

## QRUR Feedback Teleconference Transcript

**WPS Medicare**  
**Moderator: Sue Brewer**  
**March 22, 2013**  
**3:00 p.m. ET**

Operator: Good afternoon, my name is (Laverell) and I will be your conference today.

At this time, I would like to welcome everyone one to the CMS 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 that question, please press the pound key. Thank you.

I'd now like to turn the call over to Ms. (Sue Brewer).

(Sue Brewer): Well, thank you -- thank you very much.

My name is (Sue Brewer); I'm an Analyst in the Provider Outreach and Education Department at WPS Medicare. I will be facilitating today's call. I want to welcome everyone that took time on their Friday afternoon to join us today, we really appreciate that.

As part of the teleconference, there is a slide presentation and I hope everyone had a chance to pull and have it in front of them that was available on the QRUR website, qrurinfo.com. If you haven't had a chance to pull that slide presentation, please do so.

And at this time, we're going to handle this call a little bit differently. Normally, we would probably go through the full presentation, but today we're going to handle it more from an issues perspective and an additional to that, I do have some information I wanted to provide to our providers in Wisconsin, Illinois, and Minnesota, I have a couple of statistics I'd like to go over.

Currently the QRUR reports will be available only until April 30, 2013, which is about what, five weeks away and currently for Wisconsin providers, as of March 17, we've had a 30 percent pull rate for Wisconsin; Illinois, we've had 19.66 percent pull rate; and Minnesota we've had 9 percent pull rate.

So again, there are several reports out there that need to be downloaded and take -- and reviewed by our providers. So I wanted to just kind of give you a heads up on the statistics there.

At this time, I would like to turn it over to (Michael Wroblewski) from CMS and he's going to have a couple of remarks on things that he wants to bring up and then we'll open it up for questions. (Michael)?

(Michael Wroblewski): Thank you (Sue) and good afternoon everyone. Again, my name is (Michael Wroblewski), I'm with CMS in Baltimore. The Senior Technical Lead on the Physician Feedback Program and Value Based Payment Modifier.

As you all -- hopefully you all have gotten your individual feedback reports and so what I thought I would do is go through just a couple of highlights of the reports and how it fits into the value based payment modifier.

And then we'll open up for questions without going through page by page of the report unless there are questions that you would like me to do so and I'll be more than happy to finish out the slide deck.

So I'm actually looking at the slide deck and I'm on slide three, past the two introductory slides. You know, the Physician Feedback Program, CMS' physician feedback program is to provide physicians with comparative information about the cost and quality of care delivered to the Medicare fee-for-service or traditional Medicare patients. And we do this through the Quality Resource and Use Reports, QRURs.

As you all know, we released reports to groups of 25 or more eligible professionals in nine states, you all are among some of those states.

To start the preview some of the information that -- that we are trying to provide physicians and providers to help improve the quality of the services that they provide to Medicare fee for service beneficiaries.

I'm going to jump over slide four which is really just a discussion of the number of groups that we prepared reports for you can see your state. And then -- and slide number five which talks about the median size of the group of the reports.

But I think the most important part I really want to get across to you all today is the information that's on slide six.

You know the QRURs, CMS is at the beginning of this process, this is really our largest scale dissemination, and we've gotten some great feedback from these calls and other ways in which we can provide comparative quality and cost information to physicians for quality improvement purposes.

We have -- that's probably the main point and we very much welcome the feedback that we get from -- from you all.

We're using the QRURs also to help introduce Medicare fee for service providers on how Medicare's required to phase in the Value Based Payment Modifier. The value based payment modifier (VM) starts in 2015 and we'll have to apply to all physicians and groups of physicians by January 1, 2017.

These QRURs also preview some of the cost and quality -- or cost and quality information and the measures that will be used in the value modifiers

so you can start to get a rough estimate of where you stand under the value based payment modifier.

The cost measures in particular, most people are unfamiliar with how Medicare computes total per capita costs and does cost measures. And certainly the techniques that we use to make sure that we risk adjust for the underlying patient population and how we do our standardization to make sure that we take out any geographic difference in the cost so that we're making sure we make fair comparisons.

Those techniques that we're using for the value modifier are also the techniques that are in the QRURs that you all have.

And then the last point about why we think that 2011 QRURs are very, very important is that hopefully you'll look at them and see that there is other information that you would like the Medicare program to help provide information about the -- the patients that you furnish care to and -- and what information Medicare can do to help improve the quality of care that is furnished.

These next two slides I will -- are really an overview of how the value based payment modifier is going to -- how we're starting to phase it in. We have a two year phase in period 2015 and 2016 before applying to all physicians and groups of physicians.

And so this chart on page seven which I always think as my -- as my favorite chart, in the whole slide deck really shows hopefully a quick overview of how we're going to apply the value based payment modifier.

We're very much aligning with the Physician Quality Reporting System, PQRS, and you'll see that we're applying the value modifier to groups of physicians with 100 or more eligible professionals.

The VM does not apply to: Physicians in Accountable Care Organizations (ACO) that participate in the Medicare Shared Savings Plan, Pioneer ACOs, or the Comprehensive Primary Care Initiative.

We will not apply the value based payment modifier to your groups in '15 and in '16 which would be based on performance in 2013 and 2014.

So I -- I want to make that clear, we've gotten a number of questions about how that works.

But for those groups of 100 or more, that are not participating in a pioneer CPCI or an ACO, you'll see going down the left hand side, we basically put all those groups into two buckets, we call the first bucket the PQRS reporters and those are the ones that have chosen one of the PQRS reporting methodologies for 2013 and have submitted at least one measure on those. Their value modifier will be zero, meaning there will be no payment adjustment; there'll be no adjustment to their claims during 2015.

We provide those groups in election what we call the quality tiering election in which we can actually look at the performance on the quality measures that have been submitted via the PQRS reporting methodology.

To put you into or put the group into a high average or low cost tier. That's an election, don't have to do it. So if you're a PQRS reporter, the bottom line is the value modifier won't affect you in 2015, but you'll get a report starting actually this summer -- mid-Summer, September -- late Summer I suppose -- that indicates how you're -- how you would fair under the quality tiering methodology.

If you go on to the right hand side of the chart, those are the non-PQRS reporters, those are the groups of 100 or more that don't register for a PQRS group reporting option and/or register and don't do anything, basically don't submit information on one measure and they're the near value based payment modifier in 2015 will be minus one meaning that they'll get 99 percent of the paid amount for any claim submitted during 2015.

You'll see the (very) line at the very bottom. The reason why we're doing this methodology is we really believe that quality reporting is really the necessary first step towards improving quality and so we've tried to align our program with PQRS and so people can start getting a preview and work with the PQRS reporting mechanisms in order to become successful as we move forward.

I am going to -- that really is the -- the -- the overview of the -- of the value based payment modifier, how we're -- how we're moving forward with it.

These next two slides are really about -- okay, so if I'm a group of 100 and I have the option to elect quality caring/tiering because I, obviously you're listening to this call so we -- we encourage you -- we assume that you'll be registering your group if you're a group of 100 or more to participate in the value based -- or participate in the PQRS for 2013.

These two slides give a quick overview of what the quality caring/tiering methodology is about. What it basically says is that for each group, we'll create a quality of care composite score and a cost composite score.

All the quality measures that are -- that are submitted via the PQRS reporting method that you've signed up for will be classified into one of the six national quality strategy domains, clinical care, patient experience, et cetera. We'll create a standardized score for each measure and then take the average of -- weigh each measure in each domain equally, weighed each domain equally to come up with a quality of care composite score. There are five cost measures which we put in two domains, a total overall cost domain and the total overall cost domain and the total cost for beneficiaries with specific conditions domain. Once again, we'll weight the domains equally; the measures within the domains equally, create a standardized score for each of those measures to come up with a cost composite.

We then divide the -- I'm turning on to slide nine -- we divide the quality of care composites and the cost composites into three groups, low, average and high and we then -- each group's onto the 3x3 grid. So you'll see the worst place to be is in the bottom right hand corner, high cost, low quality.

If you elect quality tiering, you'll have a minus 1 percent adjustment, meaning you'll get 99 percent of the paid amount on claims submitted during the payment adjustment period which is 2015.

If you are high quality, low cost, which is the best place to be and that's in the upper left hand corner, you'll get 2x. And you may be saying x, why aren't I getting 2 percent? Well this program has to be budget neutral meaning that all the money that we take away for those groups that don't participate in the PQRS as described back on my favorite slide, back on slide seven as well as those who elect quality tiering and do -- and are in that bottom right hand corner, we've got to figure out that money and then we have to divide among all the people who are the high performers.

So what we tried to represent there is that high quality, low costs will get two times the bump up. As those who are high quality, average cost and those who are low cost, medium quality.

You'll see that there's a star there also and we would actually bump it up even more, 3x for high quality, low cost if the -- the risk profile of the beneficiaries that have been attributed to the group are in the top -- top 75 percent, about 25 percent over all.

Medicare really wants to encourage high quality care for those with the most complex cases and so our thought was if we --if -- if that is high quality care delivered at low cost or even average cost to the most complex cases, we should -- we should be rewarding that from a -- from Medicare's perspective. And so that's why there's a bump up if we're doing well with that patient population.

The reports that all groups of 100 will get -- or all groups of 25, because we want to start rolling this out in future years. All groups of 25 will get a report, as I said in September of 2013, based on showing 2012 performance under all of this quality tiering that I just went over.

So you'll be able to see which box you fall into -- your group falls into if you're a group of 25 or more.

In 2014, based on 2013 performance, so a year and a half from now we'll be providing reports to all physician groups and solo practitioners nationwide showing this -- basically this 3x3 grid so you'll know where you stand.

With that, I'm going to -- let's turn -- let me do one more slide and then I'll open it for questions and see if there are certain things that are on your mind that I can answer more directly.

I'm going to skip over -- skip over slide ten, which is how do I get my QRUR? Obviously -- hopefully you've already gone to the qrurinfo.com, put in your TIN-- your (PTAN) and NPI combinations to pull the reports.

I do want to focus on slide 11 -- excuse me, slide 12. Slide 12 is really the performance highlights page. It shows a breakdown of the performance highlights page that provides some really key information that you want to provide if you are the administrator for a group to your physicians or if you're a physician, things about your patient population.

Let me highlight those three because I think they're very important.

The first one is -- okay, we, in that first section is your Medicare patients and the physicians treating them. What we do is we indicate how many Medicare fee for service traditional Medicare patients that you -- that the physician provided services to during the performance year. These are 2011 reports, so it's during 2011.

And then the second bullet point that we put underneath there is on average, how many different Medicare fee- for -service physicians or providers -- physicians, excuse me, just physicians also treated the patients that you had submitted claims on. The average I believe is upward to 20 and that's often comes as a surprise to many Medicare fee- for- service physicians that so many other people -- physicians are providing care -- furnishing care to the beneficiaries that they're treating.

The next section of the performance highlights page shows the quality of your Medicare patients care. And that's broken into two subsections.

The first subsection is how did this particular physician do related to the measures that they reported through the PQRS system. There were about a third of the physicians in the nine state area that we did reports to this year that participate in the PQRS. And so we give a highlight as to how many of you did better than average and how many of you did worse than average on the measures -- on the measure -- on the measure by measure basis for the measures that you had submitted.

For all the physicians in the nine state area, we also provided a -- we calculated administrative claims quality measures that really looked at preventative care and care -- chronic diseases and we looked at all basically whether the beneficiaries -- not whether this physician, but whether the beneficiaries that you've treated have received the indicated care and we give a -- a highlight whether most of them have -- most of them have not.

And the reason why we had put that administrative claims quality measures in, information into these reports is because that is an option, this administrative claims option is an option for 2013 in the PQRS. And so we've actually wanted, the we believe that the physicians in these nine states actually have a leg up and can see how did they -- how did they do on the

administrative claims that would be an option for them to choose for the PQRS program for 2013 so you get a feel for where you stand.

The last section of the performance highlights talks about the cost for your patients care. And this is what I may have mentioned a little bit earlier that we talked about why these -- why I believe these reports are very, very important. It's about the risk adjustment that we've made and the techniques that we use to risk adjust patients cost.

And when I think -- when I speak of costs, these are the payments that Medicare makes on behalf of these beneficiaries to the various providers who furnish -- who furnished that care.

We risk adjust, so if a -- you'll see that the second bullet there shows whether you're unrisk adjusted costs were risk adjusted upward or downward.

I want to point out that if we have risk adjusted the costs upward; that means that your patient population is less complex, maybe a little bit healthier than the overall population. So we -- we're raising the actual cost up so we make a fair comparison because you had a healthier less complex patient population.

On the other hand, if we lowered the actual cost, that means that your patient population was that was -- that you treated -- that you treated during 2011 was actually more complex than the average Medicare fee for service patient. And so in order to make -- make sure we had fair comparisons, we lowered your actual cost so that how when we raise it, that means you have less complex patients and when we lower your actual costs, that means you had more complex patients and percentage there shows where do you fall and I think that's a very important point, most physicians don't know who their patient population compares to kind of a national mean. And so that's what that point is about.

And so we wanted to really point that out. and then after we risk adjust the third bullet there, is we then say okay, well what -- let's look at our cost measure, our total per capita cost, what did Medicare spend on for the year on average for all the beneficiaries that were treated then we calculated a total per capita cost and then we indicate whether that was higher or lower than the national average after we had done the risk adjustment.

So that risk adjustment technique I really want to make sure that people kind of get that. This is a very, very important point and it's to make sure that we are trying to compare apples to apples.

So with that, I will -- I'm going to stop, the rest of the -- the slide deck is how to read each of the reports -- each of the -- the exhibits and if people have questions about particular exhibits, I will be more than happy to -- to answer that.

I will jump -- before we; (Sue) before I turn it over to you, once again, I do want to point out on slide 23, (inaudible) directions. These reports that we've done were at the -- the individual physician level and not at the group level.

What we'll be doing later this year, as I said, September of 2013, we'll be providing groups one report to all groups of 25 or more eligible professionals.

Based on 2011, there are about 6,400 groups, there may be a little bit more for 2012. I don't know the final number yet. We'll be providing those, we will then later this summer, and as I indicated before, they'll preview where you fall -- where the group fell at least based on 2012 performance on that quality tiering methodology.

As I mentioned probably earlier from my favorite slide that groups this year of 25 or 100 or more had to register. We have a registration system where people can choose their PQRS reporting method at the group level that opens up on July 15 and closes on October 15 of 2013 later this year and at that point, if a group of 100 or more sees when they get their 2012 QRUR that they do very well under quality tiering. They want -- may want to elect quality tiering so that they would actually get an upward payment adjustment on -- on the 2015 claims.

In reports that we're disseminating later this summer, we will be adding patient level data to the physician feedback report which will be a first for these reports and in future years, not this year but in future years, we will be adding episode based cost measure for several different episodes in the physician feedback reports.

So I think these reports that you have right now preview some of the things that we're doing with the value modifier and to improve the quality of care furnished. The reports that you'll get later this summer, September, will obviously show where you do -- show how the group does on the quality tiering methodology as well as provide additional information to improve the quality of care furnished.

And then for all groups in 2014, we will be able to provide reports to everyone or to all groups and solo practitioners showing how they fair and hopefully they will be improved from the versions that you've seen, the 2011 versions that you've seen, versions that will come out in September because we do really believe this is an ongoing dialogue and want to be able to provide that information to help improve the quality of care that is furnished in Medicare fee for service beneficiaries.

So with that (Sue), I will -- I will close my remarks and -- and we can -- if you had any questions or if we can open it up to the -- to the callers, we can do that now.

(Sue Brewer): Thank you (Michael) you did address a couple issues that providers are giving to me on the ACO versus the group information, that was very helpful.

I do want to mention, I apologize, I missed my Michigan providers when I gave the stats before. Michigan providers right now as of March 17 are at a 14.14 percent pull rate for their reports, so there's quite a few reports out there for Michigan providers who still need to be pulled and realize this is like a week or two later date, I realized that.

But I just want to encourage everyone to go out to the website, [www.qrurinfo.com](http://www.qrurinfo.com) and pull them and encourage you -- those of you have, you know, connections and so on with the -- with the -- within your provider communities to go out there and pull these reports because we've only got about five weeks left until -- until they are no longer available.

Now at this time that I'd like to turn it over to our operator and you can go ahead and let them know, open for the Q&A session.

Operator: Certainly.

Ladies and gentlemen, as a reminder, in order to ask a question, please press star and then the number one on your telephone keypad. Again, that's star and the number one on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

And your first question comes from the line of (Judith Schebow). (Judith), your line is open. Your next question comes from (Brent Whitman).

(Brent Whitman): Thank you for putting together that presentation and opening us up for questions and answers today.

We actually had a group of cardiologists approach us and wonder how we can partner with them together because they -- they find it odd that they're cardiologists and they're being recognized as the provider that (inaudible) performed the number of E/M services. These patients are (inaudible) all.

So this is an (inaudible) conversation to have. What kind of -- how -- how can we provide (inaudible) direction? How can we coordinate with -- with our group which is a large group which is a large group of PCPs? How do we coordinate and work with the specialists in our area to help them understand what they're seeing on their report?

(Michael Wroblewski): That's a great question. Let me make sure I understood the factual background real quick again. You're a group of primary care or you're a group of cardiologists?

(Brent Whitman): We are a group of primary care providers and -- and the cardiologists approached us and said, hey, how can we partner to get rid of some of these things that look like primary care things to us?

(Michael Wroblewski): In terms of -- when you say and I don't mean to be picky here but I do want to be able to make sure I answer the question.

(Brent Whitman): Yeah.

(Michael Wroblewski): When you say some of these things that are -- was their concern when they saw their reports that they had too many E/M services, and was that -- was that the issue?

(Brent Whitman): It says -- well one is the how should we partner because one for their quality score they didn't perform nearly as well as what our primary docs did on the same types of measures?

And -- and then two, how do we -- how do we partner to help them better understand and use these reports?

(Michael Wroblewski): Well I think the -- and -- and I'll open this up also to my -- to our -- our colleague (Jeff Balew) who's at Mathematica Policy research who helped put these together.

You know the -- I think the areas where you can work are -- and the quality measures, if there are certain things, obviously, if there are certain quality measures that you all have done well on and they have not, obviously there's collaborative learning there.

I think in the future reports the -- for the -- and it -- so that was on -- if that was on the administrative quality measures.

If it was on the PQRS quality measure which were in exhibit one of your report, those are self reported, so you'll know the patients where you've done well, basically and the ones that you haven't and -- and -- and likewise they would to because they've reported on those patients.

If it was on the administrative claims, that -- that's a little trickier because you don't have the patient, you don't actually have all of those patients that are there.

And the point that I want to make is that, on that exhibit two, which is the administrative quality claims data, that's not only care that those cardiologists provided, but any of the care that those primary -- that those beneficiaries receive from any Medicare fee- for- service of -- of -- a provider.

So what -- what I'm hearing is that if there was a sharing of the patients, you know, if you as the primary care also saw patients that the cardiologists were seeing, they must be seeing other patients other than the ones that you're providing the primary services to because you're the -- the care that you would have given, the indicated treatment so to speak, would have shown up on their reports.

So what's happening, as was I'm thinking about this more is they may not -- the primary kind of care services that are not being provided to those patients that are solely seeing the cardiologist. Does that kind of make sense what I'm saying?

(Brent Whitman): No I'm -- yeah, I understand that's how -- that's how it works. It is just that how do we -- how do we partner with them? How do they know (inaudible) driving? If they're being recognized as the attributed physician as a cardiologist after the fact how do they know who to send to primary care that aren't receiving those services?

(Michael Wroblewski): It's a great question. The -- the way we did attribution and this -- and this is going an unsatisfactory answer but I'll give it to you anyway.

The way we did the attribution in these reports for the quality measures, the administrative quality measures is that if you touched -- you the physician touched that beneficiary, we then look to see did the -- that beneficiary receive treatment for these 28 quality measures.

As we move forward, and the reports that you'll get later this summer, in September, they will -- the attribution methodology is looking solely at those who are providing the plurality of primary care services.

We'll also indicate which beneficiaries those are. So for your group, you will receive a report that shows, okay, these are the people who've -- the beneficiaries have been attributed to my group, agreed after the fact. Because you have -- you provided the primary -- the plurality of primary care services.

It's unlikely but not out of the question that some cardiologists do probably provide primary care services, too, and could be providing the plurality over there as well.

So I think the -- going forward, I think what one of the things we learned about this past year, was that our attribution was a little bit -- was broad and that in order to make it actionable, we have to limit it a bit and so that's how we are moving forward.

So I get what you're saying. I think my answer may not have been as, I don't know, is -- is -- is as specific as you want it, but it's the -- unless (Jeff) if you have something to add I -- please do.

(Jeff): Well no (Michael) I think that was -- that was an accurate characterization. I taken the only thing that -- that I -- I or CMS might add is that the, again these administrative claims space measures is I believe you pointed out previously, you know, they're -- in a sense they're optional and not mandatory going forward; that is that groups can, you know, going forward, can elect PQRS measures over which they do have full control.

(Michael Wroblewski): May I ask the questioner a question? What information would you like us to give in order to facilitate that collaboration?

(Brent Whitman): (inaudible) a great question back to me.

I don't know, so for the -- for the cardiologist, it's really odd for them to think of themselves that they're providing a number of E/M services and it was enlightening when they heard that -- the fact that they were providing E/M services and maybe they're providing the most E/M services, that patient's received all year. It's a new way that they have to think about this stuff.

(Michael Wroblewski): Right. Right. I mean I think we -- one of the things that we're moving forward with is we've heard kind of loud and clear that, you know, we have to provide who those beneficiaries are.

And so, that is -- that is the step that we're moving forward. But is there other -- and -- and so that's a step that hopefully you'll see in the report that you'll get in September.

The -- yeah but if there's other information about -- about those beneficiaries, I mean I think, you know, part of these calls is for us to try to, you know, if you wish you had something -- what was it be -- what would it be that we could provide, you know, because we -- we obviously we have the billing claims. Right? I mean that's what we -- that's how we do this.

Is there information derived -- that could be derived from those that would help you increase that coordination? Would it be something like who's been referred or something -- I -- I don't know and I don't know if it's possible but, you know, think about that, you don't -- I'm not trying to put you on the spot right now. But if there are other ways that we can provide information, we'd be happy to do it. Or look, I would say we'd be happy to look into to see if we can do it. I'll say it that way.

(Brent Whitman): And one other comment, I don't want to take up (inaudible) questions, on exhibit five, it seemed -- it seemed like that that was number driven. So the larger the numbers, the better the chances were that your overall costs were less than the total cost -- the risk adjusted cost.

So and I'm just really cautious about small numbers in that report.

(Michael Wroblewski): Yes, I -- I hear what you're saying. We thought that it was important to give information about all the patients. One of the things that I didn't bring up but when we do the value based payment modifier and we calculate those quality (inaudible), we'll have the minimum case size up to 20 for any measure to really even be included because of what -- because of what you're saying.

(Brent Whitman): Thank you.

(Michael Wroblewski): Thank you.

Operator: Again, in order to ask a question, please press star one. And there are no further questions at this time.

(Sue Brewer): Thank you. (Tonya) did you have any comments you'd like to close with today?

(Tonya): Just to -- just to thank everyone who has been on the call and again, I'd to just encourage you, if you haven't done so, to access your report and to encourage your colleagues to do so as well if they have not done so.

(Michael Wroblewski): May I ask one quick question, I don't know if there are any callers on the line.

You know, we used the -- in order to get your report, you have to put a TIN, your NPI and your (PTAN) in and if you want to get it for the group, you have to put three unique NPI (PTAN) combinations under that TIN.

Was that a reasonable way to do it? Was that an easy way for you all to get the reports? Was that -- was -- what was your experience with that? Was that difficult, anybody know what a (PTAN) is? Any comments would be appreciated, please just, you know, if you can get back in the queue, I'd love to be able to hear.

Operator: And you have a follow up question from (Brent Whitman)?

(Brent Whitman): Because there are no other questions, I'll ask another question or comment would be, some of our local providers -- are carriers are providing us with the number of diagnosis codes per claim. That is actually quite interesting as we talk about risk adjustment and maybe something that we can -- you might want to look at providing for us.

(Michael Wroblewski): And did they tell you which diagnosis they are?

(Brent Whitman): No, they -- they aren't going to that yet, but that might be an interesting kind of idea, or maybe more specifically, so internally we've looked at things like the percent of our diabetics that are coded at 250.00 as way to understand risk adjustment and how we're doing towards that. So if there are -- there are key drivers that -- for risk adjustment to make sure that we're correctly identifying the risk of our populations.

(Michael Wroblewski): Oh, so you're looking at the different diagnoses, the different severity level so to speak and have the percentage of how many got those particular ones.

(Brent Whitman): Yes.

(Michael Wroblewski): Ah, I hear what you're saying. Okay.

(Brent Whitman): And -- and then your comment or your question about the (PTAN) and the three NPIs. I -- I found that to be very troubling. We have 340 providers through our organization and finding the right combination they need to in of the three without knowing which ones were -- were in the reporting and which ones are not was a real pain.

(Michael Wroblewski): Was it -- how could we make that better? Because what we -- what we try to do, and -- and this feedback is great. What we tried to do is anyone, obviously who billed in 2011, you know, who you would be getting a report for.

And of those (inaudible) so you said you had 340 providers who are in 2011, you could use any of those -- any of those 340, you had -- need three of them

(Brent Whitman): Who -- who billed to fee- for -service?

(Michael Wroblewski): Who billed fee- for -service, who billed -- that's correct, who billed fee- for -service during 2011. Was that kind of clear that it was fee for service?

(Brent Whitman): It was -- it was -- it was difficult for me, I had to determine which of our providers had billed fee- for -service in 2011.

(Michael Wroblewski) : Okay. How could we -- and you know, I hate this and I appreciate -- I appreciate you entertaining my questions. How could we have made that clearer or is just that you as -- as -- as kind of the central group it's -- it's very difficult to determine who those people are?

(Brent Whitman): Yeah I -- I guess one was -- was not making -- be clear what had to be billed, so I was just putting any provider in and their NPI with our (PTAN). I wasn't sure why three was the magic number. Why couldn't it have been the -- the one primary and when they're all associated with us, the same (PTAN) was it too likely that we are going to do it -- that were going to find out? So I'm not sure why it was so many levels of -- of providers needing input information for.

(Michael Wroblewski ): Okay, okay.

And when you say that you had your -- you all bill under the same (PTAN), that's a group (PTAN), right?

(Brent Whitman): That's correct.

(Michael Wroblewski) : Okay and is that group, just in your situation is that group (PTAN) -- how do I say this? I -- I don't want to use the word (inaudible) but is it -- is it all -- is it exactly all the -- the folks who were in your (TIN) or are there many group (PTANs)?

(Brent Whitman): So we have, yeah, so I'm looking at the ending so they end in like -- they start off with the same initial numbers like zero and 323 that end in like 10, 20, 30, 40? They go -- they do that kind of thing.

(Michael Wroblewski) : Okay.

(Brent Whitman): So I don't know what that means. I'm sorry, I'm not a (PTAN) expert.

(Michael Wroblewski) : Okay, okay, that's fair -- that's -- that's a fair point. Okay, so what I'm hearing is that the -- it was a level of security is what we were going for.

But maybe it wasn't clear that it was fee for service and -- and from your perspective knowing who the fee for service billers were.

(Brent Whitman): Yes.

(Michael Wroblewski): And then there are (PTANs) -- and then there at (PTANs). Okay.

(Brent Whitman): Yep and making sure that their -- that their NPIs were in that (PTAN) versus our group (PTAN) and -- yep.

(Michael Wroblewski): Okay, okay, that's a fair point, thank you. Thank you.

(Brent Whitman): Thanks.

(Michael Wroblewski): Are you able -- let me ask you one quick question.

(Brent Whitman): Sure.

(Michael Wroblewski): Were you able to get all 340 reports?

(Brent Whitman): We actually, of those, we only had 254, I think -- 244 something like that reports. We have a lot of pediatricians in our grouping so...

(Michael Wroblewski): Okay, okay. Who didn't bill Medicare. Okay.

(Brent Whitman): Yep.

(Michael Wroblewski): Okay, all right, but you were able to get all -- you got all 250 then?

(Brent Whitman): Yes.

(Michael Wroblewski): Okay, super, great.

(Brent Whitman): And I would love -- if we're going on the wish list, I would love to just be able to, you know, pull those all down like in a single reporting set. Instead of having 250 reports -- and I had to rename them all to peoples' -- to the physicians' names.

(Michael Wroblewski): Right.

(Brent Whitman): Because the numbers meant absolutely nothing and they had to be renamed because they're all PDFs -- individual PDFs.

(Michael Wroblewski): Okay. Well the report you'll get this in September of this year will be one group report, so -- so group, there won't be all those individuals, but that's -- that's a good point. Okay, thank you.

(Brent Whitman): Thanks.

(Michael Wroblewski): And one last, you know, one last question so I -- when I recount this conversation, again, which state are you located in? Is your line closed?

(Sue Brewer): (Michael), we can find that information when we get the participant report if he's gone.

(Michael Wroblewski): Okay, great, thanks, (Sue).

Operator: (Mr. Whitman's) line is open.

(Brent Whitman): So you cut out, so I didn't I didn't actually the question.

(Michael Wroblewski): I was just wondering what state you were -- is your home state?

(Brent Whitman): Michigan and we are -- we are part of an ACO, but this is still important to us. We want to make sure that we're providing quality service for all our patients.

(Michael Wroblewski): You know, that's great. You'll also get a report even though you are in an ACO in -- were you in an ACO in 2012?

(Brent Whitman): Yes.

(Michael Wroblewski): Have you done your quality reporting yet?

(Brent Whitman): It's in process right now.

(Michael Wroblewski): Okay.

(Brent Whitman): We're doing them -- medical record review portion.

(Michael Wroblewski): Okay. Okay because I know we're -- we're really trying to get all the ACOs into the quality reporting.

You will get a -- a report, it will highlight that are an ACO and that's a value model for our -- won't apply to you, et cetera, et cetera.

But we do show how you would fair under the value modifier.

(Brent Whitman): Great.

(Michael Wroblewski): All righty, okay, thanks so much.

(Brent Whitman): Thank you.

(Sue Brewer): Thanks (Brent).

(Brent Whitman): Yep, you're welcome.

Operator: And there are no further audio questions.

(Sue Brewer): Okay, we've had a lot of great feedback today, I'm very happy with that. I think all our people from CMS are too. I learned a lot, I can tell you that. I always do.

So at this time, if there are no further questions, we can certainly close the call. I want to encourage every one...Pardon me?

Operator: Excuse me, you -- you do have a question now.

(Sue Brewer): Thanks, we'll go ahead and take it then.

Operator: Your question is from (Judith).

(Judith): Yes, I have a question please? Yes, is there someone that I could speak to individually and not on this group call? If you could share a phone number, I have some questions about the reports and the data, the number of visits to me does not match what I know to be the case. So I'm not sure where like one of our doctors, I know he sees many Medicare patients and it says number of your patients 305, et cetera. I don't know why the number is so low. It doesn't make sense to what I know our (inaudible) to be. But I'd prefer to have this conversation with someone in a more confidential manner -- manner than this open call.

(Michael Wroblewski): Of course, of course.

First of all thank you for bringing it to our attention. If you can send -- and -- and (Jeff) or (Tonya), what is the -- if you can send an e-mail to -- and one of us will call you back...

(Judith): Okay, I'd appreciate it. Who should I send it to?

(Michael Wroblewski): Contact information and the e-mail -- (Tonya) would you say what the e-mail -- it it...

(Tonya): Sure. It's [grur@cms.hhs.gov](mailto:grur@cms.hhs.gov).

(Judith): [grur@cms.hhs.gov](mailto:grur@cms.hhs.gov).

(Tonya): Yes and tell me your name ma'am so that I can...

(Judith): My name is (Judith).

(Tonya: (Judith), okay (Judith)...

(Judith): Thanks. And -- and what was your name again, please? Who will I -- who will I be speaking to?

(Michael Wroblewski): It'll be -- it'll be -- we'll probably give you a call on Monday and it'll be done...

(Judith): That's fine -- oh actually, you know, I'm not going to be in the office on Monday.

(Michael Wroblewski): If you -- send us an e-mail and we'll get back in contact with you.

(Judith): Okay and I -- I -- another question just to speak to you about in -- in trying to pull these report -- download these reports, I can concur with the other gentleman, putting in three identifiers it -- it took a little playing around and actually some of the ones that I had put in actually -- or the ones that I did put in weren't the reports and yet, I chose another group of three and then I got the entire download. It would helpful to just pull it off of (TIN) or a group NPI and get the full list of providers; I think we have 49 of them or something -- 47 reports.

And -- and secondly, I would also mention, I concur with the other gentleman that having to print or save all of these reports, it was -- it would be easier if you could like go in and capture the ones you want and perhaps do a single printing, some other format of this because it's tedious and lot of paper if you were presenting a markup (inaudible) saving them. But I concur it could be a little bit simpler (inaudible) perhaps.

(Michael Wroblewski): Okay.

(Judith): But I thank you for allowing me to tell you my comment and I will e-mail you now with my contact information regarding these reports.

(Michael Wroblewski): Okay, super. Thanks so much for participating.

(Judith): Okay, thank you.

(Sue Brewer): (Judith) can you tell me -- can you tell me what state you're from?

(Judith): Michigan.

(Sue Brewer): Thank you very much.

(Judith): And I can give you my -- I don't mind giving you my phone number; I'm not concerned about someone calling that shouldn't. If you'd like, I'll give it to you.

(Michael Wroblewski): Go ahead.

(Judith): Deleted.

(Michael Wroblewski): Okay, all righty, sounds good.

(Judith): Thank you very much.

Operator: And you have another question from the line of (Hope) with (Wheaten Franciscan).

(Hope): Yes, I just have a question regarding the reporting for the 2012 data and you talked about it being reported as a group. Are the individual QRURs going to be included in that group report? Are they still going to be separate or how's that going to work?

(Michael Wroblewski): It would -- for 2012, it will only be a group report.

(Hope): So -- so there won't be any individual ones like we're seeing right now for 2011 data?

(Michael Wroblewski): There will be an appendix that shows the -- if the -- if the individual physician participated in the PQRS, the individual measures will be shown for each of the individuals. Say you're -- say (Judith's) group I think she said was 49. You know if only 20 of them participated in the PQRS, those 20 will be there in the appendix so you'll have that all there.

The administrative claims measures are actually computed at the (TIN) level and so whatever the group score is, will be -- you know we didn't have to give that 49 times, so to speak. So you'll have the quality measures at the individual level if you report them at the individual level, you'll have the administrative claims measures. If you use -- and then the cost measures are also done at the (TIN) level for the value modifier.

And so that will -- that will have the -- the QRUR will have the specific (TIN), you know, because you calculated once rather than doing it, you know, 49 times.

(Hope): So will we see reports like we -- like our -- our QRURs for 2011, will the providers have individual reports that looked like what we're looking at for 2011 for 2012 or no?

(Michael Wroblewski): No, there will be one group report that looks exactly like you're saying and there'll be an appendix with individual physician information and the quality measures reported through the PQRS.

(Hope): Right, but it won't look at all like what we're -- what we have in hand right now?

(Michael Wroblewski): Actually the group report will. It'll be -- it will look very similar, but it will just be done at the group level.

(Hope): So...

(Michael Wroblewski): The format's very similar.

(Hope): But in -- in terms of what the individual providers might see, it won't make sense to go through a whole lot of education about what this 2011 QRUR looks like and -- and what it says because they won't get these reports again?

(Michael Wroblewski): As of now, we're doing it at the group level.

(Hope): Okay. Thank you.

(Michael Wroblewski): You're welcome.

Operator: And there are no further questions.

(Sue Brewer): Okay, I'd like to thank everyone today, those who were -- like I said, spent some time with us today on this call. We've got a lot of great feedback, I really appreciate that. I guess I'd encourage your colleagues and any association you belong to and so on to get the reports pulled because they're only going to be available through April 30 of this year, 2013.

And at this time, we can certainly close the call. Thank you.

Operator: Ladies and gentlemen, we thank you for participating in today's teleconference call. You may now disconnect your line.