UNDERSTANDING YOUR QRUR

APRIL 2015

HOW TO UNDERSTAND YOUR QUALITY AND RESOURCE USE REPORT

CONTENTS

A. Background and Purpose of the Mid-Year Quality and Resource Use Reports

The 2014 Mid-Year Quality and Resource Use Reports (QRURs) are confidential feedback reports provided to physician solo practitioners and groups of physicians nationwide who billed for Medicare-covered services under a single Taxpayer Identification Number (TIN) over the Mid-Year QRUR performance period (July 1, 2013 through June 30, 2014), and that had at least one eligible case for one or more of the quality or cost measures included in the Mid-Year QRURs. This performance period differs from the actual performance period used for the Value Modifier, which extends from January 1, 2014 through December 31, 2014. Mid-Year QRURs will not impact payment. These reports contain exhibits on claims-based outcome measures and cost measures that reflect the quality and costs of the care that the physician or group provided to its attributed Fee-for-Service (FFS) Medicare beneficiaries.

The 2014 Mid-Year QRUR provides a preview of a TIN's performance on the six cost measures and three of the quality measures that will be used to calculate the 2016 Value Modifier. The cost measures included in this report, and calculated using administrative claims, are Per Capita Costs for All Attributed Beneficiaries, Per Capita Costs for Beneficiaries with Diabetes, Per Capita Costs for Beneficiaries with Chronic Obstructive Pulmonary Disease (COPD), Per Capita Costs for Beneficiaries with Coronary Artery Disease (CAD), Per Capita Costs for Beneficiaries with Heart Failure, and Medicare Spending per Beneficiary (MSPB).The claims-based quality outcome measures included in this report are the 30-day All Cause Hospital Readmission, Acute Ambulatory Care-Sensitive Condition (ACSC) Composite, and Chronic ACSC Composite measures.

Performance information on these measures may be different between a TIN's 2014 Mid-Year QRUR and the 2014 Annual QRUR. The 2014 Annual QRUR will be available in Fall 2015 and will show the TIN's actual performance on all of the quality measures and cost measures that will be used to calculate the 2016 Value Modifier. This Mid-Year QRUR report is provided for informational purposes only. The information included will not affect a TIN's Medicare payments. Physician solo practitioners and physician groups should use the data presented in this report to identify opportunities to improve the quality and efficiency of the care they deliver. This document provides suggestions for how the 2014 Mid-Year QRUR may be used to achieve these goals. Information on understanding the supplementary exhibits also follow.

B. Exhibits Included in the Mid-Year Quality and Resource Use Reports

Exhibit 1. Your Eligible Professionals

Exhibit 1 displays the count of physicians and non-physician eligible professionals[1] billing under your TIN. For a list of each eligible professional that billed under your TIN over the performance period, refer to Supplementary Exhibit 1.

Exhibit 2. Medicare Beneficiaries Attributed to Your TIN Based on Primary Care Services Provided

Exhibit 2 shows the number of FFS Medicare beneficiaries who are attributed to your TIN for the claims-based cost and quality outcome measures included in the Mid-Year QRUR. Moreover, the second and third rows of the exhibit display the number of beneficiaries who were attributed to your TIN in the first and second steps of attribution, respectively. Refer to Supplementary Exhibit 2 for a list of all beneficiaries attributed to your TIN.

Exhibit 3. Primary Care Services Provided to Medicare Beneficiaries Attributed to Your TIN

Exhibit 3 presents information on the average number of primary care services provided to beneficiaries attributed to your TIN. It includes average counts of primary care services provided by the eligible professionals in your TIN and by eligible professionals outside your TIN. If you observe that a large percentage of primary care services provided to your TIN's attributed beneficiaries is provided by eligible professionals outside your TIN, you may wish to coordinate with these eligible professionals to ensure that your TIN's attributed beneficiaries are receiving efficient, effective care. For more information on the services your TIN's attributed beneficiaries receive both inside and outside your TIN, refer to Supplementary Exhibit 2A.

Exhibit 4. Hospital Episodes and Medicare Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure

Exhibit 4 provides information on the hospitalization episodes attributed to your TIN for the MSPB measure, as well as the number of unique beneficiaries associated with these attributed episodes. A hospitalization episode is attributed to a TIN if, during the hospitalization, the TIN provided more Part B-covered services, as measured by Medicare allowed charges, than any other TIN. A lower number of unique beneficiaries associated with attributed episodes (relative to the total number of MSPB episodes of hospital care attributed to your TIN) indicates that some beneficiaries experienced multiple MSPB hospitalization episodes during the performance period. These beneficiaries may benefit from enhanced care management support. More information on the beneficiaries associated with each hospitalization episode (as well as other

[1] Eligible professionals include physicians, practitioners, physical or occupational therapists or qualified speech-language pathologists, and qualified audiologists. A physician is one of the following: doctor of medicine, doctor of osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, or doctor of chiropractic. A practitioner is any of the following: clinical nurse specialist, certified registered nurse anesthetist, anesthesiology assistant, certified nurse midwife, clinical social worker, clinical psychologist, nurse practitioner, physician assistant, or registered dietician or nutrition professional.

information relevant to your TIN's performance on the MSPB measure) can be found in Supplementary Exhibit 4.

Exhibit 5. CMS-Calculated Outcome Measure Performance

Exhibit 5 presents your TIN's performance rate and the number of eligible cases for the three CMS-calculated claims-based outcome measures included in the Value Modifier: 30-day All-Cause Hospital Readmission, Acute ACSC Composite, and Chronic ACSC Composite. Review each measure within Exhibit 5 to identify those for which your TIN's performance rates compare least favorably to your TIN's peers, defined as all TINs that had at least 20 eligible cases for the measure. Since lower performance rates indicate better performance for the three outcome measures, identify the measure(s) for which your TIN's performance rate exceeds the benchmark that is presented in the third column. You may then use this information to develop a targeted quality improvement strategy.

Exhibit 6. Hospitals Admitting Your Medicare Beneficiaries

Exhibit 6 identifies the hospitals that provided at least 5 percent of your TIN's attributed beneficiaries' inpatient stays over the performance period. This exhibit provides the hospital name, CMS Certification Number (CCN), and location of the hospital. Use the data presented in the last column to better understand which hospitals most frequently admitted your TIN's attributed beneficiaries. This information can help you target care coordination efforts most appropriately. Review Supplementary Exhibit 3 for information on each beneficiary's hospital admissions.

Exhibit 7. Per Capita Costs for Your Attributed Medicare Beneficiaries

Exhibit 7 shows the five per capita cost measures (Per Capita Costs for All Attributed Beneficiaries, Per Capita Costs for Beneficiaries with Diabetes, Per Capita Costs for Beneficiaries with COPD, Per Capita Costs for Beneficiaries with CAD, Per Capita Costs for Beneficiaries with Heart Failure) and the MSPB measure that are included in the Value Modifier, displaying for each measure the payment-standardized, risk-adjusted, and specialty-adjusted per capita or per episode costs and the number of eligible cases or episodes.

Compare your TIN's costs for each measure with the benchmark that is in the third column to better understand how your TIN fared relative to your TIN's peers, or all TINs that had at least 20 eligible cases for the measure. For example, if your TIN's Per Capita Costs for All Attributed Beneficiaries are higher than your TIN's peers, then use the detailed cost information presented in Supplementary Exhibits 2B and 5 (discussed in more detail below) to identify the types of costs incurred over the performance period for the beneficiaries attributed to your TIN. Similarly, if the MSPB costs for your TIN's attributed beneficiaries are higher than your TIN's peers, then you can use the detailed cost information presented in Supplementary Exhibit 4 to identify opportunities to improve the care for these beneficiaries, as discussed in more detail below.

The information on Per Capita Costs for Beneficiaries with Specific Conditions allows you to determine specific groups of beneficiaries for which your TIN's costs are higher than your TIN's peers. For example, if your TIN's Per Capita Costs for Beneficiaries with Diabetes are higher than your TIN's peers, then you could consider developing a strategy to improve the

efficiency of the care of these beneficiaries, perhaps by adopting care management practices or by educating beneficiaries on self-management techniques.

Exhibit 8. Differences between Your Per Capita Costs for All Attributed Beneficiaries and Mean Per Capita Costs among TINs with this Measure

Exhibit 8 displays the dollar difference between your TIN's attributed beneficiaries' payment-standardized, risk-adjusted per capita costs, by selected category, and the corresponding costs for your TIN's peer group. Your TIN's peer group is defined for each cost category as all TINs that had at least 20 eligible cases for the given cost category. Use this exhibit to identify potential areas for cost reduction. Per capita costs for inpatient care or emergency services that are higher than your TIN's peers, for instance, could suggest that additional care coordination or chronic illness management efforts may prove valuable in improving your TIN's cost performance. Refer to Supplementary Exhibit 5 for a more comprehensive cost of services breakdown.

C. Background and Purpose of the Supplementary Exhibits

The 2014 Mid-Year QRUR supplementary exhibits supplement the information provided in the Mid-Year QRURs, so that you have a better sense of your TIN's beneficiary population, their use of health care services, and an awareness of the other eligible professionals involved in your TIN's beneficiaries' care. This report's primary sources of information are the Medicare Part A and Part B claims from the performance period, submitted by all eligible professionals who treated beneficiaries attributed to your TIN, even if the eligible professionals were not affiliated with your TIN.

Specifically, these supplementary exhibits build on the information in the Mid-Year QRUR and present:

1. Information about the physician and non-physician eligible professionals billing under your TIN
2. Information about the Medicare beneficiaries attributed to your TIN for the five per capita cost measures and three quality outcome measures
3. Data on the hospital admissions for your TIN's attributed beneficiaries
4. Data on the Medicare beneficiaries attributed to your TIN for the MSPB measure
5. Information on your TIN's per capita costs, by category of service, for the Per Capita Costs for All Attributed Beneficiaries measure

The information below suggest ways you can use data from the supplementary exhibits to improve quality of care, streamline resource use, and identify care coordination opportunities for your TIN's beneficiaries. Supplementary Exhibits 2A, 2B, and 3 provide data that you can use to improve care coordination for beneficiaries attributed to your TIN. Supplementary Exhibit 1 gives data to support your TIN's practice management systems. Moreover, you can use Supplementary Exhibits 4 and 5 to better understand your TIN's performance on the MSPB measure and the Per Capita Costs for All Attributed Beneficiaries measure.

Supplementary Exhibit 1: Physicians and Non-physician Eligible Professionals Billing under Your TIN, Selected Characteristics

Supplementary Exhibit 1 provides information about the eligible professionals who billed under your TIN. For each eligible professional, this table lists the National Provider Identifier (NPI) number and name, whether the eligible professional is a physician or non-physician eligible professional, specialty designation, whether the provider was identified as part of the TIN through the Provider Enrollment, Chain, and Ownership System (PECOS) and/or Medicare billing over the performance period, and the date of the last claim billed under the TIN. In an effort to be transparent, we disclose this information for your review and understanding.

1. What should we do if some of the specialties for the eligible professionals in our TIN are listed incorrectly in the table?

Eligible professionals whose specialty is listed incorrectly should update their record in PECOS at https://pecos.cms.hhs.gov/pecos/login.do.

2. What should we do if eligible professionals identified through PECOS no longer belong to our TIN?

You should alert any eligible professionals who are still associated with your TIN in PECOS, but who no longer belong to your TIN, to update their PECOS record at https://pecos.cms.hhs.gov/pecos/login.do.

3. What should we do if an eligible professional identified through billings no longer belongs to our TIN?

If this information appears inaccurate, review your practice management system's setup, make sure the eligible professional in question has been inactivated, and let the medical group charge entry staff know the proper charge entry procedures. Moreover, you should contact your TIN's Medicare Administrative Contractor (MAC) to find out whether you can correct the claims, if you believe an eligible professional was paid erroneously.

4. There is a difference between the number of eligible professionals in my TIN identified through PECOS and those identified through billings. How did this difference arise?

Eligible professionals may be identified through PECOS but not billings if they were registered to your TIN in PECOS as of October 16, 2014, but did not bill under your TIN during the performance period. Alternatively, eligible professionals may be identified through billings, but not PECOS if they billed under your TIN during the performance period, but their record in PECOS as of October 16, 2014 did not indicate that they were associated with your TIN. To determine your TIN's group size for the purposes of the Value Modifier, CMS will use the smaller of the two eligible professional counts.

Supplementary Exhibit 2A: Beneficiaries Attributed to Your TIN and the Care that You and Others Provided

Supplementary Exhibit 2A provides information about the Medicare beneficiaries attributed to your TIN. You can use these data as a starting point for examining systematic ways to improve and maintain delivery of high-quality and efficient care to beneficiaries. The table is divided into sections that describe beneficiary characteristics, specific Medicare claims data, the eligible professionals that billed the most services for the beneficiary, the date of the last hospital admission, and whether the beneficiary had one or more of four chronic conditions requiring more integrative care.

These data can be downloaded in Microsoft Excel so that you can analyze the data and focus on specific groups of beneficiaries—such as those in the four chronic condition subgroups—whose care-delivery process you may want to examine more closely to determine whether there is potential to improve quality of care. For example, you can use the Excel file to filter or sort the data to identify groups of beneficiaries with a particular chronic condition or a set of conditions, beneficiaries who have a high ratio of evaluation and management services outside your TIN, or beneficiaries with the highest CMS Hierarchical Condition Categories (CMS-HCCs) percentile ranking. For Excel analyses using these data, you may remove personally identifiable information by deleting the first three columns of the exhibit and rely on the non-personally identifiable "Index" column to link beneficiaries between exhibits. The tips below highlight

other ways in which you can use the data in Supplementary Exhibit 2A to improve care for beneficiaries attributed to your TIN.

1. How can I use the listing of beneficiaries attributed to me?

You can use the data to confirm that you furnished services to these beneficiaries and identify the beneficiaries who are receiving the plurality of their primary care services from a physician or non-physician eligible professional under your TIN. Check the information in the column titled "Date of Last Claim Filed by TIN" to make sure that CMS captured this information correctly. The Health Insurance Claim (HIC) number will allow you to match the listed beneficiary with your TIN's practice management system's records. You may wish to use this information to better understand your TIN's performance on the Acute and Chronic ACSC Composites, 30-day All-Cause Hospital Readmission, and Per Capita Costs for All Attributed Beneficiaries, and Per Capita Costs for Beneficiaries with Specific Conditions measures, or to focus your care management efforts.

2. How should we interpret and use the CMS-HCC percentile ranking?

Use this column to help identify the high- and low-risk beneficiaries to whom your TIN provides care. The CMS-HCC risk score is derived from prior year Medicare claims data for each beneficiary and gives an estimate of the relative burden of illness for that beneficiary as reflected by those claims. The CMS-HCC risk score percentile is based on FFS Medicare beneficiaries nationwide, with 1 being low and 100 being high (83, for example, means that 83 percent of beneficiaries nationwide had relatively lower burden of illness). Higher scores tend to be associated with more severe illness (most often, multiple chronic conditions). As a result, these beneficiaries are at risk for having conditions that may benefit from more intensive efforts from your TIN at managing their chronic illness, including closer monitoring of the beneficiary's condition, actively coordinating care, and supporting beneficiaries' self-management. Such efforts may reduce unnecessary costs and improve the quality and outcomes of care.[2] You may also seek opportunities for more coordinated care for beneficiaries with low risk scores who, in the performance period, had a high percentage of total costs in unexpected categories of services (such as emergency services).

You can sort data by CMS-HCC risk score percentile, in descending order, to see the high- and low-risk beneficiaries to whom your TIN provide care. Once you identify a risk population, you can link these beneficiaries to the data in Supplementary Exhibit 2B by "Index" to examine their cost category percentages and identify opportunities for more coordinated care.

3. How should I interpret the "Basis for Attribution" column?

For the five per capita cost measures and for the three claims-based quality outcome measures, beneficiaries are attributed to your TIN using a two-step attribution process. The first step assigns a beneficiary to a TIN if the beneficiary receives the plurality (as measured by allowed charges) of his or her primary care services from primary care physicians (PCPs) within

[2] Bodenheimer, T., E. Wagner, K. Grumbach. "Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2." *Journal of the American Medical Association*, vol. 288, no. 15, 2002, pp. 1909-1914.

Coleman, K., B. Austin, C. Brach, E. Wagner. "Evidence on the Chronic Care Model in the New Millennium." *Health Affairs*, vol. 28, no. 1, 2009, pp. 75-85.

the TIN. The second step applies only to beneficiaries who did not receive a primary care service from any PCP during the performance period. Under this second step, a beneficiary is assigned to a TIN if the beneficiary (a) received at least one primary care service from a physician within the TIN and (b) received a plurality of his or her primary care services from specialist physicians and certain non-physician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) within the TIN. This column indicates the step of attribution in which each beneficiary was attributed to your TIN.

4. How can we use data in the "Number of Primary Care Services Provided by TIN" and "Percent of Primary Care Services Billed by TIN" columns?

Sort the data in the "Percent of Primary Care Services Billed by TIN" column in ascending order to identify the beneficiaries attributed to your TIN who received most of their services outside your TIN. This process will allow you to see which services were received outside your TIN's care and why, in some cases, a high percentage of evaluation and management services were provided outside your TIN. For these beneficiaries, review the data in the "Eligible Professionals Outside of TIN Billing Most Primary Care Services" column to identify which eligible professionals outside your TIN provided this care.

5. How can we learn about the services other health care professionals provided to the beneficiaries attributed to us?

Supplementary Exhibit 2A displays the eligible professionals outside your TIN who billed the most primary care services and non-primary care services for each beneficiary. This information will make you aware of other key eligible professionals who provide care to your TIN's beneficiaries, and it offers an opportunity to talk with your beneficiaries to better understand their full range of health care needs and the additional services they receive.

6. How can we use the data in the "Date of Last Hospital Admission" column?

Compare values in the "Date of Last Hospital Admission" column with values in the "Date of Last Claim Filed by TIN" column to identify beneficiaries who did not have a visit with any eligible professional in your TIN following inpatient care. This process allows you to examine why the beneficiaries attributed to your TIN did not receive follow-up care.

7. How can we use the information on the four chronic condition subgroups to improve how we care for our beneficiaries?

These four subgroups reflect widespread chronic conditions among Medicare beneficiaries—conditions for which improved management may improve beneficiary outcomes as well as efficiency of care.[3] The Mid-Year QRURs give general information regarding the patterns of utilization for beneficiaries with these chronic conditions who are attributed to your TIN. The supplementary exhibits show which beneficiaries were in each of these groups. Therefore, you can use this information to identify individual beneficiaries with these conditions

[3] Bodenheimer, T., E. Wagner, K. Grumbach. "Improving Primary Care for Patients with Chronic Illness: The Chronic Care Model, Part 2." *Journal of the American Medical Association*, vol. 288, no. 15, 2002, pp. 1909-1914.

Coleman, K., B. Austin, C. Brach, E. Wagner. "Evidence on the Chronic Care Model in the New Millennium." *Health Affairs*, vol. 28, no. 1, 2009, pp. 75-85.

who may benefit from improved chronic-illness management. For example, a higher hospital admission rate for a beneficiary with congestive heart failure represents an opportunity to re-examine how you manage such beneficiaries. You may decide to update or change beneficiaries' preventive care, self-management support, monitoring, or medical treatment plans. These beneficiaries may also benefit from greater efforts at care coordination across providers.

In general, it may be helpful to sort the data in the column labeled "Chronic Condition Subgroup," and the associated subcolumns (Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease [COPD], and Heart Failure), to identify beneficiaries with one or more of the four conditions. For each condition, consider linking beneficiary data by "Index" to Supplementary Exhibit 2B to use the data in the "Percent of Total Costs, by Category of Services Provided, All Providers" to assess whether a specific beneficiary's pattern of utilization suggests an opportunity for improved care.

Supplementary Exhibit 2B: Beneficiaries Attributed to Your TIN: Costs of Services Provided by You and Others

Supplementary Exhibit 2B provides information about the costs of the care provided to the Medicare beneficiaries attributed to your TIN (as shown in Supplementary Exhibit 2A). It provides both the beneficiary's total payment-standardized FFS Medicare costs and the distribution of these costs across categories of service. You can use this information (as well as the information in Supplementary Exhibit 3 about the hospitals admitting your TIN's attributed beneficiaries) to learn general information about the types of services used by specific beneficiaries. By reviewing your TIN's own records and the records of hospitalizations, you can determine, for specific beneficiaries, the services provided by eligible professionals who billed under your TIN, and the services billed by eligible professionals outside your TIN. If you discover unexpected patterns of service use for beneficiaries attributed to your TIN, you may want to ask other eligible professionals for additional medical records to aid efforts in coordinating care.

As with Supplementary Exhibit 2A, these data can be downloaded in Microsoft Excel so that you can manipulate the data as needed for your analysis. If you want to remove personally identifiable information, you may delete the first three columns and use the non-personally identifiable "Index" column to link beneficiaries between exhibits.

1. How should we use the "Included in the Per Capita Costs for All Attributed Beneficiaries Measure" column?

To better understand your performance on the Per Capita Costs for All Attributed Beneficiaries measure, sort by this column to identify those beneficiaries who represented an eligible case for the measure. Beneficiaries who were not included in this measure either did not meet the criteria to be considered an eligible case or were excluded in the process of risk adjustment. (More information is included in the Detailed Methodology Document for the 2014 QRUR and 2016 Value Modifier available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html.)

2. How can we interpret and use the data in the "Total Payment-Standardized FFS Medicare Costs" column?

This column displays the total FFS Medicare costs associated with the care of each beneficiary over the performance period. Since risk adjustment is applied at the TIN level in order to compare costs across TINs, these beneficiary level costs are payment standardized, but not risk adjusted. Risk adjustment accounts for differences among beneficiaries (such as age or burden of illness) that could be expected to make their costs higher or lower than average, regardless of the quality and efficiency of their care. Payment standardization removes differences in payments due to geographic location, incentive payments, and other add-on payments that support specific Medicare program goals. It allows for a more equitable comparison of Medicare payments across the nation. Payment-standardized costs are risk adjusted when used in the per capita cost measures included in the 2016 Value Modifier.

Sort the column in descending order to determine the beneficiaries who are responsible for the highest costs. The data in the "Percent of Total Costs by Category of Services" columns can help you better understand the sources of these costs and determine whether any of the high-cost beneficiaries are strong candidates for enhanced care coordination or follow-up. Beneficiaries with high payment-standardized FFS Medicare costs and for whom emergency services represent a large share of these costs may benefit most from care coordination services.

3. How can we use the data in the "Percent of Total Costs, by Category of Services" columns to improve care for the beneficiaries we manage?

This section gives a breakdown of non-risk adjusted costs for your TIN's Medicare beneficiaries for the performance period. Use these columns to identify trends in service use among beneficiaries attributed to your TIN. Some patterns of use may present opportunities for you to improve care coordination. For example, if you provided a low percentage of all primary care services for a beneficiary with substantial costs devoted to procedures, ancillary services, or hospital services, there may be opportunities for you to further engage this beneficiary in care management and coordination. Similarly, beneficiaries who have a high proportion of total costs for emergency services may benefit from outreach to improve their use of primary care for urgent concerns, as well as additional efforts at care coordination. Beneficiaries who had substantial costs in post-acute care may benefit from closer monitoring. You can sort data in descending order in each column to identify high percentages for specific service categories utilized by your TIN's beneficiaries.

Supplementary Exhibit 3: Beneficiaries Included in the Per Capita Costs for All Attributed Beneficiaries Cost Measure: Hospital Admissions for Any Cause

Supplementary Exhibit 3 provides details about each attributed beneficiary's hospitalizations over the performance period (if applicable). Data are broken down by beneficiary and the admitting hospital, along with the principal diagnosis associated with the admission.

Note: This table does **not** include hospitalizations with a primary diagnosis of alcohol and substance abuse.

Supplementary Exhibit 3 also shows whether the hospital admission was the result of an emergency department evaluation, an ambulatory care-sensitive condition, or a readmission within 30 days of prior admission. This exhibit also indicates the date of discharge and the

subsequent care environment. You can use these data as a starting point, along with your medical records, to examine systematic ways to improve or maintain the delivery of high-quality and efficient care to beneficiaries attributed to your TIN. You can also link the data in Supplementary Exhibit 3 with data in Supplementary Exhibit 2B using the "Index" column to understand the overall scope of services that a beneficiary admitted to the hospital has been receiving. Furthermore, you can study this combination to see how to better align and coordinate these services, how information may have been shared across the continuum of care, and how beneficiaries may become better engaged in their care—all of which might have worked to prevent the hospitalization.

Data can be downloaded into Excel to perform data manipulation and analysis. Personally identifiable information may be removed by deleting the first three columns of the exhibit and using the "Index" column to link beneficiaries between exhibits.

1. How can the data in the "Admitting Hospital" column help us care for beneficiaries attributed to us?

These data allow you to determine which hospitals are providing inpatient services to your TIN's Medicare beneficiaries, as well as the principal diagnoses for these admitted beneficiaries. By assessing both the frequency of hospitalization to different facilities and the types of conditions accounting for these admissions, you can identify the hospitals on which you might focus specific efforts at management of care transitions, or the types of hospitalizations for chronic illnesses that you might aim to avoid through targeted care management efforts.

2. How can we use data in the "Principal Diagnosis" column?

Sorting data in the "Principal Diagnosis" column allows you to more closely examine the conditions that are drivers of your TIN's beneficiaries' hospitalizations. This exercise may be particularly beneficial for PCPs and groups of physicians that treat a broad range of diseases. If certain diagnoses seem to appear frequently, you may find it useful to pay additional attention to how you manage that set of beneficiaries.

3. How can we identify preventable hospital admissions using the data provided in this table?

Supplementary Exhibit 3 has three key categories: ACSC admissions, admissions via the emergency department, and 30-day readmissions. Each category represents an opportunity for you to identify and take another look at beneficiaries with potentially preventable admissions.

- *ACSC admissions*: Effective coordinated care has been shown to prevent hospitalizations and other resource use for beneficiaries with conditions in this category, including asthma, chronic obstructive pulmonary disease, heart failure, diabetes mellitus, and hypertension. Therefore, this is an important group of beneficiaries on whom to focus. Use the column "ACSC Admission" to identify beneficiaries attributed to your TIN and who were admitted for one of the diagnoses in this category. For this group of beneficiaries, improved access to care, care coordination, appropriate preventive services, beneficiary self-management support, and proactive monitoring of beneficiary conditions may lead to fewer instances of worsening illness, less emergency care, and fewer hospital admissions.

- *Admissions via the emergency department*: Sort the column "Admissions via the ED" to identify beneficiaries who received emergency hospital services. You can also view the percentage of the overall costs that came from emergency department use from the "Percent of Total Costs, by Category of Services Provided" column in Supplementary Exhibit 2B. Beneficiaries who disproportionately use the emergency department in their medical care are a subset that may benefit from more intensive primary care, including improved access for urgent concerns and better care coordination.
- *Readmissions*: Filter the data in the column titled "Followed by All-Cause Readmission within 30 Days of Discharge" to focus on beneficiaries readmitted, for unplanned causes, to the hospital within 30 days of discharge. You can use these data to study how your TIN's care pathways and collaboration with the hospital might be improved to identify and follow up with beneficiaries discharged from the hospital, to reduce readmissions.

4. How can we use the information on hospital discharge status to improve the care that we provide?

Discharge information highlights which beneficiaries were discharged to post-acute care in the performance period. Better collaboration and care coordination efforts with post-acute care providers associated with adverse outcomes, such as a 30-day readmission following discharge, may prevent future complications for your TIN's beneficiaries. Sort or filter data in the "Discharge Status" column to find beneficiaries discharged to home, home care, skilled nursing facilities, and other post-acute care facilities.

Supplementary Exhibit 4: Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure

Supplementary Exhibit 4 displays information on the beneficiaries attributed to your TIN for the MSPB measure. Data are presented at the beneficiary-episode level; if a beneficiary has more than one episode that was eligible for the MSPB measure, he or she will appear in the exhibit for each episode. The table is organized into four sections: beneficiary characteristics, the apparent lead eligible professional, features of the episode hospitalization, and the episode cost by category of service. For each episode, the total payment-standardized episode cost is also displayed.

Note: This table does **not** include hospitalizations with a primary diagnosis of alcohol and substance abuse.

These data can be downloaded into Excel, and personally identifiable information may be removed by deleting the first three columns. The "Index" column may be used to link beneficiaries between exhibits. Using an Excel data file, you may perform data analyses to develop strategies to improve your TIN's performance on this measure.

1. How should we interpret the data in the "Apparent Lead Eligible Professional" sub-columns?

For each hospitalization episode included in the MSPB measure, the eligible professional associated with the plurality of the episode's Part B costs (meaning he or she was responsible for more Part B costs than any other eligible professional) is designated the apparent lead.

2. How should we interpret and use the data in the "Total Payment-Standardized Episode Cost" column?

The data presented in the "Total Payment-Standardized Episode Cost" column displays the total of Part A and Part B billings from all TINs over the period starting three days before the episode's index admission through 30 days after discharge from the index admission. By sorting the data in this column in descending order, you will be able to identify the most costly hospitalization episodes. Reviewing the principal diagnoses associated with these high-cost episodes may help you to identify the types of beneficiaries for whom efforts to reduce unnecessary hospitalizations may result in the greatest cost savings. Additionally, patterns you observe among the hospitals associated with the highest total payment-standardized episode costs may suggest opportunities to improve efficiency in the care of your TIN's beneficiaries. Approaches might include examining your TIN's care of beneficiaries with these conditions, as well as reviewing the relative costs of hospitals and post-acute care options in your region, and the quality of transitional care services offered by the hospitals to which your TIN's beneficiaries are regularly admitted.

3. How should we use the "Medicare Spending per Beneficiary, by Category of Service Furnished by All Providers" columns?

The data presented in these columns help you to understand the distribution of costs associated with your TIN's beneficiaries' hospitalizations. High costs in some of the cost categories presented in Supplementary Exhibit 4 may suggest ways to improve care management for your TIN's attributed beneficiaries and consequently, your TIN's performance on the MSPB measure. For instance, high spending for costs associated with emergency department visits or hospital readmissions may perhaps be minimized through care coordination strategies to reduce unnecessary emergency department visits or prevent avoidable readmissions post-discharge. Additionally, if you observe that your TIN's imaging costs tend to be high, consider reviewing clinical criteria for using imaging to improve the efficiency of your care.

Supplementary Exhibit 5: Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure

Similarly to Supplementary Exhibit 2B, Supplementary Exhibit 5 displays your TIN's attributed beneficiaries' costs for various types of services performed by providers both within and outside your TIN. The exhibit shows the percentage of your TIN's attributed beneficiaries using a service in a given category; your TIN's payment-standardized, risk-adjusted per capita costs; and the difference between your TIN's beneficiary per capita costs and the per capita costs of your TIN's peers, defined as all TINs with at least 20 eligible cases for the category. Review this exhibit to identify those services and procedures that are contributing most to the cost per beneficiary.

1. How should we use the "Number of Attributed Beneficiaries Using any Service in this Category" and the "Percentage of Your Attributed Beneficiaries Using any Service in this Category" columns?

The data presented in these columns may be used to identify patterns of utilization among your TIN's attributed beneficiaries, in order to better understand the care that your TIN's beneficiaries receive. If a large share of your TIN's beneficiaries received evaluation and management services from other TINs, for example, you may find increased care coordination

helpful. Alternatively, if a large percentage of your TIN's attributed beneficiaries received major procedures or ambulatory/minor procedures over the performance period, consider reviewing clinical guidelines for when particular procedures are indicated.

2. How should we interpret and use the data in the "Per Capita Costs for Your Attributed Beneficiaries" column?

Use the data presented in this column to identify the types of services that contribute most to the total costs of your TIN's attributed beneficiaries and to determine opportunities to improve the efficiency of the care your TIN provides. For example, if per capita costs for emergency services are high, consider investing in care management resources, such as enhanced access for urgent concerns or care coordination. Or, if your TIN's per capita skilled nursing facility expenses are high, perhaps consider options for arranging needed supports at home or other venues (for example, assisted living). Supplementary Exhibit 2B may be useful in identifying the particular beneficiaries who used a service in each given category.

3. How should we use the benchmark cost columns ("Benchmark Per Capita Costs" and "Amount by Which Your Costs Were Higher or (Lower) Compared to the Benchmark") to improve care for the beneficiaries we manage?

The benchmark cost columns display the payment-standardized, risk-adjusted per capita costs of your TIN's peers, defined as all TINs with at least 20 eligible cases for the given category. Use the data in the "Amount by Which Your Costs Were Higher or (Lower) Compared to the Benchmark" to discern the categories for which your TIN's per capita costs exceed those of your TIN's peers. These categories may be ideal starting points for efforts at improving care efficiency.

FEEDBACK FOR CMS

1. What additional information would you like to know about your beneficiaries and the care they receive from other Medicare providers?

You can contact CMS at the QRUR Help Desk at 1-888-734-6433 (select option 3) to share your thoughts about the content and format of these reports. We value your input and feedback to help make these reports meaningful.

2. Would you like to share other ways you have used these data?

We are interested in learning how you and your colleagues have used the report data in ways not mentioned in this document. Share your tips by contacting the QRUR Help Desk.