subject matter experts here at CMS and all the participants who joined us for today's call. Have a great day everyone, and we'll talk to you next time.

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

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