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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
CMS Finalized Policies for the Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Final Rule
MLN Connects National Provider Call
Moderator: Charlie Eleftheriou
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Contents

This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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

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

Announcements and Introduction

Charlie Eleftheriou: Thank you. This is Charlie Eleftheriou 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 CMS Finalized Policies for the Physician Value-Based Payment Modifier under the Medicare Physician Fee Schedule 2014 Final Rule. MLN Connects Calls are part of the Medicare Learning Network.

During this call, CMS subject-matter experts will cover the finalized policies for the Value-Based Payment Modifier under the 2014 Physician Fee Schedule final rule. This presentation will discuss how CMS plans to continue to phase in and expand application of the VM in 2016 based on performance in 2014.

The presentation will also describe how the VM is aligned with the reporting requirements under the Physician Quality Reporting System. A question-and-answer session will follow the presentation.

Before we get started, there are a few items I'd like to quickly cover. You should have received a link to the slide presentation for today's call in an email. If you did not see this email earlier today, you can view or download today's call's presentation from the call detail webpage, which can be found by visiting www.cms.gov/npc, as in National Provider Call. Again, that website is cms.gov/npc.

On the left side of that page, select "National Provider Calls and Events" and then select today's call by date from the list to access the call details webpage. The slide presentation is located in the "Call Materials" section.

Second, continuing education credit is available for this call. Please refer to slide 21 of the presentation today or call detail webpage for more information. 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's available. An announcement will be placed in the MLN Connects Provider eNews when these 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, and we'll address some during the presentation today. And while we're not able to address all of them, they will be used in future presentations and to develop frequently asked questions about our educational materials.

At this time, I will turn the call over Michael Wroblewski from the Performance-Based Payment Policy Group in the Center for Medicare. Michael?

Presentation

Michael Wroblewski: Thank you, Charlie, and good afternoon. And good morning to some of you on the West Coast. I am actually on slide 4 of the presentation, and I thought I'd give a quick overview of what our agenda is.

As Charlie indicated, the purpose of today's call is to discuss the finalized policies for the physician value modifier for 2016, which is the second year of the phase-in – of the 3-year phase in for the physician value modifier.

I'd like to also explain how the value modifier is aligned with the reporting requirements under the Physician Quality Reporting System, or PQRS. The third objective I have for today's call is to review the cost measures that are included in the value modifier. And those three bullets – you know, the bulk of the call, my presentation, will last maybe about 30 minutes or so, and then we'll open it up for questions and answers at the end of the call.

What Is the Value-Based Modifier?

So I'm now on to slide 5. What is the Value-Based Payment Modifier? It's a new payment adjustment that will be applied to physician payment under the Medicare Physician Fee Schedule. And it assesses both the quality of care furnished and the cost of that care.

It's a per-claim adjustment. So every group – and you'll get in – I'll get into this in just a moment – it's a per-claim adjustment, and it's – I want to make the point that it's separate from the Physician Quality Reporting payment adjustment that's really based on satisfactory reporting. So this is a different payment adjustment than the PQRS payment adjustment.

We started to phase in the value modifier starting next year in 2015, and by law we are to – we are to have the value modifier apply to all physicians and groups of physicians by 2017. So 2016, which is what I'm going to talk about today, is really our second year of the phase-in.

The implementation of the value modifier is based on participation in the Physician Quality Reporting System. I will explain that with a nice picture slide, five or six slides from now. And then, the last statement on the – on slide 5 – is really kind of a loaded statement or packed full of content for those who are new to the physician value modifier. So we are applying the value modifier to groups of physicians with 100 or more eligible professionals. So let me unpack that a little bit.

When we define a group, we mean a taxpayer – physicians or other eligible professionals – who bill under a single taxpayer identification number, a TIN. So one TIN is a group. We define the size of a group based on the number of eligible professionals.

For 2015, we're applying the value modifier to groups or TINs that had at least 100 or more eligible professionals bill under them. An "eligible professional" includes not only physicians, but also practitioners and therapists such as physician assistants, nurse practitioners, clinical nurse specialists, audiologists, certified registered nurse anesthetists, physical therapists, occupational therapists, qualified speech-language therapists. So that's how we define a group—broadly, with physicians and non-physician practitioners and therapists.

But when we apply the payment adjustment in 2015, we will only be applying the payment to those *physicians* who bill under that TIN. And we define physicians not only to include M.D.s and D.O.s, but also podiatrists, chiropractors, optometrists, doctors of dental surgery, and doctors of dental medicine.

So the payment adjustment is actually applied only to physician payment, but we define the size of a group more broadly, to include not only physicians but other non-physician clinicians. And when we say that we apply the value modifier at the group level, that means every physician under that group has the same modifier. It's applied at the group level; it's determined at the group level.

Every physician under that TIN or under that group will not have a different payment adjustment. It will all be the same adjustment. And we've gotten many questions in terms of how does that work if the composition of the group changes from the performance year to the payment adjustment year?

And what it – and the short answer to the question is that whatever the group's performance was—or, for the first year the modifier is based on, 2013—whatever that performance is determined to be, then that will be the modifier for the group and anyone who bills under it in 2015. Likewise, performance in '14 will determine group value modifiers for the value modifier that will apply in 2016. And anyone who bills in 2016, even if they weren't part of the group back in 2014, will still have that modifier applied.

So those were just some overview, kind of background information on the value modifier. For some of you – probably already know that we are applying the value modifier for the first year of our phase-in is 2015. That was based on – will be based on performance during 2013, the calendar year that we're in right now.

So for the 2016 value modifier—I'm now on slide 6—performance year, looking at the chart here, the performance year will be next year, 2014. We're moving down the group size. For 2015, the group size, as I just indicated was 100 or more eligible professionals. We have finalized for 2016 that the value modifier will apply to groups with 10 or more eligible professionals.

Quality, Outcome, and Cost Measures

The main question I would say that we get all the time is how – what quality will be used – what quality measures are going to be used to assess the performance of the physicians

in my group (assuming you're now a group of 10 or more)? For 2015, which was based on 2013 performance, groups had three choices.

You had to report at the group level for 2013 if you're a group of 100 or more. You could report a set of 22 quality measures from what we call the group practice reporting option web interface. Or you could choose measures, and you had to choose nine of them to report through – at the group level through a CMS-qualified registry. Or you could not report anything and indicate in a registration system that you wanted CMS to calculate 14 administrative claims–based measures.

For 2014, we will keep the first two – we're keeping the first two options, so the GPRO web interface, CMS-qualified registries. For 2014 performance year, you can also report as a group using electronic health records.

And then we have a new – for all those groups of 10 or more that have most of their eligible professionals reporting individually through the PQRS, we have a – basically, a default option, that if your group does not choose one of three *group* reporting options, we'll look to see if at least 50 percent of the eligible professionals in the group met the criteria to avoid the 2016 payment – PQRS payment adjustments (I'll define what those are in just a moment). But if at least 50 percent of those do, then we will roll those – all those performance scores for all those individual professionals up in your group to get a group score.

So basically, there are four reporting options for 2014—three group, and if you decide not to do a group reporting option – or reporting mechanism, then we'll look to see if at least 50 percent of the individual eligible professionals met the 2016 payment adjustment criteria.

For both years, for 2015 and 2016, we'll use the same three – we'll also use three outcome measures. In addition to what you report through PQRS, we also use three outcome measures: an all-cause hospital readmission measure and two composites—one composite of acute prevention quality indicators that really look to see if the hospital admission was preventable for three diagnoses: bacterial pneumonia, urinary tract infection, or dehydration; and then a second composite of chronic prevention quality indicators, which, once again, look to see – look for preventable hospital admissions for COPD, heart failure, and diabetes.

We're also allowing for – or new for 2016 (2014 performance period) will be patient experience. The CG, Clinician and Group CAHPS survey—and I'll discuss that in a moment—that will only be eligible for those who choose a group reporting option, and a group has to have at least 25 or more eligible professionals.

I'm on slide 7. What cost measures do we use? Currently, we use five cost measures. We use one total per capita cost measure for all the beneficiaries that have been attributed to your group. And "total per capita cost measure" means that we look at all the payments that Medicare makes for beneficiaries attributed to the group under Part A and Part B.

We also look at total per capita cost, Part A and B spending, for the subset of beneficiaries that have four chronic conditions: COPD, heart failure, coronary artery disease, and diabetes. So those are your five cost measures.

We're going to use the same ones for 2016, but we're also adding in a Medicare Spending per Beneficiary measure. And this is really a cost measure around hospitalizations, and it looks at all Part A and B spending 3 days before and following through 30 days after an inpatient hospitalization. So it really looks at cost around a window of an inpatient hospitalization.

And we actually already use this measure in – or will be using this measure – in the Hospital Value-Based Purchasing Program. So we've aligned kind of the physician value modifier with the Hospital Value-Based Purchasing Program. And we attribute that measure to the group – or each admission, so to speak, to each – to the group of physicians that provide the plurality of Part B services.

The benchmarks for cost measures…. Currently we make our comparisons of the cost measures at the group level. For 2016, we have refined that approach, and we'll be actually taking into consideration the specialties of the – of the eligible professionals that bill under that group. So you'll be really compared to folks that are in groups just like yours.

Quality Tiering

Quality tiering is the second-to-last issue I wanted to talk about. And this is what our name – quality tiering is the name of how we evaluate the group's performance on the cost or quality measures.

For 2015, quality tiering was optional. In fact, during our registration period that ended back in October, we had over 150 groups, large groups, indicate that they wanted to be – that they wanted their value modifier calculated based on their performance.

For 2016, we have – we've gotten rid of the optional nature. It will be mandatory. So for groups of 100 or more, quality tiering will – you'll either get an upward adjustment, no adjustment, or a downward adjustment, based on the performance on the PQRS measures, the three outcome measures, and the six cost measures that I just talked about.

For groups that are – that are 10 to 99, these are basically the new groups for 2016, we're phasing it in so that only groups can earn an upward adjustment or no adjustment. If there's a downward adjustment possible, then we'll hold that group harmless from that downward adjustment.

So, to repeat: quality tiering is mandatory, no more elections. And for groups of 100, they could get an upward, downward, or no adjustment, based on performance. And for groups 10 to 99, only upward or no adjustments. There will be no downward adjustments applied for groups 10 to 99. We've increased the amount of payment at risk from 1 percent to 2 percent from 2015 to 2016.

The Value Modifier and the Physician Quality Reporting System (PQRS)

I'm on slide 8 right now. I indicated earlier that really the value modifier and the Physician Quality Reporting System are really linked at the hip, and this – this is my – actually my favorite slide in this whole presentation because it kind of gives a little graphical depiction of how this works.

So if you're a group in 2016 based on 2014 performance – I have all the groups of 10 or more starting at the top. If you go down the left-hand side, these are the groups that choose one of the three group reporting options that I just mentioned—GRPO web interface, registries, or EHR—or if they don't choose one of those, get to take the 50 percent option – threshold for all those individual eligible professionals.

If that happens, then you have mandatory quality tiering for groups of 10 or more. If you go down the very far left-hand side of the graph, there's only an upward or no adjustment based on quality tiering. If you go down the right-hand side of the left-hand side of the graph, those are the groups of 100 or more, and that's an upward, downward, or a neutral adjustment.

If you look on the total right-hand side of slide 8, these are what we call the non-PQRS reporters. These are the groups that don't either elect – or, excuse me – register or self-nominate for one of the three group reporting options. And if they don't do that and they don't have 50 percent of their individual eligible professionals—say it's a group of 10 and only 4 of them meet the reporting criteria for the 2016 payment adjustment, then that group, that entire group, will get a minus downward 2 adjustment – 2-percent adjustment. And as I noted before earlier, this payment adjustment is separate from any payment adjustment under the PQRS program.

I'm on slide 9. And I know it may sound like I'm beating a dead horse here in terms of the quality reporting mechanisms and what's eligible, but I thought I'd go over it one more time. So really, groups of 10 or more have to make a decision whether they're going to report as a group or whether they're going to avail themselves of the individual reporting option, where we have to have at least 50 percent of the EPs in the group meet the 2016 payment adjustment criteria.

So as a – just as a review, groups have three reporting options to choose from – the **GPRO web interface,** which focuses on 18 measures of preventive and – preventive care and primary care for some – for chronic diseases. These measures align with those measures that are used in the shared – Medicare Shared Savings Program. Groups also can report via a **CMS-qualified registry**. And in order for the group to avoid the 2016 payment adjustment, they have to report on three measures on at least 50 percent of their patients. Or the group can choose to report at the group level using an **EHR,** and these are measures that are extracted from the EHR product, and it's nine measures across three domains.

I'm on slide 10. If a group decides not to do a group reporting option, then CMS will look to see if at least 50 percent of the eligible professionals within the group reported

measures individually, and at least 50 percent of them had to successfully avoid the 2016 payment adjustment.

There are four ways for individuals to avoid the payment adjustment. You can report traditionally via the PQRS individual claims method, in which you have to do three measures across 50 percent of your patients, or you can report three measures using a qualified CMS registry. And both of those reporting mechanisms are subject to a measure availability validation process, or a MAV process, which indicates – we've often heard that there aren't enough measures in the PQRS program for certain sub-specialists.

So if there aren't any measures and the – and an individual eligible professional only reports on one measure, we'll look to see if there were two other ones that – at least two other ones that the individual EP could have reported on. And if they're not, then that EP will not be harmed because they didn't meet the reporting of the three of them.

EPs can also report via EHRs, and they have to report nine measures, and those are, once again, extracted from the EHR product. And then new for 2014 is what we call the clinical data registry option. And, once again, the individual eligible professional has to report on three measures for at least 50 percent of the patients.

More information about these – about the group reporting options and the individual PQRS reporting options – we're having another MLN Connects Call on December 17th which will focus solely on the 2014 PQRS policies. So mark that on your calendar, 2 weeks from today, December 17th, for a PQRS call.

So I'm on slide 11 now and this is my last summary slide for PQRS reporting. So what measures do we use for quality tiering? We use the ones that the group decides to report via either one of the three group reporting options or the 50 percent eligible – individual eligible professional default option.

We'll also use three outcome measures for all groups regardless of whether they did – whichever of the PQRS reporting options they decided to choose. And then we'll also allow the CG CAHPS measures; these are optional. And when a group goes in to choose its group reporting method, it can also indicate whether it would like to use the patient experience measures of care as well.

And that survey for groups – most groups will have to pay for that, indicate – and indicate their choice of vendor. More instructions of that will be coming in the springtime when the registration process opens up for group registration for 2014.

OK. I'm on slide 12. That's done for quality measures. So hopefully you all have a good handle on what quality measures we'll be using.

For the cost measures—as I indicated earlier, we're using six cost measures. The first one is a total per capita cost measure for all beneficiaries who have been attributed to the

group. This is all Parts A and B spending. We'll calculate total per capita cost for all the beneficiaries with four chronic conditions: COPD, heart failure, CAD, and diabetes.

We'll also indicate – the sixth measure will be the Medicare spending per beneficiary measure, which is the measure that looks at costs around a hospitalization. I want to point out that all cost measures are payment-standardized. And what that means is we take out all the different geographic adjustments that Medicare makes—for example, that pay higher rates in New York City than they do in Omaha.

And then we also risk-adjust the cost measures for the underlying kind of risk factors of the attributed beneficiaries. And we look at things like history of chronic diseases; age of the beneficiary; gender; whether they were – the reason for the Medicare entitlement or enrollment, whether it was because the beneficiary was aged or disabled; whether the beneficiary is also eligible for Medicaid (we call those dual eligibles); and whether the beneficiary was also qualified or eligible for ESRD.

So we payment-standardize and risk-adjust all of our cost measures, all six of them. And then, new for 2016, based on '14 performance, we'll be making cost comparisons by taking into account the specialty composition of the group of eligible professionals.

On slide 13 gives a little bit more information about how we attribute beneficiaries for purposes of calculating the cost measures. For the five total per capita cost measures, we use an attribution process that really focuses on whether the group provides the plurality of primary care services, and we use a two-step assignment process.

We first assign beneficiaries who've had the plurality of primary care services rendered by primary care physicians. And then we look to see – if there are other beneficiaries that the group has treated, we look to see the remaining beneficiaries, and we assign them to the group who has received the plurality of primary care services rendered by any eligible professional, which could be specialists as well as other non-physician clinicians.

So we use that primary care services plurality rule for – attribution rule for the five total per capita cost measures. And we use a different rule for the Medicare spending per beneficiary measure, and we attribute the hospitalization for this measure to the group of physicians providing the plurality of Part B services during the inpatient hospitalization. So basically, the group that charge the most during the hospitalization gets that beneficiary's – gets that beneficiary, and we'll include that in their attribution for that measure.

Quality Tiering Methodology

I'm on slide 14. This is – for those who are new to the value modifier, this is kind of how we do – it's a graphical depiction of how we do the quality tiering. Quality tiering requires CMS – or Medicare – to come up with a quality score and a cost score for every group, and this is how we – how we do that.

So what we do is we look at the measures. We place each measure that the group has reported into one of the six quality domains, and those are listed on the left-hand side there, starting with clinical care. And if a measure does not – if a domain does not have a measure, then we just don't count that domain.

And then we put the other six cost measures in the bottom two domains on the left-hand side. The Medicare Spending per Beneficiary and the Total per Capita Cost measure go in the first domain, and then the remaining four condition-specific cost measures go in the bottom domain.

We calculate a standardized score for each measure. And what that means in kind of layman's terms is we look to see how the group's performance on that measure differed from the national mean. And it's called a standardized score because we look at the performance rate, subtract the national mean, and divide by the standard deviation. So we looked at – we kind of create a standardized score to see how far you're away from the national mean.

We then equally weight the measures in each of the domains to come up with a domain score. We then equally weight all the domain scores to come up with a composite score, so you'll have a composite score for quality and a composite score for cost. And then that determines what the value modifier is.

And if you turn on slide 15, you'll see the – kind of the three-by-three grid that we use. You'll see that quality is on the vertical axis, and cost is on the horizontal axis. The best place to be, obviously, is to be high quality/ low cost, which is in the upper left-hand corner, and that adjustment would be plus 2 percent x star, and I'll explain what that "x star" means in just a moment.

The worst place to be, especially for groups of 100 or more, in which quality tiering is mandatory in 2016, is in the bottom right. You don't want to be low quality/ high cost because that's an automatic 2 percent off.

So why isn't Medicare telling you what the actual payment adjustment is, the x? And the reason why is because the value modifier is budget neutral. So that means all of the groups that have downward adjustments—so all those groups of 100 that have downward adjustments, as well as all of those groups that are non-PQRS reporters. And remember my favorite slide? Back – I think it was slide 7 or 8. All those people in the right-hand side of the graph, we have to take 2 percent away from them. We'll take the adjustments away from those groups of 100 or more that are – that are in kind of the bottom right-hand side of that graph, and we'll have a pool of money. We then have to allocate that up to all the people who are high quality/ low cost, those are – who are high quality/ average cost, or those who are low cost/medium quality—basically all in the upper left-hand side of the graph.

So that's why we can't determine – we can't tell you ahead of time what the x is. We will announce it, obviously, each year in the fall before the payment adjustment begins.

You also may be wondering, what does the star mean? That star means we've put in basically a high-risk beneficiary bonus. So if the beneficiaries that have been attributed to your group are in the top quartile of risk scores because they've got a lot of risk factors. They're – have a lot of chronic diseases, they're very aged, possibly disabled. If that's the case, then we actually give an upward bonus to those groups that perform quite well in terms of providing high-quality, low-cost service to those beneficiaries.

So any of the boxes that have a star means that if you have a – if you have a group of, say, 100 or more; they're high quality/low cost and their beneficiaries are in the top 75th percentile; then their x will be really 3x rather than 2x. So whatever x is, so – if x is 1 percent, they would get a 3-percent bonus.

The Value Modifier and Payments Beginning in 2016: Timeline

I'm on slide 16. This is a kind of a timeline of activities for the value modifier that starts applying in 2016. During 2014, we'll have a group registration period that will open in the spring of 2014 and will close on September 30th, 2014. At that point, the groups of 10 or more, if they want to use a group reporting option, have to register and choose one of the group reporting options. They can also indicate that they'd like CAHPS as well during that period.

On January 1st, that's when the value modifier is applying to the groups of 100 or more in 2015. The first quarter of 2015 is when all the 2014 reporting takes place for groups, and it's usually by February or March timeframe where the first – for the – for the – quality reporting has to be complete.

We anticipate that there'll be another group registration period for the value modifier that applies in 2017 during 2015, and you see that noted there. In the fall of 2014, as well as in the fall of 2015, all TINs will be able to receive a group – what we call – or a Quality Resource and Use Report, that indicates how the group would fare under the value modifier based on the prior year's performance.

So in the fall of 2014, all TINs will be able to get a QRUR that shows how they would have done under the value modifier based on the 2013 policies. Likewise, in 2015, the third quarter, the feedback reports – feedback reports—or QRURs, as we call them—will be available in the third quarter.

And then, starting on January 1st, 2016, is when the value modifier starts applying to groups of 10 or more. Once again, it's only upward and no adjustments for groups of 10 to 99, and possible upward, neutral, or downward adjustments for groups of 100 or more.

I'm on slide 17. Just to reiterate that next summer, we anticipate we'll be giving Quality and Resource Use Reports to all groups and solo practitioners late summer of 2014. These will include drill-down tables that include all the beneficiaries who have been attributed to the group, their resource use, information about specific chronic diseases, as well as information about hospitalizations for attributed beneficiaries, as well as all of the quality measures that groups – individual eligible professionals have reported if they've

used the individual reporting method, and, if not, shows them as a group reporting method. Those will be available in late summer/early fall of 2014 and, once again, for group and solo practitioners.

And, with that, I'm done with my presentation. I will turn it back over to Charlie, and we'll be happy to take your questions after a couple of announcements. Thank you.

Keypad Polling

Charlie Eleftheriou: Sure. Yes. Before we do move into question and answers, we'll pause for a moment to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note, there will be some silence on the line while we tabulate the results. And we're now ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in.

If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you. I would now like to turn the call back over to Mr. Eleftheriou.

Question-and-Answer Session

Charlie Eleftheriou: All right. Thank you. Our subject-matter experts will now take your questions. I'd like to remind everyone once more 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 do ask that you limit your questions to one at a time. 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. We're now ready to take our first question.

Operator: To ask a question, press star, followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your questions 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 Sandy Perez.

Sandy Perez: Yes. Good afternoon—or morning, whichever it might be. Sandy Perez with Memorial Healthcare in Florida. And my question is, is the administrative claims option going away after 2014, and would claims reporting – would remain an option for PQRS reporting throughout the VM period?

Michael Wroblewski: That's a – that's a great question, and thank you for bringing that up. The CMS-calculated administrative claims option, where CMS – where – EPs didn't really – they just said, We'd like CMS to calculate some quality – 14 quality measures for us.

That is only an option for 2013. It is not an option for 2014. Individuals or professionals can still report via claims by putting on the CPT codes – G-codes on the claims, you know, using the traditional claims-based reporting method that's been in the PQRS program for 7 or 8 years now.

But the – that one option that we just only had for 2013, for the CMS-calculated administrative claims was only for 2013. It is not an option for 2014.

Sandy Perez: OK. Thank you. And will the EHR option or one of the other group reporting options then be required, although the EPs, or more than 50 percent of the Eps, are reporting PQRS through claims?

Michael Wroblewski: That's correct. That's correct. You can mix your – if you're doing a – if you're doing the 50-percent option—you're not doing a group option, you're doing the 50 percent—as long as at least 50 percent meet the PQRS 2016 payment adjustment—and the group can have some doing EHRs, some can be doing registries, some can be doing claims, some can be doing qualified clinical data registries—just as long as 50 percent of the EPs in the group met the 2016 payment adjustment.

Sandy Perez: OK. So our group registered as a GPRO under administrative claims option this year.

Michael Wroblewski: Yes.

Sandy Perez: And the question is, if we don't have any other reporting option other than claims, do we need to change our registration for the 2014 registration period and do away with the GRPO registration, or how do we do that?

Michael Wroblewski: Yes. So if you're not going to – the only GPRO registrations that are – or options that are available is if you use the web interface, if all the EPs in the group report via registry using the same measures, or if they all use an EHR reporting the same measures.

So – and that's – those are the GPRO options. If your group wants to report individually, you do not have to register because you're no longer a GPRO; you're just going to report individually. And if your group has, say, 30 eligible professionals in it, make sure at least 16 of them meet the – because that's more than 50 percent – meet the PQRS payment adjustment added for individuals. And why don't we take the next caller?

Operator: Your next question is from Andrea Lantzy.

Andrea Lantzy: Hello.

Michael Wroblewski: Hi, Andrea.

Andrea Lantzy: I am still trying to wrap my head around this whole thing. And I understand the "what" of the value-based modifier. But – and I don't mean to be confrontational, so please don't take it that way, but why? I'm not understanding why, other than the, you know, CMS purports to say they like to lessen the administrative burden on physicians, but this is not doing that. So what is the logic behind the value-based modifier?

Michael Wroblewski: That's a great question. You know, Congress in – as a part of the Affordable Care Act required CMS to implement a payment adjustment under the Physician Fee Schedule that compared the quality of care furnished compared to cost. So in order – and there were other quality reporting programs—the PQRS program is one of them—that, you know, predated that Affordable Care Act.

Andrea Lantzy: Right.

Michael Wroblewski: So what we have done is we've said, "OK. So we don't want to increase administrative burden on – for – solely for the value modifier, so we've tried to align with the PQRS program. So we've tried to give as many options as possible that reflect your group's practice.

If your group would like to participate in PQRS as a group, we've got three reporting options and ways to do that: one – you know, the GPRO web interface has a standard set of measures; the EHRs and registries, you can pick your measures.

If you don't want to do that and you just want to keep on doing PQRS like you've always done in – you know, if you're a group of 30 (that's my example; I'll keep using it) – if you're a group of 30, and at least 16 of you all – of the EPs in that group meet the criteria to avoid the 2016 payment adjustment, then you don't have to really do anything else – you don't really have to do anything for the value modifier. And assuming you're high quality/low cost, you'll actually get an upward adjustment on all your 2016 physician claims.

So I hope that – I hope that answers. You know, as – from a kind of a 60,000-foot level, you know, Medicare was required to start paying – you know, this is a part of paying for value rather than for volume.

Andrea Lantzy: Right. I understand that, and I – you know, I thought that the PQRS program did that pretty well. I just really wasn't understanding – now that you say the Affordable Care Act brought it in, I got it.

Michael Wroblewski: OK. And remember, PQRS has only been a reporting program. So …

Andrea Lantzy: Right.

Michael Wroblewski: …incentives were given for PQRS because people successfully reported; not really – you know, I hate to say this, but, you know, the performance could have been pretty poor, and we'd still pay because it was a reporting program.

Now we're actually looking at, hey, what's the quality of care on the measures that you've chosen? And we've tried to give physicians and groups of physicians an option on the measures that they – that they report and how they report them.

So as we phase this in – and, you know, this is – the one point I didn't really make—and I'm – and I'm glad you kind of raised this, I would say, you know, kind of philosophical question is that, you know, physicians have very – very varied practices. And so, as we phase this in, we're trying to really take a light touch by, you know, allowing physicians the option to – how they – what measures make sense to them.

And as we move forward and we anticipate that this will be a – you know, a growing process and a phase-in over several years as we refine our methodologies. But great question. Thank you for answering it. If we'll take the next call?

Andrea Lantzy: Thank you.

Operator: Your next question is from Jessie Johnson.

Jessie Johnson: Hi. I have a question having to do with a specialty group. We have a group of anesthesiologists of 100 or more. And so I'm understanding they can continue to report their three measures that they – that fit them through individual claims. But my question has to do with how are the outcome measures going to fit for the anesthesiology group?

Michael Wroblewski: You know, that's a great question and I didn't touch on that. We attribute beneficiaries for those measures using the – any beneficiaries that have been attributed to your group, either through the two-step attribution process, which focuses on primary care services. So likely, if you're a group of anesthesiologists, your group probably doesn't provide any primary care services, so you're not coming in that route.

But then, we also look if you get any of the – if the anesthesiologist or if your group has the plurality of Part B charges for any of the beneficiaries to whom you provide services during an inpatient hospitalization, all of those beneficiaries could be in the denominator for the three outcome measures.

Jessie Johnson: OK. And that does makes sense. The anesthesiology group is part of a teaching hospital.

Michael Wroblewski: Yes.

Jessie Johnson: So it's likely that the higher cost is going to be from the surgeons and, you know, the plurality of care for those patients is going to be for all the primary care doctors.

Michael Wroblewski: That's probably – that's probably true. And you'll be able to verify it because in the QRUR or the Physician Feedback Report that you get next summer, we'll give you a preview of how your group would have done on the Medicare Spending per Beneficiary measure, and you'll be able to see whether that actually played out in your case or not.

Jessie Johnson: But will they still meet and not be penalized if that…?

Michael Wroblewski: Yes. If we can't – if we can't have – if we can't calculate a measure for at least 20 beneficiaries, you – the group is held harmless. We won't use that measure.

Jessie Johnson: OK. Oh good.

Michael Wroblewski: Yes. That's right. Good point. Good point.

Jessie Johnson: Thank you.

Michael Wroblewski: Well, thank you.

Operator: Your next question is from Cindy Kinney.

Cindy Kinney: Hello? Can you hear me?

Michael Wroblewski: Hi, Cindy.

Cindy Kinney: Hi. The question we have is for large groups of 100 or more. We are multispecialty, and we have OB-GYN, family practice, and pediatrics. Now, would our pediatrics division be included in this group?

Michael Wroblewski: If the eligible professionals bill under the same TIN, and the TIN has at least 100 eligible professionals that have billed Medicare. You know, if only 30 of

your EPs bill Medicare and are Medicare-enrolled, then you're probably not a group of 100 for Medicare purposes. Does that make sense?

Cindy Kinney: Yes, it does. Thank you so much.

Michael Wroblewski: You're welcome.

Operator: Your next question is from Brett Grady.

Brett Grady: Hi. This is Brett Grady with Mercy Health System. I'm wondering if you are accepted into the ACO program if you're still – if your group still has the value modifier applied to them?

Michael Wroblewski: Great question, Brett. CMS will not apply the value modifier to any TIN that is participating in an ACO in 2014, and for 2013 as well. But, you know, since we're talking about the 2016 modifier, if it – if your TIN is a part of an ACO in 2014, the value modifier will not apply.

Brett Grady: Great, thank you.

Michael Wroblewski: Sure, and that's ACOs – that also applies to ACOs in the Medicare Shared Savings Program, those that are in the Pioneer Program, and those in the Comprehensive Primary Care Initiative.

Brett Grady: Thank you very much.

Michael Wroblewski: You're welcome. Thank you.

Operator: Your next question is from Cheri Cannon.

Cheri Cannon: Hi. I'm – I think I'm confused. Is this for – is this only for groups of 25 or more?

Michael Wroblewski: Ten or more.

Cheri Cannon: Ten or more. So anybody that's a group of two doesn't need to worry about this?

Michael Wroblewski: Well, the only thing that we have – that we've mentioned in this year's rule was that 2015 – so 2015 would be the performance period for the value modifier in 2017, and by law we are required to apply the modifier down to basically solo practitioners in 2017.

So if you're a group of two or more, I would – you know, in 2014 I'd use – I'd get into the PQRS, figure out how to use it. Because what we've learned is that, you know, like

anything, it takes a couple of years to kind of become proficient at a new reporting system, and you guys will be one step ahead of the game for 2015.

Cheri Cannon: So, in 2014 I'd sign up for the PQRS, get ourselves familiar with it, how it works, and then in 2015 we'll have to be reporting?

Michael Wroblewski: You got it.

Cheri Cannon: How many measures will we have to do?

Michael Wroblewski: We have not made proposals for the 2015 reporting period. I'll leave it at that. I'm sorry. I wish I could tell you more, but…

Cheri Cannon: OK. That's OK. No problem.

Michael Wroblewski: I can't answer your question right now.

Cheri Cannon: That's all right. Thank you very much.

Michael Wroblewski: OK. You're welcome. Thank you.

Operator: Your next question is from Loretta Lorie.

Loretta Lorie: Good afternoon. I am in – with an urgent care center. Is this going to – how is this going to affect us? Because of the nature of our business—it's mostly acute care visits, and the reporting is not – you know, it doesn't look like it would fit us.

Michael Wroblewski: So if you have, say, some primary care physicians that are in an urgent care center, and the urgent care center has a TIN, and you use that single TIN to bill Medicare, and assuming you have 10 or more, then – then that – those – you know, this is my hypothetical here, that those primary care physicians and other EPs that are – this is 10 or more – can choose one of the three PQRS group reporting options. And if it doesn't want to report as a group, it can report, as long as – say your group is 10, so make sure 6, because that's over 50 percent, report PQRS measures individually. And there are plenty of measures for primary care – I mean, for primary care physicians…

Loretta Lorie: For primary care, yes. But we only see these patients maybe once or twice a year, and then there's – you know, we go along. So I guess it's just the reporting part. As long as we're just reporting the numbers, then – then we'll be covered and there won't be a…

Michael Wroblewski: There won't be a downward adjustment, that's correct.

Loretta Lorie: Right. OK.

Michael Wroblewski: You know – you know, you raise a good point, and I – you know, in terms of moving forward – and if you could send your – if you could send that – you know, just the question about how to do – you know, as I mentioned to maybe the second caller, you know, we're phasing this program in, and there – we realize that our approach is a little broad right now.

And as we move forward, especially when we get into more downward adjustments, we're going to want to make sure we take some adjustments. So if you can just send a quick little email to QRUR. That's qrur@cms.hhs.gov, we'll make sure that we kind of take this into consideration as we make proposals moving forward. So we – I appreciate the question.

Loretta Lorie: I appreciate that. I appreciate that. Also, just one quick question. Actually, you hit it on the head. I'll just send my question to the QRUR. Oh, oh, would we be compared to specialties instead of primary care? I mean, I guess, that's my – where we're going to be – or should I just throw that in my question?

Michael Wroblewski: No. That's – the specialty comparisons. So what we do is we look to see how your eligible professionals, what specialty designation they have with Medicare, and these are PECOS database.

So if – for example, they're all – you know, just for illustrative purposes, are all primary care, you'll be compared to other folks with that same kind of primary care. If you have, you know, people who are emergency medicine or …

Loretta Lorie: We do.

Michael Wroblewski: …general internists or a cardiologist, then you'd be compared that way. So we take into account the specialty – specialty composition of the group.

Loretta Lorie: OK. I appreciate your help. Thank you.

Michael Wroblewski: You're welcome. Thank you.

Operator: Your next question is from Darlene Underwood.

Michael Wroblewski: Hi, Darlene. OK. Next question?

Operator: Your next question is from Jeanne Chamberlin.

Jeanne Chamberlin: Hi. Yes. Real quickly: Does any of this apply to a practice that is non-participating with Medicare?

Michael Wroblewski: Hold on for just one second. You know, Jeanne, that's a great question and I don't have the – a full answer for you right now. What we can do is – on our – we have a website where we have all – it's cms.gov/physicianfeedbackprogram.

And give us about a week or so, and we will put up – it's a great question – we have a list of FAQs there, and we'll include this in that one. That's a great question.

Jeanne Chamberlin: OK. Thank you.

Michael Wroblewski: Thank you.

Operator: Your next question is from Laurie Morgan.

Laurie Morgan: Hello. Thanks for taking my question. This is Laurie Morgan from Capko and Morgan. My question actually concerns large groups and the value modifier in 2015. If a group has – if they missed the October deadline, is there anything left that they can do to submit data to PQRS and avoid the penalty in 2015, or are they basically just – have they missed their chance?

Michael Wroblewski: So for – if it's a group of 100 or more and it did not register, then there will be a minus 1 percent to all physician claims for the value modifier in 2015. I – but as I said, this is separate from the PQRS payment adjustment.

The individual eligible professionals in your group can still avoid the PQRS payment adjustment at the individual level by meeting the criteria to avoid the PQRS payment adjustment for individuals, and that is submitting at least one – one measure – quality information on one measure one time. So you can get out of – you still have the opportunity to get out of the PQRS payment adjustment, but you have missed the window for the value modifier.

Laurie Morgan: Well, that was the answer to my question actually, because I did realize they could still do the one measure, one claim, which is pretty easy to do by the end of the year. But they don't get any – even if every single member of the group participates in that fashion, it doesn't help them avoid the 1 percent.

Michael Wroblewski: Right. It doesn't for the value modifier. That is correct.

Laurie Morgan: OK.

Michael Wroblewski: And remember, the PQRS payment adjustment for 2015 based on '13 performance is one and a half, right? Yes. So by doing – putting that one measure on one – you know, the code on one claim for one measure for each EP, you're getting out of a 1.5-percent adjustment – downward adjustment.

Laurie Morgan: Yes.

Michael Wroblewski: So it's a pretty important thing to do.

Laurie Morgan: Definitely. No argument there. I just was wondering about the other 1 percent.

Christine Estella: This is Christine. I just want to let you know also, just as Michael had mentioned, there are two ways to participate in PQRS—one as an individual and the other as part of a group practice under the GRPO. So what Michael mentioned is if you missed the deadline to be a GPRO, you can still participate as an individual because when participating as an individual, you're not required to register. So you can just start reporting. So just make sure each of your EPs in that group practice report at least one measure.

Laurie Morgan: Yes. That makes sense. But it still – again, it doesn't apply to the – I mean, if you did not register as a group in October, you still are subject to the 1 percent for sure.

Michael Wroblewski: That's correct. For the value modifier. That's right.

Laurie Morgan: Thanks very much.

Michael Wroblewski: Just make sure that – we have – September 30th is our close period for group registration for the 2014 performance period, and we're going up to 2 percent. So we hope you don't miss it next year.

Laurie Morgan: Thanks very much. Thanks for the advice.

Michael Wroblewski: You're welcome.

Operator: Your next question is from Margaret Jellenik.

Margaret Jellenik: Hello?

Michael Wroblewski: Hi, Margaret.

Margaret Jellenik: Hi. Just a quick question. I'm working with individuals, a psychologist and social worker, and I wanted to find out how this impacts their practice going forward. They are not part of a group; they're all individuals. So my concern is, would they be affected now, or would that come in 2017?

Michael Wroblewski: If they're not in a group right now and they all bill under their own TINs …

Margaret Jellenik: Yes.

Michael Wroblewski: …then nothing will affect them for the value modifier in 2016, that's correct. You know, we said that 2015 is the performance period for '17, but – and by law we're required to apply the value modifier to everybody in 2017, but we haven't made proposals on how to do that yet.

Margaret Jellenik: OK, fine. OK, very good. Thank you very much.

Michael Wroblewski: You're welcome. Thank you.

Operator: Your next question is from Kim Huser.

Kim Huser: Thank you for my – taking my question. We are a practice of physical therapists, occupational therapists, speech pathologists only, in TxTeam in South Carolina. So since we do not have any physicians in our group, then the Physician Value-Based Payment doesn't apply to us, correct?

Michael Wroblewski: That is correct.

Kim Huser: OK.

Michael Wroblewski: If you have no – and make sure – we define physicians broadly. So it's M.D.s, D.O.s, podiatrists, optometrists, chiropractors, dental surgery, and dental medicine.

Kim Huser: Correct. And then, for 2014, we could individually still just report on three PQRS measures. We don't need to go to the nine?

Michael Wroblewski: In order to avoid the payment adjustment in '16, that is correct. In order to earn a PQRS incentive, however, you have to do the nine.

Kim Huser: OK. To get the incentive in 2016, the nine.

Michael Wroblewski: That's right. That's right.

Kim Huser: OK. Thank you.

Michael Wroblewski: Great question.

Operator: Your next question is for – is from Teresa Bolden.

Teresa Bolden: Hello, this is Teresa. I'm kind of confused about just one thing. I just want to make sure I have this correct. If our physicians continue to report their quality measures via claims-based reporting, and they meet the quality measures if they do the 50 percent, then that will avoid the payment adjustment? I'm kind of confused on how that works.

Michael Wroblewski: OK. So for the value modifier, if you're a group of 10 or more, and for 2016 we're going to look at performance during 2014, and as long as your group – say your group has 10 EPs, as long as 6 of them report via claims in 2014, you will – depending upon your performance, could get an upward adjustment or no adjustment, based on your performance. Now – so that's for the value modifier.

Now, if you're that group of 10 and only 6 of you – 6 of the EPs meet the payment adjustment criteria, and the other 4 don't, well, those 6 won't get a PQRS payment adjustment, but those other 4 will. Does that make sense?

Teresa Bolden: Yes. That makes more sense.

Michael Wroblewski: OK. You're welcome.

Operator: Your next question is from Elizabeth Durante.

Elizabeth Durante: Hi. I'm Liz Durante from South Nassau Communities Hospital. My question is, we're a hospital-based provider, so I have over 100 eligible professionals, but they're of all kinds of specialty—you know, pathology, mental health, cardiologists, palliative care. What's the best way that we go about this so we're not receiving the 2-percent downward adjustment?

Last year, we were able – well, this year we did the administrative claims option; now that's going away. So it seems to me I would have to get all – all these specialists, greater 50 percent of them to start reporting?

Michael Wroblewski: If you – if you want to do that, or you can choose one of the three group reporting options, in which all of your professionals, you can – if you do the web interface, which looks at primary care and preventive care measures, and there are 18 measures that we look at, or you could do – you could report via EHRs or registry of at least three measures of your choice.

But they have to be for – and I'm going to let Christine jump in again. I just want to make sure I don't say this incorrectly. All of the physicians who have denominator-eligible patients for those measures that your group chooses, would have to report on them.

Elizabeth Durante: So it would just be three measures for the entire group? That would work for all those different specialties, and I would have to report those three measures greater than – or 50 percent of the providers have to report on that, even if it doesn't work for those providers? Is that what I'm hearing?

Michael Wroblewski: If they don't – not all of your providers will have patients who are eligible for the measures that you may choose.

Elizabeth Durante: I see. OK. I got it. So I could just pick three measures that would work across the board to best suit all of my providers.

Christine Estella: Right. So – this is Christine again. So, for example, let's say you have, you know, a multispecialty group, and you have, like, primary care physicians, but you also have, like, dermatologists. If you're only picking up or reporting on, you know, measures related to the physicians that are in primary care, then the dermatologists basically, you know – are basically off the hook on reporting, provided that they're not

also, you know, seeing patients in a primary care capacity, because the measures don't apply to them.

Elizabeth Durante: Right. None of that – none of them are seeing patients in a primary care….

Christine Estella: Right. That was – that was just an example. But you just – you have to look at the measure's denominator to make sure that, you know, the measure is not applicable to the EPs. So basically, it's a – it's a group effort in terms of reporting, if you're reporting under the GPRO.

Elizabeth Durante: Right. OK. I got it. Thank you so much.

Michael Wroblewski: You're welcome. Thank you.

Operator: Your next question is from Ellen Skinner.

Ellen Skinner: Yes. We are from a multispecialty group, 500-plus physicians, and I just wanted to clarify that the option for GPRO – I was under the impression that if you were 100-plus providers, you had to select GPRO. But based on a question earlier that you answered, it seems like that's – that's not the case, that you could do individual.

Michael Wroblewski: You – for 2013, all groups of 100 or more have to choose one of the three GPRO reporting options …

Ellen Skinner: OK.

Michael Wroblewski: …that were available in '13. But since we're talking about 2014, we've broadened it a little bit more. We've gotten rid of the GPRO administrative claims option, allowed the GPRO EHR option. And then, if you don't want to do group reporting, and instead you'd rather have – you know, because your group, say, has been – you know, you've had – you've been reporting at the individual level for a couple years now, where as long as 50 percent of your EPs are – meet the satisfactory reporting criteria for the 2016 payment adjustment, then you'll be all set for the value modifier.

Ellen Skinner: Not for the PQRS, correct?

Michael Wroblewski: And – well, the – for the PQRS, you – those – you know, say your group has – you said have – I'll say you have 500, right? Well, as long as 251—because that's 50 percent, slightly over 50 percent—meet the criteria, then you'll be fine for the – you'll be fine for the value modifier. But – and those 251 will be OK because now PQRS is looking at you as in – as a group of – as really just as individuals. So 251 of them will be OK, but the other 249 will not – will get a – at that point, a minus 2-percent adjustment because they didn't report PQRS measures individually.

Ellen Skinner: OK. Thank you.

Michael Wroblewski: You're welcome.

Operator: Your next question is from Sharen Carey.

Sharen Carey: Hi. I'm from Big Sur Health Center out here on the West Coast. And like one of your previous callers, we have two providers. One of those is a certified family practice, the other one is an emergency room physician. However, he practices as a family care provider at our clinic. Because he's emergency medicine certified, he cannot attest or participate, but he is actually acting in primary care setting. Is there some way to …?

Michael Wroblewski: So let me just make – I just want to make sure I got the premise of your question properly. You have two EPs that bill under a single TIN?

Sharen Carey: Yes.

Michael Wroblewski: OK. The value modifier does not apply to them in 2016 because it only applies to groups of 10 or more, and you said you were 2. So this does not apply to you in 2016 based on 2014 performance.

Sharen Carey: I understand that but …

Michael Wroblewski: OK.

Sharen Carey: …you also indicated that you were going to be drilling down to smaller groups and solo practitioners in late summer of 2014.

Michael Wroblewski: No. What we said was – and I'm sorry if I – if I misstated it – 2015, so, you know, not next year but the year after, will be the performance period for the value modifier that applies in 2017. And by law we're required to apply the value modifier to all physicians and all groups in 2017. So I would say, stay tuned to, you know, next summer for our proposals on how we move forward with doing that, going down to groups of your size, which would be two or more.

Sharen Carey: Exactly. And so, then, based on that, where would the emergency physician who is acting as a family practitioner in our setting fall?

Michael Wroblewski: You know – hold on for one quick second…. Hi. Sorry for that little delay there.

Sharen Carey: That's OK.

Michael Wroblewski: The – if the – if the emergency medicine physician is providing primary care service and then billing primary services claim, or any claims, under Medicare Part B, then – or under the Physician Fee Schedule, then they can report on any of the PQRS measures on – for any of those beneficiaries for which you've attributed a

claim. So it wouldn't be treated any differently unless I'm missing something in your question.

Sharen Carey: Well, I guess the reason that I asked that, and this may be a separate topic, but when I tried to register both of them and attest for Meaningful Use this year, they would not allow me to attest for him because he was emergency medicine certified and that's how he's registered. I could attest for my family practitioner. So he was kicked out of the incentive program, the ability to participate in those incentives. And so that's why I'm just trying to get on board early here in preparation for what's coming in 2014 and '15 ….

Michael Wroblewski: I know and, first of all, I applaud your kind of preparedness, so thank you. The – for PQRS, that emergency room physician could report still on – really on 2013 for PQRS purposes, and the same thing with '14. So for PQRS, it should – they'll just be treated like anybody else.

We'll make a note, though, to look into this to see if there was – why that – why that happened, and to make sure that that wouldn't be an issue for 2015. But I don't think the attestation is still around in 2015 for Meaningful Use. So I don't think that's an issue any longer. But I can double-check that.

Sharen Carey: OK. Fine. Thank you.

Michael Wroblewski: Thank you.

Operator: Your next question is from Koryn Rubin.

Koryn Rubin: Yes. Hi. This is Koryn Rubin from the American Medical Association. So if you're a provider and for purposes of avoiding the payment adjustment, you report three measures. For quality tiering, since you have the – you know, the domains, if you don't report in a certain domain, are you then scored as average in those domains?

Michael Wroblewski: Well, say – so your hypothetical would be – that would be one – so you have a group of 10 (right?), because the value modifier is only applying to groups of 10. And so you told me what one of the physicians did, and they reported three measures.

So then you'd say, "It's a group of 10. I need to make sure at least 5 other physicians reported as – or eligible professionals – reported at least three measures." And then we'd look across the group and see, OK, what measures did those 6 EPs report? And then we'd slot them into all those domains. Because, remember, this is at the group level, not at the individual EP level.

So it's likely that you would have – if you had 6 EPs in my example right here, they would not be reporting all in one domain. If they did, however, then all those measures would be equally weighted, and all the other five domains—because there are six quality

domains—wouldn't be counted. And only that one domain would be counted, and that would – you know, it would take up the slack, so to speak.

So, you know, there'd be one domain. That domain would be 100 percent of the quality score. And then all the measures in it—you know, that all six of those EPs reported—would be equally weighted.

Koryn Rubin: OK. So the other domains would then just kind of be thrown out, hypothetically.

Michael Wroblewski: Yes, yes. And the – they pick – yes. If there's only one domain, then the other ones kind of pick up the slack– it picks up the slack. So if you only report on four of the domains – you – if you have a group that reports on all six of the domains, each domain is 16.6 percent, right? If you have – if it's only four domains, then each are worth a quarter; you have only one domain, that domain is 100 percent.

Koryn Rubin: OK. Thank you.

Michael Wroblewski: Yes. Thank you.

Operator: Your next question comes from the line of Serra Schrempp.

Serra Schrempp: Hi. I just wanted to verify: With the groups of 100-plus, last year we – or this year we registered the GPRO and had the administrative claims. If next year we all report different – differently, and everybody *is* reporting, do we need to redo the GPRO registration, or do I leave that alone? Do I go back in there and change that we're going to report this individually?

Michael Wroblewski: You don't have to do anything. What you registered for was for '13 and we've got that.

Serra Schrempp: OK.

Michael Wroblewski: If you don't register in '14, then we automatically look to see did 50 percent of your EPs meet the satisfactory reporting criteria, and it sounds like they would. And then they'd be OK and we'd be all set.

Serra Schrempp: Awesome. Thank you.

Michael Wroblewski: You're welcome. Thank you.

Operator: Your next question is from Glenn Gantner.

Glenn Gantner: Hi. This is Glenn Gantner from Greenway. I just want to say I really appreciate all the details here. It's been very helpful. My question is in regards to a group avoiding the VM payment adjustment in 2016 by reporting individually. Does 50 percent

of the group have to report successfully, meaning nine measures with the 50 percent reporting rate, or can they just report enough to avoid that payment adjustment?

Michael Wroblewski: The latter—enough to avoid the payment adjustment.

Glenn Gantner: OK. Thank you so much.

Michael Wroblewski: You're welcome.

Operator: Your next question is from Elaine Bernard.

Elaine Bernard: Hi. My question has to do with when the 2014 PQRS measures and GPRO measures will be published.

Michael Wroblewski: They were published last Wednesday in the Federal Rule?

Christine Estella: So this is Christine…

Michael Wroblewski: Sorry. I may be – I may be wrong about that. Sorry.

Christine Estella: They are – they are displayed. Michael is right in that they are displayed; their descriptions and their titles are displayed in the final rule in the 2014 PFS. However, the PQRS will put out our measures list that also will contain the measure specifications.

And we're trying to push it out as soon as possible. As you know, our rule just was finalized, so we need to update any measure specs that need to be updated. We're going to try and push that out ASAP and hopefully by the end of December, so that they're ready to go beginning of January.

Elaine Bernard: So where can I – where can I access those now?

Christine Estella: Sure. They'll be – currently, if – to look at the measure title descriptions, you would just look at the 2014 PFS final rule. It's currently under public inspection. I don't have the link right in front of me right now.

Michael Wroblewski: If she were to look for the 2013 measure specifications, where would she look for that? Because that's where you'll put the '14 ones too, right?

Christine Estella: Right. Right.

Michael Wroblewski: Where would you put the '13 ones?

Christine Estella: So – so, currently, right now, for the – if you wanted just to review the measure descriptions, you could look at the final rule. But, for 2014, if you want to review those measures specs, they' be – they will be available on the PQRS website. And

would be under − we have a measures section of the PQRS website. And so those should hopefully be available within the next few weeks.

Elaine Bernard: OK. So they'll be on the PQRS site in the next few weeks?

Christine Estella: Yes.

Elaine Bernard: OK.

Christine Estella: And then I – obviously, if you have any questions, you know, from now until then, you – feel free to contact our QualityNet Help Desk, and they can help you out and check to see if any of the measures have been updated and if there are any you were reporting prior.

Elaine Bernard: OK. Thank you.

Christine Estella: No problem.

Operator: Your next question is from Camille Laabs.

Camille Laabs: Hi. I actually have a question related to the PQRS and group reporting option. I believe that we missed the October deadline to report 2014 dates of service. But you mentioned something about the spring register for the group reporting, so I'm a little bit confused.

Michael Wroblewski: OK. So what just closed in October of 2013 – so what, maybe 6 weeks ago –was the group registration process for 2013, the year we're in.

Camille Laabs: OK.

Michael Wroblewski: The group registration process for 2014 will start in the spring and will end September 30th, 2014, so what's that? Nine and a half months from now? You know, open in, you know, March–April timeframe, and then will close September 30th. And that's where groups can register for 2014, next year.

Camille Laabs: OK. Fabulous. Thank you so much.

Michael Wroblewski: You're welcome.

Operator: Your next question is from Bettina Berman.

Bettina Berman: Hi. Quick question. If we have a risk score above 75 percent—our QRUR reports from 2012 said we had a risk score at 74 percent—would we get an extra 1 percent, or did we not understand that correctly?

Michael Wroblewski: It – your – the QRUR said you were what, 74?

Bettina Berman: Yes. It was the 2012 QRUR report said we were – we had a risk score of 74 percent.

Michael Wroblewski: You will – you will not get the adjustment. You just missed it by a hair, though. If it had said 75, you would have gotten that upward adjustment, or 75 or above.

Bettina Berman: And that will be – that 1 percent for next year also, if you are 75 or above?

Michael Wroblewski: It's above 75 percent and it's 1x. And as I tried to explain earlier, we don't know what the x is because it has to be budget neutral. But it would be – you'd get an additional increment, so to speak.

Bettina Berman: OK.

Michael Wroblewski: Depending upon which box you fell into.

Bettina Berman: OK. Thank you.

Michael Wroblewski: Sure.

Bettina Berman: Bye.

Operator: Your next question is from Heidi Harting.

Heidi Harting: Yes. Real quick question. I want to confirm what you said that if an organization is participating in CPCI that – in 2014, then they would not be eligible for the value-based modifier?

Michael Wroblewski: That's right. We will not apply the value-based modifier to any TIN that is participating in CPCI in 2014. Correct.

Heidi Harting: OK. Thank you.

Michael Wroblewski: You're welcome.

Operator: Your next question is from David Waldman.

David Waldman: Hi. My question is regarding the Physician Compare website for a group 10 or more. When will those – those outcomes of those measures be published on that website?

Michael Wroblewski: OK. So that's a great question. We are – Physician Compare in 2014 is putting GPRO measures on Physician Compare late 2014. So if your group participates in a GPRO and chooses one of those three GPRO reporting options—web

interface, registry, EHR—you'll get your QRUR next – late summer/early fall. Then you'll be able to preview. You'll see what your performance is. You'll then be able to go to the Physician Compare website and look at the actual display of those measures at least 30 days before they would go public, so it wouldn't be until late '14. But you'd have a – two kind of previews of it ahead of time.

David Waldman: And if we would do just the – if we're doing individual claim reporting for the providers….

Michael Wroblewski: If you're doing individual claim reporting, that is not a GPRO, and it will not be – your 2014 performance will not be on Physician Compare.

David Waldman: OK. Thank you.

Michael Wroblewski: You're welcome.

Operator: Your next question is from Amy Hickey.

Amy Hickey: Thank you. My question was answered earlier.

Operator: Your next question is from Mitchell Slutzky.

Mitchell Slutzky: Yes. Hi. Thank you. I'm from Senior – CHE Senior Psychological Services. We have over 100 providers; we're all licensed clinical psychologists. So I just wanted to make sure I understand: Even though we're a group of over 100, we don't have any physicians in the group, therefore the value modifier does not apply to us. Is that correct?

Michael Wroblewski: That is correct.

Mitchell Slutzky: OK. So the other question related to that—and I understand, I just want to make sure I get this—we have to report either nine measures to get the incentive or just three – have 50 percent of our clinicians doing 50 percent of those three measures, and then we don't – we avoid the penalty but we will not get the incentive. I just want to make sure I understand that correctly.

Michael Wroblewski: That's right. Nine for the incentive, three to avoid the penalty.

Mitchell Slutzky: Very good. Thank you.

Michael Wroblewski: You're welcome.

Operator: Your next question is from Cathy Cahill.
Cathy Cahill: Hi. Yes. I wanted to confirm something that you had said earlier today. And that is if a provider joins the group in, say, 2015, would – and – and – and the group did not achieve the value-based modifier, would that provider also be penalized?

Michael Wroblewski: Yes.

Cathy Cahill: And – OK.

Michael Wroblewski: If it – if that provider is a physician and bills under that TIN and that TIN in 2014, which is the performance period, didn't meet the – you know, didn't register for one of the three group reporting options or the 50 – didn't meet – you know, if the EPs that were in that group during 2014, at least 50 percent didn't meet the 2016 payment adjustment for PQRS, then that – there will be a negative 2 for that – anyone who bills – any physician who bills under that TIN in 2016, even if that physician wasn't in the group in 2014.

Cathy Cahill: So actually the penalty follows the physician to wherever group they join.

Michael Wroblewski: No.

Cathy Cahill: I guess it's the same with….

Michael Wroblewski: No. Opposite – opposite way. The payment adjustments, whether up or down, follow the TIN, regardless of the NPIs that bill under it.

Cathy Cahill: OK. All right.

Michael Wroblewski: It's applied at the group level. It is not applied at the NPI or EP level.

Cathy Cahill: OK. And …

Michael Wroblewski: It's calculated, actually ….

Cathy Cahill: … the other thing ….

Michael Wroblewski: They calculate it.

Cathy Cahill: OK. Now, if – if every provider in – in the practice is using the EHR successfully, then, in essence, they have – they have met the criteria for the value-based modifier because they're going to be reporting all of those – you know, there's going to be nine measures that they have to report quality measures at 64.

Michael Wroblewski: Yes. They do. If all of them…

Cathy Cahill: Do they have to choose specifically, or can they choose any one of those nine and, you know, be OK with the value-based modifier?

Michael Wroblewski: I think – you raise a good question and I don't want to give you the wrong answer. My – if all of your EPs are using a EHR and they all have …

Cathy Cahill: Successfully.

Michael Wroblewski: …the electronic quality – clinical quality measures - CQMs, then you're OK. We will take performance rates on anything that's a non-zero for the value modifier. So if you have some that – you know, you have a denominator of zero, and you have a zero performance rate, we won't include that.

Cathy Cahill: Right.

Michael Wroblewski: What I would check, though, with your software vendor is whether you can designate which ones you want to have count for PQRS.

Cathy Cahill: Yes. We realize that we have to do that crossover. So I guess that's really the question I'm trying to get at. Are there specific measures that they must report in order to avoid the penalty?

Michael Wroblewski: No.

Cathy Cahill: There are not. So that, in essence, they can pick any one – any 9 of the 64, meet the Meaningful Use criteria successfully, and then also not be subject to the penalty for the value-based modifier.

Michael Wroblewski: You got it.

Cathy Cahill: OK. Thank you.

Michael Wroblewski: All right. Sure. Thank you. We'll take one more question.

Operator: Your next question is from Susan McClelland.

Susan McClelland: Yes. Hello. My name is Susan McClelland. I'm calling on behalf of the American Chiropractic Association. My question has to do with performance year 2014 and possibly performance year 2015.

I see that in 2014 the group size is 10 or more, so this could potentially affect our providers. However, our providers cannot report on any outcome measures. We can only report on process measures. So how will that affect us?

Michael Wroblewski: It shouldn't, as long as you report on – as long as your providers report three PQRS measures, and I believe there are at least three for chiropractors.
Susan McClelland: No, there're not. There are only two. But that's OK. Go ahead.

Michael Wroblewski: Then, you're OK. Then, there won't be any – and if we can't ….

Susan McClelland: OK. Because your little chart only refers to outcome measures.

Michael Wroblewski: What chart is that?

Susan McClelland: "Value Modifier Policies for 2015 & 2016." Under 2015, it shows outcome measures and then 2016 it says "Same as 2015," and we cannot report on any of those measures. We can't report on any outcome measures.

Michael Wroblewski: That's a great point. What we've – what I should have put there is that we – we, meaning Medicare, calculate those measures. You don't have to report on – what you're reporting is the available quality reporting mechanism. See the row right above it? That's what applies to you.

I should have put – and thank you for raising this point – I should say that these outcome measures are ones that we, CMS, calculate. And if we can't calculate them or at least can't – don't have 20 beneficiaries on which we're going to calculate that measure, then we won't use those – one of those outcome measures. So you don't have to worry about that, but that's a great point. And we can clarify this as we move forward.

Susan McClelland: OK. So we would not get the reduction, but we would also not be eligible for the increase either? Is that correct?

Michael Wroblewski: No, no…

Susan McClelland: Because the value-based modifier won't apply to us at all.

Michael Wroblewski: No. Because as long as you're – if you're a group of, you know, 15 chiropractors, and you report – and at least 50 percent of them report on three measures, we'll use the group's performance on all those individually reported measures to come up with a group quality score.

We will not include in that group quality score the outcome measures if we can't attribute 20 beneficiaries to you using our attribution methodology. So you're held harmless from the fact that we can't calculate a measure for you.

Susan McClelland: I see. But we would still be eligible – or actually, it's not even eligible – we would definitely be included in the value-based modifier bonuses or reductions or whatever, and we would….

Michael Wroblewski: Well, if you're a group of 10 to 99, they'd only be bonuses.

Susan McClelland: Right.
Michael Wroblewski: Yes. That's right. That's right. You bet.

Susan McClelland: OK. Sorry. And then in the following year, although we don't know exactly how that's going to work, it would be the same thing, that even though we can only report process measures, we would still be included in this.

Michael Wroblewski: That's correct.

Susan McClelland: OK. Very good. Thank you.

Michael Wroblewski: Sure. Thank you. Thank you for the correction, too. We'll make that moving forward.

Additional Information

Charlie Eleftheriou: OK. Thank you, everyone. That's, unfortunately, all the time we have for questions today. On slide 20 of the presentation, you'll find information on how to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you'll take a few moments to do so.

And, as I mentioned at the beginning of the call, this MLN Connects Call has been approved by CMS for CME and CEU continuing education credit. On slide 21 of the presentation you'll find a link to CE activity information instructions for this call. The document instructs how to obtain credit for attending the call today.

Again, my name is Charlie Eleftheriou, and I'd like to thank the subject-matter experts and participants of today's MLN Connects Call. Have a great day.

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

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