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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014
MLN Connects National Provider Call
Moderator: Aryeh Langer
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1:30 p.m. ET

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 Aryeh Langer. Thank you. You may begin.

Announcements and Introduction

Aryeh Langer: Hello, thank you. This is Aryeh Langer from the Provider Communications Group here at CMS. And as today's moderator, I'd like to welcome everyone to this MLN Connects National Provider Call on PQRS, "2014 Physician Fee Schedule Final Rule: Quality Reporting in 2014."

MLN Connects Calls are part of the Medicare Learning Network. During this call, CMS subject-matter experts will provide an overview of the 2014 Physician Fee Schedule final rule and covers program updates to PQRS. In particular, this call include details on how an eligible professional or group practice can meet the criteria for satisfactory reporting for the 2014 PQRS incentive and 2016 PQRS payment adjustment.

In lieu of satisfactory reporting, the call also covers how to meet the criteria for satisfactory participation under the new qualified clinical data registry option, which will be implemented in 2014 as a result of American Taxpayer Relief Act of 2012. In addition to PQRS, this presentation contains additional program updates to the EHR Incentive Program and Physician Compare. A question-and-answer session follows the presentation today.

Before we get started, there are a few items I'd like to quickly cover. You should have received the link to the slide presentation for today's call in an email earlier today. If you have not seen this email, you can view or download today's call presentation from the Call Details webpage, which can be found by visiting the CMS website at www.cms.gov/npc. Again, that URL is www.cms.gov/npc. On the left side of that page, select "National Provider Calls and Events," then select today's call date, which is listed in the Call Details webpage section. The slide presentation is located in the Call Materials section below.

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

And finally, registrants were given the opportunity to submit questions in advance of today's call. We thank those of you who took the time to do so. We will address some during the presentation today. While we are not able to address all of them, they will be used for future presentations and to develop frequently asked questions and other educational materials.

At this time, I'd like to turn the call over to Dr. Dan Green from the Center for Clinical Standards and Quality. Dr. Green?

Daniel Green: Thanks very much. Welcome, everybody. I hope everybody has a happy and safe holiday season.

We have several announcements for today's call. We're going to go over two of them, and the rest of them will – including these two, in fact, will be posted on our sponsored call page. That will be available later this afternoon. So we would encourage folks to download that document and read the remaining announcements.

First thing concerns Physician Compare, the 2012 GPRO measures preview period. As finalized in the 2012 Physician Fee Schedule Rule, which we published in November 2011, the Centers for Medicare & Medicaid Services will be publicly reporting on a subset of the 2012 PQRS group practice reporting option web interface measures. And this will be posted on our Physician Compare website.

Starting December 12, CMS will be facilitating a 30-day preview period for these quality measures, which will continue through January 16th of 2014. In accordance with the final fee schedule rule, the preview period provides an opportunity for GPROs to review their measures – excuse me – before they are publicly reported on Physician Compare. CMS recently provided materials regarding the preview process to the 66 eligible GPROs that satisfactorily reported 2012 PQRS GPRO measures. GPROs can now preview their measures using the Physician Compare measures preview website.

If you have questions about the 2012 PQRS preview process or on public reporting on Physician Compare, please contact PhysicianCompare—that's one word, no spaces—@westat.com. That's W-E-S-T-A-T.com. For more information, you can see the – visit the PQRS website, and that will give you additional details about the program.

The second announcement—just want to remind folks that the 2013 PQRS submission period is still ongoing. And we'd like to remind eligible professionals and group practices that are participating in GPROs that the submission period for the 2013 PQRS program year will occur during the first quarter of calendar year 2014. So, again, if you're a GPRO, we would expect that information to come in, if it's coming in via the web interface, between January 27, 2014, and March 21st, 2014.

For individuals that are reporting for registry or maintenance – registry and maintenance certification, the submission timeframe for that is February 1st through March 31st of 2014. And our EHR, including our EHR Direct as well as our EHR Data Submission Vendors, the portal will be open for them to submit data between January 1st, 2014 and February 28th, 2014.

Please remember this is for program year 2013 data. If y'all have additional questions regarding the submission of the 2013 quality data, please do contact our QualityNet Help Desk. Their phone number is 1-866-288-8912, or via email at qnetsupport@s – D as in

David, P as in Paul, S as in Sam – .org.[qnetsupport@sdps.org] They're open from 7 a.m. to 7 p.m. Central Standard Time, Monday through Friday.

And my last announcement is the Ravens beat the Lions last night, 18−16, so go Ravens. I'll turn it over to Christine Estella now for – to go over her presentation. Thank you.

Presentation

Christine Estella: Thanks, Dr. Green. So, our presentation today will be on the PFS Final Rule, particularly as it relates to the PQRS Physician Compare and the EHR Incentive Program.

So let's start on slide 4. Slide 4 provides you with the agenda for what – our discussion today. As you can see, I'm going to cover PQRS first, followed by a couple of changes to the EHR Incentive Program, and then Physician Compare.

2014 PQRS Program Updates

So, 2014 program updates. On slide 6, you can see – you can see the – you can see the list of eligible professionals that are eligible to participate under the PQRS. This hasn't changed particularly. However, I do want to note that on slide 6, you'll see the bottom of the paragraph it says, "Beginning in 2014, professionals who reassign benefits to a Critical Access Hospital that bills professional services at a facility level can now participate in PQRS." This is a change from prior years; prior years, CAH Method IIs were not allowed – or were not able to participate in the PQRS.

So, to the extent that EPs can't participate in the PQRS now but are billing under CAH Method II, you will be able to report via – not via claims, but via registry and EHR.

Aryeh Langer: Christine, are you still there?

Christine Estella: Yes. I'm still here. Sorry, my slide won't forward. Can you give me a minute? My slide won't forward.

Aryeh Langer: Sure. Let's take a brief pause for a moment as we're having some technical difficulties.

Molly MacHarris: Christine, this is Molly. I'll go ahead and pick up from where you left off.

Christine Estella: OK, sounds good. Thanks.

Molly MacHarris: OK. So, sorry, everyone, about that brief technical difficulty. This is Molly MacHarris. And so we're moving on to slide 7, where we will highlight some of the changes to the 2014 program. So what we included in the final rule is a strong emphasis on the 2014 incentive and the avoidance of the 2016 payment adjustment. The 2014 calendar year is the reporting period for the 2016 PQRS payment adjustment.

We also did finalize additional reporting criteria, which is nine measures covering three National Quality Strategy domains. And if eligible professionals or group practices meet this criteria, they would be able to earn the incentive payment. They would also avoid the 2016 PQRS payment adjustment.

We also did add in a new MAV process, measure applicability validation process, for registry reporters. We have had that process in place for claims-based reporters in years past, but we did add that in for registry reporters beginning in 2014.

Another change that we wanted to highlight is that all measure groups are only reportable via registry. In years past, they were able to be reported via claims and registry. So that is an additional change. And just at a high level, some of the measures that have been changed are outlined in Appendix D.

Moving on to slide 8. Some additional changes that we made for 2014 is we added an EHR reporting option for group practices. Now group practices for program year 2014 can report through the traditional method of the web interface. They can also report via registry. And they can also report through one of our two EHR options, either EHR Direct or EHR Data Submission Vendor.

We also did eliminate the administrative claims reporting option for purposes of the 2016 PQRS payment adjustment. We did include that for the 2015 PQRS payment adjustment, but as we indicated in the rule, we were only planning on having that option in place for 1 year to encourage folks to start participating in the program.

Another new option that we have for the 2014 year is a certified survey vendor option. And with that, it allows group practices to report using CG-CAHPS measures. And that is available only for group practices that registered to participate in the group practice reporting option. And CG-CAHPS measures are required for group practices of 100 or above, and it's available as an option for groups that are sizes 25 and above.

One of the additional enhancements that we made is the new qualified clinical data registry reporting option. This is authorized by the fiscal cliff deal of 2012. So we did finalize this option, and it is available only for individual eligible professionals. And just to note, we do have some additional appendices, Appendix E and F, which further outline the reporting requirements. They're pretty detailed so we won't go over that in the call today.

Slide 9 at a high level provides information on the number of measures that we finalized. We did increase our measure count from 258 from 2013 to a total of 284 for 2014. We did remove 45 measures from the program. And of those measures that were removed, they were based off of either measures that had very low reporting thresholds, measures that were similar—if we had a similar measure already within the program, or measures that were over-reported.

And slide 9 also does break down the reporting – or the measures that are available for each reporting option. And one other piece to note is our EHR measure, the 64 eCQMs, are completely aligned with the EHR Incentive Program stage 2 measure set.

Moving on to slide 10. Again, just to highlight some of the changes we've made for the group practice reporting option, we did add the EHR option for group practices. We eliminated the administrative claims option. We added a certified survey vendor option for purposes of reporting the CG-CAHPS measures. We do have the new qualified clinical data registry option, but that is only available for folks who participate as individual eligible professionals, so for purposes of the Physician value-based payment modifier, that is something you could consider.

And just an additional note that the claims-based reporting option is not available for group practices. This has never been available for group practices, and we did not propose or finalize it for the 2014 year.

Certified Survey Vendor

So moving on to the certified survey vendor. So slide 12 outlines this and it's a new reporting option for group practices. As I mentioned previously, it's available for group practices that are 25 or greater. And the data collected on these measures will be submitted on behalf of the group practice by the certified survey vendor and the results of which will be posted on the Physician Compare website.

Slide 13 outlines the survey modules that are included in the CG-CAHPS. And we do have some information on the CG-CAHPS modules that are on the bottom of page 13.

Qualified Clinical Data Registry

OK, moving on to slide 15, the qualified clinical data registry. So, again, this is something new for 2014. And a QCDR, as we defined in our regulation, is a CMS-approved entity that has self-nominated and successfully completed a qualification process that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients.

And a qualified clinical data registry, or QCDR, must be able to perform the functions such as submitting quality measures data or results to CMS, submit to CMS quality measures data on multiple payers, provide timely feedback, and possess benchmarking capacity. So this is a new and separate option from our previous registry option, which has been available in the PQRS program since 2008.

Moving on to slide 16. To become a QCDR, the entity must submit a self-nomination statement by January 31st. And then by March 31st of 2014, the QCDR would need to submit to CMS the measures that they would want to have available within their QCDR. The measures results must come to CMS in an XML format, and if the QCDR's reporting on e-measures that are available under the EHR Incentive Program, that information must come in the QRDA III format, which was finalized in the Meaningful Use stage 2 rule.

Some additional information on the QCDR measure parameters. Sorry. They must have at least nine measures, covering three of the six domains. One must be an outcome measure. They can report on process measures. And again, that information must come to CMS by March 31st.

EHR Incentive Program

Sorry. I'm getting over a cold. OK. So, moving on to the EHR Incentive Program, which begins on slide 19. So the information that we finalized for the EHR Incentive Program is also the qualified clinical data registry option, which we've talked about; a group reporting option for the Comprehensive Primary Care Initiative, the CPC Initiative; and information on the versions of the measures that must be reported for participation under PQRS and the Medicare EHR Incentive Program. For measures that are to be reported electronically, you must use the most recent version of the measure. For EPs who do not wish to report CQMs electronically, they will be allowed to report CQM data to CMS by attestation.

And the reporting periods for calendar year 2014, there are two separate reporting periods. The quarter reporting periods only apply for participation in the Medicare EHR Incentive Program. If an EP wants to participate in the Medicare EHR Incentive Program and another quality program such as PQRS, they must report using the timeframe that is defined for that program. So in that scenario the EP would have to report on a year's worth of quality data.

Physician Compare

Moving on to slides 20 and 21, Physician Compare. For Physician Compare for the 2014 GPRO web interface measures, we did finalize our proposal to expand the quality measures posted on Physician Compare to all measures collected through the web – web interface for groups of all sizes. We do plan to publicly report the 2014 data in calendar year 2015.

And for ACOs participating in the Shared Savings Program, all measures collected in 2014 will be published, including those that are collected via the web interface and the three claims-based savings and one administrative measure finalized by the SSP program for 2014.

Slide 22, the GPRO registry and EHR measures. For Physician Compare, we also did finalize the proposal to publicly report performance on group registry and EHR measures. These would only be measures that are also available for collection via the GPRO web interface. That includes a potential of 16 registry measures and 13 EHR measures.

Slide 23, we talk about the patient experience data. We did finalize the proposal to continue to publicly report the CG-CAHPS measures for groups of 100 or more who participate in PQRS as a group regardless of the submission method. So, again, that would include either web interface, registries, or the EHR option. We will be publishing CG-CAHPS for SSP ACOs reporting through the web interface.

Slide 24. For CG-CAHPS information for groups 25 to 99, we will publicly report that information as well. Again, that would be for 2014, and it would be posted in calendar year 2015.

Slide 25, so the Million – Million Hearts Initiative. We will be posting the Million Hearts information for the individual cardiovascular prevention measures in support of the Million Hearts Initiative. And again, that will be available in calendar year 2015 for program year 2014. And we did finalize our proposal to publicly report 2014 PQRS individual measures collected through an EHR, registry, or claims. And again, we would only post those that are in alignment with the GPRO web interface, so that includes a potential of 20 measures.

Resources

And to finish up the presentation, our extremely useful slide talking about where to call for help. It's the QualityNet Help Desk. Dr. Green provided this information earlier, but it is listed on this slide. And then slide 28 has a lot of information on resources that could be used. I think we'll open it up for questions.

Keypad Polling

Aryeh Langer: Victoria, before we move into the Q&A session, we'll pause for a moment to complete keypad polling so CMS has an accurate count of the number of participants on the line with us today. Please note, there will be silence on the line while we tabulate the results. Victoria, we're ready start the 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.

Please continue to hold while we complete the polling.

Thank you. I would now like to turn the call back over to Aryeh Langer.

Question-and-Answer Session

Aryeh Langer: Thank you. Our subject-matter experts will now take your questions. I'd like to remind everyone again that this call is being recorded and transcribed, so before asking your question, please state your name and the name of your organization. In an

effort to get to as many of your questions as possible, we ask that you limit your questions to one per person.

If you have more than one question, please press star 1 after your first question is answered to get back into the queue, and we'll address additional questions as time permits. Victoria, 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. Remember to pick up your handset before asking your question to assure clarity.

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

Your first question is from Lisa Fry.

Aryeh Langer: Hello, Lisa.

Lisa Fry: How are you today?

Aryeh Langer: Great.

Lisa Fry: I called QualityNet a couple of months ago in regard to this. Our physicians are all part of a rural health clinic. And at that time they told me that we did not – or we're not required to participate in PQRS. But my question is, is if we don't participate, is there still the chance of the – in 2016, the penalty for not participating?

Molly MacHarris: Sure. This is Molly MacHarris. Excuse me. So, if you go to the homepage of our website, we do have on that site a list of eligible professionals. And that calls out which types of providers can participate. It also does provide some information based off of those who participate under rural health clinics or federally qualified health centers.

And for those types of providers, they are *eligible* to participate but not *able* to participate. And our understanding is that's based off of the way that they bill. So, to answer your question, if your provider only bills an RHC or an FQHC, no, they would not be subject to the PQRS payment adjustment, and they would not be able to participate. However, if the provider has any billings that are under the traditional Medicare Part B Physician Fee Schedule, they would be subject to the PQRS payment adjustment.

Lisa Fry: OK. And that's very, very, very rare that they would. I mean, 99 percent of the claims are billed rural health. All right. Thank you very much.

Molly MacHarris: Thank you.

Operator: Your next question is from Alex Perez.

Molly MacHarris: Hi, Alex, are you there?

Alex Perez: Hi, there. Yes, I'm here.

Molly MacHarris: OK, what's your question?

Alex Perez: Yes. So the question I have is, so if you're reporting PQRS as an individual but you decide to move to a different practice, does that penalty and the bonus, does that follow the individual person or does that follow the actual facility?

Molly MacHarris: OK, that's a really great question. So, the PQRS payment adjustment is in fact at the unique TIN/NPI level. So, in your scenario, if the provider moved from – if they were billing under TIN A/ NPI X, if they moved to a completely different TIN, their bearing or their status of either being subject to the payment adjustment or not subject to the payment adjustment would not follow them.

However, if they move to, for example, another site within a large organization where there could be billing occurring at the same TIN level, then that would follow them.

Alex Perez: OK.

Molly MacHarris: Thank you.

Alex Perez: Thank you.

Operator: Your next question comes from Joanne.

Joanne: Hello?

Daniel Green: Hello.

Joanne: Hi. My question is, we're a group of 28 doctors. Will we be required to report in the GPRO program or can we still report as individuals?

Molly MacHarris: Sure. This is Molly again. So, you – so, for the Physician Quality Reporting System, you can report either as an individual or as a group practice. The Physician value-based payment modifier, they finalized that for groups that are 10 or above, the value-based payment modifier will be assessed for those groups.

So, since your group is 28 or above, we would encourage you to register as a group practice when that registration period becomes available. We will be providing additional information and announcements on when that will be available within the coming months. So you could participate as a group either through registry, the two EHR options, or the web interface option is available for groups 25 to 99.

There also is an option under the value-based payment modifier program where, if 50 percent or more of the group is reporting as an individual, they will not be assessed a negative value-based payment modifier. So that's another option that you could explore as well.

Joanne: OK. All right. Thank you.

Molly MacHarris: OK, great.

Joanne: Bye-bye.

Operator: Your next question comes from the line of Shannon.

Shannon: Yes. My question is, I want to make sure we understand this right—to avoid the 2016 payment, we must report for an entire calendar year starting in January of 2014, correct?

Molly MacHarris: Sure. So, this is Molly again. So to avoid the 2016 PQRS payment adjustment—the easiest way to avoid the payment adjustment is to report using one of the PQRS incentive eligibility criteria. And those are called out in − sorry, I'm just flipping to it now in our appendices here. That's called out in Appendix E and then Appendix F as well.

And so, we do – the majority of our reporting periods are 12 months. We do have one 6-month reporting period available. It's only for registry reporting of measure groups. And that would only be available for individual professionals, not if you're participating as a group practice.

Shannon: We only have 11 physicians, so we wouldn't be doing the group. OK, thank you.

Molly MacHarris: Thank you.

Operator: The next question is from Marty Ugarty.

Marty Ugarty: Are there any restrictions on how you can report PQRS if you're a member of an ACO? Can you still report through claims, or do you have to go through a registry then?

Alexandra Mugge: So, I'm sorry—you said that you are part of an ACO?

Marty Ugarty: Yes. If you are part of an ACO, are there limitations on your options for reporting?

Alexandra Mugge: Yes. So, for the Medicare Shared Savings Program, the SFP ACOs, they are required to report to the GPRO web interface to meet their PRQS quality

reporting requirements as part of the ACO program. So they cannot also participate outside of the ACO program in PQRS. And for the Pioneer ACO program, their TINS are a little bit different.

So, for Pioneer ACO, your TIN would need to meet the Pioneer requirements by reporting through the Pioneer program, and also meet the PQRS requirements by reporting under one of the group options or by reporting individually.

Marty Ugarty: OK, thank you.

Alexandra Mugge: Oh, and by the way, this is Alexandra Mugge. Sorry about that.

Operator: Your next question is from Sandra Pogones.

Sandra Pogones: Yes, hi. This is Sandy Pogones from Primaris. I realize in 2014 for the EHR Incentive Program providers are only required to report a quarter of clinical quality measure data in order to receive their incentive. But if a provider chooses to submit aggregate measures, like QRDA III measures, through their certified technology for the entire calendar year, and they include all their patients, not just Medicare, would that then count for both PQRS and EHR Incentive Program?

Aryeh Langer: Will you give us one moment, please?

Sandra Pogones: Sure.

Aucha Prachanronarong: This is Aucha Prachanronarong. Yes, as long as there's data on at least one Medicare patient, that would count for both programs.

Sandra Pogones: I'm sorry, I couldn't hear that answer.

Aucha Prachanronarong: Sorry, let me move closer. As long as there is data on at least one Medicare patient and the data is for a full calendar year, then you could also get credit for PQRS.

Sandra Pogones: So how would you know if there is data on at least one Medicare patient? Because you don't report at the patient level.

Daniel Green: Give us one minute, please?

Sandra Pogones: Sure.

Aucha Prachanronarong: In the QRDA III, I believe there is some sort of indication on payer for the rates, payer source for the rates?

Daniel Green: Were you able to hear that response?

Sandra Pogones: Not totally, no. I'm sorry.

Aucha Prachanronarong: In the QRDA III, I believe there is some sort of indication which – that would allow you to report a payer source with the rates.

Sandra Pogones: OK, OK. So, all right. So that QRDA III file shows the payer source. OK. Thank you.

Daniel Green: Thank you.

Operator: Your next question is from Patricia McBride.

Patricia McBride: Yes. I work for a doctor who is currently doing claims-based reporting, he reports on five claims – measures. I'm having difficulty finding what – how the measures fit into the domains. I can't find anything on the 2014 measures, what they are. I did find something on ERH, and it says all his claims fit into the clinical process slash effectiveness at this point.

So, how do I reach other domains? What is going to be available for him? He's an ophthalmologist, eye specialist.

Jamie Welch: Hi, this is Jamie. So the rule, the PFS rule, the 2014 PFS rule has the domains associated in a table for the measures that are going to – were finalized for that year. And then, the documentation and supporting documents for the PQRS measures, once they are posted, the measures list, the 2014 measures list would have the domains represented with the measure's title and description to assist with that.

Patricia McBride: OK. Where do I find that? Because I've gone on the CMS website and cannot find it.

Jamie Welch: So if – go ahead, Bill.

Bill Coddington: Yeah, this is Bill. It's not posted yet, so that's why. It will be…

Patricia McBride: OK.

Bill Coddington: Yes.

Patricia McBride: Any idea when it will be posted?

Bill Coddington: I think within the next couple of weeks, so I would check back…

Patricia McBride: Yes. Because at this point, we can't do coding for 2014 until we know what's going on. And I really hate to hold – stack up charts and not have anything going out because I don't know how to PQRS.

Daniel Green: Hi. So the specification should be posted before December 31st. So you'll be ready to start on January 2nd when your office reopens after the holiday. Additionally, as was mentioned, you could look in the rule if you so choose for the domains for the particular measures. But again, these documents are expected to be posted before December 31st.

Patricia McBride: OK. I'll keep watching for them.

Daniel Green: Thank you.

Operator: Your next question is from Jennifer Aquilar.

Jennifer Aquilar: Hi, yes. Well, the previous call, I'm calling from a podiatric office, and that addressed part of our question because it's very hard for us to plan when nothing is getting posted 'til right at the end of the year. But on that same note, last year there was only about three of the measures that were applicable to the scope of practice for podiatry. Now I see that the – and we have not participated in PQRS as of yet by reporting.

Most of ours were claim-based reporting, and now I see that option for the three measures that were applied to us in your appendix, it's been removed, that we can no longer claim-based report on those. Where, other – I called the Quality Help – Net Help Desk yesterday. Where is the best resource to find out what the difference is between registries versus the new qualified clinical data registry, as well as the MAV program? Because I find it hard to believe there is going to be nine that apply to foot and ankle.

Because yesterday, QualityNet Help Desk just told me the manual had not been published as of yet for 2014. So therefore, I'm kind of left hanging until that happens. They couldn't really give me any information.

Daniel Green: OK. So, a couple of things, since it sounds like you have sort of several questions. So you heard about the specifications being posted before the end of the year?

Jennifer Aquilar: Right.

Daniel Green: The second point about the regular registries versus clinical quality data registries: Traditional registries can report on whatever they tell us they intend to cover in terms of PQRS measures. The bottom line is the only measures that traditional registries would report would be measures that are in the PQRS program. The clinical quality data registries would be self-nominated entities, and they don't have to self-nominate until the end of January. So we don't know who they are at this point, or if there will be any for that matter. But they can report measures that – up to 20 measures that are not currently in PQRS.

So a particular specialty may have measures that they feel are important to their respective scope of practice, that they submit to CMS, and if they're approved they would

be – that's one of the elements of becoming a qualified clinical data registry. Again, we don't know who those folks will be yet.

But to answer your last question, I think, about different measures that may be applicable to podiatrists. There are some broadly applicable measures such as medication reconciliation, for example, which basically requires the eligible professional to record whatever measures – measures, I'm sorry – *medications* the patient is on when he or she comes to the doctor.

So that clearly, for example, is a very broadly applicable measure that a podiatrist, or any health care giver for that matter, could report. Similarly, there are – there's a smoking measure, for example, so there's another relatively broadly applicable measure. Again, while not specific to podiatry, I'm sure we would all agree that health care providers should be inquiring about whether or not their patients are smoking. And if they are smoking, you know, at least to advise them that they shouldn't smoke. It's a pretty – the counseling aspect of the measure is fairly limited in terms of what it requires. So again, even nontraditional M.D.s conceivably could report that measure.

Jennifer Aquilar: Even though we don't do smoking cessation programs or anything of that nature?

Daniel Green: So, what you would need to be – what you would need to be able to do is, again, ask the patient if they stopped smoking. And I think it requires something like – and don't quote me on this because I don't have the specs in front of me, but it's like 30 seconds worth of counseling. You don't need to prescribe medications like Chantix or anything like that. It may be something as simple as, you know, "You shouldn't smoke. It increases your risk of cancer." You may have the 1-800 stop smoking or quit smoking hotline as a resource that you could give to – you know, a little piece of paper with a phone number on.

So again, it's not – it's not prescribing medications. It's not having support groups convening in your office, for example. It's just referring patients on where they can, you know, get help if they do in fact want to stop smoking.

Jennifer Aquilar: OK.

Daniel Green: OK?

Jennifer Aquilar: All right, thank you.

Daniel Green: Thank you.

Operator: Your next question comes from the line of Rebecca Shibbling.

Rebecca Shibbling: Hello? Yes. I wanted to find out with this registry, where do we find them and are they free? Do you have to enroll and pay for it?

Daniel Green: So, let me just ask you a quick clarification question, please. The clinical – I'm sorry, the qualified clinical data registry or the traditional registries?

Rebecca Shibbling: Well, I'm really not sure. We have – we only have three physicians and normally we did claims-based. But I see you keep talking a lot about these qualified registries. So I don't know what these qualified registries are. Are they – is it something that you have a name of a few that we can look into, and do we have to pay for being with the registry reporting?

Daniel Green: Well, so each registry will have their own requirements. Now, the qualified clinical data registry option for reporting is brand new for 2014 because it was just passed in the fiscal cliff act, as Molly mentioned, which as you know was passed December 31st/ January 1st of 2013. So, we don't know at this point, since we have not required a self-nomination process for these folks yet – well, we've required it, it just hasn't opened yet.

So we don't know who is going to indicate that they want to participate through this mechanism. There are certain requirements around being what we would deem a qualified clinical data registry. We do know, on the other hand, that traditional registries – we're fairly confident that most of the folks that were traditional registries for 2013 will likely want to continue being traditional registries for 2014. A list of those folks is posted on our website with their contact information; the measures that they intend to report; whatever – whether they intend to report measure groups, individual measures, or both; as well as any cost information in terms of what they charge to submit data on behalf of eligible professionals. So I would encourage you as a starting point at least to look at that on our website.

Rebecca Shibbling: That's what I was going to say. So there is a list available on the CMS.gov website?

Daniel Green: Right. And again, these folks – these folks were for 2013. We expect many if not all of them to continue in 2014 and perhaps some will be added.

Rebecca Shibbling: OK. So, there is – but potentially there is information on there that will tell me if there is a charge and how it works and everything?

Daniel Green: We'll tell you who they are, if there's a charge, and it will give you their contact information so you can speak with them directly.

Rebecca Shibbling: OK, great. Thank you so much.

Daniel Green: Thank you.

Operator: Your next question is from Richard Bikowski.

Rick Bikowski: Hello, can you hear me?

Aryeh Langer: Yes, sir.

Rick Bikowski: Hey, this is Rick Bikowski, Eastern Virginia Medical School Registry. So, for 2013 as a registry, as a certified registry, we're reporting as a GPRO. And because EHR and DSV weren't available for GPRO, we were able to – we're able to submit all measures via registry. Now, DSV and EHR reporting is an option for GPRO, so does that mean that we can no longer report data if – most of our data is coming from an EHR. If they are EHR measures, we have to report via DSV again as a GPRO? Or can we continue to report as a registry those measures?

Aryeh Langer: We'll get back to you in one moment, please.

Daniel Green: We're having – I'm sorry. This is taking a little bit longer to try to get an answer to your question. So, if our contractors on the call could capture this question, we will get an answer back to you. If you want to give us your name again, your organization, and an email or phone number, we'll be happy to reach out to you in a day or two.

Rick Bikowski: OK. Rick Bikowski, Eastern Virginia Medical School Registry, and I can send an email if that would help.

Daniel Green: OK. If you want to…

Molly MacHarris: Contact the QualityNet Help Desk and provide them with your information. That would probably be the best bet. Do you have the contact number for calling that?

Rick Bikowski: Yes. Oh, yes.

Molly MacHarris: Great, thank you.

Rick Bikowski: I have them on speed dial, Molly. Thanks.

Operator: Your next question comes from Karen Lawrence.

Karen Lawrence: Hi. My question is just regarding the individual measure reporting. And I understand – it appears from the appendixes that at the individual claims level, in order to earn the incentive, a provider needs to report nine measures across three domains—obviously, less, if less, you know, applies to them. But there appears to be kind of this disclaimer that reporting less than the nine across the three domains puts them subject to the MAV process.

So, does that MAV process apply only for the incentive, or would that MAV process still apply and potentially put them at risk for an adjustment even though, you know, they report—I'm making this up, you know—eight measures across three domains? Hopefully my – that makes sense.

Daniel Green: So, let me ask you a quick – let me ask a quick question first. Are you from Boston?

Karen Lawrence: I'm not. I'm actually in North Carolina.

Daniel Green: I was teasing …

Karen Lawrence: Oh, yes, right.

Daniel Green: I didn't hear you "pahking your cahr."

Karen Lawrence: Yes, that's right.

Daniel Green: Anyway, sorry – little CMS levity here.

Karen Lawrence: I understand. Humor has to be found somewhere.

Daniel Green: Exactly. So, if they – obviously, the nine across three would earn them an incentive. If they report fewer than nine measures or fewer than three domains, they would be subject to the MAV process, which we would check them to see if there are any other clinically related measures that they could have reported. If they pass MAV, so in other words we determine that there's not, like, another diabetic measure …

Karen Lawrence Yes, I understand.

Daniel Green: OK. Then, they would be incentive eligible and obviously would avoid the payment adjustment.

Karen Lawrence: Yes.

Daniel Green: If they reported – if they reported three measures or more successfully, even only across one domain, they would avoid the payment adjustment straight off the bat.

Karen Lawrence: Right.

Daniel Green: We'd only check them for MAV for payment adjustment if they report less than three measures.

Karen Lawrence: OK. So, we started PQRS reporting this year, obviously to avoid the adjustment. And we've been focused kind of on the EHR incentive. And although we only had to report one valid measure, we did find three measures that kind of were applicable that we implemented processes to start reporting them. So then, it looks like those measures still exist.

So, assuming those measures are still valid for 2014, we continue to report those three that would – and for 50 percent or more of our Medicare patients, that would for sure avoid the penalty – I'm sorry, the adjustment. And then, it's just a matter of if there's more measures that could qualify us to potentially be incentive eligible. Is that …

Daniel Green: Yes. Everything you said is correct. The only one – the one minor caution I would just suggest, when the measure specifications are posted later this month, please – even though it's the same three measures that you…

Karen Lawrence: I understand.

Daniel Green: … because there are updates from the measure owners from time to time.

Karen Lawrence: Understand.

Daniel Green: OK.

Karen Lawrence: I need to confirm that they're still claim-eligible reporting and blah, blah, blah. Understand.

Daniel Green: Well, and also that the specs haven't changed.

Karen Lawrence: I understand, the details. Yes, got it. OK. All right, thank you.

Daniel Green: Thank you.

Operator: Your next question is from Leslie Chacey.

Leslie Chacey: Hello?

Daniel Green: Hello.

Leslie Chacey: Hi. So, we're doing individual claims-based reporting, and we've looked through at least the measures that are in the final rule. And we are not seeing any additional measures for, like – specific to radiology or pathology. So, for instance we've been, you know, reporting on the five measures for pathology. And is that an accurate assessment? That we'll basically be doing the same thing, provided we review the specs to make sure that nothing changed?

Daniel Green: Is one of the PMBR folks on, that can comment specifically about what measures are available in radiology and pathology?

Jamie Welch: Yes. This is Jamie. So, I think it might be best to just to pull you offline and sort of go through the radiology – there are radiology measures. And we do have some new measures and measures groups coming in.

Leslie Chacey: Yes. I saw the measures groups. We are doing right now and plan to continue doing claims-based individual reporting.

Jamie Welch: All right. But yes, let's go ahead and discuss this offline. And then …

Leslie Chacey: That'd be great.

Jamie Welch: … we can do a detailed review of the specifications and just see what works best for you. So if you wouldn't mind just submitting a QualityNet Help Desk ticket, and we'll go ahead and get in touch with you based on that information.

Leslie Chacey: So, if I go to the QualityNet Help Desk and just log a ticket, somebody will get back to me?

Jamie Welch: Absolutely.

Leslie Chacey: And I can refer this audio call?

Jamie Welch: You sure can. You can even, if you want to, just ask for Jamie Welch, and I'll help you.

Leslie Chacey: Jamie Welch. Thank you so much. I really appreciate it.

Jamie Welch: Yes, no problem.

Operator: Your next question comes from the line of Kelley Mancha.

Kelley Mancha: Hello?

Daniel Green: Hello.

Kelley Mancha: Hello. OK. So, we are also in individual measure claims-based reporting, which is what we did last year. And I guess I'm still just a little bit confused. So, when you're reporting, if you do not have nine applicable measures and you're reporting somewhere one through eight, it's subject to the MAV process. But if you're found to pass that process—and let's say you only have six, and they say, "Yes, there aren't any more"—is there a percentage of patients or a certain number of patients that you have to report on for that year?

So, like this past year we just did the 20 – you know, the 20 individual patient encounters because that was all that was required of us. And then, now this is saying if you have one through eight, that you have to report on at least 50 percent of your patients. What about if you have all nine?

Daniel Green: OK. So, the – I think you may have a slight confusion between measure group reporting and individual measure reporting. Measure groups require folks to report

20 – I'm sorry, all the measures on 20 patients, at least 11 of whom must be Medicare patients if it's through a registry or if it's through claims, obviously all …

Kelley Mancha: Twenty, which is what we did this year. I'm sorry.

Daniel Green: Right, for 2013.

Kelley Mancha: But if we're going to continue to claims-based report then we have to go to individual measures because there isn't any …

Daniel Green: That's right.

Kelley Mancha: … way for us to report on claims for a group measure for this upcoming year. So I guess I'm just confused. If we move to individual measures – we're a specialist, we're an allergy immunology practice. So, I don't know if we'll be able to find nine measures. But I guess my question is, if we did find nine individual measures to report on and you're reporting all year, you have to report on how many – is there still a percentage?

Daniel Green: Yes. It's 50 percent of the eligible Medicare patients for each measure.

Kelley Mancha: So, 50 percent even if you have all nine, even if you're able to have nine? So no matter what, it's 50 percent, period?

Daniel Green: Right. For individual measures, it's 50 percent of your Medicare folks. Now, the only caveat to that is some of the measures are, you know, "report once during the year," for example.

Kelley Mancha: OK.

Daniel Green: So, it's not like every visit you did something again for some of the measures, like …

Kelley Mancha: Right.

Daniel Green: … like Pneumovax, for example, if that were one of the measures, up to one time reporting per year.

Kelley Mancha: Per year, right, got you, got you.

Daniel Green: You know, on each patient, flu—it's one time per year, but it's one time per year during the flu season. So it's even – you know?

Kelley Mancha: OK. OK, so then, and then the nine measures that cover at least three NQS domains, if we're – we have to start reporting January 1st, but you're saying that

we're not even going to know where those measures fall within the three NQS domains until January 2nd when we get back to work?

Daniel Green: No, no, no. We're saying that the document should be posted before December 31st.

Kelley Mancha: OK.

Daniel Green: I mean, we're – we need to report – we need to have it posted by December 31st, I believe per …

Kelley Mancha: Guidelines.

Daniel Green: … well, it was per our rules previously. But we will have it posted by December 31st or sooner. So, that's why I said – that's why I used the example of January 2nd because, you know, that would be the worst we would expect.

Kellye Mancha: OK. OK. And then, three or more measures, individually claims reporting avoids you a penalty no matter what? And then you're not even subject to MAV? Is that…

Daniel Green: So, if you report three measures adequately—and by that I mean more than 50 percent of eligible patients, Medicare patients—and, you know, have the right G-codes, whatever. As long as they're not – there's not a zero denominator in the measures.

Kelley Mancha: OK.

Daniel Green: So, in other words, let's say it's the measure—I'm making this up—let's say the measure is "counseled about smoking," and you – your doctors reported a – what we call an AP modifier, which basically says, "I didn't do the clinical quality action and I'm not saying why." So that's a performance failure, if you will.

Kelley Mancha: Right.

Daniel Green: If they wrote that for every single patient they saw, the – we would not count that particular measure because it has a zero-percent performance rate. We would assume you're trying to game the system.

Kelley Mancha: OK.

Daniel Green: So, if you do – if you counsel at least one patient about smoking cessation so that you can report in the affirmative, even if it's one out of 100 patients, so your performance rate is a low, you know, 1 percent …

Kelley Mancha: Right.

Daniel Green: … that'd be OK. But if it's zero percent...

Kelley Mancha: It doesn't count.

Daniel Green: That's a no-no.

Kelley Mancha: OK. OK. And are you still subject to the MAV process?

Daniel Green: So if you report three measures and it's one domain, you would not be subject to MAV – and you're successful with those three measures. Again, no zero-percent performance whatever.

Kelley Mancha: OK.

Daniel Green: You would be successful for avoiding the payment adjustment. So we wouldn't MAV you for that. We would MAV you, however, for – now I'm using – MAV-ing is now, what, a verb or something?

Kelley Mancha: I know. That's – I know …

Daniel Green: We're going to have a whole new lexicon.

Kelley Mancha: That's why I'm, like, are we getting MAV-ed or not getting MAV-ed?

Daniel Green: Well, have you been naughty or…

Kelley Mancha: Right.

Daniel Green: Yes, they're telling me, like − yes. Anyway, the – you would get MAV – you would undergo MAV, though, for the – for the incentive because, you know, it could come to pass, for example, that an eligible professional may only have three measures that he or she can report. And so, you know, if they do it adequately, they would not only avoid the payment adjustment, but it's also possible that they could earn an incentive. So you would be subject to MAV for the incentive but not for the adjustment.

Kelley Mancha: OK. OK. And so – and then just one final comment: So when you say "should report" and "could report"—so, like, for us, like I said, we're very specialized. We could report, you know, like, a BMI measure. We weigh people. However, it's not necessarily appropriate to our scope of practice. Does the MAV process – like, does it determine, "Hey, you know, this is appropriate to you and everybody should be doing it." If you see a patient, you should – and you weigh them, then you should give them, you know, referral to, you know, see somebody about their BMI? Or is that not applicable to us because we're allergists? Does that make sense?

Daniel Green: Well, you know, look, I'm an OB/GYN, and, you know, there's – I mean, I don't want to tell you all how to practice, and I won't tell you how to practice, but

there's some basic things I think that we would all agree we would expect of our health care professionals. Again, I'm not saying you have to report the BMI measure, but we talked about smoking earlier …

Kelley Mancha: Right, which we do. We do do that.

Daniel Green: Much as my orthopedic surgeon, when he injects one of my joints, gripes about it, he does my blood pressure when I go in. And I think, you know, I'm sure your doctors probably or your nurses or medical assistants take blood pressure, for example. Again, we're not expecting them to be hypertensive specialists. But, you know, to screen somebody for something and at least get them to the right person, like, "Hey, you need to follow up with …"

Kelley Mancha: Referral.

Daniel Green: "… your internist because your pressure is up." I mean, I think we would all agree that that's pretty basic care that hopefully most of our eligible professionals are providing. And assuming that is the case, these would be measures you can report – I mean, again, I'm not going to tell you what to do …

Kelley Mancha: Even though they're not our specialty. And we do do that. I mean, we do. We get a blood pressure on everybody. We get a weight on everybody. And of course we would say, or the doctor would say if necessary, "Hey, you should probably see somebody about this," or whatever. So …

Daniel Green: Right. We're not expecting you to counsel them about "Okay, you should have 40 percent carbs, 40 percent …."

Kelley Mancha: Right.

Daniel Green: … you know…

Kelley Mancha: Right.

Daniel Green: "… fat and 20 percent protein. And here's your kilocalorie diet," and all that kind of stuff for BMI.

Kelley Mancha: Right, just basically referring them to the appropriate services and/or professional people to help them. Got you.

Daniel Green: Right. Right. I mean, and you know, that the more times a patient hears something, the more likely they're – they are to go get it checked out.

Kelley Mancha: Right. Right. OK. Well, thank you so much, great help guys. Thank you.

Daniel Green: Thank you.

Operator: Your next question comes from Dodie Dusenbury.

Dodie Dusenbury: Hello. My question has been answered a little bit. I was concerned about the three or more to avoid – with the individual measures that you can report three measures, you can avoid a penalty? If you're doing the EHR incentive at the same time, and I understand that those measures are aligned with PQRS, then essentially you can kill two birds with one stone, correct?

Christine Estella: This is Christine Estella. You're asking if you can report three measures and satisfy both PQRS and the EHR Incentive Program, is that what you're asking?

Dodie Dusenbury: No, that question was answered. So, in order to avoid penalty …

Christine Estella: OK.

Dodie Dusenbury: … you can do three PQRS and you're done. But if you're doing Meaningful Use, they require nine measures as well. So, if the PQRS and the Meaningful Use are aligned, then basically you don't need to do anything else, is that correct?

Christine Estella: Right. So, if – so there are a couple of caveats to that: You can report basically one time for both programs, and you would use the nine measures covering three domains criteria, which is the PQRS's incentive criteria and then the EHR incentive eCQM criteria for stage 2 in 2014.

The caveat to that, however, is that you would need to report the most recent version of the eCQM – eCQMs. So, to the extent – you'd have to check to see that your certified product could report the most recent measures because there are different versions of the measures. CMS released updated measure specification to the eCQMs in June of 2013. So those would be the measures that you would have to report, aside from there's a breast cancer measure—there was an error in that measure; you would report the December 2013 version of that.

Dodie Dusenbury: So if you're planning on upgrading, say, in February, does that throw you out for the PQRS? Because you'd be, you know, basically minus a month or 2 months?

Christine Estella: Could somebody else answer that?

Aucha Prachanronarong: Hi, this is Aucha Prachanronarong. As long as your system is certified at the time that you submit your data, that's – I guess, you don't necessarily have to have the 2014 certification for the whole entire year. But at least by the time that you submit the data that needs to be certified, and you are expected to report whatever data that's in your certified system.

Dodie Dusenbury: OK. I think that helps. And then there was a lady that was calling about – wanting to know about domains, she – Google "MDinteractive," and then they have the final rule there for the Physician Fee Schedule. And there's a good link for all of the PQRS measures if she's interested, where it will spell out the domains that they are, you know, the – if it's claims or – and what the domains are, if it's registry reporting. It's pretty good. And that's all. Thank you.

Operator: Your next question comes from Shelia Curtis.

Shelia Curtis: My question is, you had cited that 10 or more providers in a group had to report as a group. We have reported through EHR and successfully over the last couple of years. And we do have more than 10. So that means that we would have to report in 2014 as a GPRO? Is that correct?

Molly MacHarris: Sure. So, this is Molly. So, the requirements for the value-based payment modifier for the 2014 reporting period for the 2016 payment adjustment are that they will be assessing groups that are 10 or above. So the fact that you've already been reporting via EHR is great. You can continue to do that.

What we would suggest that you do is when the group practice registration period becomes available, which we will be providing additional information on when that's available in the next couple of months, you'll want to make sure that you register. And when you register, you select the EHR reporting option. And then follow the additional guidelines to submit your EHR data to us during the submission timeframe, which, for program year 2014 will be in the first quarter 2015.

Shelia Curtis: So that defines us as a GRPO though? That's …

Molly MacHarris: Yes. It will classify you as a group practice and by making that classification since you are a group with 10 or more providers, as long as you submit your quality measure data to us in a timely manner you should hopefully not be subject to the value-based payment modifier and not be subject to the PQRS payment adjustment.

Aucha Prachanronarong: This is Aucha Prachanronarong. I just wanted to clarify your question. Were you asking if you're required to participate in PQRS under the GPRO?

Shelia Curtis: Yes. Are we required to do that?

Aucha Prachanronarong: No. You're not required to do that for either PQRS or the value modifier.

Shelia Curtis: I guess I'm confused as to that. Everything I've read is if you have 10 or more, you have to – you have to report as a GPRO.

Aucha Prachanronarong: You – the value modifier will apply to you as a group practice. But as long as 50 percent of your eligible professionals successfully participate in PQRS,

then you're good for the value modifier. PQRS also does not require participation as a group practice.

Shelia Curtis: OK. Thank you.

Operator: Your next question is from Miriam McGee.

Miriam McGee: Yes, hello. My name is Miriam McGee from Practice Advantage. My situation I don't think has been addressed yet today. We've got three current practices of different specialties, which make up a total of nine providers throughout the three practices. They do share the same tax ID. But the physicians don't share practices. They're unique to their particular practice.

I've got a fourth practice that we're going to be setting up. It's a trauma surgery practice, a different specialty. And then we'll take the total providers for this tax ID over the 10, but it won't take in over the 10 until like July or August. They all currently are using EMRs, Meaningful Use reporting. We have been doing the PQRS a little different based off of each specialty practice, so some of them through the standard registries, some through claims-based reporting.

So I'm trying to take all of that and – plus adding the fourth practice in July or August to see what I really need to do for each individual practice for maybe the PQRS. And then also the value-based payment modifier that may throw us then into the 10 or greater. I'm just – I'm not for sure where to go from here.

Alexandra Mugge: Hi. This is Alexandra Mugge. And it sounds like you're not currently a practice of 10 or more, but you will be at some point during 2014.

Miriam McGee: That is correct.

Alexandra Mugge: So – and we certainly encourage you to report on behalf of your group to make sure that you avoid any payment adjustments or penalties. But we don't have the folks for the value modifier here in the room with us to address when they will be assessing your group size. I believe that they've stated that it's at the time of registration, but I don't know what that means since the registration period does run through the summer, which is the timeframe you were looking at.

So, if you would like to submit your question to the QualityNet Help Desk, we will have somebody follow up with you…

Miriam McGee: OK.

Alexandra Mugge: …to get you some more information on that. But again, we do encourage you to report on behalf of your group to ensure that you're covered regardless of your group size.

Miriam McGee: Right. We obviously want to continue to report, I'm just trying to figure out the best, you know, route to do that for each of the unique practices and specialties. All right. I'll just submit my question. Thanks.

Operator: Your next question is from Jackie Gisch.

Jackie Gisch: Hi. My question is specific to the CG-CAHPS and groups larger than 100. Trying to get clarification; I think I heard you say it slightly differently, so I want to make sure I got it correct. If we participate through GPRO, are we then required to do CG-CAHPS? And if we participate not through GPRO, are we not required to do CG-CAHPS? Is that correct?

Alexandra Mugge: Hi. This is Alex Mugge again and thanks for your question. So, to clarify, for groups of more than 100 who are participating through the GPRO web interface—so again, just to reiterate, we have three reporting options under the GPRO in 2014: You can report through an EHR, through a registry, or through the GPRO web interface. If you select GPRO web interface in 2014, you are required to do CG-CAHPS, and CMS will administer CG-CAHPS for those groups of more than 100.

For groups that are more than 100 that report through an EHR or a registry, CAHPS is an option for your group. You may report through CG-CAHPS and that would cover part of your reporting requirements, so you would do that in combination with either the registry or EHR. And of course, if you're a group of less than 100, that option of reporting through CAHPS and another reporting mechanism also applies to you. Does that answer your question?

Jackie Gisch: Yes, it does. Thank you very much.

Operator: Your next question is from Susan McClelland.

Susan McClelland: Hi. First I want to say, go Ravens. So, next is my question. Our group – I'm calling on behalf of the American Chiropractic Association. We have two measures that we are eligible to report on, and that's all, just two, and we do not expect that to change in the coming year. They are obviously individual measures and they are designated as—I've forgotten the term, but they're separate or unique, or whatever, where you can just report one although we encourage everyone to report both.

Anyway, it seems to me that for 2014, the requirements to qualify for the incentive are the same as the requirements to avoid the payment adjustment. Now, in 2013, that was not true. So, is this a change or am I reading it wrong?

Daniel Green: So, first of all, your "go Ravens"—just clarifying, was that a question at the end? I thought I might have heard your voice trail off a little bit.

Susan McClelland: Well, I'm actually a Redskins fan, but since they've kind of crumbled on me, the Ravens are my second favorite team. So that's who I'm rooting for now.

Daniel Green: OK, because if they were your first favorite team, then I would just say don't worry about any chiropractic folks, we would give them a pass and they wouldn't have to report. But since it's your second favorite…

No. So here's the story. The criteria to earn an incentive in 2014 include the nine measures across three domains. And I heard what you said about the only two measures. So, to avoid the adjustment, it's three measures across, obviously, one or more domains. Now, folks that don't report the nine would be subject to the measure applicability validation. So we would look to see if there are any clinically, you know, relevant measures that they could have reported. If we find that they've reported all that they could, they could earn an incentive even though they've only reported, you know, one to eight measures.

Susan McClelland: Right.

Daniel Green: If they report less than three measures, then we look for them to see whether they could have reported more for the payment adjustment. If we find that there were four measures they could have reported, then they would be subject to the payment adjustment, of course, and they would not get the incentive.

But if we find that there were only – let's say two measures are reported, we find that there's only two measures that could have – you know, that they could have reported on, then they would earn the incentive. They'd be subject to MAV, and if they passed MAV, they'd earn the incentive. By virtue of earning the incentive, they would avoid the adjustment.

Susan McClelland: OK. I should have been more specific. For 2013, to earn the incentive, you had to report – let's just use the premise that we only have two, and we're only going to have two, and the MAV substantiates that.

Daniel Green: OK.

Susan McClelland: So, for 2013, you had to report satisfactorily on at least 50 percent, and you had to have non-zero successful performance to earn the incentive. But to avoid the penalty, you only had to report one time.

Daniel Green: Right.

Susan McClelland: I mean, to avoid the penalty.

Daniel Green: Right.

Susan McClelland: Now it looked like from your handouts that for 2014, to earn the incentive you have to report for 50 percent or better, blah, blah, blah, just like before. But it also says to avoid the penalty you will have to report on at least 50 percent as opposed to just one. So am I reading that right?

Daniel Green: Yes. So what we've done is in 2013, since it was the first – you know, the first year of the penalty will be 2015 but based off 2013 reporting.

Susan McClelland: Right, right.

Daniel Green: Again, believe it or not, it's our goal not to penalize folks. So…

Susan McClelland: No, I believe you!

Daniel Green: We wanted to ease people into the payment adjustment by setting the bar – I don't want to say low, but I will. You know, so that …

Susan McClelland: Yes.

Daniel Green: … it would be easy to avoid the payment adjustment and would capture eligible professionals' attention but not overwhelm them. So even if they found out about this, let's say now, they could still technically avoid the adjustment in 2015 by submitting the one measure. However, that was a 1-year – that was a 1-year kind of introductory price, so to speak, even though PQRS, as you know, has been around since 2007. So now…

Susan McClelland: Right.

Daniel Green: … the bar's been raised in that you've got to report three measures on 50 percent to avoid the payment adjustment. If you report fewer than three measures, let's say you only report one or two, but again, with the 50 percent of your eligible Medicare patients, you still could avoid the adjustment. You'd just be subject to measure applicability validation.

Susan McClelland: OK. All right. I just wanted to make sure. I knew it was a 1-year pass and I knew or expected – I shouldn't say "know" (you never know with you all), but I was expecting it to go up this year. I just wasn't sure it would go up all the way to 50 percent. I thought maybe this year it would be 25 or something. So I just wanted to make sure I understood. So it's 50 percent for both?

Daniel Green: Yes. And, you know, look. I mean, the 50 percent – the program, you know, can be confusing to folks. And if we had a bunch of different percentages in there, we were concerned that it would be even more confusing to people, not to mention the programming and what have you. And 50 percent of patients, you know, could give an eligible professional at least some sort of snapshot as to how well they're performing that quality metric in their practice.

Susan McClelland: Sure. Sure. OK, thank you very much.

Daniel Green: Thank you.

Operator: Your next question is from Sharon Hibay.

Sharon Hibay: Hi, Dr. Green.

Daniel Green: Hey, Sharon.

Sharon Hibay: How are you?

Daniel Green: Good.

Sharon Hibay: So, I had a question about some information that was in the proposed rule, and I actually asked on the last National Provider Call when you gave that presentation as well.

So we had discussed the outcomes-based measures and the possibility of them being patient-reported outcomes measures as well. And in the final rule, I really scoured to attempt to find that information and came up a little empty handed. And the example of the outcomes measure that was provided was very clinical in nature. I believe it was an A1c for diabetes or something.

So I wanted to get clarification on whether or not outcomes measures with the required minimum of one would also include patient-reported outcome measures?

Daniel Green: So, I'm assuming you're talking about for clinical – qualified clinical data registries, correct?

Sharon Hibay: I am, Dr. Green.

Daniel Green: OK. I'm going to – Christine, are you still on?

Christine Estella: I am.

Daniel Green: Great. I'm going to let – because – since you're the rule writer, I'm going to defer this one to you.

Christine Estella: Sure. What was the question again?

Sharon Hibay: So, the question was whether or not for the QCDR, the outcomes measures that were – are required with the minimum of one would also include a patient-reported outcomes measure. In the final rule, the example that was provided was very clinical in nature. And when I scoured the rule, it – I really came up short trying to find language that supported that outcomes measure could also be a patient-reported outcomes measure.

Christine Estella: Sure. So, for the outcomes measures, I believe in the rule, the final rule, we defined it very broadly in terms of what an outcomes measure is. So, if you are – are you asking because you want an entity to be qualified to become a QCDR for next year?

Sharon Hibay: I'm just asking in general about the qualifications and criteria of the outcomes measures. So it does – the example about …

Christine Estella: Right. So the outcomes measure definition doesn't necessarily require that – it doesn't necessarily require anything that specific. So basically what we would do is March 31st is a deadline for entities to submit their measure specifications to us. And during that time, that's when we would analyze and determine whether or not – you know, our definition of an outcome measure is broad because as I understand it from when we've talked to other entities that wanted to become QCDRs, I mean, an outcomes measure doesn't necessarily – some of the outcomes measures doesn't necessarily fit into what somebody would consider a traditional outcome measure.

So we would probably grant some leeway, but we would check to see whether or not basically the entity's measures – or one measure at least for the outcome measure fits that definition. So I mean, it doesn't necessarily require patient-reported outcomes, I believe, in the definition. However, you know, we would analyze the outcome measure that's provided to us on that March 31st deadline to see whether or not it meets specifications.

Does that answer your question?

Sharon Hibay: OK, thank you. It sounds like (inaudible).

Christine Estella: Yes, exactly.

Sharon Hibay: OK. Thank you, Christine.

Additional Information

Aryeh Langer: Unfortunately, that's all the time we have for questions today. If you have any further questions, and you want to contact the QualityNet Help Desk, you can refer to slide 27 for their contact information. On slide 30 of the presentation you'll find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, voluntary, and strictly confidential.

We hope you will take a few minutes to evaluate your MLN Connects Call experience today. Again, my name is Aryeh Langer, and I'd like to thank our subject-matter experts here at CMS and all our participants who joined us for today's MLN Connects Call. Have a great day and a happy holiday.

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

-END-

This document has been edited for spelling and punctuation errors.