

QRUR Feedback Teleconference Transcript

WPS Medicare

Moderator: Sue Brewer

February 4, 2013

10:00 a.m. ET

9:00 a.m. CT

Operator: Good morning, my name is (Nan) and I will be your conference operator today. At this time, I would like to welcome everyone to the QRUR Feedback Conference Call.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Ms. Sue Brewer, you may begin your conference.

Sue Brewer: Thank you, (Nan). Hello everyone and good morning. My name is Sue Brewer, I'm an analyst in the Provider Outreach and Education Department of WPS, Wisconsin Physicians Service, the Medicare contractor. I wanted to welcome everyone to today's QRUR Feedback call.

WPS is pleased to host this call along with CMS and contractor staff pertaining to the feedback report. The teleconference is intended to provide our Medicare Part B providers and their billing staff who have access to 2011 QRUR report an opportunity to ask questions and provide feedback to CMS QRUR reports.

During the call today, there will be a presentation, that information and materials are available on www.qrurinfo.com website and they're also available on the CMS website as well. There's a slide deck presentation that they will be going over today.

So hopefully, you've had a chance to pull those documents and you can follow along with the presentation today.

At this time, I'll like to turn the call over to (Tonya Smith) from CMS and she'll introduce our speakers for today. Tonya

(Tonya Smith): Thanks so much, Sue. This is Tonya Smith from CMS and I'll like to welcome everyone to our QRUR Feedback teleconference. I think here in Baltimore, we are all a little excited since our Ravens won, yeah Ravens.

But to start the call, we have from our team, Mr. Michael Wroblewski, who will be going over the slide presentation and after the presentation, we will engage in a question and answer session. Michael

(Michael Wroblewski): Thanks, Tonya, and good morning everybody. The slide deck I'm going to use is entitled Physicians Feedback Program 2011, Physician Quality Resource and Use Reports, QRURs and it was dated December 2012.

I really want to hit three points today and it will take about 15 minutes to go through the slides. I wanted to give you some background about the QRUR program, then to go over the value-based payment modifier and then the reports, the QRUR reports themselves that many physicians have picked up, point out some of the – what you should be looking at and how it relates to the value-based payment modifier moving forward.

So I'm now on slide three of the slide deck and it's, what is the physician feedback program?

CMS's physician feedback program provides comparative information about the quality and cost of care delivered to Medicare fee for service patients and we do this through the QRURs that many people have picked up already.

As of right now, we have, and I just looked at the statistics in terms of how many reports have been picked up. We prepared, CMS prepared QRURs for physicians who are practicing in groups of 25 or more in nine states. And the four states that are subjects of this call, in Iowa, about 42 percent of the reports have been picked up. In Kansas, about 40 percent have been picked up; Missouri, 26 percent; and in Nebraska, 17 percent have been picked up. So we've made some progress, we still have a ways to go in terms of picking up – having physicians pick up their reports and to view them.

I'm sliding – moving on to, actually, slide six of the slide deck and this is probably the most important slide from my perspective in terms of – OK, so many physicians and practice managers are thinking, OK, so I picked up my QRUR, what am I supposed to do with it?

So these five bullets on slide six really provide what I think what you can do with the QRURs that we've prepared. First, it provides comparative quality and cost information for quality improvement purposes. In each, and I will go through this when we get to the actual report itself, but it shows not only the physicians performance rate, but also how the physician compares to their peers within their specialty. So we can point out that information. So it provides that comparative information.

Second, we're hoping that the reports introduce groups on how Medicare is phasing in the physician value-based payment modifier. As many of you probably know, the Affordable Care Act requires CMS to phase in the value modifier, starting in 2015 and applying to all physicians by – and physician groups by 20 – January 1st, 2017. And I will go over how we're making that first year of the phase in in just a few moments. But the big thing is that we are phasing in starting with groups and we define a group as a single tax payer identification number.

The third point of the QRURs is it actually previews some of the quality and cost information that will be used in the value modifier so that you can get a rough estimate of where you're standing and I will point that out and how we're doing that in a few slides.

The fourth bullet point on slide six there shows that we are using the same risk adjustment and payment standardization techniques for our cost measures that we've used in the 2011 QRURs, we will be using in the value modifier. Physicians always seem to ask, how have their cost been modified to reflect their patient characteristics and the complexity of their patients?

So the same techniques that we've used in the QRUR in 2011 will be the same techniques that we'll use for the value modifier going forward. And then the last piece, the last really main point of the QRUR is to solicit, is to have physicians look at them, have practice managers look at them and say, you know, this information is interesting but I'd really like to see this.

And so the physicians will provide feedback to CMS on how we can make these reports more actionable in the future. And there's nothing like seeing your own data in the report to say, "Hey, that may not be providing an accurate picture, I'd like to see the report show this." And so we're very open to hearing suggestions on how we can make these feedback reports more actionable and meaningful as we move forward.

OK. So I'm turning now to slide seven and these next three slides really give a quick overview of how CMS is phasing in the value modifier. As I indicated, we have to start applying the value modifier to physicians determined by the Secretary in 2015, with every – all physicians and groups of physicians by 2017.

So what we are – what slide seven shows is how we're phasing it in, we're starting with – in 2015 with groups of a 100 or more eligible professionals. And we're dividing those groups into – and the performance period that we're using to determine the modifier that will be applied in 2015 – calendar year '13. So we are actually already in the performance period for those groups of a 100.

We'll divide those groups of a hundred into two categories, those that if you go down the left hand side of that graph are called PQRS reporters. These are the ones that have signed up for one of the three group reporting options that are available, two groups under the PQRS system. And if they – as long as a group signs up for one of those reporting mechanisms and reports one measure, their value modifier will be zero. Meaning, you don't have to worry about it, there will be no payment adjustment.

If you see under the left hand side of the chart, that it says, quality tiering election, that's optional and the groups of a hundred or more will have the option of to say, "Hey, I'd like CMS to actually look at the performance on the measures that I've reported through PQRS to see – to determine whether I would be eligible for an upward adjustment based on my superior high

performance. No adjustment because I am at the national average or, you know, there will possibly be a downward adjustment for poor performance.”

But that election is optional. So the main take away going down the left hand side is that if a group of a 100 registers for the PQRS as a group and chooses one of the three reporting options, then that, their value modifier would be zero, meaning no payment adjustment and they will – and quality tiering is an option.

If you go down the right hand side of that chart, those are the four of the groups of a 100 or more that fail to register for a PQRS group reporting option. And if that occurs, the value modifier will be minus 1, meaning that they would only get 99 percent of all allowed charges during 2015 for every charge that’s billed under that TIN and 2015. So we’re really encouraging all groups of a 100 to register for one of the three groups reporting options under the PQRS.

In terms of the timing of when you do that, we have two registration periods, one just closed last Thursday. But if you did not sign up during that period, we will be opening it up on July 15th and that will be available all the way through October 15th of 2013, at which point you’ll be able – a groups of hundreds in all groups will be able to choose their group’s reporting method and groups of a hundred will be able to elect quality tiering. So that’s the kind of basic structure, we’re reinforcing the PQRS message, so to speak with participation of the value modifier.

So the next slide which is slide eight is, OK, so if – how would I know whether it makes sense for my group to choose quality tiering? How is CMS actually going to use the quality information that I have reported through the PQRS to come up to determine whether I’m a higher performer, an average performer or a low performer.

Well, what we’re going to do is we’ll look at the measures that have been reported through whatever PQRS reporting option that you have chosen and we’ll categorize those measures into one of six domains and they’re listed there on the chart. Each, we will calculate a score, a standardized score for each measure and then roll those up, equally weight those in the domain so then equally weigh a domain – each of the domains to come up with the quality of composite score.

Some domains such as patient experience or efficiency may not have any measures, so that means the remaining domains pick up the slack and they’ll be equally weighted. So each group will come up with a quality composite score and will come up the cost composite score that we will use five measures of total per capita cost to determine the group’s cost composite score.

For each attributed beneficiary, we’ll calculate what their total per capita was, so we’ll look at what total A and B spending, Medicare Parts A and B spending. We’ll look at it, that for each of the beneficiaries that have been

attributed to the group and then we'll see how far that is away from the national average. So we'll do that for overall total per capita cost as well as total per capita cost for beneficiaries that have been assigned to each TIN that have one of four chronic conditions – COPD, diabetes, heart failure, coronary artery disease.

What we'll do then is for every group, we'll then have a quality composite score and a cost composite score. And if you turn to slide nine, what we will do is we will then create – we'll take the quality composite scores and cost composite scores and divide them into high, medium and low.

So everyone's score will be designated – each quality score, each cost score will be designated high, medium and low and we'll look to see on the grid where you fall. The worst place to be would be in the bottom right hand corner that means that the groups have the most high costs and low quality. That means if the group elects quality tiering, their value modifier will be minus 1, meaning they'd get 99 percent of the allowed charges. If they're high cost, medium quality or average cost, low quality, their modifier's minus 1 – minus a half percent if they choose quality tiering.

You see that there's no adjustments for the (diagonal), so low quality, low cost, medium quality, medium cost, high quality, high cost, no adjustments.

The best place to be on the grade is in the upper left hand corner, that would be low cost, high quality and you'll see its plus 2X with a star. And you may be thinking, what does X mean? Well, this program has to be budget neutral, meaning that the dollars that are taken away from those people who are in the bottom right hand corner as well as those folks who did not register the PQRS as a group, you'll be able to term that amount of money, that penalty pool, so to speak, will then be distributed to the groups' practices that fall into those three boxes in the penalty upper left hand corner of that chart. The groups that are in the low cost, high quality will actually get two times as much as those in the low cost, medium quality and average cost, high quality.

The star is there for, if a group has beneficiaries that are in the top 25 percent of the percent half of risk course, meaning that they're the most complex patients, if they're in the top 25 percent, meaning that they have a very complex patient population and they happen to be in the upper left hand corner, they'll get three times as much, there'll be three X rather than two X.

And what we'll be doing is in the reports that we'll produce next summer, August, September time frame, will show data based on 2012 and will show every group of 25, where they will fall in terms of the cost composite and the quality composite. So you'd find – see where you would fall on that chart and then you can make an informed decision as to whether to elect quality tiering by October 15th 2013. So that's the value modifier.

Slide 10 shows – I'm going to turn onto the QRUR that you all have. Hopefully, you've all gotten them by going to qrurinfo.com, you can get them at the individual level or you can get them at – get them all for everyone

who's in the TIN. And there are instructions on the QRUR info site on how you go about doing that.

Turning to slide 11, it really provides an overview of what you're receiving and I've kind of gone through most of that introductory language that's there on slide 11. Slide 12 shows the performance highlights page and if the physicians only have time, you know, couple of minutes to look at something, I suggest they look at the performance highlights page. It's broken into three sections, the top section shows, OK, how many Medicare fee for service patients did the physician provide at least one service for?

They're listed there, that's in the first section and we also indicate that how many physicians on average also treated those beneficiaries? But we have found out as many fee- for- service – physicians who treat fee for service beneficiaries are shocked to see that the number of other physicians who are providing services to those beneficiaries is so high. On average of near 20 physicians or eligible professionals providing additional services to those beneficiaries.

The second or the middle section of the performance highlights page shows that physician's performance on two sets of quality measures. The first sets are those quality measures that the physician reported through any of the three reporting mechanisms available to individuals under the PQRS.

So if a physician filed a quality data via registries in PQRS, via EHRs or via the claims based submission using the CPT codes or the Q codes, G codes, excuse me, then their performance is listed there. And whether they did above the average, how many they were above the average, how many they were below the average compared to the national average. The second set of quality information, because only about a third of physicians in 2011 participated in the PQRS, the second half of that middle section shows how the beneficiaries that the physician provided service to, did they get recommended services on a variety, I think we have 28 different clinical indicators there. And we summarize whether on average they got more or the beneficiaries that they – the physicians treated, they got all the recommended services or did not and it's broken up that way.

Those are what we call the administrative claims base measures and that is actually one option for groups of physicians to elect for 2013. So physicians who are in the nine states that we are providing QRURs to this year actually have a leg up, because they can actually see how their performance looks on the administrative claims base measures and whether that's really a viable option for them for the 2013 reporting period.

And then the last section of the performance highlights page shows the physician's total per capita cost with a comparison to others in the same specialty. As I indicated before, all the cost that we show in the reports are standardized – payment standardized, meaning, we take out all the geographic adjustment so that everyone's treated on the apples to apples basis.

And then we make a risk adjustment calculation and I think the second bullet underneath – in the last section there, indicates on average, how much we adjusted total per capita cost for that particular physician. So you can see, if there's a negative number there, meaning that we adjusted actual cost down that would be a negative number. That means your – the underlying patients population is more complex than the national average.

If we adjusted the number up, so if there was a positive risk adjustment number there, that means that the patient population was less complex and so we had to bump up the cost, so to speak, to get them to be – to make a fair comparison. And so most physicians are very, very interested in seeing how their patient population compared to others in their specialty in terms of cost. So that those risk adjustments really play a major, major factor there, so that's a very, very key piece of information.

And then the last part of that section shows how that physician cost compared the risk adjusted cost compared to those in the same specialty. So, as I said, this page is a really important page, gives an overview of kind of where you stand from a quality perspective, especially if you participated in the PQRS in 2011. And then shows you where you stand on a cost perspective as well. OK.

So turning to slide 13, this really provides an overview of the report, as you'll see exhibit one and two are the – exhibit one is the PQRS measures more detail or the PQRS measures that the physician submitted. Exhibit two shows what the administrative claims base measures are. And then the remaining exhibits three, four, all the way through 12 show total per capita cost. And we use a different attribution methodology in the QRURs that we're using for the value modifier and I'll point out to where the similarities are when we get there.

So slide 14, this really just shows, kind of a zoom in, so to speak, of exhibit one or which shows the PQRS measures that the physician submitted. You'll see all the measures are listed down in each of the rows, are the physician's performance and the comparison groups are the columns on the right hand side.

If you turn to page 15, that same format and it's used in exhibit two for the administrative claims base quality measures where the rows indicate all the quality measures and the columns indicate the physicians performance compared to the benchmarks which are listed there on the right two columns.

Slide 16, this is where we break down the physicians that were – the beneficiaries that a physician treated into three groups depending upon the degree of involvement that the physician had. Whether they were – whether the physician directed them, whether they influenced them or whether they contributed to them – contributed to their care. Most primary care physicians will generally have directed patients and a series of contributed patients. Meaning that they directed, you know, they provided at least 35 percent of the E/M codes for that beneficiary and then they provided some – you know,

they contributed to someone else's directed patient. Many specialists will have many patients that are in the influence bucket, they didn't provide the over 35 percent of E/Ms but they provided or were responsible for at least 20 percent of the beneficiary's cost.

The next several slides go into a little – 17 and 18, go into a little more detail about how we actually did the attribution. I think I will jump though to slide – there's four more so that's six, slide 20, in which we showed total per capita cost per directed patients. And we do the same charts exhibit by – for influenced beneficiaries as well as contributed beneficiaries.

We put down on the left hand side, total per capita cost and then we give the cost categories that make up total per capita cost whether it's E/Ms, hospitalization, post acute care, et cetera. Then we provide – the column shows the physicians performance then the comparison, and then the last column on the very right hand side shows five cost categories. How much the physician was above or below in that cost category compared to the average of the others in the nine states.

And then slide 21 is a – shows what the graph looks like. We have a, I guess it's a line graph indicating where the physicians performance is, kind of on the distribution of all physicians within that specialty. Exhibit 12, I'm on to the next slide, which is slide 22, shows total per capita cost for patients with the four chronic conditions that I mentioned earlier.

I think most people are interested – the QRUR for 2011, I just kind of went over, slide 23 indicates what our future directions are for moving forward with the QRURs. And as I mentioned earlier, later this year, in September, CMS will be providing a single QRUR to all groups of 25 or more eligible professionals, which will preview all – which will preview the value modifier quality caring elections or groups will be able to determine whether they are high quality or, you know, what their quality score is versus what their cost score is. And they can see where they will fall based on 2012 at least on the three by three quality tiering group that I went over.

And the fall of 2014, we will be providing groups to all TINs, meaning, all groups nationwide, based on 2013 data. We're looking to add patient level data to the physician feedback reports. As you'll see there's no physician – there's no patient level data in the 2011 reports and in future years we will be including episode base cost into the physician feedback reports.

With that, slide 24 is my public service announcement that please have your PECOS information updated, that's very important from CMS perspective where we pull the specialty, that's indicated in every physician's report, we pull it from PECOS, so make sure PECOS information is up to date.

And the remaining slides gives the email addresses for, if you have questions about specific questions, specific calculations or things that are in your QRUR, and then the very second to last slide shows the CMS website, <http://www.cms.gov/PhysicianFeedbackProgram>, where additional

information about value modifier, about the QRURs, how to register for 2013, all that kind of program information is listed on that website.

And with that, I will close; open up to questions.

Operator: As a reminder, if you will like to ask a question at this time, please press star then the number one on your telephone keypad. Once again, to ask a question, please press star one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

Our first question comes from the line of (Paiwa Rothmans).

(Paiwa Rothmans): Hello, your presentation so far has mentioned those groups that have participated as a group and gone through to the self-nomination process, how does this apply, our organization has been participating as individuals. So all of our doctors just ...

(Michael Wroblewski): So the question is – so I'm assuming in 2012, your physicians reported group, reported in the PQRS as individuals. For 2013, if you're a group of 25 or – excuse me, if you're a group of a 100 or more – let me start again.

For 2013, if you're a group of a 100 or more and you still want to report individually, so each of your 100 physicians or 100 or more physicians want to still choose their own PQRS measures and report them individually, they can. But one person in the group, this is very important, one person in the group has to have – who is an authorized representative of the group, has to log in to register the group with the administrative claims base option for 2013. That will become available, as I indicated earlier on, July 15th, has to be done by October 15th.

If the person – if the – by doing so, that means the value modifier will be zero. You can elect the quality caring if you like but we will be using it on the administrative claims, not on the measure that are reported through the PQRS. But – and if you do that, each of the individual physicians will still be able to earn their PQRS incentive, assuming that they are a successful or satisfactory reporter based on 2013. Does that answer your question?

(Paiwa Rothmans): I think so. Can you just repeat what the one person in the group has to log in and do by July 15th?

(Michael Wroblewski): Starting July 15th, they have to do it by October 15th. They have to – they would log in and register their group for administrative claims. They would have to say I want to register the group, they get an (ICAS) account, a CMS (ICAS) account and they register the group as administrative claims. They put in an email address, et cetera, choose, there's like a little click box you'll have, so just do administrative claims, if you want to do quality caring, you can. You don't have to and that's it. And so just one person for the group has to elect administrative claims for the group and then will make sure that their value modifier is zero. And then if you want it to be, you know,

based on performance on those administrative claims, then you can elect quality caring. OK.

So that window opens up July 15th, closes up, October 15th, hard deadline, no extensions.

(Paiwa Rothmans): OK. So it's about this part of the first but I read in different publications that have come out that none of this applies to those who are participating in the (MFFP).

(Michael Wroblewski): We will not apply the value modifier to participant TINs in the shared savings program, that's correct. So if your TIN is – that's how we do it, as a group, your TIN, one TIN, a single tax payer identification number is participating in an ACO, then you do not have to do what I just told you to do. That's correct.

(Paiwa Rothmans): OK. (Inaudible) ...

(Michael Wroblewski): Because you're doing – just think of it – because you're doing your quality reporting for 2013 at the ACO level, right?

(Paiwa Rothmans): Right. Yes, we are. I guess I just ...

(Michael Wroblewski): And so ...

(Paiwa Rothmans): ... so many programs out there and I just want to make sure we're not missing something.

(Michael Wroblewski): Yes. No. No. No. I hear you, I hear you. We will not – we obviously have a list of all the ACO participant TINs and are double checking it, triple checking it to make sure that they will not be harmed by the value modifier in 2015 or 2016.

(Paiwa Rothmans): This applies to us at some point or is that TBD?

(Michael Wroblewski): TBD. You know, when we ask that question, it's a great question, when we ask that question as a comment, a number of commenters said, you know, when we did it last summer, a number said, don't do it, its conflicting programs, you know, different benchmarks. Others said, well, on the private sector, often, our members are reported – are rewarded for high performance, why shouldn't we under CMS, right? So our thought was if we look to see for these two years, how the two interact, how the two programs interact so we'll be able to make an informed decision or an informed policy proposal as we move forward.

(Paiwa Rothmans): Is QRUR reports that are out there for our providers, should we even be ...

(Michael Wroblewski): Should you even be? You cut off there.

(Paiwa Rothmans): I said should we even be reviewing the QRUR reports at this time or is it not applicable at all because of the (MFSP) participation?

(Michael Wroblewski): You know, I think that the – a couple of things that I would look at, one is just to give you an idea of where you stand. If they've reported in the PQRS individually, then I think some physicians will like to see, how do I do on the measure that I – how does my performance on the measures that I've reported on compare to others in my specialty who have reported or who – not within my specialty but just to others who have reported that same measure. So I think physicians, that part and that would be an exhibit one of the report.

Exhibit two – exhibit – the very performance highlights page, I think when we show what the risk adjustments is, I think physicians, it's been eye opening. When we've talked with physicians, most physicians are unaware that where their patient population stands in terms of kind of complexity, compared to like the national average.

And so I think that information from an informational point of view is actually quite good. And then if you look at the exhibit – I think its exhibit six, which shows the cost break down, if your costs are higher or lower than others in your specialty, we break it down as to what is driving that? Is it because you have fewer hospitalizations, is it because you have coordinated the care and your post to acute care is down? Is it because, actually, there are a lot more Part B drugs, et cetera. You can kind of look at that and I think that is actually, you know, we're trying to provide this comparative information and I think introducing your physicians to this type of thing, I think it's actually a good idea. You know, so that would be my positive, you know, two or three points if they had five minutes to look at it, those will be the things I'll point out to them.

Operator: Our next question comes from the line of (Cindy Witty).

(Cindy Witty): I have a couple of questions but I'll try to go ahead and summarize it. The first one is, we have both specialists in hospital medicine and critical care in our specialty. Most of our hospital medicine physicians come from an internal medicine or family practice background. When updating their information within PECOS NTI settings, there is a designation for those that have a family practice background to indicate that they practice in hospital medicine but that designation does not exist for internal medicine that I've been able to find.

Also when – even when we do indicate, there are family practice physicians practice hospital medicine only, their QRUR reports come back off the chart because they're only treating patients within the hospital setting. They look completely out of balance with regards to the rest of the family practice physicians who are out there and rightly so. But their care is only done in the acute care setting so they're kind of being penalized on their QRURs with regards to quality and value and cost and all of those. So I wondered if there

were – if there was something I'm missing in classifying my physicians using correctly or if there's some way to get that designation in there.

(Michael Wroblewski): You raised a good point, I was – and we will look into this kind of sub designation that you indicate, that's available there for the family practitioner. You are right in that, there is no CMS specialty designation for hospital lists and we are aware of that.

And what I can say is I know many of your members are probably members or many of your physicians in your groups are members of the Society for Hospital Medicine, to the extent that they can get that designation as a part of PECOS. That would go a long, long way to solve the very real problem that I hear you talk about. But we will take a look at that kind of sub designation and dig into the – dig more into that to see if we can make up more accurate comparison, if we don't have that hospital list PECOS designation.

(Cindy Witty): OK. And then, can I ask a second question?

(Michael Wroblewski): Of course.

(Cindy Witty): I'm looking at the other one of my physicians, she transferred from an office space family practice setting, about half way through last year, to a hospital medicine setting, which is where she is right now.

(Michael Wroblewski): OK.

(Cindy Witty): So, again, her QRUR came back, looking pretty good at the beginning of the year and then it just went off the chart. My question is and her question also was, there's a lot of patient specific information in the QRUR but the organization she was in before did not submit PQRS, and so her question is, how did this data get populated with regards to beta blockers and (inaudible) and anti-convulsive. How was – how did you guys get that information on her patient for a specific patient population to put in this report?

(Michael Wroblewski): She probably was referring to exhibit two, which is ...

(Cindy Witty): Let me see here. Yes, it is.

(Michael Wroblewski): OK. Exhibit two and those are the claims (space) measures, so all of those measures were derived just from the administrative billing claims that ...

(Cindy Witty): But you can't tell on that occasion the person was put on based on the billing.

(Michael Wroblewski): You can and I will let Dr. (Jeff Blue) who is with Mathematica, who's our contractor, there are, for all of the 28 claim measures, whether provided by a performer group or anyone else who treated that beneficiary ...

(Cindy Witty): OK.

(Michael Wroblewski):... we can add claims to meet every one of those specifications and I don't have a ...

(Cindy Witty): OK.

(Michael Wroblewski):... answer to that one of that beta blockers and maybe Dr. (Roman), if you – or Tonya, if you know the specifications particularly on one of those measures, we can probably ...

(Cindy Witty): I think she's just curious because she had no knowledge that anything like that was ever reported, so she didn't know how the information was pre fed by Medicare.

(Michael Wroblewski):Sure. And I will say we do have on the physician on <http://www.cms.gov/physicianfeedbackprogram>, we have the measures specifications for all 28 of those administrative claims based measures and so I know it's kind of – I think it's pretty prominent on that – on the site there. And for whatever particular measure you want to look at, you can then look to see, OK, these are the code, et cetera, that are in the numerator, these are the ones, the nominator, these are the ...

(Cindy Witty): Right. But they had to be reported.

(Michael Wroblewski):Right.

(Cindy Witty): They had to be reported for you to have data and she was unaware that any reporting was being done. And the same was true of physicians that got reports in the pilot program in our group. We didn't do PQRS reporting yet, we received in the pilot program, all of this detailed information about patients which we did not report at all.

(Michael Wroblewski):Right. And those – and just the one thing, for those ones in exhibit two, they – because it was for those measures we use basically, kind of a one touch attribution, so it doesn't necessarily have to be by the physicians in your group. It was any physician who treated those beneficiaries that you also treated. So it may not ...

(Cindy Witty): OK.

(Michael Wroblewski):... be something that you've reported or your group reported or a her former group reported, but somebody did.

(Cindy Witty): OK. So it's all medications, on the top, it says all Medicare patients (inaudible) used or submitted a claim ...

(Michael Wroblewski):That's right.

(Cindy Witty): ... and then it says, number of Medicare patients for whom this purpose was indicated and who received the service. And so that's not necessarily specific to that physician.

(Michael Wroblewski):That's correct.

(Cindy Witty): OK.

(Michael Wroblewski):So that's what we're showing, it's really the overall care provided to those beneficiaries that you also treated.

(Cindy Witty): OK. But how ...

(Michael Wroblewski):Better than what performance, your performance on these measures. That's (inaudible) ...

(Cindy Witty): So it's not our – its not specific to the physician?

(Michael Wroblewski):That's exactly right.

(Cindy Witty): All right. Because that's kind of confusing. I guess it does say in full print, all physicians treating them but the doctor won't see it that way when it's got their name at the top of the report.

(Michael Wroblewski):And to be honest with you, you're raising a really great question because in last year's reports, we actually had the word YOU, Y-O-U, and we ...

(Cindy Witty): Right.

(Michael Wroblewski):... took that out because the ...

(Cindy Witty): Yes. That was good.

(Michael Wroblewski):... it was you and it wasn't, it was actually everyone who treated, so we put them in bold this year.

(Cindy Witty): OK. And then I guess that's all I have, I won't take any more of your time. Thank you so much.

(Michael Wroblewski):You're welcome. Thank you.

(Tonya Smith): Hi, (Michael), can I just add to for her question, I know the caller hung up but I think this is for her as well as anyone else. We also use Part B data in addition for the claims for the beta blocker. So I just want to make sure that we also mentioned that.

(Sheila Roman): This is (Sheila Roman) and (Tonya's) actually right that in order to have the medication, the measures that the medication dependent that the beneficiary would have had to have Part B. Because that's the only way we would have had that information on the medications that we prescribe.

Operator: Our next question comes from the line of (Barbara Fontaine).

(Barbara Fontaine): Hi, one of the things that I was concerned about, I work for a group of orthopedic surgeons, there are over a 100 providers in the group. But our particular vision – there's 20 doctors and they're the only ones that are currently reporting PQRS and it's on a claims based, you know, based on claims based data.

(Michael Wroblewski): Right. Right.

(Barbara Fontaine): So in the future, should the other doctors who are not in the group that's reporting, the other 75, choose not to go ahead with PQRS, how's that going to affect our 25? And then I have specific question about a sub specialty in our group.

(Michael Wroblewski): In terms of – for 2013, if the group, because I'm assuming the group, even though you broke it down to 25 PQRS reports and 70 none individual PQRS reporters. I'm assuming they're all under the same TIN.

(Barbara Fontaine): Yes, they are.

(Michael Wroblewski): OK. one person, in order to make sure your value modifier is for 2013, the performance year 2013, which is the value modifier that's (basically), you know, that expires in '15, one person will have to go in and register the group and register for the administrative claims option.

What that does is it protects you from any downwards adjustment the value modifier, those 20 individuals who are individual PQRS reporters can still do that in 2013 and if they're successful, they can earn, I think it's a half of percentage for PQRS as incentive payment. They can continue to earn that and then by registering as a group for administrative claims, you've also protected the other 70 from the PQRS minus one and a half payment adjustment. So just need one person, probably you ...

(Barbara Fontaine): Probably.

(Michael Wroblewski): ... need to register when it opens up in July 15th, you have to get an account and we'll have a webinar, what not, on how to go do all of that, you know, as we get closer to it. Get an account, register the TIN, choose administrative claims option for your TIN and that means that – and that's all anyone has to do.

If the other folks, if those ones who are in the 70 want to participate in the PQRS because as we move forward, we've indicated that we're going to – the administrative claims option was really just a bridge and we only finalized it for one year, 2013. So it will be a great time for your physicians, the 70, to either look to say, hey, I should be participating individually or look at whether it makes sense to because you're a group of orthopedic surgeons whether there are four, at least three measures, because that's what the requirement is for 2013, that we can report as a group. So that means if we were successful as a group on those three measures, the entire group would get the half of percentage incentive payment. Does that make sense?

(Barbara Fontaine): Yes, it does. The difficulty with that is that we're actually a multi-specialty group and we have probably 10 or 15 different groups, some of them are orthopedic surgeons, some are OBGYN, some are gastro and neurology, so it's hard to find one measures group that everyone can report on. That's really a difficult for us.

(Michael Wroblewski): But remember just to make sure to – remember its group reporting, so what that means, it's not individual reporting, so what that means is as long as if you have the denominators of these measures, and (Dr. Roman), please jump in if I say this incorrectly, the denominators of these measures are, you know, always based on diagnosis codes, right?

(Barbara Fontaine): Right.

(Michael Wroblewski): These diagnosis codes will have to put on my physicians in your group.

(Barbara Fontaine): Yes.

(Michael Wroblewski): OK. So if you have three orthopedic surgeons, just for ease of example here, and they have certain things that you've done, the only patients that have to be reported on for those measures are those that you – that meet the denominator, kind of criteria. It doesn't have to be for every patient the group sees.

(Barbara Fontaine): OK.

(Michael Wroblewski): Does that make sense?

(Barbara Fontaine): Yes. It does.

(Michael Wroblewski): So you can pick three measures that are very specialty specific, so you could pick three orthopedic measures and your group would do fine.

(Barbara Fontaine): OK.

(Michael Wroblewski): You could pick four – three OBGYN measures, if that was the other, you know, multi-specialty, as long as other people in your group are putting those diagnosis on, then you can kind of figure out, am I meeting the successful criteria, you know, 50 percent. If I – if you report via the client or the claims base methodology at the individual level. So you have to pick your measures for the patient population that you have.

(Barbara Fontaine): OK. Well, my other ...

(Michael Wroblewski): On that – and I actually will would very, very much encourage you to do that as a – for 2013, to give it a try, choose administrative claims to protect yourself ...

(Barbara Fontaine): Right.

(Michael Wroblewski):... so there's no down ward adjustment. But then report at the group levels for these other ones and see if you can – actually, you would have to – actually if you – let me back up, if you decide to report at the group levels, you'll have to do it via registries for 2013.

Yes, you'll have to do it via registries, that's right Dr. Roman, that's right. You'll have to do it via registries. And in 2014, we'll allow you to do it through group reporting at the EHR level or through EHR as well as registries. But report individually, at least for 2013 and start to get – because PQRS isn't the easiest thing ...

(Barbara Fontaine): Right.

(Michael Wroblewski):... and so you may want to protect yourself by choosing administrative claims.

(Barbara Fontaine): OK. We'll do that.

(Michael Wroblewski):And try to do it to earn the incentive and then at least you'll kind of have a dry run, so to speak of the next year.

(Barbara Fontaine): OK. My other question was I had pulled the QRUR report for all my physicians and one of the things I noticed was a physician who has a sub specialty in fine surgery and only treats difficult fine cases is – appears to be being compared to just other orthopedic surgeons that are doing hips and knees and a lot simpler things. And so his scores looks like they were 6 percent higher than the norm but it's because I think that there is no designation for that subspecialty. Is there something we can do on that?

(Michael Wroblewski):It's a great point, kind of like the hospital ...

(Barbara Fontaine): Right.

(Michael Wroblewski):... the (inaudible) where the PECOS specialties that we use are the ones that are there and they don't go down to the subspecialist level. You know, when we do the value modifier, we are actually looking at the group level comparison, and so it kind of ameliorates that problem. But as we move forward, we're going to – we'll have to look for a way to make a fair comparison going forward. It's a ...

(Barbara Fontaine): Right.

(Michael Wroblewski):... good point though, we've heard it, it's one of the reasons why we're starting with groups of a 100.

(Barbara Fontaine): OK. Yes. The thing that I know is that when you fill out an 855 for a new physician, that's not one of the specialties that you can choose either orthopedic surgery or nothing. So ...

(Michael Wroblewski):OK.

(Barbara Fontaine): OK.

(Michael Wroblewski):OK.

(Barbara Fontaine): Thank you.

(Michael Wroblewski):Thank you. Thank you.

Operator: Our next question comes from the line of (Bruce Hall).

(Bruce Hall): Hi, thank you. Two questions which I hope will be quick. One is on the designation of cost outlier, I think on one of the slides it says statistically significant but I was just wondering what the criteria was. And then second question is if someone does choose or a group does choose to be evaluated under the quality side, is that a permanent election? And then I'll mute myself and take your answers.

(Michael Wroblewski):I'll take the, no, it's an annual selection, so not permanent. And then your first question, it's one standard deviation away from the mean. So what we do is we create for every measure, a standardized score where we take the group's performance on that measure, take the difference between that and the national mean and we divide it by the standard deviation and you'll get a number. So you'll see how many standard deviations you are away, say 1.3.

So if you are – its above 1 then you would be high and if you're a negative number, you know, if you're a minus 1 or minus 2, then you're, you know, it's one standard deviation is the statistically, you know, when you're beyond that. That's what makes you high or low.

(Bruce Hall): So then roughly (it adds up) like 15 or 16 percent on each detail, something like that.

(Michael Wroblewski):That's correct.

(Bruce Hall): Thank you.

(Michael Wroblewski):You're welcome.

Operator: Our next question comes from the line of (Richard Early).

(Richard Early): Hi, I think part of my question was just answered but in that the high quality or low cost tier ...

(Michael Wroblewski):Right.

(Richard Early): ... that's not the top 25 percent, that's the – you're in the top one – greater than one standard deviation or lower than one standard deviation.

(Michael Wroblewski):That's correct. That's exactly correct. For your composite, that's correct.

(Richard Early): OK. And we're a group of 30 physicians, so we don't have to do anything this year? Is that true or ...

(Michael Wroblewski): For 2013, you would still – I would – if I were you, I would in July – I don't know, how do you all – how does your group report through PQRS right now?

(Richard Early): Ninety eight percent of us do it just through claims, individual reporting measures and then we have a dermatologist who we're trying to figure out how to do registries.

(Michael Ro Wroblewski): OK.

(Richard Early): And we think we've figured that out, so we have one provider doing it through a registry, all the rest do it through just the claims individual measures.

(Michael Wroblewski): Then that's fine, you all don't have to do anything. When you pick up your report because we're going to – for next year or actually for the 2013, mid-September, you'll be able to pick up a report that looks at your 2012 performance. And we're providing them to all groups of 25 or more, so you'll be able to see how you've – you know, what your quality tier is and what your cost tier is. And you won't be able to work on – make an election because the value modifier is only in groups of a 100 but as you know, we have to phase it in to everybody by 2017. So it gives you a feel for where you stand.

(Richard Early): You were about to say something that if it was you, you'll do something in July, what was that all about?

(Michael Wroblewski): Strike that conversation because you are already reporting at the individual level, you're doing the right stuff.

(Richard Early): Well some of our physicians don't do it, like we have hospitalists and their measures don't work too well and so we have a couple of physicians who don't report any measures because it's difficult but most of us report.

(Michael Wroblewski): Then what I would do is on July 15th, when the registration period opens, have one member of the group authorize to act on behalf of the group to select administrative claims for the group. And what that does is it protects you from the downwards PQRS adjustments for those non-PQRS individual reporters. Does it make sense?

(Richard Early): OK. And that's where there were less than a 100 or not?

(Michael Wroblewski): That's right. That's right. That's right. That part of it, yes, that's correct. And the quality tiering ...

(Richard Early): (Inaudible) ...

(Michael Wroblewski): ... the quality tiering part of the website won't show up because you're not over a 100.

(Richard Early): OK. And one last quick question, is it – you know, I'm already in (IX) for looking up the PQRS report and the e-prescribing reports, do you have to sign up different for this ...

(Michael Wroblewski):No.

(Richard Early): ... this (inaudible).

(Michael Wroblewski):No. That's – you use the same (ICAS) account but your security official will have to give you a access to a different application because it's a different, you know, it's a different application, you're doing something different.

(Richard Early): OK.

(Michael Wroblewski):I can't explain all of that, so you can still use your same (AJAX) account. It will just have rights to a different part of the CMS portal and you'll have to – your security official will have to grant that. So we'll have details, we'll have a call, we'll actually have several calls later in the spring and into the summer on how all that works.

(Richard Early): OK. Thanks a lot.

(Michael Wroblewski):You're welcome. Thank you.

Operator: Once again, to ask a question, please press star one.

Our next question comes from the line of (Joy Eyre).

(Joy Eyre): I'm sorry, my question was answered by the previous gentleman.

Operator: There are no additional – I do apologize, we do have a follow up question from the line of (Bruce Hall).

(Bruce Hall): Every group just choose annually based on their projected performance, and so would you end up sort of never really having any groups that underperform?

(Michael Wroblewski):Can you start, you cut in kind of half way through and so I don't think I heard the very first part of your question, I'm sorry.

(Bruce Hall): OK. Thanks. If the election for every group is annual, won't every group have a really good idea of what their performance is going to be and so wouldn't any rational group that looks like they're underperforming always opt out for that year?

(Michael Wroblewski):Yes. But as I said, we're – quality tiering is optional now, it will become mandatory. There will be no more election in the future years, so as the optionality of it, so to speak, these are part of the phase in. So after a while they won't be – it will be mandatory.

(Bruce Hall): I see. Thank you very much.

(Michael Robleski): You're welcome.

Operator: Our next question comes from the line of (Ann Bleckley). (Ann), your line is open.

(Ann Bleckley): Yes. I have a question that has to do with the specialist team that has taxonomy code, I don't know if that as to when you sign on to PECOS and it goes down the – looks at the taxonomy codes as it relates to the MPI. When its pulling the taxonomy codes in, it doesn't always match up to the specialty exactly right, who would I talk to with regards to that?

(Michael Wroblewski): So let me just make sure I understand the question. The ...

(Ann Bleckley): We're going back to the hospitalist in that (inaudible) hospitalist and the internal medicine, family medicine issue again.

(Michael Wroblewski): The ...

(Ann Bleckley): Because ...

(Michael Wroblewski): ... I would say for the 2011 QRURs, we just picked a, kind of the, I would say, this may not be the right word, but the primary designation. So internal medicine, family practice, orthopedic surgery, surgeon, so that we didn't look any further, so there wasn't a ...

(Ann Bleckley): So if you picked that – excuse me, I'm sorry.

(Michael Wroblewski): So we didn't pick up anything, if there was – I think the one person that indicated that within family practice, you could designate underneath of that hospital medicine.

(Ann Bleckley): Yes.

(Michael Wroblewski): Well, that may be true, but our system, the way we generated the 2011 reports didn't even look there. So it wasn't ...

(Ann Bleckley): OK.

(Michael Wroblewski): ... it wasn't an error, so to speak. I think what I said that we would do is look to see if we could do that in the future years. But right now, there wasn't – there was no error.

(Ann Bleckley): Right.

(Michael Wroblewski): It's (inaudible).

(Ann Bleckley): OK. So you're pulling the taxonomy codes to do that, is what I'm asking again.

(Michael Wroblewski): Yes. To pull the main primary designation there, whether it's family practice, internal medicine, whatever.

(Ann Bleckley): OK. That was my question, is if you were using the taxonomy codes to pull that and you're basing that off of the specialty.

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

(Ann Bleckley): OK. Very good. Thank you.

(Michael Wroblewski): You're welcome. And I think, just a one quick thing, if you look at the back of your QRUR, I think it's in the – I believe it's in the reports. Has all the lists of those different specialty codes that we use, the two digits and the list of them is there. And it's not in the actual report, it's actually on the physician feedback program site of cms.gov.

(Ann Bleckley): And it's my understanding that it's supposed to be based on the educational pathway that the doctor use – has gone and not necessarily on the specialty that they're practicing in. Is that correct?

(Michael Wroblewski): That, you know, I don't know the answer to that. If you put that in – I don't know the answer to that and I'll ask Dr. (Roman) or (Tonya) or (Jeff), do you know the answer to that?

(Jeff Blue): This is (Jeff Blue) with Mathematica, (Michael). The specialties that we pick up are the ones that are input into PECOS when providers register with Medicare, so that – those can, of course, be changed over time but that's where they're coming from.

(Michael Wroblewski): Right.

(Ann Bleckley): OK. And so where would I go to find out how that's actually supposed to be put in. Obviously, they can be put in anyway but what is the preferred way?

(Michael Wroblewski): My guess is and I'm just looking at the slide that we have, if you go to PECOS, what is it, https, if you look at slide 24 ...

(Ann Bleckley): Yes.

(Michael Wroblewski): There's a web address there for PECOS.

(Ann Bleckley): Yes.

(Michael Wroblewski): My guess is it will tell you how you put those in and I don't know that. I'm not familiar with the kind of the ins and outs of what the preferred method is.

(Ann Bleckley): I understand how to put them in. I am – that I understand, my question is, are the taxonomy codes supposed to be based on the education pathway the doctor takes or the provider takes or the specialty that they're actually practicing in.

(Pam Cheetham): This is (Pam Cheetham) from CMS, actually, when people first enroll, when providers first enroll in Medicare, they're asked to provide their own specialty code. So it's left to the provider to designate his or her specialty. If they want to base it under educational background, that's certainly their option, that's why we encourage people, providers to keep their information in PECOS up to date to reflect their current practice, and their current location.

(Ann Bleckley): OK. So if that's the case, then an answer to the earlier question with regard to the family medicine, hospital medicine or internal medicine and hospital medicine question, that provider could actually put a hospital medicine taxonomy code and no one would know and it would work fine.

(Pam Cheetham) :No. It doesn't because there are limited number of specialties that CMS recognizes and bases it on. And when we actually start looking at claims, so when the (MACs) starts looking at claims and paying them, they look at the (reality) of the claim to designate the specialty. (Jeff), do you want to expand on that a little?

(Jeff Blue): Well, I think that's actually a pretty good summary, again, the, as you indicated, (Pam), the specialties are placed on claims by the MACs, the carriers, but, again, they all – in all cases, the specialties go back to what has been provided by the provider into PECOS. And again, as, (Pam), as you emphasized, the specialties that is put into PECOS is the provider's option, it's their choice.

(Ann Bleckley): Right. But if the (inaudible) medicine and internal medicine doctors were both working in hospital medicine, and so ...

(Pam Cheetham): They cannot put in an option that's not available. They can't drill down to subspecialties, CMS doesn't recognize.

(Ann Bleckley): OK. I see what you're saying. OK. I understand.

(Pam Cheetham): OK, great.

(Ann Bleckley): OK. Thank you.

(Pam Cheetham): Sure.

Operator: There are no additional questions at this time.

Sue Brewer: (Tonya), does anyone have any closing statements they would like to make before we close the call.

(Tonya Smith): Yes. I just wanted to thank everyone for participating on this call today. And within the next week or so, we would have transcripts posted from this call for anyone who didn't get an opportunity to listen on. Those transcripts will be posted to our physician feedback program website, under teleconferences and events. Thank you all.

Sue Brewer: And I would – this is Sue Brewer, I would also like to encourage every one of you who have not pulled your reports, the information is in the slide deck, we also referred to at the beginning of the call at going to www.qrurinfo.com to pull your reports. There is contact information there, we also have a live chat function, and it's available from 10 to 2 local time. So if there's anyone that you have contact within the provider community, please encourage them to take a look at their QRUR report. And we also have the information on these files available, posted probably towards the end of the month on that website as well.

And that concludes our call for today. I would like to thank everyone as well for attending and that's the end of the call.

Operator: That concludes today's ...

(Pam Cheetham): And update your PECOS information.

Sue Brewer: Correct. Good thinking.

Operator: Ladies and gentlemen, and that does conclude today's call. You may now disconnect.

END