

Centers for Medicare & Medicaid Services
Special Open Door Forum:
2010 Physician Quality Reporting Initiative (PQRI)
and Electronic Prescribing (eRx) Incentive Programs:
Group Practice Reporting Option (GPRO)
Thursday, January 14, 2010 3:30-5:00 pm ET
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will host a Special Open Door Forum on the 2010 PQRI and eRx Incentive programs. This Special Open Door Forum will focus on a new reporting option, available for the 2010 PQRI and eRx Incentive Program, known as the Group Practice Reporting Option (GPRO). Group practices that are interested in participating in the GPRO for PQRI and/or the eRx Incentive Program must submit a self-nomination letter to CMS by no later than January 31, 2010. Once a group practice (Tax Identification Number or TIN) is selected to participate in the GPRO for PQRI or eRx, this is the only method of PQRI or eRx reporting available to the group and all individual eligible professionals (National Provider Identifier or NPI) who bill Medicare under the group's TIN for 2010.

During this call, CMS will:

- Provide information on the eligibility requirements for participating in the 2010 PQRI GPRO and/or the 2010 eRx Incentive Program GPRO;
- Provide instructions for self-nominating to participate in the 2010 PQRI GPRO and/or 2010 eRx Incentive Program GPRO;
- Provide an overview of the data submission process for PQRI and the eRx Incentive Program;
- Describe the measures for the 2010 PQRI GPRO;
- Discuss the criteria for satisfactory reporting of PQRI quality measures under GPRO; and
- Discuss the criteria for successful reporting of the eRx measure under GPRO.

Following the presentation, the telephone lines will be opened to allow participants to ask questions of the CMS subject matter experts as well as of individuals who have experience with the data submission process that will be used for quality reporting under the PQRI GPRO.

The 2010 GPRO for the PQRI and eRx Incentive Programs was finalized in the 2010 Physician Fee Schedule final rule with comment period. The final regulation was published in the Federal Register on November 25, 2009. To view the entire 2010 PFS final rule with comment period, go to the CMS PQRI website <http://www.cms.hhs.gov/PQRI> and click on the "Statute/Regulations/Program Instructions" section page. PQRI GPRO information is also available by clicking on the "Group Practice Reporting Option" section page of the CMS PQRI website. eRx Incentive GPRO information is available by clicking on the "Group Practice Reporting Option" section page of the CMS eRx Incentive Program website located at <http://www.cms.hhs.gov/erx incentive> .

We look forward to your participation.

Special Open Door Forum Participation Instructions:

Dial: 1-800-837-1935 Conference ID 45243499

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will A Relay Communications Assistant will help.

An audio recording and transcript of this Special Forum will be posted to the Special Open Door Forum website at, http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp and will be accessible for downloading beginning on or around January 27, 2009.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at <http://www.cms.hhs.gov/opendoorforums/>.

Thank you for your interest in CMS Open Door Forums.

Audio files for this transcript: http://media.cms.hhs.gov/audio/PQRI_GPRO011410_Part1.mp3 and http://media.cms.hhs.gov/audio/PQRI_GPRO011410_Part2.mp3 .

**Correction Notice:

For 2010 PQRI Group Practice Reporting there is not a requirement to collect signatures from all providers.

This is a requirement for registry reporting not specifically a requirement of the registry. According to the Registry Requirements all registries must "obtain and keep on file signed documentation that each NPI whose data is submitted to the registry has authorized the registry to submit quality measures results and numerator and denominator data to CMS for the purpose of PQRI participation." This is a CMS requirement for participation in PQRI through a registry.

Centers for Medicare & Medicaid Services
Special Open Door Forum:
2010 Physicians Quality Reporting Initiative (PQRI) and Electronic Prescribing (eRx)
Initiative Programs: Group Practice Reporting Option (GPRO)
Moderator: Natalie Highsmith
January 14, 2010
3:30pm-5:00 p.m. ET
Conference Call Only

Operator: Good afternoon, my name is Natasha and I will be your conference facilitator today. At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum on 2010 Physicians Quality Reporting Initiative.

All lines have been placed on mute to prevent any background noise. After the speakers remarks there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad.

If you would like to withdraw your question press the pound key. Thank you. Mrs. Highsmith, you may begin your conference.

Natalie Highsmith: Thank you, Natasha, and happy new year to everyone and thank you for joining us for this Special Open Door Forum on the 2010 Physicians Quality Reporting Initiative and Electronic E-Prescribing Initiative Programs focusing on the Group Practice Reporting Option.

During this call, CMS staff today will provide information on the eligibility requirements, instructions for self-nomination and provide an overview of the data submission process. Also, staff will describe measures for the 2010 PQRI GPRO and discuss satisfactory criteria, and discuss the criteria for successful reporting of the E-Prescribing measure under the GPRO.

The slides for today have been posted on the CMS PQRI website and that web address is www.cms.hhs.gov/pqri under the Sponsored Calls section page you will see the slides for today. I will now turn the call over to Regina Chell, who is our PQRI Program Manager here at CMS.

Regina Chell: Thanks, Natalie. I'm happy to be here today to provide more detail with regards to our Group Practice Reporting Option. But, before we get into the meat of today's presentation, I'd like to just take a minute to talk a little bit about our two guest presenters that we're very excited about having with us today.

The first presenter, after myself will be Sheila Johnson. And Sheila is a registered nurse by training and she has a Masters in Business Administration. She has been using her clinical administrative skills to serve as Director of two Pay for Performance programs. The CMS Physician Group Practice Demonstration Project and the CIGNA medical home pilot at Dartmouth-Hitchcock.

Sheila also provides clinical and administrative leadership to ambulatory care clinical support staff, transcription services and health information services for the community group practices of Dartmouth-Hitchcock. Sheila has hands on experience utilizing the patient assessment tool as part of the CMS PGP demonstration project.

Then we're also pleased to have with us as the following presenter after Sheila, is Dr. Jim Rogers. And Dr. Rogers is in private practice and practices Internal Medicine at St. John's Health System in Springfield, Missouri. He is the

Department Chair for Primary Care at St. John's Clinic and the Medical Director for the PGP demo with CMS. He has been involved in medical advocacy through many aspects of local, regional and national level.

He is a member of the AMA, ACP, served as – serves currently as the board of directors' member for AHQA. He holds Certification in Quality Assurance. He has served as the President of the medical staff for St. John's Hospital and is Chairman-Elect for Primaris QIO for Missouri.

OK. So welcome to both of our guest speakers. And with that, I'd like to go ahead and get started giving you an overview of PQRI E-Prescribing GPRO and PQRI GPRO. And just to reiterate for those of you who may not have caught this, so that you have a chance to open the slides if you go to the CMS PQRI website at www.cms.hhs.gov/pqri you can open the slides for today's presentation, under sponsored calls.

So with that, I'd like to go ahead and get started. You're beginning slides just are the introduction and there is a disclaimer slide. So, I would like to move on to slide number four. And we're pleased to announce a new reporting option for program year 2010, and that is a Group Practice Reporting Option, which will be termed GPRO. And we've modeled this after two current demonstrations at CMS. The Physician Group Practice demo, or PGP demo, and the Medicare Management Performance demo, or the MCMP demo.

So let's talk a little bit about what a group must do to participate in GPRO. You first need to submit a self-nomination letter to CMS, you will be required to meet certain technical and other requirements. And then you will need to be selected to participate. GPRO participants who satisfactorily report will be incentive eligible. They will receive two percent of the groups practice total estimated Medicare Part B PFS allowed charges for covered professionals services furnished during the 2010 reporting period.

Now, how do we define a group practice? For the purposes of GPRO, a group practice is a single TIN, or Tax Identification Number with at least 200 or more individual eligible professionals that are identified by their NPI, or National Provider Identifier. These EPs have assigned their billing rights to the TIN.

Please note that group practices that participate in the 2010 PQRI demonstration are unable to participate in the 2010 PQRI GPRO.

You know what? Let me backup because I think I just said 2010 PQRI demonstration. And what I meant to say is group practices participating in 2010 PGP demonstration are unable to participate in 2010 PQRI GPRO. So what are the eligibility requirements for a PQRI GPRO? Potential participants must meet the group practice definition. They must self-nominate by January 31st, 2010. They must have an active IACS user account. They must provide group practice's TIN and NPI numbers of all EPs participating. They need to agree to attend and participate in all mandatory training sessions and have billed Medicare Part B on or after January 1st, 2009 and prior to October 29, 2009.

And I just want to stop here for a moment. I'm on slide six and those of you following along will see that actually the wording on slide six says references Medicare Part A. And I want to be certain to announce at this point that is an error. Part A reference is not something that physician's bill. Physicians bill Part B and we are correcting the language on this error and it will be removed from all documents. So please note the correction to eligibility is that you have billed Medicare Part B, on or after January 1st, 2009.

And then group practices that are selected to participate, their EPs must report via GPRO and may not participate in PQRI as individual EPs using that TIN NPI combination. So when we get to the data submission process the groups been selected to participate in 2010 PQRI and using this reporting option CMS will then provide additional detailed information and training. The group practice must complete a partially pre-populated data collection tool which will be provided by CMS. This tool will be for a randomly assigned set of Medicare beneficiaries based on the services provided during the 2010 reporting period.

Using Medicare claims, CMS will randomly assign a beneficiary to a group practice, if the practice provides the plurality of office or other outpatient services to the beneficiary, which is a minimum two visits between January 1st and October 29th, 2010. Selected group practices will be provided access to the partially pre-populated tool no later than quarter one 2011. Group practices populate the remaining added fields necessary for capturing quality measure

information on each of consecutively assigned Medicare beneficiaries. With respect to services that were furnished during 2010 PQRI reporting period of January 1st to December 31st, 2010.

So let's talk a little bit about the GPRO measures for 2010 PQRI GPRO. There are 26 in total, their NQF endorsed quality measures targeting high-cost chronic conditions as well as preventive care. The four disease modules are diabetes, which has eight measures; heart failure, with seven measures, coronary artery disease with four, and hypertension with three measures. Plus, there is four individual preventive care measures. Preventive care screening for mammography, colorectal cancer screening, influenza immunization for patients greater than or equal to 50 years of age, and pneumonia vaccine for patients 65 years and older.

So I've mentioned earlier about a tool, and this slide we're on slide number 10, is just simply an example of a performance assessment tool. And this was taken from the PGP demo and the GPRO tool is currently under development and is anticipated that it will be very similar to this. So to satisfactorily report for GPRO – PQRI GPRO, participants must report completely on all 26 measures included in the tool. They must complete the partially pre-populated data collection tool for the first 411 consecutively ranked and assigned beneficiaries for each disease module or preventive care module. It's important to note here, if the pool of eligible assigned beneficiaries is less than 411, the group practice must report on 100 percent of the assigned beneficiaries.

With regards to the self-nomination instructions; to be considered, group practices should send – address their requirements to CMS by 5 p.m. Eastern time on January 31st, 2010. This slide, which is slide number 12, references the PQRI website again which has all this information listed there. And then CMS will access – will review the information that we get in and we will access whether participation requirements are met by each self-nominated group practice and we will notify the group practice with a decision by the end of quarter one, 2010.

Now let's move on for some discussion around the GPRO E-Prescribing. The eligibility requirements for E-Prescribing GPRO are the potential participants

must indicate their intent to participate in E-Prescribing GPRO when they self-nominate for 2010 PQRI GPRO. They must comply with all 2010 PQRI GPRO requirements and participate in 2010 PQRI GPRO. You will report E- Prescribing measures for E- Prescribing GPRO using claims or qualified EHR product or by using a qualified registry.

The E- Prescribing GPRO is not reported through the data collection tool. To successfully report E- Prescribing, GPRO participants must have adopted and used the qualified eRx system. The group practice must report the E- Prescribing measure at an eligible patient encounter, meeting the E- Prescribing measure denominator which is at least 2,500 times during the reporting period. Incentive payment only applies to groups whose Medicare Part B PFS allowed charges for services in the E- Prescribing measure denominator are 10 percent or more of the groups' total 2010 estimated allowed charges.

Then slide 15 has some additional resources with where to begin and how to get started. You would – you find reference to GPRO requirements for submission of 2010 PQRI data. The measures list, narrative measures specifications, eRx measure specifications and we also have FAQs for questions that may have come before.

And now if we have any questions, or do we want to save questions until the end? OK, I think I just – Natalie just informed me we'll save questions to the end. So I'm going – I'd like to introduce our next presenter, Sheila Johnson. And Sheila's going to talk about her experience with the PGP demo.

Sheila Johnson: Hello, everyone. This is Sheila Johnson as Natalie just said, and I wanted to thank you very much for allowing me to have the opportunity to share our experience working with the Performance Assessment Tool. First, I would like to direct your attention to slide number two. What I'm going to do in the next few minutes is give you an overview of Dartmouth-Hitchcock.

I'm going to review the operations process for using the Performance Assessment Tool, which is also know as PAT. And I'm going to tell you a little bit about our experience with pre-collection data collection and post-collection. And then I'm also going to share our opportunities and challenges. And in my

part of the presentation I'm really going to share some of the nuts and bolts of operations and then Dr. Rogers is going to share a bit more of the reporting tools and how they're used within a clinical practice.

So if you would please go to slide number three. You'll see a map of both Vermont and New Hampshire and Vermont's on the left, New Hampshire's on the right. And at Dartmouth-Hitchcock we serve patients in both states. We're a multi-specialty physician group practice. Dartmouth-Hitchcock also includes a hospital, Mary Hitchcock Memorial Hospital. We have, Dartmouth Medical School and we also have around 900 physicians and associate providers that are spread across the two states.

We have been a participant in the CMS Physician Group Practice demonstration project, and in our most recent reporting period we had about 31,000 Medicare assigned beneficiaries. If you would go to slide four please as part of the pre-work for the data collection we have found that it was important to assign one person to serve as the system administrator, and that would happen to be me. And I also have a backup person. The System Administrator is responsible for electronic file exchange, as we do that through a secure server.

I've also ended up being a content and technical resource to our various abstractors. I help with the different sites to identify the users. We're split into five different, what we call divisions, across the states and we have identified users in each of those divisions. I also make sure that the abstractors are able to get the tool – the performance assessment tool loaded onto their computers. Then CMS and Research Triangle Institute and the Iowa Foundation for Medical Care, they have provided us with really great training and support and then I take that training and accommodate it for our Dartmouth-Hitchcock specific work flows. And also, figuring out how we can use our different electronic health records to be able to get the data collected.

If you would please go to slide five. As part of the data collection where we're actually collecting the data to put into the PAT, the tool is pre-populated with claims data for several of the measures. And then once we have the tool, then we start our manual abstraction for one part of it using the electronic health record.

The nurses at the sites they look within the charts and they abstract the information and put it into the tool.

We also, in one of our sites, have an electronic medical record that we're able to extract data from and then push it into the tool. As far as user support, as I've mentioned, CMS and RTI and IFMC – we have all of the alphabet I think there – they're very supportive and they're support is ongoing throughout the collection period. We have weekly conference calls with the groups and the other sites, and they also have provided us with a bulletin board where we can find all the technical specifications and answers to questions that users are having.

If you would now please go to slide six. After the collection is finished we upload the entire file of information to an electronic secure server and then once RTI and IFMC have had a chance to process, they send us back an audit request and they ask for 30 records for each of the topics that we have abstracted on. And our experience has been that as part of that audit, we then need to collect paper medical record documentation to provide the validation for the assessment.

Also, once we've finished with our collection then we take time to evaluate the process and the tool. Internally, we get our abstractors together, our medical and administrative leadership and we review the process of how we did with the actual assessment. We also make recommendations for how we can improve the future abstraction.

Then externally, we do debrief with the other PGP sites, CMS, RTI and IFMC and the CMS, RTI and IFMC, they've been very receptive to changes that we've recommended to work some of the bugs out with the PAT. Then we share our results internally with our physicians and staff. And we've really used our results to focus on opportunities for improvement with our Medicare beneficiaries.

If you'd please now go to slide seven. Some abstraction information that I wanted to share with you is that within the demonstration we've been responsible for 32 quality measures. And I noticed within the GPRO that there are 26 measures. The same topics are covered within the PGP, we just have a couple additional measures that we've been collecting and see – coronary artery disease

and heart failure. For the volume that we've abstracted in the last abstraction period we actually had a potential sample size of 3,690 records. This is because 615 names are sent times the six topics. Although, some records do have multi-topics assigned to that particular patient, so our actual sample size ended up being 3,402.

For our site, we were able to already achieve the performance target on breast cancer screening through our administrative claims so we did not have to abstract for that in the previous period. We ended up – of those 3,402, we actually processed 2,564 because as noted earlier, you have to have your consecutive records. And we ended up submitting, as you can see, 2,302. And I know that I was always interested in how much time this would take so we've kept track, and in our last reporting period you can see on this slide that we used 725 registered nurse hours- which equates to .35 FTE.

Now going on to slide eight. I just wanted to share a few opportunities and challenges that we've had with the assessment. One of our opportunities has really been that the method of using the PAT tool that's really provided us with a systematic way within Dartmouth to collect the data. And based on what the work that we were doing, with that we've developed registries internally that we use as well, and the PAT was really a driver for that.

As I mentioned, we've been using the results to improve our quality care – of care. The project itself has really forced us to be more attentive to the different measures. We were able to demonstrate quality and receive a financial reward. In the last reporting period we did receive the 1.5 percent of allowable charges and our monetary award was prorated based on the PGP quality results.

Something that also is an opportunity for us is we have as – as and a challenge as well, we have three different electronic medical records across our system. And so it's been a challenge to figure out how we can better have field defying data so that we can extract information and push it into the PAT. Several of our sites are switching over to epic in the future, and having worked with the PAT has really helped guide our thinking about the field defined data.

Some of the challenges that we've encountered, one of them in particular, is the assignment methodology within the PGP. Specialists have been assigned disease conditions that are traditionally managed by the PCP. And a good example is the Orthopedic Surgeon. The majority of the care for that Medicare beneficiary was provided by Dartmouth-Hitchcock, although it's provided by a specialist. And our orthopedic surgeons have not kept on all of the care of all of the different conditions to be able to provide the quality measure results. However, it has proven to be an opportunity that they've been able to communicate more regularly with the primary care provider.

The other thing that was a challenge, and very much early on, but I believe we've figured it out, is that we have an eight week turnaround. And I know within the GPRO it will be a six week turnaround. And I can tell you that if you get yourself organized and all ready, six weeks is a manageable time to do the abstraction. And then I mentioned about our three different EMRs, and if I could have one desire or wish list item that I'd like to mention, is that I think it would be really fabulous if we could figure out an electronic process for submitting the validation of the medical record document. Because there's a lot of paper that still needs to go back and forth.

So, with that, I'd like to thank you for your time, and I'll turn it back over to Natalie.

Regina Chell: Thanks so much, that was very helpful Sheila, and very informative, so thanks for sharing all that information. And next I'd like to re-introduce our next guest speaker, Dr. Jim Rogers. And Jim, are you ready to start?

Jim Rogers: Yes, I am.

Regina Chell: Thank you. Go ahead, Dr. Rogers.

Jim Rogers: Thank you for letting me participate today, I appreciate the chance to talk. I hope everybody's weather is horrible so this conference will even sound a lot better by the time we're done. The – our slide – and I'll continue with the slides, on the – I think the slide, my first slide is slide number 26, "Winning the P4P Quality Race." And some lessons with our demonstration project.

Understanding – and I'll discuss in a second, I don't want to confuse anybody. I know you are participating or looking at the PQRI opportunity and reporting through that mechanism. We've been involved in the Pay for Performance demonstration project, the P4P. And we've also been able to participate in this and as Sheila was mentioning, I will talk a lot about operations. And again, my bias is I'm a physician, Internal Medicine so I will kind of give a little bit different slant. A little bit less on the operations as far as the details of the data set as much as trying to move the information and how you might be successful in not only capturing the data but as the PQRI moves into P for – Pay for Performance. I think that has to be on everybody's mind anytime you're starting off on this.

Slide 27. In our paid political announcement here, St. John's Clinic is, we're in southwest Missouri. The number one destination for tour buses to come down to Branson, that is in our area. The – we have a medical group that has around 500 physicians. We're represented by all the specialties. We are an integrated delivery system so we have the benefit of having across our system both the clinic, the hospital and we have a health plans function that's all within that group, so that helps us.

Across our system we have about 60,000 Medicare beneficiaries that we have the privilege to take care of. Within our cohort that we study and we report on, is about 30,000 – 30 – 29 to 31,000 depending upon the year talked about. So you can see throughout our system our cohort size is a little bit smaller or about – roughly about half of the total number we do take care of.

Slide 28. Contrasting our demonstration project, the PGP, versus PQRI, the PGP, we are – in this part of the PGP we are reporting, ours is Pay for Performance. There are quality measures as Sheila mentioned. We have 32 measures we report on and depending upon our success on those measures, whatever percent success on our weighted scale that we get on those measures, is the percent of the reward we get for the PQRI payout. So, if we report and don't make our measure, we truly see – we don't see any reward from that financially.

As a contrasting across the top, Pay for Reporting is still where the PQRI sets. At this point you meet the requirements for the reporting as outlined previously

in the notes by Regina. Then you'll get your – right now it's trying to work out the operations for figuring out how to report those. The financial potential for us is 1.5 percent and the PQRI GPRO is a two percent financial potential.

Reporting in the PGP is into the patient abstraction tool, or the PAT and what was – is being corrected or modified I think for the PQRI, and be ready for prime time soon I – as I hear. There will be a patient abstraction tool which will be very closely geared to what we've learned in the demonstration project.

Slide number 29. As we begin, understanding that we, you know we –, Sheila – unlike Sheila's group in Dartmouth-Hitchcock, we didn't have – when we started this we didn't have an electronic medical record. Now we were naïve, we thought electronic medical record would solve all of our problems. And we've installed one in the year following, this third year of the demonstration project, we just finished and we're having second thoughts about it solving all of our problems. So Sheila, when you keep wishing for one single electronic record being a great thing it presents its problems anyhow.

The – as patient registry we did identify it would be critical to our success, a registry to help us track to help us identify. And as we began our process – and this was – as we developed this for the demonstration project and it turned out to be a good thing for us to report our results though we said that our registry would have to have three essential components. And we had to have the registry or we could not compete, we could not participate in this demonstration project.

And that – those three components would be automatic feeds, work flow reminders and I'll just comment on each one of those, and ad hoc reporting. Going to slide 30, considering the automatic feeds and the patient registry input. We have a – we have a saying that manual is bad and chart review is horrible, and you can imagine that's a physician saying for certain, the input is automated as much as we can. And everything we could get our hands on that we could tie into our registry, interfaces with laboratory, interfaces with scheduling.

When we did have to do manual input, we wanted to make it as intuitive as possible. And then the last thing is on any input we have, we wanted to make sure that the imputers, the providers and clinical staff had a hundred percent

editorial rights. If that's not your patient in the registry take them out and let us know. If the lab values an error correct it and we told everybody "Make sure you understand chart review or review of that." It'll have to stand the test of review, but certainly editorial rights, there was no web master or data editor that had control. The control was de-centralized. So in the patient input on the registry – excuse me, the registry input is as automated as we could get and build interfaces.

This is slide 31. Something that I would – that was born out of our first creating the registry has really caught us a lot by surprise, the practicing physicians and the office manager really pushed hard for us creating the visit planner. Visit planner in retrospect for us has been the stroke of genius. It's keyed to the scheduling system and it's very work flow sensitive. This got us this – it is a piece of paper that we generate when a patient comes in for an appointment. It has a to-do list, it's either do – has a little asterisk on it that's "do", or "not done".

We were smart at first. We thought we would just colorize it. So it would be red if we need to make it bright and people could obviously see the red and then the physicians need to attend to anything that's not been done. Whether that's a need for a lab test to be done or a referral need to be done, because the preventive measures haven't been met. And then we discovered that most of the offices do not have color printers so we had to go back to asterisks and highlighting it for words. I just mentioned that to you so – because those little operational things, you spend a lot of time making it look very nice and find out it's not very functional.

So we do print offs' in the work flow every time a patient comes into the office, we print off this visit planner. The visit planner then has the disease categories available for every patient that may – it has demographics of the patients. And if the patient has diabetes, then there is a, if you will, a title bar on that part of the document. It expands down to give us all the diabetic measures underneath there. If the patient does not have diabetes it's left as a small title bar and there's not a lot of – there's a lot more white space in the visit planner.

So, titles for diabetes, titles for coronary artery disease, heart failure and then the preventive measures are all there. Like I said, to the providers it's been

enormously popular. And what we found out was, it was an opportunity for staff and providers to look at and if there were lacking or if we were not making measures to get it corrected, most of the time while the patient's there.

And that might result in getting a blood test that had been overlooked or had not been done, during a diabetic foot exam or getting scheduled for preventive measures such as have time to discuss the real need for immunization or for a mammography or colorectal cancer screening. So it was timed to the work flow and it also saved us a whole lot of chart review to abstract the information out of it. It gave us an opportunity to improve patient care on the fly.

Slide number 32. Ad hoc reporting, this may seem a little small. It turns out that it's a huge thing for us because our reporting before then had come from centralized locations. It was- most of the reporting we had before was claims based, claims data. It almost always had the fault of needing to be reconciled so it's several months late, it's not timely. And this information, routinely the physicians would see the first one or two patients on the list were deceased or had moved off and they'd throw the whole file in the trash because it was fraught with errors due to the timeliness.

So as the ad hoc reporting gave us a chance to move the reports, to do it in a more timely fashion. It put in the hands of the physicians or the office managers to do that. So it is decentralized. So along with editing rights, of correcting the data on the fly, we also put ad hoc reporting with the ability for someone to walk through, identify the cohort of patients they want to look at. Identify the measures they want – the bundle of measures they want to look at and the time schedule.

So they could run a report from a baseline to an improvement. Or run a report after making a change in their office or see how they're doing on accumulation of something like flu season, how am I doing on my flu shot measures, as it's going on and it doesn't create that huge delay we otherwise were saddled with. So the confirmation verification of your actions within a practice setting or business unit has been very helpful.

Slide 33. The registry I'm talking about in ours was homegrown and put in place as we started. There was, like I say, a naïve approach was as soon as we get the electronic record we'll have a lot of data we can get and pull from. And we found out some of the short comings of an electronic record and even shared information was verified by those participants in the PGP project that already had electronic record. And they ran into some of the same abstraction problems that we were running into as we installed our record last year.

It's – there is the demand for what quality – identifying the quality measures. They change, they can change pretty rapidly. PQRI for instance, was not known about and talked about three years ago, four years ago. And now we're participating in a conference call trying to identify the details of it and outline the details of what must be met. So there's rapid changes for quality measures and the definition.

Electronic records don't routinely allow you to necessarily pull those off and define those to your liking. I talk to people that electronic records still yet, are very much vertically enhanced and horizontally hampered. And what I mean from there is, that in our record it gives you the opportunity to take any patient and find a lot of information and data on that patient and details from everything that's been put into the record to support that patient.

What it doesn't do is give you a horizontal look across all your patients, the mammogram rates across the whole cohort. It – Electronic records, especially ambulatory side, have not been asked to do that very much in the times past. They're getting interested in it now because there's a request. But we found those requests to be very slow to come around and also very difficult to help get us to define that.

So as we move forward with our registry and making the case for us not only building but continuing to support our registry, this helps to solve some of these problems with the ability to define quality measures. The ability to pull data and exchange across horizontally across systems to look for how have all of my diabetics doing, rather than how's Ms. Jones diabetes control and her measures doing.

And so we kind of view our registry, if you will, as – like a search engine that works and compliments our electronic record at this point. We have said open and publicly within our health system that we will celebrate the day when we don't need the registry anymore. When the electronic record has the full capacity to let us pull horizontally and vertically and do the verification we need to do. But we don't see that in the – in the near future.

Slide 34. Just a couple of – few comments right quick because you may see this as you're moving through the Pay for Reporting into the Pay for Performance phase as you gear up. I would encourage you to think PQRI is really Pay for Performance but you get a lessons learned or a – or a RND time for it. We know there's three phases of quality achievement. I'd like to lump those as I'm talking about this in the tooling up, and that's what you're into now. Acquiring the interfaces necessary, whether it's the performance or whether it's the PAT tool. Whether it is a registry interface, whether it's chart review. It's really tooling up and creating systems of finding a way to capture those very defined quality measures.

Cleaning up is the next phase. That's the one you have to – you have to be really thick skinned. It helps to be nimble and dodge things when they throw at you. Because in that respect we – you always get the things – the comments back from the physicians. “That's not my patient!” “That isn't any good”. So, therefore the first three numbers are bad, I'm going to throw out the whole 50 pieces of elements.” You have to get through that and be committed to cleaning them up correcting information as fast as you can on the fly. And that's the reason it's very important to have control over your data tracking tool that you do and to be able to report back.

And the last one is measuring up. After you go through the systems of being able to create and capture the specific data elements, you clean up your data. Then what we're finding is even some of the most – we've been fortunate to be in the project for now going on our fifth year, so we're developing a culture of acceptance and encouragement and actually taking up this approach on not only Pay for Performance. I have colleagues saying now that “I do take better care of my patients.” We have cleaned up the information to the point where we are finding those patients that, for whatever reason, didn't get the measure, the test,

what they were supposed to do. And we are correcting that and actually improving our quality now as we move forward. So we're delighted with that, that we're to that stage. But truthfully, it's taken us three years to get there.

Thirty-five, slide 35. I'll make one other comment because this we discovered, and it is a point to remember as you're trying to get not only buy in, but you're trying to get acceptance and physicians and providers to champion this. Is that the medical care and quality achievements, they're measured collectively. We all think about measuring quality, you have to – you'll hit a seventy-five percentile mark, or you'll have eighty percent of your patients have this done.

But you know medical care is delivered individually. For each and every one of the patients that I take care of, and I control their hemoglobin A1C's, they are a less drain on the expense of the health care system and they improve their quality and their outcome is better as an individual. So if I don't score seventy-five percent on all of my patients, if I score seventy-four percent I've done a tremendous job on those seventy-four percent. So if you – If you don't pay attention to that, what you get is the possibility of physicians threatening or saying or some actually doing it, "Well, gosh. If patients don't do what I tell them, I'll just not take care of them."

So if you're seventy-five percent, you'll find the temptation for people not to take care of sick patients, which really need us desperately. But they'll make their numbers look better. On the other hand, if for every patient that someone achieves a measure and that patient's improved, that's medical care delivered individually. There is a reward restructured within your system or a reward to the physician.

They understand that it's important for every single patient to be – to achieve that reward. Then nobody prunes or changes a practice because every time that they don't have a diabetic in their practice it's one less opportunity for achieving some improvement in quality. There's no harm done if they're awarded individually. So however it might need to be done from the view of the system or the health care system you know we have to meet measures collectively but remember that healthcare is delivered individually.

And last slide, number 36; What is the Pay for Performance potential? And again, quality improvement is identifying even whether you're doing responding to a PQRI request from the government or whether you're responding to your own internal drive for pursuit of improvement in payers or whether or not you have a contract through a health care entity locally or an insurance entity, identifying the appropriate measures. That whatever you measure truly drives quality and outcome. Stabilization of those measures are extremely important as much as you can, you'll have to always deal with – it may not be up to date, current and timely. On the other hand you have to be able to have some stability in those measures to get the processes in place to identify those.

And then again, just one more – one more request to consider on the provider performance. Incentives have to be aligned. It is a cultural shift in responsibilities. I talk to physicians all the time and I say “You know who in here doesn't know that you're supposed to put beta blockers and ace inhibitors into the bodies of patients with congestive heart failure?” And they all know that and they all say “I do it.” And when I show them their data they said they are amazed that they are not doing it as well as they thought they were.

So it's not lack of intent, it's lack of a shift in understanding that you need to get the processes, you need to look at your group of patients and how you're doing. And I will also tell you that's something that none of us were trained on initially, it's a little foreign to us. Rather than just treating individually but getting that horizontal look across how you deal with the disease process. So I'll close my comments at this point in time and hope some of that was helpful as far as from the physician standpoint on how you might do that.

Regina Chell:

Thank you, Dr. Rogers. I'm sure our audience found that very helpful and before we move to questions I would just take – like to take a minute to thank both Sheila Johnson and Dr. Rogers once again for sharing their experiences and their lessons learned. I think we all found this to be a very good overview of the PGP demo. Both from an operational standpoint, as well as from a quality improvement aspect. So thank you both very much.

Natalie Highsmith:

OK. Natasha, we're going to go ahead and move into our open Q and A portion. If you can, just remind everyone on how to get into the queue to ask a question.

And everyone please remember when it is your turn to restate your name, give what state you're calling from and what provider or organization you're representing today. And also in the sense of time we do have about 30 minutes allotted for questions and answers, so if you could please limit your questions to one question. And if you have follow-up questions we ask that you please get back into the queue to ask your follow-up questions. Natasha?

Operator: At this time I would like to remind everyone in order to ask a question press star then the number one on your telephone keypad. Your first question comes from the line of Sanket Shah from Illinois. Your line is open.

Sanket Shah: Hi, yes, Sanket Shah calling from Illinois Rosh Health Associates. I just had a quick question on the beginning of the presentation. You had discussed a tool for collection of data, I guess I'm a little bit confused if that's a tool that's being offered from CMS or is that just an example that was used by a third party organization?

Regina Chell: No, that's a good question. It's a tool that will be provided by CMS to group practices that are selected to participate in the GPRO. And the tool that I showed in the slide presentation is just a sample of what the tool could potentially look like. That's the tool that's currently used for the PGP demo and the GPRO tool will be similar to that but not exactly like that. And then there will be additional information with regards to the tool and training on populating the tool when we have the kickoff for those practices that have been selected to participate. Does that answer your question?

Sanket Shah: I guess so, OK.

Natalie Highsmith: Natasha, next question please.

Operator: Your next question comes from the line of Brenda Mickow from Minnesota. Your line is open.

Brenda Mickow: Hello, thank you. My name is Brenda Mickow from Mayo Clinic in Minnesota. Thanks for doing this; it was very interesting and helpful all the way around. And we really do appreciate the group practice option. My question is in relation

to the self-nomination criteria. There are a couple of areas that are somewhat nebulous and those include the software, minimum software configurations and being able to comply with a secure method of transmission of data. I think we'll be able to meet both of those but since they are somewhat nebulous will there be any additional information coming out on those with additional criteria?

Natalie Highsmith: Hold on one second.

Regina Chell: So your question then is just with regards with sending in the – repeat your question again because I want to make sure I'm understanding it.

Brenda Mickow: Sure, sure. When I look at the document that has the self-nomination criteria, there's two bullets. One talks about technical capabilities using PC software, Microsoft and other minimum software configurations. And then another bullet that talks about being able to comply with a secure method of data submission. And those are both somewhat nebulous, there's no real defined criteria. Now, I can state in our self-nomination letter that we'll meet both of those but not having more real definition to those is difficult to simply state it. I have little doubt that we'll be able to but I was just wondering if there's any more information you can provide.

Regina Chell: Thanks, sorry. We were just consulting in the room and I think what I'd like to do, just to be sure, I'll get back to you 100 percent correctly with your question is just take your contact information and the follow-up with you directly if that's OK with you.

Brenda Mickow: That's absolutely fine. My name is Brenda Mickow, m-i-c-k-o-w, and then my phone number is 507-284-1871.

Regina Chell: OK, thank you Brenda. Very good question!

Operator: Your next question comes from the line of Lynda Farwell from Kansas. Your line is open.

Lynda Farwell: Hi. I'm wondering on slide six, it talks about mandatory training. What kind of mandatory training, how much, how long? Is it just for those people like a train the trainer type training?

Regina Chell: At this time, it's not like hours and hours of training. And the training would be training that could be done either on site here or on a webinar type training. And we would have a kickoff meeting that would have some training and then some follow-up training as needed later on when you go to – when you get the pre-populated tool and your adding data. So, we're not talking hours of training. For the kickoff we're anticipating probably a two hour training session for that.

Lynda Farwall: So a two hour and then possibly a few follow-ups?

Regina Chell: Yes, correct.

Lynda Farwall: OK. And then...

Regina Chell: One or two, probably not a lot of follow-ups will be necessary.

Lynda Farwall: Well, when we have to send in – what are the – and maybe I missed this, but the requirements? What are you looking at whether to approve a group or not? As long as we meet the 200 size under our tax ID number and they all have NPIs are – is – are all groups going to be eligible? Are you only taking so many groups, is it first come first serve up to so many? How's that working?

Regina Chell: No, it's not going to be first come first serve. And as long as the groups meet the requirements that we've reviewed today then it's anticipated that they'll be eligible. But we'll review all the information that comes in with regards to the TIN NPI eligibility and everything that's stated on slide six. So they have to have an active IACS, you have to self-nominate by January 31st, agree to attend the sessions which we've just talked about and have billed Medicare Part B during the time frame.

Lynda Farwall: OK, and then...

Regina Chell: It's not – it's not just a first come first serve.

Lynda Farwall: OK. So basically anybody that meets all of those criteria are going to be able to do this?

Regina Chell: Yes, correct.

Lynda Farwall: And of course I've asked this question and I believe for individually, we're reporting right now, in case for some reason we aren't able to do a group or we decide not to. And we continue to do that until the very end it's not going to hurt anything and this is just to verify because we're never going to get paid more than our maximum incentive anyway, whichever way we go correct?

Regina Chell: Right. So it doesn't hurt you to report individually but just so you know, if you are selected as a PQRI GPRO group practice participant then you would not be eligible. The NPIs in the TIN would not be eligible for the individual PQRI incentive. But no, you would not be penalized for reporting both ways.

Lynda Farwall: OK. But if we were selected, and then decided not to do that ...

Regina Chell: OK. Let me backup on your question because what I was thinking you were saying – we've had large practices that have talked – have asked this question. And they had started reporting for – were starting for the 2010 year, reporting as individual – for individual PQRI. And they were deciding if they were going to apply to be GPRO to wait and see if they were accepted. But no, you are correct. Once you are accepted as a GPRO participant then you are not eligible to report as an individual under the same TIN NPI. So once you're selected as a GPRO PQRI participant then that is the way you need to report.

Lynda Farwall: OK. So once we're selected, we've got to stick with it no matter how hard it might be? Right?

Regina Chell: Yes, you do need to stick with it.

Lynda Farwall: OK, and then just one more thing. Sheila, it sounds like you've had great success in what you've done there. Did you find that it was a lot more work than just doing the individual reporting on the claims?

Sheila Johnson: Well, this is Sheila and I can address that. We have not been individually reporting off of claims because we've not set up our patient financial system to do that. So our participation has all been with the chart abstraction. And we did speak internally about how much more work we wanted to put onto the backs of our physicians and associate providers for checking off the different codes for the

quality measures. So our choice has been to do the chart abstraction. Does that answer your question?

Lynda Farwall: Yes, it does. It does yes. And one other thing, I was reading through the measures group reporting. When we do this when we're selected as a group, and I didn't see this in any of the presentations, but as I was reading there are G codes that say I intend to report as a measure group. Does that have to do with the group reporting or is that just the individual.

Regina Chell: You're talking about just PQRI measure groups. So that's something different, those are...

Lynda Farwall: OK. I just wanted to clarify.

Regina Chell: ...(inaudible) for just (inaudible) groups. And that's where you report a G code that you intend to report them as your group. For GPRO measures it's different because there's a total of 26 measures. And you're not determining from the practice side whether or not you're going to report on those measures.

Natalie Highsmith: OK. Linda, I'm sorry we do have to move on to the next question.

Lynda Farwall: No, and thank you this has been very helpful, thanks.

Regina Chell: Thanks.

Natalie Highsmith: Next question, please, Natasha.

Operator: Your next question comes from the line of Leonard Smith from California. Your line is open.

Leonard Smith: Thank you very much. I have two brief questions. One is there was – one of the requirements for GPRO was to have an IACS account. And we have IACS accounts for PQRI register reporting, so does this account that's specific to the GPRO and does it have to be active when we submit our letter? In other words do I have to go out and create an organization that has in some way associated with our tax ID number, does that account have to be prepared and ready to go at the time I self-nominate?

Regina Chell: If you already have an IACS account that would be – that would meet that requirement.

Leonard Smith: OK. The second question is we participated here in our organization in California and the California MCMP and we were one of two practices that did entirely electronic reporting even though there was the availability of the PAT tool for MCMP. Is that option of being able to import, export data collection electronically into the PAT going to be available in GPRO as it was in MCMP?

Regina Chell: No. Not for the 2010 GPRO.

Leonard Smith: So we're going to have to hand populated 411 patients entirely?

Regina Chell: Oh, (inaudible) – Actually do I have – I have another speaker on the line that may help me answer that question. Kathy, are you on the line?

Kathy Kain: I believe MCMP tool currently has a way to map from EHR to the tool and I think it's yet to be determined if that will still be a functionality but I think they will – it will be considered. Does that answer the question?

Leonard Smith: Yes, actually in MCMP there was an incentive built into it here in California if you reported entirely from a C-chip certified EHR and so there was encouragement and we did custom programming to do the updating of the files that you'd export out of with the claims data out of the PAT tool you could update that and then re-import it into the PAT tool and submit that after a little bit of incomplete validations.

Regina Chell: I just want to clarify, this is Regina again, one other thing because you had mentioned MCMP. So I just wanted to clarify that for the GPRO this is a large group practice – group practice reporting option. So it's a TIN with 200 or greater NPIs.

Leonard Smith: Right. The MCMP started in 2007 so we did that as small individual practices but we are a large group and can qualify for the GPRO.

Regina Chell: OK. I just wanted to clarify that because when you said that I knew that was for small practices. So that's – I wanted to bring that to your attention.

Jim Rogers: I'm – this is Jim Rogers, I might comment right quick just to that question. We did exactly what he's talking about with our registry. On our backend it does upload into the abstraction tool. So that – and whether or not, there – that – you guys are – as you find clarification if it's available, but we do map and we do upload our registry directly into that and our data submission flowing into that has been very successful for us.

Natalie Highsmith: OK. Natasha, next question please.

Operator: Your next question comes from the line of (Ron Campbell) from Kansas. Your line is open.

Ron Campbell: Yes, Ron Campbell with Stormont Vail in Topeka, Kansas. Two quick questions. The first one was I believe mention was made during the Dartmouth presentation regarding the length of time groups will have to report the data in 2011, once we receive the reporting tool. Am I correct in understanding we'll have six weeks to complete the reporting?

Regina Chell: That's correct.

Ron Campbell: OK. Mention was also briefly made about their award being prorated. Could you expand on that?

Sheila Johnson: Yes, this is Sheila Johnson, I can expand on that. In the Physician Group Practice demonstration we have our quality measures, our 32 measures. And an example, if we received ninety-two percent completions of the target then our 1.5 percent total allowable charges was taken times the ninety-two percent. So whatever our quality results were, our bucket of the 1.5 percent was prorated that way.

Ron Campbell: There is no similar prorating component to the GPRO is there?

Regina Chell: Yes, no, the GPRO is different. The – if you satisfactorily report – so the difference here is remember GPRO is for satisfactorily reporting. So, you – the incentive eligibility is 2 percent of the group practice's total estimated Medicare Part B PFS allowed charges during the 2010 reporting period.

Ron Campbell: OK.

Regina Chell: OK?

Ron Campbell: Very good, thank you.

Regina Chell: Yes.

Operator: Your next question comes from the line of – sorry, Evelyn Kropp from New York. Your line is open.

Evelyn Kropp: Hi, this is Evelyn from Basset Health Care in upstate New York. I just have two quick questions. I'm in the unfortunate position that I review 2,500 charts for the 2009 PQRI and my vendor just notified me today that I need individual consents from each provider even though they're all employed by my hospital. So I want to know if that's truly the case, if that will be – also be the case for the 2010 GPRO, and also what are the costs associated with the 2010 program?

Regina Chell: There are no costs associated with the program.

Evelyn Kropp: OK. So the tool is free. OK.

Regina Chell: The tool is free, so there's no cost from our end. We don't say "You have to pay to participate in this program."

Evelyn Kropp: OK.

Regina Chell: And I'm not sure I understand your other question. You were reporting... do the other part of the question again please.

Evelyn Kropp: OK. We decided to participate in 2009, I collected data on 90 of my providers which...

Regina Chell: Let me stop you for just one minute, OK?

Evelyn Kropp: Sure.

Regina Chell: Just because we have so many different reporting options. So when you say 2009, are you talking about 2009 PQRI, and if you could elaborate on the reporting option as well.

Evelyn Kropp: Yes, 2009 PQRI, the preventative measures (sent via a registry). So I've collected the amount of charts that I need and just today my vendor notified me that I need individual consent forms signed by each of my physicians. And they all are employed by the hospital and all under the same tax ID. So I wanted to know if that is accurate and if that will also be accurate for 2010.

Regina Chell: OK. That's a requirement that's coming out from your individual registry. So we don't determine the requirements for registries. Each individual registry often has different requirements so that's a question that you would need to take up with them.

Evelyn Kropp: OK. So CMS does not require individual consent forms signed by the providers?

Regina Chell: No, that's coming from your registry.

Evelyn Kropp: OK. That's what I needed. Thank you very much.

Regina Chell: Sure.

Operator: Your next question comes from the line of Blair Barnhart from Ohio. Your line is open.

Blair Barnhart: Hi, I have two quick questions. The first is when I look at the measures, especially if I look at measure number three, and I see that the denominator and the numerator they tell me that the patient's recent blood pressure is less greater than 140, are we responding in the numerator yes or no, or are we responding with the number?

Regina Chell: Kathy, are you – can you answer that question?

Kathy Kain: I think at this point in time that the tool actually might have a number but I'm – we're not positive on that. And I think since the tool is not fully flushed out yet it will be remained to be seen so.

Blair Barnhart: OK. And then the second question related to that then is, if in the first – if we are getting 411 patients and the patient doesn't have a specific diagnosis, do we submit N/A for that or are you then going to give us another patient to answer the question?

Regina Chell: You're not selecting the 411...

Blair Barnhart: No, no, no, you are. So if you've, – so are you – so for example, if you've selected the patient and the patient doesn't have the specific item, or are you telling me that they will always, you know that they'll always have, it will always be like a diabetic patient for measure number three?

Natalie Highsmith: Hold on one second.

Blair Barnhart: OK.

Regina Chell: OK, thanks for waiting.

Blair Barnhart: Sure.

Regina Chell: So you will need to confirm the diagnosis, and if you can't confirm the diagnosis for that measure then you'll skip to the next measure.

Blair Barnhart: OK. So if the patient does not have that – have a diagnosis of diabetes, then we'll skip that patient and go to the next patient?

Regina Chell: Right.

Blair Barnhart: OK.

Regina Chell: And we think, but if you – well, we think that the earlier question, that the answer to that is that that is a value.

Blair Barnhart: We think it's – You think it's a value rather than a yes no?

Regina Chell: Yes.

Blair Barnhart: OK. So if...

Kathy Kain: Keep in mind if you're involved in the GPRO program we will have a lot of ongoing education and support.

Blair Barnhart: So OK – so if it's a value and my numerator is, let's say it's, their blood pressure is 180 and we put in that in the numerator then are we saying this more than of a performance measure versus just a reporting measure?

Regina Chell: Remember for this – for this reporting year, for 2010 GPRO reporting year it is just Pay for Reporting. It's not Pay for Performance.

Blair Barnhart: OK. But, if I – if that's the case, then, if you put in a number in that top one and my number is – and if by putting in – I can't put in a number for that person.

Regina Chell: Well, it doesn't mean that the measure – it doesn't mean that the measures we have my not be collecting outcome data or performance information. But we're not paying for performance.

Blair Barnhart: OK.

Regina Chell: Does that make it clearer?

Blair Barnhart: Yes. So we're not – We think it's going to be a number if I heard correctly we think it's going to be a number that's reported.

Regina Chell: Yes, correct, yes.

Blair Barnhart: And that if there are – If the patient doesn't have the diagnosis. So there's not an infinite number of patients we could actually be reporting on, it would definitely just be those 411?

Regina Chell: Correct.

Blair Barnhart: Per measure, or total?

Regina Chell: (Inaudible). Sorry, there is going to be an over sampling to allow for some skips.

Blair Barnhart: So what – so I guess the total number of patients I’m going to have per measure is not 411, it could be more than that?

Regina Chell: It’s per module not measure, so...

Blair Barnhart: OK. It’s – sorry, I meant per module. So it’ll be 411 plus some extras per module?

Sheila Johnson: This is Sheila, maybe I could help out here, and I don’t know if it’s exactly the same in GPRO, but within the PGP for the PAT for example, with diabetes we’re given a sample of 615 names and we have to go through them and make sure that we get 411 that have the diagnosis that are consecutively ranked. So that over sampling, there’s 615 but we’ve not had to extract all of the 615 to get to the 411.

Blair Barnhart: OK. Do you – does – CMS is that how you would imagine this would work for the next round?

Regina Chell: Yes. Thank you, Sheila, for that clarity that was...

Blair Barnhart: OK. So what we have to do is we take your sample you give us, we have to determine which 411 would be consecutive, and then report on those.

Regina Chell: Right, go down the list consecutively.

Blair Barnhart: OK. OK. Great! Thank you very much.

Operator: Your next question comes from the line of Dennis Plante from Vermont. Your line is open.

Dennis Plante: Hi, this is Dennis Plante from Fletcher Allen in Burlington, where it is cold and snowy. I’m curious about the defining of the group practice. We have about 400 physicians in our group practice. The identifying measures really apply mostly to primary care doctors and we have probably less than 200 primary care doctors to provide the NPI numbers, on, but we have obviously 400 providers under our TIN number. So in determining the 200, is it the 200 of the whole group or the 200 that these patients would apply to? If you can, clarify that question.

Regina Chell: Sure. It is 200 of the whole group.

Dennis Plante: OK. And if – because we are right now, continuing to participate on a claims base PQRI submission, this is our third year for that. If some subgroup of the group practice decided they wanted to continue submitting in the traditional claims base methodology, if we do not include the NPI names of those providers in the group practice, can we still play the game two ways?

Regina Chell: Actually, the way the requirements have been written is that it's the TIN NPI participates in the GPRO then they cannot participate in individual PQRI. I would ask the way you have worded your question, if we could take your information and we could just get back to you with that as well.

Dennis Plante: OK.

Regina Chell: Because I just want to be sure that I give you a hundred percent accurate information.

Dennis Plante: OK. Will you just get that from the operator or you want me to give that to you now?

Regina Chell: Do you mind giving it to us now?

Dennis Plante: No. OK, it's Dennis Plante, p-l-a-n-t-e, and the phone number is area code 802-847-7143.

Shauna Kirby: Regina, this is Shauna.

Regina Chell: Oh, hi, Shauna.

Shauna Kirby: Hi. We just want to jump in and say that it is rolled up at the TIN. So if an NPI is billing under that TIN that is part of the GPRO, then they would have to report as GPRO participants and not individually.

Dennis Plante: OK. So someone can only do it one – only one way.

Shauna Kirby: Under that TIN, yes.

Dennis Plante: Right, OK, got it.

Regina Chell: Thank you, Shauna.

Natalie Highsmith: OK, Natasha, we have time for one final question.

Operator: Your last question comes from the line of Pat Lyons from Michigan. Your line is open.

Pat Lyons: Thank you. Our organization participates in the PGP demonstration project and we would still like to qualify for the E-Prescribe incentive and we do not have procedures to do so. Can you instruct us as to how best to do this?

Regina Chell: We're looking into that currently. The demo staff will get back to you on that OK?

Pat Lyons: OK. Thank you.

Natalie Highsmith: OK, Natasha, we're getting close to our 5 o'clock hour here on the east coast and I'll turn it over – back to (Regina) for closing remarks.

Regina Chell: I want to thank everybody for taking time out of their afternoon today to join us and again thank both of our guest speakers for very informative presentations. So thank you both Sheila and Dr. Rogers. And hopefully this has been helpful. I would like to remind you to please don't hesitate to access the PQRI website. Certainly PQRI has a lot more opportunities for reporting options and we do appreciate that that may generate more questions from our providers. So we have a lot of educational materials out there and whatever you cannot find the answer to, you can certainly contact us directly. So, thank you again and have a great afternoon.

Natalie Highsmith: OK. Natasha, can you tell us how many people joined us on the call today?

Operator: The peak number of participants was 349.

Natalie Highsmith: OK, wonderful. Thank you everyone.

END

