Centers for Medicare & Medicaid Services
Quality and Resource Use Reports Feedback Session Number One
National Provider Call
Moderator: Nicole Cooney
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Contents

Operator: At this time I would like to welcome everyone to the Program Year 2010 Quality and Resource Use Reports Feedback Session One Call. All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for your participation in today's call. I will now turn the call over to Nicole Cooney. Thank you Nicole, you may begin.

Introduction

Nicole Cooney: Thank you, Holley. Hello, I am Nicole Cooney from the Provider Communications Group here at CMS and I'll serve as your moderator for today's call. I would like to welcome you to the Program Year 2010 Quality and Resource Use Reports Feedback Session Number One. Today we have CMS subject matter experts here to discuss summary findings of these reports, as well as address questions and comments related to the overall reports.

We'll have a brief presentation and then we will conduct a section by section walk through of the report at which time we will address comments and questions by section. Please note that we are conducting a webinar session using Adobe Connect but that you do not need to join the Adobe Connect room in order to participate in this call. You may participate in the audio only should you prefer.

Before we get started, there are a few items that I'd like to cover. The link to the slide presentation for today's call was e-mailed to all registrants earlier this afternoon. If you did not receive this e-mail, please check your spam or junk mail folders for an e-mail from the CMS National Provider Calls Resource Box. Please note the URL to join today's Adobe Connect webinar room was included in this e-mail as well.

This call is being recorded and transcribed. An audio recording and written transcript will be posted to the CMS Physician Feedback Program's website. The URL is located on the final slide of today's presentation. A direct link to the page where these materials will be posted is also included in the e-mail that went out to registrants earlier today. I'd also like to thank those of you who submitted comments when you registered for today's call.

Your comments were shared with the speakers to help prepare slides and remarks for today's presentation. As I mentioned today's call also uses the Adobe Connect webinar technology. For more information on how this will work and what you should be seeing on your screen, I'll turn it over to my co-moderator for today, Wendy Hildt.

Wendy Hildt: Thank you, Nicole. Hello, my name is Wendy Hildt and I also work in the Provider Communications Group here at CMS. As Nicole stated, I will serve as your co-moderator today. I will also be the navigator for those who will be following along via the webinar. For those of you participating via the webinar, you should see the opening slide titled Physician Feedback Program: 2010 Individual Physician Quality and Resource Use Reports.

I would navigate through the slide presentation as well as our review of the 2010 individual QRUR template. This allows you to focus on the presentation details and not navigation, since I will be navigating for you. At this time I would like to introduce our CMS speakers for today. We are pleased to have with us Michael Wroblewski, Senior Technical Advisor for the Center of Medicare; and Dr. Sheila Roman, Senior Medical Advisor – Senior Medical Officer in the Performance-Based Payment Policy Group in the Center for Medicare.

And now it is my pleasure to turn the call over to Michael Wroblewski, who will now begin our presentation.

Presentation

Michael Wroblewski: Thanks Wendy, and welcome everyone, to the call this afternoon. Thank you for participating. I am actually going to turn it over to Dr. Roman to go through a couple of the early slides in terms of the purpose of today's call and the agenda and then I'll be back with some remarks about half way through. Dr. Roman?

Sheila Roman: Thanks, Michael. And welcome everybody, good afternoon. It's a pleasure to have all of you on this call and I want to say how much CMS really appreciates you taking the time out of your busy day to come into this call and provide us with feedback and your comments on our Physician Feedback

Reports that you have received. I also want to let you know that this is really our first major dissemination of these reports that we call the QRURs, that is, the Quality Resource Use Reports.

And we're expecting you to be quite critical and to provide us with many comments. Our goal here is really to make these reports better and to make them more action-able to you. So we're looking forward to your comments. Now on the second slide, the purpose of this feedback session—and I think as you've already gotten the information we're really going to provide you an overview of findings—some aggregate findings from the 2010 Confidential Physician Quality and Resource Use Reports, or QRURs, that we prepared for physicians in the four states, Iowa, Kansas, Missouri, and Nebraska.

And again our main purpose here is to solicit input from you, the report recipients. And we want to use this input to improve the content and display of information so that they provide meaningful and action-able information to you. And our third purpose here is to answer questions about the information and methodologies used in the QRURs that you may have as you have reviewed your reports.

Next slide is the agenda slide. Again we'll start out, Michael and I, with an overview of findings from the Program Year 2010 Confidential Individual QRURs that were sent out to the four states. And then Wendy will navigate through the QRURs, we will run through the reports, section by section, and as we mentioned, we'll be stopping three times and receiving comments from you on a section-by-section basis.

When we go through the reports, we'll give a slight overview of the section and then really open it up for your questions on each of the three sections. Next we'll take participant questions and we'll provide answers as we can, about the section and also we'll take participant suggestions for improvement in the section. And then finally we'll make some closing comments.

I'm now on slide four. What are the QRURs? The QRURs provide comparative information so that physicians can view examples of the clinical care their Medicare fee-for-service patients receive and also the total per

capita cost for these patients in relation to the average clinical care and costs of other physicians' Medicare fee-for-service patients. In this case, in the four-state region that received the report.

The 2010 QRURs did not use minimum case-size threshold, therefore some physicians – for some physicians, the QRUR may only display information about a few fee-for-service beneficiaries if that's all a physician treated in 2010. Some physicians have asked about our plans for these results. These results are confidential. CMS has announced plans to place group practice not individual physician performance data on CMS physicians – on the CMS Physician Compare website. And you see the link to that there if you're interested in looking at the information that we have displayed on Physician Compare.

Now on slide five, who receives the PY2010 Confidential Feedback Reports? CMS prepared 23,730 individual physician reports, one report for each physician in Iowa, Kansas, Missouri, and Nebraska that provided services to at least one Medicare fee-for-service beneficiary in 2010. So to receive a report what you needed was to have provided services to at least one Medicare fee-for-service beneficiary in 2010.

Slide six, what should physicians do with these reports? The reports enable you to compare the quality and cost of your Medicare fee-for-service patients' care with that of Medicare patients treated by physicians in your specialty for cost comparisons and by all physicians in Iowa, Kansas, Missouri, and Nebraska for quality comparison. The reports highlight your degree of involvement with all patients you treated based on claims you submitted to Medicare.

Patients were attributed to you for cost measures based on your office visit claims and professional claims. And we'll be much more explicit about how we defined the different attributions in a few moments. I'd like to talk now about the two types of quality of care information that you saw in the reports that you received. The first type that I'll be talking about is actually Exhibit 2. It's the claim data submitted through PQRS, and not everyone submitted data through PQRS.

Of the 23,730 physicians, 5,891, or about 25 percent, participated in PQRS through the Claims-Based Reporting Methodology. So the EHR or registry methodology options were not included. If you participated in PQRS through either of those options, you would not have seen data posted in Exhibit 2. Exhibit 2 posted only those physicians who participated in PQRS through the Claims-Based Reporting Methodology.

Also you would have received this information only if you successfully participated in PQRS. Approximately 23 percent of those who participated in PQRS, of the physicians, were primary care physicians. Specialties with the highest participation rates in the PQRS in the four state regions were ophthalmology, anesthesiology, pathology, and geriatric medicine.

On slide eight, I've listed out Selected PQRS Claims Measures that have some resemblance to the measures that you saw in the claims-based – Administrative Claims-Based Measures that I'll talk to you about in just a few minutes.

And I think the take-home message really from this slide is that the majority of these measures that you see are measures that apply primarily to primary care; they're for conditions that are of high prevalence and also high cost in the Medicare population. Now if you look at the means of performance rate, and this is a means for all physicians in Iowa, Kansas, Missouri, and Nebraska, you can see that they run between 50 percent and 91 percent but that for many of these measures, there is room for improvement.

On slide nine, I am now going to focus in on what appears in Exhibit 1 and that is Administrative Claims-Based Measures. Exhibit 1 appears in all reports and provides performance rates on up to 28 quality measures with 13 submeasures for a total of 41 measures, depending upon whether the physician treated at least one beneficiary that was eligible for the measure. On average, a physician had information on 30 of 41 measures.

And again I want to emphasize that to be eligible, the physicians had to treat at least one beneficiary that was eligible for the measure. These measures show whether the beneficiary received the indicated treatment during 2010.

The reports provide this information for any beneficiary to whom the physician provided at least one service, even if the physician did not provide the indicated treatment. This is an important point. You didn't need to have provided the service for the patient to receive the feedback on the quality measure.

13:15

CMS believes it is important to inform physicians about the quality of care that their beneficiaries receive for primary care and preventive services. Currently, physicians may be unaware whether the beneficiaries they treated received or did not receive some of the recommended care for their chronic conditions.

The reports provide this important information for the fee-for-service beneficiaries they provided services to in 2010. I also want to mention that all of these measures were NQF-endorsed, I think, except for one which is a National Committee for Quality Assurance Measure and is the measure, the medication measure for harm in Exhibit 1. And at CMS, a list of more than 70 Administrative Claims-Based Measures were vetted by internal and external physician experts and were culled down to the 28 measures that you see in Exhibit 1.

On the next slide, which is slide 10, again what I've shown here on these slides are some data from Exhibit 1 that is aggregated by the clinical categories of the measures and shows the mean performance rate on the measures in each of these categories for physicians in Iowa, Kansas, Missouri, and Nebraska. And I think as you can see again on this slide that the rates vary from a low of about 39 percent to a high of 83.5 percent, but that many measures here, too, show room for improvement.

And on slide 11, again, continuing on discussion on the Administrative Claims-Based Quality Data, on average the reports contained the following number of measures by broad specialty classification for those physicians that had at least 10 cases. And as you can see for primary care physicians, the mean number of Administrative Claims-Based Quality Measures was 19, 18 for surgeons, 27 for medical specialists, 26 for emergency medicines and 30 for all other types of physicians aggregated.

And I'll now turn the program over to Michael Wroblewski.

Michael Wroblewski: Thank you, Sheila. I wanted to give some comments on Exhibit 3, talking about – and the exhibits that follow, talking about how we attributed beneficiaries to patients – to physicians for developing cost measures. We tried a new approach in this year's reports to classify each physician's Medicare fee-for-service patients into three groups.

And as I said, these are shown on Exhibit 3 of your report which is on page six of the template. We broke them into three groups because when we were thinking about making cost comparisons, we recognized that physician involvement with patients is different and you didn't really necessarily want to mix different types of patients together. So we came up with three categories which we call Directed, Influenced, and Contributed.

Directed beneficiaries are those where the physician billed for 35 percent or more of the patient's office or other outpatient, Evaluation and Management, E&M, visits. Influenced patients on the other hand are those that the physician billed for fewer than 35 percent of the patient's outpatient and E&M visits, but for more than 20 percent of the patient's total professional cost. The last group was really the group of patients we call Contributed where the physician would contribute to the care of a beneficiary, and that is really if you're just not Directed or Influenced.

So Contributed was the physician billed for fewer than 35 percent of the patient's outpatient E&M visits and for less than 20 percent of the patient's total professional costs. On the next slide, you'll see what this really kind of means from an average point of view. We broke all the types of physicians – we grouped them by specialty, by broad specialty category. So you'll see that we have a category for primary care physicians, medical specialists, surgeons, emergency medicine, and other. "Other" really includes radiologists, pathologists, anesthesiologists.

So you'll see the number of beneficiaries – the mean number of beneficiaries attributed. So that's really all of the beneficiaries that a particular physician touched during the year meaning that they've filed at least one claim. So this

shows that, on average, a primary care physician filed claims for about 279 Medicare Fee-for-Service beneficiaries. Of those 279, 81 were Directed, meaning that the physician billed for more than 35 percent of the patient's office or other outpatient E&M services. 17 of those patients were Influenced, meaning that of those 279, 17 of them were below the 35 percent threshold to be become a Directed beneficiary but were greater than 20 percent of total professional cost.

And then you'll see that many primary care physicians had the bulk of their patients as Contributed, meaning that they did not have more than 35 percent of the E&M and they did not bill more than 20 percent of total professional costs. You'll see that we did the same analysis for medical specialists. You'll see the medical specialists had even more number of – mean number of Contributed beneficiaries, 380. Surgeons had a lot, at 217.

And the ones that probably had the most is if you look at the "other" category which 834, which is at that bottom right-hand corner, and that's really because radiologists, anesthesiologists, pathologists see lots of Medicare patients during the year in which they did not direct their care or influence it but contributed to it.

The next slide shows – the next three slides are really – it's the same information but for each of the category of type of beneficiary. So this first one looks at an analysis of Directed beneficiaries in terms of the billing and professional costs. Once again we're using the same physician categories along the left-hand side there, primary care, medical specialist, et cetera. The next column indicates the number of physicians directing care, and that 6,000 is really out of the 23,000 in the four-state area.

The mean number of Directed beneficiaries among physicians who bill – Directed beneficiaries were the 105. And the two things that I really want to point out on this slide are really the last two columns. One is that if a physician directed the care of a beneficiary, on average the physician saw the beneficiary, for a primary care, at least 3.6 times during the year and billed for nearly 90 percent of the professional costs of that particular beneficiary.

You'll see for medical specialist, the visits on average were three visits with 85 percent of professional costs. For surgeons, it was a little bit less, 2.3 visits and a little bit less in terms of average professional costs. Those are the numbers to keep in mind that I really want – that's really the takeaway from this slide which was a high degree of the percentage of professional costs billed by physicians who Directed care and then on average had at least three or about three visits with those beneficiaries.

If you turn to the next slide, we're going to look at the same analysis for Influenced beneficiaries, and I'll ask you to focus on the right-most two columns. And you'll see that in terms of the average number of visits per year for a physician influencing care that the average number of visits comes down from the Directed from about three to about one. But interestingly, if you look at the very last column, the average percentage of professional cost billed by the physician influencing care is still pretty high at about 80 percent.

Some of them are above 80 percent. You'll see some of those, right there, at 79.9 percent. If you contrast that with the next slide which is the analysis of Contributed beneficiaries, you'll see a couple of things really kind of standout on this slide. The first is that the increased number of physicians, primary care went from like 5,000 who Directed care to about 8,000 who Contribute. So showing that the beneficiary – physicians in the four-state area treat beneficiaries who see a lot of physicians.

You'll see that the average number of visits is small, in most cases, less than one. And interestingly, if you look at the very right-most column that the average percent of professional costs billed per physician contributing to care really decreases from about 85 percent or 80 percent for Directed and Influenced physicians down to about 20 percent or even less. So this is really showing that there is a difference if a beneficiary sees multiple physicians or one physician in terms of the number of visits and the average amount of professional costs that that physician bills.

If you look at the next slide which is the Mean Total Per Capita Cost in the QRURs, that relationship that I just talked about in terms of beneficiaries to which physicians contribute care, meaning really no one is responsible. If you

looked just at the right-most column, you'll see that the average per capital costs for those beneficiaries is about $20,000. Contrast that with the average per capita cost for beneficiaries that are Directed or Influenced.

And for the Directed, it's nearly, it's half of that at – I am looking at primary care, it's about $9,733 and for Influenced it's actually even lower. So it really shows that for – if you direct or influence care, per capita cost is pretty low. For beneficiaries who have, what we could say, have seen multiple physicians and multiple physicians contribute to the beneficiaries' care, it's not surprising that the average per capita cost for those beneficiaries is quite high.

All of the information on these two slides, we have made sure that we have standardized the data so that we make fair comparisons within the geographic area and that we have risk adjusted the amounts higher or lower to account for differences in expected health costs of individuals. And the risk model that we use looks at certain beneficiary demographic characteristics and prior year diagnoses to predict Part A and Part B Medicare fee-for-service payments.

The last slide that I wanted to talk about just in terms of findings and in terms of the cost measures, is we had looked at the mean of average total per capita cost for beneficiaries with four specific conditions: diabetes, COPD, coronary artery disease, and heart failure. And I think what sticks out here is that for beneficiaries with COPD and heart failure have higher per capita costs, on average, across all types of physicians than those who have COPD or diabetes. And then – so that's looking I guess across the chart.

If you look down the chart, primary care physicians, on average, if they were attributed to beneficiaries, actually had lower costs than – because, not surprisingly, they are kind of primary care chronic conditions, which are primary care physicians who would manage surgeons, specialists, emergency medicine, and other physicians have higher per capita cost for those chronic conditions. Once again all the cost data has been standardized and risk adjusted for underlying beneficiary characteristics.

So hopefully what we have gone through is that the information in these reports can help with quality improvement in terms of areas where physicians

are doing well compared to their peers, areas where there could be room for improvement. We hope that we could possibly enable care coordination for those – especially the information that's in Exhibit 1 that Dr. Roman talked about in terms of where there are opportunities for coordinating better care for certain chronic conditions.

We're hoping that the reports, in terms of the cost information, raises awareness of the resource use and total per capita costs. And we can talk about that a little bit more as we go through the section by section review of the template. And the data that's in this report are a possible candidate data for use in calculating the physician Value-Based Payment Modifier, which Medicare is obligated to implement starting in 2015.

With that, that ends, kind of, our introductory remarks. I'll turn it back over to Nicole for instructions on how we're going to proceed.

Polling

Nicole Cooney: Thank you, Michael. At this time, we will pause for just a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there may be moments of silence while we tabulate the results. Holley, we're ready to start the polling.

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

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

Please continue to hold while we complete the polling. And that does conclude the polling session for today's call. I will now turn the call back over to Nicole Cooney.

Question and Answer Session

Nicole Cooney: Thank you, Holley. So at this time we will begin our section by section walk through of the report templates. We will have three 20-minute segments to take comments and questions. Our first segment will cover the two summary pages at the beginning of the report. The second segment will address quality as illustrated in Exhibits 1 and 2 of the report. And our final segment will address the remaining exhibits dealing with cost.

I'd like to remind everyone that the purpose of today's call is to listen and address general comments and questions about the reports. If you have questions specific to the data contained within your own confidential report, please e-mail it to the address noted on slide 21 of today's presentation for appropriate research and response. I'd also like to take this time to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many questions and comments as possible, we ask that you limit your question to just one.

If after asking your one question, you'd like to ask a followup question or you have additional questions, you may press star one to get back into the queue, and if we're able to address all questions, we'll take followup questions at that time. Holley, we're ready for our first question.

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

Cristie Knudsen: Yes, this is Cristie Knudsen at Audubon County Memorial Hospital in Audubon, Iowa. We are a critical access hospital, and we own two rural health clinics, and the majority of the primary care in this area of the state is provided through rural health clinics. So the majority of the care that would be directed in this area would be reported to Medicare on a Part A claim and the majority of the care – I am sorry, can you hear me?

Nicole Cooney: Yes, we can hear you.

Cristie Knudsen: OK. And the majority of the care that would be reported to Medicare on a Part B would just be inpatient care. So our physicians would also as just being Contributors to care and not Directed, although they are directing the care of the areas, the residents of the area. Has there been any thought at all given to how this skews these numbers, particularly for the four states that you've done these reports in?

Nicole Cooney: Can you give us just one second?

Cristie Knudsen: Sure.

Michael Wroblewski: Thanks so much for that question. It's something that we're looking at in terms of rural health care clinics and critical access hospitals. And I think it's something that we're going to look further into. Other people have raised this issue and so we appreciate it. Thank you.

Cristie Knudsen: OK, thank you.

Operator: And your next question comes from the line of Michael Kitchell.

Michael Kitchell: Yes. Michael Kitchell from McFarland Clinic, Ames, Iowa. For the patients that the care that I directed, you had a slide that showed that the average percent of professional costs billed for a physician directing care was 89 percent for primary care and 85 percent for medical specialists. Now, I am a specialist and in my Directed care, the total risk adjusted per capita cost – that's on page seven Exhibit 4 – I hope I am not getting ahead of you, but for example, my cost of care was $223 and the patient's total costs were $9,400. So my directing of their care actually spent 2.3 percent of the total dollars

spent on the patients. Do you have any other way of breaking this down because I think you can see other physicians, their actual professional costs even for directing the care of their patients is actually a very small percentage, and so when you attribute physicians, the cost of the care, I think, it's important to separate out the actual direct costs of their E&M codes or their professional codes versus what the total costs of care were. And, for example, my average patient had 13 different physicians and some of my group practice physicians actually had 20 patients – or 20 physicians who saw their average patient. So to me this is going to be a little bit of a sticky attribution problem. Can you break this down as to what are the professional costs, what are the total costs? This would be interesting data to see.

Michael Wroblewski: Thank you for that comment. Yes, and I think we are looking at different ways that we can break the cost information down so that you can see those breakdowns. What we've – obviously what's shown there on Exhibit 4, page seven on the report, is one way to do it. But I hear what you're saying is that the professional costs are a small percentage of total costs. But my question back to you is, if the comparison is being made on the total costs and everyone is in the same boat, does that mitigate the concern that you are having?

Michael Kitchell: The concern I'd have is, for example, some of us specialists in particular take care of very sick Medicare patients. Obviously when you look at some of those costs for the congestive heart failure patients, these are pretty sick, expensive people. And my concern is if you attribute the cost to an individual physician, and let's say there are 20 physicians who took care of that patient, even if you directed their care, I don't see how you can really attribute the individual physician, as you probably have heard from my previous calls, I think we need to measure by groups of physicians and not individual physicians.

And this is just an example of "it's the neighborhood that matters, it's not the individual physician," because so many physicians are just playing a role, a part of the team. And so if you really want to influence the coordination of care, taking out individual physicians is not going to get to that goal of improving care, improving quality of the team and having the bottom line --

how did the patients do. So again I guess my comment is I think an individual breakdown is not going to be that helpful. I think this is going to have to be groups or teams.

Michael Wroblewski: OK. We appreciate that. Thank you very much. Thank you. If I can also just make a quick comment, we'd really love to, kind of, focus the questions and I realize people are in the queue, but really on the first two exhibits-- kind of the intro page, as well as the summary overview in terms of what you found helpful, what you found unhelpful, what you found confusing, areas for improvement.

Nicole Cooney: If you have a question on any of the other pages of the report, if you could hold them until we get to that, that section. So with that Holley we'll take our next question.

Operator: All right. And your next question comes from the line of Michelle Meier.

Michelle Meier: Hi, this is Michelle Meier in Topeka, Kansas. And I have a question on the specialty. I have several providers who are subspecialists, for instance a dermatopathologist who is listed under specialty on page one as dermatology. Is there any concern about not taking these doctors to their actual specific specialty?

Michael Wroblewski: I'll give a quick answer then our contractor, Dr. Jeff Ballou, is also on the call and I'll ask him to correct me if I am wrong. But we used the specialty designations that are on the actual claim that is submitted. And so if your question is, is that the range of specialties is just not broad enough or as robust enough, that's kind of a separate issue. I hear what you are saying but that's how we pulled the specialty designation. Jeff, did you have anything else to add?

Jeffrey Ballou: No, Michael, thank you. That is correct and the only thing I would add is that we have considered and are considering other ways that one might define specialties. The point is obviously an important point.

Michelle Meier: Yes, I would say. I mean its several things in our practice for instance dermatology is really dermatopathology and GI might really be a hepatologist.

Michael Wroblewski: OK. We hear you, go ahead.

Sheila Roman: Right, so you're saying that the physician whose report that you're speaking of is really a pathologist not a dermatologist?

Michelle Meier: You know, he is doing part of each but his – the majority of his claims submitted and the majority of dollars submitted comes from pathology, not dermatology. He practices both.

Sheila Roman: I understand what you're saying and my guess is that the specialty code that is submitted on the claim must be dermatology as we would call the dermatologist on the report.

Michelle Meier: But I guess I need to go back and look then at the total CMS and see if there is something more specific. I mean, dermatopathology, in which case then I think he is going to fall out since he practices part of the time as a dermatologist. And we can't split that on submission, I don't think.

Michael Wroblewski: OK. We hear you. I mean it's a good point. In specialty – the accuracy of the specialty designation is very key. So it's something that we've heard other comments on. So and I know the AMA has raised concerns about this. So stay tuned.

Michelle Meier: OK.

Nicole Cooney: Thank you so much. Next question, Holley.

Operator: Your next question comes from the line of Russell Onken.

Russell Onken: Hello, this is Russell Onken with the Therapeutic Radiologists in Kansas City. This is kind of a followup question to the last person. We've got 14 physicians, they are all radiation oncologists; at least one of them is listed as a surgical oncologist. And you say you somehow got that off the claims, I guess I am questioning how that is possible? And secondly, how do we

change it because if these are comparisons within categories, isn't it fairly important that they get put in the correct category?

43:33

Michael Wroblewski: We couldn't agree with you more that yes, that people are placed in the appropriate categories. If there is a specific question you'd like us to look at and if you could e-mail to us in terms of a particular set of claims, that you believe were miscategorized then we would be more than happy to look at that. And I would recommend that you do actually look at the claims, the specialty designation on the claims that you're currently submitting to make sure that they actually reflect the designation that you prefer.

Russell Onken: OK.

Nicole Cooney: And in order to send that information via e-mail, you want to send it to QRUR@cms.hhs.gov and that e-mail address is also on, I believe, it's slide 21 of the presentation.

Russell Onken: Would you repeat that more slowly please?

Nicole Cooney: Sure. It's Q as in quality, R as in resource, U as in use, R as in reports at C-M-S as in Sam dot H-H-S as in Sam dot G-O-V. And then it's also, I believe, slide 21 at the end of the presentation. It's listed there. Thank you so much for your questions.

Russell Onken: I had a second question and that's why those were in the registries weren't included?

Michael Wroblewski: It's something that we hoped to do and we are planning to do it in the next years' reports.

Russell Onken: Thank you.

Nicole Cooney: Thank you. Next question, Holley.

Operator: At this time, there are no further questions.

Nicole Cooney: OK, thank you. All right, now we'll move on to the next section beginning on page three with Exhibit 1. We'll now take any comments or questions that you may have on pages three, four, and five. Comments or questions from pages three, four, and five. Holley, we'll take our first question when you're ready.

Operator: OK. And as a reminder ladies and gentlemen, if you would like to ask a question or make a comment press star one on your telephone keypad. And your first question comes from the line of Nicki Myers.

Nicole Cooney: Hello, are you there?

Operator: That question has been withdrawn. Your next question comes from the line of Michael Kitchell.

Michael Kitchell: Yes, I had a question on page four, that's the Exhibit 1. The quality measures, "drugs to be avoided for beneficiaries" and "potentially harmful drug disease interaction for beneficiaries." Those were the main quality measures that I think most of us had a lot of respondents. Some of the other quality measures weren't very prevalent. But I believe that those two categories represent quality measures that are not endorsed by the National Quality Foundation. So could you clarify that or not, the National Quality Forum?

Sheila Roman: Yes, let me just look those up. I believe that, the "drugs to be avoided" is for beneficiaries greater than 65 is an NQF measure. I could give you the NQF number if you wanted to go out to the site. The next one is not an NQF measure and I think that is the one that is not an NQF measure in the group, potentially harmful drug-disease interactions for beneficiaries greater than or equal to 65 is an NCQA measure.

Michael Kitchell: OK, the question that I had though for the patients who really receive at least one drug to be avoided. Again I don't know that that's very action-able quality measure, it's too much of a black box, so you can just keep my comment as a comment, but I just don't see how that's really action-able especially if you have 20 different physicians interacting in the care of a patient. It's really hard unless there is some way to attribute that measure

only to the primary care physician or the coordinating entity, either the medical neighborhood or the medical home. So again I think if you wanted this action-able, that is not all that action-able. And I do think there are exceptions too, because for example, I take care of demented patients who are psychotic and we have to use certain drugs for them. I think those should be exclusions or exceptions. So anyway, those are just my comments. Appreciate you listening.

Sheila Roman: Yes, thank you. And we'll take those comments and think them over.

Nicole Cooney: Next question, Holley.

Operator: Your next question comes from the line of Nicki Myers.

Linda Goldstein: Yes, can you hear me all right?

Nicole Cooney: Yes, we can.

Linda Goldstein: OK. This is Linda Goldstein, I am here with Nicki. We're from Van Buren County Hospital. And this is kind of a followup to Cristie's question. So, are we correct in understanding that the data in these exhibits is not pulled at all from the critical access hospitals or rural health clinics data?

Michael Wroblewski: I am going to say I am going to have to get back to you on that unless Jeff can answer that more specifically. I don't want to give you wrong information.

Jeffrey Ballou: Right, thank you, Michael. This is Jeff. I think the answer is that for purposes of assigning or aligning beneficiaries with physicians and identifying specific services that physicians provided, it is correct that we are only looking at professional service claims filed by those individual physicians. However, when looking at beneficiary costs and the services that assigned beneficiaries received, we look across all of Part A and Part B.

Linda Goldstein: And so how are you gathering that data from the rural health clinics?

Jeffrey Ballou: Well we're gathering the data that are linked to the beneficiary identifier. So if the beneficiary received a service in an institutional setting or an ambulatory setting, we are using the links to that beneficiary in the claims data.

Linda Goldstein: OK.

Michael Wroblewski: May I ask you just a quick question? Do you think your data looks anomalous?

Linda Goldstein: Absolutely, being a rural health clinic, we do file on a UB which is to Part A, so I mean we have very few numbers here so that's how we are just not understanding how you came with this data and it just shows almost, you know, no direct care for our patients.

Michael Wroblewski: OK. If you can e-mail us at that e-mail box, what was it, QRUR@cms.hhs.gov, we can take a further look into this issue. It's a very important one.

Linda Goldstein: OK, thank you.

Michael Wroblewski: Sure, thank you.

Operator: And at this time, there are no further questions. You do have a question from the line of Larry Benson.

Larry Benson: Yes, we represent the specialty of nephrology in Kansas City. And one of the questions we have as we're reviewing this is that we don't feel the quality measures that are outlined here are really representative of the specialty that we are in. For example, there is nothing to look at for adequacy of dialysis, anemia—those types of issues.

Sheila Roman: Thank you for that question. And we are aware that the measures here do not represent all subspecialties of medicine. And that there are probably only one or two measures that you can pick out of this that would be specific in the practice of a nephrologist. However, are your physicians participating in PQRS?

Larry Benson: No, they are not.

Sheila Roman: I do think that there are more relevant measures for nephrologists in PQRS. And we stated, actually, in last year's rule that we are aligning these programs with each other and are encouraging physicians to report through PQRS. And I think you'll find measures there that look more like your physicians and how they practice.

Larry Benson: However, when you move to the value-based methodology of payment as we're going to in the year 2015, will you be using something like these QRUR reports or would you be going to the PQRS quality measures that are more specific to your specialty?

Michael Wroblewski: That's a great question and I think what we said in last year's final rule is that we strongly encourage people to participate in PQRS.

Larry Benson: All right, thank you.

Nicole Cooney: Thank you so much for your question. Holley, next question please.

Operator: Your next question comes from the line of Cristie Knudsen.

Cristie Knudsen: Yes, this is Cristie Knudsen again at Audubon County Memorial Hospital. All I wanted to convey was when I went out to gather my reports, I printed off the reports for our group. There were like four or five physician reports included in my group for physicians that I had never heard of before. I did find them and forward the results to them but I was concerned that those reports were sent to me. And I am not sure how they were attached to me.

Nicole Cooney: Give us one second. Hold on.

Cristie Knudsen: OK.

Michael Wroblewski: I appreciate. That's a great question. The point of contacts were identified when – back when you made your initial contact with WPS, who is the Medicare Administrative Contractor, who, you know, set up the portal to distribute these.

Cristie Knudsen: These physicians have never practiced in our area. I've been here for 16 years and they have never been here.

Michael Wroblewski: If you can send me once again, I'll give you the e-mail box, because we obviously want to fix these things, at QRUR@cms.hhs.gov. And we can take a more look into.

Cristie Knudsen: OK.

Michael Wroblewski: And we appreciate you raising this issue with us.

Cristie Knudsen: OK, thank you.

Michael Wroblewski: Thank you.

Nicole Cooney: Next question, Holley.

Operator: Your next question comes from the line of Jodi Lund.

Kris Zeller: Hi, this is Kris Zeller, actually, with Jodi at Cardiovascular Medicine in Davenport, Iowa. We have a similar followup to that. We did not receive reports on all of our physicians. And we have made four inquiries as to where the missing ones are and have not been able to get any response to that.

Michael Wroblewski: If there are specific ones, I'll give you the QRUR@cms.hhs.gov. My question – and what we can look at is if those physicians didn't – you know, we were looking at data from 2010 they had to be Medicare fee-for-service beneficiaries that were enrolled for the entire year.

Kris Zeller: They were. They were. I mean we have 25 physicians, these are just in the middle of the group. They've been long-term physicians but my comment is that we had made those inquiries, we're just not getting any response and we've done it four times. So just to know that there is some issue on not getting them perhaps she had one of mine.

Michael Wroblewski: Did you send them to the QRUR mailbox, or did you send them to the – which mailbox – just to track this down because obviously I don't want this to happen again?

Kris Zeller: The physician feedback...

Michael Wroblewski: Because then you'll have to do a fifth one.

Kris Zeller: Yes, we send it to the Physicians Feedback Program at Mathematica.

Michael Wroblewski: OK.

Kris Zeller: Is that the correct one?

Michael Wroblewski: Yes, that works fine, too.

Kris Zeller: OK.

Michael Wroblewski: We can track that down and we'll get you an answer. Thank you, Kris.

Kris Zeller: I appreciate that. Thank you.

Michael Wroblewski: Sure.

Nicole Cooney: Next question please, Holley.

Operator: Your next question comes from the line of Ruth Cornwall.

Ruth Cornwall: Hi, this is really in regards to the previous couple of callers. We have a Kansas physician practice manager who reported getting reports for physicians who were not in their group and we were able to get that – those issues resolved by going through WPS. That's all I needed – wanted to share with and WPS was very helpful and responsive.

Michael Wroblewski: Yes, Ruth, thank you so much. That's exactly what we're going to do with the previous – we'll track this down and we'll get it taken care of. And thank you for raising this issue with us.

Nicole Cooney: Next question please, Holley.

Operator: Your next question comes from the line of Linda Wood.

Linda Wood: Hi, my name is Linda Wood. I am the Compliance Director for the physicians at the University of Kansas Medical Center. And we have 18 different clinical departments. I received notices from two of my departments from administrative people that they've gotten the QRUR e-mails. And we were able to go in and research it and – with the help of WPS, because it was actually kind of confusing – figure out how they could go in there and actually get those reports by entering the NPI and the PTAN and the last five digits of the Tax ID number and the e-mail address of the person who got the e-mail. I've only heard from two departments, none of my primary care departments which kind of worries me as if, where are these letters going? Is there somewhere somehow that we could find out who the contact person is, I mean these both went to administrative people, so it must have something to do with the registration in PECOS or something for the group as to who the contact person is that should have gotten these letters. So I am thinking the people that really have a lot of information, like, I mean, my pediatrics reports, obviously, were pretty low volume, because they don't see very many Medicare patients. It would be much more interesting to see the reports that are going to our physicians that are seeing adult patients. Is there somewhere that I could ask, giving the group PTAN and NPI, who the contact person is that would have gotten these letters that can download this information?

Michael Wroblewski: First of all I extend my condolences to the University of Kansas.

Linda Wood: On basketball? We're very happy. We're very blue today.

Michael Wroblewski: Yes, I'm sorry.

Linda Wood: Thank you. We appreciate that. Second place is also an accomplishment.

Michael Wroblewski: In terms of getting the reports, the WPS contact is – that is listed on the – hold on for one quick second.

Linda Wood: Thank you.

Michael Wroblewski: We did a little conferring here. The person is really whoever the enrollment point of contact was in PECOS, which is the provider enrollment system here. And as a second order answer if you wanted, once again, I'll give you the QRUR at...

Linda Wood: I've got it.

Michael Wroblewski: I am sure of that, and if you want us to take a look at anything in particular we will.

Linda Wood: OK, but you're saying so I would really need to be contacting – going into PECOS, contacting the PECOS people. And it's related – am I correct that it's related to the group PTAN, that's exploding for all of the individual NPIs and PTANs?

Shana Olshan: Points of contact.

Michael Wroblewski: Yes. The point of contact in PECOS is the place to start. But then alternatively you can ask those physicians to put their NPI, PTAN, and the last five of the TIN in and they would just – the report would just come up.

Linda Wood: They don't have to have the e-mail address of the person?

Michael Wroblewski: That's not a mandatory field. You only need the three.

Linda Wood: Oh. OK. All right, so we could just advise our department administrators on all of their people to go in and do that?

Michael Wroblewski: That's right.

Linda Wood: To see if they are there, but if the point of contact person can actually get the report that shows everybody that got a report?

Michael Wroblewski: That's right. That's right. That's right. So unfortunately I don't know who your point of contact is for those other departments.

Linda Wood: Yes, let me – I know this is probably not a venue for complaints but one of the biggest problems that providers have with being able to try to handle

initiatives that come out of CMS are that, documents go to doctors and not administrative people. And so that really shouldn't happen because doctors depend upon their administrators and their directors to handle these situations for them. And often when they get documents, important letters, and things, even including the most recent provider revalidation, they go to the wrong place. And then things slip through the cracks and these things aren't handled. So it becomes difficult. I am just venting, sorry.

Michael Wroblewski: No, we appreciate that. I hear what you're saying. OK.

Linda Wood: All right, thank you very much. Thanks for listening.

Michael Wroblewski: Of course.

Nicole Cooney: Next question please, Holley.

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

Nicole Cooney: OK. We'll move on to the final section which will begin on page six, Exhibit 3 through to the end of the report template. So if you have any questions on any of the – or comments on any of the information on pages six, seven, eight, nine, 10, 11, 12, 13 yes, through to the end you may ask them now.

Operator: And again as a reminder, if you'd like to ask a question or make a comment press star one on your telephone keypad. To withdraw your question, press the pound key. Again to ask a question press star one. And your first question comes from the line of Michael Kitchell.

Michael Kitchell: Yes, Michael Kitchell, again, McFarland Clinic, Ames, Iowa. You talked in some of the other presentations about the reliability of the quality measures. And I think everybody feels that even though these quality measures are mostly primary care, if we specialists were part of that care, we probably contributed to the quality as well. But my concern is mostly about the – not the numerator which is the quality, it's the denominator, it's the cost. And I don't believe that you have established that these cost measurements are actually very accurate, because as I said, if you have 20 physicians, and, like I say, my average patient had 13 physicians that contributed to their care. If

you have 20 physicians I can tell you that the average physician is going to say, I had no control over the cost of this patient. The other physicians had control over that. And so this is where I believe that the emphasis of CMS for this whole pay for value should be based on group or medical neighborhood. And if physicians are willing to be collectively accountable that is what we want. We want physicians to look at things systemically, the health care system has to do better to improve quality and reduce costs. But my concern and I attend the AMA conventions every year and there is this huge pushback against quality and value measurement because they say it is not accurate. And I was a member of the Group Practice Reporting Option which we were very happy with the QRUR for group practices. And I fully support group practice measurement but when you're going to get down to cost and try to attribute individual physicians, who are one of 20 different physicians caring for the patient, it's going to be almost impossible to get physicians to agree that it's accurate. So I would just urge CMS to continue working on this, but with the emphasis on groups or accountable entities like an independent practice association.

Michael Wroblewski: Thank you for that comment. The reliability issues, obviously we're very aware of. And thank you for participating in the Group Practice Reporting Option and receiving the reports that – we did calls like these back in the fall and we appreciate everyone's input on those. So thank you for your comments and I am glad that that initiative seems to address many of your concerns that you've raised. Thanks.

Nicole Cooney: Next question please, Holley.

Operator: At this time there are no further questions. Actually, we do have two questions that have come into queue. The first from the line of Larry Benson.

Larry Benson: Yes, we have a question on the Exhibit 3 which starts on page six. And in our particular instance, when you look at the average number of E&M office visits billed, we have a zero number there. Yet, we still have a percentage of professional costs that we billed. So can you explain that, does that take into account professional costs in a hospital setting, but why would you have zero in the office visits billed?

Michael Wroblewski: Sorry, it's a great question, thank you for raising it. I'll start and then I'll let Jeff from Mathematica jump in if I have misstated something. Professional costs can include more than just office visits. So it's logical that you could potentially have zero E&Ms but you would have professional costs because not all professional costs are actually an office visit. Jeff did you want to add anything?

Jeffrey Ballou: Yes, thank you, Michael. I think that really is the crux of it, the only thing that I would add is that the E&M office visits you billed, that is rounded to the nearest full number and it's an average across all beneficiaries that were assigned to that level of care, to that individual physician. So it actually could be a number slightly greater than zero on average. It's displayed as a zero and we recognize that there might be ways to improve how we communicate that information going forward.

Larry Benson: Thank you.

Nicole Cooney: Next question please, Holley.

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

Additional Information

Nicole Cooney: OK. All right, thank you so much. I guess that will conclude our Q&A portion for today's call. If you have a comment that we were unable to address or you happen to think of one, you can e-mail it to QRUR@cms.hhs.gov, and I see that Wendy is now displaying slide 21 on the screen for the webinar. So now I'll turn it back to Michael Wroblewski for the closing.

Michael Wroblewski: Thank you, Nicole. And I want to thank everyone for participating in today's call. It's been very helpful. Many of the issues that you raised in terms of, kind of, the practical aspects in terms of the accessing the reports and specialty designation, as well as how to handle certain rural issues and things, that we'll really take into consideration to look at as we can move forward with the program.

So we appreciate that. For the people that I indicated to send any individual question to the QRUR mailbox, we'll try and respond to those as quickly as we can. And then just also as a reminder, we're going to repeat this call on Thursday, a little bit later in the day on Thursday. So if you have additional questions, we'll be back and we'll be more than happy to try to field them for you then. Thanks, thank you very much. Dr. Roman, do you have any...

Sheila Roman: No, I really have nothing to add just to thank everybody for their time and their comments. I think that we'll be looking into the comments that you've made and certainly we look forward to receiving the mails from you in the mailbox, so that we can really dig up the information that you need.

Nicole Cooney: OK. Just to note, registration for Thursday's call is open until 12:00 noon on Thursday. If you would like to join us, please make sure you register before noon on Thursday. Let's see, actually, Wendy, going back to slide 21, again, that is the QRUR@cms.hhs.gov resource box that Michael referred to. The second address there if you will be sending in a question to the Mathematica e-mail address for research into specific question about the data contained within your confidential report, please allow appropriate time for the necessary research and response of that question.

On slide 22 of the presentation, you'll find information and our URL to evaluate your experience with today's call. Evaluations are anonymous and strictly confidential. I should also point out that all registrants for today's call will receive a reminder e-mail from the CMS National Provider Calls resource box within two business days regarding the opportunity to evaluate this call. You may disregard this e-mail if you have already completed the evaluation. We appreciate your feedback.

We'd like to thank everyone for participating in today's call. An audio recording and written transcript will be posted to the Physician Feedback Program page on the CMS website which is on the final slide of our presentation under – and will be under the CMS teleconferences and events tab in approximately two weeks. Again my name is Nicole Cooney and it's been a pleasure serving as your moderator today. I'd like to thank my co-

moderator Wendy Hill as well as Dr. Sheila Roman and Michael Wroblewski as well as Jeff Ballou from Mathematica for their participation.

Have a great evening everyone.

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

END