



MLN Connects™

National Provider Call

Overview of the 2012 Quality and Resource Use Report and the Individual Eligible Professional PQRS Addendum

January 2014



Medicare Learning Network®

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Objectives of the Call

- Distinguish the QRURs from the Individual Eligible Professional (IEP) PQRS Performance Report (Released December 2013)
- Access and Download 2012 QRURs and the IEP PQRS Performance Report
- Review the Methodologies and Data in the QRURs
- Suggest Ways to Use the Data in the QRUR and in the IEP PQRS Performance Report
- 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).

What are the Individual Eligible Professional (IEP) PQRS Performance Reports?

- The IEP PQRS Performance Reports were made available on December 23, 2013 for all group practices with 25 or more EPs in which:
 - At least one EP reported PQRS measures as an individual in 2012.
- The IEP PQRS Performance Reports provide detailed information to accompany the 2012 QRURs, including:
 - Group-level performance on PQRS measures, reporting both a performance rate and the total number of eligible cases for a given measure, and
 - Information on PQRS performance at the individual eligible professional level, of all eligible professionals (EPs) affiliated with the group.
- CMS provided these IEP PQRS Performance Reports because, in 2014, group practices may wish to use IEP PQRS data as part of the value-based payment modifier calculation.

How Can I Access My QRUR and IEP PQRS Performance Report?

1. Navigate to the Portal

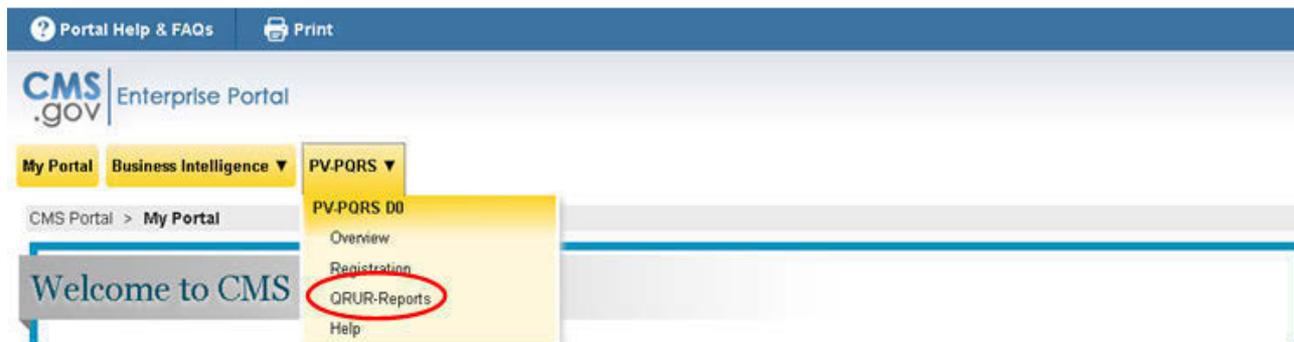
- Go to <https://portal.cms.gov>.

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 QRUR and IEP PQRS Performance Report? (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...”)

I request access to the beneficiary-specific data specified below for beneficiaries attributed to my group practice in the 2012 Group Quality and Resource Use Report (QRUR) and was used in the calculation of the quality and cost measures under the Value-based Payment Model. I am requesting the following data elements on each such beneficiary:

- Health Insurance Claim Number
- Gender
- Date of birth
- Hierarchical Condition Category risk score percentile
- If applicable, indication of the beneficiary's death during the previous year
- Date of last claim filed by TIN
- Number of primary care services provided by TIN
- Percent of Primary Care Services Billed by the TIN
- Percent of total costs by category of services provided by all providers (Evaluation and Management, Procedures, Inpatient Hospital, Outpatient Hospital, Emergency Services, Ancillary Services, Post-Acute Care, and All Other Services)
- If applicable, date of last hospital admission
- If applicable, indication of previous year's diagnosis of one of the four chronic condition subgroups (Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, or Heart Failure)
- If applicable, the following data on all hospital admissions: date of admission, admitting hospital, principal admitting diagnosis, indication of admission via the emergency department and all-care 30-day readmission, diagnosis for ambulatory patient conditions, date of discharge, and discharge disposition.

I plan to use this data in my capacity as a *

(must select one box)

- HPAA Covered Entity (CE) provider, or
- Business Associate (BA) or HPAA CE(s) in accordance with a valid HPAA Business Associate Agreement that allows us to request individually identifiable health information (IHI) for use in care coordination and quality work on behalf of the HPAA CE(s).

I confirm that my request complies with the "business necessary" data to accomplish these purposes.

5. Navigate to the Reports Folder

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

Access Your QRUR

Access a Drill-Down Report

6. Select Your Medical Group Practice

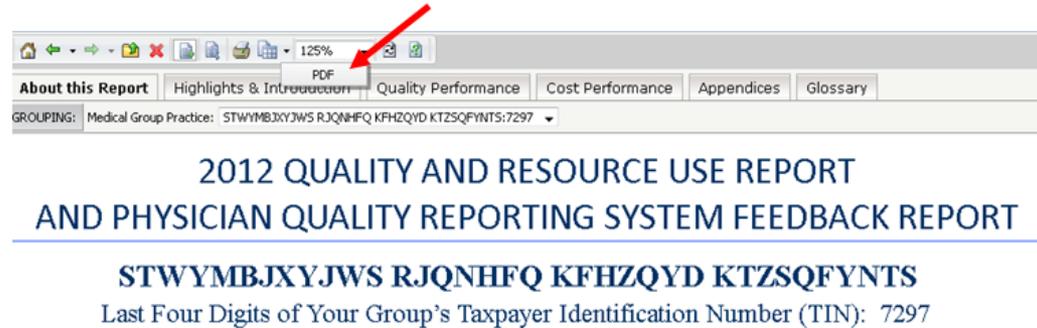
- After the report opens, select a Medical Group Practice and click Run Document.

Run Document

How Can I Access My QRUR and IEP PQRS Performance Report? (cont'd)

7. Export the QRUR

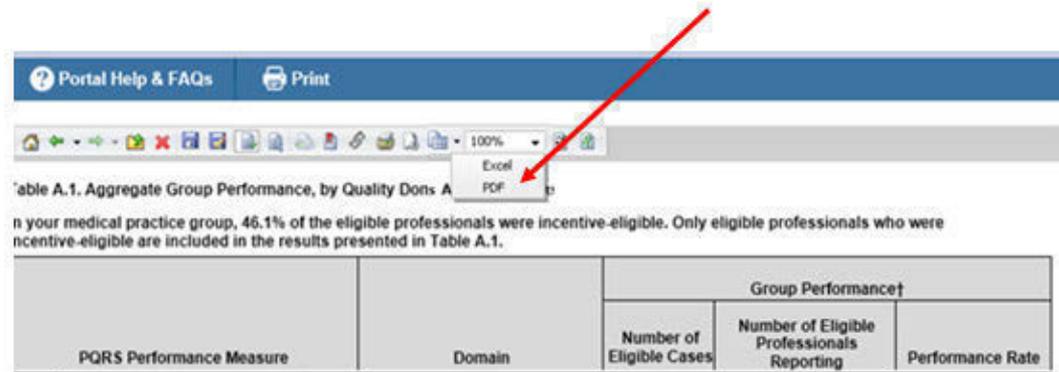
- You can view the QRUR online, as well as export and print the report to a Portable Document Format (PDF) file.



The screenshot shows a web browser window displaying the QRUR report. The browser's address bar shows a URL with a group ID. The page title is "2012 QUALITY AND RESOURCE USE REPORT AND PHYSICIAN QUALITY REPORTING SYSTEM FEEDBACK REPORT". Below the title, the group ID "STWYMBJXYJWS RJQNHFQ KFHZQYD KTZSQFYNTS" and the TIN "7297" are displayed. A navigation menu at the top includes "About this Report", "Highlights & Introduction", "Quality Performance", "Cost Performance", "Appendices", and "Glossary". A red arrow points to the "PDF" button in the browser's toolbar.

8. Export the Drill Downs

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



The screenshot shows a web browser window displaying a drill down report. The browser's address bar shows a URL with a group ID. The page title is "Table A.1. Aggregate Group Performance, by Quality Domain". Below the title, a paragraph of text states: "In your medical practice group, 46.1% of the eligible professionals were incentive-eligible. Only eligible professionals who were incentive-eligible are included in the results presented in Table A.1." A table is displayed below the text. The table has two main columns: "PQRS Performance Measure" and "Domain". The "Domain" column is further divided into "Group Performance" and "Performance Rate". The "Group Performance" column is further divided into "Number of Eligible Cases" and "Number of Eligible Professionals Reporting". A red arrow points to the "Excel" and "PDF" buttons in the browser's toolbar.

PQRS Performance Measure	Domain	Group Performance†		Performance Rate
		Number of Eligible Cases	Number of Eligible Professionals Reporting	

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 them,and
 - 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 (Table 1).
- Identify those beneficiaries that are in need of greater care coordination (Table 1).

Overview: How Can I Use the 2012 QRUR? *(cont'd)*

- Verify the EPs billing under your group's TIN during 2012 (Table 2).
- Understand which beneficiaries are driving your group's performance on the three hospital-related care coordination quality measures (Table 3).
- Understand the aggregate group performance, by quality domain and measure, for eligible professionals (EPs) in your group practice who reported PQRS measures as individuals and who were incentive-eligible under the TIN in 2012 (IEP Report Table A.1).
- Understand your performance on PQRS measures you reported in 2012, including the performance measure domain, the reporting mechanism, the number of eligible cases and the performance rate (IEP Report Table A.2).

What Information Is Included on the Performance Highlights Page?

1. Your Quality Composite Score

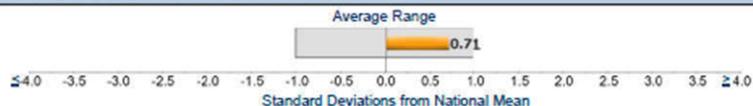
2. Your Cost Composite Score

3. Your Beneficiaries' Average Risk Score

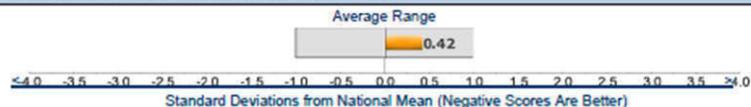
4. Your Quality Tiering Performance Graph

5. Your Payment Adjustment Based on Quality Tiering

YOUR QUALITY COMPOSITE SCORE: AVERAGE



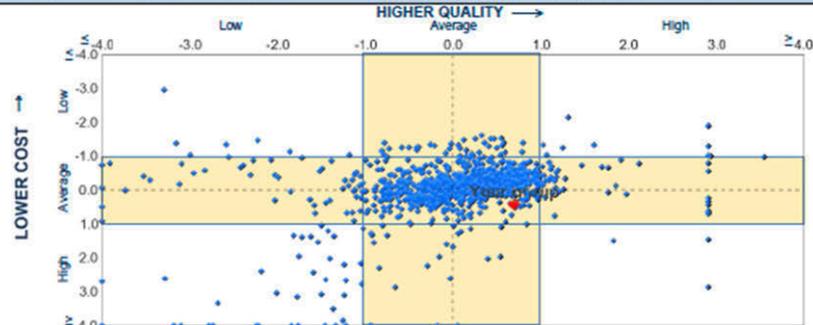
YOUR COST COMPOSITE SCORE: AVERAGE



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%

Note: x refers to a payment adjustment factor yet to be determined due to budget neutrality requirements.

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 (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 that 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	7,835	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	7,835	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 the medical group practice who <u>did not</u> bill under the group's TIN	57.0%	66.6%

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

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

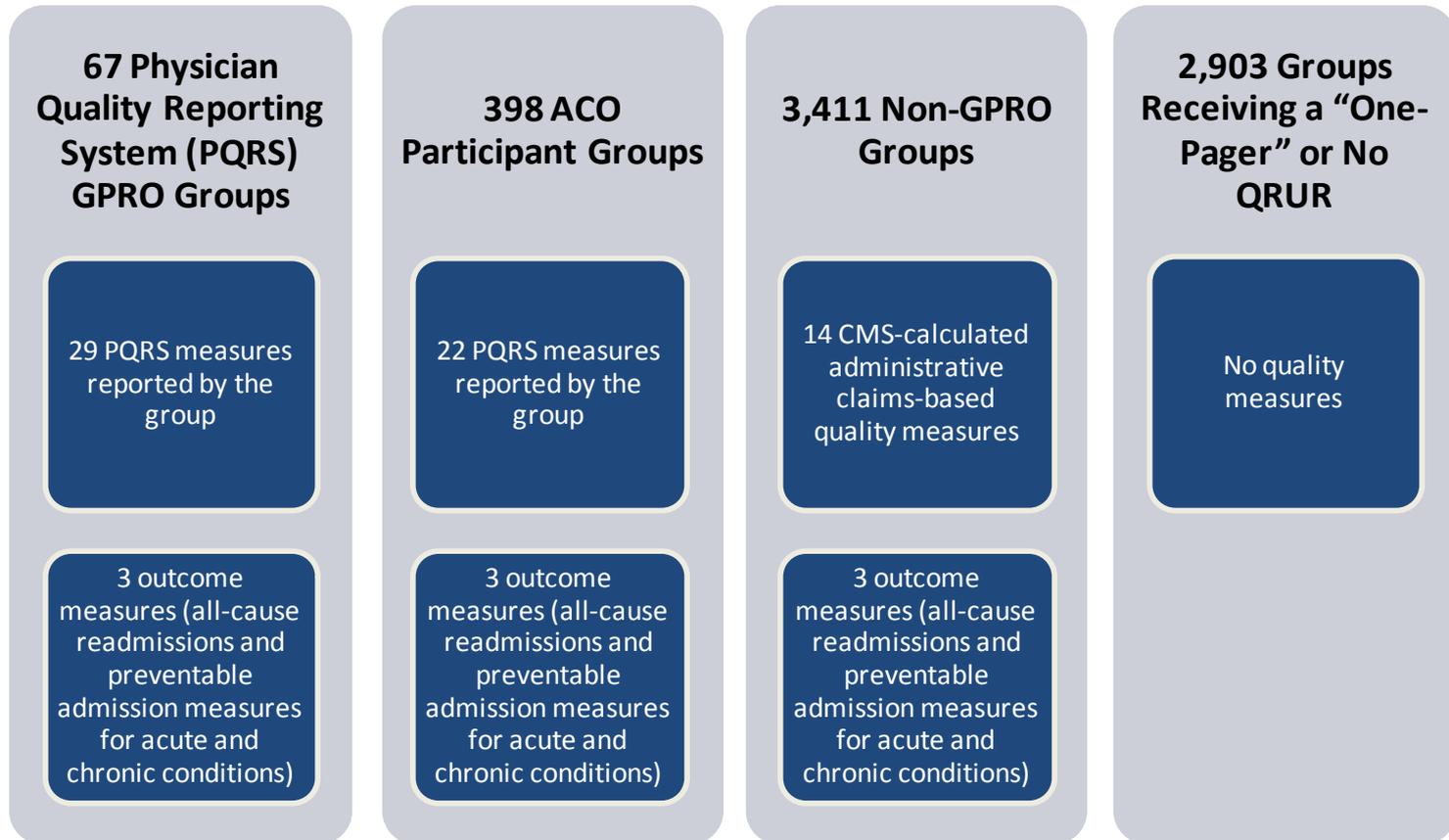
	Number of Beneficiaries	Percent of All Beneficiaries Treated by a Group of 25+ EPs	Percent of All Beneficiaries Attributed to a Group of 25+ EPs
-			
Beneficiaries Treated by a Group of 25+ EPs	24,426,157	100.0%	-
Beneficiaries Attributed to a Group of 25+ EPs	11,593,242	47.5%	100.0%
Beneficiaries Attributed 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 Clinics (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 have been finalized for the VBM in 2016 (2014 performance period). CY2014 finalized policies for the quality composite include an option to roll-up individually-reported PQRS measures into a group score.
- In December 2013, we released a new IEP PQRS Performance Report, accompanying the 2012 QRURs, for EPs to examine their rolled-up performance.
- If physicians in a group participated in PQRS as individuals during 2012, performance at the group- and individual- levels was made available.

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 QRQR 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 Exhibit 3

- Exhibit 3 displays the group's overall quality composite score and performance by quality domain (see figure below):
 1. The quality domain scores are equally-weighted averages of quality measures in the domain.
 2. The average domain score is an equally-weighted average of each quality domain score.
 3. 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 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/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2012-QRUR.html>.

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, 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 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 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 the 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) 3
Average Domain Score	0.87 2
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

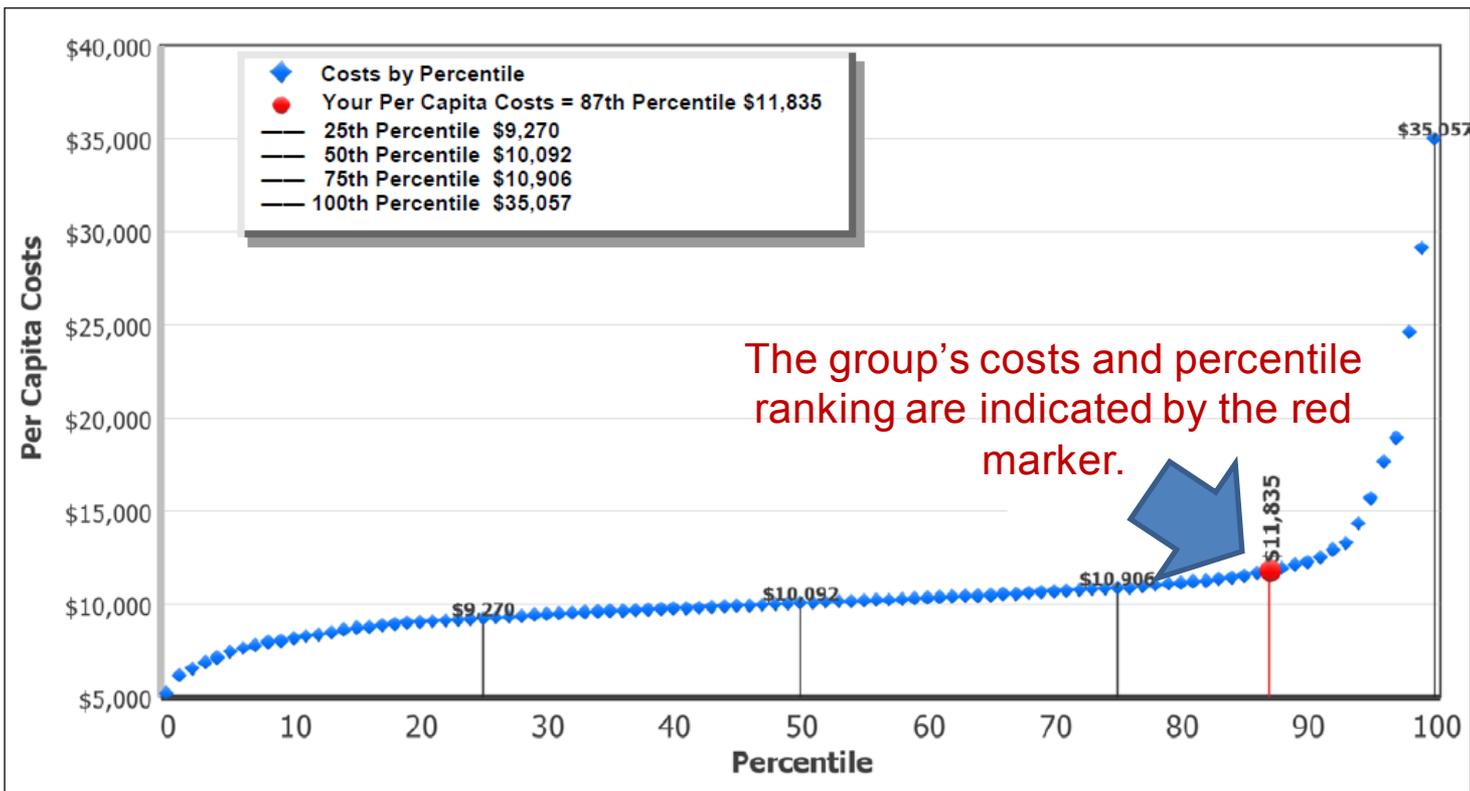
Performance on Costs: Overview of Exhibit 7 (*cont'd*)

- 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 eligible cases.
- For the CY2014 reports, CMS will further adjust the cost benchmarks 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.

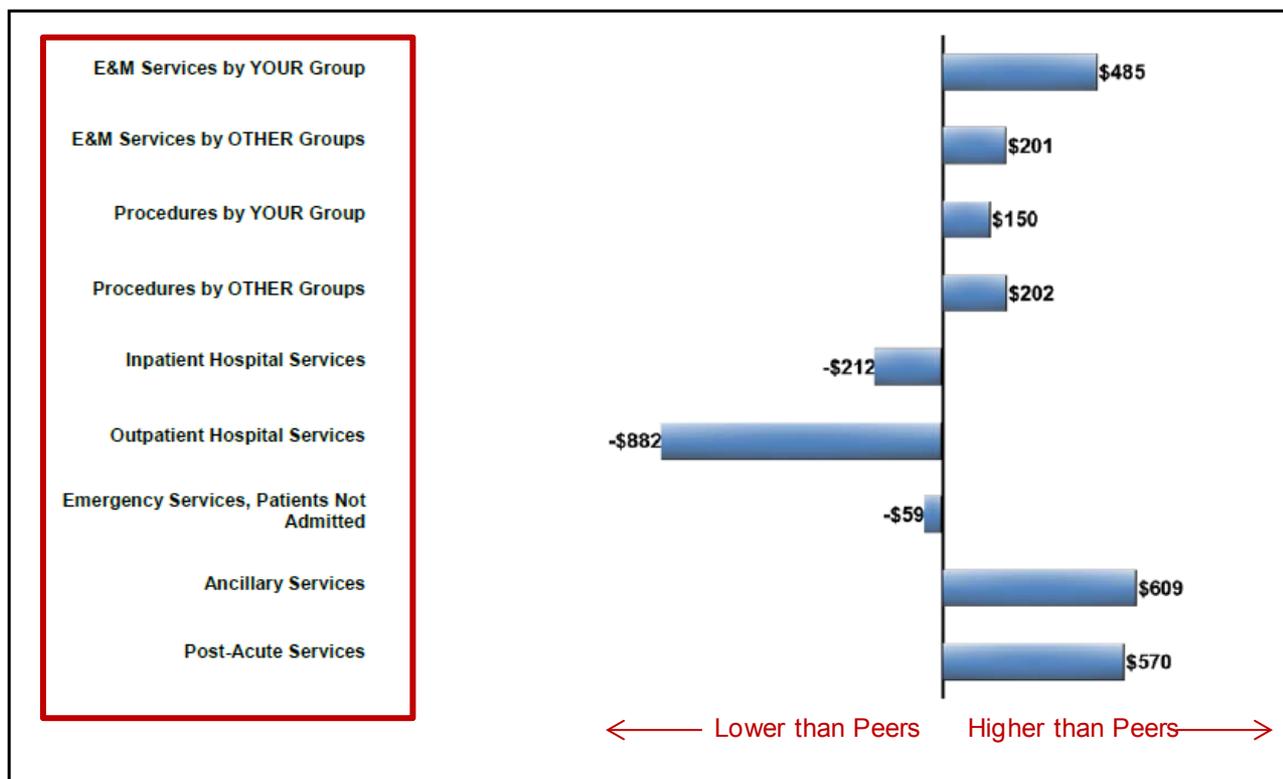
Exhibit 8. Per Capita Costs of Medicare Beneficiaries Attributed to Your Medical Group Practice in 2012, Compared to All 1,032 Medical Group Practices with at Least 100 Eligible Professionals



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

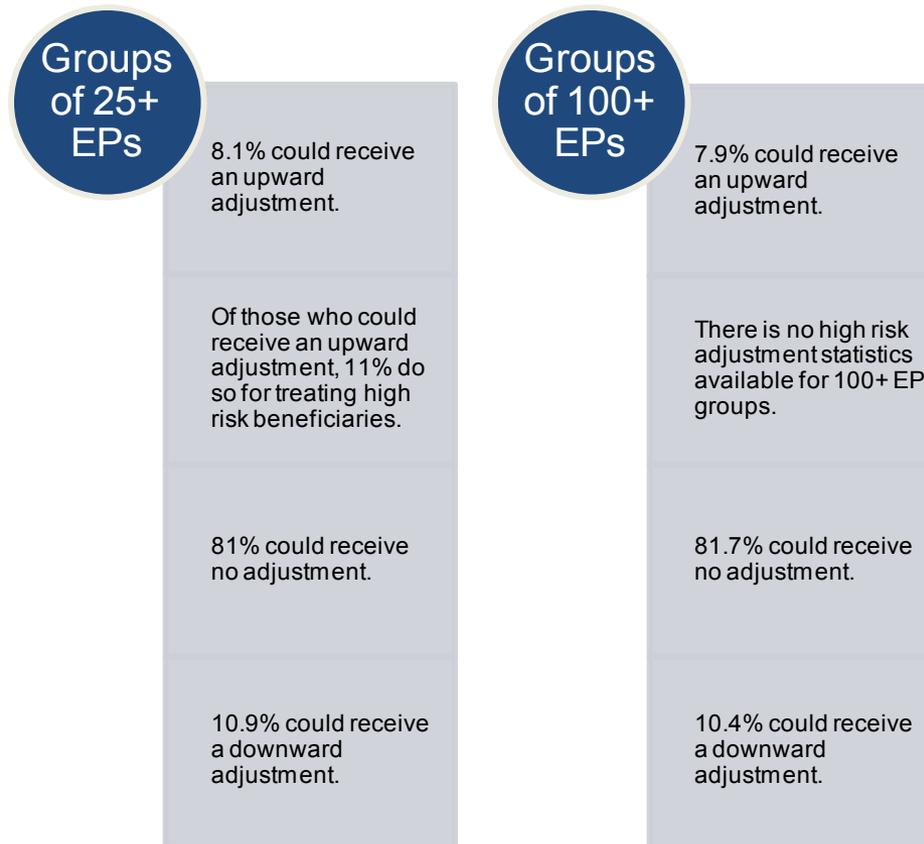
Service Category	Your Medical Group Practice		Mean for All 1,032 Groups with at Least 100 Eligible Professionals		Amount by Which Your Group's Costs Were Higher or (Lower) than Peer Group Mean	
	Your Medicare Patients Using Any Service in This Category		Risk-Adjusted Per Capita Costs	Medicare Patients Using Any Service in This Category		
	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, since the first performance year for the value modifier is 2013. The information on this slide DOES NOT reflect an actual adjustment to groups' Medicare Physician Fee Schedule reimbursements.



How Can Groups Use 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 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.

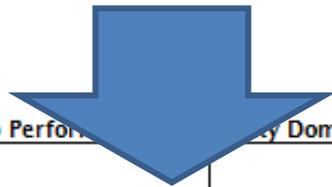
Understand where beneficiaries are being discharged.

Identify hospital readmissions.

How Can Groups Use the IEP PQRS Reports?

Table A.1 (Group Performance, by Quality Domain and Measure)

Identify the 2012 PQRS measure information and VBM quality domain classifications for measures reported by incentive-eligible EPs in the group.



Identify the number of incentive-eligible EPs reporting the measure.

Table A.1. Aggregate Group Performance by Quality Domain and Measure

PQRS Performance Measure		Domain	Group Performance*		
			Number of Eligible Cases	Number of Eligible Professionals Reporting	Performance Rate
1*	Diabetes Mellitus (DM): Hemoglobin A1c Poor Control in Diabetes Mellitus	Clinical Process/Effectiveness			
2	Diabetes Mellitus (DM): Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	Clinical Process/Effectiveness			
3	Diabetes Mellitus (DM): High Blood Pressure Control in Diabetes Mellitus	Clinical Process/Effectiveness			
5	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Clinical Process/Effectiveness			

Identify the number of eligible cases in the performance denominator.

How Can Groups Use the IEP PQRS Reports?

Table A.2 (Individual Performance on PQRS Measures)

Identify the 2012 PQRS measure information and VBM quality domain classifications for measures reported by a given EP.

Identify the EPs reporting measures in 2012, as well as their incentive-eligibility status.

Table A.2. Individual Eligible Professionals' Performance on PQRS Measures: First Name Last Name (NPI#), Incentive Eligible

PQRS Performance Measure		Domain	Eligible Professional Performance		
			Reporting Mechanism [†]	Number of Eligible Cases	Performance Rate
1*	Diabetes Mellitus (DM): Hemoglobin A1c Poor Control in Diabetes Mellitus	Clinical Process/Effectiveness	Registry		
2	Diabetes Mellitus (DM): Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	Clinical Process/Effectiveness	Claims		
3	Diabetes Mellitus (DM): High Blood Pressure Control in Diabetes Mellitus	Clinical Process/Effectiveness	Registry		
5	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Clinical Process/Effectiveness	Registry		

Identify the number of eligible cases in the performance denominator, by reporting mechanism.

Identify information on the mechanisms through which PQRS data were reported by the eligible professional.

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 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.

How to Obtain an IACS Account

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: gnetsupport@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

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 the [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>.