Centers for Medicare & Medicaid Services
CMS Proposals for the Physician Value-Based Payment Modifier
Under the Medicare Physician Fee Schedule
National Provider Call
Moderator: Nicole Cooney
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Contents

Operator: At this time, I'd like to welcome everyone to the CMS Proposals for the Physician Value-Based Payment Modifier Under the Medicare Physician Fee Schedule 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 objection, you may disconnect at this time. Thank you for your participation on today's call. I will now turn the call over to Nicole Cooney. Thank you, Ma'am. You may begin.

Introduction

Nicole Cooney: Thank you, Holley.

Hello, I'm Nicole Cooney from the Provider Communications Group here at CMS and I'll serve as your moderator for today's call. I'd like to welcome you to our National Provider Call entitled, "CMS Proposals for the Physician Value-Based Payment Modifier Under the Medicare Physician Fee Schedule."

Today, we have CMS subject-matter expert here to discuss these proposals as well as address questions and comments related to them and the overall Physician Feedback Program. Before we get started, there are a few items that I need to cover.

The slide presentation for today's call was posted on CMS Web site on Monday, July 30th. A link to this presentation was e-mailed to all registrants earlier this afternoon. If you did not receive this e-mail, please check your spam or junk mail folders for an e-mail from the CMS National Provider Calls Resource Box.

This call is being recorded and transcribed, and all your recording and written transcripts will be posted to the CMS Physician Feedback Program section. The URL for that Web site is located on the final slide of today's presentation. A direct link to where these materials will be posted was also included in the e-mail that went out to registrants earlier today.

I'd also like to thank those of you who submitted comments and questions when you registered for today's call. Your comments and questions were shared with the speakers to help prepare slides and remarks for today's presentation.

At this time, I would like to introduce our presenter for today, Dr. Sheila Roman, Senior Medical Officer in the Performance-Based Payment Policy Group in the Center for Medicare.

And now it's my pleasure to turn the call over to Dr. Roman.

Presentation

Sheila Roman: Thanks very much, Nicole. And good morning to those on the West Coast, and good afternoon to everyone else around the country. And as Holley introduced this call – on this call, we'll share proposals made for calculating the Value Modifier that we published in the July 2012 proposed Physician Fee Schedule, with special emphasis on who the Value Modifier will apply to in 2015, how it will be applied, and the proposed methodology for calculating the Value Modifier by a tiering approach.

We'll explain how participation in the Physician Quality Reporting System affects a group's participation in the Value Modifier. We will review the timeframes and deadlines for groups of physicians for whom the Value Modifier will be implemented in 2015. And then we'll open it up for answering questions.

Just in case I forget to mention later in the call, I would like to remind people that we are now in a proposed rule period. We will be accepting comments until September 4th, and I would encourage people to submit comments to us on our proposal.

I'm going to start with a summary overview which I hope will become clearer as I go through the next 14 or 15 slides of this presentation. We designed the proposals for this – for the Value Modifier to provide groups of physicians with 25 or more eligible professionals an option that their Value Modifier be zero or be calculated using a tiering approach if they were PQRS, Physician Quality Reporting System, reporters, or they would be subject to a -1%

payment reduction if they were not successful PQRS reporters or if they did not report data at all.

The focus of – we focused our payment adjustment, both the upward and downward adjustments, on those groups of physicians that are outliers—that is, on those that are significantly different from the national mean.

And finally, we aligned the Value Modifier program with the Physician Quality Reporting System program and also utilized Medicare claims data to reduce the administrative burden on groups of physicians.

Can I have the slide before that? Thank you.

We are required to begin implementation of the Value Modifier and to phase it in starting in 2015. By 2017, all physicians will be included under the Value Modifier. The Value Modifier assesses growth, quality of care furnished, compared to the cost of that care. And we'll talk both about quality measures and cost measures.

We propose to apply the Value Modifier for physician payments in all groups of 25 or more eligible professionals starting in 2015 at the tax ID level. I want to remind everyone that CMS finalized on 2013 the initial performance period in the 2012 Physician Fee Schedule Final Rules with Comments, to be applied in 2015. For the 2013 proposed rule, we propose to use calendar year 2014 as the performance period to be applied in 2015.

Next slide, please.

On this slide, as you can see, groups that are eligible for the Value Modifier—that is, groups with greater than or equal the 25 eligible professionals in 2013 who will have the Value Modifier applied in 2015—can be separated into two categories. Those categories being groups that are satisfactory PQRS reporters, and that first category includes groups of 25 or more eligible professionals who meet the required – that – who meet the criteria for satisfactory reporting under PQRS. They can have their Value Modifier set at zero just by satisfactorily submitting quality measures data under PQRS. This means that the Value-Based Payment Modifier will not affect their payments.

They will also be offered an option to elect to use a quality tiered approach based on performance tiers – high, medium, low – for their Value Modifier. This would mean an upward payment adjustment for high performance – high-quality, low-cost – or risk a downward adjustment for poor performance – low-quality, high-cost.

Groups with 25 or more eligible professionals who have not met the PQRS criteria for satisfactory reporting or chose not to participate in PQRS – this is the other category – will be subject to a Value Modifier at -1%.

Next slide, please.

On this slide, we demonstrate the proposed timeline for the Value Modifier, that applies starting January 1st, 2015. And as I mentioned, this is the – what we're talking about today are the policies and the proposed rule, so that it will be important for those on the call to be mindful that in – on November – on November 1st, we will be finalizing in the final rule the policies for the Value Modifier.

But based on the – the current policy, by January 31st, 2013, groups of 25 or more eligible professionals should self-nominate as a group for PQRS, and select a PQRS reporting method, and we'll talk about the reporting method – methods on the following slides.

By the third quarter of 2013, you should receive from CMS a Quality and Resource Use Report, a Physician Feedback Report, that shows 2012 performance data and also shows how the Value Modifier would apply to you based on your 2012 data. This should help you determine whether – determine whether you want to have a Value Modifier of zero as a successful PQRS reporter, or go on to have a Value Modifier calculated through quality tiering.

By December of that year, you will need to elect the quality tiering calculation approach for the Value Modifier that would start on 1/1/2015. On the first quarter of 2014, you would be completing submission of the 2013 information for PQRS by PQRS rules. And by the third quarter, CMS would disseminate a Physician Feedback Report to you showing 2013 performance data, and how the Value Modifier would apply starting 1/1/2015.

And finally, on January 1st, 2015, the Value Modifier applies to payment for items and services provided by physicians in groups of 25 or more eligible professionals.

Next slide.

I'm now on the next slide on the Reporting Quality Data at the Group Level slide. Group must select one of the five PQRS quality reporting methods, and that information will be used for the Value Modifier to avoid the -1% Value Modifier adjustment.

For groups between 25 and 99, they have the three options that include claims, registries, and EHRs, in which they are able to select the quality measures that they will report.

For groups that are greater than 100, they have two options, the Web interface, the PQRS Web interface, which includes 22 measures to focus on preventive care for chronic disease, and in which PQRS will give you a list of your patient population for which on – on which to report data. Or you can select the PQRS administrative claims options for 2013 and 2014, which includes 15 measures that would be calculated by CMS from administrative claims data.

On slide number 7 – this slide reviews other quality measures that we also will be calculating for all groups. And those include four outcome measures: a 30-day post-discharge visit; an all-cause readmission measure; and, using the prevention quality indicators from the Agency for Healthcare Research and Quality, potentially preventable admissions of ambulatory care – sensitive conditions that we will composite into two composites: an acute composite consisting of bacterial pneumonias, urinary tract infections, dehydration; and a chronic composite consisting of COPD, heart failure, and a composite of a series of diabetes – potentially preventable admissions.

On slide 8, I want to review the interaction between group and individual PQRS reporting. To avoid all PQRS penalties, groups of 25 or more eligible physicians can – can report at the group – at the group level, or as individuals. However, if the group reports – that is, a group of greater than or equal to 25

or more eligible professionals – at the individual level, and not at a group level, the group will be subject to the Value Modifier downward adjustment of -1%.

I want to remind everybody about the definition of eligible professionals, and eligible professionals include physicians, and those include MDs, DOs, podiatrists, optometrists, dentists, and chiropractors; practitioners including PAs, MPs, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwifes, clinical social workers, clinical psychologists, registered dietitians, nutrition professionals, and audiologists; and therapists, including PTs, OTs, and qualified speech-language therapists.

So these are included in the eligible professionals as we determine groups of 25 or greater. However, by the statute, only physicians will have the Value Modifier applied until 2017. After 2017, the Value Modifier may be applied to other eligible professionals.

On slide 9, we move now to the other half of the Value Modifier and that is really the cost measures. And the cost measures that we will be using are the cost measures that we have used in the Physician Feedback Reports for the last five years, and those include total per capita cost measures overall, and total per capita costs for beneficiaries with four chronic conditions, including chronic obstructive pulmonary disease, heart failure, coronary artery disease, and diabetes.

Our proposed attribution method is the plurality of charges, with a minimum of two E&M services. I want to remind folks that the total per capita costs are risk-adjusted for patient demographics, prior health conditions, Medicaid eligibility status, reason for Medicare eligibility, and (EFRZ) status, and that the payments are price-standardized.

The next few slides – and I'm on slide 10 now – describe the scoring for the quality tiering option calculation for the Value Modifier. And essentially, we combine each quality measure – each measure into a composite, and – using the following domains: for the quality composites, the quality measures used

in the Value Modifier are classified into one of the national quality domains that you see listed there.

Each quality measure within each domain is weighted equally, each domain is weighted equally to form a quality composite, and if there are no measures in the domain, the remaining domains are equally weighted.

For the cost composites, the five cost measures are grouped into two domains: total overall costs, the total per capita cost measure; and total cost for beneficiaries with the four specific conditions. Likewise, each measure within each domain is weighted equally, and each domain is weighted equally to form a cost composite.

OK. I think my slides may be out of sync a little bit, so I'm on – what your slide 12 should be now, which is How to Calculate the Quality of Care and Cost Composite. Essentially, we propose to create a standardized score based on how far the group's performance is from the national mean.

A standardized score of zero means the performance is at the national mean. Higher scores mean the performance is better than the national mean. A negative score means the performance is lower than the national mean.

So, essentially, we're looking at the distance from the national mean divided by the standard deviation to obtain our standardized score. And then the standardized score for each measure is averaged to create the domain score.

On slide 13, we show the quality tiering option. And essentially, this – what we do is – what we're proposing is to divide the composite score for cost and quality into three tiers. We propose one standard deviation with a 95% confidence interval away from the mean, which shows that we're really focusing on outliers.

Due to budget neutrality, we cannot speculate the upward payment adjustment, but we can show the downward payment adjustment as essentially, minus – a maximum of – 1%, similar to the category of non-PQRS participants or unsuccessful PQRS participants.

And finally, I want to point out that there is an additional upward payment adjustment for groups with patients with a highest risk scores or the most complex patients with the highest number of comorbidities.

On slide 14, we talk – I want to talk a little bit about the potential impact of quality tiering and making decisions on how to move to quality tiering. The quality tiering allows physician choice for – on which quality measures to report data and how to report that data, so that you can show high-quality care.

The quality tiering rewards most highly high quality and low cost. The proposed methodology focuses on outliers and most groups' composite scores will be classified as average. And essentially, there is no risk, only an upward payment adjustment, if the group is determined to be low cost or high quality.

And on slide 15, I want to recap a little bit – what groups of 25 or greater eligible providers need to do to avoid the downward or -1% adjustment for the Value Modifier in 2015. They need to participate in PQRS. They need to self-nominate as a group in the PQRS GPRO. They need to select one of the five PQRS GPRO reporting methods. They need to satisfactorily report the required number of measures for the required number of beneficiaries. And finally, they need to decide whether to choose the quality tiering approach to calculate the Value Modifier by assessing their risk.

I want to – on slide 16, just say a few words about the Physician Feedback Reports. Our plan is to provide to physicians in nine states this year, Fall of 2012, Physician Feedback Reports based on 2011 data, for – to be disseminated in Fall of 2013. We plan to provide Physician Feedback Reports to all groups of greater than or equal to 25 eligible professionals in 2013. And this is based on 2012 data, and will include the Value Modifier information, so that an informed decision can be made on whether to choose the quality tiering approach.

And I just want to briefly mention that for Fall 2013 based on 2012 data, Physician Compare will begin a public reporting of group practice states that data only based on those that participated in the Web-based interface.

Polling

Nicole Cooney: OK. Thank you, Sheila.

I just wanted to take a moment to apologize. I know that we had some sound quality issues there in the beginning, but I think we've now neutralized the major cause of that issue. So I appreciate everyone's patience on the line. And at that this time, we'll pause for just a few minutes to complete keypad polling, so that CMS has an accurate count of the number of participants on the line with us today.

Please note: There may be moments of silence while we tabulate the results. Holley, we're ready to start the polling.

Operator: CMS greatly appreciates that many of you minimize the Government's teleconference expense by listening to these calls together in your office using only one line.

Today we would like to obtain an estimate of the number of participants and attendants to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number between 2 and 8. 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 between 2 and 8. 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 for your participation. We will now move into the Q&A session for this call.

Question and Answer Session

Nicole Cooney: Thanks, Holley. Today we have three experts here to take your questions. Of course, we have Dr. Roman. Also in the room with us is Michael Wroblewski, senior technical advisor in the Center for Medicare, as well as Aucha Prachanronarong, Division Director in the Center for Clinical Standards and Quality, which is responsible for the PQRS program.

I'd just like to call everyone's attention to slide number 17, and I want to remind everyone the call is being recorded and transcribed, but we do have almost 700 folks – lines on the call with us today. So, in the interest of time, we're asking that everyone limit their question to one. You can get back in the queue to ask a followup question, and we will take as many questions as possible today.

Before asking your question, if you'll state your name and the name of your organization, and, Holley, we're 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, please press the pound key.

Please state your name and organization prior to asking a question, and pick up your handset before asking your question to ensure clarity. Please note, your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Your first question comes from the line of Mary Smith.

Mary Smith: Hi, Mary Smith from Pulmonary and Sleep Physicians.

Nicole Cooney: Hi, Mary. What's your question?

Mary Smith: Yes, I'm just calling – I know you're talking about groups of 25 and more. What happens to the group that are just under that?

Sheila Roman: They will be exempted from the Value Modifier for 2015.

Mary Smith: So that they would – there would be no penalty either way.

Sheila Roman: That's right.

Mary Smith: Nor would there be an ability to get the plus – it would just be a zero level.

Sheila Roman: That's right.

Mary Smith: OK, all right. I just wanted to make sure I understood that.

Sheila Roman: And they would not, you know, they would not be required to participate for the Value Modifier. Of course, for the PQRS incentive, you would be required to participate.

Mary Smith: Oh, so that – so there will be the PQRS incentive?

Sheila Roman: Yes.

Mary Smith: OK. Got it. All right. Thank you so much.

Sheila Roman: You're welcome.

Nicole Cooney: Thanks for your question, Mary.

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

Jennifer Meeks: Hi, this is Jennifer Meeks with the American Medical Association.

And my question relates to calculating the quality mean score, and I have the display version of the proposed rule, which is on pages 606 and 607, and I'm just seeking clarification of CMS proposing to come up with a quality mean score by only looking at the claims-based reporting option for PQRS – or will you do a separate mean score depending on the quality reporting option that each group practice selects?

Sheila Roman: I…

Jennifer Meeks: Hello?

Sheila Roman: Yes, you're asking if we would do a set – if someone – if the choice is for the claims-based option, how we would do that. We would do a similarly – a

standardized score measure by measure – summarize that, and then – for cost and for quality – and then do tiering.

Jennifer Meeks: Yes, sorry, maybe I wasn't clear. It states here that you propose that the benchmarks for quality measures and the PQRS administrative claims-based reporting option be the national mean of each quality measures performance – right?

Sheila Roman: Yes, yes.

Jennifer Meeks: And I guess that we're just concerned, because obviously, there are some group practices that will elect claims, registry, or EHR reporting options. And so, I just was curious as to – are you using just the PQRS claims-based reporting option to calculate this mean, or are you including each reporting option, and what they're doing – whether it's claims, EHR, registry, or claims – to calculate the mean?

Michael Wroblewski: Hey, Jennifer. It's Michael Wroblewski.

We are calculating one mean per measure, regardless of the method in which it is reported.

Jennifer Meeks: Right. Thank you.

Nicole Cooney: Thank you for your question.

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

Dennis Beck: Yes, hi, Dr. Dennis Beck with American College of Emergency Physicians.

I got a question regarding the GPRO reporting requirement for groups of 25 or more. Emergency medicine successfully has been reporting near the top of all specialties relative to PQRS on claims-based reporting. Our concern is that the GPRO measures are not really applicable to all of emergency medicine. They are longitudinal preventive care measures that can't really be applied to emergency physicians.

So, my question is how will emergency physician groups of greater than 25 successfully be able to report under this new guideline?

Aucha Prachanronarong: Hi, this is Aucha Prachanronarong. So under our proposals for PQRS, groups would have the ability to choose any of the reporting methods that are currently available for individual physicians and eligible professionals. So practice of emergency physicians could select to participate in the Group Practice Reporting Option through the claims-based reporting method, and report the same measures that you've been reporting.

Dennis Beck: So, to clarify: We can continue to report via the claims-based method.

Aucha Prachanronarong: Correct…

Dennis Beck: OK.

Aucha Prachanronarong: …based on what we've proposed for 2013.

Dennis Beck: Thank you.

Nicole Cooney: Thank you so much for your question.

Operator: The next question comes from the line of Carolyn Roberts.

Carolyn Roberts: Hi, this is Carolyn Roberts. I'm with Baystate Medical Practices, and I have one question that – well, I probably have a lot of questions, but I'm only going to ask one. I'm trying to get a concept of how the Value-Based Modifier aligns or relates with the ACO and advanced payment model? Like an overall picture of where this fits in?

Sheila Roman: That – that's a great question that I meant to list the exceptions, and we have proposed that the physicians in the Accountable Care Organization that participate in the Medicare Shared Savings Program and the Pioneer ACOs be exempted in 2015 from the Value Modifier.

I might also add that – that Federally Qualified Health Centers, and Rural Health Clinics, as well as Critical Access Hospitals billing under method 2 are exempted because they're not paid under the Physician Fee Schedule.

Carolyn Roberts: OK, so the proposal will be that those reporting – those who are approved for ACOs and – will now be – will be exempt for 2015 – right? – from the Value-Based Modifier application.

Sheila Roman: Yes.

Carolyn Roberts: What – and what about subsequent years?

Michael Wroblewski: Carolyn, this is Michael Wroblewski. We have a – we have not made proposals for 2016 and beyond. We've asked for comment, though, on how to apply the Value-Based Modifier to those physicians who are a part of ACOs, those a part of the Pioneers, and those receiving the advanced payment. So any comments on that would be appreciated.

Carolyn Roberts: OK. Thank you very much, Michael.

Michael Wroblewski: Sure, thank you.

Operator: Your next question comes from the line of Donna Stewart.

Donna Stewart: Hi, my name's Donna Stewart. I'm with Children's Health Systems.

My question with regard to the Value-Based Modifier is: I have a group that is more than 25 providers, but we are pediatric surgeon specialties. So the only reason we even participate with Medicare is for our end-stage renal disease kids, which are not typically our patients, but will commonly have a surgical need.

And so, even though we're over 25 providers because we're not primarily a Medicare provider, is there going to be an exemption process or something for those types of providers? Because we just went through the e-prescribing, and we ended – it was going to be so resource-intensive to even keep up with the exemptions that we decided to just take the reduction in our fee scheduled payments for that, but it just seems like these things are coming more and more. Is there any exemption for, like, pediatric providers?

Sheila Roman: Yes, I think that would be a great comment to send in.

Donna Stewart: OK.

Sheila Roman: Thank you.

Donna Stewart: Are you guys going to send instructions on how to do that?

Michael Wroblewski: Do you mean instructions on how to send a comment in?

Donna Stewart: Yes. Or we have to go to the Federal Register to pick it up?

Michael Wroblewski: We'll get you an answer in about five minutes, if you'll just hold the line, I'll get an answer for you, hold on, OK?

Donna Stewart: OK.

Michael Wroblewski: And we'll go to the next question.

Operator: The next question comes from the line of Brian Vamstad.

Brian Vamstad: Hi, Dr. Roman. Thank you for having this call today. It's Brian Vamstad from Gundersen Lutheran Health System in La Crosse, Wisconsin. I have a question regards to – how did you come up with groups of 25, or 25 as your established number? I was wondering what was your reasoning behind that and how you arrived at that? Thank you.

Sheila Roman: Twenty-five or greater EPs is what the Physician Quality Reporting System has used for the past year or two for its Web-based interface. So, we felt that – that that reflected a sufficient number of – of patients to suffice as a group. Also, when we think about – the statute also requires us to emphasize systems-based care, and a group of 25 or greater EPs generally has the resources to begin to deliver systems-based care to its patient population, and to look at its patient population as a whole.

Brian Vamstad: OK. Thank you.

Nicole Cooney: Thanks for your question.

Operator: The next question comes from the line of Susan Driesel.

Susan Driesel: Hi, this is Susan Driesel with Warren Clinic.

I note the nine states that will be getting this Physician Feedback Report. I just wanted to confirm that the 55 2011 GPRO participants will also be getting those reports?

Sheila Roman: Yes.

Susan Driesel: Great. Thanks.

Nicole Cooney: Thank you for your question.

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

Kathleen Stanton: My – my question has already been answered. Thank you.

Nicole Cooney: Thank you. Next question, Holley.

Operator: Your next question comes from the line Colleen Mitchell.

Colleen Mitchell: Hi, this is Colleen Mitchell with Healthstar Physicians in Hot Springs, Arkansas.

We currently have less than 25 providers, but we plan to add more providers in the near future, and we're participating in the CPCI. Now, will we be exempt from this in 2015?

Sheila Roman: I – I don't think we've put anything in the proposed rule related to that, but please send a comment in.

Colleen Mitchell: OK. Right now, we don't have greater than 25, but if we do have greater than 25 before 2015, do we need to participate – to go ahead and do this, or…?

Michael Wroblewski: We didn't make any proposals regarding participation at PCPI as we had for the Shared Savings Program and Pioneers, but it would be a great comment if you think we should.

Colleen Mitchell: OK, OK, we will do that then.

Michael Wroblewski: OK, thank you.

Colleen Mitchell: Thank you.

Operator: Your next question comes from the line of Genevieve Davis.

Genevieve Davis: Hi. We wanted to ask about the graph on slide 7. Everything talks about groups of greater than 25 or groups between 25 through 99, but the presenter made a comment about groups over 100, but I don't see them listed in any of these categories. So could you clarify that?

Sheila Roman: And I'll now ask Aucha to chime in as well. And that is that PQRS has required that groups of greater than or 100 eligible professionals for this year be required to use the Web interface.

Genevieve Davis: Right.

Sheila Roman: So that would leave you essentially two options, the Web interface or the claims-based option.

Aucha Prachanronarong: Sheila is correct. For groups – for groups of 100 or more, the only method that we've proposed for PQRS is the Web interface, or for purposes of the payment adjustment, selecting the admin claims option.

Genevieve Davis: OK. Thank you.

Nicole Cooney: Thanks for your question.

Operator: Your next question comes from the line (Debbie Cruise).

(Debbie Cruise): Yes. We are a group under 25 and are an anesthesia group only. Do we need to participate in the PQRS?

Aucha Prachanronarong: PQRS – if you don't participate in the PQRS in 2013, then you could be subject to a payment adjustment in 2015 specifically for PQRS. And in 2015, the payment adjustment is a 1–1/2% reduction.

(Debbie Cruise): And where do we find out what guidelines we should use for participation?

Aucha Prachanronarong: Those are also contained in the proposed 2013 Physician Fee Schedule, and then I'll take this as an opportunity to mention that on Tuesday, August 7th, we're having a National Provider Call as well to go over what we've proposed for PQRS.

(Debbie Cruise): OK. Thank you very much.

Michael Wroblewski: And I just wanted to get back – this is Michael Wroblewski again – I wanted to get back to the question or about how to file comments.

There are multiple ways that you can file comments. The easiest will be electronically – if you go to www.regulations.gov, and the docket number that you want to use is CMS-1590-P.

Operator: OK. Your next question comes from the line of Sharon Merrick.

Sharon Merrick: Hi, Sharon Merrick with ASA.

Getting back to the question about if a group has more than 99 providers, so that their reporting options are the Web interface or the administrative claim: If it were a specialty group – I'm with ASA – anesthesiology – I'm concerned, because the focus of the measures are essentially preventative care or chronic disease, which wouldn't necessarily apply to anesthesiologists. So what would happen in that instance?

Aucha Prachanronarong: So, at least, for PQRS, what we've proposed is groups still have the option of choosing whether to participate as a group or an eligible – or as individuals. So, in lieu of participating using the Web interface, the individuals in the group practice could individually participate using claims registry or an EHR.

Sharon Merrick: But wouldn't that – so that would take care of them for PQRS…

Aucha Prachanronarong: Right.

Sharon Merrick: …but not for VBM.

Sheila Roman: Right. You're right. It doesn't take care of the -1% for Value Modifier. And I would suggest that you send in a comment.

Sharon Merrick: OK. Great, we'll do that. Thank you.

Nicole Cooney: Thank you for your question.

Operator: Your next question comes from the line Jessica Torgerson.

Jessica Torteson: Hi, my name is Jessica Torgerson, and I'm calling with the Medical Society of Northern Virginia. And I noticed that in the nine states that you have listed for reporting, Virginia isn't one of them. So, does that mean that Virginia isn't participating in the reporting just yet?

Sheila Roman: The performance year for the beginning – the performance year for the Value Modifier, which starts on January 1st, 2015, is the performance year 2013. We have been exponentially increasing the number of reports that we send out to folks. But those folks are receiving Physician Feedback Reports that are not Value Modifier reports at this point.

Jessica Torgerson: OK. And then, just this followup questions about – sorry – can physicians – if they – if the state isn't participating, can physicians just start participating in this reporting anyways, so that when they get to the point where the state does start sending out reports, they have a little bit more to base off of?

Sheila Roman: Participating in the Physician Quality Reporting System – you're sort of half – half the way there.

Jessica Torgerson: Yes. All right, thank you very much.

Nicole Cooney: Thanks for your question.

Operator: Your next question comes from the line Jim Besjak.

Jim Besjak: Hi, this is Jim Besjak, SIU HealthCare Springfield, Illinois. And we participated in both the 2010, and just now finished up the 2011 GPRO program, and we are participating in the 2012. My question is – and it came up after we digested the data from 2010 – is you mentioned that we're going

to be compared to the national average as far as the benchmark to where we're going to have that Value-Based Modifier be determinative of our reimbursement or not. And we are just kind of concerned that, compared to the national average, it doesn't necessarily equate with quality. So if we have a national benchmark, let's say, at 50%, is that good or bad in the mammography category? And is CMS going to come up with some benchmarks that may be are more realistic of true quality as opposed to just a national average across the board?

Michael Wroblewski: What we've proposed is to use the national benchmark regardless of how the information is reported – whether at the group level or the individual level. And as Dr. Roman indicated, we're actually providing the – we're then looking at the quality measures that have been reported by a group of 25, making a quality composite, and then dividing that into high, average, and low.

So the folks who will be getting the upward adjustments will be significantly above the – the national average. And those who are below, significantly below, will be the ones who would be deemed – that quality composite would be deemed of lower quality.

So, I think the payment would be – is based on actually high-quality performance. But, if there's other ways in which to do that or to set the benchmarks, we'd welcome a comment.

Jim Besjak: OK. Thank you.

Nicole Cooney: Thank you.

Operator: Your next question comes from the line of Kristy Gould.

Kristy Gould: Hi, I was curious to find out – sorry, I was curious to find out: the patient experience side – can you tell me a little bit more about how that's going to – to play into the reporting measures?

Michael Wroblewski: We didn't make any proposals regarding patient experience measures to be included in the Value Modifier calculation.

Kristy Gould: If I'm looking at the graph on page – on page 11 of the presentation, it says, clinical care, patient experience, patient safety, care coordination, and efficiency – am I misinterpreting that?

Michael Wroblewski: No, you – it's a great question. What – what we tried to do there was to – our – the national quality strategy lays out certain domains. And those are the – the domains that are listed there – are the ones that are in the national quality strategy. If a – if a domain does not have measures yet, then that domain wouldn't be counted. So, for completeness, we have put patient experience in the chart, because it did align with the national quality strategy.

There are no PQRS measures that are – right now – that would be in that domain, so that domain would be empty, and then there's just really only four. Does that help?

Kristy Gould: It does. Is there any – as far as, we're just – we're hearing a lot more about the patient experience and required – required information to be submitted in the next couple of years, and we were just trying to figure out a little bit more about how that piece is going to play – and I don't know if you can maybe talk a little bit about that, if you're even aware of that.

Michael Wroblewski: It's a great question. We have made proposals regarding Physician Compare…

Kristy Gould: Yes.

Michael Wroblewski: …which is the – which is the Web site…

Kristy Gould: Yes.

Michael Wroblewski: …that PQRS groups that sign up for PQRS self-nominate in – next year – that CMS – we've proposed that CMS would conduct a patient experience survey using a CAPS clinician group–based survey.

Kristy Gould: Yes.

Michael Wroblewski: But CMS – the proposal is that CMS would be paying for that. And we've asked for comment. I think we've made in the proposals that we'd be

paying for it for two years, and that we would be kind of testing out the measures and the survey, and asking for comment on how to move forward with that.

But we're trying to develop an instrument at this particular time, but have made no plans to – have made no proposals at this time for how to put it into a Value-Based Payment Modifier.

Kristy Gould: Super. Thank you.

Michael Wroblewski: You're welcome.

Operator: Your next question comes from the line of Helen Royals.

Helen Royals: Hi, I'm Helen Royals from Marietta Dermatology in Marietta, Georgia.

I know that there was a question asked about the less-than-25-member groups, but I wanted to clarify – if we have less than 25 physicians in 2012 or 2013, but by 2015 we are 25 or more, how will – how do we need to qualify?

Michael Wroblewski: It's a great question. The performance fee – we'd be looking at the group size during the performance period.

Helen Royals: Yes.

Michael Wroblewski: The performance – the performance period for 2015 – that starts January 1st, 2015 – is calendar year 2013. And then, as Dr. Roman indicated, the performance period for the payment adjustment that begins for calendar year '16, would be a calendar year '14. So in the year that, you know…

Helen Royals: OK. That makes sense.

Michael Wroblewski: …does that…

Helen Royals: Yes, I wanted to make sure that – that, yes.

Michael Wroblewski: Yes, that's it.

Helen Royals: Thank you very much.

Michael Wroblewski: You're welcome.

Nicole Cooney: Thank you for your question.

Operator: Your next question comes from the line of Tom Schlesinger.

Tom Schlesinger: Hi, this is Tom Schlesinger.

I had a question. It seems like it's a fairly small group of physicians that will end up being in the Value Modifier pool, and like you said, many of those are with the systems and processes you're looking at. But then is the money just being redistributed among this sort of a higher functioning group? And you're sort of penalizing them – the people that participate – it seems.

Michael Wroblewski: The way that just – if you'll go back and look at chart – the chart on page – I think it was 6 of the slides – make sure I have it right – it's the one that has the kind of a diagram on it.

Tom Schlesinger: Yes.

Michael Wroblewski: So, the pool of – you're right that the program is budget neutral. So, the money that is taken from the groups that are nonsatisfactory reporters, that -1% downward adjustment…

Tom Schlesinger: Yes.

Michael Wroblewski: …as well as those that have high cost/low quality and have elected quality tiering – we'll go to fund those who have elected quality tiering and have high performance, meaning either high quality or low cost.

Tom Schlesinger: Oh, it's not just those who like – who like quality tiering.

Michael Wroblewski: That's correct. So the pool is actually funded by not only those who elect quality tiering, but those ones who didn't satisfactorily report.

Sheila Roman: And look at slide 13 as well.

Tom Schlesinger: What percentage of physicians are we talking, do you know, that are above 25, in groups of 25? Is it 10% docs or…?

Michael Wroblewski: It's about four to – 4 to 6,000 groups, and that number is – I can – well, put an answer – I don't want to give you – it's not an insignificant number, but I don't want to give you the wrong number…

Tom Schlesinger: Sure.

Michael Wroblewski: …because I don't have it right off the top of my head.

Tom Schlesinger: Sounds great.

Michael Wroblewski: But it's not an insignificant number.

Tom Schlesinger: Thank you.

Nicole Cooney: Thank you for your question.

Operator: Your next question comes from the line of Mahala Echols.

Mahala Echols: Hi, this is Mahala Echols with Prescribed Planning.

I have a question about the phased-in approach of the providers who choose to participate willingly, beginning with the 2012 data submitted in the first quarter of 2013. These providers have the opportunity to submit the report, the PQRS data is sent in, the evaluations are returned. In 2015, they're then subject to the VM application of that penalty, whether they're being penalized 1%, 1.5%, and so on, every year thereafter. I believe the penalties have the opportunity to increase. What happens with new practices that are established in, say, 2015 with no prior history of Medicare participation or CMS, PQRS data? Are the new practices in 2015 given an advantage over the longstanding practices that have attempted to participate in this program?

In that, I mean, do they actually begin without a penalty, or are they automatically applied the highest penalty available until they earn back that money through PQRS reporting?

Michael Wroblewski: As we proposed, right now, if there was – a group was not in existence during the performance period, there would not be a payment adjustment during – you know, so if you're not in existence in '13, you won't have a payment adjustment in '15. If you think that there should be – then, we'd appreciate a comment on that.

Mahala Echols: Yes, I just wanted to know a little bit more about the advantages of being a longstanding provider going through the efforts of this program as opposed to just beginning a practice January 1st, 2015, and you get full payment.

Michael Wroblewski: I don't know if so – if there are advantages or disadvantages – it's what we – it's how we've proposed it, to kind of operationalize it. You know, at one point, 2015 will be a performance period for a payment adjustment in the future. So, it's just a phase-in – but I understand your concern in – and a comment would be appreciated.

Nicole Cooney: Thank you so much for your question.

Operator: Your next question comes from the line of Barbara Sack.

Barbara Sack: Hello. My name is Barbara Sack. I'm with Midwest Orthopaedics in Shawnee Mission, Kansas.

And I have been trying to figure out exactly how you will be determining quality for subspecialties like surgery. I downloaded all of our physicians QRUR reports, and all of the 10 different areas that are measured do not pertain to orthopedics.

And so all of our physicians have successfully participated in the PQRS program every year, but when I looked at the reports – for example, my foot and ankle physician had average costs that were higher than the median. And my sports medicine surgeon had average costs lower than the median. And these costs are an average of the overall cost per patient in the system. And so I was not at all surprised that my sports medicine doctor would have lower cost than average, because he sees healthy, sports-minded people who have hurt themselves. And he treats them, and they get better, and overall to the system, they cost less.

Then, the foot and ankle surgeon tends to see uncontrolled diabetics who need to have their feet amputated. And overall to the system, they cost more, but it's not due to his treatment. It is due to the uncontrolled diabetes, and his only option, it would seem, to not be penalized as having costs that are too high would be to decline to participate in that patient's care.

So, I'm trying to figure out exactly how you're determining quality if you are basing it on these QRUR reports.

Sheila Roman: Well, you know, I think you're right that, you know, we don't have quality measures that are specific to some subspecialists. So that we don't have quality measures for – that specific for a foot and ankle orthopedic specialist.

But if you're in a group of 25 to 99, there are orthopedic measures that you can choose to count for the quality size of the quality tiering. And within that quality tiering, we do sub – add on substantially for more complex patients. And I'm guessing that the patients that your foot and ankle doctor cares for would fall into that category that would receive increased compensation in the quality tiering approach.

Michael Wroblewski: Yes, Barbara, I know you – we've been playing – I know we've been playing phone tag for a while to try to set up a call with you independently.

You indicated that – that your – ten of your physicians have successfully and for several years participated in PQRS. Have they used – what – what method have they used to report their PQRS measures?

Barbara Sack: Their claims-based reporting for the surgical measures.

Michael Wroblewski: OK. OK. And in the QRUR that you picked up, there should've then been two sets of quality measures. The ones that – if we're in exhibit 1, which were the administrative claims ones, which won't apply if you participate in PQRS and choose your measures. So, in exhibit 2, it would be the – the measures that would be included in the Value Modifier would be the ones that you choose to report through PQRS.

Barbara Sack: So, it's an either/or?

Michael Wroblewski: Yes, yes. We have put the – in exhibit 1, those administrative claims measures…

Barbara Sack: Correct.

Michael Wroblewski: …to give a general feel in terms of the type of care that the beneficiaries were receiving from all Medicare providers, because we found out that many providers didn't know that the care was being for that – for kind of chronic conditions – you see what those measures were, they were chronic conditions, preventive care.

Barbara Sack: Right.

Michael Wroblewski: What kind of care were those beneficiaries receiving? But for the Value Modifier, if you elect the – if you elect those measures, then you can have them. But if you report through a PQRS and you select those measures, the ones that would be in the Value Modifier would be those ones that you report through PQRS.

Barbara Sack: OK. And that's very helpful. Thank you very much.

Michael Wroblewski: You're welcome.

Operator: Your next question comes from the line of Lee Eisenberg.

Lee Eisenberg: Hi, I'm an otolaryngologist with the American Academy of Otolaryngology–Head and Neck Surgery.

Sort of backing up to the orthopedic question: You know, when I look at most of this stuff, it's very primary care oriented – a lot of chronic disease, et cetera – and most otolaryngologists do fairly low risk, not very lengthy stay oriented stuff except maybe people who do head and neck cancer.

So, my question is – how is there going to be enough information for us to put into the system to qualify for any of this? We are having a tough enough time now with our PQRS stuff, to do things. So, you know, we as an academy have some concerns about that.

Sheila Roman: Well, I think that would be a good comment, and I would also encourage the academy to create additional measures that we could use for your specialty.

Lee Eisenberg: Done just for you?

Sheila Roman: I'm sorry.

Lee Eisenberg: We can just develop our own measures without any quality backing to the measures? That's my concern. You know, I will do more by e-mail, but I'm not sure that's the best way to go about that.

Sheila Roman: OK. And obviously, you know, please send a comment in.

Lee Eisenberg: Great. Thank you.

Nicole Cooney: Thank you for your question.

Operator: Your next question comes from the line of (Sarah Shrim).

(Sarah Shrim): Hi, this is (Sarah) from Rapid City Regional Health.

I wanted to clarify the group versus individual. We have individual but more than 25 providers that currently report individually. Do I need to switch all of our providers to the GPRO to avoid the penalty, or can my providers continue to report individually?

Aucha Prachanronarong: For the PQRS penalty, wouldn't necessarily have to switch your providers to do the GPRO reporting. But, however, for the Value Modifier, you would need to self-nominate for the PQRS GPRO reporting option.

(Sarah Shrim): OK. Thank you.

Nicole Cooney: Thanks for your question.

Operator: Your next question comes from the line of Mara McDermott.

Mara McDermott: Hi, Dr. Roman. This is Mara McDermott with Akin Gump and I was calling – I noticed the proposal in the PQRS section of the proposed rule that, for the purposes of the 2015 payment adjustment, physicians and physician groups

can become satisfactory reporters by reporting a single measure or measures group. And I was just curious if there's any relationship between that proposal and the Value Modifier?

Sheila Roman: No. That's purely to avoid the PQRS payment downward adjustments.

Mara McDermott: Thank you.

Nicole Cooney: Thank you for your question.

Operator: Your next question comes from the line of Koryn Rubin.

Koryn Rubin: Yes. Hi, this is a point of clarification, and I apologize if you've all ready gone over it. I stepped away.

In regards to the quality measures that you'll be calculating the four – is that only as the practice opts to do that tiering model, or is that also to be incorporated into their PQRS, that they would be held accountable to it?

Aucha Prachanronarong: Are you referring to the 30-day post-discharge – those four measures?

Koryn Rubin: Yes. The outcomes measure.

Sheila Roman: Those outcomes measures we would be calculating for all of the groups that are greater than or equal to 25 EPs, and that would be reported back to you in the report that you would receive in the Fall of 2013. However, only those who go on to the quality tiering calculations – we would actually then use that data to determine where they fall in quality tiering.

Koryn Rubin: OK. So only if they opt for the quality tiering then?

Sheila Roman: Right. But you would be receiving feedback on that information.

Koryn Rubin: Right. Thank you.

Operator: Your next question comes from the line of Rob Cox.

Rob Cox: My answers all ready been, I mean, my question has already been answered. Thank you.

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

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

Karen Miller: Hi, I'm Karen Miller from BayCare Clinic in Green Bay.

I just want to echo – we have over 100 providers, we've been successfully participating, but we are a specialty group, so it's going to be a problem if we have – we cannot report on these preventive measures. Along the same line, on the slide about calculating cost measures: Are you going to be comparing like physicians to like physicians, and is it based on episode of care, or just that individual physician's cost?

So, for example, if you do a total per capita cost of a surgeon versus a primary care doctor, those are – that's difficult to compare and judge quality on that – and cost.

Michael Wroblewski: What we have proposed was to – for groups of 100 or more, we would attribute beneficiaries using the plurality of care with a minimum of two visits, and we'd be calculating a per capita cost at the group level…

Karen Miller: Yes.

Michael Wroblewski: …and then comparing across all groups of 25 or more.

Karen Miller: So, surgeons would be compared against primary care physicians?

Michael Wroblewski: That's correct. If you – we'd appreciate a comment on that.

Karen Miller: Thank you.

Michael Wroblewski: You're welcome.

Operator: Your next question comes from the line of Fay Shamanski.

Fay Shamanski: Hello. This is Fay Shamanski. I'm with the College of American Pathologists.

I have a question about groups which participate in an ACO, but it's only a small portion of their patients that are part of the ACO. So, I'm wondering if,

you know, they're not allowed to participate in the PQRS if they're getting credit through an ACO, but what about the – their charges on their – 88% of their other patients? Will they be – will they get the Value Modifier applied to them in those cases? And how can they avoid it?

Michael Wroblewski: If the physicians are – bill under a single TIN…

Fay Shamanski: Yes.

Michael Wroblewski: …single Taxpayer Identification Number…

Fay Shamanski: Yes.

Michael Wroblewski: …and that TIN is a part of an ACO. We have proposed to not apply the Value Modifier to them in 2015.

Fay Shamanski: What about if they have a separate TIN from the ACO for their other patients? It's the same group, but they use…

Michael Wroblewski: Then, then, it would then – all these proposals apply, assuming that that TIN has 25 or more eligible professionals.

Fay Shamanski: OK. Makes sense. Thank you.

Michael Wroblewski: Yes.

Nicole Cooney: Thank you for your question.

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

Patricia Jones: Yes, my question – I really just want to confirm what I'm thinking. From my understanding, the PAs are not eligible to report until 2017. So we have 25 providers which include the PAs. So does that mean that our MDs will not be able to report until 2017 as well?

Sheila Roman: No, the MDs will be included in the VM. The – your PAs – was it PAs? – would not be included until after 2017. By 2017, we're to implement the VM

for all physicians. After 2017, the other eligible providers may have the Value Modifier applied to them.

Aucha Prachanronarong: And I would just add that both the PQRS incentive and payment adjustments apply to PAs currently and in 2013, obviously, too.

Patricia Jones: Thank you.

Nicole Cooney: Thank you for your question.

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

Janet Schumacher: Yes, Janet Schumacher with Medical Clinic of Houston.

And I'm having trouble with – maybe just even the basic idea of this. We are just ramping up and getting the physicians to do claims-based individual modifiers. The internal med folks are doing their group measure reporting. If we have to go to – next year if we're going to have to – if we elect to do the GPRO, are they going to be able to continue to choose? So the rheumatologists have their group of things to report, and internal med has their group of things that they report on – are they still able to individually choose what they want to report, or does the whole group have to report the same thing?

Aucha Prachanronarong: For the PQRS GPRO, they would – they want to do the claims-based reporting as a group. The group would have to report on a minimum of three measures, but that doesn't preclude reporting on more measures. So, for example, if the rheumatologists wanted to continue to report the measures that apply to them, there's nothing that precludes them from doing it – as long as, as a group, you report on three measures at 50%.

Janet Schumacher: Can you say that – so – so if we report on – let's say there's, let's say nine measures, and how do you know – how do you determine 50%? Is that 50%, so that doctor – 50% of his – of his or 50 % of the whole group?

Aucha Prachanronarong: Fifty percent of the whole group claims for related to whichever of the three – whichever of the three measures that you want to report.

Janet Schumacher: Yes. I don't see how it's going to work.

Aucha Prachanronarong: But you can still have the rheumatologists continue to report their measures as well.

Sheila Roman: And what size is your group?

Janet Schumacher: We're right at – say, 35.

Sheila Roman: OK. So then, you would have the option of using claims-based registry or EHR reporting for the Value Modifier side as well. And if you report successfully there, you would successfully avoid the Value Modifier downward adjustment.

Janet Schumacher: Yes, we were trying to – yes, we've been doing just claims-based – we're trying to avoid getting in – we don't have any EHR at this point – maybe soon, but not yet.

Sheila Roman: You only have to do one of – one of the five options that are on slide 7. So…

Janet Schumacher: Right.

Nicole Cooney: Thank you so much for your question.

Operator: Your next question comes from the line of Louis Diamond.

Louis Diamond: Thank you very much.

Given that this is budget neutral, and we're working on benchmarks that are average, there will always be winners and losers, and I just want you to confirm that – that concept. And my related question is, did you consider some kind of an incentive for people who improve and a disincentive for those who deteriorate in function overtime? I'm thinking of someone who's above average, but deteriorating in their performance.

Michael Wroblewski: It's a great – it's a great question. I'll take your second one first. Because this is just the beginning, we didn't have baselines in which to look at improvement or disimprovement, I'll call it, or declines in performance.

Though I think we indicated in the – in our discussion that that would be something we'd look into as we went further along.

And that would be a great comment, if you believe that we should be looking at that, to make. And in terms of the – the budget neutrality, your observation is correct.

Nicole Cooney: Thank you so much for your question.

Operator: Your next question comes from the line of Stephen Nuckolls.

Steve Nuckolls: Yes, this is Steve Nuckolls of Coastal Carolina Health Care.

The benchmarks that people will be compared against – are they going to be based on all satisfactory PQRS reporters, or just those that elect the quality tiering calculation?

Michael Wroblewski: No, it will be for all – all providers, whether they're individually reported or group reported, that reported that measure. So, it's not just the ones who are in – who elected quality tiering. So it's truly a national benchmark.

Steve Nuckolls: Thank you.

Michael Wroblewski: Yes.

Operator: Your next question comes from the line of Chris Dugger.

Chris Dugger: Yes, thanks for giving me a chance to ask a question.

I'm with an orthopedic surgery group, and I want to follow along I guess with the Barbara Sacks question from earlier, and I'm hoping for a yes or no answer. We, for a number of years, have been reporting the PQRS measures via the administrative claims option for the surgical process measures, (DVT), et cetera, and for the only outpatient measure that we can find that's remotely applicable on that, fragility fracture.

So my question is, if we continue to report that as we have done, are we going to be satisfying the requirements – the basic requirements of this program to the degree that we will not be financially penalized until some of the other measures – lots – most of the other measures are simply not applicable to orthopedics, were not current, and don't track a lot of these chronic disease measures?

And the second question is, you know, related to the – the cost. Surely, an orthopod is going to – his costs for the patients that he is involved with are going to be compared to the costs of other orthopods, and I hope that's the case, because if his costs are being compared to a market basket or other specialties, then I don't know how this is valid.

And then just, finally, a comment – I appreciate your time. It seems to me that by setting the threshold at 25 and above, if your focus is primary chronic care and the primary care domain, you're excluding vast numbers of primary care physicians that operate in solos and small – small groups. So I would appreciate a comment on that and again, thanks for letting me ask a question.

Michael Wroblewski: How about "yes" for your first question, as long as you're reporting those three measures that you picked up at the group level. So it's the group that's reporting them.

In terms of that comparison group question, the – we've made proposals that we're making comparison at the group level, so it's whatever total per capita costs are for patients that have been attributed to that group using a plurality of care plus the two-visit minimum.

And then, in terms of the comment at the end, in terms of when – why are we starting with groups in 25 and not doing primary care physicians, you know, that – it was our proposal to phase it in, and we thought we'd phased it in with larger groups first. But we'd welcome a comment to say if you think we should redirect our efforts.

Nicole Cooney: Thank you so much for your question.

Operator: Your next question comes from the line of Bettina Berman.

Bettina Berman: Hi, this is Bettina Berman from the Thomas Jefferson University in Philadelphia.

I have a question related to page 7, or slide number 7. We have in the past, since 2007 successfully reported on claims-based PQRS reporting. So, we will now need to go to either option one or option five, is my understanding. I'm remotely familiar with, or a little bit familiar with, option number one from the GPRO – previous GPRO option, but can you elaborate a little bit on option number five? You said that the – it was going to be calculated by CMS. What would the practices have to do on option number five?

Aucha Prachanronarong: So under option five, a practice would have to elect that option, and then we would just take your normal billing data and calculate these 15 process of care measures. They're basically prevent – it's the measures that have appeared in the QRUR report in the past, like the preventive care measures, diabetes – I think maybe heart failure.

Michael Wroblewski: Just other chronic diseases. The one thing we – if you do go with that option, that does not make the group eligible for PQRS incentives.

Bettina Berman: It does not.

Michael Wroblewski: It does not.

Aucha Prachanronarong: That option is only for the PQRS payment adjustment.

Bettina Berman: But if we go to the option number one, it would – it would give us both.

Michael Wroblewski: Correct.

Bettina Berman: OK.

Michael Wroblewski: And we're assuming that your group of greater than 100.

Bettina Berman: Yes. Yes, we are. We are primary care and multispecialty.

Michael Wroblewski: Right.

Sheila Roman: Under 110?

Bettina Berman: Yes.

Michael Wroblewski: OK. Yes, it's options one and five you have available.

Bettina Berman: But basically, if we want to do both, then we only have option one available then.

Michael Wroblewski: If you want the incentive and the – and avoid any downward PQRS adjustment, avoid any downward VBM adjustment, and possibly elect to get an upward adjustment, because you provide high-quality/low-cost care, then yes, option number one is way to go.

Bettina Berman: And maybe I missed it – if I could just ask a second question – in – on slide number 5, when you say "elect quality tiering calculation," at what point does the practice elect that quality tiering?

Michael Wroblewski: We're – it would by the end of the performance period. So, by the end of '13.

Bettina Berman: And then, you would – you would be notified that you had successfully reported and then you would be elect.

Michael Wroblewski: Well, the – if you look at the timeline which is on slide…

Bettina Berman: Six.

Michael Wroblewski: Six.

Bettina Berman: Yes.

Michael Wroblewski: The thought is – is that we will – you'd have to – if you're a group of 100, and you are going to do option number one. You have to self-nominate, I think, we indicated in the rule, by January 31, 2013.

Bettina Berman: OK.

Michael Wroblewski: You'd get a Physician Feedback Report based on your '12 performance. Now, mind you, you hadn't reported as a group in '12, but we will give you at least your – what you did at the individual level of the PQRS. We'd give you the administrative claims based on 2012, and we'll give you your cost as well.

Bettina Berman: Right.

Michael Wroblewski: And then, by the – once you get that in the Fall of '12 – or, excuse me, the Fall of '13, you'd – at the same place where you pick up the report, there would be the option to then say, "OK, I'd like the – I did really quite well, I'd like to elect the quality tiering," and you'd do it then.

Bettina Berman: OK. So, we are not going – it's not going to be based on our performance for 2012. You will give it to us, but our payment or adjustment is not going to be based on that.

Michael Wroblewski: That's correct. But we thought it was helpful to inform whether it made sense for you all to choose whether to elect the quality tiering option.

Bettina Berman: OK. Thank you.

Michael Wroblewski: You're welcome.

Nicole Cooney: Thanks for your question.

Operator: Your next question comes from the line of Catherine Noel.

(Lori Johnson): Hi, this is (Lori Johnson) from University of Missouri Health Care, Columbia, Missouri.

And my question actually – I just actually need clarification. So, I think that someone had just said that on page – on slide 7, that all of these different measures – your quality would be compared to other providers that reported on the same measure. So, we are a GPRO of greater than 100. So, really, our only option is the PQRS GPRO Web interface, and those 22 measures are selected for us, our beneficiaries are given to us.

So, we will only – do I understand correctly that we will only be compared to those groups over 100 that have reported on the same measures? For example, we couldn't be compared to a group with 25 to 99 providers who chose using EHR or claims, and they chose specific metrics that they perform well on. We'll all be compared to the – on the exact same metric.

Sheila Roman: No, you will – you will be compared on a measure-by-measure basis regardless of the options on who – what the population is that sends in data on that measure.

(Lori Johnson): OK.

Sheila Roman: So it won't be just option one against option one. It will be on a total measure-by-measure basis.

(Lori Johnson): Measure-by-measure. And so, if we are reporting as a group and we have primary care and multispecialty groups, then our specialists – because none of these measures in option one are pertinent to a specialist – their performance will be based on what the primary care provider's performance is? Because the QRURs are given out to individual providers and not on a group.

Sheila Roman: Yes, but, you know, it will depend on the reporting for the – as you said, the beneficiaries that are assigned to you, which may include beneficiaries of the specialists in your group. Even though a specialist wouldn't report – wouldn't be responsible for the type of care that these measures focus on.

Michael Wroblewski: Right. And what we're – what – the proposals for the Value Modifier are to make payments at the group level.

(Lori Johnson): OK.

Michael Wroblewski: So, the group is the – you know, the physicians in that group are really dependent upon other physicians in that group, so that the group has a – you know, for that performance. One thing that we did you may want to take a look at – we did a report that we put on our Web site at cms.gov\physicianfeedbackprogram in which we analyzed the results of those who participated in the GPRO Web interface in 2010.

And we compared – there were, I'm going to say, there were 19 measures in that Web interface that individuals could report on as well. And at least, for those groups participated in 2010, had a higher performance rates on 16 of those – of 19 measures. And on some of the measures, the group's performance rates were substantially higher than those measure rates that were reported individually.

(Lori Johnson): OK. All right. Thank you.

Michael Wroblewski: You're welcome.

Nicole Cooney: Unfortunately, it looks like we are almost out of time for today. If we did not get to your question, you can e-mail it to the e-mail address that's located on slide 18 of the presentation. It's Q as in quality, R as in resource, U as in use, R as in report, at cms.hhs.gov.

Again, that's on slide 18 of the presentation. Please note that, while we will not be able to address every question, we will review them to help us develop Frequently Asked Questions, educational products, and future messaging on these programs.

On slide 19 of the presentation, you will find information on a URL to evaluate your experience with today's call. Evaluations are anonymous and strictly confidential. Registrants for today's call will receive a reminder e-mail regarding the opportunity to evaluate this call, and you may disregard this e-mail if you've all ready completed the evaluation. We appreciate your feedback.

We'd like to thank everyone for participating in today's call. An audio recording and written transcript will be posted to the Physician Feedback Program page on the CMS Web site. The URL is on the final slide of today's presentation. These documents will be under the CMS Teleconferences and Events tab in approximately two weeks.

Again, my name's Nicole Cooney, and it's been a pleasure serving as your moderator today. And I'd like to thank all our experts here at CMS for their participation. Have a great day everyone.

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

END