MLN Connects®

National Provider Call Transcript

Centers for Medicare & Medicaid Services
2015 Supplemental QRUR Physican Feedback Call
MLN Connects National Provider Call
Moderator: Aryeh Langer
October 20, 2016
1:30 pm ET

Contents

Operator: At this time, I'd 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 Aryeh Langer. Thank you. You may begin.

Announcements and Introduction

Aryeh Langer: Thank you, Holley.

And as you just heard, my name is Aryeh Langer from the Provider Communications Group here at CMS, and I am your moderator for today's call. I would like to welcome you to this MLN Connects National Provider Call on Quality and Resource Use Reports, or QRURs, and Physician Feedback Program. MLN Connects Calls are part of the Medicare Learning Network®.

During today's call, CMS subject matter experts will provide information about the 2015 Supplemental QRURs' Confidential Feedback Reports for medical group practices and solo practices on resource use for fee-for-service episodes of care. A question-and-answer session will follow the presentation.

Before we get started, I have a few announcements to share.

You should have received a link to the slide presentation for today's call in previous registration emails. If you have not already done so, please download the presentation from the following URL—www.cms.gov/npc. Again, that URL is www.cms.gov/npc as in National Provider Call. At the left side of the webpage, select National Provider Calls and Events, then select the date of today's call from the list.

This call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when these become available.

Registrants were given the opportunity to submit questions. We thank everyone who submitted questions prior to today's call, and we hope to use those as part of today's presentation.

Lastly, this MLN Connects Call is being evaluated by CMS for CME and CEU continuing education credit. For additional information, please refer to slide 72 of today's presentation for a link to the CE activity information and instructions document.

At this time, I would like to turn the call over to Dr. Rose Do for the first part of our presentation.

Presentation

Dr. Rose Do: Thank you.

And thank you, everyone, for joining us on this call today. My name is Rose Do. And our team here at Acumen, LLC, worked with CMS to produce the supplemental QRURs. I'm joined here with Rachel Liu and Devin Drewry from Acumen as well.

I'm going to start with slide 3, which lists the agenda for today's call. And during today's call, I will introduce the 2015 Supplemental Quality and Resource Use Reports, QRURs, and the episode-based measures reported in them. We will then discuss CMS' 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 presentation today is meant to be a general overview that I hope will provide you -- will help you understand and appreciate the utility of these reports.

So, on the next slide, before we move on, slide number 4 provides a number of acronyms that we will be using during today's presentation.

And, then, on slide number 5, the first section will provide an introduction to the supplemental QRURs. So, the 2015 Supplemental QRURs were distributed to all medical

group practices and solo practitioners with at least one episode in 2015. The reports are confidential and are for informational purposes only. We wanted to note that to ensure that your reports are downloaded correctly, please make sure to add https://portal.cms.gov to your list of trusted sites in the Internet Explorer web browser. We will discuss this further in the Accessing the Reports section of this presentation.

Introduction

The 2015 Supplemental QRURs provide information on the cost of care for Medicare fee-for-service patients based on episodes of care, also referred to as episodes. 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 capita total cost and quality information provided in the 2015 QRURs that were released last month.

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 a valve surgery or hip replacement. And the 2015 Supplemental QRURs included a total of 67 reported episode types. There were 23 acute condition and 44 procedural-based episode types.

And then on slide 7, episodes are defined as the 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. 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 they can be used to improve care.

CMS has developed and continues to develop Medicare-specific episodes to ensure that the episodes recognize the uniqueness of Medicare patients and unique payment rules. Medicare beneficiaries tend to be older and medically complex, and the episodes must account for this. In the next section, I will provide background information on CMS' approach and use of episodes and will outline how they can be used to provide information on patterns of medical care.

So, on slide number 9. 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 that care is being delivered. Episodes, as discussed in slide number 7, 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 QRURs 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 information on your resource use is presented and welcomes any feedback on the episodes and the report structure and content.
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 practices or solo practitioners that are responsible for the care and management of the episode. Third, the episodes are reported in the Supplemental QRURs. And the following section will describe each step in more detail.

However, at this time, we are going to pause for a brief moment, and I'd like to turn it over to our moderator, Aryeh Langer.

Keypad Polling

Aryeh Langer: Thank you very much.

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

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 one. 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 nine.

Again, if you are the only one in the room, enter one. 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 nine.

Please hold while we complete the polling.

Again, please continue to hold while we complete the polling.

Thank you for your participation. I'd now like to turn the conference back over to Aryeh Langer.

Aryeh Langer: Thank you.

And at this time, I'd like to turn the call back over to Dr. Do for the next section of our presentation.

Presentation Continued

Dr. Rose Do: Thank you very much. So, we will pick up on slide 12.

CMS Approach to Episode-Based Measures

And here 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 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.

On slide number 13, episodes are started by identifying services in a beneficiary's claims that indicate 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 inpatient 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 occur during this episode time period. Last, we end the episode by a pre-determined rule such as a break in service or a fixed time period after the clinical trigger event.

On slide 14, we describe 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 the particular condition or treatment. And 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. The clinically relevant services that are grouped to the episode are represented by the small white triangles with red outline in this diagram, and services that are not grouped to the episode are represented by the small checked black triangles.

In the last step, episodes are closed after a fixed window of time after the trigger event. And this time window or episode length is selected for each episode type based on the typical course of medical care provided for that episode type. Clinical reviewers discussed and validated these episode lengths during the episode development process.

Moving on to slide 15, we'll discuss the second step, which is 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 in the 2015 Supplemental QRURs. The types of services that are often considered clinically relevant to an episode include treatments, care for typical signs and symptoms, care for complications, diagnostic tests, and post-acute care.

In slide 16, two methods are used to construct the episodes reported in the 2015 Supplemental QRURs. Method A is used for 29 episode types, and Method B is used for 38 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 payment for medical

services as obtained from Medicare administrative claims 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 procedure codes as well as interactions between episodes. Method B defines clinically relevant services as those services delivered 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 clinically relevant by clinicians. Specifics of each method can be found in the Detailed Methods document on CMS Supplemental QRUR webpage that's linked at the end of the presentation.

In slide 17, before we move on to how episodes are attributed to providers, we want to note that both Method A and B were updated to include ICD-10 codes in their episode definitions. The update process included a clinical review of CMS General Equivalency Mappings, or GEMs, to select the most appropriate ICD-10 code for each ICD-9 code included in an episode definition. There is a crosswalk of ICD-9 and ICD-10 codes included in the Episode Definitions file posted on the CMS supplemental QRUR webpage.

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

In slide 19, we see the rules used to attribute acute condition episodes and procedural episodes to one or more medical group practices or solo practitioners as identified by their 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, acute condition episodes had an average of six to nine 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 with a trigger code during the trigger event of the episode, indicating that a physician within their TIN performed a specific procedure.

In slide 20, for informational purposes only, the 2015 Supplemental QRURs identify one or more lead eligible professionals, or EPs, as identified by their National Provider Identifier, NPI, within each attributed TIN using a similar methodology as used for attribution. The lead EPs are identified to foster coordination of care improvements and are included in Exhibit 3 and the drill down tables of the 2015 Supplemental QRURs.

For the purpose of this report, EPs are defined as those physicians, practitioners, and therapists that are eligible to participate in the Physician Quality Reporting System, PQRS. These include Medicare physician—for example, doctors of medicine; practitioners—for example, 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 NPIs within the attributed TIN billing the largest share of inpatient E&M visits during episode's trigger event. For procedural episodes, the lead EPs are identified as the NPIs within the attributed TINs billing for the performance of the procedure. Now that we have constructed episodes that are attributed to a TIN, we'll next go over the episodes reported in the 2015 Supplemental QRURs.

In slide 22, the 2015 Supplemental QRURs provide information on 67 total reported episode types, 23 major episode types, and an additional 44 episode subtypes. The 67 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 the specific treatment, such as coronary artery bypass graft surgery, as well as related followup care. Subtypes were constructed to help providers understand their treatment pattern and how care for specific subsets of episodes may differ. In addition, subtypes provide additional clinical detail and improve the actionability of the report.

In slides 23 to 27, we list all the episode types reported in the 2015 Supplemental QRURs. So this slide and the next slide list 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, or AMI, your 2015 Supplemental QRURs will categorize all your AMI episodes into six subtypes, such as AMI Non-STEMI without PCI/CABG, AMI Non-STEMI with CABG or PCI, Non-STEMI with CABG, STEMI without PCI or CABG, STEMI with PCI, and STEMI with CABG. Subtype categorizations for AMI with or without PCI or CABG are determined by MS-DRG, and Non-STEMI versus STEMI are determined by diagnosis codes billed on the trigger inpatient claim.

So we'll go to slide 24.

And on slide 25, the following slides will list the procedural episode types reported in the 2015 Supplemental QRURs. So there are several procedural episode groups that also have subtypes. For example, aortic aneurysm procedure has two subtypes for abdominal aortic aneurysm procedure and thoracic aortic aneurysm procedure. Subtype categorizations are based on CPT or HCPCS codes billed on the claim that triggered the episode.

Slide number 27 provides the last set of procedural episode types reported in the 2015 reports. Full specifications for each episode type can be found in the Episode Definitions files on the CMS Supplemental QRUR webpage that's linked at the end of the presentation.

Now, on to slide 28. Now that we have walked through the episodes types included in the reports, I will turn it over to Rachel to describe how the reported episode amount is calculated.

Episode Cost Calculation

Rachel Liu: Thank you, Rose.

So there are five steps to calculating the average payment-standardized risk-adjusted episode amount for TINs. First, we payment-standardized claims payment. Then we calculated standardized episode cost. We winsorize observed episode cost. We calculate predicted episode cost. And then calculate risk-adjusted episode cost. Note that payments reflect allowed amounts, which include both Medicare trust fund payments and beneficiary deductible and co-insurance.

On slide 29, you'll see that that first step is to standardize claim payments so that the episode costs 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, this could include payments made under the Disproportionate Share Hospital payments. Payment standardization maintains differences that result from health care deliver choices such as the setting where the service is provided, the specialty of health care provider who provides the service, the number of services provided in the same encounter, and any outlier cases.

For an overview of payment standardization, please see the Basics of Payment Standardization document that's available through the QualityNet webpage that's linked at the bottom of this slide. There's also a detailed description of the methodology applied to each claim setting in a document called CMS Price Standardization Methodology, which is also available on the QualityNet webpage.

Next, on slide 30, standardized episode amounts costs are calculated before performing risk adjustment. For each episode, standardized Medicare claim payments for group services are summed together. All group services are determined by the episode construction methodology previously described.

In a third step on slide 31, extremely high-cost and low-cost standardized episode amounts are winsorized to limit the influence of outliers on the calculation of risk adjustment. Winsorization, also known as top-coding or bottom-coding, is a statistical transformation that limits extreme values and data to reduce the effect of possibly misleading outliers.

Within each episode type, this step identifies episodes with observed payment-standardized cost below the first percentile or above the 99th percentile of the episode type's observed cost distribution. The observed costs of those episodes are set to the observed cost of the episode at the first and 99th percentile, respectively.

The fourth step on slide 32 accounts for variation in patient case mix using a multiple linear regression model. The linear regression estimates the relationship between the independent risk adjustment variables and the winsorized standardized episode cost from step three. Risk adjustment variables include factors such as age, severity of illness, episode subtype, and comorbidity interactions. Older patients and patients with

many other health conditions are more likely to require greater expense for their care, and risk adjustment is our attempt to account for this. The risk adjustment model is based on the calculation used in CMS' NQF-endorsed Medicare Spending Per Beneficiary, or MSPB, measure. The linear regression model is estimated separately for each major episode type.

The last step on slide 33 is to calculate 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 winsorized observed cost, which is step three, to its expected cost, which is calculated in step four. Then it's multiplied by the national average observed episode cost. This is displayed as a simplified mathematical formula on this slide. Episode-level risk-adjusted standardized costs are calculated and reported at both the major episode type and subtype levels.

Episode costs, as described in slide 34, are reported relative to the average of all episodes nationally. The national population includes all Medicare fee-for-service beneficiaries who had a claim in 2015 that triggered one of the episode types reported in the 2015 reports. This included approximately 5.3 million beneficiaries.

Now, on slide 35, we will now turn to the reports and provide a description and some tips for understanding them.

Understanding the 2015 Supplemental QRUR

In slide 36, you'll see 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 "2015 Supplemental QRUR," contains an introductory page, and data tables are called exhibits. The second file, labeled "2015 Supplemental QRUR Drill Down Tables," contains 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 each 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 small number of episodes, such as those fewer than 10 episodes in a given type, should be interpreted with caution.

Now, on to slide 37. An addendum to this presentation will include detailed summary statistics of the 2015 Supplemental QRURs. Summary information 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 acute condition episodes. You will be able to find this addendum on the CMS supplemental QRUR webpage approximately 1 week after this call.

The Supplemental QRURs include an overview page that lists -- 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 Supplemental QRUR webpage.

There are -- on slide 39, you'll see the report includes three appendixes that shows the definition of key terms and service categories included in the episodes.

On to slide 40. Exhibit table reports -- exhibit tables report summary information on all instances of a given episode type. They do not report on each instance of each episode type. As we shall see, that can be found in the drill down table reports that we'll go over later. In Exhibit 1, you can compare the cost of all episodes attributed to your TIN to the national average cost.

Slide 41 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. Here, you'll see negative numbers depicted as light gray in the bar -- in the graph show that your attributed episodes have an average episode cost that is lower than the national average episode cost.

Positive numbers, shown as red bars in the graph, show that your attributed episodes have an average episode cost that is higher than the national average episode cost.

In this example, you'll see that all AMI episodes that were attributed to this example TIN were about 18 percent lower in cost than the average national AMI episode cost.

On slide 42, you'll see, while Exhibit 1 provides a graphical summary of all the episode types your TIN may have, Exhibit 2 provides a basic summary of statistics that underline the display in Exhibit 1. Exhibit 2 shows the count of episodes for each major type and subtype that are attributed to your TIN. It also shows you the average cost of all episodes attributed to your TIN and the national average episode cost.

On slide 43, we'll provide an example of Exhibit 2. The Episode Frequency columns provide the number and frequency of all major episode types and subtypes attributed to your TIN. In this example, you'll see that the example TIN has 16 AMI episode types: eight AMI NSTEMI episodes without PCI or CABG, four AMI NSTEMI episodes with PCI, and four AMI NSTEMI with CABG.

On slide 44, you'll see that Exhibit 2 also shows the average risk-adjusted episode cost for all episodes attributed to your TIN and at the national level. You will see in this example that the TIN has 16 AMI episodes and the average risk-adjusted episode cost is about $14,000. The national average for AMI is about $19,400. So this TIN has a negative 28-percent cost difference and is lower in cost than the national average episode cost.

Next, on slide 45, we will discuss Exhibit 3. Exhibit 3 provides more detailed summary information on all episodes of a given episode type that your TIN have. There are four sections of Exhibit 3, each of which is outlined here on slide 45.

First, we provide 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, which is treatment and clinically associated services.

Third, we depict the average cost of the episode by select service categories such as the trigger inpatient episode hospital cost and post-acute care service cost.

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

On to slide 46. Exhibit 3.A presents summary cost information about all episodes attributed to the TIN that are from the same episode type. This exhibit shows both non-risk-adjusted and risk-adjusted average episode cost. In addition, Exhibit 3.A shows the average beneficiary risk score percentile as a relative measure of the beneficiary's predicted health care spending based on a risk adjustment model described in previous slides.

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

Slide 47 shows Exhibit 3.B. Exhibit 3.B provides the average non-risk-adjusted payment-standardized cost for each episode's component for the TIN and for the national average. The graph here shows -- allows you to make comparisons between your TIN's episodes and all TINs nationally and at the level of two components, treatment and clinically associated services.

Treatment costs include all costs in days 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. Clinically associated services -- those 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 48, you see that Exhibit 3.C presents the average non-risk-adjusted payment-standardize cost for select service categories for your TIN and for the national average. Note that the service categories shown in this exhibit, shown on slide 48, are specific aggregations of the service categories that we'll later go over in Exhibit 4. This slide provides a snapshot of the Exhibit 3.C graph and shows the categories for total episode,

inpatient hospital trigger, inpatient hospital non-trigger, physician services -- and physician services during hospitalization.

In your reports, you'll see that Exhibit 3.C will also include service categories for outpatient evaluation and management services, major procedures, and post-acute care services. Specifically, you'll see skilled nursing facility cost and home health cost shown in this graph.

Exhibit 3.D, as shown on slide 49, shows 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 facilities, and home health agencies and eligible professionals. The top five billing hospitals, skilled nursing facilities, and home health agencies overall are listed based on the cumulative cost of all episodes attributed to the TIN.

The top five eligible professionals are listed for each major episode type based on the cumulative cost of all attributed episodes within that episode type. For example, the top five billing hospitals are identified from the sum of inpatient claims reported in the inpatient hospital and post-acute care service categories and outpatient hospital claims.

Exhibit 3.D also differentiates the top hospitals, skilled nursing facilities, and home health agencies billing inside versus outside the TIN. All facilities are identified based on the criteria applied to identify cost billed, ordered, or referred to by the attributed TIN or by another TIN. Complete specifications are included in the Detailed Methods document that's posted on the CMS Supplemental QRUR webpage.

Slide 50. Exhibit 4 summarizes the cost performance by service category of episodes of a given episode type attributed to your TIN for the entire episode and for the treatment and clinically associated service components of the episode. A separate version of Exhibit 4 is created for each individual episode type and subtype, similar to what we did with Exhibit 3.

Exhibit 4 presents average non-risk-adjusted cost because risk adjustment is done at the entire episode level. Service category costs are also provided at non-risk-adjusted cost for two reasons—TINs can identify what services contribute the most to their total average cost based on non-risk-adjusted cost and determine appropriate next steps.

And, like I said earlier, risk adjustment is done at the episode type level rather than at the level of service category or claim.

The service category definitions follow Medicare FFS payment schedules and can be identified by Medicare claims. The service category breakdowns match the major service categories that are reported in the 2015 Annual QRURs. Exhibit 4.A provides the service category breakdowns for the entire episode type. Exhibits 4.B and 4.C show the service category breakdowns for the treatment and clinically associated service components of the episode, respectively.

Slide 51 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 evaluation and management or E&M services. Let's focus on that row under the Outpatient E&M Service Procedures and Therapy section of the table. Here, you'll see that the average non-risk-adjusted cost for this example TIN was about $485. The national average for this service type was about $312. So the average cost in this example TIN was about 55 percent more than the national average cost.

If you move to the columns on the right, you will see that the average percent of episodes receiving – you'll see the percent of episodes receiving outpatient E&M services. The average for this example TIN was about 77 percent, while the national average was about 79 percent.

In the last two columns of this table, you'll see the average utilization for each service for episodes attributed to this example TIN as well as the national average. 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 the utilization by service category. This will hopefully allow you to identify drivers of high episode cost compared to the national average and determine next steps to reduce unnecessary high cost.

Now, on to slide 52. The drill down tables are created for each individual episode type and subtype. The information provided in the drill down tables supplement the episode-level statistics provided in Exhibits 1 through 4. They also provide information for each individual episode that was attributed to your TIN. This includes the episode

type name, the episode risk-adjusted and non-risk-adjusted cost, the beneficiary's risk score, the episode start date, and the physician and non-physician costs by service category. We hope that these tables increase the actionability of these reports by providing beneficiary-specific information and episode-specific information.

The three drill down tables for each episode type and subtype include the following type of information. Drill Down Table 1 provides episode-level information. Drill Down Table 2 provides -- gives the episode breakdown of physician costs billed by your TIN and by other TINs. Drill Down Table 3 includes the episode breakdowns for non-physician costs.

In the next three slides, starting on slide 53, I will walk through an example of Drill Down Table 1. Drill Down Table 1 provides basic episode, beneficiary, and attribution information for each episode attributed to your TIN. If you have more than one episode of a given type, you'll see multiple rows of data in this table. In your reports, you can use the beneficiary HIC, sex, 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 non-payment-standardized and non-risk-adjusted.

On slide 54, Drill Down Table 1, you'll see it shows additional information for each episode. It shows the lead eligible professional. It shows the E&M visits performed during the episode. And it shows the total Physician Fee Schedule cost billed during the episode. The number of E&M visits attributed includes all E&M visits performed during the episode, not just during the trigger event. Similarly, the physician costs reported here are actual Medicare Physician Fee Service payment amounts based on services used during the entire episode window. These sections are for informational purposes only since acute condition episodes are attributed based off of inpatient E&M visits during the trigger stay and procedural episodes are attributed based off of the billing physician, as discussed earlier in today's presentation.

On slide 55, you'll see that we also list the providers involved in treating the episode. This includes the count of E&M or EP treating the episode within and outside your TIN. And it also shows the earliest hospitals, skilled nursing facilities, and home health agencies involved in the episode.

Slide 56. Drill Down Table 2 provides detailed information on physician costs billed by your TIN and billed by other TINs for this specific episode type. By examining the physician cost breakdown, you may be able to gauge your involvement in the episode based on the cost billed by your TIN as opposed -- as compared to the cost billed by other TINs.

In addition, you can identify trends in service use among your attributed patients. The physician costs are based on costs billed on carrier claims during the entire episode window. As noted, all costs reported in the drill down tables are actual Medicare Physician Fee Schedule payment amounts, which are non-payment-standardized and non-risk-adjusted.

Slide 57 shows the service category breakdown provided for physician costs billed by your TIN during the episode. The same service category breakdown is provided for physician costs billed by other TINs during the episode.

On slide 58, you'll see that Drill Down Table 3, on the other hand, provides detailed information on non-physician costs for episodes of this type that were attributed to your TIN. This cost breakdown can be used to identify opportunities for improvement in care coordination and management.

For example, you'll see on slide 59 -- we see that you can identify the cost from skilled nursing facilities that are contributing to your total episode costs. As mentioned before, specifications on how each column is defined are included in the Detailed Methods document posted on the CMS Supplemental QRUR webpage.

Now that we have gone over the structure and data included in the 2015 Supplemental QRURs, we will discuss how you can access your reports next.

Accessing the Reports

Slide 61 all the way to 63 will provide the steps you need to take to gain access to the Supplemental QRURs. On slide 61, you'll see that 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 have the role of a security official or group representative. If you are a solo practitioner, your account would have the role of an individual practitioner or individual practitioner representative.

Instructions on how to obtain an account can be found in the link at the bottom of slide 61.

Next, on slide 62, you can follow the step-by-step instructions listed here to access your Supplemental QRUR Reports and your Supplemental QRUR Drill Down Tables.

Slide 63. If you use Internet Explorer as your web browser, please make sure that the CMS Enterprise portal, as listed on this slide, is added to your browser's trusted sites. This will ensure that you will not run into problems exporting your reports to Excel. Alternatively, you may use Chrome or Firefox as your browser to view and export your reports.

Slide 64. If you have any questions about the reports, please contact the Physician Value help desk. If you have questions about setting up your account, please contact the QualityNet help desk. The numbers for both help desks are listed on the slide here.

Giving Feedback

Jumping to slide 66, we wanted to emphasize that we, CMS, welcomes any feedback on the episodes, the report structure, and the 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 not to include any personally identifiable information. If there is a question about your TIN's report or a specific beneficiary's episode, a call can be set up to discuss your question over the phone.

Slide 67. For further information on the 2015 Supplemental QRURs, we encourage everyone to visit the CMS Supplemental QRUR and Episode Grouper website that is linked on slide 67. There are a number of supporting documents that will help address many of your questions and help you understand your reports. There is a document that provides detailed methodology. There's a document that provides tips for understanding and using the Supplemental QRURs. There's responses to frequently asked questions.

We also provide instructions on how to access the reports. We also provide a list of all the codes that are defining each episode, as well as the ICD-9 and ICD-10 crosswalk that

Rose had mentioned earlier. And we also provide a sample of the 2015 Supplemental QRURs.

Slide 68. Specifications of episode components—such as trigger event, treatment component, clinically associated components—are included in Sections 2, 5, and 6 of the Detailed Methods document. We highly encourage you to look in that document for more information. 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 of your report.

Now, this concludes our presentation. But I will turn it over to our moderator.

Question-and-Answer Session

Aryeh Langer: Thank you very much, Rachel.

Our subject matter experts will now take your questions. But before we begin, I would like to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many of your questions as possible, we ask that you limit your question to just one.

If you would like to ask a followup question or have more than one question, you may press star one to get back into the queue, and we will address additional questions as time permits. I'd also like to ask the folks on the phone who will be answering the questions to please introduce themselves when they answer a question.

All right, Holley. We are ready to take our first question, please.

Operator: To ask a question, press star followed by the number one on your touch-tone 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. Our first question comes from the line of Deborah Masters.

Deborah Masters: Yes. Good afternoon. We have a question after reviewing our QRUR in regard to a specific provider and would like to request an informal review. And I can see the process for actually requesting on the Enterprise portal but wondered if you could also give us some additional detail as to what you would expect in the content.

Kimberly Spalding Bush: Hi. This is Kim Spalding Bush, the director of the Division of Value-Based Payment. And this call is actually specific to the Supplemental QRUR reports.

Deborah Masters: Yes.

Kimberly Spalding Bush: So, these are just the episode-based payment measures that we send out to complement the information that you did find in your Annual QRUR Report. So, there is no one here to address that informal review on the QRURs.

But, I would just suggest that you can go look at the website and, certainly, let us know what you see in your report that you think is incorrect, or if you do have a specific provider, if you could let us know which drill down table you're seeing that in, that type of thing. Just any kind of detail, and the team will take a look at that through the QRUR informal review process.

But, just for everyone else on the call—and I'm glad that this question came through early—I just want to make the distinction that they are two separate reports. We think that's something – you're probably not the only person who would benefit from that clarification. I meant that these Supplemental QRUR Reports are actually not used for calculating the value modifier payment adjustments but, rather, they are provided for informational purposes.

Deborah Masters: Okay. But, they're very – it's wonderful detail to aid in the understanding of the actual value-based modifier. Thank you very much. I'll do that.

Kimberly Spalding Bush: Sure. Thank you.

Operator: Our next question will come from the line of Dale Schumacher.

Dale Schumacher: Hi. This is a very good presentation. Dale Schumacher, Crozer-Keystone Health System. Maryland hospitals are paid differently than the other hospitals in the other 49 states. Are these reports available for physicians in Maryland?

Rachel Liu: This is Rachel Liu from Acumen. Thank you for your question. They are available for Maryland hospitals.

Dale Schumacher: So that the hospitals payments have been appropriately adjusted?

Rachel Liu: So, your physician -- if there is a physician within your TIN that had episodes in this time period of 2015, you'll receive a report.

Dale Schumacher: Okay. Very good. Thank you.

Operator: Our next question comes from the line of Rumi Manandhar.

Rumi Manandhar: Hello. This is Rumi from Optim Oncology. I know this call is for Supplemental QRUR, but I have a quick question about a QRUR Report. It said primary care services, and we only have oncologists and urologists who are specialty physicians. And what does primary care mean for specialist providers?

Kimberly Spalding Bush: Thanks. We don't have the people to answer that question. And I also want to save the time on this call to address anything pertaining to Supplemental QRURs. But if you take a look at slide 64, you'll see a phone number for the Physician Value help desk. And you can call them with questions about the report.

Rumi Manandhar: Okay. Thank you.

Operator: And our next question comes from the line of Maureen Gritz.

Maureen Gritz: Hi. This is Maureen Gritz from UPMC. Can you go into a little bit more detail about the clinically associated costs and what they mean and how we're supposed to use that information?

Dr. Rose Do: Hello. This is Rose Do from Acumen. Yes, I'll be happy to talk about that a bit. So, the clinically associated costs are -- were looked through by clinicians. And so we

kind of discussed -- the episode construction—that included triggering an episode and then anything else that seemed related to that episode—was looked at through clinicians' vetting. So those are -- also, the specifications can be found on that type of information. But, that's kind of in a nutshell of what the clinically associated costs are. So, if you had any care that was related to, let's say, aortic aneurysm procedure, those were reviewed by clinicians and deemed to be clinically associated.

Maureen Gritz: But are those costs that were incurred the days that your TIN was not providing care?

Dr. Rose Do: So, that can be -- that is part of the episode window. Yes. So, there are costs that are given to the attributed provider, and that will be TIN-specific. And then there are costs that might be incurred throughout that window that we may find from other providers as well.

Maureen Gritz: Okay. Thank you.

Operator: Your next question will come from the line of Jason Shropshire.

Jason Shropshire: Hi. I have a question. So, all this drill downs and episode exhibits you were talking about, are those available today or are they going to be available in a week?

Rachel Liu: Thank you for your question. This is Rachel from Acumen. So the reports should have been released already. So your physician group should have been notified already, and all the drill down information and the exhibits should be available to you on your account.

Jason Shropshire: Okay. Because I'm currently in the system right now. And when I select 2015, all it's saying is, none available for this year. Is something wrong with the website?

Rachel Liu: That I'm not too sure about. But I would -- the best contact probably would be to call the Physician Value help desk that's on slide 64. You can just give them a call. They should be ready to take your call as soon as possible.

Jason Shropshire: Okay. One quick question. On slide 53, I noticed the example doesn't have the beneficiary ID number listed. Does that mean -- where in these drill downs are we able to find an episode that does list the Medicare beneficiary ID so we can translate that to our internal MRN number?

Rachel Liu: Yes. That's a great question. So in your tables, you'll see the information. For this example that we shared in 53 -- on slide 53, we just blanked it out since we didn't want to even have a chance of providing an example beneficiary ID.

Jason Shropshire: Great. Thank you.

Rachel Liu: No problem.

Operator: And your next question will come from the line of Jordan Rainford.

Jordan Rainford: Hi. This is Jordan Rainford from Northside Hospital in Atlanta. My question is, are Part B drugs included in the cost measure?

Rachel Liu: Hi. This is Rachel from Acumen. Thank you for your question. Part B drugs are included.

Jordan Rainford: Okay. Thank you.

Rachel Liu: Part D, on the other hand, is not included.

Jordan Rainford: Right.

Rachel Liu: So in these episode costs, everything from Medicare Part A and Medicare Part B is included.

Jordan Rainford: Okay. Thank you.

Operator: Your next question will come from the line of Chris Ferraro.

Chris Ferraro: Hi. This is Chris Ferraro from Coastal Medical in Providence, Rhode Island. I have two questions. My first question is, for primary care groups that do not employ

hospitalists, how do we go about and review this information with regards to the acute condition episodes if all TINs billing at least 30 percent of inpatient E&M services during that visit triggered the event? And then my second would be is -- if you could further define or talk to on Exhibit 3.D what "not in your TIN" means.

Rachel Liu: Hi. This is Rachel from Acumen. Thank you for your questions. So, your Supplemental QRURs will only show episodes are attributed to your group. So, there are cases maybe that the primary care physicians within your group will have at least 30 percent of the inpatient E&Ms within the acute condition episodes.

But it sounds like that may be rare for your group. But the episodes that you do see in your reports will be ones that were attributed to you according to the attribution rules for acute condition episodes and procedural episodes. Regarding your second question about Exhibit 3.D, "not within your TIN" is defined as ones that are not billed, ordered, or referred to you by your TIN.

Christopher Ferraro: Thank you.

Rachel Liu: For more information also about how it's defined, definitely we encourage you to look at the Detailed Methods document. The appendix provides more detailed explanation of how each of these are defined.

Operator: And your next question will come from the line of Sandy Pogones.

Sandy Pogones: Hi. This is Sandy Pogones from the American Academy of Family Physicians. I'd like to verify, are these episode groups that you're looking at in this Supplemental QRUR the same episodes that are going to be used under MACRA in the cost category? And, if so, will any further episode groups be developed that will apply to chronic conditions providers that don't necessarily see patients in the hospital?

Dr. Rose Do: Hi. This is Rose Do from Acumen. Thank you for that question. I just wanted to see if there were any CMS representatives with MACRA that were on this call that might want to say anything. Otherwise, I can.

Ted Long: Rose, thank you for asking. This is Ted Long, and this -- we -- for in the development of the-- in the Division of Quality Measurement is working toward

developing some of the new measures that you're referring to. I think I would answer that in two parts. The first is that the episodes that are using -- that are going to be used to constitute the 2017 measurement period in 2019 performance or payment period for MACRA—there's 10 episodes that were selected.

And if you refer to the final rule—and I apologize, but it would be probably -- I can give you the pages if you want to take a look at this. It is a long rule. But, it's page 608 and 609. They actually have a list of these 10 episodes along with whether they were listed in the 2014 SQRUR Reports.

In terms of the future works that would be in reference to developing new measures that would be applicable, there's going to be a posting coming out next month where we are going to go into more detail about that process and what you can sort of expect moving forward and, most importantly, how you can be involved in it.

So, please look forward to that. And I hope that answers your question.

Sandy Pogones: Yes. Thank you.

Operator: And our next question will come from the line of Toni Ambrosy.

Toni Ambrosy: Yes. This is Toni Ambrosy with Northeastern Nephrology. And my question is – I'm assuming because the post- and pre-triggering costs are E&M codes, that dialysis treatment would not be included in these costs?

Dr. Rose Do: This is Rose Do from Acumen. I just want to make sure I understand the question, that you wanted to see for nephrologists in particular whether dialysis costs would be included?

Toni Ambrosy: Yes.

Dr. Rose Do: So -- and when -- I think when you're asking the question of whether they're going to be -- prior to the trigger event. Was that in particular?

Toni Ambrosy: Right.

Dr. Rose Do: Okay.

Toni Ambrosy: Yes.

Dr. Rose Do: So, not likely. It's going to mostly include the services that are kind of like pre-op type of workup that we may have. So, we have some episodes that are, you know, surgical procedures. So they may have, you know, lab tests or anything preceding that.

Toni Ambrosy: Okay. All right. Can you clarify the attribution methodology for these episodes of how a TIN is attributed the costs?

Dr. Rose Do: Yes. This is Rose Do from Acumen. I also just -- if my team members want to add anything to what I might be missing. But, for the acute condition episodes, we ended up looking at the TIN that billed the highest percentage within that stay.

And so, they were identified as the most likely to be the main providers for that acute condition. And, then, for procedural episodes, it was essentially the provider that billed for doing the procedure itself on the trigger claim. Does that answer the question?

Toni Ambrosy: Okay. Great. It is. Because in some -- you know, in some other areas of this, it's -- the attribution is based on if the patient saw a primary care or not visit during the year and if not, you know, then it's attributed down. So, I just wanted to confirm, you know, how these are attributed for these episodes of care.

Dr. Rose Do: Okay. Yes. Thank you for your question.

Toni Ambrosy: Okay. Thank you. Thank you.

Devin Drewry: Hi. This is Devin Drewry from Acumen. And I just wanted to jump in and clarify. So, for the -- first off, the attribution for these episodes, as you noted, is separate from the attribution rules used in the annual QRURs. So for acute condition episodes, it's -- we can attribute these to multiple TINs.

So any TIN that billed at least 30 percent of the IP E&M visits during the trigger event open the episode. And, so, you can either refer to slide 19 of the presentation or refer

to the Frequently Asked Questions or Detailed -- excuse me -- Detailed Methods documents online for that.

Operator: And, again, to ask a question, press star one on your telephone keypad. To withdraw a question or if your question has been answered, you may remove yourself from the queue by pressing the pound key.

And our next question comes from the line of Laura Lindberg.

Laura Lindberg: Hello. This is Laura Lindberg with Infinity HealthCare. In looking at the Supplemental Table Number 7, we have 35 eligible professionals in that specialty and 20 of them did not meet the criteria to avoid the payment adjustment.

And I'm trying to decipher the report because it doesn't seem to matter whether they met the criteria or not. When I look over at the performance rate, they all say that they performed at 100 percent. And I'm trying to figure out what the difference is, why some -- if they all performed at 100 percent, why some of them did avoid the penalty and others didn't.

Kimberly Spalding Bush: Hi. This is Kim Spalding Bush. The question you're asking is actually about your Annual QRUR Report, not the Supplemental QRUR that we're speaking to today.

Laura Lindberg: Oh, okay.

Kimberly Spalding Bush: So, I would -- if you have a question about the Annual QRUR Report, that you call the PV help desk that is on slide 64. And if you think that there's a mistake, you have until November 30th to file your informal review request. So, I would give a call to the help desk. If they're able to satisfactorily resolve your question for you, that may be all that you need to do.

But if you didn't get your answer very quickly or you don't want to wait too long, I'd -- if it is for my group, I might go ahead and file that informal review request while the window's open, you know, rather than wait in case you think that there is an error. And then they can take a look at it through that process.

Laura Lindberg: All right. Thank you very much.

Kimberly Spalding Bush: Sure.

Operator: And our next question will come from the line of Juliet Kubal.

Juliet Kubal: Hi. I was just curious. What part of the QRUR will be best used for implementing change on cost in the ambulatory setting, and if you have any suggestions on how to analyze that?

Rachel Liu: Thank you for your question. This is Rachel from Acumen. We would probably recommend that you look at your Drill Down Tables 2 and 3. And that provides cost breakdown to that level of detail. So we would encourage you to look at where those costs are driving, maybe what type of episodes have higher cost in that service category.

You can also look at Exhibit 4 to identify kind of a comparison of all the episodes that are attributed to your TIN compared to the national average. Exhibit 4 also provides the average utilization at your TIN level and at your national level.

Juliet Kubal: Okay. Thank you.

Operator: Our next question comes from the line of Cindy Walsh.

Cindy Walsh: Yes. This is Cindy at Saunders Medical in Wahoo, Nebraska. We have a question. We are a critical access hospital with two rural health clinics. Who are included in our peer group that we are measured with?

Rachel Liu: Hi. This is Rachel from Acumen. I think your peer group -- is that question related to the Annual QRURs?

Cindy Walsh: Yes.

Rachel Liu: Got it. So, just like Kim had mentioned earlier, the Annual QRURs is separate from the Supplemental QRURs. So for all questions related to the Annual QRURs, we

would recommend that you call the Physician Value help desk. And their number is listed on slide 64.

Cindy Walsh: Okay. Thank you.

Operator: And our next question comes from the line of Matthew Kline.

Matthew, your line is open.

That question has been withdrawn.

Your next question comes from the line of Loretto Gonzalez.

Loretto Gonzalez: Hi. Good morning. Good morning is in California. I don't know where you are. But my question is as follows. In our QRUR report, we don't have all of the exhibits. And I'm thinking it's because we didn't meet that data to have that exhibit. But I wanted to confirm.

Devin Drewry: Hi. This is Devin Drewry with Acumen. So, for the Supplemental QRURs, they were sent to all TINs that had at least one episode attributed to them. So, if your TIN did not have any episodes attributed, you will receive a one-page report essentially stating that you didn't have any episodes attributed to your TIN. So, that's – that's expected. And you can check to see if that's indeed what you got.

Loretto Gonzalez: Well, we do have -- it is not just a one-page. We do have some exhibits, but not all of the exhibits.

Kimberly Spalding Bush: Are you talking about your Annual QRUR Report or is that Supplemental QRUR Report?

Loretto Gonzalez: The one that was just published, the last one, the one that we're reviewing today.

Kimberly Spalding Bush: Okay. Devin, I don't -- was there anything else to add?

Devin Drewry: Yes. I think that it may be helpful to check with the PV help desk, the number listed on slide 64, if you have questions or think that there's certain data that's not showing up so they can look into your case specifically and follow up with you on that.

Loretto Gonzalez: Okay. Thank you.

Devin Drewry: Thank you.
Operator: Again, to ask a question, press star one on your telephone keypad. To withdraw a question or if your question has been answered, you may withdraw your question by pressing the pound key.

And our next question comes from the line of Marcelo Zottolo.

Marcelo Zottolo: Hi. Thank you. This is Marcelo Zottolo with Lee Health. I am looking at the Supplemental Report and I see that my report jumps from Exhibit 3.D to Exhibit 4.A, which is condition-specific. Am I supposed to have Exhibit 4? I know it was covered here on the slide -- the presentation. But, I wasn't able to find it.

Devin Drewry: Hi. This is Devin with Acumen. Yes. That is correct. So, we may not have made this as clear in this presentation. But Exhibit 4 is broken up into three exhibits, Exhibit 4.A, Exhibit 4.B, and Exhibit 4.C. So on the portal, you will not see a tab for just Exhibit 4. You will see three tabs for 4.A, 4.B, and 4.C. So, what you are seeing is indeed correct.

Marcelo Zottolo: Thank you.

Operator: And our next question comes from the line of Dawn Richetelli.

Dawn Richetelli: Hi. This is Dawn Richetelli from PACT. I'm just wondering if you guys have any recommendations of people who can help with the interpretation of these reports, both the annual and the supplemental.

Rachel Liu: Hi. This is Rachel from Acumen. So, I believe for both reports, and definitely for the Supplemental QRURs, we post a document that describes tips for understanding

and using the Supplemental QRURs. And that is going to be found on the CMS Supplemental QRUR webpage. The link to that website is on slide 67.

If you have additional questions about specific sections of the report that you don't think are answered in either the tips document or the FAQ or the Detailed Methods, definitely feel free to email your question or call the PV help desk.

Dawn Richetelli: Thank you.

Operator: Your next question will come from the line of Dana Booze.

Dana Booze: Hello. This is Dana Booze. And I am wanting to know more about -- when we submitted our PQRS data, it actually -- there was a software issue, and it falsely reported that we did not have any Medicare patients. So are filing an informal review. But I wanted to know, will we be receiving our full report and when?

Kimberly Spalding Bush: So, I'm sorry, but that question is outside the scope of this call. So, I think, you can call the PV help desk, that's on slide 64. But it sounds like you actually filed a PQRS informal review, and I don't have that help desk number with me since this call isn't focused on the Annual QRURs. But I think you can probably start with the PV help desk and they can route you to the right place if it's actually a PQRS data question.

Dana Booze: Okay. Thank you.

Kimberly Spalding Bush: Sure.

Operator: And our next question comes from the line of Juan Valle.

Aryeh Langer: Hello, Juan, your line is open.

Juan Valle: Hello is Juan Valle from Doctors Hospital at Renaissance. I just had a question on the Physician Vendor help desk. I know it's probably not associated with you guys. But I reached out to the vendor's help desk to try to interpret the reports that you guys referred the callers to. And I don't get much help through there. Are they getting like trained? Or are they highly trained or are they getting trained as they go? Because I

know this is a very new system. Can you speak to me about that? Because I have a hard time, like many callers, to interpret those reports.

Kimberly Spalding Bush: I'm sorry. We don't have anyone on this call today that can speak to a Vendor help desk.

Juan Valle: So, like if I had a -- like a concern like -- I reach out to them, they're like, I don't know if I should reveal those report, stuff like that. Then would I refer that question to them directly or…
Kimberly Spalding Bush: I'm sorry, but I don't understand the question. And I don't think that we have the right experts on the call today. You could try the PV help desk if you're having issues understanding the report. And they can route you. But I'm not familiar with that Vendor help desk.

Juan Valle: Okay. Thank you, ma'am.

Kimberly Spalding Bush: Sorry. Thanks.

Operator: And our next question comes from the line of Misty Chance.

Misty Chance: Hi. This is Misty Chance. I am with Evolution Consultants in Texas. My question has to do with overlapping episodes. So let's assume a high-risk patient is in the hospital inpatient setting being cared for, let's say, by a cardiologist. And for whatever reason, something happens and another specialist is brought in, let's say, an orthopedic surgeon.

So you've now got a very complicated episode of care -- how that is divvied out and per cost per specialist under the, I guess, same episode

Rose Do: Yes. This is Rose Do from Acumen. Thanks for the question. So, we -- essentially, I think it'll depend -- for the attribution, it will depend on the Method A or Method B instruction. I kind of have alluded to it, I think, in the earlier slides that there -- for Method A, it takes a look at the different interactions of the episodes that are currently open.

For your question, I believe, though, you're asking for the same episode if you have multiple providers that are working within that type of condition or that treatment. For an acute condition episode, it's still going to fall to the TIN that billed the 30 percent.

And then for the procedural, if it were a procedural type of episode, it's going to fall to the provider who performed the procedure at the trigger event. So, I think it's really a matter of the plurality of the claim when we're talking about attribution here.

Devin Drewry: Hi. This is Devin from Acumen.

Misty Chance: So, let's say, the patient...

Devin Drewry: No, go ahead. Go ahead.

Misty Chance: So, you all would be viewing, let's say, the patients in there for cardiac issues for whatever reason. And that would be more of the acute. And let's say they fall and roll out of their bed and now we've got an ortho fixing a hip. That's more the procedural? But there would be two costs -- two episode attributions based on the acute versus the procedural and then the cost would be split?

Devin Drewry: Hi. So, this is Devin. So I think in situations like that, it depends on which episode types or which method—Method A or Method B—creates the given episode types that you're referring to. So they handle the situation slightly differently. But, most likely what's going to happen is that you'll create one episode for the initial hospitalization.

And then, when we see a claim for the hip procedure billed, it'll create a second episode for that hip procedure. And then the two episodes will have claims grouped to them that are related to that episode. So, this may include costs like -- the IP stay could get grouped to both of those episodes, so the cost should be included in both. And then they would be attributed separately.

Misty Chance: Okay.

Devin Drewry: I think there's a little bit more information in Chapter 2, Section 2, of the Detailed Methods document about how the episodes are created and claims are

assigned that, I think, could be helpful to look at to sort of see how the situation would be handled.

Misty Chance: Awesome. Thank you.

Additional Information

Aryeh Langer: And thank you very much.

Unfortunately, that's all the time we have for questions today. If we did not get to your question, please refer to slide 64 of today's presentation for more information.
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 MLN Connects Provider eNews when these are available.

On slide 71 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 will take a few moments to evaluate your MLN Connects Call experience.

Again, my name is Aryeh Langer. I'd like to thank our presenters and also thank all of you for participating in today's MLN Connects Call. Have a great day, everyone.

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

-END-


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES


Medicare
Learning
Network
Official Information Health Care
Professionals Can Trust


MLN Connects