

QRUR Feedback Teleconference Transcript

WPS Medicare
Moderator: Sue Brewer
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10:00 am ET

Operator: Good morning, my name is (Tammy) and I will be your conference call operator today. I would like to take this time to welcome everybody to the CMS QRUR Feedback Teleconference.

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

And now, I would like to turn the call over to our host, Ms. Sue Brewer. Ms. Brewer, you may begin your conference.

Sue Brewer: Thank you, (Tammy), good morning everyone. I would like welcome everyone to the teleconference this morning. My name is Sue Brewer, I'm an analyst in the Provider Outreach Education Department at WPS Medicare. I will be facilitating today's call.

Welcome to the call today for the Quality Resource and Use Report or QRUR reports teleconference. There will be a presentation by CMS staff using the materials that are available on the contact information under upcoming events on the QRUR website at www.qrurinfo.com. If you have not had a chance to pull that slide deck, please do so. After the presentation, you will be able to ask questions and provide feedback regarding your QRUR report.

I would also like to take a moment today, this morning to talk a little bit about the actual pulling record for reports. For the State of Iowa right now, the percentage as of March 17th is 52.50 percent which is very good, Kansas has pulled 41.90 percent, Missouri has pulled 32.90 percent, and Nebraska has pulled 22.47 percent.

So there are still reports available, also reports will be available until April 30th of this year 2013 and I would like to turn the call over to Tonya Smith from CMS and she will introduce our speakers for today. Tonya?

Tonya Smith: Thanks, Sue, this is Tonya Smith from the Fulfillments Base Policy Group at CMS and I'd like to welcome everyone to our QRUR Feedback Teleconference. Today we'll start with Dr. Roman, who is our Chief Medical Officer here at CMS and she will be going over this presentation. After the presentation, we will engage in a question and answer session. Dr. Roman?

Sheila Roman: Thank you very much, Tonya, and welcome everybody on the call. It's a real pleasure to talk to the four states who got the Quality and Resource Use

Reports last year and to hear the high percentages. I would also emphasize that there's still are reports out there and they're available till April 30th.

So, if you have colleagues and I would imagine that many of you on the call have already received your – picked up your reports, but if you have colleagues or know of other groups who have not, please encourage them to pick up their reports.

I'm going to be following this slide deck that was posted on the WPS website and I'm going to start with slide three. I think that most of you from the four states who received reports last year know what the – what a physician feedbacks – what the Physician Feedback program is. Basically, it is a program which provides physicians with comparative information about the quality and cost of care delivered to their Medicare fee-for-service patients through this feedback reports that you've seen last year and this year also known as the Quality and Resource Use Reports.

And I guess the point that I would emphasize to you is that, you know, I think that this – that because we benchmark both our quality data that we show you and the cost data that we show you, and show you comparative data that it's really a performance report. So it really goes the next step beyond what you may receive from other reports that you may be getting both commercially and from Medicare through PQRS.

I'd also like to emphasize that I know you've seen last year's reports and this year's report had some changes, not dramatic changes, we expect next year's reports to show really a significant change and – but I'd like to emphasize that these reports do provide you with information about how the value modifier will effect payment and that certain of the measures or within this report are used within the value modifier for 2015 and some measures will undoubtedly go beyond 2015.

Just to talk a little bit about the value modifier here in the 2013 physician fee schedule, CMS announced that for the initial phase of implementation of the value modifier that it would include physicians practicing in groups of a 100 or more eligible professionals, they would give in an – be given an opportunity to elect from three options how their payment – what quality measures they would use for their payment modifier and they would also be given an option as to how their payment modifier would be calculated to affect their payment in 2015. And that this is based on 2013 performance so that, you know, we're, you know, essentially one quarter into the performance year for the performance year for the value modifier that will be implemented for groups of a 100 or more in 2015.

Now on slide four, which really shows you just a distribution of groups across nine states. For last year, as, you know, just the J5 region received reports and those are about 20,000 reports that we made available that this year we extended it to nine states. We included all of those individual physicians that were in groups of 25 or more eligible professionals who received reports.

And that was about 94,000 plus reports that were made available this year to physicians in these nine states.

And if we turn now to slide five, you'll see that the size of the groups are, you know, that for the QRUR so were produced very significantly from, you know, single physician practices up to a maximum of a very large practice with almost 4,500 physicians practicing within it.

So, what is the importance then of the QRUR for 2011? And, you know, as I already mentioned, it really provides you performance data for quality and cost data for quality improvement purposes and I think that this is important as we move, you know, towards this environment of paying for value that as a physician and as physicians within practice, you need to know how you're doing on quality metrics within your practice and, you know, how your cost are relative to others.

And, you know, I think all of this information will be helpful in bringing increased value both to your practice and to your patients in allowing you to make quality improvements and improve your care coordination.

The report does introduce you in to how Medicare is phasing in the value modifier as I mentioned earlier, it does preview some of the quality and cost measures to be used in the value modifier, so you can get a rough estimate of where you might stand.

And I want to point out that for the cost measures, we do – we risk adjust and payments standardize those measures and that will be using the same risk adjustment and payment standardization techniques in the value modifier.

And, I also want to encourage you to write to us, to suggest specific ways to make the QRUR as more meaningful and actionable because, you know, our bottom line is to improve the quality of care furnished to our beneficiaries and to a view and quality improvement and care coordination within your own practices.

OK, now moving to slide seven which, you know, we sort of consider the key stone slide for the value modifier for 2015 and again this little decision tree makes the point that groups of physicians with more than – with a 100 or more eligible professionals will have the value modifier applied in 2015 and the amount of adjustment to that will be applied to their fee-for-service billings will be based essentially on whether they are PQRS reporter or non PQRS reporter.

Now if we follow the left hand of the slide down, if you're a PQRS reporter, that means that you're one of these groups of a 100 or more who has self nominated to participate in one of three group practice options that PQRS is offering for 2013 and that is the GPRO Web Interface which was formerly called GPRO-1, registries or a low burden option in which CMS calculates a group of 14 administrative claims-based measures that are NQF endorsed.

To qualify as a PQRS reporter and avoid the downward adjustment for the value modifier, groups of physicians must have self-nominated for the PQRS GPRO-1 or registry option as a group and reported at least one measure or have elected the PQRS administrative claims option. The value-based payment modifier for these groups of physicians will be 0.0%, meaning no payment adjustment will be applied to physicians in these groups in 2015. Or these groups of physicians have the option to elect that their value modifier be based on quality tiering.

Now, if you do elect quality – this quality tiering calculation and you'll see this shortly, you could have an upward adjustment, no adjustment, or downward adjustment depending on how you fell with your quality and cost measures on the calculation of the value modifier.

I do want to make the point that the value modifier will not apply to physicians who are not paid under the Medicare physician fee schedule and also for 2015 and 2016, it will not apply to groups of physicians participating in the Medicare shared saving program, the pioneer Accountable Care Organization model or the Comprehensive Primary Care Initiative and that's because these three programs are collecting and reporting similar types of data and we don't want the two programs to interfere with each other. We want some time to see how the programs do interact with each other.

But I think it's a good bet that for 2017 and you'll have to follow the rules to be sure that the – if you are a participant in a Medicare Shared Savings Program or the pioneer ACO model or the CPCI that the value modifier will be applied to you in 2017 as it will to all physicians nationwide.

Let me just complete slide seven by going down the right hand side of that slide and that basically says that if you are non PQRS reporter that is you did not self nominate to participate in one of those three group practice reporting options in PQRS and did not report at least one measure, then you would be considered a non-reporter from the perspective of the value modifier and would be subject to the minus one percent downward adjustment.

And in 2015, if you're a non PQRS reporter, there will also be a second downward adjustment from PQRS of 1.5 percent, so in fact that group would have 2.5 percent downward adjustment on their fee-for-service filing.

OK, now let's turn to slide eight and which we'll talk a little bit about the quality tiering methodology and basically what we're doing in the quality tiering methodology is combining the quality measures and the cost measures into a quality of care composite score and a cost composite score that then is tiered which we'll show you in the next slide and that's how we figure out the value modifier amount that will be applied.

Now, each quality measure reported through the PQRS system is fit into one of the domains that you see on the boxes on the left hand side of the slide and those boxes correspond to the domains that are in the national quality strategy and each measure within each of the domains is weighted equally

and then each domain is weighted equally in the calculation of the quality of care composites.

Likewise for the calculation of the cost composite, right now we have two domains, one for the total overall cost (total per capita cost measure). This measure you saw last year on your reports would fit into that box. The other domain, the total cost for beneficiaries with specific conditions (total per capita cost measure for four chronic conditions) that you saw on your reports last year would be put into that domain. Then again, the measures within the domains would be weighted equally and then the domains themselves would be weighted equally in order to comprise and calculate the cost composite score.

On the following slide, you see the tiering methodology that we will be using in order to determine the calculation of the value modifier that would be applied to your – to your group. So each group receives these two composite scores for quality and cost, those are based on the group's standardized performance.

In other words how far away from the national mean and this approach identified statistically significant outliers and assigns them to their respective cost and quality tiers so that in order to move from out of medium quality into high quality and low quality, you have to be one standard deviation away from the mean if they're 95 percent confidence in their goals so that we're really looking at the outliers and the same applies for cost as well.

Now, if we look at the grid for the value modifier, you can see on the lower right hand side is the area of the – of the grid where there would be a downward payment adjustment applied and that essentially would be for low quality high cost care and the upper left hand part of the grid is the area where you would get an upward payment adjustment for high quality lower cost care.

And as you can see, we don't have percent shown in those grids because this is a budget neutral program so that until we know actually how much money we have to divvy up which would be based on the non-reporters and those who were the poor performers on quality tiering, we can just – all we can do is lay out how the bump ups would compare to each other.

I'd like to also point out that three of the boxes in the grid are eligible for an additional 1X bump up, so for instance high quality low cost would be 3X, if this was a group practice, the care for high risk beneficiaries whose beneficiary risk score was in the top 25 percent of all beneficiary risk scores.

Now, moving on to slide 10 and now we'll be shifting away from the value modifier and looking more specifically at the exhibits and the reports themselves. The slide 10 just reviews how you – how you get your QRUR right now and again the – this secure site will be open until the end of April and that's www.grurinfo.com and a representative acting on behalf of the group can obtain all the individual reports for physicians in the group or and

an individual physician within the group can access his or her report directly using several authentication elements, NPI (PTAN) and PTAN.

OK, so slide 11 is our cover page for the 2011 Quality and Resource Use Reports that went out at the end of December 2012 and it contains information about all of your Medicare patients, the quality and cost of their overall care delivered by you and also other physicians.

And I would encourage you to review your performance both for quality and cost. The cost measures that are in this report will be the cost measures that will be used in the value modifier going forward certainly 2015, 2016, and I think going forward for a number of years beyond that.

Again, you'll – you'd have – you have to keep your eye on the rule, but my sense is that this total per capita cost measures that you see in this report will be going for a number – for the foreseeable future for the value modifier.

I think, you know, the other real take home from these reports is, you know, participate in PQRS, get in now, don't leave yourself open for downward payment adjustment which is probably likely to ratchet up overtime and for the value modifier program.

And then the third opportunity here is for you to provide us feedback on how these reports can be made more useful to you for quality improvement within your own practice and within your own medical groups.

OK, so let's look at slide 12 which is the performance highlights page and on the performance highlights page, you'll see information about the number of Medicare patients that you treated.

We think this is important because often as physicians, you know, we don't really keep track of and have systems that tell us who we're treating so we think this is important and you'll see there's an exhibit later in the report that actually let, you know, of the patient's – Medicare patients that you're treating the fee-for-service Medicare patients, how many other doctors are also treating those patients because these – as you are probably aware, you know, the fee-for-service Medicare patients tend to have very fragmented care.

And one of the purposes of this program is to encourage less fragmentation and more care coordination between the physicians who are involved in the treatment of our Medicare beneficiaries.

And as I've already emphasized, you'll see your performance on the PQRS measures also on this administrative claims-based quality measures and on the cost measures within this report and the bottom of the highlights phase tells you how you look by risk adjustment and what your risk adjusted cost were for your patients. So that if you have a low risk practice, it is likely that you saw your risk adjusted cost actually go up and if you have a risk patients after risk adjustment, you probably – you should see your cost – your risk

adjusted cost go down because of the impact of risk adjustment and trying to level the playing field for the complexity of the patients that you see in your practice.

Slide 13 shows the different exhibits that are in those reports. There are two quality exhibits that we'll look at shortly. For PQRS measures and the administrative claims-based measures and you'll be able to see how the quality of care your Medicare patients received compared to that of other physicians' Medicare fee-for-service patients. And all of the other exhibits in the report relate to cost and within you'll be able to see how your Medicare patients total per capita medical – Medicare cost compared to those of all Medicare fee-for-service patients attributed to physicians practicing in your specialty.

And I just want to point out, we'll be looking at exhibits, 3, 4, 5, 6 and 7, 8, 9, 10, and 11 are very similar to those in five, six and seven and then we'll look at exhibit 12. And you'll see that exhibits 5, 6 and 7, 8, 9, 10 and 11 shows the data based on the degree of involvement that you have had – with your patients whether you directed care, you influenced care or you contributed care and I'll define that in more detail as we move forward with the slides. But and, you know, I think you get the idea that if you directed care, you have more involvement than if you only contributed to care.

Now looking at slide 14, and again this is exhibit one and shows your Physician Quality Reporting System measures that you reported and only the measures you selected by a claims registries or EHRs are shown and those are shown in the left hand column and your performance and along the rows is compared to that of all physicians participating in PQRS.

On slide 15, we show the administrative claims-based measures and on the left hand column, they're actually for last year's report as you probably recall and this year's report we look at 28 claims-based measures and sub-measures of these measures and for these measures, there's a comparison of services within your patient population compared to that of all Medicare fee-for-service patients attributed in this report and that the percent of your Medicare fee-for-service patients who received this service is shown from you or any other provider. So when we use the claims-based, it's really a one touch, so it's showing you data from yours or any other provider that may have touched this patients.

Now, as I mentioned when I showed you that decision tree for the value modifier for 2015 that one of the group practice options for 2015 is a claims-based option and that option will be using a set of 14 of these claims-based measures that you've seen in last year's report and this year's report and in this year's report, if they did not have an asterisk, then they were included – then they were the 14 measures that were included in that option for the value modifier for 2015.

OK, let's look at slide 16, this is exhibits three and four and this lays out for you based on the categories of your degree of involvement with your patient.

The number of patients in each of those, the number of office or other outpatient E/M visits you build and your share of cost build by medical professionals are for each of these categories of patients.

And exhibit four shows you the total per capita cost for your patients compare in this three categories, compared to that of all attributed Medicare fee-for-service patients in your specialty. And I just want to emphasize again that the total per capita cost or risk adjusted and in price standardized to ensure fair comparison and nationally and within your specialty.

So on slide 17, we provided for you the discreet definitions of the categories that are reflected Degree of Involvement and those are directed, you directed the care of a patient if you provided greater than or equal to 35 percent of E/M visits and we would expect that to be those who provide care and then and are in the primary care type specialties.

You influence care if you claim greater than or equal to 20 percent of Part B cost and we would expect you to fall into that category most likely if you are a proceduralist. And for all else, you contributed.

Now looking at slide 18 which makes, you know, a somewhat separate point on the slide before, you will fall into one bucket for each of your patients. So each of your – for each of your patients, you will have directed, influenced or contributed to their care. However, a patient may have seen multiple physicians also with varying degrees of involvement, therefore that patient would be attributed to multiple physicians each in the appropriate care category and you can see based on the 35 percent role for directing up to two physicians could be attributed a beneficiary as directing their care up to five physicians per influencing his care and multiple physicians can contribute to a beneficiary's care.

And slide 19 is just an example of how a – how the attribution process would result in a profile of your involvement with your Medicare beneficiaries in your practice.

OK, slide 21, we're looking at exhibit five and again five, six and seven, we're looking at directed patients but your reports will also show you exhibits for influence and contributed patients if you were attributed to such patients.

And for exhibit 5, slide 20, what we're showing is total per capita cost across seven different service categories and you see those in the column on the left and we – those are – we're showing how cost for your patients compared to those of all directed patients attributed to your specialty to your compared and you see that across the rows. So, the cost includes all Part A and B payments for service furnished by you and other Medicare physicians.

In exhibit six and seven, again in exhibit six, this is the number of other Medicare physicians your patients are seeing on average in addition to you and again, we think this is important information because I think often, we

don't realize how fragmented the care is for the fee-for-service patients that we may be seeing.

And in exhibit seven is a figure which shows the distribution of the 2011 total per capita cost of patients whose care was directed by physicians and your special team in the United States and shows where your patients Medicare cost fall relative to your specialty. And again, the same analysis is repeated in your reports for Influence and Contributed beneficiaries to you.

In exhibit 12 on slide 22, we show the total per capita cost for patients with chronic conditions that is Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease and Heart Failure and those costs are compared to patients in your specialty receiving a report. And again, the cost of risk adjusted and includes services furnished by you and all other Medicare providers seen by the beneficiary.

And I want to just make clear that the per capita cost for patients with these chronic conditions include all cost for the year, these are annual per capita cost and not just those related to the specific conditions.

So on slide 23, some of the future directions where we expect to be going. We expect to have reports out in September of 2013 that will be available through February of 2014 and these will be group reports for groups of 25 or more eligible professionals and they will be based on 2012 data. And in these reports, we will preview the quality and cost composites. So they will be calculated and displayed in these reports. So they will inform quality tiering election for groups of 100 plus EPs even though it will be based on 2012 data and not 2013.

In the calendar year 2014, Physician Feedback Reports, we expect to have reports out to cover all physicians in the fall of 2014 that's based on 2013 data. And so this will be provided to all physicians within the single TIN nationwide. And these will show the amount of the groups of value modifier and we'll show all the components and of the – of the value modifier calculation and the basis for its determination. And this will be for those groups of a 100 or more of the value modifier that will be applied in 2015.

Other directions that will be moving toward in the Physician Feedback Report is to add patient level data to the Physician Feedback Reports and we hope to build in a feature so that physicians will be able to look down into the report, so they'll be able to figure out for their patient population who is high cost or who did not get a quality service that they should have gotten.

And the other direction that we're going is toward the inclusion of episode-based cost measures for several episode types in these reports. And right now, we're working on a number of episode-based cost measures for cardiac care.

Now on slide 24 which is really a Public Service Announcement. I just want to encourage everybody that it is important for you to have your correct

information in Medicare's PECOS system because it's – this information that we use when we determine your medical specialty, the state where you practice, the location of your practice, your group practice affiliations and how to contact you.

So please go into the PECOS system, the Provider Enrollment Chain and Ownership System and check to see if the data is correct and up to date.

OK. Well that ends my comments really for today. We're ready for the Q&A section. The only other comment I would make is that if you have questions about the content of your report, the first email address on slide 25 is where you should send your question to. If you have questions on how to access your report, please visit www.grurinfo.com and other comments can always be sent to grur@cms.hss.gov for our consideration.

So, if we can open up the lines now for the question and answer period and I thank you all for your attention and for attending this morning's call.

Operator: As a reminder, if you would like to ask a question, please press star, then the number one on your telephone keypad and we'll pause just one moment to compile the Q&A roster.

And it looks like we do have a question from the line of (Barbara Hall).

(Barbara Hall): I have several questions. I'm assuming when you talk about cost on here, that's based on the amount that you guys that Medicare is actually paying right, not the cost for the actual provider side?

Sheila Roman: Yes, Medicare cost.

(Barbara Hall): OK. And then when you count the number of providers in a – in the TIN, that's based on who's assigned to that group or just to who actually submitted claims that year?

Sheila Roman: Actually, when we go in to do this, it'll be a two set process and we'll look at who submit the claims for that year.

(Barbara Hall): OK. And the year we're talking about, is that the federal fiscal year or a calendar year.

Sheila Roman: Calendar year.

(Barbara Hall): OK.

Sheila Roman: (Jeff), do you have anything to add to those?

(Jeffrey Blue): No, Sheila, you're correct on all counts.

(Barbara Hall): And the other one I have was does it make it – is there a difference when it's IPF hospital rather than a medical hospital that these doctors are providing

services in, and how big the impact is that's going to influence on this value modifier?

Sheila Roman: Well, I'm not sure. IPF is – I'm not familiar with IPF.

(Barbara Hall): Inpatient Psychiatric Facility.

Sheila Roman: Inpatient Psychiatric, all right. OK. Well, all hospital – the cost measures are based on Part A and Part B. So, the hospital cost, you know, tend to be the high cost within the cost measure and tend to be the drivers of the total per capita cost. Does that answer your question?

(Barbara Hall): Sort of. I used to notice on the reports that I pulled that I look at a couple of them that it shows that there's other providers providing services to our patient. Well, that's because we have to – we're doing – under arrangement for medical services for our psych patient. So when the doctors bill for their professional services to Medicare, they're using the place of services that they actually provided in rather than the fact that they were actually an inpatient in our facility. And so, it kind of confused it because it – ours isn't showing as a primary care physician I guess and they're been in our facility for a long time.

Sheila Roman: Yes. And (Jeff), do you have anything to add here?

(Jeffrey Blue): And thank you, Sheila. I think the one thing that I would add and this is to add to what Sheila has just said is that when a patient, a beneficiary is attributed to a medical group practice or an individual physician, that beneficiary and all of the Part A and Part B costs for services received by that beneficiary during the program year are attributed to that – to that TIN, that medical group practice or individual physician.

And so, it's not only in consistent with the attribution approach but also to be expected that many of the cost associated with the beneficiary to which, you know, who might have been attributed to you will be accounted for by other providers.

Now, to the extent that they had a hospital stay of any kind, they spent time in an IPF rehabilitation hospital, an acute short term facility, you know, those due tend to result in higher cost and so they would – in the absence of risk adjustment resulting a higher cost for that beneficiary, obviously, the purpose of risk adjustment is to identify and account for those beneficiaries who might have hospital stays and adjust cost accordingly for the – for the provider who has attributed to the beneficiary.

(Barbara Hall): Well, are going to be skew because we – most of our patients have already exhausted their psych benefits before they ever get to us. So our hospital cost won't show up. That's all my questions, thank you.

Sheila Roman: Thank you. Any other questions?

Operator: Yes. Your next question comes from the line of (Pam Worman).

(Pam Worman): I was wondering if you can tell me how to get the slide presentation. I have tried multiple ways to get it from the website and I don't know if it's just unavailable or there's a way to get that once this is over?

Sue Brewer: Sure. This is Sue from WPS. If you just want to go, probably, the quickest and easiest way is to go to the www.qrurinfo.com website.

(Pam Worman): Yes.

Sue Brewer: And when you pulled that up, you're going to get a – it's going to show Medicare dash QRUR at the top and if you go down under upcoming events...

(Pam Worman): Right, that tells us...

Sue Brewer: ... on left hand side with...

(Pam Worman): Yes.

Sue Brewer: ... teleconference and there should be – there will be a queue there at the bottom where it's going to say QRUR teleconference material.

(Pam Worman): Right. I click on that, it won't let – it brings up nothing so I guess it could be a firewall or something because I tried that a million and I get nothing so. OK.

Sue Brewer: The other way you – the other way you can do it, too is if you go to the section where it says additional information, I find the easiest way and you can go to the CMS website, it's actually posted there as well. The slide deck is there as well but I'm – I don't know, you may have the same issue. You may want to check and see. It's sound like an internal issue to me because it's coming up no problem for me right now because I'm on my computer so.

(Pam Worman): OK, All right. OK.

(Cari): And Sue, this is – this is (Cari).

Sue Brewer: Yes.

(Cari): If you took the – and I'm sorry, I didn't catch your name. If you continue to have issues and you're not able to access us on a CMS site, if you can't get it there as well, we do have the ability to bring you to send in that question, we can probably send it out to you via email. I mean, or ...

(Pam Worman): OK.

(Cari): ... we can get it to you, somehow, it is quite – it's going to be quite a large file but there are other ways that we could probably get that to you.

(Pam Worman): OK, thank you very much, I appreciate it.

(Cari): You're welcome.

Sue Brewer: You can use – you can use the live chat function from 10:00 to 2:00. You could actually – if you're having issues with accessing information regarding the call or anything like that pertaining to these reports, accessing report, you can even send me – send the live chat and we can, like (Cari) said, we can make sure you get – we can get access to you for – get it to you somehow.

(Pam Worman): OK. Well, I tried that yesterday too and every time I click on it, it says live chat support is closed. So I couldn't get in yesterday because I tried to get it before hand and it ...

Sue Brewer: Right.

(Pam Worman): ... (inaudible).

Sue Brewer: But remember it's from 10:00 to 2:00 Central Time.

(Pam Worman): Yes.

Sue Brewer: Live chat is available from 10:00 to 2:00 so.

(Pam Worman): All right. Thank you so much. Appreciate it.

Sue Brewer: OK.

Sheila Roman: And also, you can get on to the CMS website at www.cms.gov/physicianfeedbackprogram and on the left side, if you click on teleconferences, it'll take you to another screen which lists the various teleconferences and if you click on 3/20/2013, that'll bring you to the slides.

(Pam Worman): OK. I'll try that too.

Sheila Roman: Any other questions?

Operator: As a – as a reminder, if you would like to ask a question at this time, please press star then the number one on the telephone keypad.

And your next question comes from the line of (Sandra).

(Sandy Forgonets): Hi, this is (Sandy Forgonets) from (Primeras). Thank you for taking my call. We have a question on slide five that shows the number of QRUR cost we produced. It's based on there that they were produced only for physicians who practice in groups of at least 25 eligible professionals and yet on that slide, it showed that the minimum number of physicians per group was one. Why would that minimum number of physicians per group be one when it – you have to tell at least 25? I guess I'm not understanding that slide.

Sheila Roman: Yes, that's actually a very good question and relates to the fact that we use PQRS methods for determining the size of the group and that is – that is based on eligible professionals rather than physicians. And within that definition of eligible professional is included physicians, practitioners and therapists.

So there are groups who would only have one physician and the other eligible professionals within that group of 25 or more eligible professionals might be Physician Assistants, Nurse Practitioners, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist, Certified Nurse Midwife, Clinical Social Workers, Clinical Psychologist, Registered Dieticians, Nutritional professionals and Radiologists, all of these people are considered practitioners but are counted as eligible professionals when we're determining the size of groups.

(Sandy Forgonets): OK, thank you. That helps. And I did want to clarify one more thing that you just said. You are determining the size of the group based on the eligible professionals and that's all of the above that you just mentioned not as physician.

Sheila Roman: And (inaudible).

(Sandy Forgonets): That bill during that calendar year that's bill during that right, not that have that TIN listed in PECOS?

Sheila Roman: Repeat your question again. I'm sorry.

(Sandy Forgonets): I want to make certain – I want to make certain at how you're computing the size of the group – the size of the group is determined by the number of providers that bill under a TIN.

Sheila Roman: (Inaudible) eligible...

(Sandy Forgonets): (Inaudible).

Sheila Roman: ... that bill under TIN during that year and...

(Sandy Forgonets): OK.

Sheila Roman: ... for 2015, it would be the 2013 performance year.

(Sandy Forgonets): OK. And that includes all professionals not just – not just physician that bill?

Sheila Roman: That's right.

(Sandy Forgonets): OK. And so, in PECOS, if a provider happens to be listed under a TIN maybe because they just haven't updated their PECOS account. But if they don't bill under that, they won't be counted.

Sheila Roman: Well there is a two step process. Well, we first look at to PECOS and then we do another step where we look at the actual claims for that year. So, it is a two-step process.

(Sandy Forgonets): So again, my question is a – is a physician are listed under TIN and PECOS ...

Sheila Roman: Right.

(Sandy Forgonets): ... let's say do not bill that year, they won't be counted, is that correct?

Sheila Roman: They didn't bill that year. If we – if so you're saying that we're going to have claims for them that year?

(Sandy Forgonets): Correct. But they never ask the date but under PECOS, they're still listed there. Let's say the physician neither updated their file, change their TIN whatever. So the – so people under PECOS that TIN is listed, but the physician or provider never billed anything that year, so they would not be counted?

Sheila Roman: Well remember and (Jeff), I'll ask you to comment as well that the value modifier is based on TINs as you've just mentioned and is determined for the group so that everybody sinks or swims together.

(Sandy Forgonets): Right.

Sheila Roman: So I think and (Jeff), please corroborate with me that even if that TIN did not bill if they were part of that group during that year and it was a group that was greater than a 100 for 2015, they would have that value modifier that was calculated for that group applied to them.

(Jeff), is that?

(Jeffrey Blue): That is my understanding, yes. But more accurately, they would have the value modifier applied to their physician fee schedule billings under that TIN. So if they don't bill under that TIN, then you're essentially modifying zero reimbursements.

(Sandy Forgonets): Right. And then determining – my question is in determining the size, is it possible for a physician to show – to be listed under a TIN that never bill during that particular year? And if so, will they still be counted when determining the size of that TIN?

So let say TIN 1 has a 125 or providers listed under in your PECOS system. That's 30 of those have never billed that year. So, will that TIN be considered greater than a hundred or will it be considered less than a hundred? You see where I'm getting at?

Sheila Roman: Yes. And the second step is to remove group if the groups did not have a hundred plus EP's that billed under the groups TIN during 2013, so third if at

your, you know, picked up as a group of a 125 and 30 did not bill, then you would actually be a group of 95 and would not...

(Sandy Forgonets): OK.

Sheila Roman: ... qualify for 2015. And...

(Sandy Forgonets): Thank you.

Sheila Roman: ... we will not be adding groups to be – to their early list. We'll be making this first list based on PECOS October 15th and the step two will be done later.

(Sandy Forgonets): OK, thank you so much. I appreciate your clarification.

Sheila Roman: Thank you.

Operator: And we have no further questions at this time.

Sheila Roman: OK. If there are no further questions, I'd like to thank (Dr. Jeff Blue) and Tonya Smith for their input in the call today and to thank all of the participants and folks from WPS as well as for their support for this call and for their questions and attention to the material.

And, you know, if you have other questions, please feel free to write to those email addresses that are within the slide deck.

So, thank you once again for your attention.

Operator: This concludes our conference call for today. You may now disconnect.

END