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National Provider Call

How to Interpret Your 2015 Supplemental Quality and Resource Use Report (QRUR)

October 20, 2016

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Agenda

- Introduction
- CMS' Approach to Episode-Based Measures
- Understanding Your 2015 Supplemental Quality and Resource Use Report (QRUR)
- Accessing the Reports
- Giving Feedback
- Questions and Answers

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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Introduction to the 2015 Supplemental QRURs

- Distributed to all medical group practices and solo practitioners with at least one 2015 Supplemental QRUR episode
  - Reports are confidential and for informational purposes only
  - Reports will not be used to make payment adjustments
- Supplement the per capita total cost and quality information provided in the 2015 QRURs
- Examine Medicare fee-for-service patients only
- Contain a total of 67 reported episode types
  - 23 acute condition episodes
  - 44 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
- Part of Medicare's shift from a system that rewards volume of service to one that rewards efficient, effective care and reduces delivery system fragmentation

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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- Introduction
- **CMS' Approach to Episode-Based Measures**
  1. **Construct Episodes**
  2. Attribute Episodes
  3. Report Episodes
- Understanding Your 2015 Supplemental QRUR
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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. Open episode
  2. Group clinically relevant services
  3. Close episode

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

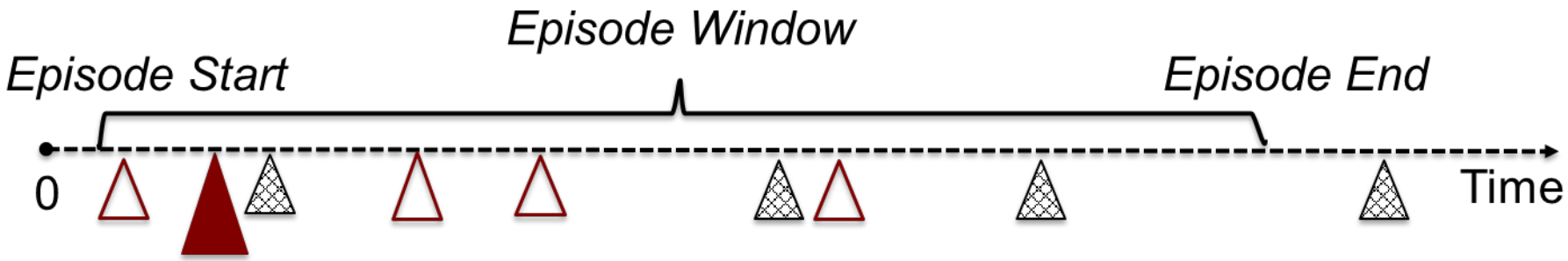
1. Open episode
   - A trigger event that is identified by certain procedure or diagnosis codes on certain types of claims that indicate the presence of the index condition/procedure
2. Group clinically relevant services
   - Services that occur during the episode time period and are identified as clinically related to episode
     - Some episodes include services and procedures occurring a few days prior to the trigger event
3. Close 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 29 episode types, and Method B is used for 38 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

Transition to ICD-10

- Both Method A and Method B were updated to include ICD-10 codes in episode definitions
- The updated process used clinical review of CMS's General Equivalency Mappings (GEMs) to select the most appropriate ICD-10 code for each ICD-9 code included in an episode definition
  - ICD-10 codes were used when constructing any episodes with dates spanning October 1st, 2015 to December 31st, 2015.
- The selected ICD-10 codes for each episode type are available for review in the Episode Definitions files

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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 6-9 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 that triggered the episode

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 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 2015 Supplemental QRURs *(1 of 5)*

- The reports contain 67 total episode types
  - 23 major episode types:
    - 9 major acute condition episode types and 14 major procedural episode types
  - 44 episode subtypes:
    - 14 acute condition episode subtypes and 30 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 2015 Supplemental QRURs *(2 of 5)*

Acute Condition Episode Types *(1 of 2)*

1. Acute Myocardial Infarction (AMI) (All)
    2. *AMI Non-ST Elevation Myocardial Infarction (NSTEMI) without PCI/CABG*
    3. *AMI NSTEMI with PCI*
    4. *AMI NSTEMI with CABG*
    5. *AMI ST Elevation Myocardial Infarction (STEMI) without PCI/CABG*
    6. *AMI STEMI with PCI*
    7. *AMI STEMI with CABG*
8. Asthma/Chronic Obstructive Pulmonary Disease (COPD), Acute Exacerbation
9. Atrial Fibrillation (AFib)/Flutter, Acute Exacerbation
10. Cellulitis (All)
    11. *Cellulitis in Diabetics*
    12. *Cellulitis in Patients with Wound, Non-Diabetic*
    13. *Cellulitis in Obese Patients, Non-Diabetic without Wound*
    14. *Cellulitis in All Other Patients*
15. Gastrointestinal (GI) Hemorrhage (All)
    16. *GI Hemorrhage, Upper and Lower*
    17. *GI Hemorrhage, Upper*
    18. *GI Hemorrhage, Lower*
    19. *GI Hemorrhage, Undefined*

Episodes in the 2015 Supplemental QRURs *(3 of 5)*

Acute Condition Episode Types *(2 of 2)*

20. Heart Failure, Acute Exacerbation
21. Ischemic Stroke
22. Kidney and Urinary Tract Infection (UTI)
23. Pneumonia, Inpatient (IP)-Based

Episodes in the 2015 Supplemental QRURs *(3 of 5)*

Procedural Episode Types *(1 of 3)*

24. Aortic Aneurysm Procedure (All)
    - *25. Abdominal Aortic Aneurysm Procedure*
    - *26. Thoracic Aortic Aneurysm Procedure*
27. Open Heart Valve Surgery (All)
    - *28. Both Aortic and Mitral Valve Surgery*
    - *29. Aortic or Mitral Valve Surgery*
    - *30. Pulmonary or Tricuspid Valve Surgery*
31. Cholecystectomy and Common Duct Exploration (All)
    - *32. Cholecystectomy*
    - *33. Surgical Biliary Tract Procedure*
34. Colonoscopy (All)
    - *35. Colonoscopy with Invasive Procedure*
    - *36. Colonoscopy without Invasive Procedure*
37. Coronary Artery Bypass Graft (CABG)
    - *38. CABG with AMI*
    - *39. CABG without AMI*
40. Hip/Femur Fracture or Dislocation Treatment, IP-Based

Episodes in the 2015 Supplemental QRURs *(4 of 5)*

Procedural Episode Types *(2 of 3)*

41. Hip Replacement or Repair (All)
    - *42. Hip Arthroplasty*
    - *43. Hip Arthroscopy and Hip Joint Repair*
44. Knee Arthroplasty
45. Knee Joint Repair (All)
    - *46. Meniscus Repair*
    - *47. Knee Ligament Repair*
48. Lens and Cataract Procedures (All)
    - *49. Cataract Surgery*
    - *50. Discission*
    - *51. Intraocular Lens (IOL) Removal/Repositioning or Secondary IOL Insertion*
52. Mastectomy for Breast Cancer (All)
    - *53. Lumpectomy or Partial Mastectomy without Reconstruction*
    - *54. Lumpectomy or Partial Mastectomy with Reconstruction*
    - *55. Simple or Modified Radical Mastectomy without Reconstruction*
    - *56. Simple or Modified Radical Mastectomy with Reconstruction*
    - *57. Subcutaneous Mastectomy*

Episodes in the 2015 Supplemental QRURs *(5 of 5)*

Procedural Episode Types *(3 of 3)*

58. Percutaneous Coronary Intervention (PCI) (All)
    59. *PCI, IP-Based*
    60. *PCI, OP-Based*
61. Spinal Fusion (All)
    62. *Anterior Fusion – Single*
    63. *Anterior Fusion – Two Levels*
    64. *Posterior/Posterior-lateral Approach Fusion – Single*
    65. *Posterior/Posterior-lateral Approach Fusion – Two or Three Levels*
    66. *Combined Fusions*
67. Transurethral Resection of the Prostate (TURP) for Benign Prostatic Hyperplasia

Episode Cost Calculation

- Calculate the average payment-standardized, risk-adjusted episode cost to Medicare for a provider in the 2015 Supplemental QRURs using the following steps:
  1. Payment-standardize claim payments
  2. Calculate standardized episode costs
  3. Winsorize 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 episode
- All grouped services are determined by the episode construction methodology described previously and occur during the episode window

3. Winsorize Observed Episode Costs

- Winsorize (i.e., “top-code”/“bottom-code”) observed cost for extremely high-cost and low-cost episodes
- Process of winsorizing 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 winsorized 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 to Medicare are reported relative to the average of all episodes nationally
  - The national population includes all Medicare FFS beneficiaries who had a claim in 2015 that triggered one of the episode types reported in the 2015 Supplemental QRURs
  - Population includes approximately 5.3 million beneficiaries

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Supplemental QRURs Overview *(1 of 2)*

- Reports include 4 exhibits and 3 drill down tables
  - The 2015 Supplemental QRUR exhibits provide results for the sum of all instances of the episodes attributed to the group
  - The 2015 Supplemental QRUR drill down tables provide detailed information for each instance of the episodes attributed to the group
  - The 2015 Supplemental QRUR appendices provide definitions for key terms and service categories included in the reports
- Episode costs to Medicare are payment-standardized and risk-adjusted, unless otherwise noted
- Results are for informational purposes only and will not be used for payment adjustments. Episode types with low counts should be interpreted with caution.

Supplemental QRURs Overview *(2 of 2)*

- An addendum to this presentation will include detailed summary statistics of the 2015 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

Report Appendices

- Provide definitions for key terms used in the reports and service categories included in the reports
- Appendix 1 shows definitions for key terms
- Appendix 2 shows service category definitions for categories listed in Exhibit 3 and Exhibit 4
- Appendix 3 shows service category definitions for categories listed in the Drill Down Tables

Exhibit 1: Summary of All Episode Types *(1 of 2)*

- Compares the cost to Medicare 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 Episode Types *(2 of 2)*

Percent Difference

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

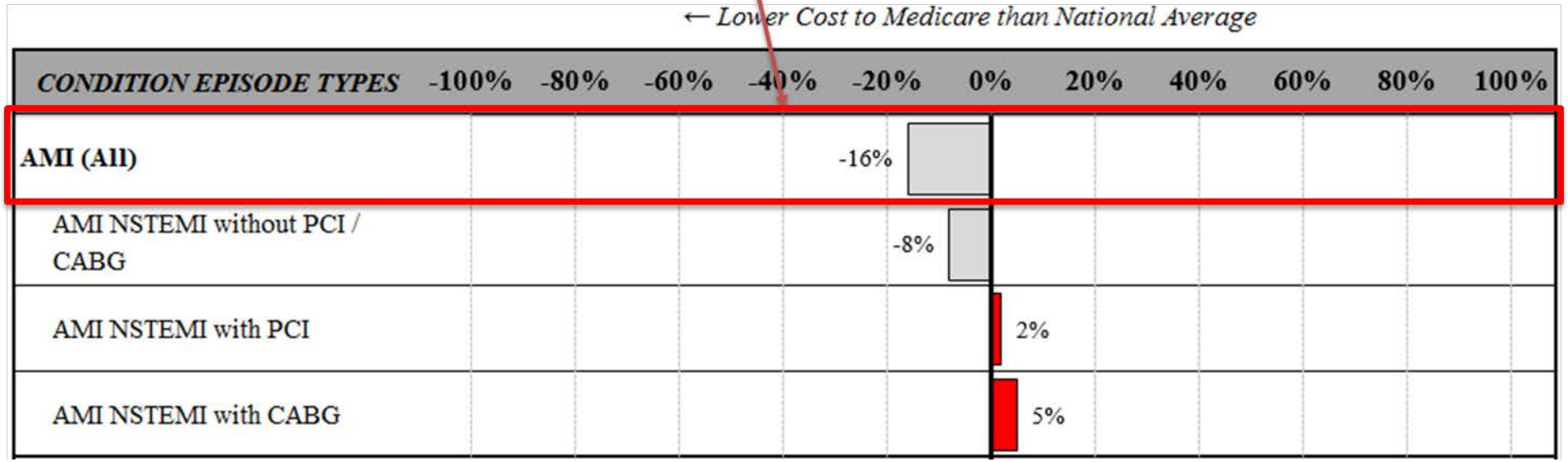

Exhibit 2: Frequency and Cost to Medicare for All Episode Types *(3 of 3)*

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

Exhibit 2: Frequency and Cost to Medicare for All Episode Types *(3 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 TO MEDICARE†		
	Your TIN	National	Your TIN	National	% Cost Difference
Condition Episode Types					
AMI (All)	16 (100%)	79%	$14,050	$19,422	-28%
-AMI NSTEMI without PCI/CABG	8 (50%)	56%	$8,263	$14,893	-45%
-AMI NSTEMI with PCI	4 (25%)	38%	$17,468	$21,086	-17%
-AMI NSTEMI with CABG	4 (25%)	6%	$50,603	$52,196	-3%

Exhibit 2: Frequency and Cost to Medicare for All Episode Types *(3 of 3)*

Average Risk-Adjusted Episode Cost

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

	EPISODE FREQUENCY†		AVG. RISK-ADJUSTED EPISODE COST TO MEDICARE†		
	Your TIN	National	Your TIN	National	% Cost Difference
Condition Episode Types					
AMI (All)	16 (100%)	79%	$14,050	$19,422	-28%
-AMI NSTEMI without PCI/CABG	8 (50%)	56%	$8,263	$14,893	-45%
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Exhibit 3: Episode Type Summary

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

Exhibit 3.A: Your Episode Type 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 to Medicare			Avg. Risk-Adjusted Episode Cost to Medicare†			Avg. % Physician Fee Schedule Costs Billed by Your TIN During Episode†
			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 to Medicare for Episode Components

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

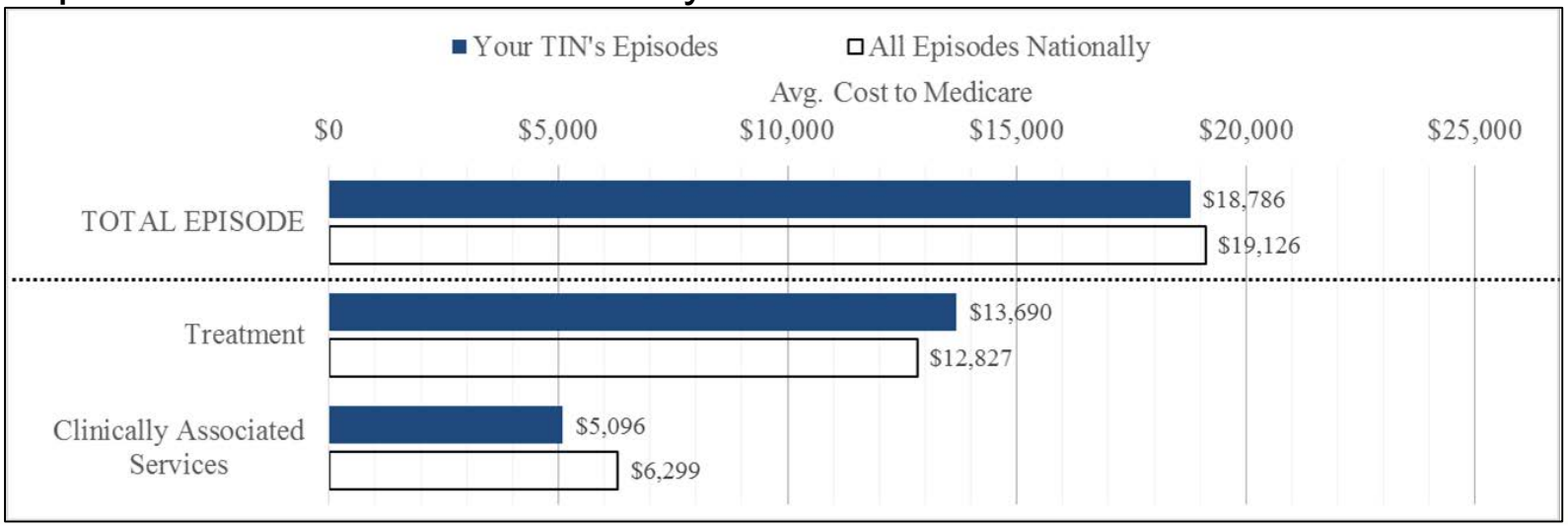

Exhibit 3.C: Average Cost to Medicare for Select Service Categories in Episode

- 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

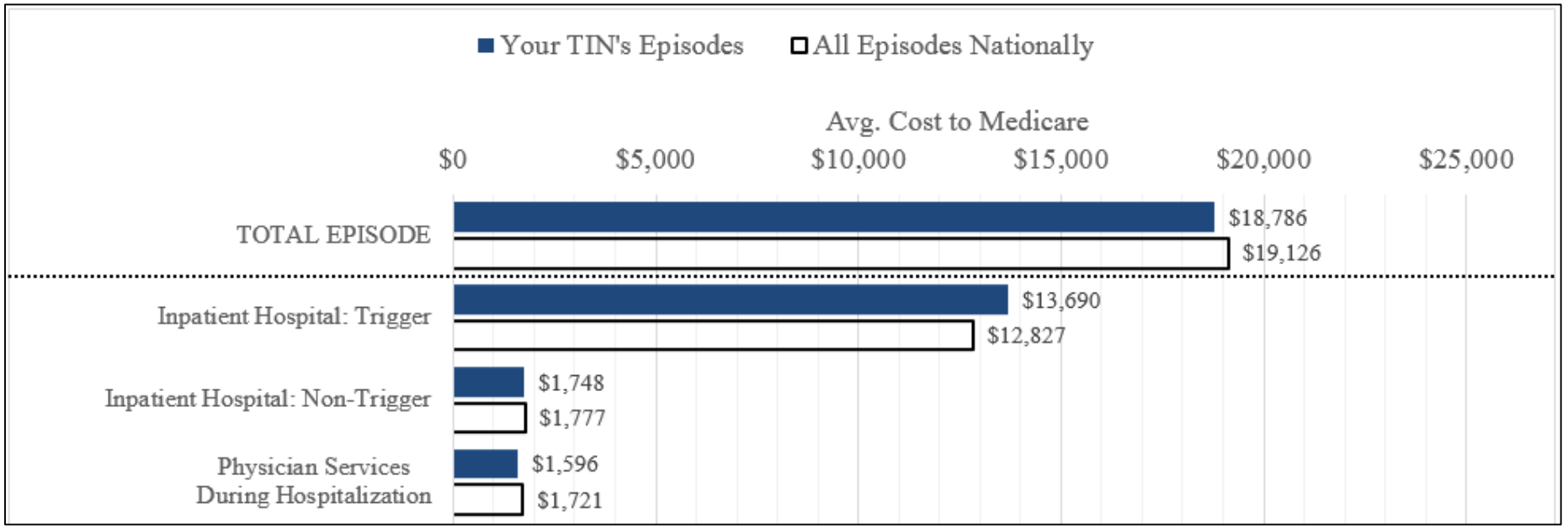

Exhibit 3.D: Top Five Highest Average-Billing Providers Treating Episode

- 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 Type Service Category Cost to Medicare 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 clinically associated services costs

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

	AVG. NON-RISK-ADJUSTED COST TO MEDICARE			AVG. % EPISODES RECEIVING SERVICE		AVG. UTILIZATION	
	Your TIN	National	% Cost 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 Summary Information
- **Drill Down Table 2:** Episode Breakdown of Physician Costs to Medicare Billed by Your TIN and Other TINs
- **Drill Down Table 3:** Episode Breakdown of Non-Physician Costs to Medicare

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 to Medicare and Risk Percentile Information *(Payment Standardized)*				Beneficiary Information				
Episode ID	**Episode Type** *(If Applicable)*	**Non-Risk-Adjusted Cost to Medicare**	**Risk-Adjusted Cost to Medicare†**	**Risk-Adjusted Cost to Medicare Percentile†**	**Risk Score Percentile†**	**Beneficiary HIC**	**Sex**	**Date of Birth**	**Episode Start Date**	**Death Date, if During Episode**
1059	AMI NSTEMI w/PCI	$15,233	$17,891	47th	58th	-	-	-	4/13/2015	-

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 to Medicare**	**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 to Medicare 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 Medicare 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 to Medicare 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 to Medicare billed by other TINs

Physician Costs to Medicare 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 to Medicare
  - 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 to Medicare 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

Agenda

- Introduction
- CMS' Approach to Episode-Based Measures
- Understanding Your 2015 Supplemental QRUR
- **Accessing the Reports**
- Giving Feedback
- Questions and Answers

Accessing the Reports *(1 of 4)*

- You can access a Supplemental QRUR on behalf of a physician group or physician 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 4)*

- If you already have or after you establish an EIDM account with the correct role, follow these steps to access your TIN's 2015 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, password, and Multi-Factor Authentication (MFA) security code to log in
  3. Select the "PV-PQRS" tab, and the "Feedback Reports" option
  4. Select "2015" and then "2015 Supplemental QRURs"
  5. Select either "View Online" or "Download in a PDF Format"
  6. Complete your role attestation
  7. Select your TIN

Accessing the Reports *(3 of 4)*

- If you use Internet Explorer (IE) as your web browser, please make sure the CMS Enterprise Portal (https://portal.cms.gov) is added to the browser's trusted sites to prevent problems exporting your feedback report(s) to Excel.
    1. On the browser tool bar, go to Tools, select Internet Options, select the Security tab and then select Trusted Sites.
    2. On the Trusted Sites screen, click on the Sites button. If you do not see the portal address in the list of trusted Websites, click the Add button to add the portal address.
    3. Select Close and then OK to save and return to the IE.
- Alternatively, you may use Chrome or Firefox as your browser to view and export your report(s).

Accessing the Reports *(4 of 4)*

- For step-by-step instructions, refer to the "Guide for Accessing the 2015 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
- For questions about your report, please contact the Physician Value (PV) Helpdesk at 888-734-6433, option 3, 8:00 AM – 8:00 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

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Giving Feedback on the 2015 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 2015 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 2015 Supplemental QRURs
  - Tips for understanding and using the Supplemental QRURs
  - Responses to frequently asked questions (FAQs)
  - Instructions to access the 2015 Supplemental QRURs
  - Episode definitions
  - A sample of the 2015 Supplemental QRUR

Further Information *(2 of 2)*

- Specifications of episode components, such as the trigger event, treatment component, and clinically associated services component, are included in Sections 2, 5, and 6 of the *Detailed Methods* document
- Service categories shown in this presentation are defined in Appendix 2 and 3 of the reports and 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

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:

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/CEInfo-MLNConnects-TC-L10202016.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