

**Centers for Medicare & Medicaid Services
2010 Physician Feedback Program Group Reports Analysis
National Provider Call
Moderator: LeTonya Smith
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Operator: At this time, I'd like to welcome everyone to the 2010 Physician Feedback Program Group Reports Analysis National Provider Call.

All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for your participation in today's call.

I'll now turn the conference over to LeTonya Smith. Thank you, ma'am, you may begin.

Introduction

LeTonya Smith: Thank you so much, Holley. I would like to welcome everyone to the call today. My name is LeTonya Smith with the Center for Medicare, and I will serve as your moderator for the call today. We appreciate your continued interest in the Quality Resource Use Report.

Today specifically, we will be discussing the 2010 Physician Feedback Program Group Reports Analysis. Our speakers for today will be Michael Wroblewski and Dr. Sheila Roman. We will start with Michael, who will give an overview of the Group Reports Analysis. After the presentation, we will take your questions. I ask that you hold your questions until that time.

Michael?

Presentation

Michael Wroblewski: Thank you, LeTonya and thank you everyone for joining us this afternoon.

This effort really grew out of suggestions – by the members of the calls that we had that received the Group Reports that we had done last fall – to be a little bit more transparent in terms of the methodologies that we were using and the results that we were finding at an overall level.

So this report was really our – or this paper is really our first attempt to provide that transparency. We anticipate that in future years, based on the comments that we get during this call and other comments, that we would make the analysis more robust, et cetera, and address concerns and issues that

you all want us to address so that we can make these reports, and the Physician Feedback Program, and, ultimately, the Valued-Based Payment Modifier more effective for you all.

You know, there aren't that – I was thinking I would go through and give a quick little overview of every section of the report. I mean, in general – and I'll do that right now, and then I think it would probably be better if after I do this quick little overview that I'll open it up to questions, and we'll just walk, you know, page by page, through the report and answer any questions that you have or suggestions or how we could make it better for the next year's reports.

So in general, what we try to do is provide an overview, who participated, and who were the – who participated in the GPRO reporting option for PQRS in 2010 and how they were chosen, and that's really page one. Page two, we try to give some information on how beneficiaries were attributed to each of the group practices and to provide kind of a distribution analysis of how many beneficiaries there were.

You know, the range of beneficiaries was between about 2,400 and 31,000, with an average size of about 12,500. We also then tried to look at – to see, OK, well how many E&M visits did they have with physicians who are fee-for-service physicians and how many of those fee-for-service physicians were actually in the group. And that's really the analysis and the charts that are on page three, it's Table Four, in which it shows, on average, a beneficiary that was attributed to a group had an average of 10 E&M visits in 2010, and about seven of those on average were with physicians within each of the groups.

We also tried to look at – to see what the – kind of the composition of the groups were, in terms of kind of broad specialty categories.

The majority of the groups were made up of, on the average, I would say profile, of the group had over – half of the physicians were primary care providers, followed by medical specialists, and surgeons. But we make a note that five of the groups were predominantly made up of medical specialists rather than primary care providers.

We then tried to do an analysis, provide a quick overview of the quality of care measures. And that's the chart that's on page five of the report, Table Six. And it's slightly different from the table that was in each of your own reports, because we added a column. People had indicated, you know, well how are the rates – you know, these 35 groups are somewhat self-selected, and how does the rates of performance compare to the rates of performance on the same quality measure if it's been reported individually within the PQRS system?

And that's really the first real data column; it's the third column on Table 6. So what we tried to do is show for each of the measures [for] which there was a corresponding individually reported measure what the difference in the mean performance rate was. And it's just kind of a high-level take away – 16 of the 19 measures in which there was an overlap of measures that could be reported at the group level or the individual level; the groups had higher performance rates for 16 of them, and individuals had higher performance rates for three.

In terms of the cost – excuse me, the Quality of Care measures; potentially Avoidable Hospital measures, we also looked – they're displayed there in Table Seven.

But what we wanted to point out and actually what we did with the other Quality of Care measures, too, is look to see what the reliability levels were. And overall, not surprisingly, given the large number of beneficiaries in the groups, the reliability ratios were quite high for both the PQRS measures as well as the Ambulatory Care Sensitive Conditions measures of potentially preventable hospital admissions.

In terms of the Cost of Care measures, this is on page seven, going onto page eight, the two points I want to highlight – the first is that we standardized the payments so that groups in different parts of the country weren't disadvantaged, because they had higher wage indexes and other geographic factors.

But the second point I wanted to highlight is, kind of, what the effect of our risk adjustment methodology was. And this is really the difference between Table Eight and Table Nine. In Table Eight, the Unadjusted Range of Total Per Capita Cost: The average total per capita cost unadjusted was about \$13,000, with a range of about \$9,100 to \$24,000.

But when we risk-adjusted it, the average actually came down – the average per capita actually came down to about \$12,652; but more important, the range of costs was reduced as well. It was reduced from about \$10,000 – \$9,932 to \$16,000; so the range was compressed by about 55, almost 56 percent due to the risk adjustment. Not surprisingly, those in the bottom third of groups had their costs elevated. The groups in the top third – most expensive third – had their costs reduced.

But those in the middle – actually it was kind of a mixed bag – on average that tercile really didn't have any adjustment, but if you looked at the individual groups, some of them were adjusted upward by about 8 ½ percent, and some of them were downward adjusted by about 10 percent.

The last thing I want to highlight – and it's the graph that's on the very back page of the report – is we just did a very simple cost-to-quality scatter diagram, in which we plotted the total per capita cost that was risk adjusted along the vertical axis, and we did just a simple weighted average of the performance rates for each of the groups, and that is along the horizontal axis. So it's really a cost-versus-quality scatter diagram.

And we looked to see what the correlation was, and it was very, very weak – only 2 percent – so really showing no relationship between the Quality of Care and per capita cost.

With that I will end my presentation, and I'll turn back over to LeTonya, and then we'll open up the line for questions.

Polling

LeTonya Smith: Thank you, Michael. At this time we will pause for just a few moments to complete keypad polling so that CMS has an accurate count of the number of

participants on the line with us today. Please note that there may be moments of silence while we tabulate these results. Holley, we are ready to start polling.

Operator: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line. Today we would like to obtain an estimate of the number of participants in attendance to better document how many of the members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

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

Please hold while we complete the polling.

Again, please continue to hold while we complete the polling.

Thank you for your participation. I'll now turn the conference back over to LeTonya.

Question and Answer Session

LeTonya Smith: Thank you, Holley. We will now begin our question and answer session. Let me just remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get in as many calls as possible, we ask that you limit your question to just one. If you have more than one question or would like to ask a followup question, you may press star one to get back into the queue. And we'll address additional questions as time permits.

Holley, we are ready to take our first question.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question, and pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

And your first question comes from the line of Mary Wheatley.

Mary Wheatley: Hi, Michael.

Michael Wroblewski: Hi, Mary.

Mary Wheatley: Thanks for – this is Mary from AANC. And I was – you know, I found this report very helpful, and I know I was one of the ones asking you for it, so I wanted to thank you for it. I did have a question: Did you by any chance—when you looked at the attribution and you looked at it by the patients—did you look at the number of patients that were assigned to each of the different cohorts and, you know, kind of the specialties that were assigned—for like the diabetes, heart failure cohorts, preventative care, and screening cohorts for the quality measures?

Michael Wroblewski: What do you mean by did we look at them? I mean...

Mary Wheatley: Like, so – for example, because I know, you know, and I'll let other people chime in – because like we keep hearing that, like some of the people that got assigned to diabetes measures were people that they weren't – we wouldn't have expected to be assigned to the diabetes measures.

So did you see, for example, a – like, a certain – you were saying that it was found on E&M services, and sometimes it's medical specialty and sometimes it was primary care; did you do that kind of analysis when you looked at the, like the 411 samples that were selected for each of the cohorts, and did you see any variations across practices that way?

Michael Wroblewski: No, we didn't. We looked at it in general to see how the folks were attributed generally, not who was kind of responsible for the – that beneficiary

in that cohort. I hear what you're saying. We looked at it at the group, kind of like at the overall group level, and we didn't look at it for each of the kind of subpopulation levels. Why would that be helpful to look at it that way?

Mary Wheatley: Well, you know, to me – again, we just heard that sometimes we got surprising patients in there, and I was just curious to see if you saw, I don't know, a different variety, like in your preventative care and screening, you're seeing specialists being assigned to it that you wouldn't necessarily see expected to it.

Michael Wroblewski: I see what you're saying.

Mary Wheatley: You know, it may not matter.

Michael Wroblewski: OK. No, it's just a – it's a – we didn't look at that; so I hear your point.

Mary Wheatley: Thanks.

Michael Wroblewski: Sure.

Operator: Once again, if you'd like to ask a question, press star one on your telephone keypad. Again, that's star one for questions.

LeTonya Smith: Holley, we are ready for the next call.

Operator: And at this time, there are no further questions.

Michael Wroblewski: Mary, I'm sure you have another question.

Operator: Once again, ladies and gentlemen, if you'd like to ask a question, press star one.

And there are still no further questions.

And currently, still no questions on the phone lines.

Michael Wroblewski: You know, if anyone has any comments, any questions – really, we can take anything.

Operator: We do have someone that's come into the queue, the line of Jackie Mathews.

Jacqueline Mathews: Hello.

Michael Wroblewski: Hi, Jackie.

Jacqueline Mathews: Hi, really quick. What are your thoughts going into the following year, based on what you've learned from this? I think the summary was very helpful and helped to break it down a little bit more. But I know in using the QRUR report for our leadership, I don't think it totally helped us drive to the areas that we needed to make changes. I don't think it gave us enough information, especially on the pieces that were outside of the GPRO information.

Are there thoughts about – in this iteration, how best – how you're going to best help us GPROs with more information so we can really utilize it to help educate our physicians and our leaders around what you're measuring and what's potentially coming down the pike? And how are you going to kind of marry this up with the Value Modifier program versus the Meaningful Use program and PQRS program? So, there's some questions for you.

Michael Wroblewski: And I'll answer the first one first. In terms of – let me ask you a question first – what information, you said it wasn't as action-able to make the changes that your physicians would have liked. What could we have put in there?

Jacqueline Mathews: Well, I think, you know, I know on the GPRO 2010 data we weren't able to equate – we worked – we tried to equate our GPRO data to physicians. We were actually to at least say these patients in this sample cohort have primary care physicians in our TIN. And, you know, we ranged between 80 and 85 for each of the cohorts that we were able to match up. So we actually felt that that was really positive. Because we – I'm at the clinic, the Cleveland Clinic, and we're – we tend to be more specialty driven than primary care. I would say that we're one of the hospitals that has high medical specialty in this report.

We don't know that in this report. I think some of the things, like the ambulatory-sensitive measures, you know, those measures are now becoming so much more important. They are identified in the ACO grouping. We know there are going to be Medicaid measures.

So what – you know, how could we have learned more from it? It just gave us a rate, or gave us our performance, and was there data that you could have, you know, given us a little bit more granular data around that? Because for some hospitals, you know, for leadership, some of these are really new things for them to understand and get their arms around.

Michael Wroblewski: Right.

Jacqueline Mathews: You know, so I think, you know. And so you want to bring to our – we want to bring to our leadership action-able data. And sometimes when it's so high, it allows them to shoot holes through the whole thing and say, "Well, you know what, it's an attribution issue." And I will tell you, it loses its power because people don't understand it, they don't have enough information to move on it, and then, you know, leadership actually loses interest in it. Because they say, "Oh, you know." So I hope that – does that make sense?

Michael Wroblewski: Yes. No, it does. And I get the – I'm struggling just a little bit with what – and I'm trying to kind of marry it with Mary's question from before, in terms of what information could we have provided. And I'm guessing that – is it the number of the – who would – you know who the beneficiaries were for each of the quality, you know, in the GPRO tool?

Jacqueline Mathews: Correct.

Michael Wroblewski: So you know who those are.

Jacqueline Mathews: Right. But we actually, you know, what our physicians want to know is whose patient is that?

Michael Wroblewski: OK.

Jacqueline Mathews: Doctors want the hard facts. Whose patient is this? It's, you know, we do believe in the GPRO method, we do think that the GPRO method is for us; it's a huge organization and over 2,000 physicians. It's an important way for us to participate in that program. And so that's a – we think it's the right way to go; but then you have to be able to provide those groups with more granular data.

And I think that we were able to do some work on our side to say, “OK, at least we can say it looks like, you know, X amount of patients were attributed – had two primary care visits over the last year.” And had the primary physician identified. So those are some of the information – so because in our organization, physicians want to see, “How does it affect me?” and, “What do I need to change?”

Michael Wroblewski: Right.

Jacqueline Mathews: And that's where you've got to get the buy-in; because for other groups, I don't know if it's the same for other groups, but you know, we're a group practice. So sometimes that individual doesn't feel the urgency that you do in a private practice. So it's different in a group. And I don't know if other groups have that issue, but for us it's definitely something, you know, that our physicians are engaged, but they want to know, “How does it affect me?” and “What do I need to change?”

And so when it's very high-level for the organization, then it's difficult to get down to that, you know, so – you know, just some things. I mean, it's not always easy to get that buy-in. And so then they write it off, you know?

Michael Wroblewski: Right. No, I hear you. And I get the “Whose patient is it?” idea. I'm just thinking of how we can do it, but I hear you.

Jacqueline Mathews: Yes, I guess if there's – as you guys learn from this data, are there things that you can share with us as organizations to say, “You know what? What we get coming across the claim is not that clean.” Or, “The physician identification is...” I guess I don't know if there are consistent data issues from your side of the fence that we as organizations can maybe make

improvements on, or, I don't know, I could be totally washed up in that thought but...

Michael Wroblewski: We can certainly look to see if there are things like that; so we appreciate that. You know, if there are other things – I guess that – whose patient is it? I get that; and we can certainly – you know, I'm not sure we, you know, what our timing on doing that would be, but I hear what you're saying.

Jacqueline Mathews: Yes. Thanks.

Michael Wroblewski: Sure. And in terms of the – your second part of your question and how does all this relate to Meaningful Use, and the PQRS payment adjustment, and incentive payments, and the Value-Based Payment Modifier? You know, as you know, we're making our proposals later this summer on all of this. And I think there's been a strong feeling that this GPRO tool is actually pretty good, and we're glad that you like it.

Jacqueline Mathews: Good.

Michael Wroblewski: And that – and so – this is the type of information that would be used. I think we're looking very much to a – I mean, what we said in last year's rule is that we were looking to align all the programs so that, you know, it's kind of one-stop shopping from a CMS perspective – from your perspective. And so I think you can expect proposals along those lines later this summer.

Jacqueline Mathews: Yes. I think that would be great because what we struggle with is definitions. You say Meaningful Use, GPRO, now ACO, and so, organizations have to say, "OK. If we're doing X, Y, and Z, what's the most stringent measure we're going to measure our physicians on, and how are we going to hold them accountable to these best practices and measure them?" So that's something that we really struggle with is the definitions and the differences.

You know, Meaningful Use and GPRO are very different. ePrescribe and Meaningful Use, very different. And so, sometimes that's – you know, you've got to engage the physician and get the physician where they

understand that, and I will tell you, our physicians are so confused, and they, you know, they kind of, unfortunately can ignore it, because we all take care of it for them; but I think that, you know, private physicians out there, they want this incentive money, and they, you know, for them, it's very important; and I think, you know – how can we start to bring all this together?

We're a big organization and we can – we have lots of resources, but that's something that we really, really struggle with, and to say, "OK. What is the definition as an organization that we're going to commit to, even though externally we're sending out, you know, different measurements?"

Michael Wroblewski: Right. No, I hear you. I hear you. No, that's a fair point, and that's a great emphasis in terms of the definitions, things that we take for granted can be very confusing looking from the other side. So...

Jacqueline Mathews: Great.

Michael Wroblewski: OK.

Jacqueline Mathews: And I love the comparison that you gave us on this report about the comparison of the, you know, private – you know, individual physician reporting versus the GPRO. That was really – that was insightful information for us. I, you know...

Michael Wroblewski: Good. Well, good, well, I'm glad you liked it. You know, do you have any objections to us making this paper by putting it up on our Web site?

Jacqueline Mathews: I would – I don't know, I'd have to talk to our leadership, but I, you know, we can talk about it offline. I would just have to make sure, because, you know, I don't think there would be a problem, but I would just clarify with my leadership.

Michael Wroblewski: OK. Thank you, and thank you for your comments.

Jacqueline Mathews: Oh, no problem.

Operator: Once again, if you'd like to ask a question, press star one on your telephone keypad. Again that's star one for questions.

And you do have a question from the line of Lisa Roberts.

Lisa Roberts: Hi, this is Lisa Roberts and I'm calling from Topeka, Kansas, and our organization is Stormont-Vail. And I would just like to add and reiterate what Jackie has pointed out, that aligning all of these different tools that we have to try to motivate performance is a big challenge, and I would just say that another challenge that we're facing is just moving from one electronic medical records system to another, and so the more alignment that can occur, the better.

Michael Wroblewski: Right. We hear you. And that – it's been, you know, we tried to signal we were doing that last year, and I think you'll – it's been kind of a guiding principal for us.

Lisa Roberts: I appreciate that. I think one of the things that I see in this picture is that GPRO, from my very short experience – and it's only been for the last few months – GPRO gives a really good quality of information; Meaningful Use tends to get more quantitative. And what I'm struggling with is trying to give feedback to the physicians on a more ongoing basis, so that they're not looking at something that's – basically they look at it as 18 months old.

Michael Wroblewski: Yes. Right. So again you're saying that Meaningful Use gives it more frequently, but it's not as...

Lisa Roberts: No. I would say that GPRO is looking at such a small sample. We are also a fairly large organization, so although I'm one of the abstractors as well for GPRO and I certainly don't know that I would want to add, you know, a lot more cases to look up. But Meaningful Use, there are some of the measures that obviously because of the electronic nature of that program, it's easier to abstract and get information back to the physicians more quickly and at a greater quantity.

Michael Wroblewski: OK. I hear what you're saying.

Lisa Roberts: So if they could be put together some magical way.

Michael Wroblewski: Right. No, right; I hear you.

Lisa Roberts: Thank you.

Michael Wroblewski: Sure, thank you for joining us.

Operator: And your next question comes from the line of Leonard Smith.

Leonard Smith: Hi, thank you for this review. One question that came to my head is how do the GPROs compare with fee-for-service Medicare and the Medicare Advantage population? Is there any ability to – I mean you've got the information on the beneficiaries and their costs. Is there any significant difference between the GPROs and the Medicare Advantage population that's probably very similar?

Michael Wroblewski: You know, we did not look at that, and I'm trying to think of, you know, in terms of the quality of care, there are probably – I know we have comparable benchmarks for some of these measures in both (NMA) plans and in Medicare fee-for-service. I don't know what the results are.

In terms of the cost, I'd have to look at that. I'd have to look at that, but it's something that we've been looking – you know, with the ACO program, you know, the measures are very similar to the ones that are in the GPRO tool from 2010 and 2011. And that – there's an effort under way to determine which are the appropriate benchmarks for scoring those. And so I know that there are ones out there for Medicare Advantage and Medicare fee-for-service.

But is that something that would be useful to kind of show? And at what level? Would it be national, would you want it regional? How?

Leonard Smith: I don't honestly know. It's a thought that came to mind, and I know that our GPRO has about half of each; about half fee-for-service Medicare and about half – and we're in Northern California – half Medicare Advantage. My guess is they're probably extremely similar. It's not like you can be seeing a patient

and remember one insurance versus another in the act of ordering a test or doing a followup.

I do think that we've been – before GPRO, we've participated in a much smaller scale with MCNP, but we started from the get-go, using that as an exercise to learn to do electronic reporting. And that's the only way that we've been able to have the resources to participate, and it's been a tremendous learning experience.

And I really think that's where your opportunity is to give feedback to the providers. The providers, I think, generally want to do well for their patients, but frankly, an 18-month or older summary data for a measurement year – a previous measurement year – does very little to help them.

It isn't a motivation issue. The answer is not run faster on the treadmill, or become more perfect. We're human, and we don't get more perfect. So the key for me is figuring out what can I do within our electronic environment that assists the physician, or the provider, at the point of care, that allows them to manage that opportune moment of a visit to go after things that might not be the reason the patient came in.

So if it's a diabetic, but they're here for an ankle pain, and we're way behind on their indicators, I need a prompt. And so we've really taken that route, where we're using this to build front-end, in essence, computerized decisions support for chronic care, a lot like Marshall Clinic and some of the other clinics have done to try to use the same technology but drive it to an action point at the point of care. And then the flip-side of that is once you know how to extract the data, you can also then approach registries if you can figure out who has the time to do it in your organization, that allows you to help manage the non-visit mode, the people who didn't come in, the people who are outliers and need to be chased, all those sort of things.

So for us it's primarily a learning experience, and it looks like it's going to be a cost of doing business, in terms of having to do PQRS or else we lose 2 percent. I'm hoping that the GPRO will be one of those options, because for

our large provider base, that's a – it's a very efficient way of helping protect us from a business aspect of a payment adjustment.

Michael Wroblewski: Right. No, we hear you. OK. OK. Thank you for those comments.

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

And at this time, there are no further questions. I'll turn the call back over to LeTonya Smith for closing remarks.

Additional Information

LeTonya Smith: Thank you, Holley, and thank you to those who were able to take part in this call. If you have any further questions or comments after this call has ended, please email them to our QRUR mailbox at qrur@cms.hhs.gov. Additional information about the QRURs can be found on the CMS Physician Feedback Program Web site at www.cms.gov/physicianfeedbackprogram. Thank you again, and enjoy your evening.

Operator: Thank you for participating in today's call. You may now disconnect.

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