TIPS TO UNDERSTAND AND USE THE 2013 QUALITY AND RESOURCE USE REPORT (QRUR) AND QRUR SUPPLEMENTARY EXHIBITS

CONTENTS

A. Background and purpose of the Quality and Resource Use Reports (QRURs)

The 2013 Quality Use and Resource Reports (QRURs) are confidential feedback reports provided to physicians and groups of physicians nationwide that include one or more eligible professionals[1] who billed for Medicare-covered services under a single taxpayer identification number (TIN) in 2013, and that had at least one eligible case for one or more of the quality or cost measures included in the QRURs. These reports contain exhibits on the quality of the care the physician or group of physicians provided to its attributed Medicare fee-for-service (FFS) beneficiaries and the costs associated with this care. They also indicate how the value-based payment modifier (VM) will impact the TIN's Physician Fee Schedule payments beginning in 2015.

Physicians 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 tip sheet provides suggestions for how the 2013 QRURs might be used to achieve these goals. Tips for using the supplementary exhibits also follow. Note that most of these exhibits are informational. Thus, those that support computation of your VM score are indicated with the phrase "for 2015 VM."

Exhibit 1. Eligible professionals billing to your TIN in 2013

Exhibit 1 displays the count of physicians and nonphysicians billing under your TIN. For a list of each of the eligible professionals that billed to your TIN in 2013, please refer to Supplementary Exhibit 1.

Exhibit 2. Your attributed Medicare beneficiaries in 2013

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

Exhibit 3. Services to your attributed Medicare beneficiaries in 2013

Exhibit 3 presents information on the average number of eligible professionals who provided services to beneficiaries attributed to you and the average number of primary care services each attributed beneficiary received. The data provided in the third and fourth columns, "In your TIN" and "Outside of your TIN," will allow you to better understand how frequently your attributed beneficiaries receive care from other providers. If you observe that a high

[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 chiropractor. A practitioner is any of the following: certified registered nurse anesthetist, anesthesiology assistant, certified nurse midwife, clinical social worker, clinical psychologist, nurse practitioner, physician assistant, or registered dietician or nutrition professional. The phrase "eligible professionals" does not include health care suppliers such as orthotists/prosthetists, opticians, independent diagnostic testing or screening centers, or independent clinical laboratories.

percentage of services are provided by eligible professionals outside of your TIN on average, efforts to improve care coordination may be valuable. For more information on the services your attributed beneficiaries receive both inside and outside of your TIN, refer to Supplementary Exhibit 2.

Exhibit 4. Your performance in 2013, by quality domain (for 2015 VM)

Exhibit 4 displays your performance score for each of the quality domains included in the value modifier, as well as the resulting standardized quality composite score. A higher standardized quality composite score (and higher quality domain-level performance scores) indicates better quality performance. A low domain-level performance score may alert you to opportunities for improvement; review Exhibit 5 corresponding to the quality domains of weakest performance to identify the quality measures on which you may wish to focus your quality improvement efforts.

Exhibit 5. 2013 performance on quality measures, by domain (for 2015 VM)

In a series of measures organized by quality domain, Exhibit 5 presents your performance rate and number of eligible cases for each quality measure, including outcomes measures, GPRO measures (if applicable), and administrative claims-based quality indicators (if applicable). The fourth column, "Contribution to your domain score," displays the standardized score for each measure and indicates which measures are included in the corresponding quality domain-level performance score and the standardized quality composite score represented in Exhibit 4. Review each measure within Exhibit 5 to identify those with the lowest standardized scores and develop a quality improvement strategy.

Exhibit 6. Hospitals admitting your attributed Medicare beneficiaries in 2013

Exhibit 6 identifies the hospitals that provided at least 5 percent of your attributed beneficiaries' inpatient stays in 2013, providing the hospital name, CMS Certification Number (CCN), and location. Use the data presented in the last column to better understand which hospitals most frequently admitted your 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. Your performance in 2013, by cost domain (for 2015 VM)

Exhibit 7 displays your performance score for each of the cost domains included in the value modifier as well as the resulting standardized cost composite score. A lower standardized cost composite score (and lower cost domain-level performance scores) indicates better cost performance compared with peers. A high domain-level performance score may alert you to opportunities for improvement; review Exhibit 8 to identify the cost measures on which you may wish to focus your efforts to improve the efficiency of your care.

Exhibit 8. Per capita costs for your attributed Medicare beneficiaries in 2013 (for 2015 VM)

Exhibit 8 shows the cost measures included in the value modifier, displaying for each measure both the payment-standardized, risk-adjusted per capita costs and the number of eligible cases. The fourth column, "Contribution to your domain score," displays the standardized score for each measure and indicates which measures are included in the domain-level performance score and standardized cost composite score represented in Exhibit 7. If the standardized score

for per capita costs for patients with certain conditions are high, consider developing a strategy to improve the efficiency of the care of these patients, perhaps by adopting care management practices or by educating patients on self-management techniques. Supplementary Exhibit 2 displays detailed information on each beneficiary's Medicare FFS costs.

Exhibit 9. Difference between per capita costs for specific services for your attributed beneficiaries and mean per capita costs among your peer group in 2013

Exhibit 9 is a graphical representation of the dollar difference between your attributed beneficiaries' payment-standardized, risk-adjusted per capita costs, by category, and the corresponding costs for your peer group. The per capita costs displayed in this exhibit are used in the calculations of the Per Capita Costs for All Attributed Beneficiaries measure included in the value modifier. Bars extending to the left of the vertical axis denote cost categories for which your per capita costs are lower than those of your peer group. Bars extending to the right of the vertical axis denote cost categories for which your per capita costs are higher. Use this exhibit to identify potential areas for cost reduction. Per capita costs for inpatient care or emergency services that are higher than your peer group, for instance, could suggest that additional care coordination or chronic illness management efforts may prove valuable in improving your cost performance.

Exhibit 10. Medicare beneficiaries' per capita costs for specific services in 2013

Exhibit 10 displays your attributed beneficiaries' costs for E&M services and procedures for providers from your TIN as well as providers outside of your TIN. The payment- standardized, risk-adjusted per capita costs, and the difference between your beneficiary per capita costs and the per capita costs of your peer group, are shown. The per capita costs displayed in this exhibit are used in the calculations of the Per Capita Costs for All Attributed Beneficiaries measure, which is included in the value modifier. Similarly to Exhibit 9, review this exhibit to identify those services and procedures that are contributing most to the cost per beneficiary.

Exhibit 11. 2013 Performance on risk-adjusted claims-based quality measures, before and after risk adjustment

Risk adjustment accounts for differences in patient characteristics that can affect their utilization and outcomes, regardless of the care provided. Exhibit 11 shows how your claims-based quality outcome measures were affected by risk adjustment. (Note that because these measures reflect negative outcomes, lower rates indicate better performance.) For information on the risk percentile of your beneficiaries, see the Performance Highlights page and Supplementary Exhibit 2.

Exhibit 12. 2013 payment-standardized per capita costs for attributed beneficiaries, before and after risk adjustment

Exhibit 12 shows how your cost measures were affected by risk adjustment. For information on the risk percentile of your beneficiaries, see the Performance Highlights page and Supplementary Exhibit 2.

Exhibit 13. 2013 Performance on cost measures included in the 2016 value-based payment modifier

Exhibit 13 is for informational purposes only and shows your 2013 performance on the cost measures that will be used in calculating the value-based payment modifier in 2016 (based on

your 2014 performance). Comparing your performance on these measures with the performance of your peer group may help you to anticipate how your performance on the standardized cost composite will be affected. The per capita cost measures displayed in this exhibit, unlike those in Exhibit 8, account for the mix of specialties in your TIN. The new Spending per Hospital Patient with Medicare (or Medicare Spending per Beneficiary) measure reflects average payment-adjusted Medicare FFS expenditures for services surrounding inpatient hospitalization episodes for the hospital patients you treated. Beneficiaries are attributed in a separate process for this measure. A hospitalization episode is attributed to a physician or group of physicians if during the hospitalization the TIN provided more Part B-covered services, as measured by Medicare allowed charges, than any other TIN.

(For more information on your performance on this measure, refer to Supplementary Exhibit 4.)

Exhibits 14. 2013 aggregate group-level performance on PQRS quality measures for the 2016 value-based payment modifier, by quality domain and measure

Exhibit 14 provides data on your 2013 performance on individual eligible professional PQRS quality measures. Each component of the exhibit displays your quality performance on one of the quality domains, listing the total number of eligible cases, number of eligible professionals in your TIN reporting the measure, and the aggregate, group-level performance rate. In 2014, groups of 10 or more eligible professionals that do not report quality measures as a group and that have at least 50 percent of their eligible professionals both participate in PQRS and meet the criteria to avoid the 2016 PQRS negative payment adjustment will have their aggregate group-level performance on individual eligible professional PQRS measures used for quality-tiering. Use this exhibit and the preceding text indicating the percentage of your TIN that is incentive-eligible to predict how you might fare if your TIN selected this option.

B. Background and purpose of the supplementary exhibits

The 2013 QRUR supplementary exhibits supplement the information provided in the QRURs, so that you have a better sense of your patient population, your patients' use of healthcare services, and awareness of the other providers involved in your patients' care. This report's primary sources of information are the 2013 Medicare Part A and Part B claims submitted by all providers who treated beneficiaries attributed to you, even if the providers were not affiliated with your TIN.

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

1. Information about the physician and nonphysician eligible professionals billing under your TIN
2. Information about the Medicare beneficiaries attributed to you
3. Data on the hospital admissions for your attributed beneficiaries
4. Data on the Medicare beneficiaries attributed to you for the Spending per Hospital Patient with Medicare (or Medicare Spending per Beneficiary) measure
5. Information on individual eligible professional performance on the 2013 PQRS measures (if eligible professionals submitted any under your TIN)

6. A summary of your 2013 GPRO earned incentive (if you were eligible to receive one)

The tips 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 beneficiaries. Supplementary Exhibits 2 and 3 provide data that you can use to improve care coordination for patients attributed to you. Supplementary Exhibit 1 gives data to support your practice management systems. Moreover, you can use Supplementary Exhibits 4 and 5 to better understand your performance on the Spending per Hospital Patient with Medicare (or Medicare Spending per Beneficiary) measure and individual PQRS measures. Finally, Supplementary Exhibit 6 displays information on your GPRO incentive (if you earned one).

Supplementary Exhibit 1: Physicians and nonphysician eligible professionals billing under your TIN, selected characteristics, 2013

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, physician or nonphysician attribution, specialty designation, 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 an eligible professional listed in the report no longer belongs to our TIN?

Only providers who billed for specific services under your TIN are listed—by date of service. If this information appears inaccurate, review your practice management system's setup, make sure the provider in question has been inactivated, or let the medical group charge entry staff know the proper charge entry procedures. Moreover, you should contact your Medicare Administrative Contractor (MAC) to find out how you can correct the claims, if you believe a provider was paid erroneously.

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

Providers whose specialty is listed incorrectly should update their record on the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) at https://pecos.cms.hhs.gov/pecos/login.do.

Supplementary Exhibit 2: Medicare FFS beneficiaries attributed to your TIN and the care that you and others provided, 2013

Supplementary Exhibit 2 provides information about the Medicare beneficiaries attributed to you. 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 patient characteristics, specific Medicare claims data, the eligible professionals that billed the most services for the beneficiary, the date of the last hospital admission, whether the patient had one or more of four chronic conditions requiring more integrative care, and both the patient's total payment-standardized Medicare FFS costs and the distribution of these costs across categories of service.

These data can be downloaded in Microsoft Excel, so that you can analyze data and focus on groups of patients—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 patients with a particular chronic condition or a set of conditions, patients who have a high ratio of evaluation and management services outside of your TIN, or patients with the highest HCC risk score. For Excel analyses using these data, you may remove personally identifiable information (PII) by deleting the first three columns of the exhibit; you may, instead, rely on the nonpersonally identifiable "Index" column to link beneficiaries between exhibits. The tips below highlight other ways in which you can use the data in Supplementary Exhibit 2 to improve care for patients attributed to you.

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

You can use the data to confirm that you furnished services to these patients. Check the information in the column titled "Date of Last Claim for Professional Services Filed by TIN" to make sure that CMS captured this information correctly. The HIC number will allow you to match the listed beneficiary with your practice management system's records.

2. How should we interpret and use the HCC risk score?

The HCC risk score is derived from prior year Medicare claims data for each patient and gives an estimate of the relative burden of illness for that patient as reflected by those claims. Use this column to identify the high- and low-risk patients to which you provide care. The HCC risk score percentile is based on Medicare FFS 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 patients are at risk for having conditions that would benefit from more intensive efforts from you at managing their chronic illness, including closer monitoring of the patient's condition, actively coordinating care, and supporting patients' self-management. Such efforts have been shown to reduce unnecessary costs and improve the quality and outcomes of care. You may also seek opportunities for more coordinated care for patients with low risk scores who, in the prior year, had a high percentage of total costs in unexpected categories of services (such as emergency services).

You can sort data by HCC risk score percentile, in descending order, to see the high- and low-risk patients to which you provide care. Once you identify a risk population, you can examine the cost category percentages to determine whether there are opportunities for more coordinated care for your selected patients.

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

Beneficiaries are attributed to you through a two-step process. The first step assigns a beneficiary to a physician or group of physicians if the beneficiary receives the plurality (as measured by allowed charges) of his or her primary care services from primary care physicians within the TIN. The second step applies only to beneficiaries who did not receive a primary care service from any primary care physician in 2013. Under this second step, a beneficiary is assigned to a physician or group of physicians 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 nonphysician 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 you.

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 patients attributed to you who received most of their services outside of your TIN. This process will allow you to see which services were received outside of your care and why, in some cases, a high percentage of evaluation and management services were provided outside of your TIN. For these patients, review the data in the "EP Outside of TIN Billing Most Primary Care Services" column to identify which EPs outside of your TIN provided this care.

5. How can we learn about the services other healthcare professionals provided to the patients attributed to us?

Supplementary Exhibit 2 displays the providers outside of your TIN who billed the most primary care and non-primary care services for each beneficiary. This information will make you aware of other key eligible professionals who provide care to your patients.

Additionally, the breakdown of costs by category shows a range of service types and providers. You can use this information (as well as the information about the hospitals admitting your attributed beneficiaries shown in Supplementary Exhibit 3) to learn general information about the types of services used by specific patients. By reviewing your own records and the records of hospitalizations, you can determine for specific patients the services you provided, the services provided by consultants who reported to you, and the hospital-based services administered by providers outside of your TIN. If you discover unexpected patterns of service use for patients attributed to you, you may wish to ask other providers for additional medical records to aid efforts in coordinating care.

The information presented in these two sets of columns offers an opportunity for providers to talk to their patients 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 patients who did not have a visit with any provider in your TIN following inpatient care. This process allows you to examine why the patients attributed to you 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 patients?

These four subgroups reflect widespread chronic conditions among Medicare beneficiaries—conditions for which improved management has been shown to improve patient outcomes as well as efficiency of care. The QRURs give general information regarding the patterns of utilization for patients with these chronic conditions who are attributed to you. The supplementary exhibits show which patients were in each of these groups. Therefore, you can use this information to identify individual patients with these conditions who may benefit from improved chronic-illness management. For example, a higher hospital admission rate for a patient with congestive heart failure represents an opportunity to re-examine how you manage such patients. You may decide to update or change patients' preventive care, self-management

support, monitoring, or medical treatment plan. These patients 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, use the data in the "Percent of Total Costs, by Category of Services Provided, All Providers" to assess whether a specific patient's pattern of utilization suggests an opportunity for improved care.

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

This column displays the total Medicare fee-for-service costs associated with the care of each beneficiary over the year. Payment standardization equalizes the costs associated with a specific service, such that a given service is priced at the same level across all providers of the same type, regardless of geographic location, differences in Medicare payment rates among facilities, or the year in which the service was provided. Sort the column in descending order to determine the beneficiaries that 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 Medicare FFS costs and for whom emergency services represent a large share of these costs may benefit most from care coordination services.

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

This section gives a breakdown of costs for your Medicare patients for the year. Use these columns to identify trends in service use among patients attributed to you. 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 patient with substantial costs devoted to procedures, ancillary services, or hospital services, there may be opportunities for you to further engage this patient in care management and coordination. Similarly, patients 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. Patients who had substantial prior-year costs in post-acute care may be at risk of frailty or re-hospitalization and, therefore, may also 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 patients.

Supplementary Exhibit 3: Attributed beneficiaries' hospital admissions for any cause, 2013

Supplementary Exhibit 3 gives details about your attributed patients' hospitalizations in 2013, by individual patient. Data are broken down by patient 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, the result of an ambulatory care sensitive condition (ACSC), or a readmission within 30 days of a prior admission. The Supplementary 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 patients attributed to you. You can also link the data in Supplementary Exhibit 3 with data in Supplementary Exhibit 2 using the "Index" column to understand the overall scope of services that a patient 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 a patient may become better engaged in his care—all of which might have worked to prevent the hospitalization.

Consider downloading the data into Excel to perform data manipulation and analysis. Personally identifiable information (PII) may be removed by deleting the first three columns of the exhibit.

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

These data allow you to determine which hospitals are providing inpatient services to your Medicare patients. Examine the hospital data, together with the principal diagnosis on admission data, for possible linkages. These steps present opportunities for better care coordination and management of care transitions for your patients.

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 patients' hospitalizations. This exercise may be particularly beneficial for primary care physicians 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 patients.

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

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

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

- Admission via the Emergency Department (ED): Sort the column "Admissions via the ED" to identify patients that needed non-elective hospital services. Moreover, from the column in Supplementary Exhibit 2, "Percent of Total Costs, by Category of Services Provided," you can view the percentage of the overall costs that came from emergency department use. Patients who disproportionately use the ED in their medical care are a subset that may benefit from more intensive primary care, including improved access for urgent concerns, as well as better care coordination.
- Readmissions: Filter the data in the column titled "Followed by All-Cause Readmission within 30 Days of Discharge" to focus on patients readmitted, for unplanned causes, to the hospital within 30 days of discharge. You can use this data to study how your care pathways and collaboration with the hospital might be improved to identify and follow-up with patients 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 patients were discharged to post-acute care last year. For example, patterns of adverse outcomes (such as a 30-day readmission following discharge) attributed to a post-acute care provider might represent an opportunity to refer to your medical records for this particular provider and contact him or her to see whether there are ways to improve communication and data sharing. Better collaboration and care coordination efforts with post-acute care providers may prevent complications for this patient or others that you share. Sort or filter data in the column "Discharge Status," in the "Discharge Disposition" section, to find patients discharged to home, home care, skilled nursing facilities, and other post-acute care facilities.

Supplementary Exhibit 4: Medicare FFS beneficiaries attributed to the TIN for the Spending per Hospital Patient with Medicare Measure, selected characteristics, 2013

Supplementary Exhibit 4 displays information on the beneficiaries who were attributed to you for the Spending per Hospital Patient with Medicare (or Medicare Spending per Beneficiary) measure. Data are presented at the beneficiary-episode level; if a beneficiary has more than one episode that was eligible for the Spending per Hospital Patient with Medicare (or Medicare Spending per Beneficiary) measure, he or she will appear in the Supplementary Exhibit for each episode. The table is organized into four sections on patient 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. Using an Excel data file, you may perform data analyses to develop strategies to improve your performance on this measure in anticipation of the 2016 value modifier.

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

For each hospitalization episode included in the Spending per Hospital Patient with Medicare (or Medicare Spending per Beneficiary) measure, the eligible professional that is associated with the plurality of the episode's Part B costs 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 patients 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 patients. Approaches might include examining your care of patients 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 your hospitals.

3. How should we use the "Spending per Hospital Patient with Medicare, 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 patients' hospitalizations. High costs in some of the cost categories presented in Supplementary Exhibit 4 may suggest ways to improve your performance on the Spending per Hospital Patient with Medicare (or Medicare Spending per Beneficiary) measure. For instance, high spending for costs associated with ER visits or hospital readmissions may perhaps be minimized through care coordination strategies to reduce unnecessary ER visits or to prevent avoidable readmissions post-discharge. Additionally, if you observe that your imaging costs tend to be high, consider reviewing clinical criteria for using imaging to improve the efficiency of your care.

Supplementary Exhibit 5: Individual eligible professional performance on the 2013 PQRS measures

Supplementary Exhibit 5 displays, for each eligible professional who participated in PQRS in your TIN in 2013, performance on submitted PQRS measures. It will also display whether each eligible professional is considered to be incentive-eligible, according to PQRS program rules.

1. How should we use information regarding which of our TIN's eligible professionals are incentive-eligible?

In 2014, groups of 10 or more eligible professionals that do not report quality measures as a group and that have at least 50 percent of their eligible professionals both participate in PQRS and meet the criteria to avoid the 2016 PQRS negative payment adjustment will have their aggregate group-level performance on individual eligible professional PQRS measures used for quality-tiering. If you plan to use this option in 2014, you may find it useful to see which of your

TIN's eligible professionals attained incentive-eligibility (and thus avoided the PQRS negative payment adjustment) in 2013, to help ensure that at least 50 percent of your eligible professionals meet the criteria to avoid the PQRS negative payment adjustment under 2014 reporting.

2. How should I use the "Performance Rate" and "Benchmark Rate" columns?

You may use these columns to identify areas for improvement for individual eligible professionals billing under your TIN. For example, for each eligible professional receiving a Supplementary Exhibit 5, sort the performance rate column to identify measures for which the given eligible professional least frequently performs the recommended quality action. Measures with low performance rates could suggest areas for your TIN to target quality-improvement efforts, including perhaps new clinical protocols or workflows. Additionally, by comparing each individual eligible professional's performance rate on a given measure with the prior year benchmark performance rate, you can understand how the eligible professional compares with others submitting the measure. An eligible professional's performance rate that is much lower than the associated benchmark may be an important indicator of an opportunity for improvement in the eligible professional's care for the beneficiaries captured in the measure. (Note that for a small number of measures, designated by two asterisks in Supplementary Exhibit 5, a lower performance rate indicates better quality; for these measures, select areas for improvement by identifying the measures with the highest performance rate or for which the performance rate is much higher than the benchmark.)

Supplementary Exhibit 6: Summary of 2013 GPRO earned incentive

Supplementary Exhibit 6 provides details about any incentive you may have earned by participating in the Group Practice Reporting Option (GPRO) in 2013. This table reports your total incentive amount and your incentive as a percentage of your total Part B Physician Fee Schedule allowed charges.

For information on how you may earn an incentive by participating in GPRO in 2014, please refer to the GPRO 2014 Requirements document at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2014_PQRS_GPRO_Requirements_010314.pdf.

Feedback for CMS

1. What additional information would you like to know about your beneficiaries and the care that 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 tips sheet. Share your tips at the QRUR Help Desk.