

**2012 PHYSICIAN QUALITY REPORTING SYSTEM
TOWN HALL
February 9, 2011
10:00 a.m. to 4:00 p.m.**

TELECONFERENCE TRANSCRIPT

Ms. Barbara Cebuhar: -- My name is Barbara Cebuhar and I work in the office of External Affairs and I work with my colleagues here in the office of Clinical Standards and Quality on a host of issues. This town hall meeting is an opportunity for us to solicit input from stakeholders about the individual quality measures and measure groups being considered for possible inclusion in the proposed set of quality measures for the 2012 physician quality reporting system.

Just a reminder, today's session is an opportunity for you to provide feedback to us. CMS is in a listening only mode. Because we are at the beginning of our process of rule making we will not be able to answer specific questions. Our goal today is to provide an overview of the objectives for the session, and receive your input on the major components of the physician's quality reporting system including the individual quality measures and the measure group suggestions we've received in response to our 2012 physician quality reporting system call for measure.

We are going to start with several presentations by my colleagues in OCSQ. Following each presentation, the meeting agenda will provide opportunities for brief, two minute comments from onsite session attendees. As time allows, we will also recognize our telephone participants to provide brief comments as well. Today's session is being recorded so we anticipate having an audio download and transcript on the CMS PQRI Web site by February the 15th.

For those of you on the phone, the presentation slides may be found at www.cms.gov/pqri. Go to the sponsored call page of the PQRI Web site and go to the downloads dated 2/9/11. Our plan is to open the floor to public comment around 10:35 this morning and then break for lunch at noon. Because of security restrictions, you are allowed access to the first floor in the basement cafeteria. We will return to start again at 1:00 pm and we will have an opportunity for two additional public comment periods. As I mentioned, the comments need to be two minutes or less. We appreciate your observing the necessary time restrictions.

We may move through the presentations more quickly, but we will try to stick to our posted agenda.

We are thrilled that you all are here with us today, and I would like to turn the meeting over to-we will be joined by Dr. Rapp very shortly who will provide opening comments; so thank you very much.

Just so everybody knows the restrooms are located outside the double doors, so if anyone needs them they are outside the double doors on this floor. If everybody could please come to the mic if you have a question or a comment; we are recording this and that's the only way we can pick up your comments. I appreciate your using the central mic here. Thank you.

Dr. Michael Rapp, MD: Good morning, I'm Michael Rapp. I'm the director of the Quality Measurement and Help Assessment Group here at CMS. Thank you for coming to our public town hall meeting on the 2012 Physician Quality Reporting System. Even though many of you are sitting in the back row, you can actually come up front if you want to. But at any rate, thank you all for coming. I know it's kind of difficult to get through all the security requirements here. I do feel quite safe in this building as you can imagine, with all the security that people have to go through to get here. So thank you for bearing with that.

We like to have these sessions. As you know, the Physician Quality Reporting System has been a real growth effort over the last few years, and we started off, as I reflect back in 2006 where we sought to have a physician voluntary reporting program, and I was looking over some materials for that recently. We came up with 36 measures at the time, and we were faced with an onslaught of criticism that that was way too many measures and that was burdensome and we needed to cut that back. So we did and cut it back to 16. And with that, physicians began very minimally to report.

At the end of that year in 2006, Congress authorized through the Tax Relief and Healthcare Act, an actual program -- an incentive program -- where we could pay 1.5% incentive for six months of reporting, which we had to get up and running within six months. We had by that time developed, through the help of our contractor, Mathematica, and the AMAPCPI and the NCQA some 74 measures which was what we started with that program. In each year for the next several years, Congress showed its continuing interest in the program by reauthorizing it or requiring us to do more things.

Eventually in the MPA legislation made it a permanent program and then the Affordable Care Act now has made it permanent in terms of either there being a positive incentive or a penalty or a payment adjustment negatively if people don't participate. I think it's truly the permanent program now, and as

you know in the Affordable Care Act there are many other provisions that affect physicians, including resource reports, working towards bringing those together with quality, having the Physician Compare Web sites and ultimately having a payment modifier based upon cost and quality brought together. We've been actively engaged with many of you; many of your organizations to try to work through the various things that we've needed implement over the last few years, particularly developing measures, figuring out what the best measures are, getting your suggestions, working through the mechanics of reporting and so forth.

This is a continuation of that effort to try to get your input both in terms of suggestions for measures, suggestions for program changes in a variety of ways. Some of the suggestions that's we gotten previously we adopted, for example, a half-year reporting program was suggested for the individual measures, which we did adopt and implement a couple of years ago. We do know the challenges that physicians have had with claims-based reporting. We've found that in general, the ability to know that when you report a CPT code it's correctly reported and so forth. We've worked through those issues, but still there are many cases that physicians and their staff miss in terms of reporting, so they weren't making the 80% threshold, so we changed that to reduce the reporting requirement to 50% for 2011.

We expect that the success rate for claims-based reporting is going to be substantially higher this year than previously, so that's important. We've expanded our registries -- I'm not quite sure what we're up to, 90 or so -- 97. That was something that Congress said with the original TRISH Act [PH] you need to consider or address registry reporting. We proposed and finalized that we were going to address it by basically testing it. At the end of 2007 Congress said that's terrific but we want you to implement it in 2008 after we had finalized what we were going to do for 2008 on November 1st. We did, and within several months we had the outline of what we would do together, and later that year, registries were up and running and I think we had 36 to start with the first year, so that's a big effort.

And then from the beginning, we've been very interested in moving to electronic health record reporting, so with that we actually achieved that. Earlier this year, in January, for the first time on a limited basis physicians are reporting from their electronic health records the data necessary to qualify for the Physician Quality Reporting System. That's really a first for CMS and I think it's for a program and we're quite pleased and proud that we were able to achieve that. One thing else I want to mention is after the 2007 program we did produce an experience report, and we put a lot of details

in how the program worked mechanically, and difficulties and how they were being addressed and so forth. We committed to you that we would address them and that we would also periodically provide information on the Web site and further, that we would come out with future experience reports. We worked on one last year but we didn't get it finished until almost the time for the 2009 payment. So we went back and we've drafted up one that really covers several years.

I think you'll find it very useful and a lot of detailed information; not just on reporting itself, but also on the performance since that's what we're really fundamentally interested in; better quality for our beneficiaries and so we have quite a bit of information that we've got drafted up. That has to go through a bit of a clearance process here internally, and once we complete that, which I don't think will take too long, we plan to release that.

That's just sort of an overview. Again thank you for coming here to CMS. Thanks to those who are joining us on the phone. I won't be able to, unfortunately, listen to the many I'm sure very helpful and useful suggestions that you're going to make to us, but we'll capture all of those. My staff is here of course and they will work through those after you make them and I think with your help we'll be able to make this an even better program. So thank you all for coming.

Ms. Barbara Cebuhar: Thank you very much Dr. Rapp. Charles, if you could advance the slides here in the auditorium that would be great. Our next speaker is Jacquelyn Kosh-Suber who will talk about individual physician quality reporting, system measures, suggestions that have been submitted as well as measure groups, as well as the timeline process for measure developers.

Ms. Jacquelyn Kosh-Suber: Thank you Barb. We're now on slide nine. Today I'll discuss Individual Physician Quality Reporting System Measure Suggestions that were submitted during their recent Call for Measures, and the measure group suggestions that were submitted. I will also go over the Physician Quality Reporting System measure work timeline process for measure developers.

Slide 10. When we did our recent call for measures that ended on December the 17th, we received suggestions from 17 requestors. We had a total of 91 measures requested for our 2012 Call for Measures; 8 of the measures were NQF-endorsed, 30 of the individual measures are in the NQF process -- that's in the endorsement process. 53 of the measures were not NQF-endorsed at the time we received the suggestions. The suggestion topics were varied and may potentially impact a

large number of our Medicare beneficiaries.

Ms. Jacquelyn Kosh-Suber (continued):

Slide 11. The measure suggestions that were permitted for individual physician quality reporting system measures by topic is represented on slide 11. There are approximately 22 topics that were suggested. Some of these topics were currently covered in the program such as coronary artery disease, colon cancer screening, hypertension and depression. But as you can see we have several new suggested topic areas.

Slide 12. The measures group suggestions that were submitted were received from 16 requesters. We had a total of eight measures groups suggested for the 2012 Quality Reporting System with the following new clinical topics: Cataracts, pulmonary rehabilitation, chronic obstructive pulmonary disease, irritable bowel syndrome, colon cancer screening and dementia. Next slide.

Everyone in the room has a copy of the list of individual measures and measures groups in their packet that you received this morning. For those of you on the line, if you don't have it available at the moment, you can get this list of measures; they're posted on our CMS Web site at www.cms.gov/pqri. Go to the left navigation and click on the sponsored call section and it's in the downloads entitled lists of individual or list of measures group for the call for measures for 2012. This list is also posted on our measure's code page. That's the page that you would go in for the measure's specs and all the updates for 2011. It's posted in that download section on the measure's codes download. We also have it on the usqualitymeasures.org Web site. This is the Web site that you registered for the town hall and all the materials in one location on their left navigation has the list of measures, today's presentation, the background paper, everything you would need for the town hall for today.

Slide 14. Now I would like to do an overview of the physician quality reporting system measure work timeline process for measure developers. The entire measure development process approximately takes 12 to 18 months at a minimum for measure development. The elements of this process include measure and/or measures groups' submission by the submitter. Verification -- we have to do a verification of the NQF status. We verify with NQF if it's endorsed/not endorsed and if it is endorsed, we verify to make sure if it has a time-limited endorsement or not. We have collaboration between measure owners and CMS for measure specification and measure development and refinement. We

Ms. Jacquelyn Kosh-Suber (continued):

have weekly meetings with their measure owners and then implementation of measure and/or measure groups. We have a regulatory process which includes a proposed rule and public comment and then we have the final rule. CMS prefers to utilize NQF endorsed measures and their measure development.

Slide 15. We'll get to the meat of why we're here today. In order to work this timeline and for it to be effective we like to get input from our stakeholders. We'd like for you to provide us input today on the following issues.

There's nine issues and I want to -- I guess we don't want to not say this enough, but after the town hall is over today, we will still be accepting comments until the 25th of this month and we'll give you the location where you'll be submitting those comments. We would like you to provide us with input on how individual quality measures and measures groups be expanded to be collected through qualified EHR.

The second issue we'd like input on is can quality-data codes, instructions, and specifications for new measures and revised measures be completed to meet CMS deadlines.

The third one, what are suggestions for considering retirement of quality measures.

Number four, what activities can CMS and stakeholders undertake to improve education and outreach for our participants and stakeholders.

Number five, suggestions for measures not particularly relevant to quality improvement, by not addressing improvement in outcomes, patient safety or health results.

Number six, which broadly applicable measures should CMS consider including in a core measure set.

Seven, which specialties, if any, lack any relevant measures.

Number eight, should CMS also consider grouping measures by relevance to a particular specialty.

Ms. Jacquelyn Kosh-Suber (continued):

Number nine, we would like to have input on the incorporation of the new ICB-10-CM codes to meet the October 2013 transition requirements by the HIPPA translation regulations.

We intend to adhere to NQF's coding maintenance framework and operational guidance for submission of our measures in meeting this incorporation of ICD-10 codes also. Our submission to AQF to meet their deadlines, all of our measures that we will be submitting between October 2011 and December 13, 2013, we will be submitting the ICB-9 and the ICB-10 codes. After December 31, 2013 and basically effective January 2014, we will not submit any measures to AQF with specifications with ICD-9 CM codes.

Slide 16, continuation of the measure work process. In our transition to ICD-10, we're going to adhere to the transition and the requirements for AQF. We have identified that the ICD-9 codes are outdated. The codes cannot reflect current medical technologies. Many of the code chapters are full, resulting in code placement and non-related chapters and the current codes are often not descriptive enough. In our transition and meeting requirements to ICD-10-CM, we will provide measures that have more codes with greater specificity, greater flexibility to add new codes and reflect current use of medical technology.

Slide 17. We've actually at CMS already have gotten together and have had some joint application meetings, development meetings to look at what we need to do to implement the ICD-10 and we've already identified that a lot of issues that we have to address reach into policies, business process and systems and requires broad business and systems focus. The implementations we may have to consider are a possible freeze of our quality measure development during this transition period from ICD-9 to 10. Possible changes in measure denominator and numerator and possible effects to quality measure analytics. Our report rates and calculations will be affected because at one point we may be utilizing ICD-9 codes, and then when 10 takes effect we will be using ICD-10. And then finally we may have effects to feedback reports for eligible professionals.

Slide 18 shows a schedule of our measure work timeline. In July of this year, the Physicians Fee for Service [PFS] proposed rule will be published for public comment on the 2011 Physician Quality Reporting and the E-prescribing. In October 2011, measure specifications review meeting will be. On October 29, the 2011 HCPCS tapes will be published, and in November 2011 the Physician Fee

Schedules Physician Quality Reporting and Electronic Prescribing and E-prescribing final rule will be published and we will post also in November of this year, the final specifications and supporting documents on the Physician Quality Reporting Web site. I want to thank you for your attention, and now we'll move into our first comment session. We welcome all constructive comments and suggestions on the issues that we noted in slide 15. We'll go back to slide 15.

Ms. Barbara Cebuhar: Thank you Jackie. I would like to introduce the first speaker today, Dr. Richard Nicholas, speaking for the Allergy/Immunology Specialist community. If you could please step to the microphone and provide your comments. If others in the audience are interested in providing comments could you please stand in line behind Dr. Nicholas? We will then turn to those of you on the phone to provide your brief, two minute comments. If you could please identify yourself and the organization you represent, we would be very grateful. Thank you for your help. Dr. Nicholas?

Dr. Richard Nicholas, MD: Thank you very much. My name is Richard Nicholas; I'm a Clinical Professor of Medicine at George Washington Medical Center. I'm here today on behalf of the specialty of allergy and immunology and specifically the American Academy, College and Joint Council of Allergy, Asthma and Immunology.

Allergists and Immunologists strongly support the development of quality measures for a spectrum of diseases treated by either generalists or specialists. In addition, support linking quality measures to maintenance of certification. We think that for our field, quality measures can best be based on practice parameters which we've been putting together for over 20 years, through a joint task force of the academy and the college, where we've established a comprehensive set of parameters that are regularly updated.

The priority quality measures to be used by allergists and immunologists in patients 65 years and older that we'd like to comment on, include asthma where we're requesting that you consider immediate action using the current PQRI asthma measures in regard to eliminating the upper age range of 50 so that these measures can include Medicare beneficiaries age 65 and older. At the same time, to exclude patients with co-existing diagnoses of Chronic Obstructive Pulmonary Disease. We feel that these changes would enable allergists and immunologists and other physicians as well to participate in PQRS, which is currently difficult with the existing measures for asthma.

Dr. Richard Nicholas, MD (continued):

We also are very interested in developing new measures for rhinitis consistent with PQRS priorities. As you know, there are no current PQRS measures that exist for this condition, although a request to develop measures for rhinitis has been submitted to PCPI. Rhinitis is a common, chronic condition in Medicare beneficiaries that can substantially affect quality of life.

Moreover, there are care gaps regarding optimal treatment in Medicare beneficiaries with rhinitis. Finally, as I'm sure you probably know, rhinitis medications are a substantial healthcare cost. For these reasons, we think that development of measures for rhinitis would really reflect the services furnished to beneficiaries by a particular specialty. Thank you very much for giving me the opportunity to do this.

Ms. Barbara Cebuhar: Thank you Dr. Nicholas. Our next speaker, if you could identify yourself and your organization please?

Ms. Tanya Alteras: Hi I'm Tanya Alteras with the National Partnership for Women and Families, and also representing the Consumer Purchaser Disclosure Project. My comments focus on the issue that we are most concerned with, which is that the current suite of measures in the PQRS is not useful to consumers or purchasers.

We believe that the PQRS should focus on measures that really effectively support consumer decision making and payment that promotes high-quality, high-value care and subsequently a greater emphasis needs to be placed on measures that assess whether a care truly made a difference for the patients. So those would be measures of patient outcomes, patient experience, health status, and care coordination and transitions. Along those lines, we strongly recommend that CMS remove measures that only address and only assess basic competencies of care, measures that reflect processes that are not strongly linked to improved outcome, and measures that simply document the presence of an evaluation or an assessment and counseling.

We feel that documentation measures, as specified currently in this program, do not assess the quality of the indicated service that was provided and lack evidence that links these measures to other important outcomes. A few examples of measures like these would be measure 148, initial visit

for back pain, and measure 179 assessment and classification of disease prognosis for rheumatoid arthritis.

Ms. Tanya Alteras (continued): We are pleased to see other measures have been considered for the program and that we would be very supportive of, such as the depression remission at 6 and 12 months. The optimal asthma care measure and health-related quality of life in COPD patients before and after a pulmonary rehab. A few other measures that we believe CMS should consider include the patient reported outcomes, measurement improved information system -- PROMISE -- it's a set that allows for the measurement of improved patient-reported functional status across an array of conditions.

The one that I mentioned earlier, the optimal diabetes care measure, which is owned by Minnesota Community Measurements. A third is patient experience surveys for all providers who have an NQS endorsed cap survey available and there are additional ones that will be coming through the pipeline which we would hope would be considered. And then MRI/Lumbar spine for low back pain measure which was developed by CMS and is NQF endorsed. Thank you.

Ms. Barbara Cebuhar: Thank you Tanya. We have one more comment, thank you.

Ms. Sharon Grotman: Good morning, Sharon Grotman with the American Society of Breast Surgeons, just a brief comment. We submitted measures 83 through 86 for consideration and would recommend that these measures be grouped together by specialty. Thank you.

Ms. Barbara Cebuhar: Thank you. Our next speaker?

Ms. Camile Bonta: Hello, Camile Bonta. On behalf of the American Society for Gastrointestinal endoscopy, I just wanted to reiterate comments that have been provided in writing in the past, and that is the addition of two other colon cancer screening measures, which are included in the handouts *The Endoscopy and Polyp Surveillance Appropriate Follow-up Interval for Normal Colonoscopy and [INDISCERNIBLE]* as well as *Endoscopy and Polyp Surveillance Comprehensive Colonoscopy Documentation*. The former has recently received in QF time limited endorsements.

Ms. Camile Bonta (continued): The *Comprehensive Colonoscopy Documentation* would fall into that category of measures that may not necessarily address improvement in outcome, but can help ensure continuity of care, and by appropriate documentation in the report following a colonoscopy, it can help inform physicians as to when follow-up colonoscopy should occur. Therefore it would help cut down on inappropriate repeat colonoscopy.

We would like to see that documentation measure included in 2012 PQRF and we are very interested in a measures group such as the one that is included in the handout. We took a close look at the measures that were being reported for 2009 and it's the assumption that there are a number of hepatitis measures and that gastroenterologists, particularly gastrointestinal endoscopics would be able to report on those measures, but they can't.

So if you look at the measures that they're reporting on, they are reporting when the screening colonoscopy and the inappropriate use. They are reporting on those measures; those are among the top measures that they're reporting on. Then they're just reporting other measures which aren't particularly relevant or specific to the specialty, so we feel it's really important as the program moves forward to make sure that there are more than two specialty-specific measures for gastrointestinal endoscopy. Thank you.

Ms. Barbara Cebuhar: Thank you. Our next speaker please.

Dr. Thomas Wiederman, MD: Good morning, my name is Dr. Thomas Wiederman, I'm a family physician and I represent Midmar Corporation. I'd like to advocate for the 2012 inclusion of a screening for sleep apnea patients who are at risk.

Sleep disordered breathing is a very serious medical problem in the US with approximately 50 million sufferers. That's larger than those who suffer from diabetes and COPD. We also know that 85% of patients who have CHF and drug-resistant hypertension have some form of sleep disordered breathing.

This puts them at higher risk for adverse effects and adverse outcomes including a two to three times risk of heart attack, up to five or ten times a normal rate of accidents on the road and up to three to

four times increased risk of cerebrovascular accidents or strokes, yet 85% of these patients are undiagnosed.

Dr. Thomas Wiederman, MD (continued): Therapies are not overly complicated. For primary care they include weight loss, lowering alcohol consumption, lifestyle modification, oral appliances and of course CPAP. Also, CMS has recently introduced two new codes to cover for the diagnosis and testing for sleep apneics and we feel there's a quality measure that could improve the diagnosis and treatment of this underserved patient population, but thank you.

Ms. Barbara Cebuhar: Thank you. Our next speaker please?

Dr. Karen Miller, MD: Hi I'm Karen Miller from Baycare Clinic in Green Bay. We are a large, multi-specialty physician group and we've been participating in PQRI since 2007. We have two measures that we've have a lot of difficulty getting down pat despite multiple efforts. The first one is measure 145 which is the measure that looks for documentation of fluoroscopy time during radiology procedures. That's easy for a radiologist to participate in that measure, but they over-read those measures for fluoroscopic procedures that occur in the operating room so they get that film after the fact and the surgeon may not have documented fluoroscopic time which ends up penalizing our radiologists on their quality. They want to achieve 100% quality and there's no exclusion in that measure for when the radiologist is not present during the procedure.

The other measure that we've had a lot of difficulty with is 148 which is the initial visit for back pain measure, which someone commented on earlier. That measure, unlike any of the other PQRI measures that we've been involved with, and we have physicians that participate in almost all of the measures, includes so many aspects of assessments. So in that initial back pain that physician has to document a presence or absence of red flags, they have to document certain functional levels on very specific functions. They have to document pain; all things that should be done on that initial visit and I believe are being done by our physicians.

Despite participating in that measure for the last two years, when I review how the coders reviewed that physicians note and applied the quality code, that's despite multiple efforts, we end up with about a 50% error rate by our coders because they're having to look for about 10 different aspects of care within that note that all have a variety of ways that physicians may say that within the note.

Dr. Karen Miller, MD (continued): So even though myself, when I review the note as a clinical person, I can see that the physician met quality; the coder is not recognizing it accurately and the presentation of that physician's quality is not accurate for what Medicare is seeing. Thank you.

Ms. Barbara Cebuhar: Thank you. Our next speaker please?

Ms. Emily Wilson: Hi, I'm Emily Wilson with the American Society for Radiation Oncology. I have one brief comment on a specific measure that was submitted. It's about radiation therapy treatment summaries being communicated to the referring physicians and I'm really hopeful that CMS will accept that measure because I think it meets the needs of some of the consumers on care coordination and transitions and making sure that we're doing a good job when we pass patients off. I have some broader questions about the overall process and timeframes.

On slide 14 you had what you described as measure development, which I think is really walking through the regulatory process of once the measures have been through PCPI or independent measure development, and in QF what it takes on CMS's end to get these measures into the PQRI, or PQRI's program and looking at these time frames in particular with some of the issues you raised about ICD-10. I'm concerned about how long it takes to get measures into the program.

We are currently undergoing an NQS evaluation project because a number of the measures that we have are time-limited and that is all going to happen at NQS this summer. If we find that some of the measures are not as great as we had hoped, we may end up being one of the specialties that doesn't have measures and how it is that you get measures in once things come out I think is something that a number of specialty societies struggle with.

We're also working on three different guidelines right now and so -- primarily on palliative care, which will be finished in the next six months which is another year for measured development and another year to get it through NQF. So then we're in like 2013/2014 and I'm just very interested in figuring out how if there's a way to make this process be more flexible so that we can meet our timelines together and I really appreciate you holding this forum because I think this dialog is really important. Thank you.

Ms. Barbara Cebuhar: Thank you. If there are no other comments from the floor here, operator I'd like to turn to the phone lines please.

Operator: If you would like to ask a question by phone, please press 01 on your telephone keypad. Again that is 01 to be placed into the queue. And we have Carolyn Winter-Rosen, please go ahead.

Ms. Carolyn Winter-Rosenberg: Hi, my name is Carolyn Winter-Rosenberg and I'm speaking on behalf of the American Academy of Sleep Medicine. I would like to recommend the approval of the four sleep medicine measures submitted for the 2012 PQRS.

The proposed measures include, assessment of sleep symptoms, severity assessment at initial diagnosis, positive airway pressure therapy prescribed, an assessment of adherence to positive airway pressure therapy. The ASM is a membership organization representing over 9,000 members. While some of our members practice sleep medicine as well as other specialties, for example neurology, internal medicine or otolaryngology, our membership also includes many physicians who specialize exclusively in sleep.

Late last month, CMS approved the ASM's request for specialty status for sleep medicine physicians. Sleep specialist physicians are currently limited by the PQRS measures they can report. By accepting the four sleep medicine measures for the 2012 PQRS program, CMS will be opening up the program to a number of sleep specialist physicians who previously could not participate. In the background paper available on the Quality Measures Web site prior to this call, CMS indicated an interest in measures that addressed a number of topics. The ASM feels that the sleep medicine measures meet or address two of the requested criteria.

The measures address gaps in the PQRS quality measures set and will expand opportunities for eligible professionals to participate. Additionally, the measures reflect the services furnished to beneficiaries by a particular specialty. If the sleep medicine measures are not accepted for the 2012 PQRS program, the ASM requests feedback on how to improve the measures and ensure their inclusion in the program in the near future. Thank you.

Ms. Barbara Cebuhar: Thank you Carolyn. Operator our second caller please?

Operator: Next we have Patrick Torcson please go ahead.

Dr. Patrick Torcson, MD: Yes good morning, this is Patrick Torcson with the Society of Hospital Medicine. Thank you for the opportunity to offer comment.

Ms. Barbara Cebuhar: I'm sorry. Could you please speak up?

Dr. Patrick Torcson, MD: Is that better?

Ms. Barbara Cebuhar: A little.

Dr. Patrick Torcson, MD: The Society of Hospital Medicine represents the 30,000 hospitalists that are practicing in the US and we care for a large number of hospitalized patients, more so than any other specialty including a large number of Medicare beneficiaries. We've been actively involved and encourage our members to participate in the PQRI/PQRS since it began in July of 2007, and really appreciate opportunities like this to give input and feedback on the program.

My comments are going to be structured within your framework of your questions and going to bullet point number two regarding revised measures to meet CMS deadlines, there's an opportunity to include more measures in the PQRS program by changing specifications of the current measures that are included in the program and specifically related to that are the pneumonia measures, number 56, 57, 58 and 59.

The current specifications of these measures limit their reporting to the outpatient setting by adding evaluation and management inpatient codes to these measures, would broaden the application for this very important disease-specific state of pneumonia and allow more physicians to report and hopefully result in improved quality of care. Basically by changing measure specifications, there's an opportunity to broaden the application of the measures, and there is a precedent for this within the PQRS program.

In 2009 all of the consultation codes were eliminated from measures in conjunction with Medicare, eliminating consultation codes and that had an impact on measure applicability and the specifications.

Dr. Patrick Torcson, MD (continued): My next comment has to do with number seven, which specialties, if any, lack relevant measures. Part of the feedback that we hear from the hospitalists in our society is that the PQRS lacks relevance because many of the measures are not necessarily relevant to a hospital medicine practice. We have proposed adding additional measures including four measures related to care transitions that were included in the proposed rule for 2011 and would encourage CMS to consider adopting these measures as part of the future PQRS program. The care transition process is something very important to hospitalists and we recognize that there is difficulty with attribution the way these measures have been created so far, and would offer to work with you on further refining the specifications to make these more applicable.

My final comment just has to do with grouping measures by relevance to a particular specialty and ask you to think in terms of perhaps grouping measures according to hospital-based specialties like hospital medicine, emergency medicine anesthesia or radiology. Physicians that practice in a hospital setting, perhaps bundling measures that might harmonize with the hospital-level performance agenda so that physicians in hospitals practicing together in the hospital setting can report on measures that are relevant to both agendas. Thank you for the opportunity to comment.

Ms. Barbara Cebuhar: Sir could you please identify yourself again?

Dr. Patrick Torcson, MD: Yes, Patrick Torcson -- T-O-R-C-S-O-N, with the Society of Hospital Medicine.

Ms. Barbara Cebuhar: Thank you. Operator our next caller please?

Operator: Okay there are no more questions.

Ms. Barbara Cebuhar: Thank you very much. We are going to be moving through our agenda a little bit more quickly than we had originally thought. Are there any other comments from the audience here at CMS? No? We are going to go ahead then and start with our next presenter, which is Dr. Daniel Green who will be discussing Reporting Options for Individual Eligible Professionals. Dr. Green?

Dr. Daniel Green, MD: Do we have the slides?

Ms. Barbara Cebuhar: Charles if we can get the slides again please.

Dr. Daniel Green, MD: This is your pre-lunch quality reporting instead of your post lunch, so that way it will curb your appetite when you hear all this stuff. Just a couple -- Suzy's going to throw something at me and I'm going to stand out of Jackie's way, but just a couple things -- we're not really supposed to respond to you guys with some of the comments you made, but I think that there's a general comment I can make which may help some of you folks with respect to some of the measured change suggestions.

I'm not talking about adding new measures or eliminating certain measures, but I'm talking more about certain codes that may appear in the denominator or the measure. Stuff you think that should be included or for instance I recall the comment about fluoroscopy with respect to the time, needing to have exclusion for fluoroscopy that's done in the operating room.

When you have specific measure change suggestions, it's helpful if you all can reach out to the measure developer/measure owner. We take many of these measures -- some of these measures are owned by CMS, but many of these measures are developed by the AMA PCPI, the NCQA or other organizations, the Society of Thoracic Surgeons, for instance and again other specialty societies. These folks in their measured development process actually decide what codes and what scenarios they think it's appropriate to have these measures reported on, and then of course as you know, many of these measures or most of them go through the NQF endorsement and then the NQF steering committees and expert panels also provide feedback and comments.

The final measure comes out and for the most part those are the measures that are implemented. So if you do you have specific changes, and not every measure -- believe me not every measure is perfect; there's certainly room for improvement in many of the measures, but if you have something that you encounter that's hey, this doesn't make sense, we can't exclude this and we really should be able to. Or this service should be included and it wasn't, it would be helpful if you all could reach out to the measure developer/measure owner and talk to them first or communicate with them first in an effort to have them consider your suggestion for possible modification.

Dr. Daniel Green, MD (continued): Certainly, if those modifications are made by the measurer owner or developer, obviously when the new program year starts we try to have the most up-to-date measures. There are minor changes, as you all know, that we make for implementation purposes in PQRS, such as, as you know Medicare does not reimburse for consultative services, so there's many measures that have consultation codes in their denominator but we take them out for implementation in the physician quality reporting system because nobody really could bill Medicare and actually have one of those codes in, because then the claim would be rejected and sent back. Think we got-are we on the same slide now?

What we're going to do in the next section, you know, Jackie gave a great overview of some of the timelines and some of the considerations with the ICD-10 etcetera that we face when we look at including measures and what have you. The next part of the presentation is really going to deal with the 2011 physician quality reporting system and some of the different reporting methods and what's in place for 2011. Then we'll look for comment from you guys in terms of how you think we might improve our reporting or if there are other options for reporting etcetera. We will be starting on slide number 22. And we're there. What do you know? PQRS as you know has two reporting periods; there's a 12 month reporting period and a six month reporting period.

The idea behind this was to encourage folks that might be a little bit late to the game, still to be able to have an opportunity to report through the physician quality reporting system. The 12 month reporting period is a calendar year and the six month reporting period starts July 1st and concludes on December 31st. The 2011 reporting options that are available to eligible professionals include the claims space option, there's a registry-based option, there's the EHR-based option as well and then there's the GPRO I and GPRO II. The GPRO II is new for 2011 and GPRO is our acronym, if you will, for Group Practice Reporting Option. So the difference between -- and we'll talk about this a little bit more this afternoon -- but the difference between GPRO I and GPRO II, GPRO I is for groups of 200 or more eligible professionals, the 200 or more NPIs practicing under one tax ID number. Whereas GPRO II, and it was basically through comments that we received in the past, looks to allow group reporting for groups that have between two and 199 eligible professionals under a tax ID number.

So the requirements are a little different and again we'll go through that a little bit later. There is a great decision tree -- I jokingly said on one of the national provider calls that was created by an

ingenious medical officer that's working on the physician quality reporting system -- that would be me -- all that and modest too; go figure.

Dr. Daniel Green, MD (continued): No-but there is a decision tree that we have that's available on our Web site and it really is helpful for folks in trying to figure out what would be the most suitable option for them to report because there are so many different reporting options that it can become a little bit confusing looking at, do I want to use registry? Do I want to use claims? Okay I want to use claims, but now what do I got to do if I'm using claims? It breaks it down basically by whether the professional wants to report the 12 month or 6 month reporting option and then which method they want to use, again, claims registry? EHR or one of the GPROs.

So I would encourage you guys to look at that decision tree offer for additional information and it basically covers the stuff that I'm going to present in the next several slides. If we look at slide number 23, you can see that under the claims reporting option this is the first way that PQRI -- well formerly PQRI, now PQRS -- could be reported. Under the claims option, an eligible professional would select three or more measures that he or she feels are appropriate to the services and care that they provide, and report on those measures. There's a 12 month and a 6 month reporting option for this.

Previously, as Dr. Rapp mentioned in his opening comments, we required eligible professionals to report on 80% or more of the eligible instances that that measure could be reported. So for 80% of patients that fell into the denominator of the measure. For the claims-based reporting option for 2011, we've lowered this to 50% and we think this will help also in making more eligible professionals satisfactory or successful reporters and earn an incentive. If folks don't report three or more measures; if they find that looking through our -- I think it's 197 measures -- if they don't find three measures that they feel are appropriate to the care and services that they provide. They can report on one or two measures but they would be subject to what we'd call MAV or Measure Applicability Validation.

Briefly, what that is, is we look at to see are there any other similar measures that the provider could have reported on? For instance, if an eligible professional reported on measure one, which is our hemoglobin A1C for diabetic patients, we would look to see, well are there any other measures that

we have in the physician quality reporting system that would also be reportable, if you will, in diabetic patients and of course there are.

Dr. Daniel Green, MD (continued): There are at least five or six measures that would be appropriate to be reported, including measures two and three which have to do with blood pressure and lipid control in diabetic patients. So that person, if they only reported measure one and no other measures at all, would fail our measure applicability validation. But somebody may report a measure like falls. Falls is not in any clinical cluster. It's a unique -- it's not even a condition. It's just did you look for evidence of falls and did you talk to the patient about their fall risk et cetera. That measure is not from a diagnosis standpoint related to any other measures, and that would be a measure for instance that would not fall in a clinical cluster, and if that's the only thing that the eligible professional felt was in his or her purview, they would be subject to MAV, but they would pass the MAV.

Okay so moving on, I think we're on slide 24 now if I'm not mistaken? The other ways to report individual measures would include registry reporting and electronic health record reporting. For registries there are two reporting periods; there's the 6 and 12 month reporting period. Three or more measures, however, are required to report via registry, so if you only have one or two measures that you think is appropriate to your specialty or to your practice, you would need to use the straight claims-based method of reporting. Three measures or more, or measures group for a registry, but there is a 6 and 12 month reporting period.

For registries, we require the 80% threshold so you do have to report on 80% of eligible instances. For electronic health records, there is only a one year reporting option. Again you'd need to report on at least 80% of eligible instances and you need to report on at least three of the measures that we have electronic specifications for. For 2011, there are 20 measures that are electronically specified, but not all of the 197 -- I keep using that number -- I hope that's correct -- measures do have these specifications, only 20 of them do. We are adding to them but 20 at this time. Moving on to slide 25, measures groups. Measures groups are basically groups of measures related to a common condition -- a clinically similar condition.

So for instance, we have a diabetes measures group and they have a similar denominator -- the measures that is -- so that an eligible professional should be able to report on all the measures in a measures group. The difference between a measures group and the individual measures is that we

mentioned that an eligible professional would have to report on 50% of all eligible instances if they were reporting via claims. If you're doing a measures group, rather than reporting on 50% of all your eligible patients, we only require that you report on 30 unique patients. You can imagine if you're an endocrinologist and you have let's say 200 diabetic patients in your practice, we would require you to report on at least 100 of those patients if you're doing the traditional claims method of reporting. On the other hand, if you're using measures groups, you'd only need to report on 30 of those 200 patients.

Dr. Daniel Green, MD (continued): So again it has to be 30 unique patients. So, if Mrs. Jones comes in today and she comes in two weeks from now to go over her labs or whatever, it still only counts as one eligible instance, but you can see depending on the volume of patients you have for particular measures, and if there's a measures group available, it may be more convenient for folks to report on a measures group rather than reporting on the individual measures. Again one change I want to point out, previously we had required that the patients be 30 consecutive patients; that's no longer the case.

Now we will accept -- they don't have to be consecutive, but they do have to be unique. Again that's for claims. Moving on to slide number 26 -- one other change I should mention, I'm sorry -- with respect to registries, previously in 2010 and before, we allowed measures groups who contained both Medicare and non-Medicare patients if they were reported by a registry and they were doing the measures group 30 consecutive patient method, we require that there be at least two Medicare part B physician fee scheduled service patients in that cohort of 30. For 2011 we've eliminated the option from registries to be able to report non-Medicare patients. So all 30 patients must have part B Medicare.

Again, they don't have to be consecutive but they have to be 30 Medicare patients. Sorry, Jackie. Now we're on 26. Measures groups, the reporting period is a 12 month reporting period. We mentioned the 30 unique patients. If an eligible professional, for whatever reason, doesn't have 30 patients that fit into the measures group, they can still report a measures group by reporting on at least 50% of eligible instances for that measure group. If they're reporting for a year though they have to report at least 15 patients; the measures group has to have at least 15 if the provider wants to get credit for the one year reporting of measures groups via claims.

Dr. Daniel Green, MD (continued): Again they have to report on at least 50% of eligible instances. Next slide, please. If they're doing the 6 month reporting period for claims using the measures group, that number 15 that we talked about drops to 8 so they have to have a minimum of 8 patients that meet the denominator for the measures group. Again, if they're reporting the measures group on claims for 6 months -- and again the reporting threshold is 50% just like it is for the individual measures. Next slide, please, Jackie.

So registry. Another important note about registries is previously we counted folks that had 0% performance in our measures groups. But we had folks that were -- occasionally, we'd have an ophthalmologist report the diabetes measures group. Well one of the measures in the diabetes measures group is an ophthalmologic measure -- it's an eye care measure. The other measures have to do with foot exam, checking the hemoglobin A1C, the LDL, blood pressure et cetera. So the ophthalmologist reported the eye care measure and basically they reported the exclusion. I didn't do it and I didn't have a reason for it. It's a performance failure if you will, for all the other measures that were in the measures group.

We eliminated this as an option; if there is a measure in the measures group, or individual measures for that matter that have 0% performance rate, we will not count them as one of the -- we will exclude that measure from being counted. That's important especially in electronic health records because many of the electronic health records we'll scan -- when they're doing the data extraction it will take all of your diabetic -- you may not want to report the diabetes measure; let's say that's not really apropos to your practice, but you have diabetic patients in your practice. When that EHR is looking at your problem list, it will extract all the patients that are diabetics. It will also report the measures that you're intending to report, but you would also be reporting the measure -- anybody that had diabetes or fell under the denominator of a given measure.

So you could see how we could get 0% performance inadvertently from folks that are submitting from an EHR. And then the other part with the registries that I was telling you about with the 0% performance, we feel like if someone never one time does the quality action that's required in the measure, either they inadvertently got drawn into reporting that because maybe they submitted their data to the registry from an electronic health record or perhaps they were trying to gain the system by just picking any three measures and saying, no I never did it for an incentive payment.

Dr. Daniel Green, MD (continued): While we would like to think that that doesn't happen too often, obviously that doesn't really move to improve the quality of care. Folks are saying we never did the recommended clinical quality action on any of our patients. So the 0% performance will be eliminated. The registry reporting of measures groups, again just like the individual measures, you have to report on 80% if you're not doing the 30 unique patient method, you need to report on the 80% of the measures group. Again the 15 and 8 numbers that we talked about with claims still would apply here. Next slide, please, Jackie.

You can see here again the 6 month reporting of measures group, if you're not doing the 30 unique patients you can report on 80% of the folks that fall into the denominator and again with the minimum of 8 patients. Next slide, please. Okay, so we're looking for input on the following issues: The advantages and disadvantages of various reporting methods, mainly claims registries, EHRs -- you haven't heard about GPROs yet, but if there are other ways that folks can think of getting this information to us we're all ears, some of the advantages and disadvantages of continuing claims-based reporting mechanism in light of some of the other options that are becoming more prevalent and are increasingly available. How can we begin to phase out claims based reporting without creating unintended barriers to participation? Claims can be burdensome; we've heard that from eligible professionals.

Sometimes the data is not as specific as we can get from electronic health records. In other words, we can find out somebody's blood pressure is above a certain threshold but we don't actually find out what the blood pressure is. When you start to look at outcomes it's helpful to know an actual number versus above this; below that, because somebody could be just above the one threshold and then with corrective action be just below the other threshold. Yes that's a change, but you wouldn't be able to compare that to somebody who was high above the threshold, who's now below the threshold.

Are the current reporting periods adequate for 6 months and 12 months? Does that work for you guys? Are there measures for eligible professionals for individual reporting reasonable? Should we identify relevant measures under measure groups for specialty eligible professionals based on claims data? And how should we ensure that eligible professionals self-designated specialty information is accurate? We have various registration programs here at CMS, as I'm sure you all are aware, but how do we know, for instance, the MPV system has accurately listed in order a provider's type of specialty? Especially if they're a sub-specialist. Sometimes folks would list cardiologist and then

internal medicine. Maybe they do both, or maybe they're only a cardiologist, but if they do both, do they do half and half? I mean, it gets a little bit tricky.

Dr. Daniel Green, MD (continued): Sometimes that information's not as accurate as it can be. Some of the implications, if a set of broadly applicable measures are applied regardless of specialty -- so for instance if we said you have to report advanced care planner, or you have to report the falls measure -- again hypothetically -- what's your opinion on that. And I don't mean those specific measures; I'm using them as examples.

Finally, the implications, if CMS requires reporting on one measures group, unless no measures groups are applicable. So what if we said that eligible professionals have to pick a measures group unless, let's say they're a pathologist and there's no measures groups available for them; then they could do the individual measures. Again, these are some of the opinions we're looking for from the audience, both in person and on the phone. Do you want to take comments or do you want to--?

Ms. Jacquelyn Kosh-Suber: [INDISCERNIBLE]

Dr. Daniel Green, MD: What time is it?

Ms. Jacquelyn Kosh-Suber: 11:30.

Dr. Daniel Green, MD: Are you going to be mad at me if I change it?

Ms. Jacquelyn Kosh-Suber: No.

Dr. Daniel Green, MD: I think what we're going to do, because the next part is E-prescribing and I'm sure they'll be a few comments on E-prescribing, so I think what we'll do is we'll open it up for a brief comment period now if anybody has any comments on anything we've talked about so far this morning, we'll do those now and then we'll do the E-prescribing because I don't want folks to either forget or get confused with that.

Ms. Barbara Cebuhar: If we could have our comments, please don't forget to identify yourself and your organization, that would be very helpful thank you. Our first comment?

Ms. Faye Shevansky: Hi I'm Faye Shevansky [PH], I'm with the College of American Pathologists and the college has asked every year for expansion of the registry option to include participants who have fewer than three measures to participate and it still continues to be a problem for us.

There are only two pathology measures and they don't apply to all pathologists and even both of those measures aren't applying to the pathologists who can participate. So it would help a lot to have that registry option opened up. There's an additional problem in that many of our physicians -- pathologists -- are hospital-based and the hospitals like to use registries for all of their physicians and then they can't for their pathologists, so it creates a problem with having to use two kinds of reporting options for their physicians in their groups.

Finally we have submitted five additional measures to include, in 2012, that will help some of our physicians but it won't help all of them. There's still a lot of variability in practice and there'll still be a lot of pathologists who won't have three measures or won't have any measures at all. Thank you.

Ms. Barbara Cebuhar: Thank you. Our next speaker please?

Ms. Mary Patton-Wheatley: Hi, Mary Patton-Wheatley at the Association of American Medical Colleges and I'd just like to make a couple comments -- I'm addressing your questions. One is I know we're in a period of transition as we have changes in physician quality reporting and we have the EHR incentive program coming along, so there's a lot of changes going on in our different practices. I would say at academic medical centers, we still have -- a lot of people are ramping up on the EHR, but until then they're using claims data. It remains the one viable option for them to submit information.

I would also say in regards to the number of measures that are submitted, we actually just recently did a review with several of our members and they said for those who are not yet in EHR implementation, that they are doing it manually and you have actually more than three or four measures, it becomes much more difficult if you're still doing it manually to do more than four measures to actually see a decrease in the recording accuracy because they can't keep track of all these things going on.

Ms. Mary Patton-Wheatley (continued): So just to keep that in mind, that while things are not completely automated, the number of measures can really impact reporting even when it's a measures group -- even when you're reporting on the same denominator, if you have too many measures and you're doing it by hand, it can be difficult to track. And then the last comment I want to make is that whenever we're looking at measures groups or reporting by specialties, just to consider that there are many, many sub-specialists that when you look at a broad set of specialty measures, may not apply to the sub-specialists. Just to keep that in mind that one size doesn't fit all, even within a single specialty. Thank you.

Ms. Barbara Cebuhar: Thank you. Our next speaker please here in the central office.

Dr. Jason Byrd, JD: Hi, Jason Byrd with the American Society of Anesthesiologists. I think I'd like to echo the prior two comments, and with respect to anesthesiologists we kind of fall in the same pattern in the sense that there are traditionally three measures that are noted as anesthesiology measures within PQRS. However, as the evolution of a variety of practitioners has progressed, and depending on the resources available and in different hospitals, we found that sort of the majority of anesthesiologists measure 76, this no longer applies because they're not laying central lines. So the default is that anesthesiologists in general now have two measures.

We're very supportive of the movement away from claims-based reporting, however we urge you to delay that or slow that up in particular in 2012. We put resources into generating a registry. We started an anesthesia quality institute. They're applying to become a registry through which anesthesiologists could participate.

However, those that are not laying central lines only have two measures and will not meet the minimum threshold for participation registry. We've got measures in the pipeline, but as we learned this morning it's a long, extensive process and there's no guarantee that at the end of the day that NQF will endorse a measure that we submit. So I would urge you to urge caution in moving and transitioning away from the claims-based reporting in the next year or so. Thank you.

Ms. Barbara Cebuhar: Thank you. Tanya? If you could introduce yourself again please?

Ms. Tanya Alteras: Tanya Alteras, National Partnership for Women and families, and the Consumer Purchaser Disclosure Project. My comments are around the sample sizes that are required, particularly for claims data.

We feel that individuals eligible for professional, small groups and large groups really need to report on enough patients to ensure sufficient reliability, particularly at the individual clinician level and that by 2012 CMS should require sample sizes and thresholds that will allow the PQRS to achieve this objective of having greater validity.

We think that setting a sample size of at least 411 patients for larger groups, find those with at least 200 eligible providers will not foster reliable reporting on individual clinicians within the group and we don't understand why the measures specified for larger groups can't be applied at the level of the individual clinician.

We also feel that for claims-based measure reporting, the reduction of the patient population from 80% to 50% is going to decrease the value of what we get out of these measures and we think that the CMS should consider other strategies for increasing the participation of individual professionals in doing those types of reporting.

We think that lowering the number of patients that participating professionals must report on jeopardizes their reliability, again and weakens the ability of the program to collect a comprehensive picture of how providers care for their patients. We also encourage CMS to ultimately transition the PQRS over time, to require eligible professionals to report on all patients who qualify for the denominator.

In terms of the reporting period, we have some concerns about the 6 month reporting period and that it may weaken reliability by reducing the denominator of applicable patients. We support CMS's interest in advancing the use of registries in the EHRs and we're very pleased to see that. We believe that these will both be increasingly important sources of information, and that the alignment between this and the meaningful use program is very encouraging and important. We are just concerned that the Meaningful Use Program may not generate a critical mass of providers that are capable of reporting through EHRs until 2015.

Ms. Tanya Alteras (continued): Even then, we don't have a guarantee on how many providers will participate in Meaningful Use. We suggest that CMS foster greater EHR adoption by finding other avenues to make reporting PQRS data via EHRs and registries more attractive in the near future. Finally, as PQRS transitions to a larger emphasis on EHRs and registries, we believe that CMS should consider how claims data can still be used to provide valuable information.

We believe that administrative claims are still the most readily available source of data at this time, despite their limitations and that these data can effectively be used to assess aspects of performance such as outcomes, processive care measures that are directly linked to outcomes and that administrative data will improve as the transition completes to ICD-10. Thank you.

Ms. Barbara Cebuhar: Thank you, Tanya. Our next speaker please.

Ms. Jennifer Shevchek: Jennifer Shevchek, American Medical Association staff. First off, we really appreciate you convening these town hall meetings. We find them very helpful and I think it's good to continue this dialog now and moving forward.

I'm going to highlight three issues. I think overall, we've appreciated CMS kind of providing flexibility and adding options and reporting periods since the inception of this program. I think we do want to encourage participation and that's critical. We do need to also balance that with burden and I think that when I do a lot of physician casework, there's physicians from across the country from various specialties, they're really struggling and trying to understand how PQRS works with the EHR incentive program stage one, as well as the E-prescribing penalties. So we just have to be sensitive when we talk about having options and doing all those things, we need to think about it connecting all the dots that these other programs with these practices are also trying to participate in successfully.

I think the third part of what I'm seeing on the slide too is standardization. When I see that second to last bullet point, implications -- like I said, broad applicable measures are applied regardless of specialty. I think we're seeing this now in the EHR stage-one Meaningful Use Program and forcing physicians to report on a core, and alternate core set of measures, and if not applicable then they need to default to the measures that are left in table six.

Ms. Jennifer Shevchek (continued): Regardless, I just think we just need to be cognizant of the fact that you don't want to just make requirements because it's creating standardizations in the program which is easier, obviously, to keep track of with these various physicians. We need to make sure it's still meaningful for them. So that's just one comment.

The other two issues I want to cover are -- and Dan you mentioned this in terms of did CMS identify relevant measures and/or measure groups for specialty eligible professionals based on claims data. At the AMA we continue to hear from many specialties that they would like to have more specific feedback; they want specialty groups in the actual program, etcetera.

The one thing that's made us really nervous that we've realized with physician compare is that in terms of how CMS is tracking through PECOS and the carriers are validating any updated information in PECOS, as there's been issues with especially identification. I think before CMS makes any decisions in terms of specialty-specific measures or what measures go into what specialty, we need to make sure that the data and those kinds of differentiations are correct. I think the AMA along with [indiscernible] would welcome the opportunity to work with CMS on that because that's extremely important in making sure we get those specialty designations correct.

Finally, we've commented on this in the past extensively, but I know there are advantages and disadvantages to continuing or discontinuing claims-based reporting, but until that truly is the option for most physicians out there today, participating with the program, and we know it can be clunky, we know there can be errors, we know it can be challenging at times, but I think until we get to beautiful, perfect, 21st Century operating systems, the CMS data systems, being interoperable with thousands of EHRs out there, I think just in light of the fact to keep this program open to as many participants as possible, we need to keep claims-based reporting included in this program. Thank you.

Ms. Barbara Cebuhar: Thank you Jennifer. We have one more comment here in Baltimore. Thank you. If you could introduce yourself again.

Dr. Karen Miller, MD: Karen Miller from Green Bay Baycare Clinic. I want to encourage you to keep the claims-based option. We far prefer to participate in a measure group method because it's far easier for us to participate, but in our hundred group surgeon specialty, we've tried to look for 40 of

our surgeons if they could participate on the perioperative measure group. Only 10 of them were able to because their volume.

Dr. Karen Miller, MD (continued): In Green Bay, most patients have Medicare Advantage plans and so they hovered around having 30 patients but we weren't confident. We'd get to 30 and then we're worried about where we'd end up. So if we were forced to participate in a measure group like that, we'd have difficulty. The other thing I want to bring up is the option of requiring physicians to participate if they have patients within the eligible denominator. Our cardiology group participates and they have about 10 measures that they could participate on.

We did initially have the plan of having all physicians participate on any eligible measures. What we found in the cardiology group, who was the largest group, which is exactly what someone else said. The more measures they participate on the more muddled the claim becomes for the coders etcetera and we ended up having divided claims, et cetera where the right code was, and what the right PQRI code et cetera. So that could be very difficult.

The other thing, the last item that you had was about requiring participation on a measure group if there was an eligible measure group. We contemplated that in our urologist group who could participate on the perioperative measure group. But there are other measures related to urologists that are far more specifically appropriate to really measuring their quality. There are prostate cancer measures. There are female incontinence measures and they elected to participate on those, especially given that the hospital is submitting all that perioperative care measure and some of the feeling amongst the physicians were that we have to submit the same data in a variety of different ways and it's a lot of added paperwork.

Dr. Daniel Green, MD: First of all we're going to do everything you said because your Packers beat the Steelers, thank you very much. It ruined my mom's birthday being from Pittsburgh, but made my kids really happy. Just kidding, I'm sorry that was a little bit of a Baltimore thing. Just real quick to one of your -- and I know we're not supposed to do this -- but for your surgeons that you mentioned were concerned about getting to 30 patients in the measures group because of the Medicare advantage, again as long as they report on at least 50% of eligible patients and they have more than 15 they still get credit for the year.

Ms. Barbara Cebuhar: I'm sorry, if you wouldn't mind offering your comments into the microphone, thank you.

Dr. Karen Miller, MD: We did realize that we could do the 50% of patients in that measure group. If that's the case though, for example, in perioperative measures I think there are four or five measures, those physicians often elected then to just do a claims-based because then they only had to participate on three measures. So they elected not to do that. Now that didn't make so much sense in terms of -- it was easier for them because one of the measures in the measure group for perioperative care is the discontinuing of antibiotics.

For that we often have to dig through the chart of when did that last antibiotic regularly be involved and the amount of coder time to do that is expensive, so they decided then to just do the three claims-based measures because they still have to do the same patients, but they have less time putting code in the chart.

Dr. Daniel Green, MD: Yeah and believe me I'm not telling you how to participate, it's just something to consider. Thank you.

Ms. Barbara Cebuhar: Operator if we could please go to the phones and see if there are any other comments I'd be grateful. Thank you.

Operator: Once again, if you would like to ask a question or make a comment, please press 01 on your telephone key pad. We have a comment from Diane Karenwaro [PH]. Please state your organization and question.

Ms. Diane Karenwaro: Hi, this is Diane Karenwaro; I'm with the American College of Chest Physicians and the American Thoracic Society, representing the pulmonary, critical care and sleep physicians in the country and I had actually written comments to Dr. Green.

I don't know if he didn't read them. I did have trouble signing on, so someone was talking about pneumonia when I had actually signed on and I apologize for my voice because I'm dealing with something down here in South Florida between meetings. The comment I did want to make was related to the measures group and when we suggested that the smoking measures that are in the

asthma measures group be used for a separate COPD measures group, I thought that we had mentioned that the ages should be 18 years and older.

Ms. Diane Karenwaro (continued):

We have more problems with the asthma measures group being 5 through 50 because that's 15 years shy of the Medicare age population. So you're only able to get those that are disabled on Medicare to participate in that measures group. We have asked for that for years and I really don't understand why that is not changing.

Also one other comment I wanted to make is that for the new combined 226, which combines the retired measure as 114 and 115 that one of our practices had recently recommended that that should include exposure to second hand smoke like the second hand smoke that is mentioned in the 231 and 232 measures. We really would be supportive of measures groups for both COPD and pulmonary rehab as we had submitted in individual measures as well. A little bit I'd like to say on the pneumonia measures is that we've had problems with pulmonologists being able to qualify for the community acquired pneumonia measures group because the way practice happens is that those patients are often seen by a cognitive physician first and then referred into the pulmonologist. They have trouble being able to qualify for all four measures because very often the patient is not acute pneumonia any longer so they have trouble getting to that 30 patients.

So I've been very concerned about the two groups that we have available; there's problems with both of them, for both the community acquired pneumonia and the asthma group. And again, I apologize for my voice. I do feel that the pulmonologists, critical care and sleep physicians are trying to participate actively in the program, but I really get unbelievable questions. I mean someone thought that -- I think it was the last week of December, they got all of their patients together and were going to submit it as individual claims because somebody in a registry told them that they had to do that.

There's just so much misinformation and what I really would suggest is that when you publish all of this in the federal registry you do a comment response that if somewhere at the end of all that you could summarize all of the --

Ms. Barbara Cebuhar: Diane you're breaking up.

Ms. Diane Karenwaro: I'm sorry, can you hear me now?

Dr. Daniel Green, MD: Diane we're hearing about 10 seconds of your comments and then we have a gap for 5 or 10 seconds so we're not able to follow you completely.

Ms. Diane Karenwaro: Well I'm very sorry.

Ms. Barbara Cebuhar: Diane if you wouldn't mind, if you would please submit your comments to measures@wvmi.org that would be really helpful and please give us a telephone number so we can get in touch with you, okay?

Ms. Diane Karenwaro: Say that again please? Wv --

Ms. Barbara Cebuhar: It's measures@wvmi.org and we are accepting public comments until Friday, February 25 at 5:00 pm EST.

Ms. Diane Karenwaro: Is that W v like Victor or Z like zebra, MI?

Ms. Barbara Cebuhar: W, V like Victor, MI.org. It's measures at WVMI.org.

Ms. Diane Karenwaro: Alright thank you. I'm sorry I was breaking up but I don't think my voice is helping either.

Dr. Daniel Green, MD: Well thank you for calling in, but one other thing just briefly to mention again, if you have issues with services that you think should or should not be included in measures, again we would encourage you to go back to the measure owner and developer and communicate those concerns with them and I'm sure they will consider it. We don't have complete control over measures that are not CMS owned measures.

Ms. Barbara Cebuhar: Thank you Diane, operator can we get our next caller please?

Operator: Yes. Next we have a question from Patrick Torcson. Please state your organization and question or comment.

Dr. Patrick Torcson, MD Hello, this is Patrick Torcson again, Society of Hospital Medicine. Is the Volume okay this time? Can you all hear me?

Ms. Barbara Cebuhar: Now we can.

Dr. Patrick Torcson, MD: Okay good. First of all I just want to acknowledge and appreciate the comments from Dr. Green about directing questions about measure specifications to the measure developers. My first comment is just to endorse and agree with the measures group methodology. For many disease-specific topics, it really does make sense in the application and implementation of these measures to group them. However, I will point out that for the 8 or 9 measures groups included in the 2011 PQRS, none of the measures allows for reporting in the inpatient setting. All of the measure denominator specifications have outpatient measures and therefore, hospital-based physicians are locked out of reporting on some very important disease-specific topics like pneumonia and heart failure that are extremely important in the inpatient setting.

Additionally, with the new group practice reporting option II, requiring reporting on one measure group, that also effectively locks out any hospital-based physicians from participating in the group practice reporting option II. Many groups like hospital medicine groups are very well structured and would be very suited towards measures group reporting. So I hope you would give that some consideration to an opportunity to adapt some of these measures that are now included in groups to include denominator changes for inpatient reporting.

My second comment is just to further endorse the previous recommendations about continuing with the claims-based reporting. I'll just point out from a personal experience that there is an expense involved in signing up and using a CMS qualified registry and for the current PQRS incentive bonus of 1% and then 0.5% going forward, the expense of the registry really isn't outweighed by the potential incentive to be earned. I know that's going to change again in 2015 and 2016 when it becomes a negative adjustment at 1.5% and 2%, but we'd just ask to remember that there is an expense associated with participating in a registry and that investment in a registry may not be offset by the potential bonus to be earned through registry reporting, making the claims-based option still a very good financial option for many individual physicians and groups. Thank you.

Ms. Barbara Cebuhar: Thank you Patrick. Operator do we have any other callers?

Operator: Yes. Next we have Debbie Robin. Please state your organization and questions or comments.

Ms. Debbie Robin: Okay thank you. Can you hear me?

Ms. Barbara Cebuhar: Yes.

Ms. Debbie Robin: Okay great. Thanks. This is Debbie Robin. I'm staff with the American Gastroenterological Association. First of all, thank you for the opportunity to participate today and for your consideration of our inflammatory bowel disease measures. I would ask, just as a note, that those measures are listed in your suggested measure documents for both measure groups and individual measures. However, on your slides today you indicated irritable bowel disease, which is not on either of those lists so that may have been a typo and I just wanted to bring that to your attention in case that needed some attention.

But we do appreciate that our measures were included in the suggested list and those measures, both as individual measures and as a measures group will be very helpful and allow participation by gastroenterologist and again, caring for IBD patients in some instances is a sub-specialty but it is not uncommon for a more general gastroenterologist to have a fair number of IBD patients that they care for without being a part of a center for excellence.

So we do appreciate that this gives a greater scope of participation both on the measures group side and the individual measures for our specialty and so I just again really wanted to let you know that we are available should there be questions as CMS moves forward in its efforts to finalize and create documentation related to the 2012 measures. Thank you very much.

Ms. Barbara Cebuhar: Thank you Debbie. Operator we have a person here in the Baltimore office that needs to offer a comment. Thank you.

Dr. Mark Froimson, MD: Thank you. My name's Dr. Mark Froimson, I'm an orthopedic surgeon representing the American Association of Hip and Knee Surgeons. We'd like to thank you for the

opportunity to provide some comments this morning and thank you for putting this session on. We think it's of great value. We support quality initiatives and the focus on the quality reporting that is of high importance to our patients.

Dr. Mark Froimson, MD (continued): We are concerned that measures should be relevant to patient outcomes and are concerned that many of the measures currently are process measures and not outcome measures. We also are concerned and would like to ensure that participation is not onerous for our members and we're concerned that participation runs the risk of asking physicians in practices to choose between devoting resources to patient care, versus devoting those same resources to the task of reporting.

With regard to process measures, specifically we're concerned about some of the perioperative care measures. Those measures related to perioperative care, including the timing and cessation of antibiotic use, as well as the mandating of VTE prophylaxis measures that offer a guideline that is countered to our own specialties recommendations, we feel are not clearly demonstrated to be associated with improved patient outcomes. As a result, it's not clear how participation and performance with regard to these measures is a reflection of the quality of care that our members provide.

Consequently it is not always clear whether the resources devoted to participation are warranted. We would like to see measures developed and we'll work to develop measures and we'll work with you to develop measures that are more clearly correlated with relevant patient outcomes for patients undergoing hip and knee arthroplasty. Thank you.

Ms. Barbara Cebuhar: Operator are there any other comments on the line please?

Operator: Yes. We have one last one from Joel Brill [PH]. Please state your organization and questionnaire comment.

Dr. Joel Brill, MD: Absolutely. I'm Dr. Joel Brill. I'm also representing the American Gastrological Association. My comments will be very brief because Debbie Robin has already made most of them. Again the AGA appreciates the foresight of CMS in holding today's town hall meeting and providing an opportunity for all stakeholders to provide comments.

Dr. Joel Brill, MD (continued): The AGA has had a CMS qualified registry for reporting measures back to PTRS and it is a challenge to get people to participate but we look forward to working collaboratively with the agency to ensure that measures are meaningful and can be reported regardless of whether a physician is still in a claims-based or in an electronic and operating environment.

Last but not least, again, as Debbie has just said, you gave the gastroenterologist a little bit of indigestion with your slides, in that the measure said and individual measures that we've submitted for consideration relates to inflammatory bowel disease, not irritable bowel syndrome. With that, thank you so much and have a great lunch.

Ms. Barbara Cebuhar: Thank you Dr. Brill.

Dr. Daniel Green, MD: Might try some Pepcid or prevacid for that. Sorry-just kidding.

Ms. Barbara Cebuhar: Thank you, Dr. Green. We are very grateful for everybody's thoughtful comments today. We are going to break for lunch now and would appreciate your returning to the auditorium and to the phone before our 1:00 pm start time. The cafeteria is located down the steps from the lobby and you have in your folder a copy of the stations in your package. Those of you on the phone should redial in at 1:00 pm. So we will begin promptly at 1:00. Thank you again.

[01:00 PM Session]

Ms. Barbara Cebuhar: Good afternoon. Welcome back to our 2012 Physician Quality Reporting System Public Town Hall Meeting. As I mentioned before the break, you can follow along, for those of you on the phone with our presentations, at www.cms.gov/pqri. Go to the "Downloads" section of the Sponsored Call page dated 2.9.11. We're on Slide 38. Our next presenter is Regina Chell who will be discussing GPRO I & II. So if you need to, please go to Slide 38. Thank you. Regina.

Ms. Regina Reymann Chell: Okay. Thanks, Barb. Welcome back to everyone. I hope everybody had a good break, and didn't have to wait too long in line in the cafeteria.

Ms. Barbara Cebuhar: Um-hmm.

Ms. Regina Reymann Chell: So we're going to be talking for the next few slides about the Group Practice Reporting Options and for, I'm sure, most of you are aware for 2011 program year, we now have two Group Practice Reporting Options. So first, if you turn to Slide 39, we're going to look at how to participate in GPRO, the group, which is our acronym for the Group Practice Return-, Reporting Option for 2011.

So in order to be eligible to participate, participants must meet the group practice definition, which is: two or more eligible professionals in a group. The practice must have billed Medicare Part B prior to January 1, 2010 and before October 29, 2010. They must have self-nominated by January 31, 2011. So obviously if you are interested in this and didn't self-nominate, you have to stay tuned for next program year.

One caveat here is that if a group practice participated in GPRO in 2010, they were able to email CMS their desire to just continue the GPRO reporting option for the 2011 program year. The groups, when they self-nominated needed to provide us with their TIN and they had to agree to a tandem participate in a kickoff meeting, as well as several mandatory training meetings, and they must have met certain technical requirements.

Then lastly, the groups are selected by CMS to participate. So first let's talk about the more specific details for the GPRO I Reporting Option. This reporting option is for group practices with 200 or more eligible professionals. They must complete a pre-populated 2011 Group Practice Reporting tool on an assigned set of Medicare beneficiaries. This tool is for GPRO using the tool. We have 26 total measures. There's four groups: high cost, chronic condition groups, heart failure, CAD, hypertension, and diabetes. Sorry, I know that, I know this like my own name, so I shouldn't have even had to hesitate. And then there are four individual preventive care measures.

The groups will be provided access to a tool that's pre-populated with data from 2011, and they'll be able to access the tool the first quarter of 2012. So then we'll turn to the next Slide, and look at the reporting option for GPRO II, which is new for the 2011 program year. And this expands group reporting to groups that have 2 to 199 NPIs in their TIN. CMS will plan to select approximately 500 groups for the group GPRO II reporting option. There is not a data collection tool. The groups will use the 2011 Physician Quality Reporting System measure specs for claims and registry, and they'll

also use the 2011 Physician Quality Reporting System specification manual for measures groups. It is important to note that for this reporting option, the group is required to report via claims unless the only applicable measure group that the group has is registry-only. If that's the case, then please note that you can access the qualified registries on the CMS Web site in the summer of 2011, that list will be posted.

Ms. Regina Reymann Chell (continued): So we'd like to invite you to comment on the group practice reporting options and we just want to put a couple ideas out there that we would, specifically would like to ask comments on. How should we expand GPRO I measures to facilitate participation in GPRO I by specialty practices? Should there be specialty-specific measure sets? Then we'd like to you also think about the definition of group practice so that it accurately reflects how group practices conduct business and operate.

Take into consideration methods for associating an individual EP with a group practice. Consideration for expanding GPRO I to smaller group practices, so less than now, keep in mind that it's a TIN with 200 or greater NPIs. If it were to be expanded, should the reporting requirements be revised? And then consideration for expanding GPRO II to larger group practices.

And again, if it's expanded, should the reporting requirements be revised? Now, a little bit later in this afternoon, we're going to invite you to comment. So now I'd like to turn it back to Barb.

Ms. Barbara Cebuhar: Great. Thank you very much, Regina. I just want to make sure folks know that we have diverted from our published schedule. We have, Molly MacHarris is going to talk next about the Maintenance of Certification program incentives, and then Christina Estella is going to be talking about feedback and informal appeals process. Then we will take public comments, again, from the folks here in the room as well as on the phone, and then we will take a break. So I do apologize for the change in schedule, but we do appreciate your patience with us. So if Molly could come up, please, I appreciate it. Thank you. Molly?

Ms. Molly MacHarris: Thank you, Barb. I'm going to be going over the Maintenance of Certification program incentive. This is a new reporting or I'm sorry. This is a new additional incentive we have for 2011. So starting on Slide 47.

Ms. Molly MacHarris (continued): Beginning in 2011, physicians can receive an additional 0.5 percent incentive payment. In order to qualify for the incentive payment, physicians will need to complete the following: satisfactorily submit data without regard to method, on quality measures under the Physician Quality Reporting System for a 12-month reporting period either as an individual physician or as a member of a group practice. And then you must also more frequently than is required to qualify for or maintain board certification, participate in a maintenance of certification program, and successfully complete a qualified maintenance of certification program practice assessment.

Slide 48. A Maintenance of Certification Program is a continuous assessment program that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, and professionalism. Such a program shall require a physician to do the following: [1] Maintain a valid, unrestricted medical license in the United States. [2] Participate in educational and self-assessment programs that require an assessment of what was learned. [3] Demonstrate through a formalized, secure examination that the physician has the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty. And [4] successfully complete a qualified Maintenance of Certification program practice assessment, including patient experience of care survey.

On Slide 49, Maintenance of Certification vendors/registries/entities will manage the program for their physicians or diplomats. Any organization may self-nominate provided that they can demonstrate how the Maintenance of Certification Program meets the definition. That was the definition I just read. Define “more frequently” the activities for practice assessment physician participation, and define “more frequently” for completion of the practice assessment. We plan to list the conditionally qualified entities by the spring of this year for the 2011 program, and individual physicians will not need to self-nominate if they’re looking to participate. They will need to work with a qualified Board or entity for potential participation.

And then we are looking to receive information directly from these qualified Maintenance of Certification Boards or entities by the spring of 2012, approximately from February through March of 2012. On Slide 50, the potential 0.5 percent incentive only applies to those physicians who qualify for a 2011 Physician Quality Reporting incentive. So this is only applicable if the physician is first,

eligible for the 12-month reporting period for Physician Quality Reporting System, and they also have to be defined as a physician. This does not apply to our full list of eligible professionals. The incentive will be paid at the same time as the 2011 Physician Quality Reporting incentive for those physicians who qualify, and we will indicate this separately on the 2011 Feedback Report.

Ms. Molly MacHarris (continued): Physicians cannot receive more than one additional 0.5 percent incentive even if they complete a Maintenance of Certification Program in more than one specialty. So if you are a physician or a diplomat who is certified in more than one specialty or subspecialty, you would still only receive one additional incentive payment.

On Slide 51, we have some information on where you can find additional documents on the Maintenance of Certification program. We have issued a separate Maintenance of Certification guidance document. We have received a couple of requests for information on how you would meet the “more frequently” requirement. So please take a look at that guidance document. And then, again, if your group would have been interested in self-nominating, we would have needed that by January 31, 2011.

On Slide 52, this provides what we are looking to receive and put on. So, should CMS consider collecting patient experience survey results in the future, specifically the level of information used and collected? And should the type/format limitations be considered? Currently for 2011, we are just looking to see whether or not the Patient Experience of Care Survey was performed.

But for future program years, we are looking for interest on what type of information on that survey we should receive. We also are interested in seeing should physicians who satisfactorily report the Physician Quality Reporting System for the six month period be eligible for the Maintenance of Certification Incentive? Again at this time, it's limited only to 12-month reporting period.

Additionally, should we expand the incentive to include all eligible professionals beyond the physician definition? And ways that CMS can apply the “more frequently” requirement to increase provider participation in the Maintenance of Certification Incentive Program. Since this is a new program, we are, of course, looking to increase participation. Back to you, Barb.

Ms. Barbara Cebuhar: Thank you very much, Molly. We appreciate your insights. Our next

presenter is Christina Estella who'll be talking about feedback as well as informal appeals process. Christina. Christine, sorry.

Ms. Christine Estella: No problem. Hi. Right now, I'm going to be talking about timely feedback. On Slide 54, the Affordable Care Act requires CMS to provide timely feedback to all eligible professionals. However, I'd just like to note that since the inception of the Physician Quality Reporting System, formerly known as PQRI, the program has provided feedback reports at the TIN/NPI level to eligible professionals who participated.

For 2011, CMS will continue to provide feedback reports on or about the time of incentive payment distribution. And for 2012, CMS anticipates providing additional interim feedback reports. CMS invites stakeholders to provide input on the following issues: Frequency of feedback reports, beneficial information for inclusion in annual feedback reports, and beneficial information for inclusion in interim feedback reports.

Now about the 2011 Informal Review Process starting with Slide 56 and Slide 57. CMS is implementing an Informal Review Process for the program year 2011 Physician Quality Reporting System. We will provide eligible professionals who were not incentive eligible for 2011 the opportunity to request a review of that determination. I just wanted to remind you that this is the only issue that will be up for determination with the informal appeals process.

As far as time limitations, an eligible professional must request an informal review within 90 days of the release of his or her feedback report. Eligible professionals may request informal review by notifying the Quality Net Helpdesk via email at qnetsupport@sdps.org. The request for review must state concerns of the eligible professional as well as reasons for requesting an informal review. And Slide 59, the Submission of Evidence is optional for this informal review process. The eligible professional may, but is not required to, submit information to assist in the review.

However, please note that there will be no evidential hearing on the information the eligible professional provides. On Slide 60, CMS will provide written response via email to the informal review requestor, where the eligible professional did satisfactorily report, the applicable incentive payment will be provided. CMS must provide a written response within 60 days of receipt of original request.

Ms. Christine Estella (continued): On Slide 61, all decisions under this informal review process are final and there will be no further review. And on Slide 62, CMS invites stakeholders to provide input on the following issues. How should CMS improve the informal review process that was implemented for the 2011 Physician Quality Reporting System?

Ms. Barbara Cebuhar: We are going to go ahead and open the floor for public comment. So if anyone has any feedback for our colleagues in OCSQ, we would appreciate your input. And if you could identify yourself and your organization again, please.

Ms. Tanya Alteras: Tanya Alteras, National Partnership for Women and Families, and the Consumer Purchaser Disclosure Project. Just wanted to extend our strong support for the inclusion of patient experience surveys and data in the Maintenance of Certification process. Collection of this data provides insight into how the patients experience their care, how their outcomes, their functional status, their care coordination, and their care transitions all took place. And we believe that while in the first year, if simply the collection whether patient experience survey was done, if that's as far as it's able to go in the first year, that's one thing.

But we strongly support the inclusion of the actual data, and what the surveys say, and what they represent in future years of the program. And that—, and including the Maintenance of Certification aspect of the program that patient experience must be a critical part. Thank you.

Ms. Barbara Cebuhar: Thanks, Tanya. Our next comment.

Ms. Jennifer Shevchek: Jennifer Shevchek, AMA staff. First, on the appeals process, I mean, I think a lot of these are great questions; it's just hard for them to provide substantive comments. AMA will be providing more substantive comments for the February 25th deadline; written comments. But one thing, it is hard to comment on a new added change to the PQRS program when we haven't really seen it actually sort of play out in terms of the appeals process. So that's just one, a side comment.

But we did provide extensive comments on the timely feedback because the Affordable Care Act did direct CMS to provide timely feedback for the fiscal year 2011 program. And while the proposed rule

did offer up providing, I think it was interim feedback reports for those that actually selected the measures group reporting option so that they could tell them whether they've hit 15 patients or where they were in kind of meeting 30 or 15, if they selected the six month reporting option.

Ms. Jennifer Shevchek (continued): I think we, the AMA, felt that that was just insignificant and that we really do need to really see more timely feedback. It's one of the biggest things we hear from our members and from physicians across the country is that they really do need more timely and meaningful feedback. And that gets into the second question that you do ask in this town hall meeting on these issues is: how can they improve the feedback reports? One is making them, I just think, overall more user friendly.

I know there's already been issues of getting the feedback reports. I've been emailing with your colleagues here in OSCQ. Just through the email option, I think, physicians have already had some frustrations just accessing that actual report itself, and that needs to be rectified. But then once they get the report, I think, and you guys have done, I mean, to your credit, you have provided some additional, I forget, [PH] medlin matter articles to help walk physicians through not only how to access reports, but also the meaning of them. But I know that in one of our meetings that the AMA convened with the specialty societies, there was a lot of discussion around the breakdown of, you know, "Okay. I reported this diabetes measure. You know, it was inaccurate because I reported the gender wrong." You know, I don't know. I'm making numbers up. "Fifty out of the 100 times I reported it," for example. It's a little bit too high level for them really to kind of take meaningful action on it. That's what I've heard from the most part.

So I think the timely feedback, that's something that we were extremely disappointed with because in the final role, CMS decided not to do anything for 2011. So they didn't even move forward on providing more timely feedback for the measures group reporting option. And we understand the reasons why. I mean, they basically said that, you know, because the majority of physicians don't do electronic prescribing, and we are still in the claims-based world, it is challenging to provide timely feedback. We get that. But we need to see a little bit more effort on behalf of CMS to get more timely feedback, whether that's really publicizing early feedback reports, or maybe doing them every other month, but there needs to be more feedback in general from the agency to physicians who participate in this program.

Dr. Daniel Green, MD: Jennifer, let me give you some timely feedback now.

Ms. Jennifer Shevchek: Yea, Dan. Thank you.

Dr. Daniel Green, MD: It's only like 20 seconds, that's pretty good, huh?

Ms. Jennifer Shevchek: That is pretty timely.

Dr. Daniel Green, MD: So with respect to the feedback report part, I can tell you for 2011, we are actually looking at ways to make the reports much more easily understood. So we've had a few meetings already, and we are continuing to meet to try to make it so that folks don't have to tear back and forth through footnotes and what have you, but can look at it and understand it pretty much at first pass. In that respect, we are making some progress. Your other comments, we will record them and thank you.

Ms. Jennifer Shevchek: And also, the AMA would be happy to facilitate. We did this for one of the first, original development of some feedback reports. If you want us to convene the specialties or have us work with the states in reviewing some drafts, we'd be happy to do that.

Dr. Daniel Green, MD: Thank you.

Ms. Barbara Cebuhar: Thank you. Our next comment.

Ms. Mary Patton-Wheatley: Yes, this is Mary Patton-Wheatley at the Association of American Medical Colleges, and I feel like this is my—, every listening session I get to put my little plug in. This is for your definition of “group practices”. Currently, you guys use Tax ID Number, which makes a lot of sense at the first pass, but there are a handful of academic medical centers that each department has its own tax ID number.

So we think it would be really great if you could have some kind of option for the group practices to say, “Okay, all these tax ID numbers belong to the same group,” and have some kind of mechanism to allow that for group reporting. Thank you.

Ms. Barbara Cebuhar: Thank you. I think we have one more comment here in Baltimore.

Ms. [PH] Corrine Rubin: Hi. Corrine Rubin, American Academy of Otolaryngology. In regards to the group practice reporting option and getting more specialty providers to use that route. As of now, even with GPRO II, one of the requirements is reporting on a measure group, and if you're in a specialty practice that doesn't have an applicable measure group, you're excluded from reporting in that manner. So if CMS moved to change the requirement of not allowing a measure group, I believe the amount of people moving in that direction would increase.

My other comment is, this is more related to CMS and providing feedback to the specialty groups, I don't recall seeing for 2009, CMS ever coming out with the full quality data report in regards to reporting. And with the threshold, I only recall seeing with the top five reported measures per specialty, not overall. And that's been a great tool for the specialty societies to go back and look at how their measures are being reported on inaccurately or correctly, and then to move forward to educate their members appropriately.

For years past, we were able to utilize those reports and change the way we were teaching how to report with PQRI or PQRS. So if you could provide that to us, that would be greatly appreciated.

Dr. Daniel Green, MD: Your wish is our desire.

Ms. Corrine Rubin: Okay.

Dr. Daniel Green, MD: So we are actually in the process of, we have a 2009 Feedback Report. I'm not sure, I think Mike mentioned it, perhaps earlier.

Ms. Corrine Rubin: Yes, Dr. Rapp provided something in the summer with just the top five measures.

Dr. Daniel Green, MD: No, no.

Ms. Corrine Rubin: But not the overall report.

Dr. Daniel Green, MD: This is a complete report.

Ms. Corrine Rubin: Yes.

Dr. Daniel Green, MD: For the 2009 program year, which is completed, and it's going through the department clearance right now. So I'm not going to give you an absolute date, but it should be forthcoming within the next, I would guess, one to two months.

Ms. Corrine Rubin: Okay. If you could also provide that in a more timely manner, that would be appreciated. I know in years past, we would receive it before the next program year started.

Dr. Daniel Green, MD: Boy, I gave you timely feedback and now you're asking for like— I'm kidding. Thank you.

Ms. Barbara Cebuhar: Thanks, Corrine. Operator, if we could open the lines for comments from the phone lines, I'd appreciate it. Thank you.

Operator: Ladies and gentlemen over the phone, if you would like to ask a question, please press zero-one at this time. Again, that's 0-1 if you would like to enter the queue to make a comment. Next queue is [PH] Scott MacDonald.

Dr. Scott MacDonald, MD: Hello, this is Scott MacDonald, the UC Davis Health System. My question may be further down the road in the sessions today, but is there a plan to merge PQRS and the EHR incentive programs, and if so, what is that timeline?

Dr. Daniel Green, MD: So the healthcare reform legislation directs CMS to develop a plan to align the two programs. The plan is due, if you will, at the beginning of 2012. So that doesn't mean necessarily that the programs will be aligned for 2012, but the plan needs to be formulated by the beginning of 2012.

Dr. Scott MacDonald, MD: Thank you.

Dr. Daniel Green, MD: Thanks.

Ms. Barbara Cebuhar: Mr. MacDonald, could you identify your organization again, please?

Dr. Scott MacDonald, MD: Oh, sure. UC Davis Health System in Sacramento.

Ms. Barbara Cebuhar: Thank you. Operator, our next comment, please.

Operator: Our next comment comes from Patrick Torcson.

Dr. Patrick Torcson, MD Yes, Patrick Torcson, again, Society of Hospital Medicine. Just a range of comments on the subjects we've just covered. First of all, I'd like to support the previous comment from the Otolaryngology Society regarding the GPRO option II.

The current methodology requires participation or reporting on a measures group, and reporting on individual measures. You really could expand GPRO II participation by limiting or not including the necessity of reporting on a measures group. As noted, many of the measures groups are not available or relevant for many specialties, including hospital medicine. So I would hope you would give that some consideration.

Regarding the MOC, I think it's a great opportunity to promote MOC participation by physicians and as well as encouraging PQRS participation. If you could consider expanding the bonus to be—, include eligibility, not necessarily just for successful PQRS participation in earning a bonus, but perhaps for participation in the program alone and reporting on measures, and still be eligible to receive the 0.5 percent without necessarily achieving the PQRS bonus being successful in that front.

And finally, regarding the feedback reports I'd, you know, just echo the comments from the AMA about the need for timely feedback. So far with '07, '08, and '09 participation, the feedback reports are being issued at a point so far removed from the time of service or implementation, or patient care that they're really not relevant as a performance improvement tool. I think the turnaround cycle needs to be more along the lines of three to six months, and I would also offer that in order to actually use the PQRS for performance improvement, we need patient-level specific data and not just the 30,000 foot overview of seeing how physicians did with the measures. So I would hope you get some consideration to making the reports more detailed at the individual patient level. Thank you.

Ms. Barbara Cebuhar: Thank you, Patrick. Our next comment, please.

Operator: Our next comment comes from Sandra Bush.

Ms. Sandra Bush: Hi, my name is Sandra Bush. I'm from St. Luke's Hospital and Physician Health Network. I want to back the timely feedback too because what's happening on our end with over 700 physicians is they're losing interest in the programs, not seeing their feedback. They also are requesting that maybe you could setup a teleconference time so that when they do appeal the performance, they can talk to somebody directly and understand the more valuable aspects of the program.

My second thought process is NCQA. I am proud of our group. We had over 56 physicians become NCQA diabetic credentialed. I'm asking for consideration that Maintenance of Certification takes this into consideration because this was a year and a half project. You don't get to pick your patients. It's randomly selected and it just shows that the doctors are doing good work. Thank you.

Dr. Daniel Green, MD: Before you run, if I could just ask you question. Excuse me.

Ms. Sandra Bush: Okay.

Ms. Barbara Cebuhar: Hold on one second. Dr. Green is having a moment.

Dr. Daniel Green, MD: Wow. All choked up by your comments.

Ms. Sandra Bush: I never had that effect on anybody on the Medicare side.

Dr. Daniel Green, MD: And I've never taken it so personally. Oh, my goodness. Sorry about that. With respect to the—

Ms. Sandra Bush: Okay.

Dr. Daniel Green, MD: Oh, my goodness. With the maintenance of— I'll ask you later.

Ms. Barbara Cebuhar: She's on the line, so you may—

Dr. Daniel Green, MD: Let's take this comment.

Ms. Barbara Cebuhar: Okay. If you wouldn't mind staying on, please, Sandra. We are going to take a comment from the room. Thank you.

Ms. Sandra Bush: Okay.

Dr. Mark Froimson, MD: We'll give you a reprieve for a little bit.

Dr. Daniel Green, MD: Is there anesthesia in the room?

Dr. Mark Froimson, MD: I'm an orthopedic surgeon, so I don't think I can help you, but Mark Froimson representing the American Association of Knee Surgeons again. I would just like to echo one of the comments I heard over the phone, which is to divorce the—, tying the potential incentive based on the Maintenance of Certification from other participation in the PQRS, and to allow it to be a standalone program, I think, would be very helpful.

I think as I alluded to earlier, we believe in our organization that there's a clear dearth of relevant measures for orthopedic surgeons, and given the long timeframe in terms of the development of new measures, we think it would be essential that separating the maintenance of certification incentive from the other participation requirements would allow more of our members an opportunity to engage in this process. Thank you.

Ms. Barbara Cebuhar: Thank you, Dr. Froimson. Can we return to the phone? Sandra, are you still on? Operator, could you return Sandra to the phone?

Operator: Sandra, your line is open.

Ms. Sandra Bush: I'm here.

Dr. Daniel Green, MD: I'm afraid to speak now.

Ms. Sandra Bush: Are you all right?

Dr. Daniel Green, MD: Sorry about that. It was such a touching comment, though. So just a quick question about the Maintenance of Certification suggestion. You had, you mentioned that, I think it was fifty-some of your doctors are doing the NCQAs diabetic recognition program. Were you suggesting that– I'm sorry?

Ms. Sandra Bush: Yes.

Dr. Daniel Green, MD: Were you suggesting that that should be satisfactory for maintenance of certification in general or for the maintenance of certification requirement for PQRS?

Ms. Sandra Bush: Well, both. I mean, if you want to go the full step, I'll take it in general, but if you want it to be part of. It's just that I'm getting so much information saying that it can't be used, and yet the American Board of Internal Medicine, the American Board of Family Practice are recognizing it as their project for recertification.

Dr. Daniel Green, MD: Okay, so just to be clear. We have no authority over the respective Boards. We can only either, you know, add the incentive as per Congress's mandate of half a percent if someone does the maintenance of certification more often than is required. But we cannot advise the Boards as to what should be successful or what their criteria should be for maintenance of certification. They're independent from CMS.

Ms. Sandra Bush: I'm throwing that in, Doctor, for strong arming because they do already accept the credentialing.

Dr. Daniel Green, MD: Okay. Again, as you know, each Board sets their own criteria for what is acceptable for maintenance, and we rely on them to report to us that an eligible professional has met the requirements more often than is otherwise required, again, to be able to earn that extra half a percent. But thank you for the clarification and the comment.

Ms. Sandra Bush: I'm just saying that for something that takes 18 months to complete, it should be considered.

Ms. Barbara Cebuhar: Sandra, we missed you.

Ms. Sandra Bush: For something, for a program that takes up to 18 months to complete, I think it should be considered.

Ms. Barbara Cebuhar: Thank you for your comment. Operator, do we have another call in the queue?

Operator: We have one more comment in queue and it comes from Carmella Nachreiner.

Ms. Carmella Nachreiner: Hi, I'm sorry. What I wanted to know is I know we talked, you talked about the PQRS butting up against the EHR demonstration, but what about "Meaningful Use"? How is this going to align with Meaningful Use or is there a plan for it to do so?

Dr. Daniel Green, MD: Is that me?

Ms. Barbara Cebuhar: Um-hmm.

Dr. Daniel Green, MD: So basically, there are two separate programs currently and my comments earlier were basically just to reiterate what the law requires us to do, which is to align the two programs, or at least have a plan in place by 2012.

The EHR Meaningful Use program, as you know, has one of the requirements includes reporting clinical quality measures via the EHR. But there are 24, I believe, other requirements including electronic prescribing, patient information, and care coordination, et cetera. So there are many other requirements for that program. The clinical quality measure part is only one segment.

Ms. Barbara Cebuhar: Carmella, could you please identify your organization?

Ms. Carmella Nachreiner: Yes, I understand that. My organization is UPMC in Pittsburgh,

Physician Services Division.

Ms. Barbara Cebuhar: Thank you.

Ms. Carmella Nachreiner: The Managed Physician Office side of that organization. Is there—, will there be still the penalty for not participating in PQRS come 2015?

We're only asking because our builds for our electronic record are totally different for each of these measures, even though the clinical measures are similar, the builds and the reporting mechanisms are totally different. So it is two separate, just talking about the clinical quality measures, they're two separate ways to do this. Could the clinical part of it count for Meaningful Use?

Dr. Daniel Green, MD: And again, we can't answer that at this point. I think that is going to be the subject of future rule making for both PQRS as well as Stages 2 and 3 of Meaningful Use.

Ms. Barbara Cebuhar: Operator, do we have any other calls in queue?

Operator: There are currently no other callers in queue, but as a reminder for those over the phone, you may press zero-one, if you do have a comment to make.

Ms. Barbara Cebuhar: Thank you. Any other comments? Okay, hearing none, we will move to the next presentation which is our own Dr. Dan Green, who will be providing some additional insights about electronic prescribing incentive programs. And if we could get our Slides, I'd be grateful, Charles. Thank you. Slide 31.

Dr. Daniel Green, MD: So I just want to be sure that everybody here has gone through security and the metal detector before we talk about the ePrescribing program. Not that I'm paranoid or anything. No, just kidding.

So we're going to basically quickly review the current proposals with respect to ePrescribing for 2011. And if you look on Slide 32, you can see that our eRx, if you will, or Electronic Prescribing program, we define electronic prescribing as the transmission of prescriptions or prescription-related information through electronic media. The ePrescribing can take place between a provider, a

dispenser, a program manager like a pharmacy benefit manager; so a health insurer, if you will and, of course, the eligible professional. You can go directly to the pharmacy, so places like Kaiser, if you will, have direct connections.

Dr. Daniel Green, MD (continued): But then, again, there are other folks that are in a more traditional private practice setting that may use an intermediary or network such as Surescripts to transmit this information. There is no registration required to participate in our electronic prescribing program unless you're participating under a GPRO, in which case, the GPRO has to self-nominate if they want to do electronic prescribing as well.

Looking on Slide 33, the ePrescribing program was authorized by the Medicare Improvements for Patients and Providers Act of 2008 and the Incentive Program began in 2009. The program provides a combination of incentive payments, and payment adjustments to eligible professionals to encourage adoption and regular use of electronic prescribing. For additional information on the program, you can see our Web site at www.cms.gov/ERXincentive.

On Slide 34, we define a "successful electronic prescriber" as someone who's eligible to receive an incentive payment, and they have to report, generate and report at least that they ePrescribed one or more prescriptions electronically at the time of a patient visit. To actually earn an incentive in 2011, an individual must do this at least 25 times during the course of the year. If they're a member of a GPRO, the number of required unique electronic prescribing events varies between 75 and 2500, depending on the size of the group.

Each visit has to be accompanied by the eRx G-code which is G8553. And basically that G-code says that at least one prescription was generated using a qualified electronic prescribing system during that visit. Electronically generated refills don't count. So if a patient is not in the office and needs a refill on her Lasik or whatever, and you send that electronically, that would not count as a unique electronic prescribing event for the eRx incentive program. If you fax a prescription, that does not count as electronic prescribing either.

The new prescriptions that aren't associated with a code in the denominator. So if you see a patient for some service that's not in the denominator of the ePrescribing measure and you generate an electronic prescription, that's terrific that you ePrescribe, but unfortunately, it doesn't count for the

program. So it has to be associated with a code in the denominator to measure, pretty much like any other measure.

Dr. Daniel Green, MD (continued): Slide 35, Jackie. So what everybody's all concerned about is, of course, the payment adjustment which is due to take place in 2012. The payment adjustment is a prospective payment adjustment, and basically it's for those eligible professionals who do not, who have not ePrescribed at least 10 times in the first six months of 2011. They will receive 99 percent of the physician fee schedule, allow charges starting in 2012.

Now, it's important to realize that the ePrescribing must be reported for the first six months of 2011 via claims. You can't—, registries and the EHR's will not be able to submit that information into us in time to avoid the payment adjustment for 2012. So again, eligible professionals would need to do this via claims. Earning an incentive, so if an eligible professional gets an incentive for 2011, that does not necessarily preclude them from a payment adjustment. So just to make that a little clearer. They have to ePrescribe 10 times or more in the first six months, and they have to ePrescribe 25 times to get the incentive during the course of the year.

So if they ePrescribe, let's say, 30 times in the first six months, they're good to go. They're going to avoid the payment adjustment and they'll also be incentive eligible provided that 10 percent of their charges, or more, are comprised of codes in the denominator to measure.

They will also avoid the payment adjustment for 2013, because they would be considered a successful electronic prescriber. If, on the other hand, that same eligible professional only ePrescribes 5 times in the first six months and, let's say, 25 times after July 1st, they would be eligible to receive the incentive. They would avoid the payment adjustment in 2013, but they would be subject to the payment adjustment in 2012 because they didn't get their 10 ePrescribing events in for services during the first six months of 2011.

So it's a little confusing. We're doing our best to try to make this clear. We mention this pretty much on every national provider call, which we hold monthly, in an effort to continue to get the word out to eligible professionals.

Dr. Daniel Green, MD Looking on Slide 36, there are some ways to avoid the payment adjustment for 2012. If you don't have at least 100 denominator-eligible cases in the first six months, so if you don't have, if you're a primary care doc, their typical codes are 99-, 201 through 205 or 211 through 215; again, in general. If you don't have at least a hundred visits for Medicare patients during the first six months, the payment adjustment will not apply to you. If you don't have at least 10 percent of your charges comprised of codes in the denominator, the payment adjustment will not apply to you. Similarly there's a code that eligible professionals can report one time on a claim that basically says, "I don't have prescribing privileges."

If for some eligible professionals who aren't able to prescribe, they could send this code in one time on an eligible claim. Similarly, we have two hardship codes. The first one is for-, designed for folks that practice in a rural setting where there may not be a high speed Internet available. And the second hardship code is basically for folks that are practicing in a more rural area that may not have any pharmacies that are capable of receiving electronic prescriptions.

And if they append one of these hardship codes to a claim, they would, they're basically stating that it's a hardship for them, and on a case by case basis, CMS will look at those, and they would not be subject to the payment adjustment as well. The hardship exemption is subject to an annual renewal, because you can imagine, somebody may not have high speed Internet this year, but they might have it next year.

So again, it is something that would need to be looked at yearly. Looking at Slide 37, we really don't want any comments or feedbacks on this subject, so thank you all for coming. Just kidding. Who said government doesn't have a sense of humor? No, all teasing aside. We would like input on the reporting thresholds for the ePrescribing incentive payment. We would like some input, if you will, on the threshold for the 2012 payment adjustment.

So if you have comments, you know, you think 10 electronic prescriptions are too few or too many. And by the way, just for point of clarification, the ten electronic prescriptions, let's say a patient comes in and you prescribe one medication electronically, but the other prescriptions you can't do electronically. They're narcotics or there's some other compelling reason why you can't or the patient doesn't want it electronic, whatever. As long as you prescribe one prescription electronically during that visit, you can report the electronic prescribing event code. If you do ten prescriptions

electronically, you still only get credit for one for that particular visit.

Dr. Daniel Green, MD (continued): And unlike the measures groups we talked about earlier today where there's 30 unique patients, if Mrs. Jones comes in today and you electronically prescribe Lasik for her today, and then she comes back next week and she's got an upper respiratory infection that you think needs antibiotics and you electronically prescribe that next week, even though it's the same patient, it's two separate encounters. So that would count as two of the electronic prescribing events that you need; two of the ten, if you will or 2 of the 25, depending on whether you're looking to avoid the penalty or to earn the incentive.

One other point I wanted to make, which isn't really on the Slide, so sorry to deviate from your schedule. Folks cannot get a 2011 ePrescribing incentive and get a Meaningful Use—, a Medicare Meaningful Use incentive payment in 2011. They can get one or the other. Now they can get the Meaningful Use incentive and still, unfortunately, have the payment adjustment applied to them for 2012.

So it's important to inform your—, the folks, the members, we have several organizations here, important to let your eligible professionals know that they, even if they're doing Meaningful Use, they will need to report at least ten times that they electronically prescribed in the first six months to avoid the payment adjustment. Now if they're doing the Meaningful Use, let's say, in February, March, and April and they have a patient that comes in that they ePrescribe for, for their, as part of their Meaningful Use program, they could report that that same ePrescribing event on a claim and send it into us as one of the ten that is required to avoid the payment adjustment. But it's an important point I wanted to just bring that.

Back to our comment thing that we're looking for. We're looking for any additional ePrescribing hardships circumstances that you think we should consider. Any changes to 2011 eRx measure, you think that we should also take under advisement. Some of the advantages and disadvantages of switching to Part D data for the incentive/payment adjustment.

The MIPPA legislation allows us to look at Part D claims, which are basically the pharmacy claims to look at which folks or which prescriptions, I should say, were electronically prescribed, so we could look at that data as well. And if we were to do that, what would be the appropriate number of Part D

prescriptions that we should look for, for incentive payment or payment adjustment? And Regina's telling me to make sure I mention GPRO is 2,500 ePrescribing events that it needs to occur in the first six months of 2011. Again, that's GPRO I. GPRO II, the number's going to vary. Anything else? Okay. Just thought I'd embarrass her. Michelle was chiming in too because Michelle's like not speaking today, so. By the way, she's the PQRS lead, Michelle. So if you have any real complaints, raise your hand, Michelle. Sorry about that.

Dr. Daniel Green, MD (continuing): One other thing, looking for comments about the alignment of the ePrescribing Incentive Program with the EHR Incentive Program. So thank you for your attention.

Ms. Barbara Cebuhar: This is the moderator's prerogative. We are going to go ahead and open the floor for comments now. If anyone does have any comments, if you could please come to the microphone and identify your name and organization; that would be very helpful.

Dr. Jim Christina, DPM: Hi, Jim Christina with the American Podiatric Medical Association. Two comments, one with additional ePrescribing hardship circumstances. It might be beneficial to look at the type of practice that certain practitioners have. They may be in settings such as nursing home and providing home care that makes up the majority of their practice, and they may not have the opportunity to do ePrescribing in those settings.

The other comment would be changes to the eRx measure. There's a lot of PPD procedure codes that are related to infections, ulcerations in which it's common to prescribe an antibiotic, and it would make sense to expand the CPT codes in the denominator of the ePrescribing measure to include those particular CPT codes since the purpose of the ePrescribing measure is to encourage ePrescribing. The opportunity where prescriptions are commonly written for certain procedures would make sense to include them in the measure.

Dr. Daniel Green, MD: Thank you. I just want to follow up to your first point real quick. You know, it's an interesting point you bring up in terms of the home health visits and nursing home codes because when the measure first came out and for 2009, those codes weren't actually in the measure, and we were inundated, if you will, from the home health physicians. There's an organization of, I think, it's about 4,000 folks that, their practice is composed or comprised, rather, of home visits and

nursing home care. And they were very vocal and adamant about us having those codes, but thank you for the comment.

Ms. Barbara Cebuhar: Thank you. Our next commenter here in Baltimore, please.

Ms. Mary Patton-Wheatley: Mary Patton-Wheatley. It's the Association of American Medical Colleges. Thanks for opening up ePrescribing. I know it is a tough subject and we certainly have been talking to a lot of our members about it, and we've discovered a few things as we've gone, as they've gone through and figured out who would have the penalty applied to them. The first thing that we discovered is that there are a handful of physicians for whom the ePrescribing is completely decoupled from the encounter visit. And we are struggling what to do with that.

Dr. Daniel Green, MD: I'm sorry. Completely what?

Ms. Mary Patton-Wheatley: So for ePrescribing is occurring outside the encounter visit. So you cannot report on the encounter. When you're doing that for the incentive program that's one thing, but when you're having a penalty applied to you, it's something else. We hear that for a limited number of physicians, even reaching the ten because it has to be coupled with that encounter code is an issue, and we could try and get back to you with more specifics on that.

The other thing that we have noticed, and you did provide clarification on this is that occasionally residents are the ones actually submitting the ePrescribe, or doing the ePrescribing. So it's the resident NPI that occurs on the claim. So in general, we are, would be, you know, in forward of looking into using Part D data, but with the caveat that we want to make sure that attendings are not being penalized because their residents are submitting the prescription.

Dr. Daniel Green, MD: Okay. I'm sorry, just if I could clarify one point with you.

Ms. Mary Patton-Wheatley: Okay.

Dr. Daniel Green, MD: So you're saying that, if I understood before the issue, if the resident is doing the ePrescribing, the actual bill, however, for the service for the patients coming in with the attending's NPI.

Ms. Mary Patton-Wheatley: That's correct.

Dr. Daniel Green, MD: So they appended appropriately because they were responsible for.

Ms. Mary Patton-Wheatley: Right, they're supervising the visit.

Dr. Daniel Green, MD: Correct.

Ms. Mary Patton-Wheatley: They're supervising the visit. So right now, we've gotten that clarified.

Dr. Daniel Green, MD: Right.

Ms. Mary Patton-Wheatley: The attending can submit the G-code.

Dr. Daniel Green, MD: But you're absolutely right with Part D.

Ms. Mary Patton-Wheatley: However, if you're looking at the Part D, we would need some kind of mechanism to make sure the attending doesn't get penalized because it's the resident's NPI, so that's just something to look at when we evaluate Part D data.

Dr. Daniel Green, MD: Well, and certainly we would encourage you if you have any suggestions about how that might be accomplished.

Ms. Mary Patton-Wheatley: Yeah. We have not looked at Part D data, but we'd be happy to work with you. And then, so I think that takes care of it for now. Thank you.

Ms. Barbara Cebuhar: Thank you.

Dr. Daniel Green, MD: Thank you.

Ms. Barbara Cebuhar: Our next comment please. Your name and organization.

Dr. Catherine A. Dimou: Sure. Cathy Dimou from Rush Health. I had a question about, I wanted to clarify the eRx and the EHR submission. If you successfully submit eRx and the EHR, how would the incentive payment work?

Dr. Daniel Green, MD: Well, you know, being that there's a budget deficit right now, the country—

Dr. Catherine A. Dimou: I know you're not going to get both.

Dr. Daniel Green, MD: —will pay you the cheapest one. I'm kidding.

Dr. Catherine A. Dimou: That's what I was wondering.

Dr. Daniel Green, MD: No, I'm teasing. Come on, guys. It's after lunch. It's supposed to be, you know, you're almost done. You've got to be a little...

Dr. Catherine A. Dimou: I laughed.

Dr. Daniel Green, MD: Thank you. No, what we would do in that circumstance is, you know, the EHR for the overwhelming majority of providers, the EHR incentive will definitely be bigger than the ePrescribing incentive because ePrescribing for 2011 is only 1 percent. Someone, an individual would have to have over \$1.8 million dollars in just Medicare covered Part B services that are covered to exceed the \$18,000 that's available in the EHR Meaningful Use incentive.

So again, you can imagine it's going to be few and far between, if anybody, that would qualify for that. However, the EHR Meaningful Use program is a three month reporting period in year one. So an eligible professional, even if they were doing the last three months of 2011, they have until the end of February to send in their attestation. And it's my understanding that the Meaningful Use folks will be trying to get that incentive out, I think, within a roughly—and don't quote me on this—but roughly about six weeks; somewhere in the six to eight week timeframe.

So that incentive payment would be paid, typically, before we would have our payments ready for the ePrescribing. You know, and then the Meaningful Use folks would notify us, you know, "Dr. Jones got Meaningful Use," so we wouldn't doubly pay them.

Dr. Catherine A. Dimou, MD: Okay. And then—, so would the—, would there still be a 1 percent not deduction—, would you still get 99 percent or would you get 100 percent of your payment?

Dr. Daniel Green, MD: So if you do the Meaningful Use, again, it's independent. All we talk about with Meaningful Use is you can't get both payments unless your provider is a Medicaid provider. You can get the Medicaid Meaningful Use incentive and the Medicare ePrescribing incentive. You can't get the Medicare-Medicare, you know, Medicare you're prescribing Medicare Meaningful Use. But, sorry. It's not supposed to be question and answer. I'm getting dirty looks over here, but I'll answer it anyway. So you, if you don't do the ten prescriptions in the first six months for the eRx program that we just talked about, yes you would get the payment adjustment in 2012.

Dr. Catherine A. Dimou, MD: Okay, but you would get the 100 percent if you submitted the ten and then did the EHR?

Dr. Daniel Green, MD: If you do the ten, right.

Dr. Catherine A. Dimou, MD: Okay.

Dr. Daniel Green, MD: And just for one more like little trick here. If I were advising folks, so off the record, which is on the record because we're in front of like however many people. I would encourage my eligible professionals—they don't have to do this—but I would encourage them to not only do the ten, but really it's not that hard to do 25 ePrescribing events in the course of a year. If they do the 25, you could say, "Well, they're not going to get the incentive anyway." You're right. If they're doing the Meaningful Use, they're not going to be both incentives. But what they do by doing that is they get them out, themselves out of having to report to avoid the 2013 penalty or payment adjustment. So if they're going to do 10, if they do 15 more during the course of the year, they're good for 2013 as well.

Dr. Catherine A. Dimou: Thank you.

Dr. Daniel Green, MD: Thanks.

Ms. Barbara Cebuhar: Thank you. We have one more comment.

Dr. Daniel Green, MD: That was off the record. Uh-oh. She's going after the AMA press.

Ms. Tanya Alteras: Hi.

Ms. Barbara Cebuhar: Go ahead.

Ms. Tanya Alteras: Tanya Alteras, National Partnership for Women and Families, and Consumer Purchaser Disclosure Project. And my comment, if you implement it will mean everything that you just said won't be necessary.

What we would like to see is complete alignment between the Meaningful Use requirement and the incentive program and that the incentive program requires eligible professionals to electronically transmit at least 40 percent of appropriate prescriptions electronically. And that's something that we put in our physician fee schedule comments, the written comments over the last few years. So appreciate the chance to give them today as well.

Dr. Daniel Green, MD: Thank you.

Ms. Barbara Cebuhar: Thank you. We have another comment here in Baltimore.

Ms. Jennifer Shevchek: Jennifer Shevchek, AMA staff. Just to piggyback some of the comments that have already been made, but on the Part D data, the AMA did provide an extensive comment letter to the Secretary of HHS in December. We are waiting a response to that letter. And we had a plethora of medical state associations and specialties that signed on to that in support of basically having CMS not move forward and applying the penalty based on 2011 data, and we continue to stand firmly by that. I think it's something that really took us by surprise and we continue to oppose it.

But with regard to and something we've spoken with OCSQ about is, you know, I think there is a lot of flexibility provided. You have a lot of authority; "you" being the Secretary of HHS and CMS. Even with the Part D data and this is something we've floated and even, I think, provided in our comment letter is applying even later on using the Medicare Part D data later on to basically said that might not even

apply the penalty at all. I mean, that's something we've been exploring with all of you in terms of maybe applying that later on so there are no penalties applied to those physicians, especially if it's proven by looking at the Part D data that they really were clinical successful ePrescribers. So that's one thing.

Ms. Jennifer Shevchek (continued): Another comment I want to make is this alignment with the EHR incentive program. And I know, I know that there are two different statutes that one, obviously provided the eRx penalty MIPPA, and now we have the [PH] aura statute which provided for the Meaningful Use program. It really behooves the agency to work closely with your ONC colleagues on this. And I know there's a lot of back and forth but you do have this entire ONC health IT cabal going on with the Health IT Policy Committee and discussions going on there.

And then there's this ePrescribing program within CMS, and I just think it's really frustrating. And we continue to work hard with the health IT policy committee and staff here at CMS, but there needs to be better coordination amongst staff within CMS, but also with ONC so that we can see more alignment, especially because there are discussions going on right now.

There's an RFI out right now for Stage 2 Meaningful Use, and if we can help facilitate some more of that discussion to get to Stage 2 Meaningful Use to at least recognize what's going on here, it would be a great help to physicians. Because this, believe it or not, we hear more negative comments about the ePrescribing penalty right now than we do about PQRI. I mean, we are flooded with calls about this. So we look forward to working with you to help rectify this moving forward.

Dr. Daniel Green, MD: Thank you. Just so you do know, we do work. We have meetings regularly with ONC and we are working closely with them on see despite the fact that there seems to be a difference in the programs.

Ms. Jennifer Shevchek: Well, that makes me happy. I'll let my colleagues know.

Dr. Daniel Green, MD: Thank you.

Ms. Barbara Cebuhar: Thank you. We have one more comment here in Baltimore. Two more.

Dr. Karen Miller, MD: Excuse me. Karen Miller from Daycare Clinic. As far as the ePrescribing penalty goes, our group did participate in 2009 going for the ePrescribing bonus. We anticipated that we would be very successful. We had a large variety of physicians that clearly saw over 10 percent of eligible patients and we're surprised in that evaluation. Not surprised about the volume of surgeons who could not meet the measure because they were making their prescriptions during the global visit, which did not have a claim go through.

And so, we will have many physicians affected by the penalty who are ePrescribing, prescribing narcotics primarily because they're surgeons. Or when they're, when the patient's at the point where they're moving to non-narcotic drugs, it's at—, over a phone call or in a visit that's happening during the global period. And I think what will be interesting as the penalty applies is for those physicians who did not participate in trying to get the ePrescribing bonus in the past, I think there are many that are going to be surprised that they actually, you know, the number 10 seems very reasonable. The number 25 seems reasonable. But I think it'll be surprising how many of those prescriptions get written over the phone or during global period visits.

Dr. Daniel Green, MD: Thank you.

Ms. Barbara Cebuhar: Thank you. We have another comment here in Baltimore.

Ms. Sharon Grutman: Hi, Sharon Grutman with the American Society of Breast Surgeons, and more of a question. You're soliciting input on possible changes to the 2011 eRx measure and if potential changes in the denominator were submitted, and those changes were subsequently accepted, what would be the timeline for that? And how would that affect the six month reporting period that would affect payment adjustments in 2012?

Dr. Daniel Green, MD: So the 2011 eRx measure, if you will, is locked down because we're in 2011.

Ms. Sharon Grutman: Okay.

Dr. Daniel Green, MD: Any suggestions, these have been, the purpose of the town hall is really looking forward for PQRS and ePrescribing for 2012 and beyond.

Ms. Sharon Grutman: So we can make suggestions for changes to the denominator for 2012 then?

Dr. Daniel Green, MD: You—

Ms. Sharon Grutman: Okay.

Dr. Daniel Green, MD: —certainly can feel free—

Ms. Sharon Grutman: Thank you.

Dr. Daniel Green, MD: —to do that. Yeah. Thank you.

Ms. Barbara Cebuhar: Thank you very much, folks in Baltimore. I think we have one more comment.

Dr. Mark Froimson, MD: Yeah, I'll be brief. Mark Froimson from orthopedic surgeons. Just to piggyback on an earlier comment. I think it would be appropriate to look at that requirement for an office visit or a billable visit in association with the ePrescribing because I can tell you from personal experience and from our group's experience that one of the unintended consequences of that may be that it would require patients to come in for an unnecessary visit in order for physicians to meet that requirement.

And so if physicians are incentivized to try to meet that requirement, and the only way that they can do it is to have a patient come in, you'd have to be wary of unintended consequences. So I think there's a clear, if you're looking for patient benefit, and if the intent is to get physicians to ePrescribe, there's really a clear indication to separate those two requirements so that you don't burden patients with unnecessary components of this rule. Thank you.

Dr. Daniel Green, MD: Thank you.

Ms. Barbara Cebuhar: Thank you. Operator, we are ready for calls or comments from the phone lines. Thank you.

Operator. To make a comment over the phone, please press zero-one. Our first comment comes from Heidi Harding.

Ms. Heidi Harding: Yes, my name is Heidi Harding from Summit Medical Group in New Jersey. And it's been raised several times now basically that to decouple the prescription or the prescribing, ePrescribing from the—, when it—, when it is done. We have many surgeons and podiatrists, for example, that do a procedure and it is only after the procedure that they write the ePrescription. If they can, some of them, as has been mentioned are controlled substances and they cannot do that within the State of New Jersey.

So if there's a G-code maybe that can account for that, I don't know if you want to call that a hardship code or whatever, but to be able to record that what they are ePrescribing. But it is not in that initial visit prior to the procedure or surgery.

Ms. Barbara Cebuhar: Thank you for your comment. Next, please.

Operator: Our next comment comes from [PH] Sarah Currier.

Ms. Sarah Currier: Hi, this is Sarah Currier from the Marshfield Clinic in Wisconsin. We currently have eligible professionals who are submitting under the Medicare eRx incentive program. We do understand that eligible professionals can choose to submit under the Medicaid EHR incentive program simultaneously with this, but we do have some concerns about the alignment of the two programs.

Currently, right now, we're reading that there will be a reduction in Medicare payments for the providers if they do not prove that they are successfully submitting those payments. So currently, right now, we are able to submit those, but for Meaningful Use, it's stating that we cannot submit the Medicare payment.

So it seems like they're not aligning right now. So the eRx, they want us to submit the Medicare and we'll penalize if we do not do that, but then if we're simultaneously working through Meaningful Use, they do not want the submission of the Medicare. So we're just concerned that those two programs don't seem to align.

Dr. Daniel Green, MD: Yeah, appreciate the comment. I think there's a little bit of a misunderstanding, perhaps. You're correct in that you cannot get an incentive under the 2011 Meaningful Use Medicare Meaningful Use and the 2011 Medicare ePrescribing programs. You can't get a bonus, if you will, for both programs.

But there's nothing that prohibits someone who's doing the Meaningful Use, the 2011 Medicare Meaningful Use program from also reporting on a claim the G-code that they electronically prescribed for a particular patient. And if they do that 10 times in the first six months, they'll avoid the payment adjustment starting January 1, 2012. If they do it 25 times, while they will not earn both incentives, they won't earn the extra 1 percent from the eRx program, they will avoid the payment adjustment in 2013 as well.

Ms. Barbara Cebuhar: Operator are there—

Ms. Sarah Currier: Thank you.

Ms. Barbara Cebuhar: —any calls?

Dr. Daniel Green, MD: Sorry.

Ms. Barbara Cebuhar: I'm sorry. Did you have another comment, Heidi or Sarah?

Operator: Sarah, if you'd like to make another comment, please press zero-one at this time.

Ms. Sarah Currier: ...meaning that the EP can choose to participate in the Medicare EHR incentive program and they can choose to participate in the Medicare eRx incentive program simultaneously.

Dr. Daniel Green, MD: I'm sorry. I missed half your comment. So again, they can do Medicaid EHR Meaningful Use and earn an incentive, and Medicare eRx incentive and also earn an incentive. So they can do Medicaid Meaningful Use, Medicare eRx, and earn incentives in both of those programs. They can do Medicare EHR Meaningful Use, earn an incentive there, but still be subject to the

payment adjustment. So they should report at least 10 electronic prescribing events in the first six months for visits that are in the denominator of the Measure to avoid the 2012 payment adjustment.

Ms. Sarah Currier: Okay. So we were just concerned about that there seems to be a misalignment with the reduction of the Medicare payment. You're saying that you are aware that they don't align, but there is a way to work around it?

Dr. Daniel Green, MD: I'm sorry. There's no misalignment, if you will. There's—, all there is if a person is doing Meaningful Use, it does not protect them or get them out of being subject to the payment adjustment. They must do, report 10 ePrescribing events in the first six months to avoid the payment adjustment.

Ms. Sarah Currier: Okay. Thank you.

Dr. Daniel Green, MD: Thank you.

Ms. Barbara Cebuhar: Operator, our next call, please.

Operator: There's one more caller in queue. Carmella Nachreiner, please go ahead.

Ms. Carmella Nachreiner: Hello. This is Carmella Nachreiner from the UPMC in Pittsburgh, Physician Services division. I just had a comment about the denominator for the amount of patients. While our physicians are very good ePrescribers, our issue here and what needs to be considered, I believe, is that a lot of our patients, the majority of our patients in Medicare are in the managed Medicare programs product.

So we don't have a lot of straight Medicare patients. I mean, I know we're Pennsylvania. We have a lot of Medicare-age patients, but they're mostly in the managed care product. And I know that it's difficult for CMS to combine these programs, but this is why our denominators are low. And we don't have a lot of, for the whole year, we don't have a lot of straight Medicare that we're prescribing to.

Dr. Daniel Green, MD: Thank you. I thought you were going to comment about my Green Bay Packer remark earlier today.

Ms. Carmella Nachreiner: No, no, no. I'm leaving that alone.

Dr. Daniel Green, MD: I got it at lunchtime. But in any case, just as a reminder, if your eligible professionals do not have—, each eligible professional, unless you're reporting as a GPRO, but let's say they're doing it individually. If they don't have at least a hundred visits that fall into the denominator of the Measure in the first six months.

Now, when I say "a hundred visits," I'm not talking about Medicare Advantage patients and Medicare Part B patients. I'm talking about only Medicare Part B patients. If they don't have at least a hundred visits in that first six months, then they're not subject to the payment adjustment anyway.

Ms. Carmella Nachreiner: Okay. That makes it more clear. Thanks.

Dr. Daniel Green, MD: Thank you.

Ms. Barbara Cebuhar: Operator, do we have any other comments?

Operator: There are no comments in queue.

Ms. Barbara Cebuhar: Thank you very much. Once again, we are going to do a little bit of an adjustment on the schedule. Auchu.

Dr. Daniel Green, MD: Easy for you to say.

Ms. Barbara Cebuhar: Auchu Prachanronarong is not available right now to do the "Physician Quality Reporting Systems Beyond 2102," but we are going to have Dr. Dan Green do that portion of the program. Charles, if you could turn on the Slides again, I'd appreciate it.

Dr. Daniel Green, MD: Just in case you guys weren't sick of hearing from me already, they let me do the last one.

Ms. Barbara Cebuhar: Slide 63.

Dr. Daniel Green, MD: 64, we can actually start.

Ms. Barbara Cebuhar: Okay. Slide 64.

Dr. Daniel Green, MD: Okay. So this is looking at beyond 2012 just to give you guys some heads up and I have to tell you, this is the first time I'm reading these Slides, so bear with me. Sorry. The Physician Quality Reporting System incentives, the incentives run through 2014. This includes the incentive for participation in Physician Quality Reporting System, as well as the additional 0.5 percent potential incentive for the Maintenance of Certification Program.

We're participating in that program more often than is required. Starting in 2015, per the legislation, a payment adjustment will apply under the PQRS. So if eligible professionals do not satisfactorily submit data on quality measures for covered services the reporting period for the year, the fee schedule amount services furnished for such professionals during the year shall be equal to the applicable percent of the fee schedule amount. But the long and short of it is in 2015, there's a 1.5 percent payment reduction fee; a less fancy way of saying it. And in 2016 and beyond, there's a 2 percent payment reduction for those folks that are not successfully participating in PQRS. We talked earlier about PQRS and the Meaningful Use/EHR reporting programs.

And as I mentioned, the Healthcare Reform calls for us to have a program in place by January 1, 2012, to integrate or align the two programs. And again, that doesn't necessarily mean the two programs will be aligned January 1, 2012 but we have to have a plan in place as to how we are going to bring that alignment together. Integration of the two programs will consist of selecting measures, harmonizing the measures. The measures, of course, will have to demonstrate Meaningful Use of an EHR for the incentive program, and the quality of care furnished to an individual or such other activities as are specified by the Secretary.

Slide 66, the Healthcare Reform, or as we call it, the Affordable Care Act does include a number of provisions related to physicians and other eligible professionals that could impact PQRS and the ePrescribing Incentive Program. These include the Physician Compare Web site. There's a program that's currently being developed about a value-based payment modifier.

Dr. Daniel Green, MD (continued): The Physician Feedback Program that Christine talked about a little bit earlier. Some of the feedback has to do with resource use as well. So how the eligible professionals are expending resources to achieve desired results and take care of patients with certain conditions. So these are all programs that are called for under the Affordable Care Act, and that we're working on, and we're looking to try to make it, make these programs, or harmonize these programs, and make them align as much as we can.

The release of the Physician Compare Web site occurred on December 30th. It contains information on eligible professionals who are enrolled in Medicare and whether the eligible professional satisfactorily reported the 2009 PQRS for the program. There's no performance information on the Physician Compare Web site, it's just that they satisfactorily participated, aka, they reported above the required threshold. By January 2013, we are required to implement a plan for posting performance information on the Compare Web site for reporting periods beginning no earlier than January 1, 2012. So that would be the earliest we would use the data for performance reporting. To the extent possible, we will use performance information for PQRS measures and other types of measures.

Looking on Slide 68, the value-based modifier payment, ah, value-based payment modifier, excuse me, is a differential payment under the fee schedule to a physician or groups of physicians based on the relative quality of the physician care. It'll be phased-in starting in January 2015. And CMS may also include information on the quality of care furnished to Medicare beneficiaries by the physician, or the group on the confidential reports that are provided under the Physician Feedback Program. Looking on Slide 69, again, the additional incentives, just to recap. Molly talked to y'all about the Maintenance of Certification Program. Christine mentioned about the establishment of the informal appeals process.

We discussed that the incentive payments per the legislation are due to continue through 2014, and the payment adjustment starting in 2015 for folks that don't satisfactorily report in PQRS. As I mentioned earlier, we are developing that plan to integrate the RO high tech or Meaningful Use EHR program with the PQRS. As you know, the Affordable Care Act does require us to give timely feedback to participants for value-based modifier, but also timely feedback in general for physician quality reporting initiative.

Dr. Daniel Green, MD (continued): The establishment of a Physician Compare Web site, also was a provision in the Affordable Care Act. And then looking on Slide 70, we look for input from you guys in terms of reporting periods that we should consider to prospectively determining the 2015 payment adjustments. So basically what we're trying to say here is you know we're using the first six months of 2011 because it's a prospective payment adjustment. Meaning, starting January 1, 2012 if you're not a satisfactory ePrescriber for the first six months of 2011, we are applying the payment adjustment.

So we're looking for comments from you guys in terms of what year should we start looking at for the payment adjustment which will take place in 2015? You know, what are your suggestions as far as that goes? What criteria should we consider when we determine the 2015 payment adjustment for PQRS? How should performance information from PQRS be reported by participating eligible professionals on the Physician Compare Web site?

So suggestions in terms of how we might list that information. And, what steps can we take to better align the various CMS initiatives? So we're going to break, I think, now for public comment. But before we do, since some of you folks maybe leaving early if you don't have comments, what have you, and those on the phone may have to go. I just want to, again, express CMS' thanks for your time today and for the valuable input that you all have made with your insightful comments.

And despite what you may think, we are trying to make this program better, more meaningful to the eligible professionals, and trying to get better information on the care that's provided to our beneficiaries. So thank you all and we'll look forward to the public comments.

Ms. Barbara Cebuhar: Now is the opportunity for more public comment. For those of you in the audience here today, please come to the mikes and tell us your name and affiliation. If we could ask our colleagues on the phone to wait, we'll recognize you after the folks get finished in the room. Thank you. Yes, sir.

Dr. Jim Christina, DPM: Jim Christina and the American Podiatric Medical Association. This is really more a point of clarification than a comment. The payment reductions related to Meaningful Use will be independent of the payment reductions related to PQRS, so that a provider could face

payment, two payment adjustments starting in 2016, I guess, if you included Meaningful Use and PQRS? Is that correct?

Dr. Daniel Green, MD: Jim, I have to tell you honestly, I don't know. So I'm sorry. The Meaningful Use folks may be able to provide you additional information about that, and I'm sorry. I would tell you if I knew. I just don't know.

Dr. Jim Christina, DPM: Okay. Thanks.

Dr. Daniel Green, MD: Anybody know if they're additive? Sorry, but feel free to email us with the question. We'll get an answer for you.

Ms. Tanya Alteras: Tanya Alteras, National Partnership for Women and Families, and the Consumer Purchaser Disclosure Project. I just want to thank you, again, for having this forum today and we really appreciate the opportunity. We will be submitting written comments on a variety of issues and specifically on some of the points that you just made about alignment with the Affordable Care Act, and ways to improve a Physician Compare.

One specific suggestion that I'll just give today and we'll put in more detail in our written comments is we'd like to see CMS provide more information on how it can make the PQRS data available to the private sector. And one suggestion we have is to use an application programming interface, and look at the HHS Community Health Data initiative as a model for how the data can be selected and then reused in the community, making it easily accessible to community health data from the government, the private sector, and then encouraging innovation to build applications for how to use that data. So putting it, using mapping techniques, using it in dashboards, putting it in search engine tools.

We think that there's great potential for the PQRS data, and we really would like to see CMS tap into that, and come up with some innovative ideas. And we would be happy to contribute ideas as well for how to really make this data useful for consumers and purchasers beyond the way it's being used right now. Thank you.

Ms. Barbara Cebuhar: Thank you, Tanya.

Dr. Daniel Green, MD: Thanks. Can you hang on just one second? I just want to see if Aucha knows the answer to Jim's question. Sorry. Thank you.

Dr. Mark Froimson, MD: Mark Froimson, AAHKS. Just one comment on the potential future use of the physician compare, the Physician Compare Web site. One of the concerns that our members have is with the methodology that CMS is going to apply to risk adjustment, and how the CMS is going to take into account the various risk profiles, both combined medical risk to the patient as well as the disease-specific risk in terms of complexity of cases that can be reflected in the Physician Compare Web site.

The motivation for this concern is that we are profoundly worried that as the Physician Compare Web site becomes more available, and that data is available on physicians, that there is an unintended consequence of physicians shying away from those patients who are at highest risk, who may end up with outcomes that may not be as—, that may be worse than expected.

So in order to mitigate against this concern, we would like to offer our suggestions at a later date, and be happy to work with CMS along with other specialty organizations to insure that the data on the Physician Compare Web site is appropriately risk adjusted. Thank you.

Ms. Barbara Cebuhar: Thank you. Any other comments here in Baltimore? Operator, we would appreciate any phone messages or comments from the—, the phone lines. Thank you.

Operator: Please press zero-one at this time if you'd like to make a comment over the phone. We have a comment from Patrick Torcson. Go ahead, please.

Dr. Patrick Torcson, MD: Yes, Patrick Torcson, the Society of Hospital Medicine. Again, thanks for the invitation, the opportunity to give comment this afternoon and just a few final thoughts here. First of all, wanted to express that our disappointment that the PQRS will be turning into strictly a negative incentive program beginning in 2015.

We had offered comment all along thinking that as a pay for reporting program, it becomes strictly a negative incentive for failure to report was not really in the true spirit of performance improvement. But I understand that it's now statute and so, we're going to be stuck with it. But in terms of the

Physician Compare Web site, the Society of Hospital Medicine would advocate that, at least for now, that individual physician level reporting even as to whether or not participation in PQRS was successful not be posted as long as this is a pay-for-reporting program, and not a true pay-for-performance program.

Dr. Patrick Torcson, MD (continued): We think that data about successful or unsuccessful participation could be misleading to consumers and patients about whether a physician just has the infrastructure to report, and is not a real reflection of a quality provider.

I also appreciate Dr. Green's comments on efforts and attempts by the folks at CMS to integrate and harmonize this number of programs that is now growing every day including the ePrescribing, the PQRS, the Physician Feedback Report, the Physician Compare Web site, and the development of the Physician Value-Based Modifier.

We think that, and we predict that all of this is leading toward a physician value-based purchasing program and we just hope that you all would continue to keep the physician community and professional organizations in the loop, and be transparent as this process develops over the next several years so we can offer input. So thanks again for the opportunity to comment this afternoon.

Dr. Daniel Green, MD Thank you for your good comments and for attending today's call.

Ms. Barbara Cebuhar: Operator, our next call, please.

Operator: We currently have no other callers in queue. As a reminder, please press zero-one. And we just had a comment come in. It comes from [PH] Mark Gould. Go ahead, sir.

Mr. Mark Gould: Hello, this is Mark Gould. I'm calling—, we're calling from EPIC. We just have a few comments based on the—, this last slide.

Looking forward to 2015, both adjustment period and looking at how to better align the various initiatives. As far as 2015, just coming from—, having to support all our customers, one of the big issues that we have with the ePrescribing for the—, avoiding the 2013 penalty is that they have to do an extra reporting period.

Mr. Mark Gould (continuing): So assuming that we use normal physician quality reporting data for the—, avoiding the 2015 penalty, the best solution as far as IN, RN, and for the amount of time that our—, the customers would need to go in and support the initiative would be to use the 2013 reporting period. So that way they can both get from the 2013 reporting data, they can both get the incentive for 2013 and avoid the 2015 penalty.

And this way they do not have to do an extra reporting period and just have the time and labor needed to go into reporting that data with a special reporting period just to avoid the 2015 data. And then the second point of—, for looking at how to align the CMS initiatives, as our colleagues over at UPMC alluded to earlier, since the letter specifications for the quality measures are so different between physician quality reporting and Meaningful Use.

It is necessary to have two different sets of data, two separate sets of logic to support both Meaningful Use and physician quality reporting. Probably one of the key ways to bring the programs in line is to use both the same specifications, quality data sets, and some of the results of using the same logic.

And therefore as a vendor, we'd only have to support one set of measures for both. Granted, the subset of measures may be different, but they are the same measures, we'd only have to support one. And our customers would only have to setup and clinically verify one set of measures. So that would take a lot of time away from having to do that, build and verify measures and get more time to looking at, to improving clinical quality in their normal course of work.

The second thing is most likely we'd probably want to stay way from objective measures. However, it would be nice if the ePrescribing, since it is a core measure and if you're a Meaningful User, you have to do ePrescribing that that would count for the Meaningful—, for the ePrescribing measure and avoid the penalty in future years.

Ms. Barbara Cebuhar: Thank you, Mark. Operator, do we have any other calls?

Operator: There are no more callers in queue.

Ms. Barbara Cebuhar: Thank you very much. We are very grateful for your insights today. These comments and those of you of those on the phone will be infinitely helpful to us as we construct a Physician Quality Reporting System that will work best for all parties. I'd like to recognize Aucha Prachanronarong who will provide some closing comments.

But just a reminder that you can download the recording of today's sessions and the transcript by going to www.cms.hhs.gov/pqri. And on the "Sponsored Call" page, there will be a transcript starting February the 15th. So as CMS is committed to continuous quality improvement, we welcome any feedback or suggestions from consumers or eligible professionals to improve the Physician Quality Reporting System. The public comment period will last through 5:00 PM eastern time on Friday, February the 25th.

Please write us at measures@wv-as in victory-mi.org. That's measures@wvmi.org. Please give us your telephone number as you may be contacted regarding your comments. Thank you, again, for the opportunity to work with you. This has been a distinct pleasure. All of us at CMS appreciate your expertise and insight. This has been very helpful to us in our thinking. Aucha.

Ms. Aucha Prachanronarong: Thanks, Barb. I just want to echo Barb's appreciation for everybody taking the time out to participate in this town hall meeting today. Your insightful comments and suggestions will definitely be considered as we develop the policies for the 2012 Physician Quality Reporting System and ePrescribing incentive program years.

And I guess what will happen next is we'll take all the comments that we receive today as well as any written comments that we receive into consideration. And then we'll put together the proposed rule. Typically, we propose the Physician Quality Reporting System and the ePrescribing incentive program as part of the physician fee schedule rule. And that rule is typically published around late June, early July of every year, and that's followed by a 60 day comment period.

And then we publish the final Physician Fee Schedule rule typically around late October, early November, and release the measure specifications for the upcoming year shortly thereafter. So again, thank you very much for you input and suggestions. We value the comments that you guys provide, and hope that we are able to make the program better for everybody. Thank you.

Ms. Barbara Cebuhar: Thank you again, for your time. We are ending a little bit early, so I do appreciate everybody's patience with us. Thank you.