



*MLN Connects*TM

National Provider Call

Physician Feedback Program: Review of the 2012 Group Quality and Resource Use Reports (QRURs)

September 2013



Medicare Learning Network®

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Objectives of the Call

- Access and Download 2012 QRURs and Drill Down Tables
- Review the Methodologies and Data in the QRURs
- Suggest Ways to Use the Data in the Drill Down Tables
- Answer Questions about the 2012 QRURs

What are the Quality and Resource Use Reports (QRURs)?

- The QRURs are annual reports that provide groups of physicians with:
 - Comparative information about the quality of care furnished, and the cost of that care, to their Medicare fee-for-service (FFS) patients
 - Beneficiary-specific information to help coordinate and improve the quality and efficiency of care furnished
 - Information on how the provider group would fare under the value-based payment modifier (VBM)
- 2012 QRURs were produced and made available to all groups of physicians with 25 or more eligible professionals (EP) (which includes physicians and other practitioners).

How Can I Access My Report and Drill-Downs?

1. Navigate to the Portal

- Go to <https://portal.cms.gov>.

2. Login to the Portal

- Select Login to CMS Secure Portal.
- Accept the Terms and Conditions and enter your IACS User ID and Password to login.

3. Enter the Portal

- Click the PV-PQRS tab, and select the QRUR-Reports option.



How Can I Access My Report and Drill-Downs? (cont'd)

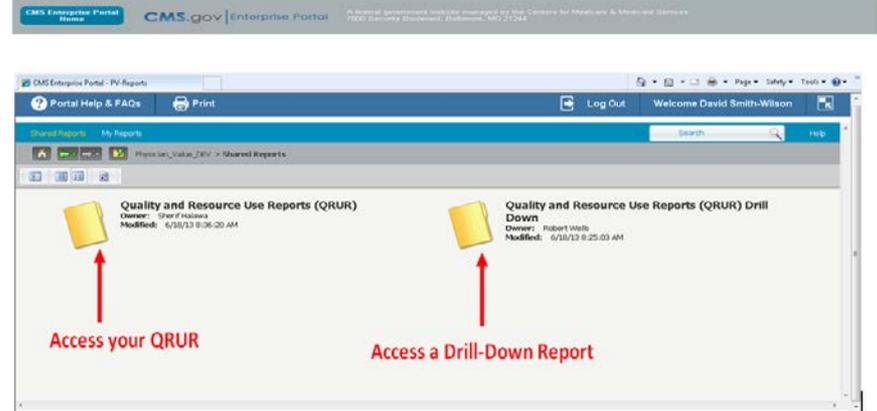
4. Complete Role Attestation

- Choose the applicable option to complete your request access (“I plan to use this data in my capacity as a...”)



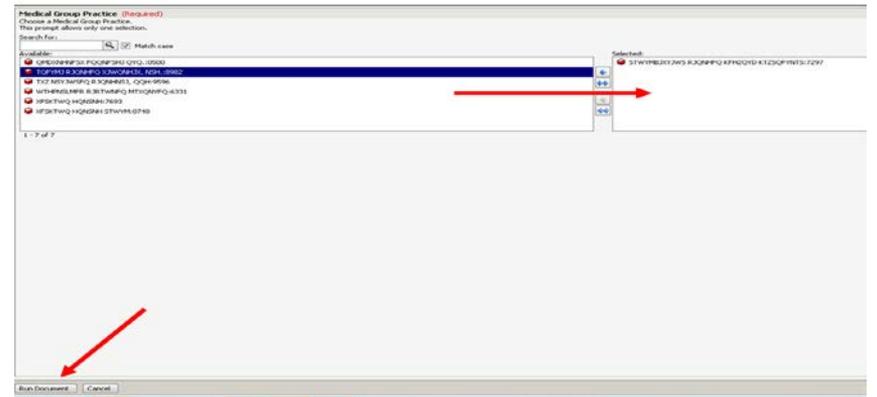
5. Navigate to the Reports Folder

- Choose your QRUR or drill-down report from the applicable reports folder.



6. Select Your Medical Group Practice

- After the report opens, select a Medical Group Practice and click Run Document.



How Can I Access My Report and Drill-Downs? (cont'd)

7. Export the QRUR

- You can view the QRUR online, as well as export and print the report to a Portable Document Format (PDF) file.

2012 QUALITY AND RESOURCE USE REPORT
AND PHYSICIAN QUALITY REPORTING SYSTEM FEEDBACK REPORT

STWYMBJXYJWS RJQNHFQ KFHZQYD KTZSQFYNTS
Last Four Digits of Your Group's Taxpayer Identification Number (TIN): 7297

8. Export Drill-Down Reports

- You can view drill-down reports online, as well as export and print the reports to either a PDF or an Excel file.

Table 1. Medicare FFS Beneficiaries A... the Medical Group Practice, Selected Characteristics, 2012

All Attributed Beneficiaries				Medicare FFS Claims			Percent of Total Costs, by Category of Services Provided, All Providers						Hospital Admission	Chronic Condition Subgroup						
HEC	Gender	Date of Birth	HEC Risk Score Exemptible	Died in 2012	Date of Last Claim for Primary Services Filed by TIN	Number of Primary Care Services Provided by TIN	Percent of Primary Care Services Billed by TIN	Evaluation & Management	Procedures	Inpatient Hospital	Outpatient Hospital	Emergency Services	Ancillary Services	Post-Acute Care	All Other Services	Date of Last Hospital Admission	Diabetes	Coronary Artery Disease	COPD	Heart Failure

No data returned for this view. This might be because the applied filter excludes all data.

What If There Is No QRUR for My Medical Group Practice?

- **Medical group practices with less than 25 eligible professionals (EPs) are not eligible to receive a QRUR this year.**
- **Medical group practices that treat too few Medicare patients to have enough eligible cases will receive a single-page report but no QRUR:**
 - This includes those that had 25+ EPs but did not have any beneficiaries attributed to themand,
 - Those that did not have at least 20 eligible cases for any quality or cost measures.

Overview: How Can I Use the 2012 QRUR?

- Determine how your group would fare under the Value Modifier (Performance Highlights page).
- Examine the number of beneficiaries attributed to your group and the basis for their attribution (Exhibits 1 and 2).
- Understand how your group's performance on quality and cost measures compares to other groups (Exhibits 3–10).
- Understand which attributed beneficiaries are driving your group's cost measures (Drill-Down Table 1).
- Identify those beneficiaries that are in need of greater care coordination (Drill-Down Table 1).
- Verify the EPs billing under your group's TIN during 2012 (Drill-Down Table 2).
- Understand which beneficiaries are driving your group's performance on the three hospital-related care coordination quality measures (Drill-Down Table 3).

What Information Is Included on the Performance Highlights Page?

1. Your Quality Composite Score

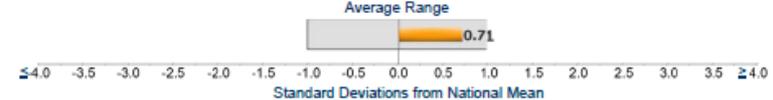
2. Your Cost Composite Score

3. Your Beneficiaries' Average Risk Score

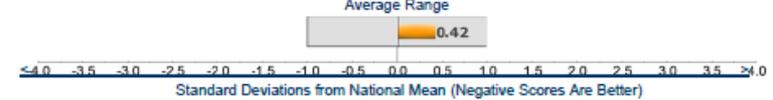
4. Your Quality Tiering Performance Graph

5. Your Payment Adjustment Based on Quality Tiering

YOUR QUALITY COMPOSITE SCORE: AVERAGE



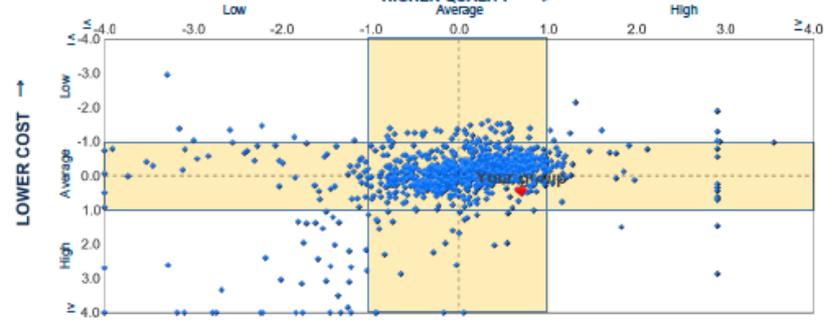
YOUR COST COMPOSITE SCORE: AVERAGE



YOUR BENEFICIARIES' AVERAGE RISK SCORE: 67TH PERCENTILE

- To account for differences in patient risk and reduce the influence of very high cost beneficiaries, the overall per capita costs of your beneficiaries were risk adjusted upward by 2.7 percent.
- Because your Medicare beneficiaries' average risk score is not at or above the 75th percentile of all beneficiary risk scores, your group would not be eligible for an additional upward adjustment under the quality tiering approach for serving high-risk beneficiaries.

YOUR QUALITY TIERING PERFORMANCE: AVERAGE QUALITY, AVERAGE COST



YOUR VALUE-BASED PAYMENT ADJUSTMENT BASED ON QUALITY TIERING

- Based on 2012 performance, electing the quality tiering approach would result in a payment adjustment of +0.0%.

Payment adjustments for each level of performance are shown below:

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x%	+2.0x%
Average Cost	-0.5%	+0.0%	+1.0x%
High Cost	-1.0%	-0.5%	+0.0%

About the Report Introduction

- The introduction and Exhibit 1 provide information on the number of eligible professionals (EP) billing to the group's TIN.
- An EP is defined as any of the following:
 - A physician (MD/DO), a doctor of dental surgery, a doctor of podiatric medicine, a doctor of optometry or a chiropractor
 - A physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist; a certified registered nurse anesthetist; a certified nurse-midwife; a clinical social worker; a clinical psychologist; or a registered dietitian or nutrition professional
 - A physical or occupational therapist or a qualified speech-language pathologist
 - A qualified audiologist
- Click on the **underlined, red, boldface** (linking) number in the first paragraph to see the list of EPs that billed under your group's TIN in 2012.

About the Report Introduction (*cont'd*)

- Table 2 of the drill-down tables (Physicians and Non-Physician Eligible Professionals (EP) Billing Under the Medical Group Practice TIN) can be used to verify the EPs that billed under the group's TIN in 2012.
 1. The table provides information on the date of the last claim billed in 2012 (see figure below).
 2. The EP's specialty is also listed in the table (see figure below).
- We encourage physicians to update PECOS (<https://pecos.cms.hhs.gov/pecos/login.do>) if their specialty code is not current.

Table 2. Physicians and Non-Physician Eligible Professionals Billing Under Medical Group Practice TIN, Selected Characteristics, 2012

NPI	Name	Physician*	Non-Physician Eligible Professional*	Specialty Designation*	Date of Last Claim Billed Under TIN
0000000000	Doe, John	X	-	Family Practice	12/20/2012
0000000000	Doe, Jane	-	X	Physician Assistant	06/21/2012
0000000000	Smith, John	X	-	Neurology	12/27/2012
0000000000	Smith, Jane	X	-	Family Practice	12/26/2012

*Terms to be defined through hover-over function.



Exhibit 1: Attribution Methodology Utilized in the QRURs

- The QRURs identify all of the beneficiaries who have had at least one primary care service (PCS)¹ rendered by a physician in the group.
- We utilize a two-step attribution process:
 - Step 1: Assign beneficiaries to the group practice who had a plurality of PCS (allowed charges) rendered by primary care physicians (PCPs)²; if unassigned, proceed to Step 2.
 - Step 2: Assign beneficiaries to the group practice, whose affiliated physicians, NPs, PAs and clinical nurse specialists, together, provided the plurality of PCS (allowed charges).
- Note that some beneficiaries may remain unassigned after this process.

¹PCS include evaluation and management visits in an office, other outpatient services, skilled nursing facility services, and those services rendered in home settings.

²PCPs include Family Practice, Internal Medicine, General Practice, and Geriatric Medicine specialty codes.

Beneficiaries Attributed to the Group: Overview of Exhibits 1 & 2

- Exhibit 1 includes information on the number of attributed beneficiaries and the basis for their attribution.

Exhibit 1. Number of Medicare Beneficiaries Attributed to Your Medical Group Practice and Basis for Attribution

	Total	Plurality of Primary Care Services Provided by Primary Care Physicians in your Group	Plurality of Primary Care Services Provided by Non-Primary Care Specialists in your Group
Number of Medicare patients attributed to your medical group practice	<u>7,835</u>	7,585	250
Average percentage of primary care services provided by your group, per attributed beneficiary	72.4%	72.2%	80.1%

- Exhibit 2 Compares groups' attributed beneficiaries to those of other groups

Exhibit 2. Medicare Beneficiaries Attributed to Your Medical Group Practice in 2012 and the Eligible Professionals Treating Them, Compared to Peers

	Your Medical Group Practice	Mean Among All 1,032 Medical Group Practices with at Least 100 Eligible Professionals
Number of Medicare patients attributed to the medical group practice	<u>7,835</u>	7,130
Average percentage of primary care services provided by the medical group practice to each attributed beneficiary	72.4%	67.0%
Average number of eligible professionals in all care settings who treated each attributed beneficiary	12.0	11.0
Percentage of eligible professionals treating beneficiaries attributed to		

Beneficiaries Attributed to the Group: Overview of Exhibits 1 & 2 (cont'd)

- The underlined, red, boldface “Number of Medicare patients attributed” data field in Exhibits 1 and 2 links to drill-down Table 1 (Medicare FFS Beneficiaries Attributed to the Medical Group Practice).

	Total
Number of Medicare patients attributed to your medical group practice	<u>7,835</u>

Table 1. Medicare FFS Beneficiaries Attributed to the Medical Group Practice, Selected Characteristics, 2012

All Attributed Beneficiaries					Medicare FFS Claims			Percent of Total Costs, by Category of Services Provided, All Providers							Hospital Admission		Chronic Condition Subgroup*			
HIC	Gender	Date of Birth	HCC Risk Score Percentile*	Died in 2012	Date of Last Claim for Professional Service Filed by TIN*	Number of Primary Care Services Provided by TIN*	Percent of Primary Care Services Billed by TIN*	Evaluation & Management	Procedures	Inpatient Hospital	Outpatient Hospital	Emergency Services	Ancillary Services	Post-Acute Care	All Other Services	Date of Last Hospital Admission	Diabetes	Coronary Artery Disease	COFD	Heart Failure
0000000000	M	04/03/1938	-	-	12/11/2012	5	71.9%	18.6%	11.1%	0.0%	62.0%	0.0%	6.6%	0.0%	1.4%	-	-	X	-	-
0000000000	M	07/23/1938	-	-	08/02/2012	3	73.9%	40.3%	0.0%	0.0%	24.7%	33.0%	2.0%	0.0%	0.0%	-	-	X	X	-
0000000000	M	11/06/1939	-	X	04/30/2012	4	51.0%	-	-	-	-	-	-	-	-	-	X	-	-	-
0000000000	M	08/31/1938	-	-	12/13/2012	4	100.0%	8.6%	15.8%	0.0%	70.9%	0.0%	3.3%	0.0%	1.4%	-	-	X	-	-

*Terms to be defined through hover-over function.

	Your Medical Group Practice
Number of Medicare patients attributed to the medical group practice	<u>7,835</u>

The Attribution Methodology Utilized in the QRURs (*cont'd*)

Table 2. National Summary Statistics of the 2012 Attribution Step for Groups of 25+ EPs

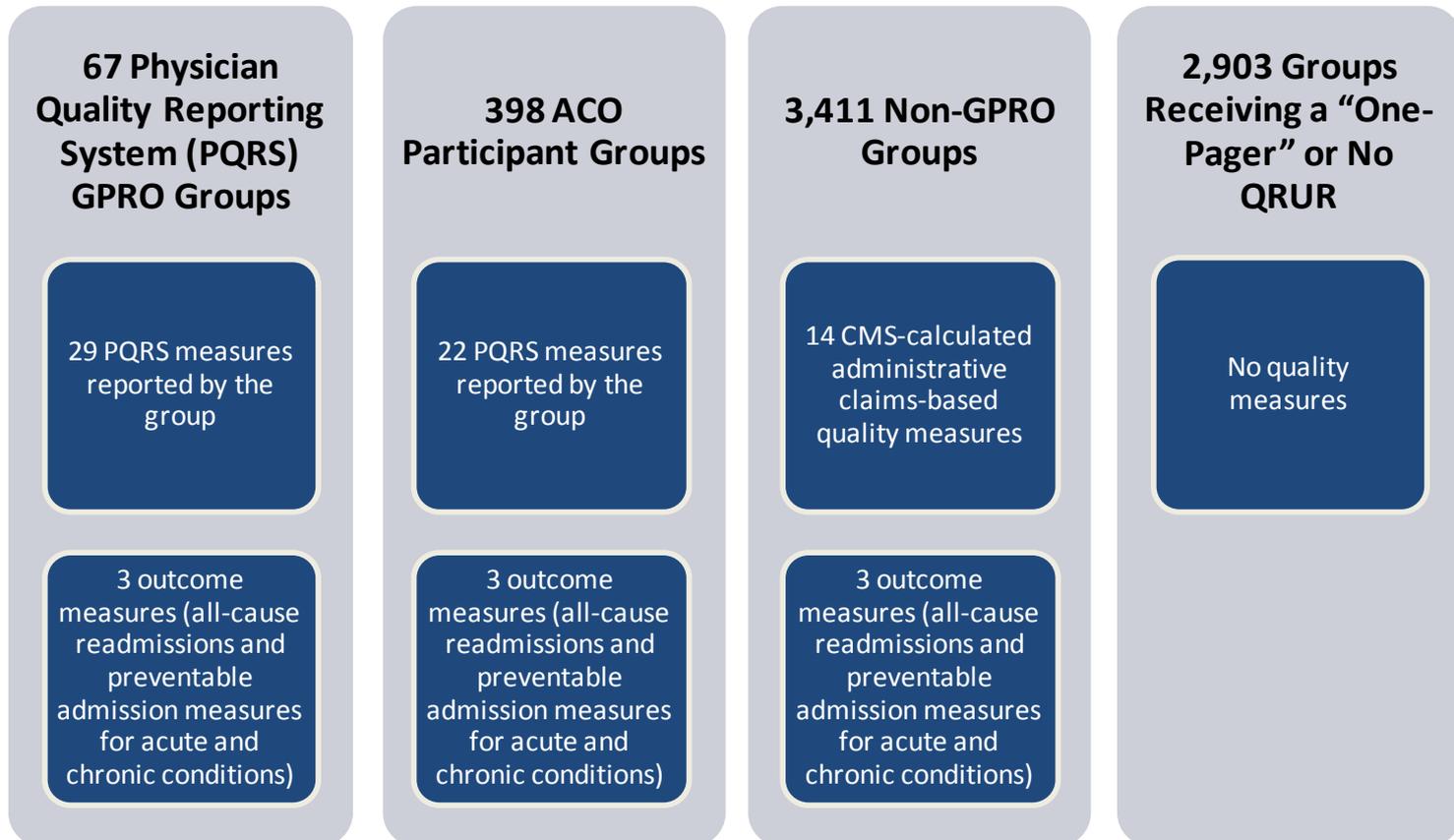
	Number of Beneficiaries	Percent of All Beneficiaries Treated by a Group of 25+ EPs	Percent of All Beneficiaries Attributed to a Group of 25+ EPs
-			
Beneficiaries Treated by a Group of 25+ EPs	24,426,157	100.0%	-
Beneficiaries Attributed to a Group of 25+ EPs	11,593,242	47.5%	100.0%
Beneficiaries Attributed in Step 1	9,956,451	40.8%	85.9%
Beneficiaries Attributed in Step 2	1,636,791	6.7%	14.1%

The Attribution Methodology Utilized in the QRURs (*cont'd*)

- **Why utilize this attribution process?** The approach attributes beneficiaries to the group practice that is well-positioned to coordinate and oversee the beneficiary's annual, total per capita costs.
- The population of attributed beneficiaries is used to calculate:
 - 3 quality outcome measures for all groups (all-cause readmission and preventable admission measures for acute- and chronic- conditions)
 - 5 total annual per capita cost measures for all groups
 - 14 CMS-calculated administrative claims-based quality measures (primary and preventive care indicators) for non-GPRO groups
- The 2013 QRURs will attribute beneficiaries to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).

Performance on Quality: Overview of Exhibits 3 & 4

- Information on the number of groups receiving QRURs and the quality measures evaluated in their QRURs (from two sources) is below.



- In PY2012, there were a total of 6,779 groups of 25+ EPs.

Performance on Quality: Overview of Exhibits 3 & 4 (cont'd)

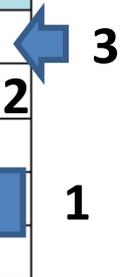
- Individually-reported PQRS measures are not included as part of the VBM calculation in 2015 (2013 performance period), but they are proposed for the VBM in 2016 (2014 performance period).
- If physicians in a group participated in PQRS as individuals during 2012, performance at the group and individual levels will be available in December 2013, in a new drill-down table in the 2012 QRURs.
- CY2014 proposals for the quality composite include an option to roll up individually-reported PQRS measures into a group score.

Performance on Quality: Overview of Exhibit 3

- Exhibit 3 displays the group's overall quality composite score and performance by quality domain (see figure below):
 - The quality domain scores are equally-weighted averages of quality measures in the domain.
 - The average domain score is an equally-weighted average of each quality domain score.
 - The standardized quality composite score shows how much a group's average score differs from the national mean.

Exhibit 3. Your Medical Group Practice's Performance by Quality Domain in 2012

Quality Domain	Number of Quality Indicators	Standardized Score
Standardized Quality Composite Score	17	0.71* (Average)
Average Domain Score	17	0.44
Clinical Process/Effectiveness	11	1.21
Patient Safety	2	-0.29
Care Coordination	4	0.41



- To be considered a high (low) quality performer, the group must be:
 - + (-) 1 standard deviation above (below) the national mean
 - Statistically different from mean at the 5% significance level

Performance on Quality: Overview of Exhibit 4-CC

Exhibit 4-CC. 2012 Performance on Quality Indicators in the Care Coordination Domain
Care Coordination Domain Score = 0.41

Performance Measures	Your Medical Group Practice's Performance		Performance of All 1032 Groups with at Least 100 Eligible Professionals			Standardized Scores (COLUMN IS NOT INCLUDED IN THE QRUR EXHIBIT. PRESENTED FOR INFORMATIONAL PURPOSES ONLY.)
	Number of Eligible Cases	Performance Rate	Benchmark Rate	Average Range		
				Benchmark - 1 Standard Deviation	Benchmark + 1 Standard Deviation	
Mental Health						
Follow-Up After Hospitalization for Mental Illness						-0.12
1. Percentage of Patients Receiving Follow-Up Within 30 Days	39	64.1%	64.1%	52.3%	75.9%	
2. Percentage of Patients Receiving Follow-Up Within 7 Days	39	33.3%	36.1%	24.9%	47.4%	
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care Sensitive Conditions						
CMS-1 Acute Conditions Composite*	7,835	5.6	8.2	5.0	11.4	0.8
PQI-11 Bacterial Pneumonia*	7,835	6.0	12.4	7.6	17.3	
PQI-12 Urinary Tract Infection*	7,835	7.1	7.5	3.5	11.4	
PQI-10 Dehydration*	7,835	3.7	4.7	2.7	6.8	
CMS-2 Chronic Conditions Composite*	3,883	41.7	58.6	45.6	71.6	1.3
Diabetes (Composite of 4 indicators) *	1,837	12.7	20.5	10.0	30.9	
PQI-5 COPD or Asthma*	1,086	61.9	82.5	58.4	106.5	
PQI-8 Heart Failure*	960	76.8	108.6	82.7	134.4	
Hospital Readmissions						
CMS-3 All-Cause Hospital Readmissions*	1,768	16.5%	16.1%	14.8%	17.3%	-0.3

*Lower performance rates on these measures indicate better performance. However, the domain score for this domain has been calculated such that positive (+) scores indicate better performance and negative scores indicate worse performance.

- Lower performance rates indicate better performance for measures CMS-1, CMS-2, and CMS-3.

Performance on Quality: Overview of Exhibits 3 & 4 (cont'd)

- Note that:
 - Benchmarks are prior-year national means.
 - “Not Available” means that the measure was not reported in 2011.
 - The minimum case size for each measure is 20 beneficiaries.
- Information on the means and standard deviations for the PQRS measures, CMS-calculated administrative claims, ACSC (composites and components) measures, all-cause readmissions measure, total per capita costs measure and condition-specific per capita costs measure can be found here: <http://www.cms.gov/physicianfeedbackprogram>.

Hospitals Admitting Your Beneficiaries: Overview of Exhibit 5

- Exhibit 5 identifies hospitals where at least five percent of the group's attributed beneficiaries' inpatient stays occurred.

Exhibit 5. Hospitals Admitting Medicare Beneficiaries Attributed to Your Medical Group Practice in 2012

Hospital		Medicare Beneficiaries Attributed to Your Medical Group Practice	
Name	Location	Number of Inpatient Stays	Percentage of All Inpatient Stays
Total		2,498	100.0%
QFWLT RJQNHFQ HJSYJW	QFWLT, KQ	1,242	49.7%
RTWYTS QQFSY MTXQNYFQ	HQJFWBFYJW, KQ	414	16.6%
RJFXJ HTZSYWDXNQJ MTXQNYFQ	XFKJYD MFWGTW, KQ	341	13.7%

- Information about the quality of care at these hospitals can be found at <http://www.hospitalcompare.hhs.gov>.

Hospitals Admitting Your Beneficiaries: Overview of Exhibit 5 (cont'd)

- The total number of inpatient stays can be verified by reviewing Table 3 of the drill-downs, which includes a list of all beneficiary hospitalizations.
- Note that admissions for alcohol and substance abuse are excluded from the drill-downs but included in Exhibit 5.

Hospital		Medicare Beneficiaries Attributed to Your Medical Group Practice	
Name	Location	Number of Inpatient Stays	Percentage of All Inpatient Stays
Total		2,498	100.0%



Table 3. Attributed Beneficiaries' Hospital Admissions for any Cause, 2012.

Attributed Beneficiaries Admitted to the Hospital			Hospital Admissions for Any Cause						Discharge Disposition	
HIC	Gender	Date of Birth	Date of Admission	Admitting Hospital	Principal Diagnosis*	Admission Via the ED	ACSC Admission*	Followed by All-Cause Readmission within 30 Days*	Date of Discharge	Discharge Status*
0000000000	M	04/14/1938	01/20/2012	TMXZ MTXQNYFQ FSQ HQNSNHX, PORTLAND, OR	99673 Comp-ren dialys dev/grft	X	-	X	01/20/2012	01 Disch Home
0000000000	F	11/27/1929	02/03/2012	TMXZ MTXQNYFQ FSQ HQNSNHX, PORTLAND, OR	5960 Bladder neck obstruction	X	-	X	02/09/2012	01 Disch Home
0000000000	F	11/27/1929	04/05/2012	TMXZ MTXQNYFQ FSQ HQNSNHX, PORTLAND, OR	4210 Ac/subac bact endocard	X	-	X	04/20/2012	01 Disch Home
0000000000	F	11/27/1929	05/29/2012	TMXZ MTXQNYFQ FSQ HQNSNHX, PORTLAND, OR	V554 Atten to enterostomy NEC	-	-	-	06/05/2012	03 Disch to SNF

*Terms to be defined through hover-over function.

Performance on Costs: Overview of Exhibit 6

- Note that costs are risk adjusted and payment standardized.
 - The cost domain scores are equally-weighted averages of cost measures in the domain.
 - The average domain score is an equally-weighted average of each cost domain score, and each domain is weighted 50 percent .
 - The standardized cost score shows how much a group's average score differs from national mean (see figure below).

Exhibit 6. Your Medical Group Practice's Performance by Cost Domain in 2012

Cost Domain	Standardized Score
Standardized Cost Composite Score	0.42* (Average)
Average Domain Score	0.87
Per Capita Costs for <i>All</i> Attributed Beneficiaries	1.02
Per Capita Costs for Beneficiaries <i>with Specific Conditions</i>	0.73

1

- To be considered a high (low) cost performer, the group must be:
 - (+)1 standard deviation below (above) the national mean
 - Statistically different from mean at the 5% significance level

Performance on Costs: Overview of Exhibit 7

- Exhibit 7 displays the per capita costs for beneficiaries attributed to your medical group practice.

Exhibit 7. Per Capita Costs for Medicare Beneficiaries Attributed to Your Medical Group Practice in 2012

Total Per Capita Costs



Condition-Specific Per Capita Costs



Cost Categories	Your Medical Group Practice's Performance			Performance of All 1032 Groups with at Least 100 Eligible Professionals		
	Number of Eligible Cases	Per Capita Costs Before Risk Adjustment	Per Capita Costs After Risk Adjustment	Benchmark Per Capita Costs (Risk-Adjusted)	Average Range	
					Benchmark - 1 Standard Deviation	Benchmark + 1 Standard Deviation
Per Capita Costs for All Attributed Beneficiaries (Domain Score = + 1.02)						
All Beneficiaries	7,313	\$11,523	\$11,835	\$10,265	\$8,722	\$11,808
Per Capita Costs for Beneficiaries with Specific Conditions (Domain Score = + 0.73)						
Diabetes	1,697	\$15,287	\$16,244	\$14,788	\$12,379	\$17,198
COPD	759	\$26,700	\$27,214	\$24,153	\$19,840	\$28,466
Coronary Artery Disease	2,654	\$17,740	\$19,123	\$17,265	\$14,415	\$20,115
Heart Failure	833	\$29,417	\$30,562	\$26,013	\$21,237	\$30,788



Only groups' risk adjusted costs are compared.

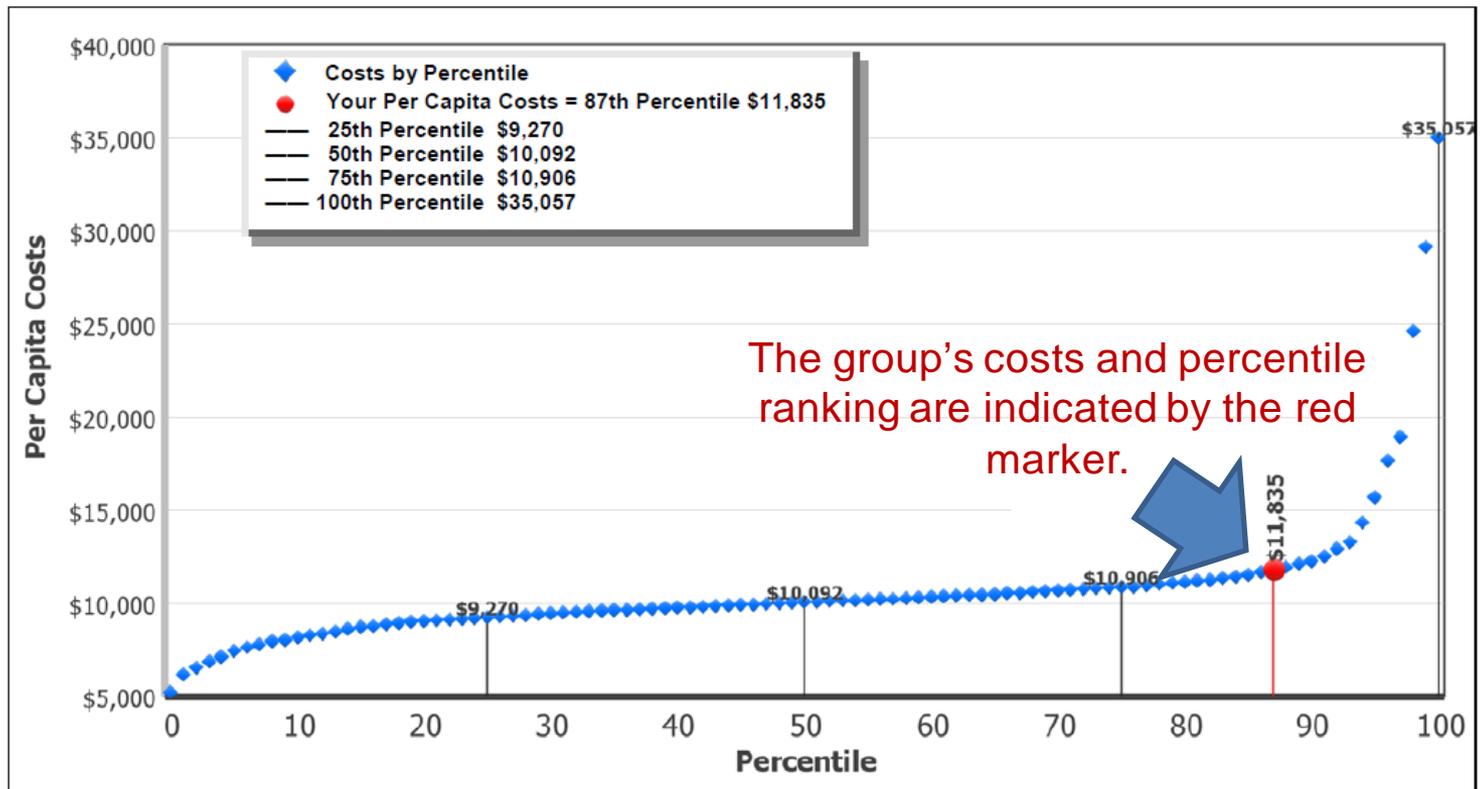
Performance on Costs: Overview of Exhibit 7 (cont'd)

- Note that:
 - The benchmark is a current-year national average.
 - The peer group for groups of 100+ EPs is other groups of 100+ EPs, while the peer group for groups of 25-99 EPs is all groups of 25+ EPs.
 - The minimum case size is 20 beneficiaries.
- CY2014 proposals will further adjust the benchmark based on the specialty composition of the groups.

Performance on Costs: Overview of Exhibit 8

- Exhibit 8 shows the range of per capita costs for the medical group practices in your peer group.

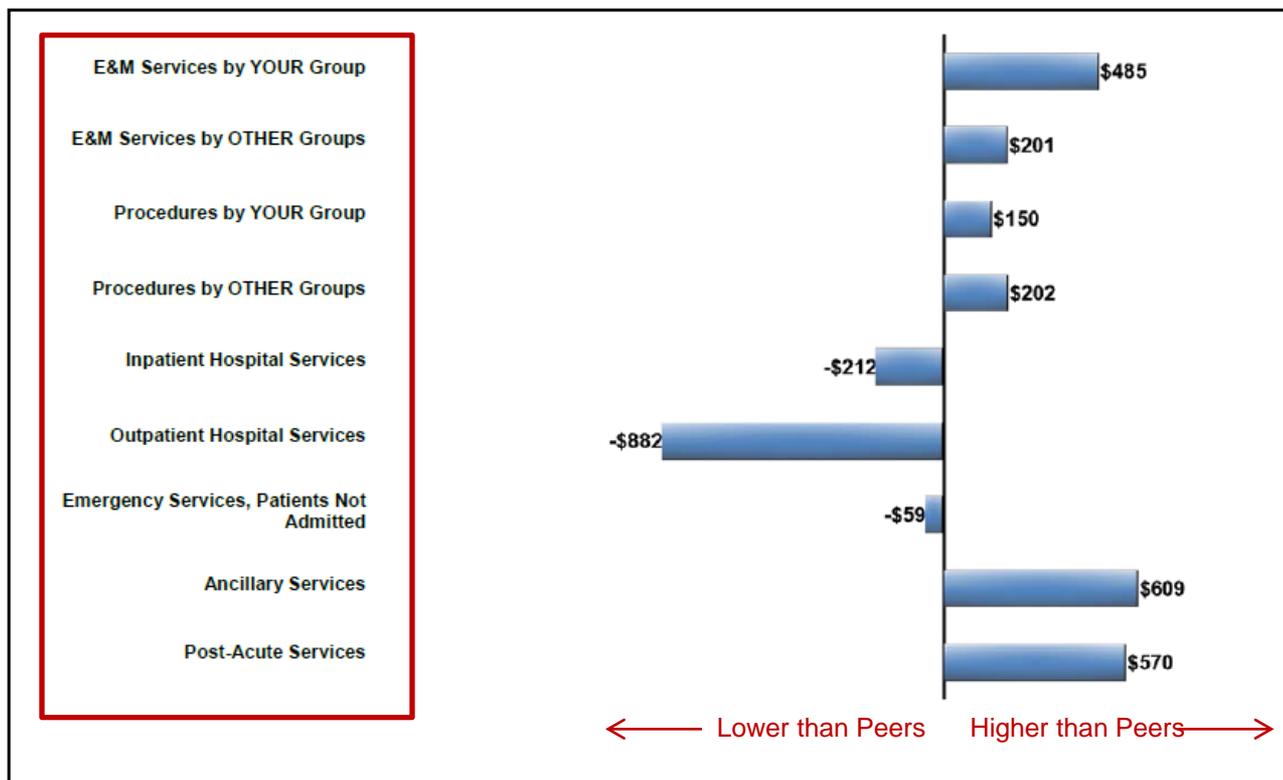
Exhibit 8. Per Capita Costs of Medicare Beneficiaries Attributed to Your Medical Group Practice in 2012, Compared to All 1,032 Medical Group Practices with at Least 100 Eligible Professionals



Performance on Costs: Overview of Exhibit 9

- Exhibit 9 shows the difference between the per capita costs of specific types of service for beneficiaries attributed to your group and the mean among all group practices in your peer group.

Exhibit 9. Difference Between Per Capita Costs for Specific Services for Your Group's Attributed Beneficiaries in 2012 and Mean Per Capita Costs Among All 1,032 Groups with at Least 100 Eligible Professionals



Performance on Costs: Overview of Exhibit 10

- Exhibit 10 shows additional detail on the per capita costs of services outlined in Exhibit 9.

Exhibit 10. Medicare Patients' Per Capita Costs for Specific Services in 2012

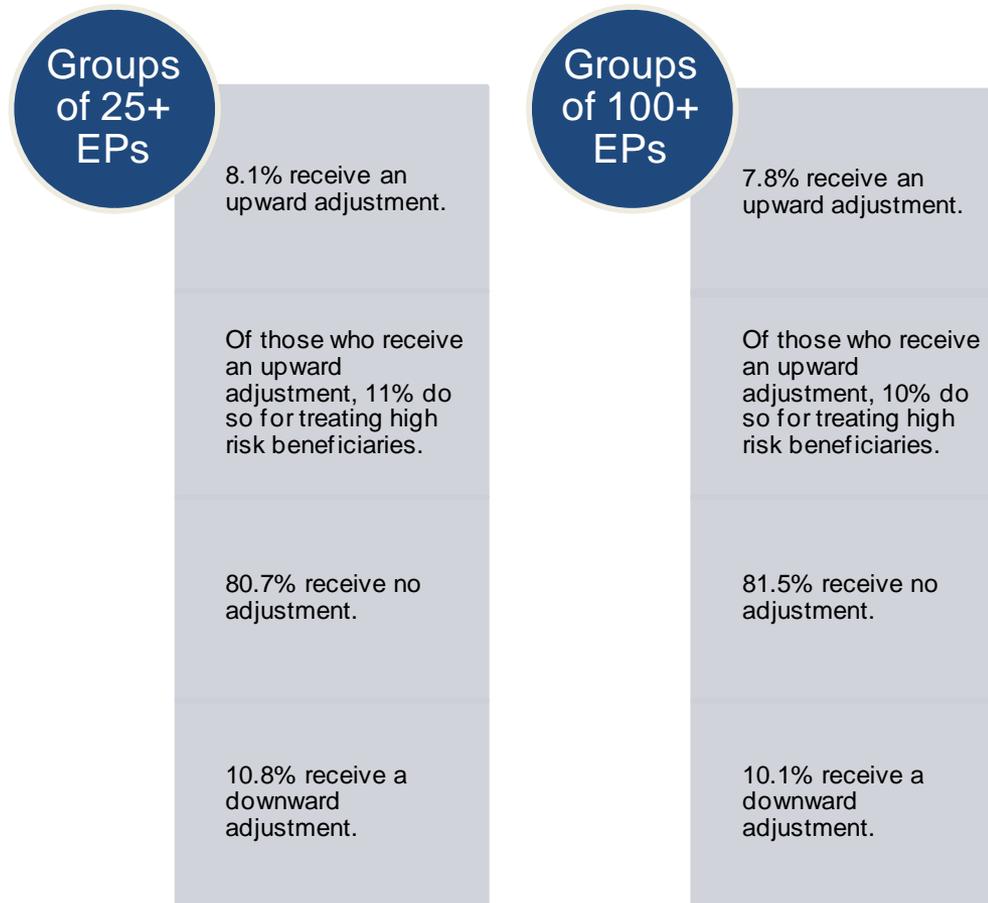
Service Category	Your Medical Group Practice		Mean for All 1,032 Groups with at Least 100 Eligible Professionals		Amount by Which Your Group's Costs Were Higher or (Lower) than Peer Group Mean	
	Your Medicare Patients Using Any Service in This Category		Risk-Adjusted Per Capita Costs	Medicare Patients Using Any Service in This Category		Risk-Adjusted Per Capita Costs
	Number	Percentage				
All Services	7,313	100.0%	\$11,835	100.0%	\$10,265	\$1,570
Evaluation and Management (E&M) Services in All Non-Emergency Settings						
All E&M Services Provided by YOUR Group	7,313	100.0%	\$1,025	100.0%	\$541	\$485
Primary Care Physicians	7,120	97.4%	\$463	78.6%	\$338	\$126
Medical Specialists	4,146	56.7%	\$242	32.3%	\$106	\$136
Surgeons	3,762	51.4%	\$135	22.4%	\$42	\$93
Other Eligible Professionals	3,299	45.1%	\$185	27.2%	\$54	\$131
All E&M Services Provided by OTHER Groups	6,120	83.7%	\$823	81.0%	\$622	\$201
Primary Care Physicians	2,087	28.5%	\$124	24.6%	\$88	\$35
Medical Specialists, Surgeons, and Other Eligible Professionals	5,958	81.5%	\$699	78.9%	\$534	\$166

Indicates the group's number of attributed beneficiaries



PY2012 Payment Adjustments: Results of the Value-Modifier

- This slide is for informational purposes only and DOES NOT reflect an actual adjustment to groups' Medicare Physician Fee Schedule reimbursements.



How Can Groups Use the Drill-Downs? A Review of Table 1 (Medicare FFS Beneficiaries Attributed to the Group)

Identify those beneficiaries that may require more care coordination with physicians outside of your group.

Identify what the group's cost drivers are.

Table 1. Medicare FFS Beneficiaries Attributed to the Medical Group Practice, Selected Characteristics

All Attributed Beneficiaries					Medicare FFS			Percent of Total Costs, by Category of Services Provided, All Providers									Hospital Admission	Chronic Condition Subgroup*			
HIC	Gender	Date of Birth	HCC Risk Score Percentile*	Died in 2012	Date of Last Claim for Professional Service Filed by TIN*	Number of Primary Care Services Provided by TIN*	Percent of Primary Care Services Billed by TIN*	Evaluation & Management	Procedures	Inpatient Hospital	Outpatient Hospital	Emergency Services	Ancillary Services	Post-Acute Care	All Other Services	Date of Last Hospital Admission	Diabetes	Coronary Artery Disease	COPD	Heart Failure	
0000000000	M	04/03/1938	-	-	12/11/2012	5	71.9%	18.8%	11.1%	0.0%	62.0%	0.0%	6.6%	0.0%	1.4%	-	-	X	-	-	
0000000000	M	07/23/1938	-	-	08/02/2012	3	73.9%	40.3%	0.0%	0.0%	24.7%	33.0%	2.0%	0.0%	0.0%	-	-	X	X	-	
0000000000	M	11/06/1939	-	X	04/30/2012	4	51.0%	-	-	-	-	-	-	-	-	-	X	-	-	-	
0000000000	M	08/31/1938	-	-	12/13/2012	4	100.0%	8.6%	15.8%	0.0%	70.9%	0.0%	3.3%	0.0%	1.4%	-	-	X	-	-	

*Terms to be defined through hover-over function.

Verify the beneficiaries attributed to your group.

Determine if beneficiaries are included in any of the per capita cost measures for beneficiaries with specific conditions.

How Can Groups Use the Drill-Downs? A Review of Table 3 (Attributed Beneficiaries' Hospital Admissions for Any Cause)

Identify preventable hospital admissions (ACSCs).

Table 3. Attributed Beneficiaries' Hospital Admissions for any Cause, 2012.

Attributed Beneficiaries Admitted to the Hospital			Hospital Admissions for Any Cause							Discharge Disposition	
HIC	Gender	Date of Birth	Date of Admission	Admitting Hospital	Principal Diagnosis*	Admission Via the ED	ACSC Admission*	Followed by All-Cause Readmission within 30 Days*	Date of Discharge	Discharge Status*	
0000000000	M	04/14/1938	01/20/2012	TMXZ MTXQNYFQ FSQ HQNSNHX, PORTLAND, OR	99673 Comp-ren dialys dev/grft	X	-	X	01/20/2012	01 Disch Home	
0000000000	F	11/27/1929	02/03/2012	TMXZ MTXQNYFQ FSQ HQNSNHX, PORTLAND, OR	5960 Bladder neck obstruction	X	-	X	02/09/2012	01 Disch Home	
0000000000	F	11/27/1929	04/05/2012	TMXZ MTXQNYFQ FSQ HQNSNHX, PORTLAND, OR	4210 Ac/subac bact endocard	X	-	X	04/20/2012	01 Disch Home	
0000000000	F	11/27/1929	05/29/2012	TMXZ MTXQNYFQ FSQ HQNSNHX, PORTLAND, OR	V554 Atten to enterostomy NEC	-	-	-	06/05/2012	02 Disch to SNF	

*Terms to be defined through hover-over function.

Identify which diagnoses are the basis for hospitalization.

Understand where beneficiaries are being discharged.

Next Steps: What You Can Do

- Review the detailed methodology, drill-down tips sheet, FAQs and other QRUR supporting materials made available through the *Physician Feedback Program* website:
<http://www.cms.gov/physicianfeedbackprogram>.
- Participate in PQRS, if your group is not already doing so. Details and deadlines for 2013 participation can be found at
<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>.
- Share your thoughts about the content and format of these reports and drill-downs via e-mail at pvhelpdesk@cms.hhs.gov.

Registration System Review

IACS Introduction

- On September 16, 2013, PY2012 Quality and Resource Use Reports (QRURs) were made available for group practices with 25 or more eligible professionals (EPs).
- QRURs can be accessed via <https://portal.cms.gov> using your “Individuals Authorized Access to the CMS Computer Services” (IACS) User ID and password.
- You will need an IACS account with one of the following group-specific PV-PQRS Registration System roles in order to retrieve your group’s QRUR:
 - Primary PV-PQRS Group Security Official
 - Backup PV-PQRS Group Security Official
 - PV-PQRS Group Representative

IACS Roles for Group Practices

- If you do not have an IACS account with a group-specific PV-PQRS Registration System Role, sign up for a new IACS account.
- If you have an existing IACS account:
 - Ensure that your account is still active by contacting the Quality Net Help Desk.
 - Add a group-specific PV-PQRS Registration System role to your account.
- The IACS website can be found via the following link:
<https://applications.cms.hhs.gov/>
- The Quick Reference Guides for obtaining an IACS account or modifying an existing account can be found here:
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html>

Technical Assistance Information

- For assistance with the IACS sign-up process or with registering in the PV-PQRS Registration System, please contact the QualityNet Help Desk:
 - Monday – Friday: 8:00 am – 8:00 pm EST
 - Phone: (866) 288-8912 (TTY 1-877-715-6222)
 - Fax: (888) 329-7377
 - Email: qnetsupport@sdps.org
- PQRS Program: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>
- Group Practice Reporting Options:
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html
- Value-Based Payment Modifier and Quality Tiering:
<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html>

Question and Answer Session

Coming in Late Summer 2013 – The Medicare Administrative Contractor Satisfaction Indicator (MSI)

Attention: Medicare-Enrolled Providers and Suppliers

- Give CMS feedback about your experience with your Medicare Administrative Contractor (MAC), the contractor that processes your Medicare claims.
- Your feedback will help CMS monitor performance trends, improve oversight, and the increase efficiency of the Medicare program.
- Only providers and suppliers who register for the MSI will be included in the random sample to rate their MAC.
- For more information and to register today for the 2013 MSI, go to <http://www.cms.gov/Medicare/Medicare-Contracting/MSI/>.

Evaluate Your Experience

- Please help us continue to improve the MLN Connects National Provider Call Program by providing your feedback about today's call.
- To complete the evaluation, visit <http://npc.blhtech.com/> and select the title for today's call.

CME and CEU

- This call has been approved by CMS for CME and CEU continuing education credit.
- To obtain continuing education credit
 - review [CE Activity Information & Instructions](#) for specific details.

Thank You

- For more information about the MLN Connects National Provider Call Program, please visit <http://cms.gov/Outreach-and-Education/Outreach/NPC/index.html>
- For more information about the Medicare Learning Network (MLN), please visit <http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html>