MLN Connects®

National Provider Call

How to Interpret Your 2014 Supplemental Quality and Resource Use Report (QRUR)

October 15, 2015

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Agenda

- Introduction
- CMS' Approach to Episode-Based Measures
- Understanding Your 2014 Supplemental Quality and Resource Use Report (QRUR)
- Accessing the Reports
- Giving Feedback
- Questions and Answers

Introduction to the 2014 Supplemental QRURs

- Distributed to all medical group practices and solo practitioners with at least one 2014 Supplemental QRUR episode
  - Confidential and for informational purposes
- Supplement the per capita total cost and quality information provided in the 2014 QRURs
- Examine Medicare fee-for-service patients only
- Contain a total of 64 reported episode types
  - Acute condition episodes
  - Procedure-based episodes

Introduction to Episode-Based Measures

- Episode-based measures
  - Organize medical claims into clinically relevant units for analysis
  - Provide actionable information on resource use
  - Can be linked to meaningful outcomes
  - Can be used to improve care
- Medicare-specific episodes address complexity of Medicare patients and Medicare's unique payment rules

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Why CMS is Developing Episode-Based Measures

- CMS' three-part quality strategy includes the following aims:
  - Better care
  - Better health
  - Affordable care
- Include in physician feedback reports, specifically the Supplemental QRURs
- Introduce and gain stakeholder feedback on episode-based measures

How CMS Will Use Episode-Based Measures

- Development and reporting of episode-based measures include:
  1. Constructing episodes
  2. Attributing episodes to managing medical group practice or solo practitioner
  3. Reporting episodes in the Supplemental QRURs
- The following slides will provide more details for each step

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- CMS' Approach to Episode-Based Measures
  1. Construct Episodes
  2. Attribute Episodes
  3. Report Episodes
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Basic Model of an Episode *(1 of 3)*

- Resource use measure
  - Includes the set of services provided to diagnose, treat, manage, and follow-up on a specified clinical condition
- Three construction steps:
  1. Begin episode
  2. Group clinically relevant services and procedures
  3. End episode

Basic Model of an Episode *(2 of 3)*

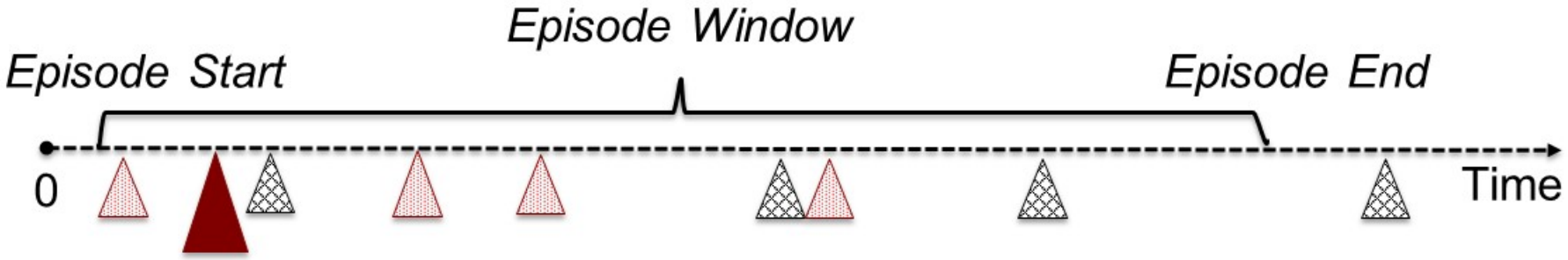
1. Begin episode
   - A trigger event that is identified by certain procedure or diagnosis codes on certain types of claims that indicate the presence of the index condition/procedure
2. Group clinically relevant services and procedures
   - Services that occur during the episode time period and are identified as clinically related to episode
     - Some episodes include services and procedures occurring a few days prior to the trigger event
3. End episode
   - A break in service, or
   - A fixed time period after the trigger event

Basic Model of an Episode *(3 of 3)*

Trigger Event (Step 1)

Clinically Relevant Service Grouped to Episode (Step 2)

Service Not Grouped to Episode



Clinically Relevant Services

- Clinical reviewers identified rules to assign relevant services to each episode type
- Types of services often considered as relevant:
  - treatments
  - care for typical signs and symptoms
  - complications of the condition itself or its usual treatments
  - diagnostic tests
  - post-acute care

Episode Grouping Methodologies

- Two methods are used to build episodes
  - Method A is used for 28 episode types, and Method B is used for 36 episode types
- Both methods group clinically relevant services to episodes within a specified length of time
  - Method A identifies clinically relevant services based on a hierarchy of rules that account for interactions between sets of diagnosis and procedure codes as well as interactions between episodes
  - Method B defines clinically relevant services as those services delivered by the managing provider and other services ruled clinically relevant by clinicians
- Information about the grouping algorithms can be found in the *Detailed Methods* document

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Attribution of Episodes

- Assign episodes to the medical group practice(s) and/or solo practitioner(s) determined to be the most responsible for the patient's initial care
  - Medical group practices and solo practitioners are identified by their Medicare-enrolled tax identification number (TIN)
- Acute condition episodes:
  - All TINs billing at least 30% of inpatient (IP) Evaluation and Management (E&M) visits during the trigger event
  - Nationally, acute condition episodes had an average of 6-8 IP E&M visits during the trigger event, and the attributed TIN billed an average of 5 IP E&M visits
- Procedural episodes:
  - The TIN(s) listed on the physician claim performing the specific procedure

Lead EP Identification

- Select lead eligible professionals (EPs), as identified by their National Provider Identifier (NPI), within the attributed TIN(s) for informational purposes
- Lead EP identification uses the same approach as episode attribution
- Acute condition episodes:
  - Within the attributed TIN(s), the top 3 NPI(s) billing the largest share of IP E&M visits during the trigger event
- Procedural episodes:
  - Within the attributed TIN(s), the NPI(s) billing for performance of the procedure

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Episodes in the 2014 Supplemental QRURs *(1 of 5)*

- The reports contain 64 total episode types
  - 26 major episode types:
    - 9 major acute condition episode types and 17 major procedural episode types
  - 38 episode subtypes:
    - 11 acute condition episode subtypes and 27 procedural episode subtypes
- Subtypes were chosen to help providers understand their treatment patterns and how care for specific subsets of the episodes may differ
- Subtypes are presented to provide additional clinical detail and improve the actionability of the reports

Episodes in the 2014 Supplemental QRURs *(2 of 5)*

Acute Condition Episode Types

1. Acute Myocardial Infarction (AMI) (All)
    2. *AMI without PCI/CABG*
    3. *AMI with PCI*
    4. *AMI with CABG*
5. Asthma/Chronic Obstructive Pulmonary Disease (COPD), Acute Exacerbation
6. Atrial Fibrillation (AFib)/Flutter, Acute Exacerbation
7. Cellulitis (All)
    8. *Cellulitis in Diabetics*
    9. *Cellulitis in Patients with Wound, Non-Diabetic*
    10. *Cellulitis in Obese Patients, Non-Diabetic without Wound*
    11. *Cellulitis in All Other Patients*
12. Gastrointestinal (GI) Hemorrhage (All)
    13. *GI Hemorrhage, Upper and Lower*
    14. *GI Hemorrhage, Upper*
    15. *GI Hemorrhage, Lower*
    16. *GI Hemorrhage, Undefined*
17. Heart Failure, Acute Exacerbation
18. Ischemic Stroke
19. Kidney and Urinary Tract Infection (UTI)
20. Pneumonia, Inpatient (IP)-Based

Episodes in the 2014 Supplemental QRURs *(3 of 5)*

Procedural Episode Types (1 of 3)

21. Aortic Aneurysm Procedure (All)
    - *22. Abdominal Aortic Aneurysm Procedure*
    - *23. Thoracic Aortic Aneurysm Procedure*
24. Aortic/Mitral Valve Surgery (All)
    - *25. Both Aortic and Mitral Valve Surgery*
    - *26. Aortic or Mitral Valve Surgery*
27. Carotid Endarterectomy
28. Cholecystectomy and Common Duct Exploration (All)
    - *29. Cholecystectomy*
    - *30. Surgical Biliary Tract Procedure*
31. Colonoscopy (All)
    - *32. Colonoscopy with Invasive Procedure*
    - *33. Colonoscopy without Invasive Procedure*
34. Coronary Artery Bypass Graft (CABG)
35. Hip/Femur Fracture or Dislocation Treatment, IP-Based
36. Hip Replacement or Repair (All)
    - *37. Hip Arthroplasty*
    - *38. Hip Arthroscopy and Hip Joint Repair*
39. Knee Arthroplasty

Episodes in the 2014 Supplemental QRURs *(4 of 5)*

Procedural Episode Types *(2 of 3)*

40. Knee Joint Repair (All)
    - *41. Meniscus Repair*
    - *42. Knee Ligament Repair*
43. Lens and Cataract Procedures (All)
    - *44. Cataract Surgery*
    - *45. Discission*
    - *46. Intraocular Lens (IOL) Removal/Repositioning or Secondary IOL Insertion*
47. Mastectomy for Breast Cancer (All)
    - *48. Lumpectomy or Partial Mastectomy without Reconstruction*
    - *49. Lumpectomy or Partial Mastectomy with Reconstruction*
    - *50. Simple or Modified Radical Mastectomy without Reconstruction*
    - *51. Simple or Modified Radical Mastectomy with Reconstruction*
52. Pacemaker (All)
    - *53. Pacemaker Placement, IP-Based*
    - *54. Pacemaker Placement, Outpatient (OP)-Based*
    - *55. Pulse Generator Replacement*

Episodes in the 2014 Supplemental QRURs *(5 of 5)*

Procedural Episode Types *(3 of 3)*

56. Percutaneous Coronary Intervention (PCI) (All)
    - *57. PCI, IP-Based*
    - *58. PCI, OP-Based*
59. Prostatectomy for Prostate Cancer
60. Spinal Fusion (All)
    - *61. Lumbar and/or Thoracic Spinal Fusion*
    - *62. Cervical Spinal Fusion*
    - *63. Long-Segment Spinal Fusion for Deformity*
64. Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia

Episode Cost Calculation

- Calculate the average payment-standardized, risk-adjusted episode amount for a provider in the 2014 Supplemental QRURs using the following steps:
  1. Payment-standardize claim payments
  2. Calculate standardized episode costs
  3. Truncate observed episode costs
  4. Calculate predicted episode costs
  5. Calculate risk-adjusted episode costs
- Payments reflect allowed amounts, which include both Medicare trust fund payments and beneficiary deductible and coinsurance

1. Payment-Standardize Claim Payments

- Standardize claim payments to adjust for geographic differences and payments from special Medicare programs that are not related to resource use (e.g., disproportionate share hospital (DSH) payments)
- Maintain differences that result from health care delivery choices such as:
  - Setting where the service is provided
  - Specialty of healthcare provider who provides the service
  - Number of services provided in the same encounter
  - Outlier cases
- Full details are available at this QualityNet webpage: http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic/Page/QnetTier4&cid=1228772057350

2. Calculate Standardized Episode Costs

- Sum all standardized Medicare claim payments grouped to the QRUR episode
- All grouped services are determined by the episode construction methodology described previously and occur during the episode window

3. Truncate Observed Episode Costs

- Truncate observed cost for extremely high-cost and low-cost episodes
- Process of truncating extremely high-cost or low-cost observed values:
  - For each episode type, identify episodes that fall below the 1st or above the 99th percentile of the episode type's observed cost distribution
  - Reset the observed cost for these episodes to the observed cost of the episode at this threshold (1st percentile or 99th percentile)

4. Calculate Predicted Episode Costs

- Account for variation in patient case mix using a linear regression
  - Linear regression estimates the relationship between risk adjustment variables and standardized episode cost
  - Risk adjustment variables include factors such as age, severity of illness, episode sub-type, and comorbidity interactions
  - Risk adjustment model is based on the calculation used in CMS' NQF-endorsed Medicare Spending Per Beneficiary (MSPB) Measure (#2158)
- Use a separate regression model for each major episode type

5. Calculate Risk-Adjusted Episode Costs

- Risk-adjusted standardized episode cost is calculated as the average of the ratios of each episode's truncated observed costs (Step 3) to its expected costs (Step 4) multiplied by the national average observed episode cost
- Episode-level risk-adjusted standardized costs can be calculated and reported at both the major episode type and sub-type levels
- For a given TIN and episode type:

$$Risk\text{–}Adjusted\ Episode\ Cost = Avg.\left(\frac{Observed\ Episode\ Cost}{Expected\ Episode\ Cost}\right) * National\ Episode\ Cost$$

National Comparison

- Episode costs are reported relative to the average of all episodes nationally
  - The national population includes all Medicare FFS beneficiaries who had a claim in 2014 that triggered one of the episode types reported in the 2014 Supplemental QRURs
  - Population includes approximately 5.6 million beneficiaries

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Supplemental QRURs Overview *(1 of 2)*

- Reports include 4 exhibits and 3 drill down tables
  - The 2014 Supplemental QRUR exhibits provide results for the sum of all instances of the episodes attributed to the group
  - The 2014 Supplemental QRUR drill down tables provide detailed information for each instance of the episodes attributed to the group
- Episode costs are payment-standardized and risk-adjusted, unless otherwise noted
- Results are for informational purposes only and small numbers should be interpreted with caution

Supplemental QRURs Overview *(2 of 2)*

- An addendum to this presentation will include detailed summary statistics of the 2014 Supplemental QRURs on:
  - Average risk-adjusted costs and service category cost drivers
  - Attribution to TIN(s) and identification of lead EP(s)
- The addendum will be available approximately one week after this National Provider Call on the Supplemental QRUR CMS webpage: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html

Introduction Page

- Provides a summary of the reports and their content
- Describes how episodes are constructed, including payment standardization and risk adjustment
- Describes how episodes are attributed to medical group practices and solo practitioners

Exhibit 1: Summary of All Episodes *(1 of 2)*

- Compares the cost of all episodes attributed to your TIN to the national average cost
- Shows your TIN's performance at a glance

Exhibit 1: Summary of All Episodes *(2 of 2)*

Percent Difference

- Shows the percent difference between your TIN's average risk-adjusted episode cost and the national average risk-adjusted episode cost
- Negative numbers mean lower cost than average and positive numbers mean higher cost than average

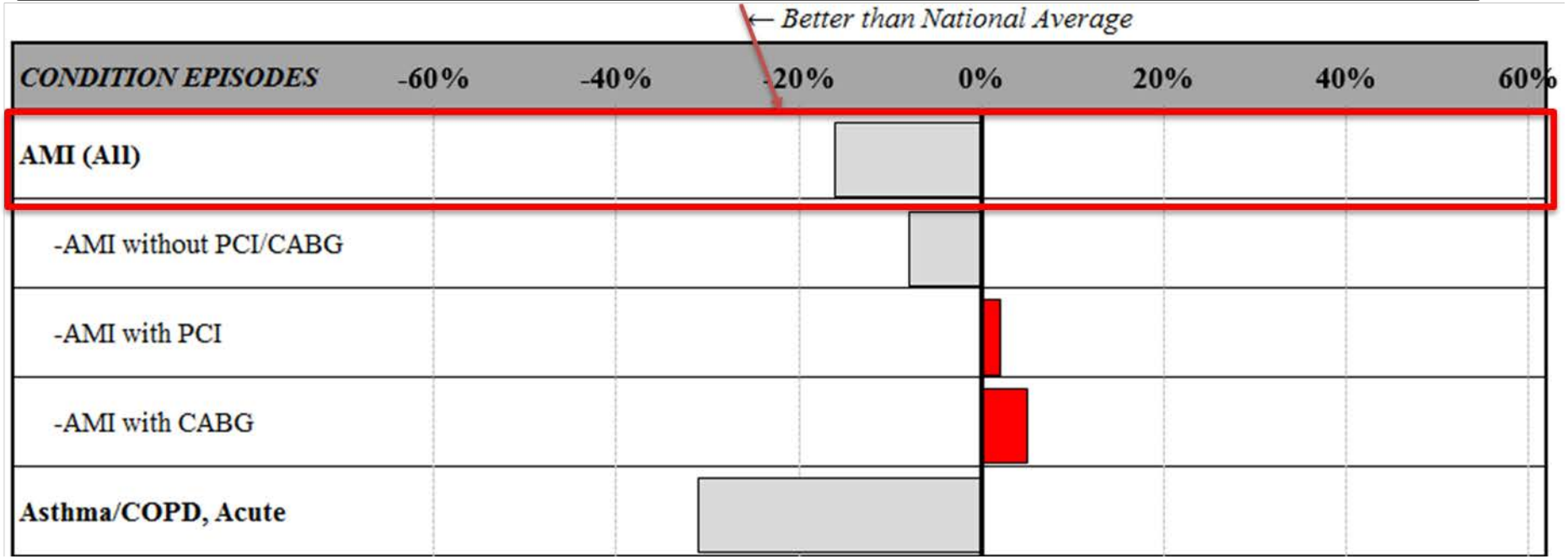

Exhibit 2: Episode Frequency and Cost *(1 of 3)*

- Shows the count of episodes of each major type and subtype that are attributed to your TIN
- Presents the cost of all episodes attributed to your TIN and the national average episode cost
- Compares to the national frequency and average cost
- Provides data displayed in Exhibit 1

Exhibit 2: Episode Frequency and Cost *(2 of 3)*

Episode Frequency

- Summarizes the number and frequency of all major episode types and subtypes attributed to your TIN

	EPISODE FREQUENCY†		AVG. RISK-ADJUSTED EPISODE COST†		
	Your TIN	National	Your TIN	National	% Cost Difference
Condition Episodes					
AMI (All)	16 (100%)	79%	$14,050	$19,422	-28%
-AMI without PCI/CABG	8 (50%)	56%	$8,263	$14,893	-45%
-AMI with PCI	4 (25%)	38%	$17,468	$21,086	-17%
-AMI with CABG	4 (25%)	6%	$50,603	$52,196	-3%
Asthma/COPD, Acute	3 (100%)	100%	$9,640	$11,704	-17%

Exhibit 2: Episode Frequency and Cost *(3 of 3)*

Average Risk-Adjusted Episode Cost

- Summarizes the cost of all episodes attributed to your TIN within your practices vs. nationally

	EPISODE FREQUENCY†		AVG. RISK-ADJUSTED EPISODE COST†		
	Your TIN	National	Your TIN	National	% Cost Difference
Condition Episodes					
AMI (All)	16 (100%)	79%	$14,050	$19,422	-28%
-AMI without PCI/CABG	8 (50%)	56%	$8,263	$14,893	-45%
-AMI with PCI	4 (25%)	38%	$17,468	$21,086	-17%
-AMI with CABG	4 (25%)	6%	$50,603	$52,196	-3%
Asthma/COPD, Acute	3 (100%)	100%	$9,640	$11,704	-17%

Exhibit 3: Episode Summary

- One exhibit per episode subtype
- Summarizes information on all episodes of that type attributed to your TIN
  - **Exhibit 3.A:** Your Episode Summary
  - **Exhibit 3.B:** Average Cost for Episode Components
  - **Exhibit 3.C:** Average Cost for Select Service Categories in Episode
  - **Exhibit 3.D:** Top Five Highest Average-Billing Providers Treating Episode

Exhibit 3.A: Your Episode Summary

- Shows summary information about your episodes of a given episode type

Your TIN's # Episodes	Your TIN's # Beneficiaries	Avg. Beneficiary Risk Score Percentile†	Avg. Non-Risk-Adjusted Episode Cost			Avg. Risk-Adjusted Episode Cost†			Avg. % Physician Fee Schedule Costs
			Your TIN	National	% Cost Difference	Your TIN	National	% Cost Difference	
26	21	55th	$23,507	$15,064	56%	$23,830	$14,893	60%	41%

†Risk Score Percentile

- A relative measure of your beneficiaries' predicted episode spending, based on the risk adjustment model
- A higher risk score percentile indicates that on average, your beneficiaries were predicted to have relatively higher costs for this episode type or subtype

Exhibit 3.B: Average Cost for Episode Components

- Allows comparison between your TIN's episodes and all episodes nationally for two episode components: treatment and indirect costs
  - Treatment costs include all costs on days in which the attributed physician within your TIN cared for the beneficiary
  - Indirect costs include all clinically relevant grouped costs on days in which the attributed physician within your TIN did not provide care for the beneficiary

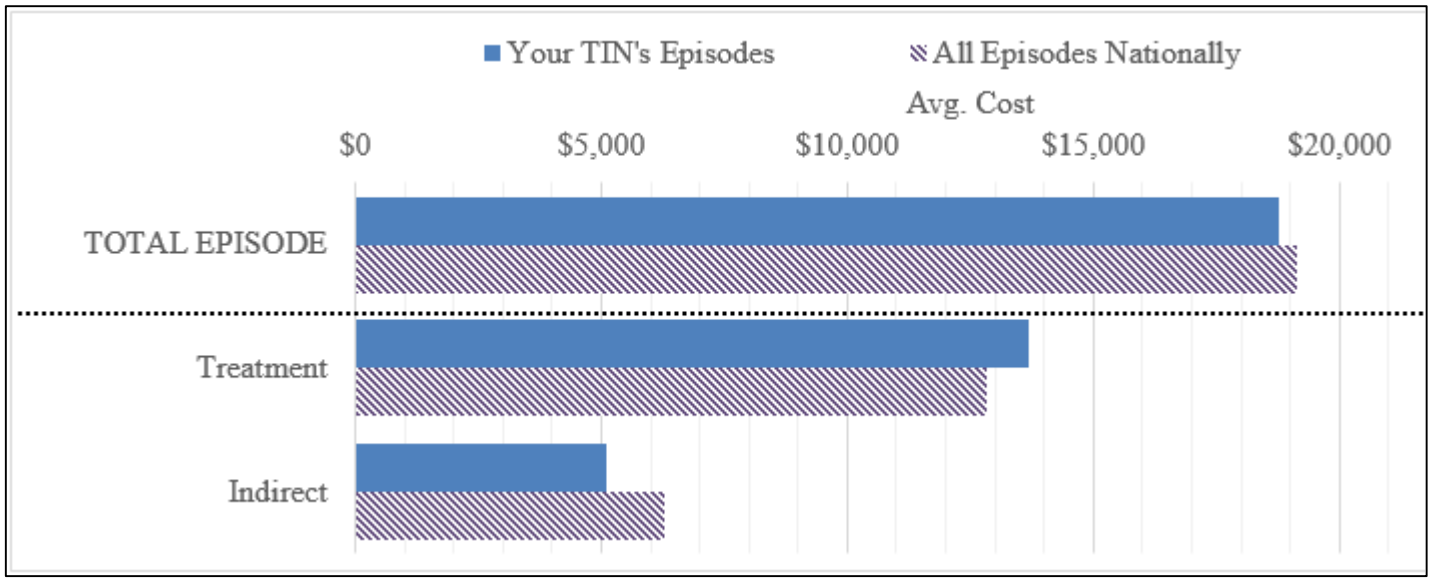

Exhibit 3.C: Average Cost for Select Service Categories in Episode

- Allows comparison between your TIN's episodes and all episodes nationally for several service categories
  - Note that the service categories shown in this exhibit are specific aggregations of the service categories shown in later exhibits

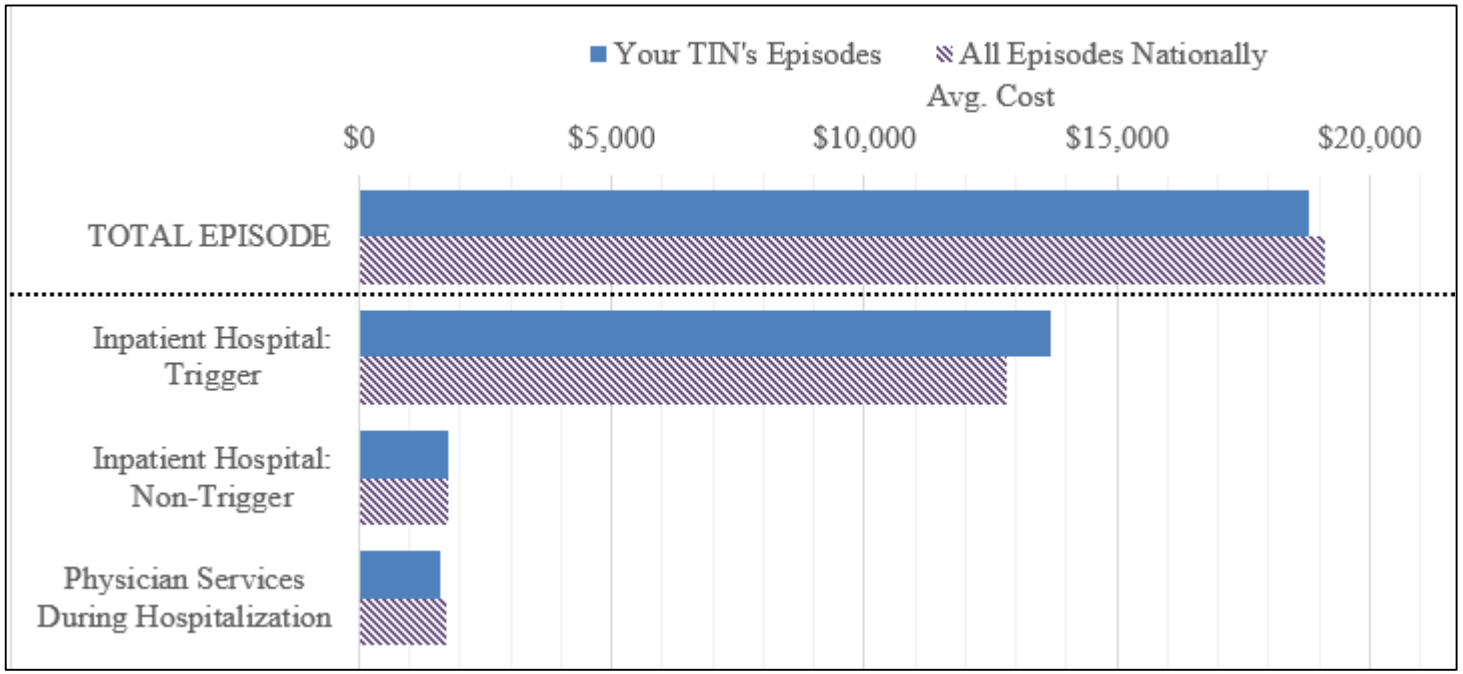

Exhibit 3.D: Top Five Highest Average-Billing Providers Treating Episode

- Displays the highest average-billing providers treating the episode both within your TIN or billed/ordered/referred by your TIN and billed/ordered/referred outside of your TIN

Category	Within Your TIN	Not in Your TIN
Hospitals	Hospital A	Hospital V
	Hospital B	Hospital W
	Hospital C	Hospital X
	Hospital D	Hospital Y
	Hospital E	Hospital Z
SNFs	SNF A	SNF V
	SNF B	SNF W
	SNF C	SNF X
	SNF D	SNF Y
	SNF E	SNF Z

Exhibit 4: Episode Service Category Cost Breakdown *(1 of 2)*

- One exhibit per episode type
- Summarizes cost performance by service category for episodes of that type attributed to your TIN
- Presents average non-risk-adjusted cost because risk adjustment is done at the entire episode level
- Each exhibit shows service category breakdowns for different components of episode costs
  - **Exhibit 4.A** shows total episode service category breakdown
  - **Exhibit 4.B** shows service category breakdowns for treatment costs
  - **Exhibit 4.C** shows service category breakdowns for indirect costs

Exhibit 4: Episode Service Category Cost Breakdown *(2 of 2)*

	AVG. NON-RISK-ADJUSTED COST			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Difference	Your TIN	National	Your TIN	National
All Services	$10,287	$12,840	-19%	100%	100%	***N/A***	***N/A***
Outpatient Evaluation and Management Services, Procedures, and Therapy (excluding emergency department)	$597	$766	-22%	77%	80%	***N/A***	***N/A***
Evaluation & Management Services	$485	$312	55%	77%	79%	5.12 Visits	3.35 Visits
Major Procedures	$112	$425	-74%	11%	5%	0.4 Services	0.27 Services
Ambulatory/Minor Procedures	$0	$29	-100%	0%	11%	0 Services	0.27 Services
Outpatient Physical, Occupational, or Speech and Language Pathology Therapy	$0	$0	-100%	0%	0%	0 Visits	0.01 Visits
Ancillary Services	$47	$213	-78%	55%	82%	***N/A***	***N/A***
Laboratory, Pathology, and Other Tests	$47	$102	-53%	55%	75%	2.05 Tests	5.84 Tests
Imaging Services	0	$93	-100%	0%	41%	0 Services	1.17 Services
Durable Medical Equipment and Supplies	0	$18	-100%	0%	7%	0 Supplies	0.33 Supplies

Drill Down Tables

- One exhibit per episode type
- Provides information for each instance of an episode attributed to your TIN
- Beneficiary information can be matched to your own records
- **Drill Down Table 1:** Episode-Level Information
- **Drill Down Table 2:** Episode Breakdown of Physician Costs Billed by Your TIN and Other TINs
- **Drill Down Table 3:** Episode Breakdown of Non-Physician Costs

Drill Down Table 1 *(1 of 3)*

- Shows basic episode, beneficiary, and attribution information for each episode attributed to your TIN
- Unless otherwise noted, all costs are actual Medicare payment amounts (non-payment standardized and non-risk adjusted) to allow TINs to compare this data to their own records based on the beneficiary information included

Episode Information		**Basic Cost and Risk Percentile Information** *(Payment Standardized)*				**Beneficiary Information**				
Episode ID	**Episode Type** *(If Applicable)*	**Non-Risk-Adjusted Cost**	**Risk-Adjusted Cost†**	**Risk-Adjusted Cost Percentile†**	**Risk Score Percentile†**	**Beneficiary HIC**	**Sex**	**Date of Birth**	**Episode Start Date**	**Death Date, if During Episode**
1059	AMI w/PCI	$15,233	$17,891	47th	58th	-	-	-	4/13/2014	-

Drill Down Table 1 *(2 of 3)*

- Shows attribution information for each episode
  - Lead Eligible Professional(s) (EP)
  - Evaluation and Management (E&M) visits performed during episode
  - Physician Fee Schedule (PFS) costs billed during episode

Lead Eligible Professional(s) (EP) (*Physician/Non-Physician Practitioner(s) Managing Episode)*		**Evaluation and Management (E&M) Visits Performed During Episode**			**Physician Fee Schedule (PFS) Costs Billed During Episode**		
Name(s)	**Specialty According to Claims**	**Total Number**	**Billed by Your TIN**	**Billed by the Lead EP(s)**	**Total Cost**	**Billed by Your TIN**	**Billed by the Lead EP(s)**
Dr. A	Cardiology	13	9	8	$1,821	$1,480	$1,480

Drill Down Table 1 *(3 of 3)*

- Displays providers involved in treating episode
  - Count of EPs treating episode within and outside your TIN
  - Earliest hospitals, skilled nursing facilities, and home health agencies involved in the episode

Providers, Hospitals, SNFs, and HH Agencies Treating Episode					
# EPs Within Your TIN	**# EPs Outside Your TIN**	**Hospital that Provided Care Earliest in Episode**	**Hospital that Provided Care Second in Episode**	**SNF/HH Agency that Provided Care Earliest in Episode**	**SNF/HH Agency that Provided Care Second in Episode**
2	4	Hospital A	Hospital B	SNF Y	-

Drill Down Table 2 *(1 of 2)*

- Shows breakdown of physician costs billed by your TIN and other TINs
  - Allows you to gauge your involvement in the episode based on the costs billed by your TIN vs. all other TINs
  - Displays the breakdown of physician costs to identify trends in service use among your attributed patients
  - The physician costs reported are actual Medicare PFS payment amounts billed on carrier claims during the entire episode window
  - Allows comparison to your own records by showing the actual Medicare payment amounts

Drill Down Table 2 *(2 of 2)*

- Physician Costs Billed By Your TIN During Episode
  - Summarizes the physician costs billed by your TIN for a given service category
  - Compare this cost to the physician costs billed by other TINs

Physician Costs Billed By Your TIN During Episode									
Services During Hospital-ization	**E&M Services**	**Major Procedures**	**Ambulatory/ Minor Procedures**	**Lab/ Pathology/ Other Tests**	**Imaging**	**Emergency Room Services**	**Anesthesia Services**	**Part B-Covered Drugs**	**All Other Services**
$1,568	$82	$0	$0	$0	$0	$0	$0	$0	$0

Drill Down Table 3 *(1 of 2)*

- Shows breakdown of non-physician costs
  - Can be used to identify opportunities for improvement in care coordination and management

Outpatient Hospital Services				Hospital Inpatient Services		Emergency Room Services			
E&M Services	Major Procedures	Ambulatory/ Minor Procedures	Outpatient PT/OT/ SLP	Trigger	Non-Trigger	E&M Services	Procedures	Lab/ Pathology/ Other Tests	Imaging
$763	$0	$32	$0	$8,013	$0	$386	$157	$0	$0

Drill Down Table 3 *(2 of 2)*

Post-Acute Care

- Summarizes the non-physician cost for each episode
- Evaluate this section to determine the cost of services provided outside of your TIN

Post-Acute Care			Hospice Care	Other Services		
Home Health	Skilled Nursing Facility	Inpatient Rehab or LTCH	Hospice	Anesthesia Services	DME/ Supplies	All Other Services Not Otherwise Classified
$0	$3,037	$0	$0	$0	$0	$27

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Accessing the Reports *(1 of 3)*

- You can access a Supplemental QRUR on behalf of a group or solo practitioner (as identified by its TIN) at https://portal.cms.gov
- First, you or one person from your TIN will need to obtain an Enterprise Identity Data Management (EIDM) account with the correct role
- For TINs with two or more EPs:
  - Security Official
  - Group Representative
- For solo practitioners (TINs with only one EP):
  - Individual Practitioner
  - Individual Practitioner Representative
- For more information on obtaining an EIDM account, refer to the "How to Obtain a QRUR" webpage: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html

Accessing the Reports *(2 of 3)*

- If you already have or after you establish an EIDM account with the correct role, follow these steps to access your TIN's 2014 Supplemental QRUR:

  1. Navigate to the CMS Enterprise Portal: https://portal.cms.gov
  2. Select "Login to CMS Secure Portal", accept the "Terms and Conditions", and enter your EIDM User ID and password to log in
  3. Select the "PV-PQRS" tab, and the "Feedback Reports" option
  4. Select "2014" and then "2014 Supplemental QRURs"
  5. Complete your role attestation
  6. Select your TIN

- For step-by-step instructions, refer to the "Guide for Accessing the 2014 Supplemental QRURs" on the "How to Obtain a QRUR" webpage http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html

Accessing the Reports *(3 of 3)*

- For questions about your report, please contact the Physician Value (PV) Helpdesk at 888-734-6433, option 3, 8 AM –8 PM ET Monday through Friday
- For questions about setting up an EIDM account, please contact the QualityNet Help Desk at 866-288-8912 (TTY 1-877-715-6222), 8:00 am – 8:00 pm ET Monday through Friday

Agenda

- Introduction
- CMS' Approach to Episode-Based Measures
- Understanding Your 2014 Supplemental QRUR
- Accessing the Reports
- Giving Feedback
- Questions and Answers

Giving Feedback on the 2014 Supplemental QRURs

- To submit written comments and suggestions, please send an email to PVHelpdesk@cms.hhs.gov
  - Do not include any personally identifiable information

Further Information *(1 of 2)*

- For further information on the 2014 Supplemental QRURs, please see: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Episode-Costs-and-Medicare-Episode-Grouper.html
- Documents available on this webpage include:
  - Detailed methodology for the 2014 Supplemental QRURs
  - Tips for understanding and using the Supplemental QRURs
  - Responses to frequently asked questions (FAQs)
  - Instructions to access the 2014 Supplemental QRURs
  - Episode definitions
  - Episode risk factors
  - A sample 2014 Supplemental QRUR

Further Information *(2 of 2)*

- Specifications of episode components, such as trigger event, treatment component, and indirect component, are included in Section 2, 5, and 6 of the *Detailed Methods* document
- Service categories shown in this presentation are defined in Appendix C of the *Detailed Methods* document
  - Costs are provided at the service category level in Exhibit 3, Exhibit 4, Drill Down Table 2, and Drill Down Table 3

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Question & Answer Session

Acronyms Included in this Presentation

Acronym	Definition
CMS	Center for Medicare and Medicaid Services
EIDM	Enterprise Identity Management
E&M	Evaluation and management
EP	Eligible professional
FFS	Fee-for-service
IACS	Individual Authorized Access to the CMS Computer Services
IP	Inpatient
MSPB	Medicare Spending per Beneficiary
NPI	National Provider Identifier
PQRS	Physician Quality Reporting System
PV	Physician Value
QRUR	Quality and Resource Use Report
TIN	Tax Identification Number

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- https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/TC-L10152015-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