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National Provider Call

Review of the 2014 Mid-Year Quality and Resource Use Reports

June 3, 2015

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Agenda and Learning Objectives

- Overview of the 2016 Value-Based Payment Modifier
- Overview of the 2014 Mid-Year QRUR
- Access the 2014 Mid-Year QRUR
- Information Contained in the 2014 Mid-Year QRUR
- Question and Answer Session

Overview of the 2016 Value-Based Payment Modifier

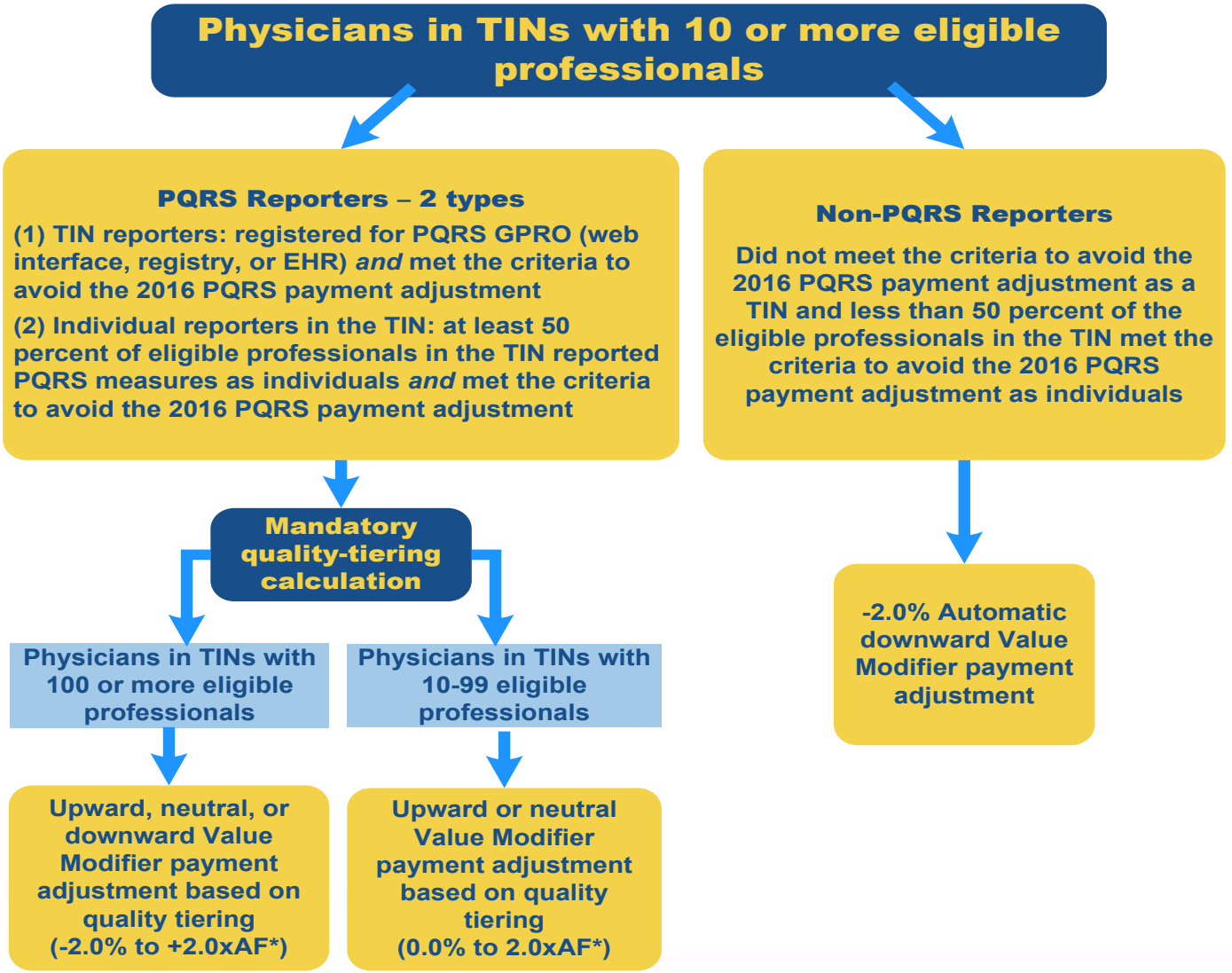
What is the Value-Based Payment Modifier (VM)?

- The VM assesses both the quality of care furnished and the cost of that care during a given performance period.
- The VM is an adjustment made on a per-claim basis to Medicare payments for items and services furnished under the Medicare Physician Fee Schedule (PFS).
  - Average/High Quality – Average/Low Cost groups and solo practitioners can qualify for upward adjustments.
  - Low/Average Quality – Average/High Cost groups and solo practitioners, including those that fail to satisfactorily report under the Physician Quality Reporting System (PQRS), are subject to downward adjustments.
- The VM is applied at the Taxpayer Identification Number (TIN) level and applies to all physician groups and solo practitioners billing under the TIN.

What is an Eligible Professional?

- Physician
  - Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Dental Surgery, Doctor of Dental Medicine, and Doctor of Chiropractic
- Practitioner
  - Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant), Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, and Audiologist
- Therapist
  - Physical Therapist, Occupational Therapist, and Qualified Speech-Language Therapist

Overview of the 2016 VM and the 2014 PQRS



Overview of the 2014 Mid-Year QRUR

What is the 2014 Mid-Year QRUR?

- The 2014 Mid-Year QRUR, disseminated in April 2015, provides interim information to TINs about their performance on three quality outcome and six cost measures that CMS calculates directly from Medicare claims, based on care provided and claims billed from July 1, 2013 through June 30, 2014.
- The following data are not included:
  - Information about the 2016 VM payment adjustment,
  - Quality and cost composite scores for the 2016 VM, and
  - Quality measures data reported under the PQRS.
- The report is for informational purposes only and it will not affect your TIN's payments under the Medicare PFS.
- Physician solo practitioners and physician groups should use the data presented in this report to identify opportunities to improve the quality and efficiency of the care they deliver.

What is the 2014 Annual QRUR?

- The 2014 Annual QRUR, disseminated in the fall of 2015, will provide information on your TIN's performance on all available quality and cost measures used to calculate the 2016 VM.
- Calendar year 2014 is the performance period for the VM in 2016.
- For physicians in TINs with 10 or more eligible professionals, the Annual QRUR will provide information on how the TIN's quality and cost performance will affect their Medicare payments in 2016.

Who Received a 2014 Mid-Year QRUR?

- All TINs (groups and solo practitioners) nationwide that met the following two criteria received a full-length 2014 Mid-Year QRUR:
  - At least one physician was in the TIN between July 1, 2013 and June 30, 2014, and
  - The TIN had at least one eligible case for at least one quality or cost measure included in the Mid-Year QRUR.
- TINs not meeting both of the above criteria received a one-page 2014 Mid-Year QRUR.
- Physician solo practitioners and groups of physicians who participated in the Medicare Shared Savings Program (MSSP), the Pioneer Accountable Care Organization (ACO) model, or the Comprehensive Primary Care (CPC) initiative in 2014 will also receive a 2014 Mid-Year QRUR.

Access the 2014 Mid-Year QRUR

How Can I Access My Report?

- You can access a QRUR on behalf of a group or solo practitioner (as identified by TIN) at https://portal.cms.gov.
- QRURs are provided for each TIN.
- First, you or one person from your TIN will need to obtain an Individuals Authorized Access to the CMS Computer Services (IACS) account with the correct role.
- For TINs with two or more eligible professionals:
  - PV-PQRS Group Security Official (primary or back-up)
  - PV-PQRS Group Representative
- For solo practitioners (TINs with one eligible professional):
  - PV-PQRS Individual (primary or back-up)
  - PV-PQRS Individual Representative
- Refer to the "How to Obtain a QRUR" webpage http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html

How Can I Access My Report? (continued)

1. Navigate to the CMS Enterprise Portal via https://portal.cms.gov.
2. Select “Login to CMS Secure Portal”, accept the “Terms and Conditions” and enter your IACS user ID and password to login.
3. Select the “PV-PQRS” tab, and the “QRUR-Reports” option.
4. Select a “Year” and desired “Report”.
5. Complete your role attestation.
6. Select your TIN.

Information Contained in the 2014 Mid-Year QRUR

What Information is Contained in the 2014 Mid-Year QRUR?

Mid-Year QRUR Report Section	Exhibit	Use the Information in the Report to:
Cover Page	-	Understand why you received a 2014 Mid-Year QRUR
About the Data in this Report	-	Read a summary of the report methodology and retrieve links to supplementary exhibits and glossary items (if viewing the report dashboard)
Eligible Professionals Billing to Your Taxpayer Identification Number (TIN)	1	Understand how many eligible professionals billed under your TIN during the performance period
Attribution of Medicare Beneficiaries and Episodes to Your TIN	2-4	Understand how Medicare FFS beneficiaries and episodes of hospital care were attributed to your TIN
Performance on Quality	5	Review your performance on the three, CMS-calculated outcome measures
Hospitals Admitting Your Patients	6	Identify the hospitals that accounted for at least five percent of your attributed beneficiaries' inpatient stays during the performance period
Performance on Costs	7-8	Review your performance on costs across two performance categories, and understand the dollar difference between your attributed beneficiaries' payment-standardized and risk-adjusted per capita costs, by category, and the corresponding costs for your peer group for the Per Capita Costs for All Attributed Beneficiaries measure

Note: All references to "episodes" in this presentation indicate episodes of hospital care for the Medicare Spending per Beneficiary measure.

What Additional Supporting Information Is Available in the Supplementary Exhibits?

Report Section	Supplementary Exhibit	Use the Information in the Supplementary Exhibit to:
Physicians and Non-Physician Eligible Professionals Billing Under Your TIN, Selected Characteristics	1	Understand how many eligible professionals billed under your TIN during the performance period
Beneficiaries Attributed to Your TIN and the Care that You and Others Provided and Costs of Services Provided by You and Others	2A, 2B	Understand which attributed beneficiaries are driving your TIN's cost measures and identify those beneficiaries that are in need of greater care coordination
Beneficiaries Included in the Per Capita Costs for All Attributed Beneficiaries Cost Measure: Hospital Admissions for Any Cause	3	Understand which beneficiaries are driving your TIN's performance on the three hospital-related, claims-based quality outcome measures
Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure	4	Understand which attributed beneficiaries were attributed to your TIN for the Medicare Spending per Beneficiary (MSPB) measure
Per Capita Costs, by Categories of Service, for the Per Capita Costs for All Attributed Beneficiaries Measure	5	Review a categories of service breakdown for the beneficiaries attributed to your TIN for the Per Capita Costs for All Attributed Beneficiaries measure

Note: All references to "episodes" in this presentation indicate episodes of hospital care for the Medicare Spending per Beneficiary measure.

Information on Your Attributed Beneficiaries and MSPB Episodes of Hospital Care

Exhibit 1. Eligible Professionals Billing to Your TIN

- Exhibit 1 shows the number and percentage of physicians and non-physician eligible professionals billing to your TIN. This number is determined by claims submitted to Medicare under your TIN during the performance period.

Review the eligible professional composition of your TIN

Exhibits 2 and 3. Attribution of Medicare Beneficiaries to Your TIN

- For five of the cost measures and the three quality outcome measures, Medicare beneficiaries are attributed to a TIN using a two-step methodology.
  - Step 1: Assign a beneficiary to a TIN if the beneficiary receives the plurality of primary care services, as measured by allowable charges, from primary care physicians within the TIN.
  - Step 2 (for beneficiaries who did not receive a primary care service from a primary care physician during the performance period): Assign a beneficiary to a TIN if the beneficiary received a plurality of the primary care services from specialist physicians, nurse practitioners, physician assistants, and clinical nurse specialists within the TIN.
  - Primary care services include evaluation and management visits in an office, other outpatient services, skilled nursing facility services, and those services rendered in home settings.
  - Primary care physicians include Family Practice, Internal Medicine, General Practice, and Geriatric Medicine specialty codes.
- Note that this is **not** the same methodology utilized to attribute beneficiaries to TINs for the Medicare Spending per Beneficiary measure.

Exhibits 2 and 3. Attribution of Medicare Beneficiaries to Your TIN (continued)

- Exhibit 2 includes information on the number of beneficiaries attributed to your TIN and the basis for their attribution.
- Exhibit 3 provides information on services provided to your attributed beneficiaries.

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

Basis for Attribution	Number	Percentage
Step 1 — All attributed beneficiaries	383	100.00%
Step 2 — Beneficiaries attributed because your primary care physicians provided the most primary care services	151	39.43%
Beneficiaries attributed because your specialist physicians or non-physician practitioners provided the most primary care services	232	60.57%

Review the proportion of beneficiaries attributed during each step

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

Primary Care Services for Attributed Beneficiaries	Average Number	Average Percentage
Primary care services provided to each attributed beneficiary	6	100.00%
Provided by physicians or non-physician practitioners in your TIN	5	82.41%
Provided by physicians or non-physician practitioners outside of your TIN	2	17.59%

Understand the degree to which your attributed beneficiaries received care from eligible professionals outside of your TIN during the performance period

Exhibit 4. Attribution of Medicare Spending per Beneficiary Episodes to Your TIN

- Exhibit 4 provides information on the total episodes of hospital care attributed to your TIN, and the number of unique Medicare FFS beneficiaries associated with the attributed episodes for the Medicare Spending per Beneficiary measure.
- A hospitalization episode is attributed to a TIN if, during the hospitalization, the TIN provided more Part B-covered services (as measured by Medicare-allowable charges) to that beneficiary during the hospitalization than any other TIN.

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

Hospital Episodes and Beneficiaries	Number
Total episodes of hospital care attributed to your TIN	772
Unique Medicare beneficiaries associated with attributed episodes of care	672

Review your attributed Medicare Spending per Beneficiary episodes

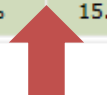
Quality Performance Section of the Mid-Year QRUR

Exhibit 5. Performance on Quality

- CMS-1, CMS-2, and CMS-3 are risk-adjusted quality outcome measures calculated by CMS using administrative claims data.
- Lower performance rates on these measures indicate better performance.
- The peer group for the quality measures is all TINs nationwide with at least 20 eligible cases for each quality measure.

Exhibit 5. CMS-Calculated Outcome Measure Performance

Performance Category	Measure Number	Measure Name	Your Eligible Cases	Your Performance Rate	Benchmark	Benchmark −1 Standard Deviation	Benchmark +1 Standard Deviation
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care Sensitive Conditions	CMS-1	**Acute Conditions Composite**	383	12.02	7.53	1.81	13.24
	-	Bacterial Pneumonia	383	16.89	11.20	1.76	20.63
	-	Urinary Tract Infection	383	13.35	7.25	0.00	15.08
	-	Dehydration	383	6.08	4.10	0.00	8.58
	CMS-2	**Chronic Conditions Composite**	142	0.00	50.43	26.19	74.66
	-	Diabetes (composite of 4 indicators)	56	0.00	18.07	0.00	38.07
	-	Chronic Obstructive Pulmonary Disease (COPD) or Asthma	24	0.00	70.23	25.43	115.03
	-	Heart Failure	90	0.00	99.75	48.72	150.77
Hospital Readmissions	CMS-3	**All-Cause Hospital Readmissions**	64	18.16%	15.94%	14.55%	17.34%



Compare your quality outcome performance to that of your peers nationwide

Information on the Hospitals Admitting Your Attributed Beneficiaries

Exhibit 6. Hospitals Admitting Your Patients

- Exhibit 6 identifies the hospitals where at least five percent of your attributed beneficiaries' inpatient stays occurred.
- Information about the quality of care at these hospitals can be found at http://www.hospitalcompare.hhs.gov.

Exhibit 6. Hospitals Admitting Your Medicare Beneficiaries

Hospital Name	Hospital CMS Certification Number	Hospital Location	Number of Stays	Percentage of All Stays
Total			214	**100%**
BFYJWGZWD MTXQNYFQ	434449	BFYJWGZWD, HY	71	33.18%
QFSGZWD MTXQNYFQ	434455	QFSGZWD, HY	53	24.77%
XY QNSHJSY'X RJQNHFQ HJSYJW	434471	GWNQLJQTWY, HY	27	12.62%
DFQJ-SJB MFQJS MTXQNYFQ	434477	SJB MFQJS, HY	23	10.75%

Understand which hospitals most frequently admitted your attributed beneficiaries

Review the number of your attributed beneficiaries' inpatient stays at these hospitals

Cost Performance Section of the Mid-Year QRUR

Exhibit 7. Performance on Costs

- Costs data for the Per Capita Costs for All Attributed Beneficiaries measure and the four Per Capita Costs for Beneficiaries with Specific Conditions measures are based on payments for Medicare Parts A and B claims submitted by all providers for Medicare beneficiaries attributed to a TIN for a given measure.
- For the Medicare Spending per Beneficiary measure, per episode costs are based on Parts A and B expenditures surrounding specified inpatient hospital stays (3 days prior to admission through 30 days post-discharge).
- Part D-covered prescription drug costs are not included.
- All cost measures have been payment-standardized, risk-adjusted, and adjusted for the TIN's mix of medical specialties (specialty-adjusted).
- The peer group for the cost measures is all TINs nationwide with at least 20 eligible cases for each cost measure.

Exhibit 7. Performance on Costs (continued)

- Exhibit 7 shows the payment-standardized, risk-adjusted, and specialty-adjusted per capita or per episode costs for the beneficiaries attributed to your TIN.

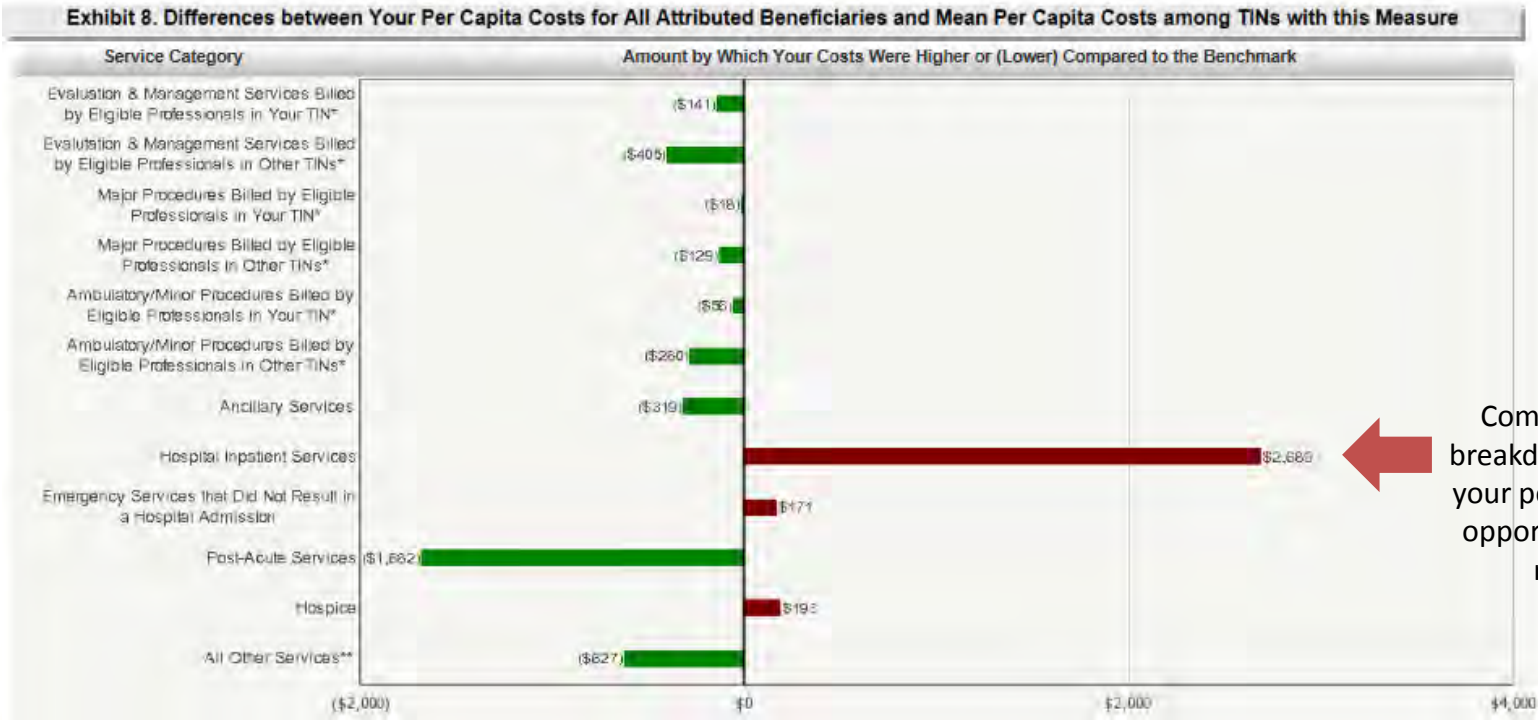
Exhibit 7. Per Capita Costs for Your Attributed Medicare Beneficiaries

Performance Category	Cost Measure	Your Eligible Cases or Episodes	Your Per Capita or Per Episode Costs	Benchmark	Benchmark – 1 Standard Deviation	Benchmark + 1 Standard Deviation
Per Capita Costs for All Attributed Beneficiaries	All Beneficiaries	354	$11,126	$11,135	$7,962	$14,309
	Medicare Spending per Beneficiary	772	$20,232	$20,339	$18,651	$22,026
Per Capita Costs for Beneficiaries with Specific Conditions	Diabetes	54	$17,785	$16,149	$11,243	$21,055
	Chronic Obstructive Pulmonary Disease (COPD)	17	$25,805	$25,179	$17,269	$33,088
	Coronary Artery Disease (CAD)	36	$23,095	$18,357	$12,780	$23,934
	Heart Failure	82	$15,686	$28,115	$19,188	$37,041

Compare your cost performance to that of your peers

Exhibit 8. Performance on Costs

- Exhibit 8 shows the difference between the per capita costs of specific services for beneficiaries attributed to your TIN and the mean among all TINs in your peer group.
- Green bars correspond to service categories for which your attributed beneficiaries' per capita costs were lower than those of your peers; red bars correspond to service categories for which costs were higher.



Compare your cost breakdowns to those of your peers and identify opportunities for cost reductions

Additional Information Contained in the Mid-Year QRUR

Supplementary Exhibit 1. Physicians and Non-Physician Eligible Professionals Billing Under Your TIN, Selected Characteristics

- Supplementary Exhibit 1 provides a listing of the eligible professionals in your TIN during the performance period.
- These data can be used to verify the eligible professional counts in Mid-Year QRUR Exhibit 1.

NPI	Name	Physician†	Non-Physician Eligible Professional†	Specialty Designation†
#	John Doe	-	X	Licensed Clinical Social Worker
#	John Smith	X	-	Internal Medicine

Verify the eligible professionals billing under your TIN and the data in Mid-Year QRUR Exhibit 1

Verify your eligible professionals' specialty designations

Identified via PECOS†	Identified via Billings†	Date of Last Claim Billed Under TIN
X	X	06/24/2014
X	X	05/30/2014

Understand how CMS determined eligible professional affiliation with your TIN

Confirm the date of the last claim billed by a given eligible professional

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

- Supplementary Exhibit 2A provides information about the Medicare beneficiaries attributed to your TIN.
- You can use these data as a starting point for examining systematic ways to improve and maintain delivery of high-quality and efficient care to beneficiaries.

Beneficiaries Attributed to Your TIN							Medicare FFS Claims Filed by Your TIN		
HIC	Gender	DOB	Index†	HCC Percentile Ranking†	Died during the Performance Period	Basis for Attribution†	Date of Last Claim Filed by TIN	Number of Primary Care Services† Provided by TIN	Percent of Primary Care Services† Billed by TIN
#	M	04/13/1939	#	#	X	Step 1	04/09/2014	#	#.##%
-	-	-	-	-	-	-	-	-	-

Verify the beneficiaries attributed to you

Identify those beneficiaries who received most of their services outside of your practice

Supplementary Exhibit 2A. Beneficiaries Attributed to Your TIN and the Care that You and Others Provided (continued)

- You can use the data in this exhibit to identify the services your TIN furnished to these beneficiaries and identify the beneficiaries who are receiving the plurality of their primary care services from a physician or non-physician eligible professional under your TIN.
- Check the information in the column titled “Date of Last Claim Filed by TIN” to make sure that CMS captured this information correctly.

EP in TIN Billing Most Primary Care Services†				EP in TIN Billing Most Non-Primary Care Services†			
NPI	Name	Specialty	Date of Last Claim Filed by NPI	NPI	Name	Specialty	Date of Last Claim Filed by NPI
#	Joe Davis	Geriatric Medicine	04/09/2014	#	Jane Davis	Vascular Surgery	04/09/2014

Review information about the eligible professionals in your TIN providing the most primary and non-primary care services to your attributed beneficiaries

Verify claims information

Supplementary Exhibit 2A. Beneficiaries Attributed to Your TIN and the Care that You and Others Provided (continued)

- Supplementary Exhibit 2A displays the eligible professionals outside your TIN who billed the most primary care services and non-primary care services for each beneficiary. These data offer an opportunity to talk with your beneficiaries to better understand their full range of health care needs and the additional services they receive.
- You can also use the exhibit to identify individual beneficiaries with chronic conditions who may benefit from improved chronic-illness management.

EP Outside of TIN Billing Most Primary Care Services†				EP Outside of TIN Billing Most Non-Primary Care Services†				Hospital Admission	Chronic Condition Subgroup†			
NPI	Name	Specialty	Date of Last Claim Filed by NPI	NPI	Name	Specialty	Date of Last Claim Filed by NPI	Date of Last Hospital Admission	Diabetes	Coronary Artery Disease	Chronic Obstructive Pulmonary Disease	Heart Failure
#	Joe Brown	Family Medicine	04/09/2014	#	Jane Brown	Gastroenterology	04/09/2014	04/09/2014	-	◇	-	-
-	-	-	-	-	-	-	-	-	-	-	-	-

Review information about the eligible professionals outside of your TIN providing the most primary and non-primary care services to your attributed beneficiaries

Determine if beneficiaries were included in any of the per capita costs measures for beneficiaries with specific conditions

Supplementary Exhibit 2B. Costs of Services Provided by You and Others

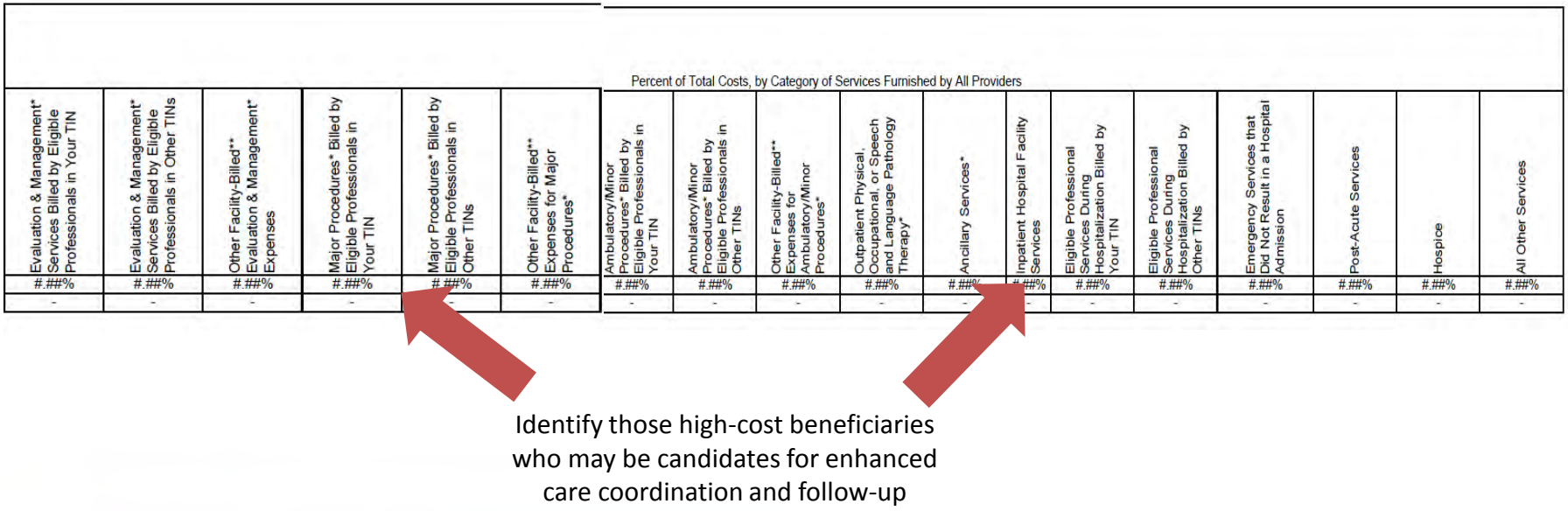
- Supplementary Exhibit 2B provides information about the costs of the care provided to the Medicare beneficiaries attributed to your TIN (as shown in Supplementary Exhibit 2A).
- It provides both the patient's total payment-standardized FFS Medicare costs and the distribution of these costs across categories of service.

Beneficiaries Attributed to Your TIN				Included in Per Capita Costs for All Attributed Beneficiaries Measure†	Total Payment-Standardized† Medicare FFS Costs
HIC	Gender	DOB	Index†		
#	M	04/13/1939	#	◇	$
-	-	-	-	-	-

Identify your cost drivers

Supplementary Exhibit 2B. Costs of Services Provided by You and Others (continued)

- You can use this information (as well as the information in Supplementary Exhibit 3 about the hospitals admitting your attributed beneficiaries) to learn general information about the types of services used by specific patients.
- By reviewing your own records and the records of hospitalizations, you can determine, for specific patients, the services you provided and the hospital-based services administered by providers outside your TIN.



						Percent of Total Costs, by Category of Services Furnished by All Providers											
Evaluation & Management* Services Billed by Eligible Professionals in Your TIN	Evaluation & Management* Services Billed by Eligible Professionals in Other TINs	Other Facility-Billed** Evaluation & Management* Expenses	Major Procedures* Billed by Eligible Professionals in Your TIN	Major Procedures* Billed by Eligible Professionals in Other TINs	Other Facility-Billed** Expenses for Major Procedures*	Ambulatory/Minor Procedures* Billed by Eligible Professionals in Your TIN	Ambulatory/Minor Procedures* Billed by Eligible Professionals in Other TINs	Other Facility-Billed** Expenses for Ambulatory/Minor Procedures*	Outpatient Physical, Occupational, or Speech and Language Pathology Therapy*	Ancillary Services*	Inpatient Hospital Facility Services	Eligible Professional Services During Hospitalization Billed by Your TIN	Eligible Professional Services During Hospitalization Billed by Other TINs	Emergency Services that Did Not Result in a Hospital Admission	Post-Acute Services	Hospice	All Other Services
#.##%	#.##%	#.##%	#.##%	#.##%	#.##%	#.##%	#.##%	#.##%	#.##%	#.##%	#.##%	#.##%	#.##%	#.##%	#.##%	#.##%	#.##%
-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Identify those high-cost beneficiaries who may be candidates for enhanced care coordination and follow-up

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

- Supplementary Exhibit 3 provides details about your attributed patients' hospitalizations over the performance period.
- Data are broken down by patient and the admitting hospital, along with the principal diagnosis associated with the admission.
- Note: This table does **not** include hospitalizations with a primary diagnosis of alcohol or substance abuse.

Attributed Beneficiaries Admitted to the Hospital			
HIC	Gender	DOB	Index†
#	F	04/01/1939	#
-	-	-	-

Verify the beneficiaries attributed to your TIN

Supplementary Exhibit 3. (continued)

- Supplementary Exhibit 3 also shows whether the hospital admission was the result of an emergency department evaluation, an ambulatory care sensitive condition, or a readmission within 30 days of prior admission. This exhibit also indicates the date of discharge and the subsequent care environment.
- You can link the data in Supplementary Exhibit 3 with data in Supplementary Exhibit 2B, using the "Index" column, to understand the overall scope of services that a patient admitted to the hospital has been receiving.

Identify preventable hospital admissions

Understand where beneficiaries were discharged

Characteristics of Hospital Admission									Discharge Disposition	
Date of Admission	Admitting Hospital				Principal Diagnosis†		Admission Via the ED	ACSC Admission†	Followed by Unplanned All-Cause Readmission within 30 Days of Discharge†	Date of Discharge	Discharge Status†
06/12/2014	Name	CMS Certification Number	City	State	481	Pneumococcal Pneumonia	X	PNEU	◇	06/19/2014	3 Disch to SNF
-	-	-	-	-	-	-	-	-	-	-	-

Verify the data in Mid-Year QRUR Exhibit 6

Identify which diagnoses were the basis for hospitalization

Identify hospital readmissions

Supplementary Exhibit 4. Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary (MSPB) Measure

- Supplementary Exhibit 4 displays information on the beneficiaries attributed to your TIN for the MSPB measure.
- Data are presented at the beneficiary-episode level; if a beneficiary has more than one episode that was eligible for the MSPB measure, he or she will appear in the exhibit for each episode.

Displays the total of Medicare Part A and Part B billings from all groups over the period, starting from 3 days before the index admission through 30 days after discharge

Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary Measure				Apparent Lead Eligible Professional				Characteristics of Hospital Admission						
HIC	Gender	DOB	Index†	NPI	Name	Specialty	Total Payment-Standardized Episode Cost†	Date of Admission	Admitting Hospital				Principal Diagnosis†	
									Name	CCN	City	State		
#	F	04/01/1939	#	#	Ted Jones	Cardiology	$	02/14/2014	-	-	-	-	481	Pneumococcal Pneumonia
-	-	-	-				-	-	-	-	-	-	-	-

Identify the eligible professional associated with the plurality of the episode's Medicare Part B costs

Understand where beneficiaries were hospitalized

Identify which diagnoses were the basis for hospitalization

Supplementary Exhibit 4. Beneficiaries Attributed to Your TIN for the Medicare Spending per Beneficiary (MSPB) Measure (continued)

- The data presented in the columns below help you to understand the distribution of costs associated with your patients’ hospitalizations. High costs in some of the cost categories presented in Supplementary Exhibit 4 may suggest ways to improve your performance on the MSPB measure.
- Note: This table does **not** include hospitalizations with a primary diagnosis of alcohol or substance abuse.

Discharge Disposition			Medicare Spending per Beneficiary, by Category of Service Furnished by All Providers																					
Date of Discharge	Discharge Status†		Evaluation and Management Services*	Major Procedures and Anesthesia*	Ambulatory/ Minor Procedures*	Outpatient Physical, Occupational, or Speech and Language Pathology Therapy*	Ancillary Laboratory, Pathology, and Other Tests	Ancillary Imaging Services	Durable Medical Equipment and Supplies	Inpatient Hospital: Trigger	Inpatient Hospital: Readmission	Physician Services During Hospitalization	ER Evaluation & Management Services	ER Procedures	ER Laboratory, Pathology, and Other Tests	ER Imaging Services	Home Health	Skilled Nursing Facility	Inpatient Rehabilitation or Long-Term Care Hospital	Hospice	Ambulance Services	Chemotherapy and Other Part B-Covered Drugs	Dialysis	All Other Services Not Otherwise Classified
03/01/2014	3	Disch to SNF	$	$	$	$	$	$	$	$	$	$	$	$	$	$	$	$	$	$	$	$	$	$
-	-	-																						

Understand where beneficiaries were discharged

Identify those high-cost beneficiaries who may be candidates for enhanced care coordination and follow-up

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

- Similarly to Supplementary Exhibit 2B, Supplementary Exhibit 5 displays your attributed beneficiaries' costs for various types of services performed by providers both within and outside your TIN.
- The exhibit shows the percentage of your TIN's attributed beneficiaries using a service in a given category; your payment-standardized, risk-adjusted per capita costs; and the difference between your beneficiary per capita costs and the per capita costs of your peers.

Service Category	Number of Your Attributed Beneficiaries Using any Service in this Category	Percentage of Your Attributed Beneficiaries Using any Service in this Category	Per Capita Costs for Your Attributed Beneficiaries	Benchmark Percentage of Beneficiaries Using Any Service in This Category	Benchmark Per Capita Costs	Amount by Which Your Costs Were Higher or (Lower) Compared to the Benchmark
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	#,###	#.##%	$##,###	#.##%	$##,###	$/($)
Evaluation & Management Services Billed by Eligible Professionals	#,###	#.##%	$##,###	#.##%	$##,###	$/($)
Billed by Your TIN						
Primary Care Physicians						
Medical Specialists						
Surgeons						
Other Eligible Professionals						
Billed by Other TINs						
Primary Care Physicians						
Medical Specialists, Surgeons, and Other Eligible Professionals						
Other Facility-Billed Evaluation & Management Expenses*						
Major Procedures Billed by Eligible Professionals						
Billed by Your TIN						
Primary Care Physicians						
Medical Specialists						
Surgeons						
Other Eligible Professionals						
Billed by Other TINs						
Primary Care Physicians						
Medical Specialists, Surgeons, and Other Eligible Professionals						
Other Facility-Billed Expenses for Major Procedures*						

Understand how care provided outside of your control is contributing to beneficiaries' costs (Costs reflect care furnished by all providers)

Determine which costs contributed most to your TIN's performance on this measure

Understand the detailed services that influence the data in Mid-Year QRUR Exhibit 8

Next Steps: What You Can Do

- Decide whether and how to participate in the PQRS in 2015:
  - Group Reporting: Register for the 2015 PQRS GPRO between **April 1, 2015 and June 30, 2015:** http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html
  - Individual reporting: No registration necessary.
- Choose a PQRS reporting mechanism and become familiar with the measures and data submission time frames: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_2015_Measure-List_111014.zip
- Review quality measure benchmarks under the VM: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
- Download your 2013 QRUR and 2014 Mid-Year QRUR now, and 2014 Annual QRUR (Fall 2015) at https://portal.cms.gov and http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html

Technical Assistance Information

- For QRUR and VM questions, contact the Physician Value Help Desk:
  - Phone: 1-888-734-6433 (select option 3)
  - Monday – Friday: 8:00 am – 8:00 pm EST
- For PQRS and IACS questions, contact the QualityNet Help Desk:
  - Phone: 1-866-288-8912 (TTY 1-877-715-6222)
  - Monday – Friday: 8:00 am – 8:00 pm EST
  - Email: qnetsupport@hcqis.org
- 2014 QRUR: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html
- How to Obtain a QRUR: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html
- VM Program: http://www.cms.gov/PhysicianFeedbackProgram
- PQRS Program: http://www.cms.gov/PQRS

Acronyms in this Presentation

- ACO: Accountable Care Organization
- CPC: Comprehensive Primary Care
- FFS: Fee-for-Service
- GPRO: Group Practice Reporting Option
- IACS: Individuals Authorized Access to the CMS Computer Services
- MSPB: Medicare Spending per Beneficiary
- MSSP: Medicare Shared Savings Program
- PFS: Physician Fee Schedule
- PQRS: Physician Quality Reporting System
- QRUR: Quality and Resource Use Report
- TIN: Taxpayer Identification Number
- VM: Value-Based Payment Modifier

Question & 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 is being evaluated by CMS for CME and CEU continuing education credit. For more information about continuing education credit, review the *CE Activity Information & Instructions* document available at the link below for specific details:

http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/TC-L06032015-Marketing-Materials.pdf

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®, please visit http://cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html.