HOW TO UNDERSTAND YOUR QUALITY AND RESOURCE USE REPORT (QRUR)

Kaitlin Nolte
Kansas Foundation for Medical Care, Inc.
QI Project Manager
Kaitlin.nolte@area-A.hcqis.org | greatplainsqin.org
785-273-2552 ext. 379

Holly Arends
South Dakota Foundation for Medical Care, Inc.
Holly.arends@area-A.hcqis.org | greatplainsqin.org
605-660-5436
About This Report From Medicare

- **Quality and Resource Use Reports (QRURs)** provide comparative information so physicians can view the clinical care their patients receive in relation to the average care and costs of other physician’s Medicare patients.

- *The information contained in the reports are believed to be accurate at the time of production. The information may be subject to change at CMS’ discretion, including, but not limited to, circumstances in which an error is discovered.*
How to Access your QRUR

- [https://portal.cms.gov](https://portal.cms.gov)
- IACS → EIDM credentials
- Once you have an EIDM account with the correct role, follow the step-by-step instructions provided in the [reference guide](https://guide.cms.gov).

Guide for Obtaining a New EIDM Account with a ‘Physician Quality and Value Programs’ Role

*Important Note*: Beginning on July 13, 2015, an IACS account can no longer be used to access Quality and Resource Use Reports (QRURs); instead, an EIDM account will be required to access QRURs at [https://portal.cms.gov](https://portal.cms.gov).
How to Access your QRUR...Important Links:

- **Analysis and Payment**
- Instructions provided [here](#) to sign up for an EIDM account
- Instructions provided [here](#) to sign up for the correct role in EIDM
- **Managing your EIDM account**

For questions about setting up an EIDM account, please contact the QualityNet Help Desk:

- Monday – Friday: 8:00 am – 8:00 pm EST
- Phone: 1 (866) 288-8912 (TTY 1-877-715-6222)
- Fax: (888) 329-7377
- Email: qnetsupport@hcqis.org
The Importance of your QRUR

- Shows you where you align with quality and cost performance, among your peers.

- Measures are:
  - Risk adjusted
  - Geographically standardized
  - By specialty
## 3 different QRUR reports

<table>
<thead>
<tr>
<th>Reports</th>
<th>Delivered</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mid-Year QRUR</td>
<td>April</td>
<td>July 1 – June 30 Cost and Administrative Claims Performance No affect on Payments</td>
</tr>
<tr>
<td>Annual QRUR</td>
<td>September</td>
<td>Last Calendar Year Cost and Quality Performance Affect On Payments</td>
</tr>
<tr>
<td>Supplemental QRUR</td>
<td>September</td>
<td>Cost by Episode Grouper No affect on Payments</td>
</tr>
</tbody>
</table>
Physician Compare is a CMS website for publicly reporting physician performances required by the Affordable Care Act (ACA) of 2010 and currently reports:

- That a physician has satisfactorily reported quality measures through PQRS
- That a physician received a bonus for electronic prescribing
Information Available on Physician Compare

- Addresses where the professional sees patients (always confirm the address when you make an appointment; some professionals work at more than one location)
- Primary and secondary specialties
- Medicare assignment status
- American Board of Medical Specialties (ABMS) board certification
- Whether the individual or group participates in select Centers for Medicare and Medicaid Services (CMS) quality programs
- Gender
- Medical school education and residency information
- Groups that individuals work with (individual profile) or individuals who work with the group (group profile)
- Hospital affiliation

The information on Physician Compare comes primarily from the Provider, Enrollment, Chain, and Ownership System (PECOS). PECOS data is checked against Medicare claims data.
The Physician Compare database is available for download [here](#).

If you have any questions about the downloadable database, contact the Physician Compare support team at [PhysicianCompare@Westat.com](mailto:PhysicianCompare@Westat.com).
Why PQRS is Important

We have moved from **bonuses** for participation to **penalties** for non-participation!

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1.5%</td>
<td>1.5%</td>
<td>2%</td>
<td>2%</td>
<td>1%</td>
<td>0.5%</td>
<td>0.5%</td>
<td>0.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penalty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2015 penalty: 0.5%
2016 penalty: 0.5%
2017 penalty: 0.5%
2018 penalty: 0.5%
2019 penalty: 0.5%
2020 penalty: 0.5%

-1.5% -2% -2% -2% -2% -2%
2016 (2018) is the Final Year in their current form:
- Physician Quality Reporting System (PQRS)
- Value Based Modifier (VBM)
- Quality Tiering
- Meaningful Use

**Merit-Based Incentive Payment System (MIPS)**
- \((\text{Quality Tiering} + \text{PQRS} + \text{VBM} + \text{EHR}) + a - b) \times N\)
  - Competition on a 100 point scale
    - 30 quality points
    - 30 resource use points
    - 25 meaningful use points
    - 15 practice improvement points
  - Increasing Adjustments
    - ±4% 2017 (2019)
    - ±9% 2020 (2022)
Meaningful Use

Payment adjustments for Meaningful Use have moved from **bonuses** for participation to **penalties** for non-participation!

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Start 2011</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$18,000</td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$2,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start 2012</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$18,000</td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td>$2,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start 2013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$15,000</td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Start 2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$12,000</td>
<td>$8,000</td>
<td>$4,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Projected Penalty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**2015 penalty**: 
-1%  
**2016 penalty**: 
-2%  
**2017 penalty**: 
-3%  
**2018 penalty**: 
-4%  
**2019 penalty**: 
-5%  
**2020 penalty**: 
-5%
Key Points

- It is important to understand how the VBM is calculated
  - Quality and cost data will populate the VBM
- It is important to participate in PQRS
  - There is a payment and performance ranking implications for non-participation
Physician Feedback Program

Quality and Resource Use Reports (QRURs)
- compare the quality and cost of the care they provide to their Medicare patients with that of other physicians
- end goal of achieving practice improvement and bonus payments

Development and implementation of the Value-Based Payment Modifier (Value Modifier)
- adjustment made on a per claim basis to Medicare payments for items and services under the Medicare PFS
Here’s what you can expect to find in your practice’s QRUR:

- performance highlights,
- benchmarking and risk adjustment that compare a practice's quality and cost measures to peer practices,
- a quality composite score,
- a cost composite score, and
- the application of the VBM
CMS judges quality and resource use performance in the following areas:

- effective clinical care,
- person- and caregiver-centered experience and outcomes,
- community/population health,
- patient safety,
- communication and care coordination, and
- efficiency and cost reduction
QRUR and Value Modifier

- Quality measures across six domains as reported via PQRS
  - Clinical Process/Effectiveness
  - Patient and Family Engagement
  - Population/Public Health
  - Patient Safety
  - Coordination
  - Efficient Use of Healthcare Resources
QRUR and Value Modifier (continued)

- QRUR shows VM score and how it was calculated based on:
  - Cost measures across two domains pulled from Medicare claims data
  - Per Capita Costs for All Attributed Beneficiaries
  - Per Capita Costs for Beneficiaries with Specific Conditions (diabetes, CAD, COPD, heart failure)
3 Cost Adjustments in your QRUR

- 20 cases must be included in any cost or quality measure comparison

<table>
<thead>
<tr>
<th>Geographic</th>
<th>All Cost Measures adjusted to Geographic Allowable Cost differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td>All Cost Measures adjusted to Specialty Averages by Specialty Mix</td>
</tr>
<tr>
<td>Risk</td>
<td>70 High Risk Conditions by HCC methodology</td>
</tr>
</tbody>
</table>
Eligibility and Adjustment
Quality Composite and Cost Composite

**Quality Composite**

A. PQRS Measures by Domain
B. Non – PQRS Measures
   (Domain = Communication and Care Coordination)
   1. Preventing Acute Illness Admissions
      • Bacterial Pneumonia
      • Urinary Tract Infections
      • Dehydration
   2. Preventing Chronic Disease Admissions
      • Uncontrolled Diabetes
      • Short term diabetic complications
      • Long Term diabetic complications
      • Diabetic Lower Extremity Amputations
      • Acute COPD Exacerbations
      • Decompensated Heart Failure
   3. All Cause Readmission

**Cost Composite**

- Attributed Patients – “Plurality of Care”
- Global Annual Per Capita Cost of Care in 5 Strata
  - A. All Patients
  - B. COPD
  - C. Heart Failure
  - D. Coronary Artery Disease
  - E. Diabetes
- Modification requires careful selection of clinical partners and coordination of Care
2 Quality Tiering years remain...

- 4% to gain or lose/per year

<table>
<thead>
<tr>
<th>Program Year</th>
<th>Service Year</th>
<th>Reporting Due</th>
<th>Adjustment Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>2015</td>
<td>March 31, 2016</td>
<td>2017 Medicare Part B Payments</td>
</tr>
<tr>
<td><strong>2019</strong></td>
<td><strong>2017</strong></td>
<td><strong>→ MIPS is Here ←</strong></td>
<td></td>
</tr>
</tbody>
</table>
# Quality Tiering

80% of Participants receive no adjustment

<table>
<thead>
<tr>
<th></th>
<th>5%</th>
<th>90%</th>
<th>5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Quality</td>
<td>0</td>
<td>+2x%</td>
<td>+4x%</td>
</tr>
<tr>
<td>Avg Quality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Quality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Cost</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avg Cost</td>
<td></td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>High Cost</td>
<td></td>
<td>5%</td>
<td></td>
</tr>
</tbody>
</table>

10% of Participants Incentive Range

High and Low Defined as 1 Standard Deviation above or below the mean
## Quality Tiering (cont.)

<table>
<thead>
<tr>
<th>VBM Program Year</th>
<th>Service Provided</th>
<th>Notes</th>
<th>Applies to</th>
<th>Reporting Complete</th>
<th>Adjustment Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>2013</td>
<td>First Year – QT Elective</td>
<td>Physicians in Groups of 100 or More</td>
<td>2014</td>
<td>2015</td>
</tr>
<tr>
<td>2017</td>
<td>2015</td>
<td>QT Expands</td>
<td>All Physicians</td>
<td>2016</td>
<td>2017</td>
</tr>
<tr>
<td>2018</td>
<td>2016</td>
<td>QT Expands</td>
<td>All Physicians, PA, NP, CRNA, APN..</td>
<td>2017</td>
<td>2018</td>
</tr>
</tbody>
</table>
Measure Information

- Per Capita Costs for Beneficiaries with Specific Conditions measures:
  - Coronary Artery Disease (CAD)
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Diabetes
  - Heart Failure

The Per Capita Costs for Beneficiaries with Specific Conditions measures are payment-standardized, risk-adjusted, and specialty-adjusted measures that evaluate the efficiency of care provided to beneficiaries with CAD, COPD, diabetes, and heart failure who are attributed to solo practitioners and groups of practitioners, as identified by their Taxpayer Identification Number (TIN)
Exclusions

- Beneficiaries are excluded from the population measured if they meet any of the following conditions:
  - were enrolled in Medicare Part A only or Medicare Part B only for any month during the performance period
  - were not enrolled in both Medicare Part A and Part B for every month during the performance period
  - were enrolled in Medicare managed care (for example, a Medicare Advantage plan) for any month during the performance period
  - resided outside the United States, its territories, and its possessions for any month during the performance period
Measure Information

- Quality outcome measures:
  - 30-day risk-standardized mortality measures
    - Acute Myocardial Infarction
    - Heart Failure
    - Pneumonia
  - 30-day risk-standardized readmission measures
    - Acute Myocardial Infarction
    - Heart Failure
    - Pneumonia
    - Hip/Knee
  - AHRQ Patient Safety Indicators (PSIs)
    - PSI 04 - Death among surgical inpatients with serious treatable complications
    - PSI 90 Composite - Complication/patient safety for selected indicators
Payment Adjustment and Value Modifier

- Value-based modifier (VBM) = provide differential payments based on quality and cost of care
- The QRUR is a precursor to the VBM and currently includes cost of care measures for patients seen by the physician and quality information calculated using claims data and from PQRS.
Value Based Modifier

- Peer group and benchmarking are based on TINs nationwide with at least 20 cases in the measure.
- Cost domain uses parts A and B claims data (Part D is excluded).
- If you qualify for an upward adjustment, you are eligible for an additional +1.0x if you are in the top 25% nationwide.
How is the Value Modifier Calculated?

Through **Quality Tiering**!

- 2-9 EPs and solo practitioners: Upward or neutral VM adjustment (+0.0% to +2.0x of MPF)
- 10 + EPs: Upward, neutral or downward VM adjustment (up to -4.0% to or +4.0x of MPFS)
How is the Value Modifier Calculated? (cont.)

<table>
<thead>
<tr>
<th>Quality/Cost</th>
<th>High Cost</th>
<th>Average Cost</th>
<th>Low Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Quality</td>
<td>+0.0x%</td>
<td>+1.0x*</td>
<td>+2.0x*</td>
</tr>
<tr>
<td>Medium Quality</td>
<td>-1.00%</td>
<td>0.00%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>Low Quality</td>
<td>-2.00%</td>
<td>-1.00%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

*= eligible for additional +1.0x if reporting clinical quality measures (cQMs) and average beneficiary risk score is in the top 25%

x= upward value modifier (VM) payment adjustment factor
The **bolded** payment adjustment will be applied to payments under the Medicare Physician Fee Schedule for physicians billing under in your TIN in 2016.

<table>
<thead>
<tr>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+0.0%</td>
<td>+ 1.0 x AF</td>
<td>+2.0 x AF</td>
</tr>
<tr>
<td>Average Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-1.0%</td>
<td>0.0%</td>
<td>+1.0 x AF</td>
</tr>
<tr>
<td>High Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-2.0%</td>
<td>-1.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

The precise size of the reward for higher performing TINs will vary from year to year, based on an adjustment factor (AF) derived from actuarial estimates of projected billings.
Q: How does one improve quality composite score?
A: Identify which measure(s) you can move that will improve the standardized score.

**Note:** High quality-low cost is the intended aim or goal.
How do I move the performance score(s) to the upper-right quadrant?

- Utilize the Great Plains Quality Innovation Network PQRS tool to focus efforts
- Identify the measure performance standardized score
- Apply theoretical improvement (25%, 30%, 70%, etc.)
- Select % that will improve standardized score
- Implement quality improvement project to improve scores
Helpful Hint: CMS uses the prior year’s benchmark and standard deviations in the Value Modifier calculation. Said benchmarks can be used to set practice goals and gauge the way one should be performing.
In this example, “X” refers to a payment adjustment factor that is yet to be determined due to budget neutral requirements.
Feedback Report

- PQRS Value Modifier Feedback reports - Quality of Care Domain*
- Higher is better
- Aim for % above the benchmark

<table>
<thead>
<tr>
<th>A1</th>
<th>Provider NPI Number</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Provider NPI Number</td>
<td>Provider Name</td>
<td>Incentive Eligible Indicator</td>
<td>PQRS Performance Measure</td>
<td>PQRS Performance Description</td>
<td>Domain</td>
<td>Reporting Mechanism</td>
<td>Number of Eligible Cases</td>
<td>Performance Rate</td>
<td>Benchmark Rate</td>
</tr>
<tr>
<td>1</td>
<td>6719175973</td>
<td>BNGCNFR QUIMXS7S</td>
<td>1</td>
<td>1*</td>
<td>Diabetes Mellitus (DM): Hemoglobin A1c Poor Control</td>
<td>Clinical</td>
<td>Claims</td>
<td>15</td>
<td>5.67%</td>
<td>71.39%</td>
</tr>
<tr>
<td>2</td>
<td>6719175973</td>
<td>BNGCNFR QUIMXS7S</td>
<td>1</td>
<td>2</td>
<td>Diabetes Mellitus (DM): Low Density Lipoprotein (LDL-C)</td>
<td>Clinical</td>
<td>Claims</td>
<td>16</td>
<td>37.50%</td>
<td>48.34%</td>
</tr>
<tr>
<td>3</td>
<td>6719175973</td>
<td>BNGCNFR QUIMXS7S</td>
<td>1</td>
<td>3</td>
<td>Diabetes Mellitus (DM): High Blood Pressure Control</td>
<td>Clinical</td>
<td>Claims</td>
<td>13</td>
<td>94.44%</td>
<td>68.53%</td>
</tr>
</tbody>
</table>

*clinical measures
Q: Is there a way to prove that one provider is performing at a lower rate than another provider?
A: Measure performance based off feedback reports with standardized scores identified and then compared across practice.
Exhibit 1

This table shows how many EPs were in your tax ID number (TIN) during identified performance period. This data is exported via PECOS data and claims data for performance period.

<table>
<thead>
<tr>
<th>Eligible Professionals in Your TIN</th>
<th>Number Identified in PECOS</th>
<th>Percentage Identified in PECOS</th>
<th>Number Identified in Claims</th>
<th>Percentage Identified in Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>All eligible professionals</td>
<td>0</td>
<td>—</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Physicians</td>
<td>0</td>
<td>—</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Non-physicians</td>
<td>0</td>
<td>—</td>
<td>0</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

PECOS: Medicare Provider Enrollment, Chain, and Ownership System

Click here for PECOS Login screen
2-Step Attribution of Patients

| Step 1 | beneficiary is attributed to the TIN whose primary care physicians provided the plurality (highest number) of allowed Medicare charges |
| Step 2 | When there are no Primary Care Provider visits, beneficiary is attributed to the TIN whose non-primary care providers provided the plurality (highest number) of allowed Medicare charges. There must be at least one Primary Care coded visit by a physician in the TIN |
Exhibit 2: Medicare Beneficiaries Attributed to your TIN based on Primary Care Services Provided

Note: Because the beneficiaries attributed to your tax ID number (TIN) may receive different numbers of services, the average percentage of services will not = average number of services / average total number of services. Exhibits will be populated with dashes (--) if no beneficiaries are attributed to your TIN in Exhibit 2.

<table>
<thead>
<tr>
<th>Basis for Attribution</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>All attributed beneficiaries</td>
<td>0</td>
<td>100.00%</td>
</tr>
<tr>
<td>Beneficiaries attributed because your TIN's primary care physicians provided the most primary care services</td>
<td>0</td>
<td>--</td>
</tr>
<tr>
<td>Beneficiaries attributed because your TIN's specialist physicians or non-physician practitioners provided the most primary care services</td>
<td>0</td>
<td>--</td>
</tr>
</tbody>
</table>
Exhibit 2 and 3

The exhibits on this page (2 and 3) provide information on beneficiaries attributed to your tax ID number (TIN) based on primary care services provided.

Note: this attribution method is used for the Per Capita Costs for All Attributed Beneficiaries measure, the four Per Capita Costs for Beneficiaries with Specific Conditions measures, and the three quality outcome measures.
Exhibit 4: information about beneficiaries that attributed to your tax ID number (TIN) for the Medicare Spending per Beneficiary measure. Please locate your “About the Data in this Report” section of your QRUR to see what services were provided during episode of care.

<table>
<thead>
<tr>
<th>Hospital Episodes and Beneficiaries</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total episodes of hospital care attributed to your TIN</td>
<td>0</td>
</tr>
<tr>
<td>Unique Medicare beneficiaries associated with attributed episodes of care</td>
<td>0</td>
</tr>
</tbody>
</table>
Exhibit 5: Your TIN’s Performance in XXXX, by Quality Domain

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>Number of Quality Measures Included in Composite Score</th>
<th>Standardized Performance Score (Quality Tier Designation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Composite Score</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Effective Clinical Care</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Person and Caregiver-Centered Experience and Outcomes</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Community/Population Health</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Patient Safety</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Communication and Care Coordination</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Efficiency and Cost Reduction</td>
<td>0</td>
<td>—</td>
</tr>
</tbody>
</table>
Exhibit 6 display information on your TIN’s performance on quality measures that were reported for your TIN through a PQRS reporting mechanism, provided your TIN had at least one measure with at least one eligible case. Only those measures for which benchmarks are available and for which your TIN had 20 or more eligible cases are included in the domain scores and the Quality Composite Score. Additionally, Exhibit 6-CCC-B provides information on the three claims-based quality outcome measures calculated by CMS, if your TIN had at least one eligible case for at least one outcome measure.
Exhibit 6 Example:

No data will be displayed if your TIN did not have at least one eligible case for at least one measure in specified domain.

Exhibit 6-ECC is not displayed because your TIN did not have at least one eligible case for at least one measure in this domain.
\textbf{Exhibit 6: Effective Clinical Care Domain Quality Indicator Performance}

<table>
<thead>
<tr>
<th>Measure Reference</th>
<th>Measure Name</th>
<th>Your TIN’s Eligible Cases</th>
<th>Your TIN’s Performance Rate</th>
<th>Benchmark</th>
<th>Benchmark –1 Standard Deviation</th>
<th>Benchmark +1 Standard Deviation</th>
<th>Standardized Score</th>
<th>Included In Domain Score?</th>
</tr>
</thead>
<tbody>
<tr>
<td>111 (GPRO Prev-8, CMS127 v2)</td>
<td>Preventive Care and Screening: Pneumococcal Vaccination for Older Adults</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00</td>
<td>No</td>
</tr>
<tr>
<td>113 (GPRO Prev-6, CMS130 v2)</td>
<td>Preventive Care and Screening: Colorectal Cancer Screening</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00</td>
<td>No</td>
</tr>
<tr>
<td>197 (GPRO CAD-2)</td>
<td>Coronary Artery Disease (CAD): Lipid Control</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00</td>
<td>No</td>
</tr>
</tbody>
</table>

Note: * = indicates that the measure is an inverse measure; lower performance rate for this measure = better performance

This all encompasses the \textbf{domain score} (+) better performance (-) worse performance
Exhibit 6-PCE is not displayed because your TIN did not have at least one eligible case for at least one measure in this domain.

Some exhibits may not populate with graphics due to your TIN not having at least one eligible case for at least one measure in this specific domain.
Exhibit 6-CPH: Effective Clinical Care Domain Quality Indicator Performance

<table>
<thead>
<tr>
<th>Measure Reference</th>
<th>Measure Name</th>
<th>Your TIN's Eligible Cases</th>
<th>Your TIN’s Performance Rate</th>
<th>Benchmark -1 Standard Deviation</th>
<th>Benchmark +1 Standard Deviation</th>
<th>Standardized Score</th>
<th>Included In Domain Score?</th>
</tr>
</thead>
<tbody>
<tr>
<td>110 (GPRO Prev-7, CMS147v2)</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00</td>
<td>No</td>
</tr>
<tr>
<td>128 (GPRO Prev-9, CMS69v2)</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Exhibit 6-CCC-B: Communication and Care Coordination Domain Quality Indicator Performance

Based off CMS-Calculated Outcome Measures

<table>
<thead>
<tr>
<th>Performance Category</th>
<th>Measure Reference</th>
<th>Measure Name</th>
<th>Your TIN’s Eligible Cases</th>
<th>Your TIN’s Performance Rate</th>
<th>Benchmark</th>
<th>Benchmark -1 Standard Deviation</th>
<th>Benchmark +1 Standard Deviation</th>
<th>Standardized Score</th>
<th>Included In Domain Score?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CMS-1</td>
<td>Acute Conditions Composite</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>Bacterial Pneumonia</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>Urinary Tract Infection</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>No</td>
</tr>
<tr>
<td>Hospitalization Rate per 1,000 Beneficiaries for Ambulatory Care-Sensitive Conditions</td>
<td>-</td>
<td>Dehydration</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>CMS-2</td>
<td>Chronic Conditions Composite</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>Diabetes (composite of 4 indicators)</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>Chronic Obstructive Pulmonary Disease (COPD) or Asthma</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>Heart Failure</td>
<td>0</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>No</td>
</tr>
<tr>
<td>Hospital Readmissions</td>
<td>CMS-3</td>
<td>All-Cause Hospital Readmissions</td>
<td>0</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00</td>
<td>No</td>
</tr>
</tbody>
</table>

CMS-1, CMS-2, and CMS-3 are calculated by CMS using administrative claims data. Lower performance rates = better performance.
Performance on Cost: Cost Composite Structure

- Summarized at TIN level
  - Summarizes cost performance
- Calculates domain scores for which your TIN had at least 20 eligible cases for at least one cost measure.
- 2 Value Modifier Cost Domains, 6 Measures
  - Domain 1-Per Capita Costs for All Attributed Beneficiaries
    - Per Capita Costs for All Attributed Beneficiaries
    - Medicare Spending per Beneficiary
  - Domain 2-Per Capita Costs for Beneficiaries with Specified Conditions
    - Diabetes
    - COPD
    - CAD
    - Heart Failure
Cost Composite Structure

- Based on claims data
  - Part A & B, Part D not included
- Exhibits 9-11 on QRUR, Exhibits 5-10 on Supplementary
- Uses tiering to place the TIN in a Cost Tier Designation - Average, High, Low
## Claims Data

<table>
<thead>
<tr>
<th>Domain/Measure</th>
<th>Part A and B claims submitted by ALL providers for Medicare Beneficiaries Attributed to a TIN</th>
<th>Per episode costs based on Part A and B expenditures surrounding specified inpatient hospital stay (3 days prior through 30 days post discharge)</th>
<th>Supplementary Exhibit for full details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1/ Per Capita Costs for All Attributed Beneficiaries</td>
<td>X</td>
<td></td>
<td>Exhibit 5</td>
</tr>
<tr>
<td>Domain 1/ Medicare Spending per Beneficiary (MSPB)</td>
<td></td>
<td>X</td>
<td>Exhibit 6</td>
</tr>
<tr>
<td>Domain 2/ Diabetes</td>
<td>X</td>
<td></td>
<td>Exhibit 7</td>
</tr>
<tr>
<td>Domain 2/ COPD</td>
<td>X</td>
<td></td>
<td>Exhibit 8</td>
</tr>
<tr>
<td>Domain 2/ CAD</td>
<td>X</td>
<td></td>
<td>Exhibit 9</td>
</tr>
<tr>
<td>Domain 2/ Heart Failure</td>
<td>X</td>
<td></td>
<td>Exhibit 10</td>
</tr>
</tbody>
</table>
Services Included

- E&M Services billed by Eligible Professionals (EPs)
- Major Procedures billed by EPs
- Ambulatory/Minor Procedures billed by EPs
- Ancillary Services
- Hospital Inpatient Services
- Emergency Services not included in Hospital Admission
- Post-Acute Services
- Hospice
- All Other Services

*Sub Category – ‘Other Facility-Billed Expenses...’ are those that are billed at facility level versus EP, for example FQHC or RHC

*Review Supplementary Exhibit 5 for full details of applicable Cost Measures, excluding MSPB, which is found in Supplementary Exhibit 6
How Can Our Costs Be Accurately Compared With Other TINs?

- Each measure is:
  - Payment-standardized
  - Risk-adjusted
  - Specialty-adjusted
Payment Standardized

- Make comparisons of service use within or across geographic areas.
- Maintains differences in choice of care setting, types of providers, and multiple services within encounters
- Utilizes a conversion factor x payment modifiers to standardize
Risk Adjustment

- Account for differences in beneficiary level risk-factors
- More accurate comparison across settings with varying beneficiary case complexities
- Compares TIN actual costs to CMS determined beneficiary expected costs, uses CMS-HCC model
- Per Capita Cost Measures – All TIN Attributed beneficiaries Part A&B costs / # of TIN Attributed Beneficiaries
- Medicare Spending Per Beneficiary Measure – adjusted by beneficiary age and severity of illness (MS DRG)
Specialty Adjustment

- Different than risk adjustment
- Performed at the TIN level
- Compares TIN’s risk adjusted costs with TINs of the same specialty
Exhibit 9: Your TIN’s Performance in 2015, by Cost Domain

- Lower score indicates better performance
- Higher score indicates opportunity for improvement
  - See Exhibit 10 for specific measures
- Three columns in table
  - Cost Domain
  - Number of Cost Measures included in Composite Score
  - Standardized Performance Score (Cost Tier Designation)
- Domain Scores represent equally-weighted average, standardized scores in the domain
Measures, with 20 eligible cases, included

<table>
<thead>
<tr>
<th>Cost Domain</th>
<th>Number of Cost Measures Included in Composite Score</th>
<th>Standardized Performance Score (Cost Tier Designation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Composite Score</td>
<td>0</td>
<td>0.00 (Average)</td>
</tr>
<tr>
<td>Per Capita Costs for All Attributed Beneficiaries</td>
<td>0</td>
<td>—</td>
</tr>
<tr>
<td>Per Capita Costs for Beneficiaries with Specific Conditions</td>
<td>0</td>
<td>—</td>
</tr>
</tbody>
</table>

Your TINs Cost Tier Designation. ‘Average’ is shown if the TINs score falls within one Standard Deviation from the mean.
Exhibit 10 – Per Capita or Per Episode Costs For Your TIN’s Attributed Medicare Beneficiaries

- Summarized at TIN level
- Payment-Standardized, risk-adjusted, and specialty adjusted per capita or per episode costs for each measure
- Only measures with 20 or more eligible cases or episodes are included
- Use this exhibit and its supplementary exhibits to identify specific areas of opportunity
Exhibit 10 – Per Capita or Per Episode Costs For Your TIN’s Attributed Medicare Beneficiaries

- For per capita costs detail use Supplementary exhibits 2B and 5 to identify types of costs incurred for beneficiaries
- For MSPB costs detail use Supplementary exhibit 4 and 6 to identify to improve care
- Identifying patterns of use and costs are the main goal of this and the supplementary exhibits
### Exhibit 10

#### National Benchmark

<table>
<thead>
<tr>
<th>Cost Domain</th>
<th>Cost Measure</th>
<th>Your TIN's Per Capita or Per Episode Costs</th>
<th>Benchmark</th>
<th>Benchmark -1 Standard Deviation</th>
<th>Benchmark +1 Standard Deviation</th>
<th>Standardized Score</th>
<th>Included in Domain Score?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Capita Costs for All Attributed Beneficiaries</td>
<td>Per Capita Costs for All Attributed Beneficiaries</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Medicare Spending per Beneficiary</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Per Capita Costs for Beneficiaries with Specific Conditions</td>
<td>Diabetes</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Coronary Artery Disease (CAD)</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Heart Failure</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Exhibit 11: Differences between Your TIN Per Capita Costs and Mean Per Capita Costs

- Displays Amount By Which Your TIN’s Costs were higher or lower
  - All Attributed Beneficiaries
  - Beneficiaries with Diabetes
  - Beneficiaries with COPD
  - Beneficiaries with CAD
  - Beneficiaries with Heart Failure
Exhibit 12: Differences Between Your TIN’s Per Episode and Mean Per Episode Costs

- Displays the Amount by which your TIN’s Costs were Higher or Lower than the Benchmark
  - MSPB
How Can I Use the Cost Information?

- Develop Strategies
  - Identify complex patients
  - Develop condition specific practice standards
  - Identify opportunities to reduce costs
    - Procedures
    - Condition specific
    - Complex Chronic Care
    - Follow up Care
  - Identify Shared Savings/Shared Risk partners
  - Identify partners in care coordination
Quality Programs

- Physician Quality Reporting System
- PQRS Maintenance of Certification Program Incentive
- Consumer Assessment of Healthcare Providers & Systems (CAHPS) for PQRS
- Electronic Health Record (EHR) Incentive Program
- Million Hearts®

Participation in quality activities is *important* because it can improve care for people with Medicare. Health care professionals and group practices can participate in various quality activities, including the Centers for Medicare & Medicaid Services (CMS) Quality Programs.

These Programs are *voluntary* activities that indicate health care professionals and group practices have a commitment to quality care.
Sources

https://www.medicare.gov/physiciancompare/staticpages/aboutphysiciancompare/informationavailable.html

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html
## Great Plains QIN Contacts

<table>
<thead>
<tr>
<th>Kansas</th>
<th>Nebraska</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KAITLIN NOLTE, BA</strong></td>
<td><strong>TAMMY MCNEIL, RHIA, CPHIT, CPEHR</strong></td>
</tr>
<tr>
<td>Quality Improvement Project Manager</td>
<td>Quality Improvement Advisor</td>
</tr>
<tr>
<td><a href="mailto:Kaitlin.Nolte@area-a.hcqis.org">Kaitlin.Nolte@area-a.hcqis.org</a></td>
<td><a href="mailto:Tammy.McNeil@area-a.hcqis.org">Tammy.McNeil@area-a.hcqis.org</a></td>
</tr>
<tr>
<td>North Dakota</td>
<td>South Dakota</td>
</tr>
<tr>
<td><strong>TRACEY REGIMBAL, RHIT</strong></td>
<td><strong>HOLLY ARENDS</strong></td>
</tr>
<tr>
<td>Health Information Technology/Quality Improvement Specialist</td>
<td>Program Manager</td>
</tr>
<tr>
<td><a href="mailto:Tracey.Regimbal@area-a.hcqis.org">Tracey.Regimbal@area-a.hcqis.org</a></td>
<td><a href="mailto:Holly.Arends@area-a.hcqis.org">Holly.Arends@area-a.hcqis.org</a></td>
</tr>
</tbody>
</table>
Contact Us

Kaitlin Nolte, Project Manager
Kaitlin.nolte@area-A.hcqis.org
Kansas Foundation for Medical Care, Inc.
2947 SW Wanamaker Dr.  |  Topeka, KS 66614
785-271-4179  |  785-273-5130 (Fax)

Holly Arends, Program Manager
Holly.arends@area-A.hcqis.org
South Dakota Foundation for Medical Care
2600 West 49th Street, Suite 300  |  Sioux Falls, SD 57105
605-660-5436  |  605-373-0580 (Fax)

This material was prepared by the Great Plains Quality Innovation Network, the Medicare Quality Improvement Organization for Kansas, Nebraska, North Dakota and South Dakota, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-GPQIN-KS-D1-30/0516