

QRUR Feedback Teleconference Transcript

WPS Medicare

Moderator: Sue Brewer

January 28, 2013

2:00 p.m. CT

Operator: Good afternoon. My name is (Sarah), 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. Miss Sue Brewer, you may begin your conference.

Sue Brewer: Thank you (Sarah). Hello everyone and good afternoon. My name is Sue Brewer, I'm an Analyst in the Provider Education Department of WPS, Wisconsin Physicians Service. I want to welcome you all to today's QRUR feedback call. WPS is pleased to host this call along with CMS and contractors staff pertaining to the feedback report.

The teleconference is intended to provide our Medicare Part B providers or billing staff who have access to 2011 QRUR reports, an opportunity to ask questions and provide feedback to Centers for Medicare & Medicaid Services or CMS about these reports. During the call today there will be a presentation, that information and materials are available on the <http://www.QRURinfo.com> website and they're also available on CMS' website. So hopefully you all had a chance to pull those documents and you can follow along with the presentation today.

At this time I'd like to turn the call over to Tonya Smith from CMS and she will introduce our speakers for today. Tonya.

Tonya Smith: Thanks so much Sue. This is Tonya Smith and on behalf of CMS I would like to welcome everyone to our QRUR feedback teleconference. We will start with Dr. Sheila Roman, Medical Officer on our team who will go over the slide presentation. Shortly after the slide presentation, CMS will engage callers in a question-and-answer session. Dr. Roman.

Sheila Roman: Thank you very much Tonya and it's a pleasure to be on the call with you this afternoon and I wish you all a good afternoon. I'd like to go ahead and get started with the slides so I'll probably walk pretty quickly through the slides because I want to leave time so that everybody can have their questions answered and I'm sure that you have many questions that we can address for you.

I'd also like to impart in this call some important information both about the feedback program, about the value based modifier which were quickly walking up towards implementation in January 2015. And also to give you

some idea of why the reports that you have received are important to you. So I'm going to move to slide three and start with what is the Physician Feedback Program.

The Physician Feedback Program is a program that provides physicians with comparative information about the quality and cost of care delivered to their Medicare fee-for-service patients, through feedback reports, also known as Quality Resource and Use Reports. And we believe that this is really the first time in these reports that physicians really get to see this information with comparative information shown as well and we think that that is really one of the real benefits of these reports. We also think that the cost information is information that physicians and their practices are really not used to seeing and certainly not with benchmarking and for comparison shown as well.

I want to point out that in the 2013 physician fee schedule rule which was published in November of 2012 that CMS did announce the initial phase working up toward implementation of the value modifier. And physicians that will be the initial physicians included in the value modifier will be those groups of a 100 or more eligible professionals or about 1,100 groups nationally that that will be included initially in the value modifier who are groups of a 100 or more eligible professionals. And they will be able to elect how their payment modifier will be calculated and I'll go over that with you in some detail shortly.

And that will affect their payment in 2015 based on 2013 performance. So that there will be options as to how their payment will be affected in 2015. And we will be using, CMS will be using future Quality Resource and Use Reports to provide physician groups with the information about how the value modifier would affect their payment.

In the next slide on slide four, we just show you the distribution of groups across the nine states that received reports in December. And there were over 94,000 individual physicians who practice in groups of 25 or more eligible professionals in these nine states that received reports. And as you can see the spread of the number of groups that were of 25 or more eligible professionals in these states and not surprisingly the more densely populated states had increased number of groups and in percentages of groups in their states.

Slide five, just reviews for you the distribution of the number of physicians of NPIs per group and you can see that the distribution is large, implying that there are many groups that, you know, have a substantial number of eligible professionals and that they are groups that were as large as having 4,441 NPIs in their group.

On slide six I think this is really an important slide that really points out the five ways that these reports are important to you. And I think firstly they do provide, as I eluded to previously, comparative quality and cost data for quality improvement purposes. And that we do believe that this is a first time that many physicians will have seen such performance information from CMS and also cross information. It introduces you to how Medicare will be phasing in the value modifier. In the appendix there is a section on the value modifier. And on the initial first page we do talk a little bit about the value modifier as well.

The report also previews some of the quality and cost measures to be used in the value modifier so you can get a rough estimate of where you could stand. And this is particularly true of the claim space measures that CMS will be calculating and that will count as one of the group options to fulfill the PQRS requirement for group reporting and also for the value modifier. I would also point out that it uses the same risk adjustment and payment standardization techniques for cost measure as the value modifier.

And I think one other point, that is on this slide that I would point out is that we're starting with groups and that we will be working at the TIN-level. And probably most importantly is this last point that, you know, we encourage you to look at these reports. We understand the reports that contain your data are much more interesting to you than a template so we encourage you to look at your report and your data. To access your report and to suggest to us specific ways that we can make the Quality Resource Use Report more meaningful and actionable to you; so that it is most useful in helping you to improve the quality of care furnished to your fee-for-service Medicare beneficiaries. And I would also point out that value modifier and the QRURs are based on your fee-for-service Medicare beneficiary population.

On slide seven we lay out how CMS will calculate the value modifier on how the implementation will work in 2015. And as I said previously groups of physicians with greater than or with a hundred or greater eligible professionals will have either zero adjustment, a minus one adjustment or will elect quality tiering calculation.

And if we walk down the left-side of that decision tree those groups that are successful PQRS reporters and by successful that means that they will have registered and will report at least one measure for the GPRO web-interface, CMS approved registries or the administrative claims option that includes administrative claims performance, quality performance measures that will be calculated by CMS that they will be considered successful PQRS reporters. And they will have the option of having zero adjustment for the value modifier applied to them or they will have the option to elect a quality tiering calculation in which there would be an upward, no, or a downward adjustment based on the quality tiering.

And if we walk down the right-side of this decision tree for those groups that may decide that the amount of downward adjustment is not worth the effort that these groups will be considered non PQRS reporters, so these would be groups that are not self-nominating to participate in the PQRS and not reporting at least one measure and they would be subject to a minus one percent downward adjustment of the value modifier. And I would also add that they would also be subject to a minus 1.5 percent downward adjustment for PQRS. So the amount of downward adjustment actually is additive for the two programs.

And we would emphasize that we do believe that reporting is a necessary first step towards improving quality and that for this initial year of the value modifier we are stimulating reporting through PQRS as a pre requisite for having the option of choosing zero adjustment or electing the quality tiering calculation for your value modifier.

On slide eight, once we have data that is quality measure data we will group and score the value modifier using quality and cost domain. And you'll see on the left-side of this slide the domains that will we be using. The top are quality domains that are based on the national quality strategy, the bottom two are the cost domains that we will be using. And the quality measures used in the value modifier are classified into one of these quality domains, each quality measure within each domain is weighted equally after being standardized.

Each domain is weighted equally to form a quality composite. And if there are no measures in the domains as they are as many of the measures fall into clinical care, patient safety and care coordination and very few into population and community health. So only the remaining domains would be used and they would be equally weighted as well.

There are five cost measures and we'll go over them in the report and they're grouped into two domains, total overall cost or the total per capita measure. And total cost of beneficiaries with specific conditions including COPD, coronary artery disease, diabetes and hearth failure. And again each measure within each domain is weighted equally and each domain is weighted equally to form a cost composite.

On slide nine, we show how we will be tiering the two composites, quality of care and cost of care based on the groups standardized performance as I eluded to. And by standardized, I mean how far away from the national mean and we'll be looking at how far away by one standard deviation you are from the average cost. So we'll be focusing on the significant outliers and we will assign them for cost and quality to their appropriate tier.

And if you look at the very right-hand bottom if you're a high cost and low quality you would have a downward adjustment of minus one percent which is the same as you would have if you were not participating. On the other hand, if you are high quality, low cost or high quality, average cost or medium quality, low cost you would have an upward adjustment. And you'll notice that we have an x next to those three categories and that's because this is a budget neutral program and until we know how much money will be in the pot from those who are not reporting or who received downward adjustment we will not be able to calculate how much money will be distributed for those and who will be receiving an upward adjustment.

You'll also notice that there is an asterisk for those three boxes on this. And that asterisk identifies that for groups that participate in these – in these boxes that they would be eligible for an additional plus 1.0% if reporting clinical data for quality measures an average beneficiary risk score is in the top 25 percent of all beneficiary risk scores. So that essentially those groups who perform at these levels if they have a complex patient population they would have an additional plus 1.0% to their value modifier.

On slide 10, this reviews how do you get your QRUR in December 2012? And I would hope that most of the audience today has already accessed their Quality Resource Use Report. But essentially physicians for those of you who are in groups of 25 or more EPs in one of the nine states will be able to

obtain their individual reports by a secure internet portal <http://ww.QRURinfo.com>. And either a representative acting on behalf of the group can obtain all the individual reports for physicians in the group or an individual physician within the group can access his or her report directly using several authentication elements including the physician NPI, TIN and PTAN.

On the next slide we begin to look at the Quality Resource Used Report itself. And essentially what I would point out about the initial page is that there is some information on the value modifier. But essentially I think the major point is- what you can do and that really is to participate in the PQRS reporting program.

I'd like to focus now on slide 12 on the performance highlight page and, you know, essentially on that page the first box shows you the number of Medicare patients that you treated. And on average the number of physicians that treated each of your Medicare patients for who you may have submitted any claims. Again, you know, we feel that these are, you know, information that is not so readily available and that is probably of interest to physicians. In the middle of the performance highlight page we show you your performance on the PQRS measures you reported compared to other PQRS participants nationwide as well as the claim space quality measures.

So this section gives a physician performance rates on PQRS submitted during 2011. And again it compares you to the performance rates of other PQRS participants nationwide who submitted data on the same quality measure regardless of their specialty. So this is not specialty specific, you'll see that the cost measures are specialty specific in their benchmarks.

The claim space quality measures section also gives information on measure of the quality of care received by beneficiaries and this is based on a physician submitting at least one claim during 2011. And this is also based on regardless of who provided the indicated care for that quality measure. This information is provided to give a preview of the measures and the performance rates that you may – you will see, if you select the PQRS administrative claims reporting option for 2013.

However, Medicare does recognize that not all of these measures assess care provided by certain specialists. And the last section on that slide actually tells you how your cost were risk adjusted for your patients. And we do risk adjustment and payment standardization on all cost measures for risk adjustment based on a physician's patients characteristics, age, gender, Medicaid eligibility, history of medical conditions and end stage renal disease, CMS risk adjust, the total per annual per capita cost up or down for all of a physician's or your patients, your Medicare patients.

And it's a little counter intuitive but if a physician's cost were adjusted upward, this means that on average a physician treated beneficiaries that were less complex than the average Medicare fee-for-service beneficiary. And conversely if a physician's cost were adjusted downward, these means that on average the beneficiaries a physician treated were more complex than the average Medicare fee-for-services beneficiary.

Slide 13 really lays out for you the different exhibits that are in the 2011 Quality Resource Use Reports. The first two exhibits are related to quality and we talk somewhat about that, we'll look a little bit closer. And the rest of the exhibits are related to cost of care for your patients.

So exhibit one shows on the left-side of the Physician Quality Reporting System measures you may have chosen and it shows your performance compared to that of all physicians participating in PQRS. Your performance in the first two boxes and in comparison to all PQRS participants in the next two boxes.

On slide 15, this shows you how we're displaying the administrative claims-based quality measures. And you'll see those listed on the left-hand – in the left-hand box. And you'll note that some of those are asterisk and the measures marked by an asterisk will not be included in the administrative claims-based options for PQRS and the VM for 2015. And again you'll see that next four rows show your – the percent of your Medicare fee-for-service patients who received this service. And remember that services from you or any other provider and then the next two boxes or the benchmark and show the comparison of the services within your patient population compared to that of all Medicare fee-for-service patients attributed in these reports.

On slide 16, we display exhibits three and four of the QRUR. And again now we've moved into the cost side of the information that's in the Quality Resource Use Report. And here is what we've done is distributed patients by your degree of involvement with each patient into directed, influenced and contributed.

Directed patients are considered those patients for whom you billed greater than 35 percent or greater of their office or other E&M visits. And this would be most characteristic of a primary care provider. The influenced box shows for those physicians who billed for less than 35 percent of office or other E&M visits but for 20 percent or more of all cost and this might be more characteristic of a medical specialist particularly one might who – one who might be a proceduralist. And then finally the contributed category and those really include the rest of – the rest of the beneficiaries and those would be less than 35 percent of office and E&M visits and less than 20 percent of cost billed by the physician.

So that your Medicare fee-for-service population is categorized into these three categories based upon your degree of involvement with each patient. And the exhibit shows you the number of patients and importantly your share of costs billed by medical professionals for your patients.

Exhibit four shows you the total per capital cost A and B, we don't have Part D data in these report for your patients compared to that of all attributed Medicare fee-for-service patients in your specialty. And the benchmark for the cost measures are again those in your specialty. And again just to reiterate that total per capita costs are all risk adjusted and price standardized to ensure fair comparison.

The next slide really just reviews for you again the definition of directed, influenced and contributed. And I think as you can see here that you will fall

into one bucket for each of your patients but that you can fall into many of these buckets.

On slide 18, again we demonstrate that a patient – and this is very common in Medicare – for Medicare fee-for-service patients may have seen multiple physicians also with varying degrees of involvement. And so that a patient would be attributed to multiple physicians, each in the appropriate care category. So you can see because of the 35 percent rule for directing, it would be up to two physicians for directing care and up to five physicians for influencing care but that multiple physicians can contribute to care.

On slide 19 we review how patients may be distributed through this attribution process. And on slide 20, review – we show you a total per capita cost and how your cost per patient. And this is for directed patients attributed to how your specialty looked for across seven different service categories. So we're showing total per capita cost across seven different services categories, we're showing the results for the Medicare patient whose care you directed, the average for Medicare patients into whose care was directed by physicians in your specialty in the nine states, and then the amount by which your Medicare patients per capita cost were higher or lower than average in the last column.

And on page 21, on slide 21 rather, we show you the number of other physicians in exhibit six in the reports who submitted claims for your patients. And again I think many physicians are unaware of how many physicians their fee-for-service patients may be seeing. And in exhibit seven at the bottom – on the bottom of slide 21 we show you where your patient Medicare cost fall relative to other physicians in your specialty whether they're higher or lower or at the means. And this same analysis is repeated for influenced and contributed and would be shown in your report if you had patients that were attributed to you in those categories.

Slide 22 is an exhibit which shows you the total per capita cost for patients with the four chronic conditions that I mentioned earlier that also comprised – that also will comprise the cost composite for the value modifier. And these costs are risk adjusted and include services furnished by you and all other Medicare providers seen by the beneficiary.

So where are we headed with this? For CY, calendar year 2014 physician feedback reports, we will provide to all groups of physicians with greater than or equal to 25 eligible professionals reports. We expect to disseminate them in the fall of 2014 based on 2013 so it's based on the performance year for the value modifier and we will show the amount of the value modifier and the basis for determination. So it would include information on the quality and the cost composite as well.

We're expecting to add patient level data to the physician feedback report this is the – we'll probably be true for the outcomes measures so that you can see which patient performed well or didn't perform well for those measures that you can actually go back and look at your charts and find out. And we'll also provide you with the beneficiaries in the reports. And we are just beginning to include episode based cost measure for several episode types in the physician feedback report. You may recall that we were mandated to

develop a Medicare specific episode grouping methodology. And we now have a prototype and we, you know, for select number of conditions including pneumonia and several cardiac conditions we hope to be starting to put in the Quality Resource Use Report information on episode based cost measures for these conditions.

And finally on slide 24 I'd like to remind everybody that the information in the QRURs and the value modifier come from the PECOS system so I encourage you to go to PECOS and to ensure that your information is current.

So that's what I really wanted to cover today. And I'd like to open the call up now to questions from you. I would first remind you that on slide 25, there is information on where you can go to get information about the content of your report for questions on access to your report please go to <http://www.QRURinfo.com>.

And now I'd like to open up the questions from the participants on the call. Thank you for your attention.

Sue Brewer: Thank you Dr. Roman. (Sarah), would you please give the instructions again for the participants.

Operator: As a reminder if you would like to ask an audio question, please press star, one on your telephone keypad.

We'll pause for just a moment to compile the Q&A roster.

Your first question comes from the line of Cathy Biga from Illinois.

Cathy Biga: Thank you very much and thank you for a very informative session. I was wondering, I have a couple of questions as this relates to our PQRS. When we pulled our PQRS report card, we could not get our QRUR data to match the PQRS data, is there a reason for that or are we missing something?

Sheila Roman: Was this for 2011 or for 2010?

Cathy Biga: No, for 2011.

Sheila Roman: For 2011 I think it should have matched. For 2010 we did not include information from registry or (HER) but for 2011 it should have matched. Does anybody else have any other comments to this question.

Michael Wroblewski: What we can do is obviously take a look at it. If the PQRS reports were done at the TIN NPI levels, where is the reports that you have is done at the NPI level. So if a particular physician was in multiple TIN there could have been a disparity there but that was relatively few. But if you use our helpdesk we can look into it, you know, in your particular case, you know, in more detail.

Cathy Biga: That would be excellent. Can I ask you one more PQRS question? It appears that a couple of the PQRS measures weren't benchmarked and weren't included in our quality assessment, specifically the three coronary

arteries disease and slight heart failure measures that weren't utilize is that something that you work through the helpdesk as well with?

Michael Wroblewski: Yes. And which were those measures again?

Cathy Biga: The ones that we have measured five, eight, 196, 197, 198, 199, 118 and 200.

Michael Wroblewski: Yes and we'll take a look at that. We'll take a look at both of those questions. Thank you so much.

Cathy Biga: That would be great. Thank you.

Operator: Your next questions comes from the line of Leanne Denissen from Wisconsin.

Leanne Denissen: Hi. We are a multi specialty group and we looked at some of our QRUR reports that are currently available for our neurologist. And I would say about a third of the patients our neurologists see are being displayed on the report as they're carried directed by those neurologists. And my concern is when we listen to our prior value based modifier call they – I believe they were telling us that if in PECOS that position is listed as a specialist that they will not be evaluated on the cost measures that are primarily related to chronic conditions and that they would be solely being looked at on their PQRS measures?

Will it be evaluated? Because we're trying to decide if we want to quality tier or not. But I believe looking at the current QRUR reports it looks like our specialist will be being judge chronic care and cost for the patients they directed.

Sheila Roman: For the value modifier, you would elect one of three possible group practice options and those would be the web based interface which is largely primary care and preventive measures. You could choose from a registry and under that circumstance you would choose the measures. And the third option would be the claim space option calculated by CMS. But you would choose which option for the quality measures that would go into the quality composite of the VM you would want.

Leanne Denissen: I understand that. But if we choose the administrative claims method, we don't get to choose which measures we get looked at for, correct?

Sheila Roman: That's right.

Leanne Denissen: But will they, like for neurologists will they pick the neurology measures or it's going to be the same measures for everybody?

Sheila Roman: It will be the same measure.

Leanne Denissen: OK. And I understand that PQRS component of the value based modifier, but in term of the other two components in terms of chronic care – chronic conditions and cost, is that looking at the value based modifier those two-thirds of the program, our specialists are going to be being looked at based

on whom Medicare believes they're direct to care of regardless as their listed as a specialist in PECOS?

Sheila Roman: No. There will be a different attribution model that will be most similar, quite similar to the directed definition that we've used in these individual reports but will be dependent on primary care services. Michael do you want to review that, I think that's where the problem is here, where her question is.

Michael Wroblewski: No, that's a great question. You know, the reports that you picked up were at the individual level.

Leanne Denissen: Correct.

Michael Wroblewski: Right. And when we're doing the value modifier we're doing at the group or the tax payer identification number. The attribution method we'll be using for the value modifier focuses on the delivery of primary services through a two step process. The first step as you've indicated looks at whether your primary care physician and then it attributes beneficiaries that way.

If a beneficiary can't be attributed because it's starts with the pool of beneficiaries who have had at least one in service. You get that pool then we look to say, OK, did the – the TIN meaning and the primary care physicians deliver the plurality of care, beneficiaries are then attributed that way.

And then there's a second step which looks at if the TIN provided the plurality of the primary care services but by non primary care physicians the beneficiary would be attributed. So, to go back to your question of will my neurologist be responsible for having people attributed to my TIN, that's kind of what your question is I think.

Leanne Denissen: Correct.

Michael Wroblewski: And the answer is, if they're in the second step, if they along with other physicians in your group provide the plurality of primary care services more to beneficiaries that don't have a primary care physician doing it then initially they could be helping have a physician – having a beneficiary attributed to your TIN. So not primarily but they could – if a beneficiary doesn't have someone who's doing it kind of for the most of their care they could add in.

You know, they're different, the reports that we provided this year, we're really using a different attribution methodology. And we're very much looking at the group when we do the value modifier and in some cases specialist will provide E&M services could be – could their services provided could be putting the group over the plurality if that makes sense?

Leanne Denissen: OK. So just because two physicians made, you know, maybe 10 out of a 100 physicians do have the plurality of E&M care for a subset of patients but if most of our doctors are doing that we're unlikely to be attributed to those patients?

Michael Wroblewski: That's true, that's true. I mean, obviously I don't have here...

Leanne Denissen: I understand.

Michael Wroblewski: Because you got to kind of look not only what the care that your TIN is providing but what other care, other TINs are providing to those beneficiaries too, right?

Leanne Denissen: I get it. Thank you very much.

Michael Wroblewski: It's a great question. Thank you.

Operator: Your next questions is from the line of Sarah Decaussin from Michigan.

Sarah Decaussin: Thank you so much. My questions – it was my understanding that the PQRS reports that came out to all the physicians were only directed for physicians that had GPRO for 2011. That data was then going to be used in the QRUR reports whereas we do not GPRO during that time and all of our physicians don't receive those reports?

Michael Wroblewski: Can you say that again, I missed your question. I'm sorry.

Sarah Decaussin: Oh, I'm sorry. My understanding was the individual PQRS reports that went out, the physicians just received them. Were based on group practices that GPRO that group reported. And it was not going to be based on physicians that individually reported. Am I correct in that assumption?

Michael Wroblewski: I don't think so. PQRS reports that I believe for 2011 there were two sets. One if you participated individually, you could pick up your individual report. And if it were about 54 groups that participated in what we call the group practice reporting option and we sent reports to them as well. The QRUR that we sent incorporated at the individual level, incorporate the individual PQRS data if the physician participated in PQRS as well as the cost data that Dr. Roman went through as well as the administrative claims data that was there too. So...

Sarah Decaussin: So I guess my questions is, for some of our physicians, the PQRS data is missing on some of this QRUR reports. So it's our understanding that they only pull that data if we have group reported because we're a group of a 100 or more, we're about 650 physicians.

Michael Wroblewski: Did your group participate in the PQRS as a group?

Sarah Decaussin: No, we did as individuals.

Michael Wroblewski: OK. Then all of your individual physicians, PQRS data should be in each individual report. And I think what you're telling me it's not?

Sarah Decaussin: Correct.

Michael Wroblewski: OK. If you can use the helpdesk and provide the TIN to the helpdesk we'll be able – and we'll track this down and figure out and make sure that we – I think I understand your question looking into it and get to the bottom of it.

Sarah Decaussin: Yes, we assumed because we did a GPRO, you know, so we thought it's only if you have a GPRO that information was included.

Michael Wroblewski: OK. Well, we'll take a look. Use the helpdesk and if you get the TIN and then we'll figure out what will happen.

Sarah Decaussin: All right. Thank you so much.

Michael Wroblewski: You're welcome. Thank you.

Operator: Your next question comes from the line of Karen Laisam from Michigan.

Karen Laisam: Yes. Basically we have the same concern or question that you just had where we have a number of physicians that did PQRS reporting and the exhibits indicate that they're not shown because we didn't participate or whatever but we did. So we'll call the helpdesk for that.

Michael Wroblewski: OK, great. Thank you.

Karen Laisam: But also we didn't get the slides for the presentation, how would we get those?

Sue Brewer: This is Sue. There's a couple of ways you could get them. I would recommend the quick and easy way is go to <http://www.QRURinfo.com> and click on the contact information page and you're going to see upcoming events right about where you found the phone number information for today's call. And below that you're going to see materials presentation and just click on that and you can pull them right up and print them off.

Karen Laisam: OK. Thank you.

Sue Brewer: They're also available I believe on CMS Web site, you could do it that way too, whichever way is easiest for you.

Karen Laisam: OK. OK, thank you.

Sue Brewer: Sure.

Operator: Your next question comes from the line of Tracy Essling from Illinois.

Tracy Essling: Hi, I just – I have a question. We are a multi specialty group and we belong to an ACO, does the value modifier in the election options still apply to us?

Michael Wroblewski: No.

Sheila Roman: Not for 2015 and 2016.

Tracy Essling: OK. So we don't have to worry about it?

Sheila Roman: That's correct.

Tracy Essling: OK. Thank you.

Sheila Roman: For those two years, after 2016 we will probably make some proposals.

Tracy Essling: OK. All right, thank you very much.

Operator: Your next question comes from the line of Debra Nusbaum from Illinois.

Debra Nusbaum: Yes, I have a couple of questions. One is we have some practices in Indiana, will this report be available for Indiana physicians next year?

Sheila Roman: For next year for the 2012 data we'll be doing groups of 25 or greater nationally will receive QRURs.

Debra Nusbaum: OK. And when do you plan – do you have a date plan of when you're going to do the VM to practices under 50 physicians?

Sheila Roman: At this time, you know, we don't. We will be making proposals in the upcoming rule that we'll be out during the summer.

Debra Nusbaum: OK. So look for some type of notification over the summer?

Sheila Roman: Yes.

Debra Nusbaum: OK. And last but not least, exhibit two in your slide presentation, you said all Medicare patient for whom you submitted the claim, we are on the nephrology practice and you're speaking about breast cancer surveillance for women, number of Medicare patients for whom the services indicated. If a number is in that column means that patient was treated by with another physician has nothing to do with us, correct?

Sheila Roman: Well, it couldn't. I mean, it could do with you but because it's a claims – because it's a claims-based we would pick up any physician who may have done the indicated care.

Debra Nusbaum: OK, that's what I need to know because all of our nephrologists were like they current – so we didn't bill for these services, I just wanted to make sure. OK, thank you.

Sheila Roman: You're welcome.

Operator: Once again if you would like to ask a question, please press star one on your telephone keypad.

Your next question is a follow-up question from the line of Cathy Biga from Illinois.

Cathy Biga: I just have one more question if you don't mind. My understanding is that CMS will be revising the attribution methodology for the 2011 QRUR and I come from a specialty group. What do we expect to see in our 2012 QRUR, will it look more like the patients that we actually direct through care or do we know yet?

Michael Wroblewski: If your group doesn't provide basically primary care services it's unlikely that beneficiaries will be attributed.

Cathy Biga: Thank you. And then if you don't mind, one other question. Our group participated in PQRS via claims and registry, as we try to appeal a report back it appears, but of course it could be wrong that CMS may have summed all of our numerators and denominators regardless of how we spend them via claims or registry?

Michael Wroblewski: Yes.

Cathy Biga: Is that what happened?

Michael Wroblewski: That is what happened.

Cathy Biga: Aha. Thank you.

Michael Wroblewski: Remember we have two questions earlier about – two question that was asked about the PQRS data and it looks like the PQRS data was missing. The one thing I do want to highlight is that we only included incentive eligible participants, so if – data. So if the physician did not – was not a satisfactory reporter and became incentive eligible then that data was not included in the 2011 report. So there could be a reason why the PQRS report, you know, any submission, we only put in those that were met the criteria to be eligible for the PQRS payment incentive, that could be one of the other reasons for the differences between the two reports.

Operator: Your next question comes from the line of Kayla Hopson from Wisconsin.

Brian Shaw: Hey, Brian Shaw it's for Kayla Hopson. We have practices in Illinois and Wisconsin, one suggestion that our team had for the per capita cost report basically exhibit four to the end would be to include standard deviation information so we can tell how our actual result compared to the mean, you know, if it's one standard deviation above or below that basically co inside with how the grouping methodology is going to work for the value based modifier. Can you comment on that?

Michael Wroblewski: That's a great point and stay tuned for the reports next year. Great point.

Brian Shaw: Thank you. That would really aid our ability to interpret the data and to make good decisions about where we actually stand.

Michael Wroblewski: I couldn't agree with you more.

Operator: There are no further questions.

Sue Brewer: There are no more questions Sarah?

Operator: No further questions.

Sue Brewer: OK. I would like to thank everyone today for joining us. Tonya does anyone else have any closing statements to make before we close the call today.

Tonya Smith: Again we just want to thank everyone for participating on the call and for your questions as well. Thank you for your time.

Sue Brewer: And I would also like to encourage everyone if you haven't pulled your report the last slide on the presentation today gave you the information, the Web site for specific QRUR report questions as Michael referred to where to send those questions. You can also send through the <http://www.QRURinfo.com> website. And we also have one available on that website as well. So if you need some help pulling your report just get the directions out there for doing so.

And that concludes our call for today. Thank you everyone.

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

Thank you and have a great day.

END