MLN Connects™

National Provider Call

Overview of the 2013 Quality and Resource Use Reports

October 2014

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Objectives of the Call

- Discuss the Interaction between the Value Modifier and the Quality and Resource Use Report (QRUR)
- Provide an Overview of the 2013 QRUR
- Discuss How to Access the 2013 QRUR
- Review the Methodologies and Data in the 2013 QRUR
- Suggest Ways to Use the Data in the 2013 QRUR
- Answer Questions about the 2013 QRURs

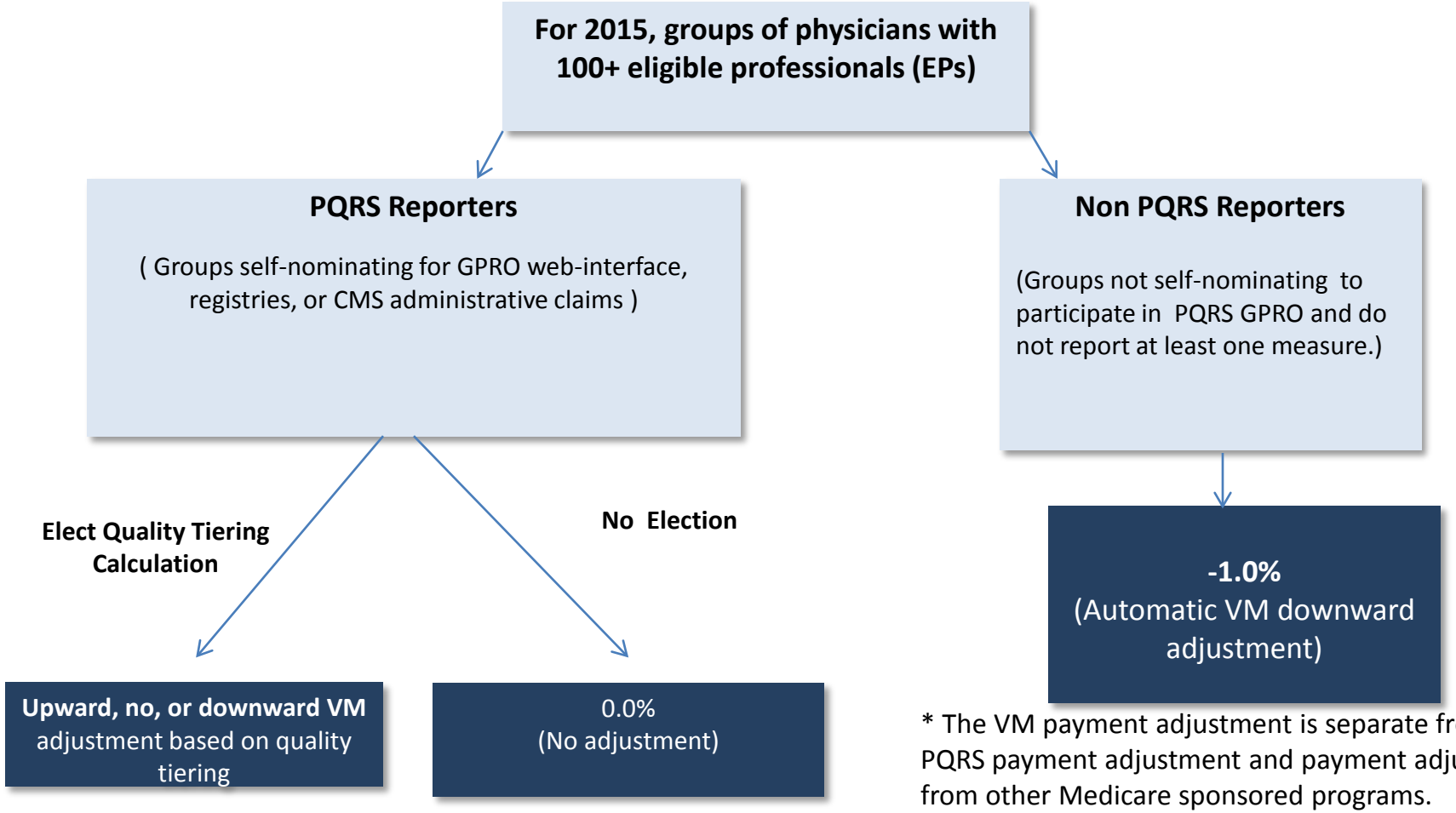
What is the Value-Based Payment Modifier?

- VM assesses both quality of care furnished and the cost of that care under the Medicare Physician Fee Schedule.
- The VM is a new per-claim adjustment under the Medicare Physician Fee Schedule that is applied at the group (Taxpayer Identification Number "TIN") level to physicians billing under the TIN.
- CY 2015 – CMS will apply the VM to groups of physicians with 100 or more eligible professionals (EPs) based on 2013 performance.
- CY 2016 - CMS will apply the VM to groups of physicians with 10 ore more EPs based on 2014 performance.
- CMS is required to apply the VM to all physicians and groups of physicians starting in 2017.
- 2015 and 2016 VM do not apply to groups that participate in the Shared Saving Program, the Pioneer ACO Model, or the CPC Initiative during the performance period.

What is an Eligible Professional

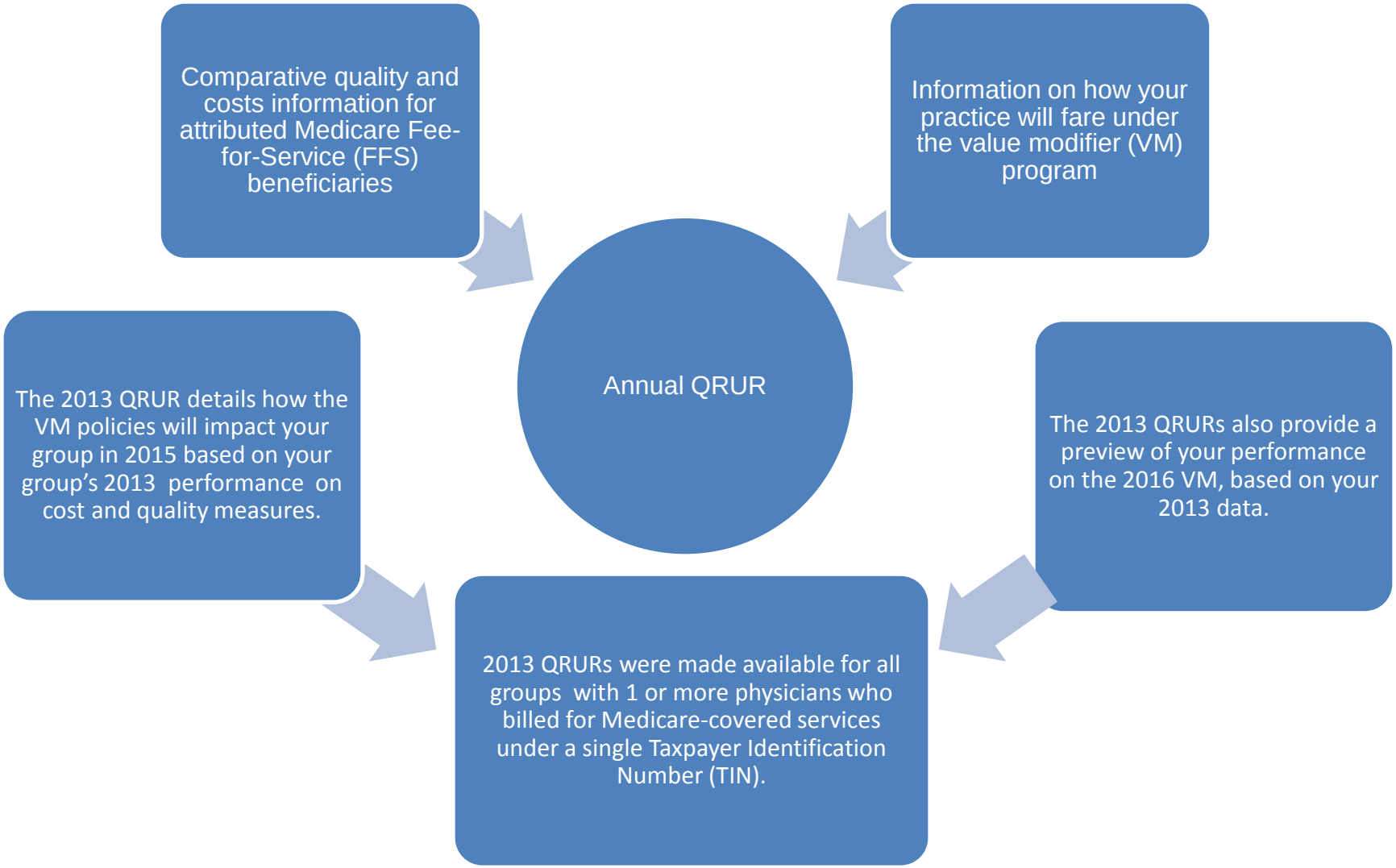
- Physician
  Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatric Medicine, Doctor of Optometry, Doctor of Oral Surgery, Doctor of Dental Medicine, and Doctor of Chiropractic
- Practitioner
  Physician Assistant, Nurse Practitioner, Clinical Nurse Specialist, Certified Registered Nurse Anesthetist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

Value Modifier and the Physician Quality Reporting System (PQRS)



* The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

What Are the Quality and Resource Use Reports?



Who Will Receive 2013 QRURs?

- All TINs (groups and solo practitioners) nationwide that meet the following two criteria will receive a 2013 QRUR:
  - At least one physician billed under the TIN in 2013, AND
  - The TIN had at least one eligible case for at least one of the quality or cost measures included in the QRUR.
- TINs with one or more physicians that participated in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care Initiative in 2013 will not receive a 2013 QRUR.

How to Access the 2013 QRUR

How Can You Access Your Report?

Authorized representatives of groups and solo practitioners can access the QRURs at https://portal.cms.gov using an Individuals Authorized Access to the CMS Computer Services (IACS) account with one of the following Physician Value (PV)-PQRS System roles:

- For groups with 2 or more EPs (TIN with 2+ NPIs):
  - PV-PQRS Group Security Official (primary or back-up)
  - PV-PQRS Group Representative
- For solo practitioners (TIN with 1 NPI):
  - PV-PQRS Individual (primary or back-up)
  - PV-PQRS Individual Representative

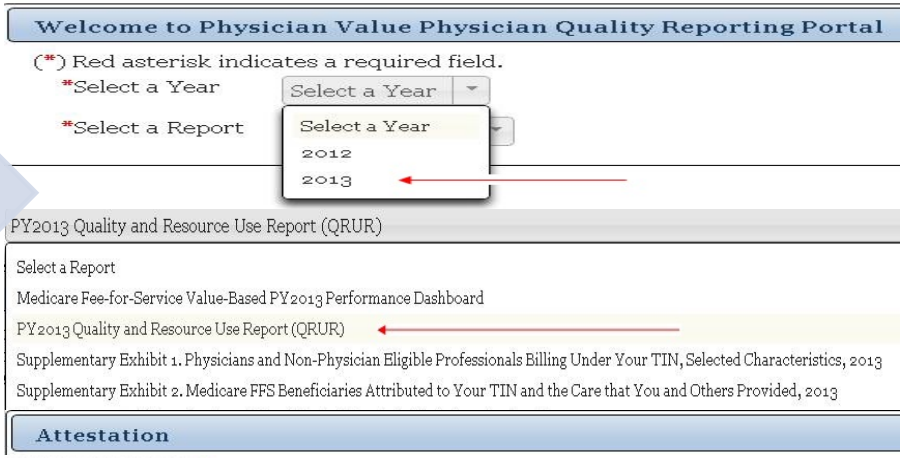
How Can You Access Your Reports? *(cont'd)*

1. Navigate to the Portal	• Go to https://portal.cms.gov.
2. Login to the Portal	• Select Login to CMS Secure Portal. • Accept the Terms and Conditions and enter your IACS User ID and Password to login.
3. Enter the Portal	• Click the PV-PQRS tab. • Select the QRUR-Reports option.

How Can You Access Your Reports? (*cont'd)*

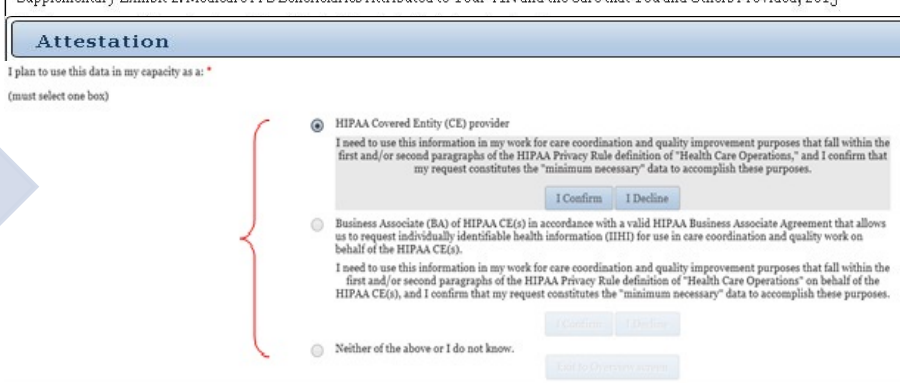
4. Select a Year and Report Type

- Select a year and desired report from the drop down.
- Reports can be exported to various file types.



5. Complete Role Attestation

- Choose the applicable option to complete your request access ("I plan to use this data in my capacity as a…")



6. Select Your Practice

- Select your practice name.

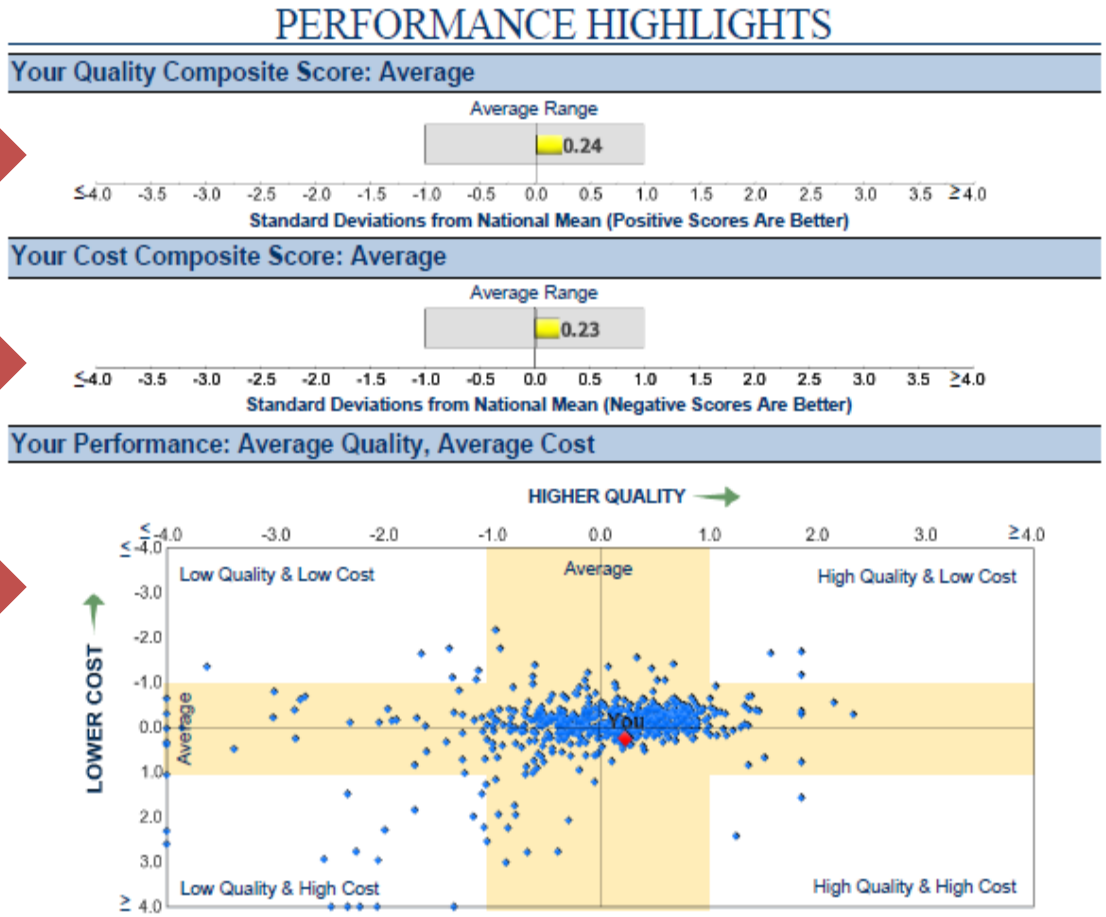
Helpful Hints to Assist in Accessing Your Report

- When setting up an IACS account, be sure you are not setting up an Enterprise Identity Management (EIDM) account instead.
- To reset your IACS account password, please access the IACS website at https://applications.cms.hhs.gov/.
- Authorized representatives must sign up for a new IACS account or modify an existing account at https://applications.cms.hhs.gov .
- Quick reference guides that provide step by step instructions for requesting each PV-PQRS System role for new or existing IACS account are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html
- A quick reference guide, which provides step by step instructions for accessing the 2013 QRUR, is available at : http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/Quick-Reference-Guide-for-Accessing-2013-QRURs.pdf

What Information Is Contained in the QRUR?

What Information Is Included on the Performance Highlights Page?

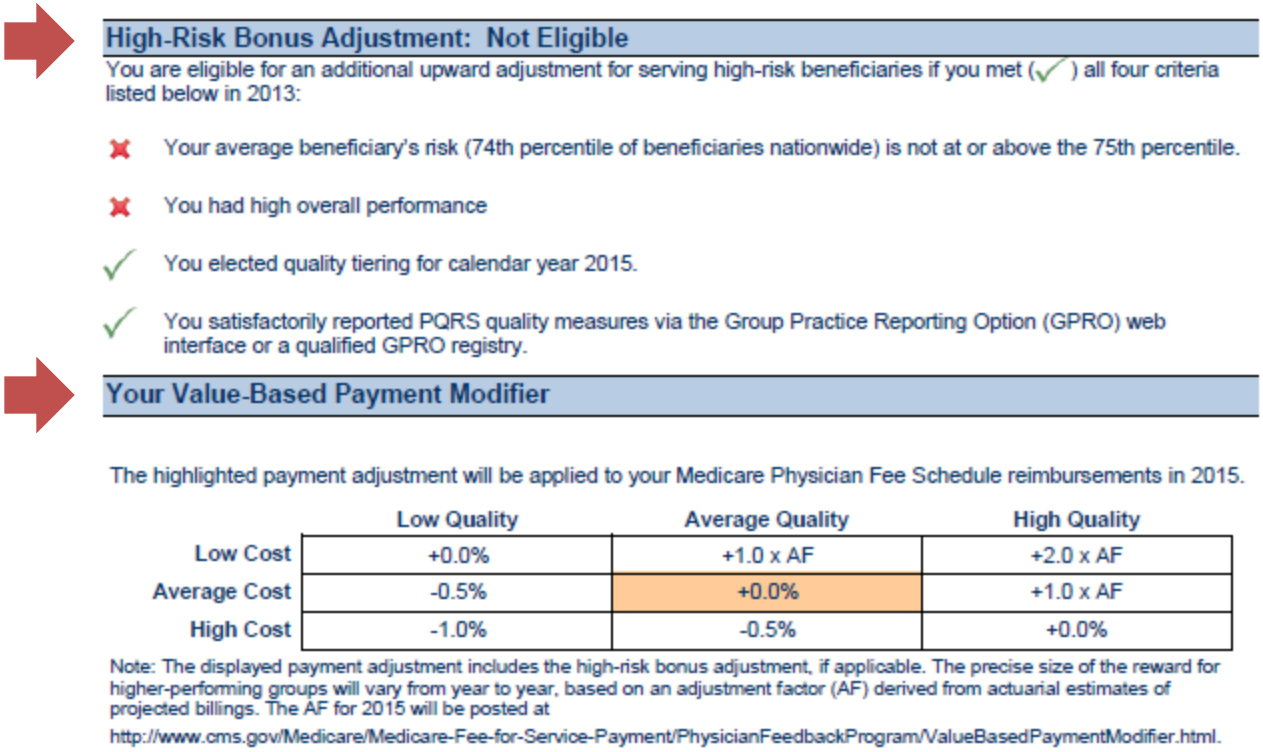
1. Your Quality Composite Score
2. Your Cost Composite Score
3. Your Quality Tiering Performance



What Information Is Included on the Performance Highlights Page? (*cont'd)*

4. Your Eligibility for a High-Risk Bonus Adjustment

5. Your Value-Based Payment Adjustment



High-Risk Bonus Adjustment: Not Eligible

You are eligible for an additional upward adjustment for serving high-risk beneficiaries if you met (✓) all four criteria listed below in 2013:

- ✗ Your average beneficiary's risk (74th percentile of beneficiaries nationwide) is not at or above the 75th percentile.
- ✗ You had high overall performance
- ✓ You elected quality tiering for calendar year 2015.
- ✓ You satisfactorily reported PQRS quality measures via the Group Practice Reporting Option (GPRO) web interface or a qualified GPRO registry.

Your Value-Based Payment Modifier

The highlighted payment adjustment will be applied to your Medicare Physician Fee Schedule reimbursements in 2015.

	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0 x AF	+2.0 x AF
Average Cost	-0.5%	+0.0%	+1.0 x AF
High Cost	-1.0%	-0.5%	+0.0%

Note: The displayed payment adjustment includes the high-risk bonus adjustment, if applicable. The precise size of the reward for higher-performing groups will vary from year to year, based on an adjustment factor (AF) derived from actuarial estimates of projected billings. The AF for 2015 will be posted at

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html.

What Information Is Contained in the 2013 QRUR?

Report Section	Use It To
Cover Page (About this Report from Medicare)	Understand why you received a QRUR in 2013
Performance Highlights Page	Identify how the performance data that your TIN generated in 2013 would inform your value-based payment modifier(VM) payment adjustment in 2015. For groups of 100 or more eligible professionals (EPs), this page includes any applicable VM payment adjustment that will be applied to the group's physician payments under the Medicare Physician Fee Schedule in 2015
Your Medicare Beneficiaries and the Eligible Professionals Treating Them (Exhibits 1, 2 and 3)	o Identify the count of physicians and non-physicians billing under your TIN (Exhibit 1) o Identify the number of Medicare beneficiaries attributed to you for the purposes of cost and quality measures (Exhibit 2) o Review the average number of eligible professionals who provided services to beneficiaries attributed to you and the average number of primary care services each attributed beneficiary received (Exhibit 3)
Quality Performance (Exhibits 4 and 5)	Review your performance on quality indicators across up to six equally weighted quality domains: o Clinical Process/Effectiveness, o Patient and Family Engagement, o Population/Public Health, o Patient Safety, o Care Coordination, and o Efficient Use of Healthcare Resources

What Information Is Contained in the 2013 QRUR? *(cont'd)*

Report Section	Use It To
Hospitals Admitting Your Attributed Beneficiaries (Exhibit 6)	Identify the hospitals that provided at least 5 percent of your attributed beneficiaries' inpatient stays in 2013
Cost Performance (Exhibits 7 and 8)	Review your performance on costs across two equally weighted cost domains: o Per Capita Costs for All Attributed Beneficiaries, and o Per Capita Costs for Beneficiaries with Specific Conditions (Diabetes, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, and Heart Failure)
Per Capita Costs for Specific Services (Exhibits 9 and 10)	o Understand the dollar difference between your attributed beneficiaries' payment-standardized, risk-adjusted per capita costs, by category, and the corresponding costs for your peer group (Exhibit 9) o Review your attributed beneficiaries' costs for Evaluation and Management (E&M) services and procedures for providers from your TIN, as well as providers outside of your TIN (Exhibit 10)
Performance on Risk Adjusted Measures (Exhibit 11 – Quality Outcome Measures, Exhibit 12 – Per Capita Costs)	o Understand how your claims-based quality outcome measures were affected by risk adjustment o Understand how your per capita cost measures were affected by risk adjustment

What Information Is Contained in the 2013 QRUR? *(cont'd)*

Report Section	Use It To
Performance on Cost Measures Included in the 2016 Value-Based Payment Modifier (Exhibit 13)	**FOR INFORMATIONAL PURPOSES ONLY** Review your 2013 performance on the cost measures to understand and improve your performance on the value-based payment modifier in 2016 (based on 2014 performance)
2013 Aggregate Group-Level Performance on PQRS Quality Measures for the 2016 Value-Based Payment Modifier, by Quality Domain and Measure (Exhibit 14)	**FOR INFORMATIONAL PURPOSES ONLY** Review your 2013 performance on the individual eligible professional PQRS quality measures to understand and improve your performance on the value-based payment modifier in 2016 (based on 2014 performance)

Additional Supporting Information Available in the Supplemental Exhibits

Report Section	Use It To
Supplementary Exhibit 1	Verify the eligible professionals billing under your TIN during 2013
Supplementary Exhibit 2	Understand which attributed beneficiaries are driving your cost measures and identify those beneficiaries who are in need of greater care coordination
Supplementary Exhibit 3	Understand which beneficiaries are driving your performance on the three hospital-related care coordination quality measures
Supplementary Exhibit 4	Understand which attributed beneficiaries were attributed to you for the Spending per Hospital Patient with Medicare (or Medicare Spending per Beneficiary measure)
Supplementary Exhibit 5	Review the eligible professionals who participated in PQRS in your TIN in 2013 and understand their performance on submitted PQRS measures
Supplementary Exhibit 6	Review any incentive you may have earned by participating in the GPRO in 2013

Quality Performance Section of the QRUR

Performance on Quality: Overview of Exhibit 4

- Exhibit 4 displays your overall quality composite score and performance by quality domain (see figure below):
  1. The quality domain scores are equally-weighted averages of quality measures that meet the minimum case threshold in the domain.
  2. The average domain score is an equally-weighted average of each non-missing quality domain score.
  3. The applicable quality composite score shows how much your average score differs from the national mean.

Exhibit 4. Your Performance in 2013, by Quality Domain

Quality Domain	Number of Quality Measures Included in Composite Score	Standardized Score
Standardized Quality Composite Score	**9**	**0.24* (Average)**
Average Quality Composite Score	9	0.33
Clinical Process/Effectiveness	4	0.22
Patient and Family Engagement	0	--
Population/Public Health	2	0.85
Patient Safety	0	--
Care Coordination	3	-0.08
Efficient Use of Health Care Resources	0	--

3
2
1

Note: The standardized quality composite score is a standardized average of equally-weighted domain scores indicating within how many standard deviations of the national mean a group practice's performance rate falls; positive scores reflect performance better than the mean, and negative scores reflect performance worse than the mean. Each domain-level performance score is an equally-weighted average of the standardized scores for all measures in the domain with at least 20 cases; the standardized score is the difference between the raw score and the peer group benchmark, divided by the peer group standard deviation. "Insufficient Data to Determine" for the standardized quality composite score indicates that, although the score was at least one standard deviation from the mean standardized quality composite score, it was not statistically significantly different from that mean at the 5 percent level. Domain scores are not computed for domains with no measure with at least 20 cases. See the glossary (Link to Glossary of Terms) for more detail on how this score is computed.

* Significantly different from the mean standardized quality composite score at the 5 percent level.

Performance on Quality: Overview of Exhibit 5-CC

Compare your performance to that of your peers

Exhibit 5-CC. Care Coordination Domain Quality Indicator Performance in 2013

PQRS Measure Number and Name	Your Performance		Peer Group Performance			Contribution to Your Domain Score	
				Average Range			
	Eligible Cases	Performance Rate	Benchmark Rate	Benchmark –1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included In Domain Score
Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions							
CMS-1** Acute Conditions Composite (links to data table)	2,082	14.12	8.38	1.99	14.77	-0.90	Yes
- PQI-11 Bacterial Pneumonia**	2,082	20.66	12.37	1.66	23.08	-	-
- PQI-12 Urinary Tract Infection**	2,082	19.41	8.11	0.00	16.76	-	-
- PQI-10 Dehydration**	2,082	3.41	4.61	0.00	9.61	-	-
CMS-2** Chronic Conditions Composite (links to data table)	1,123	52.53	54.02	26.82	81.22	0.05	Yes
- Diabetes (composite of 4 indicators)**	719	13.15	18.94	0.00	39.27	-	-
- PQI-5 Chronic Obstructive Pulmonary Disease (COPD) or Asthma**	529	68.82	78.06	28.12	127.99	-	-
- PQI-8 Heart Failure**	393	120.87	100.70	48.52	152.89	-	-
Hospital Readmissions							
CMS-3** All-Cause Hospital Readmissions (links to data table)	479	15.57%	16.43%	14.99%	17.86%	0.60	Yes
Additional Care Coordination Quality Indicators							

No data returned for this view. This might be because the applied filter excludes all data.

Identify those measures contributing to your domain score

Notes: CMS-1, CMS-2 and CMS-3 are calculated by CMS using administrative claims data.

Lower performance rates indicate better performance for these measures.

Cost Performance Section of the QRUR

Performance on Costs: Overview of Exhibit 7

- Note that:
  1. The cost domain scores are equally-weighted averages of cost measures that meet the minimum case threshold in the domain.
  2. The average domain score is an equally-weighted average of each applicable cost domain score, and each domain is weighted 50 percent.
  3. The standardized cost score shows how much your average score differs from the national mean (see figure below).

Exhibit 7. Your Performance in 2013, by Cost Domain

Cost Domain	Number of Cost Measures Included in Composite Score	Standardized Score
Standardized Cost Composite Score	5	0.23 (Average)
Average Cost Composite Score	5	0.53
Per Capita Costs for *All* Attributed Beneficiaries	1	0.66
Per Capita Costs for Beneficiaries *with Specific Conditions*	4	0.40

3
2
1

Note: The standardized cost composite score is a standardized average of equally-weighted domain scores indicating within how many standard deviations of the national mean a group practice's performance rate falls; positive scores reflect costs higher than the mean, and negative scores reflect costs lower than the mean. Each domain-level performance score is an equally-weighted average of the standardized scores for all measures in the domain with at least 20 cases; the standardized score is the difference between the raw score and the peer group benchmark, divided by the peer group standard deviation. "Insufficient Data to Determine" for the standardized cost composite score indicates that, although the score was at least one standard deviation from the mean standardized cost composite score, it was not statistically significantly different from that mean. Domain scores are not computed for domains with no measure with at least 20 cases. See the glossary(Link to Glossary of Terms) for more detail on how this score is computed.

* Significantly different from the mean standardized cost composite score at the 5 percent level.

Performance on Costs: Overview of Exhibit 8

- Exhibit 8 displays the per capita costs for beneficiaries attributed to you.

Exhibit 8. Per Capita Costs for Your Attributed Medicare Beneficiaries in 2013

Cost Categories	Your Performance		Peer Group Performance			Contribution to Your Domain Score	
				Average Range			
	Eligible Cases	Per Capita Costs	Benchmark Per Capita Costs	Benchmark –1 Standard Deviation	Benchmark +1 Standard Deviation	Standardized Score	Included in Domain Score
Per Capita Costs for All Attributed Beneficiaries							
All Beneficiaries	1,882	$11,118	$10,086	$8,525	$11,647	0.66	Yes
Per Capita Costs for Beneficiaries with Specific Conditions							
Diabetes	644	$16,118	$14,441	$11,944	$16,938	0.67	Yes
Chronic Obstructive Pulmonary Disease (COPD)	420	$23,735	$23,717	$19,242	$28,191	0.00	Yes
Coronary Artery Disease	727	$18,922	$17,183	$14,193	$20,173	0.58	Yes
Heart Failure	332	$27,666	$25,993	$20,943	$31,043	0.33	Yes

Note: Per capita costs are based on payments for Medicare Parts A and B claims submitted by all providers (including medical professionals, hospitals, and post-acute care facilities) for Medicare beneficiaries attributed to a physician group. Outpatient prescription drug costs are not included.

Details Total Per Capita Costs

Details Condition-Specific Per Capita Costs

Note that risk adjusted, payment standardized costs are compared

Identify those measures contributing to your domain score

Information on Hospitals Admitting Your Beneficiaries

Hospitals Admitting Your Beneficiaries: Overview of QRUR Exhibit 6

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

Exhibit 6. Hospitals Admitting Your Attributed Medicare Beneficiaries in 2013

Hospital			Medicare Beneficiaries Attributed to Your TIN	
Name	CMS Certification Number	Location	Number of Inpatient Stays (links to data table)	Percentage of All Inpatient Stays
Total			1,060	100.00%
QNPJQNQQJ RJQNHFQ HJSYJW	614488	QNPJQNQQJ, PD	853	80.47%

Note: CMS uses the Provider of Services file (http://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/NonIdentifiableDataFiles/ProviderofServicesFile.html) to identify the full name and location of the hospitals using the provider number contained on a given Medicare claim. For information on why the names of the hospitals displayed might be unexpected, review the Performance Year 2013 Frequently Asked Questions (FAQs) available here (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2013-QRUR.html).

Understand which hospitals most frequently admitted your attributed beneficiaries

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

Hospitals Admitting Your Beneficiaries: Overview of QRUR Exhibit 6 *(cont'd)*

- The total number of inpatient stays can be verified by reviewing Supplementary Exhibit 3 (Attributed Beneficiaries' Hospital Admissions for Any Cause), which includes a list of all beneficiary hospitalizations.
- Note that admissions for alcohol and substance abuse are excluded from Supplementary Exhibit 3 but included in QRUR Exhibit 6.

Medicare Beneficiaries Attributed to Your TIN	
Number of Inpatient Stays (links to data table)	**Percentage of All Inpatient Stays**

Click to link to Supplementary Exhibit 3

Supplementary Exhibit 3. Attributed Beneficiaries' Hospital Admissions for Any Cause, 2013

Attributed Medicare FFS Beneficiaries Admitted to the Hospital				Characteristics of Hospital Admission									Discharge Disposition	
HIC	Gender	DOB	Index †	Date of Admission	Admitting Hospital				Principal Diagnosis †	Admission Via the ED	ACSC Admission †	Followed by Unplanned All-Cause Readmission within 30 Days of Discharge †	Date of Discharge	Discharge Status †
00000000000	F	01/01/1900	0	01/01/1990	BFWR XQWNSLX WJMFGNQNYFYNTS MTXQNYFQ TK FQQJS	999999	ALLEN	TX	V5789 Rehabilitation proc NEC	-		-	01/01/1900	02 Txfr to STCH
00000000000	F	01/01/1900	0	01/01/1990	GFDQTW FQQ XFNSYX RJQNHFQ HJSYJW FY KB	999999	FORT WORTH	TX	1965 Secondary malig neo bone	-		-	01/01/1900	02 Txfr to STCH
00000000000	F	01/01/1900	0	01/01/1990	GFDQTW MJFWY FSQ QFXHZQFW MTXQNYFQ	999999	DALLAS	TX	99673 Comp-ren dialys dev/grft	-		-	01/01/1900	01 Disch Home

Additional Information Contained in the QRUR

Overview of QRUR Exhibit 13 [Informational Only]

- Exhibit 13 reviews your 2013 performance on specialty adjusted cost measures to understand and improve your performance on the value-based payment modifier in 2016 (based on 2014 performance).
- This exhibit is provided for informational purposes only and it will not affect your 2015 Medicare Physician Fee Schedule payments.

Note that both cases and hospital episodes are attributed to you

Understand your performance on the Spending per Hospital Patient with Medicare (or Medicare Spending per Beneficiary) measure

Exhibit 13. 2013 Performance on Cost Measures for the 2016 Value-Based Payment Modifier
FOR INFORMATIONAL PURPOSES ONLY

Cost Categories	Your Performance		Peer Group Performance		
				Average Range	
	Eligible Cases or Episodes	Cost	Benchmark for Cost	Benchmark -1 Standard Deviation	Benchmark +1 Standard Deviation
Per Capita Costs or per Episode Costs, as Appropriate					
All Beneficiaries	1,882	$11,676	$10,917	$8,131	$13,702
Spending per Hospital Patient with Medicare (links to data table)	2,069	$19,103	$20,101	$18,514	$21,688
Per Capita Costs for Beneficiaries with Specific Conditions					
Diabetes	644	$17,014	$15,863	$11,587	$20,139
Chronic Obstructive Pulmonary Disease (COPD)	420	$24,081	$24,882	$17,792	$31,971
Coronary Artery Disease	727	$19,669	$18,036	$13,123	$22,948
Heart Failure	332	$28,620	$27,393	$19,300	$35,487

Overview of QRUR Exhibits 14 [Informational Only]

- Exhibit 14 reviews your 2013 performance on the PQRS quality measures applicable to individual eligible professional. This information helps you understand your performance and how to improve it during 2014 for purposes of the value-based payment modifier in 2016.
- This exhibit is provided for informational purposes only and it will not affect your 2015 Medicare Physician Fee Schedule payments.

See how you might fare in 2016 (based on 2013 data) if you elected this option

Exhibit 14-CPE. Clinical Process/Effectiveness Domain PQRS Quality Indicator Performance in 2013

PQRS Measure Number and Name		Your Performance			Peer Group Performance
		Eligible Cases	Number of Eligible Professionals Reporting	Performance Rate*	Benchmark Rate
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	30	1	100.00%	97.07%
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	8	1	100.00%	97.55%
117	Diabetes Mellitus (DM): Dilated Eye Exam	27	1	100.00%	89.35%

*Only the individual eligible professional data submitted through the reporting mechanism with the highest performance are incorporated into the group performance reported here.

**Indicates an inverse measure, for which lower performance rates indicate better performance.

How Can You Use Supplementary Exhibit 1?

Supplementary Exhibit 1. Physicians and Non-Physician Eligible Professionals Billing Under Your TIN, Selected Characteristics, 2013

NPI	Name	Physician †	Non-Physician Eligible Professional †	Specialty Designation †	Date of Last Claim Billed Under TIN
1111111111	BFQQT GWFHD	X	-	Gastroenterology	12/27/2013
1111111111	BNQQNFR JQQD	-	X	Certified Registered Nurse Anesthesiologist	11/26/2013
1111111111	BNQQNFR MTQLJX	X	-	Gastroenterology	12/31/2013

Verify the EPs billing under your TIN

Verify your EPs' specialty designations

Confirm the date of the last claim billed by a given EP

How Can You Use Supplementary Exhibit 2? (Medicare FFS Beneficiaries Attributed to Your TIN)

Use the "Index" column in lieu of beneficiary identifying information when manipulating data in Excel

Supplementary Exhibit 2. Medicare FFS Beneficiaries Attributed to Your TIN and the Care that You and Others Provided, 2013

Medicare FFS Beneficiaries Attributed to the Group's Taxpayer Identification Number (TIN)							Medicare FFS Claims Filed by TIN		
HIC	Gender	DOB	Index †	HCC Percentile Ranking †	Died in 2013	Basis for Attribution †	Date of Last Claim Filed by TIN	Number of Primary Care Services † Provided by TIN	Percent of Primary Care Services † Billed by TIN
00000000000	F	01/01/1900	0		-	Step 2	01/24/2013	1	100.00%
00000000000	F	01/01/1900	0	1	-	Step 2	10/10/2013	1	100.00%
00000000000	F	01/01/1900	0	4	-	Step 2	11/08/2013	2	100.00%

Verify the beneficiaries attributed to you

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

How Can You Use Supplementary Exhibit 2? *(cont'd)* (Medicare FFS Beneficiaries Attributed to Your TIN)

EP in TIN Billing Most Primary Care Professional Services †				EP in TIN Billing Most Non-Primary Care Professional Services †			
NPI	Name	Specialty	Date of Last Claim Filed by NPI	NPI	Name	Specialty	Date of Last Claim Filed by NPI
1111111111	QFRJX BJGJW	Gastroenterology	01/24/2013	1111111111	QFRJX BJGJW	Gastroenterology	01/24/2013
1111111111	XYJQMJS QFHJD	Gastroenterology	10/10/2013	1111111111	XYJQMJS QFHJD	Gastroenterology	10/10/2013
1111111111	WFQJXM QZYHMF	Internal Medicine	11/08/2013	1111111111	WFQJXM QZYHMF	Gastroenterology	10/28/2013

Identify the EPs in your practice who billed the most primary care and non-primary care services for a given beneficiary

How Can You Use Supplementary Exhibit 2? *(cont'd)* (Medicare FFS Beneficiaries Attributed to Your TIN)

EP Outside of TIN Billing Most Primary Care Professional Services †				EP Outside of TIN Billing Most Non-Primary Care Professional Services †			
NPI	Name	Specialty	Date of Last Claim Filed by NPI	NPI	Name	Specialty	Date of Last Claim Filed by NPI
1111111111	STSJ			1111111111	YMFQNF KTWYJ	Diagnostic Radiology	02/25/2013
1111111111	STSJ			1111111111	QJFSNJHJ RZPMJWQJJ	Obstetrics/Gynecology	10/10/2013
1111111111	STSJ	Nurse Practitioner	10/21/2013	1111111111	XMNWQJD BNQQNFRX	Orthopedic Surgery	11/08/2013

Identify those providers outside of your practice who provided services to your attributed beneficiaries

Identifying information is provided to support care coordination

How Can You Use Supplementary Exhibit 2? *(cont'd)* (Medicare FFS Beneficiaries Attributed to Your TIN)

Identify your cost drivers

Hospital Admission	Chronic Condition Subgroup †					Percent of Total Costs, by Category of Services Furnished by All Providers									
Date of Last Hospital Admission	Diabetes	Coronary Artery Disease	Chronic Obstructive Pulmonary Disease	Heart Failure	Total Payment-Standardized † Medicare FFS Costs	Evaluation & Management* Services Provided by Your TIN	Evaluation & Management* Services Provided by Other TINs	Procedures* Provided by Your TIN	Procedures* Provided by Other TINs	Inpatient Hospital	Outpatient Hospital*	Emergency Services	Ancillary Services*	Hospice	All Other Post-Acute Services	All Other Services
	-	-	-	-	$2,004	3.72%	26.18%	13.12%	15.50%	0.00%	26.79%	0.00%	7.57%	0.00%	0.00%	7.11%
	-	-	-	-	$3,022	12.68%	9.00%	14.48%	1.94%	0.00%	39.48%	0.00%	16.35%	0.00%	0.00%	6.08%
01/21/2013	-	-	-	-	$10,407	7.51%	8.35%	7.00%	0.00%	35.36%	24.72%	2.46%	10.56%	0.00%	0.00%	4.05%

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

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

How Can You Use Supplementary Exhibit 3? (Attributed Beneficiaries' Hospital Admissions for Any Cause)

Verify the data in QRUR Exhibit 6

Identify preventable hospital admissions

Understand where beneficiaries were discharged

Supplementary Exhibit 3. Attributed Beneficiaries' Hospital Admissions for Any Cause, 2013

Attributed Medicare FFS Beneficiaries Admitted to the Hospital				Characteristics of Hospital Admission									Discharge Disposition		
HIC	Gender	DOB	Index †	Date of Admission	Admitting Hospital				Principal Diagnosis †		Admission Via the ED	ACSC Admission †	Followed by Unplanned All-Cause Readmission within 30 Days of Discharge †	Date of Discharge	Discharge Status †	
00000000000	F	01/01/1900	0	01/01/1990	RJQNHFQ HJSYJW TK FWQNSLYTS	999999	ARLINGTON	TX	62130	Endometrial hyperpla NOS	-		-	01/01/1900	01	Disch Home
00000000000	F	01/01/1900	0	01/01/1990	YJCFX MJFQYM FWQNSLYTS RJRTWNFQ MTXQNYFQ	999999	ARLINGTON	TX	5609	Intestinal obstruct NOS	X		◆	01/01/1900	01	Disch Home
00000000000	F	01/01/1900	0	01/01/1990	YJCFX MJFQYM QWJXGDYJWNFS MTXQNYFQ QFQQFX	999999	DALLAS	TX	1976	Sec mal neo peritoneum	-		-	01/01/1900	20	Expired

Identify which diagnoses were the basis for hospitalization

Identify hospital readmissions

How Can You Use Supplementary Exhibit 4? [Informational Only]
(Beneficiaries Attributed for the Spending per Hospital Patient with Medicare Measure)

Use the "Index" column in lieu of beneficiary identifying information when manipulating data in Excel

Supplementary Exhibit 4. Medicare FFS Beneficiaries Attributed to the TIN for the Spending per Hospital Patient with Medicare Measure, Selected Characteristics, 2013

Medicare FFS Beneficiaries Attributed to TIN for Spending per Hospital Patient with Medicare Measure				Apparent Lead Eligible Professional			
HIC	Gender	DOB	Index †	NPI	Name	Specialty	Total Payment-Standardized Episode Cost †
00000000000	F	01/01/1900	0	1111111111	XZWFQ SFNP	Lfxywtjsyjwtqtld	$26,627
00000000000	F	01/01/1900	0	1111111111	XZWFQ SFNP	Lfxywtjsyjwtqtld	$9,182
00000000000	F	01/01/1900	0	1111111111	QFZQ BWNLMY	Lfxywtjsyjwtqtld	$25,755

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

Identify beneficiaries attributed to you for the Spending per Hospital Patient with Medicare measure

Identify the EP associated with the plurality of the episode's Part B costs

How Can You Use Supplementary Exhibit 4? (con't)

[Informational Only] (Beneficiaries Attributed for the Spending per Hospital Patient with Medicare Measure)

Understand where beneficiaries were discharged

Supplementary Exhibit 4. Medicare FFS Beneficiaries Attributed to the TIN for the Spending per Hospital Patient with Medicare Measure, Selected Characteristics, 2013

Characteristics of Hospital Admission							Discharge Disposition		
Date of Admission	Admitting Hospital				Principal Diagnosis †		Date of Discharge	Discharge Status †	
01/01/1990	YJCFX MJFQYM FWQNSLYTS RJRTWNFQ MTXQNYFQ	999999	ARLINGTON	TX	56212	Dvrtclo colon w hmrhg	01/01/1900	03	Disch to Medicare SNF
01/01/1990	YJCFX MJFQYM FWQNSLYTS RJRTWNFQ MTXQNYFQ	999999	ARLINGTON	TX	4560	Esophag varices w bleed	01/01/1900	01	Disch Home
01/01/1990	YJCFX MJFQYM QWJXGDYJWNFS MTXQNYFQ WTHPBFQQ	999999	ROCKWALL	TX	0030	Salmonella enteritis	01/01/1900	01	Disch Home

Understand where beneficiaries were hospitalized

Identify which diagnoses were the basis for hospitalization

How Can You Use Supplementary Exhibit 5? (Individual Performance on 2013 PQRS Measures)

Identify the 2013 PQRS measure information and VM domain classifications for measures reported by a given EP

Identify EPs who were incentive-eligible in 2013, as you plan for the 2016 VM

Supplementary Exhibit 5. Individual Eligible Professional Performance on the 2013 PQRS Measures:QNJRSLTH QFSL(1111111111), Not Incentive-Eligible

PQRS Performance Measure		Domain	Eligible Professional Performance			Peer Group Performance
			Reporting Mechanism †	Number of Eligible Cases †	Performance Rate	Benchmark Rate
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	Clinical Process/Effectiveness	Claims	30	100.00%	97.07%
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Clinical Process/Effectiveness	Claims	8	100.00%	97.55%
117	Diabetes Mellitus (DM): Dilated Eye Exam	Clinical Process/Effectiveness	Claims	27	100.00%	89.35%

**Indicates an inverse measure, for which lower performance rates indicate better performance.
† Crosses indicate terms to be defined through the hover-over function.

Identify the mechanisms through which PQRS measures were reportedin by individual EPs

Identify the number of eligible cases in the performance denominator, by reporting mechanism

Compare your performance to that of your peers

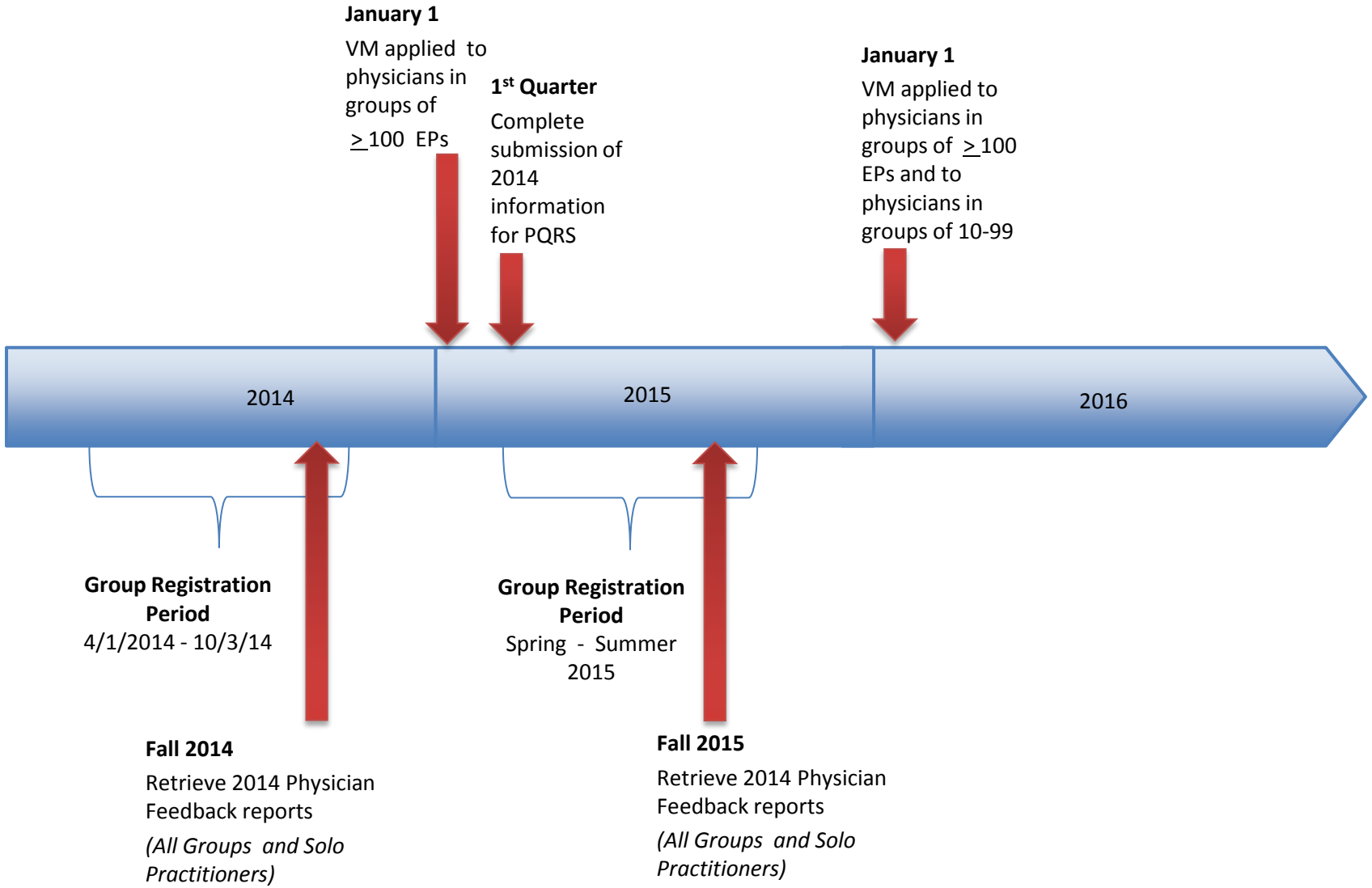
How Can You Use Supplementary Exhibit 6? (Summary of 2013 GPRO Earned Incentive)

Summarizes your 2013 GPRO earned incentive, if you are eligible to receive one

Supplementary Exhibit 6. Summary of 2013 GPRO Earned Incentive

Total Earned Incentive Amount	Total Estimated Allowed Medicare Part B Physician Fee Schedule Charges	Incentive as a Percentage of Total Part B Physician Fee Schedule Charges
$35,550	$7,255,021	0.49%

Important Dates to Remember



Next Steps: What You Can Do

- Download your 2013 QRUR at: https://portal.cms.gov
- Review the detailed methodology, tips sheet, FAQs and other QRUR supporting materials for the 2013 QRUR made available on the New* 2013 QRUR and the New* How to Obtain the 2013 QRUR web pages of the *Physician Feedback Program* website: http:/www.cms.gov/physicianfeedbackprogram.
- For questions about information contained in your QRUR, or to provide feedback to CMS, please contact the Physician Value Help Desk
  - Monday thru Friday
  - 8:00 AM – 8:00 PM EST
  - 1-888-734-6433 (Select option 3)

Help Us Improve the QRURs

- Please send your ideas for additional data elements and information to be included in upcoming reports to the Physician Value Help Desk:
  - Monday thru Friday
  - 8:00 AM – 8:00 PM EST
  - 1-888-734-6433 (Select option 3)
- We also welcome ideas on how to better display information in the reports.

Technical Assistance Information

- For assistance with the IACS sign-up process or with registering in the PV-PQRS Registration System, please contact the QualityNet Help Desk:
    - Monday – Friday: 8:00 am – 8:00 pm EST
    - Phone: (866) 288-8912 (TTY 1-877-715-6222)
    - Email: qnetsupport@sdps.org
- PQRS Program: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html
- Group Practice Reporting Options: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html
- Value-Based Payment Modifier and Quality Tiering: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html

Acronyms in this Presentation

- ACO: Accountable Care Organization
- E&M: Evaluation and Management
- EIDM: Enterprise Identity Management
- FAQ: Frequently Asked Questions
- FFS: Fee-for-Service
- GPRO: Group Practice Reporting Option
- IACS: Individuals Authorized Access to the CMS Computer Services
- MLN: Medicare Learning Network
- PQRS: Physician Quality Reporting System
- PV-PQRS: Physician Value-Physician Quality Reporting System
- QRUR: Quality and Resource Use Report
- TIN: Taxpayer Identification Number
- VM: Value Modifier

Question & Answer Session

Evaluate Your Experience

- Please help us continue to improve the MLN Connects National Provider Call Program by providing your feedback about today's call.

- To complete the evaluation, visit http://npc.blhtech.com/ and select the title for today's call.

CME and CEU

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

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Overview-of-the-2013-QRUR-CEINFO-INX-TC-L10232014.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.