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National Provider Call - Transcript

**Centers for Medicare & Medicaid Services**
**How to Interpret Your 2012 Supplemental Quality and Resource Use Report**
**MLN Connects National Provider Call**
**Moderator: Amanda Barnes**
**August 13, 2014**
**1:30 p.m. ET**

## Contents

**Operator:** At this time, I would like to welcome everyone to today's MLN Connects National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Amanda Barnes. Thank you, you may begin.

## Announcements and Introduction

Amanda Barnes: Thank you Selema. Good afternoon. I'm Amanda Barnes from the Provider Communications Group here at CMS and I am your moderator today. I would like to welcome you to this MLN Connects National Provider Call on "How to Interpret Your 2012 Supplemental Quality and Resource Use Report." MLN Connects Calls are part of the Medicare Learning Network.

During this call, CMS subject matter experts will provide an overview of the program year (PY) 2012 Supplemental Quality and Resource Use Reports, or QRURs. These confidential reports are now available for group practices with 100 or more eligible professionals that received group 2012 QRURs.

Today's presentation will walk through how to interpret your 2012 QRUR, and a question-and-answer session will follow the presentation.

Before we get started, I have a couple of announcements. You should've received a link to the slide presentation and addendum for today's call in previous registration emails. If you have not already done so, please view or download the presentation and the addendum from the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc.

At the left side of the webpage, select National Provider Calls and Events, then select the date of today's call from the list. Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when these are available.

Today's call is being evaluated by CMS for CME and CEU continuing education credit. For more information about continuing education credit, please review the CE activity information and instructions available via the link on slide 47 of today's presentation.

Lastly, CMS offers MLN Connects Calls on a variety of topics. Our next call will be held on August 19th, 2014, on National Partnership to Improve Dementia Care in Nursing Homes. You can visit www.cms.gov/npc for more information.

At this time I would like to turn the call over to John Pilotte, Director of the Performance-Based Payment Policy Group (P3) here at CMS.

# Presentation

John Pilotte: Thank you, Amanda, and thank you all for taking the time out today to join us for this call to really share with you the valuable information that we've included in our Supplemental Quality Resource and Use Report around episode-based cost measures. You'll be hearing today from members of our episode group or team here at CMS that include Craig Caplan and one of our medical officers, Mark Levine.

And basically, this is our second year in producing these Supplemental Quality Resource and Use Reports, and it's part of CMS's continued development and evolution around exploring episode-based cost. And we're really looking forward to your input into these reports both in terms of the composition of the episodes that you'll be seeing today and also the presentation of the materials and information.

These reports that we're making available this year represent a significant expansion. Last year we made reports available to 54 medical groups around the country. This year we're making available reports to over 1,200 groups. So we really are interested in your feedback, both in the composition but also in the material and the information that's presented in these reports, which include information about the care that's being delivered to patients – to your patients during these episodes both inside your organizations and outside your organizations.

This information that you give us and the feedback that you give us will be helpful in our future development and evolution of episode-based cost, which is an area that's obviously getting a lot of interest and an area we want to move into in the future. And this type of real-life practical feedback on your actual patients is something that's very informative in evolving these.

The second – or the final thing I would point out and encourage you to do is – we have a discussion in our Physician Fee Schedule rule around the Quality Resource and Use Reports and Physician Feedback Program, and including a discussion on episode development and current episode measures. And we certainly encourage you and welcome your feedback on that discussion and the issues that we identify in there. And I would encourage you to submit formal comments to us by September 2nd through the process for that.

Currently these episode-based cost measures are still in a development and evolution phase and we're providing them for informational purposes. But we really are interested in your feedback through this venue as well as through the rule to get your thoughts and ideas for how we can evolve these in the future.

So with that, I again thank you for your participation. Thank you to Craig and Mark and the rest of our episode group or team. And with that, I'll turn it over to Craig Caplan.

## Overview of 2012 Supplemental QRUR

Craig Caplan: Thank you John. Good afternoon everyone on the East Coast and good morning to those attending on the West. I'd like to welcome you to today's presentation

on How to Interpret Your 2012 Supplemental Quality and Resource Use Report, or QRUR, that was recently made available to your group practice.

My name is Craig Caplan, as John mentioned. I'm at the CMS and I will be cohosting today's presentation with Dr. Mark Levine, Chief Medical Officer in CMS's Denver Regional Office. Please note that throughout this presentation we have supplied links to documents and materials that are available on our website. There you will find answers to many of your questions.

The presentation today is meant to be a general overview that I hope will be helpful to appreciate the powerful and utility of these reports. We'll – we will start by providing background on episodes of care and outlining how they can be used to inform on patterns of medical care. Then we will demonstrate how you can use the reports to use – to see the resources that were used during the care you provide to your patient and how the resources used in caring for your patient compared to the resource use of other group practices treating similar patients.

We will also show you how you can drill down into the data to see more detail and uncover opportunities to understand and improve the care you deliver. We are working hard to find the best way to present information on resource use in a manner that is most useful to you. So we will end this session by asking for your help through comments and suggestions.

Slide 5. We're now on the Introduction to the 2012 Supplemental QRURs. These reports are called the 2012 Supplemental QRURs because they report on care that was delivered in 2012. They supplement the Quality and Resource Use Reports that were distributed to the group practices last fall. Those included both quality and per capita resource use information.

The 2012 Supplemental QRURs are distributed to medical group practices with 100 or more EPs, or eligible professionals. They're confidential and not posted publicly. These data do not affect Medicare payment, as is mentioned, and are not used in the Value-Based Payment Modifier Program for the Medicare Physician Fee Schedule.

Our goal is to provide meaningful and actionable information that will help us and you to understand the manner that care is being delivered and, hopefully, spark improvement activities that will lead to lowered cost while maintaining or improving the quality of care.

The episodes in the reports we are presenting today are based on care for Medicare fee-for-service patients with episodes that ended in 2012. Medicare Advantage patients are not included. We welcome – excuse me – we report on three different types of episodes. Some episodes describe care delivered for a particular medical condition. Condition episodes can either be acute or chronic.

The chronic ones describe either ongoing chronic care or they describe a distinct portion of the care for the condition, which is an acute condition episode. This includes an acute exacerbation, usually one that – these episodes are usually treated in the hospital. The other type of episode, the procedure-based episode, is based on the performance of a specific procedure, such as hip replacement or cataract surgery.

Now, on slide 6 – and this is the agenda – CMS's approaches to episodes of care. I'd like to turn the microphone over to Dr. Mark Levine to talk about this topic and why Medicare is working to develop episodes. Mark.

**CMS's Approach to Episodes of Care**

Dr. Mark Levine: Yes, thank you Craig. And again, this is Mark Levine. I am the Chief Medical Officer in the Denver Regional Office of CMS and have been privileged to participate in the evolution of some of these episode concepts.

I'm going to start on page – slide 7. I suspect that many of you who are listening are already familiar with the CMS quality strategy. In it we aim to simultaneously improve the health of patients and populations – improve the quality of care while also lowering medical costs. The key to reducing cost is to reduce waste, redundancy, and inefficiency. In other words, to focus on eliminating rework in the form of complications and readmissions and improve care coordination, and use performance-improvement tools and techniques that can result in a more effective and more efficient health care system.

We also believe that performance improvement cannot occur without objective and reliable measures of performance. So our goal in this resource use project is to evolve meaningful and actionable measures of the costs of care that you, our provider partners, can use to uncover opportunities to improve.

Episodes are one technique for looking into the costs of care. They organize medical claims into clinically relevant units for analysis. We intend the episodes to produce actionable information on cost and quality that is understandable and clinically meaningful and can be used in performance-improvement activities that lead to improved quality and efficiency.

At CMS we're developing Medicare-specific episodes of care to ensure that the episodes recognize the uniqueness of our beneficiaries and our program. Our beneficiaries tend to be older and medically complex and the episodes must account for this. Episodes also need to be transparent and flexible enough to be used in various ways across different Medicare programs.

So let's turn to slide 8 and talk about what exactly is an episode. It's basically a collection of medical and/or procedural services that are used in addressing a specific medical condition or a procedural event that is delivered to a patient within a defined time period. We construct these through three related operations.

We start the episode by identifying services in the stream of claims that indicate that an episode has begun. These services are called trigger events and are services such as an inpatient hospital admission or a specific diagnosis or a procedure that appears on a claim form. Next, we collect services and procedures that are clinically relevant to the episode and that occurred during the episode time period. We call this collection of clinically relevant services a group. Last, we end the episode by a predetermined rule, such as a break in service or a fixed time period after the clinical trigger event. For instance, while chronic conditions are likely to go on for years, we arbitrarily end their episodes after1 year so that we have a comparable period of time to compare. Procedural episodes usually end after 30 days.

On slide 9 we talk more about episode construction and point out that the key operation really is determining which services should be included and which should be excluded for each episode. This is a very important step and relies very heavily on clinical reasoning. At CMS we are quite grateful for the work of the clinical reviewers who have worked with us to consider the many diagnosis and procedure codes that appear on Medicare claims and recommend those that they consider clinically relevant for each episode, condition, or procedure.

As you review your reports, we would appreciate your forwarding to us your suggestions about service assignments that you think can be improved. We intend these reports to be accurate and reliable and we welcome your help in making them so. Before the call is over, we'll provide you with an email address to provide that kind of feedback.

But let's turn now to slide 10. The grouping of relevant services varies a little bit in the episodes because CMS has used two different methods for grouping. The methods are really quite similar. Both result in discrete sets of services that are clinically relevant to the specific medical condition or procedure. The methods differ in how the services are grouped to the episodes. One method, which we call Method A, aggregates the claims to episodes based on the diagnosis codes that occur on the claim without considering additional information, such as an associated service or setting.

The other method, which we call Method B, takes an alternative approach and looks for specific medical events that occur in the downstream period, such as ER visits, readmissions to the hospital, and stays in the post-acute care, etc. But the important thing to recognize is that each episode uses but a single method to construct episodes. As a result, every episode is internally consistent and comparable.

Slide 11 is the first of the two slides that list each of the 26 episodes that are reported in the reports. The first one, on slide 11, lists all the condition-based episodes. The next slide will show the procedure-based episodes. Condition episodes can be further categorized into chronic and acute condition episodes. Chronic episodes represent care for a patient's ongoing disease and are considered in 1-year increments of time.

The acute episodes are of shorter duration and describe only a defined portion of the care for the condition, usually an acute exacerbation that is treated as an inpatient. Some acute

episodes are described in even further detail to become even more homogenous. Thus, acute coronary syndrome is separated into what we call subtypes based upon whether the patient receives bypass surgery or a percutaneous intervention made.

Specific information describing the construction of each episode type and subtype is available in the detailed methods document that is available on our website and is noted in a link on one of the last slides in the deck.

Slide 12 shows the procedural episodes. Again, note how subtypes are used to differentiate coronary artery bypass graft surgery done in patients with and without coronary syndrome or myocardial infarction. We use episode subtypes then to yield a more meaningful clinical comparison for the episode. Similarly, cataract surgery episode is constructed to enable meaningful comparison, and it does this by including only patients who get cataract surgery on both eyes within 90 days of one another. This avoids including patients who get only a single eye treated and who thus predictably use fewer resources.

Slide 13 begins our discussion about medical group attribution. Once the episodes are constructed, CMS assigns them to the group practice determined to be the most responsible for the patient's care. We use different criteria based on the type of episode. Chronic condition episodes are attributed to the group practice if its Taxpayer Identification Number, or TIN, is paid for the plurality of outpatient evaluation and management, or E/M, visits during the episode.

Acute condition episodes are also attributed on the basis of plurality of E/M codes, although for the acute conditions, we only look at inpatient E/M payments. Procedural episodes are attributed to the eligible professional who is paid for performing this specific procedure if that professional is in your group and bills us using your Taxpayer Identification Number. And again, more information on medical group attribution can be found in the detailed methods documentation found on our webpage.

By the way, getting to any of these – the webpage – the easy way to do it that I found and I use all the time is just doing an Internet search for Supplemental QRUR. And your search engine should bring you right to the correct page for accessing all of these things. Be careful to look at the bottom of the page because many of the documents we're talking about are listed in the lower section under downloads.

Slide 14. We provide each group with a comparison of their episode cost to those in the national sample of fee-for-service Medicare patients. Please note that throughout this presentation we use the terms cost, spending, and resource use interchangeably. Each term represents the standardized Medicare-approved payments for the services.

Remember the Medicare-approved payment includes cost-sharing contributions from the patient in the form of deductibles and coinsurance, some of which may be paid to you from secondary insurers such as Medigap plans. So if you're trying to correlate our data

with your internal financial data, it's not a simple one-to-one related to the Medicare bill – the Medicare reimbursement.

Slide 15. We'll now turn to the reports themselves and provide some hints for making them useful.

Slide 16. Each of the more than 1,200 medical groups that received notice of a report being available will access the report to find two files. The first file, which is labeled "2012 Supplemental QRUR," contains an introductory page, data tables that are called exhibits, and an appendix. There is a second file labeled "2012 Supplemental QRUR Drill Down Tables," and this one contains additional tables called, obviously, drill down tables.

## Payment Standardization and Risk Adjustment

The following slides will provide a preview. But before we go there, I'd like to explain what we mean by payment standardization and risk adjustment. Medicare payments are frequently adjusted for reasons that have nothing to do with the medical care itself. Factors such as geographic modifiers or payments for graduate medical education or disproportionate share payments to hospitals are not under your control or influence, so we adjust them away. This results in payment standardization and makes the cost that we report much more comparable.

We also perform risk adjustment on the episodes to account for your patient's health status at the time that the condition being examined is presented. Older patients and patients with many other health conditions are more likely to require greater expense for their care, and risk adjustment is our attempt to neutralize this and account for it.

It's difficult if not impossible to perform risk adjustment and payment standardization at every level of detail. Costs of entire episodes are reported after payment standardization and risk adjustment, but payment standardization and risk adjustment are not used in some of the detailed reports in the drill down tables that I will soon describe.

## Understanding Your Report

So let's talk now about the reports themselves. As I said, there are two major sets of tables, the exhibits and the drill down tables. When you access the reports, the 2012 Supplemental QRUR option will bring you to the exhibits and appendix, while the drill down tables will obviously bring you to the drill down table. The appendix provides specifications used to define the service categories presented in exhibit 2 and a couple of the drill down tables.

But the exhibit tables is where we're going to start. They report summary information. That is, they merge all instances of a given episode and provide reports on the group's overall performance. The drill down tables is where you can drill down into every instance of each episode to uncover specific information that may help you to understand what occurred during the care of a specific patient.

So let's get started on slide 17, which shows the introductory page to the exhibits, and it contains much of the information that we've already reviewed today. The introductory page also provides a link to the complete technical documentation. Again, that's available in the detailed methods document as well as other resources that are available on our webpage.

Slide 18. The exhibit tables, again, report summary information. In other words, they merge all instances of a given episode and provide reports on the group's overall performance. They do not report on each instance of each episode. That, as we shall see, can be found in the drill down tables.

There are four exhibit tables, although we actually only use three. In exhibit table 1 you can compare the frequency and cost of your episodes to national averages. Exhibit 2 breaks those average episode costs into service categories. And note that risk adjustment is applied only at the level of the complete episode. Once the episode is broken down, as it will be in exhibit 2, risk adjustment no longer pertains.

We don't use exhibit 3; it's reserved for future use. Exhibit 4 reports the providers that are in or outside of your medical group that are the five highest-billing hospitals, skilled nursing facilities, home health agencies, and eligible professionals for the episodes that are attributed to your medical group practice. We are reporting this level of detail in the reports in response to the feedback that we received last year from the groups that received reports who requested that level of detail.

Slide 19 shows exhibit 1. It shows the frequency and cost of the episodes attributed to the group and compares them to the national average. Each episode type is reported separately. And this example shows a group's episode of pneumonia and includes its subtypes of inpatient and outpatient pneumonia. We've highlighted the portion of the table that reports the episode frequency. In this report – and this is just sample data, this is not a real group – but in this sample data, the group had 116 instances of pneumonia, of which 98 – or almost 85 percent – were treated in the hospital. This compares to a national average rate of hospitalization of 70 percent among all groups. And we'll come back to this observation later and provide some insight into it.

Please note that this slide presents, again, sample data for illustration purposes, as will all other slides in this presentation. The data that you'll see in your report will contain your own group's confidential data. But in this presentation today, it's only for illustration purposes.

So let's turn to the next slide to look more closely at exhibit 1. This is slide 20, and here we highlight the episode cost data for the pneumonia episodes. This is presented as average risk- adjusted cost for each episode subtype. It also displays the percent difference in cost to the national average. Note how much this fictional group's cost exceeded the national average – it's 28 percent higher for all pneumonia episodes, but 94 percent higher for the patients that are treated without hospitalization.

Now when interpreting these reports, it's important to analyze them carefully, with your particular circumstances in mind. Remember, on the previous slide we showed that there was a higher proportion of hospitalized patients in this fictional group. It doesn't necessarily mean that there's over hospitalization. Perhaps this group includes hospitalists or pulmonologists who were called in to attend patients who had been admitted by other physicians and that the rate of hospitalization does not resent – represent only the population of patients that could potentially have been treated as outpatients.

So make sure that you interpret the reports with your particular circumstances in mind. But the cost of caring for the patients still deserves careful study. This exhibit alone cannot tell you why the costs are high, just that they are. Further careful analysis is needed to identify areas that might lead to meaningful performance improvement. And there's information in the other reports that may help us.

Let's go to exhibit 2, slide 21. Exhibit 2 shows the costs of the pooled episodes of a given type broken down into categories of service. The costs in this exhibit continue to be payment standardized, though they are not risk adjusted. Again, risk adjustment is applied only to full episodes.

Slide 22 shows a breakdown of the post-acute care services that are provided to beneficiaries with pneumonia from a different fictional group practice. Note that 11 percent of this group's pneumonia patients received care in an inpatient rehab facility or long-term care hospital. This is almost three times the rate of the patients with pneumonia in the national sample, and it's possible that this observation may be a clue to consider for further study as you do an internal improvement project based upon your data.

Slide 23, again, exhibit 2 showing more than frequency in rates of service, it also reports the cost. For example, the average non-risk-adjusted home health cost for all pneumonia episodes nationally is $374. And this fictional patient – this fictional group's patients, cost 65 percent more than the national average. Here we see that the pneumonia patients of this fictional group had more than a high rate of use of inpatient rehab and long-term care hospital. They also had higher costs when compared to all pneumonia episodes nationally. This observation also may be a clue that could spark performance improvement.

Next we'll turn to slide 24, exhibit 4. Remember that exhibit 3 is not being used. Exhibit 4 enables you to examine the five highest billing facilities and eligible professionals within and outside your medical group practice. You can combine this data with the episode-specific information provided in the drill down tables that we'll look at next and use it to pinpoint those facilities and professionals that have the greatest influence on either driving up episode cost or potentially holding down episode cost.

Facilities are listed separately and include hospitals, skilled nursing facilities, and home health agencies. Please note that if only one eligible professional outside your medical

group bills within an episode, the cell will display an asterisk because the name of that eligible professional is hidden to protect their privacy.

OK, so now let's talk about the drill down tables on slide 25. The exhibits that we just reviewed provided episode-specific data for all the episodes attributed to the group practice but merge them into one set of data for all instances of the particular episode. The drill down tables provide patient-specific detail within each episode. Thus, the drill down tables supplement the medical group-level information provided in the exhibits. Note that the drill down tables can be exported from the website into a spreadsheet. In this way you can then manipulate, filter, sort, or bend, fold, spindle, whatever it is that you wish to meet your data needs and study the data as you see fit.

The first drill down table allows you to verify how episodes were attributed. Tables 2 and 3 allow you to analyze the breakdown of episode costs from the claims billed, ordered, or referred by eligible professionals within and outside your group practice, respectively. So let's take a look.

Slide 26. The start of each drill down table presents information about the episode and the beneficiary. To protect patient privacy, the sample reports that we display on this sample slide has blank cells for the episode's start date, beneficiary, health insurance claim, or HIC number, the beneficiary date – and the beneficiary date of birth. And by the way, all of the sample reports that are available on our website also are blank on those things.

Your group's report, however, will display full beneficiary information and thus allow you to supplement the episode information in the report with your own medical record. The episode ID is also used in the drill down tables as a unique identifier of one condition or treatment episode for one beneficiary, and thus allows you to track through all the drill down tables to obtain the complete data for any specific instance of an episode.

Slide 27. Drill down table 1 includes attribution and cost information for each instance of an episode that is attributed to your group. It documents why the episode was attributed to your group, it summarizes the patient's relative health status – we'll talk about that – and provides data on the episode's risk-adjusted cost compared with the national sample of episodes of the same type and subtype.

Slide 28. The attribution information shows how we identified the apparent lead eligible professional. For procedural episodes, the lead professional is the professional who performed the triggering procedure. This table enables you to confirm that we did this accurately.

Condition episodes, both chronic and acute, are attributed based on billed E/M visits. In the case of a tie, condition episodes are attributed to the group with a higher share of the Physician Fee Schedule costs. If no apparent lead eligible professional is identified for an episode, the corresponding cell will display an asterisk. Please note that the episode ID and beneficiary HIC appear on each line of the drill down tables. And again, those

correlate as unique identifiers and enable you to track each episode through each of the tables.

Slide 29. In addition to identifying the apparent lead professional for the episode, drill down table 1 also shows the relative amount of cost billed by members of your group. I should point out that it's entirely possible that a professional other than the apparent lead is responsible for the majority of the professional costs, especially for the condition episodes. Remember, attribution for condition episodes is based only on E/M billings, not on all professional billings.

Slide 30. Drill down table 1 also reports total cost information, including each patient's risk score and risk-adjusted cost information. A higher risk score is assigned to a patient who is more complex than are other patients within episodes of the same subtype. It is expressed as a percentile relative to all patients in the national sample who have episodes of the same subtype.

A patient's episode cost is adjusted by the risk score to yield the risk-adjusted cost percentile. The higher the risk-adjusted cost percentile, the more expensive was that episode relative to the cost predicted by the national benchmark. Again, the details of this adjustment and all other technical detail are found in the detailed message document that you can access on the CMS Episode QRUR website.

Slide 31, drill down table 2, presents the breakdown of service costs billed, ordered, or referred by the eligible professionals within your group practice. You can examine this to find opportunities for improvement in care coordination and management by identifying facilities or providers within your medical group that might be drivers of cost or utilization. You can also identify providers that are low cost and low utilization. You can also see here which services contributed the most to the cost of each episode.

So let's take a look on slide 32. Here we see the facilities where your attributed patients received their care and the costs from claims billed, ordered, or referred by eligible professionals that are within your medical group practice. In the exhibits we had seen which facilities were most frequently involved in your group's episodes. But in the drill down tables, we can see exactly which facilities contributed to the care of a specific patient, and this may be the more actionable information.

Slide 33 shows more detail from drill down table 2, showing the many different service categories that are reported for your group practice – in this case, inpatient care, post-acute care, and outpatient care. Note the second column from the left reports readmissions. You may wish to pay close attention to this important information as readmissions are not only an important driver of cost, it's a driver of cost that is frequently manageable and preventable.

Like drill down table 1, drill down table 2 can be exported and manipulated. In this way, again, you can dig far into the details to better understand what and who is driving the cost of the episodes attributed to your group.

Slide 34 shows drill down table 3, which is quite similar to drill down table 2, except that it reports the details of services billed, ordered – services that are billed or ordered by professionals or facilities outside of your medical group. It, too, can be exported, filtered, and manipulated to identify cost drivers and other opportunities for improvement. You can use this information to identify the providers outside your group who most influence your group's performance and, again, use that to improve care coordination and lower the cost of care.

Now that we've described the exhibit tables and the drill down tables and shared some hints on how to make these reports actionable, let's turn our attention now to the bigger picture. What is CMS learning from these reports?

**Key Findings**

Slide 36, we have published an addendum that summarizes information gleaned from analysis of all of the episodes reported for all of the groups across the nation.

This addendum is available from the appointment that you received for this call and will also be available on our webpage within the next week. It includes data on the specialty of the attributed physicians with the different episode types and subtypes, the different attribution rules that were used to identify the apparent lead eligible professional for each episode type and subtype, and also presents reliability testing of each episode and much, much more.

The following slide will show some high level observations taken from the addendums that you may find interesting, and that's on slide 37.

Since we want to leave some time for questions, we have briefly summarized some of the key findings from the addendum. Additional details on these reports can be found within that document.

First, we found that high cost episodes – makes sense – are driven by certain service categories, specifically the acute condition and procedural episodes in the top decile of cost, the higher cost episodes for acute conditions and procedural episodes. They had high post-acute care on readmission cost compared to all other episodes of the same type.

Second, we attributed episodes mainly by the rules that we talked about, the plurality of evaluation of management visits during the trigger event or episodes. We only had to go to the tie-breaking rules occasionally. We found that a majority of episodes were attributed on the basis of the plurality of E/M visits.

Last, we tested each of the episodes for reliability and found that most episodes had a high or moderate level of reliability, which means that the episode grouping and attribution methodology was consistent in distinguishing performance between the groups.

Slide 38 goes back to the agenda. In the next few slides we want to review the steps that you need to take to obtain your group's report and show you how to share with us your feedback.

Before we go there, I want to turn the microphone back to Amanda Barnes with the Provider Communication Group in our Office of Communications, who works with the Medicare Learning Network, and she's going to take things from here. Amanda.

## Keypad Polling

Amanda Barnes: Thank you Mark. At this time, we will pause for a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there will be a few moments of silence while we tabulate the results. Selema, we're ready to start polling.

**Operator**: CMS appreciates that you minimize the government's teleconference expense by listening to these calls together using one phone line. At this time, please use your telephone keypad and enter the number of participants that are currently listening in.

If you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Once more, if you are the only person – the only person listening in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling. Please hold while we complete the polling. Please hold while we complete the polling.

And I will now turn the conference call back over to Amanda Barnes.

## Presentation continued

Amanda Barnes: Thank you Selema. And now we'll resume our presentation with Craig Caplan.

### Accessing Your Report

Craig Caplan: Thank you Amanda. We're on slide 39, which is – shows how to access your report – these are two slides of this. As a reminder, the 2012 Supplemental QRURs are distributed to medical group practices with over a hundred or more eligible professionals, or EPs. They are confidential and are not posted publicly. These data do not affect Medicare payments and are not used in the Value-Based Payment Modifier Program for the Medicare fee – Physician Fee Schedule, as I mentioned earlier.

Authorized representatives of group practices can view the Supplemental QRURs at https://portal.cms.gov, which is on the slide, the first bullet, using their Individual's Authorized Access to the CMS computers – Computer Services, or IACS, user ID, and

password. You will need an IACS account with either a primary or backup PV-PQRS group security official or PV-PQRS group representative role to access your group's report.

We're now on slide 40, continuing how to access your report. You can view your medical group's report on the web with the instructions on this slide. Exhibits 1, 2, and 4 can be downloaded as PDFs. The drill down tables can be downloaded as spreadsheets for further analysis. A quick reference guide on how to access the report and all supporting documentation can be found on the CMS webpage. You can get to the webpage by clicking on the hyperlink text on this slide and by doing – or by doing an Internet search for Supplemental QRUR. The documentation can be found at the bottom of the webpage under downloads. For questions about accessing your report, please call the Physician Value, or PV, help desk, which is staffed Monday through Friday, from 8 a.m. to 8 p.m. eastern time.

Slide 41, where this explains how to provide feedback. We at CMS are very interested in hearing from you suggestions on how we can improve our supplemental reports of quality and resource use.

Slide 42. This explains the process for giving feedback on the 2012 Supplemental QRURs. The episode of care work is an ongoing project and we welcome constructive feedback for making improvement. Some suggested topics are listed here. To submit written comments and suggestions on these topics, please email QRUR@cms.hhs.gov. Again, that's QRUR@cms.hhs.gov. Please be as specific as possible to help us incorporate your feedback in future reports. Please note that the email box is not frequently monitored and it is not an appropriate place to obtain help in accessing or interpreting your own group's confidential Supplemental QRUR. For questions of that nature, please contact the PV help desk, or Physician Value help desk. Information on the PV help desk was discussed previously in the accessing the report slide. In addition, when sending comments and questions, as a reminder, please do not post or email any person-level identifiers or other confidential information as stipulated by Federal Government regulations.

Slide 43. Further information about the reports is posted to the CMS webpage, episode grouping for Medicare and Supplemental Quality and Resource Use Reports, QRURs. This link is provided on this slide. This presentation and the addendum, which includes detailed summary statistics of the 2012 Supplemental QRURs, will also be posted on the CMS webpage. There's a wealth of information on the CMS webpage that is provided on the slide. Thank you for your time and attention. We look forward to working closely with you on our shared journey to an ever improving health care system.

Slide 44. We're now at the part where we want to hear from you, hear your feedback, or ask any questions you may have. Thank you very much for your time.

## Question-and-Answer Session

Amanda Barnes: Thank you Craig. Our subject matter experts will now take your questions about the 2012 Supplemental QRURs. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization.

In an effort to get to as many callers, we ask that you limit your question to just one. If you would like to ask a followup or have more than one question, you may press star 1 to get back into the queue. And we'll address additional question as time permits.

All right Selema, we're ready to take our first question.

**Operator:** To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

Your first question comes from the line of Therese Kaag.

Therese Kaag: Hi, I'd like to ask a question about the drill down tables. I've been experiencing issues with trying to export those to Excel. And while I have a case open with the help desk, I'm just curious to know if you had other feedback of users who are having the same issue that I might be having.

Craig Caplan: Hi, this is Craig Caplan. I think I'm going to try to hand this off to Anastasia Cooper, who's – she's with the PV help desk.

Anastasia Cooper: Hi, this is Anastasia. Yes, we actually do have your ticket and we're actually working towards a resolution. We're not sure why you're not able to export those GIF yet. And actually, after this call, I was going to put in a call to you. I needed some more information. So, you and I will speak a little bit further after this call is over, OK?

Therese Kaag: OK, great. So it does seem to just be isolated to me then instead of a known issue.

Anastasia Cooper: Well, we've had few issues. Mostly, it's just about how you're trying to export it. But we'll talk about it after this call. We'll do it offline.

Therese Kaag: Great, thank you so much.

Anastasia Cooper: You're welcome.

**Operator**: Your next question comes from the line of Jill Labelle.

Jill Labelle: Yes, I just wanted to clarify, the only people being able to see reports are going to be practices over 100?

Craig Caplan: Yes, for now. There are 1,236 groups of that size. But yes, those are the only groups that received the 2012 Supplemental QRURs.

Jill Labelle: So, if you're smaller than that, you just don't get a report period?

Craig Caplan: Not the 2012 Supplemental QRURs.

Jill Labelle: Thank you.

Craig Caplan: Yes.

**Operator**: The next question comes from the line of Debra Seyfried.

Debra Seyfried: Hi, thank you. On slide 30 you referenced the risk score for the patient. And I'm wondering where is that – how is that risk score calculated for the patient? What's the information that makes that up?

Craig Caplan: Hi, this is Craig. I think I'm going to pass this up to Acumen. Acumen is our contractor on the supplemental reports and some of the experts from the consult – that consultant are on the line.

Jay Bhattacharya: Hello, this is Jay Bhattacharya from Acumen. The way that we calculate the risk score is based on the predicted cost based on your – on the clinical conditions of your patients. It's a detailed methodology that's available in the appendix if you want to look – or in the supplemental materials if you want to look up. It – we also take into account the age of your patient. The – whether the patient's qualified for Medicare via ESRD or disability in some cases. And in some cases – and as well, if the patient was in long-term care in some cases.

So it's – the idea behind the risk score is to get as complete a picture as possible of how the patient is, the clinical condition of the patient at the time that the triggering episode happened.

Debra Seyfried: Does that have anything to do with the diagnosis at all?

Jay Bhattacharya: Yes, it does. So – well, it does not have anything to do with the triggering diagnosis, but it has to do with the comorbid conditions that exist at the time of the diagnosis or the time of the triggering event.

Debra Seyfried: OK.

**Operator**: Your next question comes from the line of Marissa Fermin.

Marissa Fermin: Hi, this is Marissa from the University of New Mexico. I assume a Data Use Agreement is needed. And I was just wondering how long we will have the data for before it needs to be disposed of?

Craig Caplan: What you're – I don't believe that you need – I think it's – you have to go through the PV portal. I don't believe you have to sign a DUA for this – for the 2012 Supplemental QRURs. Anastasia, do you want to – is there anything you can add to that? Is that correct?

Amanda Barnes: We'll have to get back to you. Could you actually send that question in to the resource box, the QRUR@cms?

Marissa Fermin: Sure.

Amanda Barnes: That would be great. Thank you so much.

Marissa Fermin: OK.

**Operator**: And the final question comes from the line of Elizabeth Handy.

Elizabeth Handy: Hi, this is Elizabeth Handy from Carolinas Healthcare in Charlotte, North Carolina. I just want to clarify one more time on, is it all TINs over 100 or just a select group, because we didn't see our – any of our reports out there and if not, who do we contact.

Craig Caplan: It's the same groups that received the main QRURs in the fall.

Elizabeth Handy: OK. So if we received those, we should have a supplemental report?

Craig Caplan: I believe so.

Elizabeth Handy: OK.

Craig Caplan: So, yes. I mean if you – yes.

Amanda Barnes: Yes. If you could send – that would be another good question to send through box as well, if you wouldn't mind. That way, we could …

Craig Caplan: Actually, I think it would be better to – if it's personal, then to call the PV help desk.

Amanda Barnes: OK.

Craig Caplan: This is about their group. The help – the email box is meant to be more general questions. So actually, if you could call the PV help desk which, you know, the information – the phone number is on the slide.

Amanda Barnes: Slide 40.

Craig Caplan: Yes, slide 40.

Amanda Barnes: Slide 40, ma'am.

Elizabeth Handy: All right. Thank you so much.

Amanda Barnes: You're welcome.

**Operator**: As a reminder, to ask an audio question, simply press star then the number 1. The next question comes from the line of Sharon McIlrath.

Sharon McIlrath: Hi, I was wondering – it's sort of the same question that someone just asked. The 1,236 groups are not all groups of 100 and more, they are groups that had enough patients attributed to meet that 20-patient minimum, is that correct? I mean, what was the universe of groups of 100?

Amanda Barnes: One second please.

Craig Caplan: Anastasia, do you – can you answer that question?

Anastasia Cooper: I was actually trying to go through some notes that I have here available looking to see if I could answer that question. If she would just call the Physician Value help desk after this call and ask for me, I'll be glad to get her information so I can research it and get back to her with an answer.

Sharon McIlrath: OK. And just as a followup, can you talk to us, are there any additional sort of plans that you have for evaluating – so, when you're looking at reliability, who fell out? I mean are there patterns in the people that, you know, look high or low? I mean just any sort of additional analysis that is going to be underway in terms of evaluating sort of who might get hurt, who might win, what some conclusions that we could draw about is consistent across every group? Or are there areas of the country, are there certain kinds of practices? You know, what happens when you have something where the site of service is the hospital outpatient department generally, because the group is affiliated with a hospital versus the practice where it isn't? I mean just – are there other kinds of – sort of statistical analysis that CMS is planning either with the episode-based QRURs or the others?

Craig Caplan: Hi, this is Craig. Well, thank you for your comment. The – there is an addendum that will be coming out that includes some reliability data. That will be posted soon on the CMS webpage, and as well as the MLN pages. That's …

Amanda Barnes: It should already be posted.

Craig Caplan: Yes, OK. It may already be posted. And, you know, if there – if you have …

Sharon McIlrath: Is that – that's different than this addendum that we had available today?

Craig Caplan: No, that is it. That's the one. If you have suggestions for additional analysis, I mean we'd certainly welcome it if you could send it to that QRUR, that Resource Use mailbox. I mean, we'd certainly welcome your ideas.

Sharon McIlrath: All right.

Craig Caplan: Thank you.

**Operator**: Your next question comes from the line of Stacy Witt.

Stacy Witt: Hello, I have a question on the Supplemental QRUR method drill down. When we have sections where there isn't any data, it doesn't even say NA, what does that mean?

Craig Caplan: Hi, this is Craig. Can I ask – I'm going to hand this off to Acumen to answer that question.

Stacy Witt: OK.

Craig Caplan: Thank you.

Camille Chicklis: Hi, this is Camille Chicklis from Acumen. That's a great question. So there are a couple instances in the drill down tables where you're going to see blank information. Are you saying that your entire row is blank or you're just seeing a blank in certain cells?

Stacy Witt: Like entire rows. For example, exhibit 2, you know, first we have the –all ACS, N = 0. There are NAs in a couple of those rows – I mean columns. But then when we come down to like inpatient hospital facility services and all those details and post-acute care, and those are all blank, there isn't an NA or anything in them. Are there – and I think it's the first couple of pages are like that – the first two pages at least for us.

Camille Chicklis: And you have episodes of that type?

Stacy Witt: I really have to …

Camille Chicklis: The only reason you should have blanks in those instances is if you had zero episodes of that given type, so the exhibits are structured by episode type. So if you have no episodes, you're still going to see the template for that episode type, but all the information will be blank.

Stacy Witt: So, it wouldn't say NA or zero, it would just be blank, correct?

Camille Chicklis: Yes, that is correct.

Stacy Witt: OK. And I believe that answers – there's like another section where it lists the top five EPs and that was also blank, that would be another scenario like that?

Camille Chicklis: Yes, that would also be the case. But if you have a specific question, feel free to contact us and we can pull your report in particular.

Stacy Witt: All right. Thank you.

**Operator**: Your next question comes from the line of Kathy Brady.

Kathy Brady: Hi, this is Kathy. I was just wondering – can you hear me?

Amanda Barnes: Yes, we can.

Kathy Brady: OK, great. When the 2013 QRUR reports may be available?

Amanda Barnes: One second please.

Craig Caplan: Hi, this is Craig. And right now, the plan is for next summer.

Kathy Brady: Really? I mean because there was just something from the MGMA that said …

Craig Caplan: Oh, I'm sorry. Are you talking about the Supplemental QRURs or the main QRURs?

Kathy Brady: Well, it's – which would – the ones that would preview our performance scores, used to calculate …

Craig Caplan: OK, OK. Yes, I'm sorry. That's later this summer. I'm sorry. Yes, 2013, the main. I was thinking the – I was answering as if you were asking about the Supplemental QRURs and I misunderstood. So, yes, it's later this summer.

Kathy Brady: OK. And they will be on the same web page as the 2012?

Craig Caplan: The PV portal?

Kathy Brady: Yes.

Craig Caplan: Yes, yes.

Kathy Brady: OK, great. Thank you.

Craig Caplan: You're welcome.

**Operator**: Your next question comes from the line of Scott Barrette.

Scott Barrette: Hi, this is Scott Barrette calling from Banner Health. I was just trying to figure out slide number 30, and I'm just having a hard time understanding it. What is that showing?

Craig Caplan: Hi, this is Craig. Do you – Acumen, do you want to answer that one since it's related to a similar question before?

Jay Bhattacharya: Sure, this is Jay Bhattacharya at Acumen. So the way to read slide number 30 is that it shows – this is one of the drill down tables. So it's showing at a patient level for your – for the beneficiary that you're – that had been attributed, what is the risk associated with that patient – for that patient.

So the first column that's highlighted shows the risk percentile and the episode subtype. So if that score is higher, that means that patient is more complex within that – within that subtype. The non-risk-adjusted cost shows the cost – the cost information. But then the third column, which is the risk-adjusted cost percentile in the major episode, it shows you for patients like that, what the risk-adjusted cost would be – the expected cost would be higher.

So the first row, the guy is very complicated because his score is 97, but you would have expected his score to be low. And then for the fourth column is the risk-adjusted cost percentile for the episodes nationally, so that shows you how, compared to the national average, the person actually ended up. So in this case, the guy would have expected that very high cost because he's 97 percentile, but in fact he ended up having very low cost, in the 6th percentile.

Scott Barrette: OK. So this is – it's by each patient then, not by doctor?

Jay Bhattacharya: I'm trying to remember exactly. But I believe that that's – I'm sorry, it's by doctor. That's right, it's by – no, it's by patient. It's by patient. Yes, I'm sorry. Yes, I looked back on the previous slide. But yes, it's by patient. So you can actually drill down for the – for each patient that's attributed to see, you know, what contribution each patient made relative to their expected cost.

Scott Barrette: OK. All right, thanks.

Camille Chicklis: Yes, this is Camille from Acumen. We had to kind of – we had some space constraints on the PowerPoint presentation, so you're only seeing a select part of the table. But when you look at the drill downs in full, you'll have at the far left information about each – about the beneficiary and episode. And each row is information for a single beneficiary's episode.

Scott Barette: OK, whereas if you look at Slide 29, it's by doctor, right?

Camille Chicklis: In this case, on slide 29, each row is still a single beneficiary and their episode. But the doctor that you're seeing is apparently the EP who is identified for the episode. So you might see repeats. I think in this example there aren't any repeats. But you could see the same doctor multiple times if they were identified as a current lead EP for multiple episodes.

Scott Barrette: OK, now that helps. Thanks.

Camille Chicklis: Thanks.

Dr. Mark Levine: Yes. And this is Mark Levine. To correlate between, let's say the expected utilization, the risk score, and the doctor, and to see whether or not a particular doctor had a different pattern of resource use, you'd need to combine information that is present in these tables in different ways. You can sort this by doctor in order to get all of the – of a particular EP – attributed EP or lead EP's, patients. But that's why you need to export the file and manipulate it in order to be able to look at it on a physician-specific level. You can do that internally to yourself. The report is not natively presented in that manner.

Scott Barrette: OK.

Amanda Barnes: Thank you.

**Operator**: And the final question comes from the line of Judith Kutler.

Judith Kutler: Yes. We wanted to know if there are similar reports that are created for groups that are less than 100 providers.

Craig Caplan: Hi, this is Craig. No, these – the 2012 Supplemental QRURs are only for groups with 100 or more EPs.

Judith Kutler: Will they ever have reports – when will they have reports that are created for smaller groups?

Craig Caplan: We have – we're still – that's undetermined right now in terms of like how, you know, we – the next iteration, the 2013 Report. So more details to come.

Judith Kutler: All right, thank you.

Craig Caplan: All right.

**Operator**: And there are no further questions at this time.

## Additional Information

Amanda Barnes: Thank you Selema. We're going to wrap up our call today. An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We will release an announcement in the MLN Connects Provider eNews when these are available.

On slide 46 of the presentation you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous and confidential and voluntary. We hope you will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Amanda Barnes and I'd like to thank our presenters and also thank you for participating in today's MLN Connects Call on How to Interpret Your 2012 Supplemental Quality and Resource Use Report.

Have a great day everyone.

**Operator:** This concludes today's call. Presenters, please hold.

**-END-**