MLN Connects®

National Provider Call Transcript

**Centers for Medicare & Medicaid Services**
**2014 Supplemental QRUR Physician Feedback Program**
**MLN Connects National Provider Call**
**Moderator: Amanda Barnes**
**October 15, 2015**
**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 Kalia. 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 the 2014 Supplemental QRUR Physician Feedback Program. MLN Connects Calls are part of the Medicare Learning Network®. The 2014 Supplemental QRURs report on 26 major episode types and an additional 38 episodes subtypes, resulting in 64 total reported episode types. The 2014 Supplemental QRURs are for informational purposes only.

Before we get started, I have a couple of announcements. You should have received a link to today's slide presentation email. If you have not already done so, you may view or download the presentation from the following URL, www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the web page, select National Provider Calls and Events, then select the date of today's call from the list, and download the presentation from there.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. Registrants will receive an email when these materials become available.

Lastly, registrants were given the opportunity to submit questions. We thank you to everyone who submitted those questions.

At this time, I would like to turn the call over to Rachel Yong. Rachel?

## Presentation

Rachel Yong: Thank you Amanda. And thank you everyone for joining us on this call today. I'm going to start with slide 3, which lists the agenda for today's call.

During today's call, I will introduce the 2014 Supplemental Quality and Resource Use Reports, also referred to as QRURs, and episode-based measures reported in them. We will then discuss CMS's approach to episode-based measures in more detail and walk through the Supplemental QRURs that were distributed at the end of September.

Last, we will discuss how you can access the reports and provide feedback. Please note that throughout this presentation, I will reference documents and materials that are

available on the CMS Supplemental QRUR and Episode Grouper website. There you will find more specific details that may answer many of your questions. The present today — presentation today is meant to be a general overview that I hope will help you understand the utility of these reports.

The 2014 Supplemental QRURs were distributed to all medical group practices and solo practitioners with at least one episode in 2014. The reports are confidential and are for informational purposes only. The data presented in the reports do not affect the Medicare Physician Fee Schedule Value-Based Payment Modifier. Instead, the data presented supplement the per capital total cost and quality information provided in the 2014 QRURs that were released last month.

The 2014 Supplemental QRURs provide information on the cost of care for Medicare fee-for-service patients based on the episodes of care, also abbreviated as episodes. The reports include two different types of episodes — acute condition and procedural episode types. Acute condition episodes represent care delivered for a distinct portion of care for a particular medical condition, namely an acute exacerbation which is treated in a hospital. Procedural episodes represent the performance of a specific procedure, such as valve surgery or hip replacement.

Episodes are defined as a set of services provided to treat, manage, diagnose, and follow up on a clinical condition or treatment, and they may be used within a resource use measure. As you see on slide 5, episode-based measures organize medical claims into clinically relevant units for analysis. They provide actionable information on resource use, they can be linked to meaningful outcomes, and can be used to improve care.

CMS has developed and continues to develop Medicare-specific episodes to ensure that episodes recognize the uniqueness of Medicare patients and unique payment rules. Medicare beneficiaries tend to be older, more medically complex, and the episodes must account for this.

In the next section, I will provide background on CMS's approach and use of episodes and will outline how they can be used to provide information on patterns of medical care.

**CMS's Approach to Episode-Based Measures**

Moving on to slide 7, you'll see that CMS aims to simultaneously provide better care and improve the health of patients, while also lowering medical costs and making care more affordable. To accomplish this, CMS aims to provide meaningful and actionable information that will help CMS and you understand the manner in which care is being delivered. Episodes as discussed in slide 5 are one way to present information on your resource use since they organize medical claims into clinically relevant units for analysis.

The goal of the Supplemental QRUR is to allow you to evaluate the resources used in caring for your patients compared to the resources used by other group practices treating similar patients. Each year, CMS aims to improve how — the way the information on your resource use is presented and welcomes any feedback on the episodes and report structuring content.

Now on slide 8, so how will CMS use episode-based measures?

- First, the episodes must be developed and created.

- Second, the episodes must be attributed to one or more medical group practice or solo practitioner that is responsible for the care and management of the episode.

- Third, the episodes are reported in the Supplemental QRURs.

The following section describes each step in more detail.

In slide 10, we see a basic definition of an episode and three steps required as part of constructing an episode. As mentioned at the start of this presentation, an episode can be used as part of a resource use measure and includes a set of services that — provided to diagnose, treat, manage, and follow up on a specific clinical condition within a defined time period. Episodes are first opened, or triggered, then clinically relevant services and procedures are identified and grouped, and, last, the episode ends.

Slide 11. Episodes are started by identifying services in a beneficiary's claims that indicate that the episode has begun. These are called trigger events. A trigger event is identified by certain procedure or diagnosis codes on certain types of claims, such as an IP stay or an office visit, that indicate the presence of an index condition or procedure. Next, we collect services and procedures that are clinically relevant to the episode and that occurred during the episode time period. 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.

On slide 12 we see these three episode construction steps in a visual diagram. In the first step, episodes are triggered, or opened, based on the occurrence of a trigger event. The specific medical codes that identify a trigger event, also known as trigger codes, are codes on certain types of claims which reflect strong evidence of a beneficiary having a particular condition or treatment. The trigger event is represented by the large red triangle in this diagram.

In the second step, clinically relevant services are identified and grouped to the episode. These are services that are provided for the management, treatment, or evaluation of a particular condition or treatment. Some episodes start a few days before the trigger

event to capture any diagnostic testing, procedures, and prior visits with the main provider of care. As a result, some episodes include services and procedures occurring a few days prior to the trigger event.

Clinically relevant services are grouped to the episode — are represented by the smaller red triangles in this diagram. Services that are not grouped to the episodes are represented by the small checked black triangles.

In the last set, episodes are closed after a fixed window of time after the trigger event. This time period, or episode link, was selected for each episode type based on the typical course of medical care provided for that episode type. Clinical reviewers reviewed and discussed and validated these episode links during the episode development process.

Moving on to slide 13, we see that — we will discuss the second step, grouping clinically relevant services in more detail. As part of the episode development process, clinical reviewers identified rules to assign relevant services to each episode type reported. The type of services are often clinically relevant to an episode include treatment, care for typical signs and symptoms, care for complications, diagnostic test, and post-acute care.

Moving on to slide 14. Two methods are used to construct the episodes reported in the 2014 Supplemental QRURs. Method A is used for 28 episode types, and Method B is used for 36 episode types. The methods were developed by two groups at CMS working to design episode grouping algorithms for provider profiling. Both methods implement clinical logic to open episodes. Both methods also distribute payments for medical services as obtained by a Medicare administrative claim to one or more episodes during a specific length of time.

Method A identifies clinically relevant services based on a hierarchy of rules that account for interactions between sets of diagnosis and procedural codes, as well as interactions between episodes. Method B defines clinically relevant services as those services rendered by the managing provider, which is defined as the attributed provider most responsible for care during the trigger event. Clinically relevant services can also include other services ruled as relevant by clinicians.

Specifics of each method can be found in a Detailed Methods document, as well as the episode definition workbooks on the CMS Supplemental QRUR web page that is linked at the end of the presentation.

Now that we have gone over how episodes are constructed, we will next discuss how episodes are attributed to a medical group practice or solo practitioner that is determined to be most responsible for the care provided.

## Attributing Episodes

In slide 16, we see the rules used to attribute acute condition episodes and procedural episodes to one or more medical group or solo practitioner, as identified by the Medicare-enrolled tax identification number, or TIN.

Acute condition episodes are attributed to all TINs billing at least 30 percent of inpatient evaluation and management, or E&M, visits during the trigger event. Nationally, we see that acute condition episodes had an average of six to eight inpatient E&M visits during the trigger event. And the attributed TIN billed an average of five inpatient E&M visits.

Procedural episodes are attributed to all TINs that bill a physician claim where the trigger code during the trigger event of the episode, indicating that the physician within their TIN performed the specific procedure. For informational purposes only, the 2014 Supplemental QRURs identify one or more lead eligible professional, as identified by their National Provider Identifier, within each attributed TIN using a similar methodology as we used for attribution. The lead EPs are identified as foster care of coordination improvements and are included in Exhibit 3 and the drill down tables of the 2014 report.

For the purposes of this report, eligible professionals are defined as those physicians, practitioners, and therapists that are eligible to participate in the Physician Quality Reporting System. These include Medicare physicians, for example, doctors of medicine, practitioners, such as physician assistants, and therapists who are paid for treating Medicare fee-for-service beneficiaries.

For acute condition episodes, the lead EPs are identified as the top three National Provider Identifiers, NPIs, within the attributed TIN billing the largest share of inpatient E&M visits during the episode trigger event. The procedural episodes — for procedural episodes, the lead EPs are identified as those within the attributed TIN billing for the performance of the procedure.

Now that we have constructed episodes that are attributed to a TIN, we will next go over episodes reported in the 2014 Supplemental QRURs.

## Episodes Reported in the 2014 Supplemental QRURs

As you can see in slide 19, the 2014 Supplemental QRURs provide information on 64 total reported episode types — 26 major episode types and an additional 38 episode subtypes. The 64 reported episode types represent acute conditions and procedures that are costly and prevalent in the Medicare population. Acute condition episodes include all the care provided for the treatment of a condition. For example, it would include initial and followup care for an acute myocardial infarction.

Procedural episodes include the care associated with a specific treatment, such as coronary artery bypass graft surgery, as well as related followup care. Subtypes are constructed that help providers understand their treatment patterns and how care for specific subsets of episodes may differ. In addition, subtypes provide additional clinical detail and improve the actionability of the reports.

Slides 20 to 23 list all the episode types reported in the 2014 Supplemental QRURs.

Slide 20 lists the acute condition episode types. Episode types are further stratified by patient and/or treatment characteristics. As an example, if your TIN treats a lot of beneficiaries with acute myocardial infarction, AMI, your 2014 QRURs will categorize all your AMI episodes into four subtypes:

- AMI without percutaneous coronary intervention, PCI, or coronary artery bypass graft CABG surgeries during the episode,
- AMI with a PCI procedure during the episode, and
- AMI with the CABG during the episode.

Subtype categorizations for AMI is determined by the MS-DRG billed on the trigger inpatient claim.

The following slide lists the procedural episode types reported in the 2014 report. For those of you who have reviewed and seen the previous Supplemental QRURs in the past 2 years, you will notice that the list of episode types has expanded greatly. For example, one new procedural episode type is the aortic and mitral valve surgery episode type. This episode type has two subtypes — one for episodes that include surgery on both the aortic and mitral valve, and another for episodes which have a surgery on either the aortic or mitral valve.

Clinicians determine that these are the most appropriate subtypes because the cost and complexity of valve surgery correlates strongly with the number of valves the surgeon operates on. By separating this major episode type into two subtypes, you can compare the resource use of your TIN to treat beneficiaries with aortic and mitral valve surgery to the resource use of other TINs treating similar beneficiaries.

For slide 22, you will notice that pacemaker is an episode type that we reported in last year's 2012 Supplemental QRURs. This year, in the 2014 reports, we provide three subtypes to compare TINs treating similar beneficiaries and to provide actionable data.

Physicians perform pacemaker surgeries in both inpatient and outpatient settings. Emergency situations or patients' doctors can influence a choice of setting. Since it is likely that surgeons do not have complete control on the setting in which the surgery occurs, we separate pacemaker surgeries performed in inpatient setting from patient — from pacemaker surgeries performed in outpatient setting. We also report pacemaker

surgeries where the surgeon only replaces the pulse generator as a separate episode subtype. This is because those procedures are generally lower in cost than the procedure where the surgeon replaced the whole pacemaker.

Slide 23 provides the last set of procedural episode types reported in the 2014 reports. Full specifications of each episode type can be found in the episode definition files in the CMS Supplemental QRUR website.

**Episode Cost Calculation**

Now on slide 24. Now that we have walked through the episode types included in the report, I will describe how the reported episode amount is calculated. There are five steps to calculate the average payment-standardized, risk-adjusted episode amount for TIN. First, you payment-standardize claims amount — claim payments, then you calculate the standardized episode cost, then you truncate observed episode cost and you calculate the predicted episode cost, and finally you calculate risk-adjusted episode cost. Note that the payments reflect allowed amounts, which include both Medicare Trust payments — Trust Fund payments and beneficiary's deductible and coinsurance.

The first step to standardize claims payments so that the episode cost — it can be compared across the country. This is because payment standardization adjusts for geographic differences and payments from special Medicare programs that are not related to resource use, for example, the disproportionate share hospital payments. Payments standardization maintains differences that result from health care delivery choices, such as setting where the service is provided, specialty of health care provider who provides the service, the number of services provided in the same encounter, and outlier cases.

For an overview of payment standardization, please see the basics for payment — of payment standardization document available on QualityNet, as linked on the slide. For a detailed description, there will also be a document called CMS Price Standardization Methodology document that is also available on QualityNet.

Next, on slide 26, standardized episode costs are calculated before performing risk adjusted — risk adjustments. For each episode, standardized Medicare claims payments for group services are summed together. All group services are determined by the episode construction methodology previously discussed.

In the third step, as shown in slide 27, extremely high cost and low cost standardized episode costs are truncated to limit the influence of outliers on the calculation of risk adjustment. Truncation, also known as Winsorization, is a statistical transformation that limits extreme values and data to reduce the effect of costly misleading outliers.

Within each episode type this step identifies episodes within observed payment standardized cost below the 1$^{st}$ percentile and above the 99$^{th}$ percentile of the observed

cost distribution. The observed cost for these episodes are then set to the observed cost of the episode at the 1st and 99th percentile, respectively.

The fourth step accounts for variation in patient case mix using a multi — multiple linear regression model. The linear regression estimates the relationship between the independent risk-adjustment variables and the truncated standardized episode cost from Step 3. Risk adjustment variables include the factors such as age, severity of illness, episode subtype, and comorbidity interactions. Older patients and patients with other health care conditions are more likely to require greater expense for their care, and risk adjustment is our attempt to account for this. Risk adjustment model is based on the calculation used in the CMS NQF-endorsed Medicare Spending per Beneficiary Measure. The linear regression model is estimated separately for each major episode type.

The last step, on slide 29, is to calculate the final risk-adjusted episode cost for each TIN. For a given TIN and episode type, risk-adjusted standardized episode cost is calculated as the average of the ratios of each episode's truncated observed cost from Step 3 to the expected cost from Step 4. This is then multiplied by the national average observed episode cost. This is displayed as a simplified mathematical formula at the bottom of the slide. Episode-level risk-adjusted standardized costs are calculated and reported at both the major episode type and subtype levels.

Now on slide 30, you'll see the episode costs are reported relative to the average of all episodes nationally. The national population includes all Medicare fee-for-service beneficiaries who have a claim in 2014 that triggered one of the episode types reported in the 2014 reports. This includes approximately 5.6 million beneficiaries.

Now I'm moving on to slide 31. We're going to take a quick break. I'll hand it over — back to Amanda to do some keypad polling, and then we'll continue on and discuss the reports in more detail.

## Keypad Polling

Amanda Barnes: Thank you Rachel. At this time, we will pause for a few moments to complete keypad polling. Kalia, we're ready to start.

**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.

Please hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling. Please continue to hold while we complete the polling.

Thank you for your participation. I would now like to turn the call back over to Amanda Barnes.

## Presentation Continued

Amanda Barnes: Thank you Kalia. Rachel, we're ready to resume the presentation.

Rachel Yong: OK, great. Thanks Amanda.

### Understanding Your 2014 Supplemental QRURs

So now resuming back on slide 31, we're going to return to the reports and provide a description and some tips for understanding the reports. Each TIN received a notice about their Supplemental QRURs. Once you access your report, you will find that there are two sets of reports. The first, labeled "2014 Supplemental QRURs," which contain an introductory page, and data tables are called exhibits. The second one will be called "The 2014 Supplemental QRUR Drill Down Tables," and these contain more detailed data sets, called drill down tables.

The exhibit tables report summary information. They merge all instances of a given episode type and provide reports on the TIN's overall performance. The drill down tables, on the other hand, allow you to drill down into every instance of an episode to uncover specific information that may help you to understand what occurred during the care of a specific patient. Episode costs are payment-standardized and risk-adjusted, unless otherwise noted.

As we noted in the beginning, the Supplemental QRURs are for informational purposes only, and data on episode types with a given — with a small number of episodes, such as those with fewer than 10 episodes in a given type —those data should be reported or interpreted with caution.

Now on to slide 33. An addendum of this presentation will include summary statistics of the 2014 Supplemental QRURs. Summary findings will include national average episode cost for each episode type and statistics related to attribution, such as the number of inpatient E&M visits during the trigger event for an acute condition episode. You will be able to find this addendum on the Supplemental QRUR website approximately 1 week after this call.

The Supplemental QRURs include an overview page that includes a list of episodes we went over earlier and a table of contents. The reports also include an introduction page that describes how episodes are constructed, including payment standardization and

risk adjustment. The introduction also describes how episodes are attributed to medical group practices and solo practitioners. Complete documentation is included in the Detailed Methods document and other supporting documents on the CMS website.

Now on slide 35. Exhibit tables report summary information on all instances of a given episode type. They do not report on each instance, and as you can see, that can be found in the drill down tables.

In Exhibit 1, you can compare the cost of all episodes attributed to your TIN to the national average cost. Slide 36 provides a snapshot of Exhibit 1. Exhibit 1 shows the percent difference between your TIN's average risk-adjusted episode cost and the national average risk-adjusted episode cost. Negative numbers, depicted by the light gray bars in the graph, show that the attributed episode has an average episode cost that is lower than the national average. Positive numbers, shown as red bars in the graph, show that your attributed episode have an average episode cost that is higher than the national average. In this example, you see that all EMI episodes attributed to the TIN were about 18 percent lower in cost than the national average.

While Exhibit 1 provides a graphical summary of all of the episode types your TIN may have, Exhibit 2, as you can see in slide 37, provides the basic summary statistics that underline the graphical display in Exhibit 1. Exhibit 2 shows the count of episodes of each major type and subtype that is attributed to your TIN. It also shows even average cost of all episodes attributed to your TIN and the national average episode cost.

Slide 38 provides an example of Exhibit 2. The episode frequency columns provide the number and frequency of all major episode types and the subtypes attributed to your TIN. In this example, the TIN has 16 AMI episode types — eight AMI episodes without PCI or CABG, four AMI episodes with CABG, and four AMI episodes with PCI.

Exhibit 2, as you can see in slide 39, also shows the average risk-adjusted episode cost for all episodes attributed to your TIN and at the national level. In this example, you see that the TIN has 16 AMI episodes, and the average risk-adjusted episode cost is $14,050. The national average for AMI episodes is about $19,400. So the TIN has a negative 28 percent cost difference and is lower in cost than the national average episode.

Next, we will describe Exhibit 3. Exhibit 3 provides more detailed summary information on all episodes of a given episode type that are attributed to your TIN. There are four sections of Exhibit 3, each of which is outlined on slide 40.

First, we provide a summary — a basic summary of episodes of a given episode type and the average risk score. Second, we show the average cost of the total episode and two service components of the episode — treatment and indirect services. Third, we depict the average cost of the episode by select service categories, such as the trigger inpatient hospital cost and post--acute care service cost. Last, we list the top five billing inpatient

or outpatient hospitals, skilled nursing facilities, home health agencies, and eligible professionals within and outside of the TIN for a given episode type. To improve the clarity and actionability of the report, a separate version of Exhibit 3 is created for each major episode type and subtype.

Now moving on to slide 41, Exhibit 3.A presents a summary cost information about all episodes attributed to the TIN that are of the same type. This exhibit shows both nonrisk-adjusted amount and risk-adjusted average episode cost. In addition, Exhibit 3.A shares the average beneficiary risk score percentile as a relative measure of the beneficiary's predicted health care spending, based on the risk-adjustment model.

This number is calculated as the average episode risk score percentile for all the episodes attributed to your TIN. A higher risk score percentile indicates, on average, beneficiaries were predicted to have a relatively higher cost than the average for this episode type.

Slide 42 shows Exhibit 3.B, which provides the average nonrisk-adjusted payment-standardized cost for each episode component for your TIN and for the national average. The graph shown in Exhibit 3.B allows you to make comparison between your TIN's episodes and all episodes nationally at the total episode cost level and at the level of two components of the episode — treatments and indirect costs.

Treatment costs include all costs on a day in which the attributed physician within your TIN cared for the beneficiary. These services comprise the medical care occurring during the initial care directly related to the management of the episode. Indirect costs include all clinically relevant services on days in which the attributed physician within your TIN did not provide care for the beneficiary.

On slide 43, we see that Exhibit 3.C presents the average nonrisk adjusted payment-standardized cost of select service categories for the TIN and for the national average. Note that the service categories shown in this exhibit are specific aggregations of service categories shown in Exhibit 4. This slide provides a snapshot of Exhibit 3.C graph — of the Exhibit 3.C graph and shows the categories of total episode inpatient trigger, inpatient hospital nontrigger, and physician services during hospitalization. In your reports, Exhibit 3.C will also include service categories for outpatient E&M services, major procedures, and post-acute care services, specifically skilled nursing facility and home health cost.

Exhibit 3.D, as shown in slide 44, lists the top five billing providers within and outside of the TIN that are involved in the care of the attributed episode. Specifically, Exhibit 3.D shows the top five billing hospitals, skilled nursing facility, home health agency, and eligible professional. The top five billing hospital, skilled nursing facility, and home health agencies are listed based on the cumulative cost for all episodes attributed to

the TIN. The top five eligible professionals are listed based on the cumulative cost of all attributed episodes within that type.

For example, the top five billing hospitals are identified from the sum of inpatient claims reported on the inpatient hospital and post-acute care serve — categories and outpatient hospital claims. Exhibit 3.D also differentiates the top hospitals, skilled nursing facilities, and home health agencies billing inside vs. outside of your TIN. All facilities are based on the criteria applied to identify cost billed orders and referred by the attributed TIN. Specific — complete specification of this categorization is included in the Detailed Methods document.

Slide 45. Exhibit 4 summarizes the cost performance by service category of episodes of a given episode type attributed to the TIN and for their entire episode and for the treatment and indirect components of the episode. Just like Exhibit 3, a separate version of Exhibit 4 is created for each individual episode subtype and type. Exhibit 4 presents average nonrisk-adjusted cost because risk adjustment is done at the entire episode level.

Service category costs are provided as nonrisk-adjusted cost for two reasons. TINs can identify what services contribute the most to their total average cost based on nonrisk-adjusted cost and determine appropriate next steps. And risk adjustment is done at the episode level rather than the service category claim level.

The service category definitions follow Medicare fee-for-service payment schedules and can be identified for Medicare claims. And the service category breakdowns match the major service categories reported in the 2014 QRURs. Exhibit 3.A provides the service category breakdown for the entire episode. Exhibit 4.B and 4.C show the service category cost breakdown for the treatment and indirect component of the episode, respectively.

Slide 46 provides an example of Exhibit 4. As an example of how you can walk through the data presented in this table, let's focus on the evaluation and management services row and your outpatient E&M service procedures and therapy. Here we see the average nonrisk-adjusted cost for the example TIN was about $485. The national average cost for this service category was $312. So the average cost in the TIN was about 55 percent more than the national average cost.

If you move to the column to the right, you will see that the average percent of episodes receiving — you will see the average percent of episodes receiving outpatient E&M services. The average for this TIN was 77 percent, while the national average was about 79 percent. The last two columns show the average utilization for each service for episodes attributed to the TIN and for episodes across the nation. In this example, episodes have an average of five outpatient E&M visits, while the national average was about three outpatient E&M visits.

Exhibit 4 allows you to examine your average episode cost and utilization by service category. This will, hopefully, allow you to identify drivers of high episode costs compared to the national average and determine next steps to reduce unnecessary high cost.

Now I'm moving on to slide 47. The drill down tables are created for each individual episode type and subtype. The information provided in drill down tables supplement the episode-level statistics provided in Exhibits 1 through 4 and provide information for each instance of an episode attributed. This includes the episode type, episode risk score, nonrisk-adjusted cost, the beneficiary's risk score, the episode start day, and physician and nonphysician cost by service category. We hope that the tables increase the actionability of reports by providing beneficiary-specific information and episode-specific information.

As you can see on the slide, Drill Down Table 1 will provide episode-level information, Drill Down Table 2 will provide episode breakdown of physician costs billed by your TIN and by other TINs, Drill Down Table 3 includes the episode breakdown cost for nonphysician costs.

For the next three slides, starting on slide 48, I will walk through an example of Drill Down Table 1. Drill Down Table 1 provides the basic episode, beneficiary, and attribution information for your episode — for each episode attributed to your TIN. If you have more than one episode for a given episode type, you will see multiple rows of data in this table. In your reports, you can use the beneficiary HIC, sex, date of birth, and date of birth to compare this data to your own records. To help facilitate this, all costs are actual Medicare payment amounts that are nonpayment standardized and nonrisk-adjusted.

Drill Down Table 1 shows the additional information for each episode, including lead eligible professional, evaluation and management visits performed during the episode, and Physician Fee Schedule cost billed during the episode. The number of E&M visits reported include all E&M visits performed during the episode, not just during the trigger event. Similarly, the physician costs reported are actual Medicare fee-for — Physician Fee Schedule payment amounts, based on services use during the entire episode window.

These sections are for informational purposes only since acute condition episodes are attributed based on inpatient E&M visits during the trigger stay, and procedural episodes are attributed based on the billing physician, as discussed earlier on slide 16.

Drill Down Table 1, as shown on slide 50, also lists the providers involved in treating the episode. This includes the count of EPs treating episodes within and outside your TIN and the earliest hospitals, skilled nursing facility, and home health agencies involved in the episode.

Drill Down Table 2 provides detailed information on physician costs billed by the TIN and other TINs for episodes of this type. By examining physician cost breakdown, you will be able to gauge your involvement in the episode based on the cost billed by your TIN vs. billed by other TINs. In addition, you can identify trends and service use among your attributed patients. The physician costs are based on cost billed on carrier claims during the entire episode window. As noted, all costs reported in the drill down tables are actual Physician Fee Schedule payment amounts, which are nonpayment-standardized and nonrisk-adjusted.

Slide 52 shows the service category breakdown provided for physician costs billed by your TIN during the episode. The same service category breakdown is also provided for physician costs billed by other TINs during the episode.

On slide 53, Drill Down Table 3 provides detailed information on nonphysician cost for episodes of this type that were attributed to your — the TIN. This cost breakdown can be used to identify opportunities for improvement in care coordination and management.

For example, in slide 54, we can see that you can identify the costs from skilled nursing facilities that are contributing to your total episode cost. As mentioned before, specifications for how each column is defined is included in the Detailed Methods document posted on the CMS Supplemental QRUR web page.

Now that we have gone over the structure and data included in the 2014 Supplemental QRURs, we will next discuss how to access your reports.

**Accessing Your Report**

Slides 56 and 57 provide the steps you needed to take to gain access to the Supplemental QRURs. The first step is to obtain an Enterprise Identity Data Management account with the correct role, as listed here. If your TIN has two or more eligible professionals, your account should either be the role of a secretary — a security official or a group representative. If you are a solo practitioner, your account should have the role of individual practitioner or individual practitioner representative.

Instructions on how to obtain an Enterprise Identity Data Management account can be found at the bottom of this slide.

Next, you can follow the step-by-step instructions listed on slide 57 to access your 2014 Supplemental QRURs and your 2014 Supplemental QRUR Drill Down Tables. If you have any questions about the report, please contact the Physician Value help desk. If you have questions about setting up an Enterprise Identity Data Management account, please contact the QualityNet help desk.

Now I'm moving on to slide 60. CMS welcomes any feedback on the episode report structure and report content. If you have any comments or suggestions to improve how episodes are reported in the Supplemental QRURs, please email the Physician Value help desk email address at PVHelpdesk@cms.hhs.gov. Please be sure to not include any personally identifiable information. If there is a question about the TIN's report or a specific beneficiary's episode, a call can be set up to discuss your question over the phone.

**Resources**

For further information on the 2014 Supplemental QRURs, we encourage everyone to visit the CMS web page. There are a number of supporting documents that will help address many of your questions. On the web page, you'll find a detailed methodology of the report, tips for understanding and using the report, responses to frequently asked questions, instructions on how to access the report, episode definitions, and a sample of 2014 Supplemental QRURs.

Specifications for episode components, as you can see on slide 62, 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 Exhibit C of the Detailed Methods document. Costs are provided at the service category level and Exhibit 3 and 4 and Drill Down Tables 2 and 3 of your 2014 reports.

Now I would like to turn it over to Amanda to facilitate the question-and-answer section of this call.

## Question-and-Answer Session

Amanda Barnes: Thank you so much Rachel. At this time, our subject matter experts will now take your questions about the 2014 Supplemental QRURs. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Please state your name and the name of your organization once your line is open. In an effort to get to as many participants as possible, we ask that you limit your question to just one.

All right, Kalia, we're ready to start Q&A.

**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. Please hold while we compile the Q&A roster.

Your first question comes from the line of Julia Keith.

Julia Kyles: Hi, this is Julia Kyles from DecisionHealth. And I just wanted to know if you can — could you confirm on page 52, did you say that other — providers will be able to see other services provided during the episode, like if someone — if the patient had anesthesia, they could see that?

Rachel Yong: Yes. This is Rachel from Acumen. You — as I said on slide 52, it's going to be …

Julia Kyles: Right.

Rachel Yong: … a breakdown of physician costs for your TIN and then also by other TINs. It's going to be a summary of all the costs from all other TINs that were involved in that patient care delivery.

Julia Kyles: Thank you very much.

Rachel Yong: No problem.

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

Gene Q.: Hi, this is Gene Q. from the University of Missouri. We're trying to get some clarification on the knee and joint repair. Does that include all knee and joint replacement?

Amanda Barnes: Rachel, are you able to answer? One second.

Rachel Yong: Oh! Yes, this is Rachel. So, all knee replacement surgeries that your TIN may have been responsible for would fall under the knee arthroplasty episode type. And then all the joint repairs would fall under the knee joint repair episode, and the subtypes are meniscus repair and knee ligament repair.

Does that answer the question?

Gene Q.: OK. So, basically, anything that's, say, I guess, under 41 and 42, that goes into the knee joint repair — under 40, right? Those are just subcategories?

Rachel Yong: Yes. So you'll see for all the knee joint repairs will either be categorized into those two buckets. And I definitely encourage you to look at the episode definition files that we posted on the CMS webpage.

Gene Q: OK.

Rachel Yong: And you'll find a file specific for each sub — for each episode type. So, for example, you'll want to look at the knee joint repair episode file, and you'll see all the trigger codes and how we defined the two subtypes and how we categorize them.

Gene Q.: OK, thank you.

Rachel Yong: No problem.

**Operator**: If you would like to ask a question, press star 1 on your telephone keypad. To withdraw your question or if your question has been answered, you may remove yourself from the queue by pressing the pound key. Your next question comes from the line of Chris Evans.

Chris Evans: Hi, this is Chris Evans with Advanced Dermatology in Allentown, Pennsylvania. In reference to prescription drugs that we don't actually sell, but we write a prescription for part of an episode, say, for psoriasis, will that amount — will the cost of prescription drugs be attributed to our episode of care?

Rachel Yong: That's a great question. So, for these measures, any Part D cost is not included. But, for example, if your physician — if those pharma — those drugs were covered under Part B, and they were deemed as clinically relevant based on their codes, and you'll see those codes on the episode definition files, if those are deemed as both under Part B and clinically relevant, then that will be included in the episode.

Christopher Evans: Thank you.

Rachel Yong: No problem.

**Operator**: And there are no further questions. We did just have one that came back into queue. It comes from the line of Janet.

Janet Brier: Hi, this is Janet Brier calling from Professional Orthopaedic Associates in Scranton, Pennsylvania. And I was on the phone with the operator when I heard the answer to that — when the answer to that drug question was given. And I didn't hear it. Are they or are they not a part of the episode of care?

Rachel Yong: Oh, no problem, I can — I can restate what I said before. So…

Janet Brier: OK.

Rachel Yong: …Part D, the episode cost only includes Part A and Part B Medicare cost.

Janet Brier: OK.

Rachel Yong: So any Part D cost …

Janet Brier: OK.

Rachel Yong: … any drugs that were covered under Part D wouldn't be included, but drugs…

Janet Brier: OK.

Rachel Yong: …that are covered under Part B may be included…

Janet Brier: Um-hum.

Rachel Yong: …if they are deemed as clinically relevant.

Janet Brier: My confusion — I thought it was something like that, OK, and then — but the reason I was calling is, when can we get these reports? I missed that, too.

Rachel Yong: The reports are actually …

Janet Brier: When would they be available to us? Will we be notified or do we just do this proactively?

Rachel Yong: The reports — actually, you should have been notified already.

Janet Brier: OK.

Rachel Yong: They went — they went live at the end of September.

Janet Brier: OK.

Rachel Yong: Do you have an Enterprise Identity Data Management …

Janet Brier: I do.

Rachel Yong: …account?

Janet Brier: Um-hum.

Rachel Yong: You should be able to access it through that.

Janet Brier: OK, thank you very much.

Rachel Yong: No problem.

**Operator**: If you would like to ask a question, press star 1 on your telephone keypad. To withdraw your question, or if your question has been answered, you may remove yourself from the queue by pressing the pound key. Your question comes from the line of Tracy.

Tracy Leavitt: This is Tracy Leavitt, and I'm calling from a pathology group. And we did not receive — what, basically, in our reports, a large part of them is kind of missing. I mean, obviously, this episode of care, this type of thing. Is that because of our specialty, or am I just missing part of our report?

Rachel Yong: It may most likely be 'cause you're not — it may be because your TIN is entirely specialized — is not touching episodes of other episode types. But this is definitely something that you can submit through your — the PV help desk, for them to double check that you aren't missing anything. But I would — I couldn't hear what specialty or what association you're from.

Tracy Leavitt: We're with — we're pathology.

Rachel Yong: OK, yes, the reason may be because your TIN is not touching all the episode types that we reported.

Tracy Leavitt: OK, I mean, should it — should our — that TIN touch all the episode types, you know — if we don't bill E&M codes, would that have anything to do with it?

Rachel Yong: Yes, that could be. Because the way we attribute acute condition episodes is based on inpatient E&M during the trigger event. So that may be a large part of it.

Amanda Barnes: Thank you so much for your question. Kalia, next one please.

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

Elizabeth: Hi. In a little bit reference to the last question about — maybe two questions ago about timing, is there any plan to release these earlier in the future years? Releasing them three-quarters of the way through the year can present challenges in actually implementing any changes from the results of these supplemental exhibits.

Kim Spalding Bush: Hi, this is Kim Spalding Bush from Centers for Medicare & Medicaid Services. At this time, we don't have a plan to release the reports any earlier. And I think a large part of that is because after the performance period we allow at least a 3-month claim runout to ensure that we have completeness of claims because these are all claims-based measures. And so then after pulling the claims data, the measures have to get calculated and the reports populated and then posted. So we certainly do recognize

the interest in receiving timely data, and we do our best to get it out as soon as possible. But in terms of releasing them significantly earlier, no, we don't have a view to doing that.

And just so — reminder for everyone, as Rachel stated at the beginning of the call, that these are reports that we provide for informational purposes. They don't currently contain data that affects the Value Modifier. So I just want to make that point clear. But we do understand that you're looking to improve performance and improve efficiency on these conditions, and we understand that. So we do try to get them out to you as soon as we can. But the short answer is, no, we don't have a plan to get them out very much earlier.

Elizabeth: I'm sorry, were you saying that you don't actually impact the Value Modifier?

Kim Spalding Bush: Correct. These are Supplemental Quality and Resource Use Reports. They're separate from the Quality and Resource Use Report that would contain your Value Modifier, measure performance rates. And if you are in a TIN that's subject to the Value Modifier, that main Quality and Resource Use Report would also contain your payment adjustment information. The Supplemental QRUR reports just provide you with information about the cost of services that you're providing to patients for certain episode types.

Elizabeth: But there could potentially be overlap between the cost metrics in the supplemental ones and the cost measures that are actually part of the official Value Modifier program?

Kim Spalding Bush: There is not overlap, no. And if you — if CMS were to want to include this in a payment adjustment program in the future, we would have to do that through notice and comment rulemaking. So, these measures are actually for your information to just improve on the efficiency of the care that you're providing to your beneficiaries.

Elizabeth: Great, thank you.

Kim Spalding Bush: Sure.

**Operator**: Your next question comes from the line of Toni Ambrosy.

Toni Ambrosy: Yes, this is Toni with the North Houston Nephrology, and our specialty is nephrology. So I just — your answer on the previous question regarding these particular supplemental quality reports do not impact our Value-Based Modifier. How does nephrology — because we've printed out our reports — how does nephrology for end stage renal disease and chronic kidney disease, does it — how does it factor into the episodes that you have listed?

Amanda Barnes: Rachel, are you able to answer that question related to the specific episodes included in the Supplemental QRURs?

Toni Ambrosy: Because that could include …

Toni Ambrosy: …dialysis — acute dialysis.

Rachel Yong: So, in the report you'll see — I just wanted to make sure, are you looking at the Supplemental QRUR report and not the QRUR report?

Toni Ambrosy: We were in both.

Rachel Yong: OK.

Toni Ambrosy: Using data for both.

Rachel Yong: Great. So the episode type that might be most relevant to your group will probably be the kidney and UTI episode type in the Supplemental …

Toni Ambrosy: OK.

Rachel Yong: … QRURs.

Toni Ambrosy: OK, great. Thank you.

Rachel Yong: No problem.

**Operator**: Your next question comes from the line of Wendy Pitts.

Wendy Pitts: Hi, this is Wendy. The reports are based on claim-based data. Are there any plans to supplement the report in the future with GPRO or PQRS reporting information?

Kim Spalding Bush: Hi, this is Kim from CMS again. No, there's not plans to include the GPRO PQRS data in the Supplemental QRUR reports. We do use the PQRS data, whether reported through GPRO option or another reporting option, in the Value Modifier calculation. So that data is included in the main Quality and Resource Use Report that lets groups know how they performed on the measures that are used for the VM calculation.

Wendy Pitts: OK, thank you.

Rachel Yong: Sure.

**Operator**: Your next question comes from the line of Sharron Harmon.

Sharron Harmon: Oh, I'm sorry, my question has already been answered.

Amanda Barnes: Thank you.

**Operator**: You do have a followup question from the line of Gene Q.

Gene Q.: Hi. So we were wondering if the episodes for knee replacements and hip — or not knee replacement — hip and knee, if those could be used as any ways like a predictive model for the Comprehensive Care Joint Replacement Program or if those are, like, completely separate?

Kim Spalding Bush: Hi, this is Kim from CMS. I am actually not familiar with the construct of the bundle, so I couldn't respond to that question. And we don't have anyone here from the comprehensive payment program, so I don't think we can answer that question. But there are different measures.

Gene Q.: OK, that's fine.

Amanda Barnes: Thank you.

**Operator**: And your next question comes from the line of Karen Smith.

Karen Smith: Yes, this is Karen Smith with the Surgical Clinic of Central Arkansas. And you said that we would receive notice that these supplemental reports were available. I'm not receiving a notice. How was I supposed to receive this notice? The only reason I knew about the supplemental report was because I signed up for this call.

Kim Spalding Bush: Hi, this is Kim from CMS, thanks. So we send out listserv messages through a variety of channels that announce the availability of these reports. So you wouldn't have received a direct email to your organization. It comes out on CMS, like eNews listservs and a couple of other listservs …

Karen Smith: OK.

Kim Spalding Bush: …that you may subscribe to.

Karen Smith: Got you. OK, thank you very much.

Kim Spalding Bush: Sure.

**Operator**: And there are no further questions.

## Additional Information

Amanda Barnes: Thank you so much. 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 66 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous, confidential, and voluntary. We hope you take a few moments to evaluate your experience.

Again, my name is Amanda Barnes, and I'd like to thank our presenter and also thank you for participating in today's MLN Connects Call on 2014 Supplemental QRURs. Have a great day everyone.

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

**-END-**


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