MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
Physician Compare Initiative Call
MLN Connects National Provider Call
Moderator: Aryeh Langer
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Contents

Operator: At this time, I would like to welcome everyone to today's MLN Connects® National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Aryeh Langer. Thank you. You may begin.

Announcements and Introduction

Aryeh Langer: Thank you very much. And as you just heard, my name is Aryeh Langer from the Provider Communications Group here at CMS, and I'm your moderator for today's call. I would like to welcome you to this MLN Connects National Provider Call on the Physician Compare Initiative. MLN Connects Calls are part of the Medicare Learning Network®.

Today's MLN Connects National Provider Call topic is Physician Compare, which provides information to consumers to help them make informed health care decisions and gives incentives to physicians to maximize their performance. CMS subject matter experts will walk you through the information currently available, upcoming plans, and the future of Physician Compare under the Medicare Access and CHIP Reauthorization Act, also known as MACRA. A question-and-answer session follows today's presentation.

Just two quick announcements—You should have received a link to today's slide presentation in an email earlier today. If you've not already done so, you may view or download the presentation from the following URL: www.cms.gov/npc. Again, that URL is www.cms.gov/npc, as in National Provider Call. At the left side of the webpage, click on National Provider Calls and Events. And then on the following page, select the date of today's call from the list, and the presentation can be found under the Call Materials section.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. Registrants will receive an email when these materials become available.

At this time, I would like to turn the call over to our first presenter. Alesia Hovatter is a health policy analyst in the Division of Electronic and Clinician Quality here at CMS. Alesia?

Presentation

Alesia Hovatter: Great. Thanks so much, Aryeh. This is Alesia. So for those of you following along, we're on slide 3.

So again, hello and welcome to our first ever National Provider Call for Physician Compare. So today we're going to talk about what you need to know about Physician Compare.

So again, I am in the Quality Measurement and Value-Based Incentives Group, which is also known as QMVIG. And QMVIG is responsible for evaluating and supporting the implementation of quality measure programs. These programs aim to assess health care quality in a broad range of settings, such as hospitals, health care professionals' offices, nursing homes, home health agencies, and dialysis facilities. Our group actively works with many stakeholders to promote widespread participation in the quality measurement, development, and consensus process.

Our agenda for today's call is on the slide that you're currently looking at. Again, that's slide 3. And I'll begin with an overview of Physician Compare, and then I'm going to turn the presentation over to the Physician Compare Support Team to highlight the information that is currently available on the Physician Compare website, a review of performance data and public reporting, and then, finally, we'll share information about the future of Physician Compare.

During the second half of the call, we're going to open the lines to answer any questions that you have about Physician Compare and public reporting. So, please start getting your questions ready, okay?

Physician Compare Overview

Alesia Hovatter: Now we're going to turn to slide 4, so, Physician Compare Background and Overview. So let's get started with a brief overview and background of Physician Compare.

Next, slide 5. So on this slide 5, we provide some background on Physician Compare. CMS was required by Section 10331 of the Patient Protection and Affordable Care Act, also known as ACA, to establish the Physician Compare website. As a result, the site was launched on December 30th of 2010.

Since then, CMS has been working continually to enhance the site and its functionality, improve the site's information that's available, and also include more and increasingly useful information about physicians and other health care professionals listed on the Physician Compare website.

Moving to slide 6, the continual efforts to improve the Physician Compare website along with the addition of quality measures on the site help it serve its twofold purpose, which is first, to provide more information to encourage and enable consumers to make informed health care decisions and second, to create explicit instances for physicians and other health care professionals to maximize performance.

Now we're going to have a brief pause, and I'm going to turn it over to the operator for some polling.

Keypad Polling

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad, and enter the number of participants that are currently listening in. If you're the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Thank you for your participation. I'd now like to turn the call back over to Aryeh Langer.

Presentation Continued

Aryeh Langer: And I'm going to turn over the call to Glynis Jones from the Physician Compare Support Team for the next portion of our presentation. Glynis?

Information Available on Physician Compare

Glynis Jones: Thank you, Aryeh. Let's move on to slide 8 and review the information that is available on Physician Compare.

Currently, Physician Compare allows consumers to search for physicians and other health care professionals and group practices who are actively participating in fee-for-service Medicare. Newly enrolled Medicare practitioners are also included. To find which types of health care professionals are included on Physician Compare, visit the specialty definitions page on Physician Compare, which is linked to at the end of this presentation. You can also find information about Shared Savings Program and Pioneer Accountable Care Organizations, or ACOs, from the link on the Physician Compare home page. We will provide a link to this page and other useful resources at the end of this presentation.

The table on slide 9 shows the information available on the website about health care professionals and group practices. Currently, users can view information about approved Medicare professionals, such as name, primary and secondary specialties, practice locations, group affiliations, hospital affiliations that link to the hospital's profile on Hospital Compare, Medicare assignment status, education, residency, and board certification information.

In addition, for group practices, users can view group practice names, practice locations, Medicare assignment status, and affiliated health care professionals, that is, health care professionals who practice as a part of that group and the specialties of those health care professionals.

Slide 10. Slide 10 outlines the CMS quality activities that are indicated on the profile pages. Participation in quality activities is important because doing so can improve care for people with Medicare. The most recent information on quality activities is from 2014. And this information is indicated by green checkmarks on the Physician Compare profile pages.

Groups and individuals who satisfactorily reported Physician Quality Reporting System, or PQRS, measures during program year 2014 have a green checkmark next to the phrase "reported quality measures." If the individual health care professional reported as part of a group practice, that is noted. And if an individual or group reported as part of an ACO, that is also indicated.

Health care professionals who participated in the PQRS Maintenance of Certification Program will have that indicated on their profile page.

Health care professionals who met the Meaningful Use requirements for 2014 have an indicator noted that they used electronic health records.

And finally, individuals who satisfactorily reported four individual EP-level PQRS cardiovascular prevention measures have a checkmark that says "committed to heart health through the Million Hearts® initiative," to indicate their support for that important program.

More information about participation in quality activities is also available on the About the data page on the Physician Compare website. That link is also provided at the end of this presentation.

On slide 11, you can see where the information on Physician Compare comes from. Physician Compare's primary data source is the Medicare Provider Enrollment, Chain and Ownership System, also known as PECOS. PECOS is the system Medicare uses to enroll and revalidate physicians and other health care professionals. Physician Compare uses PECOS because it is the only verified source of Medicare data. Some information, such as first and last name, gender, specialty, practice location, education, and group practice affiliation is pulled from PECOS. Because of this, it is important for health care professionals to keep their information and PECOS up to date, so it'll be accurate on Physician Compare. Physicians, health care professionals, and group practices can update this information themselves through Internet-based PECOS. There is a link to Internet-based PECOS included in the additional resources at the end of this presentation.

We also use Medicare fee-for-service claims data to verify practice locations, hospital affiliations, and group practice affiliations.

Information about board certification comes from the boards themselves. We currently have board certification information available from the American Board of Medical Specialties, the American Osteopathic Association, and the American Board of Optometry.

On slide 12, there is a table with the necessary criteria for health care professionals and group practices to be listed on Physician Compare.

To be included on the website, a health care professional must be in approved status in PECOS for Medicare, provide at least one practice location address, have at least one specialty noted. and have submitted a Medicare fee-for-service claim within the last 12 months or be newly enrolled in PECOS for Medicare within the last 6 months to be included on the website.

Group practices must be in approved status, have a legal business name, a valid mailing address, a tax identification number, or TIN, and at least two health care professionals who have reassigned their benefits to the group's TIN and have actively billed under this TIN in the last 12 months, or be newly enrolled in PECOS for Medicare within the last 6 months.

We need you to help us ensure Physician Compare is as up to date and as accurate as possible. If you have any questions or concerns about your data on the website or the best way to update your information, never hesitate to reach out to the Physician Compare Support Team at PhysicianCompare@Westat.com. This email is also included on slide 33, Contact Physician Compare.

Now that we've reviewed the information available on Physician Compare and what is required to be listed on the site, let's move to slide 13 and walk through how you would find this information on the Physician Compare website. You can search for health care professionals and group practices within a certain location by name, specialty, or medical condition. To look up a health care professional, use the search box on the first tab labeled "Find physicians and other health care professionals," highlighted on this screenshot with a blue arrow. To search for group practices, use the search box on the second tab, "Find group practices," where you see the green arrow here. Let's say you have typed in a location and started to type the health care professional's last name. You then select the health care professional's name from the dropdown menu that will appear below the "What are you searching for?" box. This takes you to his or her profile page.

Slide 14 shows an example of a health care professional's profile page. At the top of the screenshot, you can see his name and specialty. On the "General information" tab, you can see his participation in quality activities. In this case, the green checkmark says, "Reported quality measures," and indicates that the health care professional satisfactorily reported PQRS quality measures in 2014. Underneath that, you can see his board certification, gender, education information, hospital affiliations, and Medicare assignment status. If you were to click on the "Locations" tab to the right of the "General information" tab, you would see a map and list of locations and phone numbers for practices where this health care professional provides services, with phone numbers. We will talk about the third tab, "Clinical quality of care," later in this presentation.

On slide 15, you can see that group profile pages are similar to health care professional profile pages. The first tab, "General information," and second tab, "Locations," have much of the same information that is on a health care professional's page. The final tab, "Affiliated health care professionals," lists physicians and other health care professionals who are a part of the group.

Now that we have reviewed some of the information available about health care professionals and group practices, we'll move on to slide 16 and I'll pass things over to my colleague, Allison Newsom, to discuss performance data and public reporting.

Performance Data and Public Reporting

Allison Newsom: Thank you, Glynis. We're now moving to slide 17, and I'd like to talk a bit about performance data. Performance data can improve care for people with Medicare and are one indication that health care professionals and group practices have a commitment to providing quality care. CMS is committed to providing accurate, valid, reliable, and comparable data on Physician Compare that are useful to consumers in assisting them and making informed health care decisions. To support this, CMS publicly reports performance measures for health care professionals and group practices on the Physician Compare website.

Slide 18 displays a graphical representation of how we select measures for public reporting on Physician Compare.

All measures available for public reporting on Physician Compare are decided via the rulemaking process. If a measure is designated as available for public reporting and the relevant physician fee schedule rule, then it may be publicly reported on Physician Compare. However, CMS decides which measures to publicly report based on the published public reporting standards, which we will now walk through.

First, we conduct various analyses to ensure that the data posted on the Physician Compare website meet the public reporting standards of being statistically valid, reliable, accurate, and comparable. In addition, there is a 20-patient minimum threshold

for every measure. Only those measures that meet these standards will be considered for inclusion on the website.

Next, the Physician Compare Support Team develops plain-language titles and descriptions for measures that may be publicly reported on Physician Compare.

Then, we conduct consumer testing to evaluate the best measures to include on the public-facing profile pages. This testing includes having consumers evaluate the plain-language measure descriptions to ensure that they are being accurately interpreted. Also during testing, we discuss with consumers if and how the measures they are evaluating would help them make a decision about choosing a health care professional or a group practice.

CMS also keeps lines of communication open with stakeholders to ensure that the measures considered for public reporting are clinically relevant and consistent with current public – or current practice standards. If a measure meets all of the public reporting standards except for the requirement that it resonates with consumers, it may be added to the downloadable database, but it will not be included on the public-facing profile pages. The primary audience for this database is health care professionals and group practice representatives, like many of you, as well as third-party data users.

This database can be found on data.medicare.gov. A link to the database is included in the additional resources at the end of this presentation.

Speaking of the downloadable database, we appreciate that many of you have asked when the 2014 data will be available for download. The database is officially targeted for public release by the end of this month. Although a subset of 2014 data were publicly reported on the website in December 2015, any data for health care professionals or groups that were going through the informal process – review process were suppressed. As this process is now complete, the final data set will be released.

We've talked about how a measure is chosen for the Physician Compare website. And let's move to slide 19 to see the progression of the phased approach to public reporting, which started in February 2014.

Over the years, the number and type of measures have continued to increase. In 2014, CMS reported the first set of quality measures on the Physician Compare website. This included performance for groups and ACOs on a small subset of PQRS measures reported via the Web Interface. CMS started with the 2012 program year data. The 2013 program year data were reported later in 2014. Again, there were just a small subset of Web Interface measures made available for group practices and ACOs.

The December 2014 measure release did include Consumer Assessment of Health Care Providers and Systems, or CAHPS®, for ACO patient experience data for the first time.

Most recently, in December 2015, significantly more data were added to the website. First, a larger number of group practice and ACO Web Interface measures were included. There are now up to 14 measures reported for each group or ACO. And CAHPS for PQRS data were added for group practices. Significantly, CMS publicly reported performance data for individual health care professionals for the first time in late 2015. There are now up to six claims measures available on the website for approximately 37,000 individual health care professionals that reported under PQRS via claims in 2014.

Slide 20 lists the types of performance data that are currently available on Physician Compare. For individual health care professionals submitting measures under PQRS, we publicly reported preventive care general health measures, patient safety measures, and heart disease measures. For groups and ACOs, we publicly reported preventive care measures, including general health and cancer screening measures, patient safety measures, diabetes measures, and hearth disease measures. In addition, we publicly reported patient experience summary survey measures for groups and ACOs.

The screenshot on slide 21 shows how some of the general health measures are displayed on a group practice's profile page as an example. The PQRS measures and performance rates are shown on the "Clinical quality of care" tab.

In addition to the clinical quality of care measures, group practices also have a tab labeled "Survey of patients' experiences." On this tab, you can find CAHPS for PQRS summary survey measures. These patient experience measures are displayed in the same way as the clinical quality of care measures. Although we are showing an example of a group practice "Clinical quality of care" tab, understand that the measures are similarly displayed for individual health care professionals' clinical quality of care measures.

As you see on the slide, measures are displayed with a percent and stars. Currently, the stars are graphical representations of the percent. Each star represents 20 percentage points. So, 100 percent is five stars, 80 percent is four stars, and so on. The group practice scored 73 percent on the "Getting a flu shot during the flu season" measure. So, there are three completely filled stars and a fourth star that is almost completely filled.

Although the stars on Physician Compare do not currently rate or rank one group practice against another group or one health care professional against another health care professional, the stars do indicate quality. So, more stars are better for each measure. Consumers can use the stars to evaluate group practices and health care professionals on quality measures that are important to them. Let's say you are interested in learning more about the general health measure "Getting a flu shot during flu season." If you click on the bar for that measure, the bar expands to show additional information.

On slide 22, you can see what happens when you expand that measure bar. You still see the measure title and performance rate, but you can also see a description of the measure. The titles and descriptions for the measure are in plain language. As mentioned, we conduct consumer testing to ensure that the measures are labeled accurately and accompanied by explanations that are true to the measure specification and understood by health care consumers. This is true of all measures listed on the public-facing profile pages.

Next slide. We've reviewed what information and data are currently on Physician Compare. Now I will hand things over to Denise St. Clair to outline the future of Physician Compare.

The Future of Physician Compare

Dr. Denise St. Clair: Thanks, Allison. Let's move on to slide 24. As we move forward, we will continue the phased approach to public reporting that CMS started with the 2012 program year data, as Allison just explained. CMS is committed to providing useful and current quality performance data to give consumers easy-to-use information that can help them make informed decisions about the health care they receive through Medicare.

Looking ahead, CMS plans to continue to expand the amount of information available for public reporting on Physician Compare. The two primary additions planned for 2016 and 2017 are the addition of qualified clinical data registry, or QCDR, data and an item-level benchmark.

In late 2016, based on the data collected for 2015, individual health care professional-level QCDR, PQRS, and non-PQRS measures will be available for public reporting. Group-level PQRS and non-PQRS QCDR measures become available for public reporting in 2017, based on the 2016 data. QCDR data are useful because they can provide health care professionals and group practices with the ability to report specialty-specific measures beyond what is currently available in the PQRS program.

Please note that, for everything shown in this table on slide 24, while all of these measures are available for public reporting, as discussed earlier, not every single one of these measures will actually be reported on a public-facing profile page. We will again analyze the data and look at our public reporting standards and ensure the best measures get up there for consumers and the – statistically, some measures get in the downloadable database for everyone else. And of course, no first-year measures are ever publicly reported on Physician Compare.

Publicly Reported Benchmark

Dr. Denise St. Clair: So moving on to slide 25, I'm now going to talk to you more about the benchmark that is coming forward for Physician Compare. We're pretty excited about the benchmark being available.

So currently, Physician Compare, as noted, does not include any benchmark data. Benchmarks are, of course, very beneficial because they can help consumers better understand the quality data that is on the website. They can put the data into context and they can provide a really valuable and accurate point of comparison.

We previously proposed a benchmark methodology in the 2015 Physician Fee Schedule proposed rule. The benchmark proposed was aligned with the Shared Savings Program ACO benchmark methodology that was current at that time. However, shortcomings emerged when we were trying to look at this and apply the methodology to a group practice or individual health care professional. So, that proposal wasn't finalized.

Last year, the Physician Compare Support Team conducted outreach with a wide array of stakeholders to evaluate the best approach for developing a benchmark. The team spoke with specialty societies, professional organizations, health care professionals, quality measure experts, consumer advocates, as well as many CMS programs that are involved in quality measurement, and our own technical expert panel.

As a result of this factfinding process, we proposed an item-level benchmark, or measure-level benchmark, derived using the Achievable Benchmark of Care, or ABC™, methodology. This benchmark was finalized in the 2016 Physician Fee Schedule final rule. The benchmark will be based on the PQRS performance rates that are most recently available. So, we're currently targeting to publicly report the 2016 data in late 2017, and this means a benchmark published in late 2017 will be derived from the 2016 PQRS performance rate. Therefore, the benchmark will use that current year data.

On slide 26, you can see some of the benefits of the ABC methodology. This methodology is well-tested and it's data driven. It allows us to account for all of the data collected for a specific quality measure and determine the top performers. It also allows us to set a point of comparison for all of those groups or individuals who reported a given measure.

In addition, the ABC methodology has been historically well-received by the health care professionals and entities being measured because the benchmark represents quality while being realistic and achievable. It also encourages continuous quality improvement, and it has been shown to lead to improved quality of care.

Finally, it's based on the currently available data. So, the benchmark is achievable regardless of the unique circumstances of data collection or the measures available in a given reporting year.

Now on slide 27, we are going to explain just how this ABC methodology works. So for the purpose of this explanation, I'm going to refer to a health care professional who reported PQRS measures as an individual health care professional. However, the same methodology will be applied to group practices.

So, ABC starts with a paired mean. This is the mean of the best performers on a measure for at least 10 percent of the patient population—not the population of health care professionals reporting—10 percent of the patient population. This is, then, the top 10 percent of all patients measured who got the best care on the specific measure.

To find the paired mean, we rank order health care professionals from highest to lowest performance score. Then, we create a subset of the health care professionals by selecting the best performers until we have selected enough reporters to represent at least 10 percent of all patients for that measure. We derive the benchmark by dividing this high-scoring subset of patients by the total number of patients that were measured by the top-performing subset. This produces a benchmark that represents the best care provided to the top 10 percent of patients.

To account for low denominators, ABC includes a calculation of an adjusted-performance fraction, a Bayesian estimator. This ensures that very small sample sizes do not overinfluence the benchmark, and it allows all data to be included in the benchmark calculation.

Similar to quality measure performance rates, the benchmark must meet our public reporting standards. In addition, the benchmark will only be applied to measures deemed valid and reliable that are reported by enough health care professionals or group practices to produce a valid result.

The next steps of the benchmark are listed on slide 28. We will use the ABC methodology for each measure that meets our public reporting standards. This is an item-level benchmark, so there will be a different benchmark for every measure. In addition, we will stratify the benchmark according to reporting mechanism to ensure data on Physician Compare are comparable. Creating a benchmark for each measure by each reporting mechanism will help remove the complexity and potential differences between the same measure that is collected via multiple reporting mechanisms, such as registry, EHR, and claims, for instance. It will also remove the burden of interpretation across reporting mechanisms from the consumers.

As a reminder, 2017 is the earliest that this benchmark will be publicly reported. And at this time, the benchmark will be used as the basis of our five-star rating system.

We're committed to moving to a rating system on Physician Compare, as this is a consumer-friendly way to share complex information. As with all information for – available for public reporting on Physician Compare, the benchmark information and the resulting star rating need to meet our public reporting standards. They must be statistically valid, accurate, reliable, and comparable. And, of course, they must resonate with consumers.

The goal of the benchmark is to establish a star rating system that distinguishes statistically significant differences. Using the ABC methodology can help us ensure that five-star performance is statistically different from four-star performance and so on. Currently, we're analyzing the most recently available data, but have not yet finalized the approach to assigning stars specifically based on the benchmark. Information about how stars will be specifically assigned using the ABC methodology will be shared with stakeholders as available. In addition, we will continue to work to ensure that the star rating system is accurately understood and interpreted by consumers. As a result, consumer testing is ongoing.

It's really an exciting time for public reporting, and we are looking forward to the continued evolution of public reporting on Physician Compare.

And as we move to slide 29, we start to think more about the future. And that future is going to be defined by the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA. And MACRA was enacted into law on April 16, 2015.

This legislation not only repeals the Sustainable Growth Rate formula, but it's really critical for Physician Compare because it streamlines many of the quality reporting programs that currently factor into public reporting on the website. And these several programs are now encapsulated under the new Merit-Based Incentive Payment System, or MIPS, program. MACRA also establishes incentive payments for participation in advanced alternative payment models, or APMs.

This fresh start with quality programs will significantly increase the data available for public reporting on Physician Compare, and further forward our mission to help consumers make informed decisions about their health care.

As indicated on slide 30, at this time, the MACRA proposed rule is available for public comment. The 60-day comment period closes on June 27th, and we strongly encourage everyone to review the proposals and submit formal comment, if appropriate.

CMS will not consider feedback during this call as formal comment on the rule. And we are in rulemaking, so we will not be able to answer specific questions about proposals laid out in the rule. But do consult this slide for details about how to submit comments.

Slide 31 provides more information about MIPS. Essentially, MIPS streamlines three currently independent programs and adds a new fourth component. The four components of MIPS are quality, resource use, clinical practice improvement activities, which is the new addition, and advancing care information, which relates to meaningful use of electronic health records.

MACRA and MIPS provide great opportunities for Physician Compare and support the continuation of the public reporting initiative CMS began under ACA. As you'll see in the proposed rule, CMS proposes to continue the phased approach to public reporting and continue the public reporting standards we've discussed today.

CMS also proposes to continue the 30-day preview period for all data available for public reporting on Physician Compare. Under MIPS, a correction process is proposed as part of this process. And CMS proposes continuing to include utilization data in the downloadable database, which is something that we'll start with the 2015 data in 2016.

Some notable new items proposed include publicly reporting on each of the four MIPS performance categories—quality, resource use, clinical practice improvement activities, also regularly referred to as CPIA, and advancing care information. This includes proposals to include aggregate information such as composite scores and ranges. In addition, CMS proposes a reliability threshold to replace the current 20-patient minimum for public reporting quality data. And CMS proposes making APM data available in a similar manner to how ACO data is currently made available on Physician Compare.

As was – as explained in the rule, not all performance information is proposed to be reported as a performance rate or a representation of a performance rate, such as our current stars, or on a health care professional group practice's profile pages. Depending on the nature of the data point and our public reporting standards, information may be displayed as a consumer-friendly indicator, or the data may be included in the downloadable database only.

CMS is also proposing which data to consider for Year 1 of MIPS and which data may more likely be publicly reported in future years.

So again, we encourage you all to review the proposed rule and to formally submit comment by June 27. We also look forward to your feedback and to the opportunity to continue this conversation with you about public reporting on Physician Compare.

So, this concludes today's presentation portion of the call. And next, we'll answer some questions. And I turn things back over to Aryeh, our moderator.

Question-and-Answer Session

Aryeh Langer: Thank you, Denise. Our subject matter experts will now take your questions. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. In an effort to get to as many participants as possible, we ask that you please limit your question to just one.

Operator, we are ready to take our first question, please.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Yes. Your first question comes from the line of Hector Flores.

Hector Flores: Hello, thank you. My question is, is there a workgroup or a series of workgroups looking at social determinants and how those should be coded so that they can get included in this Physician Compare?

Dr. Denise St. Clair: Thank you for the question, Hector. This is Denise St. Clair with the Physician Compare Support Team.

We strongly encourage you to review the MACRA proposed rule and submit comment by June 27th. You will note that there is a "seek comment" item on that specific topic in the rule. So we strongly encourage you to evaluate that and provide your feedback.

Hector Flores: Thank you.

Operator: Your next question comes from the line of Lori Johnson.

Lori Johnson: Hi, my question is about slide 27, about the ABC benchmark. So, I see that the denominator is the number of patients in the top-scoring subset. What is the numerator? Is it a mean of the performance score for that measure or is it a patient count?

Aryeh Langer: Can you give us one moment, please?

Lori Johnson: Sure.

Dr. Denise St. Clair: So, it's the number of patients who make up that top 10 percent for that measure divided by the total number of – the total patient population. So, you're basically looking at the best – the 10 percent of patients who got the best care against the full population of patients in the denominator of the measure. Does that make sense?

Lori Johnson: So, it's just a number of patient counts? Yes. I think – so in the explanation on the slide, it reads, "We derive the benchmark by dividing this high-scoring subset of patients by the total number of patients that were measured by the top performing subset." So, it – maybe it should be corrected to read "by the total number of patients"?

Dr. Denise St. Clair: No. So, it's – what we're looking at is – we're looking at essentially the population of patients and evaluating – getting the top subset of those patients and seeing who they are and where they fit on the continuum, as it were, and then evaluating what the performance score was for that population. So, to sort of figure out what the performance rate you're evaluating, you're first finding out where the patient population is situated on that continuum of performance from 0 to 100 percent.

Lori Johnson: Okay. I...

Dr. Denise St. Clair: There are some...

Lori Johnson: ...as I read the explanation, it almost seems like you're dividing the same number for the numerator and the denominator. And it says, "high-scoring subset of patients divided by the…number of patients in the top performing subset.

Dr. Denise St. Clair: So, it's a little hard to do without the ability to have a whiteboard in the math. No.

Lori Johnson: Yes. So that's what I was doing. I was kind of scratching it out on a piece of paper.

Dr. Denise St. Clair: So again, I – if it's – to help for clarification, so with the paired mean, what we're doing is we are taking the top 10 percent of all patients who measure – who were measured on that specific measure and we're rank ordering them—so, from highest to lowest performance score. Then we take that subset of health care professionals by selecting the performers until we have enough reporters for that top 10 percent. So those are our top performers.

We then derive the benchmark by dividing this high-scoring subset of patients by the total number of patients that were measured. So this produces that benchmark and represents the best care provided to those top 10 percent of patients.

I appreciate that, in abstract, it's a little bit complex.

Lori Johnson: Yes.

Dr. Denise St. Clair: So, what we can do is on our – in our materials, we can make some links to some of the background information about how ABC works—some of the groundbreaking literature on that available—so that you can dig into the details and the math a little bit more.

Alesia Hovatter: Yes, and hi, Karen. This is Alesia Hovatter from CMS. Just to add in—the 2016 Physician Fee Schedule rule under the Physician Compare section—we had included an example, and our links are also in there so you can review that as well, but...

Lori Johnson: Oh, that would be perfect. Yes.

Alesia Hovatter: Yes, we'll definitely include some additional information because, you know, this is going to be the first time we'll have star ratings. So, it's – you know, we want to make sure it's kind of clearly understood.

And then also, I want you to be on the lookout for when we start to make announcements, when we go a little bit further along with, you know, how the display of star ratings is really going to look. So, you know, we're going to be doing that in the future, and we're going to be soliciting, you know, some feedback from our stakeholders. So just make sure that you're on the lookout for that so you can provide input as we get, you know, moving forward in that in the future.

Lori Johnson: Thank you so much.

Operator: Your next question comes from the line of Crystel Sherlock.

Crystel Sherlock: Hi. When I first heard about Physician Compare, I started looking on the website to see what was showing up for our providers. We have about 90 physicians over 13 clinics. And I noticed that, when I typed in the ZIP code for the majority of our clinics, that none of my physicians was showing up.

We have one clinic that's about 15 miles outside of the center of the majority of our clinics. And when I typed the ZIP code for that, all my physicians showed up. So it looks like all of my physicians actually belong to this one clinic.

So I started doing some research. And I know on slide 12 it says that you have to provide at least one practice location address for them to show up for Physician Compare. And what I've discovered is that, when we originally – when the company that handles our Medicare enrollments originally set all of our providers up at that time, they didn't include the practice location. They only included the physical location, which is not what you pull from. So I'm going now trying to correct all those. I guess my question is, Why is

it pulling all of the physicians and then showing them at the wrong location if the practice location address is the requirement?

Dr. Denise St. Clair: So, what – this is, again, Denise St. Clair from the Physician Compare Support Team. What is – what the situation is is – what we do is we look at the relationship of your physicians to your group. So in PECOS, we can see that your physicians have reassigned their billing privileges to your group practice. So that's Step 1. And so, there is a link there. Then, in PECOS, your group practice has provided a list of practice locations. So that, we would imagine, are the 13 clinics where your 90 physicians are providing services.

Then, from there, there's a couple of ways that groups and individual doctors and other health care professionals can let us know exactly which of the clinics they provide services at. And this is something near and dear to our hearts as we know this is something really important to our consumers using the site.

So one thing you can do is, through Internet-based PECOS, you can assign a primary practice location for the physicians. So you can say, you know, Dr. Smith only provides services in Location 1. And – or, you know, Dr. Jones only provides services in Location 13. And in that way, that will be the location listed on Physician Compare, and we will be sure to point folks to their primary location. If primary practice location is not indicated within PECOS, then we will look at the practice location as indicated on claims.

And if – there's been situations where, perhaps, you've got all doctors showing up in one clinic because the practice location, as indicated, is – there's a single practice, perhaps, being indicated in that, making it appear as if all the doctors are providing their services in that one location.

So, a couple of key points is making – are making sure that, in PECOS, the available practice locations for the group practice map exactly to the 13 clinic locations that you want to see your physicians listed at and then ensuring that either the primary location is set for those physicians or we also – or we have that information about their practice location on the claims.

Crystel Sherlock: Right. And I'm going through that process. It's just a lengthy process of – when you have that many physicians, trying to get them all to actually log in to PECOS and sign off on that, or send back paper copies of those authorizations.

I guess my main concern is that anybody using the site now is seeing all of our physicians at the wrong address when it doesn't sound like they should be showing up at all until we get that corrected.

Dr. Denise St. Clair: We do encourage you, if you have specific questions about your unique case, never hesitate to reach out to the Physician Compare Support Team at PhysicianCompare@Westat.com, and we're happy to work with you.

Crystel Sherlock: Okay. Thank you.

Operator: Your next question comes from the line of Peggy Bradley.

Peggy Bradley: Hi. I'm with Hereford Regional Medical Center in Hereford, Texas. Our rural health clinic is – of course, we bill Part A. We're considering joining an ACO. And part of the ACO, to participate in the Medicare Shared Savings Program, is that we report, you know, quality measures—physician quality measures, PQRS. How are we going to do that? Is there any proposal about how a rural health clinic that bills on a Part A UB form is going to be able to do that? Because I know right now you have to be reporting on 1,500 for fee-for-service.

Dr. Denise St. Clair: Thank you, Peggy. Unfortunately, that is a question that we would need to direct to the Accountable Care Organization team, the Shared Savings Program team. And you can contact the QualityNet Help Desk and specifically ask that question, and that team can get back to you on that item.

Peggy Bradley: Okay. Thank you.

Dr. Denise St. Clair: Thank you.

Operator: Your next question comes from the line of Debbie Young.

Debbie Young: Hello. I had a question about star ratings and how that comes into play for providers who decide not to, like, report anything for MIPS. They don't report any quality measures or participate in Meaningful Use attestation.

Dr. Denise St. Clair: So right now, under the Physician Quality Reporting System and the data that we have available to date, and obviously, anything related to MIPS is not finalized, and we're still in rulemaking, so we can't really speak to...

Debbie Young: Okay.

Dr. Denise St. Clair: ...exactly how things will happen under MIPS. But we can speak to what's been previously finalized. And so, that's the data that are currently available for 2014 and the 2015 data that will be publicly reported at the end of 2016, and then the 2016 data are targeted for public reporting at the end of 2017.

It is the 2016 data where a star rating is first available for public reporting using the achievable benchmark of care methodology per the physician fee schedule rule. So, there's the context.

Debbie Young: So…

Dr. Denise St. Clair: If a physician or other health care professional is not reporting data, then there will simply not be a "Clinical quality of care" tab on their profile page. Or under quality activities, there will simply not be a checkmark that says, "Reported quality measures." So, there is nothing that indicate – or says anything other than a lack of an indicator. So, if someone chooses not to report, they will just not have that information or that tab available. Anyone who is reporting will therefore, you know, have the indicator that they reported quality measures and/or the data themselves, if the measures they reported are measures that are ultimately selected for public reporting.

Debbie Young: I guess I'm more concerned about – so, the star rating is based on, like, your – how you report your measures. But if you don't report measures at all, does that mean you'll have, like, a zero-star rating, or it'll just say you didn't report, or what will reflect?

Dr. Denise St. Clair: You just won't have a star rating at all.

Debbie Young: Okay.

Dr. Denise St. Clair: So, the star ratings will be measure by measure. So, if we – if you think about how the measures are currently displayed and you have, you know, "Getting a flu shot during flu season," there would be a star rating for that measure. If you don't have that measure, you won't have a "Clinical quality of care" tab; you won't have a rating.

Debbie Young: Okay. Okay. So really, I mean, a poor performer looks worse than somebody who doesn't report at all.

Dr. Denise St. Clair: Consumers do interpret lack of information and low quality in various ways, so that's something that we're constantly evaluating but important to consider.

Aryeh Langer: Thank you very much.

Operator: Your next question comes from the line of Lucy Marini.

Lucy Marini: Hi. I'd like to ask you a question about how MIPS will factor into the star ratings that are going to be moving forward.

Dr. Denise St. Clair: As we're still in rulemaking, nothing related to MIPS has been finalized. So, that is something for future discussion, but again, we encourage you to review the MACRA proposed rule and submit comments and feedback.

Lucy Marini: Okay. Thank you.

Operator: Your next question comes from the line of Helen Tselentis.

Helen Tselentis: Hi. I have a general question. Has CMS considered the legal ramifications of publicly posting performance scores and their star ratings for health care providers?

I'll give you a specific example. If a patient dies of pneumonia, it would be very easy for a lawyer to look up that patient's health care provider on Physician Compare, and then they could see how that individual scored on the pneumococcal vaccination measure. If that provider's performance score happens to be low, don't you think that this could be used against them in a malpractice suit?

Aryeh Langer: One moment, please.

Helen Tselentis: Sure.

Dr. Denise St. Clair: Thank you for your comment. We are required to work with our mandate and with the regulation as finalized. And the Affordable Care Act did legislate the need for public reporting, and that is forwarded through MACRA. And everything that is made available for public reporting is finalized through the rulemaking process. So again, we strongly encourage stakeholders to raise their concerns through the formal rulemaking process. And there is the opportunity to do that by June 27th with the MACRA proposed rule. So, we strongly encourage that.

Aryeh Langer: Thank you very much.

Operator: Your next question comes from the line of Dana Garay.

Dana Garay: Hi, this is Dana from Texas Tech. And my question – and I apologize if I missed it. I pulled up two of my providers, and I don't see any quality data on either one of those, and I don't see us as a group practice with any quality data. Do you know when that's going to be available, or did I just miss that?

Dr. Denise St. Clair: So, the data that are currently on the website are the 2014 program year data. And as explained in the presentation and, again, the materials are available, and so we know we hit you with a lot of detail today. But for 2014, a subset of measures

are made public. So, you would have quality measure data, a "Clinical quality of care" tab on your group profile page or your individual profile page if you meet these criteria.

As a group, you would have had to report one of the available 14 Web Interface PQRS measures. If you reported via registry or EHR, those data were not made public this year, so you would not have a "Clinical quality of care" tab. You would, however, have a checkmark on your "General information" tab that says you did report quality measures. You just wouldn't have the actual performance rate.

And as an individual, you would have needed to report as an individual and report one of the six claims measures that was made available for public reporting. And so, we do appreciate that there are well more than six measures available in PQRS, so it's likely that a physician or other health care professional just reported another measure. And so, in that case, again, there wouldn't be a performance rate but there would be a checkmark on general information that measures are reported. And again, we only publicly reported a small subset of claims measures to start. And so, again, if anyone – if an individual reported via registry or EHR, those data would not be available. And again, we are looking at 2014 right now.

Alesia Hovatter: Yes. And Dana, this is Alesia Hovatter from CMS. Additionally, we have those measures that Denise was just speaking of on our Physician Compare Initiative page, so we have documentation for that.

Also, as we mentioned earlier in the presentation, we will be releasing additional information now that informal review has closed. So, just to let you know, that'll be coming up soon.

Dr. Denise St. Clair: Yes.

Dana Garay: Yes...

Dr. Denise St. Clair: So target is for the end of the month.

Dana Garay: Yes, I'm looking at the page. It doesn't say that our physicians – and we reported by EHR on many, many measures, I'm sure. But it doesn't say they participated. It just says if they did participate, it will be indicated below, and all it says is we use electronic health records, but doesn't say anything about quality.

Dr. Denise St. Clair: Okay, that checkmark that says "Used electronic health records" is the indicator that you were a successful EHR Incentive Program participant. And if you do have additional questions about your use-specific case, we do encourage you to email us at PhysicianCompare@Westat.com so that we can dig into your specific case

more. And we will remind you that, on slide 35, there are the additional resources with a number of links to information we've discussed today that you might find helpful.

Dana Garay: Okay. Thank you.

Operator: Your next question comes from the line of Janet Brier.

Janet Brier: Hi. I'm calling from Professional Orthopaedics Associates in Scranton, Pennsylvania. And my question was—and I've asked this to regional folks as well—we're looking at the 2014 data, but right now, we're reporting 2016 data that will have a significant impact on the 2018—not just the star ratings, but also now reimbursement. And my question is: Is there a possibility of getting our information in a more timely manner, like on a quarterly basis? For instance, the first quarter of 2016 I can look at in the second quarter of 2016? Since this data that we're constantly, you know, reporting, we really have no feedback. I really can't tell where the heck we are at any given time until it's well over with.

Dr. Denise St. Clair: Thank you for your comment. The timeline is currently set through rulemaking. So for the 2015 data, it's set to be released at the end of 2016, and the 2016 data targeted for release is the end of 2017. We are on an annual rollout period.

However, again, we strongly encourage you to review the MACRA proposed rule. There is discussion of timeline and opportunities under MACRA and MIPS.

Janet Brier: Well, my question, you know, was, Is there a plan to provide feedback in a more timely manner?

Dr. Denise St. Clair: So again, the timeline for the next 2 years is already set as an annual release of information per the physician fee schedule rule...

Janet Brier: Okay.

Dr. Denise St. Clair: ...but we do encourage you to raise your concern and comment as part of the MACRA proposed rule process. And again, those comments are due by June 27th.

Janet Brier: Okay. When you look at slide 20, you know, the PQRS measures don't particularly pertain to specialists, especially orthopedic surgeons. So, I'm just wondering how we will appear in a star rating.

Dr. Denise St. Clair: So first, again, the measures available for public reporting are defined through rulemaking, and CMS did take a phased approach to public reporting.

And so, the measures – we started with a small subset of measures that were very much focused on more of the primary care activities and heart disease. And that has to do with the Medicare population and the largest, sort of, number of physicians who are reporting early in the reporting process.

And then – so for the 2013 data available in 2014, we were focused highly on primary care for groups. And 2014 data that were just released at the end of 2015, that was expanded to individual health care professionals. But we were still only looking at an available subset of about 20 measures that you'll notice really are more for that primary care heart disease focus.

Janet Brier: Right.

Dr. Denise St. Clair: And then, the public reporting plan brings us in through our phased approach. And starting with data available for 2015, which are targeted for release in 2016, we have a much larger set of measures available for public reporting. So as noted, we basically have all of the measures in PQRS available for public reporting starting with the 2015 year data.

Janet Brier: Okay.

Dr. Denise St. Clair: So that will open opportunities for measures that are available under the PQRS program. So in – per rulemaking, it is measures within PQRS that are available for public reporting.

Janet Brier: Okay, thank you.

Operator: Your next question comes from the line of Jake Duby.

Aryeh Langer: Your line is open, Jake.

Jake Duby: I believe you already answered mine. This is more individual. Thank you.

Operator: Your next question comes from the line of Sandra Scott.

Sandra Scott: Hi. I have a kind of a two-part question. I'm calling – I have a question regarding the information in PECOS.

My first question is: Is CMS considering any enhancements to PECOS? We are a very large organization. We have nine tax IDs. We have 1,800 providers. We have almost 400 groups. Managing records in PECOS is not easy; it's time consuming, and it would be helpful if it was more user friendly.

And my second – the second part to it is, is there – the MAC payers don't seem to be familiar with Physician Compare. And so we're more – we're paper – we sent our application paper. We do go into PECOS. And we have been into PECOS for the last couple of years. We've been doing a lot of work in PECOS trying to update our records. The problem is that, when we submit our applications in PECOS, the MAC payers still have to go in and they have to approve our application. Well, when we make changes in PECOS, they don't approve our changes, and so – and for instance, locations—primary and secondary locations. We took a – it took us a whole year to get through all of our tax IDs and all of our provider records. They didn't update any of our records. They didn't put – add any of the addresses that we requested they – that they add. There was other information that just did not – it did not get updated as we requested.

I have asked this question many times. I went to a conference in Texas, proposed the question to CMS. They eluded the question about Physician Compare. So, I guess I'm not understanding. If we're responsible for the information to be accurate in Physician Compare and the information is coming from PECOS, CMS needs to allow organizations to be able to update the information.

Dr. Denise St. Clair: We appreciate your comment and appreciate the situation you're explaining. PECOS is operated by CPI. So in terms of enhancements to PECOS, that question would need to be directed to CPI. Regarding the struggles of getting the information updated and your challenges – your personal challenges of working with the MAC on getting the changes approved, we strongly encourage you to reach out to us, again, PhysicianCompare@Westat.com, so we can talk with you about your specific situation so we can see what the opportunities are there.

Alesia Hovatter: Yes, and Sandra, this is Alesia Hovatter from CMS. So, CPI is the acronym for the Center for Program Integrity, and that's a different branch at CMS from where we work under for Physician Compare.

Sandra Scott: Yes. Okay. Yes, and we have actually reached out to Physician Compare, and we have worked – I have worked with a couple of people with Physician Compare, and they were able to actually – because our information—our data—was completely messed up. And they actually helped us with updating a lot of the information. However, the problem is that, when Physician Compare is being refreshed from PECOS, because the information still isn't right in PECOS, now, it's still pulling inaccurate data. So, it's just – it's a huge struggle for us, for a large organization.

Dr. Denise St. Clair: If you could – again, that would be something that we would like to work with you on a one-on-one basis because, of course, that shouldn't happen. So, let us know if you could, please do reach out to us and we'll be happy to continue to work with you.

Sandra Scott: Okay.

Aryeh Langer: Thank you.

Sandra Scott: Thank you.

Operator: If you would like to ask a question, press star 1 on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

Your next question comes from the line of Kelly Trombley.

Kelly Trombley: Hi. I'm calling from Syracuse Gastro in Syracuse, New York. I've heard you talking about the measures and whatnot. We're a specialty office. So if I understand correctly, we won't show up with the "Clinical quality" tab? Is that correct?

Dr. Denise St. Clair: It depends on which measures that your professionals have submitted—or your group practice, depending on if you're reporting at the group practice level or at the individual clinician level. As noted, for the 20 – the data currently available, it was very much focused on to the primary care set of measures. But moving into 2015 data available for public report in 2016, they're – basically, every measure in the PQRS program becomes available for public reporting.

Now, again, not every single measure will be put on a profile page. It has to meet our public reporting standards. And it may, you know – therefore, some data may not make the cut for public reporting in this year, and/or it may be reported simply in the downloadable database vs. in the – on the profile pages if it really isn't well-understood or resonating with consumers.

But there is the opportunity per rulemaking to make any of the measures available in PQRS available for public reporting starting with 2015. So it really does depend on which measures were publicly report – or were reported to CMS by your group or by the professionals within your group, and then the analyses of those measures.

As explained earlier, there is a 30-day preview period for all measures made available for public reporting. And as you will often hear from us, once we get close to that period, we will start sharing information about the preview period. And it will be an opportunity to see which, if any, of your measures are on the docket for publicly reporting for the year.

So that's the official confirmation of you or your group or individuals have measures available for public reporting. And we obviously do a lot of outreach around which are the measures selected for public reporting, so you can look against what you reported and see if you'll have measures for that year.

Kelly Trombley: Okay. Yes, we report via QCDR for each individual provider, and they're all colonoscopy measures. So basically, they may or may not be part of Physician Compare when the new data comes out.

Dr. Denise St. Clair: Yes. It will depend on the measure analyses and if they meet the public reporting standards, but the QCDR data are technically available for public reporting.

Kelly Trombley: Okay. But we – so that aside, we should at least have that green checkmark?

Dr. Denise St. Clair: Yes. If you satisfactorily report via the QCDR, then you would have the checkmark.

Kelly Trombley: Okay. Because we did and we don't have any green checkmarks.

Dr. Denise St. Clair: Again, for – if you have a question about your personal group or individual situation, please do let us know, again, PhysicianCompare@Westat.com.

Kelly Trombley: Okay.

Operator: Your next question comes from the line of Robert Solfest.

Robert Solfest: Hi. I have a question in regards to the benchmark. When I – I'm from HealthPartners in Minneapolis, Minnesota.

The question is, it looks like the benchmark is a weighted average of the performance for the top physicians—perhaps, say, a 95th percentile. How is this top-tier benchmark planned to be used or related to the star ratings?

Dr. Denise St. Clair: So, it's not quite a weighted average. And again, as Alesia pointed out, there are wonderful links in the 2016 Final Physician Fee Schedule rule to a few seminal articles on the Achievable Benchmark of Care that really do dig into the methodology. So for those who are interested, that's a great way to dig into the details a little bit more.

In terms of how the benchmark will translate to the star rating, as we mentioned in the presentation, we're currently analyzing the data to assess the best possible approach. And we are actively reaching out and discussing findings, as we go, with stakeholders. We held the first round of webinars on potential approaches to the benchmark just in the last – at the end of 2015. And we'll be continuing those conversations. So we strongly encourage folks to keep an eye out for additional outreach and webinars on that as we continue to analyze the data and think through the possible – the best possible approach to taking the benchmark in assigning the stars. So again, do look at

the Physician Compare Initiative page for more information about upcoming discussions on that.

Robert Solfest: So, I'm not sure that my question's answered. Sorry, but – so the benchmark, it sounds like it's in process of figuring out how you're going to use it. But for a consumer, then, looking at it, it's meant to represent, say, the top roughly 5 percent performing docs or the level of – for the highest performing physicians? Is that how you're seeing it?

Dr. Denise St. Clair: So from the consumer perspective, they're going to see a star rating. And they're going to see that a five-star doctor is, statistically, performing better than a four-star doctor. And sort of the mechanism behind that will be the detail of the calculation of the benchmark itself. The benchmark itself is based on the performance of the physicians serving the top 10 percent of the patient population. So that's part of the calculation, but actually, the application to the star rating and what's viewed from the consumer perspective is the culmination in the star rating.

Robert Solfest: So, they won't see the benchmark itself?

Dr. Denise St. Clair: The benchmark is – we're still evaluating exactly how the data will be displayed. Obviously, it won't be a secret. But in terms of what is on that profile page for consumers vs. what's in more detailed information, say, in the downloadable or in additional information, that's to be determined. And one of the key factors in that will be consumer testing and, of course, discussion with our stakeholders.

Robert Solfest: Okay, thank you.

Operator: Your next question comes from the line of Lou Galterio.

Lou Galterio: Yes, hi. This is Lou. I had you on mute.

I have a question, I also put in writing, that I wonder if you could clarify a little bit with us. We work – we are a PQRS registry and a QCDR ourselves. And one of our things that we're curious about is when physicians – the way they report that quality is PQRS linked up to their tax ID number. Now, if a particular year goes by and a doctor's circumstances change, and that tax ID number's no longer valid, then the next year, they're not going to show up in Physician Compare, and they probably wouldn't get the penalty either, because the tax ID number would not be getting funding since it's – the doctor's no longer affiliated with it and then putting their claims through another TIN. So that's – and I've actually heard some doctors looking at that as a strategy, too. So, I'm curious, is there any action going on where there is some kind of a trail of an NPI that's linked to a TIN that's your normal unit of tracking quality? What happens when that TIN keeps changing? Has there been any thought on that?

Dr. Denise St. Clair: So, from an operational perspective, this is something that would be addressed by the Physician Quality Reporting System because, obviously, the PQRS program is defining the rules around how data are associated with an individual or a group.

What we can say from the Physician Compare side is that, as explained earlier, there does need to be active billing to a TIN for that TIN to be represented on the website. So, that's the Physician Compare side, but very much appreciate the issue raised and would encourage bringing that issue to the PQRS program. And one way to do that is via the QNet Help Desk. And we did receive your email and can share that email address with you.

Lou Galterio: Well, thank you very much.

Operator: Your next question comes from the line of Cathy Grant.

Cathy Grant: Hi, guys. Thank you so much for your call today. And for the folks that's interested in—or the audience, I would say—the downloadable database, do you guys have any plans on doing a similar sort of session or presentation for that?

Dr. Denise St. Clair: If there's interest in more information on just the downloadable database, it is something that can be considered, so thank you for that feedback.

Cathy Grant: Welcome.

Operator: And your next question comes from the line of Lucy Marini.

Lucy Marini: Yes, I have a question on the CAHPS survey. Is that something that only groups will see in their tab, or is that something that, if you as an office conduct that survey, it can be reported?

Dr. Denise St. Clair: So, the CAHPS surveys—the surveys of patients' experience—are collected at the group practice level vs. at, let's say, the clinic practice location level. So if they're being submitted to CMS at the group practice level (I'm going to just use an example for you all on the phone, hi)—so, if you are reporting CAHPS as Dean Clinic and you are visiting just the Sun Prairie, Wisconsin, location, the survey would actually be reported at the Dean Clinic level, not at the Sun Prairie Clinic level. So, it is aggregated to the group practice level, not the clinic location.

Lucy Marini: So, do individual practitioners have to participate in these surveys? Or will the consumers ever, you know – the patients ever receive this survey for them?

Dr. Denise St. Clair: So, the individual – at the moment, CAHPS is collected at the group practice level only, so there is currently not administration of the survey of patients'

experience for individual doctors. Now, when a consumer gets a survey, it will say, "You recently were seen by Doctor X," but that's simply to put it into the context of the group. The data are reported at the group practice level. So at this moment in time, those data are reported at the group practice level, not individual physicians.

Lucy Marini: Does that mean a certain group size because, I mean, we are a group, we have a group tax ID with four physicians? Is that – how is that differentiated? I'm not sure I understand the difference between a group that CMS looks at vs. how we identify ourselves as a group.

Dr. Denise St. Clair: So – oh, if you're – if you are a group and you have designated yourself as a report – you designated with CMS, either you've registered as a group practice reporting option group and you're going to submit data as a group, then CMS would see you as such. The CAHPS surveys are officially available for groups of two or more. And as a group, you would elect to submit those data and you would work with CMS and the appropriate vendors. There's additional information on cms.gov about the CAHPS surveys and administration of the surveys and how all of that works. But that's...

Lucy Marini: Okay.

Dr. Denise St. Clair: ...something that would be – you would initiate.

Lucy Marini: Okay, thank you.

Operator: There are no more questions at this time.

Additional Information

Aryeh Langer: Okay, great. Well, thank you very much, everybody here in the room. I just want to remind everybody, if they have any questions or comments after this call is over, you can refer to slide 33 and send an email to the PhysicianCompare@Westat.com for any other questions.

As a reminder, an audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement on the MLN Connects Provider eNews when it becomes available.

On slide 36 of today's presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous and confidential. We hope you will take a few moments to evaluate your MLN Connects Call experience today.

Again, my name is Aryeh Langer. I'd like to thank our presenters here at CMS. And also, thank you all on the lines for taking time out of your busy schedules to participate in today's MLN Connects Call. Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

-END-


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